HOUSE OF REPRESENTATIVES
FINAL BILL ANALYSIS

BILL #:	HB 5201	**FINAL HOUSE FLOOR ACTION:**	
SUBJECT/SHORT TITLE	Medicaid Services	109 **Y's**	3 **N's**
SPONSOR(S):	Health Care Appropriaitons Subcommittee; Brodeur	**GOVERNOR'S ACTION:**	Approved
COMPANION BILLS:	SB 2514		

SUMMARY ANALYSIS

HB 5201 passed the House on May 8, 2017, as SB 2514. The bill conforms statutes to the funding decisions related to Medicaid Services included in the General Appropriations Act (GAA) for Fiscal Year 2017-2018. The bill:

- Redirects cigarette tax revenues to National Cancer Institute research entities for pediatric cancer research and creates the Live Like Bella Initiative to award peer reviewed grants for pediatric cancer research.
- Amends definition of "rural hospital" to include any sole community hospital.
- Consolidates the Project AIDS Care waiver, Adult Cystic Fibrosis waiver, and Traumatic Brain Injury and Spinal Cord Injury waiver within the Medicaid Long Term Care waiver, effective January 1, 2018.
- Removes obsolete language for ambulatory surgical centers and Hospital Outpatient reimbursements due to implementation of a prospective payment system.
- Requires local governments to submit Intergovernmental Transfers to the Agency for Health Care Administration (AHCA) no later than October 31 unless an alternative plan is specifically approved by AHCA.
- Modifies the Statewide Medicaid Residency Program to include Hospital Outpatient Medicaid rates due to prospective payment implementation and enables qualifying institutions to receive start up bonus payments.
- Revises the years of audited data used in determining Disproportionate Share Hospital payments and includes a new children's hospital in the specialty children's hospitals DSH program.
- Authorizes Medicaid reimbursement for mobile x-ray services for recipients residing in an assisted living facility or a recipient's home.
- Makes optional, rather than mandatory, that Medicaid managed care plans offer a network contract to home medical equipment and supply vendors.
- Implements a Nursing Home Prospective Payment system effective October 1, 2018; specifies parameters for the system; allows Nursing Home leasehold trust fund revenues and quality assessments to be used for enhanced payments to nursing homes.
- Amends statutes related to the oversight and integrity of the Medicaid program and allows the sharing of explanation of medical benefits with service recipients on a sampling basis.
- Modifies the definition of "third party" and amends statute to address federal compliance issues related to responsibility for payments on behalf of Medicaid-eligible persons.
- Authorizes a new PACE programs in Leon County; amends the existing PACE program in Palm Beach County; and expands the existing Lake County PACE program.
- Provides a $1.5 billion appropriation for the Low Income Pool (LIP) program and a $246 million appropriation for the medical school faculty physician supplemental payment program. Subject to federal approvals, the AHCA is directed to submit separate budget amendments to release these funds.
- Provides conforming cross-references.

The bill was approved by the Governor on June 16, 2017, ch. 2017-129, L.O.F., and will become effective on July 1, 2017 except as otherwise provided in this act.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:
Current Situation

Cigarette Tax - Biomedical Research

Section 210.20(c), F.S., provides for the payment of monthly distributions from 1.0 percent of the net cigarette tax collections received by the Division of Alcoholic Beverages and Tobacco within the Department of Business and Professional Regulation. These funds are deposited into the Cigarette Tax Collection Trust Fund and transferred to the Biomedical Research Trust Fund within the Department of Health. The funds are appropriated annually in an amount not to exceed $3 million for the purpose of establishing activities and grant opportunities in relation to biomedical research. The Department of Health and the Sanford Burnham Prebys Medical Discovery Institute are required to use the funding to work in conjunction for these purposes.

Pediatric Cancer Research

According to the National Cancer Institute, cancer remains the leading cause of death from disease among children. The major types of cancers in children ages 0 to 14 years, which account for over half of pediatric cancer incidence, are:

- Acute lymphocytic leukemia;
- Brain and other central nervous system (CNS) tumors; and
- Neuroblastoma.[1]

Pediatric cancer death rates have dropped considerably in the last several decades; however, even when long-term survival is achieved, many survivors of childhood cancer may experience long-term adverse effects from the disease or its treatment. Research is needed to develop treatments for childhood cancer that are more effective and safe for children.

Bankhead-Coley Program

In 2006, the Legislature created the William G. “Bill” Bankhead, Jr., and David Coley Cancer Research Program (Bankhead-Coley Program) within the Department of Health (DOH). The purpose of the program was to advance progress towards cures for cancer through grant awards.

The funds are distributed as grants to researchers seeking cures for cancer, with emphasis given to the efforts that significantly expand cancer research capacity in the state.[2] The Biomedical Research Advisory Council (BRAC) is responsible for assisting in developing guidelines for fairness, neutrality, principles of merit, and quality in the conduct of the Bankhead-Coley Program, and develops guidelines, criteria and standards for the solicitation, review, and award of research grants and fellowships.[3]

The Bankhead-Coley Program distributes multi-year grant awards based on the recommendation of the State Surgeon General, after consultation with the BRAC.[4] Unspent awards are deposited back into the Biomedical Research Trust Fund after five years.[5] Any university or research institute in Florida may

[1] See http://www. www.cancer.gov/types/childhood-cancers (last viewed May 9, 2017)
[2] Section 381.921, F.S.
[3] Section 215.5602(3), F.S.
[4] Section 215.5602(5)(b), F.S.
[5] Section 20.435(7)(c), F.S.

apply for grant funding to support the goals of the Bankhead-Coley Program. All qualified institutions have an equal opportunity to compete for funding. The following types of applications may be considered for funding:

- Investigator-initiated research grants;
- Institutional research grants; and
- Collaborative research grants, including those that advance the finding of cures through basic or applied research.[6]

In Fiscal Year 2016-2017, the Bankhead-Coley Program received a $10 million appropriation from the Biomedical Research Trust Fund.[7]

The Department of Health has experience with other research programs besides the Bankhead-Coley Cancer Research Program, such as the James and Esther King Biomedical Research Program for tobacco-related diseases, and the Ed and Ethel Moore Alzheimer's Disease research program.

Mental Health and Substance Abuse Services in Florida

The Office of Substance Abuse and Mental Health (SAMH) is housed in the Department of Children and Families (DCF) and serves as the single state authority for mental health and substance abuse services. The Office of Substance Abuse and Mental Health administers a statewide system of safety-net services that serves children and adults who are otherwise unable to obtain mental health and substance abuse treatment services. This group includes individuals who are eligible for Medicaid, Medicaid enrolled individuals who require services not covered under Florida Medicaid, and those who are not financially able to cover medical expenses independently.

In 2008, the legislature required the Department of Children and Families (DCF) to implement a system of behavioral health managing entities that would serve as regional agencies to manage and pay for mental health and substance abuse services.[8] Prior to this time, the department, through its regional offices, contracted directly with behavioral health service providers. The legislature found that a management structure that places the responsibility for publicly-financed behavioral health treatment and prevention services within a single private, nonprofit entity at the local level would promote improved access to care, promote service continuity, and provide for more efficient and effective delivery of substance abuse and mental health services. There are currently seven managing entities across the state.

Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a federal and state partnership established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families, the Department of Health (DOH), the Agency for Persons with Disabilities, and the Department of Elderly Affairs (DOEA).

The Florida Medicaid program covers approximately 4 million low-income individuals, including approximately 2.3 million, or 58.7%, of the children in Florida.[9] Medicaid is the second largest single

[6] Section 381.922(3a), F.S.
[7] Chapter 2016-66, Laws of Florida. See Specific Appropriation 470.
[8] Chapter 2008-243, Laws of Florida
[9] Agency for Health Care Administration, *Florida Statewide Medicaid Monthly Enrollment Report*, February 2017, available at http://www.fdhc.state.fl.us/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last accessed March 17, 2017).

program in the state, behind public education, representing 31 percent of the total FY 2016-2017 budget. Medicaid expenditures represent over 19 percent of the total state funds appropriated in FY 2016-2017.

Medicaid Waivers

States have some flexibility in the provision of Medicaid services. Section 1915(b) of the Social Security Act provides authority for the Secretary of the U.S. Department of Health and Human Services to waive requirements to the extent that he or she "finds it to be cost-effective and efficient and not inconsistent with the purposes of this title." Also, Section 1115 of the Social Security Act allows states to use innovative service delivery systems that improve care, increase efficiency, and reduce costs.

States may also ask the federal government to waive federal requirements to expand populations or services, or to try new ways of service delivery. For example, Florida has a Section 1115 waiver to use a comprehensive managed care delivery model for primary and acute care services, the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program.[10] In addition to the Section 1115 waiver for the MMA program, Florida also has a waiver under Sections 1915(b) and (c) of the Social Security Act to operate the SMMC Long-term Care (LTC) program.[11]

Approximately 82% of the Medicaid population in Florida is enrolled in the MMA and LTC programs.[12]

Florida's Medicaid Managed Care Long-term Care Program

The LTC program provides long-term care services to eligible Medicaid beneficiaries. Individuals must enroll in the LTC program if they are age 65 or older and eligible for Medicaid, age 18 or older and eligible for Medicaid by reason of a disability, or determined by the Comprehensive Assessment and Review of Long-term Care Services (CARES) unit[13] at DOEA to need nursing facility level of care and also meets one or more established criteria, such as receiving TANF or enrolled in hospice care.[14]

The LTC program also allows individuals who are eligible for various other Home and Community-based Services (HCBS) waivers[15] to enroll. Such waivers include:

- Developmental Disabilities Waiver (iBudget);
- Traumatic Brain and Spinal Cord Injury Waiver;
- Project AIDS Care Waiver; and
- Adult Cystic Fibrosis Waiver.[16]

LTC plan providers also cover some expanded benefits, such as dental, emergency financial assistance, non-medical transportation, over-the-counter medications/supplies, and vision services.[17]

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[10] S. 409.964, F.S.
[11] Id.
[12] Supra, FN 9.
[13] CARES is a federally mandated pre-admission screening program to assess each individual who requests Medicaid reimbursement for nursing facility placement, or who seeks to receive home and community-based services through other Medicaid waivers.
[14] Agency for Health Care Administration, Statewide Medicaid Managed Care, *Long-term Care Program Snapshot*, December 6, 2016, available at https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/SMMC_LTC_Snapshot.pdf (last accessed February 27, 2017).
[15] Infra, FN 18; Medicaid HCBS waivers are authorized by Section 2176 of the Omnibus Budget Reconciliation Act of 1981 and incorporated into Title XIX of the Social Security Act as Section 1915(c). States can use this authority to offer a broad array of services not otherwise available through Medicaid that are intended to prevent or delay institutional placement. Florida's HCBS waivers vary on a number of dimensions. Some waivers are limited to persons with specific diseases or physical conditions (such as cystic fibrosis); others serve broader groups (such as persons who are elderly and/or have disabilities). Waivers also differ with respect to the number and types of services provided, payment method, and whether waiver services are available statewide or limited to a few counties.
[16] Supra, FN 14.
[17] Id.

Traumatic Brain and Spinal Cord Injury Waiver

The Traumatic Brain and Spinal Cord Injury (TB/SCI) waiver is an HCBS waiver operated by DOH that provides services for individuals with traumatic brain injuries and spinal cord injuries.[18] For purposes of the waiver, "traumatic brain injury" is an injury that produces an altered state of consciousness or anatomic, motor, sensory, or cognitive/behavioral deficits and "spinal cord injury" is an injury that has significant involvement of two of the following: motor deficit, sensory deficit, or bowel and bladder dysfunction.[19] To be eligible, individuals must be 18 years of age or older, be Medicaid eligible, have one of the conditions previously described, and meet nursing home level of care as determined by CARES.[20]

The TB/SCI waiver includes services such as assistive technologies, attendant care, adult companion, counseling, personal care, and support coordination. Currently, the TB/SCI waiver has approximately 350 individuals enrolled with 350 on the waitlist.[21]

Adult Cystic Fibrosis Waiver

The Adult Cystic Fibrosis (ACF) waiver is an HCBS waiver operated by DOH that provides services for individuals with a diagnosis of cystic fibrosis; a chronic, progressive, and terminal genetic disorder that affects a person's lungs and digestive system.[22] To be eligible, individuals must be 18 years of age or older, be Medicaid eligible, have a diagnosis of cystic fibrosis, and meet nursing home level of care as determined by CARES.[23]

The ACF waiver includes services such as case management, counseling, personal care, prescription drugs, respite care, and respiratory therapy. Currently, the ACF waiver has approximately 140 individuals enrolled with none on the waitlist.[24]

Project AIDS Care Waiver

The Project AIDS Care (PAC) waiver is an HCBS waiver operated by AHCA that provides services for individuals with a diagnosis of acquired immune deficiency syndrome (AIDS). To be eligible, individuals must be Medicaid eligible, have a diagnosis of AIDS, have an AIDS-related opportunistic infection, be at risk for hospitalization, and meet income eligibility requirements of the Social Security Administration for
SSI,[25] and not be enrolled in the MMA or LTC programs.[26] To meet SSI income requirements, an individual must not earn more than $2,205 per month, or 300% of the Federal Benefits Rate (FBR).[27]

[18] Office of Program Policy Analysis and Government Accountability, *Profile of Florida's Medicaid Home and Community-Based Services Waivers*, Report No. 13-07, March 2013, available at http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1307rpt.pdf (last accessed February 27, 2017).
[19] Id.
[20] Id.
[21] Agency for Health Care Administration, Agency Analysis of 2017 House Bill 619, p. 3 (Feb. 6, 2017).
[22] Supra, FN 18.
[23] Id.
[24] Supra, FN 21
[25] SSI is the Supplemental Security Income program, a federal income supplement program designed to help aged, blind, and disabled people with little to no income by providing cash to meet basic needs such as food, clothing and shelter; *See* Social Security Administration, Supplemental Security Income Home Page – 2016 Edition, *What is Supplemental Security Income?*, available at https://www.ssa.gov/ssi/ (last accessed February 27, 2017).
[26] Supra, FN 18.
[27] Current FBR is $735 per month; Department of Children and Families, *SSI-Related Programs – Financial Eligibility Standards*, available at http://www.dcf.state.fl.us/programs/access/docs/esspolicymanual/a_09.pdf (last accessed February 26, 2017).

The PAC waiver includes services such as case management, home-delivered meals, personal care, restorative massage, specialized medical equipment, and skilled nursing. Currently, the PAC waiver has approximately 7,800 individuals enrolled with none on the waitlist.

Sole Community Hospitals

The federal Medicare program classifies a hospital as a "sole community hospital" based on criteria specified in title 42, s. 412.92, of the Code of Federal Regulations, including whether the hospital is situated in a federally-designated rural area, the hospital's capacity, and the hospital's distance from other hospitals. A sole community hospital is given special treatment and is eligible for payment adjustments from the Medicare program due to the federal government's consideration of the hospital's accessibility to residents of rural areas who have limited options for hospital services.

In 2016, the Legislature amended the definition of a rural hospital to include hospitals classified as sole community hospitals having up to 175 licensed beds, beginning in the 2016-2017 fiscal year.[28] Chapter 2016-66, Laws of Florida provided non-recurring funding for the increased cost associated with amending the definition to include hospitals classified as sole community hospitals.

Nursing Home Reimbursement

Currently, Florida Medicaid reimbursement for nursing home services is reimbursed through a cost-based methodology. Each nursing home has its reimbursement rate per diem established based upon allowable nursing home costs as reported in an annual cost report. The nursing homes are reimbursed their per diem for each day a Medicaid resident is in the nursing home. The nursing home rates are based on unaudited, historical cost reports submitted prior to services being rendered. The reimbursement rates are adjusted post-payment for some facilities each year based on audited cost reports. The cost report audit and rate adjustment processes can take several years for full reconciliation and finalization of payment.

During the 2016 Legislative Session, the Legislature required the Agency for Health Care Administration to develop a plan to convert Medicaid payments for nursing home services from a cost-based reimbursement methodology to a prospective payment system and identify steps necessary for the transition to be completed in a budget neutral manner.

A prospective payment system is a reimbursement system in which rates are determined in advance of payment and considered final upon payment. A fully prospective payment system will eliminate the need for retroactive rate adjustments, allowing nursing facilities and AHCA to record final reimbursement amounts in a more expedient manner. In addition, a payment method in which rates are more uniform across facilities will provide more incentives for nursing facilities to control costs.

Outpatient Reimbursement

Florida Medicaid currently reimburses hospital outpatient services using hospital specific cost-based rates which pay a flat rate referred to as a "per diem" to each payable revenue code submitted on an outpatient claim. The hospital outpatient rates are based on unaudited, historical cost reports submitted prior to services being rendered. The reimbursement rates are adjusted post-payment for some facilities each year based on audited cost reports. The cost report audit and rate adjustment processes can take several years for full reconciliation and finalization of payment.

[28] Chapter 2016-65, Laws of Florida

During the 2015 Legislative Session, the Legislature authorized the study and design of an Outpatient Prospective Payment System (OPPS) for Florida Medicaid[29]. The Legislature required that the Agency for Health Care Administration develop a plan to convert Medicaid payments for outpatient services, including hospital outpatient services and ambulatory surgery centers, to a prospective payment system and identify steps necessary for the transition to be completed in a budget neutral manner.

During the 2016 Legislative Session, the Legislature amended s. 409.905, F.S., replacing AHCA's existing per diem and retroactive adjustment fee methodology for Medicaid outpatient care, with a prospective payment system. Under the new system, AHCA will calculate reimbursement rates annually for Hospital Outpatient Services. Additionally, s. 409.908(5), F.S., was amended to reflect the transition to prospective payment system for ambulatory surgical centers. The new rates are required to go into effect on July 1, 2017, and on July 1 every year thereafter. The new methodology must function like an outpatient prospective payment system by categorizing the amount and type of services used in outpatient visits, and group together procedures that share similar characteristics and costs.

Intergovernmental Transfers

Certain programs, including but not limited to the Statewide Medicaid Residency Program, the Graduate Medical Education Startup Bonus Program, the Disproportionate Share Hospital (DSH), and certain hospital reimbursement exemptions are funded through county and other local tax dollars that are transferred to the state and used to draw federal match. Local dollars transferred to the state and used in this way are known as "intergovernmental transfers" or IGTs. IGTs may be used to augment hospital payments in other ways, specifically through direct payment programs authorized by the federal Centers for Medicare and Medicaid Services (CMS) through waivers or state plan amendments. Examples include the Upper Payment Limit (UPL) and Low Income Pool (LIP) programs. All IGTs are contingent upon the willingness of counties and other local taxing authorities to transfer funds to the state in order to draw down federal match. The local taxing authorities commit to sending these funds to the state in the form of an executed Letter of Agreement with the AHCA. In order for AHCA to make timely payments to hospitals, AHCA must know which local governments will be submitting IGTs and the amount of the funds prior to using the funds to draw the federal match. Current law requires local governments who will be submitting IGTs to submit to AHCA the final executed letter of agreement containing the total amount of the IGTs authorized by the entity, no later than October 1 of each year. Currently, there is no date requirement for the local governments to transfer the actual IGTs to AHCA.

Statewide Medicaid Residency Program

In 2013, the Legislature created the Statewide Medicaid Residency Program (SMRP) to fund graduate medical education (GME).[30] GME is the education and training of physicians following graduation from a medical school in which physicians refine the clinical skills necessary to practice in a specific medical field (surgery, dermatology, family practice, etc.). GME or "residency" programs for allopathic and osteopathic physicians include internships, residency training, and fellowships. These residency programs vary in length from three to seven years. Previously, graduate medical education was reimbursed through hospital inpatient and outpatient reimbursements.

The SMRP defines "Medicaid payment" as payments made to reimburse a hospital for direct inpatient services, as determined by AHCA. Consequently, AHCA must calculate an allocation fraction in accordance with statutory formula on or before September 15 of each year. A hospital's annual allocation equals the funds appropriated for the SMRP in the GAA multiplied by its allocation fraction. Regardless of the formula, a hospital's annual allocation may not exceed two-times the average per resident amount for all hospitals. Any funds beyond this amount must be redistributed to participating

[29] Chapter 2015-232, Laws of Florida
[30] Chapter 2013-48, Laws of Florida

hospitals whose annual allocation does not exceed this limit. AHCA must distribute each participating hospital's annual allocation in four installments on the final business day of each quarter of the state fiscal year.[31]

Disproportionate Share Hospital Program

The Medicaid Disproportionate Share Hospital (DSH) Program funding distributions are provided to qualifying hospitals that provide a disproportionate share of the Medicaid or charity care services to uninsured individuals. Each year, the Legislature delineates how the funds will be distributed to each eligible facility either through statutory formulas or other direction in the implementing bill or proviso.

Third Party Liability

Federal law requires that a state, in the administration of its Medicaid program, take reasonable measures to determine the legal liability of third parties to pay for any medical assistance provided, and seek recovery from a third party for any claims that have been paid for which a third party is liable.[32] When a state identifies probable third party liability (TPL), it uses one of two methods to ensure that Medicaid is the payer of last resort: cost avoidance and pay-and-chase.[33] Cost avoidance is the method used to avoid payment when other insurance resources are available to the beneficiary. Federal regulations generally require states to use cost avoidance when probable TPL is established.[34] In contrast, the pay-and-chase method is used when a state pays health care service providers for submitted claims and then attempts to recover payments from liable third parties.[35] This usually occurs when TPL is later identified.

In 2005, Congress passed the Deficit Reduction Act (DRA)[36] that, among other things, clarified a state's duties to pursue reimbursement from third parties for medical assistance provided by Medicaid. Specifically, the DRA:

- Clarified the specific entities considered "third parties" and "health insurers" that may be liable for payment;
- Prohibited third parties and health insurers from discriminating against individuals on the basis of Medicaid eligibility; and
- Required that states pass laws requiring health insurers to:
    - Provide the state with eligibility and coverage information needed to identify potentially liable third parties;
    - Accept the assignment to the state of the Medicaid beneficiary's right to payment by such insurers for health care items or services for which Medicaid has paid;
    - Respond to any inquiry regarding a claim for payment of any health care item or service that is submitted within three years after the date of service; and
    - Agree not to deny such assignment or refuse to pay claims by Medicaid based on procedural reasons, if the claim is submitted within three years of the date of service and

[31] S. 409.909, F.S.
[32] 42 U.S.C. s. 1396a(a)(25). States are not required to seek reimbursement if is not cost-effective to do so.
[33] The state may contract with a vendor to fulfill this responsibility.
[34] 42 CFR s. 433.139(b).
[35] Under 42 U.S.C. s. 1396a(a)(25), a state must also pay and chase for prenatal care, preventive pediatric care, or if the coverage is through a parent whose obligation to pay support is enforced by the state's child support enforcement agency.
[36] Pub. Law No. 109-171.

any action to enforce the state's right with respect to such claim is commenced within six years of the state's submission of the claim.

Under the Medicaid Third Party Liability Act,[37] Medicaid is the payor of last resort for medically necessary goods and services furnished to Medicaid beneficiaries. All other sources of payment are primary to Medicaid. If third party benefits are discovered or become available after medical assistance is provided by Medicaid, state law requires Medicaid to be paid in full and prior to any other person, program, or entity.[38]

An individual who is eligible for Medicaid assigns his or her right to third party benefits or payments to AHCA by applying for or accepting Medicaid benefits.[39] A Medicaid lien is automatically applied when a beneficiary receives services paid by Medicaid for which a third party may be liable. A verified claim of lien may be filed with the clerk of the circuit court in the beneficiary's last known county of residence.[40]

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

PACE is a capitated benefit model authorized by the federal Balanced Budget Act of 1997 that features a comprehensive service delivery system and integrated federal Medicare and state Medicaid financing. The model was tested through the federal Centers for Medicare and Medicaid Services (CMS) demonstration projects that began in the mid-1980s. The PACE model was developed to address the needs of long-term care clients, providers, and payers.

For most participants, the comprehensive service package permits them to continue living at home while receiving services rather than receiving services in other more costly long term care settings. Capitated financing allows providers to deliver all the services that participants need rather than being limited to those services reimbursable under the Medicare and Medicaid fee-for-service systems.

The Balanced Budget Act of 1997 established the PACE model of care as a permanent entity within the Medicare program and enabled states to provide the PACE services to Medicaid recipients as a state option without a Medicaid waiver. The state plan must include PACE as an optional Medicaid benefit before the state and federal governments can enter into program agreements with PACE providers.

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

Florida PACE Project

The Florida PACE project is one project among many that provide alternative, long-term care options for elders who qualify for Medicare and the state Medicaid program. The PACE project was initially

[37] S. 409.910, F.S.

[38] Id. Florida Medicaid contracts with Health Management Systems, which subcontracts to Conduent Payment Integrity Solutions to pursue these reimbursements. See http://flmedicaidtplrecovery.com/tortcasualty/ (last visited March 10, 2017). For recipients enrolled in the statewide Medicaid managed care program, the managed care organization is responsible for TPL collections. See AHCA, SMMC Model Contract, Core Contract Provisions, available at http://www.fdhc.state.fl.us/medicaid/statewide_mc/pdf/Contracts/2017-02-01/02-01-17_Attachment_II.pdf (last visited March 10, 2017).

[39] S. 409.910(6), F.S.

[40] S. 409.910(6)(c)2., F.S. A lack of a properly filed claim of lien will not affect AHCA's assignment rights or the existence of the lien, but only the effective date of notice.

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

In addition to receiving the necessary legislative authority, the development of a new PACE organization or the expansion of an existing program is a lengthy process that includes: identifying a service area, acquiring and renovating a PACE facility, and processing the PACE application through the state and the federal review systems.

PACE projects have been approved and are operational in several Florida counties, including Lee, Miami-Dade, Pinellas, Polk, Highlands, Hardee, Palm Beach, Manatee, Sarasota, Desoto, and Broward. Most recently, PACE projects have been approved and are in various stages of the application process in Escambia and surrounding counties, Duval and surrounding counties, and Lake, Orange, and Hillsborough counties.

Low Income Pool

The Low Income Pool (LIP) was originally created as a result of the original 1115 Waiver that established the Managed Medicaid Pilot program. Pursuant to s. 409.91211(1)(b), F.S., the Managed Medicaid Pilot waiver was "contingent upon federal approval to preserve the upper-payment-limit funding mechanism for hospitals, including a guarantee of a reasonable growth factor, a methodology to allow the use of a portion of these funds to serve as a risk pool for demonstration sites, provisions to preserve the state's ability to use intergovernmental transfers, and provisions to protect the disproportionate share program." The LIP was to be used to provide supplemental payments to hospitals that provide services to Medicaid recipients, the uninsured and underinsured individuals. The LIP program also authorized supplemental Medicaid payments to provider access systems, such as federally qualified health centers, county health departments, and hospital primary care programs, to cover the cost of providing services to Medicaid recipients, the uninsured and the underinsured.

Florida law provides that distribution of the Low-Income Pool funds should:

- Assure a broad and fair distribution of available funds based on the access provided by Medicaid participating hospitals, regardless of their ownership status, through their delivery of inpatient or outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;
- Assure accessible emergency inpatient and outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;
- Enhance primary, preventive, and other ambulatory care coverages for uninsured individuals;
- Promote teaching and specialty hospital programs;
- Promote the stability and viability of statutorily defined rural hospitals and hospitals that serve as sole community hospitals;
- Recognize the extent of hospital uncompensated care costs;
- Maintain and enhance essential community hospital care;
- Maintain incentives for local governmental entities to contribute to the cost of uncompensated care;
- Promote measures to avoid preventable hospitalizations;
- Account for hospital efficiency; and

- Contribute to a community's overall health system.

On April 12, 2017, the CMS announced the federal government's continuation of funding for the LIP in Florida in the amount of $1.5 billion.

Physician Faculty Supplemental Payments

Currently, the 2016-2017 General Appropriations Act includes funding for AHCA to make direct payments for the costs associated with graduate medical education, supplemental payment or differential fee schedule for payments for services provided by doctors of medicine and osteopathy as well as other licensed health care practitioners acting under the supervision of those doctors employed by or under contract with a medical school in Florida. The purpose of this funding is to support access to care from faculty plans of Florida medical schools.

In early 2017, the CMS finalized a rule that, unless changed or repealed, will preclude Medicaid managed care plans from passing through these supplemental payments to the faculty physicians.

Effect of Proposed Bill

Cigarette Tax - Biomedical Research

The bill amends s. 210.20(2)(c), F.S., relating to the distribution of cigarette tax revenue for biomedical research purposes, to redirect the cigarette tax distribution funds that would otherwise be used for the Sanford Burnham Prebys Medical Discovery Institute for distribution to National Cancer Institute research entities for advancement of cures for cancers impacting pediatric populations through basic or applied research, including but not limited to, clinical trials and nontoxic drug discovery.

Pediatric Cancer Research / Bankhead-Coley Program

The bill amends s. 381.922 (2), F.S., relating to the Bankhead-Coley Cancer Research Program and stipulates that efforts to improve both research and treatment through greater participation in clinical trials networks shall include identifying ways to increase pediatric and adult enrollment in clinical trials. In addition, the Live Like Bella Initiative is created within the Bankhead-Coley Program to advance progress toward curing pediatric cancer by awarding grants according to the peer-reviewed, competitive process established the Bankhead-Coley Cancer Research Program.

Mental Health and Substance Abuse Programs in Florida

The bill amends s. 394.9082(10)(a), F.S., relating to behavioral health managing entities and the related acute care services utilization database, to revert the statute back to the reporting requirements in place when the database was initially created in 2015. The bill also requires the Department of Children and Families to post the data on its website.

Sole Community Hospitals

The bill amends s. 395.602, F.S., to provide that a hospital classified as a sole community hospital is included in the definition of "rural hospital" regardless of the number of licensed beds located at the facility.

Nursing Home Reimbursement

The bill implements a Nursing Home Prospective Payment system effective October 1, 2018, and specifies the parameters for the prospective payment system.

Beginning October 1, 2018, and ending September 30, 2021, the AHCA shall reimburse nursing home providers the greater of their September 2016 cost-based reimbursement rate or their prospective payment rate. Effective October 1, 2021, the AHCA shall reimburse providers the greater of 95 percent of their cost-based rate or their rebased prospective rate, using the most recently audited cost report for each facility. Pediatric, Florida Department of Veterans Affairs, and government-owned facilities are exempt from this new pricing model. Related provisions are modified to keep in place applicable rate-setting ceilings and targets for those facilities that remain on cost-based reimbursement. Changes are made for calculations of direct care costs, and other patient care costs. Prospective rates are to be rebased every four years, and direct care supplemental payments may be made under specified circumstances. Additionally, the bill allows the use of Nursing Home leasehold trust fund revenues and quality assessments for enhanced payments to nursing homes as specified in the GAA as part of the transition to a Nursing Home prospective payment.

Outpatient Reimbursement

During the 2016 Legislative Session, the Legislature required that the Agency for Health Care Administration implement prospective payments for outpatient services, including hospital outpatient services and ambulatory surgery centers.[41] The bill deletes obsolete language in s. 409.908(5), F.S., due to the statutorily required implementation of a prospective payment system effective July 1, 2017. The new rates go into effect on July 1, 2017, and on July 1 every year thereafter. Additionally, the bill eliminates hospital outpatient services from the statutory rate freeze that ensures no increase in statewide expenditures resulting from a change in unit costs effective July 1, 2011.

Medicaid Reimbursement for X-Ray Services

The bill amends s. 409.908(5), F.S., to specify that Medicaid reimbursement will be provided for deductibles and coinsurance for Medicare Part B services provided for mobile x-ray services rendered to a person who is Medicare and Medicaid dually eligible when such services are delivered in an assisted living facility or a home, just as such reimbursement is presently provided for a nursing home resident.

Intergovernmental Transfers

The bill amends s. 409.908, F.S., to require the local governments to submit to AHCA the total amount of the IGTs as agreed upon in the executed letter of agreement, no later than October 31 of the year the IGTs are pledged unless an alternative plan is specifically approved by AHCA.

Statewide Medicaid Residency Program

This legislation amends s. 409.909, F.S., such that a qualifying institution, as defined under the program, may receive the same types of program payments as hospitals. Under the program, a qualifying institution is defined as a Federally Qualified Health Center which holds an Accreditation Council for Graduate Medical Education institutional accreditation.

[41] Chapter 2016-65, Laws of Florida

The bill also modifies the definition of “Medicaid payments” under the SMRP to include outpatient services. This change is necessitated by the statutory transition to a prospective outpatient payment system. This is similar to the transition that occurred when Florida moved to inpatient Diagnosis Related Groups.

Disproportionate Share Hospital Program

The bill amends s. 409.911, F.S., to update existing law to provide payments for the 2017-2018 fiscal year related to hospitals in the Disproportionate Share Hospital (DSH) Programs and Medicaid DSH based upon the average of the 2009, 2010, and 2011 audited disproportionate share data to determine each hospital’s Medicaid days and charity care.

The bill amends s. 409.9119, F.S., relating to the disproportionate share program for specialty children’s hospitals, to modify the specialty children’s hospitals that qualify for funds under this section to include those that have a specific federal certification number, meet the Medicare and Medicaid day criteria, and that were licensed on January 1, 2013.

Third Party Liability

The bill amends s. 409.901(27), F.S., to modify the definition of “third party” as that term is used in the Florida Medicaid program.

The bill amends s. 409.910, F.S., relating to responsibility for payments on behalf of Medicaid-eligible persons when other parties are liable, and address federal compliance issues in the current statute. Specifically addressed are applicable federal law limits on recoveries, evidentiary standards, applicability to third party payers, and payment response requirements. Outdated provisions are deleted from the statute.

The bill amends s. 409.913(36), F.S., relating to oversight of the integrity of the Medicaid program and the sharing of explanation of medical benefits with service recipients, to authorize that such documents be shared with recipients on a sampling basis rather than to all recipients, other than the exemptions already provided from such distributions.

Medicaid Waivers

The bill requires PAC, ACF, and TB/SCI waiver beneficiaries to transition to the LTC program by January 1, 2018. Once all eligible Medicaid beneficiaries have transitioned, AHCA must seek federal approval to terminate the waivers. Waiver consolidation removes administrative burdens on AHCA and DOH by transferring Medicaid beneficiaries from these HCBS waivers into the LTC program. Similar services, and in some cases expanded services, are available to the waiver beneficiaries in the LTC program as are currently available through the waivers.

Project AIDS Care Waiver Consolidation

The bill transfers approximately 7,800 individuals from the PAC waiver to the LTC program.

The bill amends eligibility requirements, subject to federal approval, for individuals who would otherwise be eligible for the PAC waiver but do not meet the eligibility requirements for the LTC program. The bill makes those individuals with a diagnosis of AIDS, an AIDS-related opportunistic infection, at risk of hospitalization as determined by AHCA, and income at or below 300% of the FBR eligible for Medicaid. This change in the eligibility requirement would allow an individual otherwise eligible for the PAC waiver, who does not meet the nursing home level of care requirement for the LTC program, to be eligible for the MMA program.

The LTC program offers similar services to those offered under the PAC waiver. Some services will not be available, such as massage therapy, but other services available under the LTC program will replace those services.

Adult Cystic Fibrosis Waiver Consolidation

The bill transfers approximately 140 individuals from the ACF waiver to the LTC program.

The bill amends CARES screening requirements to include "hospital level of care" for individuals diagnosed with cystic fibrosis. Currently, to meet LTC eligibility requirements, CARES must determine an individual requires "nursing facility care." This change will allow those individuals diagnosed with cystic fibrosis who do not meet the nursing facility level of care requirement to be eligible for the LTC program.

The LTC program offers similar services to those offered under the ACF waiver, but certain services are not available, such as nutritional supplements and the amount of sterile saline needed by individuals with ACF. AHCA will require LTC program plans to cover over-the-counter benefits to fill the gap in available services.

Traumatic Brain Injury and Spinal Cord Injury Waiver

The bill transfers approximately 350 individuals from the TB/SCI waiver to the LTC program, and 350 individuals from the TB/SCI waiver waitlist to the LTC program waitlist. It is likely those individuals transferred onto the LTC waitlist will transition into the LTC program faster than they would have moved into the TB/SCI waiver due to their high level of acuity and the large number of people enrolled per year from the waitlist into the LTC program.

The LTC program offers services similar to those available through the TB/SCI waiver and expanded benefits will be available to individuals who transfer.

The bill also deletes s. 409.906(13)(b), F.S., a section of law that allows AHCA to consolidate certain waiver programs that will become obsolete upon passage of the bill.

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

The bill authorizes the creation of new PACE programs in Leon County to serve individuals in Leon, Jefferson, Gadsden, and Wakulla counties. The bill amends chapter law to authorize the existing PACE provider in Palm Beach County to expand services to eligible enrollees in Martin, St. Lucie, Okeechobee, and Indian River Counties. Finally, the bill authorizes the current Lake County hospice-based PACE provider to expand services into the Orlando area.

Low Income Pool

The bill creates an undesignated section of law to provide a $1.5 billion appropriation in Fiscal Year 2017-2018 for the Low Income Pool program. Subject to federal approval of special terms and conditions for the program, the Agency is directed to submit a budget amendment for release of the reserved funds.

Physician Faculty Supplemental Payments

The bill creates an undesignated section of law to provide a $246 million appropriation in Fiscal Year 2017-2018 to continue the medical school faculty physician supplemental payment program. Subject to

federal approval to continue these supplemental payments, the Agency is directed to submit a budget amendment for release of the reserved funds.

Except as otherwise provided, the bill has an effective date of July 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

$1,559,153,101 in federal Medicaid funds will be generated through the implementation of the Hospital Outpatient Prospective Payment System, the GME program, the DSH programs, the LIP Program, and Physician Faculty Supplemental Payments:

- Hospital Outpatient Services = $142,211,200
- Graduate Medical Education = $121,576,260
- Disproportionate Share Hospital Program = $219,313,128
- Low Income Pool Program = $924,467,313
- Physician Faculty Supplemental Payments = $515,585,200

The bill creates a positive fiscal impact of $250,000 ($79,159 General Revenue) due to the sharing of explanation of medical benefits with service recipients to allow documents to be shared with recipients on a sampling basis.

The bill may have an indeterminate positive fiscal impact on AHCA, as it may recover more reimbursements from third parties that are liable to pay for medical services under the extended time to file a lien, the extended time frame within which a cause of action for reimbursement may be brought, and the expanded definition of "third party."

2. Expenditures:

The bill will require a transfer of General Revenue funds from DOH to AHCA relating to the TB/SCI waiver in the amount of $1,977,856. The bill will require a transfer of General Revenue funds from DOH to AHCA related to the ACF waiver in the amount of $149,207. The bill will require AHCA to internally transfer General Revenue of $1,668,324 between budget categories to transfer the PAC waiver to the LTC program.

The bill will require AHCA to make payments to eligible DSH providers, based on the statutory formulas, a total amount of $310,541,853 ($6.5 million General Revenue).

The bill has a fiscal impact of $651,381 ($250,000 General Revenue) to allow Medicaid reimbursements for mobile x-ray services for a dually eligible Medicare and Medicaid recipient residing in an assisted living facility or a home.

The bill does not increase the Medicaid outpatient reimbursements as the transition from a cost-based reimbursement system to a prospective payment system is required to be budget neutral.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   In order to earn matching federal dollars for IGT funded programs, local governments and other local political subdivisions would be required to provide $800,819,712 in contributions, no later than October 31, 2017.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

   None.

D. FISCAL COMMENTS:

   The bill requires the funds for the LIP and the Physician Faculty Supplemental Payments to be placed in reserve. Once federal approval has been obtained, the AHCA is required to submit a budget amendment to request the release of the funds. The nonfederal shares of the funds are required to be provided through IGTs in the Grants and Donations Trust Fund. The State of Florida is not obligated to make payments if the IGTs are not available.