Conference Committee on

House – Health Care Appropriations Subcommittee

Senate - Appropriations Subcommittee on Health and Human Services

Health Care Implementing Bill

House Offer #1

Monday, March 9, 2020

9:15 a.m.

212 (Knott Bldg.)

FY 2020-2021 Implementing Bill
House Health Care Appropriations Subcommittee / Senate Health and Human Services Appropriations
Side by Side

Line	HB 5003 Section	SB 2502 Section	Description	House Offer #1
1	4	13	**MEDICAID HOSPITAL FUNDING PROGRAMS.** Provides the calculations for the Medicaid Disproportionate Share Hospital, and Hospital Reimbursement programs, for the 2020-2021 fiscal year contained in the document titled "Medicaid ~~Disproportionate Share Hospital and~~ Hospital ~~Reimbursement~~ Funding Programs," are incorporated by reference for the purpose of displaying the calculations used by the Legislature.	**House Modified**
2	5	14	**STATEWIDE MEDICAID MANAGED CARE REALIGNMENT-AHCA/DOH.** Authorizes AHCA & DOH to submit a budget amendment to realign funding within and between agencies based on the implementation of the Managed Medical Assistance component of the Statewide Medicaid Managed Care porgram for the Children's Medical Services program within DOH. The funding realignment shall reflect the actual enrollment changes due to the transfer of beneficiaries from fee-for-service to the capitated Children's Medical Services Network. Also authorizes AHCA to submit a request for non-operating budget authority to transfer the federal funds to the Department of Health, pursuant to s. 216.181(12), Florida Statutes.	**Identical**
3	N/A	15&16	**MEDICAID NURSING HOME PROSPECTIVE PAYMENT.** Amends s. 409.908(23), F.S., relating to Medicaid rate setting for specified provider types, to specify the prospective payment system reimbursement for nursing home services will be governed by s. 409.908(2), F.S., and the General Appropriations Act. Language relating to county health department reimbursement is restructured but not changed substantively.	**Senate**
4	N/A	17&18	**LOW INCOME POOL.** Amends s. 409.908(26), F.S, to include Low Income Pool (LIP) payments and requires that Letters of Agreement for LIP be received by AHCA by October 1 and the funds outlined in the Letters of Agreement be received by October 31. House Modified to **also** include essential provider language: To be eligible for low-income pool funding or other forms of supplemental payments funded by intergovernmental transfers, and in addition to any other applicable requirements, essential providers under s. 409.975(1)(a) and (1)(b)2. and 4. must contract with each managed care plan in their region and essential providers under s. 409.975(1)(b)1. and 3. must contract with each managed care plan in the state.	**House Modified**

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5	N/A	19	**MEDICAID RETROACTIVE ELIGIBILITY.** Requires AHCA to see authorization from federal Centers for Medicare and Medicaid to eliminate the Medicaid retroactive eligibility period for nonpregnant adults in a manner that ensures that the elimination becomes effective July 1, 2020. Eligibility will continue to begin the first day of the month in which a nonpregnant adult applied for Medicaid.	**Senate**
6	N/A	20	**RETROACTIVE MEDICAID ELIGIBILTY REPORT.** Requires AHCA to submit a report regarding the impact of the waiver on Medicaid retroactive eligibility on beneficiaries and providers.	**House No Language**
7	N/A	21&22	**FLORIDA HEALTHY KIDS CORPORATION/MEDICAL LOSS RATIO** Amends s. 624.91(5)(b). F.S., to require the Florida Healthy Kids Corporation to validate and calculate a refund amount for Title XXI providers who achieve a Medical Loss Ratio below 85 percent. These refunds shall be deposited into the General Revenue Fund, unallocated.	**Senate**
8	N/A	23&24	**FLORIDA CONSORTIUM OF NATIONAL CANCER INSTITUTE CENTERS PROGRAM.** Amends s. 381.915, F.S. to provide that a cancer center's participation in Tier 3 may not extend beyond July 1, 2021.	**Senate**
9	N/A	25	**PRESCRIPTION DRUG MONITORING PROGRAM.** Prohibits use of settlement funds for program.	**Senate**
10	N/A	26-28	**DISPROPORTIONATE SHARE HOSPITAL PROGRAM.** Amends s. 409.911, F.S. to direct AHCA to distribute moneys to hospitals providing a disproportionate share of Medicaid or charity care services as provided in the General Appropriations Act (GAA). Also modifies years of audited data that shall be used in calculating disproportionate share payment. Amends s. 409.9113, F.S., to direct AHCA to make disproportionate share payments to teaching hospitals as provided in the GAA. Amends s. 409.9119, F.S. to direct AHCA to make disproportionate share payments to specialty hospitals for children.	**Senate**
11	6	29	**AHCA-MEDICAID BUDGET AMENDMENT.** Authorization for AHCA to realign Medicaid Expenditure categories without LBC approval to maximize use of state trust funds and pay expenditures in the appropriate category.	**Identical**

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12	N/A	30	**PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY.** Provides for PACE organization to serve persons in Escambia, Okaloosa and Santa Rosa Counties.	**Senate**
13	7	31	**AHCA BUDGET AMENDMENTS FOR FLORIDA KIDCARE.** Authorization for AHCA and DOH to realign KidCare expenditure categories without LBC approval to maximize use of state trust funds and pay expenditures in the appropriate category.	**Identical**
14	8	32-33	**DEPARTMENT OF HEALTH RULE ADOPTION - MEDICAL MARIJUANA.** Amends s. 381.986, F.S.to provide that the Department of Health is not required to prepare a statement of estimated regulatory costs when promulgating rules relating to medical marijuana testing laboratories, and any such rules adopted prior to July 1, 2021, are exempt from the legislative ratification provision of s. 120.541(3), F.S. Medical marijuana treatment centers are authorized to use a laboratory that has not been certified by the department until rules relating to medical marijuana testing laboratories are adopted by the department, but no later than July 1, 2021. Senate bill: Also amends s. 381.988, F.S.	**Senate**
15	N/A	34-35	**DEPARTMENT OF HEALTH RULE ADOPTION - MEDICAL MARIJUANA.** Amends subsection (1) of section 14 of chapter 2017-232, Laws of Florida, to provide emergency rulemaking authority to the Department of Health to adopt rules necessary to implement provisions of s. 381.986, F.S., and to provide that rules adopted under the nonremergency rulemating procedures of the Administrative Procedures Act to replace emergency rules adopted under section 14 of ch. 2017-232, L.O.F., are exempt from the legislative ratification provisions of ss. 120.54(3)(b) and 120.541, F.S.	**Senate**
16	9	37	**DCF BUDGET AMENDMENTS.** Allows the DCF to submit a budget amendment to realign funding within appropriations for the Guardianship Assistance Program.	**Identical**
17	10	38	**PATH FORWARD INITIATIVE.** Authorizes the DCF to establish a formula to distribute funding for the Path Forward initiative due to the expiration of the federal Title IV-E Waiver.	**House**
18	N/A	39	**DVA PERSONAL NEEDS ALLOWANCE INCREASE.** Allows a resident of a State Veterans' Nursing Home to retain $130/month as a personal needs allowance rather than $105/month.	**Senate**
19	11	n/a	**DOH BUDGET AMENDMENT - HIV/AIDS PREVENTION AND TREATMENT.** Authorizes DOH to submit budget amendment to increase budget authority for the HIV/AIDS Prevention and Treatment Program if additional federal revenues become available.	**House**

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20	n/a	40	**SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM.** Authorizes DCF to submit budget amendment to increase budget authority if additional federal revenue specific to the program becomes available.	**Senate**
21	12	41	**DCF BUDGET AMENDMENTS - FAMILY SAFETY PROGRAM.** Authorizes DCF to submit a budget amendment to realign funding between specific appropriation categories within the Family Safety Program to bring funding in line with Title IV-E federal program requirements and maximize the use of federal funds.	**Identical**
22	13	n/a	**MANAGED CARE PLAN PAYMENTS.** Amends s. 409.968, F.S. to require AHCA to set aside a portion of the managed care rates from the rate cells for special needs and home health services in the managed medical assistance and managed long term care programs to implement a home health performance incentive program. The agency must direct Medicaid managed care plans to submit to the agency proposals to ensure all covered and authorized home health services are provided to recipients, methods for measuring provider compliance and mechanisms for documenting compliance to the agency. Plans must implement a method for families and caregivers to report provider failures to provide services in real time. The agency may disburse the withheld portion of rate in the last quarter of the fiscal year only upon a documented determination by the agency that the plans ensured all covered and authorized home health services were provided.	**House**
23	14	36	**FLORIDA MEDICAID MANAGEMENT INFORMATION SYSTEM.** Requires AHCA to replace the current Florida Medicaid Management Information System and provides requirements of the system. This section also establishes the executive steering committee (ESC) membership, duties and the process for ESC meetings and decisions.	**House New** **See Attachment #1**
24	N/A	N/A	**NURSING HOME LEASE BOND ALTERNATIVE THRESHOLD REDUCTION.** Reduces the Medicaid nursing home lease bond alternative collection threshold from $25 million to $10 million.	**House New**
25	N/A	N/A	**FLORIDA NURSING HOME UNIFORM REPORTING SYSTEM.** Requires nursing homes and home offices to report audited financial information to the Agency for Health Care's uniform reporting system.	**House New** **See Attachment #2**

Line	HB 5003 Section	SB 2502 Section	Description	House Offer #1
26	N/A	N/A	**DEFINITIONS.** Defines Florida Nursing Home Uniform Reporting System (FNHURS) and home office. 408.07 Definitions.—As used in this chapter, with the exception of ss. 408.031-408.045, the term: (19) "FNHURS" means the Florida Nursing Home Uniform Reporting System developed by the agency. (29) "Home office" has the same meaning as provided in the Provider Reimbursement Manual, Part 1 (Centers for Medicare and Medicaid Services, Pub. 15-1), as that definition exists on the 288 effective date of this act.	**House New**
27	N/A	N/A	**TECHNICAL CORRECTIONS.** Provides for technical corrections to statutory cross references in Managed Care Plan Accountability and Appropriations to First Accredited Medical Schools due to the change in the number of definitions listed in s. 408.07, F.S.	**House New**
28	N/A	N/A	**PROVIDER AUTOMATIC ENROLLMENT AND CERTIFICATION OF VIABILITY.** Amends AHCA's automatic enrollment policies for Medicaid managed care to ensure new managed care plans and provider service networks can obtain a viable enrollment level and AHCA Secretary's certification of viable enrollment.	**House New** **See Attachment #3**
29	N/A	N/A	**DOH BUDGET AMENDMENT - DECLARED PUBLIC HEALTH EMERGENCIES.** Authorizes DOH to submit a budget amendment to increase budget authority for the response to a public health emergency upon additional federal revenues become available. Effective upon becoming law, in order to implement Specific Appropriations 424 through 542 of the 2019-2020 General Appropriations Act and Specific Appropriations 426 through 545 of the 2020-2021 General Appropriations Act, and notwithstanding ss. 216.181 and 216.292, Florida Statutes, the Department of Health may submit a budget amendment, subject to the notice, review, and objection procedures of s. 216.177, Florida Statutes, to increase budget authority for public health emergencies declared pursuant to s. 381.00315, Florida Statutes, if additional federal revenues specific to response to a declared public health emergency become available in the 2019-2020 or 2020-2021 fiscal year. This section expires July 1, 2021.	**House New**

ATTACHMENT 1
AHCA FX IB Governance

(1) The Agency for Health Care Administration shall replace the current Florida Medicaid Management Information System (FMMIS) and fiscal agent operations with a system that is modular, interoperable, and scalable for the Florida Medicaid program that complies with all applicable federal and state laws and requirements. The agency may not include in the project to replace the current FMMIS and fiscal agent contract:

(a) Functionality that duplicates any of the information systems of the other health and human services state agencies; or

(b) Procurement for agency requirements external to Medicaid programs with the intent to leverage the Medicaid technology infrastructure for other purposes without legislative appropriation or legislative authorization to procure these requirements.

The new system, the Florida Health Care Connection (FX) system, must provide better integration with subsystems supporting Florida's Medicaid program; uniformity, consistency, and improved access to data; and compatibility with the Centers for Medicare and Medicaid Services' Medicaid Information Technology Architecture (MITA) as the system matures and expands its functionality.

(2) For purposes of replacing FMMIS and the current Medicaid fiscal agent, the Agency for Health Care Administration shall:

(a) Prioritize procurements for the replacement of the current functions of FMMIS and the responsibilities of the current Medicaid fiscal agent, to minimize the need to extend all or portions of the current fiscal agent contract.

(b) Comply with and not exceed the Centers for Medicare and Medicaid Services funding authorizations for the FX system.

(c) Ensure compliance and uniformity with published MITA framework and guidelines.

(d) Ensure that all business requirements and technical specifications have been provided to all affected state agencies for their review and input and approved by the executive steering committee established in paragraph (g).

(e) Consult with the Executive Office of the Governor's working group for interagency information technology integration for the development of competitive solicitations that provide for data interoperability and shared information technology services across the state's health and human services agencies.

(f) Implement a data governance structure for the project to coordinate data sharing and interoperability across state healthcare entities.

(g) Implement a project governance structure that includes an executive steering committee composed of:

1. The Secretary of Health Care Administration, or the executive sponsor of the project.
2. The Assistant Secretary for Child Welfare of the Department of Children and Families, or his or her designee.

3. The Assistant Secretary for Economic Self-Sufficiency of the Department of Children and Families, or his or her designee.

4. Two employees from the Division of Medicaid of the Agency for Health Care Administration, appointed by the Secretary of Health Care Administration.

5. A representative of the Division of Health Quality Assurance of the Agency for Health Care Administration, appointed by the Secretary of Health Care Administration.

6. A representative of the Florida Center for Health Information and Transparency of the Agency for Health Care Administration, appointed by the Secretary of Health Care Administration.

7. A representative of the Division of Operations of the Agency for Health Care Administration, appointed by the Secretary of Health Care Administration.

8. The Chief Information Officer of the Agency for Health Care Administration, or his or her designee.

9. The state chief information officer or designee.

10. The Deputy Secretary for Children's Medical Services of the Department of Health, or his or her designee.

11. A representative of the Agency for Persons with Disabilities who has experience with the preparation and submission of waivers to the Centers for Medicare and Medicaid Services, appointed by the director of the Agency for Persons with Disabilities.

12. A representative from the Florida Healthy Kids Corporation.

13. A representative from the Department of Elderly Affairs who has experience with the Medicaid Program within that department, appointed by the Secretary of Elderly Affairs.

14. A representative of the Department of Financial Services who has experience with the state's financial processes including development of the PALM system, appointed by the Chief Financial Officer.

(3) The Secretary of Health Care Administration or the executive sponsor of the project shall serve as chair of the executive steering committee, and the committee shall take action by a vote of at least 10 affirmative votes with the chair voting on the prevailing side. A quorum of the executive steering committee consists of at least 11 members.

(4) The executive steering committee has the overall responsibility for ensuring that the project to replace FMMIS and the Medicaid fiscal agent meets its primary business objectives and shall:

(a) Identify and recommend to the Executive Office of the Governor, the President of the Senate, and the Speaker of the House of Representatives any statutory changes needed to implement the modular replacement to standardize, to the fullest extent possible, the state's healthcare data and business processes.

(b) Review and approve any changes to the project's scope, schedule, and budget which do not conflict with the requirements of subsections (1) and (2).

(c) Ensure that adequate resources are provided throughout all phases of the project.

(d) Approve all major project deliverables.

(e) Approve all solicitation-related documents associated with the replacement of the current FMMIS and Medicaid fiscal agent.

(5) This section expires July 1, 2021.

ATTACHMENT 2
Nursing Homes Uniform Reporting System

408.061 Data collection; uniform systems of financial reporting; information relating to physician charges; confidential information; immunity.—

(4) Within 120 days after the end of its fiscal year, each health care facility and nursing home home office, excluding continuing care facilities, and hospitals operated by state agencies~~, and nursing homes~~ as those terms are defined in s. 408.07, shall file with the agency, on forms adopted by the agency and based on the uniform system of financial reporting, its actual financial experience for that fiscal year, including expenditures, revenues, and statistical measures. Such data may be based on internal financial reports which are certified to be complete and accurate by the provider. However, hospitals', nursing homes', and nursing home home offices' actual financial experience shall be their audited actual experience. A home office may submit audited actual experience at the home office level as long as it includes a schedule that details the financial experience for each individual nursing home that is part of the home office entity to meet the audit submission requirements for the home office and individual nursing homes included in the consolidated report. This provision does not remove the requirement that the nursing home must file its actual experience on the agency adopted forms. Every nursing home shall submit to the agency, in a format designated by the agency, a statistical profile of the nursing home residents. The agency, in conjunction with the Department of Elderly Affairs and the Department of Health, shall review these statistical profiles and develop recommendations for the types of residents who might more appropriately be placed in their homes or other noninstitutional settings.

ATTACHMENT 3
Automatic Enrollment and Certification of Viability

Section 1. Subsection (5) is added to section 409.966, Florida Statutes, to read:

409.966 Eligible plans; selection.

(5) CERTIFICATION OF PLANS. Before executing a contractfor a plan to operate in a specific region, the Secretary of Health Care Administration shall certify to the Governor, the President of the Senate, and the Speaker of the House of Representatives, that the plan has sufficiently documented its capability of providing quality services to Medicaid enrollees consistent with the agency's requirements. The secretary shall further certify that the agency's plan selection decisions and automatic assignment procedures will not systematically prevent the plan from achieving an enrollment level congruent with the plan's pro forma financial statement and determined by the agency to be reasonable and necessary for sustainable operations. Such certification does not guarantee assignment of enrollees to any plan that fails to meet quality standards.

Section 2. Subsection (1) of section 409.977, Florida Statutes, is amended to read:

409.977 Enrollment.—

(1) The agency shall automatically enroll into a managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969. The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s. 409.967 and may not automatically enroll recipients in a plan that is deficient in those performance or quality standards. When a specialty plan is available to accommodate a specific condition or diagnosis of a recipient, the agency shall assign the recipient to that plan. In the first year of the first contract term only, if a recipient was previously enrolled in a plan that is still available in the region, the agency shall automatically enroll the recipient in that plan unless an applicable specialty plan is available. Except as otherwise provided in this part, the agency may not engage in practices that are designed to favor one managed care plan over another, unless it is temporarily necessary to enable a new plan in a region to attain a sustainable enrollment level and accommodate the certification made by the Secretary of Health Care Administration pursuant to s. 409.966(5).

ATTACHMENT 3
Automatic Enrollment and Certification of Viability

Section 3. Subsection (1) of section 409.984, Florida Statutes, is amended to read:

409.984 Enrollment in a long-term care managed care plan.

(1) The agency shall automatically enroll into a long-term care managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969. The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s. 409.967 and may not automatically enroll recipients in a plan that is deficient in those performance or quality standards. If a recipient is deemed dually eligible for Medicaid and Medicare services and is currently receiving Medicare services from an entity qualified under 42 C.F.R. part 422 as a Medicare Advantage Preferred Provider Organization, Medicare Advantage Provider-sponsored Organization, or Medicare Advantage Special Needs Plan, the agency shall automatically enroll the recipient in such plan for Medicaid services if the plan is currently participating in the long-term care managed care program. Except as otherwise provided in this part, the agency may not engage in practices that are designed to favor one managed care plan over another, unless it is temporarily necessary to enable a new plan in a region to attain a sustainable enrollment level and accommodate the certification made by the Secretary of Health Care Administration pursuant to 560 s. 409.966(5).