

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Appropriations

BILL: SB 2508

INTRODUCER: Appropriations Committee

SUBJECT: Health Care Services

DATE: February 3, 2016

REVISED: _____

ANALYST

Brown

STAFF DIRECTOR

Kynoch

REFERENCE

ACTION

AP Submitted as Committee Bill

I. Summary:

SB 2508 revises various statutes relating to aspects of the Medicaid program and the Florida Kidcare program, including:

- The definition of “rural hospital;”
- Eligibility for Medicaid and Kidcare;
- Fair hearings to appeal decisions made by various state agencies;
- Reimbursement of Medicaid providers;
- Overpayments to Medicaid providers;
- The Statewide Medicaid Residency Program;
- Disproportionate Share Hospital programs;
- Statewide Medicaid Managed Care; and
- The Program for All-Inclusive Care for the Elderly.

The bill conforms Medicaid-related statutes to the Senate General Appropriations Bill for Fiscal Year 2016-2017, SB 2500.

II. Present Situation:

The Medicaid Program

The Florida Medicaid program is a partnership between the federal and state governments. Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare & Medicaid Services (CMS). The state plan outlines Medicaid eligibility standards, policies, and reimbursement methodologies.

Florida Medicaid is administered by the Agency for Health Care Administration (AHCA) and financed with federal and state funds. Over 3.9 million Floridians are currently enrolled in

Medicaid, and the program's estimated expenditures for the 2015-2016 fiscal year are over \$24.9 billion.¹

Eligibility for Florida Medicaid is based on a number of factors, including age, household or individual income, and assets. State Medicaid eligibility payment guidelines are provided in statute under s. 409.903, F.S., (Mandatory Payments for Eligible Persons) and s. 409.904, F.S., (Optional Payments for Eligible Persons). Minimum coverage thresholds are established in federal law for certain population groups, such as children.

Statewide Medicaid Managed Care

Part IV of ch. 409, F.S., was created in 2011 by ch. 2011-134, L.O.F., and governs the Statewide Medicaid Managed Care program (SMMC). The program, authorized under federal Medicaid waivers, is designed for the AHCA to issue invitations to negotiate² and competitively procure contracts with managed care plans in 11 regions of the state to provide comprehensive Medicaid coverage for most of the state's enrollees in the Medicaid program. SMMC has two components: managed medical assistance (MMA) and long-term care managed care (LTCMC).

The LTCMC component began enrolling Medicaid recipients in August 2013 and completed its statewide roll-out in March 2014. The MMA component began enrolling Medicaid recipients in May 2014 and finished its roll-out in August 2014. As of December 2015, 3.19 million Medicaid recipients were enrolled in an SMMC plan while 793,515 were enrolled in Medicaid on a fee-for-service basis.³

Rural Hospitals

Part III of ch. 395, F.S., governs rural hospitals. A rural hospital is defined in s. 395.602(2)(e), F.S., as a licensed, acute care hospital having 100 or fewer licensed beds and an emergency room which is:

- The sole provider in a county with a population density no greater than 100 persons per square mile;
- An acute care hospital in a county with a population density no greater than 100 persons per square mile which is at least 30 minutes of travel time from any other acute care hospital in the same county;
- A hospital supported by a tax district or sub-district whose boundaries encompass an area of 100 persons or fewer per square mile;
- A hospital with a service area of fewer than 100 persons per square mile, with service area being defined as the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent five-year period; or

¹ Agency For Health Care Administration Presentation to Senate Health and Human Services Committee October 20, 2015 available at <http://bit.ly/1ZZ8nYU> (last visited Jan. 29, 2016).

² An "invitation to negotiate" is a written or electronically posted solicitation for vendors to submit competitive, sealed replies for the purpose of selecting one or more vendors with which to commence negotiations for the procurement of commodities or contractual services. *See* s. 287.012(17), F.S.

³ The Agency for Health Care Administration, "Florida Statewide Medicaid Monthly Enrollment Report," December 2015, available at http://ahca.myflorida.com/Medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited Dec. 23, 2015).

- A hospital designated as a critical access hospital under s. 408.07(15), F.S.⁴

An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of the definition will be granted rural hospital status upon submitting an application, including supporting documentation, to the Agency for Health Care Administration (AHCA).⁵

Currently, 28 hospitals meet the statutory definition of rural hospitals:

Rural Hospital	County	City	Beds
Baptist Medical Center - Nassau	Nassau	Fernandina Beach	62
Calhoun-Liberty Hospital	Calhoun	Blountstown	25
Campbellton-Graceville Hospital	Jackson	Graceville	25
Desoto Memorial Hospital	Desoto	Arcadia	49
Doctors Memorial Hospital	Holmes	Bonifay	20
Doctors' Memorial Hospital Inc.	Taylor	Perry	48
Ed Fraser Memorial Hospital	Baker	MacClenny	25
Fishermen's Hospital	Monroe	Marathon	25
Florida Hospital Flagler	Flagler	Palm Coast	99
Florida Hospital Wauchula	Hardee	Wauchula	25
George E Weems Memorial Hospital	Franklin	Apalachicola	25
Healthmark Regional Medical Center	Walton	Defuniak Springs	50
Hendry Regional Medical Center	Hendry	Clewiston	25
Jackson Hospital	Jackson	Marianna	100
Jay Hospital	Santa Rosa	Jay	49
Lake Butler Hospital Hand Surgery Center	Union	Lake Butler	25
Lakeside Medical Center	Palm Beach	Belle Glade	70
Madison County Memorial Hospital	Madison	Madison	25
Mariners Hospital	Monroe	Tavernier	25
Northwest Florida Community Hospital	Washington	Chipley	59
Putnam Community Medical Center	Putnam	Palatka	99
Raulerson Hospital	Okeechobee	Okeechobee	100
Regional General Hospital Williston ⁶	Levy	Williston	40
Sacred Heart Hospital On The Emerald Coast	Walton	Miramar Beach	58
Sacred Heart Hospital On The Gulf	Gulf	Port Saint Joe	19
Shands Lake Shore Regional Medical Center	Columbia	Lake City	99
Shands Live Oak Regional Medical Center	Suwannee	Live Oak	25
Shands Starke Regional Medical Center	Bradford	Starke	49

Rural hospitals are eligible to participate in Medicaid’s rural hospital financial assistance programs under s. 409.9116, F.S. Rural hospitals may also receive special consideration in the General Appropriations Act for Medicaid reimbursement due to their rural status.

⁴ Section 408.07(15), F.S., defines a critical access hospital as “a hospital that meets the definition of ‘critical access hospital’ in s. 1861(mm)(1) of the Social Security Act and that is certified by the Secretary of Health and Human Services as a critical access hospital.”

⁵ See s. 395.602(2)(e), F.S.

⁶ Formerly known as Tri County Hospital - Williston.

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.

Florida contains seven sole community hospitals.⁷ In 2014, the Legislature amended the definition of rural hospital to include hospitals classified as sole community hospitals having up to 340 licensed beds, beginning in the 2014-2015 fiscal year.⁸ Prior to the 2014-2015 fiscal year, two of Florida’s sole community hospitals did not qualify under Florida statutes as rural hospitals.⁹ The 2014 legislation had the effect of classifying all seven sole community hospitals as rural hospitals. However, one year later, the Legislature amended the definition once again to remove the provision added in 2014, which means the two sole community hospitals newly classified as rural in Fiscal Year 2014-2015 no longer meet the definition.

Fair Hearings

Under federal regulations, Medicaid applicants and recipients are entitled to adequate notice of state agency actions and a meaningful opportunity for a hearing to review those decisions whenever a claim for benefits is denied or not acted upon with reasonable promptness. This includes any action or inaction that affects either the person’s eligibility to be enrolled in Medicaid or the person’s receipt of a particular medical service covered by the program.¹⁰

State agency hearings of such Medicaid appeals are often called “fair hearings.” The same notice and hearing rights apply to disputes regarding Medicaid eligibility and to disputes regarding whether an eligible Medicaid enrollee has a medical need for a particular service, regardless of whether the benefits are administered through the fee-for-service system or a Medicaid managed care plan.

The Department of Children and Families (DCF) currently handles fair hearings related to its duty to determine eligibility for the Medicaid program. Additionally, under s. 409.285, F.S., s. 65-2.042, F.A.C., and a memorandum of understanding between the DCF and the AHCA, the DCF also handles fair hearings related to decisions made by the AHCA or a Medicaid managed care plan to deny, reduce, suspend, or terminate Medicaid services. This is a remnant of the dissolution of the former Department of Health and Rehabilitative Services, which was once the

⁷ The sole community hospitals in Florida are: Desoto Memorial Hospital (Arcadia); Doctors’ Memorial Hospital (Perry); Ed Fraser Memorial Hospital (MacClenny); Flagler Hospital (St. Augustine); Raulerson Hospital (Okeechobee); Jackson Hospital (Marianna); and Lower Keys Medical Center (Key West).

⁸ See ch. 2014-57, Laws of Florida.

⁹ Flagler Hospital and Lower Keys Medical Center.

¹⁰ See 42 CFR Part 431, Subpart E, available at <http://www.ecfr.gov/cgi-bin/retrieveECFR?n=sp42.4.431.e>, last visited Dec. 23, 2015.

single state agency that administered both the Medicaid eligibility system and the entire Medicaid health care delivery system.¹¹

For the Medicaid waiver authorizing the Agency for Persons with Disabilities (APD) to administer programs for home and community-based services, s. 393.125, F.S., provides parameters for APD waiver clients or applicants, or their parents, guardians, or authorized representatives, to request a fair hearing. Under s. 393.125(1)(a), F.S., such hearings related to the APD waiver are provided by the DCF.

With the implementation of SMMC, the AHCA's role in fair hearings has changed when hearings are related to actions taken by Medicaid managed care plans. Such hearings are not directly related to actions taken by the AHCA. Most, if not all, of the witnesses involved in fair hearings related to SMMC are employees or subcontractors of the managed care plan in which the Medicaid recipient is enrolled. Likewise, any documentary evidence at issue in a fair hearing related to SMMC are documents created by, and in the sole possession of, the managed care plan.¹²

Federal law requires that in fair hearings directly related to decisions made by a managed care plan, the plan itself must appear as a party to the fair hearing. However, the DCF's current rule governing DCF fair hearings pre-dates the implementation of SMMC and conflicts with federal law in that the rule limits parties to fair hearings to include only the appellant and state agencies.¹³

Florida Kidcare Program

The Florida Kidcare Program (Kidcare) was created in 1998 by the Florida Legislature in response to the federal enactment of the Children's Health Insurance Program (CHIP) in 1997.¹⁴ Initially authorized for 10 years, the program was re-authorized¹⁵ by Congress through 2019 with federal funding through September 30, 2015.

To address re-authorization again, federal funding for the CHIP was extended in April 2015 for an additional two-year period through September 30, 2017.¹⁶ Figure 1 below illustrates the re-authorization timeline for CHIP since its inception.

¹¹ Email from the Agency for Health Care Administration, Sept. 23, 2015, on file with staff of the Senate Appropriations Subcommittee on Health and Human Services.

¹² *Id.*

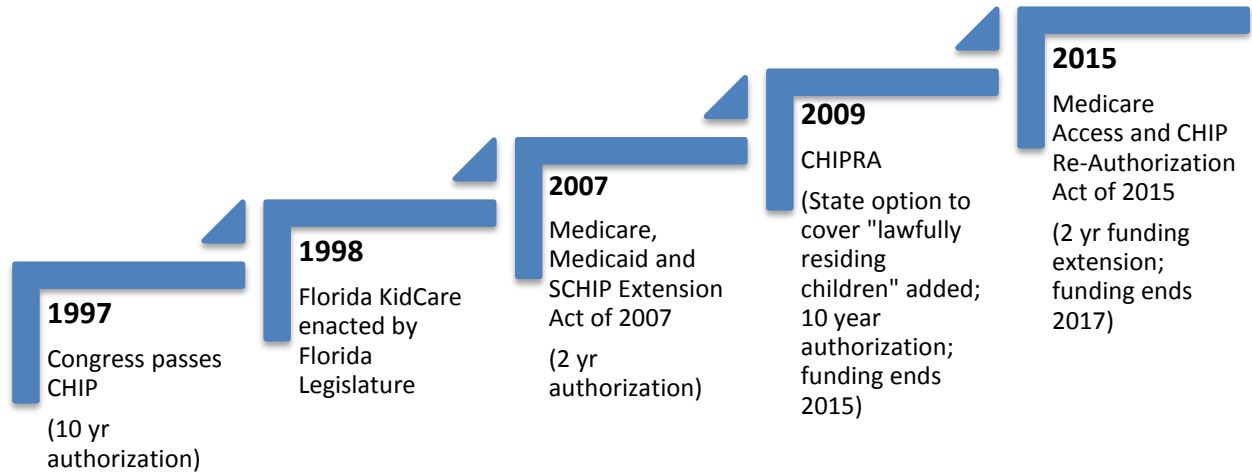
¹³ *Id.*

¹⁴ Social Security Administration, *Title XXI - State Children's Health Insurance Program*, http://www.ssa.gov/OP_Home/ssact/title21/2100.htm (last visited Oct. 27, 2015).

¹⁵ Children's Health Insurance Re-Authorization Act of 2009, Pub. Law 2009-3, <http://www.gpo.gov/fdsys/pkg/PLAW-111publ3/pdf/PLAW-111publ3.pdf> (last visited Oct. 27, 2015).

¹⁶ *See* Pub. L. No. 114-10, s. 301 (2015).

Figure 1-Milestones in the Medicaid and CHIP Program

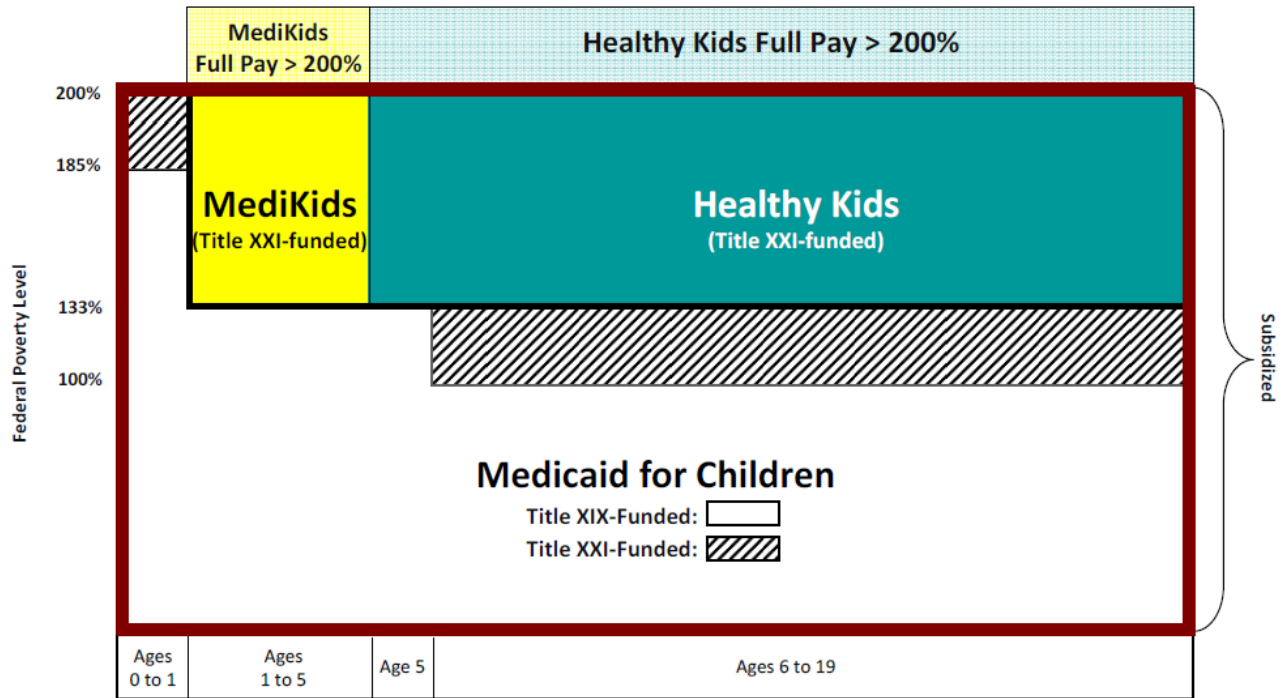


The CHIP provides subsidized health insurance to uninsured children who do not qualify for Medicaid but who have family incomes under 200 percent of the federal poverty level (FPL) and meet other eligibility criteria.

The state statutory authority for Kidcare is found under part II of ch. 409, ss. 409.810 through 409.821, F.S. Kidcare includes four operating components: Medicaid for children, Medikids, the Children’s Medical Services Network (CMS Network), and the Florida Healthy Kids Corporation (FHKC). The following chart illustrates the different program components and funding sources:¹⁷

¹⁷ State of Florida, Florida KidCare Program, State Plan Amendment #25 to Florida’s Title XXI Child Health Insurance Plan (July 1, 2014), p. 5. available at https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/program_policy/FLKidCare/PDF/KidCare_Program_Amendment_25_to_Title_XXI_2014-07-01.pdf (last visited Oct. 27, 2015).

Florida KidCare Eligibility



CMS Network
(Title XIX and Title XXI)

Eff. 1/1/2014

Coverage for the non-Medicaid components are funded through Title XXI of the federal Social Security Act. Title XIX of the Social Security Act (Medicaid), state funds, and family contributions also provide funding for the different components. Family contributions under the Title XXI component are based on family size, household incomes, and other eligibility factors. Families above the income limits for premium assistance or who are not otherwise eligible for premium assistance are offered the opportunity to participate in Kidcare at a non-subsidized rate (full pay). Currently, the income limit for premium assistance is 200 percent of the FPL.

Several state agencies and the FHKC share responsibilities for Kidcare. The AHCA, the Department of Children and Families (DCF), the Department of Health (DOH), and the FHKC have specific duties under Kidcare as detailed in part II of ch. 409, F.S. The DCF determines eligibility for Medicaid. The FHKC receives all Kidcare applications and screens for Medicaid eligibility and determines eligibility for all Title XXI programs, referring applications to the DCF, as appropriate, for a complete Medicaid determination.

To enroll in Kidcare, families may apply online or use a paper application that determines eligibility for multiple programs, including Medicaid and CHIP, for the entire family. Applications are available in English, Spanish, and Creole. Eligibility for premium assistance is determined first through electronic data matches with available databases or, in cases where

income cannot be verified electronically, through submission of current pay stubs, tax returns, or W-2 forms.

The 2015-2016 General Appropriations Act appropriated \$405,203,249 for the Title XXI (CHIP) components.¹⁸ As of September 1, 2015, a total of 2,391,259 children were enrolled in Kidcare.¹⁹

PROGRAM	ENROLLMENT
Medicaid - Title XIX funded	2,054,470
Medicaid - Title XXI funded	119,999
Healthy Kids - Total	176,001
Children's Medical Services Network	11,429
Medikids	29,360
Total Florida Kidcare Enrollment:	2,391,259

Under s. 409.814, F.S., Kidcare's eligibility guidelines are described in conformity with current Title XIX and Title XXI terminology and requirements for each funding component. A child who is an alien, but does not meet the definition of a qualified alien in the United States, is specifically excluded from eligibility from Title XXI premium assistance.

Eligibility of Alien Children for Medicaid and the CHIP

The Immigration and Nationality Act (INA) was created in 1952 to consolidate a variety of statutes governing immigration law. The INA has been amended numerous times since 1952. The INA defines the term "alien" as "any person not a citizen or national of the United States."²⁰ Nationals of the United States are citizens of the United States, or persons who, though not a citizen of the United States, owe permanent allegiance to the United States.²¹

Generally, under the INA, an alien is not eligible for any state or local public benefit, including health benefits, unless the alien is:²²

- A qualified alien;²³
- A nonimmigrant alien;²⁴ or
- An alien who is paroled into the United States under the INA.²⁵

There are limited exceptions to the ineligibility for public benefits for treatment of emergency medical conditions, emergency disaster relief, immunizations, and services such as soup kitchens, crisis counseling and intervention, and short-term shelter.²⁶

¹⁸ Chapter 2015-232, ss. 167-172, Laws of Florida.

¹⁹ The Agency for Health Care Administration, *Florida Kidcare Enrollment Report - September 2015*, (on file with the Senate Committee on Health Policy).

²⁰ See 8 U.S.C. s. 1101(a)(3).

²¹ See 8 U.S.C. s. 1101(a)(21) and (22).

²² See 8 U.S.C. s. 1621(a).

²³ See 8 U.S.C. s. 1641(b) and (c). There are nine classes of qualified aliens.

²⁴ See 8 U.S.C. s. 1101(a)(15). There are 22 classes of nonimmigrant aliens identified in this section.

²⁵ See 8 U.S.C. s. 1182(d)(5).

²⁶ See 8 U.S.C. s. 1621(b).

The INA gives states the authority to provide that an alien who is not lawfully present in the United States is eligible for any state or local public benefit for which the alien would otherwise not be eligible, but only through the enactment of a state law which affirmatively provides for such eligibility.²⁷

The enactment of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (Public Law 104-193), placed limitations on federal funding for health care of immigrant families. The law imposed a 5-year waiting period on certain groups of qualified aliens, including most children and pregnant women who were otherwise eligible for Medicaid.²⁸ Medicaid coverage for individuals subject to the 5-year waiting period and for those who do not meet the definition of qualified alien was limited to treatment of an emergency medical condition. The 5-year waiting period also applies to children and pregnant women under the CHIP. The PRWORA did not affect eligibility of undocumented aliens, and these individuals remain ineligible for services, except for emergency services under Medicaid.

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (Public Law No. 111-3), permits states to cover certain children and pregnant women who are "lawfully residing in the United States" in both Medicaid and CHIP, notwithstanding certain provisions under PRWORA. States may elect to cover these groups under Medicaid only or under both Medicaid and CHIP. The law does not permit states to cover these new groups in the CHIP without also extending the option to Medicaid children.²⁹

Prior to the enactment of the CHIPRA, the term "lawfully residing" had not been used to define eligibility for either Medicaid or CHIP; however, the term has been used by the U.S. Department of Agriculture (USDA) and the Social Security Administration (SSA). The federal Centers for Medicare & Medicaid Services utilized existing regulations from these agencies to define a lawful presence for Medicaid and CHIP through a letter to state health officials dated July 1, 2010.³⁰ The letter states that children and pregnant women who fall into one of the following categories will be considered "lawfully present:"

- A qualified alien as defined in section 431 of the PRWORA;
- An alien in non-immigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;
- An alien who has been paroled into the United States pursuant to section 212(d)(5) of the INA for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
- An alien who belongs to one of the following classes:
 - Temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. s. 1160 or 1255a, respectively);
 - Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. s. 1254a), and pending applicants for TPS who have been granted employment authorization under 8 C.F.R. s. 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);

²⁷ See 8 U.S.C. s. 1621(d).

²⁸ Section 403 of Pub. L No. 104-193, H.R. 3734, 104th Congress (Aug. 22, 1996).

²⁹ See 42 U.S.C. s. 1397gg(e).

³⁰ Centers for Medicare and Medicaid Services, *Medicaid and CHIP Coverage of "Lawfully Residing" Children and Pregnant Women*, State Health Official Letter, CHIPRA#17 (July 1, 2010), <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO10006.pdf> (last visited Oct. 27, 2015).

- Family Unity beneficiaries pursuant to section 301 of Public Law 101-649, as amended;
- Deferred Enforced Departure (DED) pursuant to a decision made by the president of the United States;
- Deferred action status; or,
- Visa petition has been approved and has a pending application for adjustment of status;
- A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. s. 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. s. 1231) or under the Convention Against Torture, who has been guaranteed employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;
- An alien who has been granted withholding of removal under the Convention Against Torture;
- A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. s. 1101 (a)(27)(J));
- An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. s. 1806(e); or
- An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

These individuals are eligible for Medicaid and CHIP, if the state elects the option under the CHIPRA and if the child or pregnant woman meets the state residency requirements and other Medicaid or CHIP eligibility requirements. As of January 2015, 28 states cover lawfully residing children under Medicaid or CHIP without the five-year waiting period.³¹

Medicaid Payments for Hospital Emergency Department Visits

In 2012, the Legislature amended s. 409.905(5), F.S., to require the AHCA to limit payment for hospital emergency department visits for non-pregnant Medicaid recipients 21 years of age or older to six visits per fiscal year. When this provision was enacted, the cost savings were estimated at \$19.6 million in general revenue for Fiscal Year 2012-13.³² The limitation became effective August 1, 2012,³³ roughly two years prior to the statewide phase-in of the MMA component of SMMC.

The AHCA implemented this limitation to payments made by the AHCA directly to hospitals on a fee-for-service basis for emergency department services. The limitation was not applied to emergency department visits by recipients enrolled in Medicaid managed care plans. With the implementation of SMMC, the limitation pertains to only a small portion of Florida's Medicaid population.

The AHCA applied to federal CMS for an amendment to Florida's Medicaid state plan to the effect of the limitation. On December 13, 2012, CMS denied the AHCA's state plan amendment. The AHCA requested reconsideration of the denial; however, CMS has still not approved the

³¹ Based on results from a national survey by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015, <http://kff.org/report-section/modern-era-medicare-and-chip-eligibility/> (last visited Oct. 27, 2015).

³² Staff of the Senate Budget Committee, "Bill Analysis and Fiscal Impact Statement," SB 1988, Feb. 15, 2012, available at <http://www.flsenate.gov/Session/Bill/2012/1988/Analyses/2012s1988.bc.PDF>, last visited Dec. 23, 2015.

³³ See s. 5 of ch. 2012-33, L.O.F.

state plan amendment and has suggested that continuation of this policy could jeopardize Florida's federal matching funds for Medicaid.³⁴

Medicaid Coverage of Housing-Related Activities

On June 26, 2015, federal CMS published an informational bulletin³⁵ to assist states in designing Medicaid benefits and to clarify the circumstances under which Medicaid reimburses for certain housing-related activities with the goal of promoting community integration for individuals with disabilities, older adults needing long-term services and supports, and those experiencing chronic homelessness. According to the bulletin, housing-related activities include a range of flexible services and supports available to eligible individuals, including:

- Individual Housing Transition Services – services that support an individual's ability to prepare for and transition to housing;
- Individual Housing & Tenancy Sustaining Services – services that support the individual in being a successful tenant in his/her housing arrangement and thus able to sustain tenancy; and
- State-level Housing Related Collaborative Activities – services that support collaborative efforts across public agencies and the private sector that assist a state in identifying and securing housing options for individuals with disabilities, older adults needing long-term services and supports, and those experiencing chronic homelessness.

Section 1915(i) of the Social Security Act

The Deficit Reduction Act of 2005 added section 1915(i) to the Social Security Act, providing states the option to offer home and community-based services (HCBS) through the a state's Medicaid state plan, which had previously been available only through a waiver. Initially, states could only serve individuals eligible under the state plan with incomes at or below 150 percent of the federal poverty level and could offer some, but not all, HCBS services and supports available through a waiver. In addition, states were not able to target 1915(i) state plan options to particular populations within the state.

In 2010, coverable services under section 1915(i) were expanded to include any HCBS permitted through a waiver, certain services for individuals with mental health and substance use disorders, and other services requested by a state and approved by the Secretary of the U.S. Department of Health and Human Services. In addition, the changes require states to offer the benefit statewide and enable states to target 1915(i) state plan HCBS to particular groups of participants but not limit the number of participants who may receive the benefit.³⁶

³⁴ *Supra*, note 11.

³⁵ Bulletin from Vikki Wachino, Director, Center for Medicaid and CHIP Services, Centers for Medicare & Medicaid Services, June 26, 2015, available at <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf> (last visited Jan. 25, 2016)

³⁶ Centers for Medicare & Medicaid Services, "Fact Sheet: Summary of the Key Provisions of the Final Rule for 1915(i) Home and Community-Based Services State Plan Option," January 10, 2014, available at <http://bit.ly/1JMbKR3> (last visited Jan. 29, 2016)

Phelan-McDermid Syndrome

Phelan-McDermid Syndrome, also known as 22q13.3 deletion syndrome, is a disorder in humans caused by the loss of a small piece of chromosome 22. The deletion occurs near the end of the chromosome at a location designated q13.3.³⁷

Characteristic signs and symptoms include developmental delay, moderate to profound intellectual disability, decreased muscle tone (hypotonia), and absent or delayed speech. Some people with this condition have autism or autistic-like behavior that affects communication and social interaction, such as poor eye contact, sensitivity to touch, and aggressive behaviors. They may also chew on non-food items such as clothing. Less frequently, people with this condition have seizures.³⁸

Individuals with Phelan-McDermid Syndrome tend to have a decreased sensitivity to pain. Many also have a reduced ability to sweat, which can lead to a greater risk of overheating and dehydration. Some people with this condition have episodes of frequent vomiting and nausea (cyclic vomiting) and backflow of stomach acids into the esophagus (gastroesophageal reflux).³⁹

People with Phelan-McDermid Syndrome typically have distinctive facial features, including a long, narrow head; prominent ears; a pointed chin; droopy eyelids (ptosis); and deep-set eyes. Other physical features seen with this condition include large and fleshy hands and/or feet, a fusion of the second and third toes (syndactyly), and small or abnormal toenails. Some affected individuals have accelerated growth.⁴⁰

The condition is rare; however, due to difficulties with diagnosis, an accurate and well-recognized measure of the prevalence of the disorder has not been made. At least 500 cases are known to exist.⁴¹ The Phelan-McDermid Syndrome Foundation estimates that roughly 55 households in Florida include a family member with Phelan-McDermid Syndrome.⁴²

Overpayments to Out-of-Business Medicaid Providers

Under s. 409.907, F.S., a Medicaid provider agreement is a voluntary contract between a provider and the AHCA, and an entity that agrees to become a Medicaid provider must comply with all laws, rules, and policies related to Florida's Medicaid program.

The Medicaid Program Integrity unit, within the Office of Inspector General at the AHCA, routinely audits Medicaid providers and may determine that an overpayment has occurred. In such cases, the provider is required to return funds to the Medicaid program. When the AHCA discovers an overpayment has been made to a provider that has since gone out of business, a

³⁷ National Institutes of Health, "22q13.3 Deletion Syndrome," September 2009, available at <http://ghr.nlm.nih.gov/condition/22q133-deletion-syndrome> (last visited Jan. 29, 2016)

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² Email from the Phelan-McDermid Syndrome Foundation, Jan. 22, 2016. On file with staff of the Senate Appropriations Subcommittee on Health and Human Services.

refund from the provider is still pursued, but, historically, less than one percent of such overpayment debts are recovered.⁴³

Under federal law, the state is required to refund to federal CMS the federal share of the overpayment no later than one year after the state discovers that an overpayment has been made, regardless of whether the state has collected a refund from the provider.⁴⁴

However, federal law provides that the requirement to refund the federal share to CMS can be waived in cases in which the state is unable to recover the overpayment because the provider has been determined bankrupt or out of business.⁴⁵ For an out-of-business provider, in order for the federal refund requirement to be waived, the state must, within one year of discovering the overpayment:

- Document its efforts to locate the provider and its assets; and
- Make available an affidavit or certification from the appropriate state legal authority establishing that the provider is out of business and that the overpayment cannot be collected under state law and procedures.⁴⁶

Currently, the AHCA is not afforded a means under state law and procedures to certify that a Medicaid provider is out of business. Therefore, the provision for the federal refund requirement to be waived cannot be triggered. During Fiscal Year 2012-13, the AHCA was required to refund to CMS approximately \$520,000, which represented the federal share of overpayments made to providers that had gone out of business. In Fiscal Year 2011-12, the sum was approximately \$2.9 million.⁴⁷

School-based Medicaid Services and the Certified School Match Program

The purpose of Florida's Medicaid certified school match program is to provide reimbursement for medically necessary services provided by or arranged by a school district for certain Medicaid-eligible students. School districts that are part of the public education system are eligible to participate in the certified school match program. School districts determine how the funding will be distributed among the individual schools. All 67 school districts are enrolled in Florida Medicaid to provide services through the certified school match program.⁴⁸

A charter school may participate in the program if participation is allowed in its contract with its school district. Under such an arrangement, the school district submits Medicaid claims for services provided by or through the charter school, as is done for public schools. The AHCA reports having no information on the number of charter schools that are contracted with their school districts to participate.⁴⁹ Private schools are not eligible to participate in the program because public school expenditures for the services count as the state share of Medicaid funds

⁴³ *Supra*, note 11.

⁴⁴ *See* 42 CFR 433.312(a)(2).

⁴⁵ *See* 42 CFR 433.312(b).

⁴⁶ *See* 42 CFR.433.318(d).

⁴⁷ *Supra*, note 11.

⁴⁸ Email from the AHCA, Jan. 24, 2016. On file with staff of the Senate Appropriations Subcommittee on Health and Human Services.

⁴⁹ *Id.*

that draw federal match, and such expenditures by private entities do not qualify as the state share under federal law.⁵⁰

School-based services that may be provided under the certified school match program are available to children with specified disabilities who are eligible for both Medicaid and part B or part H of the federal Individuals with Disabilities Education Act or who meet other developmental disability criteria.⁵¹

Services include, but are not limited to, physical, occupational, and speech therapy services, behavioral health services, mental health services, transportation services, Early Periodic Screening, Diagnosis, and Treatment (EPSDT) administrative outreach for the purpose of determining eligibility for exceptional student education, and any other such services,⁵² including autism therapy services allowed by federal law.⁵³ Services specifically excluded from the certified school match program are family planning, immunizations, and prenatal care.

Medicaid Nursing Home Reimbursement

Medicaid reimburses nursing home providers through a cost-based reimbursement methodology. Cost-based reimbursement is accomplished through establishing a reimbursement rate based upon each individual nursing home's historic cost of providing services, which is then indexed using pre-determined health care inflation indices to provide an inflationary increase. The AHCA collects the cost data from annual cost reports submitted by the nursing homes to use in calculating and setting cost-based reimbursement rates. Other provider types that are reimbursed using a cost-based methodology include intermediate care facilities for the developmentally disabled, hospital outpatient services, rural health clinics, county health departments, hospices, and federally qualified health centers. These provider types may be subject to specified reimbursement ceilings and targets.

In 2008, the Legislature directed the AHCA to establish provider rates for hospitals, nursing homes, county health departments, intermediate care facilities for the developmentally disabled, and prepaid health plans in a manner that would ensure no automatic increase in statewide expenditures resulting from a change in unit costs for a period of two fiscal years beginning July 1, 2009.⁵⁴ In 2011, the Legislature revised this provision to ensure no automatic increase in statewide expenditures resulting from a change in unit costs based on the July 1, 2011, unit costs.⁵⁵ The 2011 revision was made effective in perpetuity. In 2015, intermediate care facilities for the developmentally disabled were removed from the list of providers to which the provision applies.

⁵⁰ The Agency for Health Care Administration, "Certified School Match: School District Provider Qualifications," available at <http://www.fdhc.state.fl.us/medicaid/childhealthservices/schools/index.shtml> (last visited Feb. 1, 2016)

⁵¹ See s. 409.9071(1), F.S.

⁵² See s. 1011.70(1), F.S.

⁵³ See s. 1011.70(4), F.S.

⁵⁴ See ch. 2008-143, Laws of Florida.

⁵⁵ See ch. 2011-61, Laws of Florida.

Graduate Medical Education and the Statewide Medicaid Residency Program

In 2013, the Legislature created the Statewide Medicaid Residency Program (SMRP) to fund graduate medical education (GME).⁵⁶ 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, and can range from three to six years or more in length of time.⁵⁷

Under the SMRP:

- A resident is defined as 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.
- A full-time equivalent (FTE) is defined as a resident who is in his or her initial residency period, not to exceed five years. A resident training beyond the initial residency period is counted as one-half of one FTE, unless his or her chosen specialty is in general surgery or primary care, in which case the resident is counted as one FTE. For the SMRP, primary care specialties include:
 - Family medicine;
 - General internal medicine;
 - General pediatrics;
 - Preventive medicine;
 - Geriatric medicine;
 - Osteopathic general practice;
 - Obstetrics and gynecology; and
 - Emergency medicine.
- Medicaid payments are defined as payments made to reimburse a hospital for direct inpatient services, as determined by the AHCA, during the fiscal year preceding the date on which calculations for the program’s allocations take place for any fiscal year.
- On or before September 15 of each year, the AHCA is required to calculate an allocation fraction for each hospital participating in the program based on a formula defined in statute.
- A hospital’s annual allocation equals the funds appropriated for the SMRP in the GAA multiplied by its allocation fraction. However, if the calculation results in an annual allocation that exceeds two times the average per FTE resident amount for all hospitals, the hospital’s annual allocation must be reduced to a sum that equals no more than two times the average per FTE resident amount and the excess funds must be redistributed to participating hospitals whose annual allocation does not exceed two times the average per FTE resident amount for all hospitals.
- The AHCA is required to distribute to each participating hospital one-fourth of that hospital’s annual allocation on the final business day of each quarter of a state fiscal year.

⁵⁶ See ch. 2013-48, Laws of Florida.

⁵⁷ Florida Department of Health, *Annual Report on Graduate Medical Education in Florida*, January 2010.

Disproportionate Share Hospital Programs

Federal law requires state Medicaid programs to make Disproportionate Share Hospital (DSH) payments to qualifying hospitals that serve a large number of Medicaid recipients and uninsured individuals. The federal government annually provides a limited DSH allotment to each state. States may appropriate these federal funds based on the amount of state dollars appropriated as matching funds for the federal DSH allotment, up to but not exceeding the federal limit. The Legislature delineates how DSH funds will be distributed to each eligible facility in the General Appropriations Act and according to parameters within the Florida Statutes.

For states to receive DSH payments, federal law requires states to submit an independent certified audit and an annual report to the secretary of the U.S. Department of Health and Human Services, describing DSH payments made to each DSH hospital. Florida law requires the AHCA to use audited data from specified years to determine the amount of Medicaid and charity care to be used in calculating DSH payments.⁵⁸

Payments by Medicaid Managed Care Plans for Emergency Services

Three sections of the Florida Statutes contain requirements for the amounts a Medicaid managed care plan must pay a non-contracted provider for emergency services.⁵⁹ Federal law also contains certain requirements for such payments.⁶⁰ Florida law is not consistent with federal law.

Section 409.9128(5), F.S.,⁶¹ provides that reimbursement for emergency services provided to an enrollee of a Medicaid managed care plan by a provider that does not have a contract with the managed care plan must be the lesser of the:

- Provider's charges;
- Usual and customary provider charges for similar services in the community where the services were provided;
- Charge mutually agreed to by the managed care plan and the provider within 60 days after submittal of the claim; or
- Medicaid rate.

Section 409.967(2)(b), F.S., provides that Medicaid managed care plans operating under MMA must pay for emergency services rendered by a non-contracted provider at a rate equaling the lesser of the:

- Provider's charges;
- Usual and customary provider charges for similar services in the community where the services were provided;
- Charge mutually agreed to by the managed care plan and the provider within 60 days after submittal of the claim; or

⁵⁸ See s. 409.911(2), F.S.

⁵⁹ See ss. 409.9128(5), 409.967(2)(b), and 641.513(6), F.S.

⁶⁰ See 42 U.S.C. s. 1396u-2(b)(2)(D).

⁶¹ This section of statute predates SMMC and was applied to Medicaid managed care plans operating in Florida prior to the implementation of SMMC. For plans participating in SMMC, s. 409.967(2)(b), F.S., supersedes s. 409.9128(5), F.S., by virtue of s. 409.961, F.S. However, s. 409.9128(5), F.S., may still be applied if managed care plans are engaged to participate in Medicaid outside of SMMC.

- Rate the AHCA would have paid on the most recent October 1st.

Section 641.513(6), F.S., which is part of the Florida Insurance Code, provides that reimbursement for emergency services provided by a non-contracted provider to subscribers of a health maintenance organization who are Medicaid recipients must be the lesser of the:

- Provider's charges;
- Usual and customary provider charges for similar services in the community where the services were provided;
- Charge mutually agreed to by the managed care plan and the provider within 60 days after submittal of the claim; or
- Medicaid rate.⁶²

The Rogers Amendment

The requirements of federal law, however, differ from the requirements of Florida law found in the statutes cited above. Under 42 U.S.C. s. 1396u-2(b)(2)(D), federal law provides:

Any provider of emergency services that does not have in effect a contract with a Medicaid managed care entity that establishes payment amounts for services furnished to a beneficiary enrolled in the entity's Medicaid managed care plan must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the beneficiary received medical assistance under this subchapter other than through enrollment in such an entity...

This provision of federal law, commonly known as the Rogers Amendment, requires that, in Florida, a payment by a Medicaid managed care plan to a non-contracted provider of emergency services must be no more than the fee-for-service rate that the AHCA would pay, less any amounts included in the AHCA's fee-for-service rate that represent indirect costs of medical education and direct costs of graduate medical education. Meanwhile, Florida law requires that such a payment must not exceed "the Medicaid rate," without accounting for the medical education costs that federal law requires to be deducted from the Medicaid rate.

The Rogers Amendment was included in the federal Deficit Reduction Act of 2005,⁶³ which was enacted on February 8, 2006. On March 31, 2006, federal CMS sent guidance to all state Medicaid programs regarding implementation of the Rogers Amendment, directing states to amend contracts with Medicaid managed care plans in order to comply with the Rogers Amendment no later than January 1, 2007.⁶⁴ The AHCA's model contract for MMA managed

⁶² These provisions are identical to those found under s. 409.9128(5), F.S.

⁶³ See Pub. L. No. 109.171.

⁶⁴ Letter from Dennis G. Smith, Director, Center for Medicaid and State Operations, Centers for Medicare & Medicaid Services, March 31, 2006, available at <https://www.medicare.gov/Federal-Policy-Guidance/downloads/SMD06010.pdf> (last visited Jan. 22, 2016)

care plans, dated November 1, 2015,⁶⁵ requires that managed care plans pay non-contracted providers for emergency services according to s. 409.967(2)(b), F.S., as opposed to the requirements of the Rogers Amendment.

SMMC Waiver Authority

Florida's federal waiver authority for SMMC waives a number of federal Medicaid laws and regulations and covers provisions related to enrollment, benefit packages, cost-sharing, delivery systems, consumer protections, choice counseling, and the Low Income Pool, among other provisions. The Special Terms and Conditions for the waiver authority, as amended on October 15, 2015,⁶⁶ specify that "All requirements of the Medicaid Program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to this demonstration."⁶⁷ Florida's waiver authority for SMMC does not expressly waive the requirements of the Rogers Amendment.

Medical Education Costs in Hospital Reimbursement

Florida Medicaid uses a prospective payment system known as a diagnosis-related group, or DRG, methodology for calculating fee-for-service rates for hospital inpatient services⁶⁸ that does not include costs for medical education in hospital inpatient reimbursement. For hospital outpatient services, however, the state uses a cost-based methodology for determining reimbursement rates, which includes some costs of graduate medical education (GME) incurred by hospitals.

The Governor's proposed budget for Fiscal Year 2016-2017 includes a realignment of \$17.3 million out of the hospital outpatient and prepaid health plan categories and into the GME category,⁶⁹ which is part of the Governor's proposal to transition from the current cost-based reimbursement methodology for hospital outpatient services to a prospective payment system. The sum of \$17.3 million represents GME costs that are currently contained in outpatient reimbursement that would no longer be part of outpatient reimbursement if the prospective payment system proposed by the Governor were to be implemented.

MMA Essential Providers

Section 409.975(1), F.S., creates a designation in MMA of Medicaid providers known as "essential Medicaid providers" and a separate designation for "statewide essential providers." These designations relate to requirements for Medicaid managed care plans to maintain adequate provider networks. Plans are allowed to limit the providers in their networks based on credentials, quality indicators, and price, except for the requirements found in s. 409.975, F.S.

⁶⁵ Agency for Health Care Administration, "SMMC Plans, Model Contract, Attachment II – Core Contract Provisions, Exhibit II-A, Managed Medical Assistance Program," November 1, 2015, p. 27, available at http://ahca.myflorida.com/Medicaid/statewide_mc/plans.shtml (last visited Jan. 22, 2016).

⁶⁶ Centers for Medicare & Medicaid Services, "Florida Managed Medical Assistance Program, Special Terms and Conditions," Oct. 15, 2015, available at <http://bit.ly/1neCQWb> (last visited Jan. 22, 2016).

⁶⁷ *Id.*, p. 5.

⁶⁸ See s. 409.905(5)(c), F.S.

⁶⁹ Governor Rick Scott's Florida First Budget, 2016-2017, Medicaid Services to Individuals, Realignment of Graduate Medical Education Expenditures, available at <http://bit.ly/1ndKZdG> (last visited Jan. 22, 2016).

Essential Medicaid Providers

Under s. 409.975(1)(a), F.S., a managed care plan is required to contract with all providers in a region that are classified by the AHCA as essential Medicaid providers, unless the AHCA approves of an alternative arrangement for the plan to secure the types of services offered by such providers. The statute specifies that providers are essential for serving Medicaid enrollees if:

- They offer services that are not available from any other provider within a reasonable access standard, or
- They provided a substantial share of the total units of a particular service used by Medicaid patients within the region during the last three years and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid patients.

Using the criteria above, the AHCA is charged with determining which individual providers are classified as essential Medicaid providers. The AHCA is required to make those determinations within, at a minimum, four categories of providers:

- Federally qualified health centers;
- Statutory teaching hospitals;
- Trauma centers; and
- Hospitals located at least 25 miles from any other hospital with similar services.

A managed care plan that has not contracted with all essential Medicaid providers in its region or regions as of the first date of recipient enrollment, or with whom an essential provider has terminated its contract, must negotiate in good faith with the non-contracted essential provider or providers for one year or until an agreement is reached, whichever is first.

- During that year, payments for services rendered by a non-contracted essential provider must be made at the applicable Medicaid rate as of the first day of the contract between the AHCA and the plan, and a rate schedule for all essential providers must be attached to the contract between the AHCA and the plan;
- At the end of the year, a managed care plan that is unable to contract with one or more essential providers must notify the AHCA and propose an alternative arrangement for securing the essential services for Medicaid enrollees;
- An alternative arrangement, if proposed, must rely on contracts with other participating providers, regardless of whether those providers are located within the same region as the non-contracted essential provider;
- If an alternative arrangement is approved by the AHCA, payments to the non-contracted essential provider or providers in question after the date of the AHCA's approval must equal 90 percent of the applicable Medicaid rate; and
- If the alternative arrangement is not approved by the AHCA, a plan's payment to the non-contracted essential provider or providers in question must equal 110 percent of the applicable Medicaid rate.

The AHCA is prohibited from classifying physicians and individual practitioners as essential providers.

Statewide Essential Providers

Under s. 409.975(1)(b), F.S., certain providers are classified as “statewide essential providers” for all managed care plans in all regions. All managed care plans must include these statewide essential providers in their networks. Statewide essential providers include:

- Faculty plans of Florida medical schools;
- Regional perinatal intensive care centers (RPICCs);⁷⁰
- Specialty children’s hospitals; and
- Accredited and integrated systems serving medically complex children comprising separately licensed, but commonly owned, health care providers delivering at least the following services:
 - Medical group home;
 - In-home and outpatient nursing care and therapies;
 - Pharmacy services;
 - Durable medical equipment; and
 - Prescribed pediatric extended care.

Managed care plans that have not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment must continue to negotiate in good faith. In such instances, under s. 409.975(1)(b), F.S.:

- Payments to physicians on the faculty of non-contracted Florida medical schools must be made at the applicable Medicaid rate;
- Payments for services rendered by RPICCs must be made at the applicable Medicaid rate as of the first day of the contract between the AHCA and the plan; and
- Payments to non-contracted specialty children’s hospitals must equal the highest rate established by contract between that provider and any other Medicaid managed care plan.

Excluding Essential Providers from Managed Care Plan Networks

Under s. 409.975(1)(c), F.S., after an essential provider has actively participated in a managed care plan’s network for 12 months, the plan may exclude the essential provider from its network for failure to meet quality or performance criteria. If a plan excludes an essential provider from its network under this provision, the plan must provide written notice to all recipients who have chosen that provider for care, and the notice must be provided at least 30 days before the effective date of the exclusion.

MMA Rates, Methods, and Terms of Payment for Managed Care Plans and Hospitals

Section 409.975(6), F.S., contains requirements for managed care plans participating in MMA relating to the rates, methods, and terms of payment negotiated between the plans and hospitals. For rates, methods, and terms of payment negotiated after a contract between the AHCA and the managed care plan is executed, which resulted from the competitive procurement for the MMA component of SMMC, managed care plans are required to negotiate with hospitals for rates of

⁷⁰ Regional perinatal intensive care centers are units within a hospital specifically designed to provide a full range of obstetrical services to women with high-risk pregnancies and health care for newborns with special health needs, such as critical illness or low birth weight. *See* ch. 383, F.S. Eleven Florida hospitals are designated by the Department of Health as RPICC hospitals.

payment that must be no lower than the rate the AHCA would have paid the hospital on the first day that the contract between the plan and the hospital takes effect.

While such rates of payment are required to be no less than the AHCA's fee-for-service rates, when those rates are negotiated after a managed care plan executes a contract with the AHCA following the competitive procurement, payments by the plan to contracted hospitals also must not exceed 120 percent of the AHCA rate unless specifically approved by the AHCA.

These provisions of current law have the effect of limiting the reimbursement amounts that a managed care plan may negotiate with a hospital following the competitive procurement to a range of no less than the fee-for-service rate and no more than 120 percent of the fee-for-service rate, unless the AHCA specifically approves a contracted rate greater than 120 percent of the fee-for-service rate. The statute makes no allowance for a managed care plan to negotiate a rate less than the fee-for-service rate and is silent on the terms of multi-year contracts between managed care plans and hospitals that may have been in effect prior to a competitive procurement.

The statute is also silent on how the rates, methods, and terms of payment within a managed care plan contract with a hospital may be measured in order to achieve an accurate comparison between managed care plan payments and the AHCA's fee-for-service rates. Managed care plan payments might or might not use the same basis and methodologies used by the AHCA, which could result in inaccurate or incompatible comparisons.

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 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.

A PACE organization is a not-for-profit private or public entity that is primarily engaged in providing the PACE services and must:

- Have a governing board that includes community representation;
- Be able to provide the complete service package regardless of frequency or duration of services;

- Have a physical site to provide adult day services;
- Have a defined service area;
- Have safeguards against conflicts of interest;
- Have demonstrated fiscal soundness; and
- Have a formal participant bill of rights.

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-site 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 authorized in ch. 98-327, L.O.F., and is 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.

In 2012, the Legislature directed the AHCA, subject to federal approval, to contract with a current PACE organization authorized to provide PACE services in Southeast Florida to develop and operate a PACE program in Broward County to serve frail elders residing in that county with up to 150 initial enrollee slots.⁷¹

III. Effect of Proposed Changes:

Section 1 amends s. 322.143, F.S., to provide that, for the purpose of combatting health care fraud, the Department of Highway Safety and Motor Vehicles will provide photographic access, pursuant to a written agreement, with hospitals, insurance companies, or their software providers, for the purpose of verifying a patient's identity or Medicaid eligibility by swiping an individual's driver's license or identification card.

Section 2 amends s. 395.602, F.S., to provide that a hospital classified as a sole community hospital which has up to 175 licensed beds is included in the definition of "rural hospital."

Section 3 amends s. 409.285, F.S., to provide the following regarding Medicaid fair hearings:

⁷¹ See s. 18, ch. 2012-33, L.O.F.

- Appeals related to Medicaid programs directly administered by the Agency for Health Care Administration (AHCA), including those related to Statewide Medicaid Managed Care, must be directed to the AHCA;
- The hearing authority for Medicaid appeals heard by the AHCA may be the Secretary of the AHCA, a panel of AHCA officials, or a hearing officer appointed for that purpose;
- The AHCA's hearing authority is responsible for a final administrative decision on behalf of the AHCA, and such a decision is final and binding on the AHCA and must be carried out promptly;
- Notwithstanding ss. 120.569 and 120.57, F.S., fair hearings conducted by the AHCA are exempt from the uniform rules of procedure under s. 120.54(5), F.S., and do not need to be conducted by an administrative law judge;
- The AHCA is required to seek federal approval necessary to implement the bill's provisions related to Medicaid fair hearings;
- The AHCA is authorized to adopt rules necessary to implement the bill's provisions related to Medicaid fair hearings; and
- Appeals related to Medicaid programs administered by the Agency for Persons with Disabilities (APD) are subject to the APD's appeals process provided under s. 393.125, F.S.

Section 4 amends definitions under s. 409.811, F.S., to permit certain non-citizen children to receive federal financial premium assistance under Medicaid or the Children's Health Insurance Program (CHIP).

A definition of a "lawfully residing child" is added to s. 409.811, F.S., and is a child who:

- Is present in the United States as defined under 8 C.F.R. s. 103.12(a);
- Meets Medicaid or CHIP residency requirements, and
- May be eligible for federal financial premium assistance under s. 214 of the Children's Health Insurance Program Reauthorization Act (CHIPRA) and related federal regulations.

The definition of a "resident" in s. 409.811, F.S., is amended to substitute "lawfully residing child" in place of "qualified alien." And, the definition for a "qualified alien" is deleted from s. 409.811, F.S.

Section 5 amends s. 409.814, F.S., to replace a reference to "qualified alien" with a reference to "lawfully residing child" when referring to children who are not eligible for Title XXI funded premium assistance. The bill also clarifies that Kidcare program eligibility is not being extended to undocumented immigrants.

Section 6 amends s. 409.904, F.S., relating to optional Medicaid payments, to designate that a child younger than 19 years of age who is a lawfully residing child, as defined in s. 409.811, F.S., is eligible for Medicaid under s. 409.903, F.S. The bill also clarifies that Medicaid eligibility is not being extended to undocumented immigrants.

Section 7 amends s. 409.905, F.S., to delete the requirement for the AHCA to limit payment for hospital emergency department visits for non-pregnant Medicaid recipients 21 years of age or older to six visits per fiscal year.

Section 8 amends s. 409.906, F.S., to require the AHCA to seek federal approval to pay for flexible services for persons with severe mental illness or substance abuse disorders, including, but not limited to, temporary housing assistance. Payment for such services may be made as enhanced rates or incentive payments to managed care plans within Statewide Medicaid Managed Care.

Section 9 creates s. 409.9064, F.S., to require the AHCA to seek federal approval of a section 1915(i) state plan option for home and community-based services for individuals diagnosed with Phelan-McDermid Syndrome. The bill requires that financial eligibility for Medicaid benefits under such a state plan option will be determined in the same manner as the home and community-based services waiver currently administered by the Agency for Persons with Disabilities.

Section 10 amends s. 409.907, F.S., to authorize the AHCA to certify that a Medicaid provider is out of business and that any overpayments made to the provider cannot be collected under state law.

Section 11 creates s. 409.9072, F.S., to authorize the AHCA to reimburse private schools and charter schools for providing Medicaid school-based services identical to those offered under the Medicaid certified school match program and under the same eligibility criteria as children eligible for services under that program.

Private and charter schools wishing to become Medicaid providers of such school-based services must apply to the AHCA and agree to specified conditions, such as verifying Medicaid eligibility, developing and maintaining financial and individual education plan records needed to document the appropriate use of state and federal funds, complying with all state and federal laws, rules, regulations, and policies relating to Medicaid, and being responsible for reimbursing the cost of any state or federal disallowance that results from failure to comply with state or federal Medicaid laws, rules, or regulations. The Senate General Appropriations Bill for Fiscal Year 2016-2017, SB 2500, appropriates \$4 million of recurring general revenue to serve as the state share of Medicaid funding for private schools and charter schools that are not participating in the certified school match program and which become Medicaid providers under the bill.

For reimbursements to private and charter schools, the AHCA is directed to apply the reimbursement schedule developed for providers within the certified school match program.

Section 12 amends s. 409.908, F.S., to remove nursing homes from the list of providers for which the AHCA is required to set rates at levels that ensure no increase in statewide expenditures resulting from changes in unit costs, effective July 1, 2017.

Section 13 amends s. 409.909, F.S., to add psychiatry to the list of primary care specialties as specified within the Statewide Medicaid Residency Program.

Section 14 amends s. 409.911, F.S., to require the AHCA to use the average of the 2007, 2008, and 2009 audited disproportionate share hospital (DSH) data to determine each hospital's Medicaid days and charity care for the 2016-2017 fiscal year. The bill also provides that, notwithstanding the provisions of s. 409.911, F.S., to the contrary, for the 2016-2017 fiscal year,

the AHCA must distribute moneys to hospitals providing a disproportionate share of Medicaid or charity care services as provided in the 2016-2017 General Appropriations Act (GAA).

Section 15 amends s. 409.9113, F.S., to provide that, notwithstanding the provisions of s. 409.9113, F.S., to the contrary, for the 2016-2017 fiscal year, the AHCA must make disproportionate share payments to teaching hospitals, as defined in s. 408.07, F.S.,⁷² as provided in the 2016-2017 GAA.

Section 16 amends s. 409.9115, F.S., to provide that, notwithstanding the provisions of s. 409.9115, F.S., to the contrary, for the 2016-2017 fiscal year, and for hospitals that qualify for mental health disproportionate share payments under s. 409.9115(2), F.S., the AHCA must distribute funds for the DSH program for mental health hospitals under the same manner as in the 2015-2016 fiscal year.

Section 17 amends s. 409.9119, F.S., to provide that, notwithstanding the provisions of s. 409.9119, F.S., to the contrary, for the 2016-2017 fiscal year, and for hospitals that fully comply with requirements under the DSH program for specialty children's hospitals under s. 409.9119(3), F.S., the AHCA must make disproportionate share payments to children's specialty hospitals as provided in the 2016-2017 GAA.

Section 18 amends s. 409.9128, F.S., to conform that statute to federal law regarding the requirements of the Rogers Amendment and to provide a cross-reference to changes made in Section 19 of the bill.

Section 19 amends s. 409.967, F.S., regarding payments required of a managed care plan within the Statewide Medicaid Managed Care program to a non-contracted provider that has rendered emergency services to a member of the managed care plan. The bill conforms this statute to federal law regarding the requirements of the Rogers Amendment. The bill also requires the AHCA to post on its website annually, or more frequently as needed, the applicable fee-for-service fee schedules and their effective dates, less any amounts for indirect costs of medical education and direct costs of graduate medical education that would otherwise be included in the fee-for-service payments.

Section 20 amends s. 409.968, F.S., to require the AHCA to establish a payment methodology to fund managed care plans within Statewide Medicaid Managed Care for flexible services for persons with severe mental illness and substance abuse disorders, including, but not limited to, temporary housing assistance. After receiving such payments for at least one year, a managed care plan must document the results of its efforts to maintain the target population in stable housing up to the maximum duration allowed under federal approval.

⁷² Section 408.07(45), F.S., provides that "teaching hospital" means any Florida hospital officially affiliated with an accredited Florida medical school which exhibits activity in the area of graduate medical education as reflected by at least seven different graduate medical education programs accredited by the Accreditation Council for Graduate Medical Education or the Council on Postdoctoral Training of the American Osteopathic Association and the presence of 100 or more full-time equivalent resident physicians, and that the director of the AHCA is responsible for determining which hospitals meet this definition.

Section 21 amends s. 409.975, F.S., to clarify that the term “essential provider” includes providers determined to be essential Medicaid providers under s. 409.975(1)(a), F.S., and providers specified as statewide essential providers under s. 409.975(1)(b), F.S., for the purpose of applying the criteria for excluding an essential provider from a managed care plan network for failure to meet quality or performance standards under s. 409.975(1)(c), F.S.

The bill provides a cross-reference to changes made in Section 19 of the bill regarding payments required of a managed care plan within the Statewide Medicaid Managed Care program to a non-contracted provider that has rendered emergency services to a member of the managed care plan, in order to comply with the Rogers Amendment.

The bill also deletes the provision in s. 409.975(6), F.S., requiring that for rates, methods, and terms of payment negotiated after an MMA contract between the AHCA a managed care plan has been executed, the managed care plan must pay hospitals within its provider networks, at a minimum, the rate that the AHCA would have paid on the first day of the contract between the provider and the plan. The bill also deletes the provision requiring that such payments to hospitals cannot exceed 120 percent of the rate the AHCA would have paid on the first day of the contract between the provider and the plan, unless specifically approved by the AHCA.

Section 22 amends s. 624.91, F.S., the Florida Healthy Kids Corporation Act, to conform to changes made under the bill and update references to modified or deleted terms.

Section 23 amends s. 641.513, F.S., to provide that, as part of the Florida Insurance Code, the amount of reimbursement paid by a health maintenance organization (HMO) to a non-contracted provider for emergency services provided to a member of the HMO who is a Medicaid recipient, will be determined under ch. 409. The bill also provides, as required by the Rogers Amendment, that the amount of reimbursement for emergency services provided to subscribers who are enrolled in an HMO pursuant to the Florida Healthy Kids program by a provider for whom no contract exists between the provider and the HMO, will be the lesser of the:

- Provider’s charges;
- Usual and customary provider charges for similar services in the community where the services were provided;
- Charge mutually agreed to by the managed care plan and the provider within 60 days after submittal of the claim; or
- Medicaid rate.

Section 24 creates a non-statutory provision of Florida law authorizing a current Program of All-Inclusive Care for the Elderly (PACE) organization that is authorized to provide PACE services for up to 150 frail elders in Broward County under ch. 2012-33, L.O.F., to also use those PACE slots for frail elders residing in Miami-Dade County, subject to federal approval and a contract amendment with the AHCA.

Section 25 creates a non-statutory provision of Florida law directing the AHCA, subject to federal approval to become a PACE site, to contract with one private, not-for-profit hospice organization located in Escambia County that owns and manages health care organizations

licensed in Hospice Service Areas 1, 2A, and 2B⁷³ which provide comprehensive services, including, but not limited to, hospice and palliative care, to frail elders residing in the specified hospice service areas. Under the bill, such a PACE organization is exempt from the requirements of ch. 641, F.S. The bill authorizes up to 100 initial enrollee slots, subject to an appropriation by the Legislature.

Section 26 provides that, except as otherwise expressly provided, the bill has an effective date of July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Sole community hospitals that meet the definition of “rural hospital” under SB 2508 may experience increased Medicaid reimbursements for inpatient services.

Expanding eligibility for Medicaid and the Children’s Health Insurance Program (CHIP) to additional children who may currently be uninsured may have a positive fiscal impact on health care providers. Accordingly, uncompensated care costs incurred by health care providers for currently uninsured children may be reduced to the extent that children who become eligible under the bill actually enroll in Medicaid or the CHIP.

Families that include individuals with Phelan-McDermid Syndrome who qualify for home and community-based services under the bill may experience relief from the financial constraints associated with caring for persons with the disorder.

⁷³ Florida has 27 hospice service areas, established by local area health councils. Hospice Service Area 1 comprises Escambia, Okaloosa, Santa Rosa, and Walton counties. Hospice Service Area 2A comprises Bay, Calhoun, Gulf, Holmes, Jackson, and Washington counties. Hospice Service Area 2B comprises Franklin, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor, and Wakulla counties.

Medicaid managed care plans and non-contracted providers of emergency services may experience differences in payments made by plans to such providers. Florida Healthy Kids health maintenance organizations and non-contracted providers of emergency services may experience differences in payments made by plans to such providers.

C. Government Sector Impact:

The Senate General Appropriations Bill for Fiscal Year 2016-2017, SB 2500, contains the following appropriations related to the provisions in SB 2508:

- \$250,000 of non-recurring general revenue is appropriated to the Agency for Health Care Administration (AHCA) to competitively procure a contract for enhanced Medicaid fraud prevention services in Miami-Dade County. The vendor must be capable of applying biometrics and the use of photographic images to ensure that Medicaid services are provided to eligible recipients.
- \$935,762 of non-recurring general revenue and \$1,464,246 of non-recurring federal matching funds are provided to increase inpatient reimbursements for sole community hospitals that qualify as rural hospitals.
- Two full-time equivalent (FTE) positions, plus \$31,954 of recurring general revenue and \$26,414 of recurring federal matching funds, are transferred from the Department of Children and Families (DCF) to the AHCA for the purpose of transferring the responsibility for fair hearings related to Medicaid programs administered by the AHCA.
- A \$28,835,214 recurring increase in federal matching funds is appropriated for the purpose of eliminating the five-year wait period for lawfully residing children in terms of Medicaid and Kidcare eligibility. This provision is estimated to have no impact on the General Revenue Fund.⁷⁴
- \$4 million of recurring general revenue and \$6,259,041 of recurring federal matching funds are appropriated for flexible services for persons with severe mental illness or substance abuse disorders, including, but not limited to, temporary housing assistance, subject to federal approval.
- \$2 million of recurring general revenue and \$3,129,520 of recurring federal matching funds are appropriated for home and community-based services for individuals diagnosed with Phelan-McDermid Syndrome, subject to federal approval.
- \$4 million of recurring general revenue and \$6,259,041 of recurring federal matching funds are appropriated for school-based services provided by private schools or charter schools that are not participating in the certified school match program.
- The regular Disproportionate Share Hospital (DSH) program is appropriated \$7,295,351 of recurring general revenue, \$87,562,687 of recurring funds from the Grants and Donations Trust Fund, and \$148,954,120 of recurring federal matching funds.

VI. Technical Deficiencies:

None.

⁷⁴ The Agency for Health Care Administration, *2016 Legislative Bill Analysis, HB 89*. On file with staff of the Senate Appropriations Subcommittee on Health and Human Services.

VII. Related Issues:

The Agency for Health Care Administration must submit amendments to the federally-required state plans for both Medicaid and CHIP for federal approval to implement the Medicaid and Kidcare eligibility changes contained in SB 2508.

VIII. Statutes Affected:

The bill substantially amends the following sections of the Florida Statutes: 322.143, 395.602, 409.285, 409.811, 409.814, 409.904, 409.905, 409.906, 409.907, 409.908, 409.909, 409.911, 409.9113, 409.9115, 409.9119, 409.9128, 409.967, 409.968, 409.975, 624.91, and 641.513.

The bill creates the following sections of the Florida Statutes: 409.9064 and 409.9072.

The bill creates two undesignated sections of Florida Law.

IX. Additional Information:**A. Committee Substitute – Statement of Changes:**

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.