

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 2514

INTRODUCER: Appropriations Committee

SUBJECT: Health Care

DATE: April 6, 2017

REVISED: _____

ANALYST

Williams

STAFF DIRECTOR

Hansen

REFERENCE

ACTION

AP Submitted as Comm. Bill/Fav

I. Summary:

SB 2514 revises various statutes relating to aspects of multiple health care programs and services, including:

- Pediatric cancer research;
- A framework for maximizing revenue for behavioral health services;
- The definition of “rural hospital;”
- Authority for various Medicaid waivers and transition of enrollees into Statewide Medicaid Managed Care, Long-term Care Managed Care;
- Reimbursement of Medicaid providers, including:
 - Transition to a prospective payment system for nursing home providers, and
 - A one-year delay, from July 1, 2017 to July 1, 2018, for the transition of a prospective payment system for Medicaid hospital outpatient services;
- Disproportionate Share Hospital programs; and
- The Program for All-Inclusive Care for the Elderly (PACE).

The bill conforms health care statutes to the funding policies used in Senate Bill 2500, the Senate General Appropriations Act for Fiscal Year 2017-2018.

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 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. Approximately 4 million Floridians are currently enrolled

in Medicaid, and the program's estimated expenditures for the 2016-2017 fiscal year are over \$26.0 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 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 SMMC, 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 February 2017, 3.96 million Medicaid recipients were enrolled in an SMMC plan while 720,243 were enrolled in Medicaid on a fee-for-service basis.³

Voluntary Enrollment in LTC Managed Care

Some individuals who are enrolled in waiver programs or other coverages may enroll in the LTC program, but are not required to, and those include:

- Developmental Disabilities waiver program;
- Traumatic Brain and Spinal Cord Injury waiver;
- Project AIDS Care (PAC) waiver;
- Adult Cystic Fibrosis waiver;
- Program of All-Inclusive Care for the Elderly (PACE);
- Familial Dysautonomia waiver;
- Model waiver; or
- Other creditable coverage, excluding Medicare.⁴

¹ Social Services Estimating Conference, Medicaid Caseloads and Expenditures, February 17, February 27, and March 9, 2017--Executive Summary: <http://edr.state.fl.us/Content/conferences/medicaid/execsummary.pdf> (last visited March 24, 2017).

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," March 2017, available at http://ahca.myflorida.com/Medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited March 31, 2017).

⁴ *See* s. 409.972, F.S.

Prior to the implementation of SMMC, at least 14 different waivers provided home and community based services (HCBS) to these same groups of beneficiaries, in both the voluntary and mandatory enrollment groups, at a cost of \$1.47 billion to state agencies in the Fiscal Year 2012-2013.⁵

Adult Cystic Fibrosis Waiver

The AHCA administers and the Department of Health (DOH) operates the waiver for individuals with a diagnosis of cystic fibrosis, a chronic, progressive, and terminal genetic disorder that affects a person's lungs and digestive system.⁶ To be eligible for the waiver, an individual must:

- Be 18 years of age or older;
- Be Medicaid eligible;
- Have a cystic fibrosis diagnosis; and
- Meet inpatient hospital level of care.⁷

The waiver includes services such as case management, counseling, skilled nursing, prescribed drugs, respite care, therapies, dental, meal delivery, and specialized medical equipment.⁸ There are approximately 140 people enrolled in this waiver.⁹

Project AIDS Care (PAC) Waiver

Preventing or delaying the institutionalizing through the promotion, maintenance, and optimization of the health of persons living with AIDS is the goal of the Project AIDS Care waiver. The waiver provides HCBS services to Medicaid eligible persons with a documented diagnosis of AIDS that choose to live at home or in the community.¹⁰

The PAC waiver provides services to recipients who:

- Are Medicaid eligible;
- Have an income of no more than 300 percent of the Social Security Income Federal Benefits Rate (approximately 222 percent of the federal poverty level);
- Have a diagnosis of Acquired Immune Deficiency Syndrome (AIDS);
- Have an AIDS-related opportunistic infection;
- Have been determined disabled by the Social Security Administration;
- Are not enrolled in a Medicaid managed care plan; and

⁵ Office of Program Policy Analysis and Government Accountability, *Profile of Florida's Medicaid Home and Community-Based Services Waivers*, Report No. 13-07, March 2013, <http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1307rpt.pdf> (last viewed Mar. 31, 2017).

⁶ Id.

⁷ Id.

⁸ Agency for Health Care Administration, *Adult Cystic Fibrosis Waiver Services - Procedures Codes and Fee Schedule - October 2013*, http://ahca.myflorida.com/medicaid/review/Reimbursement/2013_10_31_Adult_Cystic_Fibrosis_FS_Adoption.pdf (last viewed Mar. 31, 2017).

⁹ Agency for Health Care Administration, *Senate Bill 694 Analysis*, p. 4, (March 7, 2017) (on file with the Senate Committee on Health Policy).

¹⁰ Agency for Health Care Administration, *Project AIDS Care Waiver Services Coverage and Limitations Handbook* (July 2003) http://ahca.myflorida.com/medicaid/review/Specific/CL_06_051201_Waiver_PAC_ver1_1.pdf (last visited Mar. 31, 2017).

- Meet hospital or nursing facility level of care.¹¹

The recipients enrolled in the PAC waiver are primarily receiving case management services while service utilization remains low due to the advances made over the past decade. The waiver facilitates coverage for Medicaid for those who might not otherwise have access. Some of the other services that are covered are chore services, home delivered meals, personal care, skilled nursing, specialized equipment and supplies, day health, and restorative massage.¹² Currently, approximately 7,800 people are enrolled in the PAC waiver.¹³

Traumatic Brain and Spinal Cord Injury Waiver

The Department of Health (DOH) operates the TBI/SCI waiver, which provides services for individuals with traumatic brain injuries and spinal cord injuries. To be eligible for the waiver, an individual must:

- Be 18 year of age or older;
- Be Medicaid eligible;
- Have one of the following injuries:
 - traumatic brain injury, defined as an insult to the skull, brain, or its covering from external trauma, which produces an altered state of consciousness or anatomic, motor, or sensory, or cognitive/behavioral deficits; or
 - spinal cord injury, defined as a lesion to the spinal cord or cauda equine resulting from external trauma with evidence of significant involvement of two of the following: motor deficit, sensory deficit, or bowel or bladder dysfunction;
- Meet nursing home level of care;
- Be referred to the state's Brain and Spinal Cord Injury Program's central registry in accordance with s. 381.75, F.S.¹⁴

Individuals enrolled in the waiver receive services and supports such as assistive technology, attendant care, counseling, life skills training, medical supplies, personal care, behavioral programming, and adaptive health and wellness.¹⁵

The TBI/SCI population is already eligible for enrollment in the LTC program as a voluntary population. Currently, approximately 300 people are enrolled in the TBI/SCI waiver with an additional 350 on the waitlist.¹⁶

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:

¹¹ *Supra* note 9.

¹² *Supra* note 10.

¹³ *Supra* note 9, at 3.

¹⁴ *Supra* note 9, at 11.

¹⁵ *Id.*

¹⁶ *Supra* note 9, at 3.

- 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
- A hospital designated as a critical access hospital under s. 408.07(15), F.S.¹⁷

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).¹⁸

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 ¹⁹	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

¹⁷ 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.”

¹⁸ See s. 395.602(2)(e), F.S.

¹⁹ Formerly known as Tri County Hospital - Williston.

Rural Hospital	County	City	Beds
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.

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.²⁰ 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.²¹ Prior to the 2014-2015 fiscal year, two of Florida’s sole community hospitals did not qualify under Florida statutes as rural hospitals.²² 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.

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 determines each year 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

²⁰ 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).

²¹ See ch. 2014-57, Laws of Florida.

²² Flagler Hospital and Lower Keys Medical Center.

to use audited data from specified years to determine the amount of Medicaid and charity care to be used in calculating DSH payments.²³

Medicaid Nursing Home Reimbursement

AHCA currently reimburses nursing facility care using facility-specific, cost-based per diem rates. As of September 1, 2015, these rates are updated yearly. Prior to September 1st of each year, annual rates are calculated using inflated historical facility-specific cost information. The rates and reimbursements may be adjusted post-payment if cost reports for the timeframe in which services were rendered are audited or adjusted. For rate year 2016/17, which started on September 1, 2016, these per diem rates ranged from \$161.25 to \$308.35 per patient day. The unweighted (each facility counted once) average per diem was \$228.79. Thus, the facility with the lowest per diem receives 70 percent of the statewide average and the facility with the highest per diem receives 135 percent of the statewide average.

The nursing facility industry in Florida is sizeable and is heavily dependent on Medicaid reimbursement. As of September 1, 2016, there were 658 nursing facilities participating in the Florida Medicaid program. These nursing facilities account for a total of 81,835 beds, with an average of 124 beds per facility. These facilities account for over 26.35 million resident days a year, of which over 16 million, or 61 percent are Medicaid days, corresponding to a Medicaid daily census of approximately 44,070 individuals statewide. The number of beds per facility ranges from a minimum of 20 to a maximum of 438. Statewide, the average occupancy rate for a Medicaid participating nursing facility is 88 percent. The fiscal year 2016-2017 estimated total Medicaid spend for nursing facility care is approximately \$3.6 billion.

Since 2013, nearly all long term care for Florida Medicaid has been administered through Medicaid managed care. The managed care plans are required to pay nursing facilities the same rates that are calculated for Medicaid fee-for-service. The specific language that documents this requirement in the AHCA-to-managed care plan contract is,

“The Agency will set facility-specific payment rates based on the rate methodology outlined in the most recent version of the Florida Title XIX Long-term Care Reimbursement Plan. The Managed Care Plan shall pay nursing facilities an amount no less than the nursing facility specific payment rates set by the Agency and published on the Agency website. The Managed Care Plan shall use the published facility-specific rates as a minimum payment level for all payments.”

Thus, the calculated per diem rates currently apply to both the Medicaid fee-for-service and managed care programs.

Current statutory provisions specific to Medicaid reimbursement are found in s. 409.908(2), F.S. The Fiscal Year 2016-2017 General Appropriations Act (GAA) directed AHCA to explore a prospective payment system for Medicaid nursing facility reimbursement. The specific direction for the study directed AHCA to:

²³ See s. 409.911(2), F.S.

“...contract with an independent consultant to develop a plan to convert Medicaid payments for nursing facility services from a cost-based reimbursement methodology to a prospective payment system. The study shall identify steps necessary for the transition to be completed in a budget neutral manner.”

The legislation directed that the study be completed and submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than January 1, 2017. The legislative request also included a review of hospice rates, which are currently derived from nursing facility rates. The AHCA contracted with Navigant Consulting to complete this study. The report was submitted on December 29, 2016.²⁴

As noted above, the language in the 2016-2017 GAA required consideration of a prospective payment system that is not cost-based. The instructions also indicated that the new prospective payment method should be designed in a budget neutral manner in aggregate for the entire Medicaid nursing facility program. The report outlined the design of a new nursing facility payment method that is both prospective and budget neutral. The design described in the report took into consideration the impact of Medicaid reimbursement on nursing facilities and the unique circumstances for the nursing facility industry in Florida – most notably, the relatively high minimum staffing requirements. The payment method design also takes into consideration the goals of AHCA and feedback from the Florida nursing facility industry. AHCA’s goals for this new payment method were communicated via five meetings between Navigant and AHCA’s internal “Nursing home Prospective Payment System (NPPS) Governance Committee” which comprised all affected members of AHCA’s management team. Feedback from the Florida nursing facility industry was garnered over a six month period through six formal public meetings and from numerous less formal meetings with individual stakeholders.

The proposed new method described in report balances financial incentives for high quality care with incentives for efficiency. The payment method also attempts to provide fair and equitable payments for similar services. More specifically, the new payment method contains the following components:

- Standardized rates, some with pricing floors, for Direct Care, Indirect Care, and Operations components of per diems. This will reward facilities that operate and provide care most efficiently;
- Facility peer groupings, which account for higher costs in South Florida;
- A Quality Incentive Program, which uses quality metrics to increase reimbursement to high performing facilities. Facilities with, for example, low infection rates, high star ratings, Gold Seal status, and/or external industry quality accreditation can earn higher rates. The new system projects to provide approximately \$10 million in additional reimbursement to four star, five star, and Gold Seal facilities in the first year of implementation, given the quality scores we have modelled to date;
- A fair rental value property component, which pays a reasonable amount to providers for well-maintained and updated facilities;
- A transition period that allows facilities to adjust to the new incentive structure;

²⁴ See report entitled: Nursing Facility Payment Method Recommendations Report; prepared for Florida Agency for Health Care Administration by Navigant, on file with Appropriations Committee staff.

- No case mix adjustment; and
- Additional payments for specific high cost services to promote access to care.

With these outlined components, the report indicated that all providers have the opportunity to earn higher rates through demonstration of high quality and/or increased efficiency.

The report's recommendations reflected 18 decision areas, and a total of 28 options selected in these decision areas.

Mental Health and Substance Abuse

Mental illness creates enormous social and economic costs.²⁵ Unemployment rates for persons with mental disorders are high relative to the overall population.²⁶ People with severe mental illness have exceptionally high rates of unemployment, between 60 percent and 100 percent.²⁷ Mental illness increases a person's risk of homelessness in America threefold.²⁸ Studies show that approximately 33 percent of our nation's homeless live with a serious mental disorder, such as schizophrenia, for which they are not receiving treatment.²⁹ Often the combination of homelessness and mental illness leads to incarceration, which further decreases a person's chance of receiving proper treatment and leads to future re-offenses.³⁰

According to the National Alliance on Mental Illness (NAMI), approximately 50 percent of individuals with severe mental health disorders are affected by substance abuse.³¹ NAMI also estimates that 29 percent of all people diagnosed as mentally ill abuse alcohol or other drugs.³² When mental health disorders are left untreated, substance abuse is likely to increase. When substance abuse increases, mental health symptoms often increase as well or new symptoms may be triggered. This could also be due to discontinuation of taking prescribed medications or the contraindications for substance abuse and mental health medications. When taken with other medications, mental health medications can become less effective.³³

Mental illness affects millions of people in the United States each year. Only about 17% of adults in the United States are considered to be in a state of optimal mental health.³⁴

²⁵ Mental Illness: The Invisible Menace, *Economic Impact* <http://www.mentalmenace.com/economicimpact.php>

²⁶ Mental Illness: The Invisible Menace, *More impacts and facts* <http://www.mentalmenace.com/impactsfacts.php>

²⁷ *Id.*

²⁸ Family Guidance Center, *How does Mental Illness Impact Rates of Homelessness?* (February 4, 2014) available at <http://www.familyguidance.org/how-does-mental-illness-impact-rates-of-homelessness/>

²⁹ *Id.*

³⁰ *Id.*

³¹ Donna M. White, LPCI, CACP, Psych Central.com, *Living with Co-Occurring Mental & Substance Abuse Disorders*, (October 2, 2013) available at <http://psychcentral.com/blog/archives/2013/10/02/living-with-co-occurring-mental-substance-abuse-disorders/>

³² *Id.*

³³ *Id.*

³⁴ Mental illness can range in severity from no or mild impairment to significantly disabling impairment. Serious mental illness is a mental disorder that has resulted in a functional impairment which substantially interferes with or limits one or more major life activities. *Any Mental Illness (AMI) Among Adults*, National Institute of Health. <http://nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adult.shtml> (last viewed on March 16, 2016).

Significant social and economic costs are associated with mental illness. Persons diagnosed with a serious mental illness experience significantly higher rates of unemployment compared with the general population.³⁵

Mental Health and Substance Abuse Services in Florida

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

Florida law requires DCF to implement a system of care to provide substance abuse treatment and mental health services as follows:

- Adults who have substance abuse disorders and a history of intravenous drug use;
- Individuals diagnosed as having co-occurring substance abuse and mental health disorders;
- Parents whose substance abuse disorder puts their children at risk for involvement in the dependency system;
- Individuals who have a substance abuse disorder and have been ordered by the court to receive treatment;
- Children at risk for initiating drug use;
- Children under state supervision;
- Children who have a substance abuse disorder but who are not under the supervision of a court or in the custody of a state agency; and
- Individuals identified as being part of a priority population as a condition for receiving services funded through federal Substance Abuse Treatment and Prevention Block Grants.

The DCF's system of care is required to prevent and remediate the consequences of substance abuse for persons with substance abuse disorders through the provision of a comprehensive continuum of accessible and quality substance abuse prevention, intervention, and treatment services in the least restrictive environment of optimum care (see s. 394.67, F.S.). The system of care is comprised of the following broad categories of substance abuse services:

- Prevention services,
- Assessment services,
- Intervention services,
- Rehabilitation services, and
- Ancillary services, including:
 - Self-help and other support groups and activities;
 - Aftercare provided in a structured, therapeutic environment;
 - Supported housing;

³⁵ *Account for Unemployment Among People with Mental Illness*, Baron RC, Salzer MS, *Behav. Sci. Law.*, 2002;20(6):585-99 <http://ncbi.nlm.nih.gov/pubmed12465129> (last viewed on March 16, 2016).

- Supported employment;
- Vocational services; and
- Educational services.

In 2008, the legislature required the department to implement a system of behavioral health managing entities that would serve as regional agencies to manage and pay for mental health and substance abuse services.³⁶ Prior to this time, the department, through its regional offices, contracted directly with behavioral health service providers. The legislature found that a management structure that places the responsibility for publicly-financed behavioral health treatment and prevention services within a single private, nonprofit entity at the local level would promote improved access to care, promote service continuity, and provide for more efficient and effective delivery of substance abuse and mental health services. There are currently seven managing entities across the state.³⁷

The SMMC program requires the AHCA to create an integrated managed care program for Medicaid enrollees to provide all the mandatory and optional Medicaid benefits for primary and acute care through a Managed Medical Assistance (MMA) program. Behavioral health care is covered by Medicaid managed care plans for MMA program enrollees.

Mental Health and Substance Abuse Revenue Maximization

Section 394.761, F.S., requires AHCA and the Department of Children and Families (DCF) to develop a plan to obtain federal approval for increasing the availability of federal Medicaid funding for behavioral health care. The plan was provided December 31, 2016, and identified the funding appropriated for mental health and substance abuse services that could be used as state Medicaid match to increase federal funding.³⁸ The plan also evaluated alternative uses of increased Medicaid funding and identified the advantages and disadvantages of each alternative.

According to the report, DCF has identified \$412,411,814 in general revenue funding appropriated during fiscal year 2016-2017 for mental health and substance abuse services that may be eligible to be used as state match to receive additional Medicaid funding depending on the delivery system enhancements implemented.

DCF is currently spending general revenue funds on these services for individuals with serious mental illness or substance use disorder. DCF offers several services that are funded above the service level provided under Florida Medicaid. Such services include: assessments, group and individual therapy, day treatment, medical services, case management, substance abuse inpatient detoxification, and inpatient hospital services.

Eliminating the service limitations that are in place under Florida Medicaid for these eight services provided by DCF would eliminate the need for Medicaid recipients to access these services through the managing entities. If AHCA is directed to cover these services, the receipt

³⁶ See s. 394.9082, F.S., as created by Chapter 2008-243, Laws of Fla.

³⁷ Department of Children and Families website, <http://www.myflfamilies.com/service-programs/substance-abuse/managing-entities>, (last visited Jan. 11, 2016).

³⁸ See report entitled: Behavioral Health Services Revenue Maximization Plan, Report to the Florida Legislature Pursuant to Section 394.761(5), Florida Statutes; on file with Appropriations Committee staff.

of federal matching funds would free up general revenue. AHCA would be eligible to receive approximately 60 percent of the cost of services provided from the federal government. This would make it possible to replace prior general revenue expenditures on those services provided through the managing entities.

DCF also offers certain services that are not covered at all under Florida Medicaid using state general revenue funding. The most heavily used of these services by Medicaid recipients are: residential services, room and board with supervision, incidental expenses, crisis stabilization, residential detoxification, supportive housing and supportive employment. AHCA could pursue authority through a Section 1115 waiver to provide these non-covered services through the managing entities to Medicaid recipients contending with a serious mental illnesses or substance use disorder.

Other options to be considered by AHCA to increase Medicaid funding for Medicaid enrollees with Chronic Mental Illness and Substance Use Disorders include:

- Adjustment of the capitation rate for Medicaid enrollees
- Increase reimbursement rates for behavioral health services
- Increase reimbursement rates to providers through incentive payments
- Make supplemental payments to providers
- Use of intergovernmental transfers from counties, local taxing districts, county health departments, publicly funded hospitals, and in some cases other state agencies to AHCA
- Use certified public expenditures to draw down federal funds to account for uncompensated costs for medical care provided to Medicaid recipients
- Create designated state health programs to provide safety-net health care services for low-income or uninsured individuals.

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

PACE is a capitated benefit model³⁹ authorized by the federal Balanced Budget Act of 1997 that features a comprehensive service delivery system and integrated federal Medicare and state Medicaid financing. The model was tested through the federal Centers for Medicare and Medicaid Services (CMS) demonstration projects that began in the mid-1980s. The PACE model was developed to address the needs of long-term care clients, providers, and payers.

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

The Balanced Budget Act of 1997 established the PACE model of care as a permanent entity within the Medicare program and enabled states to provide the PACE services to Medicaid recipients as a state option without a Medicaid waiver. The state plan must include PACE as an

³⁹ Under such a model, the contracted provider entity is paid a set dollar amount per month to see patients regardless of how many treatments or the number of services the patient receives. The agreement is that the provider will get a flat, prearranged payment in advance per member per month.

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-sight readiness review before a PACE organization can be authorized to serve patients. An approved PACE organization must sign a contract with the CMS and the state Medicaid agency.

Florida PACE Project

The Florida PACE project is one project among many that provide alternative, long-term care options for elders who qualify for Medicare and the state Medicaid program. The PACE project was initially authorized in ch. 98-327, L.O.F., and was codified in s. 430.707(2), F.S. The PACE model targets individuals who would otherwise qualify for Medicaid nursing home placement and provides them with a comprehensive array of home and community based services at a cost less than the cost of nursing home care. The PACE project is administered by the Department of Elder Affairs in consultation with the AHCA.

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

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

Cigarette Tax: Biomedical Research

Section 210.20(c), F.S., provides for the payment of monthly distributions from 1.0 percent of the net cigarette tax collections received by the Division of Alcoholic Beverages and Tobacco in the Department of Business and Professional Regulation which are deposited into the Cigarette

Tax Collection Trust Fund and transferred to the Biomedical Research Trust Fund in the Department of Health. These funds are appropriated annually in an amount not to exceed \$3 million for the purpose of establishing activities and grant opportunities in relation to biomedical research. The Department of Health and the Sanford Burnham Prebys Medical Discovery Institute are required to use the funding to work in conjunction for these purposes.

Pediatric Cancer Research

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

- Acute lymphocytic leukemia;
- Brain and other central nervous system (CNS) tumors; and
- Neuroblastoma.⁴⁰

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

Pediatric cancer is relatively uncommon, representing less than one percent of all new cases of cancer diagnosed in the United States each year.⁴¹ This presents a major challenge in conducting pediatric cancer research, especially considering the unique nature of certain types of pediatric cancers with respect to the types of cancer that present in children compared to adults and the need for less toxic treatments that cause fewer adverse effects.

Pediatric clinical trials are an essential component of the research process that ensures new treatments are found to be safe and effective in treating disease before the treatment is made widely available to patients. The substantial progress that has been made in identifying curative therapies for pediatric cancers is directly attributable to the success of clinical trials.⁴² Strong collaboration amongst pediatric cancer centers is vital to the continued success of clinical trials due to the unique nature, and low prevalence, of many types of pediatric cancers. Securing adequate funding to support pediatric cancer research and clinical trials is a challenge.

In 2014, pediatric cancer research awarded by the National Institutes of Health totaled approximately \$200 million,⁴³ which represented only 5.9 percent of the total funding allocated for research.⁴⁴ Florida received a fraction of the total amount awarded for pediatric cancer research with only \$8,498,573 awarded to Florida-based institutions in 2014.⁴⁵

⁴⁰ See <https://www.cancer.gov/types/childhood-cancers> (last viewed Mar. 31, 2017)

⁴¹ See <https://www.cancer.gov/research/areas/childhood> (last viewed Mar. 31, 2017)

⁴² *Id.*

⁴³ See <https://fundedresearch.cancer.gov/nciportfolio/search/SearchForm> (last viewed Mar. 31, 2017)

⁴⁴ National Cancer Institute Budget Fact Book for Fiscal Year 2014 (Page 5). See <https://www.cancer.gov/about-nci/budget/fact-book/archive/2014-fact-book.pdf> (last viewed Mar. 31, 2017)

⁴⁵ *Supra* note 42.

Bankhead-Coley Program

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

The funds are distributed as grants to researchers seeking cures for cancer, with emphasis given to the efforts that significantly expand cancer research capacity in the state.⁴⁶ The goals of the Bankhead-Coley Program are to expand significantly cancer research capacity and cancer treatment in the state by:

- Identifying ways to attract new research talent and attendant national grant-producing researchers to cancer research facilities in this state;
- Implementing a peer-reviewed, competitive process to identify and fund the best proposals to expand cancer research institutes in this state;
- Funding, through available resources, proposals that demonstrate the greatest opportunity to attract federal research grants and private financial support;
- Encouraging the employment of bioinformatics in order to create a cancer informatics infrastructure that enhances information and resource exchange and integration through researchers working in diverse disciplines to facilitate the full spectrum of cancer investigations;
- Facilitating the technical coordination, business development, and support of intellectual property as it relates to the advancement of cancer research;
- Aiding in other multidisciplinary, research-support activities for the advancement of cancer research;
- Improving both research and treatment through greater participation in clinical trials networks; and
- Reducing the impact of cancer on disparate groups.

The Biomedical Research Advisory Council (BRAC) is responsible for assisting in developing guidelines for fairness, neutrality, principles of merit, and quality in the conduct of the Bankhead-Coley Program, and develops guidelines, criteria and standards for the solicitation, review, and award of research grants and fellowships.⁴⁷

The Bankhead-Coley Program distributes multi-year grant awards based on the recommendation of the State Surgeon General, after consultation with the BRAC.⁴⁸ Unspent awards are deposited back into the Biomedical Research Trust Fund after five years.⁴⁹ Any university or research institute in Florida may apply for grant funding to support the goals of the Bankhead-Coley Program. All qualified investigators in the state, regardless of the institution, have an equal opportunity to compete for funding. The following types of applications may be considered for funding:

- Investigator-initiated research grants;
- Institutional research grants; and

⁴⁶ Section 381.921, F.S.

⁴⁷ Section 215.5602(3), F.S.

⁴⁸ Section 215.5602(5)(b), F.S.

⁴⁹ Section 20.435(7)(c), F.S.

- Collaborative research grants, including those that advance the finding of cures through basic or applied research.⁵⁰

In Fiscal Year 2016-2017, the Bankhead-Coley Program received \$10 million from funds in the Biomedical Research Trust Fund.⁵¹

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

Research that has resulted from Bankhead-Coley and other DOH biomedical research programs has been leveraged by Florida-based researchers to bring in an additional \$260 million of federal funding to our state.⁵²

The appropriation of additional funding for pediatric cancer research hopefully will result in a similar return on investment seen with other biomedical research programs recently established by the legislature, such as the Ed and Ethel Moore Alzheimer's Disease Research Program. Federal funding for Alzheimer's research in our state increased by over \$10 million in 2015, making Florida the 7th highest funded state, up from 12th the year before.⁵³

III. Effect of Proposed Changes:

Section 1 amends s. 212.20(2)(c), F.S., relating to the distribution of cigarette tax revenue for biomedical research purposes, to redirect the cigarette tax distribution funds that would otherwise be used for the Sanford Burnham Prebys Medical Discovery Institute for distribution to National Cancer Institute research entities under s. 381.915, F.S., for advancement of cures for cancers impacting pediatric populations through basic or applied research, including but not limited to, clinical, trials and nontoxic drug discovery.

Section 2 amends s. 381.922 (2), F.S., relating to the Bankhead-Coley Cancer Research Program, and specifically grants thereunder, to stipulate that efforts to improve both research and treatment through greater participation in clinical trials networks shall include identifying ways to increase pediatric and adult enrollment in clinical trials. In addition, the Live Like Bella Initiative is created within the Bankhead-Coley Program to advance progress toward curing pediatric cancer by awarding grants according to the peer-reviewed, competitive process established under subsection (3) of this section. The implementation of this new initiative is subject to an annual appropriation.

Section 3 amends s. 394.9082, F.S., relating to behavioral health managing entities, to provide for a Substance Abuse and Mental Health (SAMH) Safety Net Network. The Department of Children and Families (DCF) and the Agency for Health Care Administration (AHCA) are

⁵⁰ Section 381.922(3)(a), F.S.

⁵¹ Chapter 2016-66, Laws of Florida. See Specific Appropriation 470.

⁵² Presentation by Surgeon General Dr. Celeste Philip to Senate Subcommittee on Health and Human Services. (February 15, 2017).

⁵³ Id.

directed to establish the SAMH Network by adding specific services currently provided by managing entities to the state Medicaid plan and by adjusting the amount of units of services for specific Medicaid services to better serve target populations. The DCF is directed to submit general revenue expenditure documentation to the agency for state match for services and for the agency to pay managing entities the federal Medicaid share for services rendered. The state share of funding for implementation of these provisions is to be re-directed general revenue funds in the DCF that are used to fund SAMN services, excluding residential services. The need for these state-only funds will be offset by the infusion of federal funds made available to the Safety Net.

Section 4 directs the AHCA, in conjunction with DCF, to seek federal authority for administrative claiming for Community Action Teams and Family Intensive Treatment Teams, for Community Based Care case management activities, and central receiving facilities.

Section 5 directs DCF, in collaboration with AHCA, to document the extent to which local funding is used for behavioral health services, and directs AHCA to seek federal matching funds for this local contribution as certified public expenditures.

Section 6 amends s. 395.602, F.S., to provide that a hospital classified as a sole community hospital is included in the definition of “rural hospital” regardless of its bed size.

Section 7 amends s. 409.904(11), F.S., to expand optional payments for eligible persons in Medicaid, to add as a person for whom Medicaid payment may be made someone who meets the following criteria: a person who is diagnosed with acquired immune deficiency syndrome (AIDS); who has an AIDS-related opportunistic infection and is at risk of hospitalization; and whose income is at or below 300 percent of the federal benefit rate.

Section 8 amends s. 409.908, F.S., relating to reimbursement of Medicaid providers, to direct that, beginning October 1, 2017, and ending September 30, 2020, the Agency reimburse nursing home providers the greater of their September 2016 cost-based reimbursement rate or their prospective payment rate. Effective October 1, 2020, the Agency shall reimburse providers the greater of 95 percent of their cost-based rate or their rebased prospective rate, using the most recently audited cost report for each facility. Pediatric, Florida Department of Veterans Affairs, and government-owned facilities are exempt from this new pricing model. Related provisions are modified to keep in place applicable rate-setting ceilings and targets for those facilities that remain on cost-based reimbursement. Changes are made for calculations of direct care costs, and other patient care costs. Prospective rates are to be rebased every four years, and direct care supplemental payments may be made under specified circumstances.

This section specifies that Medicaid reimbursement will be provided for deductibles and coinsurance for Medicare Part B services provided for mobile x-ray services rendered to a person who is Medicare and Medicaid dually eligible when such services are delivered in an assisted living facility or a home, just as such reimbursement is presently provided for a nursing home resident.

Section 9 amends s. 409.9082(4), F.S., relating to the uses of revenue generated by the quality assessment on nursing home facilities, to authorize as a use the partial funding of the quality incentive program for nursing facilities that exceed quality benchmarks, in lieu of use for that

portion for the facilities' rate not otherwise addressed by the subsection provisions relating to rate reduction and assessment amounts.

Section 10 amends s. 409.909, F.S., to modify the Statewide Medicaid Residency Program such that a qualifying institution, as defined under the program, may receive the same types of program payments as hospitals. Under the program, a qualifying institution is defined as a Federally Qualified Health Center which holds an Accreditation Council for Graduate Medical Education institutional accreditation.

Section 11 amends s. 409.911, F.S., relating to the Regular Disproportionate Share Program, to require the AHCA to use the average of the 2009, 2010, and 2011 audited disproportionate share hospital (DSH) data to determine each hospital's Medicaid days and charity care for the 2017-2018 fiscal year.

Section 12 amends s. 409.9119, F.S., to modify the specialty children's hospitals that qualify for funds under this section to include those that have a specific federal certification number, and meet Medicare and Medicaid day criteria. There is an update of the year referenced for fund distribution purposes.

Section 13 amends s. 409.913 (36), F.S., relating to oversight of the integrity of the Medicaid program and the sharing of explanation of medical benefits with service recipients, to authorize that such documents be shared with recipients on a sampling basis rather than to all recipients, other than the exemptions already provided from such distributions.

Section 14 amends s. 409.975, F.S., relating to managed care plan accountability, to direct AHCA to contract with the Safety Net to plan, coordinate, and contract for the delivery of certain community SAMN services. The contract must require the managing entities to provide specified services to Medicaid-eligible services. Prior to contracting, the AHCA, with participation by the DCF, shall conduct a readiness review based on specified criteria. The AHCA is directed to work with the DCF and the managing entities in developing rates for contracted services.

Section 15 amends s. 409.979, F.S., relating to eligibility for Long-term Care Managed Care program, to include those who meet hospital level of care for individuals with cystic fibrosis. In addition, this section specifies that those individuals enrolled in the Traumatic Brain and Spinal Cord Injury Waiver, the Adult Cystic Fibrosis Waiver, and the Project AIDS Care Waiver who meet all applicable criteria shall be transitioned to Long-term Care Managed Care program by January 1, 2018. Once all such persons have been transitioned out of their waiver, the agency may seek federal authorization to terminate these waivers.

Section 16 directs the AHCA, subject to federal approval to become a PACE site, to contract with an additional not-for-profit organization located in Miami-Dade County. The organization shall have a history of primarily serving the Hispanic community by providing primary care services, nutrition, meals, and adult day care to senior citizens. The applicant organization shall leverage existing community-based care providers and health care organizations to provide PACE services. The AHCA, in conjunction with the Department of Elder Affairs and subject to a subsequent appropriation, shall approve up to 250 initial enrollees in this PACE program.

Section 17, notwithstanding section 27 of chapter 2016-65, Florida Statutes, directs the AHCA, subject to federal approval to become a PACE site, to contract with a not-for-profit organization formed by a partnership with a not-for-profit hospital, not-for-profit agency serving seniors, and a not-for-profit hospice in Leon County. The organization is authorized to serve eligible enrollees in Leon, Jefferson, Gadsden, and Wakulla counties. The AHCA, in conjunction with the Department of Elder Affairs and subject to a subsequent appropriation, shall approve up to 300 initial enrollees in this PACE program.

Section 18 amends section 17 of chapter 2011-61, Laws of Florida, to authorize the existing PACE provider in Palm Beach County to expand services to eligible enrollees in Martin, St. Lucie, Okeechobee, and Indian River Counties. The initial 150 enrollees were residents of Palm Beach County, and the enrollment in Martin County can be up to 150 persons.

Section 19, effective June 30, 2017, amends section 9 of chapter 2016-65, Laws of Florida, which amended s. 409.905, F.S., relating to Medicaid mandatory services, to delay from July 1, 2017 to July 1, 2018, the implementation of a prospective payment system for Medicaid outpatient hospital services, referred to as enhanced ambulatory payment group (or EAPGs).

Section 20 amends section 29 of chapter 2016-65, Laws of Florida, to authorize the Lake County hospice-based PACE provider to expand services into the Orlando area with an initial enrollment of 150.

Section 21 directs the AHCA, subject to federal approval to become a PACE site, to contract with one not-for-profit organization that satisfies specific criteria to provide PACE services to frail and elderly persons who reside in Alachua County. The AHCA, in conjunction with the Department of Elder Affairs and subject to a subsequent appropriation, shall approve up to 150 initial enrollees in this PACE program.

Section 22 directs the AHCA, subject to federal approval to become a PACE site, to contract with an organization located in Miami-Dade County that owns and operates primary care medical centers in South Florida. The organization shall leverage its existing community-based providers to provide PACE services to frail elders who reside in Broward, Miami-Dade, and Palm Beach Counties. The AHCA, in conjunction with the Department of Elder Affairs and subject to a subsequent appropriation, shall approve up to 300 initial enrollees in this PACE program.

Section 23 provides that, except as otherwise expressly provided in the act, and this section, which shall take effect upon becoming law, the bill has an effective date of July 1, 2017.

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 2514 may receive increased Medicaid reimbursements.

C. Government Sector Impact:

SB 2500, the Senate General Appropriations Act for Fiscal Year 2017-2018, contains the following appropriations relating to the changes made in this bill:

- The regular Disproportionate Share Hospital (DSH) program is appropriated \$8,515,536 of recurring general revenue, \$82,713,189 of recurring funds from the Grants and Donations Trust Fund, and \$219,313,128 of recurring federal matching funds;
- \$5,000,000 in recurring funds from the General Revenue Fund, \$17,115,783 in recurring funds from the Grants and Donations Trust Fund and \$35,507,414 in recurring funds from the Medical Care Trust Fund are provided to fund a three year transition period to implement the prospective payment system, guaranteeing all providers the greater of their 2016 cost based rate or the PPS rate calculated in accordance with the new methodology. Provider gains are capped at 4.075 percent so that all potential losses can be prevented;
- \$20,214,906 is provided from the Medical Care Trust Fund for a rate increase for certain Medicaid behavioral health services. These funds are to be paid to the Substance Abuse and Mental Health Safety Net Network for services provided, contingent on passage of legislation creating this network.
- \$256,087 from the General Revenue Fund and \$411,155 from the Operations and Maintenance Trust Fund are provided to fund 50 slots for PACE in Clay, Duval, St. Johns, Baker, and Nassau counties, effective July 1, 2017;
- \$349,460 from the General Revenue Fund and \$561,066 from the Operations and Maintenance Trust Fund are provided to increase the Program for PACE by 30 slots in Miami-Dade County, and 75 slots in Broward County effective July 1, 2017;
- \$312,721 from the General Revenue Fund and \$502,081 from the Operations and Maintenance Trust Fund are provided to increase the Program for PACE by 30 slots in Collier County, effective July 1, 2017;
- Reduces \$95,950 from the General Revenue Fund and \$154,050, from the Medical Care Trust Fund because of the modification of requirements for Medicaid explanation of medical benefits;

- \$2,400,000 from the Biomedical Research Trust Fund for the Florida Consortium of National Cancer Institute Centers Program for the advancement of cures for cancers afflicting pediatric populations;
- \$2,000,000 in nonrecurring funds from the Biomedical Research Trust Fund for the Live Like Bella Initiative to be administratively housed within the Bankhead-Coley Cancer Research Program. This initiative shall award grants on a peer-reviewed, competitive basis to advance progress toward curing pediatric cancer;
- Requires the DCF to transfer up to \$17,241,519 of general revenue funds from the Grants and Aids - Community Mental Health Services and the Grants and Aids - Community Substance Abuse Services appropriation categories to AHCA to be used as state matching funds for the purpose of eliminating Medicaid service limitations for certain behavioral health services and substance abuse targeted case management services; and also
- Requires DCF to transfer up to \$7,758,481 of general revenue funds from the Grants and Aids - Community Mental Health Services and the Grants and Aids - Community Substance Abuse Services appropriation categories to AHCA to be used as state matching funds for a rate increase for certain Medicaid behavioral health services.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The AHCA must submit amendments to the federally-required state plans for Medicaid for federal approval to implement the Medicaid service changes relating to behavioral health services.

VIII. Statutes Affected:

The bill substantially amends the following sections of the Florida Statutes: 210.20, 381.922, 394.9082, 395.602, 409.904, 409.908, 409.9082, 409.909, 409.911, 409.9119, 409.913, 409.975, and 409.979.

The bill amends two sections of Florida Law.

The bill creates seven 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.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.
