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 Health Policy

BILL:	CS/SB 694
INTRODUCER:	Health Policy Committee; and Senators Hutson and Passidomo
SUBJECT:	Consolidation of Medicaid Waiver Programs
DATE:	March 28, 2017
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Fav/CS**
2.			AHS	
3.			AP	
4.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Technical Changes

I. Summary:

CS/SB 694 consolidates three Medicaid waivers and provides for a January 1, 2018, deadline for eligible waiver participants to transition to the Statewide Medicaid Managed Care (SMMC) Long-Term Care (LTC) program. The bill also terminates the Medication Therapy Management program.

The Agency for Health Care Administration (AHCA) is directed to seek federal approval to terminate the waivers after all Medicaid eligible participants have transitioned to the SMMC-LTC program. The bill updates eligibility requirements for the LTC component of the SMMC and conforms cross-references to changes made in CS/SB 694.

The bill has no fiscal impact on state government.

The effective date of the bill is July 1, 2017.

II. Present Situation:

Florida Medicaid

The Medicaid program is a partnership between the federal and state governments to provide medical care to low income children and disabled persons. Each state operates its own Medicaid

program under a state plan that must be approved by the federal Centers for Medicare and Medicaid Services (CMS). The state plan outlines Medicaid eligibility standards, policies, and reimbursement methodologies.

Florida Medicaid serves as the safety net to Florida's healthcare delivery system. Medicaid currently is the second largest expenditure in Florida's budget behind education.

Over 4 million Floridians are currently enrolled in Medicaid accounting for 20 percent of Florida's population and estimated expenditures for the state fiscal year 2016-2017 of $25.8 billion.[1] Florida has the fourth largest Medicaid population in the country.[2]

Medicaid currently covers:
- 47 percent of Florida's children;
- 63 percent of Florida's births;
- 61 percent of Florida's nursing homes days; and
- 1.7 million adults, - parents, aged, and disabled.[3]

Applicants for Medicaid must be United States citizens or qualified noncitizens, must be Florida residents, and must provide social security numbers for data matching. Minimum eligibility coverage thresholds are established in federal law for certain population groups, such as children, as well as minimum benefits and maximum cost sharing.

However, Florida Medicaid does not cover all low-income Floridians. The maximum income limits for programs are illustrated below as a percentage of the federal poverty level (FPL).

Florida's Current Medicaid and CHIP Eligibility Levels in Florida[4]
(With Income Disregards and Modified Adjusted Gross Income)

Children's Medicaid			**CHIP (Kidcare)**	**Pregnant Women**	**Parents**	**Childless Adults**
Age 0-1	Age 1-5	Age 6-18	Ages 0-18			
206% FPL	140% FPL	133% FPL	210% FPL	191% FPL	31% FPL	0% FPL

Florida Medicaid is administered by the AHCA and is financed with federal and state funds. The Department of Children and Families (DCF) determines Medicaid eligibility and transmits that

[1]Agency for Health Care Administration, Senate Health and Human Services Appropriations Committee Presentation, *Agency for Health Care Administration - Florida Medicaid* (January 11, 2017), slide 2, http://www.flsenate.gov/PublishedContent/Committees/2016-2018/AHS/MeetingRecords/MeetingPacket_3554.pdf (last visited Mar. 17, 2017).
[2]Agency for Health Care Administration, Senate Health and Human Services Appropriations Committee Presentation, *Agency for Health Care Administration - Florida Medicaid* (January 11, 2017), slide 2, http://www.flsenate.gov/PublishedContent/Committees/2016-2018/AHS/MeetingRecords/MeetingPacket_3554.pdf (last visited Mar. 17, 2017).
[3] Id at 10.
[4] U.S. Centers for Medicare and Medicaid Services, Medicaid.gov, *Florida*, http://www.medicaid.gov/medicaid-chip-program-information/by-state/florida.html (last visited Mar. 17, 2017).

information to the AHCA. As the single state agency, the AHCA has the lead responsibility for the overall program.[5]

The structures of state Medicaid programs vary from state to state, and each state's share of expenditures also varies and is largely determined by the federal government. Federal law and regulations set the minimum amount, scope, and duration of services offered in the program, among other requirements. State Medicaid benefits 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).

Waivers to the state plan may be requested and negotiated by the state through the federal CMS by the AHCA. Florida has several such Medicaid waivers, including those which implemented the SMMC program. Current federal law requires the state to obtain a waiver to implement managed care. Through these waivers, the states have limited flexibility to design their Medicaid programs; however, even within waiver authorities, federal regulations prescribe requirements for benefits, delivery systems, cost sharing limitations, and population coverages. States may also seek federal waivers to expand populations or services.

Statewide Medicaid Managed Care (SMMC)

The SMMC has two components: Managed medical assistance (MMA) and long-term care managed care (LTC). The current MMA waiver expires on June 30, 2017, and the existing LTC waiver was recently extended through December 27, 2021.[6] Florida's LTC program serves elderly and disabled individuals who require long-term nursing facility level of care.

Part IV of ch. 409, F.S., was created in 2011 by ch. 2011-134, Laws of Fla., and governs the SMMC program. The LTC component began enrolling recipients in August 2013, and completed its statewide rollout in March 2014. The MMA component began enrolling Medicaid recipients in May 2014, and finished its rollout in August 2014.

The LTC program provides services in two settings: nursing facilities or home and community based services (HCBS) such as a recipient's home, an assisted living facility, or an adult family care home. Nursing facility services are an entitlement program for eligible enrollees and no waitlist exists; however, HCBS are delivered through waivers and are dependent on the availability of annual funding in the General Appropriations Act (GAA).

Of those recipients enrolled in the LTC waiver, more than half or 47,465 recipients are receiving HCBS as of February 1, 2017. The remaining enrollees are receiving nursing facility services.[7]

[5] *See* s. 409.963, F.S.

[6] The current Managed Medical Assistance waiver is approved as an 1115 waiver and was last approved for the time period of July 31, 2014 through June 30, 2017. The Long-Term Care Managed Care waiver is approved as a section 1915(b) and section 1915(c) combination waiver and was most recently approved through December 27, 2021, by the federal Centers for Medicare and Medicaid Services.

[7] Agency for Health Care Administration, *Senate Bill Analysis 682* (Feb. 13, 2017), pg. 2, (on file with the Senate Committee on Health Policy).

Statewide Medicaid Managed Care - February 1, 2017			
Component	**Enrollment Start Date**	**Budget[8]**	**Enrollment[9] *(as of Feb. 2017)***
Long-Term Care Plan	August 2013	$3.97 billion	94,844
Home & Community Based Services			*47,465[10]*
Managed Medical Assistance	May 2014	$14.4 billion	3,237,296

Services for LTC program enrollees are delivered through six managed care plans, which vary based on the recipient's region; however, each region has at least two plans. Plans are paid on a capitated basis meaning that a LTC plan must pay for all covered services under the contract regardless of whether the capitated rate covers the full cost of services for that recipient.

Enrollment in the HCBS portion of LTC is managed based on a priority system and wait list. For the 2016-2017 waiver year, the state is approved for 62,500 unduplicated recipients in the HCBS portion of the program.[11]

Eligibility and Enrollment

The AHCA is the single state agency for Medicaid; however, through an interagency agreement with the Department of Elder Affairs (DOEA), the DOEA is Florida's federally mandated pre-admission screening program for nursing home applicants through its Long-Term Care Services (CARES) program, including for LTC services.[12] The CARES program has 18 field offices across the state, which are staffed with physicians, nurses, and other health care professionals who evaluate the level of care an individual may or may not need for waiver services. To receive long-term care services, an individual must be both financially eligible under Medicaid and be determined clinically eligible under the CARES program. The frailty-based assessment results in a priority score for an individual, who is then placed on the wait list based on his or her priority score if funding is not available.

The Legislature has specifically directed funding in the past several years through the GAA to serve elders off the waitlist who have a priority score of 4 or higher.[13] Individuals who are more frail or have a more immediate need for services receive a higher rank on the waitlist. Those who have resided in a nursing facility for more than 60 days receive priority enrollment into the

[8] Agency for Health Care Administration, *Statewide Medicaid Managed Care (Presentation to House Health and Human Services Committee - Jan. 10, 2017)*, slide 2, http://ahca.myflorida.com/medicaid/recent_presentations/House_Health_Human_Services_Med_101_2017-01-10.pdf (last visited Mar. 1, 2017).
[9] Agency for Health Care Administration, *SMMC MMA Enrollment by County by Plan* (as of February 1, 2017), *http://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml* (last visited Mar. 1, 2017).
[10] *Supra* note 10.
[11] Letter from U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services to Beth Kidder, Interim Deputy Secretary for Medicaid, Agency for Health Care Administration (Dec. 19, 2016), *available at* http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/LTC_Approval_Letter_2016-12-19.pdf (last visited Mar. 1, 2017).
[12] Florida Dep't of Elder Affairs, *Comprehensive Assessment and Review for Long-Term Care Services (CARES)*, http://elderaffairs.state.fl.us/doea/cares.php (last visited Mar. 1, 2017).
[13] *See* Ch. Law 2016-66, line item 232; Ch. Law 2015-232, line item 226; and Ch. Law 2014-51, line item 242. In state fiscal year 2013-14, GAA provided funding during the first year of the LTC program for those on the wait list with priority scores of 5 or higher. (Ch. Law 2013-40, line item 414).

HCBS portion of the program. Other exemptions from the waitlist exist under s. 409.979(3)(f), F.S.

Before being released from the waitlist; however, individuals must meet the following eligibility requirements to enroll in the program:[14]

- Be age 65 years or older or age 18 and eligible for Medicaid by reason of a disability; and
- Be determined by the CARES preadmission screening program to require nursing facility care as defined in s. 409.985(3), F.S.

Individuals, both those who are enrolled in LTC and those on the wait list, must be re-screened at least annually or whenever there is a significant change in circumstances, such as change in caregivers or medical condition.[15]

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 are:

- 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.[16]

Prior to the implementation of SMMC, at least 14 different waivers provided 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 state fiscal year 2012-2013.[17]

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.[18] 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

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[14] *See* s. 409.979, F.S.
[15] Application for §1915(c) Home and Community-Based Services Waiver (Effective July 1, 2013), pp. 45-46, http://www.fdhc.state.fl.us/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/mma/LTC_1915c_Application.pdf (last visited Mar. 1, 2017).
[16] *See* s. 409.972, F.S.
[17] 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. 20, 2017).
[18] *Id.*

- Meet inpatient hospital level of care.[19]

The waiver includes services such as case management, counseling, skilled nursing, prescribed drugs, respite care, therapies, dental, meal delivery, and specialized medical equipment.[20]

There are approximately 140 people enrolled in this waiver.[21]

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.[22]
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
- Meet hospital or nursing facility level of care.[23]

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.[24]

Currently, approximately 7,800 people are enrolled in the PAC waiver.[25]

Traumatic Brain and Spinal Cord Injury Waiver

The 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;

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[19] *Id.*
[20] 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. 17, 2017).
[21] Agency for Health Care Administration, *Senate Bill 694 Analysis*, p. 4, (March 7, 2017) (on file with the Senate Committee on Health Policy).
[22] 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. 20, 2017).
[23] *Supra* note 21.
[24] *Supra* note 24.
[25] *Supra* note 25, at 3.

- 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.[26]

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.[27]

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.[28]

Medication Therapy Management (MTM) Program

The AHCA is statutorily required to operate the prescription drug management program known as the Medicaid Therapy Management (MTM) program.[29] The goals of the MTM program are:

- Improve the quality of care and prescribing practices based on best-practice guidelines;
- Improve patient adherence to medication plans;
- Reduce clinical risk; and
- Lower prescribed drug costs and the rate of inappropriate spending for certain Medicaid prescription drugs.[30]

The AHCA contracts with the University of Florida to conduct the comprehensive prescribed drug case management, if the Medicaid recipient chooses to participate. Trained pharmacists help resolve medication-related and health-related problems, optimize medication use for improved patient outcomes, and promote patient self-management of medication.[31] The center notifies prescribers of potential issues or problems via phone or fax, depending on the urgency of the issue. MTM services to patients are mostly provided via telephone.[32]

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[26] *Supra* note 21, at 11.
[27] *Id.*
[28] *Supra* note 25, at 3.
[29] Section 409.912(8)(a)11, F.S.
[30] Agency for Health Care Administration, *1115 MEDS-AD Waiver - Post Award Forum* (April 21, 2016), slide 6, http://ahca.myflorida.com/medicaid/MEDS-AD/post_award_forum_2016-04-21.shtml (last visited Mar. 20, 2016).
[31] Fla. Office of Attorney General and Agency for Health Care Admin., *The State's Efforts to Control Medicaid Fraud and Abuse* (FY 2015-16), p. 20, http://ahca.myflorida.com/Executive/Inspector_General/docs/Medicaid_Fraud_Abuse_Annual_Reports/2015-16_MedicaidFraudandAbuseAnnualReport.pdf (last visited Mar. 20, 2017).
[32] University of Florida, *University of Florida Medicaid Management Center* http://mmc.pharmacy.ufl.edu/services/mtm/ (last visited Mar. 20, 2017).

The MTM program provides services for up to 150 program recipients enrolled in the MEDS-AD program and not in a Medicaid managed care plan.

The MEDS-AD program is approved through a federal 1115 Demonstration grant waiver and provides coverage for certain aged and disabled individuals with incomes up to 88 percent of the federal poverty level and have assets of less than $5,000 for individual or $6,000 for couples. Quoting from the Special Terms and Conditions letter from the federal CMS in 2015, which extended the grant at that time through December 31, 2015: "The Demonstration was predicated on the assumption that continued access to medical care, including HCBS services and pharmacy management services, would delay deterioration in health status which drives hospitalization and/or institutionalization."[33]

Delivery System and Benefits

The AHCA conducted a competitive procurement to select LTC plans in each of the 11 regions in 2012. Contracts were awarded to health maintenance organizations (HMOs) and provider service networks (PSNs). Six non-specialty plans are currently contracted, including one PSN that is available in all 11 regions and one HMO that is in 10 regions. Recipients receive choice counseling services to assist them in selecting the plan that will best meet their needs.

Each plan under LTC is required to provide a minimum level of services. These required services include:

- Adult companion care;
- Adult day health care;
- Assisted living;
- Assistive care services;
- Attendant care;
- Behavioral management;
- Care coordination and case management;
- Caregiver training;
- Home accessibility training;
- Home-delivered meals;
- Homemaker;
- Hospice;
- Intermittent and skilled nursing;
- Medical equipment and supplies;
- Medication administration;
- Medicaid management;
- Nursing facility;
- Nutritional assessment/risk reduction;
- Personal care;
- Personal emergency response system;

[33] *Special Terms and Conditions - Florida MEDS-AD section 1115(a) Medicaid Demonstration extension (Jan. 1, 2015 - December 31, 2015)* http://ahca.myflorida.com/medicaid/MEDS-AD/docs/Special_Terms_and_Conditions.pdf, (last visited Mar. 20, 2017).

- Respite care;
- Therapies; and
- Non-emergency transportation.[34]

A LTC plan may elect to offer expanded benefits to its enrollees. Some of the approved expanded benefits within LTC include:

- Cellular phone service;
- Dental services;
- Emergency financial assistance;
- Hearing evaluation;
- Mobile personal emergency response system;
- Non-medical transportation;
- Over-the-counter medication and supplies;
- Support to transition out of a nursing facility;
- Vision services; and
- Wellness grocery discount.[35]

The LTC enrollees who are not eligible for Medicare also receive their medical services through an MMA plan. Some plans participate in both components in the same regions, and a recipient may choose the same managed care plan for both components, known as a comprehensive plan.

III. Effect of Proposed Changes:

Section 1 amends s. 409.904, F.S., relating to optional eligibility groups for Medicaid to add those individuals who have been diagnosed with Acquired Immune Deficiency Syndrome (AIDS), who have an AIDS-related opportunistic infection, who are at risk of hospitalization, as determined by the AHCA or its designee, and whose incomes are at or below 300 percent of the federal benefit rate (approximately 222 percent of the federal poverty level). Currently, to be eligible for Medicaid, an individual would need to meet one of the other eligibility categories such as being determined disabled or elderly with an income at or below 88 percent of the federal poverty level.

CS/SB 694 would transition approximately 7,800 of the existing enrollees from the waiver program if they meet nursing facility level of care into the Statewide Medicaid Managed Care LTC program. If the participant does not meet the nursing facility level of care, the participant would still receive his or her medical care services through the Managed Medical Assistance plan.

Section 2 removes obsolete language under s. 409.906, F.S., relating to services that are optional under the Medicaid program.

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[34] *See* s. 409.98, F.S.

[35] Agency for Health Care Administration, MMA - Model Contract - Attachment I - Scope of Services (Effective date Feb. 1, 2017) pp. 4-6, http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2017-02-01/02-01-17_MODEL_Attachment_I-Scope_of_Services.pdf (last visited Mar. 20, 2017).

Section 3 amends s. 409.912, F.S., relating to the cost-effective purchasing of health care to repeal the MTM Program. The bill removes all requirements for the AHCA to implement and maintain the MTM program.

The MTM program is available only to Medicaid recipients who are not enrolled in a Medicaid managed care plan. The program currently has 50 enrollees that would be impacted by the termination of the program and has a program capacity for 250 participants.

Section 4 amends s. 409.979, F.S., relating to eligibility for the Long-Term Care Managed Care program. The bill amends the criteria for eligibility to add alternative language for cystic fibrosis participants. CS/SB 694 recognizes that for cystic fibrosis, the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARE) preadmission screening services, standard for needed level of care is hospital-level, not nursing facility care.

The bill further amends this section to authorize enrollees in the following waivers to participate in the LTC managed care program when all of the eligibility criteria have been met and they shall be transitioned by January 1, 2018:

- Traumatic Brain and Spinal Cord Injury Waiver;
- Adult Cystic Fibrosis Waiver; and
- Project AIDS Care Waiver.

The AHCA is directed to seek federal approval to terminate these same waivers after all eligible Medicaid recipients have transitioned into the LTC managed care program.

Section 5 amends s. 393.0661, F.S., relating to home and community based services delivery systems for persons with developmental disabilities to conform cross references based on changes in this bill.

Section 6 amends s. 409.968, F.S., relating to managed care plan payments to conform a cross reference to changes contained in this bill.

Section 7 provides 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:

Eligible participants in the waiver programs will be transitioned to the LTC managed care plans by January 1, 2018. This transition may impact which providers these participants access in the community from individual physicians to different health care facilities depending on which managed care plan the participant selects during the choice counseling process. While this is a small number of participants to roll into Medicaid from a statewide perspective, it could have an impact on certain doctors or facilities in smaller communities.

The participants in these waivers are also among some of the highest utilizers of health care services, and the most fragile. Depending on where these participants reside and if they congregate in one or two specific plans, it could have a financial effect on those select managed care plans.

C. Government Sector Impact:

If the former waiver enrollees select the same one or two plans, there may be an impact on the overall rates that cannot be offset by the rest of the plan's enrollment. This effect would have an impact on the state and the rates paid to the MMA and LTC plans in the future.

Secondly, the Medication Therapy Management program is a project of the University of Florida. The call center is staffed by 4th year student pharmacists and overseen by college faculty as an experiential practice site.[36] While Florida Medicaid is not the call center's only client, elimination of this program would have a financial and educational impact to the call center.

The AHCA believes this activity was duplicative of other efforts at the state level as participants in the MMA plans received these services through their managed care plans. For those enrolled in fee-for-service Medicaid, the AHCA noted that it was difficult to identify willing participants since the program was voluntary. With such a small pool, the AHCA reported that evaluation results were also unreliable.[37]

The DOH would be relieved of oversight of two waivers: Adult Cystic Fibrosis Waiver and Traumatic Brain and Spinal Cord Injury Waiver. The AHCA would be gaining oversight of these participants as they would be transitioned into the SMMC program. Compared to the overall size of the Medicaid program, the numbers are small for the

[36] University of Florida, *Medication Management Center* http://mmc.pharmacy.ufl.edu/ (last visited Mar. 20, 2017).
[37] Agency for Health Care Administration, *Senate Bill 694 Analysis* (Feb. 7, 2017) (on file with the Senate Committee on Health Policy).

enrollees in these waivers and the AHCA will be able to transition these members when appropriate. The DOH will have two fewer programs to administer.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The AHCA uses the MTM program to satisfy its research and demonstration component under the state's 1115 MEDS-AD waiver, a federal requirement. If this change is adopted and the MTM program is eliminated, the AHCA will need to identify other mechanisms to ensure that this requirement is met and that the MEDS-AD population continues to have access to services.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.904, 409.906, 409.912, 409.979, 393.0661, and 409.968.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on March 27, 2017:
The CS amended the title to more accurately reflect the contents of the bill.

B. Amendments:

None.