HOUSE OF REPRESENTATIVES STAFF FINAL BILL ANALYSIS

BILL #: SB 2510 Health
SPONSOR(S): Appropriations
TIED BILLS: **IDEN./SIM. BILLS:**

FINAL HOUSE FLOOR ACTION: 111 **Y's** 0 **N's** **GOVERNOR'S ACTION:** Approved

SUMMARY ANALYSIS

SB 2510 passed the House on May 5, 2023, as amended by the conference committee.

The bill conforms law to the Fiscal Year 2023-2024 General Appropriations Act. The bill:

- Increases the income threshold above which a resident in a State Veterans' nursing facility would be required to contribute to his or her account from $130 to $160 per month.
- Clarifies the premiums paid under Florida KidCare's full-pay programs are based on the combined-risk premium.
- Increases the nursing home prospective payment reimbursement methodology for the Quality Incentive Program Payment Pool from 6 percent to 10 percent of the September 2016 non-property related payments of included facilities.
- Creates the Graduate Medical Education Slots for Doctors Program.
- Provides for a portion of the Statewide Medicaid Managed Care achieved savings rebate to be repaid to the federal government.
- Establishes a Medicaid managed care pilot program to provide home and community-based services to individuals with developmental disabilities in Hardee, Highlands, Hillsborough, Manatee, Polk, Miami-Dade and Monroe counties (Medicaid regions D and I).
- Prohibits the Agency for Health Care Administration from requiring a home health agency to meet the requirements of Medicare certification, if a home health agency does not provide Medicaid-skilled private duty nursing and attendant care nursing services, beginning October 1, 2021.

The bill was approved by the Governor on June 15, 2023, ch. 2023-243, L.O.F., and will become effective on July 1, 2023 except as otherwise provided.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Florida Medicaid

Background

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

The structure of each state's Medicaid program varies and what states must pay for is largely determined by the federal government, as a condition of receiving federal funds.[1] Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states. The federal government sets the minimum mandatory populations to be included in every state Medicaid program. The federal government also sets the minimum mandatory benefits to be covered in every state Medicaid program. These benefits include home health services.[2] States can add benefits, with federal approval.

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

Florida operates under a Section 1115 waiver to use a comprehensive managed care delivery model for primary and acute care services, the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program.[3] Florida also has a waiver under Sections 1915(b) and (c) of the Social Security Act to operate the SMMC Long-Term Care (LTC) program to provide long-term care services, including nursing facility and home and community-based services, to individuals age 65 and over and individuals age 18 and over who have a disability.[4]

State Veterans' Homes

Background

Once Medicaid eligibility is established for an individual requiring an institutional level of care, some of his or her income is used to pay for Medicaid services. For individuals residing in an institution to receive medical care or services, most of their incomes are applied to the cost of that care, with the exception of a small personal needs allowance used to pay for personal needs that are not covered by Medicaid.[5] A personal needs allowance is the amount of income a resident may retain for personal expenditures not covered by the nursing home, such as toiletries and haircuts.

[1] Title 42 U.S.C. §§ 1396-1396w-5; Title 42 C.F.R. Part 430-456 (§§ 430.0-456.725) (2016).
[2] S. 409.905, F.S.
[3] S. 409.964, F.S.
[4] *Id.*
[5] 42 U.S.C. s. 1396a (q).

The Florida Department of Veterans' Affairs operates eight skilled nursing facilities and one assisted living facility.[6] Every resident of a state veteran domiciliary or nursing home who receives a pension, compensation, or gratuity from the United States Government or income from any other source of more than $130 per month is required to contribute to his or her maintenance and support while residing in a home, pursuant to a schedule of payment determined by the home administrator and department director that shall not exceed the actual cost of operating and maintaining the home.[7]

Effect of the Bill

The bill amends s. 296.37, F.S., to increase the personal needs allowance to $160 per month for residents of State Veterans' Homes.

KidCare

Background

The Florida KidCare Program (KidCare or Program) was created by the Florida Legislature in 1998 in response to the passage of the Children's Health Insurance Program (CHIP) in 1997.[8] The CHIP provides federal funding to states to provide subsidized health insurance coverage to uninsured children in families with incomes that are too high to qualify for Medicaid but who meet other eligibility requirements. When created, CHIP was initially authorized and allotted funding for 10 years. However, due the program's capped funding structure, the federal government has had to repeatedly reauthorize and extend funding.[9] Most recently, the 2023 Consolidated Appropriations Act extended federal funding for CHIP through fiscal year 2029.[10]

KidCare encompasses four programs.

1. Medicaid for children
2. The MediKids program
3. The Children's Medical Services Network (for children with special needs)
4. The Florida Healthy Kids program

Three of the four programs, MediKids, Healthy Kids, and the Children's Medical Services Network (CMSN), directly receive federal CHIP funding and constitute Florida's CHIP program. The CHIP was designed as a federal and state partnership, similar to Medicaid, with the goal of expanding health insurance to children whose families earn too much income to be eligible for Medicaid, but not enough money to purchase private, comprehensive health insurance.

The CHIP is administered by states, according to federal requirements. The program is funded jointly by states and the federal government. The federal CHIP is authorized and funded through Fiscal Year 2027 via the Bipartisan Budget Act of 2018 (P.L. 115-123).[11]

CHIP funding is also used to enhance the match rate for some children in Medicaid. More specifically:

- MediKids is a Medicaid "look-alike" program administered by AHCA for children ages 1 through 4 who are at or below 200 percent of the federal poverty level (FPL).[12] Families whose income

[6] Florida Department of Veterans' Affairs, *State Veterans' Homes, available at* https://floridavets.org/locations/state-veterans-nursing-homes/ (last visited May 10, 2023).
[7] Section 296.37, F.S
[8] CHIP was created as part of the Balanced Budget Act of 1997 (BBA 97, Pub. L. No. 105.33, s. 4901).
[9] The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, Pub. L. No. 111–3, s.101) reauthorized CHIP through fiscal year (FY) 2013, the Patient Protection and Affordable Care Act of 2010, (ACA, Pub. L. No. 111–148, s. 10203) extended CHIP funding through FY 2015, the Medicare Access and CHIP Reauthorization Act of 2015 (Pub. L. No. 114–10, s. 301) extended funding through FY 2017, the Healthy Kids Act extended funding to FY 2023 (Pub. L. No. 115-120, s. 3002), and the Bipartisan Budget Act of 2018, (Pub. L. No. 115-123, s. 50101) extended funding for CHIP through 2023 .
[10] Consolidated Appropriations Act, 2023, Pub. L. No. 117-328, s. 5111.
[11] The Medicaid and CHIP Payment and Access Commission, *State Children's Health Insurance Program (CHIP)*, (February 2018) *available at* https://www.macpac.gov/wp-content/uploads/2018/02/State-Children%E2%80%99s-Health-Insurance-Program-CHIP.pdf (last visited May 10, 2023).
[12] Section 409.8132(6), F.S.

exceeds 200 percent of the FPL can elect to participate in the MediKids full-pay premium option.[13]

- Healthy Kids is for children ages 5 through 18 and administered by the Florida Healthy Kids Corporation (FHKC). Children in families with income between 133 percent and 200 percent of the FPL ($33,383 and $50,200 for a family of four) are eligible for subsidized coverage through the Healthy Kids program.[14] Families whose income exceeds 200 percent of the FPL can elect to participate in the Healthy Kids full-pay option.[15]
- Children's Medical Services Network (CMSN) is a program for children from birth through age 18 with special health care needs.[16] The Department of Health (DOH) operates the program which is open to all children who meet the clinical eligibility criteria that are Medicaid or Title XXI eligible.[17]
- Medicaid eligibility is determined by DCF and provides Title XIX coverage to infants from birth to age 1 who are at or below 200 percent of the FPL and children ages 1 through 18 who are at or below 133 percent of the FPL.[18]

Families who receive Medicaid are not responsible for paying premiums or co-payments. Families with children that qualify for other KidCare program components are responsible for paying monthly premiums and co-payments for certain services. The Healthy Kids program[19] and the MediKids program[20] both utilize a combined-risk premium model of Title XXI-subsidized and full-pay enrollments for medical insurance payments.

The total monthly family payment for CHIP enrollees is $15 or $20 for families with incomes between 133 percent and 200 percent of the FPL.[21] The per-child monthly premium rate is $210.18 for full-pay MediKids coverage and $259.50 for full-pay Healthy Kids coverage, including dental coverage.[22]

As of March 2023, 4,883 children are enrolled in subsidized MediKids; 3,280 children are enrolled in MediKids under the full-pay option; 76,340 children are enrolled in subsidized Healthy Kids; 21,650 children are enrolled in Healthy Kids under the full-pay option; 6,575 children are enrolled in the CMSN; and 2,466,597 children are enrolled in the Medicaid program.[23]

Effect of Bill

The bill amends s. 409.814, F.S., to clarify the premiums paid under Florida KidCare's full-pay programs are based on the combined-risk premium.

Nursing Prospective Payment System

Background

On October 1, 2018, Florida Medicaid nursing homes transitioned from facility-specific cost based rates to the prospective rate reimbursement methodology, which determines rates in advance of payment.

[13] Agency for Health Care Administration, Florida KidCare, *Welcome to MediKids*, https://ahca.myflorida.com/content/download/11063/file/FLORIDA_MEDIKIDS_INFORMATION_12-1-2021.pdf (last visited May 10, 2023).
[14] Florida Healthy Kids Corporation, *Subsidized Premiums/Copays*, https://www.healthykids.org/cost/subsidized/ (last visited May 10, 2023).
[15] *Id.*
[16] *See* ch. 391, F.S.
[17] *Id.*
[18] Florida Healthy Kids, *Florida KidCare Health and Dental Insurance Program Eligibility Overview*, https://www.floridakidcare.org/_docs/Florida_KidCare_Income_Guidelines.pdf (last visited May 10, 2023).
[19] Chapter 2019-115, Laws of Fla., Specific Appropriation 178.
[20] Chapter 2020-111, Laws of Fla., Specific Appropriation 185.
[21] *Supra,* note 18.
[22] *Id.*
[23] Agency for Health Care Administration, Florida KidCare, *Florida KidCare Enrollment Report, March 2023* (on file with the Senate Appropriations Committee on Health and Human Services).

Section 409.908, F.S., provides the methodology[24] and parameters for rate setting including reimbursement rates for direct care, indirect care, and operating costs.

The methodology includes a parameter for a Quality Incentive Payment, in which a provider is awarded points for process, outcome, structural and credentialing measures using most recently reported data on May 31 of the rate period year.[25]

The Quality Incentive Payment calculation[26] is as follows:

$$\frac{\text{Facility Annualized Medicaid Days}}{\text{Average Annualized Medicaid Days}} \times \frac{\text{Quality Points with Lower Limit}}{\text{Sum of Total Points Awarded to All Facilities}} \times \frac{\text{Total Quality Budget}}{\text{Facility Annualized Medicaid Days}}$$

Payment amounts are limited to 6 percent of the September 2016 non-property related payments of included facilities.[27]

Effect of the Bill

The bill amends s. 409.908, F.S., modifying the parameters governing the nursing home prospective payment methodology for Medicaid provider reimbursement to increase the quality incentive payment pool from 6 percent to 10 percent of the September 2016 non-property related payments of included facilities.

Graduate Medical Education

Background

Graduate medical education (GME) refers to the training residents complete after medical school graduation to develop clinical and professional skills required to practice medicine. During this education, residents train in a specialty (e.g., general surgery, pediatrics, or internal medicine).[28] All medical school graduates must complete a period of GME, or residency training, to be licensed to practice medicine in the United States. GME comprises the second phase, after medical school, of the formal education that prepares doctors for medical practice. During residency, doctors learn skills and techniques specific to their chosen specialty under the supervision of attending physicians and serve as part of a care team.[29]

GME programs include residencies and fellowships. First year GME students fill categorical or preliminary resident positions. Categorical residents begin a multi-year program with a sponsoring institution during their first year of GME training. During their first year, preliminary residents receive prerequisite training. After receiving prerequisite training, preliminary residents transfer to categorical resident programs. After completing a residency program, physicians may also pursue advanced GME training by completing a fellowship in a subspecialty program, such as cardiology or vascular surgery.[30]

[24] Nursing Home Prospective Payment System Calculation: (Operating Price + Direct Care Price - Floor Reduction + Indirect Care Price - Floor Reduction + FRVS Rate + Pass Through Payments) * Budget Neutrality Factor + Quality Incentive Payment + Medicaid Share of NFQA + Ventilator Supplemental Payment + High Medicaid Utilization and High Direct Patient Care Add-On)) + Unit Cost Rate Increase
[25] R. 59G-6.010(2)(y), F.A.C.
[26] *Id.*
[27] S. 409.908(2)(e), F.S. (2022).
[28] Office of Program Policy Analysis and Government Accountability, *Florida's Graduate Medical Education System (Report No. 14-08), available at* https://oppaga.fl.gov/Documents/Reports/14-08.pdf (last visited May 10, 2023).
[29] Association of American Medical Colleges, *State-by-State Graduate Medical Education Data, available at* https://www.aamc.org/advocacy-policy/state-state-graduate-medical-education-data (last visited May 10, 2023).
[30] *Id.*

Graduate Medical Education Accreditation

The Accreditation Council for Graduate Medical Education (ACGME) accredits allopathic GME programs, and the American Osteopathic Association (AOA) accredits osteopathic GME programs.

The ACGME is a private, 501(c)(3), not-for-profit organization that accredits GME (physician residency and fellowship) and certain medically related post-doctoral fellowship programs and the institutions that sponsor them in the United States.[31] ACGME accreditation is overseen by a Review Committee made up of volunteer specialty experts from the field that set accreditation standards and provide peer evaluation of Sponsoring Institutions and specialty and subspecialty residency and fellowship programs. In academic year 2019-2020, there were approximately 865 ACGME-accredited institutions sponsoring approximately 12,000 residency and fellowship programs in 182 specialties and subspecialties.[32]

The AOA is the primary certifying body for osteopathic physicians and the accrediting agency for all osteopathic medical schools. The AOA represent more than 178,000 osteopathic physicians and medical students across the United States. The AOA accredits Osteopathic Postdoctoral Training Institutions, which train residents in community-based settings.[33] With osteopathic residency programs, a college of osteopathic medicine serves as the academic sponsor and has an agreement with a base institution. Residents in these programs train at base institutions, which are most often hospitals. The base institution maintains administrative and financial responsibility.[34]

Florida's Graduate Medical Education Programs

Florida's GME program consists of the Statewide Medicaid Residency, the Startup Bonus, and the High Tertiary, Primary Care, Mental and Behavioral Health, and Psychiatry programs. In Fiscal Year 2022-2023, $291,644,448 was appropriated to fund GME programs.[35]

Florida's Graduate Medical Education (GME) Programs[36]	
Statewide Medicaid Residency	Provides $97,300,000 in funding to hospitals and qualifying institutions for residency programs associated with the Medicaid program, using a statutory allocation formula to equitably distribute GME funding. Qualifying hospitals must be licensed under part I of chapter 395, Florida Statutes. Qualifying institution means a Federally Qualified Health Center holding an Accreditation Council for Graduate Medical Education institutional accreditation.
Startup Bonus	Provides $100,000,000 in funding to hospitals and qualifying institutions up to $100,000 per newly created residency slot that is dedicated to a physician specialty or subspecialty in statewide shortage. "Qualifying institution" means a Federally Qualified Health Center holding an Accreditation Council for Graduate Medical Education institutional accreditation.
High Tertiary Care	Provides $66,000,000 in funding to statutory teaching hospitals that provide charity care greater than $15 million and also provide highly specialized tertiary care.

[31] Accreditation Council for Graduate Medical Education, *ACGME Frequently Asked Questions (FAQs), available at* https://www.acgme.org/about-us/acgme-frequently-asked-questions/ (last visited May 10, 2023).
[32] Accreditation Council for Graduate Medical Education, *What We Do, available at* https://www.acgme.org/What-We-Do/Overview (last visited May 10, 2023).
[33] American Osteopathic Association, *About Us, available at* https://osteopathic.org/about/ (last visited May 10, 2023).
[34] *Supra*, note 23.
[35] Chapter 2022-156, Laws of Fla., Specific Appropriation 202.
[36] *Id.*

	Primary Care	Provides $22,600,000 in funding in primary care and training in Medicaid regions with primary care demand greater than supply by 25 percent or more.
	Mental & Behavioral Health	Provides $4,400,000 in funding to address the declining GME in severe deficit of physicians trained in mental health and behavioral health facilities licensed under section 394, Florida Statutes.
	Psychiatry	Provides $1,344,447 in funding for psychiatry residency slots in adult and child psychiatry for accredited Federally Qualified Health Centers.

Physician Shortage

Despite enhanced GME funding having a positive impact, due to a growing population and an aging physician workforce, signs indicate a physician shortage is looming in Florida. Florida's physician licensure data suggests that in 2019 there were 55,083 full-time equivalent (FTE) physicians actively practicing in Florida. Of these physicians, the average age is 51 and approximately 26 percent are over the age of 60 years old. [37]

Florida's 2019 physician supply was approximately 3,835 FTEs lower than estimated demand, meaning, that Florida's supply was only able to meet 93 percent of estimated demand relative to national averages. However, the report suggests that if current trends continue, Florida's projected 2035 supply and demand could yield a shortfall of approximately 17,924 FTE physicians with supply sufficient to meet only 77 percent of projected demand.[38]

Demand for physicians across the United States is projected to grow faster than supply leading to a potential nationwide shortfall of as many as 124,000 FTE physicians in 2034. This includes a projected shortage of between 17,800 and 48,000 primary care physicians, between 15,800 and 30,200 surgeons, between 3,800 and 13,400 internal medicine and pediatric specialists, and between 10,300 and 35,600 physicians across the other specialties.[39]

Effect of the Bill

The bill amends s. 409.909, F.S. to create the Graduate Medical Education Slots for Doctors Program to address the physician shortage by increasing the supply of highly trained physicians through the creation of new resident positions. The bill requires the Agency for Health Care Administration to allocate $100,000 to hospitals and qualifying institutions for each newly created resident position that is accredited by the Accreditation Council for Graduate Medical Education or Osteopathic Postdoctoral Training Institution in an initial or established accredited training program that is in a physician specialty or subspecialty in a statewide supply-and-demand deficit as identified in the General Appropriations Act. The bill further prohibits funds from the program to be used for resident positions that previously received funding under the Statewide Medicaid Residency Program.

Statewide Medicaid Managed Care (SMMC) Program

Background

In 2011, the Legislature established the Medicaid program as a statewide, integrated managed care program for all covered services, and directed AHCA to create the Statewide Medicaid Managed Care (SMMC) program and contract with managed care plans on a regional basis to provide services to eligible recipients.[40] The SMMC minimum benefits are authorized by federal authority and are

[37] IHS Market, *Florida Statewide Regional Physician Workforce Analysis: 2019 to 2023 (December 2021), available at* https://safetynetsflorida.org/wp-content/uploads/Florida-Physician-Workforce-Analysis.pdf (last visited May 10, 2023).
[38] *Id.*
[39] *Id.*
[40] Chapter 2011-134, Laws of Fla.

specifically required in s. 409.973, F.S., for Managed Medical Assistance (MMA) plans and s. 409.98, F.S., for Long-Term Care (LTC) plans.

Today, the majority of Florida Medicaid recipients receive their services through a managed care plan contracted with AHCA under the SMMC program. The SMMC program has three components:

- MMA: provides Medicaid covered medical services like doctor visits, hospital care, prescribed drugs, mental health care, and transportation to these services.[41]
- LTC: provides Medicaid LTC services like care in a nursing facility, assisted living, or at home. To get LTC you must be at least 18 years old and meet nursing home level of care (or meet hospital level of care if you have Cystic Fibrosis).[42]
- Dental: provides all Medicaid dental services for children and adults. All individuals on Medicaid must enroll in a dental plan.[43]

Achieved Savings Rebate

Background

AHCA implemented the Achieved Savings Rebate (ASR) Program as an incentive for proper use of state funds. The program monitors plans' premium revenues, medical and administrative costs, and income or losses in a uniform manner.[44] AHCA is responsible for verifying the achieved savings rebate (ASR) for all Medicaid prepaid plans. Prepaid plans are required to provide AHCA with unaudited quarterly and annual reports that detail managed care plan financial operations and performance for the applicable reporting period. If a plan reports that its profits exceed a certain percent of revenue (thereby achieving savings for the overall program), the plan must return a portion of the profits (a rebate) to the state.[45]

The ASR is established by determining pretax income as a percentage of revenues and applying the following income sharing ratios:

- All profit up to five percent of revenue is retained by the plan. Half of the profit above five percent and up to 10 percent of revenue is retained by the plan and the other half refunded to the state. All profit above 10 percent of revenue is refunded to the state. All refunds to the state are transferred to the General Revenue Fund, unallocated.[46]
- Plans may retain an additional one percent of revenue if they meet or exceed quality measures defined by AHCA, including plan performance for managing complex, chronic conditions that are associated with an elevated likelihood of recurring high-cost medical treatments.[47]

Effect of the Bill

The bill amends s. 409.967, F.S. to provide for the Statewide Medicaid Managed Care achieved savings rebate to be adjusted for the Federal Medical Assistance Percentage, and for the federal share to be transferred to the Medical Care Trust Fund.

Medicaid Home- and Community-Based Waiver for Persons with Developmental Disabilities

Under federal law, fee-for-service Medicaid provides coverage for health care services to cure or ameliorate diseases; generally, Medicaid does not cover not services that will not cure or mitigate the underlying diagnosis, or social services. However, people with developmental disabilities, while certainly requiring traditional medical services, need other kinds of services to maintain their

[41] Agency for Health Care Administration, *Statewide Medicaid Managed Care, Health Plans and Programs, available at* https://www.flmedicaidmanagedcare.com/health/comparehealthplans (last visited May 10, 2023).
[42] *Id.*
[43] *Id.*
[44] Office of Program Policy Analysis and Government Accountability, *AHCA Reorganized to Enhance Managed Care Program Oversight and Continues to Recoup Fee-for-Service Overpayments (Report No. 16-03), available at* https://oppaga.fl.gov/Documents/Reports/16-03.pdf (last visited May 10, 2023)
[44] *Id.*
[45] Section 409.967(3), F.S.
[46] Section 409.967(3)(f), F.S.
[47] Section 409.967(3)(g), F.S.

independence and avoid institutionalization. Home- and community-based services (HCBS) are an alternative to institutionalizing people with developmental disabilities.

To obtain federal Medicaid funding for HCBS, Florida obtained a Medicaid waiver.[48] This allows coverage of non-medical services to avoid institutionalization, and allows the state to limit the scope of the program to the number of enrollees deemed affordable by the state. In this way, the HCBS waiver is not an entitlement; it is a first-come-first-served, slot-limited program.

Under the HCBS waiver, known as iBudget Florida, serves eligible[49] persons with developmental disabilities. Eligible diagnoses include disorders or syndromes attributable to intellectual disability, cerebral palsy, autism, spina bifida, Down syndrome, Phelan-McDermid syndrome, or Prader-Willi syndrome. The disorder must manifest before the age of 18, and it must constitute a substantial handicap that can reasonably be expected to continue indefinitely.[50]

The Agency for Persons with Disabilities (APD) administers the iBudget program, offering 27 supports and services delivered by contracted service providers to assist individuals to live in their community. Examples of waiver services are residential habilitation, behavioral services, companion, adult day training, employment services, and physical therapy.[51]

While providers and individual support coordinators each have a role in helping the iBudget enrollee assess and coordinate their care, the program essentially operates as a fee-for-service program, with no comprehensive care management in the traditional sense. The HCBS services are not integrated with acute medical services or behavioral health services, as those Medicaid services are administered by AHCA (usually through the fee-for service model, not the managed care model).

Historically, despite the utilization management tools authorized in law and the entitlement flexibilities provided by the federal waiver, and despite legislative funding increases, APD has frequently been unable to manage the waiver program within the budget appropriated by the Legislature, resulting in significant deficit spending.[52]

In 2019, the Legislature directed the agency to implement better monitoring and accounting procedures, and to take corrective action when deficits are projected to develop. In addition, APD was required to develop a plan to redesign the program if a deficit were to re-occur in the 2018-2019 fiscal year.[53] APD did generate a deficit that year; however, the submitted redesign plan promised to stay within the appropriated budget only if that budget were significantly increased.[54]

For FY 2022-2023, the Legislature appropriated $1,871,531,214 to APD for the iBudget waiver program, of which $742,997,892 are state funds.[55] Currently, the program serves over 35,300 enrolled people.[56]

iBudget Waiver Waitlist

APD maintains a waitlist of people who would like to enroll in the waiver. Currently, the waitlist includes 22,535 people. About 660 of those receive other, limited, services from APD, and over 9,000 people on

[48] Florida Developmental Disabilities Individual Budgeting Waiver (0867.R02.00), March 4, 2011, authorized under s. 1915b of the Social Security Act.
[49] The HCBS waiver retains the Medicaid requirement that enrollees be low-income, but measures only the developmentally disabled person's income; not the income generated by the whole household.
[50] S. 393.063(12), F.S.
[51] Agency for Persons with Disabilities, Quarterly Report on Agency Services to Floridians with Developmental Disabilities and Their Costs: First Quarter Fiscal Year 2022-2023, Nov. 15, 2023, available at https://apd.myflorida.com/publications/reports/docs/FY%202023%20Quarterly%20Report%201st%20Quarter%20report.pdf (last viewed May 10, 2023).
[52] For example, the Legislature made retroactive appropriations to address APD deficits that occurred in FY 17-18 ($56,895,137), FY 2018-2019 ($107,848,988), and FY 2019-2020 ($133,505,542). *See* Sections 30, 30, and 29, respectively, of the respective General Appropriations Acts in those years.
[53] Ch. 2019-116, s. 26, Laws of Fla.
[54] Agency for Persons with Disabilities and Agency for Health Care Administration, 2029 iBudget Waiver Redesign, Sept. 30, 2019.
[55] Ch. 2022-156, Laws of Fla., Specific Appropriation 245.
[56] *Supra*, note 51.

the waitlist are otherwise eligible for, and receive, Medicaid coverage for medical care. About 13,500 people on the waiver waitlist receive no APD or Medicaid services.[57]

As new funding becomes available, APD enrolls people from the waitlist in a statutory order of priority in seven categories, described below.[58]

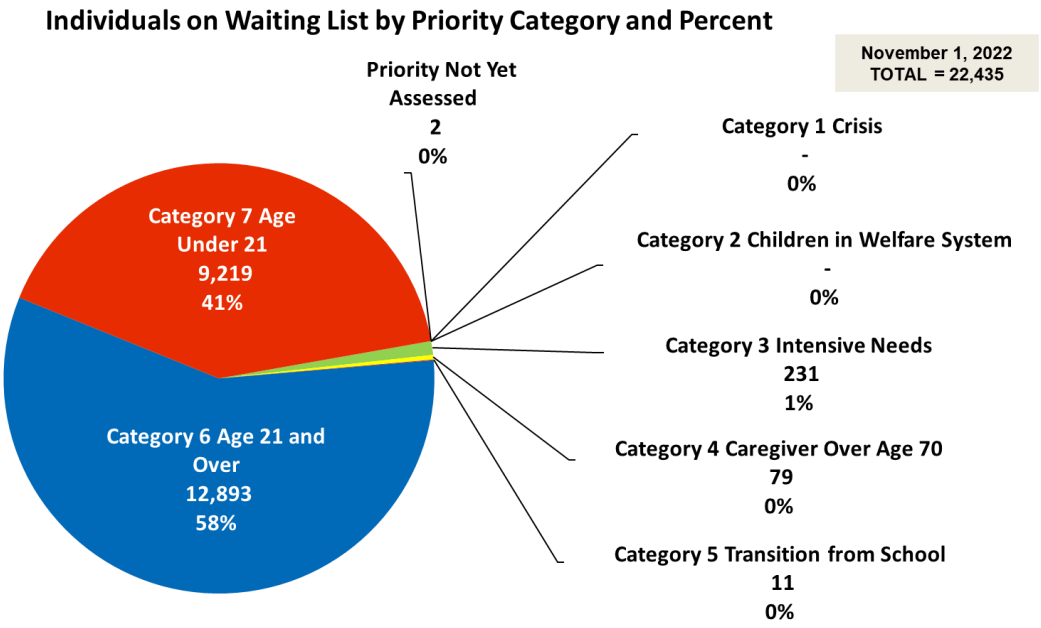
Category	Description
1	Crisis, as defined by APD

2	Individuals:
	• From the child welfare system with an open case who are either:
	  ○ Transitioning out of the child welfare system at the finalization of an adoption, a reunification with family members, a permanent placement with a relative, or a guardianship with a nonrelative; or
	  ○ At least 18 years but not yet 22 years of age and who need both waiver services and extended foster care services; or
	• 18-21 years old who chose not to remain in extended foster care.

3	Individuals: • Whose caregiver has a documented condition that is expected to render the caregiver unable to provide care within the next 12 months and for whom a caregiver is required but no alternate caregiver is available; • At substantial risk of incarceration or court commitment without supports; • Whose documented behaviors or physical needs place them or their caregiver at risk of serious harm and other supports are not currently available to alleviate the situation; or • Who are identified as ready for discharge within the next year from a state mental health hospital or skilled nursing facility and who require a caregiver but for whom no caregiver is available or whose caregiver is unable to provide the care needed.
4	Individuals whose caregivers are 70 years of age or older and for whom a caregiver is required but no alternate caregiver is available.
5	Individuals expected to graduate from high school within the next 12 months who need support to obtain a meaningful day activity, maintain competitive employment, or attend postsecondary education.
6	Individuals age 21 or older who do not meet the criteria for Categories 1-5.
7	Individuals under age 21 who do not meet the criteria for Categories 1-4.

[57] *Id*.
[58] S. 393.065(5), F.S.

The chart below indicates the percent of people in each category on the current waitlist.



Category 1--Individuals in crisis--are enrolled onto the waiver and therefore are not considered to be waiting for services.

APD rarely moves beyond Category 1 in enrolling people off the wait list. In Fiscal Years 2020-2021 and 2021-2022, for example, APD enrolled a total of 2,646 new enrollees in the waiver program. Of those, 1,841 (70%) were Category 1 – crisis – enrollees.[59]

Medicaid Coverage for iBudget Enrollees

iBudget waiver benefits include Medicaid coverage for medical services, administered by AHCA. The vast majority of full-coverage Medicaid recipients receive services through the SMMC managed care model, in which the recipient can choose from different health plans – including HMOs and PSNs – to provide their care. However, under current law, using the managed care model is an option for iBudget enrollees; not a requirement. iBudget participants can opt to use the traditional fee-for-service model of service delivery.[60]

Because clinical services and home- and community-based services are provided by two different programs in two different state agencies, these services are not integrated or managed as a whole service for the individual.

HCBS and Managed Care Models

Some states use managed care models for HCBS for persons with developmental disabilities, in varying forms.

Iowa and Kansas use a long-term care managed care model to provide developmental disability services. These states use a single, risk-bearing, managed care plan to coordinate all services for this

[59] *Supra,* note 51. Of the 2,646 new enrollees, 182 were in Category 2 (children aging out of the child welfare system); the remainder were in special categories authorized by the Legislature to jump the queue (military dependents, people with Phelan-McDermid Syndrome, and people in ICFs or nursing facilities), *see* s. 393.064(6), (7), F.S.
[60] S. 409.972(1)(e), F.S.

population – acute care, behavioral health and long-term care services. Tennessee takes a similar approach, but its managed care plans do not bear risk.[61]

New York obtained a federal waiver to transition the Medicaid developmental disability population into managed care in a phased model, beginning with integrated care coordination under a single, comprehensive plan. In addition, New York offers operates a service delivery model which fully integrates with Medicare coverage (for people with dual eligibility), offering acute, long-term care and habilitation services.[62]

Using managed care for the developmental disability population requires careful adaptation of acute care models to address factors that differentiate this population from a typical long-term care population. These factors include: the longer length of time individuals will require these services, often for a lifetime; the role of community services and supports, and the need to integrate them into the model; and the unique developmental disability provider community, composed of smaller organizations exclusively dependent on government funding and inexperienced at navigating a managed care environment; among other differentiating factors.[63]

Florida does not use a risk-based managed care model for HCBS services, and the Medicaid acute care managed care model is rarely used by iBudget enrollees. Medicaid acute care services and HCBS services are not integrated, or coordinated by any single entity for the individual enrollee.

Effect of the Bill

The bill would create a pilot program in SMMC Region D (Hardee, Highlands, Hillsborough, Manatee and Polk counties) and Region I (Miami-Dade and Monroe counties), establishing a managed care model for integrating medical care and home and community-based services for persons with developmental disabilities. AHCA is required to seek federal approval to implement the pilot program by September 1, 2023.

Under the pilot program AHCA is responsible for the following:

- Seeking federal authority to amend the Medicaid state plan or Medicaid waiver as necessary to implement the pilot program;
- Negotiating with and selecting qualified plans to participate in the pilot program;
- Making capitated payments for to managed care organizations for comprehensive coverage under the pilot program;
- Evaluating the feasibility of statewide implementation of the capitated managed care model used by the pilot program to serve individuals with developmental disabilities;

Under the pilot program, the APD is responsible for the following:

- Approving a needs assessment methodology to determine functional, behavioral, and physical needs of prospective enrollees. The methodology may be administered by persons who have completed such training as may be offered by AHCA.

Participant Eligibility

Participation in the pilot program is limited to the maximum number of enrollees specified in the General Appropriations Act, if any. The pilot program will be available, on a volunteer basis, to Medicaid eligible individuals who:

- Are Medicaid-eligible and 18 years of age or older,

[61] National Association of States United for Aging and Disabilities, MLTSS Institute, "MLTSS for People with Intellectual and Developmental Disabilities: Strategies for Success (2018), available at http://www.advancingstates.org/sites/nasuad/files/2018%20MLTSS%20for%20People%20with%20IDD-%20Strategies%20for%20Success_0.pdf (last viewed May 10, 2023).
[62] Center for Health Care Strategies, "Enrolling Individuals in Intellectual/Developmental Disabilities in Managed Care: A strategy for Strengthening Long-Term Services and Supports", March 2019, available at https://www.chcs.org/media/Integration-Strategy-3-Strengthening-LTSS-Toolkit_032019.pdf (last viewed May 10, 2023).
[63] *Id.*

- Have been assigned to categories 1 through 6 on the iBudget waitlist, and
- Reside in a pilot program region.

Pilot Program Benefits

The plans participating in the pilot program must, at a minimum, provide the following services through a single, integrated model of care:
- Medical care benefits described in s. 409.973, F.S., including access to prepaid dental plans;
- Long-term care benefits described in s. 409.98, F.S.;
- Home and community-based services described in 393.066, F.S.; and
- Services currently listed in the Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook, and prevocational services.

Services must be provided in accordance with an individualized care plan that is evaluated and updated as warranted by changes in a participant's circumstances. Support coordination services provided under the plan must maximize the use of natural supports and community partnerships.

All service providers of home and community-based services under the pilot program must meet the same provider qualifications as service providers under the iBudget waiver. The iBudget waiver service provider qualifications are outlined in the Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook.[64]

Plan Eligibility and Selection

For a plan to be selected to participate in the pilot program, the plan must have been awarded a contract to provide long-term care services pursuant to s. 409.981 as a result of an invitation to negotiate.

AHCA must select the plans, with which they will negotiate, based on specific criteria that must include, but is not limited to, the following:
- Experience serving similar populations and achieving specific quality standards;
- Establishment of provider partnerships that create opportunities for re-investment in community-based services;
- Provision of additional benefits including behavioral health services, coordinated dental care, and mental health therapy and analysis;
- Evidence of established relationships with providers;
- Experience in the provision of person-centered planning; and
- Experience in provider development program that result in increased availability of providers to serve individuals with developmental disabilities.

Disenrollment

Enrollees must be given an opportunity to disenroll from the pilot program and enroll in any appropriate existing Medicaid waiver program if any of the following conditions occur:
- At any point during the operation of the pilot program, an enrollee declares an intent to voluntarily disenroll, provided that he or she has been covered for the entire previous plan year by the pilot program.
- AHCA determines the enrollee has good cause to disenroll.
- The pilot program ceases to operate.

Plan Accountability

[64] *See,* Rule 59G-13.070, F.A.C.

Managed care plans participating in the pilot program must consult with APD for the purpose of ensuring adequate provider capacity before placing an enrollee of the pilot program in a group home licensed by the APD.

Plan Payment

The plans will receive an actuarially sound per-member, per-month payment. The revenues and expenditures of the selected plan which are associated with the implementation of the pilot program must be included in the reporting and regulatory requirements established in s. 409.967(3).

Pilot Program Reporting and Evaluation

The bill requires AHCA to evaluate the feasibility of statewide implementation of the capitated managed care model used by the pilot program.

Upon implementation of the pilot program, the bill authorizes AHCA, in consultation with the APD to conduct audits of the plan's implementation of person-centered planning and quality assurance monitoring. Quality assurance monitoring must include client satisfaction with services, health and safety outcomes, well-being outcomes, and service delivery in accordance with the client's care plan.

Additionally, AHCA, in consultation with the APD, must submit the following reports:

- By December 31, 2023, a report on the progress made toward federal approval of the pilot program.
- By December 31, 2024, a report on the implementation of the pilot program.
- By December 31, 2025, and annually thereafter, a report on the operation of the pilot program, including, but not limited to, the following:
  - Program enrollment data;
  - Any complaints received; and
  - Access to approved services.
- By October 1, 2029, an evaluation of the pilot program, including, but not limited to, the following:
  - Specific measures of access, quality, and costs;
  - Assessments of cost savings;
  - Consumer education, choice, and access to services;
  - Plans for future capacity and the enrollment of new Medicaid providers;
  - Coordination of care;
  - Person-centered planning, and person-centered well-being outcomes;
  - Health and quality-of-life outcomes;
  - Quality of care; and
  - Any barriers to implementation and operation of the pilot program.

The evaluation required by the bill must be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1, 2029.

Home Health Nursing Services

Background

Home health services are a mandatory Medicaid benefit, which under federal law, states are required to provide through their state programs.[65] Specifically, a state must provide "for the inclusion of home health services for any individual who, under the State plan, is entitled to nursing facility services".[66] Home health services within state plans must include: nursing services; home health aide services; and medical supplies, equipment, and appliances. Home health services must be provided to: categorically needy beneficiaries age 21 or over, categorically needy beneficiaries under age 21, if the plan provides

[65] Medicaid.gov, Mandatory & Optional Medicaid Benefits, available at https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html (last visited May 10, 2023).
[66] Sec, 1902(a)(10)(D), 42 U.S.C. 1396a

skilled nursing facility services for them, and medically needy beneficiaries to whom skilled nursing facility services are provided under the plan.[67]

Under Medicare federal law, home health services include nursing services, home health aide services, and medical supplies, equipment, and appliances suitable for the use in any setting in which normal life activities take place.[68] Home health services may include, physical therapy, occupational therapy, or speech pathology and audiology services.[69] In other words, according to CMS, a home health agency "is primarily engaged in providing *skilled* nursing services *and other therapeutic services*."[70]

Under Florida licensure law, a home health agency means "a person that provides *one or more* home health services".[71] Home health services means "health and medical services and medical supplies furnished to an individual in the individual's home or place of residence. The term includes the following: [72]

- Nursing care;
- Physical, occupational, respiratory, or speech therapy;
- Home health aide services;
- Dietetics and nutrition practice and nutrition counseling; and
- Medical supplies, restricted to drugs and biologicals prescribed by a physician".

Private duty nursing, attendant care nursing, and skilled nursing are services that can be provided by a licensed practical nurse (LPN) or a registered nurse (RN).[73] Private duty nursing and attendant care nursing services can be provided by a home health agency enrolled as a skilled nursing provider or a home health agency enrolled as a non-skilled nursing provider.[74] A Florida-licensed home health agency does not have to provide skilled nursing services. A Florida-licensed home health agency may provide just one service, including non-skilled nursing services such as private duty nursing or attendant nursing care services. Florida currently covers those services despite a discrepancy created by a recent change made to the Florida Medicaid Provider Enrollment Policy.

In January of 2022, AHCA updated their provider enrollment policy to require home health providers to "meet one of the following requirements to qualify for limited or full enrollment in Florida Medicaid:" [75]

- Have Medicare certification.
- Meet the requirements for Medicare certification by demonstrating compliance during a survey conducted by the Division of Health Quality Assurance (HQA).
- Be accredited and surveyed for deemed status as meeting the CMS CoPs by:
    - The Joint Commission (TJC),
    - The Community Health Accreditation Partner (CHAP), or
    - The Accreditation Commission for Health Care (ACHC)

However, it is not possible for Florida home health agencies who do not provide skilled nursing services to receive Medicare certification because Medicare certification requirements require a home health agency to provide skilled nursing services. Of the three approved accrediting organizations,[76] none will

[67] 42 CFR § 441.15.
[68] 42 C.F.R. § 440.70(b).
[69] 42 C.F.R. § 440.70(b)(4).
[70] Centers for Medicare & Medicaid Services, Home Health Providers, available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/HHAs (last visited May 10, 2023).
[71] S. 400.462(12), F.S.
[72] S. 400.462(15), F.S.
[73] Agency for Health Care Administration, Florida Medicaid Home Health Visit Services Coverage Policy (November 2016), available at https://www.flrules.org/gateway/RuleNo.asp?title=MEDICAID%20POLICY&ID=59G-4.130 (last visited May 10, 2023).
[74] Agency for Health Care Administration, Private Duty Nursing Services Coverage Policy, Section 4.2, available at https://www.flrules.org/gateway/RuleNo.asp?title=MEDICAID%20POLICY&ID=59G-4.261 (last visited May 10, 2023).
[75] Agency for Health Care Administration, Florida Medicaid Provider Enrollment Policy at pg. 48 (January 2022), available at https://www.flrules.org/Gateway/reference.asp?No=Ref-13974 (last visited May 10, 2023).
[76] Agency for Health Care Administration, Home Health Agencies Accrediting Organizations for Skilled Home Health Agencies, available at https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Lab_HomeServ/HHA/hha_accreditation.shtml (last visited May 10, 2023).

schedule a survey for deemed status without a letter from CMS approving their 855A form.[77] This form indicates an applicant's intent to enroll as a Medicare provider.

AHCA based this rule change on the assumption that Medicare certification is required, however; AHCA notes that federal law is ambiguous on this point.[78]

Effect of the Bill

The bill prohibits AHCA from requiring a home health agency to meet the requirements of Medicare certification, if a home health agency does not provide Medicaid-skilled private duty nursing and attendant care nursing services, beginning October 1, 2021.

The bill was approved by the Governor on June 15, 2023, ch. 2023-243, L.O.F., and will become effective on July 1, 2023 except as otherwise provided.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The Fiscal Year 2023-2024 General Appropriations Act (GAA) provides $17.7 million, of which $7.1 million is from the General Revenue Fund, to increase the personal needs allowance from $130 to $160 for residents in state institutional care facilities, including veteran's nursing homes.

   The GAA provides $93.2 million, of which $38.0 million is from the General Revenue Fund, to increase the quality component of nursing home Medicaid rates from 6 percent of non-property funds to 10 percent of non-property funds, effective October 1, 2023.

   The GAA provides $30.0 million, of which $12.2 million is from the General Revenue Fund, for the Graduate Medical Education Slots for Doctors Program.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

[77] U.S. Department of Health & Human Services, Medicare Enrollment Application, Institutional Providers, available at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855a.pdf (last visited May 10, 2023).
[78] Agency for Health Care Administration, Agency Analysis of 2023 HB 871 (March 25, 2023), On file with the House Health Care Appropriations Subcommittee