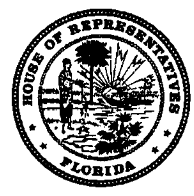
Health Care Appropriations Subcommittee

March 17th, 2015
12:30 PM – 2:30 PM
Webster Hall

Steve Crisafulli
Speaker

Matt Hudson
Chair



The Florida House of Representatives

Appropriations Committee

Health Care Appropriations Subcommittee

Steve Crisafulli Speaker	Matt Hudson Chair

March 17, 2015

AGENDA
12:30 PM – 2:30 PM
Webster Hall

I. Call to Order/Roll Call

II. Chair's Budget Proposal for Fiscal Year 2015-16

III. PCB HCAS 15-01—Medicaid

IV. PCB HCAS 15-02—Department of Children & Families

V. PCB HCAS 15-03—Alzheimer's Disease Research

VI. Closing/Adjourn

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PCB HCAS 15-01

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCAS 15-01 Medicaid
SPONSOR(S): Health Care Appropriations Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Care Appropriations Subcommittee		Clark	Pridgeon

SUMMARY ANALYSIS

The bill conforms statutes to the funding decisions related to the Medicaid Program included in the House proposed General Appropriations Act (GAA) for Fiscal Year 2015-2016. The bill:

- Amends the definition of "rural hospital" to exclude hospitals meeting the qualifications of a federal "sole community hospital" having up to 340 beds.
- Continues the rural designation of certain critical access hospitals beyond June 30, 2015.
- Eliminates Intermediate Care Facilities for the Developmentally Disabled from the statutory rate freeze.
- Revises the years of audited data used in determining Medicaid and charity care days for hospitals in the Disproportionate Share Hospital (DSH) program.
- Continues Medicaid DSH distributions for nonstate, government-owned or operated hospitals eligible for payment on July 1, 2011.
- Clarifies that Achieved Savings Rebates that are refunded to the state will be placed in General Revenue, unallocated.
- Clarifies the Grants and Donations Trust Fund as the designated state trust fund that managed care plans can contribute to for purposes of supporting Medicaid and indigent care.
- Repeals 409.97, F.S., related to the Low Income Pool program.
- Removes reference to supporting the Healthy Start contract with certified public expenditures.
- Clarifies the factors upon which the Agency for Health Care Administration shall reconcile the payments made to Long Term Care Managed Care Plans for changes in Nursing Home rates.
- Prohibits the Agency for Health Care Administration from entering into a contract with any other state or territory for joint fiscal agent operations.

The bill provides an effective date of July 1, 2015, unless expressly provided in the bill, which shall take effect upon becoming a law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Rural Hospitals

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

- The sole provider in a county with a population density up to 100 persons per square mile;
- An acute care hospital in a county with a population density up to 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 up to 100 persons per square mile;
- A hospital classified as a sole community hospital under 42 C.F.R., s. 412.92 which has up to 340 licensed beds;
- A hospital with a service area that has a population of up to 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), Florida Statutes. Hospitals under this section that have received funding under the Disproportionate Share Financial Assistance Program for Rural Hospitals beginning no later than July 1, 2002, are deemed rural hospitals through June 30, 2015.

The bill amends s. 395.602(2)(e), F.S., to revise the definition of "rural hospital." The bill deletes the provision regarding a hospital that is classified as a sole community hospital under Title 42, s. 412.92, of the Code of Federal Regulations, having up to 340 licensed beds. Additionally, the bill continues the rural hospital designation for those facilities that received funding under the Disproportionate Share Financial Assistance Program for Rural Hospitals beginning no later than July 1, 2002, from June 30, 2015 to June 30, 2021, after the next United States census.

Intermediate Care Facilities for the Developmentally Disabled (ICF/DD)

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

Chapter 2008-143, L.O.F., directed the Agency to establish provider rates for hospitals, nursing homes, community intermediate care facilities for the developmentally disabled and county health departments in a manner that would result in the elimination of automatic cost-based rate increases for a period of two fiscal years, until July 1, 2011. Chapter 2011-61, L.O.F., revised statute to ensure there would be no rate increases above the July 1, 2011 average unit cost level.

The bill amends s. 409.908(23)(c), F.S., to exclude the community intermediate care facilities for the developmentally disabled Medicaid reimbursement rates from being limited to the July 1, 2011 level.

Disproportionate Share Hospital Program (DSH)

The Medicaid Disproportionate Share Hospital Program (DSH) funding distributions are provided to hospitals that provide a disproportionate share of the Medicaid or charity care services to uninsured individuals. Each year, the Legislature delineates how the funds will be distributed to each eligible facility.

The bill updates existing law to provide payments for the 2015-2016 fiscal year related to hospitals in the DSH programs and Medicaid DSH distributions for nonstate, government-owned or operated hospitals that were eligible for payment on July 1, 2011.

Achieved Savings Rebate

Chapter 2011-134, L.O.F., created the Statewide Medicaid Managed Care (SMMC) program, thereby establishing the Medicaid program as a statewide, integrated managed care program for all covered services. Medicaid consists of two managed care programs:

- Medicaid Managed Medical Assistance Program (MMA) – primary and acute care; and
- Long-Term Care Managed Care Program (LTC) – residential and home and community based care, lone or paired with primary acute care for comprehensive coverage.

The Achieved Savings Rebate program is specific to the MMA component of managed care and was created to monitor plan expenditures and impose incentives and disincentives to ensure proper use of state funds.

To calculate whether the plans have achieved a savings for the reporting year and whether they may retain them or must pay a rebate to the state, the plans must submit to the Agency an annual financial audit. Plans regulated by the Office of Insurance Regulation must also submit an annual statement pursuant to s. 624.424, Florida Statutes. In addition, the Agency must audit the plans' financial information. The Agency must contract with independent certified public accountants to conduct the audits, and plans must pay these costs.

The achieved savings rebate will be calculated by determining pre-tax income as a percentage of revenues and applying the following income sharing ratios:

- 100% of the income up to and including 5% of the revenue will be retained by the plan.
- 50% of the income above 5% and up to 10% of the revenue will be retained by the plan with the other 50% refunded to the state.
- 100% of the income above 10% will be refunded to the state.

If the plan meets or exceeds quality measures defined by the Agency, then the plan may retain an additional 1% of revenue.

Plans that are required to pay a rebate to the state, must refund the money to the state; however, current statute does not specify in to which fund it shall be deposited. The bill amends s.409.967(3)(f)(2) and (3), Florida Statutes, to specify that the achieved savings rebates will be deposited into the General Revenue Fund, unallocated, less any applicable federal share to be paid back to the federal government.

Medical Loss Ratio

The SMMC also permitted the Agency to calculate a medical loss ratio for managed care plans. The calculation allows for use of uniform financial data collected from all plans and shall be computed for each plan on a statewide basis. The method of calculating the medical loss ratio is required to meet the following criteria:

- Must be consistent with Title 45 Code of Federal Regulations, part 158;
- Funds provided by the plans to graduate medical education institutions shall be classified as medical expenditures, provided the funding is sufficient to sustain the positions for the number of years necessary to complete the residency requirements and the residency positions funded by the plans are active providers of care to Medicaid and uninsured patients; and
- Prior to final determination of the medical loss ratio for any period, a plan may contribute to a designated state trust fund for the purpose of supporting Medicaid and indigent care and have the contribution counted as a medical expenditure for the period.

Plans that contribute funds for the purpose of supporting Medicaid and indigent care are to deposit funds in a designated state trust fund; however, current statute does not specify in to which fund it shall be deposited. The bill amends s. 409.967(4)(c), F.S., to specify that the funds be deposited into the Grants and Donations Trust Fund within the Agency.

Low Income Pool

The Low Income Pool (LIP) was originally created as a result of the original 1115 Waiver that established the Managed Medicaid Pilot program. Pursuant to s. 409.91211(1)(b), F.S., the Managed Medicaid Pilot waiver was "contingent upon federal approval to preserve the upper-payment-limit funding mechanism for hospitals, including a guarantee of a reasonable growth factor, a methodology to allow the use of a portion of these funds to serve as a risk pool for demonstration sites, provisions to preserve the state's ability to use intergovernmental transfers, and provisions to protect the disproportionate share program." The LIP was to be used to provide supplemental payments to hospitals that provide services to Medicaid recipients, the uninsured and underinsured individuals. The LIP program also authorized supplemental Medicaid payments to provider access systems, such as federally qualified health centers, county health departments, and hospital primary care programs, to cover the cost of providing services to Medicaid recipients, the uninsured and the underinsured.

Florida law provides that distribution of the Low-Income Pool funds should:

- Assure a broad and fair distribution of available funds based on the access provided by Medicaid participating hospitals, regardless of their ownership status, through their delivery of inpatient or outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;
- Assure accessible emergency inpatient and outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;
- Enhance primary, preventive, and other ambulatory care coverages for uninsured individuals;
- Promote teaching and specialty hospital programs;
- Promote the stability and viability of statutorily defined rural hospitals and hospitals that serve as sole community hospitals;
- Recognize the extent of hospital uncompensated care costs;
- Maintain and enhance essential community hospital care;
- Maintain incentives for local governmental entities to contribute to the cost of uncompensated care;
- Promote measures to avoid preventable hospitalizations;

- Account for hospital efficiency; and
- Contribute to a community's overall health system.

On April 11, 2014, the Centers for Medicaid and Medicare Services (CMS) extended the 1115 demonstration waiver, titled Managed Medical Assistance, for three years; however, they only extended the LIP for one year from July 1, 2014 through June 30, 2015. The total computable amount of LIP funding for the year is approximately $2.16 billion. As of the date of this analysis, CMS has not yet approved LIP beyond June 30, 2015. Therefore, the bill repeals statutory provisions related to the LIP program in its entirety. Upon federal approval of a new LIP program alternative, statute will need to be drafted based on federal parameters.

MomCare Network

Under SMMC, the Agency is directed to contract with an administrative services organization representing all Healthy Start Coalitions in order to continue the MomCare waiver services of care coordination, and other services. All managed care plans must contract with the Healthy Start Coalitions in their regions in order to coordinate services provided to pregnant women and infants. Current statute provides that the Agency will support this contract with certified public expenditures of general revenue appropriated for Healthy Start services and any earned federal matching funds.

Chapter 2014-51, L.O.F., transferred the funding from the Department of Health to the Agency, thereby, no longer relying on certified public expenditures to support the contracts. The bill amends s. 409.975(4)(a), F.S., to remove reference to certified public expenditures.

Nursing Home Pass-through Reconciliation

Under SMMC, the long-term care managed care plans must offer a network contract to nursing homes, hospices, and aging network providers who previously participated in home and community based waivers. Nursing home and hospice providers must participate in all selected plans that offer them contracts. The plans and the providers are required to negotiate mutually acceptable payment terms and rates. However, both nursing home and hospice providers shall receive a "pass-through" rate set by the Agency. This means that nursing home and hospice providers continue to receive a Medicaid reimbursement rate based upon historical data as provided in each facility's Medicaid cost report.

Current statute provides that the Agency reconcile the long-term care managed care plan rates based on any change in Medicaid reimbursement rate for a nursing home or hospice. However, the statute does not define the parameters upon which the reconciliation shall be based. The bill amends s. 409.983(6), F.S., to clarify that the reconciliation is based on changes in nursing home provider reimbursement rates, and not reconciled based on actual days experienced by the long-term care managed care plans.

Fiscal Agent Operations

The Agency is the single State agency responsible for administering the Medicaid program in Florida. As such, the Agency contracts with an entity to operate as the state's fiscal agent. Fiscal agent operations consist of distributing Medicaid publications and forms, providing enrollment broker services to Medicaid recipients, enrolling Medicaid providers, maintaining the recipient eligibility system, and processing and paying all Medicaid claims.

Recent Medicaid program changes, including the transition to Statewide Medicaid Managed Care, conversion to Diagnosis Related Groupings for inpatient reimbursements, and other federally mandated requirements, have required expanded operations and required revisions to the Florida Medicaid Management Information System and Decision Support System. Due to these continuing revisions, the

bill prohibits the Agency from entering into a contract with any other state or territory to provide additional fiscal agent operations to another state or territory beyond the scope of Florida's current fiscal agent responsibilities.

B. SECTION DIRECTORY:

Section 1: Amends s. 395.602, F.S., relating to the definition of a rural hospital, and extends the designation of certain critical access hospitals.
Section 2: Amends s. 409.908. F.S., to remove Intermediate Care Facilities for the Developmentally Disabled from a restriction on changes in reimbursement rates.
Section 3: Amends s. 409.911, F.S., to revise the years of audited data used for hospitals in the disproportionate share program and continues Medicaid disproportionate share distributions of nonstate, government-owned or operated hospitals eligible for payment on a specified date.
Section 4: Amends s. 409.967, F.S., to provide that Achieved Savings Rebates refunded to the state will be placed in General Revenue, unallocated. Provides that deposit of contributions by managed care plans to support Medicaid and indigent care be deposited within the Grants and Donations Trust Fund.
Section 5: Amends s. 409.975, F.S., to remove reference to supporting the Healthy Start contract with certified public expenditures.
Section 6: Amends s. 409.983, F.S., to specify the factors upon which the Agency for Health Care Administration shall reconcile the payments made to Long Term Care Managed Care Plans for changes in Nursing Home rates.
Section 7: Repeals s. 409.97, F.S., relating to State and local Medicaid partnerships (Low Income Pool).
Section 8: Creates an undesignated section of law that prohibits the Agency for Health Care Administration from entering into a contract with another state or territory for joint fiscal agent operations.
Section 9: Provides an effective date of July 1, 2015, unless otherwise specified in the bill.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   $213,428,126 in federal Medicaid funds will be generated through the implementation of the DSH programs; however, the State will not earn federal funds of $1,291,241,942 due to the expiration of the Low Income Pool program.

2. Expenditures:

   The House proposed GAA contains the following appropriation:

	FY 2015-16
REGULAR DISPROPORTIONATE SHARE (DSH)	
General Revenue	$ 750,000
Grants and Donations Trust Fund	$ 89,205,900
Medical Care Trust Fund	$ 138,764,925
Total	**$ 228,720,825**
MENTAL HEALTH HOSPITAL DSH	
Medical Care Trust Fund	$ 72,256,892
Total	**$ 72,256,892**
TUBERCULOSIS DSH	
Medical Care Trust Fund	$ 2,406,309
Total	**$ 2,406,309**
DISPRPORTIONATE SHARE HOSPITAL (DSH) SUBTOTAL	
General Revenue	*$ 750,000*
Grants and Donations Trust Fund	*$ 89,205,900*
Medical Care Trust Fund	*$ 213,428,126*
SUBTOTAL	***$ 303,384,026***
INTERMEDIATE CARE FACILITIES / DEVELOPMENTALLY DISABLED	
General Revenue	$ 82,403,570
Grants and Donations Trust Fund	$ 15,147,690
Medical Care Trust Fund	$ 149,476,494
Total	**$ 247,027,754**
TOTAL BUDGETARY IMPACT	
General Revenue	**$ 83,153,570**
Grants and Donations Trust Fund	**$ 89,205,900**
Medical Care Trust Fund	**$ 362,904,620**
GRAND TOTAL	**$ 535,264,090**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   In order to earn matching federal dollars, local governments and other local political subdivisions would be required to provide $89,205,900 in contributions for the DSH program.

   Local governments and other local political subdivisions that contribute Intergovernmental Transfers (IGTs) under the current Low Income Pool in the amount of $867,606,672 will no longer submit these funds to the state due to the expiration of the program.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Hospitals providing a disproportionate share of Medicaid or charity care services will receive additional reimbursement toward the cost of providing care to uninsured and underinsured individuals.

Hospitals designated as "sole community" were funded with nonrecurring funds during Fiscal Year 2014-15. As a result, the statute must be amended and these hospitals will not receive $7,542,036 in state and federal funds.

Rural hospitals that received funding under the Disproportionate Share Financial Assistance Program for Rural Hospitals beginning no later than July 1, 2002, will continue to receive funds of $1,896,907 (state and federal) through June 30, 2021.

D. FISCAL COMMENTS:

The AHCA will distribute a total of $303,384,026 through federal Disproportionate Share Hospital (DSH) Program to hospitals providing a disproportionate share of Medicaid or charity care services.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   None.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to Medicaid; amending s. 395.602,
3 F.S.; revising the definition of the term "rural
4 hospital"; extending the designation of certain
5 critical access hospitals as rural hospitals until a
6 specified date; amending s. 409.908, F.S.; removing
7 community intermediate care facilities for the
8 developmentally disabled from a restriction on changes
9 in reimbursement rates; amending s. 409.911, F.S.;
10 updating references to data used for calculating
11 disproportionate share program payments to certain
12 hospitals; providing for continuance of Medicaid
13 disproportionate share distributions for certain
14 nonstate government owned or operated hospitals;
15 amending s. 409.967, F.S.; providing that certain
16 achieved savings rebates be placed in the General
17 Revenue Fund, unallocated; providing for the deposit
18 of contributions by managed care plans to support
19 Medicaid and indigent care; amending s. 409.975, F.S.;
20 removing a requirement that the Agency for Health Care
21 Administration support Healthy Start services with
22 public expenditures and federal matching funds;
23 amending s. 409.983, F.S.; specifying factors that the
24 agency must consider to reconcile payments to long-
25 term care managed care plans; repealing s. 409.97,
26 F.S., relating to state and local Medicaid

27 partnerships; prohibiting the agency from entering
28 into out-of-state partnerships for certain fiscal
29 services; specifying exclusivity of the Florida
30 Medicaid Management Information System and Decision
31 Support System to the state; providing effective
32 dates.
33
34 Be It Enacted by the Legislature of the State of Florida:
35
36 Section 1. Paragraph (e) of subsection (2) of section
37 395.602, Florida Statutes, is amended to read:
38 395.602 Rural hospitals.—
39 (2) DEFINITIONS.—As used in this part:
40 (e) "Rural hospital" means an acute care hospital licensed
41 under this chapter, having 100 or fewer licensed beds and an
42 emergency room, which is:
43 1. The sole provider within a county with a population
44 density of up to 100 persons per square mile;
45 2. An acute care hospital, in a county with a population
46 density of up to 100 persons per square mile, which is at least
47 30 minutes of travel time, on normally traveled roads under
48 normal traffic conditions, from any other acute care hospital
49 within the same county;
50 3. A hospital supported by a tax district or subdistrict
51 whose boundaries encompass a population of up to 100 persons per
52 square mile;

53 ~~4. A hospital classified as a sole community hospital~~
54 ~~under 42 C.F.R. s. 412.92 which has up to 340 licensed beds;~~
55 <u>4.</u>~~5.~~ A hospital with a service area that has a population
56 of up to 100 persons per square mile. As used in this
57 subparagraph, the term "service area" means the fewest number of
58 zip codes that account for 75 percent of the hospital's
59 discharges for the most recent 5-year period, based on
60 information available from the hospital inpatient discharge
61 database in the Florida Center for Health Information and Policy
62 Analysis at the agency; or
63 <u>5.</u>~~6.~~ A hospital designated as a critical access hospital,
64 as defined in s. <u>408.07(15)</u> ~~408.07~~.
65
66 Population densities used in this paragraph must be based upon
67 the most recently completed United States census. A hospital
68 that received funds under s. 409.9116 for a quarter beginning no
69 later than July 1, 2002, is deemed to have been and shall
70 continue to be a rural hospital from that date through June 30,
71 <u>2021</u> ~~2015~~, if the hospital continues to have up to 100 licensed
72 beds and an emergency room. An acute care hospital that has not
73 previously been designated as a rural hospital and that meets
74 the criteria of this paragraph shall be granted such designation
75 upon application, including supporting documentation, to the
76 agency. A hospital that was licensed as a rural hospital during
77 the 2010-2011 or 2011-2012 fiscal year shall continue to be a
78 rural hospital from the date of designation through June 30,

79 2021 ~~2015~~, if the hospital continues to have up to 100 licensed
80 beds and an emergency room.
81 Section 2. Paragraph (c) of subsection (23) of section
82 409.908, Florida Statutes, is amended to read:
83 409.908 Reimbursement of Medicaid providers.—Subject to
84 specific appropriations, the agency shall reimburse Medicaid
85 providers, in accordance with state and federal law, according
86 to methodologies set forth in the rules of the agency and in
87 policy manuals and handbooks incorporated by reference therein.
88 These methodologies may include fee schedules, reimbursement
89 methods based on cost reporting, negotiated fees, competitive
90 bidding pursuant to s. 287.057, and other mechanisms the agency
91 considers efficient and effective for purchasing services or
92 goods on behalf of recipients. If a provider is reimbursed based
93 on cost reporting and submits a cost report late and that cost
94 report would have been used to set a lower reimbursement rate
95 for a rate semester, then the provider's rate for that semester
96 shall be retroactively calculated using the new cost report, and
97 full payment at the recalculated rate shall be effected
98 retroactively. Medicare-granted extensions for filing cost
99 reports, if applicable, shall also apply to Medicaid cost
100 reports. Payment for Medicaid compensable services made on
101 behalf of Medicaid eligible persons is subject to the
102 availability of moneys and any limitations or directions
103 provided for in the General Appropriations Act or chapter 216.
104 Further, nothing in this section shall be construed to prevent

105 or limit the agency from adjusting fees, reimbursement rates,
106 lengths of stay, number of visits, or number of services, or
107 making any other adjustments necessary to comply with the
108 availability of moneys and any limitations or directions
109 provided for in the General Appropriations Act, provided the
110 adjustment is consistent with legislative intent.
111 (23)
112 (c) This subsection applies to the following provider
113 types:
114 1. Inpatient hospitals.
115 2. Outpatient hospitals.
116 3. Nursing homes.
117 4. County health departments.
118 ~~5. Community intermediate care facilities for the~~
119 ~~developmentally disabled.~~
120 5.~~6.~~ Prepaid health plans.
121 Section 3. Paragraph (a) of subsection (2) and paragraph
122 (d) of subsection (4) of section 409.911, Florida Statutes, are
123 amended to read:
124 409.911 Disproportionate share program.—Subject to
125 specific allocations established within the General
126 Appropriations Act and any limitations established pursuant to
127 chapter 216, the agency shall distribute, pursuant to this
128 section, moneys to hospitals providing a disproportionate share
129 of Medicaid or charity care services by making quarterly
130 Medicaid payments as required. Notwithstanding the provisions of

131 s. 409.915, counties are exempt from contributing toward the
132 cost of this special reimbursement for hospitals serving a
133 disproportionate share of low-income patients.
134 (2) The Agency for Health Care Administration shall use
135 the following actual audited data to determine the Medicaid days
136 and charity care to be used in calculating the disproportionate
137 share payment:
138 (a) The average of the ~~2005,~~ 2006, ~~and~~ 2007, and 2008
139 audited disproportionate share data to determine each hospital's
140 Medicaid days and charity care for the 2015-2016 ~~2014-2015~~ state
141 fiscal year.
142 (4) The following formulas shall be used to pay
143 disproportionate share dollars to public hospitals:
144 (d) Any nonstate government owned or operated hospital
145 eligible for payments under this section on July 1, 2011,
146 remains eligible for payments during the 2015-2016 ~~2014-2015~~
147 state fiscal year.
148 Section 4. Paragraph (f) of subsection (3) and paragraph
149 (c) of subsection (4) of section 409.967, Florida Statutes, are
150 amended to read:
151 409.967 Managed care plan accountability.—
152 (3) ACHIEVED SAVINGS REBATE.—
153 (f) Achieved savings rebates validated by the certified
154 public accountant are due within 30 days after the report is
155 submitted. Except as provided in paragraph (h), the achieved
156 savings rebate is established by determining pretax income as a

157 percentage of revenues and applying the following income sharing
158 ratios:
159 1. One hundred percent of income up to and including 5
160 percent of revenue shall be retained by the plan.
161 2. Fifty percent of income above 5 percent and up to 10
162 percent shall be retained by the plan, and the other 50 percent
163 refunded to the state and transferred to the General Revenue
164 Fund, unallocated.
165 3. One hundred percent of income above 10 percent of
166 revenue shall be refunded to the state and transferred to the
167 General Revenue Fund, unallocated.
168 (4) MEDICAL LOSS RATIO.—If required as a condition of a
169 waiver, the agency may calculate a medical loss ratio for
170 managed care plans. The calculation shall use uniform financial
171 data collected from all plans and shall be computed for each
172 plan on a statewide basis. The method for calculating the
173 medical loss ratio shall meet the following criteria:
174 (c) Prior to final determination of the medical loss ratio
175 for any period, a plan may contribute to a designated state
176 trust fund for the purpose of supporting Medicaid and indigent
177 care and have the contribution counted as a medical expenditure
178 for the period. Funds contributed for this purpose shall be
179 deposited into the Grants and Donations Trust Fund.
180 Section 5. Paragraph (a) of subsection (4) of section
181 409.975, Florida Statutes, is amended to read:
182 409.975 Managed care plan accountability.—In addition to

183 the requirements of s. 409.967, plans and providers
184 participating in the managed medical assistance program shall
185 comply with the requirements of this section.
186 (4) MOMCARE NETWORK.—
187 (a) The agency shall contract with an administrative
188 services organization representing all Healthy Start Coalitions
189 providing risk appropriate care coordination and other services
190 in accordance with a federal waiver and pursuant to s. 409.906.
191 The contract shall require the network of coalitions to provide
192 counseling, education, risk-reduction and case management
193 services, and quality assurance for all enrollees of the waiver.
194 The agency shall evaluate the impact of the MomCare network by
195 monitoring each plan's performance on specific measures to
196 determine the adequacy, timeliness, and quality of services for
197 pregnant women and infants. ~~The agency shall support this~~
198 ~~contract with certified public expenditures of general revenue~~
199 ~~appropriated for Healthy Start services and any earned federal~~
200 ~~matching funds.~~
201 Section 6. Subsection (6) of section 409.983, Florida
202 Statutes, is amended to read:
203 409.983 Long-term care managed care plan payment.—In
204 addition to the payment provisions of s. 409.968, the agency
205 shall provide payment to plans in the long-term care managed
206 care program pursuant to this section.
207 (6) The agency shall establish nursing-facility-specific
208 payment rates for each licensed nursing home based on facility

209 costs adjusted for inflation and other factors as authorized in
210 the General Appropriations Act. Payments to long-term care
211 managed care plans shall be reconciled to reimburse actual
212 payments to nursing facilities resulting from changes in nursing
213 home per diem rates, but may not be reconciled to actual days
214 experienced by the long-term care managed care plans.
215 Section 7. Section 409.97, Florida Statutes, is repealed.
216 Section 8. Effective upon this act becoming a law, the
217 Agency for Health Care Administration shall not partner with any
218 other state or territory for the purposes of providing Medicaid
219 fiscal agent operations. The Florida Medicaid Management
220 Information System and Decision Support System shall be for use
221 only by the State of Florida.
222 Section 9. Except as otherwise expressly provided in this
223 act and except for this section, which shall take effect upon
224 this act becoming law, this act shall take effect July 1, 2015.

PCB HCAS 15-02

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCAS 15-02 Department of Children & Families
SPONSOR(S): Health Care Appropriations Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Care Appropriations Subcommittee		Fontaine, Dobson	Pridgeon

SUMMARY ANALYSIS

The bill conforms statutes to the funding decisions included in the proposed General Appropriations Act (GAA) for Fiscal Year 2015-2016.

The bill amends the equity allocation model provided in section 409.991, Florida Statutes, to modify the percentage allocation of existing, recurring child welfare core service funds to Community Based Care lead agencies. This modification contained in this bill will change the distribution of funds among CBCs beginning with the 2015-16 fiscal year.

The bill creates s. 414.455, F.S. requiring to the Department of Children and Families to obtain legislative authorization before seeking, applying for, or accepting federal waivers to the work requirement for Supplemental Nutrition Assistance Program eligibility.

The effective date of the bill is July 1, 2015.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Florida's child welfare services are provided through 20 regional organizations known as Community-Based Care lead agencies (CBC). The 1998 Florida Legislature mandated the outsourcing of foster care and related child welfare services, and by July 2005, the Department of Children and Families transitioned the provision of child welfare services from a department-based operation to community-based care. The allocation of funding among the CBCs was intended to be equitable, with equality being based upon statewide, per-child budgeted amounts as prescribed through proviso language in multiple GAAs. Proviso in the General Appropriations Act for FY 2010-11 departed from these previous methodologies by providing an equity allocation model using weighted factors to indicate the need for child welfare resources.

The equity allocation model codified by the 2011 Florida Legislature now appears in 409.991, Florida Statutes. It allocates CBCs' core service funds using the following four weighted factors:

- Number of children in poverty (30 percent);
- Number of reports to the department's abuse hotline (30 percent);
- Number of children in care (30 percent); and,
- CBC lead agency contribution in the reduction of out-of-home care (10 percent).

The statute defines "core services funding" as all funds provided to CBCs with the exceptions of independent living, maintenance adoption subsidies, training for child protective investigators, mental health wrap-around services, nonrecurring appropriations, and those designated for a specific project. For Fiscal Year 2014-15, CBCs received $587.1 million for core service functions.

Effect of the Bill

The current statute allocates 10 percent of CBC core service funds upon the equity allocation model and 90 percent upon the previous year's distribution. The current formula has the effect of transitioning each CBC lead agency's core service allocation towards full utilization of the equity allocation model. This legislation slows the transition towards the equity allocation model by making 95 percent of CBCs' core service funds based on the previous year's distribution and the remaining five percent based on the equity allocation model. The proposed effects are budget neutral in total, but the allocation of core service funds among the CBCs will be modified.

Supplemental Nutrition Assistance Program (SNAP)

History of the Food Stamp Program

The federal food stamp program began in 1939, providing a discount for surplus food to people on relief. Between 1939 and 1943, those who qualified were able to purchase stamps redeemable for the purchase of food and were given additional stamps redeemable only towards purchasing surplus food.[1] The Food Stamp Act of 1964 expanded the use of food stamps to "all items eligible for consumption, with the exception of alcohol and imported foods."[2]Since then, a number of changes and reforms to the program have taken place including changing the name of the program to SNAP, changing eligibility determinations and the introduction of an Electronic Benefits Transaction card for spending benefits.[3]

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[1] 1 A Short History of SNAP, USDA Food and Nutrition Service, *available at*: http://www.fns.usda.gov/snap/rules/Legislation/about.htm. (Last visited 3/4/15).

[2] *Id.*

[3] *Id.*

The Florida Department of Children and Families (DCF) administers Florida's food assistance program.[4] Benefits for the Food Assistance Program are 100 percent federally-funded with administrative costs being equally split between the state and federal governments.[5] The United States Department of Agriculture (USDA) determines the amount of food assistance benefits an individual or family receives, based on the families' income and resources.[6] Food assistance benefits are supplemental to a family's food budget. Households may need to utilize their own resources, along with their food assistance benefits, to buy enough food for a month.[7]

Eligibility for SNAP Benefits

A SNAP household is considered a group of individuals who buy and cook their food together.[8] Eligibility is based on the status of all household members and hinges on three factors: income, assets, and employment.[9]

The USDA has issued waivers to the SNAP eligibility requirements to accommodate various circumstances. A waiver to the employment requirement may be granted only if the state's unemployment rate exceeds 10 percent, or if there are not enough jobs to employ prospective applicants.[10] Currently, Florida applicants are exempt from the employment requirement pursuant to a waiver implemented by DCF on July 1, 2009. This waiver expires December 31, 2015.[11] Once the waiver expires, healthy adults ages 18 to 49 without dependent children are limited to three months of food assistance benefits every three years unless they work an average of 20 hours per week or participate in a work or workfare program.[12]

Effect of the Bill

Once the bill goes into effect, DCF will have to obtain specific legislative authorization before applying for, or renewing, work requirement waivers from the federal government. The waiver currently in effect will not be impacted and will still expire in December 2015. Once the waiver expires, 989,103 persons, including 290,938 able-bodied adults without dependents, will be ineligible for SNAP benefits unless they participate in the work program or show good cause for not participating.[13] However, a maximum of three months of food assistance continues to be available every three years for those who are unemployed or do not participate in a workfare program.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.991, F.S, to modify the equity allocation model that affects the distribution of core service funds among Community-Based Care lead agencies.

Section 2: Creates s. 414.455, F.S., to require the Department of Children and Families to obtain legislative authorization prior to seeking, applying for, accepting, or renewing any waiver of work requirements established by the federal Supplemental Nutrition Assistance Program.

Section 3: Providing an effective date of July 1, 2015.

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[4] s. 414.31, F.S.
[5] Subcommittee on Healthcare Appropriations Meeting Packet 02/18/2015 available at: http://www.myfloridahouse.gov/Sections/Documents/publications.aspx?CommitteeId=2834&PublicationType=Committees&DocumentType=Meeting Packets&SessionId=76
[6] *Id.*
[7] DCF Food Assistance Program Fact Sheet, www.dcf.state.fl.us/programs/access/docs/fafactsheet.pdf. (last visited 3/4/15)
[8] but see note 11 (Children and parents under the age of 22, spouses, and as adults exercising parental control over minors are automatically considered household members)
[9] *Supra* note 11.
[10] 7 U.S.C.A.§2015(2014)
[11] email from Nicole Stookey, Deputy Director, Office of Governmental Affairs, Department of Children and Families, Follow up SNAP Questions (Feb. 24, 2015)
[12] *Id.*
[13] *Id.*

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The House proposed General Appropriations Act includes $587.1 million for recurring CBC core service functions, plus an additional $15.7 million of new funding for recurring core service functions in Fiscal Year 2015-16.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Modifications to the equity allocation model will realign funding distributions to CBC lead agencies. There may be an increase to the state's workforce population should those SNAP beneficiaries who have not been employed due to the waiver exemption are now required to do so to continue receiving food assistance. There may be a decrease in food purchases should those SNAP beneficiaries currently exempt from the work requirement choose to not participate from this requirement upon expiration of the waiver.

D. FISCAL COMMENTS:

This bill is budget neutral. It modifies the equity allocation model that affects the distribution of recurring core service funds among Community-Based Care lead agencies. SNAP benefits are federally-funded, so changes in the number of persons eligible do not impact state revenue or expenditures.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to the Department of Children and
3 Families; amending s. 409.991, F.S.; revising the
4 recurring core services funding for community-based
5 care lead agencies; creating s. 414.455, F.S.;
6 requiring the department to receive legislative
7 authorization before seeking, applying for, accepting,
8 or renewing any waiver of work requirements under the
9 federal Supplemental Nutrition Assistance Program;
10 providing an effective date.
11
12 Be It Enacted by the Legislature of the State of Florida:
13
14 Section 1. Subsection (3) of section 409.991, Florida
15 Statutes, is amended to read:
16 409.991 Allocation of funds for community-based care lead
17 agencies.—
18 (3) Beginning in the 2015-2016 ~~2013-2014~~ state fiscal
19 year, 95 ~~90~~ percent of the recurring core services funding for
20 each community-based care lead agency shall be based on the
21 prior year recurring base of core services funds and 5 ~~10~~
22 percent shall be based on the equity allocation model.
23 Section 2. Effective January 1, 2016, section 414.455,
24 Florida Statutes, is created to read:
25 414.455 Supplemental Nutrition Assistance Program;
26 legislative authorization.—Notwithstanding s. 414.45, and unless

27 expressly required by federal law, the department must obtain
28 specific authorization from the Legislature before seeking,
29 applying for, accepting, or renewing any waiver of work
30 requirements established by the Supplemental Nutrition
31 Assistance Program under 7 U.S.C. s. 2015(o).
32 Section 3. This act shall take effect July 1, 2015.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCAS 15-03 Alzheimer's Disease Research
SPONSOR(S): Health Care Appropriations Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Care Appropriations Subcommittee		Garner, Dobson	Pridgeon

SUMMARY ANALYSIS

The bill conforms statutes to the funding decisions included in the proposed General Appropriations Act (GAA) for Fiscal Year 2015-2016.

The bill amends s. 381.82, F.S., allowing the Ed and Ethel Moore Alzheimer's Disease Research Program to carry forward general revenue appropriations up to 5 years after an appropriation's effective date if obligated by July 1 of the first year after appropriated.

The effective date of the bill is July 1, 2015.

This document does not reflect the intent or official position of the bill sponsor or House of Representatives.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

The Florida Legislature created the Ed and Ethel Moore Alzheimer's Disease Research Program in 2014 (program). The program is housed in the Department of Health (DOH) and is administered by an 11 member board known as the Alzheimer's Disease Research Grant Advisory Board (board). The program's purpose is to fund research leading to prevention of, or a cure for, Alzheimer's disease.

The board must consist of 11 members appointed by the State Surgeon General and must include two gerontologists, two geriatric psychiatrists, two geriatricians, two neuroscientists, and three neurologists, who serve 4-year staggered terms. The board must elect a chairperson from the membership of the board who will serve a term of two years, establish operating procedures, follow rigorous guidelines for ethical conduct, and adhere to a strict policy with regard to conflicts of interest. DOH staff assists the board in carrying out its duties. Board members do not receive compensation, or reimbursement for per diem or travel. Board activities are exempt from public records requirements.

The board must submit recommendations for funding of research proposals to the State Surgeon General by December 15 of each year. Upon receiving consultation from the board, the State Surgeon General is authorized to award grants on the basis of scientific merit. Applications for research funding may be submitted by any university or established research institute in the state, and all qualified investigators in the state must have equal access and opportunity to compete for research funding. The implementation of the program is subject to legislative appropriation. Statute specifies certain types of applications to be considered for funding, including:

- Investigatory-initiated research grants;
- Institutional research grants;
- Pre-doctoral and post-doctoral research fellowships; and
- Collaborative research grants, including those that advance the finding of cures through basic or applied research.

The board is required to annually submit a fiscal-year progress report on the research program to the Governor, President of the Senate, Speaker of the House of Representatives, and the State Surgeon General by February 15. The report must include:

- A list of research projects supported by grants or fellowships awarded under the program;
- A list of recipients of program grants or fellowships;
- A list of publications in peer-reviewed journals involving research supported by grants or fellowships awarded under the program;
- The state ranking and total amount of Alzheimer's disease research funding currently flowing into the state from the National Institute of Health;
- New grants for Alzheimer's disease research which were funded based on research supported by grants or fellowships awarded under the program;
- Progress toward programmatic goals, particularly in the prevention, diagnosis, treatment, and cure of Alzheimer's disease; and
- Recommendations to further the mission of the program.

In the Alzheimer's Disease Research Grant Advisory Board Annual Report 2014-15 the recommendations to further the mission of the program identified difficulties for researchers to complete the necessary research within the limited time frame of one year that a general revenue appropriation allows. The board recommended future appropriations made to the Ed and Ethel Moore Alzheimer's

Disease Research Program be funded from the Biomedical Research Trust Fund to allow research projects to span multiple years.[1]

In 2014, The Legislature appropriated $3,000,000 in general revenue funds to the Ed and Ethel Moore Alzheimer's Disease Research Program. By default, general revenue appropriations that remain unspent at the end of a fiscal year revert to the state.[2] However, the legislature may supersede this provision by passing a law that specifically authorizes the appropriation to be carried forward.[3] The program awarded eleven grants ranging from $112,500 to $500,000 each fully expending the $3,000,000 appropriation for fiscal year 2014 - 2015.[4]

Table 1
Ed and Ethel Moore Alzheimer's Disease Research Program Grant Awards, Fiscal Year 2014/2015

Grant Recipients	Research Projects	Institution	Award Amount
Ertekin-Taner, Nilufer	Florida Consortium for African-American Alzheimer's Disease Studies (FCA3DS)	Mayo Clinic Florida	$ 500,000.00
Loewenstein, David	A Consortium to Study Novel Markers of Early Alzheimer's Disease	University of Miami Miller School of Medicine	$ 500,000.00
Rademakers, Rosa	Identification of novel AD genes and disease associated pathways through FPADS: a Florida Presenile Alzheimer's Disease Subjects registry	Mayo Clinic Florida	$ 500,000.00
Lewis, Jada	Developing biotherapies for Alzheimer's Disease	University of Florida	$ 250,000.00
Dore, Sylvain	Therapeutic potential of PGE2 EP1 receptor selective antagonist.	University of Florida	$ 225,000.00
Bu, Guojun	ApoE and gender effects on Alzheimer's disease and cerebral amyloid angiopathy	Mayo Clinic Florida	$ 200,000.00
Kang, David	Targeting the Slingshot-Cofilin Pathway in AD	University of South Florida	$ 200,000.00
Moraes, Carlos T.	The Role of Mitochondrial Oxidative Phosphorylation Dysfunction in Alzheimer's Pathology	University of Miami, Miller School of Medicine	$ 200,000.00
Wahlestedt, Claes	Epigenetic approach for the treatment of Alzheimer's disease	University of Miami Miller School of Medicine	$ 200,000.00
Lee, Daniel C.	Modulation of Arginine Metabolism and Polyamines to Mitigate Alzheimer's disease Pathology	University of South Florida	$ 112,500.00
Tan, Jun	Flavonoid-diosmin, a novel gamma-secretase modulator, for the treatment of Alzheimer's disease	University of South Florida	$ 112,500.00

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[1] *See* Alzheimer's Disease Research Grant Advisory Board, Annual Report 2014-15 p. 6.
[2] s. 216.301, F.S.
[3] s.216.351, F.S.
[4] *See* Alzheimer's Disease Research Grant Advisory Board, Annual Report 2014-15 p.4.

Effect of Proposed Changes

The bill implements the board's recommendation to allow the program to carry forward unspent general revenue appropriations up to five years after an appropriation's effective date if obligated by July 1 of the first year after appropriated thus allowing research projects to span multiple years. In the past, DOH has indicated that such a change allows them to offer longer grant periods, thus enabling researchers to conduct clinical trials that are more likely to result in a marketable product.[5] Five years is consistent with grant timeframes seen in other research programs such as the National Institutes of Health.[6]

B. SECTION DIRECTORY:

Section 1. Amends s. 381.82, F.S., allowing the Ed and Ethel Moore Alzheimer's Disease Research Program to carry forward unspent general appropriations funds for a period of five years.

Section 2. Provides an effective date of July 1, 2015.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The General Appropriations Act provides a $3,000,000 recurring general revenue appropriation for this purpose.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Researchers will be able to perform multiyear projects and will benefit from having access to allocated grant funds over the course of a five year period.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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[5] *See generally* Health and Human Services Committee Bill Analysis of 2012, House Bill 655 p. 4 (3/26/12).

[6] National Institutes of Health, http://grants.nih.gov/grants/funding/funding_program.htm (last visited 3/5/2015).

Not applicable, this bill does not affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to Alzheimer's disease research;
3 amending s. 381.82, F.S.; providing for the
4 carryforward of any unexpended balance of an
5 appropriation for the Ed and Ethel Moore Alzheimer's
6 Disease Research Program; providing an effective date.
7
8 Be It Enacted by the Legislature of the State of Florida:
9
10 Section 1. Subsection (8) is added to section 381.82,
11 Florida Statutes, to read:
12 381.82 Ed and Ethel Moore Alzheimer's Disease Research
13 Program.—
14 (8) Notwithstanding s. 216.301 and pursuant to s. 216.351,
15 the balance of any appropriation from the General Revenue Fund
16 for the Ed and Ethel Moore Alzheimer's Disease Research Program
17 which is not disbursed but which is obligated pursuant to
18 contract or committed to be expended by June 30 of the fiscal
19 year in which the funds are appropriated may be carried forward
20 for up to 5 years after the effective date of the original
21 appropriation.
22 Section 2. This act shall take effect July 1, 2015.