HOUSE OF REPRESENTATIVES STAFF FINAL BILL ANALYSIS

BILL #: HB 5201 PCB HCAS 21-01 Health Care
SPONSOR(S): Health Care Appropriations Subcommittee, Avila and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 2518

FINAL HOUSE FLOOR ACTION: 117 **Y's** 0 **N's** **GOVERNOR'S ACTION:** Pending

SUMMARY ANALYSIS

HB 5201 passed the House on April 30, 2021, as SB 2518. The bill conforms to the 2021-2022 General Appropriations Act. The bill:

- amends s. 296.37(1), F.S., and repeals s. 296.37(3), F.S., allowing the Department of Veterans Affairs to continue the personal needs allowance of residents of State Veterans' Nursing Homes at $130 per month,
- amends s. 400.179(2)(d), F.S., to reduce the Agency for Health Care Administration's (AHCA) collection threshold for the Medicaid nursing home lease bond alternative from $25 million to $10 million,
- amends s. 408.061, F.S., to require nursing homes and their home offices to annually submit to AHCA financial data using a uniform system of financial reporting,
- amends s. 408.07, F.S., to provide definitions for the terms Florida Nursing Home Uniform Reporting System and Home Office,
- amends s. 409.903(5), F.S., extending Medicaid eligibility for postpartum women from 60 days to 12 months,
- amends s. 409.904(12), F.S., to permanently continue the policy of retroactive Medicaid eligibility for non-pregnant adults to the first day of the month in which an application for Medicaid is submitted,
- amends s. 409.908(23), F.S., to permanently eliminate the nursing home Medicaid reimbursement rate freeze established on July 1, 2011,
- amends s. 409.908(23), F.S., to continue the rate freeze for County Health Department's reimbursement rates to the July 1, 2011 level,
- amends s. 409.908(26), F.S., to require the Letters of Agreement for the Low Income Pool program to be received by the AHCA by October 1; the funds outlined in the Letters of Agreement to be received by October 31; and requires essential providers to contract with managed care plans to be eligible to receive supplemental payments, thereby making certain that those who receive supplemental payments treat Medicaid patients,
- amends ss. 409.911(2), 409.911(10), 409.9113(3), 409.9119(4), F.S., to update the years of audited data used to determine disproportionate share payments to hospitals, teaching hospitals, and specialty hospitals for children,
- amends s. 409.975(1)(a), F.S., as a technical correction to conform a cross reference due to amending s. 408.07, F.S.,
- amends s. 430.502(1), F.S., to redesignate the West Florida Regional Medical Center memory disorder clinic to the Medical Center Clinic in Pensacola,
- amends s. 624.91(5)(b), F.S., to continue to require the Florida Healthy Kids Corporation to validate and calculate a refund amount for Title XXI providers who achieve a Medical Loss Ratio below 85 percent and to deposit any refunds into the General Revenue Fund, unallocated,
- amends s. 1011.52(2)(e), F.S., as a technical correction to conform a cross reference due to amending s. 408.07, F.S.,
- authorizes additional Programs of All Inclusive Care for the Elderly (PACE) in various locations throughout the state.

Subject to the Governor's veto powers, the effective date of this bill is July 1, 2021.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Current Situation

Veterans Nursing Homes

Once an individual requiring an institutional level of care has established Medicaid eligibility, some of his or her income is used to pay for Medicaid services. For individuals residing in an institution, 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. 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.

Section 296.37, F.S., requires 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 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. Chapter 2017-157, Laws of Florida, amended s. 296.37, F.S., to increase the personal needs allowance to $105 per month from $35 per month. For the past three fiscal years, the General Appropriations Act implementing legislation increased the personal needs allowance to $130 per month.[1] This provision expires July 1, 2021.

Florida Medicaid Program

The Agency for Health Care Administration (AHCA) is the single state agency responsible for the administration of the Florida Medicaid program, authorized under Title XIX of the Social Security Act. This authority includes establishing and maintaining a Medicaid state plan, approved by the Centers for Medicare and Medicaid Services.

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

The Florida Medicaid program covers approximately 4.6 million low-income individuals, including approximately 2.2 million children in Florida. These children make up 55.2% of the Florida Medicaid population.[2] Medicaid is the second largest single program in the state, behind public education, representing 32.2% of the total FY 2020-21 budget.

A Medicaid state plan is an agreement between a state and the federal government describing how a state administers its Medicaid program. It establishes groups of individuals covered, services that are provided, payment methodologies, and other administrative and organizational requirements. In order to participate in Medicaid, federal law requires states to cover certain population groups (mandatory eligibility groups) and gives them the flexibility to cover other population groups (optional eligibility groups). States set individual eligibility criteria within federal minimum standards.

[1] Chapters 2016-116, 2018-10, 2019-116, and 2020-114, Laws of Florida.

[2] Agency for Health Care Administration, *Florida Statewide Medicaid Monthly Enrollment Report*, January 2021, available at https://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last accessed March 11, 2021).

In Florida, the majority of Medicaid recipients receive their services through a managed care plan contracted with AHCA under the Statewide Medicaid Managed Care (SMMC) program. The SMMC program has three components: the Managed Medical Assistance (MMA) program, the Long-Term Care (LTC) program and the Dental program. Florida's SMMC program benefits are authorized by federal authority and are specifically required by the Florida Legislature in sections 409.973 and 409.98, F.S.

AHCA contracts with managed care plans on a regional basis to provide services to eligible recipients. The MMA program, which covers most medical and acute care services for managed care plan enrollees, was fully implemented in August 2014 and then was re-procured. Current contracts end in 2024.

Nursing Home Lease Bond Alternative

All nursing home facilities currently leasing the property where nursing facility services are provided are required to submit a Surety Bond annually. As an alternative, a nonrefundable fee may be presented to the AHCA in the amount equal to 1% of 3 months of Medicaid payments to the facility based on the preceding 12-month average Medicaid payments to the facility as calculated by the AHCA. These funds are held in a trust fund as a Medicaid nursing home overpayment account. These fees are used at the sole discretion of the AHCA to repay nursing home Medicaid overpayments should a facility be unable to pay the liability but does not release the licensee from any liability for any Medicaid overpayments. Each year, the AHCA will assess the fund after all overpayments have been repaid and, if the balance after all other amounts have been subtracted is greater than $25 million, collections of the fee will be suspended for the subsequent fiscal year.

Nursing Home Uniform Reporting System

Currently, nursing homes, continuing care facilities, and state run hospitals are exempt from the requirement to submit their actual financial experience for the fiscal year to the AHCA. All other health care facilities are mandated to do so. In addition, hospitals must submit their actual audited financial experience and submit the information in the Florida Hospital Uniform Reporting System (FHURS). The FHURS is a database designed by the AHCA expressly for the reporting of the hospitals' audited actual financial experience. The hospitals have had this requirement since 1992 and it has been an aid to the AHCA to make management decisions and the Legislature to make policy and budgetary decisions. The hospital financial information has been used to determine revenues for the Public Medical Assistance Trust Fund, hospital assessments, review certificates of need, licensure condition compliance, for research, to prepare hospital financial data reports, and to respond to media and legislative requests.

Medicaid Postpartum Eligibility

Medicaid covers pregnant women for their entire pregnancy and a short while after, but, unless a woman qualifies for the program under other criteria, the coverage ends 60 days after birth. Medicaid pays for approximately 56% of Florida's births and provides health care coverage for just under half the state's children. About 700 women die each year in the United States as a result of pregnancy or delivery complications. In Florida, several initiatives at the state and provider level have been put into place in recent years to address the issue of maternal mortality. These efforts have helped lower the state's overall maternal mortality rate by 25%, reduced the rate for non-Hispanic Black women by half, and reduced the rate for Hispanic women and the Black-White disparity gap both by 75% – making Florida a model for the country. Although Florida is trending in the right direction, more can be done to combat maternal mortality in order to keep mothers and their babies safe and healthy.

Medicaid Retroactive Eligibility

The Social Security Act provides the requirements under which state Medicaid programs must operate. Federal law directs state Medicaid programs to cover, and provides federal matching funds for, medical bills up to three months prior to a recipient's application date.[3] The federal Medicaid statute requires that Medicaid coverage for most eligibility groups include retroactive coverage for a period of 90 days prior to the date of the application for medical assistance, however, this requirement can be waived pursuant to federal regulations.

An initial analysis by the AHCA indicated that approximately 39,000 non-pregnant adults were made retroactively eligible under the 90-day requirement of federal regulations in State Fiscal Year 2015-2016.[4] A more recent AHCA analysis indicates that 11,466 distinct individuals were granted such retroactive eligibility and utilized services during their retroactive period during State Fiscal Year 2017-2018.[5] In compliance with the federal requirement for 90 days of retroactive eligibility, the Florida Medicaid State Plan previously provided that "[c]overage is available beginning the first day of the third month before the date of application if individuals who are aged, blind or disabled, or who are AFDC-related,[6] would have been eligible at any time during that month, had they applied." These provisions had been applicable to the Florida Medicaid State Plan since at least October 1, 1991.[7]

In 2018, the Florida Legislature, via the General Appropriations Act (GAA)[8] and the Implementing Bill accompanying the GAA[9], approved a measure to direct the AHCA to seek a waiver from the federal Centers for Medicare and Medicaid Services (CMS) to eliminate the 90-day retroactive eligibility period for non-pregnant adults aged 21 and older. For these adults, eligibility would become retroactively effective on the first day of the month in which their Medicaid application was filed, instead of the first day of the third month prior to the date of application.

The waiver request that included the retroactive eligibility item was submitted to federal CMS by AHCA on April 27, 2018, and was approved by federal CMS on November 30, 2018 to be effective February 1, 2019. The waiver included the stipulation that the waiver authority ends on June 30, 2019 and that AHCA must timely submit a letter to CMS by May 17, 2019 if legislative approval is granted to continue the waiver past June 30, 2019.[10] Legislative approval was granted in section 30 of the 2019 General Appropriations Act Implementing Bill[11] and the letter was sent timely to CMS on May 17, 2019. In 2020, the Legislature again granted approval in section 16 of the 2020 General Appropriations Act Implementing Bill.[12]

Nursing Homes Reimbursement

On October 1, 2018, Medicaid nursing homes migrated to the prospective rate reimbursement methodology. Under the new methodology, nursing home providers were limited to the greater of their

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[3] 42 U.S.C. s. 1396a.

[4] See Agency for Health Care Administration, Florida's 1115 Managed Medical Assistance (MMA) Prepaid Dental Health Program (PDHP), Low Income Pool (LIP), and Retroactive Eligibility Amendment Request (March 28, 2018), Power Point presentation, available at: http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/MMA_PDHP_LIP-Retro_Elig_amendment_presentation_032818.pdf (last visited March 11, 2021).

[5] Agency for Health Care Administration, Senate Bill 192 Analysis (February 27, 2019).

[6] Aid to Families with Dependent Children (AFDC) was a federal assistance program in effect from 1935 to 1996 created by the Social Security Act and administered by the United States Department of Health and Human Services that provided financial assistance to children whose families had low or no income.

[7] See Florida Medicaid State Plan, page 373 of 431, available at https://ahca.myflorida.com/medicaid/stateplanpdf/Florida_Medicaid_State_Plan_Part_I.pdf (last visited March 11, 2021).

[8] See Specific Appropriation 199 of the General Appropriations Act for Fiscal Year 2018-2019, Chapter 2018-9, Laws of Florida, available at http://laws.flrules.org/2018/9 (last visited March 11, 2021).

[9] See section 20 of the Implementing bill for Fiscal Year 2018-2019, Chapter 2018-10, Laws of Florida, available at http://laws.flrules.org/2018/10 (last visited March 22, 2021).

[10] See the November 30, 2018, CMS letter and waiver approval document, including waiver Special Terms and Conditions, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-mma-ca.pdf (last visited January 9, 2020).

[11] See section 30 of the Implementing bill for Fiscal Year 2019-2020, Chapter 2019-116, Laws of Florida, available at http://laws.flrules.org/2019/116 (last visited March 22, 2021).

[12] See section 16 of the Implementing bill for Fiscal Year 2020-2021, Chapter 2020-114, Laws of Florida, available at http://laws.flrules.org/2020/114 (last visited March 11, 2021).

September cost-based rate or their prospective rate. This limitation will end on September 30, 2021. On October 1, 2021, each facility will be limited to the greater of 95% of their September cost-based rate or their rebased prospective rate that was calculated using the most recently audited cost report. This limitation will end on September 30, 2023.[13]

County Health Departments

Section 19 of the 2019 General Appropriations Act Implementing Bill, Ch. 2019-116, Laws of Florida, amended s. 409.908(23), F.S., to provide that Nursing Home Medicaid reimbursement would no longer be held to a rate freeze, but rather be based upon a prospective payment system. This change left only the county health departments subject to the rate freeze.

Low Income Pool

The terms and conditions of CMS Florida Managed Medical Assistance Waiver Approval Document created a Low Income Pool (LIP) to be used to provide supplemental payments to providers who provide services to Medicaid and uninsured patients. This pool constituted a new method for such supplemental payments, different from the prior program called Upper Payment Limit. 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. The current LIP pool is authorized for $1.5 billion and has federal approval to operate through the 2029-2030 fiscal year.[14]

The LIP is funded through county and other local tax dollars that are transferred to the state and used to draw federal match. Local dollars transferred to the state and used in this way are known as "intergovernmental transfers" or IGTs. The local taxing authorities commit to sending these funds to the state in the form of an executed Letter of Agreement with the AHCA. In order for AHCA to make timely payments to hospitals, AHCA must know which local governments will be submitting IGTs and the amount of the funds prior to using the funds to draw the federal match. Current law requires local governments who participate in IGT-funded programs, to submit to AHCA the final executed letter of agreement containing the total amount of the IGTs authorized by the entity, no later than October 1 of each year. Additionally, the local governments are required to transfer the actual IGT funds to AHCA by October 31. There is currently no requirement for local governments to comply with these date requirements for the participation in the LIP program.

Section 409.975, F.S., defines certain Medicaid providers as "essential" providers. These providers are essential for serving Medicaid enrollees if they offer services that are not available from any other provider within a reasonable area, or they serve a particular Medicaid population within a region that has limited access to services. Some essential providers are essential only to their own region, whereas others are essential statewide. Medicaid managed care plans are required to contract with these essential providers; however, the law does not require the essential providers to contract with the managed care plans. Essential providers that fail to contract with managed care plans, cannot serve Medicaid patients, thereby leaving these patients with no provider.

Many essential providers receive supplemental payments through the General Appropriations Act. During Fiscal Year 2020-2021, the Legislature appropriated over $2.9 billion in supplemental payments across health care services. While not all essential providers receive supplemental funding, many of them do. Currently, there is no requirement that essential providers receiving supplemental funding contract with managed care plans to serve Medicaid patients.

[13] See Chapter 2017-129, Laws of Florida.

[14] Agency for Health Care Administration, CMS Florida Managed Medical Assistance Waiver Approval Document, available at https://ahca.myflorida.com/Medicaid/Finance/finance/LIP-DSH/lip/docs/FL_MMA_Extension_STCs_1.15.2021.pdf, (last visited March 15, 2021).

Disproportionate Share Hospital Program

Federal law requires state Medicaid programs to make payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. This is known at the Disproportionate Share Hospital (DSH) program. The federal government annually provides a limited DSH allotment to each state based on the amount of state dollars appropriated as matching funds for the federal DSH allotment, up to, but not exceeding the federal limit. The legislature determines each year how DSH funds will be distributed to each qualifying hospital in the GAA and according to parameters within Florida law. For states to receive DSH payments, federal law requires states to submit an independent certified audit and an annual report to the secretary of the United States Department of Health and Human Services, describing DSH payments made to each qualifying hospital. Florida law requires the AHCA to use audited data from specified years to determine the amount of Medicaid and charity care to be used in calculating DSH payments.[15]

Memory Disorder Clinic

In 1985, the Legislature established a memory disorder clinic (MDC) at each of the three medical schools in the state of Florida, a major private nonprofit research-oriented teaching hospital, and/or any of the other affiliated teaching hospitals, for the purpose of conducting research and training in a diagnostic and therapeutic setting for persons suffering from Alzheimer's Disease and related memory disorders.[16]

There are currently 17 MDCs operating in 13 distinct service areas throughout the state. All 17 MDCs participate in funded research projects and are required to provide comprehensive assessments, diagnostic services, and treatment to individuals who exhibit symptoms of Alzheimer's disease and related dementias.[17] Memory Disorder Clinic locations are as follows:

- AdventHealth Orlando (Orlando)
- Broward Health North (Deerfield Beach)
- Florida Atlantic University (Boca Raton)
- Health First (Melbourne)
- Lee Memorial (Fort Myers)
- Mayo Clinic (Jacksonville)
- Miami Jewish Health (Miami)
- Mt. Sinai Medical Center (Miami Beach)
- Morton Plant (Clearwater)
- Orlando Health (Orlando)
- St. Mary's Medical Center (West Palm Beach)
- Sarasota Memorial (Sarasota)
- Tallahassee Memorial (Tallahassee)
- University of Florida (Gainesville)
- University of Miami (Miami)
- University of South Florida (Tampa)
- West Florida Hospital (Pensacola)

Florida Healthy Kids Corporation

The Florida Healthy Kids Corporation was created in 1990 by the Florida Legislature as a public-private effort to improve access to health insurance for the state's uninsured children. The program came

[15] Section 409.911(2), F.S.
[16] See Chapter 85-145, s. 2, Laws of Florida.
[17] Department of Elder Affairs (DOEA), Programs and Services, Memory Disorder Clinics Report 2020, available at http://elderaffairs.state.fl.us/doea/documents/MDC%202020%20Annual%20Report_FINAL.pdf (last visited Mar. 21, 2021).

about as a result of an article published in the March 31, 1988, New England Journal of Medicine by Steve A. Freedman, Ph.D., F.A.A.P., then-Director of the Institute for Child Health Policy at the University of Florida.

Since its beginning, Healthy Kids has covered millions of children in Florida. Identified as one of three state programs that was grandfathered into the original Children's Health Insurance Program (CHIP) legislation in 1997. Healthy Kids was joined with two other existing state health care programs for children (Medicaid and Children's Medical Services) and a new program (Medikids) to create Florida's KidCare program in 1998.[18]

In s. 624.91, F.S., Florida Healthy Kids Corporation is mandated to purchase goods and services in the most cost-effective manner consistent with the delivery of quality medical care to uninsured and underinsured children through contracts with health care providers. These contracted health care providers must maintain a minimum medical loss ratio (MLR) of 85% and maximum administrative costs of 15%.

Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) provides comprehensive medical and social services to certain frail, community-dwelling elderly individuals, most of whom are dually eligible for Medicare and Medicaid benefits. An interdisciplinary team of health professionals provides PACE participants with coordinated care. For most participants, the coordinated care and services enables them to remain in the community rather than receive care in a nursing home.[19]

In Florida, the PACE is administered by the Department of Elder Affairs (DOEA) in consultation with the AHCA. The DOEA oversees the contracted PACE organizations, but is not a party to the contract between the federal CMS, the AHCA, and the PACE organizations. The DOEA, the AHCA, and the federal CMS must approve any applications for new PACE organizations if expansion is authorized by the Legislature.[20]

A PACE organization is a non-profit private or public entity that is primarily engaged in providing PACE health care services. To qualify for PACE, organizations must have:

- A governing board that includes community representation;
- A physical site to provide adult day services;
- A defined service area;
- The ability to provide the complete service package regardless of frequency or duration of services;
- Safeguards against conflict of interest; and
- Demonstrated fiscal soundness.[21]

In order to enroll in a PACE program, federal law requires eligible individuals to meet the following criteria:

- Be 55 years of age or older;
- Be determined by the state to need the level of care required under the State Medicaid plan
- for coverage of nursing facility services;
- Reside in the service area of the PACE organization; and

[18] Florida Healthy Kids Corporation History, 2019, retrieved from https://www.healthykids.org/healthykids/history/ (last visited March 11, 2021).

[19] Medicaid.gov, *Program of All-Inclusive Care for the Elderly*, available at https://www.medicaid.gov/medicaid/long-termservices-supports/program-all-inclusive-care-elderly/index.html (last visited Mar. 22, 2021).

[20] DOEA and AHCA, *Program of All-Inclusive Care for the Elderly and Statewide Medicaid Managed Care Long-term Care Program Comparison Report* (January 14, 2014), available at https://ahca.myflorida.com/Medicaid/recent_presentations/PACE_Evaluation_2014.pdf (last visited Mar. 22, 2021).

[21] Medicaid.gov, *Program of All-Inclusive Care for the Elderly*, available at https://www.medicaid.gov/medicaid/long-termservices-supports/program-all-inclusive-care-elderly/index.html (last visited Mar. 22, 2021).

- Be able to live in a community setting without jeopardizing his or her health or safety.[22]

Individuals enrolled in PACE have both their medical and long-term care needs managed through a single organization. PACE covered services and benefits include adult day care, dentistry, primary care, hospital care, laboratory/x-ray services, meals, nursing home care, physical therapy, and prescription drugs, among others.[23]

Currently, six PACE organizations operate in Florida and provide services to participants within specific zip codes in Broward, Charlotte, Clay, Collier, Duval, Lee, Miami-Dade, Palm Beach, and Pinellas counties. There are 2,347 individuals enrolled in Florida PACE organizations as of February 2021.[24]

When enrollees enter a PACE program, the individual is filling a slot within that particular program. Slots are authorized by the Legislature for a specific PACE area; however, slots may not always be fully funded in the same year the program is authorized. Some PACE providers need additional time to complete the application process, obtain necessary licensures, or to finalize operations. The 2020-2021 GAA provided just over $73 million in PACE program funding to PACE organizations around the state.[25]

Effect of Proposed Changes

Veterans Nursing Homes

The bill amends s. 296.37(1), F.S., to permanently set the personal needs allowance at $130 per month to reflect Medicaid funding in the General Appropriations Act for the 2021-2022 Fiscal Year.

Nursing Home Lease Bond Alternative

The bill amends s. 400.179(d), F.S., to decrease the collection threshold for the nursing home lease bond alternative from $25 million to $10 million.

Nursing Home Uniform Reporting System

The bill requires nursing homes and their respective home offices to submit annually financial information to the agency in a uniform reporting system. Nursing homes will now have similar reporting requirements as other health care facilities, with the exception of continuing care facilities and state run hospitals.

Medicaid Postpartum Eligibility

The bill amends s. 409.903(5), F.S., to extend postpartum Medicaid-eligibility of pregnant women from 60 days following birth to 12 months following birth. The extension of full Medicaid benefits to these women for 12 months, will improve access to care, lead to better health outcomes, and combat maternal mortality.

Medicaid Retroactive Eligibility

The bill amends s. 409.904, F.S., to continue the policy that began in the 2018-2019 fiscal year by providing payments for Medicaid eligible services for eligible non-pregnant adults retroactive to the first

[22] United States Department of Health and Human Services, federal CMS, *CMS Manual System: Pub. 100-11 Programs of All-Inclusive Care for the Elderly (PACE) Manual* (issued June 9, 2011), available at https://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/Downloads/pace111c01.pdf (last visited Mar. 22, 2021).

[23] See Medicaid.gov, *Program of All-Inclusive Care for the Elderly*.

[24] AHCA, *Florida Statewide Medicaid Monthly Enrollment Report* (February 28, 2021), available at https://ahca.myflorida.com/Medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited Mar. 21, 2021).

[25] See Chapter 2020-111, Laws of Florida.

day of the month in which an application for Medicaid is submitted. Eligible children and pregnant women will continue to have retroactive Medicaid eligibility for a period of no more than 90 days before the month in which an application for Medicaid is submitted.

Nursing Homes Reimbursement

The bill amends s. 409.908(23), F.S., to eliminate the nursing home Medicaid reimbursement rate freeze established on July 1, 2011, thereby allowing for the recurring rate increase provided in Fiscal Year 2020-2021 to nursing homes reimbursed under the prospective payment sytem.

County Health Departments

The bill amends s. 409.908(23), F.S., to reenact the language in Section 19 of the 2019 General Appropriations Act Implementing Bill, Ch. 2019-116, Laws of Florida, that is applicable to the reimbursement of county health departments, thereby keeping the county health departments subject to the rate freeze.

Low Income Pool

The bill amends s. 409.908(26), F.S., to include the Low Income Pool program among the other programs that rely on IGTs to be provided to AHCA. Local governments, on behalf of providers participating in the LIP program, will be required to submit a final, executed Letter of Agreement to AHCA no later than October 1, which will delineate the amount of funds the local government will submit. Additionally, the funds pledged in the Letter of Agreement on behalf of a provider participating in the LIP program, must be transferred to AHCA no later than October 31, unless an alternative plan is approved by AHCA.

The bill amends s. 409.908(26), F.S., to require that essential providers contract with the relevant managed care plans as a condition of receiving supplemental payments.

Disproportionate Share Hospital Program

The bill amends ss. 409.911(2), 409.911(10), 409.9113(3), 409.9119(4), F.S., to update the years of audited data used to determine disproportionate share payments to hospitals, teaching hospitals, and specialty hospitals for children

Memory Disorder Clinic

The bill amends s. 430.502(1), F.S., to redesignate a memory disorder clinic from the West Florida Regional Medical Center to the Medical Center Clinic in Pensacola

Florida Healthy Kids Corporation

The bill amends s. 624.91, F.S., to require the Florida Healthy Kids Corporation to validate and calculate a refund amount for Title XXI authorized insurers and providers of health care services who achieve a MLR below 85%. These refunds shall be deposited into the General Revenue Fund, unallocated.

PACE

The bill authorizes the AHCA, upon federal approval, to contract with an organization that meets all specified requirements to be a site for the Program of All Inclusive Care for the Elderly (PACE) program and provide comprehensive long-term care services to up to:

- 200 enrollees who reside in Escambia, Okaloosa, and Santa Rosa counties;
- 100 enrollees who reside in Northwest Miami-Dade County;

- 500 enrollees who reside in Hillsborough, Pasco, and Hernando counties;
- 300 enrollees who reside in Broward County;
- 300 enrollees who reside in Baker, Clay, Duval, Nassau, and St. Johns counties. Enrollees in Alachua and Putnam Counties are also eligible, subject to a contract amendment with the AHCA; and
- 500 enrollees who reside in Seminole, Volusia, or Flagler counties.

The bill also:

- authorizes the consolidation of 150 enrollee slots for Orange and Osceola counties and Lake and Sumter counties and 150 enrollee slots for Seminole County to provide services to up to 300 enrollees who reside in Orange, Osceola, Lake, Sumter, or Seminole counties, and
- authorizes the AHCA, upon federal approval, to contract with one public hospital operating in the northern two-thirds of Broward County to provide comprehensive services to up to 200 enrollees residing in the northern two-thirds of Broward County.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:
   With the collection threshold for the Lease Bond Alternative decreasing from $25 million to $10 million, revenues would decrease due to the new, lower threshold for halting collections. The fund would also keep a lower balance, leading to a decrease in interest earned. The current balance of the fund is $16.0 million.

   In order for providers to earn matching federal dollars for LIP, local governments and other local political subdivisions will be required to provide to AHCA an executed letter of agreement by October 1 of each fiscal year and the transfer of all funds as pledged in the LIP IGT agreement letter, no later than October 31 of each fiscal year, unless an alternative plan is approved by AHCA.

   In Fiscal Year 2018-2019, $3.99 million in refunds were collected due to the Title XXI provider plans not achieving the 85% MLR. In future periods, the refunds will be transferred to the General Revenue Fund, unallocated. It is unknown if the refunds will continue at the same level as the prior year, or whether adjusted premiums, increased services, or other approaches will mitigate the refund amounts.

2. Expenditures:
   Medicaid Retroactive Eligibility began in FY 2018-2019 under the 2018 GAA Implementing Bill. The 2018 GAA included a recurring savings due to the implementation of Medicaid Retroactive Eligibility. AHCA estimates that the Legislature will need to appropriate an additional $103.6 million if this policy is not continued.

   The Nursing Home Unit Cost Increase began in the FY 2020-2021 General Appropriations Act, 2020-111, Laws of Florida. It was effective on July 1, 2020 and totaled $74.8 million recurring ($28.6 million GR recurring). It provided nursing homes a unit cost increase add-on to the greater of the cost-based rate or their prospective payment rate.

   The extension of Medicaid Postpartum eligibility for mothers to 12 months is estimated to cost $239.8 million ($93.0 million GR). Approximately 97,600 Medicaid beneficiaries will receive full Medicaid coverage for the extended 12 month period.

The new PACE programs, including consolidations, are estimated to cost $17.6 million and will provide comprehensive long-term care services to 2,500 enrollees in various locations throughout the state.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:
None.

2. Expenditures:
In order to earn matching federal dollars for LIP, local governments and other local political subdivisions would be required to provide all funds pledged in LIP IGT agreements, no later than October 31, 2021.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:
With the decrease in the threshold from $25 million to $10 million to halt collection of the lease bond alternative, the private sector nursing homes may pay less in lease bond alternative fees.

Residents in a veteran's nursing home will retain $130 per month as a personal needs allowance.

The Nursing Home unit cost increase was a $74.8 million increase to nursing homes providing services to the State's most needy.

Requires essential providers to contract with the relevant managed care plans as a condition of receiving supplemental payments.

D. FISCAL COMMENTS:
None.