HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCA 20-01 Health Care
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	8 Y, 4 N	Nobles	Clark

SUMMARY ANALYSIS

The bill conforms statutes to the funding decisions related to Health Care included in the House proposed General Appropriations Act (GAA) for Fiscal Year 2020-2021. The bill:

- Terminates the Welfare Transition Trust Fund and provides for the disposition of balances in and revenues of the trust fund and payment of debts and obligations of the terminated trust fund;
- Continues the personal needs allowance of residents of Veterans Nursing Homes at $130 per month;
- Reduces the Medicaid nursing home lease bond alternative collection threshold from $25 million to $10 million;
- Requires nursing homes and home offices to report audited financial information to the Agency for Health Care's uniform reporting system;
- Defines Florida Nursing Home Uniform Reporting System (FNHURS) and home office;
- Continues 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 statute to continue to hold the County Health Departments' reimbursement to the level established on July 1, 2011;
- Amends statute to include the Low Income Pool (LIP) program to conform to the other program's due dates that rely on Intergovernmental Transfers (IGTs) for funding. Requires that Letters of Agreement for LIP be received by the Agency for Health Care Administration (AHCA) by October 1 and the funds outlined in the Letters of Agreement be received by October 31;
- 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 the years of audited data to be used to determine disproportionate share payments to hospitals, teaching hospitals, and specialty hospitals for children;
- Amends AHCA's automatic enrollment policies for Medicaid managed care to ensure new managed care plans and provider service networks can obtain a viable enrollment level;
- Requires 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. These refunds shall be deposited into the General Revenue Fund, unallocated;
- Administratively assigns the Correctional Medical Authority (CMA) to the Department of Health;
- Transfers powers, duties, functions, records, offices, personnel, associated administrative support positions, property, pending issues, existing contracts, administrative authority, and administrative rules relating to the CMA in the Executive Office of the Governor to the Department of Health;
- Provides for technical corrections to statutory cross references in Managed Care Plan Accountability and Appropriations to First Accredited Medical Schools due to the change in the number of definitions listed in s. 408.07, F.S.

The bill provides for an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Welfare Transition Trust Fund

The Welfare Transition Trust Fund was created within the Department of Health (DOH) for the purpose of receiving federal block grant funds under the Temporary Assistance for Needy Families Program.[1]

Trust fund dollars are to be used exclusively for the purpose of providing services to individuals eligible for Temporary Assistance for Needy Families pursuant to the requirements and limitations of part A of Title IV of the Social Security Act, as amended, or any other applicable federal requirement or limitation.[2]

Funds credited to the trust fund consist of those funds collected from the Temporary Assistance for Needy Families Block Grant.[3]

The Department of Health no longer provides services related to the Temporary Assistance for Needy Families Block Grant.

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 two fiscal years the General Appropriations Act implementing legislation increased the personal needs allowance to $130 per month.[4] This prior legislation expires July 1, 2020.

Medicaid

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. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families, the Department of Health (DOH), the Agency for Persons with Disabilities (APD), and the Department of Elderly Affairs (DOEA).

---

[1] s. 20.435(8)(a), F.S.

[2] *Id.*

[3] *Id.*

[4] Ch. 2018-10 and Ch. 2016-116, Laws of Florida.

The Florida Medicaid program covers approximately 3.8 million low-income individuals, including approximately 2.2 million, or 57.1%, of the children in Florida.[5] Medicaid is the second largest single program in the state, behind public education, representing 31.3 percent of the total FY 2019-20 budget.

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 percent 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 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.[6] 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.[7] 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.[8] 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-

---

[5] Agency for Health Care Administration, *Florida Statewide Medicaid Monthly Enrollment Report*, November 2019, available at https://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last accessed January 9, 2020).

[6] 42 U.S.C. s. 1396a.

[7] 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 January 9, 2020).

[8] Agency for Health Care Administration, Senate Bill 192 Analysis (February 27, 2019) (on file with Senate Committee on Health Policy).

related,[9] 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.[10]

In 2018, the Florida Legislature, via the General Appropriations Act (GAA)[11] and the Implementing Bill accompanying the GAA[12], 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 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.[13] Legislative approval was granted in section 30 of the 2019 General Appropriations Act Implementing Bill[14] and the letter was sent timely to CMS on May 17, 2019.

County Health Departments

Section 19 of the 2019 General Appropriations Act Implementing Bill, Ch. 2019-116, L.O.F., 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 Florida's Medicaid reform 1115 waiver 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 2021-2022 fiscal year.

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.

---

[9] 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.

[10] 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 January 9, 2020).

[11] 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 January 10, 2020).

[12] 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 January 10, 2020).

[13] 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).

[14] 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 January 10, 2020).

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 2019-20, the Legislature appropriated over $1.8 billion in supplemental payments through the Low Income Pool and Physician Supplemental programs. 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.

Disproportionate Share Hospital Program

The Medicaid Disproportionate Share Hospital (DSH) Program 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 either through statutory formulas or other direction in the implementing bill or proviso.

Medicaid Managed Care Plans Enrollment

When an individual applies for Medicaid eligibility, they are provided the opportunity to choose which Medicaid health plan they would like to enroll in. If they are determined Medicaid eligible, the Agency will enroll them into the health plan they initially chose during the application process. If they do not have a health plan choice on file, the Agency routes them through the daily auto-assignment process. After they are enrolled into a Medicaid health plan, they have 120 days to pick another plan, if they choose to do so. After the 120 days, the recipient is required to stay in the health plan until their next open enrollment period, unless they there is good cause to change plans.

When recipients do not choose a plan, the Agency uses an automatic assignment methodology that can be grouped into four high level components when assessing each individual for assignment. The high-level components include: Recipient Existing Plan Relationship, Specialty Plan Eligibility, Family Member Already in a Medicaid Plan, and Round Robin Distribution. Approximately half of the automatic assignment enrollments occur in components 1-3 and the others are assigned through the fourth component, Round Robin.

As a result, new Medicaid managed care plans, particularly Provider Service Networks, can be at a disadvantage in entering regions where pre-existing plans have full enrollment. In these regions, new plans may be unable to enroll enough Medicaid recipients to make their plan financially viable.

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 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.[15]

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 are mandated to maintain a minimum medical loss ratio (MLR) of 85 percent and maximum administrative costs of 15 percent.

Correctional Medical Authority

The State of Florida Correctional Medical Authority (CMA) was created in 1986.[16] The CMA is housed within the Executive Office of the Governor (EOG) for administrative purposes but is not subject to the control or supervision by the EOG or the Department of Corrections.[17]

According to section 945.603, F.S.:

> The purpose of the CMA is to assist in the delivery of health care services for inmates in the Department of Corrections by advising the Secretary of Corrections on the professional conduct of primary, convalescent, dental, and mental health care and the management of costs consistent with quality care, by advising the Governor and the Legislature on the status of the Department of Corrections' health care delivery system, and by assuring that adequate standards of physical and mental health care for inmates are maintained at all Department of Corrections institutions.[18]

Pursuant to this section the CMA has the authority to:

1. Review and advise the Secretary of Corrections on cost containment measures the Department of Corrections could implement.
2. Review and make recommendations regarding health care for the delivery of health care services including, but not limited to, acute hospital-based services and facilities, primary and tertiary care services, ancillary and clinical services, dental services, mental health services, intake and screening services, medical transportation services, and the use of nurse practitioner and physician assistant personnel to act as physician extenders as these relate to inmates in the Department of Corrections.
3. Develop and recommend to the Governor and the Legislature an annual budget for all or part of the operation of the State of Florida prison health care system.
4. Review and advise the Secretary of Corrections on contracts between the Department of Corrections and third parties for quality management programs.
5. Review and advise the Secretary of Corrections on minimum standards needed to ensure that an adequate physical and mental health care delivery system is maintained by the Department of Corrections.
6. Review and advise the Secretary of Corrections on the sufficiency, adequacy, and effectiveness of the Department of Corrections' Office of Health Services' quality management program.
7. Review and advise the Secretary of Corrections on the projected medical needs of the inmate population and the types of programs and resources required to meet such needs.
8. Review and advise the Secretary of Corrections on the adequacy of preservice, inservice, and continuing medical education programs for all health care personnel and, if necessary, recommend changes to such programs within the Department of Corrections.
9. Identify and recommend to the Secretary of Corrections the professional incentives required to attract and retain qualified professional health care staff within the prison health care system.

---

[15] Florida Healthy Kids Corporation History, 2019, retrieved from https://www.healthykids.org/healthykids/history/ (last visited January 9, 2020).

[16] Ch. 86-183, Laws of Florida.

[17] s. 945.602, F.S.

[18] s. 945.603, F.S.

10. Coordinate the development of prospective payment arrangements as described in s. 408.50 when appropriate for the acquisition of inmate health care services.
11. Review the Department of Corrections' health services plan and advise the Secretary of Corrections on its implementation.
12. Sue and be sued in its own name and plead and be impleaded.
13. Make and execute agreements of lease, contracts, deeds, mortgages, notes, and other instruments necessary or convenient in the exercise of its powers and functions under this act.
14. Employ or contract with health care providers, medical personnel, management consultants, consulting engineers, architects, surveyors, attorneys, accountants, financial experts, and such other employees, entities, or agents as may be necessary in its judgment to carry out the mandates of the Correctional Medical Authority and fix their compensation.
15. Recommend to the Legislature such performance and financial audits of the Office of Health Services in the Department of Corrections as the authority considers advisable.

The governing board of the CMA is composed of seven persons appointed by the Governor subject to confirmation by the Senate. Members of the CMA are not compensated for the performance of their duties but are paid expenses incurred while engaged in the performance of such duties pursuant to s. 112.061, F.S.[19]

Prior to July 1, 2012, the CMA was administratively housed within the Department of Health (DOH). During the 2012 Regular Legislative Session, Senate Bill 1958 was passed and subsequently signed into law by the Governor. The bill transferred the CMA from the DOH to the EOG.[20]

Effect of Proposed Changes

Welfare Transition Trust Fund

The bill repeals Subsection (8) of Section 20.435, F.S., related to the creation of the Welfare Transition Trust Fund.

The bill terminates the Welfare Transition Trust Fund within the Department of Health and provides for the balance, and all revenues, to be transferred to the Federal Grants Trust Fund.

The bill directs the Department of Health to pay any outstanding debts and obligations of the Welfare Transition Trust Fund as soon as practicable, and the Chief Financial Officer to close out and remove the Welfare Transition Trust Fund from the various state accounting systems.

Veterans Nursing Homes

The bill permanently sets the personal needs allowance at $130 per month to reflect Medicaid funding in the General Appropriations Act for the 2020-2021 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 audited financial information to the agency in a uniform reporting system. Nursing homes will now have the same requirements as all other health care facilities, with the exception of continuing care facilities and state run hospitals.

---

[19] *Supra* note 2.
[20] Ch. 2012-122, Laws of Florida.

Medicaid Retroactive Eligibility

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

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, L.O.F., 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, 409.9113, and 409.9119, F.S., to update existing law to provide payments for the 2020-2021 fiscal year related to hospitals in the Medicaid Disproportionate Share Hospital (DSH) Program based upon the average of the 2012, 2013, and 2014 audited disproportionate share data to determine each hospital's Medicaid days and charity care.

Medicaid Managed Care Plans Enrollment

This bill amends ss. 409.666, 409.977, and 409.984, F.S., to require the AHCA Secretary to certify to the Legislature and the Governor that the agency's policies do not prevent new plans from reaching the enrollment level they need to be viable and allows AHCA to make temporary automatic assignment changes to ensure new plan viability.

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 percent. These refunds shall be deposited into the General Revenue Fund, unallocated.

Correctional Medical Authority

The bill reassigns, for administrative purposes, the State of Florida Correctional Medical Authority from the Executive Office of the Governor to the Department of Health. All powers, duties, functions, records, offices, personnel, associated administrative support positions, property, pending issues, existing contracts, administrative authority, and administrative rules relating to the CMA in the Executive Office of the Governor are transferred to the Department of Health.

This bill provides for an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Terminates the Welfare Transition Trust Fund within the Department of Health and provides for the disposition of balances in and revenues of the trust fund and payment of debts and obligations of the terminated fund.
Section 2: Repeals s. 20.435(8), F.S., relating to the Welfare Transition Trust Fund.
Section 3: Amends s. 296.37(1), F.S., relating to personal needs allowances for residents of Veterans Nursing Homes.
Section 4: Amends s. 400.179, F.S., relating to nursing home lease bonds.
Section 5: Amends s. 408.061, F.S., relating to reporting audited financial information.
Section 6: Amends s. 408.07, F.S., relating to definitions for Health Care Administration.
Section 7: Amends s. 409.904, F.S., relating to Medicaid Eligibility.
Section 8: Amends s. 409.908(23), F.S., relating to provider reimbursement.
Section 9: Amends s. 409.908(26), F.S., relating to Low Income Pool and Supplemental Payments.
Section 10: Amends s. 409.911, F.S., relating to Disproportionate Share Program for hospitals.
Section 11: Amends s. 409.9113(3), F.S., relating to Disproportionate Share Program for teaching hospitals.
Section 12: Amends s. 409.9119(4), F.S., relating to Disproportionate Share Program for specialty hospitals for children.
Section 13: Amends s. 409.966, F.S., relating to Eligible Plans.
Section 14: Amends s. 409.977, F.S., relating to Enrollment.
Section 15: Amends s. 409.984, F.S., relating to Enrollment in a long-term care managed care plan.
Section 16: Amends s. 624.91, F.S., relating to Florida Healthy Kids Corporation.
Section 17: Amends s. 945.602, F.S., transferring the CMA from the EOG to the DOH for administrative purposes.
Section 18: Transfers all powers, duties, functions, records, offices, personnel, associated administrative support positions, property, pending issues, existing contracts, administrative authority, and administrative rules relating to the CMA from the EOG to the DOH.
Section 19: Amends s. 409.975(a), F.S., relating to Managed Care Plan Accountability.
Section 20: Amends s 1011.52(2), F.S, relating to appropriations to first accredited medical schools.
Section 21: Provides an effective date of July 1, 2020.

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 $14.67 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.

2. Expenditures:

   In Fiscal Year 2018-2019, $3.99 million in refunds were collected due to the Medicaid 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.

   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 House proposed General Appropriations Act for Fiscal Year 2020-2021 transfers six FTE and $748,674 in recurring General Revenue from the Executive Office of the Governor to the Department of Health to cover operating costs for the Correctional Medical Authority.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

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, 2020.

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 veterans nursing home will retain $130 per month as a personal needs allowance.

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

Medicaid recipients' auto-enrollment to a Medicaid managed care plan will ensure viability of new plans.

D. FISCAL COMMENTS:

The Welfare Transition Trust Fund cash balance at the beginning of Fiscal Year 2015-2016 was $0.00. There have been no receipts nor has the trust fund carried a balance since that time.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

2. Other:

B. RULE-MAKING AUTHORITY:

Correctional Medical Authority: Rule-making authority is transferred to the DOH from the EOG.

C. DRAFTING ISSUES OR OTHER COMMENTS:

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 28, 2020, the Health Care Appropriations Subcommittee adopted two amendments to PCB HCA 20-01. The amendments:

- require essential providers to contract with relevant managed care plans to be eligible to receive supplemental payments, and
- require the agency to ensure its automatic assignment policies do not prevent new plans from reaching the enrollment level they need to be viable and allows AHCA to make temporary automatic assignment changes to ensure new plan viability.

The bill was reported favorably as amended.