HOUSE OF REPRESENTATIVES STAFF ANALYSIS

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

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Care Appropriations Subcommittee	15 Y, 0 N	Nobles	Clark
1) Appropriations Committee		Nobles	Pridgeon

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 2021-2022. The bill:

- 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 Administration's (AHCA) uniform reporting system;
- Defines Florida Nursing Home Uniform Reporting System (FNHURS) and home office;
- Extends postpartum Medicaid eligibility for pregnant women to 12 months;
- 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;
- Provides a methodology to spread the nursing home rate increase across all providers, even if the provider is held to the September 2016 rate;
- Holds the County Health Departments' reimbursement to the level established on July 1, 2011;
- Conforms the Low Income Pool (LIP) program 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 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;
- 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%. These refunds shall be deposited into the General Revenue Fund, unallocated;
- 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, 2021.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED 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 Medicaid under other criteria, the coverage ends 60 days after birth. This program is particularly important for pregnant women and children. It pays for 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 reduce the state's overall maternal mortality rate by 25%, cut the rate for non-Hispanic Black women nearly in 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 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]

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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).

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 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

[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).

them do. Currently, there is no requirement that essential providers receiving supplemental funding contract with managed care plans to serve Medicaid patients.

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 must maintain a minimum medical loss ratio (MLR) of 85% and maximum administrative costs of 15%.

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 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.

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.

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

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 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

This bill amends s. 409.908(2)(b), F.S., to reenact language in Section 47 of the 2020 General Appropriations Act Implementing Bill, Ch. 2020-114, Laws of Florida, that is applicable to nursing homes reimbursed under the prospective payment system and gave those nursing homes a unit cost increase add-on to the greater of the cost-based rate or their prospective payment rate. This unit cost increase was included in the 2020 General Appropriations Act, Ch. 2020-111, Laws of Florida.

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.

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.

B. SECTION DIRECTORY:

Section 1: Amends s. 296.37(1), F.S., relating to personal needs allowances for residents of Veterans Nursing Homes.
Section 2: Reenacts s. 400.179, F.S., relating to nursing home lease bonds.
Section 3: Amends s. 408.061, F.S., relating to reporting audited financial information.
Section 4: Amends s. 408.07, F.S., relating to definitions for Health Care Administration.
Section 5: Amends s. 409.903, F.S., relating to postpartum Medicaid eligibility.
Section 6: Amends s. 409.904, F.S., relating to Medicaid eligibility.
Section 7: Reenacts s. 409.908, F.S., relating to reimbursement of Medicaid providers, prospective payments, the Low Income Pool, supplemental payments, and essential providers.
Section 8: Amends s. 409.975(a), F.S., relating to a technical correction of a statutory cross reference.
Section 9: Reenacts s. 624.91, F.S., relating to Florida Healthy Kids Corporation.
Section 10: Amends s 1011.52(2), F.S, relating to a technical correction of a statutory cross reference.
Section 11: Provides an effective date of July 1, 2021.

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 $18.8 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.

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.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

None.