

**The Florida Senate**  
**COMMITTEE MEETING EXPANDED AGENDA**

**HEALTH POLICY**  
**Senator Bean, Chair**  
**Senator Sobel, Vice Chair**

**MEETING DATE:** Tuesday, February 17, 2015  
**TIME:** 9:00 a.m.—12:00 noon  
**PLACE:** Pat Thomas Committee Room, 412 Knott Building

**MEMBERS:** Senator Bean, Chair; Senator Sobel, Vice Chair; Senators Braynon, Flores, Gaetz, Galvano, Garcia, Grimsley, and Joyner

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	<b>SB 450</b> Benacquisto (Identical H 4017)	Pain Management Clinics; Deleting provisions relating to the future repeal of ss. 458.3265 and 459.0137, F.S., etc.  HP     02/17/2015 Favorable AHS AP	Favorable Yeas 8 Nays 0
2	<b>SB 322</b> Stargel	Medicaid Reimbursement for Hospital Providers; Requiring the Agency for Health Care Administration to provide written notice, pursuant to ch. 120, F.S., to providers of hospital reimbursement rates established by the agency; providing that such notice constitutes final agency action; prohibiting the agency from being compelled by an administrative body or court to pay a monetary judgment relating to the establishment of hospital reimbursement rates beyond a specified date, etc.  HP     02/03/2015 Temporarily Postponed HP     02/17/2015 Favorable FP	Favorable Yeas 8 Nays 0
3	<b>SB 294</b> Garcia	Florida Kidcare Program; Providing eligibility for optional payments for medical assistance and related services for certain lawfully residing children; clarifying that undocumented immigrants are excluded from eligibility for optional Medicaid payments or related services, etc.  HP     02/17/2015 Favorable AHS AP	Favorable Yeas 8 Nays 0

**COMMITTEE MEETING EXPANDED AGENDA**

Health Policy

Tuesday, February 17, 2015, 9:00 a.m.—12:00 noon

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	<b>SB 296</b> Garcia (Identical H 43)	Diabetes Advisory Council; Requiring the council, in conjunction with the Department of Health, the Agency for Health Care Administration, and the Department of Management Services, to develop plans to manage, treat, and prevent diabetes; requiring a report to the Governor and Legislature, etc.  HP 02/17/2015 Fav/CS GO AHS FP	Fav/CS Yeas 8 Nays 0
5	<b>SB 478</b> Bean / Joyner (Compare H 545)	Telemedicine Services; Authorizing an emergency medical technician, a paramedic, or a health care practitioner to provide telemedicine services through the use of certain telecommunications technology to a patient who is a resident of this state; requiring telemedicine services to be covered by specified Medicaid programs in the same manner as services provided to a recipient in person; prohibiting the regulation of telemedicine services from being construed to restrict the delivery of certain emergency medical services, etc.  HP 02/17/2015 Fav/CS AHS AP	Fav/CS Yeas 8 Nays 0
Consideration of proposed bill:			
6	<b>SPB 7032</b>	Public Records/Reports of a Deceased Child; Exempting information held by the State Child Abuse Death Review Committee or a local committee which identifies a deceased child whose death is reported to the central abuse hotline but whose death is not the result of abuse or neglect and the identity of the surviving siblings, family members, or others living in the home of such a deceased child; providing for future legislative review and repeal of the exemption under the Open Government Sunset Review Act; providing a statement of public necessity, etc.	Submitted as Committee Bill Yeas 8 Nays 0
7	<b>Presentation on Florida Physician Workforce</b> by Tim Dall, Managing Director, IHS Global, Inc.		Presented
Other Related Meeting Documents			

**The Florida Senate**  
**BILL ANALYSIS AND FISCAL IMPACT STATEMENT**

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

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Prepared By: The Professional Staff of the Committee on Health Policy

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BILL: SB 450

INTRODUCER: Senator Benacquisto

SUBJECT: Pain Management Clinics

DATE: February 10, 2015

REVISED: \_\_\_\_\_

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall	HP	<b>Favorable</b>
2.			AHS	
3.			AP	

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**I. Summary:**

SB 450 saves the regulation of pain management clinics from repeal on January 1, 2016.

**II. Present Situation:**

**Pain Management Clinics**

A pain management clinic is any facility that either advertises pain management services or where a majority of patients are prescribed opioids, benzodiazepines, barbiturates, or carisoprodol for the treatment of chronic nonmalignant pain.<sup>1</sup> All pain management clinics must register with the Department of Health (DOH) and meet provisions concerning staffing, sanitation, recordkeeping, and quality assurance.<sup>2</sup> Clinics are exempt from these provisions if they are:

- Licensed as a hospital, ambulatory surgical center, or mobile surgical facility;
- Staffed primarily by surgeons;
- Owned by a publicly held corporation with total assets exceeding \$50 million;
- Affiliated with an accredited medical school;
- Not involved in prescribing controlled substances for the treatment of pain;
- Owned by a corporate entity exempt from federal taxation as a charitable organization;
- Wholly owned and operated by board-eligible or board-certified anesthesiologists, psychiatrists, rheumatologists, or neurologists; or

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<sup>1</sup> “Chronic nonmalignant pain” is defined as pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery. See ss. 458.3265 and 459.0137, F.S.

<sup>2</sup> Sections 458.3265 and 459.0137, F.S. Chapter 458, F.S., is the Medical Practice Act, and Chapter 459, F.S., is the Osteopathic Medical Practice Act. The two sections regulating pain management clinics are substantively identical.

- Wholly owned and operated by a physician multispecialty practice with physicians holding credentials in pain medicine and who perform interventional pain procedures routinely billed using surgical codes.

All clinics must be owned by at least one licensed physician or be licensed as a health care clinic under part X of ch. 400, F.S., to be eligible for registration as a pain management clinic. Pain management clinics must also designate a physician who is responsible for complying with all the registration and operation requirements designated in ss. 458.3265 or 459.0137, F.S. A pain management clinic may not be owned by, or have a contractual or employee relationship with, a physician that has had his or her Drug Enforcement Administration (DEA) license number revoked, has had his or her application for a license to practice using controlled substances denied by any jurisdiction, or has had any convictions or pleas for illicit drug felonies within the past 10 years.

The DOH is required to conduct an annual inspection of each pain management clinic. Through the inspection, the DOH ensures the following requirements are met:

- The pain management clinic is registered with the department and the department has been notified of the designated physician;
- Every physician meets the training requirements to practice at the clinic;
- The clinic, including its grounds, buildings, furniture, appliances and equipment is structurally sound, in good repair, clean, and free from health and safety hazards;
- Storage and handling of prescription drugs complies with ss. 499.0121 and 893.07, F.S.;
- Physicians maintain control and security of prescription blanks and other methods for prescribing controlled substances and report in writing any theft or loss of prescription blanks to the DOH within 24 hours;
- Physicians are in compliance with the requirements for counterfeit-resistant prescription blanks; and
- The designated physician reported all adverse incidents to the DOH as set forth in s. 458.351, F.S.<sup>3</sup>

The DOH may suspend or revoke clinic registration or impose administrative fines of up to \$5,000 per violation for any offenses against state pain management clinic provisions or related federal laws and rules. If the registration for a pain management clinic is revoked for any reason, the clinic must cease to operate immediately, remove all signs or symbols identifying the facility as a pain management clinic, and dispose of any medication on the premises. The DOH may impose an administrative fine of up to \$5,000 per day for a clinic that operates without a registration. No owner or operator of a pain management clinic that had its registration revoked may own or operate another pain clinic for 5 years after such revocation.<sup>4</sup>

These provisions expire on January 1, 2016.

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<sup>3</sup> Department of Health, *Senate Bill 450 Analysis*, (on file with the Senate Health Policy Committee).

<sup>4</sup> Section 458.3265, F.S. Similar language is found in s. 459.0137, F.S. Related rules are found in Rules 64B8-9 and 64B15-14, F.A.C.

### **Pain Management Clinic Regulation and Closures between 2010 and 2015**

In 2009, the Florida Legislature enacted ch. 2009-198, L.O.F., which, along with establishing the prescription drug monitoring database, required all pain management clinics to register with the DOH. The DOH began registering pain management clinics on January 1, 2010, and by September 2010, had registered 943 pain management clinics in the state.<sup>5</sup>

In 2010, the Florida Legislature enacted ch. 2010-211, L.O.F., which created ss. 458.3265 and 459.0137, F.S. The Legislature again enhanced regulation of pain management clinics in 2011, with the passage of ch. 2011-141, L.O.F., (CS/HB 7095) which specified requirements for facility and physical operations, infection control, health and safety requirements, quality assurance, and data collection and reporting. This act also added the expiration date for the sections relating to the regulation of pain management clinics.

Since 2010, the DOH has administratively closed a total of 1261 pain management clinics.<sup>6</sup> Also, the total number of pain management clinics registered in Florida has fallen from 941, at the end of Fiscal Year 2010-2011, to 359, as of January 13, 2015.<sup>7</sup>

Currently, registered pain management clinics have improved their policies and procedures to meet the standards set out in ss. 458.3625 and 459.0137, F.S. When conducting the annual inspection of a pain management clinic, the DOH is required to make a reasonable attempt to discuss each violation with the owner or designated physician of the pain management clinic before issuing a formal written notification. The number of pain management clinics passing the inspection the first time has increased from 53 percent in Fiscal Year 2012-2013 to 85 percent in Fiscal Year 2013-2014. This increasing passage rate indicates that clinic owners and physicians are learning from the inspection process.<sup>8</sup>

### **Effectiveness of Prescription Drug Regulations in Florida**

It is likely that the increased regulation of pain management clinics, along with other controlled substance prescribing changes, have had a direct and significant impact in reducing the number of drug overdose deaths in Florida. In 2010, Florida led the nation in diverted prescription drugs which resulted in seven Floridians dying every day as well as the many more additional deaths across the nation.<sup>9</sup> A Centers for Disease Control and Prevention report published on July 4, 2014, documents a 61 percent increase in drug overdose deaths in Florida from 2003 to 2010.<sup>10</sup> Additionally, Florida had become the primary destination for distributors and abusers of diverted

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<sup>5</sup> Supra note 3.

<sup>6</sup> Department of Health, Chart of pain management clinic disciplinary actions from FY 10-11 to January 13, 2015 (on file with the Senate Committee on Health Policy) *Note: this number includes clinics that have voluntarily relinquished their registration or have closed without disciplinary action being taken.*

<sup>7</sup> Id.

<sup>8</sup> Supra note 3.

<sup>9</sup> Office of the Attorney General of Florida, *Pill Mill Initiative* (2012-2015), available at <http://myfloridalegal.com/pages.nsf/Main/AA7AAF5CAA22638D8525791B006A30C8>, (Last visited Feb. 13, 2015)

<sup>10</sup> The Centers for Disease Control and Prevention, *Decline in Drug Overdose Deaths after State Policy Changes — Florida, 2010–2012*, July 4, 2014, available at [http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6326a3.htm?s\\_cid=mm6326a3\\_w#Fig1](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6326a3.htm?s_cid=mm6326a3_w#Fig1) (Last visited Feb. 12, 2015).

prescription drugs through the proliferation of illegitimate pain management clinics known as pill mills.<sup>11</sup>

However, instead of continuing the upward trend of the past seven years, between 2010, when many of the current controlled substance prescribing regulations became effective, and 2012, drug overdose deaths in Florida fell by 16.7 percent. Also, during that time period deaths from prescription drugs declined by 23.2 percent and deaths from oxycodone declined by 52.1 percent.<sup>12</sup> Prescription drug deaths also continued to fall in 2013, when compared with 2012, with 8.3 percent fewer people dying with at least one prescription drug in their system that was identified as the cause of death.<sup>13</sup> Additionally, between 2010 and 2013, the number of doctors in Florida who prescribed high volumes of narcotics fell from a high of 98, to 13 in 2012, and again to 0 in 2013.<sup>14</sup>

### III. Effect of Proposed Changes:

SB 450 strikes the expiration date of January 1, 2016 from the regulation of pain management clinics under the Medical Practice Act in s. 458.3265, F.S., and under the Osteopathic Medical Practice Act in s. 459.0137, F.S.

The provisions in the bill are effective upon becoming law.

### IV. Constitutional Issues:

#### A. Municipality/County Mandates Restrictions:

None.

#### B. Public Records/Open Meetings Issues:

None.

#### C. Trust Funds Restrictions:

None.

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<sup>11</sup> Supra note 9, Pill mills are pain management clinics that serve as a front for drug traffickers and can be identified through characteristics which include: taking only cash, not taking appointments, employing armed guards, keep little to no medical records, performing only grossly inadequate physical examinations, and prescribing large doses of narcotics that exceed the boundaries of acceptable medical care.

<sup>12</sup> Supra note 10.

<sup>13</sup> Florida Department of Law Enforcement, *Medical Examiners Commission 2013 Annual Report*, p. i, published October 2014, available at <http://www.fdle.state.fl.us/Content/getdoc/05c6ff97-00cc-49b2-9ca5-5dacd4539b1a/2013-Annual-Drug-Report.aspx> (Last visited Feb. 13, 2015).

<sup>14</sup> Sabrina Tavernise, *Prescription Overdose Deaths in Florida Plunge After Tougher Measures, Report Says*, THE NEW YORK TIMES, July 1, 2014, available at [http://www.nytimes.com/2014/07/02/health/prescription-drug-deaths-in-florida-plunge-after-tougher-laws.html?\\_r=0](http://www.nytimes.com/2014/07/02/health/prescription-drug-deaths-in-florida-plunge-after-tougher-laws.html?_r=0), (last visited Feb. 12, 2015). Also see supra note 10.

**V. Fiscal Impact Statement:****A. Tax/Fee Issues:**

None.

**B. Private Sector Impact:**

SB 450 continues the current regulation of pain management clinics.

**C. Government Sector Impact:**

SB 450 continues the current regulation of pain management clinics.

**VI. Technical Deficiencies:**

None.

**VII. Related Issues:**

None.

**VIII. Statutes Affected:**

This bill substantially amends the following sections of the Florida Statutes: 458.3265 and 459.0137.

**IX. Additional Information:****A. Committee Substitute – Statement of Changes:**

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

**B. Amendments:**

None.

By Senator Benacquisto

30-00718-15

2015450\_\_

1                                   A bill to be entitled  
2           An act relating to pain management clinics; amending  
3           ss. 458.3265 and 459.0137, F.S.; deleting provisions  
4           relating to the future repeal of those sections;  
5           providing an effective date.  
6  
7   Be It Enacted by the Legislature of the State of Florida:  
8  
9           Section 1. Subsection (6) of section 458.3265, Florida  
10          Statutes, is amended to read:  
11           458.3265 Pain-management clinics.-  
12          ~~(6) EXPIRATION. This section expires January 1, 2016.~~  
13          Section 2. Subsection (6) of section 459.0137, Florida  
14          Statutes, is amended to read:  
15           459.0137 Pain-management clinics.-  
16          ~~(6) EXPIRATION. This section expires January 1, 2016.~~  
17          Section 3. This act shall take effect upon becoming a law.





## THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

### COMMITTEES:

Banking and Insurance, *Chair*  
Appropriations, *Vice Chair*  
Appropriations Subcommittee on Health  
and Human Services  
Education Pre-K-12  
Higher Education  
Judiciary  
Rules

**SENATOR LIZBETH BENACQUISTO**

30th District

### JOINT COMMITTEE:

Joint Legislative Auditing Committee  
Joint Select Committee on Collective Bargaining

January 29th, 2013

The Honorable Aaron Bean  
Senate Health Policy, Chair  
302 Senate Office Building  
404 South Monroe Street  
Tallahassee, FL 32399

**RE: SB450 – Relating to Pain Management Clinics**

Dear Mr. Chair:

Please allow this letter to serve as my respectful request to agenda SB 450, Relating to Pain Management Clinics, for a public hearing at your earliest convenience.

Your kind consideration of this request is greatly appreciated. Please feel free to contact my office for any additional information.

Sincerely,

A handwritten signature in black ink that reads "Lizbeth Benacquisto".

Lizbeth Benacquisto  
Senate District 30

Cc: Sandra Stovall

REPLY TO:

- 2310 First Street, Suite 305, Fort Myers, Florida 33901 (239) 338-2570
- 326 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5030

Senate's Website: [www.flsenate.gov](http://www.flsenate.gov)

**ANDY GARDINER**  
President of the Senate

**GARRETT RICHTER**  
President Pro Tempore

THE FLORIDA SENATE  
**APPEARANCE RECORD**

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/17/15

Meeting Date

450

Bill Number (if applicable)

Topic Pain Management Clinics

Amendment Barcode (if applicable)

Name Sheriff Prummell

Job Title Sheriff of Charlotte County

Address 2617 Mahan Drive

Phone 850-877-2165

Street

Tallahassee FL 32308

City

State

Zip

Email \_\_\_\_\_

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing Florida Sheriffs Association

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

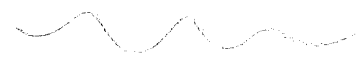
While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE  
**APPEARANCE RECORD**

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)



2/17/15

Meeting Date

450

Bill Number (if applicable)

Topic \_\_\_\_\_

Amendment Barcode (if applicable)

Name Chris Nuland

Job Title \_\_\_\_\_

Address 1000 Riverside Ave

Phone 904-233-3051

Street

Jacksonville, FL 32204

Email nulandlaw@aol.com

City

State

Zip

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing Florida Public Health Association / Florida Chapter, American College of Physicians

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE  
**APPEARANCE RECORD**

WAIVE TIME  
IN SUPPORT

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-17-2015

Meeting Date

Topic PAIN MANAGEMENT CLINICS

Bill Number SB 450  
*(if applicable)*

Name STEPHEN R. WINN

Amendment Barcode \_\_\_\_\_  
*(if applicable)*

Job Title EXECUTIVE DIRECTOR OF THE FOMA

Address 2007 APACHE PARKWAY

Phone 878-7364

Street

TALLAHASSEE

FL

32301

E-mail \_\_\_\_\_

City

State

Zip

Speaking:  For  Against  Information

Representing FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

**This form is part of the public record for this meeting.**

S-001 (10/20/11)

THE FLORIDA SENATE  
**APPEARANCE RECORD**

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-17-2013

Meeting Date

450

Bill Number (if applicable)

Topic Pain Mgt. Clinics

Amendment Barcode (if applicable)

Name Paul Runk

Job Title Deputy Director - Legislative Affairs

Address 2585 Merchants Row Blvd.

Phone 850-245-4006

Street

Tallahassee FL 32399

Email \_\_\_\_\_

City

State

Zip

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing Florida Department of Health

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

**This form is part of the public record for this meeting.**

S-001 (10/14/14)

**The Florida Senate**  
**BILL ANALYSIS AND FISCAL IMPACT STATEMENT**

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

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Prepared By: The Professional Staff of the Committee on Health Policy

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BILL: SB 322

INTRODUCER: Senator Stargel

SUBJECT: Medicaid Reimbursement for Hospital Providers

DATE: February 2, 2015

REVISED: \_\_\_\_\_

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	<b>Favorable</b>
2.			FP	

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**I. Summary:**

SB 322 clarifies reimbursement provisions, provider notification requirements, and the administrative challenge process for Medicaid inpatient and outpatient hospital rates. The bill specifies that the written notice of the hospital reimbursement rates provided by the Agency for Health Care Administration (AHCA or agency) constitutes final agency action for purposes of administrative challenges to the rate. Challenges to the rate are barred if the hospital fails to timely file a petition and include all documentation supporting the challenge in the petition.

The bill also establishes time limitations for rate corrections or adjustments to within the first rate period after either an administrative order or civil judgment is final, but it must occur within five years after the date on which the provider received AHCA's written notice of the reimbursement rate. An administrative body or court may not compel the agency to pay a monetary judgment relating to the hospital reimbursement rates beyond the 5-year timeframe.

These clarifications are deemed remedial in nature and apply retroactively to all proceedings pending or commenced on or after the effective date of this act.

The fiscal impact of the bill is indeterminate; however, should the state not prevail in pending or potential administrative challenges, the state's liability could reach \$30 million.

The bill is effective upon becoming a law.

**II. Present Situation:**

**Florida Medicaid**

Medicaid is a joint federal and state funded program that provides health care for low income Floridians. The program is administered by the AHCA and financed with federal and state funds.

Over 3.7 million Floridians are currently enrolled in Medicaid<sup>1</sup> and its enrollees make up 20 percent of Florida's population.<sup>2</sup> The state statutory authority for the Medicaid program is contained in ch. 409, F.S.

Medicaid's estimated expenditures for Fiscal Year 2014-2015 are over \$23.3 billion.<sup>3</sup> The total budget for the current state fiscal year is over \$24.5 billion with \$14.6 billion of those funds coming from federal sources.<sup>4</sup>

Nationally, Medicare and Medicaid account for 58 percent of all care provided by hospitals.<sup>5</sup> The Florida Hospital Association reports providing more than \$1.4 billion in community benefit to Florida Medicaid and other government programs in 2012.<sup>6</sup>

While hospital participation in Medicaid is voluntary, in order for a hospital receive a federal tax exemption for providing health care to the community, not for profit hospitals are required to care for Medicare and Medicaid beneficiaries.<sup>7</sup>

Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare and Medicaid Services (CMS). The plan outlines current Medicaid eligibility standards, policies, and reimbursement methodologies, including inpatient and outpatient hospital rate charges. Florida's Medicaid state plan and its attachments provide the methodology for the reimbursement of both inpatient and outpatient services.

### ***Hospital Reimbursements for Medicaid***

Prior to July 1, 2013, rates for hospital inpatient and outpatient services under the Florida Medicaid program were set on a facility-specific basis based on each facility's reported costs.<sup>8,9</sup> Outpatient services continue to be facility-specific based on each facility's reported costs. Hospital rates based on reported costs for services provided by the hospital to Medicaid recipients on a fee-for-service basis are an all-inclusive "per diem" rate.

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<sup>1</sup> Agency for Health Care Administration, *Number of Medicaid Eligibles by Age, by Assistance Category as of 12/31/2014 Plus Medikids A, Medikids B, & Medikids C*, [http://ahca.myflorida.com/medicaid/about/pdf/age\\_assistance\\_category\\_2014-12-31.pdf](http://ahca.myflorida.com/medicaid/about/pdf/age_assistance_category_2014-12-31.pdf) (Last visited Jan. 29, 2015).

<sup>2</sup> Agency for Health Care Administration, *Agency for Health Care Administration - An Overview - Presentation to Senate Health and Human Services Appropriations Subcommittee* (January 22, 2015), slide 2, available at <http://edr.state.fl.us/Content/conferences/medicaid/medsummary.pdf> (Last visited Jan. 29, 2015).

<sup>3</sup> Social Services Estimating Conference, *Medicaid Caseloads and Expenditures, June 27, July 22, and August 4, 2014 Executive Summary*, <http://edr.state.fl.us/Content/conferences/medicaid/medsummary.pdf> (Last visited Jan. 29, 2015).

<sup>4</sup> Agency for Health Care Administration, *see supra* note 2, at slide 3.

<sup>5</sup> American Hospital Association, *Underpayment by Medicare and Medicaid Fact Sheet-2015*, <http://www.aha.org/content/15/medicaremedicaidunderpmt.pdf> (last visited Jan. 28, 2015).

<sup>6</sup> Florida Hospital Association, *2014 Florida Hospitals' Community Benefit Report*, p. 4, available at <http://www.fha.org/> (Last visited Jan. 28, 2015).

<sup>7</sup> American Hospital Association, *see supra* note 5.

<sup>8</sup> Agency for Health Care Administration, *Senate Bill 322 Analysis* (January 28, 2015) (on file with Senate Health Policy Committee).

<sup>9</sup> Beginning July 1, 2013, the agency began paying Medicaid inpatient hospital fee-for-service claims under the Diagnosis Related Groups (DRG) method. Under Statewide Medicaid Managed Care, hospitals providing services to Medicaid managed care enrollees are paid by managed care plans typically in accordance with negotiated rates.

The hospital cost report<sup>10</sup> details costs for the entire year and includes any appropriate adjustments as required by the state's adopted *Medicaid Hospital Outpatient or Inpatient Reimbursement Plans* for allowable costs.<sup>11, 12</sup> Both inpatient and outpatient hospital rate reimbursement plans are promulgated as rules under the Florida Administrative Procedures Act and are made available for public comment and inspection.<sup>13</sup>

Hospitals participating in the Medicaid program submitted cost reports to the agency for both inpatient and outpatient services twice a year (July and January) and then just once a year beginning in 2011. These reports are now due no later than five calendar months after the close of the hospital's cost-reporting year.<sup>14,15,16</sup> The AHCA must retain all cost reports for at least 5 years following the date of submission pursuant to the record keeping requirements of 45 CFR 205.60.

Hospitals were notified of their "per diem" rates via letters sent from the AHCA. As amended or updated cost reports were submitted by hospitals, rates were adjusted to reflect the updated reported cost, if applicable. However, hospital rates, once set, are only adjusted under limited circumstances. Those circumstances are:<sup>17</sup>

- The fiscal intermediary<sup>18</sup> or AHCA made an error in the calculation.
- A hospital submits an amended cost report within three years of the initial rate's effective date and the change is material.
- Desk or field audits of the cost reports disclose material changes in the reports.<sup>19,20</sup>
  - For cost reports received on or after October 1, 2003, all desk or onsite audits of these cost reports are final and may not be reopened past three years of the date that the audit adjustments are noticed through a revised per diem rate completed by the agency.
  - Effective October 1, 2013, for cost reports received prior to October 1, 2003, all desk or onsite audits of these cost reports are final and not subject to reopening.

These limitations do not apply when Medicare audit re-openings result in the issuance of revised Medicaid cost report schedules. Also, a cost report may be reopened for inspection, correction, or referral to a law enforcement agency at any time by the agency

<sup>10</sup> The cost report forms are established by the federal CMS. See 42 U.S.C.s. 1396a(6) (2012).

<sup>11</sup> Fla. Admin. Code R. 59G-6.030, *infra*, Note 14, Section I, Paragraph C.

<sup>12</sup> Fla. Admin. Code R. 59G-6.020, *infra* note 15, Section I, Paragraph N.

<sup>13</sup> Fla. Admin. Code R. 59G-6.020, *infra* note 15, Section V, Paragraph B(7).

<sup>14</sup> Fla. Admin. Code R. 59G-6.030, *Florida Title XIX Outpatient Hospital Reimbursement Plan, Version XL*, (Effective July 1, 2013) Section I, Paragraph A (Attachment 4.19-B, Part I)

[http://ahca.myflorida.com/Medicaid/cost\\_reim/pdf/Florida\\_Title\\_XIX\\_Hospital\\_Outpatient\\_Plan\\_Version\\_v24.pdf](http://ahca.myflorida.com/Medicaid/cost_reim/pdf/Florida_Title_XIX_Hospital_Outpatient_Plan_Version_v24.pdf) (Last visited Jan. 30, 2015).

<sup>15</sup> Fla. Admin. Code R. 59G-6.020, *Florida Title XIX Inpatient Hospital Reimbursement Plan, Version XXIV* (Effective July 1, 2013) <https://www.flrules.org/gateway/reference.asp?No=Ref-04814> Section I, Paragraph A (Attachment 4.19-A, Part I) (Last visited Jan. 30, 2015).

<sup>16</sup> A hospital filing a certified cost report audited by independent auditors may receive a 30-day extension.

<sup>17</sup> Fla. Admin. Code R. 59G-6.030, *supra* note 14, Section IV, Paragraph G.

<sup>18</sup> The Agency has entered into written agreements with Medicare intermediaries to conduct common hospital cost report audits. These audits are conducted on hospitals located in Florida, Georgia, and Alabama which participate in various federal programs.

<sup>19</sup> Fla. Admin. Code R. 59G-6.020, *supra* note 15, Section I, Paragraph J.

<sup>20</sup> Fla. Admin. Code R. 59G-6.030, *supra* note 14, Section I, Paragraph K.



or its contractor if program payments appear to have been obtained by fraud, similar fault, or abuse.

- The charge structure of a hospital changes.

The *Medicaid Hospital Outpatient Plan* and the *Inpatient Reimbursement Plan* each include a provision for challenging any rate adjustment or denial of a rate adjustment by the AHCA under Rule 28-106 of the Florida Administrative Code and s. 120.57, F.S.

Beginning July 1, 2013, the agency implemented a new prospective payment methodology that uses Diagnosis Related Groups (DRG) for Medicaid inpatient hospital fee-for-service claims. Under this reimbursement methodology, hospital inpatient per diem reimbursement rates are not noticed, except for the state mental health hospitals which will continue to be paid based on a per diem methodology.<sup>21</sup> DRG payments are based on the classification of inpatient stays and then a determination of price based on a combination of the classification and the hospital where the services were performed.<sup>22</sup> Classification of the hospital stay is based on the diagnoses describing the patient's condition, the surgical procedures performed, if any, patient age, and discharge status.<sup>23</sup> These payments are generally fixed based on the DRG assignment, rather than a unique rate per hospital.

### **Legislation Limiting Hospital Reimbursement Rate Adjustments**

In 2011, the Legislature amended s. 409.905(5), F.S., relating to hospital inpatient services with, among other provisions, the following new language:

Errors in cost reporting or calculation of rates discovered after September 30 must be reconciled in a subsequent rate period. The agency may not make any adjustment to a hospital's reimbursement rate more than 5 years after a hospital is notified of an audited rate established by the agency. The requirement that the agency may not make any adjustment to a hospital's reimbursement rate more than 5 years after a hospital is notified of an audited rate established by the agency is remedial and shall apply to actions by providers involving Medicaid claims for hospital services.<sup>24</sup>

In 2012, the Legislature again amended s. 409.905(5), F.S., and republished the above language changing the September 30 date to October 31 along with a technical, grammatical modification.<sup>25</sup>

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<sup>21</sup> Agency for Health Care Administration, *Hospital Rates*, [http://ahca.myflorida.com/Medicaid/cost\\_reim/hospital\\_rates.shtml](http://ahca.myflorida.com/Medicaid/cost_reim/hospital_rates.shtml) (Last visited Jan. 29, 2015).

<sup>22</sup> Navigant, *DRG Conversion Implementation Plan - Final* (December 21, 2012)

[http://ahca.myflorida.com/medicaid/cost\\_reim/pdf/DRG\\_Payment-Conversion\\_Implementation\\_Plan-FL\\_AHCA-Final.pdf](http://ahca.myflorida.com/medicaid/cost_reim/pdf/DRG_Payment-Conversion_Implementation_Plan-FL_AHCA-Final.pdf) (Last visited Jan. 29, 2015).

<sup>23</sup> *Id.*

<sup>24</sup> Ch. 2011-135, s. 9, Laws of Fla.

<sup>25</sup> Ch. 2012-33, s. 5, Laws of Fla.

Then in 2013, the Legislature amended s. 409.905(5), F.S., again modifying the provision somewhat and amended subsection (6) relating to hospital outpatient services, with identical new language. Those two subsections now provide:

Errors in source data or calculations discovered after October 31 must be reconciled in a subsequent rate period. However, the agency may not make any adjustment to a hospital's reimbursement more than 5 years after a hospital is notified of an audited rate established by the agency. The prohibition against adjustments more than 5 years after notification is remedial and applies to actions by providers involving Medicaid claims for hospital services.<sup>26</sup>

### **Administrative Challenges**

Under current law, hospital providers are bringing administrative challenges to fee-for-service, per diem hospital rates regardless of the time passed since the initial rate setting period. Currently, the AHCA is involved in several challenges to hospital rates set under the old, per diem methodology. Some of these challenges involve rates initially set as far back as the 1990's, and even the 1980's.<sup>27</sup> In addition to the costs of litigation, given the passage of time for some of these challenges and the expedited timeframe for administrative hearings, the AHCA may not have all the documentation readily available that is necessary to support and defend the rates challenged.

### **III. Effect of Proposed Changes:**

SB 322 amends s. 409.908, F.S., to clarify provider notification requirements and the administrative challenge process for Medicaid inpatient and outpatient fee-for-service hospital rates by placing clear limits on the time within which hospital reimbursement rates may be challenged, procedural steps for challenging those rates, and time frames for final disposition.

Although the agency has historically provided written notice of the reimbursement rates, the bill requires such notice and specifies the notice is final agency action in order to set the point of entry for an administrative challenge under the Florida Administrative Procedures Act. As a result, the agency may re-notice historical rates in accordance with this bill to start the 21-day clock in order to put an end to the perceived open-ended period for challenging rates.

The bill further provides:

- Any administrative challenge must be filed within 21 days after receipt of the written notice along with all documentation upon which the provider intends to rely, otherwise the hospital reimbursement rate is deemed conclusively accepted by the provider.
- Any correction or adjustment of a hospital reimbursement rate resulting from the challenge must be reconciled in the first rate period after the order or judgment becomes final but within 5 years after the provider received the written notice of the rate.

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<sup>26</sup> Ch. 2013-48, s. 3, Laws of Fla.

<sup>27</sup> Agency for Health Care Administration, *see supra* note 8.

- Neither an administrative body nor court may compel the agency to pay a monetary judgment relating to hospital reimbursement rates more than 5 years after the date on which the provider received written notice.
- The periods of time set out in this bill are not tolled by the pendency of any administrative or civil proceeding.
- These clarifications are deemed remedial in nature and apply retroactively to all proceedings pending or commenced upon the act becoming law.

Other sections of related Medicaid and Kidcare statutes, ss. 383.18, 409.8132(4), 409.905(5)(c), and (6)(b), and 409.91211(3)(y), F.S., are reenacted for the purpose of incorporating the amendment made by SB 322.

The bill takes effect upon becoming law.

#### **IV. Constitutional Issues:**

##### A. Municipality/County Mandates Restrictions:

None.

##### B. Public Records/Open Meetings Issues:

None.

##### C. Trust Funds Restrictions:

None.

#### **V. Fiscal Impact Statement:**

##### A. Tax/Fee Issues:

None.

##### B. Private Sector Impact:

Specific timelines for filing challenges and addressing corrections or adjustments will establish finality in hospital reimbursements. The bill could affect the ability of privately owned hospitals to seek increased retroactive rate enhancements. Several administrative challenges are currently pending. The results of those petitions is unknown. Private hospitals will have 21 days from re-notice under this bill to file petitions. The fiscal impact of any subsequent challenges is indeterminate at this time according to the AHCA's analysis.<sup>28</sup>

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<sup>28</sup> Agency for Health Care Administration, *see supra* note 8.

**C. Government Sector Impact:**

As with the private sector impact, specific timelines for filing challenges and addressing corrections or adjustments will establish finality in hospital reimbursements. The bill could affect the ability of public hospitals to seek increased retroactive rate enhancements. Several administrative challenges are currently pending. The results of those petitions is unknown. Should the state not prevail in the pending challenges, the state's liability could reach \$30 million.<sup>29</sup> Public hospitals will have 21 days from re-notice under this bill to file petitions. The fiscal impact of any subsequent challenges is indeterminate at this time.

**VI. Technical Deficiencies:**

None.

**VII. Related Issues:**

None.

**VIII. Statutes Affected:**

This bill substantially amends sections 409.908, 383.18, 409.8132, 409.905, and 409.91211 of the Florida Statutes.

**IX. Additional Information:****A. Committee Substitute – Statement of Changes:**

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

**B. Amendments:**

None.

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This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

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<sup>29</sup> Agency for Health Care Administration, *see supra* note 8.

By Senator Stargel

15-01026-15

2015322\_\_

A bill to be entitled

An act relating to Medicaid reimbursement for hospital providers; amending s. 409.908, F.S.; requiring the Agency for Health Care Administration to provide written notice, pursuant to ch. 120, F.S., to providers of hospital reimbursement rates established by the agency; providing that such notice constitutes final agency action; specifying procedures and requirements for a substantially affected provider to challenge the final agency action; providing that the failure to timely file a petition in compliance with the requirements is deemed conclusive acceptance of the reimbursement rates; specifying when a correction or adjustment of a hospital reimbursement rate required by an administrative order or civil judgment may occur; prohibiting the agency from being compelled by an administrative body or court to pay a monetary judgment relating to the establishment of hospital reimbursement rates beyond a specified date; prohibiting specified periods of time from being tolled under certain circumstances; reenacting ss. 383.18, 409.8132(4), 409.905(5)(c) and (6)(b), and 409.91211(3)(y), F.S., to incorporate the amendment made to s. 409.908, F.S., in references thereto; providing that the act is remedial and intended to clarify existing law; providing for retroactive application; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

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**CODING:** Words ~~stricken~~ are deletions; words underlined are additions.

15-01026-15

2015322\_\_

Section 1. Paragraph (e) is added to subsection (1) of section 409.908, Florida Statutes, to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions

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**CODING:** Words ~~stricken~~ are deletions; words underlined are additions.

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59 provided for in the General Appropriations Act, provided the  
60 adjustment is consistent with legislative intent.

61 (1) Reimbursement to hospitals licensed under part I of  
62 chapter 395 must be made prospectively or on the basis of  
63 negotiation.

64 (e)1. Pursuant to chapter 120, the agency shall furnish to  
65 providers written notice of the hospital reimbursement rates  
66 established by the agency. The written notice constitutes final  
67 agency action. A substantially affected provider may request an  
68 administrative hearing to challenge the final agency action by  
69 filing a petition with the agency within 21 days after receipt  
70 of the written notice. The petition must include all  
71 documentation supporting the challenge upon which the provider  
72 intends to rely at the administrative hearing or in any  
73 subsequent civil action. The failure to timely file a petition  
74 in compliance with this subparagraph is deemed conclusive  
75 acceptance of the hospital reimbursement rates established by  
76 the agency.

77 2. A correction or adjustment of a hospital reimbursement  
78 rate that is required by an administrative order or civil  
79 judgment shall be reconciled in the first rate period after the  
80 order or judgment becomes final; however, such reconciliation  
81 may not occur more than 5 years after the date on which the  
82 provider received written notice under subparagraph 1.

83 3. The agency may not be compelled by an administrative  
84 body or court to pay a monetary judgment relating to the  
85 establishment of hospital reimbursement rates by the agency more  
86 than 5 years after the date on which the provider received  
87 written notice under subparagraph 1.

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88 4. The periods of time specified in this paragraph are not  
89 tolled by the pendency of an administrative or civil proceeding.

90 Section 2. Section 383.18, subsection (4) of s. 409.8132,  
91 paragraph (c) of subsection (5) and paragraph (b) of subsection  
92 (6) of s. 409.905, and paragraph (y) of subsection (3) of s.  
93 409.91211, Florida Statutes, are reenacted for the purpose of  
94 incorporating the amendment made by this act to s. 409.908,  
95 Florida Statutes, in references thereto.

96 Section 3. The amendment made by this act to s. 409.908,  
97 Florida Statutes, is remedial in nature, is intended to clarify  
98 existing law, and applies retroactively to all proceedings  
99 pending or commenced on or after the date on which this act  
100 takes effect.

101 Section 4. This act shall take effect upon becoming a law.

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**CODING:** Words ~~stricken~~ are deletions; words underlined are additions.

**Florida Medicaid Hospital Inpatient Cost Based Per Diem  
Rate Setting and Audit Process and Timeline**

**Background:**

Under the Medicaid program, rates for some institutional providers are set on a facility specific basis, based on each facility's reported costs.

For these providers, rates are established as all inclusive, "per diem" rates, based on reported costs for services provided to Medicaid recipients on a fee-for-services basis.

Cost reports are prepared in accordance with the method of reimbursement and cost finding under the Medicare program and are subject to audit.

Limitations for what is considered allowable costs for the purpose of rate setting are defined in the federal Centers for Medicare and Medicaid Services (CMS) Publication 15-1 (Provider Reimbursement Manual) and the Florida Title XIX Reimbursement Plans.

Hospitals participating in the Florida Medicaid program were paid a cost-based per diem rate for inpatient hospital services until the implementation of the DRG implementation methodology on July 1, 2013.

Audits are still ongoing for hospital inpatient rates that were set prior to the July 1, 2013 transition to DRGs.

**Hospital Inpatient Cost Report Audit and Retroactive Rate Adjustment Process:**

The Florida Medicaid program contracts with a vendor, Myers and Stauffer, to conduct audits on cost reports submitted to the Agency for the purpose of hospital rate setting.

- Myers and Stauffer is tasked with performing compliance examinations on Medicaid hospital cost reports in accordance with standards established by the American Institute of Certified Public Accountants, the Florida Administrative Code and Florida Statutes to ensure that providers participating in the Medicaid program are conforming to cost reporting requirements according to the Title XIX Inpatient and Outpatient Hospital Reimbursement Plans and the Centers for Medicare and Medicaid Services publication 15-1.
- Myers and Stauffer is tasked with assuring that Medicaid hospital rates are based on allowable and supportable cost and for using the results of their examinations to appropriately change Medicaid rates and identify over/under payments to providers.

Hospitals are required to file cost reports with the Agency within 5 months after the providers fiscal year end. The Agency does not dictate the facilities fiscal year, rather the fiscal year is determined by each individual hospital.

**Florida Medicaid Hospital Inpatient Cost Based Per Diem  
Rate Setting and Audit Process and Timeline**

Process:

1. Each hospital submits an unaudited (referred to as “as-filed”) cost report simultaneously with the Agency and with Myers and Stauffer.
2. The Agency establishes the per diem reimbursement rate for the facility, for the subsequent rate period, based on the as-filed cost report.
3. Myers and Stauffer processes, once Medicare has completed their audit process, the as-filed cost report and completes the audit.
4. The audited cost report is submitted to the Agency for retroactive rate processing upon completion of the audit by Myers and Stauffer.
  - Audited cost reports are processed on a first in, first out basis.
  - Upon receipt of the audited cost report from Myers and Stauffer:
    - An analysis is done per provider to determine if all audits for prior rate semesters have been received prior to processing to ensure that rate targets can be applied correctly for the retroactive rate adjustment.
    - A review is conducted for completeness and accuracy of the audit report, including review for errors and/or missing information.
    - Profiling of the audit occurs: Data is extracted from the audit for entrance into the hospital rate setting program.
5. The retroactive rate processing is completed based on the audited cost report:
  - Adjustment of the rates pursuant to the audit is completed and adjusted rates are issued to the Medicaid fiscal agent (HP) for retro processing. In addition, the rates are mailed to the hospital.
6. If the cost report submission is complete and the audit is without errors or omissions, the rate setting and audit process should be finalized within 1 year of submission of the initial as-is cost report. However final audits and the resulting retroactive adjustment of rates can be delayed significantly due to several factors:
  - Complexity of Audit: Based on the complexity of the audit work it can take up to 3 years for the vendor (Myers and Stauffer) to complete their audit.
  - Availability of Contracted Services Funds: The vendor contract, and the number of audits that the vendor is able to complete each year, is impacted by the available budget. The annual contract amount determined how many audits the vendor can complete each year.
  - Re-opening of audits: Currently, the approved Title XIX (Medicaid) Hospital Inpatient Reimbursement plan, as approved by federal CMS and incorporated into the Florida Medicaid State Plan and Florida Administrative Code Rule, includes provisions which allow for hospitals to request that a cost report audit be re-opened.
    - Specifically, for any cost report received on or after October 1, 2003, audits can be re-opened for 3 years after the date that the audit adjustments were noticed through a revised per diem rate completed by the Agency.



**Florida Medicaid Hospital Inpatient Cost Based Per Diem  
Rate Setting and Audit Process and Timeline**

- Effective October 31, 2013, for cost reports received prior to October 1, 2003, all desk or onsite audits of these cost reports were considered final and not subject to reopening. (Note: These audits can be reopened if a Medicare audit is reopened or if the Agency believes that payments appear to have been obtained by fraud, similar fault, or abuse). Under Medicare policy, a hospital has a 3-year time limit to contest the audit findings and ask for a reopening.
- If a reopening is requested and granted, the process starts over for the amended/revised audit.
- On more than one occasion the Agency has completed all sequential audits for a facility and are on the verge of retroactively adjusting the rate when the provider request numerous reopening's for audit years in the sequence. When this occurs, the facility will request that the retroactive adjustments be pended until the re-opening is completed.
- The ability for facilities to re-open completed audits results in the Agency processing the same cost report year/ rate setting multiple times and can impact the processing of related audits for the same facility which must be place on hold to ensure that the application of targets, exemptions and IGT's is appropriate.
- Backlog: The Agency and the industry currently have a backlog of audits that have been completed by the vendor and are pending Agency review and/or the calculation of retroactive rates based on the audits.
  - Providers that are not exempt must have all audits completed in sequential order. If all audits for prior rate semesters have not been received this will delay the retroactive rate adjustment, and contribute to a backlog.
  - If the audit received from the vendor is found to have errors and/or be missing information, this will delay the retroactive rate adjustment, and contribute to a backlog.
  - If a provider requests that their audit be re-opened, this can result in numerous reopening's for a particular FYE and can delay all previous and future audits from being completed by the Agency, contributing to a backlog.
  - A backlog of audits left from prior contactor, First Coast Service Options.
- Program Issues:
  - The current hospital rate setting program utilized for the actual calculation of the hospital inpatient/outpatient rates was built in the early 1990's and is not supported by Microsoft or our Agency's IT department at this time. The Agency is in the process of rebuilding this program to be more efficient and run smoothly with an anticipated completion date of July 2015.
  - Under the current program we have experienced errors such as deletions, target issues, and system crashes that have resulted in the need for data restores and data compaction done several times daily to ensure the program runs smoothly. The rebuilding will allow the new program to work under the current Microsoft

**Florida Medicaid Hospital Inpatient Cost Based Per Diem  
Rate Setting and Audit Process and Timeline**

platform. Both the Nursing Home and ICF rate setting programs have been rebuilt and the rate setting process is much more efficient.

- These program issues have contributed to the delay of final audit results being processed and retroactive rate adjustments from occurring.

**Additional Information:**

Cost Report Audits In Progress with Vendor (Myers and Stauffer) (Not including re-opened audits) as of February 11, 2015.

	2009	2010	2011	2012	2013	2014
<i>Net Workload</i>	44	151	208	154	146	
<i>NPRs received from providers excluded from above workload</i>	38	6	1	0	N/A	N/A
<i>Review letters received from providers but instructed to leave on workload</i>	3	0	0	0	N/A	N/A
<i>Total Cost Reports for Acceptability</i>					227	232
<i>Received</i>	40	141	199	148	221	61
<i>Complete Packages</i>	28	100	145	110	169	36
<i>Missing Items</i>	12	41	55	38	52	25
<i>Not Submitted-Based on Workload</i>	4	10	9	6	4	

Re-Opened Audits In Progress with Vendor (Myers and Stauffer)

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
<i>Net Workload</i>	4	1	2	3	3	0	2	0	3	3	3
<i>Received</i>	4	1	2	3	3	0	2	0	3	3	3
<i>Waiting on Info from Providers/Missing Items</i>	3	1	2	3	3	0	1	0	3	3	3
<i>Complete Packages (Final)</i>	1	0	0	0	0	0	1	0	0	0	0

THE FLORIDA SENATE  
**APPEARANCE RECORD**

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/17/15  
Meeting Date

SB 322  
Bill Number (if applicable)

2

Topic STATE of limitation

Amendment Barcode (if applicable)

Name TONY CARVALHO

Job Title PRESIDENT SAFETY NET Hosp Assoc

Address 101 N. GARDEN

Phone 850 201-2096

Street

Wallohassoe, FL

32301

Email TONY@SNHAF.NET

City

State

Zip

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing Safety Net Hospital Association of FL

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

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**THE FLORIDA SENATE**  
**APPEARANCE RECORD**

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/17/18  
Meeting Date

SB 322  
Bill Number (if applicable)

Topic SB 322 - Hospital Reimbursement

Amendment Barcode (if applicable)

Name Justin Senior

Job Title Medicaid Director

Address 2727 Manan Dr.  
Street

Phone 850-412-3626

Talahassee FL 32308  
City State Zip

Email \_\_\_\_\_

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing Agency for Health Care Admin

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

**This form is part of the public record for this meeting.**



Medicaid and the program's estimated expenditures for the 2014-2015 fiscal year are \$23.3 billion.<sup>1</sup>

Eligibility for the Medicaid program is based on a number of factors, including age, household or individual income, and assets. State Medicaid eligibility payment guidelines are provided in statute under s. 409.903, F.S., (Mandatory Payments for Eligible Persons) and s. 409.904, F.S., (Optional Payments for Eligible Persons). Minimum coverage thresholds are established in federal law for certain population groups, such as children.

### **Florida Kidcare Program**

The Florida Kidcare Program (the program) was created in 1998 by the Florida Legislature in response to the federal enactment of the Children's Health Insurance Program (CHIP) in 1997.<sup>2</sup> Initially authorized for 10 years and then re-authorized<sup>3</sup> through 2019 with federal funding through September 30, 2015, CHIP provides subsidized health insurance coverage to uninsured children who do not qualify for Medicaid but who have family incomes under 200 percent of the federal poverty level (FPL) and meet other eligibility criteria.

Federal funding for CHIP has not been authorized beyond September 30, 2015. As of February 12, 2015, no separate federal legislation extending funding has been filed; however, Senator Sherrod Brown (D-Ohio) introduced an amendment during a January U.S. Senate committee markup to H.R. 22, *Hire More Heroes Act of 2015*, that would extend funding through federal fiscal year 2019.<sup>4</sup> Senator Brown has announced intentions to also file a separate CHIP extension bill.<sup>5</sup>

The state statutory authority for the program is found under part II of ch. 409, ss. 409.810 through 409.821, F.S. The program includes four operating components: Medicaid for children, Medikids, the Children's Medical Services Network, and the Florida Healthy Kids Corporation (FHKC). The following chart illustrates the different program components and funding sources:<sup>6</sup>

<sup>1</sup> Office of Economic and Demographic Research, *Social Services Estimating Conference Medicaid Caseloads and Expenditures, June 27, July 22, and August 4, 2014 Executive Summary*

<http://edr.state.fl.us/Content/conferences/medicaid/medsummary.pdf> (last visited Feb. 4, 2015).

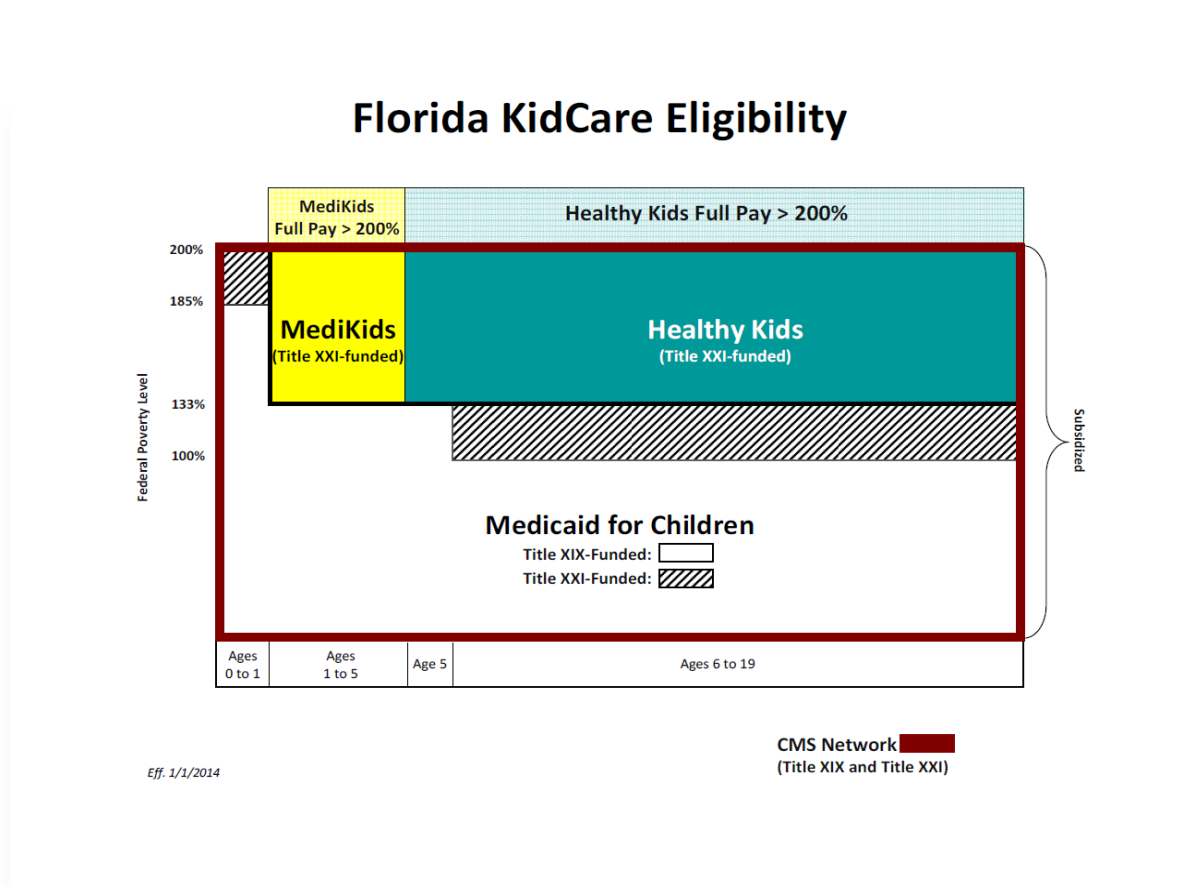
<sup>2</sup> Social Security Administration, *Title XXI - State Children's Health Insurance Program*, [http://www.ssa.gov/OP\\_Home/ssact/title21/2100.htm](http://www.ssa.gov/OP_Home/ssact/title21/2100.htm) (last visited Jan. 15, 2015).

<sup>3</sup> Children's Health Insurance Re-Authorization Act of 2009, Pub. Law 2009-3, <http://www.gpo.gov/fdsys/pkg/PLAW-111publ3/pdf/PLAW-111publ3.pdf> (last visited Jan. 15, 2015).

<sup>4</sup> U.S. Senate Finance Committee, Amendment List to H.R. 22: The Hire More Heroes Act of 2015, <http://www.finance.senate.gov/imo/media/doc/Amendments%20to%20H.R.%2022.pdf> (last visited Feb. 12, 2015).

<sup>5</sup> Mollie Warner, *Senator Hopes to Extend CHIP Funding*, TIMESLEADER ONLINE.COM, Jan. 29, 2015, [http://www.timesleaderonline.com/page/content\\_detail/id/570566.html](http://www.timesleaderonline.com/page/content_detail/id/570566.html) (last visited Feb. 12, 2015).

<sup>6</sup> Department of Health - Florida Kidcare, *Florida Kidcare Eligibility Chart*, <http://www.floridahealth.gov/AlternateSites/KidCare/images/data/2014KidCareFlag.pdf> (last visited Jan. 15, 2015).



Coverage for the non-Medicaid program components are funded through Title XXI of the federal Social Security Act. Title XIX of the Social Security Act (Medicaid), state funds and family contributions also provide funding for the different components. Family contributions under the Title XXI component are based on family size, household incomes, and other eligibility factors. Families above the income limits for premium assistance or who are not otherwise eligible for premium assistance are offered the opportunity to participate in the program at a non-subsidized rate (full pay). Currently, the income limit for premium assistance is 200 percent of the FPL.

Several state agencies and the FHKC share responsibilities for the program. The Agency for Health Care Administration (AHCA), the Department of Children and Families (DCF), the Department of Health (DOH), and the FHKC have specific duties under Kidcare as detailed in part II of ch. 409, F.S. The DCF determines eligibility for Medicaid. The FHKC receives all Kidcare applications and screens for Medicaid eligibility and determines eligibility for all Title XXI programs, referring applications to the DCF, as appropriate, for a complete Medicaid determination.

To enroll in Kidcare, families may apply online or use a paper application that determines health care coverage eligibility for multiple programs, including Medicaid and a CHIP, for the entire family. Applications are available in English, Spanish, and Creole. Eligibility for premium assistance is determined first through electronic data matches with available databases or, in

cases where income cannot be verified electronically, through submission of current pay stubs, tax returns, or W-2 forms.

The 2014-2015 General Appropriations Act appropriated \$493,561,069 for the Title XXI (CHIP) components.<sup>7</sup> As of January 1, 2015 a total of 2,263,369 children enrolled in Kidcare.<sup>8</sup>

<b>PROGRAM</b>	<b>ENROLLMENT</b>
Medicaid - Title XIX funded	1,936,397
Medicaid - Title XXI funded	107,646
Healthy Kids - Total	180,791
Children’s Medical Services Network	14,641
Medikids	29,099
<b>Total Florida Kidcare Enrollment:</b>	<b>2,263,369</b>

Under s. 409.814, F.S., the program’s eligibility guidelines are described in conformity with current Title XIX and Title XXI terminology and requirements for each funding component. A child who is an alien, but does not meet the definition of a qualified alien in the United States, is specifically excluded from eligibility from Title XXI premium assistance.

**Eligibility of Alien Children for Medicaid and the CHIP**

The Immigration and Nationality Act (INA) was created in 1952 to consolidate a variety of statutes governing immigration law. The INA has been amended numerous times since 1952. The INA defines the term “alien” as “any person not a citizen or national of the United States.”<sup>9</sup> Nationals of the United States are citizens of the United States, or persons who, though not a citizen of the United States, owe permanent allegiance to the United States.<sup>10</sup>

Generally, under the INA, an alien is not eligible for any state or local public benefit, including health benefits, unless the alien is:<sup>11</sup>

- A qualified alien;<sup>12</sup>
- A nonimmigrant alien;<sup>13</sup> or,
- An alien who is paroled into the United States under the INA.<sup>14</sup>

There are limited exceptions to the ineligibility for public benefits for treatment of emergency medical conditions, emergency disaster relief, immunizations, and services such as soup kitchens, crisis counseling and intervention, and short term shelter.<sup>15</sup>

<sup>7</sup> 2014-2015 General Appropriation Act, ch 2014-51, ss. 174-179, Laws of Fla.

<sup>8</sup> Agency for Health Care Administration, *Florida Kidcare Enrollment Report - January 2015*, (on file with the Senate Committee on Health Policy).

<sup>9</sup> See 8 U.S.C. s. 1101(a)(3).

<sup>10</sup> See 8 U.S.C. s. 1101(a)(21) and (22).

<sup>11</sup> See 8 U.S.C. s. 1621(a).

<sup>12</sup> See 8 U.S.C. s.1641(b) and (c). There are nine classes of qualified aliens.

<sup>13</sup> See 8 U.S.C. s. 1101(a)(15). There are 22 classes of nonimmigrant aliens identified in this section.

<sup>14</sup> See 8. U.S.C. s. 1182(d)(5).

<sup>15</sup> See 8 U.S.C. s. 1621(b).



The INA gives states the authority to provide that an alien who is not lawfully present in the United States is eligible for any state or local public benefit for which the alien would otherwise be eligible, but only through the enactment of a state law which affirmatively provides for such eligibility.<sup>16</sup>

The enactment of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (Public Law 104-193), placed limitations on federal funding for health care of immigrant families. The law imposed a 5-year waiting period on certain groups of qualified aliens, including most children and pregnant women who were otherwise eligible for Medicaid.<sup>17</sup> Medicaid coverage for individuals subject to the 5-year waiting period and for those who do not meet the definition of qualified alien was limited to treatment of an emergency medical condition. The 5-year waiting period also applies to children and pregnant women under the CHIP. The PRWORA did not affect eligibility of undocumented aliens and these individuals remain ineligible for services, except for emergency services under Medicaid.

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (Public Law 111-3), permits states to cover certain children and pregnant women who are "lawfully residing in the United States" in both Medicaid and CHIP, notwithstanding certain provisions under PRWORA. States may elect to cover these groups under Medicaid only or under both Medicaid and CHIP. The law does not permit states to cover these new groups only in CHIP, without also extending the option to Medicaid children.<sup>18</sup>

Prior to the enactment of the CHIPRA provisions, the term "lawfully residing" had not been used to define eligibility for either Medicaid or CHIP; however, the term has been used by the United States Department of Agriculture (USDA) and the Social Security Administration (SSA). The federal Centers for Medicare and Medicaid Services utilized existing regulations from these agencies to define a lawful presence for Medicaid and CHIP through a July 1, 2010 "Dear State Health Official" letter.<sup>19</sup> The letter states that children and pregnant women who fall into one of the following categories will be considered "lawfully present." These individuals are eligible for Medicaid and CHIP, if the state elects the option under CHIPRA, and the child or pregnant woman meets the state residency requirements and other Medicaid or CHIP eligibility requirements.

- A qualified alien as defined in section 431 of PRWORA;
- An alien in non-immigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;
- An alien who has been paroled into the United States pursuant to section 212(d)(5) of the INA for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
- An alien who belongs to one of the following classes:

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<sup>16</sup> See 8 U.S.C. s. 1621(d).

<sup>17</sup> Section 403 of Pub. L No. 104-193, H.R. 3734, 104th Congress (Aug. 22, 1996).

<sup>18</sup> See 42 U.S.C. s. 1397gg(e).

<sup>19</sup> Centers for Medicare and Medicaid Services, *Medicaid and CHIP Coverage of "Lawfully Residing" Children and Pregnant Women*, State Health Official Letter, CHIPRA#17 (July 1, 2010), <http://downloads.cms.gov/cmmsgov/archived-downloads/SMDL/downloads/SHO10006.pdf> (last visited Jan. 15, 2015).

- Temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. s. 1160 or 1255a, respectively);
- Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. s. 1254a), and pending applicants for TPS who have been granted employment authorization under 8 C.F.R. s. 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
- Family Unity beneficiaries pursuant to section 301 of Public Law 101-649, as amended;
- Deferred Enforced Departure (DED) pursuant to a decision made by the President;
- Deferred action status; or,
- Visa petition has been approved and has a pending application for adjustment of status.
- A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. s. 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. s. 1231) or under the Convention Against Torture, who has been guaranteed employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;
- An alien who has been granted withholding of removal under the Convention Against Torture;
- A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. s. 1101 (a)(27)(J));
- An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. s. 1806(e); or,
- An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

As of March 24, 2014, 21 states cover lawfully residing children in both Medicaid and CHIP and 29 states, including Washington, D.C., cover these children in Medicaid only.<sup>20</sup>

### III. Effect of Proposed Changes:

**Section 1** amends definitions under s. 409.811, F.S., to permit certain non-citizen children to receive federal financial premium assistance (medical care) under Medicaid or CHIP.

The definition of a “lawfully residing child” is added as a child who:

- Is present in the United States as defined under 8 C.F.R. s. 103.12(a);
- Meets Medicaid or Children’s Health Insurance Program (CHIP) residency requirements, and,
- May be eligible for federal financial premium assistance under s. 214 of CHIPRA and related federal regulations.

The definition of a “resident” is amended to substitute a “lawfully residing child” rather than a “qualified alien.”

The definition for a “qualified alien” is deleted from s. 409.811, F.S.

<sup>20</sup> Centers for Medicare and Medicaid Services, *Medicaid and CHIP Coverage of Lawfully Residing Children and Pregnant Women*, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Outreach-and-Enrollment/Lawfully-Residing.html> (last visited Jan. 15, 2015).

**Section 2** amends s. 409.814, F.S., to replace a reference to “qualified alien” with “lawfully residing child” when referring to children who are not eligible for Title XXI funded premium assistance. The bill also clarifies that Kidcare program eligibility is not being extended to undocumented immigrants.

**Section 3** amends s. 409.904, F.S., relating to optional Medicaid payments, to designate that a child younger than 19 years of age who is a lawfully residing child as defined in s. 409.811, F.S., is eligible for Medicaid under s. 409.903, F.S. The bill also clarifies that Medicaid program eligibility is not being extended to undocumented immigrants.

**Section 4** amends s. 624.91, F.S., the Florida Healthy Kids Corporation Act, to conform to changes made under the act and update references to modified or deleted terms.

**Section 5** provides an effective date of July 1, 2015.

#### **IV. Constitutional Issues:**

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

#### **V. Fiscal Impact Statement:**

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Expanding eligibility to additional children who may currently be uninsured may have a positive impact on health care providers that currently provide health care services to this population without compensation or at a discount. Accordingly, uncompensated care costs by the health care system may be reduced with increased insured rates.

C. Government Sector Impact:

*Agency for Health Care Administration*

The total state funds required for the 2015-2016 fiscal year for recurring and non-recurring state costs is related to enrollment of 22,602 children in Medicaid and an additional 2,077 children per month in CHIP. Section 214 of the federal CHIPRA

legislation allows states to claim the CHIP enhanced federal match rate for both CHIP and Medicaid children during their 5-year waiting period.

During SFY 2015-16, under Title XXI (CHIP) the break out is:

Total Additional Cost	\$ 4,617,745
Less Federal Funds under Title XXI (84.08%)	\$ 3,882,536
Less: Grants & Donation Trust Fund (6.11%)	\$ 282,260
State General Revenue Requires (9.81%)	\$ 452,950

During SFY 2015-2016, under Title XIX (Medicaid) the break out is:

Total Additional Cost	\$ 41,979,373
Less Federal Funds under Title XXI (84.08%)	\$ 37,593,578
Less: Grants & Donation Trust Fund (6.11%)	\$ 0
State General Revenue Requires (9.81%)	\$4,385,795

The total General Revenue impact is \$4,838,745.<sup>21</sup>

Both a Medicaid and CHIP State Plan Amendment will need to be submitted for federal approval to implement the changes proposed in SB 294.

***Department of Children and Families***

In addition to the enrollment costs above, the DCF estimates SB 294 will generate administrative costs for workload increases related to additional enrollment and non-recurring costs for programming changes to the eligibility system. These costs are indeterminate and will be absorbed within existing resources.<sup>22</sup>

***Florida Healthy Kids Corporation***

The Florida Healthy Kids Corporation reports no additional impact. Enrollment in the Children’s Medical Services Network component is incorporated in the Title XXI and Title XIX projections.

**VI. Technical Deficiencies:**

In a prior year’s legislation which included the same language, AHCA interpreted s. 409.904, F.S., as not extending eligibility for optional Medicaid services to immigrant children lawfully residing in the United States. This interpretation would also require CHIP enrollees to wait as Federal law does not allow a state to extend eligibility to CHIP enrollees without also extending coverage to Medicaid enrollees.<sup>23</sup>

<sup>21</sup> Agency for Health Care Administration, *Senate Bill 294 Analysis* (Jan. 9, 2015) (on file with the Senate Committee on Health Policy).

<sup>22</sup> Department of Children and Families, *Senate Bill 294 Analysis* (Jan. 21, 2015) (on file with the Senate Committee on Health Policy).

<sup>23</sup> See 42 U.S.C. s.1397gg(e)(1)(J).

The AHCA suggests the provision be re-written to clarify that these lawfully-residing children are eligible for Medicaid *goods and services* to correct any ambiguity of eligibility.<sup>24</sup>

**VII. Related Issues:**

None.

**VIII. Statutes Affected:**

This bill substantially amends sections 409.811, 409.814, 409.904, and 624.91 of the Florida Statutes.

**IX. Additional Information:**

**A. Committee Substitute – Statement of Changes:**

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

**B. Amendments:**

None.

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This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

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<sup>24</sup> Agency for Health Care Administration, *House Bill 7 Agency Analysis* (Jan. 21, 2014) (on file with Senate Committee on Health Policy). Conversation via telephone with Gail Hansen, Agency staff, confirming that SB 282 contains similar conflict on Mar. 20, 2014.

By Senator Garcia

38-00163-15

2015294\_\_

A bill to be entitled

An act relating to the Florida Kidcare program; amending s. 409.811, F.S.; defining the term "lawfully residing child"; deleting the definition of the term "qualified alien"; conforming provisions to changes made by the act; amending s. 409.814, F.S.; revising eligibility for the program to conform to changes made by the act; clarifying that undocumented immigrants are excluded from eligibility; amending s. 409.904, F.S.; providing eligibility for optional payments for medical assistance and related services for certain lawfully residing children; clarifying that undocumented immigrants are excluded from eligibility for optional Medicaid payments or related services; amending s. 624.91, F.S.; conforming provisions to changes made by the act; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Present subsections (17) through (22) of section 409.811, Florida Statutes, are redesignated as subsections (18) through (23), respectively, a new subsection (17) is added to that section, and present subsection (23) and subsection (24) of that section are amended, to read:

409.811 Definitions relating to Florida Kidcare Act.—As used in ss. 409.810-409.821, the term:

(17) "Lawfully residing child" means a child who is lawfully present in the United States, meets Medicaid or Children's Health Insurance Program (CHIP) residency

Page 1 of 3

**CODING:** Words ~~stricken~~ are deletions; words underlined are additions.

38-00163-15

2015294\_\_

requirements, and may be eligible for medical assistance with federal financial participation as provided under s. 214 of the Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, and related federal regulations.

~~(23) "Qualified alien" means an alien as defined in s. 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, Pub. L. No. 104-193.~~

(24) "Resident" means a United States citizen, or lawfully residing child ~~qualified alien~~, who is domiciled in this state.

Section 2. Paragraph (c) of subsection (4) of section 409.814, Florida Statutes, is amended to read:

409.814 Eligibility.—A child who has not reached 19 years of age whose family income is equal to or below 200 percent of the federal poverty level is eligible for the Florida Kidcare program as provided in this section. If an enrolled individual is determined to be ineligible for coverage, he or she must be immediately disenrolled from the respective Florida Kidcare program component.

(4) The following children are not eligible to receive Title XXI-funded premium assistance for health benefits coverage under the Florida Kidcare program, except under Medicaid if the child would have been eligible for Medicaid under s. 409.903 or s. 409.904 as of June 1, 1997:

(c) A child who is an alien, but who does not meet the definition of a lawfully residing child ~~qualified alien, in the United States. This paragraph does not extend eligibility for the Florida Kidcare program to an undocumented immigrant.~~

Section 3. Present subsections (8) and (9) of section 409.904, Florida Statutes, are redesignated as subsections (9)

Page 2 of 3

**CODING:** Words ~~stricken~~ are deletions; words underlined are additions.

38-00163-15

2015294\_\_

59 and (10), respectively, and a new subsection (8) is added to  
60 that section, to read:

61 409.904 Optional payments for eligible persons.—The agency  
62 may make payments for medical assistance and related services on  
63 behalf of the following persons who are determined to be  
64 eligible subject to the income, assets, and categorical  
65 eligibility tests set forth in federal and state law. Payment on  
66 behalf of these Medicaid eligible persons is subject to the  
67 availability of moneys and any limitations established by the  
68 General Appropriations Act or chapter 216.

69 (8) A child who has not attained the age of 19 who,  
70 notwithstanding s. 414.095(3), would be eligible for Medicaid  
71 under s. 409.903, except that the child is a lawfully residing  
72 child as defined in s. 409.811. This subsection does not extend  
73 eligibility for optional Medicaid payments or related services  
74 to an undocumented immigrant.

75 Section 4. Paragraph (b) of subsection (3) of section  
76 624.91, Florida Statutes, is amended to read:

77 624.91 The Florida Healthy Kids Corporation Act.—

78 (3) ELIGIBILITY FOR STATE-FUNDED ASSISTANCE.—Only the  
79 following individuals are eligible for state-funded assistance  
80 in paying Florida Healthy Kids premiums:

81 (b) Notwithstanding s. 409.814, a legal ~~alien~~ ~~aliens~~ who ~~is~~  
82 are enrolled in the Florida Healthy Kids program as of January  
83 31, 2004, who does ~~de~~ not qualify for Title XXI federal funds  
84 because he or she is ~~they are~~ not a lawfully residing child  
85 qualified ~~aliens~~ as defined in s. 409.811.

86 Section 5. This act shall take effect July 1, 2015.



## THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

### COMMITTEES:

Communications, Energy, and Public Utilities, Vice  
Chair  
Appropriations Subcommittee on Criminal and  
Civil Justice  
Appropriations Subcommittee on Health and Human  
Services  
Transportation  
Health Policy  
Agriculture  
Transportation

### JOINT COMMITTEE:

Joint Committee on Administrative Procedures, Chair

### SENATOR RENE GARCIA

38th District

January 27, 2015

The Honorable Aaron Bean  
Chair, Health Policy Committee  
302 Senate Office Building  
404 S. Monroe Street  
Tallahassee, FL 32399-1100

Dear Chairman Bean:

This letter should serve as a request to have my bill *SB 294, Florida Kidcare Program* heard at the next possible committee meeting. If there is any other information needed please do not hesitate to contact me. Thank you.

Sincerely,

A handwritten signature in black ink, appearing to read "René García".

State Senator René García  
District 38  
RG:JT

CC: Sandra Stovall, Staff Director

#### REPLY TO:

- 1490 West 68 St., Suite 201 Hialeah, FL 33014 (305) 364-3100
- 310 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5038

Senate's Website: [www.flsenate.gov](http://www.flsenate.gov)

**DON GAETZ**  
President of the Senate

**GARRETT RICHTER**  
President Pro Tempore



THE FLORIDA SENATE  
**APPEARANCE RECORD**

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

294  
Bill Number (if applicable)

Meeting Date \_\_\_\_\_

Topic Kid Care

Amendment Barcode (if applicable) \_\_\_\_\_

Name Jessica Scher

Job Title Director, Public Policy, United Way

Address 3250 SW 3<sup>rd</sup> Ave

Phone 305 327 6143

City Miami State FL Zip 33129

Email jscherj@unitedway.com

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing United Way of Miami-Dade

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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THE FLORIDA SENATE  
**APPEARANCE RECORD**

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/17/15  
Meeting Date

294  
Bill Number (if applicable)

Topic KIDCARE

Amendment Barcode (if applicable)

Name DIANA RAGBLEK

Job Title DIRECTOR PUBLIC POLICY

Address ~~THE~~  
Street

Phone 305 571 5700

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing THE CHILDREN'S TRUST

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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THE FLORIDA SENATE  
**APPEARANCE RECORD**

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/17/15

Meeting Date

294

Bill Number (if applicable)

Topic Florida Kidcare

Amendment Barcode (if applicable)

Name Karen Woodall

Job Title Director

Address 579 E. Call St.

Phone 850-321-9386

Street

Tallahassee

City

FL

State

32301

Zip

Email fcfep@yahoo.com

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing Florida Center for Fiscal + Economic Policy / Kidswell Fla.

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE  
**APPEARANCE RECORD**

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

294  
Bill Number (if applicable)

Meeting Date \_\_\_\_\_

Amendment Barcode (if applicable) \_\_\_\_\_

Topic Florida Kid Care

Name Phillis Oeters

Job Title VP Community Govt Relations

Address 6812 San Vicente

Phone \_\_\_\_\_

Street  
Coral Gables, FL

33146

Email philliso@baptisthealth.net

City State Zip

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing \_\_\_\_\_

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

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THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/17/15

Meeting Date

SB 294

Bill Number (if applicable)

Topic Florida Kidcare Program

Amendment Barcode (if applicable)

Name Amy Liem

Job Title

Address 2425 Torrey Dr

Phone 385-7900

Street

Tallahassee FL 32303

Email amy@floridalegal.org

City

State

Zip

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [X] In Support [ ] Against (The Chair will read this information into the record.)

Representing Florida Legal Services

Appearing at request of Chair: [ ] Yes [ ] No

Lobbyist registered with Legislature: [X] Yes [ ] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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THE FLORIDA SENATE  
**APPEARANCE RECORD**

2/17/15  
Meeting Date

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

SB 294  
Bill Number (if applicable)

Topic Kid Care

Amendment Barcode (if applicable)

Name Crystal Stickle

Job Title VP Gov Affairs

Address 300 East Colleege  
Street

Phone 850 445 4844

TLH  
City State Zip

Email \_\_\_\_\_

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing Florida Hospital Assoc

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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THE FLORIDA SENATE  
**APPEARANCE RECORD**

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-17-15  
Meeting Date

SB 294  
Bill Number (if applicable)

Topic Florida Kidcare Program

Amendment Barcode (if applicable)

Name Pam Bergsma

Job Title Grandma

Address 619 South K ST.

Phone 561-379-6374

Street

LAKE WORTH

City

FL

State

33460

Zip

Email lovejoey@bellsouth.net

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing Joey Bergsma Retinoblastoma Awareness Foundation

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE  
**APPEARANCE RECORD**

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/17/15  
Meeting Date

SB 294  
Bill Number (if applicable)

Topic Florida Kidcare Program

Amendment Barcode (if applicable)

Name Ron Watson

Job Title Lobbyist

Address 3738 Murdon Way

Phone (850) 567-1202

Street

City

Tallahassee

State

Zip

Email watson.strategies@comcast.net

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing Florida CHAIN

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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THE FLORIDA SENATE  
**APPEARANCE RECORD**

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

17 FEB 2015

Meeting Date

SB 294

Bill Number (if applicable)

Topic KID CARE Amendment Barcode (if applicable)

Name MICHAEL MCQUONE (MCCUE-ONE)

Job Title ASSOCIATE DIRECTOR FOR HEALTH

Address 201 W. PARK AVE

Phone 850-284-9130

Street

TALLAHASSEE, FL 32301

City

State

Zip

Email mmcquone@flacathconf.org

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing FLORIDA CONFERENCE OF CATHOLIC BISHOPS

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE  
**APPEARANCE RECORD**

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-16-15

Meeting Date

294

Bill Number (if applicable)

Topic Kidcare

Amendment Barcode (if applicable)

Name Fely Curva, Ph.D.

Job Title Senior Partner, Curva Associates LLC

Address 1212 Piedmont Dr.

Phone (858) 548-2256

Street

Tallahassee FL 32312

Email curva@mindspring.com

City

State

Zip

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing FL IMPACT; Budd Bell Clearinghouse on Human Services

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

**This form is part of the public record for this meeting.**

S-001 (10/14/14)

**The Florida Senate**  
**BILL ANALYSIS AND FISCAL IMPACT STATEMENT**

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

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Prepared By: The Professional Staff of the Committee on Health Policy

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BILL: CS/SB 296

INTRODUCER: Health Policy Committee and Senator Garcia

SUBJECT: Diabetes Advisory Council

DATE: February 18, 2015

REVISED: \_\_\_\_\_

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	<b>Fav/CS</b>
2.			GO	
3.			AHS	
4.			FP	

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

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**I. Summary:**

CS/SB 296 creates a process for ongoing assessment of the state's diabetes-related activities. Specifically, the bill directs the Diabetes Advisory Council, in conjunction with the Department of Health (DOH), the Agency for Health Care Administration (AHCA), and the Department of Management Services (DMS), to prepare a report regarding the impact of diabetes on state-funded or operated programs, including Medicaid, the State Group Insurance Program, and public health programs. Required components of the report include: the health consequences and financial impact of diabetes; the effectiveness of diabetes programs implemented by each agency; a description of the coordination among the agencies; and the development and ongoing revision of an action plan for reducing and controlling the incidence of diabetes.

The report is due to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 10 of each odd-numbered year.

CS/SB 296 also modifies the composition of the Diabetes Advisory Council to indicate who may serve on the council rather than must, and adds a representative of the American Association of Diabetes to the list of possible members.

The bill has an indeterminate fiscal impact.

## II. Present Situation:

Diabetes is a group of diseases in which the body produces too little insulin,<sup>1</sup> is unable to use insulin efficiently, or both. When diabetes is not controlled, glucose and fats remain in the blood and eventually cause damage to vital organs.

The most common forms of diabetes are:

- **Type 1:** Sometimes known as juvenile diabetes, type 1 is usually first diagnosed in children and adolescents and accounts for about five percent of all diagnosed cases. Type 1 diabetes is an autoimmune disease in which the body's own immune system destroys cells in the pancreas that produce insulin. Type 1 may be caused by genetic, environmental, or other risk factors. At this time, there are no methods to prevent or cure type 1 diabetes, and treatment requires the use of insulin by injection or pump.
- **Type 2:** Sometimes known as adult-onset diabetes, type 2 accounts for about 95 percent of diagnosed diabetes in adults and is usually associated with older age, obesity, lack of physical activity, family history, or a personal history of gestational diabetes. Studies have shown that healthy eating, regular physical activity, and weight loss can prevent or delay the onset of type 2 diabetes or eliminate the symptoms and effects post-onset.
- **Gestational diabetes:** This type of diabetes develops and is diagnosed as a result of pregnancy in 2 to 10 percent of pregnant women. Gestational diabetes can cause health problems during pregnancy for both the child and mother. Children whose mothers have gestational diabetes have an increased risk of developing obesity and type 2 diabetes.<sup>2</sup>

Complications of diabetes include: heart disease, stroke, high blood pressure (hypertension), blindness and other eye problems, kidney disease, nervous system disease, vascular disorders, and amputations. Death rates for heart disease and the risk of stroke are about two to four times higher among adults with diabetes than among those without diabetes. Diabetes and its potential health consequences can be managed through physical activity, diet, self-management training, and, when necessary, medication.<sup>3</sup>

People with "pre-diabetes" are at high risk of developing type 2 diabetes, heart disease, and stroke. Their blood glucose levels are higher than normal, but not high enough to be classified as diabetes. Although an estimated 33 percent of adults in the United States have pre-diabetes, less than 10 percent of them report having been told they have the condition. Thus, awareness of the risk is low. People with pre-diabetes who lose five to seven percent of their body weight and get at least 150 minutes per week of moderate physical activity can reduce the risk of developing type 2 diabetes by 58 percent.<sup>4</sup>

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<sup>1</sup> Insulin is a hormone that allows glucose (sugar) to enter cells and be converted to energy.

<sup>2</sup> U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Diabetes Report Card*, 1 (2012), available at <http://www.cdc.gov/diabetes/pubs/reportcard.htm> (last visited Jan. 20, 2015).

<sup>3</sup> U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Diabetes Latest* <http://www.cdc.gov/features/diabetesfactsheet/> (last visited Jan. 20, 2015).

<sup>4</sup> *Supra* note 2, at 4.

Risk factors for diabetes include:<sup>5</sup>

- Being over the age of 45;
- Overweight;
- Having a parent or sibling with diabetes;
- Having a minority family background;
- Developing diabetes while pregnant, gave birth to a baby weighing 9 pounds or more; and
- Being physically active less than three times per week.

Persons with any of the above risk factors are also at risk of developing pre-diabetes. Individuals with pre-diabetes are five to 15 times more likely to develop type 2 diabetes, heart disease, and stroke.<sup>6</sup> The Centers for Disease Control estimates that as many as one out of every three American adults has pre-diabetes and half of all Americans aged 65 years and older have pre-diabetes.<sup>7</sup>

Minorities have a higher prevalence of diabetes than whites, and some minorities have higher rates of diabetes-related complications and death. Non-Hispanic black, Hispanic, and American Indian/Alaska Native adults are about twice as likely to have diagnosed diabetes as non-Hispanic white adults.<sup>8</sup>

In 2013, the American Diabetes Association released a report updating its earlier studies (2002, 2007) estimating the economic burden of diagnosed diabetes. In 2012, the total estimated cost of diagnosed diabetes in the United States was \$245 billion, including \$176 billion in direct medical costs and \$69 billion in reduced productivity. This represents a 41 percent increase over the 2007 estimate. The largest components of these costs are hospital inpatient care (43 percent) and medications to treat complications (18 percent). People with diagnosed diabetes incur average medical costs of about \$13,700 per year, of which about \$7,900 is attributed to diabetes. Care for people with diagnosed diabetes accounts for more than one in five dollars spent on health care in the United States, and more than half of that is directly attributable to diabetes. Overall, average medical expenses for a person with diabetes are 2.3 times higher than they are for a person without diabetes.<sup>9</sup>

### **Diabetes in Florida**

Diabetes was the sixth leading cause of death in 2012 in Florida.<sup>10</sup> The prior year, diabetes had been the seventh leading cause of death. As a percent of total deaths in the state, diabetes

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<sup>5</sup> Florida Department of Health, *Diabetes, Warning Signs and Risk Factors* <http://www.floridahealth.gov/diseases-and-conditions/diabetes/warning-signs.html> (last visited Feb. 4, 2015).

<sup>6</sup> Florida Department of Health, *Prediabetes, What is Prediabetes?*, <http://www.floridahealth.gov/diseases-and-conditions/diabetes/prediabetes.html> (last visited Feb. 4, 2015).

<sup>7</sup> *Id.*

<sup>8</sup> *Id.* at 1.

<sup>9</sup> American Diabetes Association, *Economic Costs of Diabetes in the U.S. in 2012*, *Diabetes Care* 36: 1033 – 1046, 2013, available at, <http://care.diabetesjournals.org/content/36/4/1033.full.pdf+html> (last visited Jan. 20, 2015).

<sup>10</sup> Florida Department of Health, *Florida Mortality Atlas: 2012 Major Causes of Death*, <http://www.floridacharts.com/charts/SpecReport.aspx?RepID=7226&tn=33> (last visited Feb. 4, 2015).

accounted for 2.9 percent of all deaths, and over a 3-year period (2011 - 2013), diabetes had an age adjusted death rate per 100,000 of 19.6 or 15,317 deaths.<sup>11</sup>

Florida’s population base also includes large concentrations of groups that have been identified as at risk for diabetes. In 2013, only 35 percent of Floridians were at a healthy weight with 25 percent identified as overweight and the remaining 25 percent identified as obese.<sup>12</sup> If Floridians follow the current trend, by 2030, almost 60 percent of the population will be obese.<sup>13</sup>

Florida has a number of other demographic characteristics that match the high risk factors, such as:<sup>14</sup>

<b>Risk Factor</b>	<b>Florida Population (2013)</b>
Persons Over Age 65	18.7% of population
Black or African American	16.7% of population
Hispanic or Latino	23.6 % of population
<b>Total FL Population:</b>	<b>19,552,860</b>

**Diabetes Advisory Council**

The Diabetes Advisory Council (council) was reinstated in law in 1980 to guide statewide policy on diabetes prevention, diagnosis, education, care, treatment, impact, and costs.<sup>15</sup> It serves in an advisory capacity to the DOH, other agencies, and the public. The council consists of 26 members appointed by the Governor who have experience related to diabetes. Twenty-one of the members are representatives of a broad range of health and public health-related interests. The remaining five members are representatives of the general public, at least three of whom are affected by diabetes. The council meets annually with the State Surgeon General to make recommendations regarding the public health aspects of the prevention and control of diabetes.<sup>16</sup>

**Florida Diabetes Prevention and Control**

The Bureau of Chronic Disease Prevention and Health Promotion (bureau) within the DOH was established in 1998 to improve individual and community health by preventing and reducing the

<sup>11</sup> Florida Department of Health, *Florida Charts: Diabetes Deaths - Three Year Trends* <http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0090> (last visited Feb. 4, 2015).

<sup>12</sup> Florida Department of Health, *Healthy Weight - Healthiest Weight Florida*, <http://www.floridahealth.gov/programs-and-services/prevention/healthy-weight/index.html> (last visited Feb. 4, 2015).

<sup>13</sup> *Id.*

<sup>14</sup> United States Census Bureau, *State and County Quick Facts: Florida*, <http://quickfacts.census.gov/qfd/states/12000.html> (last visited Feb. 4, 2015).

<sup>15</sup> Ch. 1980-62, Laws of Fla. (reinstating the Diabetes Advisory Council into Chapter 381, F.S., pertaining to health.) The council had previously been located under ch. 241, F.S., relating to education and had been repealed by the 1979 Legislature. *See Florida Legislature - 1980 Summary of General Legislation*, p. 145, <http://www.law.fsu.edu/library/collection/FlSumGenLeg/FlSumGenLeg1980.pdf> (last visited Feb. 12, 2015).

<sup>16</sup> Section 385.203, F.S. The 2013 recommendations of the Council are on file with the Senate Health Policy Committee.

impact of chronic diseases and disabling conditions, including diabetes. Diabetes-related activities of the Bureau include:

- Providing support to the Diabetes Advisory Council and the Florida Alliance for Diabetes Prevention and Care;
- Compiling, analyzing, translating, and distributing diabetes data;
- Increasing access to diabetes self-management education;
- Increasing access to diabetes medical care by advocating for the use of community health workers;
- Preventing diabetes in populations disproportionately affected by diabetes;
- Increasing diagnosis and treatment for pre-diabetes; and
- Managing the Insulin Distribution Program.<sup>17</sup>

The Office of Minority Health administers the Closing the Gap grant program, which seeks to improve health outcomes and eliminate racial and ethnic health disparities in Florida by providing grants to increase community-based health promotion and disease prevention activities, including diabetes prevention.<sup>18</sup>

## **Medicaid**

Medicaid is a joint federal and state funded program that provides health care for low income Floridians. The program is administered by the AHCA and financed with federal and state funds. Over 3.7 million Floridians are currently enrolled in Medicaid and the program's estimated expenditures for Fiscal Year 2014-2015, are approximately \$23.3 billion.<sup>19</sup> The statutory authority for the Medicaid program is contained in ch. 409, F.S.

Part IV of ch. 409, F.S., was created in 2011 by ch. 2011-134, L.O.F., and governs the Statewide Medicaid Managed Care program (SMMC). The AHCA competitively procured contracts with managed care plans in 11 regions of the state to provide comprehensive Medicaid coverage for most of the state's enrollees in the Medicaid program. Full implementation of the SMMC occurred in August 2014.

## **State Group Insurance Program**

Section 110.123, F.S., creates the State Group Insurance Program. As implemented by the DMS, the program offers four types of health plans from which an eligible employee may choose: a standard statewide Preferred Provider Organization (PPO) Plan, a Health Investor PPO Plan, a standard Health Maintenance Organization (HMO) Plan, or a Health Investor HMO Plan. In

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<sup>17</sup> Florida Department of Health, *Resource Manual for the Florida Department of Health* (Fiscal Year 2012-2013) (on file with the Senate Committee on Health Policy).

<sup>18</sup> Sections 381.7353 – 381.7356, F.S.

<sup>19</sup> Office of Economic and Demographic Research, *Social Services Estimating Conference, Medicaid Caseloads and Expenditures, June 27, July 22, and August 4, 2014, Executive Summary*, <http://edr.state.fl.us/Content/conferences/medicaid/medsummary.pdf> (last visited Jan., 2015).

Fiscal Year 2013-2014, the State Group Insurance Program covered 171,960 members at a cost of \$1.98 billion.<sup>20</sup>

### III. Effect of Proposed Changes:

The bill directs the Diabetes Advisory Council, in conjunction with the DOH, the AHCA, and the DMS, to submit a report by January 10 in each odd-numbered year to the Governor, the President of the Senate, and the Speaker of the House of Representatives, regarding the impact of diabetes on state funded or operated programs. Specifically, the report must include:

- Information on the public health consequences and financial impact of diabetes and its complications on the state, including the number of persons covered by Medicaid and the State Group Insurance Program, and the number of persons impacted by state diabetes programs and activities;
- A description and assessment of the effectiveness of diabetes programs and activities implemented by the agencies, the amount and sources of their funding, and the cost savings they achieve;
- A description of the coordination among the agencies of programs, activities, and communications related to diabetes prevention and treatment; and
- A detailed action plan for reducing and controlling the number of new cases of diabetes, including action steps to reduce its impact, expected outcomes of the plan, and benchmarks.

The Diabetes Advisory Council membership is also amended to identify who *may* serve on the council rather than *must* serve, and a representative of the American Association of Diabetes Educators is added to the list of possible members.

The bill has an effective date of July 1, 2015.

### IV. Constitutional Issues:

#### A. Municipality/County Mandates Restrictions:

None.

#### B. Public Records/Open Meetings Issues:

None.

#### C. Trust Funds Restrictions:

None.

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<sup>20</sup> Florida Department of Management Services, Division of State Group Insurance, *State Employees' Group Health Self-Insurance Trust Fund, Report on the Financial Outlook* (July 30, 2014), <http://edr.state.fl.us/Content/conferences/healthinsurance/HealthInsuranceOutlook.pdf> (last visited Jan. 20, 2015).



**V. Fiscal Impact Statement:**

## A. Tax/Fee Issues:

None.

## B. Private Sector Impact:

None.

## C. Government Sector Impact:

CS/SB 296 will have no fiscal impact on the DOH in its capacity as staff to support to the Diabetes Advisory Council. While the creation of the biennial report may require significant DOH staff time to generate, the DOH reports that such time may be absorbed within existing resources.<sup>21</sup>

The DMS reports an indeterminate fiscal impact.<sup>22</sup>

**VI. Technical Deficiencies:**

None.

**VII. Related Issues:**

None.

**VIII. Statutes Affected:**

This bill substantially amends section 385.203 of the Florida Statutes.

**IX. Additional Information:**

## A. Committee Substitute – Statement of Substantial Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

**CS by Health Policy on February 17, 2015:**

The committee substitute identifies who *may* serve on the Diabetes Advisory Council rather than *must*, and adds a representative of the American Association of Diabetes Educators to the list of possible members.

## B. Amendments:

None.

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<sup>21</sup> Florida Department of Health, *Senate Bill 296 Analysis* (Jan. 12, 2015) (on file with the Senate Committee on Health Policy).

<sup>22</sup> Florida Department of Management Services, *Senate Bill 296 Analysis* (Jan. 9, 2015) (on file with the Senate Committee on Health Policy).

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This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

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275700

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/17/2015	.	
	.	
	.	
	.	

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The Committee on Health Policy (Garcia) recommended the following:

**Senate Amendment (with directory and title amendments)**

Between lines 51 and 52  
insert:

(3) The council shall be composed of 26 citizens of the state who have knowledge of, or work in, the area of diabetes mellitus as follows:

(b) Twenty-one members, who may ~~must~~ include one representative from any ~~each~~ of the following areas: nursing with diabetes-educator certification; dietary with diabetes



275700

11 educator certification; podiatry; ophthalmology or optometry;  
12 psychology; pharmacy; adult endocrinology; pediatric  
13 endocrinology; the American Diabetes Association (ADA); the  
14 American Association of Diabetes Educators; the Juvenile  
15 Diabetes Foundation (~~JDF~~); the Florida Academy of Family  
16 Physicians; a community health center; a county health  
17 department; an ADA-recognized ~~American Diabetes Association~~  
18 ~~recognized~~ community education program; each medical school in  
19 the state; an osteopathic medical school; the insurance  
20 industry; a Children's Medical Services diabetes regional  
21 program; and an employer.

22  
23 ===== D I R E C T O R Y C L A U S E A M E N D M E N T =====

24 And the directory clause is amended as follows:

25 Delete lines 15 - 16

26 and insert:

27 (d), and a new paragraph (c) is added to that subsection, and  
28 paragraph (b) of subsection (3) of that section is amended, to  
29 read:

30  
31 ===== T I T L E A M E N D M E N T =====

32 And the title is amended as follows:

33 Delete line 9

34 and insert:

35 the report; providing that the council membership may  
36 be, rather than must be, representative of certain  
37 areas of specialization or certain institutions,  
38 organizations, and industries; adding an organization  
39 from which a representative may be selected to serve



40  
41

as a council member; providing an effective date.

By Senator Garcia

38-00254-15

2015296\_\_

A bill to be entitled

An act relating to the Diabetes Advisory Council; amending s. 385.203, F.S.; requiring the council, in conjunction with the Department of Health, the Agency for Health Care Administration, and the Department of Management Services, to develop plans to manage, treat, and prevent diabetes; requiring a report to the Governor and Legislature; specifying the contents of the report; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Present paragraph (c) of subsection (1) of section 385.203, Florida Statutes, is redesignated as paragraph (d), and a new paragraph (c) is added to that subsection, to read:

385.203 Diabetes Advisory Council; creation; function; membership.—

(1) To guide a statewide comprehensive approach to diabetes prevention, diagnosis, education, care, treatment, impact, and costs thereof, there is created a Diabetes Advisory Council that serves as the advisory unit to the Department of Health, other governmental agencies, professional and other organizations, and the general public. The council shall:

(c) In conjunction with the department, the Agency for Health Care Administration, and the Department of Management Services, by January 10 of each odd-numbered year, submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report containing the following

Page 1 of 2

**CODING:** Words ~~stricken~~ are deletions; words underlined are additions.

38-00254-15

2015296\_\_

information:

1. The public health consequences and financial impact on the state of all types of diabetes and resulting health complications, including the number of persons with diabetes covered by Medicaid, the number of persons with diabetes who are insured by the Division of State Group Insurance, and the number of persons with diabetes who are impacted by state agency diabetes programs and activities.

2. A description and an assessment of the effectiveness of the diabetes programs and activities implemented by each state agency, the amount and source of funding for such programs and activities, and the cost savings realized as a result of the implementation of such programs and activities.

3. A description of the coordination among state agencies of their respective programs, activities, and communications designed to manage, treat, and prevent all types of diabetes.

4. The development of and revisions to a detailed action plan for reducing and controlling the number of new cases of diabetes and identification of proposed action steps to reduce the impact of all types of diabetes, identification of expected outcomes if the plan is implemented, and the establishment of benchmarks for preventing and controlling diabetes.

Section 2. This act shall take effect July 1, 2015.

Page 2 of 2

**CODING:** Words ~~stricken~~ are deletions; words underlined are additions.



## THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

### COMMITTEES:

Communications, Energy, and Public Utilities, Vice  
Chair  
Appropriations Subcommittee on Criminal and  
Civil Justice  
Appropriations Subcommittee on Health and Human  
Services  
Transportation  
Health Policy  
Agriculture  
Transportation

### JOINT COMMITTEE:

Joint Committee on Administrative Procedures, Chair

### SENATOR RENE GARCIA

38th District

January 27, 2015

The Honorable Aaron Bean  
Chair, Health Policy Committee  
302 Senate Office Building  
404 S. Monroe Street  
Tallahassee, FL 32399-1100

Dear Chairman Bean:

This letter should serve as a request to have my bill *SB 296, Diabetes Advisory Council* heard at the next possible committee meeting. If there is any other information needed please do not hesitate to contact me. Thank you.

Sincerely,

A handwritten signature in black ink, appearing to read "René García".

State Senator René García  
District 38  
RG:JT

CC: Sandra Stovall, Staff Director

#### REPLY TO:

- 1490 West 68 St., Suite 201 Hialeah, FL 33014 (305) 364-3100
- 310 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5038

Senate's Website: [www.flsenate.gov](http://www.flsenate.gov)

**DON GAETZ**  
President of the Senate

**GARRETT RICHTER**  
President Pro Tempore

THE FLORIDA SENATE  
**APPEARANCE RECORD**

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)



296

Bill Number (if applicable)

275700

Amendment Barcode (if applicable)

Meeting Date

Topic Diabetes Advisory Council

Name Melanie Bostick

Job Title Vice President

Address \_\_\_\_\_  
Street

Phone (850) 688-3183

City

State

Zip

Email \_\_\_\_\_

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing American Association

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

**This form is part of the public record for this meeting.**



**The Florida Senate**  
**BILL ANALYSIS AND FISCAL IMPACT STATEMENT**

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

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Prepared By: The Professional Staff of the Committee on Health Policy

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BILL: CS/SB 478

INTRODUCER: Health Policy Committee and Senators Bean and Joyner

SUBJECT: Telehealth Services

DATE: February 18, 2015

REVISED: \_\_\_\_\_

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	Fav\CS
2.			AHS	
3.			AP	

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**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

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**I. Summary:**

CS/SB 478 creates s. 456.4501, F.S., relating to the provision of telehealth services. The bill defines telehealth services and telehealth provider. CS/SB 478 establishes that the standard of care for a telehealth service is the same as the standard of care for a health professional providing in-person services. A telehealth provider is not required to research the patient's medical history or conduct a physical examination if the telehealth provider conducts an evaluation sufficient to diagnose and treat the patient. Additionally, a telehealth provider must document health care services in the patient's medical record under the same standard as for in-person care.

The bill specifies that a non-physician telehealth provider who is using telehealth and acting within the relevant scope of practice is not practicing medicine without a license.

The bill prohibits a telehealth provider from prescribing lenses, spectacles, eyeglasses, contact lenses, or other optical lenses based solely on the use of computer controlled device through telehealth.

Additionally, controlled substances may not be prescribed through telehealth for chronic non-malignant pain. However, this provision does not preclude a physician from using telehealth to order a controlled substance for an inpatient in a hospital or for a hospice patient.

## II. Present Situation:

Telemedicine utilizes various advances in communications technology to provide health care services through a variety of electronic mediums. Telemedicine is not a separate medical specialty and does not change what constitutes proper medical treatment and services. According to the American Telemedicine Association, services provided through telemedicine include:<sup>1</sup>

- Primary care and specialist referral services that involve a primary care or allied health professional providing consultation with a patient or specialist assisting the primary care physician with a diagnosis;
- Remote patient monitoring that include home tele health, using devices to remotely collect and send data to home health agencies or remote diagnostic testing facilities;
- Consumer medical and health information that offers consumers specialized health information and online discussion groups for peer to peer support; and
- Medical education that provides continuing medical education credits.

The term telehealth is sometimes used interchangeably with telemedicine. Telehealth; however, generally refers to a wider range of health care services that may or may not include clinical services.<sup>2</sup> Telehealth often collectively defines the telecommunications equipment and technology that is used to collect and transmit the data for a telemedicine consultation or evaluation.

The federal Centers for Medicare and Medicaid Services (CMS) defines telehealth as:

*The use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance. Telehealth includes such technologies such as telephones, facsimile machines, electronic mail systems, and remote patient monitoring devices which are used to collect and transmit data for monitoring and interpretation.*<sup>3</sup>

### Board of Medicine Rulemaking

Florida's Board of Medicine (board) convened a Telemedicine Workgroup in 2013 to review its rules on telemedicine which had not been amended since 2003. The 2003 rules had focused on standards for the prescribing of medicine via the Internet. On March 12, 2014, the Board of Medicine's new Telemedicine Rule, 64B8-9.0141, became effective for Florida licensed physicians. The new rule defined telemedicine, established standards of care, prohibited the

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<sup>1</sup> American Telemedicine Association, *What is Telemedicine?* <http://www.americantelemed.org/about-telemedicine/what-is-telemedicine#.VN5LgU0cSpp> (last visited Feb. 10, 2015).

<sup>2</sup> Anita Majerowicz and Susan Tracy, "Telemedicine: Bridging Gaps in Healthcare Delivery," *Journal of AHIMA* 81, no. 5, (May 2010); 52-53, 56.  
[http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1\\_047324.hcsp?dDocName=bok1\\_047324](http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_047324.hcsp?dDocName=bok1_047324) (last visited Feb. 10, 2015).

<sup>3</sup> Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Telemedicine*, <http://www.medicare.gov/medicaid-chip-program-information/by-topics/delivery-systems/telemedicine.html> (last visited Feb. 17, 2015).

prescription of controlled substances, permitted the establishment of a doctor-patient-relationship via telemedicine, and exempted emergency medical services.<sup>4</sup>

An emergency rule followed shortly after the initial rule's implementation to address concerns that the prohibition on physicians ordering controlled substances may also preclude physicians from prescribing controlled substances via telemedicine for hospitalized patients. The board said it was never their intention through its new rule to prohibit physicians from this practice.<sup>5</sup> The emergency rule went into effect on April 30, 2014, and was later incorporated during the regular rulemaking process.

Subsequent changes have also been made to the Telemedicine Rules to clarify medical record requirements and the relationship between consulting or cross-coverage physicians.

### **Telemedicine in Other States**

As of February 2015, at least 23 states and the District of Columbia have mandated that private insurance plans cover telemedicine services at reimbursement rates equal to an in-person consultation.<sup>6</sup> Such laws require insurance companies and health plans to reimburse providers the same amount for the same visit regardless of whether the visit was conducted face to face or via electronic communications.

Forty-six state Medicaid programs also reimburse for some form of telemedicine via live video according to a state survey completed in September 2014.<sup>7</sup> A smaller number of states offer reimbursement for other types of telemedicine services such as store-and-forward activities,<sup>8</sup> facility fees for hosting either the telemedicine provider, patient, or both; and remote patient monitoring.<sup>9</sup>

Rural counties have utilized telemedicine to fill the void for specialty care in their emergency rooms and to avoid costly and time-consuming transfers of patients from smaller hospitals to the larger tertiary centers for care.

In a California project, rural hospital emergency rooms received video conference equipment to facilitate the telemedicine consultations. The rural hospital physicians and nurses were linked with pediatric critical care medicine specialists at the University of California, Davis.<sup>10</sup> As a

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<sup>4</sup> Rule 64B15-14.0081, F.A.C., also went into effect March 12, 2014 for osteopathic physicians.

<sup>5</sup> Florida Board of Medicine, *Latest News - Emergency Rule Related to Telemedicine*, <http://flboardofmedicine.gov/latest-news/emergency-rule-related-to-telemedicine/> (last visited Feb. 10, 2015).

<sup>6</sup> American Telemedicine Association, *2015 State Telemedicine Legislation Tracking (as of 2/6/2015)*, <http://www.americantelemed.org/docs/default-source/policy/2015-ata-state-legislation-matrixEF9F3AD41F02.pdf?sfvrsn=18> (last visited Feb. 10, 2015).

<sup>7</sup> Center for Connected Health Policy, *Telehealth Medicaid & State Policy*, <http://cchpca.org/telehealth-medicare-state-policy> (last visited Feb 10, 2015).

<sup>8</sup> Store and forward technology refers to the electronic transmission of medical information and data such as digital images, documents and pre-recorded images for review by a physician or specialist at a later date, not simultaneously with the patient.

<sup>9</sup> *Supra*, Note 7.

<sup>10</sup> Futurity, *In Rural ERs, Kids Get Better Care with Telemedicine*, <http://www.futurity.org/in-rural-ers-kids-get-better-care-with-telemedicine/> (last visited Feb. 10, 2015).

*Futurity* article notes, “while 21 percent of children in the United States live in rural areas, only 3 percent of pediatric critical-care medicine specialists practice in such areas.”<sup>11</sup>

### **Federal Provisions for Telemedicine**

Federal laws and regulations address telemedicine from several angles, from prescribing controlled substances and setting hospital emergency room guidelines, to establishing reimbursement rates for the Medicare program.

#### ***Prescribing Via the Internet***

Federal law specifically prohibits the prescribing of controlled substances via the Internet without an in-person evaluation. Federal regulation, 21 CFR §829 specifically states:

*No controlled substance that is a prescription drug as determined under the Federal Food, Drug, and Cosmetic Act may be delivered, distributed or dispensed by means of the Internet without a valid prescription.*

A valid prescription is further defined under the same regulation as one issued by a practitioner who has conducted an in-person evaluation. The in-person evaluation requires that the patient be in the physical presence of the provider without regard to the presence or conduct of other professionals.<sup>12</sup> However, the Ryan Haight Online Pharmacy Consumer Protection Act,<sup>13</sup> signed into law in October 2008, created an exception for the in-person medical evaluation for telemedicine practitioners. The practitioner is still subject to the requirement that all controlled substances be issued for a legitimate purpose by a practitioner acting in the usual course of professional practice.

The Drug Enforcement Administration (DEA) of the federal Department of Justice issued its own definition of telemedicine in April 2009 as required under the Haight Act.<sup>14</sup> The federal regulatory definition of telemedicine under the DEA includes, but is not limited to, the following elements:

- The patient and practitioner are located in separate locations;
- Patient and practitioner communicate via a telecommunications system;
- The practitioner must meet other registration requirements for the dispensing of controlled substances via the Internet; and
- Certain practitioners (Department of Veterans Affairs’ employees, for example) or practitioners in certain situations (public health emergencies) may be exempted from registration requirements.<sup>15</sup>

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<sup>11</sup> Id.

<sup>12</sup> 21 CFR §829(e)(2).

<sup>13</sup> Ryan Haight Online Consumer Protection Act of 2008, Public Law 110-425 (H.R. 6353).

<sup>14</sup> Id., at sec. 3(j).

<sup>15</sup> 21 CFR §802(54).

### ***Medicare Coverage***

Specific telehealth services delivered at designated sites are covered under Medicare. Regulations of federal CMS require both a distant site (location of physician delivering the service via telecommunications) and an originating site (location of the patient).

To qualify for Medicare reimbursement, the Medicare beneficiary must be located at an originating site that meets one of three qualifications. These three qualifications are:

- A rural Health Professional Shortage Area either outside of a Metropolitan Statistical Area (HPSA) or in a rural census tract;
- A county outside of a MSA; or
- Participation in a federal telemedicine demonstration project approved by the Secretary of Health and Human Services as of December 31, 2000.<sup>16</sup>

Additionally, federal requirements provide that an originating site must be one of the following location types as further defined in federal law and regulation:

- The offices of physicians or practitioners;
- Hospitals;
- Critical access hospitals (CAH);
- Rural health clinics;
- Federally qualified health centers;
- Hospital-based or CAH-based renal dialysis centers (including satellites);
- Skilled nursing facilities; and,
- Community mental health centers.<sup>17</sup>

Distant site practitioners are limited, subject also to state law, under Medicare to:

- Physicians;
- Nurse practitioners;
- Physician assistants;
- Nurse-midwives;
- Clinical nurse specialists;
- Certified registered nurse anesthetists;
- Clinical psychologists and clinical social workers (limited CPT codes); and,
- Registered dietitians and nutrition professionals.

For 2015, Medicare added four new services under telehealth:

- Annual wellness visits;
- Psychoanalysis;
- Psychotherapy; and,

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<sup>16</sup> Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Telehealth Services- Rural Health Fact Sheet* (Dec. 2014), <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctshst.pdf> (last visited Feb. 10, 2015).

<sup>17</sup> See 42 U.S.C. sec. 1395(m)(4)(C)(ii).

- Prolonged evaluation and management services.<sup>18</sup>

Reimbursement for the distant site is established as “an amount equal to the amount that such physician or practitioner would have been paid under this title had such service been furnished without the use of a telecommunications system.”<sup>19</sup> Federal law also provides for a facility fee for the originating site that started and remained at \$20 through December 31, 2002, and then, by law, is subsequently increased each year by the percentage increase in the Medicare Economic Index or MEI. For calendar year 2015, the originating fee for telehealth is 80 percent of the lesser of the actual charge or \$24.83.<sup>20</sup>

## **Telemedicine Services in Florida**

### ***University of Miami***

The University of Miami (UM) initiated telehealth services in 1973 and claims the first telehealth service in Florida, the first use of nurse practitioners in telemedicine in the nation, and the first telemedicine program in correctional facilities.<sup>21</sup> Today, UM has several initiatives in the area of telehealth, including:

- Tele-dermatology;
- Tele-trauma;
- Humanitarian and disaster response relief;
- School telehealth services; and
- Acute tele-neurology or telestroke.

While some of UM’s activities reach their local community, others reach outside of Florida, including providing Haiti earthquake relief and tele-dermatology to cruise line employees. Telehealth communications are also used for monitoring hospital patients and conducting training exercises.

### ***Florida Medicaid Program***

Florida’s Medicaid program reimburses only physicians for telemedicine services where there is two-way, real-time interactive communication between the patient and the physician at the distant site.<sup>22</sup> Equipment is also required to meet specific technical safeguards under 45 CFR 164.312, where applicable, which require implementation of procedures for protection of health information, including unique user identifications, automatic log-offs, encryption, authentication of users, and transmission security. Telemedicine services must also comply with all other state and federal laws regarding patient privacy.

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<sup>18</sup> Department of Health and Human Services, Centers for Medicare and Medicaid Services, *MLN Matters - News Flash #MM9034* (Dec. 24, 2014), <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9034.pdf> (last visited Feb. 10, 2015).

<sup>19</sup> See 42 U.S.C. s. 1395(m)(m)(2)(A).

<sup>20</sup> *Supra*, Note 18.

<sup>21</sup> University of Miami, Miller School of Medicine, *UM Telehealth - Our History*, <http://telehealth.med.miami.edu/about-us/our-history> (last visited Feb. 10, 2015).

<sup>22</sup> Agency for Health Care Administration, *Practitioner Services Handbook - Telemedicine Services (April 2014)* p.136, [http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/Practitioner%20Services%20Handbook\\_Adoption.pdf](http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/Practitioner%20Services%20Handbook_Adoption.pdf) (last visited Feb. 10, 2015).

For Medicaid, the distant or hub site is site where the consulting physician delivering the telemedicine service is located. The spoke site is the location of the Medicaid recipient at the time the service occurs. The spoke site does not receive any reimbursement unless the provider located at the spoke site performs a separate service for the Medicaid recipient on the same day as the telemedicine consultation. The telemedicine referral consultation requires the presence of the referring practitioner and the Medicaid recipient.<sup>23</sup>

Under fee for services Medicaid, reimbursement for telemedicine services are limited to certain services and settings. The following minimum services are currently covered:<sup>24</sup>

- Behavioral Health
  - Telepsychiatry services for psychiatric medication management by practitioners licensed under ch. 458 or 459, F.S.
  - Telebehavioral health services for a provision of individual and family behavioral health therapy services by qualified practitioners licensed under ch. 490 or 491, F.S.
- Dental Services
  - Provided using video conferencing between a registered dental hygienist employed by and under contract with a Medicaid-enrolled group provider and supervising dentist.
  - Services provided include oral prophylaxis, topical fluoride application and oral hygiene instructions.
- Physician Services
  - Services provided using audio and video equipment that allow for two-way, real-time, interactive communication between the physician and patient.
  - Consultation services provided via telemedicine.
  - Physicians actively licensed in Florida may also interpret diagnostic testing results through telecommunications and information technology.
  - Synchronous emergency services provided under parts III and IV of ch. 409, F.S., using an all-inclusive rate.

Medicaid does not reimburse for the following telemedicine services:

- Telephone conversations;
- Video cell phone conversations;
- E-mail messages;
- Facsimile transmission;
- Telecommunication with recipient at a location other than the spoke; and,
- “Store and forward” consultations which are transmitted after the recipient or physician is no longer available.<sup>25</sup>

Medicaid also does not reimburse providers for the costs of any equipment related to telemedicine services.

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<sup>23</sup> *Supra*, Note 21 at 137.

<sup>24</sup> Agency for Health Care Administration, *Senate Bill 478 Analysis* (Feb. 4, 2015) p. 3, (on file with the Senate Committee on Health Policy).

<sup>25</sup> *Id.*

Coverage of telemedicine services under Medicaid includes specific documentation requirements. The clinical record must include the following information:

- A brief explanation of why the services were not provided face-to-face;
- Documentation of telemedicine service provided including the results of the assessment; and,
- A signed statement from the recipient (parent or guardian, if a child), indicating their choice to receive services through telemedicine. This statement may be for a set period of treatment or a one-time visit.<sup>26</sup>

Under Medicaid Managed Care Assistance (MMA), the model contract executed by the plans provides a telemedicine coverage option and permits the plan to use telemedicine for behavioral health, dental services, and physician services.<sup>27</sup> The plan may use telemedicine for other services if approved by the Agency for Health Care Administration. The contract's model Attachment includes a check-off for the inclusion specifically for behavioral health care and dental services under telemedicine.<sup>28</sup>

Most of the same reimbursement guidelines, technology requirements and privacy provisions apply under the MMA contract as were applicable under the Medicaid fee-for-service and general Medicaid Provider Handbook.<sup>29</sup>

### ***Child Protection Teams***

The Child Protection Team (CPT) program under the Children's Medical Services Network utilizes a telemedicine network to perform child assessments. The CPT is a medically directed multi-disciplinary program that works with local Sheriff's offices and the Department of Children and Families in cases of child abuse and neglect to supplement investigative activities.<sup>30</sup> The CPT patient is seen at a remote site and a registered nurse assists with the medical exam. A physician or Advanced Registered Nurse Practitioner (ARNP) is located at the hub site and has responsibility for directing the exam.<sup>31</sup>

Hub sites are comprehensive medical facilities that offer a wide range of medical and interdisciplinary staff, whereas the remote sites tend to be smaller facilities that may lack medical diversity.<sup>32</sup> Twenty four hub sites throughout the state facilitate these child abuse assessments and with the evaluation of suspected cases of child abuse. The University of Florida

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<sup>26</sup> Id.

<sup>27</sup> Agency for Health Care Administration, *2012-2015 Medicaid Health Plan Model Agreement Attachment II - Exhibit II-A*, [http://ahca.myflorida.com/medicaid/statewide\\_mc/pdf/mma/Attachment\\_II\\_Exhibit\\_II-A\\_MMA\\_Model\\_2014-01-31.pdf](http://ahca.myflorida.com/medicaid/statewide_mc/pdf/mma/Attachment_II_Exhibit_II-A_MMA_Model_2014-01-31.pdf), p. 63-64 (Last visited Feb. 10, 2015).

<sup>28</sup> Agency for Health Care Administration, *2012-2015 Medicaid Health Plan Model Contract Attachment I - Scope of Services (PSN Model)*, [http://ahca.myflorida.com/mchq/managed\\_health\\_care/MHMO/docs/contract/1215\\_Contract/2012-2015/Jan2013/2012-15\\_HP-ContractAtt-I-FFS-JAN-2013-CLEAN.pdf](http://ahca.myflorida.com/mchq/managed_health_care/MHMO/docs/contract/1215_Contract/2012-2015/Jan2013/2012-15_HP-ContractAtt-I-FFS-JAN-2013-CLEAN.pdf) p. 6, (Last visited Feb. 10, 2015).

<sup>29</sup> *Supra*, Note 25.

<sup>30</sup> Florida Department of Health, *Child Protection Teams*, [http://www.floridahealth.gov/AlternateSites/CMS-Kids/families/child\\_protection\\_safety/child\\_protection\\_teams.html](http://www.floridahealth.gov/AlternateSites/CMS-Kids/families/child_protection_safety/child_protection_teams.html) (Last visited Feb. 10, 2015).

<sup>31</sup> Florida Department of Health, *Children Protection Team - Telemedicine Network* [http://www.floridahealth.gov/AlternateSites/CMS-Kids/families/child\\_protection\\_safety/documents/cpt\\_telemedicine\\_fact\\_sheet.pdf](http://www.floridahealth.gov/AlternateSites/CMS-Kids/families/child_protection_safety/documents/cpt_telemedicine_fact_sheet.pdf) (Last visited Feb. 10, 2015)

<sup>32</sup> Id.



Child Abuse Protection Team, for example, serves a 12 county area and for the first 6 months of 2012 provided over 250 telemedicine examinations with medical community partners.<sup>33</sup>

### **Compliance with Health Insurance Portability and Accountability Act (HIPAA)**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects personal health information (PHI). Privacy rules were initially issued in 2000 by the federal Department of Health and Human Services and later modified in 2002. These rules address the use and disclosure of an individual's health information as well as create standards for privacy rights. Additional privacy and security measures were adopted in 2009 with the Health Information Technology for Economic Clinical Health (HITECH) Act.

Only certain entities are subject to HIPAA's provisions. These "covered entities" include:

- Health plans;
- Health care providers;
- Health care clearinghouses; and
- Business Associates.

While not a covered entity as an individual, the patient still maintains his or her privacy and confidentiality rights regardless of the method in which the medical service is delivered. The HITECH Act specifically identified telemedicine as an area for review and consideration and funding was provided, in part, to strengthen infrastructure and tools to promote telemedicine.<sup>34</sup>

Under the provisions of HIPAA and the HITECH Act, a health care provider or other covered entity participating in telemedicine is required to meet the same technical and physical HIPAA and HITECH requirements as would be required for a physical office visit. These requirements include ensuring that the equipment and technology is HIPAA compliant.

### **III. Effect of Proposed Changes:**

CS/SB 478 creates s. 456.4501, F.S., relating to the provision of telehealth services and designates by chapter which health care practitioners may provide such services. The telehealth provision covers all health care practitioners as defined under s. 456.001, F.S.,<sup>35</sup> with the exception of naturopaths and nursing home administrators. The definition of a telehealth provider also includes radiological personnel and an emergency medical technician or a paramedic certified under part III of ch. 401, F.S.

The bill defines telehealth as the "use of synchronous or asynchronous telecommunications to perform services that include, but are not limited to:

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<sup>33</sup> Sunshine Arnold and Debra Esernio-Jensen, *Telemedicine: Reducing Trauma in Evaluating Abuse*, pp. 105-107, <http://cdn.intechopen.com/pdfs-wm/41847.pdf> (Last visited Feb. 14, 2015).

<sup>34</sup> Public Law 111-5, s. 3002(b)(2)(C)(iii) and s. 3011(a)(4).

<sup>35</sup> The definition of a "health care practitioner" includes 26 different disciplines: Acupuncture, medical practice, osteopathic medicine, chiropractic medicine, podiatry, naturopathy, optometry, nursing, pharmacy, dentistry, midwifery, speech-language-pathology-audiology, nursing home administration, occupational therapy, respiratory therapy, dietetics and nutrition practice, athletic trainers, orthotics, prosthetics, and pedorthotics, electrolysis, massage, clinical laboratory personnel, medical physicists, dispensing of optical devices and hearing aids, physical therapy, psychological services, and clinical, counseling, and psychotherapy.

- Patient assessment;
- Diagnosis;
- Consultation;
- Treatment;
- Monitoring;
- Transfer of medical data; and,
- Provision of patient and professional health related education.

CS/SB 478 specifically excludes from the definition of telehealth audio-only transmissions, email messages, or facsimile transmissions. The term also does not include consultations between a telehealth provider located in this state and a provider lawfully licensed in another state when the Florida licensed provider maintains responsibility for the patient in this state.

A telehealth provider is prohibited from solely using telehealth to prescribe lenses, spectacles, eyeglasses, contact lenses, or other optical devices or prescribe based solely on the use of a computer-controlled device such as an autorefractor.

Controlled substances may not be prescribed through telehealth for chronic non-malignant pain.<sup>36</sup> However, a physician may use telehealth to order a controlled substance for an inpatient admitted to a hospital facility licensed under ch. 395, F.S., or a hospice patient under ch. 400, F.S.

CS/SB 478 provides other practice standards for practicing via telehealth. The standards of care for services delivered via telehealth must be comparable to in-person health care services with a patient evaluation sufficient to diagnose and treat. The telehealth provider must maintain record-keeping that is also comparable to in-person health care services.

The bill clarifies that a non-physician practicing via telehealth within the applicable scope of practice for a telehealth provider is not deemed to be practicing medicine.

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

#### **IV. Constitutional Issues:**

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

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<sup>36</sup> “Chronic non-malignant pain” is defined as pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery.

**V. Fiscal Impact Statement:****A. Tax/Fee Issues:**

None.

**B. Private Sector Impact:**

Telemedicine services are currently available in Florida. Health care technology companies that provide the equipment for these services may see an increase in demand from health care practitioners for new equipment and maintenance needs of any existing equipment.

Patients in Florida may have greater access and more convenient access to health care services.

**C. Government Sector Impact:**

To the same extent that privately funded health care facilities may demand the expanded use of health care technology, publicly funded facilities and providers may see an equivalent increase in demand from health care practitioners for new equipment and maintenance needs of any existing equipment.

Patients located in more rural areas or areas with physician workforce shortages that rely on county health departments, federally qualified health centers or rural health clinics may see an increased benefit in the use and availability of telehealth technology.

**VI. Technical Deficiencies:**

None.

**VII. Related Issues:**

There are numerous other sections of state law that refer to “in person” or “face to face” requirements for certain medical services or health care related activities. While CS/SB 478 does not define “in person” for purposes of this legislation either, there are other usages of this phrase in statute.

**VIII. Statutes Affected:**

This bill creates section 456.4501 of the Florida Statutes.

**IX. Additional Information:****A. Committee Substitute – Statement of Changes:**

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

**CS by Health Policy on February 17, 2015:**

The committee substitute:

- Changes the subject of and references in the bill to telehealth rather than telemedicine.
- Specifies the practitioners who may be telehealth providers.
- Prohibits a telehealth provider from using telehealth to prescribe lenses, spectacles, eyeglasses, contact lenses, or other optical devices or prescribe based solely on a computer controlled device.
- Provides practice standards for practicing via telehealth.
- Deletes:
  - The Medicaid provision for coverage parity;
  - Rulemaking authority for the boards and the department, there is no practice board; and
  - Protection clause for the delivery of emergency medical services.

**B. Amendments:**

None.



813832

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/17/2015	.	
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The Committee on Health Policy (Bean) recommended the following:

**Senate Amendment (with title amendment)**

Delete everything after the enacting clause  
and insert:

Section 1. Section 456.4501, Florida Statutes, is created  
to read:

456.4501 Use of telehealth to provide services.-

(1) DEFINITIONS.-As used in this section, the term:

(a) "Telehealth" means the use of synchronous or  
asynchronous telecommunications technology by a telehealth



813832

11 provider to provide health care services, including, but not  
12 limited to, patient assessment, diagnosis, consultation,  
13 treatment, and monitoring; the transfer of medical data; patient  
14 and professional health-related education; public health  
15 services; and health care administration. The term does not  
16 include audio-only transmissions, e-mail messages, facsimile  
17 transmissions, or consultations between a telehealth provider in  
18 this state and a provider lawfully licensed in another state  
19 when the provider licensed in this state maintains  
20 responsibility for the care of a patient in this state.

21 (b) "Telehealth provider" means any person who provides  
22 health care and related services using telehealth and who is  
23 licensed under chapter 457; chapter 458; chapter 459; chapter  
24 460; chapter 461; chapter 463; chapter 464; chapter 465; chapter  
25 466; chapter 467; part I, part III, part IV, part V, part X,  
26 part XIII, or part XIV of chapter 468; chapter 478; chapter 480;  
27 parts III and IV of chapter 483; chapter 484; chapter 486;  
28 chapter 490; or chapter 491, or who is certified under part III  
29 of chapter 401.

30 (2) PRACTICE STANDARDS.—

31 (a) The standard of care for a telehealth provider  
32 providing medical care to a patient is the same as the standard  
33 of care generally accepted for a health care professional  
34 providing in-person health care services to a patient. If a  
35 telehealth provider conducts a patient evaluation sufficient to  
36 diagnose and treat the patient, the telehealth provider is not  
37 required to research the patient's medical history or conduct a  
38 physical examination of the patient before using telehealth to  
39 provide services to the patient. A telehealth provider may use



813832

40 telehealth to perform a patient evaluation.

41 (b) A telehealth provider and a patient may be in separate  
42 locations when telehealth is used to provide health care  
43 services to the patient.

44 (c) A nonphysician telehealth provider using telehealth and  
45 acting within the relevant scope of practice is not deemed to be  
46 practicing medicine without a license under any provision of law  
47 listed in paragraph (1)(b).

48 (d) A telehealth provider who is otherwise authorized to  
49 prescribe a controlled substance named or described in Schedules  
50 I through V of s. 893.03 may use telehealth to prescribe the  
51 controlled substance, except that telehealth may not be used to  
52 prescribe a controlled substance to treat chronic nonmalignant  
53 pain as defined in s. 458.3265. This paragraph does not preclude  
54 a physician from using telehealth to order a controlled  
55 substance for an inpatient admitted to a facility licensed under  
56 chapter 395 or a hospice patient under chapter 400.

57 (3) RECORDS.—A telehealth provider shall document in the  
58 patient's medical record the health care services rendered using  
59 telehealth according to the same standard used for in-person  
60 health care services pursuant to ss. 395.3025(4) and 456.057.

61 Section 2. This act shall take effect July 1, 2015.

62  
63

64 ===== T I T L E A M E N D M E N T =====

65 And the title is amended as follows:

66 Delete everything before the enacting clause  
67 and insert:

68 A bill to be entitled



813832

69 An act relating to telehealth; creating s. 456.4501,  
70 F.S.; defining the terms "telehealth" and "telehealth  
71 provider"; providing for certain practice standards  
72 for telehealth providers; authorizing telehealth  
73 providers to use telehealth for prescribing controlled  
74 substances, with an exception; providing for the  
75 maintenance and confidentiality of medical records;  
76 providing an effective date.





539316

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/17/2015	.	
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The Committee on Health Policy (Galvano) recommended the following:

1           **Senate Amendment to Amendment (813832) (with title**  
2 **amendment)**

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4           Between lines 56 and 57  
5 insert:

6           (e) A telehealth provider may not use telehealth to  
7 prescribe lenses, spectacles, eyeglasses, contact lenses, or  
8 other optical devices or prescribe based solely on the  
9 refractive error of the human eye generated by a computer-  
10 controlled device such as an autorefractor.



539316

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===== T I T L E A M E N D M E N T =====

And the title is amended as follows:

Delete line 74

and insert:

substances, with an exception; prohibiting the use of  
telehealth or specified computer-controlled devices to  
prescribe optical devices; providing for the

By Senators Bean and Joyner

4-00604-15

2015478\_\_

A bill to be entitled

An act relating to telemedicine services; creating s. 456.4501, F.S.; defining the term "telemedicine services"; authorizing an emergency medical technician, a paramedic, or a health care practitioner to provide telemedicine services through the use of certain telecommunications technology to a patient who is a resident of this state; requiring telemedicine services to be covered by specified Medicaid programs in the same manner as services provided to a recipient in person; prohibiting the prescription of controlled substances for certain chronic nonmalignant pain through the use of telemedicine services; authorizing the Department of Health and any applicable regulatory board to adopt rules to administer the section; specifying that such rules may not prohibit the use of telemedicine services; prohibiting the regulation of telemedicine services from being construed to restrict the delivery of certain emergency medical services; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 456.4501, Florida Statutes, is created to read:

456.4501 Use of telemedicine services.—

(1) As used in this section, the term "telemedicine services" means the use of synchronous or asynchronous telecommunications technology to perform services that include,

Page 1 of 2

**CODING:** Words ~~stricken~~ are deletions; words underlined are additions.

4-00604-15

2015478\_\_

but are not limited to, patient assessment, diagnosis, consultation, treatment, and monitoring, the transfer of medical data, and the provision of patient and professional health-related education. The term does not include audio-only transmissions, e-mail messages, or facsimile transmissions.

(2) An emergency medical technician or a paramedic certified pursuant to s. 401.27 or a health care practitioner may provide telemedicine services to a patient who is a resident of this state. Such services shall be covered by Medicaid under parts III and IV of chapter 409 in the same manner as services that are provided to a recipient in person.

(3) A controlled substance as defined in s. 893.02 may not be prescribed for chronic nonmalignant pain as defined in s. 456.44 through the use of telemedicine services.

(4) Rules to administer this section may be adopted by the department for emergency medical technicians and paramedics certified pursuant to s. 401.27 and health care practitioners who are not subject to regulation by a board, and by any applicable health care practitioner board. Such rules may not prohibit the use of telemedicine services.

(5) This section may not be construed to restrict the delivery of emergency medical services as defined in s. 401.107.

Section 2. This act shall take effect July 1, 2015.

Page 2 of 2

**CODING:** Words ~~stricken~~ are deletions; words underlined are additions.



## THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

### COMMITTEES:

Appropriations Subcommittee on Criminal and  
Civil Justice, *Vice Chair*  
Appropriations  
Health Policy  
Higher Education  
Judiciary  
Rules

### JOINT COMMITTEE:

Joint Legislative Budget Commission

### SENATOR ARTHENIA L. JOYNER

*Democratic Leader*  
19th District

February 3, 2015

Senator Aaron Bean, Chair  
Senate Committee on Health Policy  
530 Knott Building  
404 S. Monroe Street  
Tallahassee, FL 32399-1100

Dear Chairman Bean:

This is to request that Senate Bill 478, Telemedicine Services, for which we are co-prime sponsors be placed on the agenda for the Committee on Health Policy. Your consideration of this request is greatly appreciated.

Sincerely,

A handwritten signature in cursive script that reads "Arthenia L. Joyner".

Arthenia L. Joyner  
State Senator, District 19

#### REPLY TO:

- 508 W. Dr. Martin Luther King, Jr. Blvd., Suite C, Tampa, Florida 33603-3415 (813) 233-4277
- 200 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5019 FAX: (813) 233-4280

Senate's Website: [www.flsenate.gov](http://www.flsenate.gov)

**ANDY GARDINER**  
President of the Senate

**GARRETT RICHTER**  
President Pro Tempore

THE FLORIDA SENATE  
**APPEARANCE RECORD**

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/17/15  
Meeting Date

478  
Bill Number (if applicable)

Q 813832  
Amendment Barcode (if applicable)

Topic Telemedicine

Name David Christian

Job Title VP - Governmental Affairs

Address 136 S. Bronough St.  
Street  
Tallahassee FL 32301  
City State Zip

Phone 850/521-1211

Email dchristian

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing FL Chamber of Commerce

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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2/17/15  
Meeting Date

478  
Bill Number (if applicable)  
P13832  
Amendment Barcode (if applicable)

Topic TELEHEALTH

Name JACK McRAY

Job Title \_\_\_\_\_

Address 200 W. COLLEGE ST. #304  
Street

Phone 850-577-5127

TLH FL 32301  
City State Zip

Email jmcray@aarp.org

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing AARP

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

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2/17/15  
Meeting Date

478  
Bill Number (if applicable)

013832  
Amendment Barcode (if applicable)

Topic ~~TELEHEALTH~~ Tele Health

Name Vences Troncoso

Job Title Vice President + General Counsel

Address 200 W. College St. Phone 850-212-2178

Tallahassee FL 32307  
City State Zip

Email \_\_\_\_\_

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing Florida Association of Health Plans

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

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2/17  
Meeting Date

478  
Bill Number (if applicable)

Topic Telemedicine

Amendment Barcode (if applicable)

Name Chris Hansen

Job Title Lobbyist

Address Ballard Partners

Phone 577-0444

Street

Tallahassee  
City State Zip

Email Chansen@ballardfl.com

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing Florida Podiatric Medical Association

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

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S-001 (10/14/14)



THE FLORIDA SENATE  
**APPEARANCE RECORD**

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/17  
Meeting Date

478  
Bill Number (if applicable)

Topic Telehealth

Amendment Barcode (if applicable)

Name Alisa LaPolt

Job Title \_\_\_\_\_

Address PO BOX 1344  
Street

Phone 850 443-1319

Tallahassee FL 32302  
City State Zip

Email alisa~~lapolt~~@go to psent.com

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing Florida Nurses Association

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

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THE FLORIDA SENATE  
**APPEARANCE RECORD**

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2/17/2015  
Meeting Date

SB 478  
Bill Number (if applicable)

Topic Telemedicine

Amendment Barcode (if applicable)

Name Kim Landry MD

Job Title Emergency Physician & EMS Medical Director

Address 405 waterford lane  
Street

Phone 850-982-9384

Gulf Breeze  
City

Florida  
State

32561  
Zip

Email Kim.Landry@lifeguardambulance.com

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing Several EMS Ambulance Services

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

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S-001 (10/14/14)

# APPEARANCE RECORD

2/17/15

Meeting Date

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

SB 478

Bill Number (if applicable)

Topic Telehealth

Amendment Barcode (if applicable)

Name Crystal Strick

Job Title VP Gov Affairs

Address 306 E College

Phone 850 445 4844

Street

TLH FL

City

State

Zip

Email

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing Florida Hospital Assoc

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

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# APPEARANCE RECORD

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2/17/2015

Meeting Date

SB 478

Bill Number (if applicable)

Topic Telehealth / Telemedicine

Amendment Barcode (if applicable)

Name Skylar Zander

Job Title Deputy State Director

Address 200 W. College Ave, Ste 113

Phone 850-728-4522

Street

Tallahassee

FL

State

32301

Zip

Email SZander@AFHQ.org

City

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing Americans for Prosperity

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

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THE FLORIDA SENATE

APPEARANCE RECORD

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50478  
Bill Number (if applicable)

Meeting Date

Amendment Barcode (if applicable)

Topic Telehealth

Name Stan Whitaker

Job Title Chairman

Address 6294 N. W. Tolney Ave Rd Phone \_\_\_\_\_

Street

Bristol

City

FL

State

32321

Zip

Email StanWhit@aol.com

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing FL Association of Nurse Practitioners

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

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THE FLORIDA SENATE

APPEARANCE RECORD

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478

Meeting Date

Bill Number (if applicable)

Topic Telemedicine

Amendment Barcode (if applicable)

Name Phillip Oeters

Job Title VP Govt & Community Relations

Address 6812 San Vicente

Phone

Street

Coral Gables, FL

33146

Email phillso@baptisthealth.net

City

State

Zip

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

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S-001 (10/14/14)

# APPEARANCE RECORD

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2/17/15

Meeting Date

SB 478

Bill Number (if applicable)

Topic \_\_\_\_\_

Amendment Barcode (if applicable)

Name Jeff Scott

Job Title \_\_\_\_\_

Address 1430 Piedmont Dr. E.

Phone 224-6496

Street

Tallahassee

FL

32308

City

State

Zip

Email jscott@flmedical.org

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing Florida Medical Association

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

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# APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

478  
Bill Number (if applicable)

Meeting Date \_\_\_\_\_

Amendment Barcode (if applicable) \_\_\_\_\_

Topic Telehealth

Name Jess Scher

Job Title Director, ~~United Way of Miami Dade~~ Public Policy

Address 3250 SW 3<sup>rd</sup> Ave

Phone 305 322 6143

Street

Miami, FL

City

33129

State

Zip

Email schersj@unitedwaymiami.org

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing United Way of Miami Dade

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

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THE FLORIDA SENATE

APPEARANCE RECORD

2/17/15  
Meeting Date

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

545

Bill Number (if applicable)

813832

Amendment Barcode (if applicable)

Topic Tele medicine

Name Paul Lambert

Job Title \_\_\_\_\_

Address \_\_\_\_\_  
Street

IN SUPPORT

Phone \_\_\_\_\_

City

State

Zip

Email \_\_\_\_\_

Waive

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing FLA. CHIROPRACTIC ASSO.

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

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THE FLORIDA SENATE  
**APPEARANCE RECORD**

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2/12/15  
Meeting Date

SB 478  
Bill Number (if applicable)

Topic Telemedicine

Amendment Barcode (if applicable)

Name Larry Gonzalez

Job Title General Counsel

Address 223 S. Gadsden ST

Phone 850-222-0465

Street

Tallahassee

City

FL

State

32

Zip

Email lawgonz@earthlink.net

Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing Florida Society of Health-System Pharmacists

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

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**The Florida Senate**  
**BILL ANALYSIS AND FISCAL IMPACT STATEMENT**

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

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Prepared By: The Professional Staff of the Committee on Health Policy

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BILL: SPB 7032

INTRODUCER: Health Policy Committee

SUBJECT: Public Records/Reports of a Deceased Child

DATE: February 13, 2015

REVISED: \_\_\_\_\_

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ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. Looke	Stovall		<b>HP Submitted as Committee Bill</b>

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## I. Summary:

SPB 7032 reenacts and amends the public records and public meetings exemptions for certain identifying information held by the State Child Abuse Death Review Committee or a local child abuse death review committee to reflect changes to the child welfare laws enacted during the 2014 Session. Specifically, the bill extends the exemption to cases reviewed by a committee where the death was determined not to be the result of abuse or neglect and limits the exemption for cases involving verified abuse or neglect. Identifying information related to deaths from verified abuse or neglect, with the exception of surviving siblings, is now posted on the Child Fatality Prevention Website of the Department of Children and Families. As such, confidentiality under s. 383.412, F.S., is no longer warranted for other family members or others living in the home. The bill also authorizes release of confidential information to a governmental agency in furtherance of its duties or a person or entity for research or statistical purposes.

The exemption is subject to the Open Government Sunset Review Act and will stand repealed on October 2, 2020, unless reviewed and reenacted by the Legislature.

The bill contains a public necessity statement as required by the Florida Constitution.

Because this bill expands a public records exemption, a two-thirds vote of the members present and voting in each house of the Legislature is required for passage.

## II. Present Situation:

### Public Records and Open Meetings Requirements

The Florida Constitution provides that the public has the right to access government records and meetings. The public may inspect or copy any public record made or received in connection with the official business of any public body, officer, or employee of the state, or of persons acting on their behalf.<sup>1</sup> The public also has a right to be afforded notice and access to meetings of any

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<sup>1</sup> FLA. CONST., art. I, s. 24(a).

collegial public body of the executive branch of state government or of any local government.<sup>2</sup> The Legislature's meetings must also be open and noticed to the public, unless there is an exception provided for by the Constitution.<sup>3</sup>

In addition to the Florida Constitution, the Florida Statutes specify conditions under which public access must be provided to government records and meetings. The Public Records Act<sup>4</sup> guarantees every person's right to inspect and copy any state or local government public record.<sup>5</sup> The Sunshine Law<sup>6</sup> requires all meetings of any board or commission of any state or local agency or authority at which official acts are to be taken to be noticed and open to the public.<sup>7</sup>

The Legislature may create an exemption to public records or open meetings requirements.<sup>8</sup> An exemption must specifically state the public necessity justifying the exemption<sup>9</sup> and must be tailored to accomplish the stated purpose of the law.<sup>10</sup>

### **Open Government Sunset Review Act**

The Open Government Sunset Review Act (referred to hereafter as the "OGSR") prescribes a legislative review process for newly created or substantially amended public records or open meetings exemptions.<sup>11</sup> The OGSR provides that an exemption automatically repeals on

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<sup>2</sup> FLA. CONST., art. I, s. 24(b).

<sup>3</sup> FLA. CONST., art. I, s. 24(b).

<sup>4</sup> Chapter 119, F.S.

<sup>5</sup> Section 119.011(12), F.S., defines "public record" to mean "all documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of the physical form, characteristics, or means of transmission, made or received pursuant to law or ordinance or in connection with the transaction of official business by any agency." Section 119.011(2), F.S., defines "agency" to mean as "any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law including, for the purposes of this chapter, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency." The Public Records Act does not apply to legislative or judicial records. *Locke v. Hawkes*, 595 So.2d 32 (Fla. 1992). The Legislature's records are public pursuant to section 11.0431, F.S.

<sup>6</sup> Section 286.011, F.S.

<sup>7</sup> Section 286.011(1)-(2), F.S. The Sunshine Law does not apply to the Legislature; rather, open meetings requirements for the Legislature are set out in the Florida Constitution. Article III, section 4(e) of the Florida Constitution provide that legislative committee meetings must be open and noticed to the public. In addition, prearranged gatherings, between more than two members of the Legislature, or between the Governor, the President of the Senate, or the Speaker of the House of Representatives, the purpose of which is to agree upon or to take formal legislative action, must be reasonably open to the public.

<sup>8</sup> FLA. CONST., art. I, s. 24(c). There is a difference between records the Legislature designates as exempt from public records requirements and those the Legislature designates *confidential* and exempt. A record classified as exempt from public disclosure may be disclosed under certain circumstances. *Williams v. City of Minneola*, 575 So.2d 687 (Fla. 5th DCA 1991). If the Legislature designates a record as confidential, such record may not be released, to anyone other than the persons or entities specifically designated in the statutory exemption. *WFTV, Inc. v. The School Board of Seminole*, 874 So.2d 48 (Fla. 5th DCA 2004).

<sup>9</sup> FLA. CONST., art. I, s. 24(c).

<sup>10</sup> FLA. CONST., art. I, s. 24(c).

<sup>11</sup> Section 119.15, F.S. Section 119.15(4)(b), F.S. provides that an exemption is considered to be substantially amended if it expanded to include more information or to include meetings. The OGSR does not apply to an exemption that is required by federal law or that applies solely to the Legislature or the State Court System pursuant to section 119.15(2), F.S.

October 2 of the fifth year after creation or substantial amendment; in order to save an exemption from repeal, the Legislature must reenact the exemption.<sup>12</sup>

The OGSR provides that a public records or open meetings exemption may be created or maintained only if it serves an identifiable public purpose and is no broader than is necessary.<sup>13</sup> An exemption serves an identifiable purpose if it meets one of the following criteria:

- It allows the state or its political subdivision to effectively and efficiently administer a program, and administration would be significantly impaired without the exemption;<sup>14</sup>
- Releasing sensitive personal information would be defamatory or would jeopardize an individual's safety. If this public purpose is cited as the basis of an exemption, however, only personal identifying information is exempt;<sup>15</sup> or
- It protects trade or business secrets.<sup>16</sup>

In addition, the Legislature must find that the identifiable public purpose is compelling enough to override Florida's open government public policy and that the purpose of the exemption cannot be accomplished without the exemption.<sup>17</sup>

The OGSR also requires specific questions to be considered during the review process.<sup>18</sup> In examining an exemption, the OGSR asks the Legislature to carefully question the purpose and necessity of reenacting the exemption.

If, in reenacting an exemption, the exemption is expanded, then a public necessity statement and a two-thirds vote for passage are required.<sup>19</sup> If the exemption is reenacted without substantive changes or if the exemption is narrowed, then a public necessity statement and a two-thirds vote for passage are *not* required. If the Legislature allows an exemption to sunset, the previously exempt records will remain exempt unless provided for by law.<sup>20</sup>

### **Child Abuse Death Review**

Current law establishes the State Child Abuse Death Review Committee and local child abuse death review committees within the Department of Health.<sup>21</sup> The committees must review the facts and circumstances of all deaths of children from birth through age 18 that occurred in Florida and are reported to the central abuse hotline of the Department of Children and

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<sup>12</sup> Section 119.15(3), F.S.

<sup>13</sup> Section 119.15(6)(b), F.S.

<sup>14</sup> Section 119.15(6)(b)1., F.S.

<sup>15</sup> Section 119.15(6)(b)2., F.S.

<sup>16</sup> Section 119.15(6)(b)3., F.S.

<sup>17</sup> Section 119.15(6)(b), F.S.

<sup>18</sup> Section 119.15(6)(a), F.S. The specified questions are: What specific records or meetings are affected by the exemption? Whom does the exemption uniquely affect, as opposed to the general public? What is the identifiable public purpose or goal of the exemption? Can the information contained in the records or discussed in the meeting be readily obtained by alternative means? If so, how? Is the record or meeting protected by another exemption? Are there multiple exemptions for the same type of record or meeting that it would be appropriate to merge?

<sup>19</sup> FLA. CONST., art. I, s. 24(c).

<sup>20</sup> Section 119.15(7), F.S.

<sup>21</sup> Section 383.402, F.S.

Families.<sup>22</sup> The state committee must prepare an annual statistical report on the incidence and causes of death resulting from reported child abuse in the state. The report must include recommendations for:

- State and local action, including specific policy, procedural, regulatory, or statutory changes; and
- Any other recommended preventive action.<sup>23</sup>

The law provides the committees with broad access to any information related to the deceased child, or his or her family, that is necessary to carry out its duties, including:

- Medical, dental, or mental health treatment records;
- Records in the possession of a state agency or political subdivision; and
- Records of law enforcement which are not part of an active investigation.<sup>24</sup>

Records typically obtained by the committees include, among others: death and birth certificates; medical examiner report; law enforcement report; criminal history reports; first responder reports; physician, hospital, and/or substance abuse and mental health records; and the Department of Children and Families case file.<sup>25</sup>

### **Exemptions Under Review**

Current law provides a public records and a public meetings exemption for the State Child Abuse Death Review Committee and local child abuse death review committees.<sup>26</sup>

Information that reveals the identity of the surviving siblings, family members, or others living in the home of a deceased child who is the subject of review by the state committee or a local committee is confidential and exempt from public records requirements.<sup>27</sup> In addition, confidential or exempt information obtained by the state committee or a local committee retains its confidential or exempt status.<sup>28</sup> The state and local committees may share with each other any relevant confidential or exempt information regarding case reviews.<sup>29</sup> Any person who knowingly or willfully violates the public records exemption commits a misdemeanor of the first degree.<sup>30,31</sup>

Portions of meetings of the State Child Abuse Death Review Committee or a local committee at which confidential and exempt information is discussed are exempt from public meetings

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<sup>22</sup> Section 383.402(1), F.S.

<sup>23</sup> Section 383.402(3)(c), F.S.

<sup>24</sup> Section 383.412(8) & (9), F.S.

<sup>25</sup> Email from Bryan Wendel, Office of Legislative Planning, Florida Dept. of Health, (August 25, 2014) (on file with the Senate Committee on Health Policy).

<sup>26</sup> Section 383.412, F.S.

<sup>27</sup> Section 383.412(2)(a), F.S.

<sup>28</sup> Section 383.412(2)(b), F.S.

<sup>29</sup> Section 383.412(4), F.S.

<sup>30</sup> Section 383.412(5), F.S.

<sup>31</sup> A misdemeanor of the first degree is punishable by a term of imprisonment not to exceed one year and a fine not to exceed \$1,000. *See* 775.082(4)(a) and 775.083(1)(d), F.S.

requirements.<sup>32</sup> Any portion of a closed meeting must be recorded and the recordings maintained by the state committee or local committee. No portion of the closed meeting may be off the record. The recording of a closed meeting is exempt from public records requirements.<sup>33</sup>

Pursuant to the Open Government Sunset Review Act, these exemptions will repeal on October 2, 2015, unless reenacted by the Legislature.<sup>34</sup>

The public records exemption was initially enacted by the Legislature in 1999 and amended and reenacted, thereafter in 2005 and 2010.<sup>35,36</sup> The stated purpose for the exemption was “to increase the potential for reduced morbidity or mortality of children and reduce the potential for poor outcomes for children, thereby improving the overall quality of life for children.”<sup>37</sup> The Legislature found that the release of sensitive, personal information could hamper open communication and coordination among parties during the death review and that the harm resulting from the release of such information substantially outweighed any public benefit.<sup>38</sup>

### **Senate Review of s. 383.412, F.S.**

In the course of conducting the Open Government Sunset Review of s. 383.412, F.S., Senate Health Policy Committee Staff met with representatives from the Department of Health and the Department of Children and Families and requested written input from the Florida Sheriffs Association.

Staff also reviewed ch. 2014-224, Laws of Florida (SB 1666), which contains substantial reforms to Florida’s child welfare laws, to determine its effect on the exemption. Since 2004, the statewide and local child abuse death review committees have reviewed only cases reported to the central abuse hotline that were determined to be the result of abuse or neglect.<sup>39</sup> Thus, the public records exemption related only to identifying information of the surviving siblings, family members, or others living in the home of a child who died as a result of verified abuse or neglect. SB 1666 expanded the scope of cases reviewed by the committees to include all deaths reported to the child abuse hotline, whether or not the result of verified abuse or neglect.<sup>40</sup>

SB 1666 also directed the Department of Children and Families to post certain information on its website when a child death is reported to the central abuse hotline. Data required to be posted includes the following deidentified demographic data: the date and alleged or verified cause of death; county of residence; existence of prior reports of abuse; whether the child was under 5

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<sup>32</sup> Section 383.412(3), F.S.

<sup>33</sup> Section 383.412(3)(b), F.S.

<sup>34</sup> Section 383.412(6), F.S.

<sup>35</sup> See Chs. 99-210, 2005-190, and 2010-40, Laws of Florida

<sup>36</sup> The initial act sunset in 2004 when legislation to reenact the exemption failed to pass both chambers of the Legislature. See Florida Senate, *Website Archive*, Senate 0462: Relating to Child Fatalities/Pub. Rec./OGSR [http://archive.flsenate.gov/session/index.cfm?BI\\_Mode=ViewBillInfo&Mode=Bills&ElementID=JumpToBox&SubMenu=1&Year=2004&billnum=462](http://archive.flsenate.gov/session/index.cfm?BI_Mode=ViewBillInfo&Mode=Bills&ElementID=JumpToBox&SubMenu=1&Year=2004&billnum=462) (last visited Feb. 13, 2015).

<sup>37</sup> Ch. 99-210, s. 2, Laws of Fla.

<sup>38</sup> *Id.*

<sup>39</sup> Ch. 2004-350, s. 14, Laws of Fla.

<sup>40</sup> Ch. 2014-224, s. 21, Laws of Fla.

years of age; and the involved community-based care lead agency, if applicable.<sup>41</sup> SB 1666 provides that posted data are supplemental to records that may be available to the public pursuant to a public records request.<sup>42</sup>

Section 39.202(1), F.S., makes all records held by the Department of Children and Families concerning reports of child abandonment, abuse, or neglect confidential and exempt from disclosure under the public records law. However, those files become publicly-available once the cause of death is determined to be the result of abuse, abandonment, or neglect, subject to the following exceptions:

- Information that identifies the person who reported the abuse, abandonment, or neglect;
- Information that is otherwise confidential and exempt;<sup>43</sup>
- Information that would identify siblings of a deceased child.<sup>44</sup>

Before SB 1666 was passed, the Department of Children and Families released the records of reported deaths resulting from verified abuse on a case-by-case basis, in response to individual public records requests. After SB 1666 was passed, the Department of Children and Families implemented its transparency requirements by launching the Child Fatality Prevention Website. Data and features on the website exceed the requirements of SB 1666.<sup>45</sup>

Among the expanded data elements are child fatality case summaries that reflect summary information contained in a deceased child's case file, including:

- Circumstances surrounding the death;
- Other children in the family; and
- Summary of prior agency involvement with the family.

Posted summary reports about child deaths resulting from verified abandonment, abuse, or neglect have been redacted to remove only sibling names. The names of others living in the household are published. Posted summary reports about deaths that are determined not to be the result of abandonment, abuse, or neglect report case files have been redacted to remove all identifiers.<sup>46</sup> Currently, identifying information that has been publicly-available from the case file, but was infrequently accessed, is now broadly accessible on demand from a public website.

---

<sup>41</sup> *Id.* at s. 7.

<sup>42</sup> *Id.*

<sup>43</sup> Section 39.202(2)(o), F.S.

<sup>44</sup> The Department of Children and Families interprets ss. 39.202(1) and (2)(o), F.S., as prohibiting release of information that would identify siblings of a deceased child. When a sibling is named in a report about a deceased child, the Department views information related to the sibling as a new report of abuse, abandonment, or neglect that is protected under s. 39.202(1), F.S.. See Email from Tim Parson, Office of Legislative Affairs, Florida Dept. of Children and Families (June 25, 2014) (on file with the Senate Health Policy Committee).

<sup>45</sup> Department of Children and Families, *DCF Launches Child Fatality Prevention Website Solidifying Commitment to Transparency* (June 25, 2014) <http://www.myflfamilies.com/press-release/dcf-launches-child-fatality-prevention-website-solidifying-commitment-transparency> (last visited Feb. 13, 2015).

<sup>46</sup> See e.g., Total Miami-Dade County Child Fatalities 2014: 31, Accidental Death Occurring 1/20/2014 as compared with Death From Verified Abuse Occurring 4/24/2014, available at <http://www.dcf.state.fl.us/childfatality/localresults.shtml?county=Miami-Dade&minage=0&maxage=18&year=2014&cause=&prior12=&verified=> (last visited Jan. 24, 2015).



### III. Effect of Proposed Changes:

The bill reenacts the public records and public meetings exemptions provided by s. 383.412, F.S., and aligns them with the transparency of data involving child deaths reported to the central abuse hotline that are posted on the Child Fatality Prevention Website. Specifically, the bill narrows the exemption for identifying information related to cases of verified abuse and neglect to information that identifies the deceased child's siblings. The bill also expressly extends the exemption to information held by the committees which reveals the identity of a deceased child whose death is not the result of verified abuse or neglect or the identity of the surviving siblings, family members, or others living in the home.

The bill also authorizes release of confidential information to a governmental agency in furtherance of its duties or a person or entity for research or statistical purposes. The person or entity must enter into a privacy agreement with the Department of Health and comply with all laws and rules governing the use of the information and may not disclose identifying information.

The bill extends the repeal date for the exemptions from October 2, 2015, to October 2, 2020. It also provides a public necessity statement as required by the State Constitution.

The bill takes effect upon becoming a law.

### IV. Constitutional Issues:

#### A. Municipality/County Mandates Restrictions:

None.

#### B. Public Records/Open Meetings Issues:

##### **Vote Requirement**

Article I, s. 24(c) of the Florida Constitution requires a two-thirds vote of the members present and voting in each house of the Legislature for passage of a newly-created or expanded public records or public meetings exemption. Because this bill expands a public records exemption, it requires a two-thirds vote for passage.

##### **Public Necessity Statement**

Article I, s. 24(c) of the Florida Constitution requires a public necessity statement for a newly-created or expanded public records or public meetings exemption. This bill expands a public records exemption and includes the required public necessity statement.

#### C. Trust Funds Restrictions:

None.

**V. Fiscal Impact Statement:**

## A. Tax/Fee Issues:

None.

## B. Private Sector Impact:

None.

## C. Government Sector Impact:

None.

**VI. Technical Deficiencies:**

None.

**VII. Related Issues:**

None.

**VIII. Statutes Affected:**

This bill substantially amends section 383.412 of the Florida Statutes.

**IX. Additional Information:**

## A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

## B. Amendments:

None.

FOR CONSIDERATION By the Committee on Health Policy

588-01519A-15

20157032pb

1 A bill to be entitled  
 2 An act relating to public records; amending s.  
 3 383.412, F.S.; exempting information held by the State  
 4 Child Abuse Death Review Committee or a local  
 5 committee which identifies a deceased child whose  
 6 death is reported to the central abuse hotline but  
 7 whose death is not the result of abuse or neglect and  
 8 the identity of the surviving siblings, family  
 9 members, or others living in the home of such a  
 10 deceased child; authorizing release of the information  
 11 to specified persons under certain circumstances;  
 12 providing for future legislative review and repeal of  
 13 the exemption under the Open Government Sunset Review  
 14 Act; providing a statement of public necessity;  
 15 providing an effective date.

16  
 17 Be It Enacted by the Legislature of the State of Florida:

18  
 19 Section 1. Section 383.412, Florida Statutes, is amended to  
 20 read:

21 383.412 Public records and public meetings exemptions.—

22 (1) For purposes of this section, the term "local  
 23 committee" means a local child abuse death review committee or a  
 24 panel or committee assembled by the State Child Abuse Death  
 25 Review Committee or a local child abuse death review committee  
 26 pursuant to s. 383.402.

27 (2) (a) Any information held by the State Child Abuse Death  
 28 Review Committee or a local committee which reveals the identity  
 29 of the surviving siblings of a deceased child whose death

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CODING: Words ~~stricken~~ are deletions; words underlined are additions.

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30 occurred as the result of a verified report of abuse or neglect  
 31 is confidential and exempt from s. 119.07(1) and s. 24(a), Art.  
 32 I of the State Constitution.

33 (b) Any information held by the State Child Abuse Death  
 34 Review Committee or a local committee which ~~that~~ reveals the  
 35 identity of a deceased child whose death has been reported to  
 36 the central abuse hotline but determined not to be the result of  
 37 abuse or neglect, or the identity of the surviving siblings,  
 38 family members, or others living in the home of such a deceased  
 39 child, who is the subject of review by and which information is  
 40 held by the State Child Abuse Death Review Committee or a local  
 41 committee is confidential and exempt from s. 119.07(1) and s.  
 42 24(a), Art. I of the State Constitution.

43 (c) ~~(b)~~ Information made confidential or exempt from s.  
 44 119.07(1) and s. 24(a), Art. I of the State Constitution that is  
 45 obtained by the State Child Abuse Death Review Committee or a  
 46 local committee shall retain its confidential or exempt status.

47 (3) (a) Portions of meetings of the State Child Abuse Death  
 48 Review Committee or a local committee at which information made  
 49 confidential and exempt pursuant to subsection (2) is discussed  
 50 are exempt from s. 286.011 and s. 24(b), Art. I of the State  
 51 Constitution. The closed portion of a meeting must be recorded,  
 52 and no portion of the closed meeting may be off the record. The  
 53 recording shall be maintained by the State Child Abuse Death  
 54 Review Committee or a local committee.

55 (b) The recording of a closed portion of a meeting is  
 56 exempt from s. 119.07(1) and s. 24(a), Art. I of the State  
 57 Constitution.

58 (4) The State Child Abuse Death Review Committee and local

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59 committees may share any relevant information regarding case  
 60 reviews involving child death which is made confidential and  
 61 exempt by this section:

62 (a) With each other;

63 (b) With a governmental agency in furtherance of its  
 64 duties; or

65 (c) With any person or entity authorized by the Department  
 66 of Health to use such relevant information for bona fide  
 67 research or statistical purposes ~~any relevant information~~  
 68 ~~regarding case reviews involving child death, which information~~  
 69 ~~is made confidential and exempt by this section. A person or~~  
 70 ~~entity who is authorized to obtain such relevant information for~~  
 71 ~~research or statistical purposes shall enter into a privacy and~~  
 72 ~~security agreement with the Department of Health and shall~~  
 73 ~~comply with all laws and rules governing the use of such records~~  
 74 ~~and information for research or statistical purposes. Anything~~  
 75 ~~identifying the subjects of such relevant information must be~~  
 76 ~~treated as confidential by the person or entity and may not be~~  
 77 ~~released in any form.~~

78 (5) Any person who knowingly or willfully makes public or  
 79 discloses to any unauthorized person any information made  
 80 confidential and exempt under this section commits a misdemeanor  
 81 of the first degree, punishable as provided in s. 775.082 or s.  
 82 775.083.

83 (6) This section is subject to the Open Government Sunset  
 84 Review Act in accordance with s. 119.15, and shall stand  
 85 repealed on October 2, ~~2020~~ 2015, unless reviewed and saved from  
 86 repeal through reenactment by the Legislature.

87 Section 2. The Legislature finds that it is a public

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20157032pb

88 necessity that any information held by the State Child Abuse  
 89 Death Review Committee or a local committee as defined in s.  
 90 383.412, Florida Statutes, which reveals the identity of a  
 91 deceased child whose death has been reported to the central  
 92 abuse hotline but determined not to be the result of abuse or  
 93 neglect, or the identity of the surviving siblings, family  
 94 members, or others living in the home of such deceased child, be  
 95 held confidential and exempt from public records requirements.  
 96 The Legislature further finds that it is a public necessity that  
 97 these committees have the authority to maintain the confidential  
 98 or exempt status of records otherwise confidential or exempt  
 99 which are provided to them regarding such children. In 1999, the  
 100 Legislature authorized the creation of the committees to review  
 101 the facts and circumstances surrounding the deaths of children  
 102 in this state which occur as the result of reported child abuse  
 103 or neglect and to prepare an annual statistical report on the  
 104 incidence and causes of death resulting from child abuse. Since  
 105 2004, cases analyzed by the committees have been limited to  
 106 reports of verified abuse or neglect. The Legislature made  
 107 identifying information of the surviving siblings, family  
 108 members, or others living in the home of the child who died as a  
 109 result of verified abuse or neglect confidential and exempt from  
 110 public records requirements to ensure that cases could be vetted  
 111 thoroughly through open communication without risk of disclosure  
 112 of the identifying information. In 2014, the Legislature  
 113 expanded the scope of cases reviewed by the committees to  
 114 include all deaths reported to the child abuse hotline,  
 115 regardless of whether the deaths were the result of verified  
 116 abuse or neglect, and this bill expands the public records

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117 exemption accordingly. If the identifying information related to  
118 these reports were to be disclosed, it could result in emotional  
119 or reputational harm to the family and caregivers and an  
120 unnecessary invasion of their privacy and the privacy of the  
121 deceased child. In addition, the committees must be able to  
122 maintain the otherwise confidential and exempt status of records  
123 that are provided to them to ensure continued access to such  
124 records and the opportunity for a thorough and open review of  
125 cases. Therefore, the Legislature finds that the harm that may  
126 result from the release of such information substantially  
127 outweighs any minimal public benefit that may be derived from  
128 its disclosure.

129 Section 3. This act shall take effect upon becoming a law.



FEBRUARY 2015

# MODELING FLORIDA'S PHYSICIAN WORKFORCE

## Statewide and Regional Analysis

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# Presentation Overview

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- Study goals
- Overview of modeling methods
- Key findings
- Summary and conclusions
- Additional slides on physician supply and demand inputs
- Q&A



# Study Goals

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- Obtain an accurate picture of the current and projected supply and demand for physicians in Florida through 2025
  - Impact of changing demographics on demand
  - Impact of the Affordable Care Act
- Identify current & projected future gaps between supply and demand
  - For State and 11 Medicaid regions
  - By individual specialty
  - By specialty categories
    - Traditional (core) primary care: family practice, general internal medicine, pediatrics, geriatric medicine
    - Expanded primary care: core specialties + general surgery, emergency medicine, ob-gyn
    - Non-primary care specialties



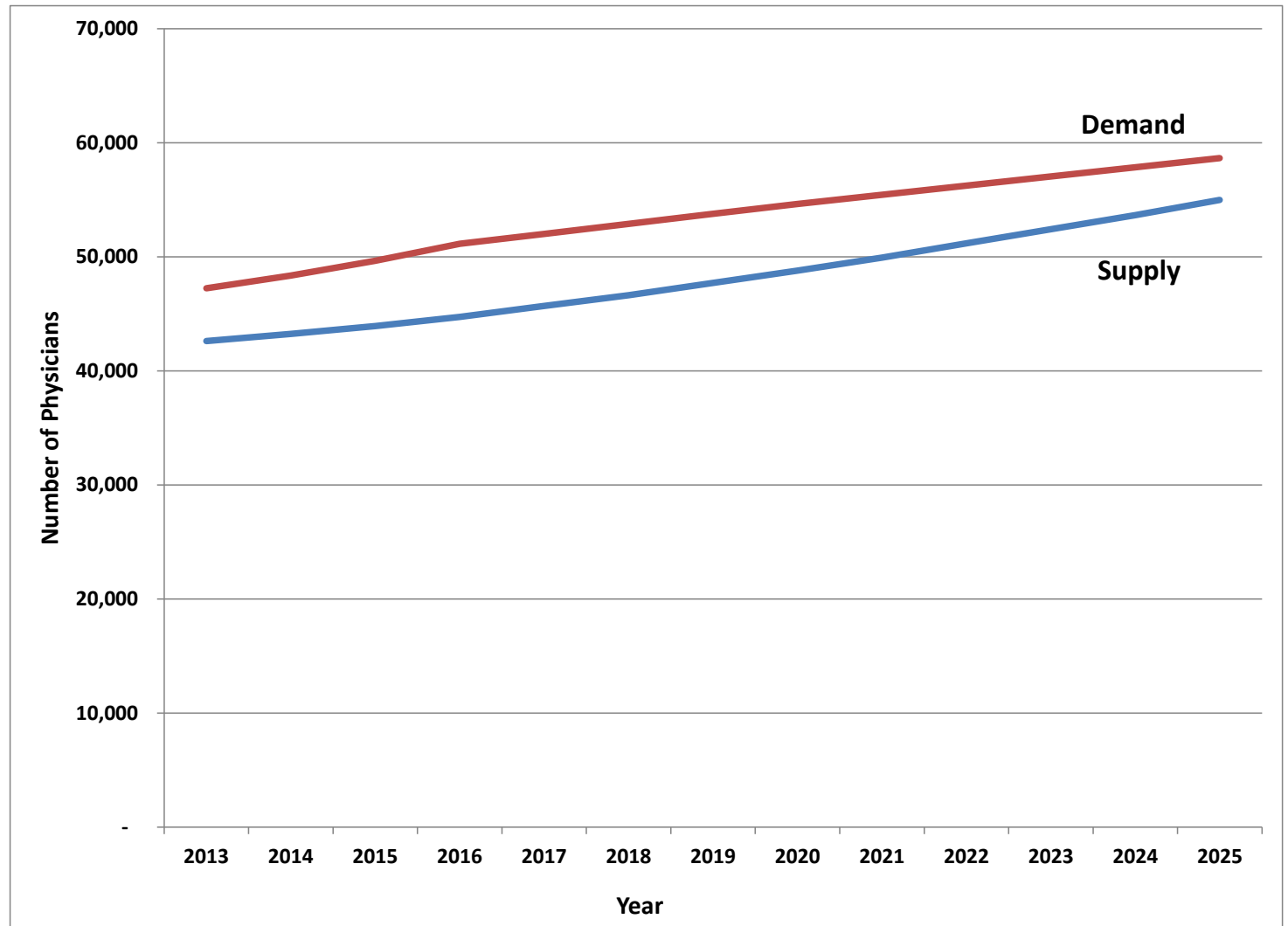
# Modeling Approach

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- Study used state-of-the-art microsimulation models
  - Healthcare Demand Microsimulation Model
  - Heath Workforce Supply Model
- Models are used to develop projections for approx. 40 health occupations for the federal Bureau of Health Professions
  - Nursing <http://bhw.hrsa.gov/healthworkforce/supplydemand/nursing/workforceprojections/index.html>
  - Forthcoming: oral health; allied health professions; physicians/advanced practice nurses/physician assistants
- Models used to support workforce studies for other states, professional associations, hospital systems
- Published information on the models
  - *Health Affairs* (2013): An Aging Population and Growing Disease Burden will Require a Large and Specialized Health Care Workforce by 2025
  - *Neurology* (2013): Supply and demand analysis of the current and future US neurology workforce
  - *Journal of Women's Health* (2013): Estimated Demand for Women's Health Services by 2020
- Models adapted to Florida using Florida-specific data where available

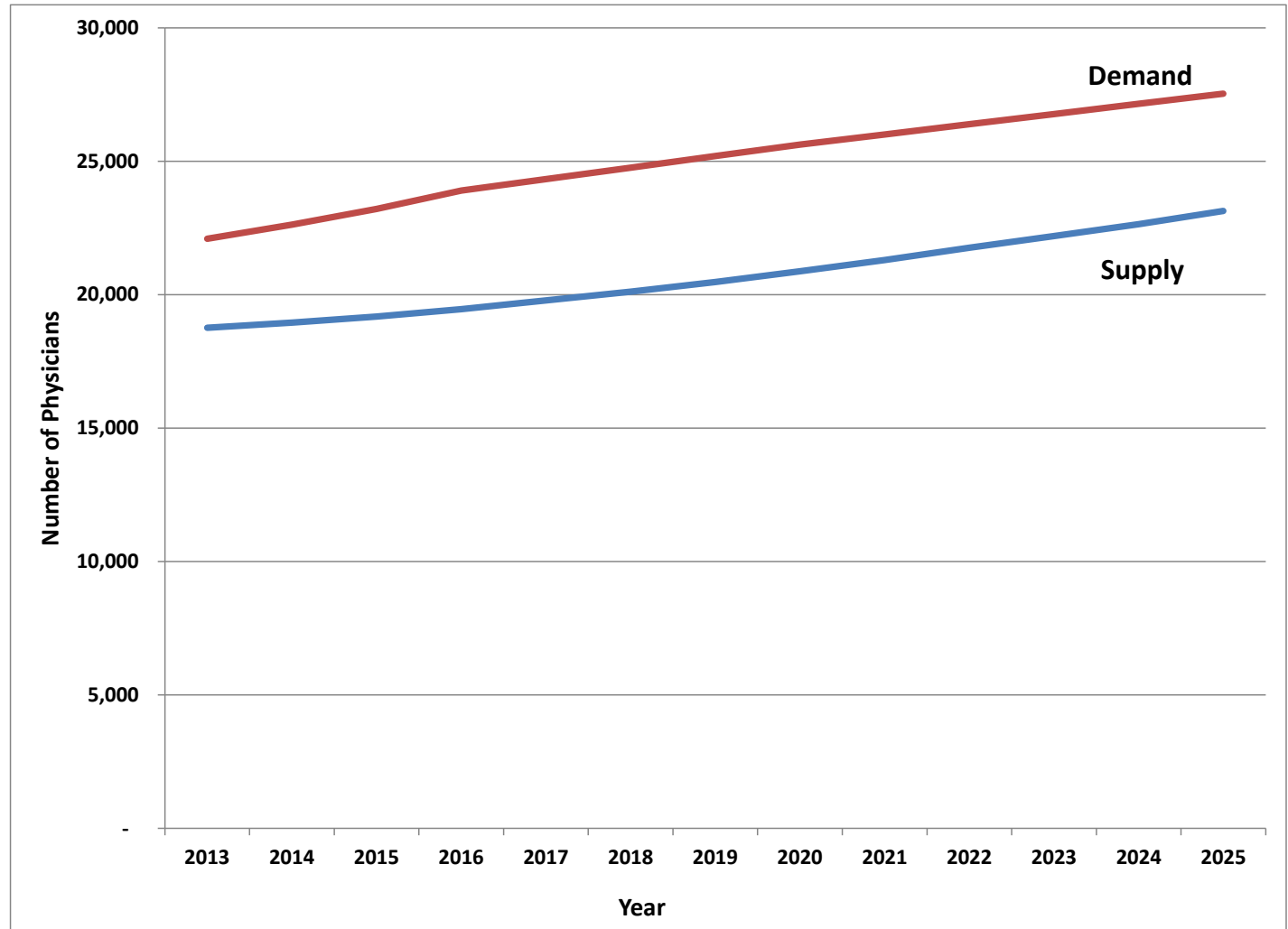
# Key Finding #1: Moderate Shortfall of Physicians Projected to Persist if Current Trends Continue

- Florida has estimated 11% shortfall of physicians
- Supply growing at slightly faster rate than demand (29% vs 24%)
- By 2025, project 7% statewide shortfall

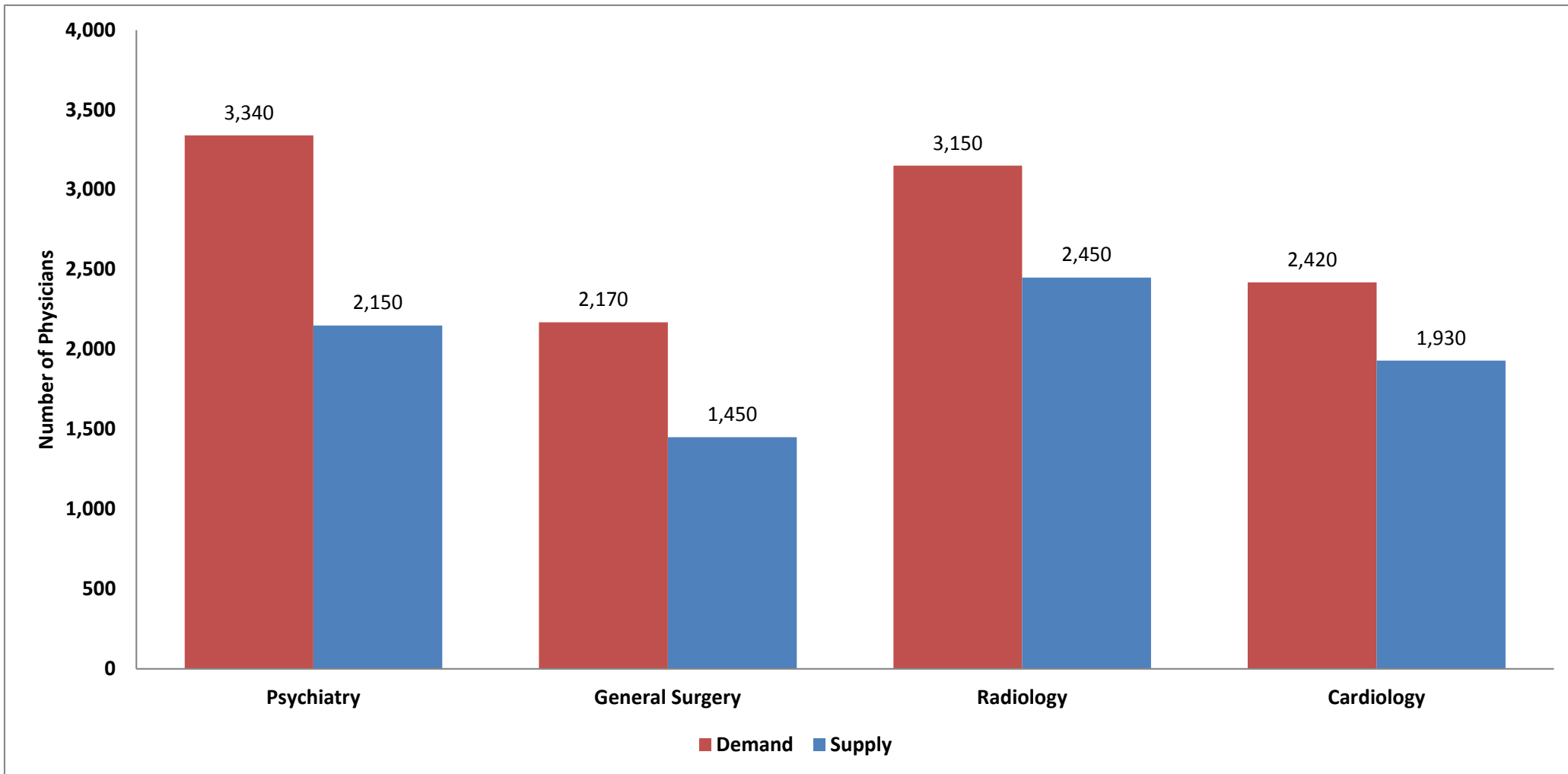


# Key Finding #2: Continued Shortfall of Specialists

- Florida's current shortfall (18%) of non-primary care specialties will likely persist
- Likely 19% shortfall by 2025



# Key Finding #3: Large Shortfalls Projected for Some Specialties by 2025



Note: Projections rounded to nearest 10.

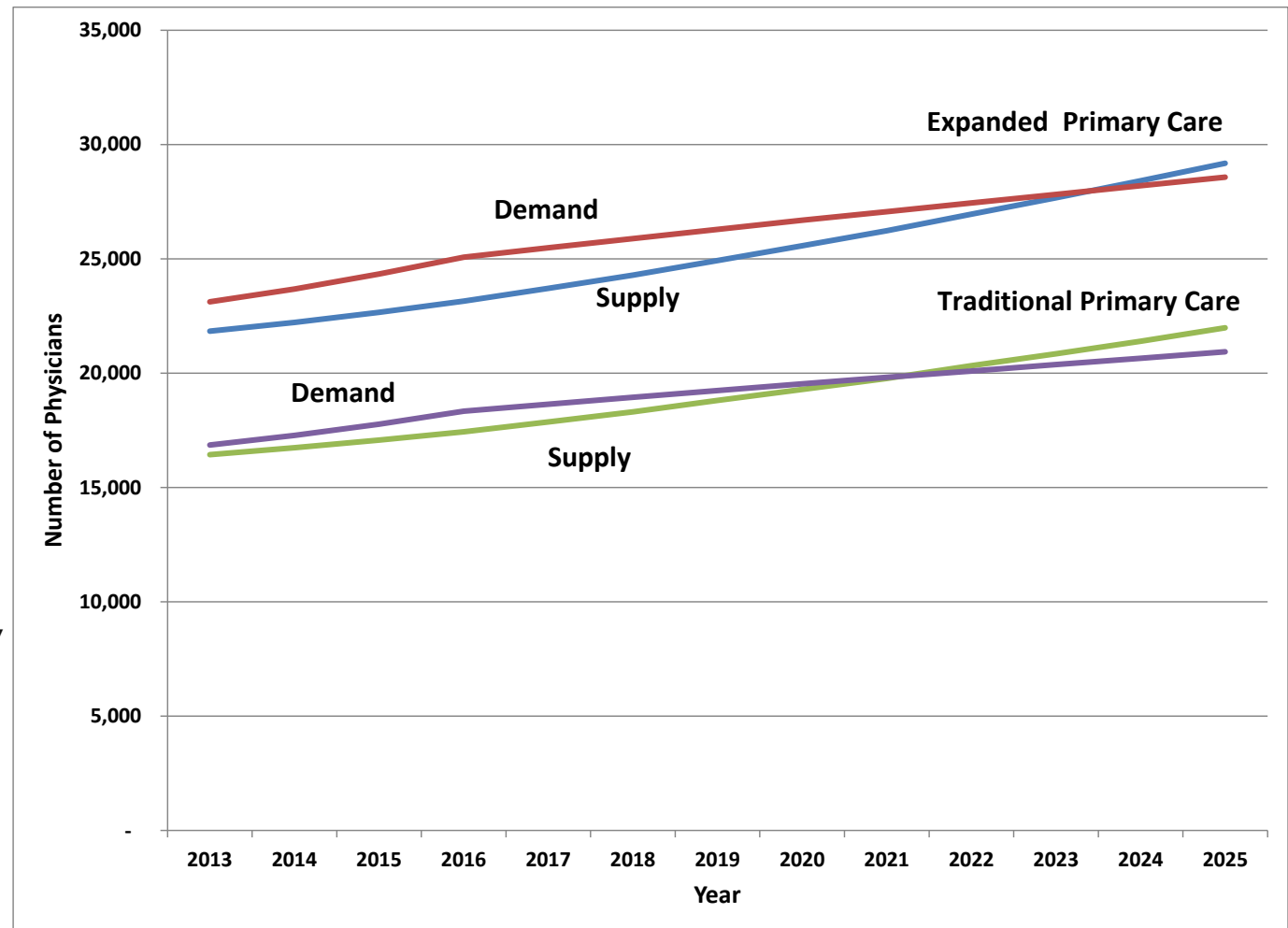
# FL Adequacy of Physician Supply Varies by Specialty

---

- Dermatology, pediatrics, plastic surgery supply looks more than adequate at state level to provide national average level of care
- Psychiatry, neurology, endocrinology, other specialties have large, persistent shortfalls
- Some specialties in Florida are difficult to assess versus national average because there may be demand factors unique to Florida
  - Examples: Emergency care, critical care/pulmonology, dermatology
  - Unique factors: in-migrating “Snowbirds”, large numbers of tourists, climate/sun exposure

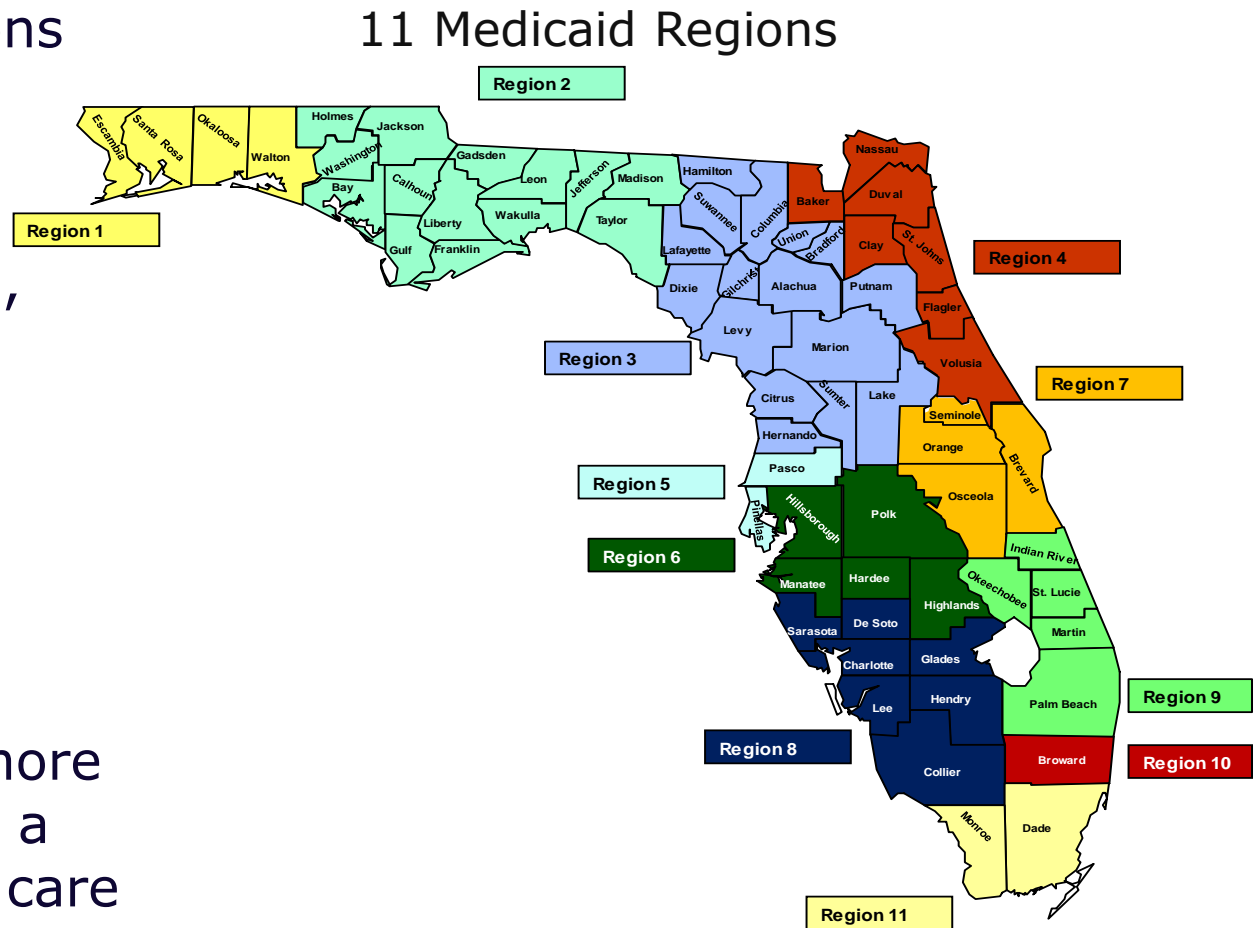
# Key Finding #4: Small Primary Care Physician Shortfall, but Supply & Demand Converging

- Florida has current small shortfall of primary care physicians
  - 6%-expanded
  - 3%-traditional
- Supply and demand converging, 2025
  - +2%-expanded
  - +5%-traditional
- Primary care defined:
  - Expanded Primary Care tracks Florida's Statewide Medicaid Residency Program that includes general surgery, emergency medicine and obstetrics/gynecology in addition to the traditional primary care specialties
  - Traditional Primary Care includes general and family practice, general internal medicine, general pediatrics and geriatric medicine

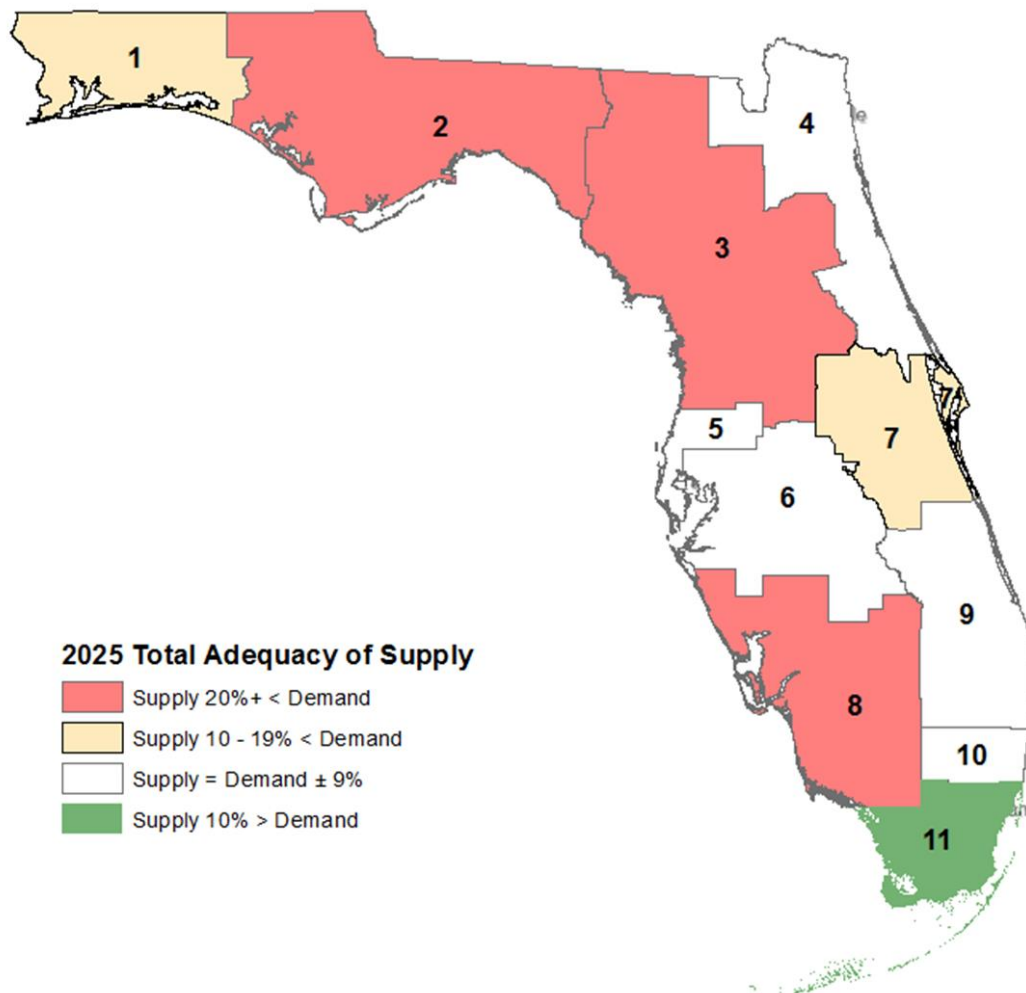


# Key Finding #5: Substantial Variation in Adequacy of Physician Supply by Medicaid Region

- Shortfalls across all regions for general surgery, hematology/oncology, psychiatry, pulmonology/critical care, radiology
- In Regions 2, 3 and 8, demand appears to be consistently higher than supply both in 2013 and 2025
- In Region 11, supply is more than sufficient to provide a national average level of care for many specialties



# Key Finding #6: Future (2025) Physician Shortfalls in Many FL Medicaid Regions





# THE DATA

Exhibit A-4:

# Physician Gap/Demand by Statewide/Regional Deficit, 2025

Specialty	Medicaid Region											State
	1	2	3	4	5	6	7	8	9	10	11	
Psychiatry	-51%	-46%	-34%	-108%	-47%	-38%	-122%	-65%	-56%	-61%	-22%	-55%
General Surgery	-17%	-14%	-75%	-46%	-70%	-22%	-47%	-107%	-73%	-74%	-26%	-50%
Rheumatology	0%	-225%	-131%	-139%	-24%	-60%	-153%	-32%	2%	-32%	10%	-43%
Allergy and Immunology	8%	-120%	-191%	-46%	26%	-3%	-34%	-82%	-80%	-100%	-5%	-38%
Thoracic Surgery	-333%	-33%	-6%	-86%	-4%	-29%	-55%	-57%	-30%	-88%	-13%	-38%
Hematology & Oncology	-79%	-214%	-11%	-35%	-40%	-11%	-73%	-97%	-54%	-8%	-5%	-36%
Pulmonology & Critical Care	-68%	-185%	-37%	-36%	-44%	-67%	-84%	-63%	-2%	16%	-1%	-32%
Radiology	-61%	-71%	-40%	-14%	-24%	-13%	-37%	-97%	-35%	-7%	-3%	-29%
Cardiology	-81%	-100%	-47%	-39%	-14%	-43%	-33%	-34%	-15%	-10%	10%	-25%
Anesthesiology	-3%	-113%	-35%	-20%	-47%	-14%	-42%	-107%	-22%	20%	-4%	-23%
Endocrinology	-229%	-340%	-67%	-7%	0%	-91%	-8%	-94%	6%	15%	13%	-19%
Obstetrics/Gynecology	-13%	-44%	-90%	-18%	-26%	-16%	-34%	-57%	-6%	17%	4%	-18%
Orthopedic Surgery	6%	-25%	-78%	-47%	-8%	-21%	-32%	-27%	8%	7%	1%	-17%
Ophthalmology	-96%	-58%	-43%	-50%	4%	-7%	-41%	8%	6%	-5%	-2%	-15%
Otolaryngology	0%	-26%	-55%	-21%	-9%	-26%	-28%	-14%	16%	-28%	-5%	-15%
Urology	-20%	-17%	-21%	-48%	-17%	-4%	-12%	-21%	-3%	-15%	-10%	-15%
General/Family Practice	7%	7%	-29%	10%	15%	-37%	-7%	-54%	-56%	-17%	1%	-13%
Infectious Diseases	-69%	-62%	-41%	8%	-29%	4%	13%	-39%	-56%	-13%	23%	-8%
Nephrology	-257%	-29%	7%	15%	13%	-4%	4%	-27%	-42%	25%	-17%	-4%
Neurology	-17%	-42%	-21%	11%	-22%	-1%	-18%	-18%	-12%	4%	24%	-4%

Key

Supply 10%+ > Demand	
Supply =demand ± 9%	
Supply 10-19% < Demand	
Supply 20%+ < Demand	



Exhibit A-3:

# Physician Gap/Demand by Statewide/Regional **Deficit**, 2025

Specialty	Region											State
	1	2	3	4	5	6	7	8	9	10	11	
Psychiatry	-40	-36	-70	-183	-72	-115	-235	-115	-128	-112	-84	<b>-1,190</b>
General/Family Practice *	23	22	-177	100	103	-268	-64	-263	-312	-98	15	<b>-920</b>
General Surgery	-11	-9	-91	-73	-65	-47	-80	-109	-101	-77	-56	<b>-720</b>
Radiology	-42	-39	-83	-43	-51	-45	-100	-173	-97	-16	-8	<b>-700</b>
Anesthesiology	-3	-60	-81	-63	-84	-51	-121	-177	-69	74	-17	<b>-650</b>
Cardiology	-38	-40	-80	-73	-22	-86	-66	-62	-36	-18	31	<b>-490</b>
Obstetrics/Gynecology	-12	-33	-121	-47	-41	-51	-103	-94	-17	51	17	<b>-450</b>
Hematology & Oncology	-22	-30	-14	-39	-31	-17	-66	-71	-55	-8	-7	<b>-360</b>
Pulmonology & Critical Care	-18	-28	-34	-35	-28	-60	-65	-47	-3	19	-1	<b>-300</b>
Orthopedic Surgery	4	-13	-79	-66	-10	-41	-55	-39	17	12	2	<b>-270</b>
Ophthalmology	-25	-18	-39	-51	4	-12	-51	11	9	-6	-3	<b>-180</b>
Rheumatology	-	-9	-21	-25	-6	-18	-29	-10	1	-8	5	<b>-120</b>
Endocrinology	-16	-17	-24	-5	-	-39	-6	-31	5	11	13	<b>-110</b>
Urology	-5	-4	-14	-29	-9	-4	-10	-14	-3	-9	-9	<b>-110</b>
Thoracic Surgery	-10	-3	-2	-18	-1	-10	-16	-12	-9	-14	-5	<b>-100</b>
Allergy and Immunology	1	-6	-21	-11	8	-1	-10	-14	-16	-14	-2	<b>-90</b>
Otolaryngology	-	-5	-22	-13	-4	-18	-19	-8	15	-13	-4	<b>-90</b>
Infectious Diseases	-9	-8	-18	6	-10	3	11	-17	-25	-6	24	<b>-50</b>
Neurology	-7	-14	-23	19	-18	-2	-25	-20	-16	5	51	<b>-50</b>
Nephrology	-18	-6	6	14	7	-3	3	-14	-23	21	-15	<b>-30</b>
<b>Grand Total</b>	<b>-248</b>	<b>-356</b>	<b>-1008</b>	<b>-635</b>	<b>-330</b>	<b>-885</b>	<b>-1107</b>	<b>-1279</b>	<b>-863</b>	<b>-206</b>	<b>-53</b>	<b>-6980</b>

\* Offset by more general internists (+700) and geriatrician (+200) supply than required to provide a national average level of care.



## Exhibit A-4: Physician Gap/Demand by Statewide/Regional **Surplus**, 2025

Specialty	Region											State
	1	2	3	4	5	6	7	8	9	10	11	
Geriatric Medicine	13%	0%	53%	-13%	29%	20%	41%	13%	-4%	56%	55%	33%
Pediatrics	18%	-31%	27%	13%	47%	12%	20%	4%	15%	34%	51%	26%
Dermatology	16%	-26%	-4%	-2%	16%	14%	-70%	38%	56%	37%	34%	23%
Emergency Medicine	43%	10%	-13%	33%	33%	13%	23%	0%	10%	43%	22%	22%
Plastic Surgery	-16%	-11%	-47%	-8%	-7%	1%	-18%	24%	41%	40%	52%	18%
Neurological Surgery	38%	-63%	0%	15%	18%	9%	-14%	-14%	25%	-42%	28%	9%
General Internal Medicine	-31%	-33%	-4%	-14%	23%	9%	-10%	-22%	14%	6%	34%	6%
Specialties demand not modeled	-21%	-28%	-21%	-8%	11%	28%	12%	-38%	-10%	33%	17%	6%
Vascular Surgery	10%	33%	-13%	-7%	-10%	11%	19%	9%	-27%	-26%	22%	3%
Gastroenterology	-44%	-118%	-12%	29%	-3%	-7%	-17%	-24%	21%	15%	6%	1%

### Key

Supply 10%+ > Demand	
Supply =demand ± 9%	
Supply 10-19% < Demand	
Supply 20%+ < Demand	

## Exhibit A-3: Physician Gap/Demand by Statewide/Regional **Surplus**, 2025

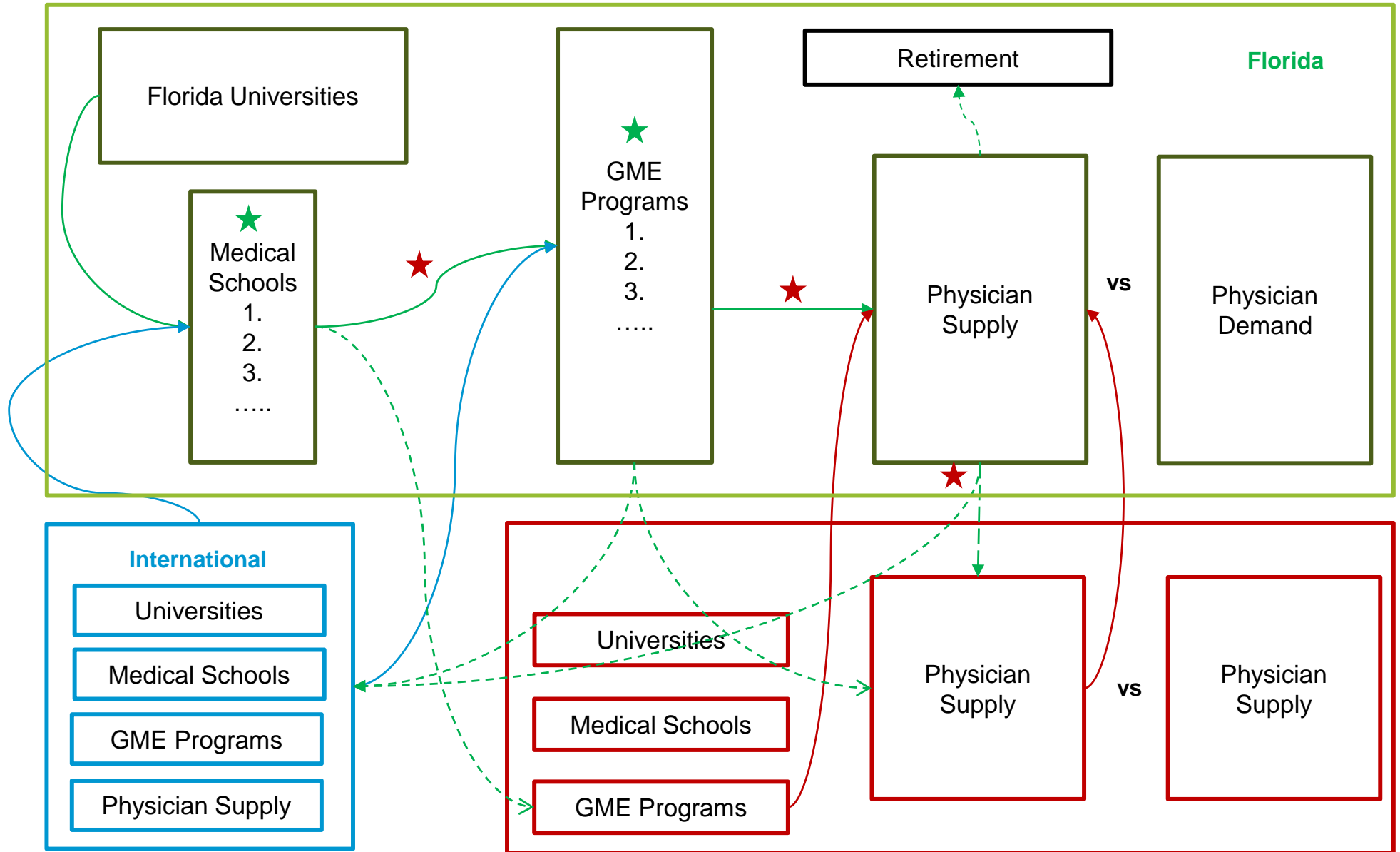
Specialty	Region											State
	1	2	3	4	5	6	7	8	9	10	11	
Pediatrics	29	-28	89	54	187	64	123	10	60	156	495	<b>1,240</b>
Emergency Medicine	68	10	-26	130	86	47	96	1	31	159	95	<b>700</b>
General Internal Medicine*	-74	-73	-35	-116	199	111	-99	-157	160	51	574	<b>540</b>
Dermatology	6	-6	-3	-2	13	18	-44	54	127	42	54	<b>260</b>
Geriatric Medicine*	2	-	44	-5	14	12	29	7	-2	44	54	<b>200</b>
Specialties demand not modeled	-15	-18	-42	-20	23	117	39	-66	-26	105	63	<b>160</b>
Plastic Surgery	-3	-2	-18	-5	-3	1	-11	19	46	32	71	<b>130</b>
Neurological Surgery	9	-5	-	8	7	5	-6	-5	16	-11	21	<b>40</b>
Gastroenterology	-12	-20	-11	47	-2	-9	-19	-20	32	16	8	<b>10</b>
Vascular Surgery	1	4	-3	-2	-2	4	7	3	-7	-5	10	<b>10</b>
<b>Grand Total</b>	<b>11</b>	<b>-138</b>	<b>-5</b>	<b>89</b>	<b>522</b>	<b>370</b>	<b>115</b>	<b>-154</b>	<b>437</b>	<b>589</b>	<b>1445</b>	<b>3290</b>

\* Offset by projected shortfall in General & Family Practice (-920).



# **PHYSICIAN EDUCATION PIPELINE ANALYSIS**

# Overview of Physician Pipeline Conceptual Model



★ Points of influence; ★ Points of leakage

# Florida Physician Medical Education Pipeline Policy Levers

---

## ★ Green stars: Points of influence in the UME/GME pipeline:

- Maximizing numbers of approved GME slots filled in priority specialties
- Expanding UME capacity and/or GME capacity in priority specialties
- Optimizing UME/GME enrollment to maximize physician retention probability

## ★ Red stars: Points of leakage in the UME/GME pipeline:

- Between Florida medical schools and Florida GME/residency training
  - Migration to other areas of the U.S. for GME/residency training
- Between Florida GME/residency training and new active physician supply in Florida
  - Physician migration to other areas of the U.S.
  - International migration





# Florida Physician Medical Education Pipeline Analysis

## Retention Probability of Florida UME Graduates (2000 Onwards)

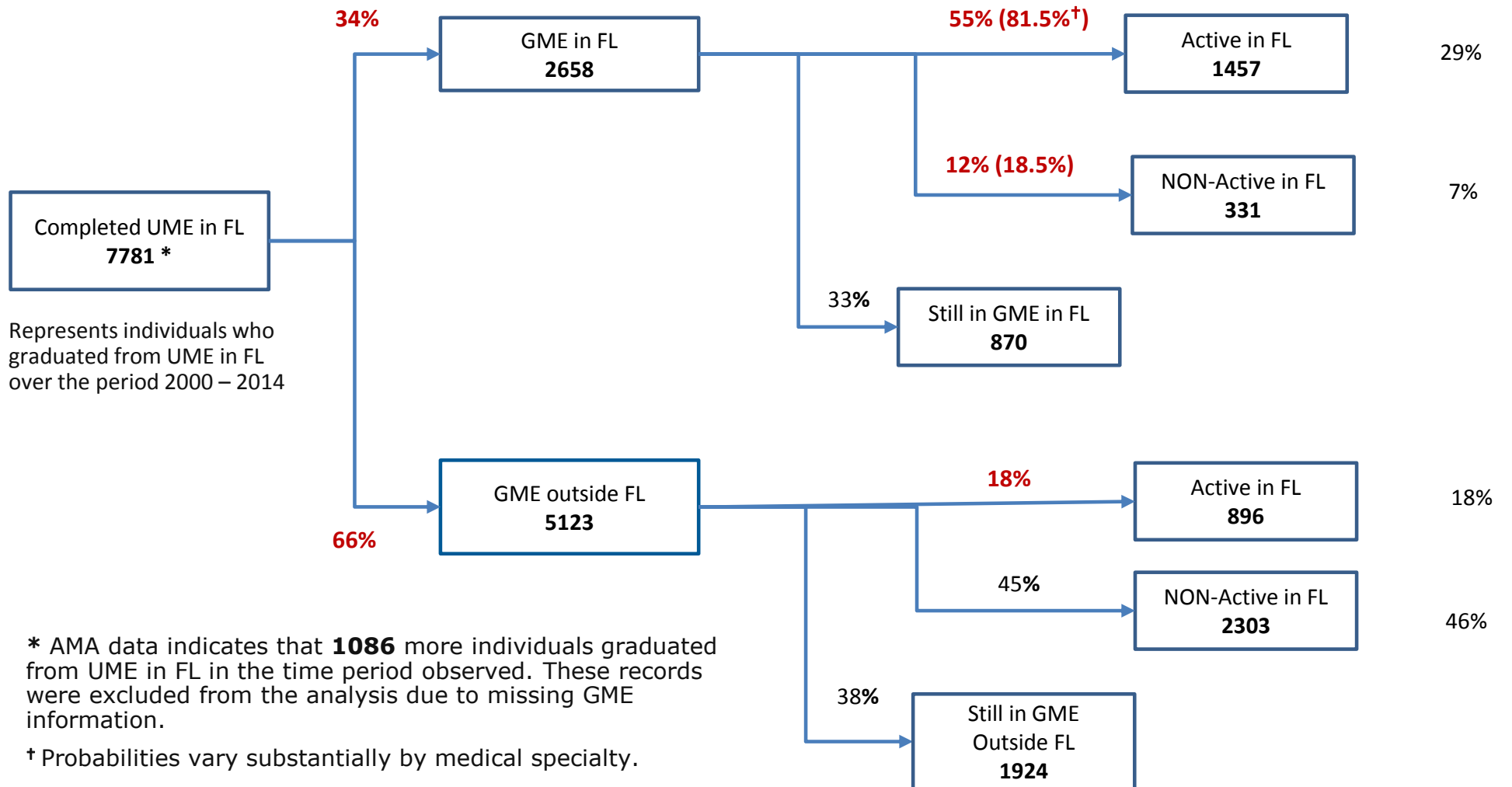
**Key**

UME = Undergraduate Medical Education

GME = Graduate Medical Education

IMG=International Medical Graduates

% FL UME graduates  
post-GME



# Conclusions

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- Overall state-wide shortfall in many specialist categories, shortfall projected to persist through 2025
- Small state-wide shortfall in primary care, supply and demand converging
- Substantial geographic variation
  - Medicaid Regions 2, 3 & 8 have particularly low physician supply relative to demand
  - Shortfalls across all regions for general surgery, hematology/oncology, psychiatry, pulmonology/critical care, radiology
- Demand growth through 2025
  - Primarily driven by changing demographics
  - Some growth from expanded insurance coverage under ACA
  - Future research might explore potential impact of changes in care delivery models (e.g., Accountable Care Organizations, team-based care), technology, and other trends
- Florida's efforts to attract and retain physicians come at a time when other states are pursuing similar efforts
  - Florida will face increased competition from other states with growing and aging populations to attract and retain physicians
- Florida might have more success with growing supply if efforts are focused on graduate medical education opportunities in FL



**ADDITIONAL SLIDES**

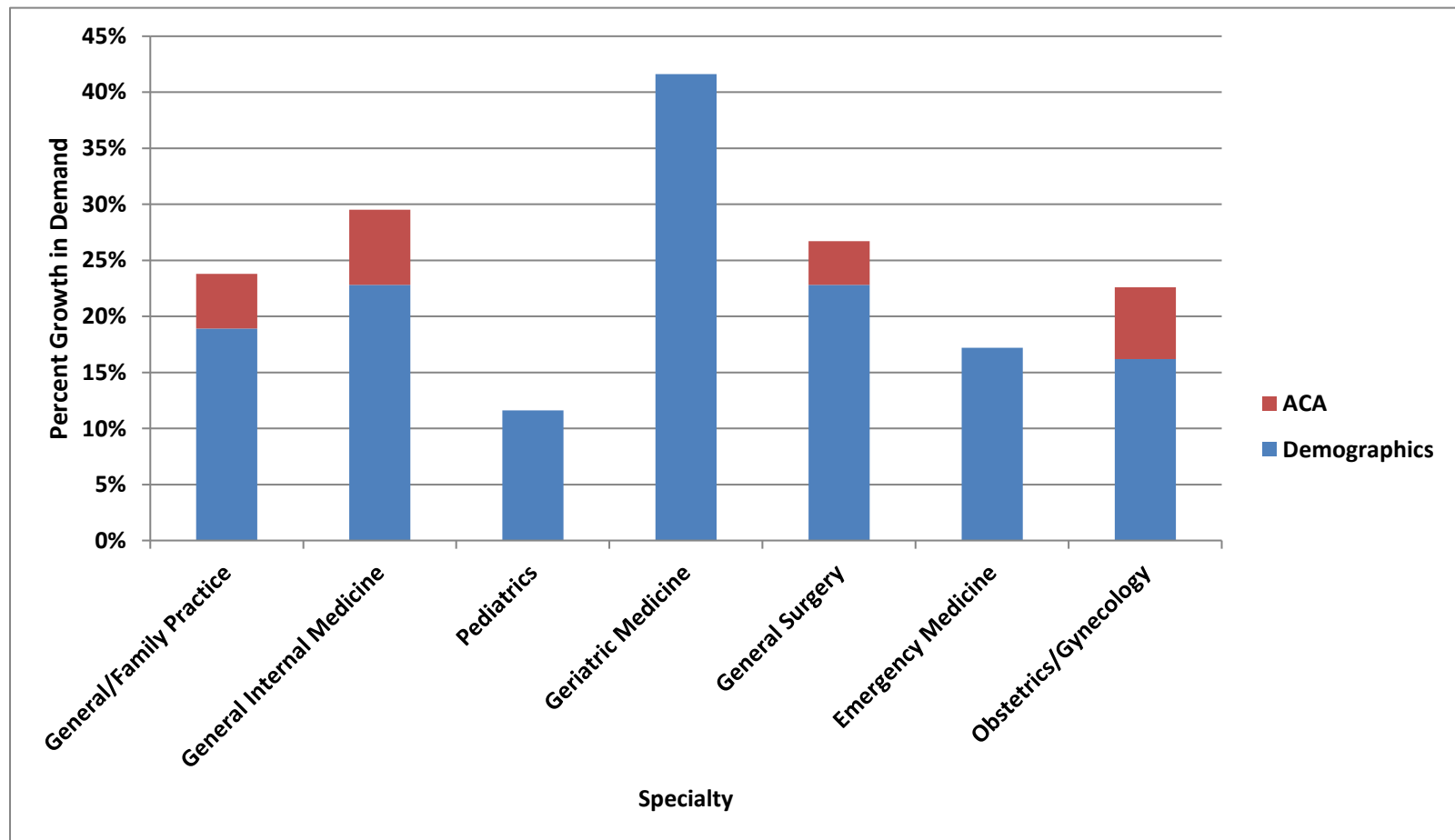
# Projected Growth in Service Demand by Setting and Source

- Across care settings growth in service demand from changing demographics and ACA will impact Florida more than the U.S. by 2025

Care Setting	Growth from Changing Demographics		Growth from Insurance Coverage Expansion under ACA	
	Florida	U.S.	Florida	U.S.
Office visits	19%	14%	+6%	+4%
Outpatient visits	20%	15%	+4%	+2%
Emergency visits	17%	12%	+0%	+0%
Hospital inpatient days	27%	23%	+2%	+1%

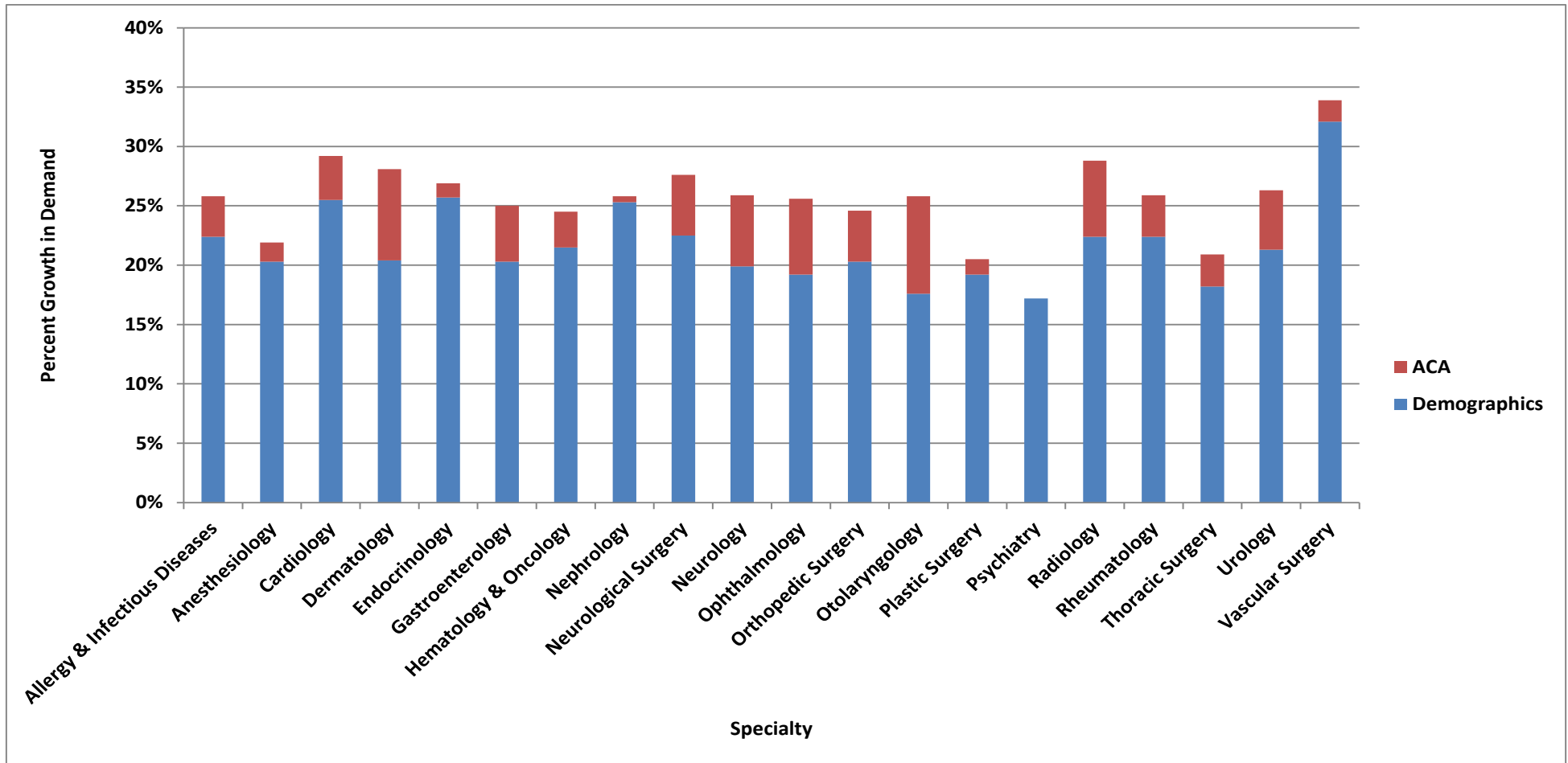
# Projected Growth in Florida Primary Care Physician Demand (2013-2025)

- Changing demographics will influence demand growth for primary care specialties (12%-41%) more than ACA insurance expansion (0%-7%)



# Projected Growth in Florida Specialist Demand (2013-2025)

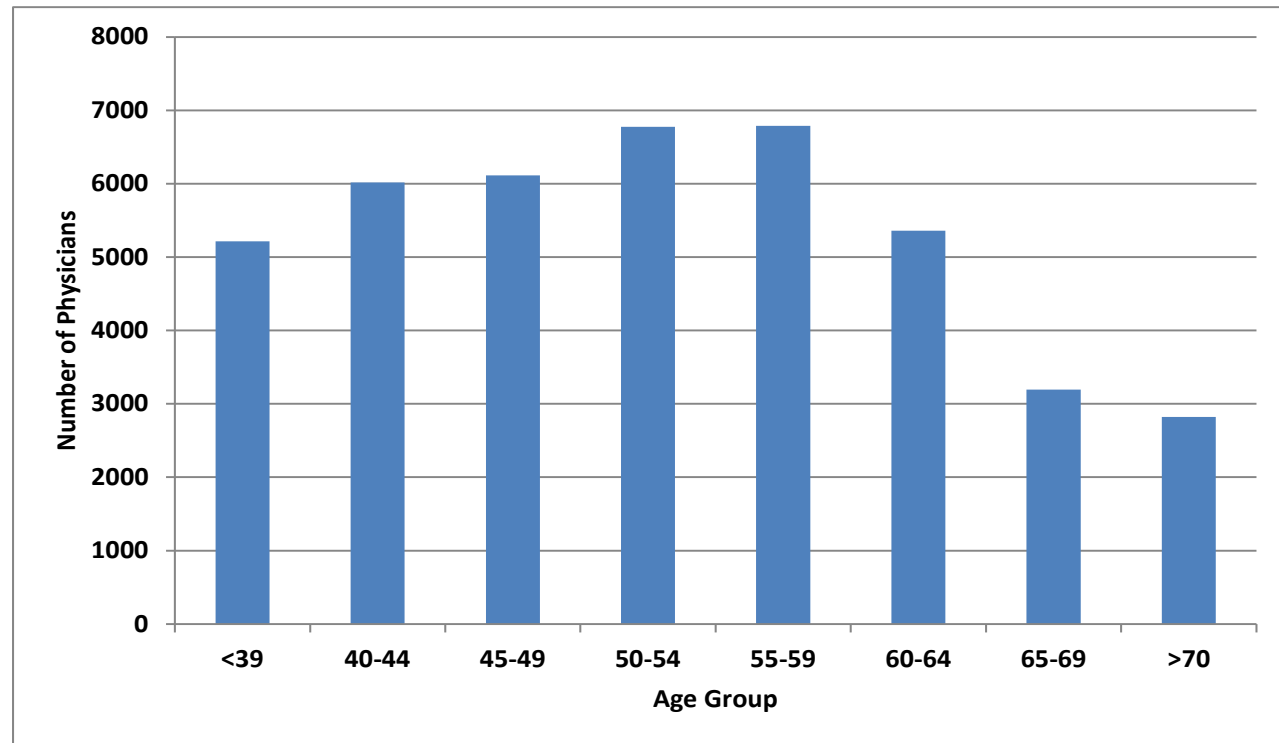
- ACA demand impact for non-primary care specialties (2%-8%);  
changing demographics (17%-32%)



# Demographics of Current Statewide Physician Supply: 2013

- 42,610 licensed and active physicians
  - 21,830 (51%) in primary care (using expanded definition\*)
  - 20,780 (49%) in non-primary care specialties
- Gender
  - 31,530 (74%) males
  - 11,080 (26%) female

Age Distribution of Active Physicians

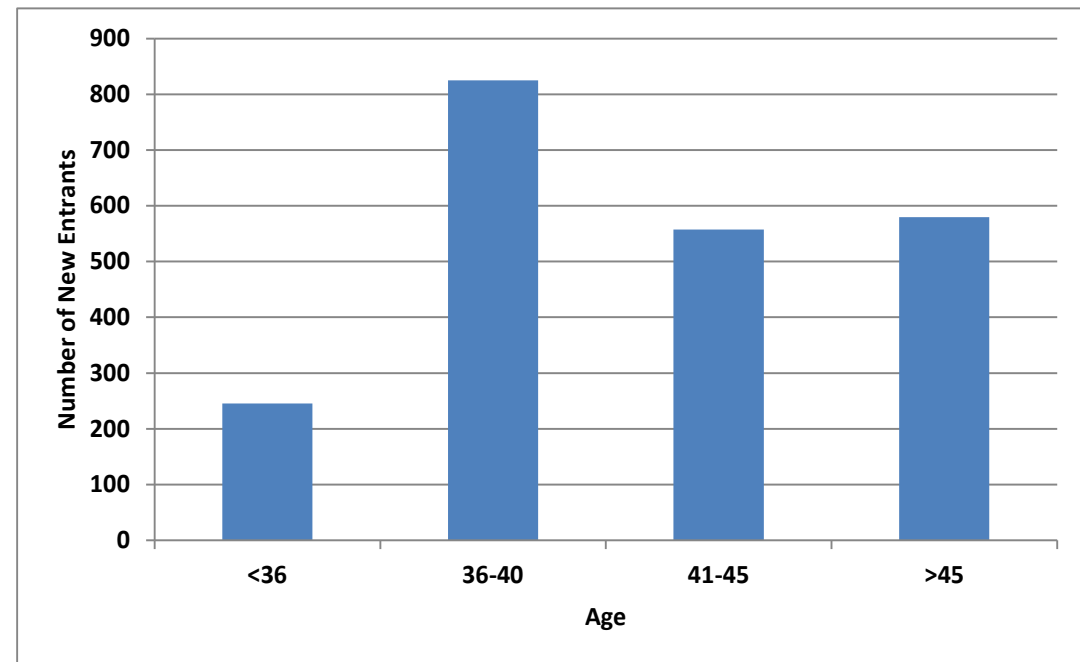


\* Includes general and family practice, general internal medicine, general pediatrics, geriatric medicine, general surgery, obstetrics and gynecology, and emergency medicine.

# Annual New Entrants to Florida's Physician Workforce

- Estimated 2,230 new physicians entered FL workforce in 2013
  - Includes physicians completing residency/fellowships, and physicians moving into Florida from other states
  - 1,220 (55%) in primary care specialty (expanded definition)
  - 1,010 (45%) in non-primary care specialty
- Gender
  - 1,450 (65%) males
  - 780 (35%) females
- Age Distribution
  - Most new entrants enter the workforce in their late thirties and early forties

Age Distribution of New Entrants

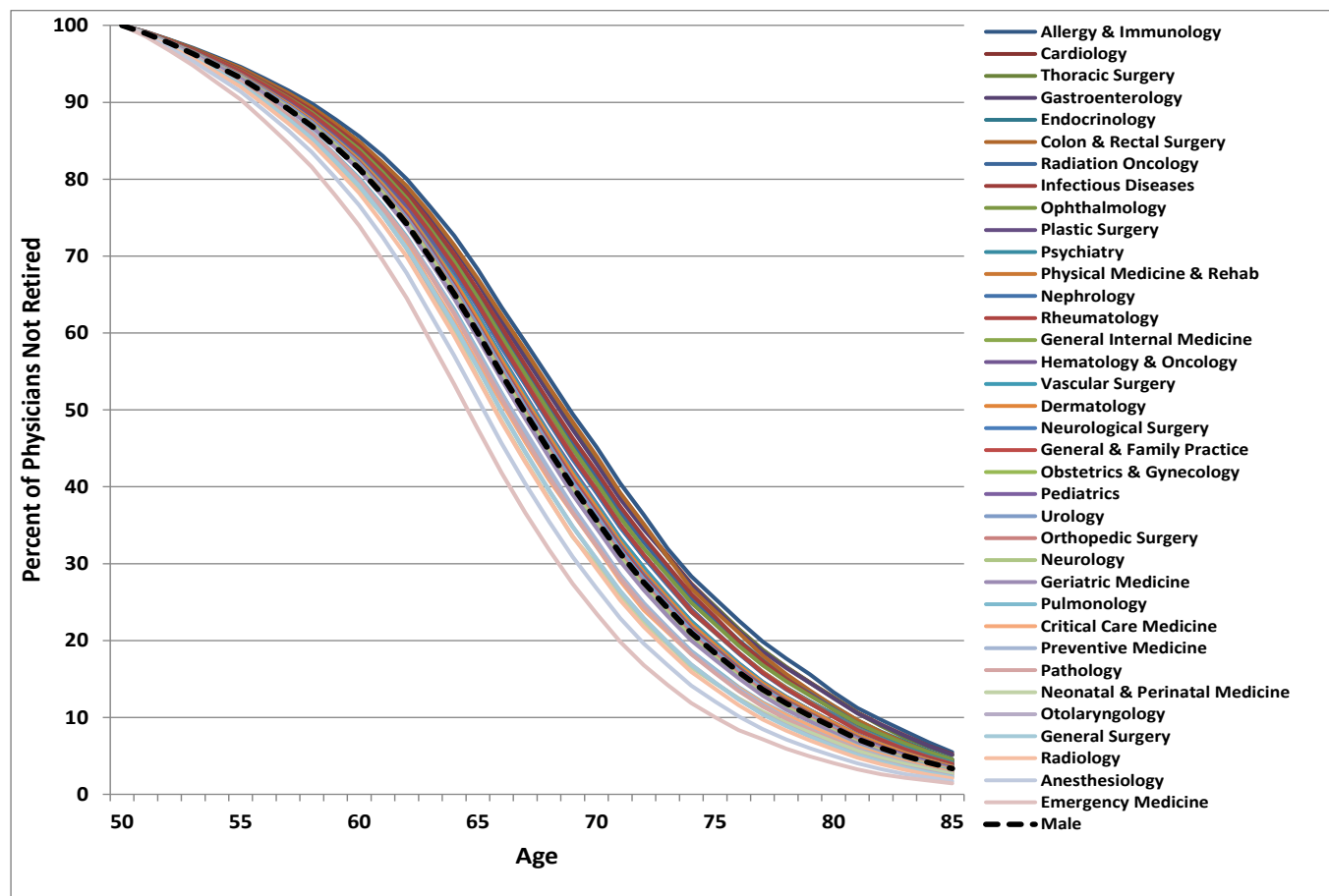




# Florida Physician Workforce Attrition

- On average, about 1,080 Florida physicians will retire annually between 2013-2025
- Male/female physicians have similar attrition patterns
- Variation by specialty
- Sources:
  - FL licensure survey question: “Intend to retire in next 5 years?”
  - CDC mortality rates

## Retirement Patterns for Males



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# Florida Statewide and Regional Physician Workforce Analysis: Estimating Current and Forecasting Future Supply and Demand

**Prepared for:**

**SAFETY NET HOSPITAL ALLIANCE OF FLORIDA**

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## Executive Summary

Obtaining an accurate picture of the current and projected future adequacy of physician supply in Florida is essential to inform policy and planning initiatives; to guide medical school and graduate medical education (GME) residency training priorities; and to ensure that Florida has a future physician workforce that can continue to provide access to high quality and affordable care.

With funding support from the Safety Net Hospital Alliance of Florida (SNHA), IHS Global Inc. (IHS) was engaged to study the Florida physician workforce at the State level. This study presents estimates of current and projected future supply and demand by medical specialty.

Study guiding research questions include:

- In Florida, are there specialties where supply and demand currently are not in balance? If so, which specialties, and what is the estimated gap between supply and demand?
- What are the potential implications of health care reform initiatives, emerging care delivery models and other market factors on Florida's physician workforce supply and demand?
- To what extent will the future projected supply of physicians be adequate to meet projected statewide population service demand?

### Synopsis of Study Methods

This study combined data on the physician workforce in Florida, data on the demographics, socioeconomics, and health risk factors of the population in Florida, data on health care use and delivery patterns from national sources, and two computer simulation models—the Healthcare Demand Microsimulation Model and the Health Workforce Supply Model. The demand model applies national health care use and delivery patterns to a population database that contains a representative sample of Florida's population. The demand estimates and projections take into consideration current and projected future demographics, presence of disease and other health risk factors among the population, and medical insurance coverage changes associated with the Affordable Care Act (ACA).

The supply model uses a microsimulation approach to model the likely career decisions of physicians taking into consideration the number, specialty mix and demographics of new entrants to Florida's physician workforce, and patterns of out-of-state migration, retirement patterns, and hours worked. Supply data and inputs come primarily from the 2012 and 2013 bi-annual Physician Workforce Licensure Surveys administered by the Florida Department of Health.

The analysis compares current and projected future supply to the number of physicians required to provide a level of care consistent with the national average, and taking into consideration national shortages for primary care, psychiatrists, and select other specialties.



## Key Findings

Physician adequacy of supply and demand and supply estimates for 2013 and projected for 2025 are summarized in Exhibits ES-1 and ES-2. Key study findings include the following:

- **Supply Versus Demand**

- **Small primary care shortfall.** Florida's total current supply of primary care physicians falls short of the number needed to provide a national average level of care (-6%). Under a traditional definition of primary care specialties (i.e., general and family practice, general internal medicine, general pediatrics and geriatric medicine) supply falls short of demand by -3%. Over the next several years, this shortfall will grow slightly as more people obtain insurance coverage as mandated by ACA. However, if current trends continue, this shortfall should disappear within a decade. While supply may be adequate at the state level to provide a national average level of care, there is substantial geographic variation in adequacy of care as evidenced by the state's numerous designated Primary Care Health Professional Shortage Areas.
- **Modest specialist physician shortfall.** The supply of specialists in Florida is insufficient to provide a level of care consistent with the national average, after taking into consideration differences in the demographics and health risk factors between Florida and the nation. The current 18% shortfall is likely to persist over the foreseeable future.
- **Severe shortfall for some medical specialties.** Specialties where the state's supply of physicians is much smaller than required to provide a level of care consistent with the national average include general surgery, psychiatry, hematology & oncology, endocrinology, radiology, nephrology, thoracic surgery, and rheumatology.
- **Abundance of some specialties.** Florida appears to have more than sufficient plastic surgeons and dermatologists to provide a level of care consistent with the national average, though there may be environmental factors in Florida that increase demand for these specialties beyond those characteristics in the demand model used.

- **Current and Future Demand**

- In 2013, the number of physicians required to provide a national average level of care (adjusting for national shortages in primary care and select other specialties) was 47,230 FTEs.
- Between 2013 and 2025 effects of changing demographics on healthcare service demand in Florida will exceed the U.S. across all care settings modeled.
  - Hospital inpatient days will grow by about 27% versus 23% for the U.S.
  - Emergency care visits will grow by about 17% versus 12% for the U.S.
  - Physician office visits will grow by about 19% versus 14% for the U.S.
  - Outpatient visits will grow by about 20% versus 15% for the U.S.





- Total demand for physicians is projected to increase by about 11,430 FTEs (24%) between 2013 and 2025. Changing demographics is projected to increase statewide physician demand by about 9,550 FTEs (20%) between 2013 and 2025.
- Expanded medical insurance coverage under ACA will increase demand by 1,880 FTEs (4%). Most of this increase in demand will occur between 2014 and 2017.
- ACA will increase demand for general internists and family practitioners by about 790 physicians. In percentage terms, the impact is also high for otolaryngology (+8%), dermatology (+8%), general internal medicine (+7%), obstetrics & gynecology (+6%), radiology (+6%), and ophthalmology (+6%).
- Specialties with the highest projected growth in demand through 2025 predominantly provide care to the elderly, with growth rates highest for geriatric medicine (+42%), vascular surgery (+34%), general internal medicine (+30%), and cardiology (+29%).
- **Current and Future Supply**
  - In 2013, there were approximately 42,610 full time equivalent (FTE) physicians actively practicing in the State.
  - An estimated 2,230 new physicians enter Florida's workforce each year. This includes physicians who complete their undergraduate and/or graduate medical education in Florida, as well as physicians trained or practicing in other states.
  - Approximately 1,080 physicians will retire each year between 2013 and 2025. When combined with physicians who leave Florida, changes in average hours worked as a growing proportion of physicians are women and as the workforce ages, Florida's physician workforce is growing by approximately 1,030 FTEs per year.
  - If current workforce participation patterns and number of new entrants to the workforce remain unchanged, between 2013 and 2025 Florida's physician workforce is projected to grow by about 12,360 FTEs (29%), reaching 54,970 physicians in 2025. The total supply of primary care physicians is projected to grow about 34% and supply of specialists is projected to grow by 23%.

### **Report Addendum: Florida Medicaid Region Physician Workforce Analysis**

In 2014, Florida implemented the Statewide Medicaid Managed Care Managed Medical Assistance program under which almost all Medicaid recipients are enrolled in a health maintenance organization (HMO) or HMO-like plan. The program is operated in eleven Medicaid regions. Building upon statewide findings, this analysis estimated the current and future adequacy of supply by Medicaid region through 2025. Key findings include:

- There is substantial geographic variation in adequacy of supply for both primary care and non-primary care specialties across state Medicaid regions.
- Physician supply is inadequate to provide a national average level of care (i.e., demand) in ten of Florida's eleven Medicaid regions. In four regions there is an



- estimated physician shortfall of 20% or greater: Region 2 (-43%), Region 8 (-34%), Region 3 (-23%) and Region 7 (-24%).
- By 2025 physician demand will exceed available supply in eight Medicaid regions. Regions with projected shortfalls of 20% or more include Region 8 (-34%), Region 2 (-33%) and Region 3 (-23%).

## **Conclusion**

Overall, demand for physicians in Florida exceeds supply for many medical specialties. The state-wide shortfall of primary care physicians is small, and if current trends continue this shortfall will disappear within the next decade. However, there is substantial variation in adequacy of primary care supply across regions as evidenced by the large number of areas and communities designated as Health Profession Shortage Areas. The state-wide shortfall of specialists is projected to persist for the foreseeable future, with large variation in magnitude of the shortfall across regions.

Emerging care delivery models will continue to affect care use and delivery patterns, which in turn will affect supply of and demand for physicians. Greater use of advanced practice nurses, physician assistants, and other health workers will affect demand for physicians. As Florida works to attract and retain physicians to care for its growing and aging population, the state will face increased competition from other states who are dealing with similar trends.



**Exhibit ES-1: Projected Growth Rates of Physician Supply and Demand, 2013-2025**

Specialty	Supply				Demand			
	2013 Supply	2025 Supply	Growth	% Growth	2013 Demand <sup>a</sup>	2025 Demand <sup>a</sup>	Growth	% Growth
<b>Total Primary Care</b>	<b>21,830</b>	<b>29,180</b>	<b>7,350</b>	<b>34%</b>	<b>23,120</b>	<b>28,590</b>	<b>5,470</b>	<b>24%</b>
<b>Traditional Primary Care</b>	<b>16,430</b>	<b>22,000</b>	<b>5,570</b>	<b>34%</b>	<b>16,850</b>	<b>20,940</b>	<b>4,090</b>	<b>24%</b>
General/Family Practice	5,580	7,180	1,600	29%	6,540	8,100	1,560	24%
General Internal Medicine	6,870	9,530	2,660	39%	6,940	8,990	2,050	30%
Pediatrics	3,440	4,680	1,240	36%	3,080	3,440	360	12%
Geriatric Medicine <sup>a</sup>	540	610	70	13%	290	410	120	41%
General Surgery	1,090	1,450	360	33%	1,710	2,170	460	27%
Emergency Medicine	2,300	3,220	920	40%	2,150	2,520	370	17%
Obstetrics/Gynecology	2,010	2,510	500	25%	2,410	2,960	550	23%
<b>Total Non-Primary Care (excluding specialties not modeled)</b>	<b>18,760</b>	<b>23,140</b>	<b>4,380</b>	<b>23%</b>	<b>22,090</b>	<b>27,580</b>	<b>5,490</b>	<b>25%</b>
Allergy & Immunology	220	240	20	9%	260	330	70	27%
Anesthesiology	2,200	2,790	590	27%	2,820	3,440	620	22%
Cardiology	1,640	1,930	290	18%	1,870	2,420	550	29%
Dermatology	920	1,140	220	24%	690	880	190	28%
Endocrinology	370	570	200	54%	530	680	150	28%
Gastroenterology	920	1,100	180	20%	870	1,090	220	27%
Hematology & Oncology	740	1,010	270	36%	1,090	1,370	280	25%
Infectious Diseases	430	590	160	37%	510	640	130	25%
Nephrology	450	700	250	56%	580	730	150	26%
Neurological Surgery	320	460	140	44%	330	420	280	26%
Neurology	1,060	1,320	260	25%	1,080	1,370	290	24%
Ophthalmology	1,170	1,240	70	6%	1,130	1,420	290	26%
Orthopedic Surgery	1,380	1,630	250	18%	1,520	1,900	380	25%
Otolaryngology	510	610	100	20%	550	700	150	27%
Plastic Surgery	630	720	90	14%	490	590	100	20%
Psychiatry	1,820	2,150	330	18%	2,850	3,340	490	17%
Pulmonology & Critical Care <sup>b</sup>	690	950	260	38%	1,000	1,250	250	25%
Radiology	1,910	2,450	540	28%	2,440	3,150	710	29%
Rheumatology	260	280	20	8%	320	400	80	25%



Specialty	Supply				Demand			
	2013 Supply	2025 Supply	Growth	% Growth	2013 Demand <sup>a</sup>	2025 Demand <sup>a</sup>	Growth	% Growth
Thoracic Surgery	240	260	20	8%	300	360	60	20%
Urology	650	710	60	9%	650	820	170	26%
Vascular Surgery	230	290	60	26%	210	280	70	33%
<b>Total (specialties modeled)</b>	<b>40,590</b>	<b>52,320</b>	<b>11,730</b>	<b>29%</b>	<b>45,210</b>	<b>56,170</b>	<b>10,960</b>	<b>24%</b>
Specialties demand not modeled <sup>c</sup>	2,020	2,650	630	31%	2,020	2,490	470	23%
<b>Total</b>	<b>42,610</b>	<b>54,970</b>	<b>12,360</b>	<b>29%</b>	<b>47,230</b>	<b>58,660</b>	<b>11,430</b>	<b>24%</b>

Notes: <sup>a</sup> Demand is defined as the number of physicians required to provide a level of care consistent with the national average in 2013. For specialties such as geriatric medicine, demand should be considered in the context of availability of general internists and other primary care providers. <sup>b</sup> A substantial proportion of pulmonologists practice critical care medicine, and to be consistent with demand estimates based on national patterns we combined the categories of pulmonology, pulmonology/critical care, and critical care. Excluded from this category are critical care physicians in anesthesiology, surgery, and obstetrics/gynecology, as these categories are categorized elsewhere. <sup>c</sup> Physician specialties omitted from the demand model include: colon-rectal cancer, neonatal/perinatal medicine, pathology, physical medicine & rehabilitation, preventive medicine and radiation oncology. Initial demand for services for this category is assumed equal to supply, and assumed to grow at the same rate as the overall demand for non-primary care specialties. Supply is modeled separately by specialty, but combined for presentation for comparison to demand. Note: Specialties included in the expanded definition of primary care are general and family practice, general internal medicine, general pediatrics, geriatric medicine, general surgery, obstetrics and gynecology, and emergency medicine.



**Exhibit ES-2: Current (2013) and Projected Future (2025) Adequacy of Physician Supply in Florida**

Specialty	2013				2025			
	Supply	Demand <sup>a</sup>	Supply - Demand	% Variance	Supply	Demand <sup>a</sup>	Supply - Demand	% Variance
<b>Total Primary Care</b>	<b>21,830</b>	<b>23,120</b>	<b>(1,290)</b>	<b>-6%</b>	<b>29,180</b>	<b>28,590</b>	<b>590</b>	<b>2%</b>
<b>Traditional Primary Care</b>	<b>16,430</b>	<b>16,850</b>	<b>(420)</b>	<b>-3%</b>	<b>22,000</b>	<b>20,940</b>	<b>1,060</b>	<b>5%</b>
General/Family Practice	5,580	6,540	(960)	-17%	7,180	8,100	(920)	-13%
General Internal Medicine	6,870	6,940	(70)	-1%	9,530	8,990	540	6%
Pediatrics	3,440	3,080	360	10%	4,680	3,440	1,240	26%
Geriatric Medicine <sup>a</sup>	540	290	250	46%	610	410	200	33%
General Surgery	1,090	1,710	(620)	-57%	1,450	2,170	(720)	-50%
Emergency Medicine	2,300	2,150	150	7%	3,220	2,520	700	22%
Obstetrics/Gynecology	2,010	2,410	(400)	-20%	2,510	2,960	(450)	-18%
<b>Total Non-Primary Care (excluding specialties not modeled)</b>	<b>18,760</b>	<b>22,090</b>	<b>(3,330)</b>	<b>-18%</b>	<b>23,140</b>	<b>27,580</b>	<b>(4,440)</b>	<b>-19%</b>
Allergy & Immunology	220	260	(40)	-18%	240	330	(90)	-38%
Anesthesiology	2,200	2,820	(620)	-28%	2,790	3,440	(650)	-23%
Cardiology	1,640	1,870	(230)	-14%	1,930	2,420	(490)	-25%
Dermatology	920	690	230	25%	1,140	880	260	23%
Endocrinology	370	530	(160)	-43%	570	680	(110)	-19%
Gastroenterology	920	870	50	5%	1,100	1,090	10	1%
Hematology & Oncology	740	1,090	(350)	-46%	1,010	1,370	(360)	-36%
Infectious Diseases	430	510	(80)	-19%	590	640	(50)	-8%
Nephrology	450	580	(130)	-29%	700	730	(30)	-4%
Neurological Surgery	320	330	(10)	-3%	460	420	40	9%
Neurology	1,060	1,080	(20)	-2%	1,320	1,370	(50)	-4%
Ophthalmology	1,170	1,130	40	3%	1,240	1,420	(180)	-15%
Orthopedic Surgery	1,380	1,520	(140)	-10%	1,630	1,900	(270)	-17%
Otolaryngology	510	550	(40)	-8%	610	700	(90)	-15%
Plastic Surgery	630	490	140	22%	720	590	130	18%
Psychiatry	1,820	2,850	(1,030)	-57%	2,150	3,340	(1,190)	-55%
Pulmonology & Critical Care <sup>b</sup>	690	1,000	(310)	-45%	950	1,250	(300)	-32%



Specialty	2013				2025			
	Supply	Demand <sup>a</sup>	Supply - Demand	% Variance	Supply	Demand <sup>a</sup>	Supply - Demand	% Variance
Radiology	1,910	2,440	(530)	-28%	2,450	3,150	(700)	-29%
Rheumatology	260	320	(60)	-23%	280	400	(120)	-43%
Thoracic Surgery	240	300	(60)	-25%	260	360	(100)	-38%
Urology	650	650	0	0%	710	820	(110)	-15%
Vascular Surgery	230	210	20	9%	290	280	10	3%
<b>Total (specialties modeled)</b>	<b>40,590</b>	<b>45,210</b>	<b>(4,620)</b>	<b>-11%</b>	<b>52,320</b>	<b>56,170</b>	<b>(3,850)</b>	<b>-7%</b>
Specialties demand not modeled <sup>c</sup>	2,020	2,020	0	0%	2,650	2,490	160	5%
<b>Total</b>	<b>42,610</b>	<b>47,230</b>	<b>(4,620)</b>	<b>-11%</b>	<b>54,970</b>	<b>58,660</b>	<b>(3,690)</b>	<b>-7%</b>

Notes: <sup>a</sup> Demand is defined as the number of physicians required to provide a level of care consistent with the national average in 2013. For specialties such as geriatric medicine, demand should be considered in the context of availability of general internists and other primary care providers. <sup>b</sup> A substantial proportion of pulmonologists practice critical care medicine, and to be consistent with demand estimates based on national patterns we combined the categories of pulmonology, pulmonology/critical care, and critical care. Excluded from this category are critical care physicians in anesthesiology, surgery, and obstetrics/gynecology, as these categories are categorized elsewhere. <sup>c</sup> Physician specialties omitted from the demand model include: colon-rectal cancer, neonatal/perinatal medicine, pathology, physical medicine & rehabilitation, preventive medicine and radiation oncology. Initial demand for services for this category is assumed equal to supply, and assumed to grow at the same rate as the overall demand for non-primary care specialties. Supply is modeled separately by specialty, but combined for presentation for comparison to demand. Note: Specialties included in the expanded definition of primary care are general and family practice, general internal medicine, general pediatrics, geriatric medicine, general surgery, obstetrics and gynecology, and emergency medicine.



## I. Introduction

Florida's healthcare sector operates in an environment with economic and regulatory pressures to improve access to quality care while containing medical costs. In Florida, the use of health care services, the available supply of services, and how care is delivered is determined by the choices made by the state's population of over 19 million people, thousands of health professionals, practicing in the State, numerous health care facilities and payers, employers, and federal and State regulatory and payment policies. Furthermore, the use of services and care delivery patterns continue to evolve based on changing demographics, evolving care delivery models, emerging technologies, and policies such as requirements of the federal Affordable Care Act (ACA).

To help ensure an adequate supply of physicians to meet growing demand for health care services, Florida has added four new medical schools over the past decade and expanded other training programs. All the states compete for physicians in a national labor market, and historically 59.4% of physicians who complete their graduate medical education (GME)/residency in Florida remain in the state. With this expansion in medical school capacity, expansion in capacity to provide GME/residency is also needed for the state to retain these physicians trained in Florida.<sup>1</sup>

Between 2000 and 2012, Florida's population gained about 3.3 million people, an increase of 21% from a 2000 population of 16.0 million.<sup>2</sup> The population in Florida will likely reach close to 21.1 million by 2020 and 23.6 million by 2030.<sup>3</sup>

The Urban Institute estimated that ACA would decrease the number of uninsured nonelderly persons in Florida by about 2.2 million, a decrease of 14.6 percentage points.<sup>4</sup> Should Florida elect to participate in the Medicaid and CHIP expansions under ACA, about one million newly eligible persons would be phased-in to these programs by State fiscal year 2017-2018.<sup>5</sup> Expanded health insurance coverage under ACA is projected to increase demand for a wide range of medical services. For example, Hofer et al (2011) project that demand for primary care physicians in the U.S. will rise by 4,310 to 6,940 as a result of ACA.<sup>6</sup> Petterson et al (2013) estimate a national increase of 3% (about 8,000 additional primary care physicians) will be

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<sup>1</sup> <http://safetynetsflorida.org/2013-legislative-priorities>

<sup>2</sup> <http://www.bebr.ufl.edu/articles/population-studies/trends-floridas-population-growth-2000-2012>

<sup>3</sup> All Races Population Projections by Age and Sex for Florida and Its Counties, 2015–2040, With Estimates for 2012, Bureau of Economics and Business Research, University of Florida, June 2013.

<sup>4</sup> <http://www.urban.org/uploadedpdf/1001520-Uninsured-After-Health-Insurance-Reform.pdf>

<sup>5</sup> Social Services Estimating Conference: Estimates Related to Federal Affordable Care Act: Title XIX (Medicaid) & Title XXI (CHIP) Programs: Adopted March 7, 2013.

<sup>6</sup> Hofer AN, Abraham JM. and Moscovice I. Expansion of Coverage under the Patient Protection and Affordable Care Act and Primary Care Utilization. *Milbank Quarterly*, 2011; 89: 69–89.



needed to accommodate insurance expansion under the ACA.<sup>7</sup> Estimates of ACA insurance expansion impact by Dall et al. (2013) suggest the nation will experience approximately a 4% increase in demand for adult primary care physicians, with Florida projected to have a 6% increase in demand for primary care providers reflecting the demographics and health risk factors among the state's uninsured population.<sup>8</sup> The impact of expanded medical coverage under ACA will vary throughout Florida based on community rates of unemployment, demographics, socioeconomic characteristics, disease prevalence and health risk factors.

Changing demographics, care use and delivery patterns, economic factors, and policy changes are likely to have a dramatic impact on demand for and supply of health professionals at State and local levels. Having an accurate picture of the current and projected future size, specialty mix and characteristics of Florida's physician workforce and an accurate picture of future demand for services is essential to identify possible disparities in access to care and to inform health care policy making.

The primary purpose of this study is to quantify and assess the current and future adequacy of supply for selected physician specialties in Florida through 2025 under alternative scenarios that reflect different demand and supply trends and assumptions. Study findings are intended to be used to help decision makers throughout the State better understand how trends in physician supply and demand determinants will affect Florida, and the circumstances that may influence the physician specialty selected by medical school graduates.

Study guiding research questions include:

- In Florida, are there specialties where supply and demand currently are not in balance? If so, which specialties, and what is the estimated gap between supply and demand?
- What are the potential implications of health care reform initiatives, emerging care delivery models and other market factors on Florida's physician workforce supply and demand?
- To what extent will the future projected supply of physicians be adequate to meet projected statewide population service demand?

The remainder of this report is organized to present an assessment of current and future adequacy of physician supply (Section II), a summary of inputs and projections for current and future physician demand (Section III) and supply (Section IV), and a discussion of key findings and implications (Section V). A technical appendix provides additional information on how the workforce models were adapted for Florida.

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<sup>7</sup> Petterson SM, Liaw WR, Phillips RL, Rabin DL, Meyers DS, and Bazemore AW. Projecting US Primary Care Physician Workforce Needs: 2010-2025. *Annals of Family Medicine*, 2013; 10(6):503-509.  
<http://www.annfammed.org/content/10/6/503.full.pdf+html>

<sup>8</sup> Dall TM, Gallo PD, Chakrabarti R, West T, Semilla AP, Storm, MV. An Aging Population and Growing Disease Burden Will Require A Large and Specialized Health Care Workforce By 2025. *Health Affairs*, 2013; 32:2013-2020.  
<http://content.healthaffairs.org/content/32/11/2013.abstract>





## II. Current and Future Adequacy of Physician Supply

This section compares Florida physician supply and demand in 2013, as well as projected to 2025. The 28 medical specialties covered by both the demand and supply analyses include 7 primary care specialties and 21 other medical and surgical specialties, and jointly account for 95% of active physicians in Florida. This study uses two definitions of primary care specialties. The medical specialties of general/family practice, general internal medicine, general pediatrics, and geriatric medicine are referred to as “Traditional” primary care specialties. At the request of SNHA we also model an expanded definition of primary care referred to as “Total” primary care specialties. In addition to the Traditional primary care specialties, Total primary care also includes obstetrics and gynecology, emergency medicine, and general surgery.

When comparing supply to demand for individual specialties, one should take into consideration the following:

1. **Shortfall or surplus severity.** When comparing supply to demand, if estimated imbalances are within  $\pm 5\%$  one might consider supply to be essentially equal to demand. This level of imbalance is within the measurement error of any workforce model, and slight imbalances between supply and demand tend not to cause large disruptions in access to care. When imbalances are in the 5-10% range, this might be indicative of a mild shortfall (or surplus).
2. **Physician “plasticity”.** There is often overlapping scope of services provided by physicians in different specialties—this is sometimes referred to as plasticity. For example, primary care services provided to the elderly are typically provided by physicians in internal medicine and family practice as well as geriatric medicine. General internists often provide care that could be provided by internal medicine subspecialties—e.g., cardiologists and endocrinologists.
3. **Advanced practice nurses, physician assistants, and other health care providers.** The comparisons presented here compare supply to estimated demand based on national care use and delivery patterns, taking into account the characteristics of Florida’s population. The comparisons do not take into account whether use of nurse practitioners, physician assistants, or other health care providers is similar or different from national care delivery patterns. To the extent that Florida uses more (less) non-physician providers relative to national patterns, then demand for physicians will be lower (higher) than projected by the Healthcare Demand Microsimulation Model.
4. **Self-correcting mechanisms.** The supply projections through 2025 indicate what is likely to happen if the number and mix of physicians trained and workforce participation remains unchanged from current patterns. As shortages or surpluses start to develop, there are self-correcting mechanisms that help prevent imbalances from becoming too severe. Physicians completing medical school will select residency and fellowship training opportunities that will lead to productive careers and these individuals will tend to gravitate away from specialties with projected surpluses and into specialties with projected shortages. Therefore,



over the long term it may be more important to focus on the total number of new physicians being trained and less on the specialty distribution which will self-correct to prevent severe imbalances. Likewise, physicians in specialties with an abundance of supply might move out of Florida, while specialties with inadequate supply might find more success in attracting physicians to Florida and retaining physicians already in the state.

A comparison of current supply and demand suggests that Florida has about 4,620 fewer physicians (11% shortfall) than required to meet demand (Exhibit 1). When comparing the traditional primary care specialties (family practice, internal medicine, pediatrics, and geriatric medicine), the state appears to use more pediatricians and geriatricians relative to the national average, but uses fewer family practitioners and general internists relative to the national average. Combining these traditional primary care specialties, the supply of 16,430 physicians is just 3% shy of the 16,850 demanded—suggesting that at the state level the population receives a level of services from primary care physicians consistent with the national average (where the national shortfall is about 3.6%).

Within Florida there is substantial distribution in supply of primary care providers as evidenced by the approximately 858 primary care providers (physicians, as well as nurse practitioners) that would be needed to remove the Primary Care Health Profession Shortage Area designation currently in place for 13 single counties and 108 other communities.<sup>9</sup>

Using the more expansive definition of primary care that includes general surgery, emergency medicine, and obstetrics/gynecology, it appears that the state has a shortfall of about 1,290 physicians. Florida has substantially fewer general surgeons (1,090) than is estimated to meet demand (1,710) for services. That Florida currently uses 7% more emergency physicians than is required to provide a national average level of care, given the characteristics of Florida's population, could be indicative of (1) higher than national average rates of uninsured and Medicaid recipients who might seek non-urgent care in emergency settings, (2) the large amount of tourism in the state, or (3) other factors not accounted for in the Healthcare Demand Microsimulation Model used.

For many surgical specialties state supply appears relatively consistent with estimated demand—e.g., otolaryngology (40 shortfall), neurological surgery (10 shortfall), urology (no shortfall), and vascular surgery (20 excess). The state has more than sufficient plastic surgeons to provide a level of care consistent with the national average (+140 physicians, or +22%), but insufficient thoracic surgeons (-60, or -25%).

Consistent with the shortfall of surgeons, the supply of anesthesiologists is less (by 620 physicians) than expected to meet demand. However, the State's 2,542 licensed Certified Registered Nurse Anesthetists (CRNAs) in 2011 suggests that Florida has a CRNA-to-anesthesiologist ratio of 1.16:1, whereas the national ratio is approximately 0.82:1. This suggests that Florida has

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<sup>9</sup> <http://datawarehouse.hrsa.gov/geoadvisor/shortagedesignationadvisor.aspx>



approximately 230 more CRNAs than required to be consistent with national staffing patterns, which partially offsets the estimated 620 anesthesiologist shortfall.

The supply of dermatologists appears to be more than adequate to meet demand for services in 2013. Specialties where demand appears to be significantly greater than supply include: general surgery, psychiatry, oncology, endocrinology, radiology, thoracic surgery, and rheumatology. At the sub-state level, there is likely even greater imbalances between supply and demand in rural and small, metropolitan areas.



**Exhibit 1: Estimated Supply and Demand for Physicians by Specialty, 2013**

Specialty	Supply	Demand <sup>a</sup>	Supply - Demand	% Variance
<b>Total Primary Care</b>	<b>21,830</b>	<b>23,120</b>	<b>(1,290)</b>	<b>-6%</b>
<b>Traditional Primary Care</b>	<b>16,430</b>	<b>16,850</b>	<b>(420)</b>	<b>-3%</b>
General/Family Practice	5,580	6,540	(960)	-17%
General Internal Medicine	6,870	6,940	(70)	-1%
Pediatrics	3,440	3,080	360	10%
Geriatric Medicine <sup>a</sup>	540	290	250	46%
General Surgery	1,090	1,710	(620)	-57%
Emergency Medicine	2,300	2,150	150	7%
Obstetrics/Gynecology	2,010	2,410	(400)	-20%
<b>Total Non-Primary Care (excluding specialties not modeled)</b>	<b>18,760</b>	<b>22,090</b>	<b>(3,330)</b>	<b>-18%</b>
Allergy & Immunology	220	260	(40)	-18%
Anesthesiology	2,200	2,820	(620)	-28%
Cardiology	1,640	1,870	(230)	-14%
Dermatology	920	690	230	25%
Endocrinology	370	530	(160)	-43%
Gastroenterology	920	870	50	5%
Hematology & Oncology	740	1,090	(350)	-46%
Infectious Diseases	430	510	(80)	-19%
Nephrology	450	580	(130)	-29%
Neurological Surgery	320	330	(10)	-3%
Neurology	1,060	1,080	(20)	-2%
Ophthalmology	1,170	1,130	40	3%
Orthopedic Surgery	1,380	1,520	(140)	-10%
Otolaryngology	510	550	(40)	-8%
Plastic Surgery	630	490	140	22%
Psychiatry	1,820	2,850	(1,030)	-57%
Pulmonology & Critical Care <sup>b</sup>	690	1,000	(310)	-45%
Radiology	1,910	2,440	(530)	-28%
Rheumatology	260	320	(60)	-23%
Thoracic Surgery	240	300	(60)	-25%
Urology	650	650	0	0%
Vascular Surgery	230	210	20	9%
<b>Total (specialties modeled)</b>	<b>40,590</b>	<b>45,210</b>	<b>(4,620)</b>	<b>-11%</b>
Specialties demand not modeled <sup>c</sup>	2,020	2,020	0	0%
<b>Total</b>	<b>42,610</b>	<b>47,230</b>	<b>(4,620)</b>	<b>-11%</b>

Notes: <sup>a</sup> Demand is defined as the number of physicians required to provide a level of care consistent with the national average in 2013. For specialties such as geriatric medicine, demand should be considered in the context of availability of general internists and other primary care providers. <sup>b</sup> A substantial proportion of pulmonologists practice critical care medicine, and to be consistent with demand estimates based on national patterns we combined the categories of pulmonology, pulmonology/critical care, and critical care. Excluded from this category are critical care physicians in anesthesiology, surgery, and obstetrics/gynecology, as these categories are categorized elsewhere. <sup>c</sup> Physician specialties omitted from the demand model include: colon-rectal cancer, neonatal/ perinatal medicine, pathology, physical medicine & rehabilitation, preventive medicine and radiation oncology. Initial demand for services for this category is assumed equal to supply, and assumed to grow at the same rate as the overall demand for non-primary care specialties. Supply is modeled separately by specialty, but combined for presentation for comparison to demand. Note: Specialties included in the expanded



definition of primary care are general and family practice, general internal medicine, general pediatrics, geriatric medicine, general surgery, obstetrics and gynecology, and emergency medicine.

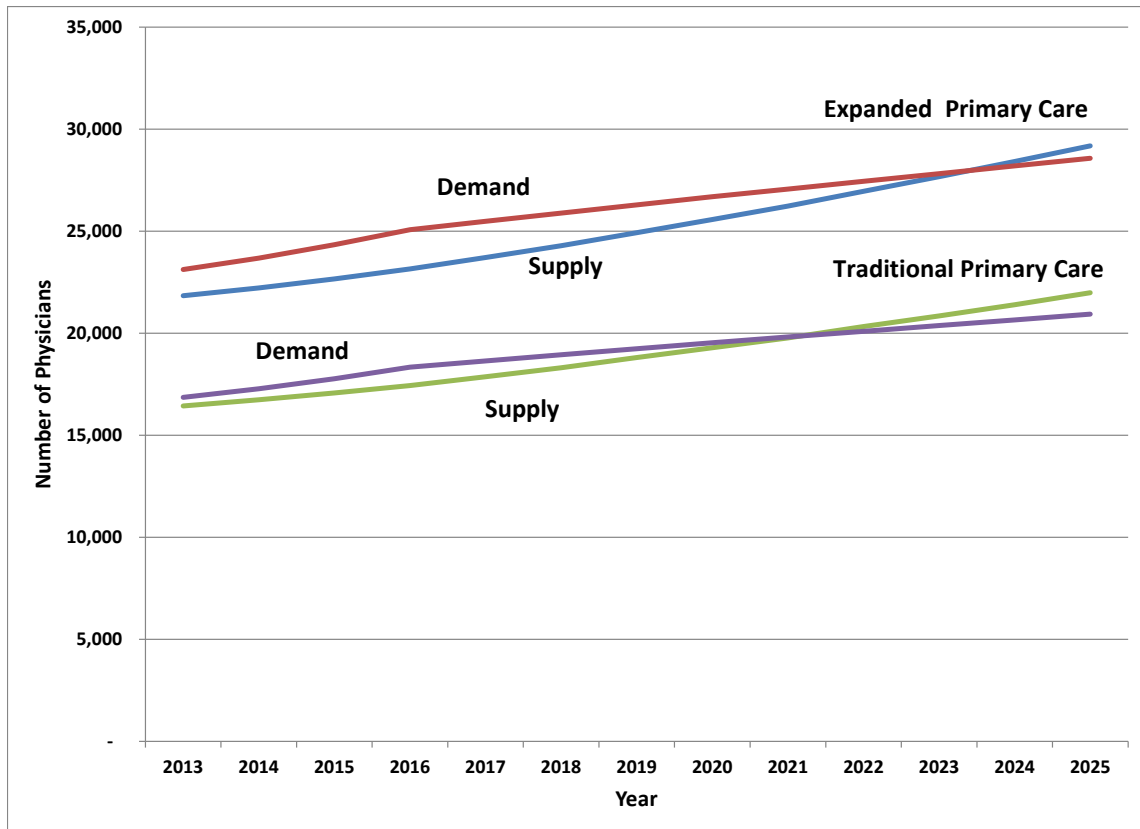
Florida's supply and demand for primary care providers should remain roughly in equilibrium over the foreseeable future (Exhibit 2). The current shortfall of about 1,290 primary care physicians (a modest 6%), will grow to about 7.5% shortfall (1,770 physicians) by 2017. This growth in the shortfall of primary care providers is largely associated with the projected 4% growth in demand for primary care services between 2014 and 2017 from expanded insurance coverage under ACA.

Between 2013 and 2025, though, the supply of physicians for both traditional primary care specialties and those modeled under an expanded definition of primary care is projected to grow faster than demand (34% versus 24% growth). As a result, by 2023 supply and demand are projected to be in equilibrium. To the extent that the State's supply of nurse practitioners and physician assistants in primary care grows faster than 24% (i.e., faster than demand for primary care services), then the modest gap that exists between supply and demand for primary care physicians could disappear before 2023.

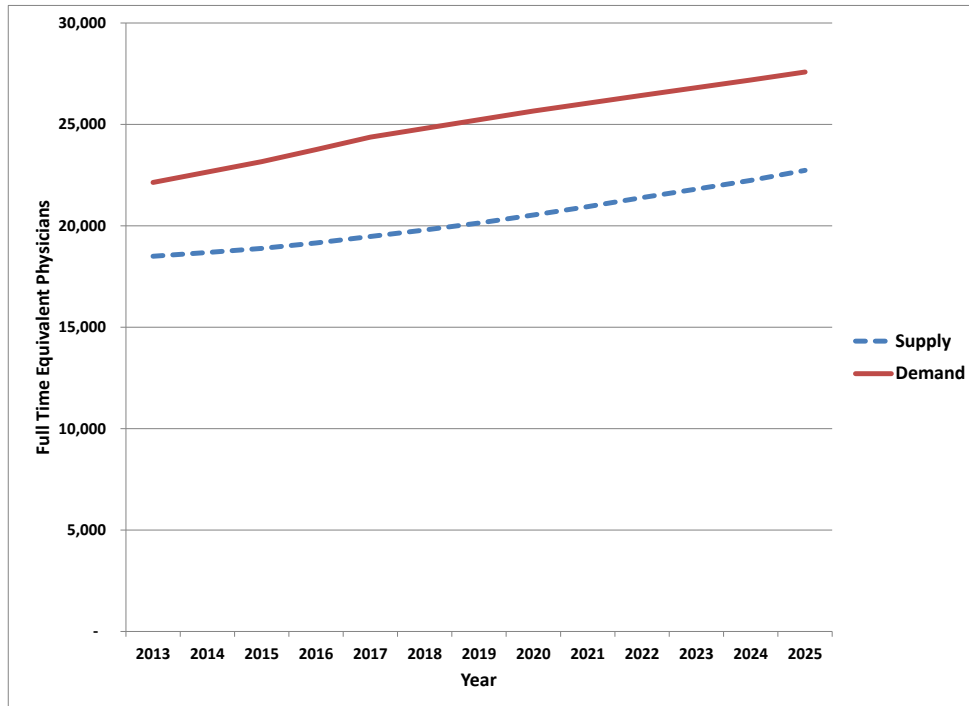
However, over the foreseeable future, growth in demand for non-primary care physicians is projected to slightly exceed growth in supply (25% compared to 23%) between 2013 and 2025 (Exhibit 3). As a result, by 2025 projected demand will exceed supply by about 4,440 physicians (-19%). Across all medical specialties, between 2013 and 2025 the current estimated shortfall of 4,620 physicians (-11%) is projected to decline to about 3,690 (-7%) (Exhibit 4).



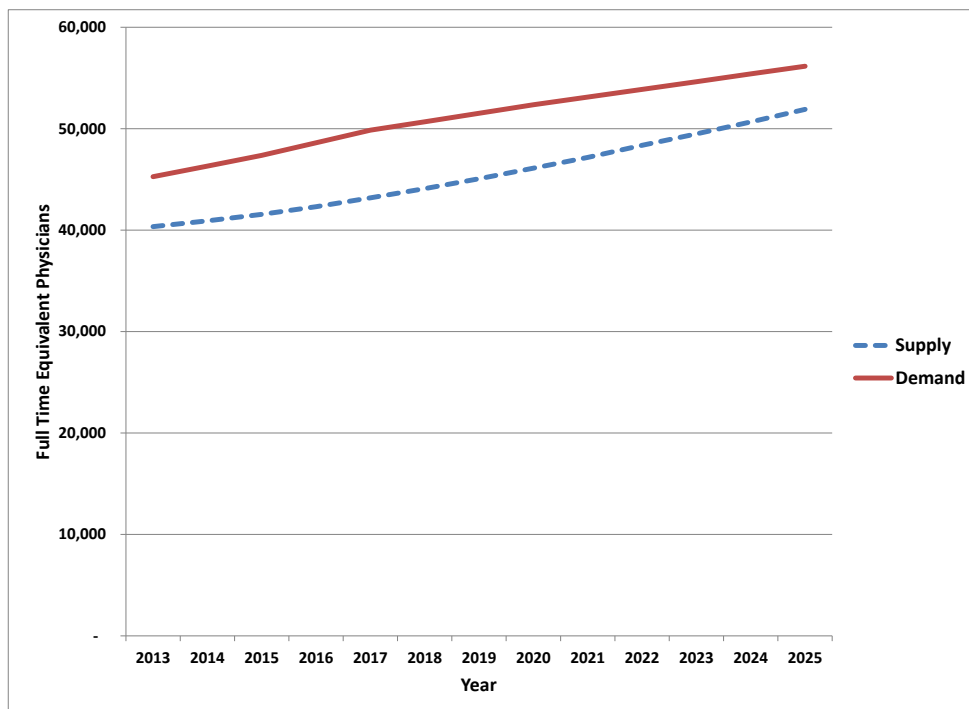
**Exhibit 2: Projected Supply and Demand for Primary Care Physicians, 2013-2025**



**Exhibit 3: Projected Supply and Demand for Specialist Physicians, 2013-2025**



**Exhibit 4: Projected Total Supply and Demand for Physicians, 2013-2025**





By 2025, the total supply of primary care providers should be sufficient to provide a level of care consistent with national patterns of care in 2013 (Exhibit 5). However, individual primary care specialties show both shortages and excess supply. For example, if current trends continue the estimated shortfall of general surgeons is projected to persist. The state's supply of pediatricians also appears to be growing faster than growth in numbers of children—which is the primary driver of demand for pediatric services.

If current patterns continue, specialties where supply is projected to be substantially less than demand include: psychiatry, general surgery, rheumatology, thoracic surgery, and radiology. For many internal medicine subspecialties supply is also projected to be adequate to meet demand for services. The few specialties where supply is projected to exceed the number demanded to provide a level of care consistent with national 2013 patterns are pediatrics, dermatology, emergency medicine, and plastic surgery. For emergency medicine, demand estimates based on national patterns of care do not take into consideration that Florida has more tourism than most parts of the nation—which might help explain why the number of practicing emergency physicians in Florida exceeds estimated demand based on the characteristics of the state's resident population. As noted earlier, self-correcting mechanisms in specialty choice suggest that large shortages or surpluses in individual professions are unlikely to persist.<sup>10</sup>

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<sup>10</sup> Note: Supply and demand were not modeled at the sub-specialty level, and trends affecting a subspecialty might not be the same as trends affecting the larger specialty in which the subspecialty is categorized.





**Exhibit 5: Projected Supply and Demand for Physicians by Specialty, 2025**

Specialty	Supply	Demand <sup>a</sup>	Supply - Demand	% Variance
<b>Total Primary Care</b>	<b>29,180</b>	<b>28,590</b>	<b>590</b>	<b>2%</b>
<b>Traditional Primary Care</b>	<b>22,000</b>	<b>20,940</b>	<b>1,060</b>	<b>5%</b>
General/Family Practice	7,180	8,100	(920)	-13%
General Internal Medicine	9,530	8,990	540	6%
Pediatrics	4,680	3,440	1,240	26%
Geriatric Medicine <sup>a</sup>	610	410	200	33%
General Surgery	1,450	2,170	(720)	-50%
Emergency Medicine	3,220	2,520	700	22%
Obstetrics/Gynecology	2,510	2,960	(450)	-18%
<b>Total Non-Primary Care (excluding specialties not modeled)</b>	<b>23,140</b>	<b>27,580</b>	<b>(4,440)</b>	<b>-19%</b>
Allergy & Immunology	240	330	(90)	-38%
Anesthesiology	2,790	3,440	(650)	-23%
Cardiology	1,930	2,420	(490)	-25%
Dermatology	1,140	880	260	23%
Endocrinology	570	680	(110)	-19%
Gastroenterology	1,100	1,090	10	1%
Hematology & Oncology	1,010	1,370	(360)	-36%
Infectious Diseases	590	640	(50)	-8%
Nephrology	700	730	(30)	-4%
Neurological Surgery	460	420	40	9%
Neurology	1,320	1,370	(50)	-4%
Ophthalmology	1,240	1,420	(180)	-15%
Orthopedic Surgery	1,630	1,900	(270)	-17%
Otolaryngology	610	700	(90)	-15%
Plastic Surgery	720	590	130	18%
Psychiatry	2,150	3,340	(1,190)	-55%
Pulmonology & Critical Care <sup>b</sup>	950	1,250	(300)	-32%
Radiology	2,450	3,150	(700)	-29%
Rheumatology	280	400	(120)	-43%
Thoracic Surgery	260	360	(100)	-38%
Urology	710	820	(110)	-15%
Vascular Surgery	290	280	10	3%
<b>Total (specialties modeled)</b>	<b>52,320</b>	<b>56,170</b>	<b>(3,850)</b>	<b>-7%</b>
Specialties demand not modeled <sup>c</sup>	2,650	2,490	160	5%
<b>Total</b>	<b>54,970</b>	<b>58,660</b>	<b>(3,690)</b>	<b>-7%</b>

Notes: <sup>a</sup> Demand is defined as the number of physicians required to provide a level of care consistent with the national average in 2013. For specialties such as geriatric medicine, demand should be considered in the context of availability of general internists and other primary care providers. <sup>b</sup> A substantial proportion of pulmonologists practice critical care medicine, and to be consistent with demand estimates based on national patterns we combined the categories of pulmonology, pulmonology/critical care, and critical care. Excluded from this category are critical care physicians in anesthesiology, surgery, and obstetrics/gynecology, as these categories are categorized elsewhere. <sup>c</sup> Physician specialties omitted from the demand model include: colon-rectal cancer, neonatal/perinatal medicine, pathology, physical medicine & rehabilitation, preventive medicine and radiation oncology. Initial demand for services for this category is assumed equal to supply, and assumed to grow at the same rate as the overall demand for non-primary care specialties. Supply is modeled separately by specialty, but combined for presentation for comparison to demand. Note: Specialties included in the



expanded definition of primary care are general and family practice, general internal medicine, general pediatrics, geriatric medicine, general surgery, obstetrics and gynecology, and emergency medicine.

### III. Current and Projected Future Physician Demand

This section first provides a brief overview of how demand is defined and the approach used to model current and future demand for health care services and physicians. Then, demand projections are presented for both health care services and providers under alternative scenarios.

#### A. Overview

The demand for health services is defined as the level and mix of services that consumers are able and willing to purchase at current prices given epidemiological and economic considerations. Current demand, therefore, is equivalent to the quantity of services utilized plus any services not utilized because provider shortages prevented patients from accessing care. Demand for services does not equal “need,” where need is based on a clinical definition taking into account patient epidemiological considerations combined with an assessment of appropriate patient care—regardless of ability to pay for services.

The demand for physicians is based on the demand for health care services, but taking into consideration care delivery patterns. The number of physicians in a particular specialty to meet demand for services is based, in part, on the adequacy of supply of physicians in other specialties whose scope of practice might partially overlap this specialty. Furthermore, the availability and use of advanced practice nurses, physician assistants, and other health workers can affect demand for physicians. Changes over time in technology, physician productivity, average levels of patient acuity, and mix of services can change how many patients can be cared for by an individual physician and the state’s overall demand for physicians

The Healthcare Demand Microsimulation Model used for this analysis has three major components:

1. **Population database.** A population database contains characteristics (demographics, socioeconomic, health risk-related behaviors, and presence of chronic conditions) for each person in a representative sample of the State population through 2025.
2. **Health care use forecasting equations.** Equations based on national data relate health care use patterns to each person’s characteristics and presence of disease and other health risk factors that affect their health care utilization patterns.
3. **Care delivery patterns.** The model reflects national average staffing patterns in terms of the number of physicians required to provide a set amount of services by medical specialty and care delivery setting.

The model components, and the data used to adapt the model for Florida, are described in more detail in Appendix A.



The demand projections presented here take into account projected population growth and changing demographics from 2013 to 2025, as well as anticipated expansion in health insurance coverage from ACA. The demand estimates reflect the number and mix of physicians that Florida requires to provide a national average level of care given the characteristics of Florida's population and economic factors.

The national average level of care is not necessarily equivalent to a best-practice level of care. Many might argue, for example, that the national supply of mental health workers, primary care providers, and other practitioners currently is inadequate to meet the demand for services of the nation's population. This is evidenced by long wait times for appointments and delays in hiring new practitioners in some occupations and medical specialties. Consequently, when calculating national patterns of care this analysis assumes the following in terms of the supply and demand for physicians prior to implementation of the Affordable Care Act:

1. There is a national primary care provider shortfall of approximately 8,000 (3.6%) physicians reflecting the number of practitioners required to de-designate the federally designated primary care health professional shortage areas.
2. Similarly, there is a national shortfall of 2,800 (-6%) psychiatrists which reflects the number of mental health practitioners required to de-designate the federally designated mental health professional shortage areas.
3. As reflected in a recent report the nation likely has a current shortage of ~1,700 (-10%) adult neurologists and ~470 (-20%) pediatric neurologists.<sup>11</sup> Another recent study suggests a shortage of ~100 (-10%) shortage of pediatric endocrinologists and ~1,500 (-25%) shortage of adult endocrinologists.<sup>12</sup> The endocrinologist shortfall estimates are based on vacancy rates, and after adjusting for a natural vacancy rate to reflect normal delays in hiring we assume that at the national level the overall endocrinologist shortage is about 15%.
4. For some other specialties, there is inconclusive evidence of a current national shortfall. For example, the nation has approximately 5,100 neurosurgeons and recent estimates of 305 job vacancies suggested that hospitals or practices were trying to hire neurosurgeons.<sup>13</sup> While this suggests potentially a 6% current national shortfall of neurosurgeons, because of normal delays to fill a position when one becomes available, this estimate likely represents an upper bound on the degree of current shortfall. Furthermore, a large portion of these positions are for emergency department coverage—suggesting that overall the nation might have an adequate supply of neurosurgeons but

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<sup>11</sup> Dall TM, Storm MV, and Chakrabarti R. Supply and demand analysis of the current and future US neurology workforce. *Neurology*. 2013; 81(5): 470-478. <http://www.neurology.org/content/early/2013/04/17/WNL.0b013e318294b1cf.short>

<sup>12</sup> Vigersky R, Fish L, Hogan P, et al. The Clinical Endocrinology Workforce: Current Status and Future Projections of Supply and Demand. *The Journal of Clinical Endocrinology & Metabolism*. 2014

<sup>13</sup> Rosman JI, Slane S, Dery B, Vogelbaum MA, Cohen-Gadol AA, Couldwell WT. Neurosurgery. Is there a shortage of neurosurgeons in the United States? *Neurosurgery*. 2013 Aug;73(2):354-5.



that within that supply many choose not to provide certain types of care—such as emergency department coverage.

## **B. Projected Service Demand by Specialty and Setting**

Between 2012 and 2025, Florida’s population will grow by about 3.3 million people (17%) from its current level of 19 million.<sup>14</sup> This compares with a smaller 10% projected national population growth rate during the same period.<sup>15</sup> Florida’s population age sixty-five and older is projected to grow by about 1.5 million (45%) during this period, while the seventy-five and older population is projected to grow by about 661,000 (42%). High rates of projected population growth, especially among the elderly “Baby Boomer” population, portend rapidly growing demand for health care services with highest growth expected for those specialties that disproportionately serve the elderly.

Demographic shifts in race and ethnicity also are modeled, as these shifts inform projected changes over time in population characteristics, in turn related to projected changes in chronic disease prevalence and other health risk factors that are determinants of health care service use. Between 2012 and 2025, Florida’s non-Hispanic white population will grow by about 899,000 people (8%). By comparison, the Hispanic population is projected to grow by about 1.6 million people (37%) and the non-Hispanic black population by about 690,000 people (23%). Historically, many ethnic groups have experienced large disparities in mortality, health status and disease prevalence. Care use patterns also differ by race and ethnicity, with minority populations generally using fewer health care services relative to a non-Hispanic, white population after controlling for other demographics and health risk factors, insurance status, and household income.

For example, our analysis of the Medical Expenditure Panel Survey finds that Hispanic and black adults have only about 50% as many office visits to a psychiatrist during the year compared to white adults. In some cases, though, racial or ethnic minorities use more services. For example, black adults are more likely than white and Hispanic adults to use emergency services related to cardiovascular problems.

Projected statewide growth rates in service demand by care setting (Exhibit 6) account for changing demographics and expanded medical insurance. As noted above, ACA is projected to reduce the numbers of uninsured by about 2.2 million individuals in Florida by 2016. The demand projections presented here assume that people who gain coverage under ACA will have similar patterns of care as their privately insured peers—taking into account demographic and socioeconomic characteristics as well as health risk factors. Thus, the impact of expanded

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<sup>14</sup> All Races Population Projections by Age and Sex for Florida and Its Counties, 2015–2040, With Estimates for 2012, Bureau of Economics and Business Research, University of Florida, June 2013.

<sup>15</sup> US Census Bureau. National Population Projections 2012 to 2060 (based on 2010 Census). 2012



coverage represents the expected increase in use of health care services compared to estimated use rates prior to gaining insurance coverage.

Demand projections suggest that the effects of changing demographics in Florida will have a much greater influence on future service demand than will the effects of ACA. Demand for hospital inpatient care will grow by about 27% between 2013 and 2025, compared to 23% for the U.S. overall based on changing demographics alone. Similarly, demand will grow by about 17% for emergency care compared to 12% for the U.S.; 19% for physician office visits compared to 14% for the U.S.; and 20% for outpatient visits compared to 15% for the U.S. These numbers compare to projected 17% population growth for Florida and 10% population growth for the U.S. between 2013 and 2025

Expansion of medical coverage under ACA is projected to impact service demand in Florida to a greater extent than the nation as a whole across most care delivery settings modeled. Demand for physician office visits is projected to grow by an additional 6 percentage points, demand for outpatient visits by an additional 4 percentage points, and demand for inpatient days by an additional 2 percentage points.

Demand for emergency care is projected to be largely unaffected by ACA, with the projected increase in use of emergency care due to lower out-of-pocket expenditures almost entirely offset by non-emergent care shifted from emergency departments to other ambulatory settings.

**Exhibit 6: Projected Growth in Service Demand by Care Setting/Source, 2013-2025**

Care Setting	Growth from Changing Demographics		Growth from Insurance Coverage Expansion under ACA	
	Florida	U.S.	Florida	U.S.
Office visits	19%	14%	+6%	+4%
Outpatient visits	20%	15%	+4%	+2%
Emergency visits	17%	12%	+0%	+0%
Hospital inpatient days	27%	23%	+2%	+1%

Reflecting the rising burden of disease associated with Florida’s growing and aging population, service utilization is projected to increase significantly across care settings and most medical specialties, particularly those that treat an aging population with high chronic disease prevalence (Exhibit 7). For example, by 2025 statewide hospital inpatient days of care are projected to increase about 30% for patients with cardiology-related conditions; physician office visits to geriatric care providers will likely rise by about 42% and outpatient visits associated with diagnosis and treatment of diabetes and other endocrinology related diagnoses are forecast to rise by about 21%.



Across all medical specialties, hospital days are projected to grow by 27%, which is much higher than projected growth in demand for outpatient (20%), office (19%) and emergency (17%) visits. The appendix provides growth projections for all the specialties modeled. In contrast to the high-growth specialties, specialties that predominantly treat children are projected to grow more slowly. Office visits to pediatricians are projected to grow about 11% between 2013 and 2025.

**Exhibit 7: Projected Percent Growth in Service Demand by Setting among Top 10 Highest Growth Specialties in Florida, 2013-2025**

Specialty	Hospital Inpatient Days	Emergency Visits	Physician Office Visits	Outpatient Visits
Geriatrics	40%		42%	42%
Endocrinology	30%	23%	25%	21%
Cardiology	30%	22%	24%	24%
Rheumatology	27%	19%	23%	25%
Pulmonology	30%	17%	20%	20%
Oncology	24%	19%	22%	21%
General Surgery	27%	16%	21%	19%
Nephrology	35%		24%	23%
Allergy & Infectious Diseases	30%	15%	17%	20%
Orthopedic Surgery	29%	17%	20%	16%
<b>Total Growth (all specialties)</b>	<b>27%</b>	<b>17%</b>	<b>19%</b>	<b>20%</b>

Note: Demand projections reflect current national patterns of care use and delivery applied to Florida’s current and projected future population. Specialty for hospital inpatient days and emergency visits was determined based on primary ICD-9 diagnosis codes associated with the hospitalization or visit. Specialty for office and outpatient visits was determined by reported physician specialty.

These service demand projections assume that future care delivery patterns remain relatively unchanged from current patterns. To the extent that emerging care delivery models such as Accountable Care Organizations (ACOs) gain market share in Florida sufficient to substantially alter care delivery patterns, then service demand in hospital emergency departments might grow at a slower pace while demand in ambulatory care settings might grow more rapidly than projected here.

### C. Statewide Projected Physician Demand by Specialty

Statewide projected growth in physician demand reflecting changing demographics and expanded Medical coverage under ACA is summarized in Exhibit 8 and Exhibit 9. Overall, statewide demand for physicians is projected to increase by about 11,430 FTEs (24%) between 2013 and 2025. Projected growth in physician demand includes 5,470 FTE primary care providers, with an additional 5,480 FTEs among the 21 non-primary care specialties included in



the Healthcare Demand Microsimulation Model and 470 additional FTE among the specialties not modeled (assuming a similar growth rate in demand as the non-primary care specialties modeled).

However, the impacts of changing demographics and expanded medical coverage under ACA will differ substantially across specialties. In absolute terms, demand growth is highest for general internal medicine (2,050) and general and family practice (1,560). In percentage terms, overall demand growth is highest for geriatric medicine (42%) and vascular surgery (34%).

For specialties that predominantly serve an older population (e.g., cardiology, endocrinology, rheumatology), demand growth is projected to be in the 25-30% range. Projected growth in demand for psychiatrists is 17%, consistent with the states projected 17% population growth rate. This reflects that expanded medical coverage under ACA is not anticipated to grow demand for psychiatrists. However, other provisions of ACA not modeled in our analysis are designed to improve access to mental health services. Therefore, these demand growth projections for psychiatry are likely conservative. Projected growth in demand for pediatricians (12%) reflects the expectation that younger age cohorts are projected to grow less rapidly than the general population.

The projected impact of ACA on demand for emergency physicians is projected to be small based upon the Massachusetts experience to date and an assumption that Florida will elect not to expand the current state Medicaid program. ACA has many of the same design features as the Massachusetts reform. The Massachusetts' health care reform law has thus far neither increased nor decreased ED utilization relative to that in other states. The similarity among states is to be expected if the level of ED use is dominated by broader trends in population health, such as health status, that are not affected by health insurance expansion. Alternatively, it is possible that this result arises from two equal forces pushing in opposite directions — that the Massachusetts insurance expansion increased prevention, thereby reducing ED use, but that this effect has been offset by the reduced out-of-pocket cost of using the ED or difficulties in finding primary care physicians.<sup>16</sup>

Were Florida to expand its current Medicaid program, the demand projection for ED physicians would have to be adjusted upward, as adult Medicaid beneficiaries have higher ED utilization rates compared to both uninsured and privately insured patients. This could reflect access constraints for Medicaid beneficiaries seeking care in outpatient settings.

Changes in technology, reimbursement policies, and other trends not modeled could affect future demand for services. For example, efforts to control medical costs could lead to larger patient out-of-pocket expenses for items such as hip and knee replacements. Larger out-of-pocket expenses could dampen demand for services, resulting in slower projected growth in demand for

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<sup>16</sup> Chen, C, Scheffler G, and Chandra, A.. Massachusetts' Health Care Reform and Emergency Department Utilization. The New England Journal of Medicine. November 2011;



orthopedic surgeons and other specialties. Changes in technology can also increase demand for services, offering patients treatment options that might now be unavailable.

Compared to the magnitude of changing demographics, expanded healthcare coverage under ACA is projected to increase demand relatively modestly by about 1,880 FTEs (4%). For modeling purposes, we assume that the impact of expanded coverage under ACA is phased in between 2014 and 2017. Specialties with the largest projected increases in demand due to medical coverage expansions include otolaryngology and dermatology (8%), and general internal medicine (7%). ACA alone is expected to have little or no effect on demand for geriatricians, pediatricians, and several other specialties, as the patient populations treated by these specialties largely already have medical coverage (e.g., through Medicare in the case of geriatric medicine, or Medicaid and Commercial insurance).





**Exhibit 8: Projected Growth in Florida’s Physician Demand, 2013-2025**

Specialty	Demand 2013 <sup>a</sup>	Projected growth by demand driver, 2013 to 2025			Demand 2025	Percent growth by demand driver, 2013 to 2025		
		Demographics	ACA Expanded Coverage <sup>b</sup>	Total		Demographics	ACA Expanded Coverage <sup>b</sup>	Total <sup>c</sup>
<b>Total Primary Care</b>	<b>23,120</b>	<b>4,450</b>	<b>1,020</b>	<b>5,470</b>	<b>28,590</b>	<b>19.2%</b>	<b>4.4%</b>	<b>23.6%</b>
<b>Traditional Primary Care</b>	<b>16,850</b>	<b>3,300</b>	<b>790</b>	<b>4,090</b>	<b>20,940</b>	<b>19.6%</b>	<b>4.7%</b>	<b>24.3%</b>
General/Family Practice	6,540	1,240	320	1,560	8,100	18.9%	4.9%	23.8%
General Internal Medicine	6,940	1,580	470	2,050	8,990	22.8%	6.7%	29.5%
Pediatrics	3,080	360	<10	360	3,440	11.6%	0.0%	11.6%
Geriatric Medicine <sup>a</sup>	290	120	<10	120	410	41.6%	0.0%	41.6%
General Surgery	1,710	390	70	460	2,170	22.8%	3.9%	26.7%
Emergency Medicine	2,150	370	<10	370	2,520	17.2%	0.0%	17.2%
Obstetrics/Gynecology	2,410	390	160	550	2,960	16.2%	6.4%	22.6%
<b>Total Non-Primary Care</b>	<b>22,090</b>	<b>4,670</b>	<b>790</b>	<b>5,480</b>	<b>27,580</b>	<b>21.2%</b>	<b>3.6%</b>	<b>24.8%</b>
Allergy & Immunology	260	60	10	70	330	23.5%	3.4%	26.9%
Anesthesiology	2,820	570	50	620	3,440	20.3%	1.6%	21.9%
Cardiology	1,870	480	70	550	2,420	25.5%	3.7%	29.2%
Dermatology	690	140	50	190	880	20.4%	7.7%	28.1%
Endocrinology	530	140	10	150	680	25.7%	1.2%	26.9%
Gastroenterology	870	180	40	220	1,090	20.3%	4.7%	25.0%
Hematology & Oncology	1,090	250	30	280	1,360	22.9%	2.8%	25.7%
Infectious Diseases	510	110	20	130	640	22.1%	3.4%	25.5%
Nephrology	580	150	<10	150	730	25.5%	0.5%	25.8%
Neurological Surgery	330	70	20	90	420	22.5%	5.1%	27.6%
Neurology	1,080	220	60	280	1,360	20.4%	5.6%	25.9%
Ophthalmology	1,130	220	70	290	1,420	19.2%	6.4%	25.6%
Orthopedic Surgery	1,520	310	70	380	1,900	20.3%	4.3%	24.6%
Otolaryngology	550	100	50	150	700	17.6%	8.2%	25.8%
Plastic Surgery	490	90	10	100	590	19.2%	1.3%	20.5%
Psychiatry	2,850	490	<10	490	3,340	17.2%	0.0%	17.2%

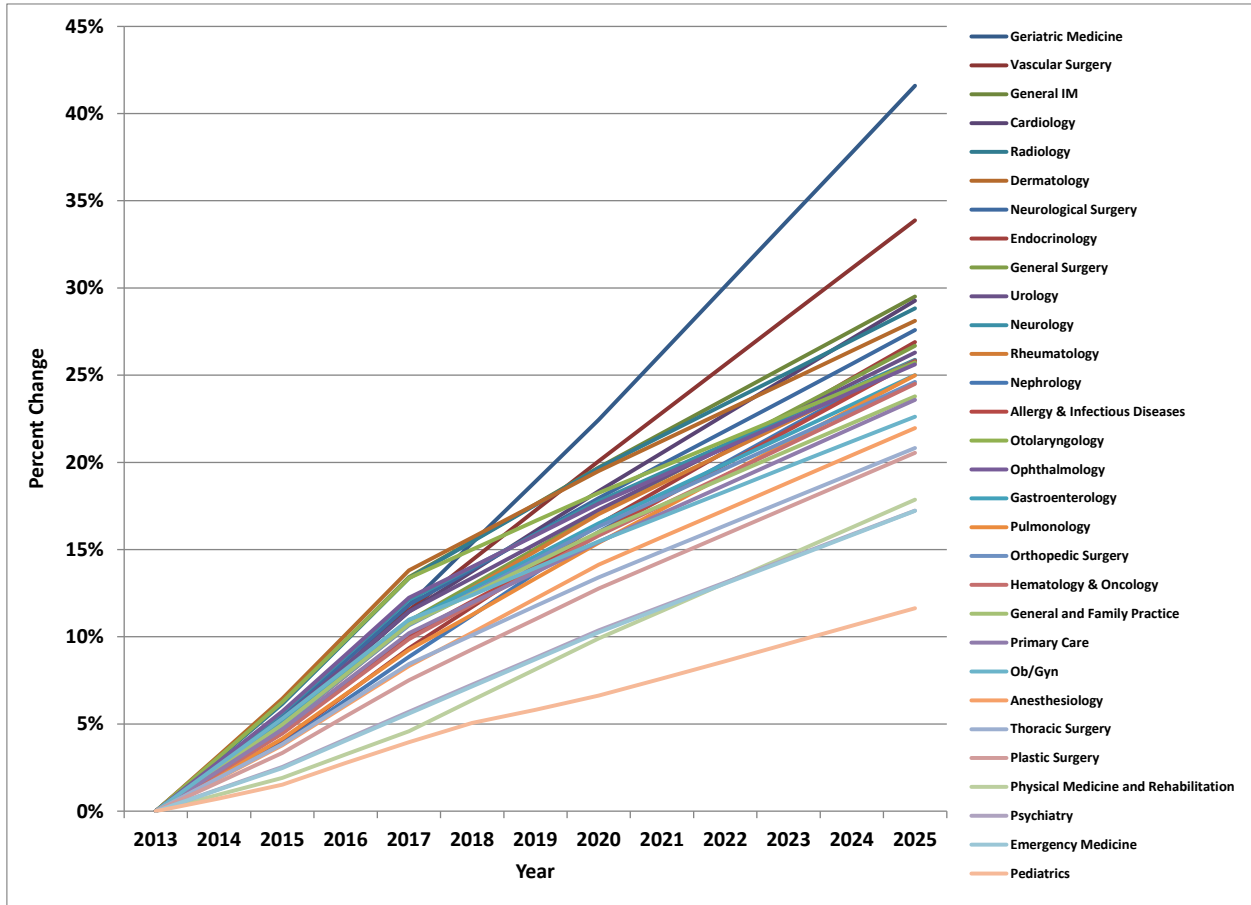


Specialty	Demand 2013 <sup>a</sup>	Projected growth by demand driver, 2013 to 2025			Demand 2025	Percent growth by demand driver, 2013 to 2025		
		Demographics	ACA Expanded Coverage <sup>b</sup>	Total		Demographics	ACA Expanded Coverage <sup>b</sup>	Total <sup>c</sup>
Pulmonology & Critical Care <sup>b</sup>	1,000	230	20	250	1,250	22.6%	2.4%	25.0%
Radiology	2,440	550	160	710	3,150	22.4%	6.4%	28.8%
Rheumatology	320	70	10	80	400	22.4%	3.5%	25.9%
Thoracic Surgery	300	50	10	60	360	18.2%	2.7%	20.9%
Urology	650	140	30	170	820	21.3%	5.0%	26.3%
Vascular Surgery	210	70	<10	70	280	32.1%	1.8%	33.9%
<b>Total (specialties modeled)</b>	<b>45,210</b>	<b>9,140</b>	<b>1,810</b>	<b>10,950</b>	<b>56,160</b>	<b>20.2%</b>	<b>4.0%</b>	<b>24.2%</b>
Specialties demand not modeled <sup>c</sup>	2,020	410	60	470	2,490	20.3%	3.0%	23.3%
<b>Total</b>	<b>47,230</b>	<b>9,550</b>	<b>1,880</b>	<b>11,430</b>	<b>58,660</b>	<b>20.2%</b>	<b>4.0%</b>	<b>24.2%</b>

Notes: <sup>a</sup> Demand is defined as the number of physicians required to provide a level of care consistent with the national average in 2013. For specialties such as geriatric medicine, demand should be considered in the context of availability of general internists and other primary care providers. <sup>b</sup> A substantial proportion of pulmonologists practice critical care medicine, and to be consistent with demand estimates based on national patterns we combined the categories of pulmonology, pulmonology/critical care, and critical care. Excluded from this category are critical care physicians in anesthesiology, surgery, and obstetrics/gynecology, as these categories are categorized elsewhere. <sup>c</sup> Physician specialties omitted from the demand model include: colon-rectal cancer, neonatal/perinatal medicine, pathology, physical medicine & rehabilitation, preventive medicine and radiation oncology. Initial demand for services for this category is assumed equal to supply, and assumed to grow at the same rate as the overall demand for non-primary care specialties. Supply is modeled separately by specialty, but combined for presentation for comparison to demand.



**Exhibit 9: Projected Growth in Florida FTE Physician Demand by Specialty, 2013-2025**



Note: Specialties excluded from demand analyses due to data constraints include critical care medicine, colon-rectal surgery, neonatal/perinatal medicine, pathology, physical medicine, preventive medicine and specialties designated as “other.”



## IV. Current and Projected Future Supply of Physicians

This study used a Health Workforce Supply Model (HWSM) that reflects state of the art techniques for health workforce modeling. HWSM has been used to model supply of physicians and other health professionals at the state and national level. In this section we provide a brief description of supply inputs. A more comprehensive description is provided in the technical appendix. We then present a range of supply projections under alternative scenarios reflecting uncertainty in key supply inputs.

As a microsimulation model, the HWSM simulates expected workforce decisions of physicians by specialty and demographic. There are four major components of the supply model:

- A. **Starting supply.** The starting point for modeling future supply is to obtain an accurate picture of current supply by estimating the number of physicians in active practice by specialty, age, and gender.
- B. **New entrants.** Each year, physicians enter practice in Florida. This includes a portion of physicians who complete their GME/residency in Florida and remain in the state to practice, as well as physicians who migrate from other states.
- C. **Attrition.** Retirement patterns and mortality are highly correlated with physician age and, to a lesser degree, gender and specialty. The probability of exiting the state to work in another state varies by specialty and demographic.
- D. **Workforce participation level.** For those physicians in active practice, patient care hours worked differ by demographic and specialty.

### A. Current Supply

Estimates of the current size and characteristics of Florida's physician workforce come from the combined 2012 and 2013 bi-annual Physician Workforce Licensure Surveys administered by the Florida Department of Health.<sup>17</sup> This source contains information on all licensed and active physicians in Florida. The supply estimate reflects the subset of physicians who reported practicing medicine at any time during the year in Florida; provided a valid self-reported practice address; reported a "clear" and "active" license status; and are not in a residency, internship, or fellowship program.

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<sup>17</sup> The Physician Workforce Survey is part of the licensure renewal process for Florida physicians. Licensed physicians are divided into two groups with each group renewing every other year. The result is a combination of two years of data for a total set of Florida physician workforce data.



In 2012-2013, there were 62,310 physicians with an active license in Florida, or about 336 per 100,000 populations.<sup>18</sup> Only 12 states reported fewer licensed physicians per 100,000 populations. Florida's 2013 Physician Workforce Annual Report, based on analysis of 2012 and 2013 state physician workforce licensure survey data, reports that about 43,410 licensed physicians are actively practicing in the State.<sup>19</sup> The same source reports that approximately 26% of the physician workforce is female and about two-thirds (62%) are age 50 or older.

The supply estimates presented in this report are largely consistent with estimates in Florida's 2013 Physician Workforce Annual Report, though there are slight differences in categorizing some physician specialties to make supply estimates and projections comparable to demand estimates and projections. In addition, physicians over the age of 85 were removed from these supply estimates and newly licensed physicians over age 60 were excluded from the supply estimates under the concern that new physicians moving to the state after age 60 are likely not in full time clinical practice. Consequently, our supply estimate of 42,610 active physicians in 2013 is lower than the 43,410 reported in the Florida 2013 Workforce report.

## B. New Entrants

The careers of physicians often span 30 to 40 years, so the number and demographic distribution of new health professionals trained each year and in- and out-migration patterns have profound implications for future physician supply. Based on analysis of Florida's licensure data base, and taking into account physicians' cross-state migration patterns, there are annually approximately 2,230 new entrants to Florida's physician workforce each year across the projection period.

Data from physicians newly licensed in 2006-2009 and active in Florida in 2012-2013 were used to estimate the age, gender, and specialty distribution of new entrants (Exhibit 10). Physicians newly licensed between 2010-present will not have completed the follow-up survey which is used to determine if the person has completed GME/residency and is still practicing in Florida. The majority of new entrants to the Florida physician workforce range in age from their early-thirties to mid-forties. The overall gender distribution in recent years has been about 62% male and 38% female. Among newly licensed physicians, about 55% practice in primary care specialties, of which about 60% are male.

The new entrant estimates do not take into consideration future growth in residency training programs at nine institutions in Florida that as of January 2014 received accreditation but were not yet administering residency programs.<sup>20</sup>

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<sup>18</sup> Young, A, Chaudhry, HJ, Thomas, JV, Dugan, M. A census of Actively Licensed Physicians in the United States, 2012. *Journal of Medical Regulation*. 2013;99 (2):11-24.

<sup>19</sup> Florida Department of Health. November, 2013. 2013 Physician Workforce Annual Report.

<sup>20</sup> Source: The Florida Legislature: Office of Program Policy Analysis. *Florida's Graduate Medical Education System. Report No. 14-08*. February, 2014. The nine institutions accredited but not administering residency programs as of January, 2014 were not individually identified.



**Exhibit 10: Number and Characteristics of New Entrants**

Specialty	New Entrants		% Male	Age Distribution			
	#	%		<36	36-40	41-45	>45
<b>Total Primary Care</b>	<b>1,219</b>	<b>54.7%</b>	<b>60%</b>	<b>12%</b>	<b>35%</b>	<b>26%</b>	<b>28%</b>
<b>Traditional primary care</b>	<b>909</b>	<b>40.8%</b>	<b>61%</b>	<b>11%</b>	<b>32%</b>	<b>27%</b>	<b>30%</b>
General/Family Practice	290	13.0%	63%	14%	36%	25%	26%
General Internal Med.	400	17.9%	73%	5%	29%	29%	36%
Pediatrics	193	8.7%	35%	18%	33%	24%	24%
Geriatric Medicine	26	1.2%	52%	12%	37%	22%	28%
General Surgery	62	2.8%	53%	17%	30%	25%	28%
Emergency Medicine	149	6.7%	69%	18%	45%	19%	18%
Obstetrics/Gynecology	99	4.4%	39%	12%	42%	28%	18%
<b>Total Non-Primary Care</b>	<b>876</b>	<b>39.3%</b>	<b>73%</b>	<b>10%</b>	<b>42%</b>	<b>24%</b>	<b>24%</b>
Allergy & Immunology	7	0.3%	56%	22%	33%	17%	28%
Infectious Diseases	25	1.1%	57%	17%	35%	30%	17%
Anesthesiology	120	5.4%	74%	12%	41%	23%	24%
Cardiology	67	3.0%	86%	4%	40%	32%	25%
Colon & Rectal Surgery	9	0.4%	61%	9%	35%	35%	22%
Critical Care Medicine	19	0.9%	84%	12%	45%	24%	18%
Dermatology	44	2.0%	43%	24%	34%	27%	15%
Endocrinology	26	1.2%	48%	17%	44%	23%	17%
Gastroenterology	37	1.7%	74%	8%	59%	17%	16%
Hematology & Oncology	28	1.3%	64%	6%	34%	30%	30%
Neonatal & Perinatal	5	0.2%	38%	15%	31%	23%	31%
Nephrology	31	1.4%	78%	12%	40%	33%	15%
Neurological Surgery	21	0.9%	92%	4%	38%	19%	40%
Neurology	52	2.3%	67%	11%	33%	29%	27%
Ophthalmology	41	1.8%	68%	22%	47%	13%	18%
Orthopedic Surgery	62	2.8%	90%	7%	51%	19%	23%
Other Specialties	2	0.1%	20%	0%	80%	20%	0%
Otolaryngology	24	1.1%	82%	8%	49%	25%	18%
Pathology	47	2.1%	50%	10%	17%	29%	45%
Physical Med. & Rehab.	25	1.1%	61%	11%	39%	27%	23%
Plastic Surgery	26	1.2%	82%	7%	48%	33%	12%
Preventive Medicine	6	0.3%	33%	7%	7%	27%	60%
Psychiatry	88	3.9%	52%	13%	31%	22%	35%
Pulmonology	22	1.0%	89%	5%	47%	27%	20%
Radiation Oncology	22	1.0%	73%	11%	34%	21%	34%
Radiology	99	4.4%	80%	7%	48%	23%	22%
Rheumatology	10	0.4%	46%	12%	46%	27%	15%
Thoracic Surgery	9	0.4%	92%	4%	8%	38%	50%
Urology	26	1.2%	95%	2%	46%	23%	29%
Vascular Surgery	11	0.5%	96%	0%	56%	19%	26%
<b>Total</b>	<b>2,230</b>	<b>100%</b>	<b>65%</b>	<b>11%</b>	<b>37%</b>	<b>25%</b>	<b>26%</b>



## C. Workforce Attrition

Statewide about 5,720 currently practicing physicians (13%) report planning to retire in the next five years and about 1,600 (4%) plan to relocate to other states or elsewhere. Primary reasons for relocation cited include family considerations, compensation and liability exposure.

We used Florida-specific estimates of annual retirement probability and probability of moving to another state to practice. Estimates differ by age, gender, and specialty. Mortality rates by age and sex are sourced from the Centers for Disease Control and Prevention (CDC). The rates used in the HWSM take into consideration that people in professional occupations tend to have lower mortality rates through age 65 as compared to national average mortality rates for men and women. Johnson et al. estimate age-adjusted mortality rates for professional and technical occupations are approximately 25% lower than overall national rates for men and 15% lower for women.<sup>21</sup>

The HWSM simulates who remains in the workforce and who leaves in each year based on probability of exit. Retirement patterns for physicians come from analysis of the combined 2012 and 2013 Florida Physician Workforce Survey which includes a question asking respondents if they plan to retire within the next five years. The projections assume that retirement probability begins at age 50, and that the few physicians still in the workforce by age 84 will all be retired by age 85.

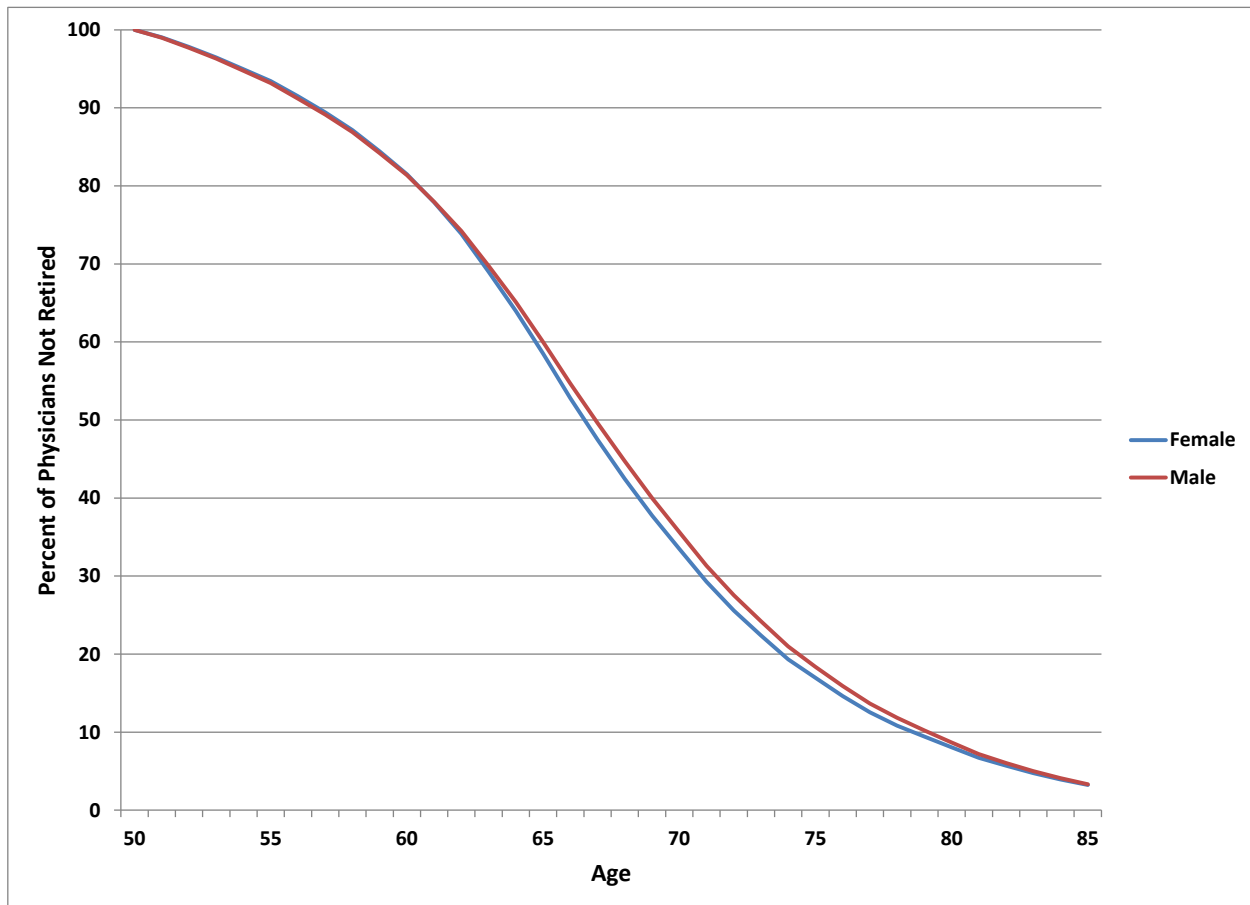
Analysis of the literature suggests that although female physicians report that they expect to retire slightly earlier than men, their historical retirement patterns are similar to those of men after adjusting for higher mortality rates among men. For every thousand physicians active at age 50, we estimate that approximately 600 males and 580 females will still be active past age 65 (Exhibit 11).

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<sup>21</sup> Johnson NJ, Sorlie PD, Backlund E. The Impact of Specific Occupation on Mortality in the U.S. National Longitudinal Mortality Study. *Demography*. 1999;36(3):355-367.



**Exhibit 11: Workforce Attrition Patterns by Physician Age and Gender**



Applying these attrition patterns to the current workforce suggests that, on average, about 1,080 Florida physicians will retire each year between 2013 and 2025. The actual number retiring each year varies over time. The Bureau of Labor Statistics (BLS) reports that many older workers have been delaying retirement, with this pattern expected to exist even after economic recovery.<sup>22</sup> Among the age 65 and older population, labor force participation rates grew slightly from 11.8% in 1990 to 12.9% in 2000. This was followed by a substantial increase to 17.4% in 2010, and in 2020 BLS projects that 22.6% of individuals age 65 and older will remain part of the labor force.

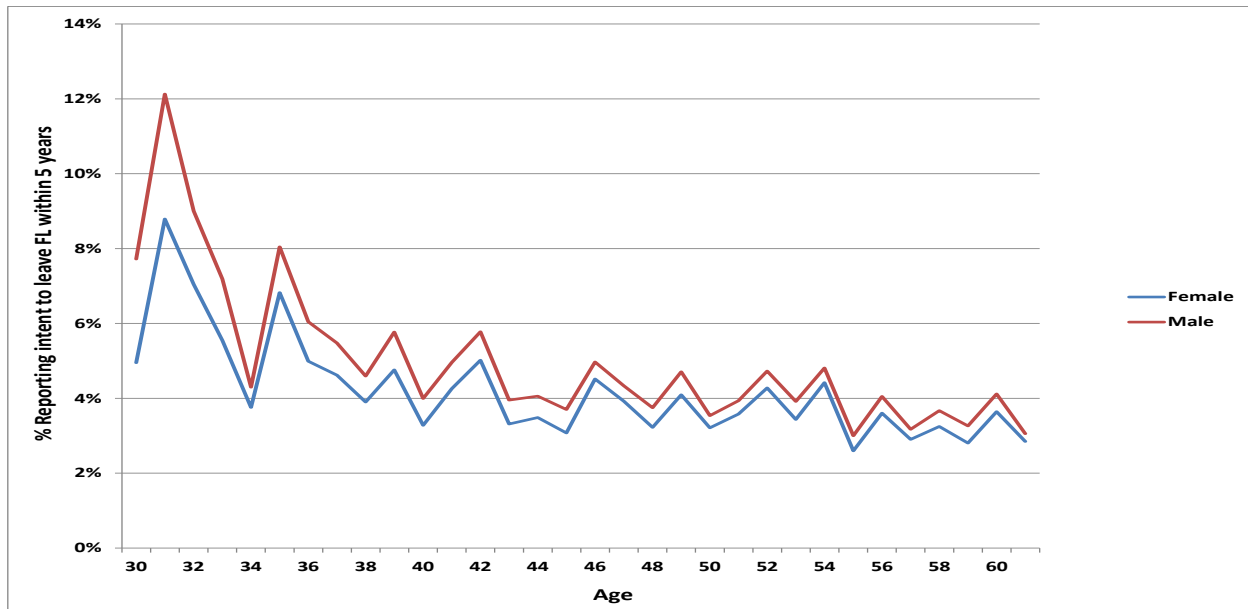
Physician migration patterns were identified from analysis of the combined 2012 and 2013 Florida Physician Workforce Survey which includes a question asking respondents if they plan to relocate to another state within the next five years. Probability of intention leave Florida to

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<sup>22</sup> Toossi, M. "Labor force projections to 2010: a more slowly growing workforce," Monthly Labor Review, January 2012, pp. 43-64, <http://www.bls.gov/opub/mlr/2012/01/art3full.pdf>

work in another state was modeled using logistic regression, with probabilities estimated by physician age, gender and specialty. Summary findings by age and gender (Exhibit 12) find that probability of outmigration is highest for younger physicians and slightly higher for men versus women (controlling for medical specialty). However, once established in their careers, data suggests that physicians have a lower propensity to relocate than do many professions because of the large investments made into their practice.

**Exhibit 12: Florida Physician Outmigration Patterns by Age and Gender, 2012-2013**



Physicians in some specialties expressed greater intention to leave Florida. For example, physicians in emergency medicine had 2.7 times the odds of intention to leave compared to family practice. The relative odds for neonatal & perinatal were 2.9, and the odds for preventive medicine were 1.9. Physicians in most office-based, non-primary care specialties were less likely to express an intention to leave Florida relative to family practitioners. Intention-to-relocate rates were similar for family medicine, internal medicine, and pediatrics.

#### **D. Patient Care Hours Worked**

The supply estimates and projections take into consideration the changing demographics of the Florida physician workforce and that average patient care hours worked per week differ by provider age, sex, and specialty. The supply estimates and projections are all expressed in terms of full time equivalent (FTEs), where 1 FTE is defined as the average weekly hours worked by physicians in a particular specialty as reported in Florida’s combined 2012 and 2013 biannual Physician Licensure Workforce Surveys. The few physicians who reported working more than



100 hours per week and physicians reporting fewer than eight hours weekly were excluded from the hours worked analysis.

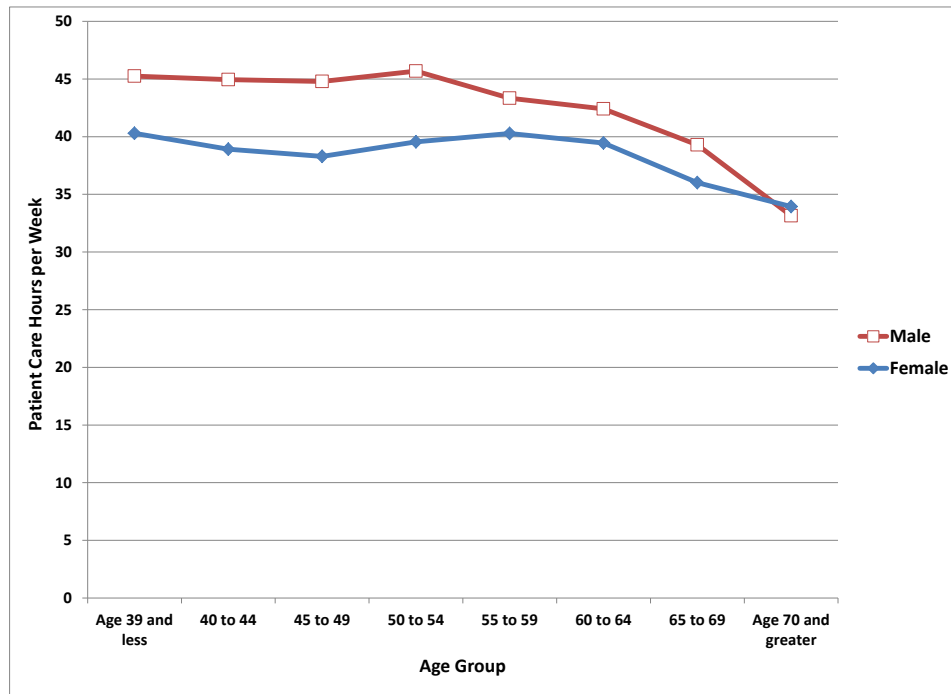
Exhibit 13 and Exhibit 14 show differences in average patient care weekly hours worked by active male and female physicians across age groups. The average across all physicians is about 41 patient care hours worked weekly, with male physicians working an average of 42 hours weekly compared to 39 weekly hours reported by female physicians. Average patient care hours worked per week tend to remain relatively constant through the 50-54 age group, and then decline. Similarly, gender differences in average hours worked also by and large remain consistent through the 50-54 age group before narrowing as both genders reduce their patient care workload.

However, males age 40-54 exceed the overall average weekly hours worked by about 10%. Therefore, males in this age group are counted as 1.10 FTEs. On the other hand, both males and females age 70 and older tend to work only about 73% of the statewide average and thus are counted as 0.73 FTEs. By applying these FTE factors to a physician by age and gender the likely impact of changing physician demographics on patient care hours worked can be modeled. Average patient care hours per week differ by specialty, so 1 FTE is counted differently in each specialty to reflect patterns of hours worked in that specialty.

For example, relative to family practice, physicians in dermatology and emergency medicine work about 4 patient care hours less per week. Specialties with higher patient care hours worked per week, relative to family practice, are nephrology (+9), neurological surgery (+8), general surgery (+7), cardiology (+7), and gastroenterology (+6).

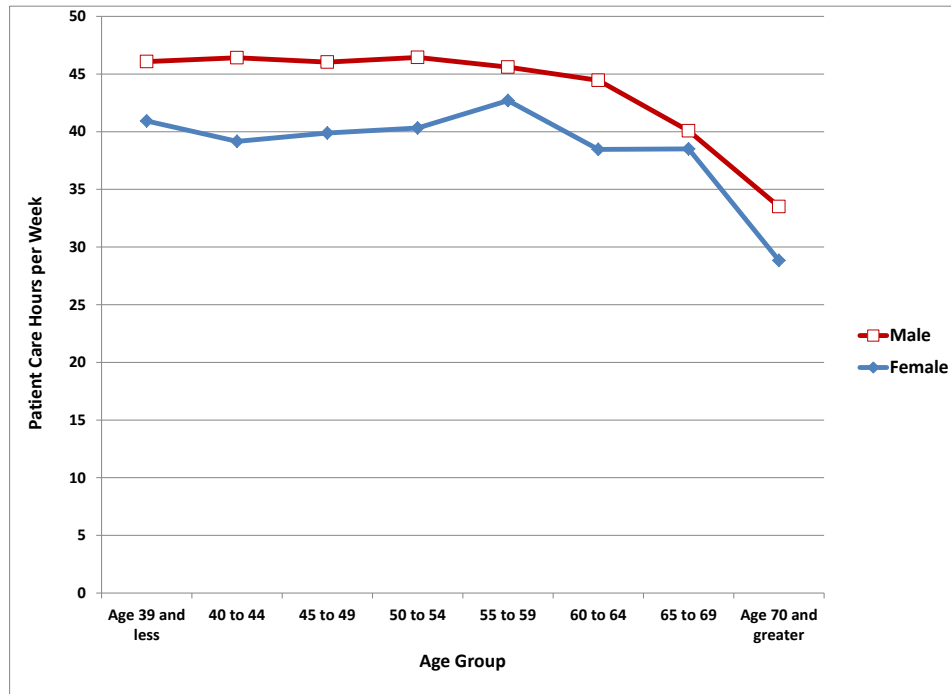
The increasing proportion of women entering the physician workforce and the aging of the workforce portend a possible decline over time in average patient care hours worked per week. Other trends with potential implications for modeling future average hours worked include: (1) generational shifts in work-life balance expectations, (2) magnitude of imbalances between supply and demand for physician services, (3) changes in the economics of practice, and (4) changes in technology and care delivery patterns that could affect distribution of patient care hours across settings.

**Exhibit 13: Average Weekly Patient Care Hours by Primary Care Physicians**



Note: Specialties included in this expanded definition of primary care are general and family practice, general internal medicine, general pediatrics, geriatric medicine, general surgery, obstetrics and gynecology, and emergency medicine.

**Exhibit 14: Average Weekly Patient Care Hours Worked by Specialists**



## E. Supply Estimates and Projections

If current workforce participation patterns and number of new entrants to the workforce remain unchanged, then between 2013 and 2025 Florida’s physician workforce is projected to grow by about 12,370 FTEs (29%), reaching 54,970 physicians in 2025 (Exhibit 15). The supply of primary care physicians is projected to grow about 34% and supply of specialists is projected to grow by 24%.

Supply projections for individual specialties likely have a larger degree of prediction error than do projections of total physicians—as physician choices (e.g., specialty choice, hours worked, cross-state migration) will be influenced by whether there appears to be current or projected future surpluses or shortages in a particular specialty. Likewise, projections for smaller specialties likely have a greater degree of precision error compared to larger specialties—as the sample size for determining the number of new entrants to Florida’s workforce is smaller for these specialties.

Specialties with the highest projected growth rate between 2013 and 2025 are nephrology (56%) and endocrinology (54%). Specialties with low projected growth rates over this period are ophthalmology (6%), rheumatology (8%), and urology (9%).

These projections assume that the number of new entrants to Florida’s physician workforce remain constant at current levels, and assume that future retirement patterns reflect current probabilities of intention to will retire.



A scenario that could increase patient care average hours worked was postulated by Blanchfield et al. (2010), who estimated that streamlining the clinical services billing process could save four hours per physician each week.<sup>23</sup> The American Board of Internal Medicine (ABIM) Practice Characteristics Survey findings are that geriatricians and general internists spend approximately 13% and 15%, respectively, of their professional hours handling paperwork associated with patient care.<sup>24</sup>

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<sup>23</sup> Blanchfield BB, Heffernan JL, Osgood B, Sheehan RR, Meyer GS. 2010. Saving Billions of Dollars—And Physicians’ Time—By Streamlining Billing Practices. *Health Affairs*. Web Exclusive, April 29, 2010

<sup>24</sup> ABIM Practice Characteristics Survey data reported at the AAMC 6th Annual Workforce Conference (May 2010). Survey reflects 61,758 diplomates who completed surveys between January 2006 and February 2010.



**Exhibit 15: Current and Projected Physician Supply in Florida, 2013-2025**

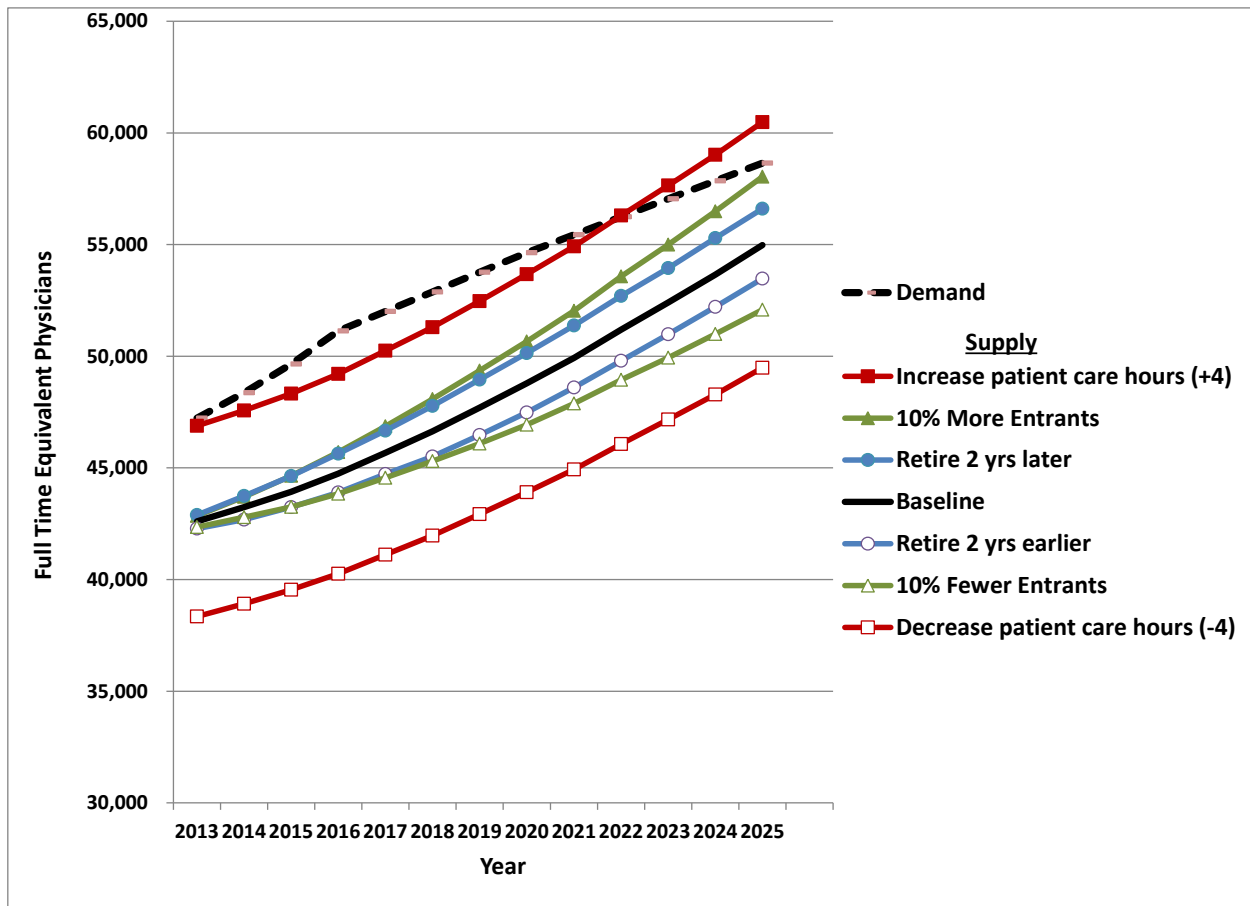
Specialty	2013	2015	2020	2025	Growth 2013-2025	
					#	%
<b>Total Primary Care</b>	<b>21,830</b>	<b>22,220</b>	<b>24,930</b>	<b>29,180</b>	<b>7,350</b>	<b>34%</b>
<b>Traditional primary care</b>	<b>16,430</b>	<b>16,740</b>	<b>18,810</b>	<b>22,000</b>	<b>5,570</b>	<b>34%</b>
General/Family Practice	5,580	5,650	6,190	7,180	1,600	29%
General Internal Medicine	6,870	7,040	8,060	9,530	2,660	39%
Pediatrics	3,440	3,510	3,990	4,680	1,240	36%
Geriatric Medicine	540	540	570	610	70	13%
General Surgery	1,090	1,100	1,240	1,450	360	33%
Emergency Medicine	2,300	2,360	2,700	3,220	920	40%
Obstetrics/Gynecology	2,010	2,020	2,180	2,510	500	25%
<b>Total Non-Primary Care</b>	<b>20,760</b>	<b>21,030</b>	<b>22,770</b>	<b>25,800</b>	<b>5,040</b>	<b>24%</b>
Allergy & Immunology	220	220	230	240	20	9%
Anesthesiology	2,200	2,240	2,430	2,790	590	27%
Cardiology	1,640	1,660	1,760	1,930	290	18%
Colon & Rectal Surgery	140	150	180	210	70	50%
Critical Care Medicine	270	280	340	410	140	52%
Dermatology	920	930	1,000	1,140	220	24%
Endocrinology	370	380	460	570	200	54%
Gastroenterology	920	930	1,020	1,100	180	20%
Hematology & Oncology	740	760	870	1,010	270	36%
Infectious Diseases	430	440	500	590	160	37%
Nephrology	450	470	570	700	250	56%
Neurological Surgery	320	330	380	460	140	44%
Neurology	1,060	1,070	1,170	1,320	260	25%
Ophthalmology	1,170	1,160	1,160	1,240	70	6%
Orthopedic Surgery	1,380	1,390	1,450	1,630	250	18%
Otolaryngology	510	510	530	610	100	20%
Other	30	40	40	40	10	33%
Pathology	860	880	950	1,090	230	27%
Physical Med & Rehab	400	410	490	580	180	45%
Plastic Surgery	630	630	660	720	90	14%
Preventive Medicine	140	140	130	140	0	0%
Psychiatry	1,820	1,830	1,930	2,150	330	18%
Pulmonology	420	420	450	540	120	29%
Radiation Oncology	340	350	400	490	150	44%
Radiology	1,910	1,930	2,130	2,450	540	28%
Rheumatology	260	260	270	280	20	8%
Thoracic Surgery	240	240	250	260	20	8%
Urology	650	650	660	710	60	9%
Vascular Surgery	230	240	260	290	60	26%
<b>Total</b>	<b>42,610</b>	<b>43,250</b>	<b>47,700</b>	<b>54,970</b>	<b>12,370</b>	<b>29%</b>

Note: Numbers might not sum to totals because of rounding.

Exhibit 16 summarizes projected growth in Florida’s physician supply compared to demand for six alternative supply scenarios. These include: 1) retiring two years earlier, on average; 2) retiring two years later, on average; 3) increasing by 10% annually the number of new physician entrants to the Florida workforce; 4) decreasing by 10% annually the number of new physician entrants to the Florida workforce; 5) increasing the weekly number of patient care hours worked by four; and 6) decreasing the weekly number of patient care hours worked by four.

Relative to the baseline scenario, by 2025 physician supply would be higher relative to current patterns under the increased patient care hours (+13,000) and increased numbers of new entrants (+14,500) scenarios. Supply would be lower if the physician workforce decreases patient care hours worked relative to current patterns (-12,000), or reduces number of new entrants by 10% (-9,500). By 2025 projected physician demand will continue to exceed supply under all scenarios modeled except for the increased number of patient care hours worked scenario.

**Exhibit 16: Alternative Physician Supply Projections, 2013-2025**







## V. Discussion

This study combined data on the physician workforce in Florida, data on the demographics, socioeconomics, and health risk factors of the population in Florida, data from national sources on patient care use and delivery patterns, and health workforce simulation models of supply and demand to estimate the current and future demand and supply of physicians in Florida through 2025. In this section we discuss the key findings and their implications. We also discuss study strengths and limitations.

### A. Key Findings and Implications

The following are key study findings and implications.

- **Small primary care shortfall.** Florida's total current supply of primary care physicians falls short of the number needed to provide a national average level of care (-6%)—taking into consideration differences between Florida and the rest of the nation in terms of demographics, prevalence of health risk factors, insurance coverage rates. Under a traditional definition of primary care specialties (i.e., general and family practice, general internal medicine, general pediatrics and geriatric medicine) supply falls short of demand by -3%, in line with the national average shortfall. Over the next several years, this shortfall will grow slightly as more people obtain insurance coverage as mandated by ACA. However, if current trends continue, this shortfall should disappear within a decade. While supply may be adequate at the state level to provide a national average level of care, there is substantial geographic variation in adequacy of care as evidenced by the state's numerous designated Primary Care Health Professional Shortage Areas.
- **Modest specialist physician shortfall.** The supply of specialists in Florida is insufficient to provide a level of care consistent with the national average, after taking into consideration differences in the demographics and health risk factors between Florida and the nation. The current 19% shortfall is likely to persist over the foreseeable future.
- **Severe shortfall for some medical specialties.** Specialties where the state's supply of physicians is much smaller than the number required to provide a level of care consistent with the national average include: general surgery, psychiatry, endocrinology, hematology & oncology, radiology, nephrology, thoracic surgery, and rheumatology.
- **Abundance of some specialists.** Florida appears to have more than sufficient plastic surgeons and dermatologists to provide a level of care consistent with the national average, though there may be environmental factors in Florida that increase demand for these specialties beyond those characteristics in the demand model used.



- **Impact of the Affordable Care Act.** ACA has numerous provisions that affect care use and delivery. The primary impact, which is modeled in this study, is expanded medical coverage. Based on the characteristics of the uninsured (prior to ACA) in Florida and the number and characteristics of those likely to obtain coverage, ACA will likely increase demand for general internists and family practitioners by about 790 physicians. Most of this increase in demand will occur between 2014 and 2017. In percentage terms, the impact is also high for otolaryngology (+8%), dermatology (+8%), general internal medicine (+7%), obstetrics & gynecology (+6%), radiology (+6%), and ophthalmology (+6%).
- **Total increase in demand.** The major driver of demand growth is changing demographics—particularly, the growing elderly population. The projected 24% growth in total demand for physicians consists of 4% growth associated with expanded coverage under ACA and 20% growth associated with changing demographics. Specialties with the highest projected growth in demand predominantly provide care to the elderly, with growth rates highest for geriatric medicine (+41%), vascular surgery (+33%), general internal medicine (+30%), and cardiology (+29%).
- **Total increase in supply.** An estimated 2,230 new physicians enter Florida’s workforce each year and, on average, approximately 1,080 physicians will retire each year between 2013 and 2025. The state’s physician supply is projected to increase by 12,360 FTEs (29%) from 42,610 in 2013 to 54,970 in 2025.

As noted in a recent *Health Affairs* article, the demographic trends and ACA impact affecting Florida are contributing to demand for physicians across the entire nation.<sup>25</sup> Consequently, Florida’s efforts to attract and retain physicians will come at a time when other states are also ramping up their efforts to attract and retain physicians. As national and state shortages grow, this could exacerbate the mal-distribution of physicians across the state as smaller cities and towns find it increasingly difficult to compete with larger metropolitan areas in their efforts to attract and retain physicians.

Of interest is the need to better understand the factors driving future trends in Florida’s physician supply, projected to increase about 29% between 2013 and 2025. One contributing factor to these physician supply projections is recent trends in annual numbers of newly licensed physicians, which increased between 2007 and 2013 from about 2,610 to 4,100 (57%). However, based on historical trends, we estimate that about 2,230 new physicians are entering active practice in Florida each year (including those completing their graduate medical education and those migrating from other states). After factoring out physicians who leave the workforce through retirement, mortality, and migrating out of state, as well as trends in hours worked as the physician workforce ages and women constitute a larger portion of the physician workforce, the state’s supply is growing by about 1,030 physicians per year.

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<sup>25</sup> Dall TM, Gallo PD, Chakrabarti R, West T, Semilla AP, Storm, MV. An Aging Population and Growing Disease Burden Will Require A Large and Specialized Health Care Workforce By 2025. *Health Affairs*.2013; 32:2013-2020.



Contributing to growth in Florida's physician workforce is the addition of five new medical schools since 2000. Between 2001 and 2013 the number of students in undergraduate medical education (UME) grew by 77%. However, over almost the same period, between 2001 and 2011 the AAMC reports that Florida's GME resident positions only grew by 29%. Consequently, over this period the number of students in UME grew by about 2.6 times the growth in number of GME/residency positions. This shortfall in GME resident positions is also apparent when compared to other states. Florida ranks near the bottom (at 42<sup>nd</sup>) in terms of number of GME residents and fellows per 100,000 population. Florida's shortcomings in residents' growth may be slightly offset by higher retention rates of GME graduates. Nearly 59% of physicians who complete their GME residency remain in Florida to practice; 78% of students who complete both medical school and GME in Florida remain and practice in the state.

## B. Study Strengths and Limitations

The primary strengths of this study are the use of Florida-specific data and the latest methods and tools for health workforce modeling.

- **Demand data.** Florida-specific data were used to model demand for health care services and providers, using detailed data on the demographics, socioeconomic characteristics, and health risk factors present among the state's population.
- **Supply data.** Florida-specific data on the number, characteristics, and workforce participation patterns of the physician workforce were used to estimate current and project future supply.
- **Models and modeling approach.** The demand and supply microsimulation models used for this analysis have been used by the federal government, states, professional associations, and other stakeholders for workforce studies across a range of health occupations and medical specialties. These models use the latest data and methods for workforce modeling, and the microsimulation approach allows for more precise adaptation of the models to Florida's physician workforce and population health care requirements.

Study limitations stem primarily from lack of data or the narrow scope of this study, and include the following:

- **Physician supply data gaps.** Data is needed to better understand what factors influence Florida's ability to attract and retain physicians, and the level of labor force participation for newly licensed physicians. For example, our supply analysis excludes newly licensed physicians over age 60 as many within this cohort could be temporarily practicing as locum tenens or otherwise not engaged in full time practice.
- **Physician demand data gaps.** On the demand side, there is a current paucity of information on how care delivery patterns might change over time in response to ACA and other evolving market factors. Efforts to expand use of the patient centered medical



home model could increase demand for primary care providers. In the short term, greater use of team-based care could place additional demands on physician time. Over time, to the extent that these models and greater use of Accountable Care Organizations can improve population health or shift care from expensive hospital settings to ambulatory settings, there could be both a shift in where care is provided (e.g., office versus inpatient) and the level of specialist care required. Although the projected demand implications of expanded medical coverage under ACA have been modeled, insufficient data is currently available to assess the health workforce supply and demand implications of other ACA provisions that support development of new care delivery models (e.g., accountable care organizations and patient centered medical homes) and expanded primary care capacity (e.g., federally qualified health centers). The speed of adoption and growth of these and other emerging care delivery models will be an important factor in assessing implications for future physician supply and demand.

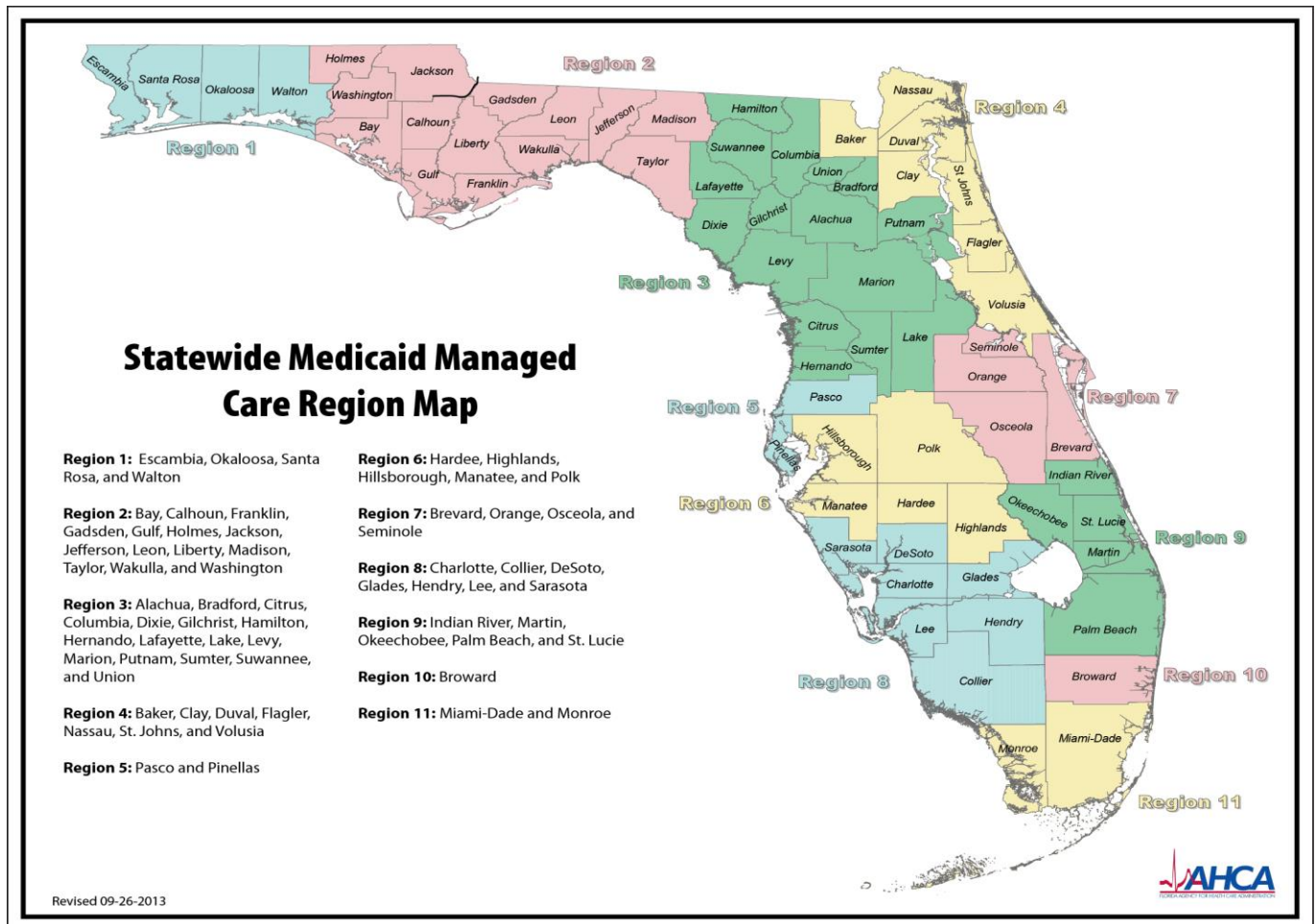
- **State versus local community supply.** The focus of this study is the entire state of Florida. An addendum to this report presents information by Medicaid region within Florida. At the county and local community level, there is even greater variation in adequacy of physician supply.
- **The non-physician workforce.** Understanding the adequacy of physician supply should be considered within the context of the adequacy of supply and scope of practice of physician extenders, such as advanced practice nurses and physician assistants. For example, study findings suggest that Florida has fewer anesthesiologists than is required to meet demand based on national patterns of care use and delivery. However, this shortfall is partially offset by the state's greater use of nurse anesthetists relative to national average staffing patterns.

Because patterns of care use and delivery continue to evolve, and economic and other considerations affect both supply and demand for services, it is important to continue to monitor the adequacy of provider supply to inform health workforce policies and training priorities.

## VI. Addendum: Florida Medicaid Region Physician Workforce Analysis

Florida implemented the Statewide Medicaid Managed Care Managed Medical Assistance program in 2014. Under this program almost all of the State's approximately 3.6 million Medicaid recipients are required to enroll in an HMO or HMO-like plan. The statewide program is operated in eleven Medicaid managed care regions, all but one of which consists of two or more counties (Map 1).

**Map 1: Florida's Medicaid Regions**



The 14 hospitals and health systems represented by the Safety Net Hospital Alliance of Florida (SNHA) share a mission unique to safety net providers, including playing a critical role in caring for vulnerable populations and training many of the state's future physicians. Florida's safety-net hospitals provide nearly 50% of all statewide Medicaid hospital care and all include one or more of the new Medicaid managed care regions within their service areas. Therefore, obtaining an accurate picture of the current and projected numbers and distribution of physician specialties at the sub-state level is important to help identify possible imbalances and access barriers to care.

This addendum builds upon the findings of the Florida Physician Workforce Analysis and is intended to help SNHA members and Florida decision makers better understand how differences in the current and projected numbers and distribution of physicians and in demand for healthcare services may affect access to care across regions. This addendum provides estimates of the current and projected future adequacy of physician supply by Medicaid region through 2025.



## **A. Overview of Physician Modeling Approach**

This regional analysis used the same IHS Healthcare Demand and Supply Micro-simulation as was used for the state-level analysis. Both models use a micro-simulation approach, where a person is the unit of analysis. This section of the addendum provides additional detail on how we adapted the models to each region.

### **1. Physician Supply Modeling by Florida Medicaid Region**

The conceptual framework for modeling the future supply of physicians by Medicaid region begins with the current physician workforce, adds new entrants, and subtracts those who leave the workforce due to retirement or out-of-state migration to arrive at next year's supply. The level of workforce participation for each physician is then modeled as a function of his or her age, gender, and specialty.

The primary data source for analyzing the current physician workforce, attrition rates and hours worked patterns was the 2012 and 2013 physician licensure data furnished by the Florida Department of Health. This data is collected as part of the biannual physician licensure renewal application process. The file contains information on all physicians licensed and active in providing patient care in Florida, and using work address information we placed each physician within a region. Many physicians listed multiple practice locations, but very few listed practice locations in separate regions.

The mechanism for modeling new entrants to the physician workforce was based on recent licensure data of newly practicing physicians in Florida. The expected distribution of new physicians across regions was based upon the estimated growth in employment opportunities by region based upon projected growth in demand and physician retirements. Within a given specialty, if growth in physician demand plus retirements indicated that, say, 10% of the new job opportunities were in a particular region then we assumed that 10% of new entrants to the Florida workforce within that specialty would practice in that region.

### **2. Physician Demand Modeling by Florida Medicaid Region**

The major components of the demand model include: 1) a population database that contains characteristics and health risk factors for a representative sample of the population in each Medicaid region, 2) predictive equations based on national data that relate a person's demographic, socioeconomic and health risk factor characteristics to his or her demand for healthcare services by care delivery setting, and 3) national care delivery patterns that convert demand for healthcare services to demand for FTE physicians. For purposes of physician



workforce modeling the relevant settings are physician offices, outpatient clinics, hospital emergency departments, and hospital inpatient settings.

While the forecasting equations and staffing patterns are based on national data, we constructed a population database that was representative of the population in each region. This was done using county-level population information (e.g., age-gender-race/ethnicity) and whether a county was considered metropolitan or non-metropolitan, and information from the Behavioral Risk Factor Surveillance System (BRFSS) for the population in Florida—including summary statistics by county for factors such as prevalence of obesity, diabetes, current smoking status, and other risk factors used in the model.

Applying the model to Florida, therefore, produced estimates of physician demand if people in each region were to receive a level of care consistent with the national average—but adjusting for differences across regions and the nation in demographics, health and economic factors that affect demand for health care services.

## **B. Summary of Regional Analysis Findings**

### **1. Adequacy of Physician Supply by Florida Medicaid Region**

As noted in the state-wide workforce projections, Florida currently (2013) has about 4,620 fewer physicians (-11%) than required to meet statewide demand. Between 2013 and 2025 the supply of primary care physicians is projected to grow faster than demand (34% versus 24% growth) while demand for non-primary care specialties is projected to exceed supply by about 19%, leading to a small overall shortage of about 3,690 physicians. To place these findings into context, when supply is within  $\pm 5\%$  of demand then one might consider the workforce to be in equilibrium. Shortages or surpluses in the 5-10% range might be considered mild imbalances. More severe imbalances will disproportionately affect the Medicaid population and other vulnerable populations (e.g., uninsured without the financial means to pay full price for services).

Physician demand estimates by Medicaid region are influenced not only by population size, but also demographic profiles, prevalence of health risk factors and chronic diseases and levels of health insurance coverage. Across the state's Medicaid managed care regions there is substantial geographic variation in access to primary care specialties accompanied by even greater variation in access to non-primary care specialties.

Patients' healthcare seeking patterns complicate identifying and analyzing local geographic imbalances between supply and demand. For example, commuting patterns, levels of insurance coverage and network configurations and presence of large healthcare delivery capacity may cause some residents in Florida Medicaid regions with current physician shortfalls to seek some portion of their care from providers practicing in region 11 or other regions with relatively small shortages.

Exhibit A-2 and Map 2 below show that current physician demand exceeds supply in 10 of 11 regions. In four regions there is an estimated physician shortfall of 20% or greater. Areas with the



largest percent shortfall are Region 2 (-43%), Region 8 (-34%), Region 3 (-23%) and Region 7 (-24%). In Region 11 (Miami- Dade and Monroe Counties) the supply of physicians is about 12% higher than the level needed to provide a national average level of care. Both counties in Region 11 are metropolitan areas with large concentrations of healthcare settings, physicians and other healthcare providers.

By 2025 physician demand will likely continue to exceed available supply in eight regions (Exhibit A-4 and Map 3). Regions with percent shortfalls of 20% or more are Region 8 (-34%), Region 2 (-33%) and Region 3 (-23%). Physician supply is projected to be more than adequate in 2025 to provide the current national average level of care in Region 11 (+16%), Region 10 (+7%) and Region 5 (+4%).

## **2. Regional Adequacy of Primary Care Physician Specialties**

As depicted in Exhibit A-2 and Map 4, under a traditional definition of primary care specialties (i.e., general and family practice, general internal medicine, general pediatrics and geriatric medicine) overall, statewide physician supply and demand currently are roughly in equilibrium. Under Florida's more expansive definition of primary care specialties which also include general surgery, emergency medicine and obstetrics/gynecology a small shortfall exists (-6%).

While supply of primary care physicians may be adequate at the state level to provide a national average level of care, there is considerable geographic variation across Medicaid regions. Currently, demand for traditional primary care physicians exceeds supply in six regions, and in Region 8 there is an estimated primary care physician shortfall of -26%.

With four regions currently experiencing shortages of 20% or more, general & family practice is the traditional primary care specialty with the most pervasive shortfalls across regions. Region 11 (Miami-Dade and Monroe) currently has about 23% more primary care providers than is required to provide a national average level of care, with pediatrics and general internal medicine specialties where there is an abundance of physicians (relative to national averages).

If current trends continue, the statewide supply of primary care physicians is projected to grow faster than demand. As a result, by 2025 supply of primary care specialties will exceed the level needed to provide the current national average level of care in five regions compared to the current two (Exhibit A-4 and Map 5). In addition, among the four regions currently experiencing shortfalls of 20% or more, three regions will continue to do so. However, among primary care specialties, shortfalls among general & family practice and general internal medicine will likely remain across six regions.

## **3. Regional Adequacy of Non-Primary Care Physician Specialties**

Statewide, current demand for non-primary care physician specialties is estimated to exceed supply by about 18%. Similar to the distribution of primary care physician specialties, current demand for non-primary care physicians exceeds supply in ten regions (Exhibit A-2 and Map 6).





In six regions there is an estimated non-primary care physician shortfall of 20% or greater and one (Region 2) with a shortage of more than 60%.

Other areas with large percent shortfalls in supply include Region 8 (-38%), Region 7 (-38%) and Region 1 (-30%). Supply and demand are currently at or near equilibrium in Regions 9 and 11. Specialties currently experiencing shortfalls across all eleven regions include psychiatry, hematology & oncology, general surgery and radiology.

Looking to the future, if current patterns continue to 2025, statewide demand for non-primary care physicians will remain high, exceeding supply by about 19%. Nine regions will likely experience shortfalls in non-primary care physicians, and shortfalls of 20% or more are projected for six regions (Exhibit A-4 and Map 7). Five regions are likely to experience shortages of 30% or more. Supply and demand are projected to be at or near equilibrium in Regions 9 and 11. By 2025, medical and surgical specialties likely to experience shortfalls across all Medicaid regions include psychiatry, general surgery, hematology & oncology, and thoracic surgery.

### **C. Conclusion**

This analysis combined county- and Medicaid region-level data on the physician workforce in Florida; the demographic, socioeconomic and health risk factors of the population in Florida counties and Medicaid regions, data from national sources, and a Healthcare Workforce Micro-simulation Model to estimate the current and future supply and demand for physician specialties across Florida's eleven Medicaid regions. Substantial geographic imbalances in adequacy of supply currently exist, and these imbalances are likely to persist through 2025.

Despite geographic imbalances, some regions appear to have sufficient numbers of providers in some specialties to care for the population residing in their own region, and likely are providing care to populations in neighboring regions where supply may be inadequate to meet demand. Future work to assess trends in patient migration patterns, appointment wait times for emergent/urgent and routine care and other access indicators such as provider willingness to accept new Medicaid patients may help inform the issue of local adequacy of physician supply.

These findings heighten the importance of ensuring that Florida has a future physician workforce adequate in size and distribution to ensure continued access to high quality care. This includes optimizing the dynamics of Florida's medical school and GME/residency training pipeline in order to retain in-state a high proportion of graduates from medical school and GME/residency training programs to help close gaps in current and projected future adequacy of physician supply. Policies might explore not just how to attract and retain physicians in Florida, but how to attract and retain physicians in those areas experiencing large provider shortfalls.



## D. Tables by Medicaid Region

### 1. Current and Projected Physician Supply minus Demand by Florida Region

Current (2013) and projected (2025) physician supply minus demand by specialty within Florida's eleven Medicaid regions is summarized in Exhibits A1-A4 below.

**Exhibit A- 1: Physician Supply minus Demand by Specialty and Medicaid Region, 2013**

Specialty	Region											State
	1	2	3	4	5	6	7	8	9	10	11	
<b>Total Primary Care</b>	<b>(65)</b>	<b>(168)</b>	<b>(298)</b>	<b>(23)</b>	<b>53</b>	<b>(269)</b>	<b>(377)</b>	<b>(480)</b>	<b>(226)</b>	<b>(61)</b>	<b>620</b>	<b>(1,290)</b>
<b>Traditional Primary Care</b>	<b>(56)</b>	<b>(99)</b>	<b>(115)</b>	<b>4</b>	<b>147</b>	<b>(188)</b>	<b>(225)</b>	<b>(329)</b>	<b>(143)</b>	<b>(80)</b>	<b>662</b>	<b>(420)</b>
General/Family Practice	14	(1)	(114)	71	2	(236)	(93)	(181)	(253)	(154)	(18)	<b>(960)</b>
General Internal Medicine	(67)	(64)	(61)	(93)	69	46	(153)	(134)	73	(20)	334	<b>(70)</b>
Pediatrics	(8)	(40)	26	15	56	(18)	(8)	(21)	16	52	290	<b>360</b>
Geriatric Medicine	5	6	34	11	20	20	29	7	21	42	56	<b>250</b>
General Surgery	(8)	(28)	(72)	(35)	(68)	(42)	(75)	(95)	(79)	(67)	(52)	<b>(620)</b>
Emergency Medicine	14	(7)	(23)	64	26	-	5	(5)	4	63	9	<b>150</b>
Obstetrics/Gynecology	(15)	(34)	(88)	(56)	(52)	(39)	(82)	(51)	(8)	23	1	<b>(400)</b>
<b>Total Non-Primary Care (excluding specialties not modeled)</b>	<b>(180)</b>	<b>(308)</b>	<b>(450)</b>	<b>(307)</b>	<b>(301)</b>	<b>(322)</b>	<b>(731)</b>	<b>(589)</b>	<b>(121)</b>	<b>(155)</b>	<b>141</b>	<b>(3,330)</b>
Allergy and Immunology	(1)	(2)	(14)	(3)	4	(1)	(3)	(8)	(6)	(6)	2	<b>(40)</b>
Anesthesiology	(10)	(50)	(69)	(44)	(86)	(48)	(96)	(140)	(75)	19	(21)	<b>(620)</b>
Cardiology	(17)	(35)	(31)	(18)	(13)	(54)	(34)	(46)	(13)	(7)	37	<b>(230)</b>
Dermatology	(1)	(3)	-	2	13	17	(19)	47	89	37	50	<b>230</b>
Endocrinology	(15)	(10)	(23)	(10)	(13)	(32)	(15)	(29)	(7)	(6)	2	<b>(160)</b>
Gastroenterology	(8)	(16)	1	28	2	1	(13)	(11)	31	15	20	<b>50</b>
Hematology & Oncology	(17)	(23)	(24)	(25)	(32)	(17)	(58)	(66)	(47)	(27)	(15)	<b>(350)</b>
Infectious Diseases	(8)	(6)	(17)	-	(13)	(1)	(6)	(15)	(16)	(10)	18	<b>(80)</b>
Nephrology	(14)	(10)	(13)	9	(2)	(19)	(12)	(24)	(22)	(7)	(17)	<b>(130)</b>
Neurological Surgery	4	(4)	2	4	(6)	4	(8)	-	1	(11)	6	<b>(10)</b>
Neurology	(8)	(14)	(12)	18	(4)	(1)	(20)	(14)	4	(6)	39	<b>(20)</b>
Ophthalmology	(12)	(12)	(14)	(18)	19	12	(38)	19	45	9	27	<b>40</b>
Orthopedic Surgery	10	(17)	(45)	(25)	(3)	(27)	(38)	(29)	24	7	2	<b>(140)</b>
Otolaryngology	(1)	(3)	(10)	(2)	(5)	-	(17)	5	13	(16)	(3)	<b>(40)</b>
Plastic Surgery	(2)	(4)	(16)	1	5	13	(6)	17	40	27	66	<b>140</b>
Psychiatry	(40)	(33)	(66)	(140)	(70)	(108)	(186)	(103)	(98)	(129)	(57)	<b>(1,030)</b>
Pulmonology & Critical Care	(10)	(23)	(28)	(28)	(28)	(35)	(51)	(49)	(21)	(20)	(19)	<b>(310)</b>
Radiology	(24)	(32)	(49)	(28)	(60)	(28)	(74)	(125)	(75)	(13)	(22)	<b>(530)</b>
Rheumatology	4	(7)	(10)	(18)	(5)	(8)	(17)	(9)	8	(5)	5	<b>(60)</b>
Thoracic Surgery	(8)	(5)	1	(10)	(1)	1	(15)	(11)	3	(12)	(3)	<b>(60)</b>
Urology	(2)	(3)	(9)	-	(4)	-	(5)	(3)	9	3	14	-
Vascular Surgery	-	4	(4)	-	1	9	-	5	(8)	3	10	<b>20</b>
<b>Total (specialties modeled)</b>	<b>(245)</b>	<b>(476)</b>	<b>(748)</b>	<b>(330)</b>	<b>(248)</b>	<b>(591)</b>	<b>(1,108)</b>	<b>(1,069)</b>	<b>(347)</b>	<b>(216)</b>	<b>761</b>	<b>(4,620)</b>
Specialties demand not modeled	(12)	(22)	(16)	(20)	6	63	(7)	(55)	(21)	48	37	-
<b>Total</b>	<b>(257)</b>	<b>(498)</b>	<b>(764)</b>	<b>(350)</b>	<b>(242)</b>	<b>(528)</b>	<b>(1,115)</b>	<b>(1,124)</b>	<b>(368)</b>	<b>(168)</b>	<b>798</b>	<b>(4,620)</b>

Note: Region numbers might not sum to State totals because of rounding.



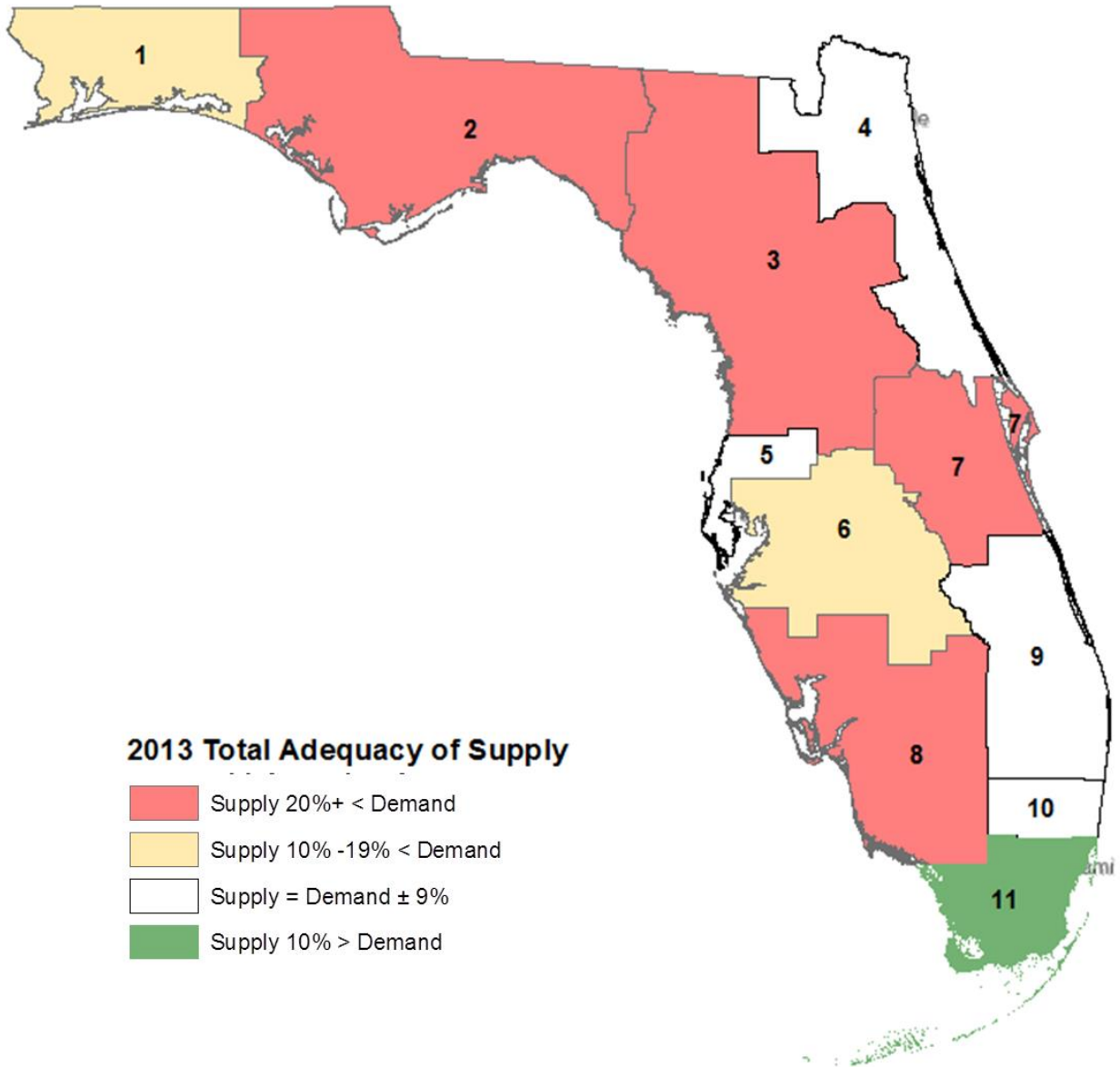
**Exhibit A- 2: Physician Gap ÷ Supply by Specialty and Medicaid Region, 2013**

Specialty	Region											State
	1	2	3	4	5	6	7	8	9	10	11	
<b>Total Primary Care</b>	-9%	-25%	-18%	-1%	3%	-11%	-15%	-30%	-10%	-3%	17%	-6%
<b>Traditional Primary Care</b>	-10%	-20%	-9%	0%	10%	-10%	-12%	-27%	-9%	-5%	23%	-3%
General/Family Practice	6%	0%	-23%	10%	0%	-43%	-13%	-44%	-58%	-35%	-2%	-17%
General Internal Medicine	-39%	-38%	-11%	-15%	11%	5%	-23%	-25%	9%	-3%	27%	-1%
Pediatrics	-7%	-58%	11%	4%	22%	-5%	-2%	-11%	5%	14%	40%	10%
Geriatric Medicine	38%	46%	56%	30%	43%	38%	50%	15%	35%	65%	63%	46%
General Surgery	-16%	-90%	-85%	-26%	-106%	-26%	-60%	-132%	-72%	-77%	-30%	-57%
Emergency Medicine	15%	-10%	-14%	23%	14%	0%	2%	-3%	2%	24%	3%	7%
Obstetrics/Gynecology	-21%	-59%	-82%	-29%	-43%	-15%	-35%	-36%	-3%	9%	0%	-20%
<b>Total Non-Primary Care (excluding specialties not modeled)</b>	-30%	-68%	-30%	-16%	-21%	-14%	-38%	-38%	-5%	-8%	5%	-18%
Allergy & Immunology	-13%	-29%	-156%	-14%	17%	-3%	-11%	-50%	-27%	-33%	5%	-18%
Anesthesiology	-11%	-109%	-40%	-18%	-60%	-17%	-39%	-101%	-31%	7%	-7%	-28%
Cardiology	-37%	-125%	-20%	-11%	-10%	-33%	-19%	-31%	-7%	-4%	14%	-14%
Dermatology	-4%	-15%	0%	3%	19%	17%	-29%	41%	54%	37%	37%	25%
Endocrinology	-500%	-143%	-110%	-23%	-48%	-107%	-31%	-138%	-14%	-14%	3%	-43%
Gastroenterology	-35%	-107%	1%	24%	3%	1%	-14%	-15%	25%	16%	15%	5%
Hematology & Oncology	-77%	-177%	-30%	-29%	-54%	-15%	-85%	-132%	-60%	-42%	-15%	-47%
Infectious Diseases	-89%	-55%	-59%	0%	-52%	-2%	-11%	-45%	-41%	-28%	21%	-19%
Nephrology	-280%	-77%	-29%	14%	-5%	-40%	-23%	-80%	-55%	-15%	-26%	-29%
Neurological Surgery	27%	-57%	7%	11%	-30%	9%	-25%	0%	3%	-55%	12%	-3%
Neurology	-26%	-56%	-14%	14%	-5%	-1%	-18%	-16%	3%	-6%	22%	-2%
Ophthalmology	-41%	-41%	-17%	-19%	18%	8%	-37%	16%	27%	8%	15%	3%
Orthopedic Surgery	16%	-46%	-49%	-19%	-3%	-18%	-26%	-25%	13%	5%	1%	-10%
Otolaryngology	-5%	-18%	-28%	-4%	-14%	0%	-33%	9%	18%	-46%	-4%	-8%
Plastic Surgery	-13%	-31%	-57%	2%	11%	18%	-11%	26%	43%	39%	54%	22%
Psychiatry	-66%	-48%	-42%	-95%	-53%	-46%	-103%	-76%	-50%	-86%	-16%	-57%
Pulmonology & Critical Care	-43%	-194%	-42%	-40%	-56%	-42%	-78%	-99%	-23%	-30%	-16%	-45%
Radiology	-39%	-74%	-30%	-13%	-38%	-11%	-35%	-86%	-35%	-7%	-9%	-28%
Rheumatology	27%	-233%	-56%	-120%	-24%	-27%	-81%	-38%	18%	-21%	11%	-23%
Thoracic Surgery	-267%	-83%	4%	-50%	-5%	3%	-68%	-69%	9%	-75%	-8%	-25%
Urology	-10%	-15%	-18%	0%	-9%	0%	-7%	-5%	11%	5%	15%	0%
Vascular Surgery	0%	40%	-25%	0%	6%	27%	0%	17%	-47%	14%	27%	9%
<b>Total (specialties modeled)</b>	-18%	-43%	-24%	-8%	-8%	-12%	-25%	-34%	-8%	-5%	11%	-11%
Specialties demand not modeled	-21%	-48%	-10%	-11%	4%	21%	-3%	-39%	-10%	21%	12%	0%
<b>Total</b>	-18%	-43%	-23%	-8%	-7%	-10%	-24%	-34%	-8%	-4%	12%	-11%

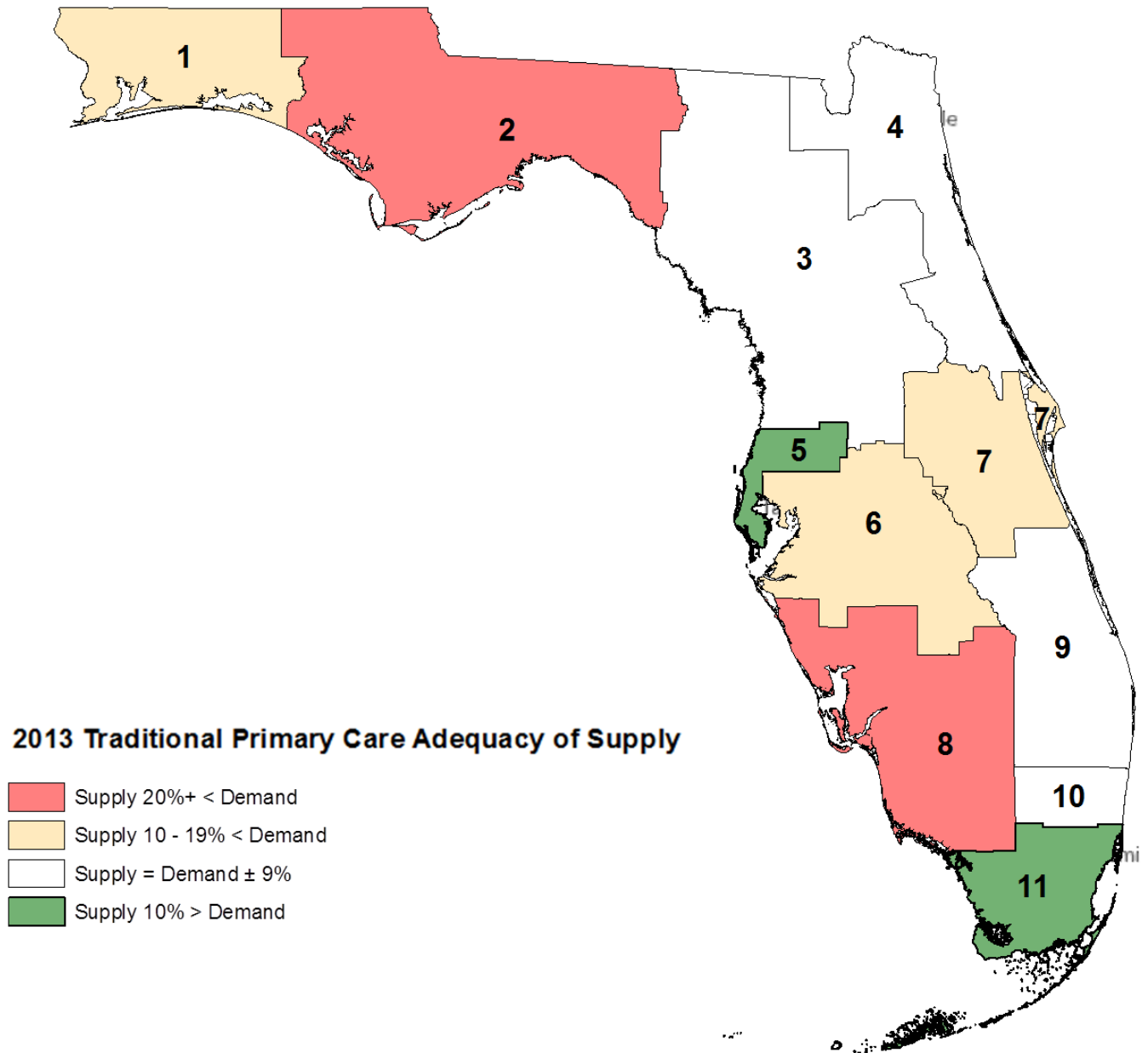
Key

Supply 10%+ > Demand	
Supply =demand ± 9%	
Supply 10-19% < Demand	
Supply 20%+ < Demand	

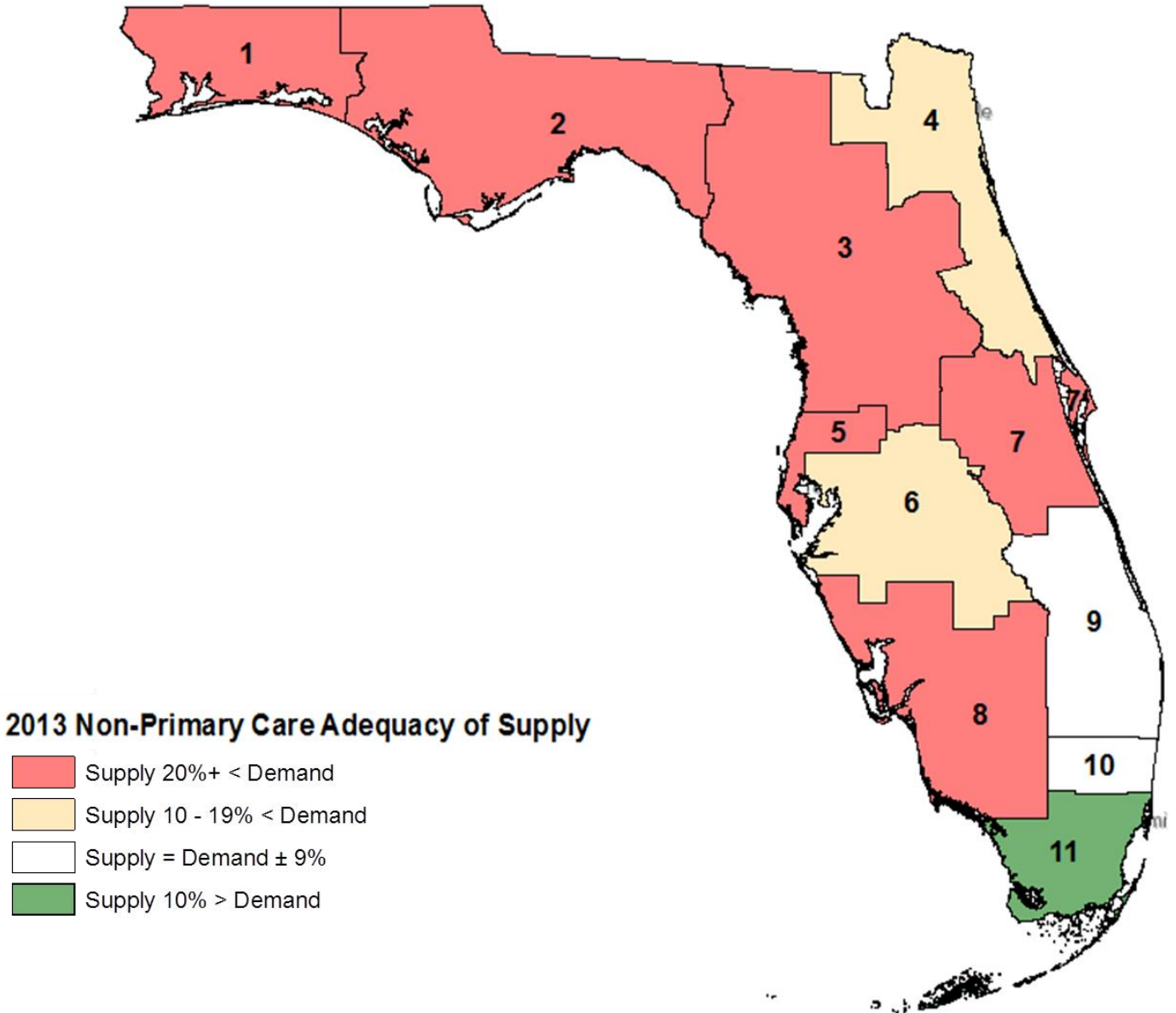
Map 2: Adequacy of Physician Supply by Medicaid Region, 2013



**Map 3: Adequacy of Traditional Primary Care Physician Supply by Medicaid Region, 2013**



Map 4: Adequacy of Non-Primary Care Physician Supply by Medicaid Region, 2013





**Exhibit A- 3: Physician Supply minus Demand by Specialty and Medicaid Region, 2025**

Specialty	Region											State
	1	2	3	4	5	6	7	8	9	10	11	
<b>Total Primary Care</b>	<b>25</b>	<b>(111)</b>	<b>(317)</b>	<b>43</b>	<b>483</b>	<b>(132)</b>	<b>(98)</b>	<b>(605)</b>	<b>(181)</b>	<b>286</b>	<b>1,194</b>	<b>590</b>
<b>Traditional Primary Care</b>	<b>(20)</b>	<b>(79)</b>	<b>(79)</b>	<b>33</b>	<b>503</b>	<b>(81)</b>	<b>(11)</b>	<b>(403)</b>	<b>(94)</b>	<b>153</b>	<b>1,138</b>	<b>1,060</b>
General/Family Practice	23	22	(177)	100	103	(268)	(64)	(263)	(312)	(98)	15	(920)
General Internal Medicine	(74)	(73)	(35)	(116)	199	111	(99)	(157)	160	51	574	<b>540</b>
Pediatrics	29	(28)	89	54	187	64	123	10	60	156	495	<b>1,240</b>
Geriatric Medicine	2	-	44	(5)	14	12	29	7	(2)	44	54	<b>200</b>
General Surgery	(11)	(9)	(91)	(73)	(65)	(47)	(80)	(109)	(101)	(77)	(56)	<b>(720)</b>
Emergency Medicine	68	10	(26)	130	86	47	96	1	31	159	95	<b>700</b>
Obstetrics/Gynecology	(12)	(33)	(121)	(47)	(41)	(51)	(103)	(94)	(17)	51	17	<b>(450)</b>
<b>Total Non-Primary Care (excluding specialties not modeled)</b>	<b>(247)</b>	<b>(365)</b>	<b>(654)</b>	<b>(569)</b>	<b>(314)</b>	<b>(500)</b>	<b>(933)</b>	<b>(762)</b>	<b>(219)</b>	<b>(8)</b>	<b>135</b>	<b>(4,440)</b>
Allergy and Immunology	1	(6)	(21)	(11)	8	(1)	(10)	(14)	(16)	(14)	(2)	<b>(90)</b>
Anesthesiology	(3)	(60)	(81)	(63)	(84)	(51)	(121)	(177)	(69)	74	(17)	<b>(650)</b>
Cardiology	(38)	(40)	(80)	(73)	(22)	(86)	(66)	(62)	(36)	(18)	31	<b>(490)</b>
Dermatology	6	(6)	(3)	(2)	13	18	(44)	54	127	42	54	<b>260</b>
Endocrinology	(16)	(17)	(24)	(5)	-	(39)	(6)	(31)	5	11	13	<b>(110)</b>
Gastroenterology	(12)	(20)	(11)	47	(2)	(9)	(19)	(20)	32	16	8	<b>10</b>
Hematology & Oncology	(22)	(30)	(14)	(39)	(31)	(17)	(66)	(71)	(55)	(8)	(7)	<b>(360)</b>
Infectious Diseases	(9)	(8)	(18)	6	(10)	3	11	(17)	(25)	(6)	24	<b>(50)</b>
Nephrology	(18)	(6)	6	14	7	(3)	3	(14)	(23)	21	(15)	<b>(30)</b>
Neurological Surgery	9	(5)	-	8	7	5	(6)	(5)	16	(11)	21	<b>40</b>
Neurology	(7)	(14)	(23)	19	(18)	(2)	(25)	(20)	(16)	5	51	<b>(50)</b>
Ophthalmology	(25)	(18)	(39)	(51)	4	(12)	(51)	11	9	(6)	(3)	<b>(180)</b>
Orthopedic Surgery	4	(13)	(79)	(66)	(10)	(41)	(55)	(39)	17	12	2	<b>(270)</b>
Otolaryngology	-	(5)	(22)	(13)	(4)	(18)	(19)	(8)	15	(13)	(4)	<b>(90)</b>
Plastic Surgery	(3)	(2)	(18)	(5)	(3)	1	(11)	19	46	32	71	<b>130</b>
Psychiatry	(40)	(36)	(70)	(183)	(72)	(115)	(235)	(115)	(128)	(112)	(84)	<b>(1,190)</b>
Pulmonology & Critical Care	(18)	(28)	(34)	(35)	(28)	(60)	(65)	(47)	(3)	19	(1)	<b>(300)</b>
Radiology	(42)	(39)	(83)	(43)	(51)	(45)	(100)	(173)	(97)	(16)	(8)	<b>(700)</b>
Rheumatology	-	(9)	(21)	(25)	(6)	(18)	(29)	(10)	1	(8)	5	<b>(120)</b>
Thoracic Surgery	(10)	(3)	(2)	(18)	(1)	(10)	(16)	(12)	(9)	(14)	(5)	<b>(100)</b>
Urology	(5)	(4)	(14)	(29)	(9)	(4)	(10)	(14)	(3)	(9)	(9)	<b>(110)</b>
Vascular Surgery	1	4	(3)	(2)	(2)	4	7	3	(7)	(5)	10	<b>10</b>
<b>Total (specialties modeled)</b>	<b>(222)</b>	<b>(476)</b>	<b>(971)</b>	<b>(526)</b>	<b>169</b>	<b>(632)</b>	<b>(1,031)</b>	<b>(1,367)</b>	<b>(400)</b>	<b>278</b>	<b>1,329</b>	<b>(3,850)</b>
Specialties demand not modeled	(15)	(18)	(42)	(20)	23	117	39	(66)	(26)	105	63	<b>160</b>
<b>Total</b>	<b>(237)</b>	<b>(494)</b>	<b>(1,013)</b>	<b>(546)</b>	<b>192</b>	<b>(515)</b>	<b>(992)</b>	<b>(1,433)</b>	<b>(426)</b>	<b>383</b>	<b>1,392</b>	<b>(3,690)</b>

Note: Region numbers might not sum to State totals because of rounding.



**Exhibit A- 4: Physician Gap ÷ Supply by Specialty and Medicaid Region, 2025**

Specialty	Region											State
	1	2	3	4	5	6	7	8	9	10	11	
<b>Total Primary Care</b>	2%	-13%	-14%	1%	19%	-4%	-3%	-30%	-6%	11%	25%	2%
<b>Traditional Primary Care</b>	-3%	-12%	-4%	1%	25%	-3%	0%	-26%	-4%	8%	30%	5%
General/Family Practice	7%	7%	-29%	10%	15%	-37%	-7%	-54%	-56%	-17%	1%	-13%
General Internal Medicine	-31%	-33%	-4%	-14%	23%	9%	-10%	-22%	14%	6%	34%	6%
Pediatrics	18%	-31%	27%	13%	47%	12%	20%	4%	15%	34%	51%	26%
Geriatric Medicine	13%	0%	53%	-13%	29%	20%	41%	13%	-4%	56%	55%	33%
General Surgery	-17%	-14%	-75%	-46%	-70%	-22%	-47%	-107%	-73%	-74%	-26%	-50%
Emergency Medicine	43%	10%	-13%	33%	33%	13%	23%	0%	10%	43%	22%	22%
Obstetrics/Gynecology	-13%	-44%	-90%	-18%	-26%	-16%	-34%	-57%	-6%	17%	4%	-18%
<b>Total Non-Primary Care (excluding specialties not modeled)</b>	-34%	-66%	-34%	-24%	-18%	-17%	-40%	-39%	-8%	0%	4%	-19%
Allergy and Immunology	8%	-120%	-191%	-46%	26%	-3%	-34%	-82%	-80%	-100%	-5%	-38%
Anesthesiology	-3%	-113%	-35%	-20%	-47%	-14%	-42%	-107%	-22%	20%	-4%	-23%
Cardiology	-81%	-100%	-47%	-39%	-14%	-43%	-33%	-34%	-15%	-10%	10%	-25%
Dermatology	16%	-26%	-4%	-2%	16%	14%	-70%	38%	56%	37%	34%	23%
Endocrinology	-229%	-340%	-67%	-7%	0%	-91%	-8%	-94%	6%	15%	13%	-19%
Gastroenterology	-44%	-118%	-12%	29%	-3%	-7%	-17%	-24%	21%	15%	6%	1%
Hematology & Oncology	-79%	-214%	-11%	-35%	-40%	-11%	-73%	-97%	-54%	-8%	-5%	-36%
Infectious Diseases	-69%	-62%	-41%	8%	-29%	4%	13%	-39%	-56%	-13%	23%	-8%
Nephrology	-257%	-29%	7%	15%	13%	-4%	4%	-27%	-42%	25%	-17%	-4%
Neurological Surgery	38%	-63%	0%	15%	18%	9%	-14%	-14%	25%	-42%	28%	9%
Neurology	-17%	-42%	-21%	11%	-22%	-1%	-18%	-18%	-12%	4%	24%	-4%
Ophthalmology	-96%	-58%	-43%	-50%	4%	-7%	-41%	8%	6%	-5%	-2%	-15%
Orthopedic Surgery	6%	-25%	-78%	-47%	-8%	-21%	-32%	-27%	8%	7%	1%	-17%
Otolaryngology	0%	-26%	-55%	-21%	-9%	-26%	-28%	-14%	16%	-28%	-5%	-15%
Plastic Surgery	-16%	-11%	-47%	-8%	-7%	1%	-18%	24%	41%	40%	52%	18%
Psychiatry	-51%	-46%	-34%	-108%	-47%	-38%	-122%	-65%	-56%	-61%	-22%	-55%
Pulmonology & Critical Care	-68%	-185%	-37%	-36%	-44%	-67%	-84%	-63%	-2%	16%	-1%	-32%
Radiology	-61%	-71%	-40%	-14%	-24%	-13%	-37%	-97%	-35%	-7%	-3%	-29%
Rheumatology	0%	-225%	-131%	-139%	-24%	-60%	-153%	-32%	2%	-32%	10%	-43%
Thoracic Surgery	-333%	-33%	-6%	-86%	-4%	-29%	-55%	-57%	-30%	-88%	-13%	-38%
Urology	-20%	-17%	-21%	-48%	-17%	-4%	-12%	-21%	-3%	-15%	-10%	-15%
Vascular Surgery	10%	33%	-13%	-7%	-10%	11%	19%	9%	-27%	-26%	22%	3%
<b>Total (specialties modeled)</b>	-12%	-33%	-23%	-10%	4%	-10%	-18%	-34%	-7%	6%	16%	-7%
Specialties demand not modeled	-21%	-28%	-21%	-8%	11%	28%	12%	-38%	-10%	33%	17%	6%
<b>Total</b>	-13%	-33%	-23%	-9%	4%	-8%	-16%	-34%	-7%	7%	16%	-7%

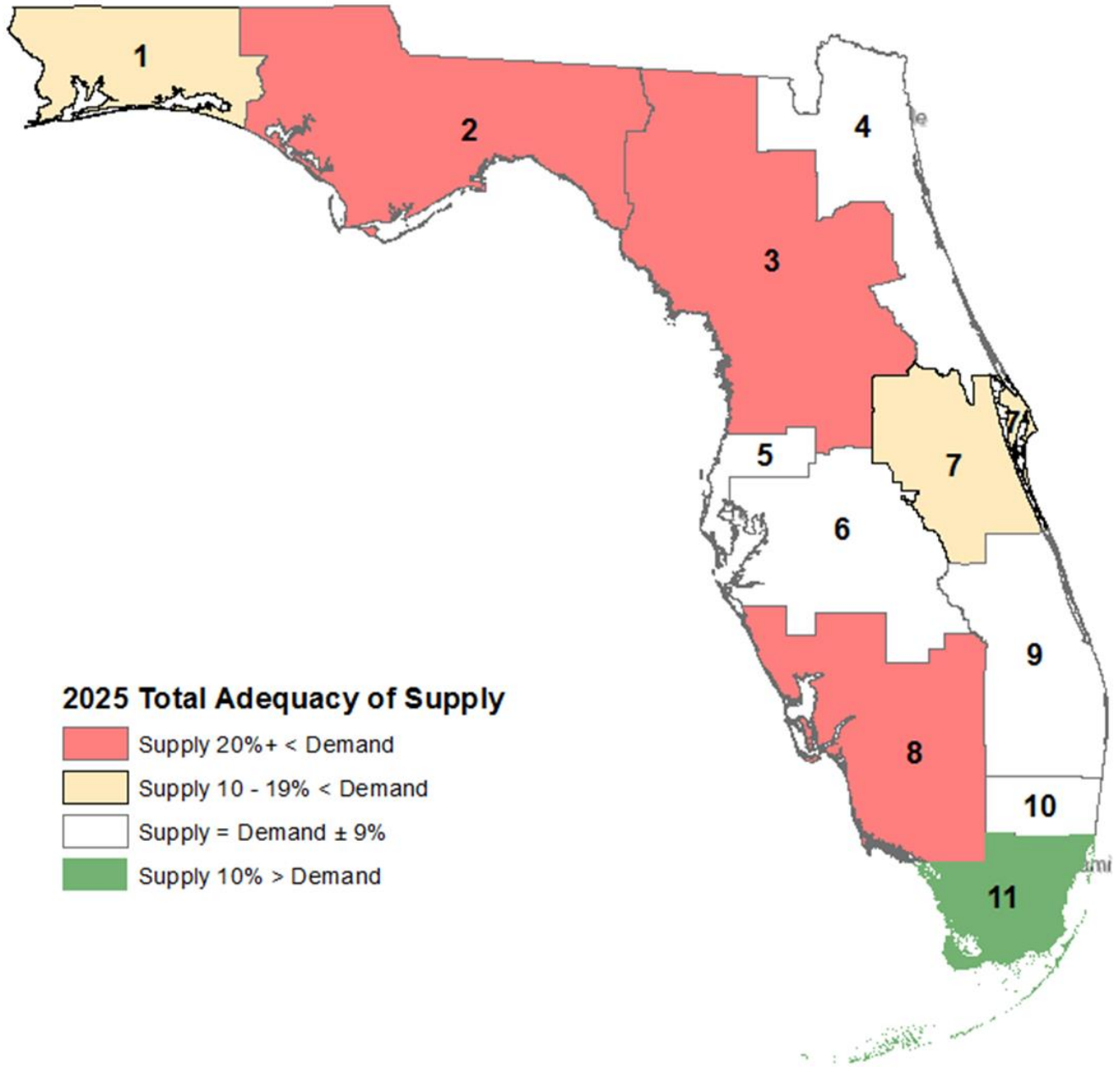
Key

Supply 10%+ > Demand	
Supply =demand ± 9%	

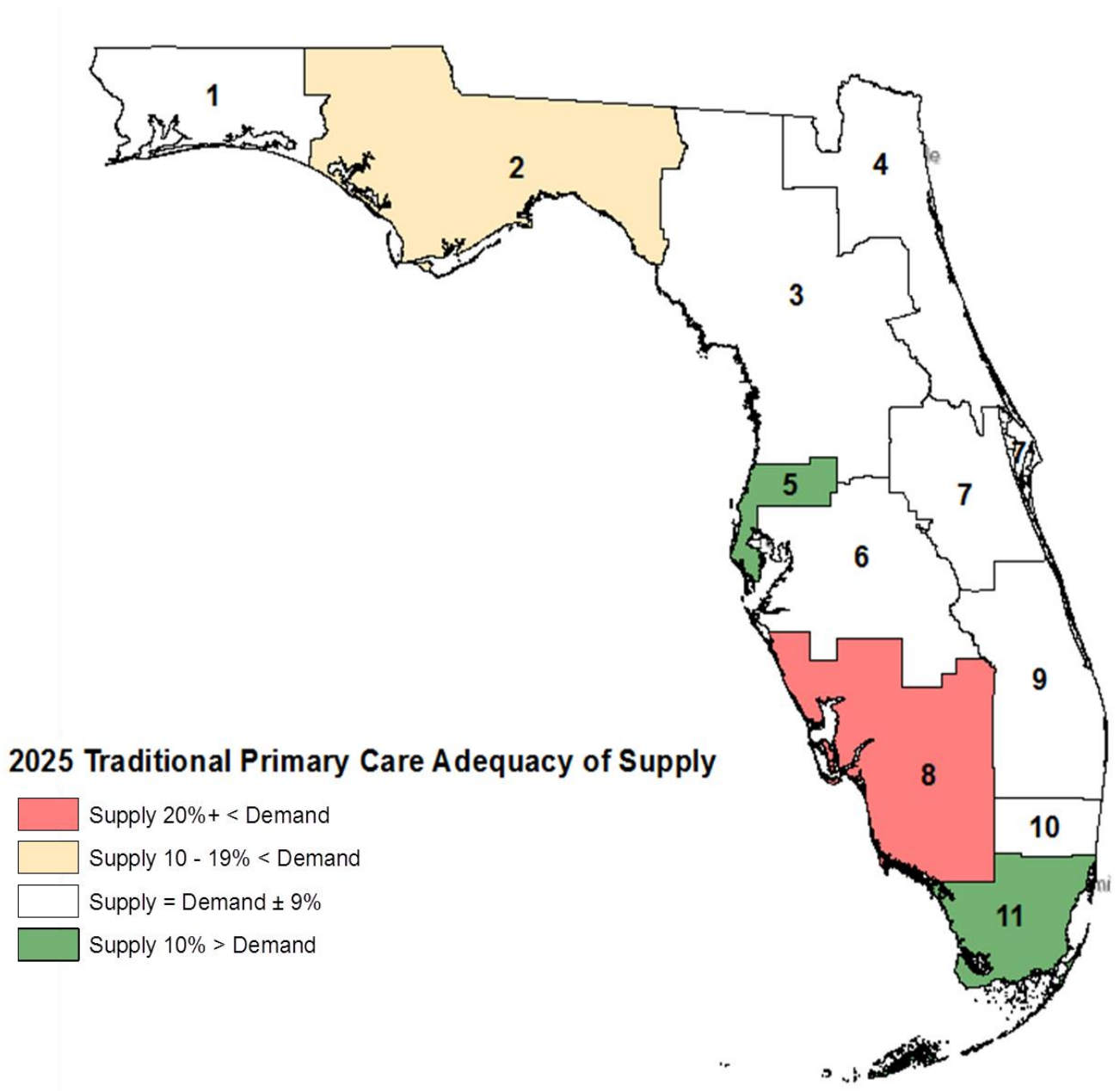


Supply 10-19% < Demand	
Supply 20%+ < Demand	

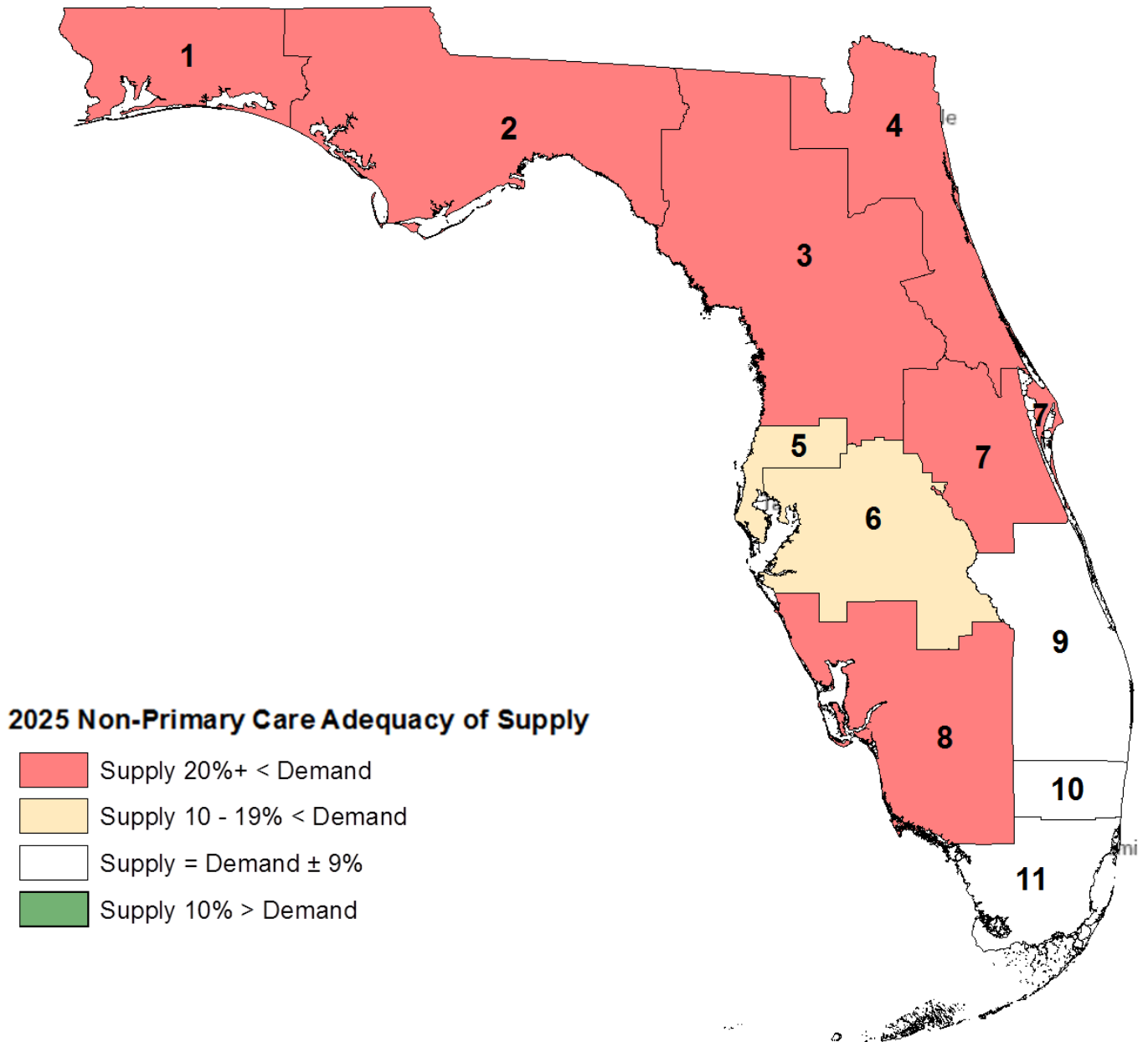
Map 5: Adequacy of Physician Supply by Medicaid Region, 2025



**Map 6: Adequacy of Traditional Primary Care Physician Supply by Medicaid Region, 2025**



Map 7: Adequacy of Non-Primary Care Physician Supply by Medicaid Region, 2025





## 2. Current and Projected Physician Demand by Florida Region

Current and projected physician demand by specialty within Florida region is summarized in Exhibits B-1-B2 below.

**Exhibit B- 1: Estimated Demand for Physicians by Specialty and Medicaid Region, 2013**

Specialty	Region											State
	1	2	3	4	5	6	7	8	9	10	11	
<b>Total Primary Care</b>	<b>827</b>	<b>827</b>	<b>1,978</b>	<b>2,348</b>	<b>1,721</b>	<b>2,790</b>	<b>2,876</b>	<b>2,072</b>	<b>2,455</b>	<b>2,156</b>	<b>3,072</b>	<b>23,120</b>
<b>Traditional Primary Care</b>	<b>603</b>	<b>596</b>	<b>1,438</b>	<b>1,712</b>	<b>1,260</b>	<b>2,035</b>	<b>2,089</b>	<b>1,526</b>	<b>1,802</b>	<b>1,569</b>	<b>2,221</b>	<b>16,850</b>
General/Family Practice	235	246	600	663	485	779	796	589	687	600	862	<b>6,540</b>
General Internal Medicine	240	234	600	696	551	813	830	680	775	634	887	<b>6,940</b>
Pediatrics	120	109	211	327	198	411	434	218	301	312	439	<b>3,080</b>
Geriatric Medicine	8	7	27	26	26	32	29	39	39	23	33	<b>290</b>
General Surgery	59	59	157	169	132	201	200	167	189	154	223	<b>1,710</b>
Emergency Medicine	78	80	188	219	155	260	270	185	222	201	292	<b>2,150</b>
Obstetrics/Gynecology	87	92	195	248	174	294	317	194	242	232	336	<b>2,410</b>
<b>Total Non-Primary Care (excluding specialties not modeled)</b>	<b>777</b>	<b>759</b>	<b>1,950</b>	<b>2,227</b>	<b>1,734</b>	<b>2,615</b>	<b>2,652</b>	<b>2,146</b>	<b>2,433</b>	<b>2,002</b>	<b>2,789</b>	<b>22,090</b>
Allergy and Immunology	9	9	23	25	19	31	31	24	28	24	35	<b>260</b>
Anesthesiology	100	96	243	290	229	332	340	278	314	257	342	<b>2,820</b>
Cardiology	63	63	183	182	148	217	210	195	212	163	235	<b>1,870</b>
Dermatology	25	23	58	70	55	82	85	67	76	62	85	<b>690</b>
Endocrinology	18	17	44	53	40	62	63	50	58	50	73	<b>530</b>
Gastroenterology	31	31	79	88	67	103	105	82	94	79	112	<b>870</b>
Hematology & Oncology	39	36	105	111	91	130	126	116	125	92	118	<b>1,090</b>
Infectious Diseases	17	17	46	50	38	61	60	48	55	46	68	<b>510</b>
Nephrology	19	23	58	56	41	66	65	54	62	55	83	<b>580</b>
Neurological Surgery	11	11	26	33	26	39	40	32	37	31	44	<b>330</b>
Neurology	39	39	96	110	83	128	131	101	117	99	137	<b>1,080</b>
Ophthalmology	41	41	98	115	86	134	140	103	120	105	149	<b>1,130</b>
Orthopedic Surgery	54	54	136	154	118	180	184	144	165	138	193	<b>1,520</b>
Otolaryngology	20	20	46	56	41	67	69	49	58	51	72	<b>550</b>
Plastic Surgery	18	17	44	50	39	59	59	49	54	43	57	<b>490</b>
Psychiatry	101	102	224	288	203	344	367	238	294	279	410	<b>2,850</b>
Pulmonology & Critical Care	34	35	95	98	77	117	116	98	110	88	132	<b>1,000</b>
Radiology	86	75	212	250	217	288	286	270	290	207	259	<b>2,440</b>
Rheumatology	11	10	28	33	26	38	38	33	36	29	39	<b>320</b>
Thoracic Surgery	11	11	26	30	22	36	37	27	32	28	39	<b>300</b>
Urology	23	23	60	65	51	77	77	64	71	58	80	<b>650</b>
Vascular Surgery	7	6	20	20	17	24	23	24	25	18	27	<b>210</b>
<b>Total (specialties modeled)</b>	<b>1,604</b>	<b>1,586</b>	<b>3,928</b>	<b>4,575</b>	<b>3,455</b>	<b>5,405</b>	<b>5,528</b>	<b>4,218</b>	<b>4,888</b>	<b>4,158</b>	<b>5,861</b>	<b>45,210</b>
Specialties demand not modeled	69	68	181	200	154	240	238	196	224	184	266	<b>2,020</b>
<b>Total</b>	<b>1,672</b>	<b>1,654</b>	<b>4,110</b>	<b>4,776</b>	<b>3,611</b>	<b>5,646</b>	<b>5,767</b>	<b>4,415</b>	<b>5,113</b>	<b>4,342</b>	<b>6,127</b>	<b>47,233</b>

Note: Region numbers might not sum to State totals because of rounding.



**Exhibit B- 2: Estimated Demand for Physicians by Specialty and Medicaid Region, 2025**

Specialty	Region											State
	1	2	3	4	5	6	7	8	9	10	11	
<b>Total Primary Care</b>	<b>1,020</b>	<b>984</b>	<b>2,601</b>	<b>3,060</b>	<b>2,016</b>	<b>3,563</b>	<b>3,553</b>	<b>2,643</b>	<b>3,087</b>	<b>2,429</b>	<b>3,635</b>	<b>28,590</b>
<b>Traditional Primary Care</b>	<b>752</b>	<b>713</b>	<b>1,901</b>	<b>2,252</b>	<b>1,486</b>	<b>2,612</b>	<b>2,581</b>	<b>1,947</b>	<b>2,277</b>	<b>1,777</b>	<b>2,642</b>	<b>20,940</b>
General/Family Practice	292	291	787	870	568	996	982	747	866	678	1,023	<b>8,100</b>
General Internal Medicine	315	294	834	969	674	1,085	1,066	887	1,009	759	1,098	<b>8,990</b>
Pediatrics	132	117	241	369	209	484	492	264	350	306	476	<b>3,440</b>
Geriatric Medicine	13	11	39	44	35	47	41	49	52	34	45	<b>410</b>
General Surgery	76	73	212	232	158	262	252	211	240	181	271	<b>2,170</b>
Emergency Medicine	91	90	233	269	172	316	316	226	267	214	328	<b>2,520</b>
Obstetrics/Gynecology	101	108	255	307	200	373	404	259	303	257	394	<b>2,960</b>
<b>Total Non-Primary Care (excluding specialties not modeled)</b>	<b>980</b>	<b>915</b>	<b>2,587</b>	<b>2,976</b>	<b>2,052</b>	<b>3,362</b>	<b>3,286</b>	<b>2,702</b>	<b>3,070</b>	<b>2,304</b>	<b>3,337</b>	<b>27,580</b>
Allergy and Immunology	11	11	32	35	23	41	39	31	36	28	42	<b>330</b>
Anesthesiology	123	113	315	376	264	417	412	343	386	289	402	<b>3,440</b>
Cardiology	85	80	251	262	181	288	267	244	274	197	291	<b>2,420</b>
Dermatology	32	29	79	96	67	108	107	87	99	73	104	<b>880</b>
Endocrinology	23	22	60	72	49	82	81	64	75	60	91	<b>680</b>
Gastroenterology	39	37	105	117	80	133	130	105	119	91	134	<b>1,090</b>
Hematology & Oncology	50	44	139	151	109	168	157	144	157	108	142	<b>1,370</b>
Infectious Diseases	22	21	62	68	45	79	76	61	70	53	82	<b>640</b>
Nephrology	25	27	76	78	49	85	80	66	78	64	101	<b>730</b>
Neurological Surgery	15	13	36	45	31	51	50	41	48	37	53	<b>420</b>
Neurology	49	47	130	148	100	168	165	130	150	115	166	<b>1,370</b>
Ophthalmology	51	49	130	153	102	174	175	132	154	120	180	<b>1,420</b>
Orthopedic Surgery	68	65	180	205	139	232	228	183	209	158	232	<b>1,900</b>
Otolaryngology	26	24	62	76	49	88	88	64	76	59	88	<b>700</b>
Plastic Surgery	22	20	56	64	45	73	71	59	66	48	66	<b>590</b>
Psychiatry	118	115	278	353	226	418	428	291	355	295	463	<b>3,340</b>
Pulmonology & Critical Care	44	43	127	133	91	150	143	122	138	103	157	<b>1,250</b>
Radiology	111	94	291	342	263	382	371	351	372	251	320	<b>3,150</b>
Rheumatology	14	13	37	43	31	48	48	41	45	33	47	<b>400</b>
Thoracic Surgery	13	12	33	39	25	45	45	33	39	30	45	<b>360</b>
Urology	30	28	81	90	61	100	95	80	91	68	96	<b>820</b>
Vascular Surgery	9	8	27	30	22	32	30	30	33	24	35	<b>280</b>
<b>Total (specialties modeled)</b>	<b>2,000</b>	<b>1,899</b>	<b>5,188</b>	<b>6,036</b>	<b>4,068</b>	<b>6,925</b>	<b>6,839</b>	<b>5,345</b>	<b>6,157</b>	<b>4,733</b>	<b>6,972</b>	<b>56,170</b>
Specialties demand not modeled	87	82	239	267	180	304	291	242	278	209	310	2,490
<b>Total</b>	<b>2,087</b>	<b>1,981</b>	<b>5,427</b>	<b>6,303</b>	<b>4,248</b>	<b>7,229</b>	<b>7,130</b>	<b>5,587</b>	<b>6,435</b>	<b>4,942</b>	<b>7,282</b>	<b>58,660</b>

Note: Region numbers might not sum to State totals because of rounding.



### 3. Current and Projected Physician Supply by Florida Region

Current estimated and projected future physician supply by Medicaid region is summarized in Exhibits C-1-C2 below.

**Exhibit C- 1: Estimated Supply of Physicians by Specialty and Medicaid Region, 2013**

Specialty	Region											State
	1	2	3	4	5	6	7	8	9	10	11	
<b>Total Primary Care</b>	<b>762</b>	<b>659</b>	<b>1,680</b>	<b>2,325</b>	<b>1,774</b>	<b>2,521</b>	<b>2,499</b>	<b>1,592</b>	<b>2,229</b>	<b>2,095</b>	<b>3,692</b>	<b>21,830</b>
<b>Traditional Primary Care</b>	<b>547</b>	<b>497</b>	<b>1,323</b>	<b>1,716</b>	<b>1,407</b>	<b>1,847</b>	<b>1,864</b>	<b>1,197</b>	<b>1,659</b>	<b>1,489</b>	<b>2,883</b>	<b>16,430</b>
General/Family Practice	249	245	486	734	487	543	703	408	434	446	844	<b>5,580</b>
General Internal Medicine	173	170	539	603	620	859	677	546	848	614	1,221	<b>6,870</b>
Pediatrics	112	69	237	342	254	393	426	197	317	364	729	<b>3,440</b>
Geriatric Medicine	13	13	61	37	46	52	58	46	60	65	89	<b>540</b>
General Surgery	51	31	85	134	64	159	125	72	110	87	171	<b>1,090</b>
Emergency Medicine	92	73	165	283	181	260	275	180	226	264	301	<b>2,300</b>
Obstetrics/Gynecology	72	58	107	192	122	255	235	143	234	255	337	<b>2,010</b>
<b>Total Non-Primary Care (excluding specialties not modeled)</b>	<b>597</b>	<b>451</b>	<b>1,500</b>	<b>1,920</b>	<b>1,433</b>	<b>2,293</b>	<b>1,921</b>	<b>1,557</b>	<b>2,312</b>	<b>1,847</b>	<b>2,930</b>	<b>18,760</b>
Allergy and Immunology	8	7	9	22	23	30	28	16	22	18	37	<b>220</b>
Anesthesiology	90	46	174	246	143	284	244	138	239	276	321	<b>2,200</b>
Cardiology	46	28	152	164	135	163	176	149	199	156	272	<b>1,640</b>
Dermatology	24	20	58	72	68	99	66	114	165	99	135	<b>920</b>
Endocrinology	3	7	21	43	27	30	48	21	51	44	75	<b>370</b>
Gastroenterology	23	15	80	116	69	104	92	71	125	94	132	<b>920</b>
Hematology & Oncology	22	13	81	86	59	113	68	50	78	65	103	<b>740</b>
Infectious Diseases	9	11	29	50	25	60	54	33	39	36	86	<b>430</b>
Nephrology	5	13	45	65	39	47	53	30	40	48	66	<b>450</b>
Neurological Surgery	15	7	28	37	20	43	32	32	38	20	50	<b>320</b>
Neurology	31	25	84	128	79	127	111	87	121	93	176	<b>1,060</b>
Ophthalmology	29	29	84	97	105	146	102	122	165	114	176	<b>1,170</b>
Orthopedic Surgery	64	37	91	129	115	153	146	115	189	145	195	<b>1,380</b>
Otolaryngology	19	17	36	54	36	67	52	54	71	35	69	<b>510</b>
Plastic Surgery	16	13	28	51	44	72	53	66	94	70	123	<b>630</b>
Psychiatry	61	69	158	148	133	236	181	135	196	150	353	<b>1,820</b>
Pulmonology & Critical Care	24	12	67	70	49	82	65	49	89	68	113	<b>690</b>
Radiology	62	43	163	222	157	260	212	145	215	194	237	<b>1,910</b>
Rheumatology	15	3	18	15	21	30	21	24	44	24	44	<b>260</b>
Thoracic Surgery	3	6	27	20	21	37	22	16	35	16	36	<b>240</b>
Urology	21	20	51	65	47	77	72	61	80	61	94	<b>650</b>
Vascular Surgery	7	10	16	20	18	33	23	29	17	21	37	<b>230</b>
<b>Total (specialties modeled)</b>	<b>1,359</b>	<b>1,110</b>	<b>3,180</b>	<b>4,245</b>	<b>3,207</b>	<b>4,814</b>	<b>4,420</b>	<b>3,149</b>	<b>4,541</b>	<b>3,942</b>	<b>6,622</b>	<b>40,590</b>
Specialties demand not modeled	57	46	165	180	160	303	231	141	203	232	303	<b>2,020</b>



<b>Total</b>	<b>1,416</b>	<b>1,156</b>	<b>3,345</b>	<b>4,425</b>	<b>3,367</b>	<b>5,117</b>	<b>4,651</b>	<b>3,290</b>	<b>4,744</b>	<b>4,174</b>	<b>6,925</b>	<b>42,610</b>
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Note: Region numbers might not sum to State totals because of rounding.

**Exhibit C- 2: Projected Supply of Physicians by Specialty and Medicaid Region, 2025**

Specialty	Region											State
	1	2	3	4	5	6	7	8	9	10	11	
<b>Total Primary Care</b>	<b>1,045</b>	<b>873</b>	<b>2,284</b>	<b>3,103</b>	<b>2,499</b>	<b>3,431</b>	<b>3,455</b>	<b>2,038</b>	<b>2,906</b>	<b>2,715</b>	<b>4,829</b>	<b>29,180</b>
<b>Traditional Primary Care</b>	<b>732</b>	<b>634</b>	<b>1,822</b>	<b>2,285</b>	<b>1,989</b>	<b>2,531</b>	<b>2,570</b>	<b>1,544</b>	<b>2,183</b>	<b>1,930</b>	<b>3,780</b>	<b>22,000</b>
General/Family Practice	315	313	610	970	671	728	918	484	554	580	1,038	<b>7,180</b>
General Internal Medicine	241	221	799	853	873	1,196	967	730	1,169	810	1,672	<b>9,530</b>
Pediatrics	161	89	330	423	396	548	615	274	410	462	971	<b>4,680</b>
Geriatric Medicine	15	11	83	39	49	59	70	56	50	78	99	<b>610</b>
General Surgery	65	64	121	159	93	215	172	102	139	104	215	<b>1,450</b>
Emergency Medicine	159	100	207	399	258	363	412	227	298	373	423	<b>3,220</b>
Obstetrics/Gynecology	89	75	134	260	159	322	301	165	286	308	411	<b>2,510</b>
<b>Total Non-Primary Care (excluding specialties not modeled)</b>	<b>733</b>	<b>550</b>	<b>1,933</b>	<b>2,407</b>	<b>1,738</b>	<b>2,862</b>	<b>2,353</b>	<b>1,940</b>	<b>2,851</b>	<b>2,296</b>	<b>3,472</b>	<b>23,140</b>
Allergy and Immunology	12	5	11	24	31	40	29	17	20	14	40	<b>240</b>
Anesthesiology	120	53	234	313	180	366	291	166	317	363	385	<b>2,790</b>
Cardiology	47	40	171	189	159	202	201	182	238	179	322	<b>1,930</b>
Dermatology	38	23	76	94	80	126	63	141	226	115	158	<b>1,140</b>
Endocrinology	7	5	36	67	49	43	75	33	80	71	104	<b>570</b>
Gastroenterology	27	17	94	164	78	124	111	85	151	107	142	<b>1,100</b>
Hematology & Oncology	28	14	125	112	78	151	91	73	102	100	135	<b>1,010</b>
Infectious Diseases	13	13	44	74	35	82	87	44	45	47	106	<b>590</b>
Nephrology	7	21	82	92	56	82	83	52	55	85	86	<b>700</b>
Neurological Surgery	24	8	36	53	38	56	44	36	64	26	74	<b>460</b>
Neurology	42	33	107	167	82	166	140	110	134	120	217	<b>1,320</b>
Ophthalmology	26	31	91	102	106	162	124	143	163	114	177	<b>1,240</b>
Orthopedic Surgery	72	52	101	139	129	191	173	144	226	170	234	<b>1,630</b>
Otolaryngology	26	19	40	63	45	70	69	56	91	46	84	<b>610</b>
Plastic Surgery	19	18	38	59	42	74	60	78	112	80	137	<b>720</b>
Psychiatry	78	79	208	170	154	303	193	176	227	183	379	<b>2,150</b>
Pulmonology & Critical Care	26	15	93	98	63	90	78	75	135	122	156	<b>950</b>
Radiology	69	55	208	299	212	337	271	178	275	235	312	<b>2,450</b>
Rheumatology	14	4	16	18	25	30	19	31	46	25	52	<b>280</b>
Thoracic Surgery	3	9	31	21	24	35	29	21	30	16	40	<b>260</b>
Urology	25	24	67	61	52	96	85	66	88	59	87	<b>710</b>
Vascular Surgery	10	12	24	28	20	36	37	33	26	19	45	<b>290</b>
<b>Total (specialties modeled)</b>	<b>1,778</b>	<b>1,423</b>	<b>4,217</b>	<b>5,510</b>	<b>4,237</b>	<b>6,293</b>	<b>5,808</b>	<b>3,978</b>	<b>5,757</b>	<b>5,011</b>	<b>8,301</b>	<b>52,320</b>
Specialties demand not modeled	72	64	197	247	203	421	330	176	252	314	373	<b>2,650</b>
<b>Total</b>	<b>1,850</b>	<b>1,487</b>	<b>4,414</b>	<b>5,757</b>	<b>4,440</b>	<b>6,714</b>	<b>6,138</b>	<b>4,154</b>	<b>6,009</b>	<b>5,325</b>	<b>8,674</b>	<b>54,970</b>

Note: Region numbers might not sum to State totals because of rounding.



## VII. Technical Appendix: Data and Methods

This study used a Healthcare Demand Microsimulation Model (HDMM) to estimate current and future demand for health care services and providers, and a Health Workforce Supply Model (HWSM) to forecast future supply. Both models use a microsimulation approach, where a person is the unit of analysis. Additional information about these models and model validation activities has been published elsewhere.<sup>26</sup> This appendix provides additional detail on how the model was adapted for Florida.

### 1. Physician Demand Modeling

As depicted in Exhibit D-1, the major components of the demand model include: 1) a population database that contains characteristics and health risk factors for a representative sample of the population in Florida, 2) equations based on national data that relate a person's characteristics to his or her demand for healthcare services by care delivery setting, and 3) national care delivery patterns that convert demand for healthcare services to demand for FTE physicians. While the HDMM simulates demand for health care services across the health care system, for purposes of physician workforce modeling the relevant settings are physician offices, outpatient clinics, hospital emergency departments, and hospital inpatient settings.

The forecasting equations and staffing patterns are based on national data, while the population database was constructed to be representative of the population in Florida. Applying the model to Florida, therefore, produces estimates of demand for providers if people in Florida were to receive a level of care consistent with the national average—but adjusting for differences between Florida and the nation in health and economic factors that affect demand for health care services.

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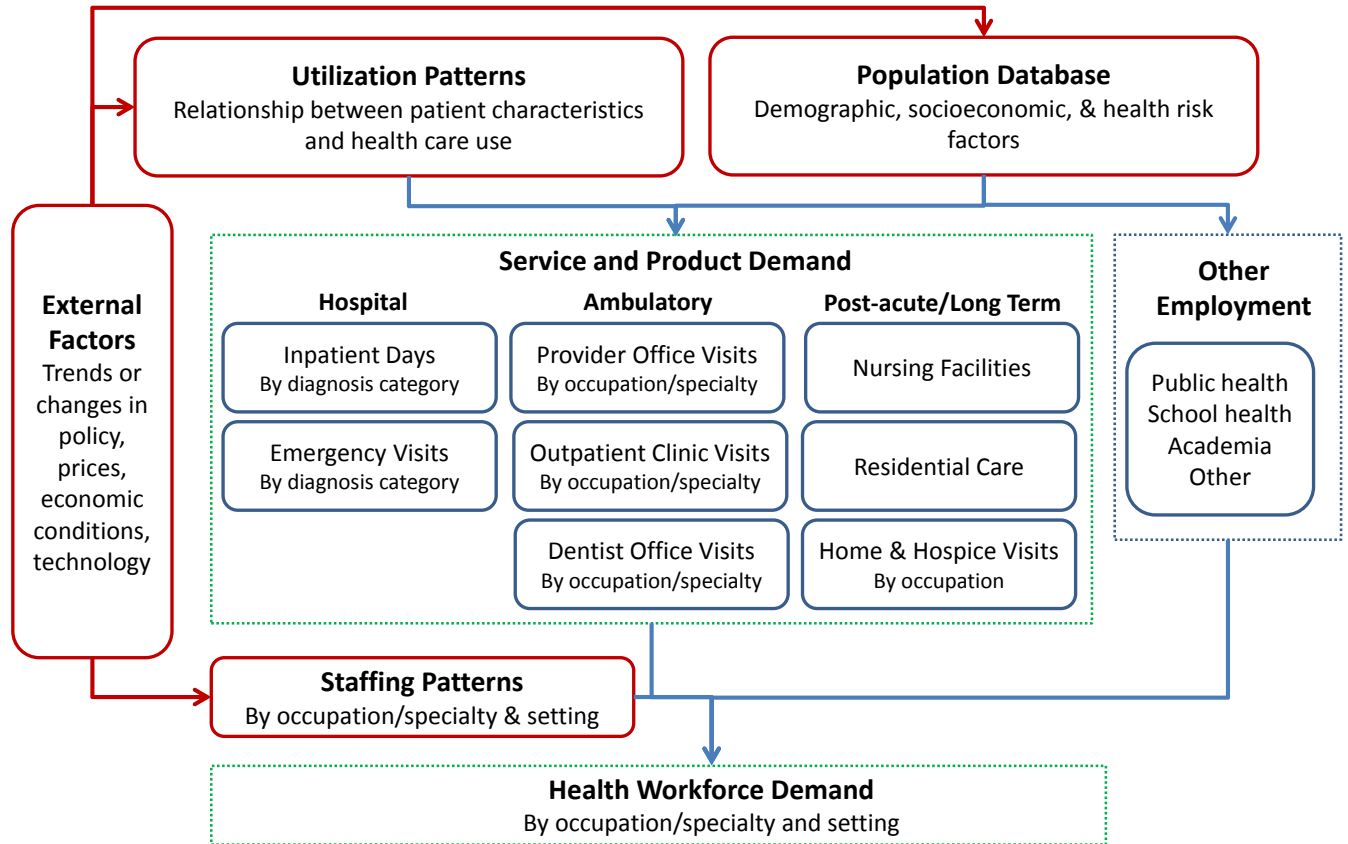
<sup>26</sup> Dall TM, Gallo PD, Chakrabarti R, West T, Semilla AP, Storm, MV. An Aging Population and Growing Disease Burden Will Require A Large and Specialized Health Care Workforce By 2025. *Health Affairs*. 2013; 32:2013-2020. <http://content.healthaffairs.org/content/32/11/2013.abstract>

Dall TM, Chakrabarti R, Storm MV, Elwell EC, and Rayburn WF. Estimated Demand for Women's Health Services by 2020. *Journal of Women's Health*. 2013; 22(7): 643-8. <http://www.ncbi.nlm.nih.gov/pubmed/23829185>

Dall TM, Storm MV, and Chakrabarti R. Supply and demand analysis of the current and future US neurology workforce. *Neurology*. 2013; 81(5): 470-478. <http://www.neurology.org/content/early/2013/04/17/WNL.0b013e318294b1cf.short>



### Exhibit D- 1: Health Care Demand Microsimulation Model Overview



#### a) *Creating the Florida Population Database*

The demand model contains health, demographic, and socioeconomic characteristics for each person in a stratified random sample of the state’s population. The database was populated with information for Florida gathered from the United States Census Bureau’s 2012 American Community Survey (ACS), and the 2011 and 2012 Centers for Disease Control and Prevention’s Behavioral Risk Factor Surveillance System (BRFSS) files. Information from the 2004 National Nursing Home Survey (NNHS) is also used in the model.

Information for each individual in this population database used to model demand for health care services includes:

- Demographics
  - Age group (0-2, 3-5, 6-13, 14-17 years for children; 18-34, 35-44, 45-64, 65-74, 75+ years for adults)
  - Sex

- Race/ethnicity (non-Hispanic white, non-Hispanic black, non-Hispanic other, Hispanic)
- Health-related lifestyle indicators
  - Body weight status (unknown, normal, overweight, obese)
  - Current smoker status
- Socioeconomic conditions
  - Household annual income (<\$10,000, \$10,000 to <\$15,000, \$15,000 to < \$20,000, \$20,000 to < \$25,000, \$25,000 to < \$35,000, \$35,000 to < \$50, 000, \$50,000 to < \$75,000, \$75,000+)
  - Medical insurance type (private, public, self-pay)
- Chronic conditions
  - Diagnosed with arthritis, asthma, cardiovascular disease, diabetes, or hypertension
  - History of heart attack, or history of stroke
- Geographic location
  - Living in a metropolitan area

Creating a representative population sample for Florida involved the following steps:

1. We first employed a statistical matching process that combined (1) socioeconomic data from approximately 3 million people in the 2012 ACS, (2) health risk factors and chronic conditions from over 1 million people in the combined 2011 and 2012 files of the BRFSS which covers the non-institutionalized population, and (3) health data from approximately 16,000 nursing home residents in the 2004 NNHS. Use of data on nursing home residents is important because this institutionalized population has poorer health and different health care use patterns compared to their peers living in the community.

Using information on residence type, we divided the ACS population in Florida into those in nursing facilities to be matched to people in the NNHS, and those not in nursing facilities to be matched to people in the BRFSS. For the non-institutionalized population, each ACS individual in Florida was randomly matched with someone in the BRFSS from Florida with the same sex, age (15 age groups used), race/ethnicity, insured/uninsured status, and household income level (8 income levels used).

Individuals categorized as residing in a nursing home were randomly matched to a person in the NNHS in the same age group, sex and race-ethnicity strata. The final matched ACS-BRFSS-NNHS database includes a sample weight for each person. This weight reflects the number of people he or she represents among the general population. Applying the sample weights to this population produces estimates for the population in Florida in 2012.

Using population estimates and projections from the University of Florida, we recalibrated the sample weights in the ACS-BRFSS-NNHS matched population file, by demographic, such that the sum of the sample weights were consistent with population projections for each



year through 2025 by age, sex, and race/ethnicity.<sup>27</sup> This process created a health and socioeconomic profile for each individual in a representative sample of the State's population.

***b) Developing Health Care Use Forecasting Equations***

Patterns of health seeking behavior were generated by regression analysis using data from approximately 169,000 participants in the pooled 2007-2011 files of the Medical Expenditure Panel Survey (MEPS). There are several hundred prediction equations in the simulation model. We estimated each equation using either Poisson regression (to model annual number of physician office and outpatient visits with a particular provider type); or using logistic regression (to model annual probability of hospitalization or emergency department visit for one of approximately 30 diagnosis categories (e.g., hospitalization for a cardiovascular condition). The dependent variable reflected annual use of health care services, while the explanatory variables consisted of the demographic characteristics, health risk factors, medical conditions, and socioeconomic factors described previously. We pooled multiple years of data to provide a sufficient sample size for regression analysis. Applying the health forecasting equations estimated through regression analysis to the population data described above provided projections of health care use by care delivery setting and type of care provided.

An example of the regressions is provided in Exhibit D-2 where findings are presented for adult cardiology services. Controlling for patient characteristics, men had 13% more office visits and 61% more outpatient visits to a cardiologist relative to women. People categorized as non-Hispanic other race and non-Hispanic white had similar patterns for cardiology-related ambulatory services. Hispanics had only 86% as many office visits and non-Hispanic blacks had only 79% as many office visits as the comparison group (non-Hispanic other race). Use of cardiology services is highly correlated with older age. The presence of endocrine and cardiovascular conditions is correlated with significantly higher use of cardiology services.

Applying the prediction equations to the current and projected future population in Florida produced estimates of the growth in demand for health care services by specialty and care delivery setting (Exhibit D-3). For primary care specialties, the growth estimates for care delivered in hospital inpatient settings represents potential growth in hospital rounds. Florida's licensure database, similar to the American Medical Association Masterfile, lists few physicians as hospitalists. A large portion of these physicians are trained as general internists or other specialties, and both the supply and demand projections list these physicians by their trained specialty.

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<sup>27</sup> All Races Population Projections by Age and Sex for Florida and Its Counties, 2015–2040, With Estimates for 2012, Bureau of Economics and Business Research, University of Florida, June 2013.



**Exhibit D- 2: Health Care Use Regression Example (Adult Cardiology Services)**

	Parameter	Office Visits <sup>a</sup>	Outpatient Visits <sup>a</sup>	Emergency Visits <sup>b</sup>	Hospitalization <sup>b</sup>
<b>Race-Ethnicity</b>	Hispanic	0.86 **	0.63 **	0.93	0.84 **
	Non-Hispanic black	0.79 **	1.68 **	1.34 **	1.31 **
	Non-Hispanic white	1.04	1.04	0.88 **	0.97
	Non-Hispanic other race	1.00	1.00	1.00	1.00
	Male	1.13 **	1.61 **	0.89 *	0.98
<b>Age</b>	18-34 years	0.11 **	0.11 **	0.53 **	0.35 **
	35-44 years	0.25 **	0.47 **	0.94	0.74 **
	45-64 years	0.51 **	0.67 **	1.14 **	1.20 **
	65-74 years	0.83 **	1.18 **	1.23 **	1.64 **
	75+ years	1.00	1.00	1.00	1.00
	Current smoker	0.81 **	0.71 **	1.06	1.03
<b>Diagnosed with</b>	Hypertension	1.66 **	1.53 **	3.41 **	2.24 **
	Coronary heart disease	8.83 **	8.59 **	2.96 **	4.20 **
	History of heart attack	1.58 **	2.00 **	2.58 **	2.58 **
	History of stroke	1.09 **	0.79 **	2.87 **	3.15 **
	Diabetes	1.19 **	1.50 **	1.02	1.24 **
	Arthritis	1.06 **	1.48 **	0.98	0.95
	Asthma	1.08 **	1.08 **	1.12	1.12
	History of cancer	1.16 **	0.83 **	0.89	0.91
	Insured	2.10 **	1.62 **	0.86	1.10
	Medicaid	1.27 **	1.47 **	1.56 **	1.58
<b>Household Income</b>	<\$10,000	0.91 **	0.76 **	1.29 **	1.20 **
	\$10,000 to <\$15,000	0.92 **	0.63 **	1.16 *	1.23 **
	\$15,000 to <\$20,000	0.86 **	0.86 **	0.88	0.99
	\$20,000 to <\$25,000	0.98	0.47 **	1.17 *	1.05
	\$25,000 to <\$35,000	0.88 **	0.80 **	1.18 **	1.03
	\$35,000 to <\$50,000	1.03	0.77 **	0.91	0.94
	\$50,000 to <\$75,000	0.98	0.90 **	0.82 **	0.85 **
	\$75,000 or higher	1.00	1.00	1.00	1.00
<b>Body Weight</b>	Normal	0.96 **	1.00	0.85 **	0.78 **
	Obese	1.05 **	0.74 **	0.91 *	0.96 *
	Overweight	1.00	1.00		
	Metro Area	1.29 **	1.00	1.05	0.92

<sup>a</sup> Rate ratios estimated by Poisson regression using annual visits as the dependent variable. <sup>b</sup> Odds ratios estimated by logistic regression using any emergency visit or hospitalization where the primary ICD-9 diagnosis code indicated a cardiovascular condition as the primary diagnosis. \* Indicates statistically significant at the 0.05 level. \*\* Indicates statistically significant at the 0.01 level.



**Exhibit D- 3: Projected Growth in Service Demand from Changing Demographics, 2013-2025**

Specialty	Hospital Inpatient	Hospital ED	Physician Office	Outpatient
Allergy & Infectious Diseases	30%	15%	17%	20%
Cardiology	30%	22%	24%	24%
Dermatology	26%		20%	20%
Endocrinology	30%	23%	25%	21%
Gastroenterology	25%	17%	20%	18%
General & Family Medicine	26%		19%	19%
General Internal Medicine	27%		21%	21%
General Surgery	27%	16%	21%	19%
Geriatrics	40%		42%	42%
Hematology & Oncology	24%	19%	22%	21%
Nephrology	35%		24%	23%
Neurological Surgery	23%			
Neurology	27%	18%	20%	18%
Obstetrics & Gynecology	14%	17%	17%	19%
Ophthalmology	24%	18%	19%	18%
Orthopedic Surgery	29%	17%	20%	16%
Otolaryngology	23%	14%	18%	17%
Pediatrics	14%		11%	12%
Physical Medicine & Rehab	27%		18%	21%
Plastic Surgery	19%	16%	19%	22%
Psychiatry	18%	16%	17%	15%
Pulmonology	30%	17%	20%	20%
Rheumatology	27%	19%	23%	25%
Thoracic Surgery	26%	18%	20%	11%
Urology	26%	18%	21%	22%
Vascular Surgery	32%			
<b>Total</b>	<b>27%</b>	<b>17%</b>	<b>19%</b>	<b>20%</b>

***c) FTE Physician Staffing to Meet Demand for Health Care Services***

The number and mix of physicians by specialty required to provide the level of health care services demanded is influenced by how the care system is organized and care is reimbursed, provider scope of practice requirements, economic constraints, technology, and other factors. To convert projected demand for services into demand for physicians we determined how each unit of service demanded (e.g., psychiatrist office visits, hospital inpatient days) translates into



demand for a partial FTE provider (i.e., the fraction of an FTE provider's time to provide care during that one patient encounter).

Demand for psychiatrists, for example, was linked to projected numbers of office and outpatient visits to a psychiatrist, and emergency department visits and hospitalizations requiring psychiatry related services and procedures (e.g., ICD-9 CM codes 290-319). The demand estimates provided in this report are based on the current care delivery model and do not reflect emerging care delivery models.

Data on provider productivity to estimate the portion of a physician FTE associated with patient encounters in different care settings came from numerous sources—including the Medical Group Management Association's Physician Compensation and Production Survey, the American Board of Internal Medicine (ABIM) Practice Characteristics Survey, surveys and workforce studies conducted for individual medical specialties.

The following examples illustrate how provider demand varies by patient characteristics:

- The population of non-Hispanic, black, females, age 75+, insured, obese, and with diabetes and hypertension requires about 26 FTE providers in traditional primary care specialties (family practice, internal medicine, geriatric medicine) per 10,000 population.
- The population of non-Hispanic, black, females, age 75+, insured, normal weight, without diabetes or hypertension requires about 8.6 FTE primary care providers per 10,000 population.
- The population of non-Hispanic, black, females, age 18-34, insured, normal weight, without diabetes or hypertension requires about 2.4 FTE primary care providers per 10,000 population.

These estimates are based on patterns of how patient health risk factors affect the level health care services by medical specialty and care delivery setting, and how the health care system is currently staffed to meet the demand for services.

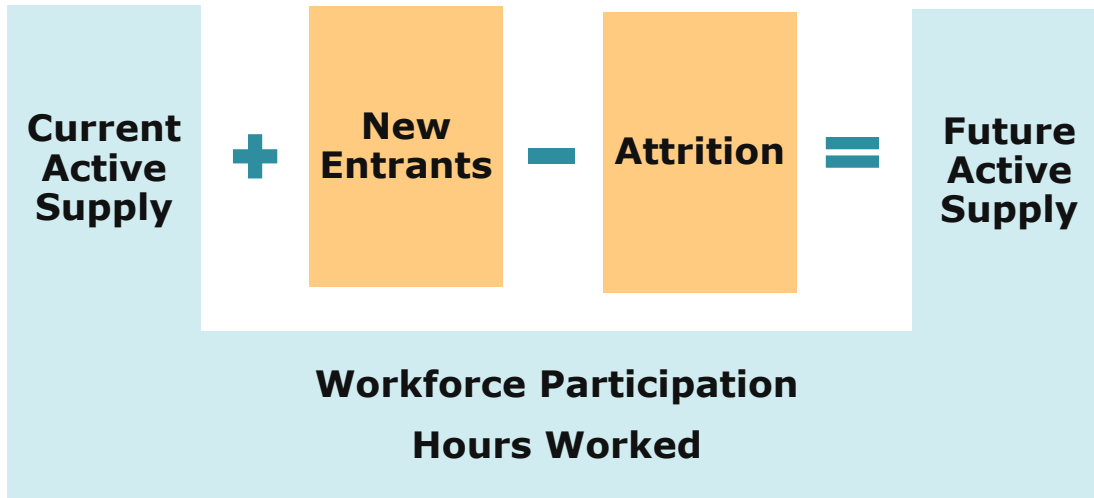
## **2. Modeling Supply of Florida Physician Specialties**

The conceptual framework for modeling the future supply of physicians (Exhibit D-4) starts with the current workforce, adds new entrants, and subtracts those leaving due to retirement or out-of-state migration to arrive at next year's supply. The level of workforce participation for each physician is then modeled as a function of his or her age, gender, and specialty.

The primary data source for supply is the 2012 and 2013 physician licensure data furnished by the Florida Department of Health. This data is collected as part of the biannual physician renewal application process. The file contains information on all physicians licensed and active in providing patient care in Florida. Information on this list (including self-reported medical specialty) was compared to the American Medical Association's specialty codes to help group physicians by specialty category.

The mechanism for adding new entrants to the workforce is done via the creation of a “synthetic” population. This population is created such that the age, gender, and specialty distribution for each new cohort of providers reflects the demographic and specialty distribution seen in recent years. For each year from 2013 through 2025, “representative” physicians are created by the model to represent each new physician entering the Florida workforce. Each new physician is assigned an age, gender, and specialty that reflect current distributions for newly licensed physicians in Florida.

**Exhibit D- 4: Conceptual Model for Health Workforce Supply**



*a) Patient Care Hours Worked*

Supply projections reflect the changing demographic composition of Florida’s physician workforce, and that hours worked differ by physician age, gender, and specialty. With survey data collected during the licensure process, we used ordinary least squares regression analysis to analyze hours per week engaged in patient care activities. We limited our analysis to the 18,016 physicians who in 2012-2013 reported direct patient care hours worked per week, and we limited the analysis to physicians working at least 8 hours per week in professional activities.

As shown in Exhibit D-5, hours worked patterns differed systematically by specialty. Compared to vascular surgery (the comparison specialty), physicians in allergy & immunology and in dermatology work about 11 fewer patient care hours per week. Physicians in cardiology, obstetrics & gynecology, and many of the surgical specialties have about the same number of patient care hours per week as vascular surgeons. From age 55 onward, patient care hours per week start to decline. Female physicians tend to work about 3.3 hours fewer per week in patient care activities compared to their male peers (and controlling for specialty and age). Women under age 55 work about 5 hours per week less than their male peers, while women over age 55 work about 2 hours per week less than their male peers.



**Exhibit D- 5: OLS Regression of Weekly Patient Care Hours Worked**

	<b>Parameter (Hours)</b>	<b>Probability</b>
Intercept	49.5	<.0001
Specialty (Vascular Surgery is reference category)		
Allergy & Immunology	(11.0)	<.0001
Anesthesiology	(2.6)	0.099
Cardiology	0.5	0.739
Colon & Rectal Surgery	(0.9)	0.726
Critical Care Medicine	(0.8)	0.720
Dermatology	(10.8)	<.0001
Emergency Medicine	(10.6)	<.0001
Endocrinology	(3.7)	0.051
Gastroenterology	(0.8)	0.614
General & Family Practice	(6.9)	<.0001
General Internal Medicine	(3.5)	0.022
General Surgery	0.5	0.775
Geriatric Medicine	(6.7)	0.000
Hematology & Oncology	(1.3)	0.452
Infectious Diseases	(2.4)	0.194
Neonatal & Perinatal Medicine	4.8	0.143
Nephrology	2.7	0.129
Neurological Surgery	1.5	0.446
Neurology	(3.9)	0.019
Obstetrics & Gynecology	(1.4)	0.392
Ophthalmology	(8.8)	<.0001
Orthopedic Surgery	(3.7)	0.022
Otolaryngology	(5.4)	0.003
Pathology	(8.3)	<.0001
Pediatrics	(6.8)	<.0001
Physical Medicine & Rehab	(6.5)	0.001
Plastic Surgery	(7.8)	<.0001
Preventive Medicine	(14.2)	<.0001
Psychiatry	(8.1)	<.0001
Pulmonology	3.0	0.085
Radiation Oncology	(6.0)	0.002
Radiology	(5.4)	0.001
Rheumatology	(3.4)	0.087
Thoracic Surgery	1.7	0.413
Urology	(0.5)	0.769
Age (<40 is reference category)		
Age 40 to 44	0.3	0.615
Age 45 to 49	0.2	0.777
Age 50 to 54	0.6	0.290
Age 55 to 59	(0.4)	0.390
Age 60 to 64	(1.7)	0.001
Age 65 to 69	(5.5)	<.0001
Age 70+	(11.4)	<.0001
Female		
Female x Age 40 to 44	(1.9)	0.030
Female x Age 45 to 49	(1.8)	0.046
Female x Age 50 to 54	(1.4)	0.119
Female x Age 55 to 59	1.6	0.077
Female x Age 60 to 64	0.6	0.530
Female x Age 65 to 69	1.4	0.294
Female x Age 70+	4.1	0.010
Summary statistics: n=18,016; R <sup>2</sup> =0.101; Mean hours worked=42.5		





### ***b) Attrition***

The supply model uses age-sex-specialty dependent annual attrition probabilities to simulate providers leaving the workforce. These attrition probabilities were created by summing (1) the probability of leaving the workforce due to career change or retirement, and (2) mortality probability. The model simulates whether a particular physician will remain in the workforce each year by generating a random number which is compared to the probability of retirement for a physician of his or her age, sex, and specialty.

Retirement patterns generated using the combined 2012 and 2013 Florida Physician Workforce Surveys are based on response to the question of whether the respondent plans to retire within the next five years. These responses were generally consistent with historical retirement patterns generated from analysis of a 2006 survey of physicians age 50 and older conducted by the Association of American Medical Colleges.<sup>28</sup> Included among this AAMC survey sample was a population of retired physicians who were asked at what age they retired.

Mortality rates by age and sex come from the Centers for Disease Control and Prevention. The rates used in the HWSM take into consideration that people in professional occupations tend to have lower mortality rates through age 65 as compared to national average mortality rates for men and women. Johnson et al. estimate age-adjusted mortality rates for professional and technical occupations are approximately 25% lower than national rates for men and 15% lower for women.<sup>29</sup>

Exhibit D-6 shows results of this analysis for male physicians, summarizing how many physicians are likely to still be in the workforce from an initial cohort of 100 physicians age 50. (Patterns for female physicians are similar.) For example, a cohort of 100 physicians in allergy & immunology will have about 68 still in active practice by age 65 and 45 still in practice by age 70. Emergency physicians have a much higher attrition rate. From a cohort of 100 emergency physicians age 50, only 47 are still active at age 65 and 23 are still active at age 70 (with many in this older age working reduced hours).

Specialties with the lowest attrition rates are allergy & immunology, cardiology, thoracic surgery, and gastroenterology. Specialties with the highest attrition rates are emergency medicine, anesthesiology, radiology, and general surgery.

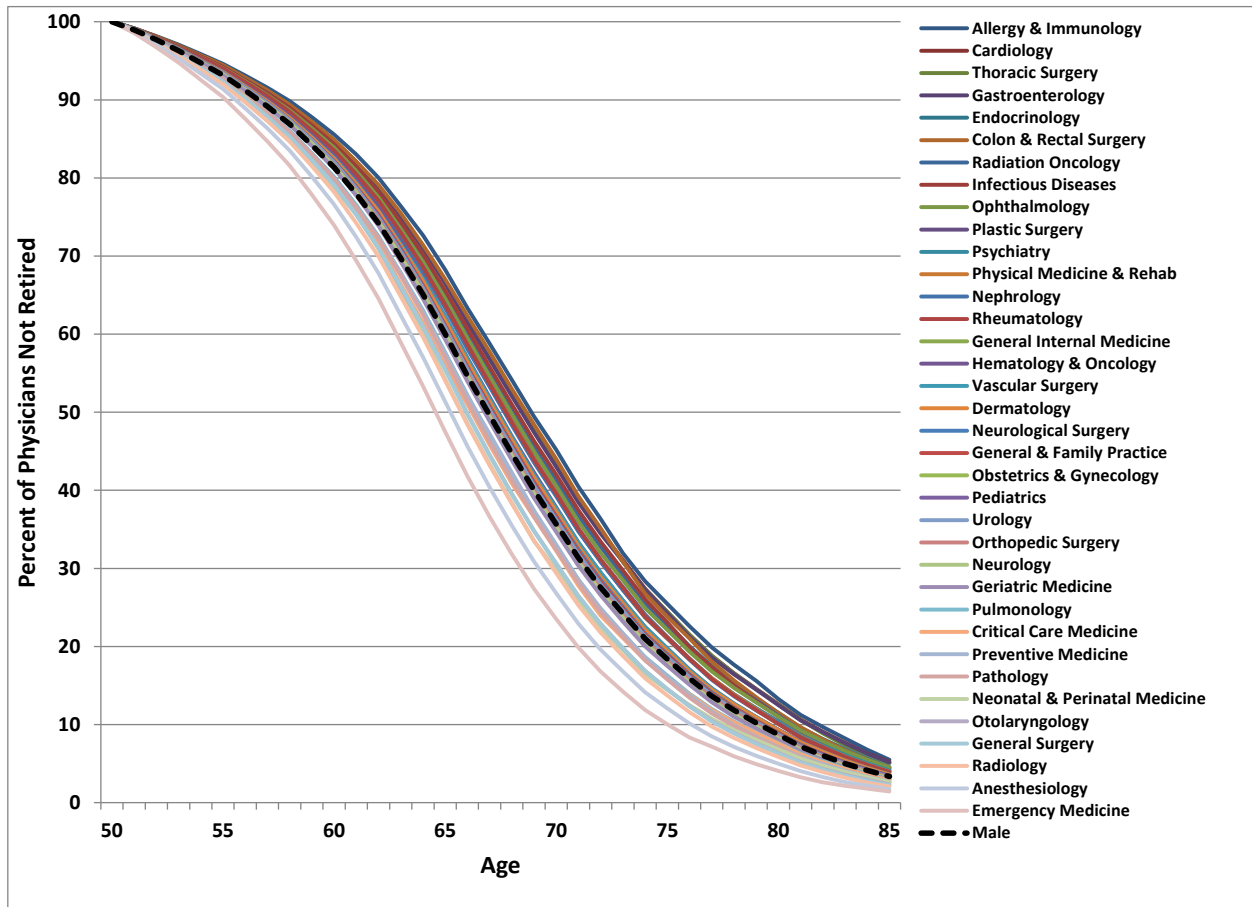
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<sup>28</sup> These retirement patterns have been used to develop U.S. physician supply projections. See, for example, Dill MJ and Salsberg ES. *The Complexities of Physician Supply and Demand: Projections through 2025*. Association of American Medical Colleges, November 2008.  
U.S. Department of Health and Human Services. *The Physician Workforce: Projections and Research into Current Issues Affecting Supply and Demand*. 2008.

<sup>29</sup> Johnson NJ, Sorlie PD, Backlund E. The Impact of Specific Occupation on Mortality in the U.S. National Longitudinal Mortality Study. *Demography*. 1999;36(3):355-367.



Exhibit D- 6: Male Physician Retirement Patterns by Specialty and Age Cohort



THE FLORIDA SENATE  
**APPEARANCE RECORD**

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-17-15  
Meeting Date

\_\_\_\_\_  
Bill Number (if applicable)

Topic Florida's Physician Workforce

\_\_\_\_\_  
Amendment Barcode (if applicable)

Name Timothy M. Dall

Job Title Managing Director, IHS Life Sciences

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Speaking:  For  Against  Information

Waive Speaking:  In Support  Against  
(The Chair will read this information into the record.)

Representing IHS Life Sciences

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

**This form is part of the public record for this meeting.**



## THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

**COMMITTEES:**  
Communications, Energy, and Public Utilities, *Chair*  
Agriculture  
Appropriations  
Appropriations Subcommittee on Health  
and Human Services  
Health Policy  
Transportation

**JOINT COMMITTEES:**  
Joint Administrative Procedures Committee  
Joint Legislative Budget Commission

### SENATOR DENISE GRIMSLEY

*Deputy Majority Leader*  
21st District

February 17, 2015

The Honorable Aaron Bean, Chair  
Health Policy Committee  
404 S. Monroe Street  
Tallahassee, Florida 32399

Dear Chairman Bean:

I respectfully request permission to be excused from the Health Policy Committee meeting on 2/17/2015 due to illness associated with fever.

Sincerely,

A handwritten signature in cursive script that reads "Denise Grimsley".

Denise Grimsley  
District 21

cc: Sandra Stovall, Staff Director  
Celia Georgiades, Administrative Assistant

A handwritten signature in cursive script that reads "Aaron Bean", with an "x" written to the left of the signature.

**REPLY TO:**

- 205 South Commerce Avenue, Suite A, Sebring, Florida 33870 (863) 386-6016
- 212 East Stuart Avenue, Lake Wales, Florida 33853 (863) 679-4847
- 306 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5021

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**ANDY GARDINER**  
President of the Senate

**GARRETT RICHTER**  
President Pro Tempore

# CourtSmart Tag Report

Room: KN 412

Case:

Type:

Caption: Senate Committee on Health Policy Judge:

Started: 2/17/2015 9:01:17 AM

Ends: 2/17/2015 10:27:49 AM Length: 01:26:33

9:01:21 AM Sen. Bean, Chair  
9:01:44 AM Roll Call  
9:01:49 AM Quorum Present  
9:02:44 AM Sen. Joyner, Opening Remarks  
9:03:40 AM TAB 1-SB 450 by Benacquisto (Identical to H 4017) Pain Managent Clinics  
9:04:42 AM Paul Runk, Deputy Director-Legislative Affairs, FL Dept. of Health, Waives in Support  
9:04:51 AM Stephen R. Winn, Executive Director of the FOMA, Waives in Support  
9:05:01 AM Chris Nuland, Florida Public Health Association, Waives in Support  
9:05:16 AM Sheriff Prummell, Sheriff of Charlotte County, Representing FL Sheriff's Association, Waives in Support  
9:05:40 AM Roll Call on SB 450  
9:06:01 AM SB 450 Reported Favorably  
9:06:41 AM TAB 4-SB 296 by Garcia; (Identical to H 0043) Diabetes Advisory Council  
9:07:43 AM Am 275700 Considered  
9:07:58 AM Melanie Bostick, Vice President, American Association, Waives in Support  
9:08:20 AM Am is Adopted  
9:08:47 AM SB 296 Considered as a Committee Substitute  
9:09:07 AM Committe Subsitute for SB 296 Reported Favorably  
9:09:21 AM TAB 3: SB 294 by Garcia; Florida Kidcare Program  
9:10:44 AM Dr. Fely Curva, Senior Partner with Curva Associates LLC, Representing FL Impact, Waives in Support  
9:10:49 AM Michael McQuone, Associate Directoe for Health, FL Conference of Catholic Bishops, Speaks in Support  
9:12:19 AM Chair Opens for Questions  
9:12:33 AM Ron Watson, Lobbyist, Florida CHAIN, Waives in Support  
9:12:38 AM Pam Bergsma, Joey Bergsma, Retinoblastoma Awareness Foundation, Waives in Support  
9:12:48 AM Crystal Stickle, VP of Gov. Affairs, Florida Hospital Association, Waives in Support  
9:12:55 AM Amy Liem, Florida Legal Services, Waives in Support  
9:13:05 AM Phillis Oeters, VP Community Govt. Relations, Waives in Support  
9:13:08 AM Karen Woodall, Director, Florida Center for Fiscal and Economic Policy/Kidswell Fla., Waives in Support  
9:13:21 AM Diana Ragbeer, Director Pulic Policy, The Children's Trust, Waives in Support  
9:13:31 AM Jessica Scher, Director of Public Policy, United Way of Miami-Dade, Waives in Support  
9:13:47 AM Chair Opens for Debate  
9:14:11 AM Sen. Garcia  
9:14:40 AM Chair  
9:14:49 AM Roll Call on SB 294  
9:15:05 AM SB 294 Reported Favorably  
9:15:27 AM TAB 5: SB 478 by Bean, Joyner; (Compare to H 0545) Telemedicine Services  
9:15:46 AM Sen. Joyner Recognized to Explain Amendment 813832  
9:18:26 AM Chair  
9:19:28 AM Sen. Joyner  
9:19:48 AM Chair Opens for Questions  
9:19:53 AM Sen. Flores  
9:20:49 AM Chair  
9:21:37 AM Sen. Flores  
9:22:36 AM Chair  
9:23:50 AM Sen. Sobel, Vice Chair  
9:24:38 AM Chair  
9:26:15 AM Vice Chair  
9:26:17 AM Chair  
9:26:28 AM Am to Am 539316 Considered  
9:26:42 AM Sen. Galvano Recognized  
9:27:36 AM Sen. Gaetz Recognized  
9:27:49 AM Sen. Galvano  
9:28:03 AM Chair

9:28:06 AM Public Testimony  
9:28:35 AM Amendment is Adopted  
9:28:56 AM 813832 Strike-all Amendment is Adopted  
9:29:23 AM David Christian, VP-Governmental Affairs, FL Chamber of Commerce, Waives in Support  
9:29:44 AM Jack McRay, AARP, Waives in Support  
9:29:56 AM Wences Troncoso, VP and General Counsel, Florida Association of Health Plans, Waives in Support  
9:30:05 AM Chris Hansen, Lobbyist, FL Podiatric Medical Association, Waives in Support  
9:30:17 AM Alisa LaPolt, Florida Nurses Association, Waives in Support  
9:30:23 AM Kim Landry, Emergency Physician and EMS Medical Director, Representing Several EMS Ambulance Services, Speaks in Favor of the Bill  
9:33:46 AM Chair  
9:33:55 AM Chair Opens for Questions  
9:34:01 AM Crystal Stickle, VP Gov Affairs, FL Hospital Association, Waives in Support  
9:34:08 AM Sklylar Zander, Deputy State Director, Americans for Prosperity, Waives in Support  
9:34:18 AM Stan Whittaker, FL Association of Nurse Practitioners, Waives in Support  
9:34:27 AM Phillis Oeters, VP of Govt. Community Relations, Waives in Support  
9:34:39 AM Jeff Scott, FL Medical Association, Waives in Support  
9:34:48 AM Jess Scher, Director of Public Policy, United Way of Miami Dade, Waives in Support  
9:35:03 AM Paul Lambert, FL Chiropractic Association, Waives in Support  
9:35:11 AM Chair Opens for Questions  
9:35:16 AM Vice Chair  
9:36:41 AM Chair  
9:36:42 AM Sen. Garcia  
9:37:10 AM Chair  
9:37:58 AM Sen. Joyner Recognized to Close  
9:39:21 AM Chair  
9:39:26 AM Sen. Gatez Moves to Consider SB 478 as a Committee Substitute  
9:39:45 AM Roll Call on SB 478  
9:39:56 AM Committee Substitute Reported Favorably  
9:40:13 AM TAB 2: SB 322 by Stargel (CO-INTRODUCERS) GAetz; Medicaid Reimbursement for Hospital Providers  
9:40:36 AM Sen. Joyner Recognized  
9:41:16 AM Sen. Stargel Speaks on Bill  
9:42:04 AM Sen. Joyner  
9:42:07 AM Sen. Stargel Responds  
9:42:17 AM Sen. Joyner  
9:42:23 AM Sen. Stargel Responds  
9:43:32 AM Sen. Joyner  
9:43:34 AM Sen. Stargel Responds  
9:43:54 AM Sen. Joyner  
9:44:05 AM Sen. Stargel Responds  
9:45:13 AM Chair  
9:45:17 AM Vice Chair Recognized  
9:45:40 AM Sen. Stargel Responds  
9:46:15 AM Vice Chair  
9:46:21 AM Sen. Gaetz  
9:47:17 AM Sen. Stargel Responds  
9:47:26 AM Sen. Joyner  
9:47:47 AM Sen. Stargel Responds  
9:48:19 AM Chair Opens for Public Testimony  
9:48:48 AM Committee Staff Recognized  
9:49:07 AM Tony Carvalho, President, Safety Net Hospital Association of FL, Recognized  
9:50:40 AM Chair  
9:50:49 AM Chair Opens for Debate  
9:50:55 AM Sen. Joyner  
9:51:28 AM Chair  
9:51:41 AM Justin Senior, Medicaid Director, Agency for Health Care Admin., Recognized  
9:52:46 AM Sen. Joyner  
9:53:10 AM Justin Senior Responds  
9:55:48 AM Chair  
9:55:55 AM Justin Senior Responds  
9:56:04 AM Chair  
9:56:11 AM Sen. Gaetz Recognized

9:56:30 AM Justin Senior Responds  
9:56:35 AM Sen. Gaetz  
9:56:39 AM Justin Senior Responds  
9:56:42 AM Chair  
9:56:55 AM Chair Opens for Debate  
9:57:03 AM Sen. Garcia Recognized to End Debate  
9:57:53 AM Chair  
9:57:57 AM Sen. Joyner  
9:58:45 AM Chair  
9:58:46 AM Sen. Stargel Recognized to Close on Bill  
9:59:03 AM Chair  
9:59:11 AM SB 322 Roll Call  
9:59:18 AM SB 322 Reported Favorably  
9:59:33 AM Sen. Braynon Recognized  
9:59:44 AM Sen. Braynon Requests to be Recognized as a Yes on SB 478; Accepted  
10:00:25 AM Chair  
10:00:31 AM TAB 6: SPB 7032 by HP; Public Records/Reports of a Deceased Child  
10:01:08 AM Sandra Stovall, Staff Director, Recognized  
10:03:08 AM Chair  
10:03:08 AM Sen. Galvano moves that we consider SPB 7032 as a Committee Bill  
10:03:39 AM Roll Call  
10:03:51 AM Proposed SPB 7032 Reported Favorably  
10:04:05 AM TAB 7: Presentation on Florida Physician Workforce by Tim Dall, Managing Director, IHS Global, Inc.  
10:05:06 AM Tim Dall Recognized  
10:06:09 AM Study Goals  
10:06:51 AM Modeling Approach  
10:10:00 AM Key Finding: Moderate Shortfall of Physicians Projected to Persist if Current Trends Continue  
10:10:49 AM Key Finding: Continued Shortfall of Specialists  
10:11:12 AM Key Finding: Large Shortfalls Projected for Some Specialists by 2025  
10:12:19 AM Key Finding: Small Primary Care Physician Shortfall, but Supply and Demand Converging  
10:12:53 AM Key Finding: Substantial Variation in Adequacy of Physician Supply by Medicaid Region  
10:14:08 AM Key Finding: Future Physician (2025) Shortfalls in Many FL Medicaid Regions  
10:14:48 AM Key Data  
10:16:47 AM Overview of Physician Pipeline Conceptual Model  
10:18:35 AM Chair  
10:18:38 AM Tim Dall Responds  
10:19:54 AM Chair  
10:19:57 AM Tim Dall Responds  
10:20:16 AM Chair Opens for Questions  
10:20:22 AM Vice Chair  
10:20:52 AM Tim Dall Responds  
10:21:02 AM Chair  
10:21:15 AM Tim Dall Responds  
10:21:40 AM Chair  
10:21:46 AM Tim Dall Responds  
10:22:33 AM Vice Chair  
10:23:22 AM Tim Dall Responds  
10:23:33 AM Chair  
10:23:35 AM Vice Chair  
10:23:41 AM Tim Dall Responds  
10:24:10 AM Sen. Gaetz  
10:24:26 AM Sen. Galvano  
10:25:59 AM Chair  
10:27:35 AM Sen. Gaetz Moves to Rise