| | |
|---|---|
| **Tab 1** | **CS/SB 682** by **HP, Stargel**; (Compare to H 01059) Medicaid Managed Care |

| | | | | | | |
|---|---|---|---|---|---|---|
| 625180 | A | S | RCS | AHS, Stargel | Delete L.171 - 174: | 04/13 05:48 PM |

| | |
|---|---|
| **Tab 2** | **SB 916** by **Grimsley (CO-INTRODUCERS) Stargel**; (Compare to 1ST ENG/H 07117) Statewide Medicaid Managed Care Program |

| | | | | | | |
|---|---|---|---|---|---|---|
| 587308 | A | S | RCS | AHS, Grimsley | Delete L.175 - 177: | 04/13 05:48 PM |
| 306190 | A | S | RCS | AHS, Grimsley | Delete L.325 - 353: | 04/13 05:48 PM |
| 167498 | A | S | RCS | AHS, Grimsley | Delete L.411 - 435: | 04/13 05:48 PM |

| | |
|---|---|
| **Tab 5** | **SB 714** by **Garcia**; (Compare to CS/H 00899) Comprehensive Transitional Education Programs |

| | | | | | | |
|---|---|---|---|---|---|---|
| 346524 | A | S | RCS | AHS, Garcia | Delete L.47 - 75: | 04/20 04:53 PM |

| | |
|---|---|
| **Tab 6** | **SB 1050** by **Simmons**; (Similar to H 00883) Memory Disorder Clinics |

| | |
|---|---|
| **Tab 7** | **SB 1056** by **Garcia (CO-INTRODUCERS) Campbell**; (Identical to H 06021) Home Health Care Agency Licenses |

| | |
|---|---|
| **Tab 8** | **CS/SB 1406** by **HP, Powell (CO-INTRODUCERS) Passidomo, Baxley**; (Similar to CS/CS/CS/H 00785) Stroke Centers |

| | | | | | | |
|---|---|---|---|---|---|---|
| 374610 | A | S | RCS | AHS, Powell | Delete L.68 - 96: | 04/19 03:51 PM |

**The Florida Senate**

# COMMITTEE MEETING EXPANDED AGENDA

**APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES**
**Senator Flores, Chair**
**Senator Stargel, Vice Chair**

**MEETING DATE:** Thursday, April 13, 2017
**TIME:** 2:30—3:30 p.m.
**PLACE:** *James E. "Jim" King, Jr. Committee Room,* 401 Senate Office Building

**MEMBERS:** Senator Flores, Chair; Senator Stargel, Vice Chair; Senators Artiles, Baxley, Book, Passidomo, Powell, and Rader

| TAB | BILL NO. and INTRODUCER | BILL DESCRIPTION and SENATE COMMITTEE ACTIONS | COMMITTEE ACTION |
|---|---|---|---|
| 1 | **CS/SB 682**<br>Health Policy / Stargel<br>(Compare H 1059, H 7117, S 916) | Medicaid Managed Care; Requiring that nursing home facilities be prepared to provide confirmation within a specified timeframe to the Agency for Health Care Administration as to whether certain nursing home facility residents are candidates for certain services; providing that covered services for long-term care under the Medicaid managed care program are those specified in part IV of ch. 409, F.S.; providing that certain residents of nursing facilities are exempt from participation in the long-term care managed care program, etc.<br><br>HP 03/27/2017 Fav/CS<br>AHS 04/13/2017 Fav/CS<br>AP | Fav/CS<br>Yeas 8 Nays 0 |
| 2 | **SB 916**<br>Grimsley<br>(Compare H 7117, CS/S 682) | Statewide Medicaid Managed Care Program; Deleting the fee-for-service option as a basis for the reimbursement of Medicaid provider service networks; requiring provider service networks to be prepaid plans; revising the number of eligible Medicaid health care plans the agency must procure for certain regions in the state, etc.<br><br>HP 03/27/2017 Favorable<br>AHS 04/13/2017 Fav/CS<br>AP<br>RC | Fav/CS<br>Yeas 8 Nays 0 |

| TAB | OFFICE and APPOINTMENT (HOME CITY) | FOR TERM ENDING | COMMITTEE ACTION |
|---|---|---|---|
| | **Senate Confirmation Hearing:** A public hearing will be held for consideration of the below-named executive appointments to the offices indicated. | | |
| | **Secretary of Health Care Administration** | | |
| 3 | Senior, Justin M. (Tallahassee) | Pleasure of Governor | Recommend Confirm<br>Yeas 7 Nays 0 |
| | **State Surgeon General** | | |
| 4 | Philip, Celeste (Tallahassee) | Pleasure of Governor | Recommend Confirm<br>Yeas 7 Nays 0 |

| TAB | BILL NO. and INTRODUCER | BILL DESCRIPTION and SENATE COMMITTEE ACTIONS | COMMITTEE ACTION |
|---|---|---|---|
| 5 | **SB 714**<br>Garcia<br>(Compare CS/H 899) | Comprehensive Transitional Education Programs; Authorizing the Agency for Persons with Disabilities to petition a court for the appointment of a receiver for a comprehensive transitional education program under certain circumstances; providing that no new comprehensive transitional education programs may be licensed after a specified date, etc.<br><br>CF 03/06/2017 Favorable<br>AHS 04/13/2017 Not Considered<br>AP | Not Considered |
| 6 | **SB 1050**<br>Simmons<br>(Similar H 883) | Memory Disorder Clinics; Establishing a memory disorder clinic at Florida Hospital in Orange County, etc.<br><br>HP 03/14/2017 Favorable<br>AHS 04/13/2017 Not Considered<br>AP | Not Considered |
| 7 | **SB 1056**<br>Garcia<br>(Identical H 6021) | Home Health Care Agency Licenses; Removing a prohibition against the issuance of an initial home health agency license to an applicant who shares common controlling interests with another licensed home health agency located within 10 miles of the applicant and in the same county, etc.<br><br>HP 04/03/2017 Favorable<br>AHS 04/13/2017 Not Considered<br>AP | Not Considered |
| 8 | **CS/SB 1406**<br>Health Policy / Powell<br>(Similar CS/CS/CS/H 785) | Stroke Centers; Directing the Agency for Health Care Administration to include hospitals that meet the criteria for acute stroke ready centers on a list of stroke centers; requiring the Department of Health to establish a statewide stroke registry, etc.<br><br>HP 03/27/2017 Fav/CS<br>AHS 04/13/2017 Not Considered<br>AP | Not Considered |
| | 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.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

| | |
|---|---|
| BILL: | PCS/CS/SB 682 (219746) |
| INTRODUCER: | Appropriations Subcommittee on Health and Human Services; Health Policy Committee; and Senator Stargel |
| SUBJECT: | Medicaid Managed Care |
| DATE: | April 17, 2017 REVISED: |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Lloyd | Stovall | HP | **Fav/CS** |
| 2. | Forbes | Williams | AHS | **Recommend: Fav/CS** |
| 3. | | | AP | |

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

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

PCS/CS/SB 682 exempts from the Long-Term Care component (LTC) of the Statewide Medicaid Managed Care (SMMC) program those Medicaid recipients who have resided in a nursing facility for 60 or more consecutive days, with certain exceptions. The bill also exempts those recipients in the LTC component who are receiving hospice care while residing in a nursing facility. These recipients would receive long-term care services through fee-for-service Medicaid providers and other medical services through the managed medical assistance component (MMA) of the SMMC program. This section of the bill is effective October 1, 2018.

The bill provides that a nursing home resident will not be exempt from the LTC component if the resident has been identified as a candidate for home and community-based services (HCBS) by specified individuals. The agency must confirm whether an individual has been identified as a candidate for HCBS before determining that a person is exempt from the LTC component. The bill provides notice provisions should the nursing home resident later be identified as a candidate for HCBS services. The additional exceptions apply to a Medicaid recipient who is aged 18 or older and eligible for Medicaid due to a disability or a person who has priority enrollment for home and community-based services.

Effective July 1, 2017, the bill requires the Agency for Health Care Administration (AHCA) to impose fines and authorizes other sanctions for willful violations with the prompt pay provisions of ss. 641.315, 641.3155, 641.513, and 409.982(5), F.S.

Managed care plans must also contract with all nursing homes and hospices that meet credentialing and re-credentialing requirements as specified in the plan's contract with the AHCA for the first 12 months following a procurement in any regions where a plan is awarded a contract and that region was not previously served by that plan during the most recent procurement period. If a plan excludes a nursing home or hospice for the remainder of the contract period, the AHCA must require the plan to submit the performance and quality criteria that was used to exclude the provider and to demonstrate how the provider failed to meet the plan's criteria.

The AHCA believes that if nursing facility residents who meet specified criteria are exempted from the LTC program, costs will increase by an estimated $200 million per year. The Florida Health Care Association disagrees with the AHCA assessment and believes this change will save the state a total of $67.8 million a year.

Except as otherwise provided, the bill is effective upon becoming law.

## II. Present Situation:

### Florida Medicaid

The Medicaid program is a partnership between the federal and state governments to provide medical care to low income children and disabled persons. 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 state plan outlines Medicaid eligibility standards, policies, and reimbursement methodologies.

Florida Medicaid serves as the safety net to Florida's health care delivery system. Medicaid currently is the second largest expenditure in Florida's budget behind education with estimated expenditures for the 2016-2017 state fiscal year of $25.8 billion[1]and covers 20 percent of all Floridians. Over 4 million Floridians are currently enrolled in Medicaid, including:

- 47 percent of Florida's children;
- 63 percent of Florida's births; and
- 61 percent of Florida's nursing home days.[2]

However, Florida Medicaid does not cover all low-income Floridians. The maximum income limits for programs are illustrated below as a percentage of the federal poverty level (FPL).

[1] Office of Economic and Demographic Research, Social Services Estimating Conference, Medicaid Caseload and Expenditures (February 17, February 27, and March 9, 2017) Executive Summary, http://edr.state.fl.us/Content/conferences/medicaid/execsummary.pdf (last visited Mar. 21, 2017).
[2] Agency for Health Care Admin., Senate Health and Human Services Appropriations Committee Presentation, *Agency for Health Care Administration - Florida Medicaid* (January 11, 2017), slide 2, http://www.flsenate.gov/PublishedContent/Committees/2016-2018/AHS/MeetingRecords/MeetingPacket_3554.pdf (last visited Mar. 17, 2017).

| **Florida's Current Medicaid and CHIP Eligibility Levels in Florida[3]** (With Income Disregards and Modified Adjusted Gross Income) | | | | | | |
|---|---|---|---|---|---|---|
| **Children's Medicaid** | | | **CHIP (Kidcare)** | **Pregnant Women** | **Parents** | **Childless Adults** |
| Age 0-1 | Age 1-5 | Age 6-18 | Ages 0-18 | | | |
| 206% FPL | 140% FPL | 133% FPL | 210% FPL | 191% FPL | 31% FPL | 0% FPL |

Florida Medicaid is administered by the AHCA and is financed with federal and state funds. The Department of Children and Families (DCF) determines Medicaid eligibility and transmits that information to the AHCA. As the single state agency for Medicaid, the AHCA has the lead responsibility for the overall program.[4]

The structures of state Medicaid programs vary from state to state, and each state's share of expenditures varies and is largely determined by the federal government. Federal law and regulations set the minimum amount, scope, and duration of services offered in the program, among other requirements. State Medicaid benefits 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).

Applicants for Medicaid must be United States citizens or qualified noncitizens, must be Florida residents, and must provide social security numbers for data matching. While self-attestation is permitted for a number of data elements on the application, most components are matched through the Federal Data Services Hub.[5] Applicants must also agree to cooperate with Child Support Enforcement during the application process.[6]

Minimum eligibility coverage thresholds are established in federal law for certain population groups, such as children, as well as minimum benefits and maximum cost sharing. The minimum benefits include items such as physician services, hospital services, home health services, and family planning.[7] States can add benefits, pending federal approval. Florida has added benefits, including prescription drugs, adult dental services, and dialysis.[8] For children under age 21, the benefits must include the Early and Periodic Screening, Diagnostic and Treatment services, which are those health care and diagnostic services and treatment and measures that may be needed to correct or ameliorate defects or physical and mental illnesses and conditions discovered by screening services, consistent with federal law.[9]

Waivers to the state plan may be requested and negotiated by the state through the federal Centers for Medicare and Medicaid Services (CMS) by the AHCA. Florida has several such Medicaid waivers, including one, which implemented the SMMC program. Current federal law requires the state to obtain a waiver to implement managed care. Through these waivers, the

[3] U.S. Centers for Medicare and Medicaid Services, Medicaid.gov, *Florida*, http://www.medicaid.gov/medicaid-chip-program-information/by-state/florida.html (last visited Mar. 17, 2017).
[4] *See* s. 409.963, F.S.
[5] Florida Dep't of Children and Families, *Family-Related Medicaid Programs Fact Sheet*, p. 4 (April 2016) http://www.dcf.state.fl.us/programs/access/docs/Family-RelatedMedicaidFactSheet.pdf (last visited Mar. 21, 2017).
[6] Id.
[7] Section 409.905, F.S.
[8] Section 409.906, F.S.
[9] *See* Section 1905 9(r) of the Social Security Act.

states have limited flexibility to design their Medicaid programs; however, even within waiver authorities, federal regulations prescribe requirements for benefits, delivery systems, cost sharing limitations, and population coverages.

***Statewide Medicaid Managed Care (SMMC)***

The SMMC program is designed for the AHCA to issue invitations to negotiate and competitively procure 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. The SMMC has two components: managed medical assistance (MMA) and long-term care managed care (LTC). The MMA waiver expires on June 30, 2017, and the LTC waiver was recently extended through December 27, 2021.[10]

Part IV of ch. 409, F.S., was created in 2011 by ch. 2011-134, L.O.F., and governs the SMMC program. The LTC component began enrollment in August 2013 and completed its statewide rollout in March 2014. The MMA component began enrolling Medicaid recipients in May 2014 and finished its rollout in August 2014.

Services are delivered through six managed care plans, which vary, based on the recipient's region; however, each region has at least two plans. Plans are paid on a capitated basis meaning that a LTC plan must pay for all covered services under the contract regardless of whether the capitated rate covers the cost of services for that recipient. For nursing facilities and hospices, the plans are required to pay those designated providers at a rate set by the AHCA.

Of those recipients enrolled in the LTC waiver, 47,646 recipients are receiving home and community based services (HCBS) as of March 1, 2017. The remaining enrollees are receiving nursing facility services.[11]

| **Statewide Medicaid Managed Care - February 1, 2017** | | | |
|---|---|---|---|
| **Component** | **Enrollment Start Date** | **Budget[12]** | **Enrollment *(as of Mar. 2017)*** |
| Long-Term Care Plan | August 2013 | $3.97 billion | 94,803 |
| *Home & Community Based Services* | | | *47,646* |
| Managed Medical Assistance | May 2014 | $14.4 billion | 3,233,235 |

The LTC program provides services in two settings: nursing facilities or HCBS such as a recipient's home, an assisted living facility, or an adult family care home. Nursing facility services are an entitlement program for eligible enrollees and no waitlist exists; however, HCBS

[10] The current Managed Medical Assistance waiver is approved as an 1115 waiver and was last approved for the time period of July 31, 2014 through June 30, 2017. The Long-Term Care Managed Care waiver is approved as a section 1915(b) and section 1915(c) combination waiver and was most recently approved through December 27, 2021 by the federal Centers for Medicare and Medicaid Services.
[11] Agency for Health Care Admin., *SMMC MMA Enrollment by County by Plan* (as of March 1, 2017), *http://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml* (last visited April 7, 2017).
[12] Agency for Health Care Admin., *Statewide Medicaid Managed Care (Presentation to House Health and Human Services Committee - Jan. 10, 2017)*, slide 2, http://ahca.myflorida.com/medicaid/recent_presentations/House_Health_Human_Services_Med_101_2017-01-10.pdf (last visited Mar. 1, 2017).

are delivered through waivers and are dependent on the availability of annual funding in the general appropriations act (GAA), and there are 43,195 on the waitlist as of April 3, 2017.

Enrollment in the HCBS portion of LTC is managed based on a priority system and wait list. For the 2016-2017 waiver year, the state is approved for 62,500 unduplicated recipients in the HCBS portion of the program.[13] In order to be eligible for the program, a recipient must be both clinically eligible as required under s. 409.979, F.S., and financially eligible for Medicaid.

***Eligibility and Enrollment***

The AHCA is the single state agency for Medicaid; however, through an interagency agreement with the Department of Elderly Affairs (DOEA), the DOEA is Florida's federally mandated pre-admission screening program for nursing home applicants through its Long-Term Care Services (CARES) program, including for LTC.[14] The CARES program has 18 field offices across the state, which are staffed with physicians, nurses, and other health care professionals who evaluate the level of care an individual may or may not need. The frailty-based assessment results in a priority score for an individual, who is then placed on the wait list based on his or her priority score.

To receive nursing facility care, an individual must also be determined to meet the requirements of s. 409.985(3), F.S. This subsection requires:

> The CARES program shall determine if an individual requires nursing facility care and, if the individual requires such care, assign the individual to a level of care as described in s. 409.983(4), F.S. When determining the need for nursing facility care, consideration shall be given to the nature of the services prescribed and which level of nursing or other health care personnel meets the qualifications necessary to provide such services and the availability to and access by the individual of community or alternative resources. For the purposes of the long-term care managed care program, the term "nursing facility care" means the individual:
>
> (a) Requires nursing home placement as evidenced by the need for medical observation throughout a 24-hour period and care required to be performed on a daily basis by, or under the direct supervision of, a registered nurse or other health care professional and requires services that are sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse because of a mental or physical incapacitation by the individual;
>
> (b) Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and

[13] Letter from U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services to Beth Kidder, Deputy Secretary for Medicaid, Agency for Health Care Administration (December 19, 2016), http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/LTC_Approval_Letter_2016-12-19.pdf (last visited Mar. 1, 2017).

[14] Florida Dep't of Elder Affairs, *Comprehensive Assessment and Review for Long-Term Care Services (CARES)*, http://elderaffairs.state.fl.us/doea/cares.php (last visited Mar. 1, 2017).

> care and the constant availability of medical and nursing treatment and requires services on a daily or intermittent basis that are to be performed under the supervision of licensed nursing or other health professionals because the individual is incapacitated mentally or physically; or
>
> (c) Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and care and the constant availability of medical and nursing treatment and requires limited services that are to be performed under the supervision of licensed nursing or other health professionals because the individual is mildly incapacitated mentally or physically.

Individuals are released from the wait list periodically, based on the availability of funding and their priority scores. The Legislature has specifically directed funding in the past several years through the GAA to serve elders off the waitlist who have a priority score of four or higher.[15] Individuals who are more frail or have an immediate need for services receive a higher rank on the waitlist. Those who have resided in a nursing facility for more than 60 days receive priority enrollment into the HCBS portion of the program. Exemptions from the wait list also exist under s. 409.979(3)(f), F.S. Those exempted individuals include:

- Persons who are 18, 19, or 20 years of age who have a chronic, debilitating disease or condition of one or more physiological or organ systems which generally make the individual dependent upon 24-hour-per-day medical, nursing, or health supervision, or intervention;
- Nursing facility residents who request to transition into the community and who have resided in a Florida-licensed skilled nursing facility for at least 60-consecutive days; or
- Persons referred by the DCF pursuant to the Adult Protective Services, ss. 415.101-415.113, F.S., as high risk and who are placed in an assisted living facility temporarily funded by the DCF.

Before being released from the waitlist, however, individuals must meet the following eligibility requirements to enroll in the program:[16]

- Be age 65 years or older or age 18 and eligible for Medicaid by reason of a disability; and
- Be determined by the CARES preadmission screening program to require nursing facility care as defined in s. 409.985(3), F.S.

Some individuals who are enrolled in waiver programs or other coverages may enroll in the LTC program, but are not required to, and those are:

- Developmental Disabilities waiver program;
- Traumatic Brain and Spinal Cord Injury waiver;
- Project AIDS Care (PAC) waiver;
- Adult Cystic Fibrosis waiver;
- Program of All-Inclusive Care for the Elderly (PACE);
- Familial Dysautonomia waiver;
- Model waiver; or

[15] *See* Ch. Law 2016-66, line item 232; Ch. Law 2015-232, line item 226; and Ch. Law 2014-51, line item 242. In state fiscal year 2013-14, the GAA provided funding during first year of the LTC program for those on the wait list with priority scores of 5 or higher. (Ch. Law 2013-40, line item 414).
[16] *See* s. 409.979, F.S.

- Other creditable coverage excluding Medicare.[17]

Individuals, both those who are enrolled in LTC and those on the wait list, must be re-screened at least annually or whenever there is a significant change in circumstances, such as change in caregivers or medical condition.[18]

***Delivery System and Benefits***

The AHCA conducted a competitive procurement to select LTC plans in each of the 11 regions in 2012. Contracts were awarded to health maintenance organizations (HMOs) and provider service networks (PSNs). Six non-specialty plans are currently contracted, including one PSN that is available in all 11 regions and one HMO that is in 10 regions. Recipients receive choice counseling services to assist them in selecting the plan that will best meet their needs.

Each plan under LTC is required to provide a minimum level of services. These services include:

- Adult companion care;
- Adult day health care;
- Assisted living;
- Assistive care services;
- Attendant care;
- Behavioral management;
- Care coordination and case management;
- Caregiver training;
- Home accessibility training;
- Home-delivered meals;
- Homemaker;
- Hospice;
- Intermittent and skilled nursing;
- Medical equipment and supplies;
- Medication administration;
- Medicaid management;
- Nursing facility;
- Nutritional assessment/risk reduction;
- Personal care;
- Personal emergency response system;
- Respite care;
- Therapies; and
- Non-emergency transportation.[19]

An LTC plan may elect to offer expanded benefits to its enrollees. Some of the approved expanded benefits within LTC include:

---

[17] *See* s. 409.972, F.S.
[18] Application for §1915(c) Home and Community-Based Services Waiver (Effective July 1, 2013), pp. 45-46, http://www.fdhc.state.fl.us/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/mma/LTC_1915c_Application.pdf (last visited Mar. 1, 2017).
[19] *See* s. 409.98, F.S.

- Cellular phone service;
- Dental services;
- Emergency financial assistance;
- Hearing evaluation;
- Mobile personal emergency response system;
- Non-medical transportation;
- Over-the-counter medication and supplies;
- Support to transition out of a nursing facility;
- Vision services; and
- Wellness grocery discount.[20]

LTC enrollees who are not eligible for Medicare also receive their medical services through an MMA plan. Some plans participate in both components in the same regions, and a recipient may choose the same managed care plan for both components, known as a comprehensive plan.

The AHCA's contract with the LTC plans include a statutorily required incentive payment adjustment to encourage increased utilization of HCBS services and a matching reduction in nursing facility placements. The incentive adjustment must be modified in each successive rate period in accordance with s. 409.983, F.S., as follows:

> (5) The agency shall make an incentive adjustment in payment rates to encourage the increased utilization of home and community-based services and commensurate reduction of institutional placement. The incentive adjustment shall be modified in each successive rate period during the first contract period, as follows:
> (a) A 2-percentage point shift in the first rating-setting period;
> (b) A 2-percentage point shift in the second rate-setting period, as compared to the utilization mix at the end of the first rate-setting period; or
> (c) A 3-percentage point shift in the third rate-setting period, and in each successive rate setting period during the first contract period, as compared to the utilization mix at the end of the immediately preceding rate-setting period.
>
> The incentive adjustment shall continue in subsequent contract periods, at a rate of three percentage points per contract year as compared to the utilization mix at the end of the immediately preceding rate-setting period, until no more than 35 percent of the plan's enrollees' are placed in institutional settings. The agency shall annually report to the Legislature the actual change in the utilization mix of home and community-based services compared to institutional placements and provide a recommendation for utilization mix requirements for future contracts.

During the first year of the LTC program, the AHCA reports a 12.1 percent decrease in the number of Medicaid recipients residing in a nursing facility.[21]

---

[20] Agency for Health Care Administration, MMA - Model Contract - Attachment I - Scope of Services (effective date Feb. 1, 2017) pp. 4-6, http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2017-02-01/02-01-17_MODEL_Attachment_I-Scope_of_Services.pdf (last visited Feb. 1, 2017).
[21] Agency for Health Care Adm., *Senate Bill 682 Analysis* (Feb. 13, 2017) (on file with Senate Committee on Health Policy).

**Reprocurement of the SMMC Contracts**

The AHCA has started the process for the re-procurement of the managed care contracts for the SMMC program. The contracts were initially procured in 2012 and became effective in 2013 as 5-year contracts. An invitation to negotiate (ITN) will be released in the summer of 2017.[22] The AHCA posted a request to receive non-binding Letters of Intent to Bid on its website with a deadline of February 13, 2017. The AHCA received 41 total responses from interested providers and plans for the ITN.[23] The databook will be posted to AHCA's website on March 30, 2017, and a public meeting to review the databook with the AHCA's contracted actuary is scheduled for April 12, 2017.

**Americans with Disabilities Act**

In June of 2009, the United States Supreme Court held that public entities must provide community-based services to persons with disabilities when such services would be appropriate; when affected persons are not opposed to such treatments; and when such services can be reasonably accommodated. To not provide the opportunity for persons with disabilities to receive services in the community constitutes discrimination in violation of Title II of the Americans with Disabilities Act (ADA).[24]

The *Olmstead* decision is further supported through federal regulation, which states:

> No qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subject to discrimination by any public entity.[25]

The Department of Justice's (DOJ) Civil Rights Division has conducted more than 40 *Olmstead* review cases in 25 states from 2009 to 2012, including cases in Florida.[26] Intervention from the DOJ may come through two different forms: A statement of interest where the DOJ intervenes in an existing lawsuit, but is not a party, or secondly, the DOJ investigates allegations and issues a letter of findings and a settlement agreement. A DOJ investigation or intervention may also result in litigation to enforce a mandate.[27]

In July 2013, the federal DOJ filed a lawsuit against the State of Florida alleging that the state had failed to move nearly 200 disabled children from nursing homes and institutional care to less

---

[22] Agency for Health Care Administration, *AHCA Announces Start of Re-Procurement Process for Statewide Medicaid Managed Care Program* (Feb. 3, 2017) http://ahca.myflorida.com/Executive/Communications/Press_Releases/pdf/ReprocurementPressRelease.pdf (last visited: Mar. 21, 2017).

[23] Agency for Health Care Administration, *Statewide Medicaid Managed Care Program Non-Binding Letters of Intent Received by 2/13/2017, in response to Intent to Bid Posted 2/3/2017,* http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Intent_to_Bid_Responses.pdf (last visited Mar. 21, 2017).

[24] Olmstead v. L.C., 527 U.S. 581(1999);138 F.3d 893, affirm in part, vacated, and remanded.

[25] 28 CFR section 35.130(a) (2016).

[26] MaryBeth Musumeci and Henry Claypool, KFF.org, *Olmstead's Role in Community Integration for People with Disabilities under Medicaid: 15 Years after the Supreme Court's Olmstead's Decision* (June 18, 2014) http://kff.org/report-section/olmsteads-role-in-community-integration-for-people-with-disabilities-under-medicaid-issue-brief (last visited Mar. 3, 2017).

[27] *Id.*

restrictive environments in violation of the ADA.[28] The complaint included other allegations relating to the state's policies, procedures, reimbursement levels, method of service denials, and network capacity issues in its programs for children with significant medical needs.

A previous December 2011, investigation by the DOJ is detailed in the complaint, including notice that the parties met on several occasions to attempt resolution of the issues.[29] The DOJ complaint sought a declaratory judgement that the state had violated Title II of the ADA, to award compensatory damages, and any other relief as the court may find appropriate.[30] The case has been consolidated with a private lawsuit against the state alleging similar issues, that the state's practices and policies have unnecessarily placed children with disabilities in nursing facilities or placed them at risk of placement in nursing facilities.[31] Litigation may also be brought by individuals to enforce a mandate.

The state has disputed the allegations in the DOJ complaint and argued that with the implementation of managed care and other policy changes in Medicaid, these issues are moot. The court has rejected these arguments thus far. Florida has most recently sought partial summary judgement to remove monetary damages as a legal remedy.[32]

Guidance from the federal CMS stresses that all waiver programs for long-term care support programs, such as LTC, "must be delivered in the most integrated fashion, in the most integrated setting, and in a way that offers the greatest opportunities for active community and workforce participation."[33] Consistency with the *Olmstead* decision is found in every "essential element" of the guidance document.

The CMS guidance document also indicates that states will be expected to incorporate all services into the managed care plan capitation payment and that any exemptions will require comprehensive justification of how the goals of integration, efficiency and improved health and quality of life will be achieved.[34] Exclusion of any services will require routine re-assessment to ensure no violations of any federal laws, including the ADA or *Olmstead* requirements.[35]

---

[28] *U.S. v. Florida*, No. 12-CV-60460, (SD. Fla., filed July 22, 2013).
[29] *U.S. v. Florida*, No. 12-CV-60460, (SD. Fla., filed July 22, 2013), 21.
[30] *Id.* at 23.
[31] U.S. Dep't of Justice, *Americans with Disabilities Act - Olmstead Enforcement,* https://www.ada.gov/olmstead/olmstead_cases_list2.htm#fla (last visited Mar. 3, 2017); *see A.R. v. Dudek*, No. 12-CV 60460 (S.D. Fla. 2012).
[32] U.S. Dep't of Justice, *Americans with Disabilities Act - Olmstead Enforcement,* https://www.ada.gov/olmstead/olmstead_cases_list2.htm#fla (last visited Mar. 3, 2017).
[33] Centers for Medicare and Medicaid Services, *Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs* (5/20/13), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf, p. 8, (last visited Mar. 3, 2017).
[34] *Id.* at 12.
[35] *Id.*

**Prompt Payment of Claims**

Florida's prompt pay laws govern payment of claims submitted to insurers and HMOs, including Medicaid managed care plans in accordance with ss. 641.315, 641.3155, and 641.513, F.S.[36] These provisions establish HMO provider contract requirements, prompt payment guidelines for provider payments, and requirements for the provision of emergency services and care for HMO enrollees. An HMO or insurer has 12 months after payment is made to a provider to make a claim for overpayment against the provider, if the provider is licensed under ch. 458, F.S., or ch. 459, F.S., (physicians), ch. 460, F.S., (chiropractors), ch. 461, F.S. (podiatrists), or ch. 466, F.S., (dentists). For all other types of providers, an insurer or HMO has up to 30 months after such payment to make a claim for overpayment, and a 40-day timeline for providers to pay, deny, or contest the claim for overpayment.[37] The law provides a process and timeline for providers to pay, deny, or contest the claim. Further, the law prohibits an insurer or HMO from retroactively denying a claim because of the ineligibility of an insured or subscriber more than one year after the date the claim is paid. The statutes do not include any provisions for the imposition of fines for non-compliance; however, the AHCA enforces these standards through the imposition of liquidated damages or sanctions, including fines.[38]

## III. Effect of Proposed Changes:

**Section 1** amends s. 400.141, F.S., effective October 1, 2018, to add a requirement for nursing home facilities to confirm for the AHCA whether a nursing home facility resident who is a Medicaid recipient, or whose Medicaid eligibility is pending, is a candidate for home and community-based services (HCBS) under s. 409.965(3)(c), no later than the resident's 50th consecutive day of residency in the nursing home facility. The nursing home facility's notice to the AHCA is to assist in the identification of nursing home residents who may be eligible for both HCBS and the LTC component.

**Section 2** amends s. 409.964, F.S., to remove obsolete dates relating to the submission of state plan amendments or waivers by a date certain, all of which have passed.

**Section 3** amends s. 409.965, F.S., to create a new exemption from mandatory enrollment in the LTC program. Effective October 1, 2018, the section exempts persons who are assigned into level of care 1 under s. 409.983(4), F.S., and have resided in a nursing facility for 60 or more consecutive days. The exemption shall become effective on the first day of the first month after the person meets the criteria for the exemption. An exemption under this section has no bearing on an individual's eligibility for the MMA program.

An exemption from mandatory participation in the LTC program is also created for recipients receiving hospice care while residing in a nursing facility. The exemption shall become effective

[36] The prompt pay provisions apply to HMO contracts and major medical policies offered by individual and group insurers licensed under ch. 624, F.S., including preferred provider policies and an exclusive provider organization, and individual and group contracts that only provide direct payments to dentists.
[37] Section 641.3155, F.S., provide exceptions to this time limit in cases relating to fraud.
[38] Agency for Health Care Administration, *Senate Bill 682 Analysis* (Feb. 2, 2017), p. 6, (on file with the Senate Committee on Health Policy).

on the first day of the first month after the person meets the criteria for the exemption. An exemption under this section has no bearing on an individual's eligibility for the MMA program.

The effect of these exemptions is that nursing homes and hospices will be paid on a fee-for-service basis from the AHCA for these Medicaid recipients rather than receiving payment from the managed care plans.

Notwithstanding the exemptions provided above, the agency shall authorize the enrollment or continued enrollment of a Medicaid recipient in or into the LTC program who:

- Is eligible for the LTC program under s. 409.979, F.S., is 18 years of age or older, and is eligible for Medicaid by reason of disability;
- A person who is given priority enrollment for HCBS under s. 409.979(3)(f), F.S., or
- A person who has been identified as a candidate for HCBS by the nursing facility administrator and any long-term care plan case manager assigned to the resident.

The identification of the resident as a candidate for HCBS must be made in consultation with:

- The resident or the resident's legal representative or designee;
- The resident's personal physician or, if the resident does not have a personal physician, the facility's medical director; and
- A registered nurse who has participated in developing, maintaining, or reviewing the indivdiual's resident care plan[39] as defined in s. 400.021, F.S.

Before determining that a nursing home resident is exempt from the long-term care managed care program, the agency is required to confirm whether the person has been identified as a candidate for HCBS services. If a nursing facility resident who has been identified as exempt is later identified as a candidate for HCBS, the nursing facility administrator must promptly notify the AHCA to ensure candidates are transitioned smoothly between programs, if appropriate.

**Section 4** amends s. 409.967, F.S., relating to managed care plan accountability, to direct the AHCA to impose fines, and to authorize the imposition of other sanctions on a plan that willfully fails to comply with the managed care plan accountability provisions of ss. 641.315 (provider contracts), 641.3155 (prompt payment of claims), 641.513 (requirements for providing emergency services and care), and the added cross-referenced provision, s. 409.928(5), F.S., (long-term care managed care plan accountability provisions).

**Section 5** amends s. 409.979, F.S., relating to the pre-requisite criteria for eligibility for enrollees in the LTC program. This section clarifies that only those Medicaid recipients who are not exempt under s. 409.965, F.S., and who meet all of the criteria under this section may be eligible to receive long-term care services by participating in the LTC program. The amended language aligns the eligibility with the modifications made in Section 2 of the bill.

[39] A resident care plan is a written plan which must be reviewed not less than quarterly by a registered nurse, with participation by other staff and the resident or his or her legal representative, which includes, a comprehensive assessment of the needs of an individual resident; the type and frequency of services required to provide the necessary care for the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being; a listing of services provided; and an explanation of goals.

**Section 6** amends s. 409.982, F.S., relating to provider networks of a long-term care managed care plan. This section requires the managed care plans to offer a network contract to all nursing homes and hospices for the first 12 months of a contract period in a region if that region was not served by that plan prior to the procurement, i.e., under the prior contract period. The nursing homes and hospices must meet the credentialing and recredentialing requirements specified in the plan's contract with the agency.

After the 12-month period, the plan may exclude any nursing home or hospice for failure to meet quality or performance standards; however, the plan must provide 30 days' written notice before the effective date to all affected recipients. If the plan excludes providers from its network or fails to renew a provider's contract, the AHCA must require a report from that plan which shows the quality or performance indicators used to exclude the provider and demonstrates how the provider failed to meet the plan's criteria.

**Section 7** provides that except as otherwise provided in this act, and except for this section, which shall take effect upon becoming a law, this act shall take effect July 1, 2017.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

The *Olmstead* decision requires the state to deliver services "in the most integrated setting appropriate to meet the needs of qualified individuals with disabilities." The requirement applies whether the state delivers those services using a managed care delivery system or fee-for-service process. However, as noted earlier, the federal CMS has also released guidance statements since that 1999 decision about the exclusion of services from managed care and how the agency will review those actions. Such action by states will receive strict scrutiny from federal CMS and require justification that services are still being rendered in the most integrated manner.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

This bill changes how services are delivered for the LTC component when the new contracts are effective under the invitation to negotiate which will be conducted this summer. Changes in the delivery of benefits may impact private providers that are currently providing services to recipients in the program now; however, that may have occurred regardless with any changeover in managed care contracts. There is no guarantee that the same providers will receive contracts in the same areas of the state.

The revisions to the prompt-pay section of the bill may impact the private sector to a larger degree if it results in providers and facilities receiving payment for services on a more expedient basis. The AHCA indicates that the statutes already permit the imposition of sanctions for noncompliance with the prompt pay requirements and that sanctions have been applied. A more aggressive enforcement effort may have been lacking due to the inability to determine from the available claims data that the prompt pay provision has been violated.

Requiring managed care plans to contract with all nursing facilities and hospices that meet credentialing requirements in an awarded region for 12 months following any new procurement for the LTC program may require the plans to contract with providers that they previously non-renewed or terminated 4-5 years ago. The AHCA indicates that this number of non-renewed or terminated providers is low.

C. Government Sector Impact:

The agency maintains the fiscal position from its analysis of the bill in its original form, despite the significant differences between the original bill and the committee substitute. The agency reports that the bill will have a significant fiscal impact on the Medicaid program, resulting in millions of dollars lost in cost avoidance. It is believed these estimates are significantly overstated, however. The agency indicates that by exempting nursing facility services for those meeting specified criteria from the LTC managed care program, costs will re-appear from the previous LTC program at an estimated additional cost of $200 million per year.

By contrast, however, the Florida Health Care Association estimates that by exempting nursing facility residents who have been in care over 60 days and meet specified criteria, avoidable costs related to case management ($31.3 million) and administrative expenses ($36.5 million) paid to managed care plans can be saved each year by the state.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

The PCS/CS/SB 682 includes a requirement for the long-term care managed care plans to offer a contract to all nursing homes and hospices in a region which meet the recredentialing or credentialing requirements of the plan’s contract with the AHCA if that

the region was not served by that plan after the most recent procurement. This language may be confusing as to which procurement process is the baseline for determining which nursing homes and hospices must be offered a contract and in which regions the mandatory contracting would be applicable. It may be better to reference those providers who did not have contracts immediately prior to the most recently concluded procurement process.

## VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.964, 409.965, 409.967, 409.979, and 409.982.

## IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

**Recommended CS/CS by Appropriations Subcommittee on Health and Human Services on April 13, 2017:**
Clarifying amendment that replaces language that states the region was not served by the plan after the most recent procurement, to the plan was not serving the regions immediately prior to the procurement in that region related to long-term managed care procurement.

**CS by Health Policy on March 27, 2017:**
The CS:

- Requires a nursing home to be prepared to confirm for the AHCA whether a nursing home resident, who is a Medicaid recipient or whose Medicaid eligibility is pending, is a candidate for HCBS, by the resident's 50th consecutive day of residency in the nursing home facility;
- Establishes the effective date for those exempted from the LTC managed care program;
- Provides that a nursing facility resident is not exempt from the LTC managed care program if the resident has been identified as a candidate for HCBS by the nursing facility administrator and any LTC case manager assigned to the resident;
- Establishes an identification and evaluation process for nursing facility residents for HCBS;
- Requires confirmation from the AHCA as to whether the person has been identified as a candidate for HCBS before a determination can be made that an individual is exempt from the LTC managed care program;
- Requires nursing facility administrators to promptly notify the AHCA of any exempt nursing home residents who have later been identified as candidates for HCBS; and
- Requires a plan to contract with all credentialed nursing homes and hospices if a new region is awarded under a new procurement cycle.

B. Amendments:

None.

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

625180

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 04/13/2017 | . | |
| | . | |
| | . | |
| | . | |

Appropriations Subcommittee on Health and Human Services (Stargel) recommended the following:

**Senate Amendment**

Delete lines 171 - 174

and insert:

care program under s. 409.981, if a plan has been ~~period between October 1, 2013, and September 30, 2014, each~~ selected for a region that the plan was not serving immediately prior to the procurement, the plan must offer a network contract to

**By** the Committee on Health Policy; and Senator Stargel

588-02955-17 2017682c1

A bill to be entitled

An act relating to Medicaid managed care; amending s. 400.141, F.S.; requiring that nursing home facilities be prepared to provide confirmation within a specified timeframe to the Agency for Health Care Administration as to whether certain nursing home facility residents are candidates for certain services; amending s. 409.964, F.S.; providing that covered services for long-term care under the Medicaid managed care program are those specified in part IV of ch. 409, F.S.; deleting an obsolete provision; amending s. 409.965, F.S.; providing that certain residents of nursing facilities are exempt from participation in the long-term care managed care program; providing for application of the exemption; providing that eligibility for the Medicaid managed medical assistance program is not affected by such provisions; providing conditions under which the exemption does not apply; requiring the agency to confirm whether certain persons have been identified as candidates for home and community-based services; requiring a certain notice to the agency by nursing facility administrators; amending s. 409.967, F.S.; requiring the agency to impose fines and authorizing other sanctions for willful failure to comply with specified payment provisions; amending s. 409.979, F.S.; providing that certain exempt Medicaid recipients are not required to receive long-term care services through the long-term care managed care program;



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



588-02955-17 2017682c1

amending s. 409.982, F.S.; revising parameters under which a long-term care managed care plan must contract with nursing homes and hospices; specifying that the agency must require certain plans to report information on the quality or performance criteria used in making a certain determination; providing effective dates.

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

Section 1. Effective October 1, 2018, paragraph (v) is added to subsection (1) of section 400.141, Florida Statutes, to read:

400.141 Administration and management of nursing home facilities.—

(1) Every licensed facility shall comply with all applicable standards and rules of the agency and shall:

(v) Be prepared to confirm for the agency whether a nursing home facility resident who is a Medicaid recipient, or whose Medicaid eligibility is pending, is a candidate for home and community-based services under s. 409.965(3)(c), no later than the resident's 50th consecutive day of residency in the nursing home facility.

Section 2. Section 409.964, Florida Statutes, is amended to read:

409.964 Managed care program; state plan; waivers.—The Medicaid program is established as a statewide, integrated managed care program for all covered services, including long-term care services as specified under this part. The agency



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

shall apply for and implement state plan amendments or waivers of applicable federal laws and regulations necessary to implement the program. Before seeking a waiver, the agency shall provide public notice and the opportunity for public comment and include public feedback in the waiver application. The agency shall hold one public meeting in each of the regions described in s. 409.966(2), and the time period for public comment for each region shall end no sooner than 30 days after the completion of the public meeting in that region. ~~The agency shall submit any state plan amendments, new waiver requests, or requests for extensions or expansions for existing waivers, needed to implement the managed care program by August 1, 2011.~~

Section 3. Effective October 1, 2018, section 409.965, Florida Statutes, is amended to read:

409.965 Mandatory enrollment.—All Medicaid recipients shall receive covered services through the statewide managed care program, except as provided by this part pursuant to an approved federal waiver.

(1) The following Medicaid recipients are exempt from participation in the statewide managed care program:

(a) ~~(1)~~ Women who are eligible only for family planning services.

(b) ~~(2)~~ Women who are eligible only for breast and cervical cancer services.

(c) ~~(3)~~ Persons who are eligible for emergency Medicaid for aliens.

(2)(a) Persons who are assigned into level of care 1 under s. 409.983(4) and have resided in a nursing facility for 60 or more consecutive days are exempt from participation in the long-





term care managed care program. For a person who becomes exempt under this paragraph while enrolled in the long-term care managed care program, the exemption shall take effect on the first day of the first month after the person meets the criteria for the exemption. This paragraph does not affect a person's eligibility for the Medicaid managed medical assistance program.

(b) Persons receiving hospice care while residing in a nursing facility are exempt from participation in the long-term care managed care program. For a person who becomes exempt under this paragraph while enrolled in the long-term care managed care program, the exemption takes effect on the first day of the first month after the person meets the criteria for the exemption. This paragraph does not affect a person's eligibility for the Medicaid managed medical assistance program.

(3) Notwithstanding subsection (2):

(a) A Medicaid recipient who is otherwise eligible for the long-term care managed care program, who is 18 years of age or older, and who is eligible for Medicaid by reason of a disability is not exempt from the long-term care managed care program under subsection (2).

(b) A person who is afforded priority enrollment for home and community-based services under s. 409.979(3)(f) is not exempt from the long-term care managed care program under subsection (2).

(c) A nursing facility resident is not exempt from the long-term care managed care program under paragraph (2)(a) if the resident has been identified as a candidate for home and community-based services by the nursing facility administrator and any long-term care plan case manager assigned to the

resident. Such identification must be made in consultation with the following persons:

1. The resident or the resident's legal representative or designee;

2. The resident's personal physician or, if the resident does not have a personal physician, the facility's medical director; and

3. A registered nurse who has participated in developing, maintaining, or reviewing the individual's resident care plan as defined in s. 400.021.

(d) Before determining that a person is exempt from the long-term care managed care program under paragraph (2)(a), the agency shall confirm whether the person has been identified as a candidate for home and community-based services under paragraph (c). If a nursing facility resident who has been determined exempt is later identified as a candidate for home and community-based services, the nursing facility administrator shall promptly notify the agency.

Section 4. Paragraph (j) of subsection (2) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(j) *Prompt payment.*—Managed care plans shall comply with ss. 641.315, 641.3155, and 641.513, and the agency shall impose fines, and may impose other sanctions, on a plan that willfully fails to comply with those sections or s. 409.982(5).





Section 5. Subsection (1) of section 409.979, Florida Statutes, is amended to read:

409.979 Eligibility.—

(1) PREREQUISITE CRITERIA FOR ELIGIBILITY.—Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and, unless exempt under s. 409.965, must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) preadmission screening program to require nursing facility care as defined in s. 409.985(3).

Section 6. Subsections (1) and (2) of section 409.982, Florida Statutes, are amended to read:

409.982 Long-term care managed care plan accountability.—In addition to the requirements of s. 409.967, plans and providers participating in the long-term care managed care program must comply with the requirements of this section.

(1) PROVIDER NETWORKS.—Managed care plans may limit the providers in their networks based on credentials, quality indicators, and price. For the first 12 months of a contract period following a procurement for the long-term care managed care program under s. 409.981, if a plan is ~~period between October 1, 2013, and September 30, 2014, each~~ selected for a region and that region was not served by the plan after the most recent procurement, the plan must offer a network contract to

all nursing homes in that region which meet the recredentialing requirements and to all hospices in that region which meet the credentialing requirements specified in the plan's contract with the agency ~~the following providers in the region:~~

~~(a) Nursing homes.~~

~~(b) Hospices.~~

~~(c) Aging network service providers that have previously participated in home and community-based waivers serving elders or community-service programs administered by the Department of Elderly Affairs~~. After a provider specified in this subsection has actively participated in a managed care plan's network for 12 months ~~of active participation in a managed care plan's network~~, the plan may exclude the provider ~~any of the providers named in this subsection~~ from the plan's network for failure to meet quality or performance criteria. If a ~~the~~ plan excludes a provider from its network under this subsection ~~the plan~~, the plan must provide written notice to all recipients who have chosen that provider for care. The notice must be provided at least 30 days before the effective date of the exclusion. The agency shall establish contract provisions governing the transfer of recipients from excluded residential providers. The agency shall require a plan that excludes a provider from its network or that fails to renew the plan's contract with a provider under this subsection to report to the agency the quality or performance criteria the plan used in deciding to exclude the provider and to demonstrate how the provider failed to meet those criteria.

(2) SELECT PROVIDER PARTICIPATION.—Except as provided in this subsection, providers may limit the managed care plans they





join. Nursing homes and hospices that are enrolled Medicaid providers must participate in all eligible plans selected by the agency in the region in which the provider is located, with the exception of plans from which the provider has been excluded under subsection (1).

Section 7. Except as otherwise provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect July 1, 2017.

# THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

**COMMITTEES:**
Appropriations Subcommittee on Finance and Tax, *Chair*
Appropriations Subcommittee on Health and Human Services, *Vice Chair*
Appropriations
Children, Families, and Elder Affairs
Communications, Energy, and Public Utilities
Military and Veterans Affairs, Space, and Domestic Security

**SENATOR KELLI STARGEL**
22nd District

March 28, 2017

The Honorable Anitere Flores
Senate Appropriations Subcommittee on Health and Human Services, Chair
201 The Capitol
404 S. Monroe Street
Tallahassee, FL 32399

Dear Chair Flores:

I respectfully request that the following bills be placed on the next committee agenda:

- SB 682, related to *Medicaid Managed Care*.
- SB 780, related to *Adoption Benefits*; the House companion is in its third committee.

Thank you for your consideration and please do not hesitate to contact me should you have any questions.

Sincerely,

Kelli Stargel
State Senator, District 22

Cc: Phil Williams/ Staff Director
Robin Jackson/ AA

REPLY TO:
❒ 2033 East Edgewood Drive, Suite 1, Lakeland, Florida 33803
❒ 322 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5022

Senate's Website: *www.flsenate.gov*

**JOE NEGRON**
**President of the Senate**

**ANITERE FLORES**
**President Pro Tempore**

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

4/13/17
*Meeting Date*

1082
*Bill Number (if applicable)*

Topic Medicaid Managed care

*Amendment Barcode (if applicable)*

Name Geoff Fraser

Job Title Senior Vice President

Address 4200 S. Tropical Trail
*Street*

Merritt Island FL 32952
*City* *State* *Zip*

Phone 321-288-0171

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Clear Choice Health Care

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)

4/13/17
*Meeting Date*

682
*Bill Number (if applicable)*

Topic Medicaid Managed Care

*Amendment Barcode (if applicable)*

Name Ron Reid

Job Title Administrator

Address 2255 Centerville Rd
*Street*
Tallahassee FL 32308
*City* *State* *Zip*

Phone 850-525-0447

Email rreid@centrepointerehab.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Centre Pointe Health & Rehab

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)

Meeting Date

1082
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Medicaid Managed Care

Name Deborah Franklin

Job Title Senior Director of Quality

Address 307 West Park Ave
Street

Phone 850-224-3907

TLH FL 32301
City State Zip

Email dfranklin@fhca.org

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Health Care 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.*

***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.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

| | |
|---|---|
| BILL: | PCS/SB 916 (188616) |
| INTRODUCER: | Appropriations Subcommittee on Health and Human Services and Senator Grimsley |
| SUBJECT: | Statewide Medicaid Managed Care Program |
| DATE: | April 17, 2017 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Lloyd | Stovall | HP | **Favorable** |
| 2. | Forbes | Williams | AHS | **Recommend: Fav/CS** |
| 3. | | | AP | |
| 4. | | | RC | |

## I. Summary:


PCS/SB 916 modifies the Statewide Medicaid Managed Care program (SMMC) and deletes obsolete provisions from the implementation of the program. The bill specifically:

- Deletes the fee-for-service reimbursement option for provider service networks (PSNs);
- Revises the requirements for the contents of the databook used for rate setting to be consistent with actuarial rate-setting practices and standards;
- Collapses regions, re-groups counties within new regions, and revises the plan limitations within the regions for the procurement process for the Medicaid Managed Medical Assistance (MMA) and Long-Term Care (LTC) components; and
- Removes obsolete provisions.

The bill has no impact on state revenues or expenditures.

The effective date of the bill is July 1, 2017.


## II. Present Situation:

### Florida Medicaid

The Medicaid program is a partnership between the federal and state governments to provide medical care to low income pregnant women, children and disabled persons. 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 state plan outlines Medicaid eligibility standards, policies, and reimbursement methodologies.

Florida Medicaid serves as the safety net to Florida's healthcare delivery system. Medicaid currently is the second largest expenditure in Florida's budget behind education and covers 20 percent of all Floridians, including:

- 47 percent of Florida's children;
- 63 percent of Florida's births; and
- 61 percent of Florida's nursing home days.[1]

However, Florida Medicaid does not cover all low-income Floridians. The maximum income limits for programs are illustrated below as a percentage of the federal poverty level (FPL).

**Florida's Current Medicaid and CHIP Eligibility Levels in Florida[2]**
(With Income Disregards and Modified Adjusted Gross Income)

| Children's Medicaid | | | CHIP (Kidcare) | Pregnant Women | Parents Caretaker Relatives | Childless Adults |
|---|---|---|---|---|---|---|
| Age 0-1 | Age 1-5 | Age 6-18 | Ages 0-18 | | | |
| 206% FPL | 140% FPL | 133% FPL | 210% FPL | 191% FPL | 31% FPL | 0% FPL |

Florida Medicaid is administered by the AHCA and is financed with federal and state funds. The Department of Children and Families (DCF) determines Medicaid eligibility and transmits that information to the AHCA. As the single state agency for Medicaid, the AHCA has the lead responsibility for the overall program.[3]

Applicants for Medicaid must be United States citizens or qualified noncitizens, must be Florida residents, and must provide social security numbers for data matching. While self-attestation is permitted for a number of data elements on the application, most components are matched through the Federal Data Services Hub.[4] Applicants must also agree to cooperate with Child Support Enforcement during the application process.[5]

The structures of state Medicaid programs vary from state to state, and each state's share of expenditures varies and is largely determined by the federal government. Federal law and regulations set the minimum amount, scope, and duration of services offered in the program, among other requirements. State Medicaid benefits 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).

---

[1] Agency for Health Care Admin., Senate Health and Human Services Appropriations Subcommittee Presentation, *Agency for Health Care Administration - Florida Medicaid* (January 11, 2017), slide 2, http://www.flsenate.gov/PublishedContent/Committees/2016-2018/AHS/MeetingRecords/MeetingPacket_3554.pdf (last visited Mar. 14, 2017).
[2] U.S. Centers for Medicare and Medicaid Services, Medicaid.gov, *Florida*, http://www.medicaid.gov/medicaid-chip-program-information/by-state/florida.html (last visited Mar. 14, 2017).
[3] *See* s. 409.963, F.S.
[4] Florida Dep't of Children and Families, *Family-Related Medicaid Programs Fact Sheet*, p. 3 (April 2016), http://www.dcf.state.fl.us/programs/access/docs/Family-RelatedMedicaidFactSheet.pdf (last visited Mar. 15, 2017).
[5] Id.

Minimum eligibility coverage thresholds are established in federal law for certain population groups, such as children, as well as minimum benefits and maximum cost sharing. The minimum benefits include items such as physician services, hospital services, home health services, and family planning.[6] States can add benefits, pending federal approval. Florida has added benefits, including prescription drugs, adult dental services, and dialysis.[7] For children under age 21, the benefits must include the Early and Periodic Screening, Diagnostic and Treatment services, which are those health care and diagnostic services and treatment and measures that may be needed to correct or ameliorate defects or physical and mental illnesses and conditions discovered by screening services, consistent with federal law.[8]

Waivers to the state plan may be requested and negotiated by the state through the federal Centers for Medicare and Medicaid Services (CMS) by the AHCA. Florida has several such Medicaid waivers, including one that implemented the Statewide Medicaid Managed Care (SMMC) program. Current federal law requires the state to obtain a waiver to implement managed care. Through these waivers, the states have limited flexibility to design their Medicaid programs; however, even within waiver authorities, federal regulations prescribe requirements for benefits, delivery systems, cost sharing limitations, and population coverages.

***Statewide Medicaid Managed Care (SMMC)***

The SMMC program is currently designed for the AHCA to issue invitations to negotiate (ITN) and competitively procure 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. The 11 regions reflect areas that were initially set by the original Department of Health and Rehabilitative Services which was re-organized and downsized into several smaller agencies in the 1990s.

The SMMC has two components: managed medical assistance (MMA) and long-term care managed care (LTC). The MMA waiver expires on June 30, 2017, and the LTC waiver was recently extended through December 27, 2021.[9]

The LTC component began enrolling in August 2013 and completed its statewide roll-out in March 2014. The MMA component began enrolling Medicaid recipients in May 2014 and finished its roll-out in August 2014. These contracts will be re-procured in 2017 with contract execution and implementation expected during the last part of 2018, according to the AHCA.

The chart below shows the enrollment in each of these components as of March 1, 2017:

[6] Section 409.905, F.S.
[7] Section 409.906, F.S.
[8] *See* Section 1905 9(r) of the Social Security Act.
[9] The current Managed Medical Assistance waiver is approved as an 1115 waiver and was last approved for the time period of July 31, 2014 through June 30, 2017. The Long-Term Care Managed Care waiver is approved as a section 1915(b) and section 1915(c) combination waiver and was most recently approved through December 27, 2021 by the federal Centers for Medicare and Medicaid Services.

| Statewide Medicaid Managed Care - March 2017 | | | |
|---|---|---|---|
| **Component** | **Enrollment Start Date** | **Budget[10]** | **Enrollment[11] *(as of Mar. 2017)*** |
| Long-Term Care Plan | August 2013 | $3.97 billion | 94,803 |
| Managed Medical Assistance | May 2014 | $14.4 billion | 3,233,235 |

The LTC program provides services in two settings: nursing facilities or home and community based services (HCBS) such as a recipient's home, an assisted living facility, or an adult family care home. Nursing facility services are an entitlement program for eligible enrollees and no waitlist exists; however, HCBS are delivered through waivers and are dependent on the availability of annual funding in the general appropriations act (GAA).

Enrollment in the HCBS portion of LTC is managed based on a priority system and wait list. For the 2016-2017 waiver year, the state is approved for 62,500 unduplicated recipients in the HCBS portion of the program.[12] In order to be eligible for the program, a recipient must be both clinically eligible as required under s. 409.979, F.S., and financially eligible for Medicaid under s. 409.904, F.S.

***Eligibility and Enrollment***

The AHCA is the single state agency for Medicaid; however through an interagency agreement with the Department of Elderly Affairs (DOEA), the DOEA is Florida's federally mandated pre-admission screening program for nursing home applicants through its Long-Term Care Services (CARES) program, including for the LTC component.[13] The frailty-based assessment results in a priority score for an individual, who is then placed on the wait list based on his or her priority score.

Individuals are released from the wait list periodically, based on the availability of funding and their priority scores. The Legislature has specifically directed funding in the past several years through the GAA to serve elders off the waitlist who have a priority score of 4 or higher.[14] Individuals who are more frail or have an immediate need for services receive a higher rank on the waitlist. Those who have resided in a nursing facility for more than 60 days receive prior enrollment into the HCBS portion of the program. Exemptions from the wait list also exist under s. 409.979(3)(f), F.S.

---

[10] Agency for Health Care Admin., *Statewide Medicaid Managed Care (Presentation to House Health and Human Services Committee - Jan. 10, 2017)*, slide 2, http://ahca.myflorida.com/medicaid/recent_presentations/House_Health_Human_Services_Med_101_2017-01-10.pdf (last visited Mar. 14, 2017).

[11] Agency for Health Care Administration, *SMMC MMA Enrollment by County by Plan* (As of Mar. 1, 2017), http://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited Mar. 14, 2017).

[12] Letter from U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services to Beth Kidder, Interim Deputy Secretary for Medicaid, Agency for Health Care Administration (Dec. 19, 2016), *available at http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/LTC_Approval_Letter_2016-12-19.pdf* (last visited Mar. 14, 2017).

[13] Florida Dep't of Elderly Affairs, *Comprehensive Assessment and Review for Long-Term Care Services (CARES)*, http://elderaffairs.state.fl.us/doea/cares.php (last visited Mar. 14, 2017).

[14] *See* Ch. Law 2016-66, line item 232; Ch. Law 2015-232, line item 226; and Ch. Law 2014-51, line item 242. In state fiscal year 2013-14, GAA provided funding during first year of the LTCMC program for those on the wait list with priority scores of 5 or higher. (Ch. Law 2013-40, line item 414).

Individuals who are enrolled in the following programs may enroll in the LTC program, but are not required to:

- Developmental Disabilities waiver program;
- Traumatic Brain and Spinal Injury waiver;
- Project AIDS Care waiver;
- Adult Cystic Fibrosis waiver;
- Program of All-Inclusive Care for the Elderly (PACE);
- Familial Dysautonomia waiver; or
- Model waiver.[15]

Individuals, both those who are enrolled in LTC and those on the wait list, must be re-screened at least annually or whenever there is a significant change in circumstances, such as change in caregivers or medical condition.[16]

***Delivery System and Benefits***

The AHCA conducted a competitive procurement to select LTC and MMA plans in each of the 11 regions in 2012. Under the Invitation to Negotiate for MMA plans, the AHCA selected 10 different companies to serve as the health care delivery system. Of the plans selected, 11 of the awarded contracts went to general, non-specialty plans, of which five were PSNs.[17] Five different specialty plans and the Children's Medical Services plan were also awarded contracts.[18,19] Currently, MMA recipients receive services through 11 different managed care plans, of which two are PSNs.

In 2012, the AHCA awarded seven LTC contracts, including one statewide contract.[20] One of the original LTC contracts operated as a PSN; however, that plan is no longer participating in SMMC. The LTC services are now delivered through six managed care plans, which vary based on the recipient's region. Each region has at least two plans to allow for recipient choice. For nursing facilities and hospices, the plans are required to pay those designated providers a rate set by the AHCA. All six of the LTC plans also participate in the MMA program.

In addition to these plans, there are six specialty plans that serve unique populations: Children's Medical Services for children with chronic conditions; two plans for individuals with HIV/AIDS; a plan for child welfare enrollees; a plan for recipients eligible for both Medicaid and Medicare

---

[15] *Id.*

[16] Application for §1915(c) Home and Community-Based Services Waiver (Effective July 1, 2013), pp. 45-46, http://www.fdhc.state.fl.us/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/mma/LTC_1915c_Application.pdf (last visited Mar. 15, 2017).

[17] Agency for Health Care Admin., *Florida Managed Medical Assistance Program - 1115 Research and Demonstration Waiver (3rd Quarter Progress Report: January 1, 2014 - March 31, 2014),* p. 15, (on file with the Senate Committee on Health Policy).

[18] *Id.*

[19] Agency for Health Care Administration, *Medicaid and Managed Care* (Sept. 3, 2014), http://ahca.myflorida.com/Medicaid/recent_presentations/Child_Protection_Summit_2014-09-03.pdf (last visited Mar. 20, 2017).

[20] Agency for Health Care Administration, *Statewide Medicaid Managed Care Update* (Oct. 8, 2013) (on file with the Senate Committee on Health Policy).

with chronic conditions, such as diabetes or congestive heart failure; and a plan for individuals with serious mental illness. Recipients in both components of the program receive choice counseling services to assist them in selecting the plan that will best meet their needs.

The total enrollment in the specialty plans as of March 1, 2017 is shown in the chart below:[21]

| **Specialty Plan Enrollment - March 2017** | |
|---|---|
| **Component** | **Enrollment ( As of March 1, 2017)** |
| Child Welfare Plan | 31,810 |
| Specialty Plans (Capitated) | 78,842 |
| Children's Medical Services Network | 50,924 |
| **Total:** | **161,576** |

The managed care plans under both components are required to cover a minimum level of benefits as prescribed under s. 409.973, F.S., for the MMA plans, and s. 409.98, F.S., for the LTC plans. However, the statutes also permit the plans to offer an expanded menu of optional benefits.

| **Mandatory Benefits - Statewide Medicaid Managed Care** | |
|---|---|
| **Managed Medical Assistance** | **Long-Term Care** |
| Advanced registered nurse practitioner services | Nursing facility care |
| Ambulatory surgical treatment center services | Services provided in assisted living facility |
| Birthing center services | Hospice |
| Chiropractic services | Adult day care |
| Dental services | Medical equipment and supplies, including incontinence supplies |
| Early periodic screening diagnostic and treatment services for recipients under age 21 | Personal care |
| Emergency services | Home accessibility adaption |
| Family planning services and supplies | Behavior management |
| Healthy Start services (with exceptions) | Home-delivered meals |
| Hearing services | Case management |
| Home health agency services | Therapies |
| Hospice services | Occupational therapy |
| Hospital inpatient services | Speech therapy |
| Hospital outpatient services | Respiratory therapy |
| Laboratory and imaging services | Physical therapy |
| Medical supplies, equipment, prostheses, and orthoses | Intermittent and skilled nursing |
| Mental health services | Medication administration |
| Nursing care | Medication management |
| Optical services and supplies | Nutritional assessment and risk reduction |

[21] Agency for Health Care Administration, SMMC MMA Specialty Capitated Enrollment Report (As of Mar. 1, 2017).

| Mandatory Benefits - Statewide Medicaid Managed Care | |
|---|---|
| **Managed Medical Assistance** | **Long-Term Care** |
| Optometrist services | Caregiver training |
| Physical, occupational, respiratory, and speech therapy services | Respite care |
| Physician services, including physician assistant services | Transportation |
| Podiatric services | Personal emergency response system |
| Prescription drugs | |
| Renal dialysis services | |
| Respiratory equipment and supplies | |
| Rural health clinic services | |
| Substance abuse treatment services | |
| Transportation to access covered services | |

The LTC enrollees who are not eligible for Medicare also receive their medical services through an MMA plan. Some plans participate in both components in the same regions, and a recipient may elect the same managed care plan for both components. These plans are referred to as comprehensive plans.

***Provider Service Networks***

The payment design of the SMMC was intended to facilitate a smooth transition from a mix of fee-for-service, primary care case management, and managed care delivery to a statewide system of Medicaid managed care. The statute permitted the PSNs to be reimbursed on a fee-for-service or prepaid basis, but only for the first two years of the plan's operation or until the contract year beginning September 1, 2014, whichever is later. The AHCA is required to conduct cost reconciliations for the fee-for-service PSNs to determine cost reconciliations. All other managed care plans under SMMC are paid on a capitated basis meaning that a plan must pay for all covered services under the contract regardless of whether the capitated rate covers the cost of services for that recipient.

During the procurement process, at least one of the contract awards must be to a PSN if any PSNs submit a responsive bid. However, the AHCA must also issue an additional ITN following the end of a procurement, only for provider service networks, in those regions where no provider service networks submitted a responsive bid.

## III. Effect of Proposed Changes:

**Provider Service Networks (Sections 1, 3, 4, 6, 7, and 8)**

The bill removes the option for PSNs, under both the MMA and LTC components, to be reimbursed on a fee-for-service basis. Prepaid PSNs shall be reimbursed only on a per-member, per month basis. Currently, PSNs could elect to receive payments for the first 2 years of a contract or until the contract year beginning September 1, 2014, whichever is later, under fee-for-service or on a capitated basis. The bill also deletes provisions relating to quality selection criteria specific to savings under PSNs, which are calculated under fee-for-service rates.

The reconciliation and cost savings review process sections relating to the PSN fee-for-service payment process are deleted from the MMA and LTC sections of the SMMC program. Provisions relating to how the cost reconciliations shall be conducted and the reconciliation deadline are removed to correspond to the removal of those now obsolete provisions.

The ITN process for both the MMA and LTC components is modified to no longer require the AHCA to conduct a separate procurement process within 12 months of the initial procurement process if no PSN is selected during the initial procurement.

**Managed Care Plan Selection (Sections 3, 6, and 8)**

The bill modifies the AHCA's responsibilities for compiling and publishing a databook as part of the ITN process to require a comprehensive set of utilization and spending data that is consistent with actuarial rate-setting practices and standards. The modification eliminates specific requirements that the data include the three most recent contract years for all Medicaid recipients by region or county. The source of the data in the databook report must include the most recent 24 months of validated data from the Medicaid Encounter Data System. The health care delivery regions for both the MMA and LTC components are also collapsed and changed to letters from numbers. These modifications provide for administrative streamlining and will enhance plan stability through increased market share by the plans, according to the AHCA. Since the original regions were created in the 1990s, the AHCA believes these revised regions more accurately reflect the health care market and current utilization patterns.[22] The larger regions will also assist the AHCA in ensuring compliance with the access and appointment standards by the managed care plans as a wider choice of plans is likely to be available to recipients. The pooling of additional membership across the collapsed regions will likely draw more interested parties to some of the less populated areas of the state.

The table below shows the proposed re-groupings of counties and the minimum and maximum number of plans for the procurement. The same range of plan limitations apply for MMA and LTC.

[22] Agency for Health Care Administration, *Senate Bill 916 Analysis* (Feb. 24, 2017), p. 3, (on file with the Senate Committee on Health Policy).

| *Proposed Region Changes and Plan Limitations* | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| ***Current Region*** | ***Counties*** | ***Plan Min.*** | ***Plan Max.*** | ***New Region*** | ***Counties*** | ***Plan Min.*** | ***Plan Max.*** |
| ***1*** | *Escambia, Okaloosa, Santa Rosa, Walton* | *2* | *0* | ***A*** | *Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, Washington* | *3* | *4* |
| ***2*** | *Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, Washington* | *2* | *0* | ***B*** | *Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, Volusia* | *3* | *6* |
| ***3*** | *Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, Union* | *3* | *5* | ***C*** | *Hardee, Highlands, Hillsborough, Manatee, Pasco, Pinellas, Polk* | *5* | *10* |
| ***4*** | *Baker, Clay, Duval, Flagler, Nassau, St. Johns, Volusia* | *3* | *5* | ***D*** | *Brevard, Orange, Osceola, Seminole* | *3* | *6* |
| ***5*** | *Pasco, Pinellas* | *2* | *4* | ***E*** | *Charlotte, Collier, Desoto, Glades, Hendry, Lee, Sarasota* | *3* | *4* |
| ***6*** | *Hardee, Highlands, Hillsborough, Manatee, Polk* | *4* | *7* | ***F*** | *Indian River, Martin, Okeechobee, Palm Beach, St. Lucie* | *3* | *5* |
| ***7*** | *Brevard, Orange, Osceola, Seminole* | *3* | *6* | ***G*** | *Broward* | *3* | *6* |
| ***8*** | *Charlotte, Collier, Desoto, Glades, Hendry, Lee, Sarasota* | *2* | *4* | ***H*** | *Miami-Dade and Monroe* | *5* | *10* |
| ***9*** | *Indian River, Martin, Okeechobee, Palm Beach, St. Lucie* | *2* | *4* | | | | |
| ***10*** | *Broward* | *2* | *4* | | | | |
| ***11*** | *Miami-Dade, Monroe* | *5* | *10* | | | | |

**Obsolete Language (Sections 2, 5, 6, and 7)**

Sections 2, 5, 6, and 7 amend ss. 409.964, 409.971, and 409.974(1), and 409.978(1), F.S., respectively, to remove obsolete language. These sections contain references to dates or activities associated with program implementation, the initial procurement process, and expired deadlines.

**Effective Date (Section 9)**

The effective date of the bill is July 1, 2017.

## 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:

PCS/SB 916 reorganizes the regions and the number of plans that may be selected in each region. The AHCA plans to re-procure the SMMC contracts in late 2017 giving the health plan industry, both those currently with contracts and those who wish to gain a contract, an opportunity to bid on the new ITN. The AHCA believes that collapsing regions will result in administrative streamlining and more accurately reflects today's health care utilization patterns. These changes may result in more competitive proposals from more managed care organizations during the upcoming procurement process, resulting in savings to the state and more choices for the consumer. In response to a voluntary Intent to Bid request, the AHCA received 41 responses from PSNs and HMOs that were interested in all three types of plans: long-term care, specialty, and managed medical assistance.[23]

Any changes in which managed care organizations receive contracts under a new procurement will impact the health care provider community in 2017 and 2018. Not only will Medicaid managed care enrollees possibly be transitioning to new providers, but the provider community may have to adapt to a new group of managed care plans.

C. Government Sector Impact:

According to the AHCA, the bill has no impact on state revenues or expenditures.[24] However, the AHCA also believes, and notes in its bill analyses that collapsing regions will result in administrative streamlining and that these new regions will more accurately

[23] Agency for Health Administration, *Statewide Medicaid Managed Care (SMMC) Program Non-Binding Letters of Intent Received by 2/13/2017, in response to Intent to Bid Posted 2/3/2017*, http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Intent_to_Bid_Responses.pdf (last visited Mar. 16, 2017).
[24] *Supra* note 20, at 4.

reflect today's health care utilization patterns. These changes in the regions may result in more competitive proposals from more managed care organizations during the upcoming procurement process, resulting in additional savings to the state and more choices for the consumer.

## VI. Technical Deficiencies:

Strike the word, "Prepaid" from line 101.

## VII. Related Issues:

The AHCA plans to release an ITN in the summer of 2017. Non-binding letters of Intent to Bid were requested from interested bidders by February 13, 2017, using the current 11 regions.[25] With changes to the current business process, an effective date of July 1, 2017, may keep the AHCA from maintaining their current deadlines.

## VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.912, 409.964, 409.966, 409.968, 409.971, 409.974, 409.978, and 409.981.

## IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

**Recommended CS by Appropriations Subcommittee on Health and Human Services on April 13, 2017:**

- Requires that when selecting a plan for participation in the Medicaid program, the agency compile and publish a databook consisting of a comprehensive set of utilization and spending data consistent with actuarial rate-setting practices and standards. The source of the data in the databook report must include the most recent 24 months of validated data from the Medicaid Encounter Data System.
- Changes the following regions to the a new structure for the Managed medical assistance program: At least three plans and up to four plans for Region A; at least three plans and up to six plans for Region B; at least five and up to 10 plans for Region C; at least three and up to four plans for Region E; at least three plans and up to five plans for Region F; and at least three plans and up to five six plans for Region G.
- Changes the following regions to a new structure for the long-term care managed care program: At least three plans and up to four plans for Region A; at least three plans and up to six plans for Region B; at least five and up to eight plans for Region C; at least three and up to four plans for Region E; at least three plans and up to five plans for Region F; and at least three and up to four plans for Region G.

[25] Agency for Health Care Administration, *Non-binding Letters of Intent from Potential SMMC Plans,* http://ahca.myflorida.com/medicaid/statewide_mc/SMMC_LOI.shtml (last visited Mar. 16, 2017).

B. Amendments:

None.

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

587308

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 04/13/2017 | . | |
| | . | |
| | . | |
| | . | |

Appropriations Subcommittee on Health and Human Services (Grimsley) recommended the following:

**Senate Amendment (with title amendment)**

Delete lines 175 - 177

and insert:

~~or county~~. The source of the data in the databook ~~report~~ must include the 24 most recent months of ~~both historic fee-for-service claims and~~ validated data from the Medicaid Encounter Data System. ~~The report must be available in~~

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

587308

And the title is amended as follows:

Between lines 9 and 10

insert:

requiring that the source of such data include the 24 most recent months of validated data from the Medicaid Encounter Data System; deleting provisions relating to a report and report requirements;

306190

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 04/13/2017 | . | |
| | . | |
| | . | |
| | . | |

Appropriations Subcommittee on Health and Human Services (Grimsley) recommended the following:

**Senate Amendment**

Delete lines 325 - 353

and insert:

eligible plans for the managed medical assistance program through the procurement process described in s. 409.966. ~~The agency shall notice invitations to negotiate no later than January 1, 2013.~~

(a) The agency shall procure at least three ~~two~~ plans and up to four plans for Region A ~~Region 1~~. At least one plan shall

306190

be a provider service network if any provider service networks submit a responsive bid.

(b) The agency shall procure at least three plans and up to six ~~two~~ plans for Region B ~~Region 2~~. At least one plan shall be a provider service network if any provider service networks submit a responsive bid.

(c) The agency shall procure at least five ~~three~~ plans and up to 10 ~~five~~ plans for Region C ~~Region 3~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(d) The agency shall procure at least three plans and up to six ~~five~~ plans for Region D ~~Region 4~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(e) The agency shall procure at least three ~~two~~ plans and up to four plans for Region E ~~Region 5~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(f) The agency shall procure at least three ~~four~~ plans and up to five ~~seven~~ plans for Region F ~~Region 6~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(g) The agency shall procure at least three plans and up to five ~~six~~ plans for Region G ~~Region 7~~. At least one plan

167498

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 04/13/2017 | . | |
| | . | |
| | . | |
| | . | |

Appropriations Subcommittee on Health and Human Services (Grimsley) recommended the following:

**Senate Amendment**

Delete lines 411 - 435

and insert:

eligible plans for the long-term care managed care program through the procurement process described in s. 409.966. The agency shall procure:

(a) At least three ~~two~~ plans and up to four plans for Region A ~~Region 1~~. At least one plan must be a provider service network if any provider service networks submit a responsive

bid.

(b) At least three ~~Two~~ plans and up to six plans for Region B ~~Region 2~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(c) At least five ~~three~~ plans and up to eight ~~five~~ plans for Region C ~~Region 3~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(d) At least three plans and up to six ~~five~~ plans for Region D ~~Region 4~~. At least one plan must be a provider service network if any provider service network submits a responsive bid.

(e) At least three ~~two~~ plans and up to four plans for Region E ~~Region 5~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(f) At least three ~~four~~ plans and up to five ~~seven~~ plans for Region F ~~Region 6~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(g) At least three plans and up to four ~~six~~ plans for

**By** Senator Grimsley

26-00434A-17 2017916__

A bill to be entitled

An act relating to the statewide Medicaid managed care program; amending s. 409.912, F.S.; deleting the fee-for-service option as a basis for the reimbursement of Medicaid provider service networks; amending s. 409.964, F.S.; deleting an obsolete provision; amending s. 409.966, F.S.; requiring that a required databook consist of data that is consistent with actuarial rate-setting practices and standards; revising the designation and county makeup of regions of the state for purposes of procuring health plans that may participate in the Medicaid program; adding a factor that the Agency for Health Care Administration must consider in the selection of eligible plans; deleting a requirement related to fee-for-service provider service networks; amending s. 409.968, F.S.; requiring provider service networks to be prepaid plans; deleting a fee-for-service option for Medicaid reimbursement for provider service networks; amending s. 409.971, F.S.; deleting an obsolete provision; amending s. 409.974, F.S.; revising the number of eligible Medicaid health care plans the agency must procure for certain regions in the state; deleting an obsolete provision; amending s. 409.978, F.S.; deleting an obsolete provision; amending s. 409.981, F.S.; revising the number of eligible Medicaid health care plans the agency must procure for certain regions in the state; deleting a requirement that the agency consider a specific factor relating to the selection



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



26-00434A-17 2017916__

of managed medical assistance plans; providing an effective date.

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

Section 1. Subsection (2) of section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician’s opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. s. 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify



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

trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer





review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers are not entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(2) The agency may contract with a provider service network~~, which may be reimbursed on a fee-for-service or prepaid basis~~. Prepaid provider service networks shall receive per-member, per-month payments. ~~A provider service network that does not choose to be a prepaid plan shall receive fee-for-service rates with a shared savings settlement. The fee-for-service option shall be available to a provider service network only for the first 2 years of the plan's operation or until the contract year beginning September 1, 2014, whichever is later. The agency shall annually conduct cost reconciliations to determine the amount of cost savings achieved by fee-for-service provider service networks for the dates of service in the period being reconciled. Only payments for covered services for dates of service within the reconciliation period and paid within 6 months after the last date of service in the reconciliation period shall be included. The agency shall perform the necessary adjustments for the inclusion of claims incurred but not reported within the reconciliation for claims that could be~~

~~received and paid by the agency after the 6-month claims processing time lag. The agency shall provide the results of the reconciliations to the fee-for-service provider service networks within 45 days after the end of the reconciliation period. The fee-for-service provider service networks shall review and provide written comments or a letter of concurrence to the agency within 45 days after receipt of the reconciliation results. This reconciliation shall be considered final.~~

(a) A provider service network that ~~which~~ is reimbursed by the agency on a prepaid basis shall be exempt from parts I and III of chapter 641, but must comply with the solvency requirements in s. 641.2261(2) and meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency.

(b) A provider service network is a network established or organized and operated by a health care provider, or group of affiliated health care providers, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the provider service network organization.

Section 2. Section 409.964, Florida Statutes, is amended to read:





409.964 Managed care program; state plan; waivers.—The Medicaid program is established as a statewide, integrated managed care program for all covered services, including long-term care services. The agency shall apply for and implement state plan amendments or waivers of applicable federal laws and regulations necessary to implement the program. Before seeking a waiver, the agency shall provide public notice and the opportunity for public comment and include public feedback in the waiver application. The agency shall hold one public meeting in each of the regions described in s. 409.966(2), and the ~~time~~ period for public comment for each region shall end no sooner than 30 days after the completion of the public meeting in that region. ~~The agency shall submit any state plan amendments, new waiver requests, or requests for extensions or expansions for existing waivers, needed to implement the managed care program by August 1, 2011.~~

Section 3. Subsection (2) and paragraphs (a), (d), and (e) of subsection (3) of section 409.966, Florida Statutes, are amended to read:

409.966 Eligible plans; selection.—

(2) ELIGIBLE PLAN SELECTION.—The agency shall select a limited number of eligible plans to participate in the Medicaid program using invitations to negotiate in accordance with s. 287.057(1)(c). At least 90 days before issuing an invitation to negotiate, the agency shall compile and publish a databook consisting of a comprehensive set of utilization and spending data consistent with actuarial rate-setting practices and standards ~~for the 3 most recent contract years consistent with the rate-setting periods for all Medicaid recipients by region~~

~~or county. The source of the data in the report must include both historic fee-for-service claims and validated data from the Medicaid Encounter Data System. The report must be available in electronic form and delineate utilization use by age, gender, eligibility group, geographic area, and aggregate clinical risk score~~. Separate and simultaneous procurements shall be conducted in each of the following regions:

(a) Region A ~~Region 1~~, which consists of Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, ~~and~~ Walton, and Washington Counties.

(b) Region B ~~Region 2~~, which consists of Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, and Volusia ~~Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington~~ Counties.

(c) Region C ~~Region 3~~, which consists of Hardee, Highlands, Hillsborough, Manatee, Pasco, Pinellas, and Polk ~~Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union~~ Counties.

(d) Region D ~~Region 4~~, which consists of Brevard, Orange, Osceola, and Seminole ~~Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia~~ Counties.

(e) Region E ~~Region 5~~, which consists of Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota ~~Pasco and Pinellas~~ Counties.





(f) Region F ~~Region 6~~, which consists of Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie ~~Hardee, Highlands, Hillsborough, Manatee, and Polk~~ Counties.

(g) Region G ~~Region 7~~, which consists of Broward County ~~Brevard, Orange, Osceola, and Seminole Counties~~.

(h) Region H ~~Region 8~~, which consists of Miami-Dade and Monroe ~~Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota~~ Counties.

~~(i) Region 9, which consists of Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie Counties.~~

~~(j) Region 10, which consists of Broward County.~~

~~(k) Region 11, which consists of Miami-Dade and Monroe Counties.~~

(3) QUALITY SELECTION CRITERIA.—

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:

1. Accreditation by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body.

2. Experience serving similar populations, including the organization’s record in achieving specific quality standards with similar populations.

3. Availability and accessibility of primary care and specialty physicians in the provider network.

4. Establishment of community partnerships with providers that create opportunities for reinvestment in community-based services.

5. Organization commitment to quality improvement and documentation of achievements in specific quality improvement projects, including active involvement by organization leadership.

6. Provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes.

7. Evidence that an eligible plan has written agreements or signed contracts or has made substantial progress in establishing relationships with providers before the plan submitting a response.

8. Comments submitted in writing by any enrolled Medicaid provider relating to a specifically identified plan participating in the procurement in the same region as the submitting provider.

9. Documentation of policies and procedures for preventing fraud and abuse.

10. The business relationship an eligible plan has with any other eligible plan that responds to the invitation to negotiate.

11. Whether a plan is proposing to establish a comprehensive long-term care plan.

(d) For the first year of the first contract term, the agency shall negotiate capitation rates or fee for service payments with each plan in order to guarantee aggregate savings of at least 5 percent.





~~1.~~ For prepaid plans, determination of the amount of savings shall be calculated by comparison to the Medicaid rates that the agency paid managed care plans for similar populations in the same areas in the prior year. In regions containing no prepaid plans in the prior year, determination of the amount of savings shall be calculated by comparison to the Medicaid rates established and certified for those regions in the prior year.

~~2. For provider service networks operating on a fee-for-service basis, determination of the amount of savings shall be calculated by comparison to the Medicaid rates that the agency paid on a fee-for-service basis for the same services in the prior year.~~

(e) To ensure managed care plan participation in Regions A and E ~~Regions 1 and 2~~, the agency shall award an additional contract to each plan with a contract award in Region A ~~Region 1~~ or Region E ~~Region 2~~. Such contract shall be in any other region in which the plan submitted a responsive bid and negotiates a rate acceptable to the agency. If a plan that is awarded an additional contract pursuant to this paragraph is subject to penalties pursuant to s. 409.967(2)(i) for activities in Region A ~~Region 1~~ or Region E ~~Region 2~~, the additional contract is automatically terminated 180 days after the imposition of the penalties. The plan must reimburse the agency for the cost of enrollment changes and other transition activities.

Section 4. Subsection (2) of section 409.968, Florida Statutes, is amended to read:

409.968 Managed care plan payments.—

(2) Provider service networks shall ~~may~~ be prepaid plans and receive per-member, per-month payments negotiated pursuant

to the procurement process described in s. 409.966. ~~Provider service networks that choose not to be prepaid plans shall receive fee-for-service rates with a shared savings settlement. The fee-for-service option shall be available to a provider service network only for the first 2 years of its operation. The agency shall annually conduct cost reconciliations to determine the amount of cost savings achieved by fee-for-service provider service networks for the dates of service within the period being reconciled. Only payments for covered services for dates of service within the reconciliation period and paid within 6 months after the last date of service in the reconciliation period must be included. The agency shall perform the necessary adjustments for the inclusion of claims incurred but not reported within the reconciliation period for claims that could be received and paid by the agency after the 6-month claims processing time lag. The agency shall provide the results of the reconciliations to the fee-for-service provider service networks within 45 days after the end of the reconciliation period. The fee-for-service provider service networks shall review and provide written comments or a letter of concurrence to the agency within 45 days after receipt of the reconciliation results. This reconciliation is considered final.~~

Section 5. Section 409.971, Florida Statutes, is amended to read:

409.971 Managed medical assistance program.—The agency shall make payments for primary and acute medical assistance and related services using a managed care model. ~~By January 1, 2013, the agency shall begin implementation of the statewide managed medical assistance program, with full implementation in all~~



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



~~regions by October 1, 2014.~~

Section 6. Subsections (1) and (2) of section 409.974, Florida Statutes, are amended to read:

409.974 Eligible plans.—

(1) ELIGIBLE PLAN SELECTION.—The agency shall select eligible plans through the procurement process described in s. 409.966. ~~The agency shall notice invitations to negotiate no later than January 1, 2013.~~

(a) The agency shall procure at least two plans and up to four plans for Region A ~~Region 1~~. At least one plan shall be a provider service network if any provider service networks submit a responsive bid.

(b) The agency shall procure at least three plans and up to five ~~two~~ plans for Region B ~~Region 2~~. At least one plan shall be a provider service network if any provider service networks submit a responsive bid.

(c) The agency shall procure at least four ~~three~~ plans and up to seven ~~five~~ plans for Region C ~~Region 3~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(d) The agency shall procure at least three plans and up to six ~~five~~ plans for Region D ~~Region 4~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(e) The agency shall procure at least two plans and up to four plans for Region E ~~Region 5~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(f) The agency shall procure at least two ~~four~~ plans and up



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

to four ~~seven~~ plans for Region F ~~Region 6~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(g) The agency shall procure at least two ~~three~~ plans and up to four ~~six~~ plans for Region G ~~Region 7~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(h) The agency shall procure at least five ~~two~~ plans and up to 10 ~~four~~ plans for Region H ~~Region 8~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

~~(i) The agency shall procure at least two plans and up to four plans for Region 9. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(j) The agency shall procure at least two plans and up to four plans for Region 10. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(k) The agency shall procure at least five plans and up to 10 plans for Region 11. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~If no provider service network submits a responsive bid, the agency shall procure no more than one less than the maximum number of eligible plans permitted in that region. Within 12 months after the initial invitation to negotiate, the agency shall attempt to procure a provider service network. The agency~~



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



~~shall notice another invitation to negotiate only with provider service networks in those regions where no provider service network has been selected.~~

(2) QUALITY SELECTION CRITERIA.—In addition to the criteria established in s. 409.966, the agency shall consider evidence that an eligible plan has written agreements or signed contracts or has made substantial progress in establishing relationships with providers before the plan submits ~~submitting~~ a response. The agency shall evaluate and give special weight to evidence of signed contracts with essential providers as defined by the agency pursuant to s. 409.975(1). The agency shall exercise a preference for plans with a provider network in which more than ~~over~~ 10 percent of the providers use electronic health records, as defined in s. 408.051. ~~When all other factors are equal, the agency shall consider whether the organization has a contract to provide managed long-term care services in the same region and shall exercise a preference for such plans.~~

Section 7. Subsection (1) of section 409.978, Florida Statutes, is amended to read:

409.978 Long-term care managed care program.—

(1) Pursuant to s. 409.963, the agency shall administer the long-term care managed care program described in ss. 409.978-409.985, but may delegate specific duties and responsibilities for the program to the Department of Elderly Affairs and other state agencies. ~~By July 1, 2012, the agency shall begin implementation of the statewide long-term care managed care program, with full implementation in all regions by October 1, 2013.~~

Section 8. Subsection (2) and paragraphs (c), (d), and (e)



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

of subsection (3) of section 409.981, Florida Statutes, are amended to read:

409.981 Eligible long-term care plans.—

(2) ELIGIBLE PLAN SELECTION.—The agency shall select eligible plans through the procurement process described in s. 409.966. The agency shall procure:

(a) At least two plans and up to four plans for Region A ~~Region 1~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(b) At least three ~~Two~~ plans and up to five plans for Region B ~~Region 2~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(c) At least four ~~three~~ plans and up to seven ~~five~~ plans for Region C ~~Region 3~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(d) At least three plans and up to six ~~five~~ plans for Region D ~~Region 4~~. At least one plan must be a provider service network if any provider service network submits a responsive bid.

(e) At least two plans and up to four plans for Region E ~~Region 5~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(f) At least two ~~four~~ plans and up to four ~~seven~~ plans for Region F ~~Region 6~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(g) At least two ~~three~~ plans and up to four ~~six~~ plans for



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



Region G ~~Region 7~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(h) At least five ~~two~~ plans and up to 10 ~~four~~ plans for Region H ~~Region 8~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

~~(i) At least two plans and up to four plans for Region 9. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(j) At least two plans and up to four plans for Region 10. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(k) At least five plans and up to 10 plans for Region 11. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~If no provider service network submits a responsive bid in a region other than Region 1 or Region 2, the agency shall procure no more than one less than the maximum number of eligible plans permitted in that region. Within 12 months after the initial invitation to negotiate, the agency shall attempt to procure a provider service network. The agency shall notice another invitation to negotiate only with provider service networks in regions where no provider service network has been selected.~~

(3) QUALITY SELECTION CRITERIA.—In addition to the criteria established in s. 409.966, the agency shall consider the following factors in the selection of eligible plans:

~~(c) Whether a plan is proposing to establish a~~



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

~~comprehensive long-term care plan and whether the eligible plan has a contract to provide managed medical assistance services in the same region.~~

(c) ~~(d)~~ Whether a plan offers consumer-directed care services to enrollees pursuant to s. 409.221.

(d) ~~(c)~~ Whether a plan is proposing to provide home and community-based services in addition to the minimum benefits required by s. 409.98.

Section 9. This act shall take effect July 1, 2017.



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

The Florida Senate

# Committee Agenda Request

**To:** Senator Anitere Flores, Chair
Appropriations Subcommittee on Health and Human Services

**Subject:** Committee Agenda Request

**Date:** March 29, 2017

---

I respectfully request that **Senate Bill #916**, relating to Statewide Medicaid Managed Care, and **Senate Bill #1760**, Health Care Facility Regulation, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Denise Grimsley
Florida Senate, District 26

File signed original with committee office

# RICK SCOTT
GOVERNOR

RECEIVED
17 JAN 18 AM 9:3
OFFICE OF THE SECRETARY OF STATE

January 12, 2017

Secretary Kenneth W. Detzner
Secretary of State
State of Florida
R. A. Gray Building, Room 316
500 South Bronough Street
Tallahassee, Florida 32399-0250

Dear Secretary Detzner:

Please be advised that I have made the following appointment under the provisions of Section 20.42, Florida Statutes:

Mr. Justin Senior
3131 Dickinson Drive
Tallahassee, Florida 32311

as Secretary of Health Care Administration, subject to confirmation by the Senate. This appointment is effective October 3, 2016, for a term ending at the pleasure of the Governor.

Sincerely,

Rick Scott
Governor

RS/cr

THE CAPITOL
TALLAHASSEE, FLORIDA 32399 • (850) 717-9249

# OATH OF OFFICE

**(Art. II. § 5(b), Fla. Const.)**

RECEIVED
17 FEB -2 AM 10:21
DIVISION OF ELECTIONS
SECRETARY OF STATE

**STATE OF FLORIDA**

**County of** Leon

I do solemnly swear (or affirm) that I will support, protect, and defend the Constitution and Government of the United States and of the State of Florida; that I am duly qualified to hold office under the Constitution of the State, and that I will well and faithfully perform the duties of

Secretary of the Agency for Health Care Administration

(Title of Office)

on which I am now about to enter, so help me God.

**[NOTE: If you affirm, you may omit the words "so help me God." *See* § 92.52, Fla. Stat.]**

*Signature*

*Sworn to and subscribed before me this* 31st *day of* January, 2017.

IRISH O. GUYTON
Commission # FF 218248
Expires April 11, 2019
Bonded Thru Troy Fain Insurance 800-385-7019

*Signature of Officer Administering Oath or of Notary Public*

Irish O. Guyton

*Print, Type, or Stamp Commissioned Name of Notary Public*

*Personally Known* ☑ ***OR*** *Produced Identification* ☐

***Type of Identification Produced***

---

# ACCEPTANCE

**I accept the office listed in the above Oath of Office.**

**Mailing Address:** ☐ Home ☑ Office

2727 Mahan Drive, MS#1
Street or Post Office Box

Tallahassee, FL 32308
City, State, Zip Code

Justin M. Senior
**Print Name**

**Signature**

**DS-DE 56 (Rev. 11/16)**

A black and white copy of this document is not official

35

# STATE OF FLORIDA
# DEPARTMENT OF STATE
## Division of Elections

I, Ken Detzner, Secretary of State,
do hereby certify that

***Justin Senior***

is duly appointed

**Secretary,**
**Agency for Health Care Administration**

for a term beginning on the Third day of October, A.D., 2016, to serve at the pleasure of the Governor and is subject to be confirmed by the Senate during the next regular session of the Legislature.

*Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Twentieth day of February, A.D., 2017.*

Ken Detzner

Secretary of State

DSDE 99 (3/03)

If photocopied or chemically altered, the word "VOID" will appear.

Seal of Florida appears in small letters across the face of this 8½ x 11" document.

The original document has a reflective line mark in paper. Hold at an angle to view when checking.

**The Florida Senate**

# Committee Notice Of Hearing

IN THE FLORIDA SENATE
TALLAHASSEE, FLORIDA

IN RE: Executive Appointment of

Justin M. Senior

Secretary of Health Care Administration

**NOTICE OF HEARING**

TO: Secretary Justin M. Senior

YOU ARE HEREBY NOTIFIED that the Appropriations Subcommittee on Health and Human Services of the Florida Senate will conduct a hearing on your executive appointment on Thursday, April 13, 2017, in the James E. "Jim" King, Jr. Committee Room, 401 Senate Office Building, commencing at 2:30 p.m., pursuant to Rule 12.7(1) of the Rules of the Florida Senate.

Please be present at the time of the hearing.
DATED this the 10th day of April, 2017

Appropriations Subcommittee on Health and Human Services

Anitere Flores

Senator Anitere Flores
As Chair and by authority of the committee

cc: Members, Appropriations Subcommittee on Health and Human Services
Office of the Sergeant at Arms

THE FLORIDA SENATE

# COMMITTEE WITNESS OATH

**CHAIR:**

**Please raise your right hand and be sworn in as a witness.**

**Do you swear or affirm that the evidence you are about to give will be the truth, the whole truth, and nothing but the truth?**

**WITNESS'S NAME:** Justin M. Senior

**ANSWER:** I do

Pursuant to §90.605(1), *Florida Statutes*: "The witness's answer shall be noted in the record."

**COMMITTEE NAME:** Appropriations Subcommittee on Health and Human Services

**DATE:** April 13, 2017

**The Florida Senate**

# COMMITTEE RECOMMENDATION ON EXECUTIVE APPOINTMENT

**COMMITTEE:** Appropriations Subcommittee on Health and Human Services
**MEETING DATE:** Thursday, April 13, 2017
**TIME:** 2:30—3:30 p.m.
**PLACE:** James E. "Jim" King, Jr. Committee Room, 401 Senate Office Building

---

TO: The Honorable Joe Negron, President

FROM: Appropriations Subcommittee on Health and Human Services

The committee was referred the following executive appointment subject to confirmation by the Senate:

**Office:** Secretary of Health Care Administration

**Appointee:** Senior, Justin M.

**Term:** 10/3/2016-Pleasure of Governor

After inquiry and due consideration, the committee recommends that the Senate **confirm** the aforesaid executive appointment made by the Governor.

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

4/13/17
*Meeting Date*

*Bill Number (if applicable)*

Topic Confirmation Hearing

*Amendment Barcode (if applicable)*

Name Justin M. Senior

Job Title Secretary Agency for Health Care Administration

Address 2727 Mahan Drive
*Street*

Phone 850-412-3612

Tallahassee FL 32304
*City* *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☑ Information

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

Representing AHCA

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)

4/13/17
*Meeting Date*

N/A
*Bill Number (if applicable)*

Topic Justin Senior confirmation

*Amendment Barcode (if applicable)*

Name Ron Watson

Job Title Lobbyist

Address 3738 Mundon Way
*Street*

Tallahassee FL 32309
*City* *State* *Zip*

Phone 850 562-1202

Email watson.strategies@comcast.net

Speaking: ☐ For ☐ Against ☐ Information

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

Representing FL Renal Coalition

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)

*Meeting Date*

*Bill Number (if applicable)*

Topic Confirmation of Justin Senior, J.D

*Amendment Barcode (if applicable)*

Name Paul Wharton

Job Title Lobbyist

Address 8458 Drayton Park Drive
*Street*

Phone (904) 563-0627

Jax FL 32216
*City* *State* *Zip*

Email drpaulwharton@gmail.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Flagler Hospital

Will speak - if time permits

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)

RICK SCOTT
GOVERNOR

RECEIVED
17 JAN 18 AM 9:38
DIVISION OF ELECTIONS
SECRETARY OF STATE

January 13, 2017

Secretary Kenneth W. Detzner
Department of State
State of Florida
R. A. Gray Building, Room 316
500 South Bronough Street
Tallahassee, Florida 32399-0250

Dear Secretary Detzner:

Please be advised I have amended the following appointment under the provisions of Section 20.43, Florida Statutes:

Dr. Celeste Philip
Florida Department of Health
4052 Bald Cypress Way
Tallahassee, FL 32399

As State Surgeon General and State Health Official, subject to confirmation by the Senate. This appointment is effective March 11, 2016 for a term ending at the pleasure of the Governor.

Sincerely,

Rick Scott
Governor

RS/mb

RECEIVED
17 FEB 15 PM 4:52
APPROPRIATIONS
STAFF DIR. STAFF

THE CAPITOL
TALLAHASSEE, FLORIDA 32399 • (850) 717-9249

# OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.)

16 DEC 20 PM 4:58

DIVISION OF ELECTIONS
SECRETARY OF STATE

**STATE OF FLORIDA**

**County of** Leon

I do solemnly swear (or affirm) that I will support, protect, and defend the Constitution and Government of the United States and of the State of Florida; that I am duly qualified to hold office under the Constitution of the State, and that I will well and faithfully perform the duties of

State Surgeon General and Secretary of Health

(Title of Office)

on which I am now about to enter, so help me God.

**[NOTE: If you affirm, you may omit the words "so help me God." *See* § 92.52, Fla. Stat.]**

*Signature*

*Sworn to and subscribed before me this* 19th *day of* December, 2016

Bloscile T. Williams

*Signature of Officer Administering Oath or of Notary Public*

BLOSCILE T WILLIAMS
Commission # FF 243211
Expires August 27, 2019
Bonded Thru Troy Fain Insurance 800-385-7019

*Print, Type, or Stamp Commissioned Name of Notary Public*

*Personally Known* ☑ *OR* *Produced Identification* ☐

*Type of Identification Produced*

# ACCEPTANCE

**I accept the office listed in the above Oath of Office.**

Mailing Address: ☐ Home ☑ Office

4052 Bald Cypress Way Bin A00

Street or Post Office Box

Tallahassee, Florida 32399

City, State, Zip Code

Celeste Philip, MD, MPH

**Print Name**

**Signature**

**DS-DE 56 (Rev. 11/16)**

A black and white copy of this document is not official

Amended
1030

# STATE OF FLORIDA
# DEPARTMENT OF STATE
## Division of Elections

I, Ken Detzner, Secretary of State,
do hereby certify that

***Celeste Philip***

is duly appointed

**State Surgeon General and Secretary,**
**Department of Health**

for a term beginning on the Eleventh day of March, A.D., 2016, to serve at the pleasure of the Governor and is subject to be confirmed by the Senate during the next regular session of the Legislature.

*Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Eighteenth day of January, A.D., 2017*

Ken Detzner

Secretary of State

DSDE 99 (3/03)

If photocopied or chemically altered, the word "VOID" will appear.

"State of Florida" appears in small letters across the face of this 8½ x 11" document.

The original document has a reflective line mark in paper. Hold at an angle to view when checking.

**The Florida Senate**

# Committee Notice Of Hearing

IN THE FLORIDA SENATE
TALLAHASSEE, FLORIDA

IN RE: Executive Appointment of

Celeste Philip

State Surgeon General

**NOTICE OF HEARING**

TO: Dr. Celeste Philip

YOU ARE HEREBY NOTIFIED that the Appropriations Subcommittee on Health and Human Services of the Florida Senate will conduct a hearing on your executive appointment on Thursday, April 13, 2017, in the James E. "Jim" King, Jr. Committee Room, 401 Senate Office Building, commencing at 2:30 p.m., pursuant to Rule 12.7(1) of the Rules of the Florida Senate.

Please be present at the time of the hearing.
DATED this the 10th day of April, 2017

Appropriations Subcommittee on Health and Human Services

Anitere Flores

Senator Anitere Flores
As Chair and by authority of the committee

cc: Members, Appropriations Subcommittee on Health and Human Services
Office of the Sergeant at Arms

THE FLORIDA SENATE

# COMMITTEE WITNESS OATH

**CHAIR:**

**Please raise your right hand and be sworn in as a witness.**

**Do you swear or affirm that the evidence you are about to give will be the truth, the whole truth, and nothing but the truth?**

**WITNESS'S NAME:** Celeste Philip

**ANSWER:** I do

Pursuant to §90.605(1), *Florida Statutes*: "The witness's answer shall be noted in the record."

**COMMITTEE NAME:** Appropriations Subcommittee on Health and Human Services

**DATE:** April 13, 2017

**The Florida Senate**

# COMMITTEE RECOMMENDATION ON EXECUTIVE APPOINTMENT

**COMMITTEE:** Appropriations Subcommittee on Health and Human Services
**MEETING DATE:** Thursday, April 13, 2017
**TIME:** 2:30—3:30 p.m.
**PLACE:** James E. "Jim" King, Jr. Committee Room, 401 Senate Office Building

---

TO: The Honorable Joe Negron, President

FROM: Appropriations Subcommittee on Health and Human Services

The committee was referred the following executive appointment subject to confirmation by the Senate:

**Office:** State Surgeon General

**Appointee:** Philip, Celeste

**Term:** 3/11/2016-Pleasure of Governor

After inquiry and due consideration, the committee recommends that the Senate **confirm** the aforesaid executive appointment made by the Governor.

**THE FLORIDA SENATE**

# APPEARANCE RECORD

4-13-17 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

*Meeting Date*

*Bill Number (if applicable)*

*Amendment Barcode (if applicable)*

Topic Confirmation Hearing

Name Celeste Philip

Job Title State Surgeon General

Address 2585 Merchants Row Blvd. Phone

*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 Dept. 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**

# APPEARANCE RECORD

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

*Meeting Date*

*Bill Number (if applicable)*

Topic Dr Celeste Phillip confirmation

*Amendment Barcode (if applicable)*

Name Ron Watson

Job Title Lobbyist

Address 3738 Mundan Way

*Street*

Tallahassee FL 32309

*City* *State* *Zip*

Phone 850 567 1202

Email watson.strategies@comcast.net

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against

*(The Chair will read this information into the record.)*

Representing Alt Med

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)

4/13/17
*Meeting Date*

*Bill Number (if applicable)*

Topic Surgeon General Confirmation

*Amendment Barcode (if applicable)*

Name Chris Nuland

Job Title

Address 1000 Riverside Ave #240
*Street*

Phone 904-233-3051

Jacksonville, FL 32204
*City* *State* *Zip*

Email nuland

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Public Health 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)

4.13.17
*Meeting Date*

*Bill Number (if applicable)*

Topic Confirmation Surgeon General

*Amendment Barcode (if applicable)*

Name Victoria Zepp

Job Title Exec. Dir, Gov't Affairs

Address 121 N. Monroe St. 9007
*Street*

Phone 850.241.6309

TLH FL 32301
*City* *State* *Zip*

Email Victoria@Clarity-1.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing FL Coalition for Children

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)

4.13.17
*Meeting Date*

*Bill Number (if applicable)*

Topic Confirmation Surgeon General

*Amendment Barcode (if applicable)*

Name Victoria Zepp

Job Title

Address 121 N. Monroe St. 9007
*Street*

TLH FL 32301
*City* *State* *Zip*

Phone

Email

Speaking: ☒ For ☐ Against ☐ Information

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

Representing CFO's appointee Children's Youth Cabinet

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.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

| | |
|---|---|
| BILL: | PCS/SB 714 (897830) |
| INTRODUCER: | Appropriations Subcommittee on Health and Human Services and Senator Garcia |
| SUBJECT: | Comprehensive Transitional Education Programs |
| DATE: | April 20, 2017 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Crosier | Hendon | CF | **Favorable** |
| 2. | Loe | Williams | AHS | **Recommend: Fav/CS** |
| 3. | | | AP | |

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

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

PCS/SB 714 authorizes the Agency for Persons with Disabilities (APD) to petition a court for the appointment of a receiver for a comprehensive transitional education program under certain circumstances.

The bill has no direct impact on state revenues or expenditures.

The bill has an effective date of July 1, 2017.

## II. Present Situation:

A comprehensive transitional education program (CTEP) serves individuals with developmental disabilities who also have moderate to severe maladaptive behaviors. There are two CTEPs licensed in Florida.[1] CTEP licenses are issued for a 12-month period. No fees are charged for the initial application or subsequent licensure renewal.

In s. 393.062, F.S., the legislature has expressed its intent that community-based programs and services for individuals with developmental disabilities are preferred to programs operated

[1] The two CTEP licenses are held by the same company that operates a CTEP in Mt. Dora, Florida. Section 393.18(4), F.S., limits the total number of residents served in a CTEP to 120 per license. The CTEP in Mt. Dora, Florida, serves more than 120 residents and is thus required to hold two separate licenses.

directly by the state.[2] Pursuant to the recently issued federal Medicaid waiver guidelines, there has been a shift to provide person-centered care and for care to be provided in home and community-based settings, moving away from institutionalized settings as currently utilized.[3] The new Medicaid waiver guidelines become effective March 2019.[4]

**Receivership**

A receiver is "[an] indifferent person between the parties appointed by a court to collect and receive the rents, issues and profits of land, or the produce or person estate, or other things which it does not seem reasonable to the court that either party should do; or where a party is incompetent to do so.[5] Pursuant to s. 393.0678, F.S., APD may petition a court for the appointment of a receiver for a residential habilitation center or a group home facility owned and operated by a corporation or partnership when certain conditions exist:

- A person is operating a facility without a license and refuses to make an application for a license;
- The licensee is closing the facility or has informed the department that it intends to close the facility, and adequate arrangements have not been made for relocation of the residents within seven days, exclusive of weekends and holidays, of the closing of the facility;
- The agency determines that conditions exist in the facility which present an imminent danger to the health, safety, or welfare of the residents of the facility or which present a substantial probability that death or serious physical harm will result; or
- The licensee cannot meet its financial obligations to provide food, shelter, care, and utilities.[6]

## III. Effect of Proposed Changes:

**Section 1** amends s. 393.0678(1), F.S., to add Comprehensive Transitional Education Programs to the list of entities for which APD can initiate receivership proceedings.

**Section 2** provides that the bill becomes effective upon becoming a law.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

[2] Agency for Persons with Disabilities legislative analysis dated February 23, 2017.
[3] *Id*.
[4] Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers; Final Rule 79 Fed. Reg. 2948 (Jan. 16, 2014). The effective date of the final regulations was March 14, 2014, and the regulations allow each state up to five years to bring its home and community-based programs into compliance with the home and community-based settings requirements.
[5] *Black's Law Dictionary* (Online Dictionary 2nd Ed.)
[6] Section 393.0678(1)(a)-(d), F.S.

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:

The transition from the current comprehensive transitional education program in Lake Nona, Florida, to smaller residential group homes will require all clients, including those with private insurance, to move into a new residential group home. The location and expense of the smaller residential group homes are not known at this time.

C. Government Sector Impact:

The bill has no direct impact on state revenues or expenditures. However, in the event a receiver is appointed, APD will be required to provide assessments and transition plans to current residents residing at the comprehensive transitional education program in Mt. Dora, Florida. APD will also be required to provide the licensing and oversight of the smaller group homes. These requirements will increase workload for agency staff, and can be absorbed within existing resources.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends the following section of the Florida Statutes: 393.0678.

## IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

**Recommended CS by Appropriations Subcommittee on Health and Human Services on April 18, 2017:**

- Removes the sunset provision for comprehensive transitional education program licensure application and renewal.

B. Amendments:

None.

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

346524

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 04/20/2017 | . | |
| | . | |
| | . | |
| | . | |

Appropriations Subcommittee on Health and Human Services (Garcia) recommended the following:

**Senate Amendment (with title amendment)**

Delete lines 47 - 75

and insert:

Section 2. This act shall take effect upon becoming a law.

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

And the title is amended as follows:

Delete lines 7 - 12

and insert:

346524

under certain circumstances; providing an effective date.

**By** Senator Garcia

36-01178-17 2017714__

A bill to be entitled

An act relating to comprehensive transitional education programs; amending s. 393.0678, F.S.; authorizing the Agency for Persons with Disabilities to petition a court for the appointment of a receiver for a comprehensive transitional education program under certain circumstances; amending s. 393.18, F.S.; providing that no new comprehensive transitional education programs may be licensed after a specified date; providing that no licenses may be renewed for comprehensive transitional education programs after a certain specified date; providing an effective date.

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

Section 1. Subsection (1) of section 393.0678, Florida Statutes, is amended to read:

393.0678 Receivership proceedings.—

(1) The agency may petition a court of competent jurisdiction for the appointment of a receiver for a comprehensive transitional education program, a residential habilitation center, or a group home facility owned and operated by a corporation or partnership when any of the following conditions exist:

(a) Any person is operating a facility or program without a license and refuses to make application for a license as required by s. 393.067.

(b) The licensee is closing the facility or has informed the department that it intends to close the facility; and adequate arrangements have not been made for relocation of the residents within 7 days, exclusive of weekends and holidays, of the closing of the facility.



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



36-01178-17 2017714__

(c) The agency determines that conditions exist in the facility which present an imminent danger to the health, safety, or welfare of the residents of the facility or which present a substantial probability that death or serious physical harm would result therefrom. Whenever possible, the agency shall facilitate the continued operation of the program.

(d) The licensee cannot meet its financial obligations to provide food, shelter, care, and utilities. Evidence such as the issuance of bad checks or the accumulation of delinquent bills for such items as personnel salaries, food, drugs, or utilities constitutes prima facie evidence that the ownership of the facility lacks the financial ability to operate the home in accordance with the requirements of this chapter and all rules promulgated thereunder.

Section 2. Subsection (7) is added to section 393.18, Florida Statutes, to read:

393.18 Comprehensive transitional education program.—A comprehensive transitional education program serves individuals who have developmental disabilities, severe maladaptive behaviors, severe maladaptive behaviors and co-occurring complex medical conditions, or a dual diagnosis of developmental disability and mental illness. Services provided by the program must be temporary in nature and delivered in a manner designed to achieve the primary goal of incorporating the principles of self-determination and person-centered planning to transition individuals to the most appropriate, least restrictive community living option of their choice which is not operated as a comprehensive transitional education program. The supervisor of the clinical director of the program licensee must hold a



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

doctorate degree with a primary focus in behavior analysis from an accredited university, be a certified behavior analyst pursuant to s. 393.17, and have at least 1 year of experience in providing behavior analysis services for individuals in developmental disabilities. The staff must include behavior analysts and teachers, as appropriate, who must be available to provide services in each component center or unit of the program. A behavior analyst must be certified pursuant to s. 393.17.

(7) After July 1, 2017, a license may not be granted under this section to a new comprehensive transitional education program. After December 31, 2019, a license may not be renewed for an existing comprehensive transitional education program.

Section 3. This act shall take effect July 1, 2017.



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

**Please reply to:**

☐ **District Office:**

1490 West 68 Street
Suite # 201
Hialeah, FL. 33014
Phone# (305) 364-3100

# The Florida Senate

State Senator René García
36th District

March 10th, 2017

The Honorable Anitere Flores
Chair, Appropriations Subcommittee on Health and Human Services
201 The Capitol
404 S. Monroe Street
Tallahassee, FL 32399-1100

Dear Senator Flores,

Please have this letter serve as my formal request to have **SB 714: Comprehensive Transitional Education Programs** be heard during the next scheduled Appropriations Subcommittee on Health and Human Services Subcommittee Meeting. Should you have any questions or concerns, please do not hesitate to contact my office.

Sincerely,

State Senator René García
District 36

CC: Phil Williams
Robin Jackson

**Committees:** Children, Families, and Elder Affairs, Chairman, Banking and Insurance, Appropriations Subcommittee on General Government, Appropriations Subcommittee on Finance and Tax, Vice Chair, Judiciary

**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.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

| | |
|---|---|
| BILL: | SB 1050 |
| INTRODUCER: | Senator Simmons |
| SUBJECT: | Memory Disorder Clinics |
| DATE: | April 12, 2017 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Lloyd | Stovall | HP | **Favorable** |
| 2. | Forbes | Williams | AHS | **Recommend: Favorable** |
| 3. | | | AP | |

## I. Summary:

SB 1050 establishes a memory disorder clinic at Florida Hospital in Orange County.

This bill does not impact state revenues or expenditures

The bill is effective July 1, 2017.

## II. Present Situation:

### Alzheimer's Disease

Alzheimer's disease is a degenerative brain disease and the most common cause of dementia.[1] It accounts for 60 to 80 percent of dementia cases.[2] An estimated 5.5 million Americans are living with the disease in 2017, including 1 in 10 people aged 65 and older. For Florida, the number is estimated to be 520,000 for 2017 and it is projected to grow to 720,000 by 2025, a growth rate of 38.5 percent.[3]

Dementia is a syndrome of the disease and is actually a group of symptoms that has a number of causes that include difficulties with memory, language, problem-solving, and other cognitive skills that affect a person's ability to perform everyday activities.[4] In Alzheimer's patients, these difficulties occur because of brain abnormalities. The nerve cells or neurons that are involved with cognitive brain function have been damaged or destroyed causing a loss of connection

[1] Alzheimer's Association, *2017 Alzheimer's Disease Facts and Figures,* http://www.alz.org/documents_custom/2017-facts-and-figures.pdf, p. 5, (last visited Mar. 8, 2017).
[2] Alzheimer's Association, *About Alzheimer's and Dementia,* http://www.alz.org/research/science/alzheimers_research.asp (last visited Mar. 9, 2017).
[3] *Id.* at 21.
[4] *Id.* at 5.

among brain cells.[5] Eventually, those with Alzheimer's disease become bed bound and require around the clock care. The disease is fatal and there is currently no cure.

The brains of individuals with Alzheimer's show inflammation, dramatic shrinkage from cell loss, and widespread debris from dead and dying neurons.[6] Other changes associated with Alzheimer's and other dementias include:

- Memory loss that disrupts daily life;
- Challenges in planning or solving problems;
- Difficulty completing familiar tasks;
- Confusion with time or place;
- Trouble understanding visual images and spatial relationships;
- New problems with words in speaking or writing;
- Misplacing things and losing the ability to retrace steps;
- Decreased or poor judgement;
- Withdrawal from work or social activities; or
- Change in mood and personality.[7]

For those living with Alzheimer's, management of the disease can lead to an improved quality of life. Active management of the disease may include:

- Appropriate use of available treatment options;
- Effective management of coexisting conditions;
- Coordination of care among physicians, other health care providers and lay caregivers;
- Participation in activities that are meaningful and bring purpose to one's life; and
- Have opportunities to connect with others living with dementia; support groups and supportive services.[8]

**Florida Alzheimer's Disease Initiatives**

Florida's Alzheimer's Disease Initiative (ADI) was created by the 1985 Legislature to meet the changing needs of individuals with Alzheimer's and similar memory disorders and their families. The Florida Department of Elder Affairs (department) coordinates and develops policy in conjunction with a 10-member advisory committee appointed by the Governor for the initiative. The program includes four components:

- Supportive services which include counseling, consumable medical supplies, and respite caregiver relief;
- Memory Disorder Clinics that provide diagnosis, research, treatment, education, and referrals;
- Model day care programs to test new care alternatives; and
- A brain bank to support research.[9]

[5] *Id.*
[6] *Id.*
[7] *Id.* at 9.
[8] *Id.* at 14.
[9] Dep't of Elder Affairs, *Alzheimer's Disease Initiative*, http://elderaffairs.state.fl.us/doea/alz.php (last visited Mar. 9, 2017).

The ADI includes in-home, facility-based (usually at adult day care centers), emergency, and extended care (up to 30 days) for caregivers who serve patients with memory disorders.[10] During FY 2014-2015, 2,652 individuals received respite and support services, including case management, specialized medical equipment, services, and supplies, and caregiver counseling, support groups, and training.[11]

The 2016-2017 General Appropriations Act includes $22,139,517 from the General Revenue Fund for the ADI services.[12] The appropriated funds are allocated to each of the Area Agencies on Aging to fund providers of model day care and respite care programs based on each county's population age 75 and older and probable number of Alzheimer's cases. Additional Alzheimer disease services are administered through contracts with designated Memory Disorder Clinics and the Florida Brain Banks. Remaining funds are allocated to local funding initiatives based on legislative direction in the General Appropriations Act.[13]

Participants in the ADI program are assessed co-payments and other partial payment amounts based on their ability pay and in accordance with Rule 58C-1.007, F.A.C. The co-pay schedule is set on a sliding scale, not to exceed 3 percent of an individual's monthly income in 2016.[14] Provider agencies are responsible for the collection of fees for ADI services and report their collections annually to the department.[15]

### *Respite for Caregiver Relief*

Respite care programs for caregivers are established in all 67 of Florida's counties.[16] Many Alzheimer's patients require around the clock care, especially in the late stages of the disease. Caregivers may also receive supportive services such as training and support groups, counseling, consumable medical supplies, and nutritional supplements.

### *Memory Disorder Clinics*

There are 15 state-funded Memory Disorder Clinics in the state of Florida that provide comprehensive assessments, diagnostic services, and treatment to individuals who show signs of Alzheimer's disease and related memory disorders. The Memory Disorder Clinics are also required to conduct specific research in coordination with the department. The clinics are established at medical schools, teaching hospitals, and public and private, not-for-profit hospitals.[17] From July 1, 2015 through June 30, 2016, the Memory Disorder Clinics completed

[10] Dep't of Elder Affairs, *Alzheimer's Disease Initiative*, http://elderaffairs.state.fl.us/doea/alz.php , (last visited Mar. 9, 2017).
[11] *Id.*
[12] Specific Appropriations 410 of chapter 2016-66, Laws of Fla. (General Appropriations Act for the 2016-2017 fiscal year).
[13] Dep't of Elder Affairs, *2016 Summary of Programs and Services - Section D,* p. 94, http://elderaffairs.state.fl.us/doea/pubs/pubs/sops2016/2016_SOPS_D.pdf (last visited Mar. 9, 2017).
[14] Dep't of Elder Affairs, *Department of Elder Affairs Programs and Services Handbook, Appendix B - Co-Payment for Service Guidelines (ADI and CCE Programs), Attachment 2: 2016 Co-Pay Schedule for Individual,* http://elderaffairs.state.fl.us/doea/notices/July16/2016_Appendix_B_Co-Payment_for_Service_Guidelines.pdf, (last visited Mar. 9, 2017).
[15] *Id.* at B-34.
[16] *Id.*
[17] *Id.* The 15 Memory Disorder Clinics are: West Florida Hospital, Tallahassee Memorial Hospital, Mayo Clinic Jacksonville, University of Florida, Orlando Health Center for Aging, East Central Florida, Madonna Ptak Center for Memory Disorders at Morton Plant Mease, University of South Florida, St. Mary's Medical Center, Florida Atlantic University Louis and Anne

9,810 medical memory evaluations, saw 4,745 new patients, with 16,569 office visits made by patients and their caregivers.[18] Over 7,000 family caregivers also received educational training from the clinics on how to care for a loved one with dementia during this same time period.[19] For the 2016-2017 state fiscal year, the clinics used $3,464,683 in state funding to serve almost 7,000 unduplicated clients.[20]

The law currently provides that memory disorder clinics funded as of June 30, 1995, shall not receive decreased funding due solely to subsequent additions of memory disorder clinics. As of June 30, 1995, the following clinics were included in the statute:
A memory disorder at each of the three medical schools in the state;
A memory disorder clinic at a major non-profit research-oriented teaching hospital, and may fund a memory disorder clinic at any of the other affiliated teaching hospitals;

- A memory disorder clinic at the Mayo clinic in Jacksonville;
- A memory disorder clinic at the West Florida Regional Medical Center;
- The Central Florida Memory Disorder Clinic at the Joint Center for Advanced Therapeutics and Biomedical Research at the Florida Institute of Technology and Holmes Regional Medical Center, Inc.; and
- A memory disorder clinic located at a public hospital that is operated by an independent special hospital taxing district that governs multiple hospitals and is located in a county with a population greater than 800,000.[21]

Florida Hospital in Central Florida opened a self-funded memory disorder program in 2012. The Florida Hospital Maturing Minds Clinic serves patients with Alzheimer's disease and related disorders in Orange, Seminole, and Osceola counties. It is estimated that 30,000 people with Alzheimer's disease live in these three counties.[22] The clinic conducts over 360 new patient memory loss evaluations each year and provides services and referrals to other local organizations.[23] The clinic does not plan to request state funding at this time, but will seek national and local grants and the state designation will assist the clinic in that process, according to local representatives.[24]

### *Model Day Care*

Model day care programs provide a safe environment where Alzheimer's patients can meet and socialize during the day as well as receive therapeutic interventions which improve their

---

Green Memory and Wellness Center, Sarasota Memorial Hospital, Lee Memorial Health System, Broward Health North, The Wien Center for Alzheimer's Disease and Memory Disorders Mt. Sinai Medical Center, and University of Miami Memory Disorders Center, Center on Aging Mental Health Hospital Center.

[18] Dep't of Elder Affairs, *2015-2016 Year End Summary - Alzheimer Disease Initiative,* p. 3, http://elderaffairs.state.fl.us/doea/alz/MDC_Year_End_Summary_2015-2016.pdf (last visited: Mar. 9, 2017).

[19] *Id.*

[20] Dep't of Elder Affairs, *2016 Summary of Programs and Services - Section D, Memory Disorder Clinics Appropriation History and Numbers Served,* p. 97, http://elderaffairs.state.fl.us/doea/pubs/pubs/sops2016/2016_SOPS_D.pdf (last visited: Mar. 9, 2017).

[21] Chapter Law 1995-253, s. 1, Laws of Fla.

[22] Fla. Hospital, *Memory Disorder Clinics Handout - Support HB 883/SB 1050* (on file with the Senate Committee on Health Policy).

[23] Fla. Hospital, *Memory Disorder Clinics Handout - Support HB 883/SB 1050* (on file with the Senate Committee on Health Policy).

[24] Conversation with Jean Van Smith, Florida Hospital Representative (March 9, 2017).

cognitive functioning. Model day care programs have been established in Gainesville, Tampa, and Miami.[25]

***Florida Brain Bank***

The Florida Brain Bank was created in 1987, is administered by Mount Sinai Medical Center, and facilitated by an additional four regional centers. The Florida Brain Bank conducts research related to Alzheimer's disease and other degenerative disorders of the brain. Participants elect to "bank" their brain making the patient's brain tissue available to researchers upon the patient's death.[26] Upon the patient's death, a final pathology report would also be made available to the patient's family and physicians. Currently, the only way to get an accurate diagnosis of Alzheimer's disease or related dementia disorders is a brain autopsy at the time of death.[27] The Brain Bank's 2016-2017 State General Revenue appropriation was $117,535 and the bank registered 87 individuals and conducted 79 autopsies during that fiscal year.[28]

The Alzheimer's Disease Advisory Committee is statutorily created under s. 430.501(2), F.S., and includes 10 members appointed by the Governor. The members advise the department on legislative, programmatic, and administrative matters that relate to individuals with Alzheimer's disease and their caregivers. Members serve 4-year, staggered terms and select one of its own members to serve as chair of the committee for a 1 year term.[29]

## III. Effect of Proposed Changes:

**Section 1** republishes and amends s. 430.502, F.S., relating to the establishment of the Alzheimer Disease Initiative program's memory disorder clinics and adds a memory disorder clinic at Florida Hospital in Orange County. The memory disorder clinics conduct research and training in a diagnostic and therapeutic setting for persons suffering from Alzheimer's disease and related memory disorders.

Current statute provides that any memory disorder clinic funded as of June 30, 1995, shall not receive decreased funding due solely to the subsequent additions of memory disorder clinics. The addition of Florida Hospital in Orange County makes 16 total memory disorder clinics created under the statute, of which at least seven have been added since June 30, 2015.

**Section 2** reenacts s. 1004.445, F.S., relating to the Johnnie S. Byrd, Sr., Alzheimer Center and Research Institute, for the purpose of incorporating the amendment made to the underlying act, s. 430.502, F.S.

**Section 3** provides an effective date of July 1, 2017.

---

[25] Dep't of Elder Affairs, *Alzheimer's Disease Initiative*, http://elderaffairs.state.fl.us/doea/alz.php (last visited Mar. 9, 2017).
[26] Dep't of Elder Affairs, *The Florida Brain Bank*, http://elderaffairs.state.fl.us/doea/BrainBank/howto.php (last visited Mar. 9, 2017).
[27] *Id.*
[28] Department of Elder Affairs, *2016 Summary of Programs and Services - Section D, Brain Bank Appropriation History and Client Served*, p. 98, http://elderaffairs.state.fl.us/doea/pubs/pubs/sops2016/2016_SOPS_D.pdf (last visited Mar. 9, 2017)
[29] Dep't of Elder Affairs, *Alzheimer's Disease Advisory Committee,* http://elderaffairs.state.fl.us/doea/advisory_alz.php (last visited Mar. 9, 2017).

## 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:

The costs associated with the Memory Disorder Clinic at Florida Hospital in Orange County will be funded through Florida Hospital. The hospital anticipates competing for several local, state, and national grants which may bring additional funds and resources to the state for Alzheimer's research. Receiving a statutory designation as a state Memory Disorder Clinic may help the hospital in its efforts to receive those grant and research dollars.

C. Government Sector Impact:

The bill does not impact state revenues or expenditures.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 430.502 and 1004.445.

## 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.

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

**By** Senator Simmons

9-00495-17 20171050__

A bill to be entitled

An act relating to memory disorder clinics; amending s. 430.502, F.S.; establishing a memory disorder clinic at Florida Hospital in Orange County; reenacting s. 1004.445(3), F.S., relating to providing assistance to memory disorder clinics, to incorporate the amendment made to s. 430.502, F.S., in a reference thereto; providing an effective date.

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

Section 1. Subsection (1) of section 430.502, Florida Statutes, is amended, and subsection (2) is republished, to read:

430.502 Alzheimer's disease; memory disorder clinics and day care and respite care programs.—

(1) There is established:

(a) A memory disorder clinic at each of the three medical schools in this state;

(b) A memory disorder clinic at a major private nonprofit research-oriented teaching hospital, and may fund a memory disorder clinic at any of the other affiliated teaching hospitals;

(c) A memory disorder clinic at the Mayo Clinic in Jacksonville;

(d) A memory disorder clinic at the West Florida Regional Medical Center;

(e) A memory disorder clinic operated by Health First in Brevard County;



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



9-00495-17 20171050__

(f) A memory disorder clinic at the Orlando Regional Healthcare System, Inc.;

(g) A memory disorder center located in a public hospital that is operated by an independent special hospital taxing district that governs multiple hospitals and is located in a county with a population greater than 800,000 persons;

(h) A memory disorder clinic at St. Mary's Medical Center in Palm Beach County;

(i) A memory disorder clinic at Tallahassee Memorial Healthcare;

(j) A memory disorder clinic at Lee Memorial Hospital created by chapter 63-1552, Laws of Florida, as amended;

(k) A memory disorder clinic at Sarasota Memorial Hospital in Sarasota County;

(l) A memory disorder clinic at Morton Plant Hospital, Clearwater, in Pinellas County; ~~and~~

(m) A memory disorder clinic at Florida Atlantic University, Boca Raton, in Palm Beach County; and

(n) A memory disorder clinic at Florida Hospital in Orange County,

for the purpose of conducting research and training in a diagnostic and therapeutic setting for persons suffering from Alzheimer's disease and related memory disorders. However, memory disorder clinics funded as of June 30, 1995, shall not receive decreased funding due solely to subsequent additions of memory disorder clinics in this subsection.

(2) It is the intent of the Legislature that research conducted by a memory disorder clinic and supported by state



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

funds pursuant to subsection (1) be applied research, be service-related, and be selected in conjunction with the department. Such research may address, but is not limited to, diagnostic technique, therapeutic interventions, and supportive services for persons suffering from Alzheimer's disease and related memory disorders and their caregivers. A memory disorder clinic shall conduct such research in accordance with a research plan developed by the clinic which establishes research objectives that are in accordance with this legislative intent. A memory disorder clinic shall also complete and submit to the department a report of the findings, conclusions, and recommendations of completed research. This subsection does not apply to those memory disorder clinics at the three medical schools in the state or at the major private nonprofit research-oriented teaching hospital or other affiliated teaching hospital.

Section 2. For the purpose of incorporating the amendment made by this act to section 430.502, Florida Statutes, in a reference thereto, subsection (3) of section 1004.445, Florida Statutes, is reenacted to read:

1004.445 Johnnie B. Byrd, Sr., Alzheimer's Center and Research Institute.—

(3) BUDGET.—The institute's budget shall include the moneys appropriated in the General Appropriations Act, donated, or otherwise provided to the institute from private, local, state, and federal sources, as well as technical and professional income generated or derived from practice activities at the institute. Any appropriation to the institute shall be expended for the purposes specified in this section, including conducting





and supporting research and related clinical services, awarding institutional grants and investigator-initiated research grants to other persons within the state through a peer-reviewed competitive process, developing and operating integrated data projects, providing assistance to the memory disorder clinics established in s. 430.502, and providing for the operation of the institute.

Section 3. This act shall take effect July 1, 2017.

The Florida Senate

# Committee Agenda Request

**To:** Senator Anitere Flores, Chair
Appropriations Subcommittee on Health and Human Services

**Subject:** Committee Agenda Request

**Date:** March 15, 2017

---

I respectfully request that **Senate Bill 1050**, relating to Memory Disorder Clinics, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator David Simmons
Florida Senate, District 9

File signed original with committee office

S-020 (03/2004)

**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.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

| | |
|---|---|
| BILL: | SB 1056 |
| INTRODUCER: | Senator Garcia |
| SUBJECT: | Home Health Care Agency Licenses |
| DATE: | April 12, 2017 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Stovall | Stovall | HP | **Favorable** |
| 2. | Forbes | Williams | AHS | **Recommend: Favorable** |
| 3. | | | AP | |

## I. Summary:

SB 1056 removes a prohibition on the Agency for Health Care Administration (AHCA) from issuing an initial home health agency license to an applicant that shares common controlling interests with another licensed home health agency that is located in the same county and within 10 miles of the applicant.

There is no fiscal impact on any state revenues or expenditures.

The effective date of the bill is July 1, 2017.

## II. Present Situation:

### Home Health Agencies (HHA)

An HHA is an organization that provides home health services and staffing services.[1] Home health services provided by an HHA include health and medical services and medical supplies provided to an individual in his or her home, such as nursing care, physical and occupational therapy, and home health aide services.[2,3]

[1] Section 400.462(12), F.S.
[2] Section 400.462(14), F.S. Additional services may include dietetics and nutrition practice and nutrition counseling.
[3] Home health aide services may include hands-on personal care, simple procedures as an extension of therapy or nursing services, assisting in ambulation or exercises, and assisting with the self-administration of medication. *See* s. 400.462(15), F.S.

Home health agencies are regulated by the AHCA pursuant to part III of ch. 400, F.S., and the general licensing provisions in part II of ch. 408, F.S. As of March 31, 2017, there are 1950 licensed HHAs in the state.[4]

A license is required to operate as an HHA unless an exemption applies.[5] Numerous exemptions exist and the most common exemptions apply to an HHA operated by the federal government or home health services provided by a state agency, licensed health care practitioner operating under his or her professional license, or other licensed health care facility.[6]

An HHA must designate a geographic service area (one or more counties within an AHCA district) in which the HHA will operate. These counties are identified on the license. An HHA may apply to amend the geographic service area to expand within the AHCA district under the same license.[7]

A licensed HHA may also operate satellite offices under the main HHA license. A satellite office must be located in the same geographic service area as the HHA's main office and share administration, fiscal management, supervision, and service provision with the main office. Supplies and records may be stored at a satellite office and signs and advertisements can notify the public of the satellite office location. If an HHA wants to open an office outside of the geographic services area where the main licensed office is located, it must obtain a separate license.[8]

Section 400.471(7), F.S., prohibits the AHCA from issuing an initial license to an applicant for an HHA license if the applicant shares common controlling interest with another licensed HHA that is located within 10 miles of the applicant and is in the same county. This restriction was enacted in ch. 2008-246, Laws of Fla.

"Controlling interest" means:[9]

- The applicant or license or
- A person or entity that serves as an officer of, is on the board of directors of, or has a five percent or greater ownership interest in the
  - Applicant or licensee or
  - Management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider.

[4] Agency for Health Care Administration, FloridaHealthFinder.gov, search on home health agencies, available at: http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx (last visited March 31, 2017),
[5] Section 400.464, F.S.
[6] Section 400.464(5), F.S.
[7] Rule 59A-8.007, F.A.C. The AHCA reviews the HHA's previous history of survey results and administrative action to assess the HHA's ability to provide quality services within the requested expanded area.
[8] Rule 59A-8.003(7), F.A.C.
[9] Section 408.803(7), F.S.

**Medicare and Medicaid Fraud**

The HHA industry in Florida has been marred with years of uncontrolled growth and health care fraud. The Florida Senate studied HHAs in Florida in 2007, issuing an interim report[10] that outlined unusually rapid growth in licensed HHAs, particularly in South Florida, and indications of possible quality-of-care problems and Medicaid fraud. Numerous regulatory reforms were enacted in 2008 and 2009 which focused on fraud and abuse prevention in the HHA industry.[11]

Ongoing monitoring and Medicare and Medicaid fraud enforcement action continues. Most recently, in fiscal year 2015-2016, 24 HHAs were terminated from participation in the Medicaid program as a result of fraud and abuse,[12] and 26 HHAs were denied enrollment or reenrollment in the Medicaid program because of suspected fraud and abuse.[13]

In addition, the Centers for Medicare and Medicaid Services (CMS) has imposed a federal moratoria on new HHAs in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) in order to target fraud in Florida.[14]

- In July 2013, CMS implemented a moratorium on the enrollment of new HHAs in the Miami area.
- CMS extended the moratorium in 2014 to the metropolitan areas of Fort Lauderdale. The moratoria have since been extended at 6-month intervals and remain in place in both Miami and Ft. Lauderdale.
- Effective July 29, 2016, CMS expanded the moratoria statewide and made it applicable to Medicare, Medicaid, and the CHIP.[15]

There is no indication at this point as to the duration of the CMS imposed moratoria. The CMS has created a Provider Enrollment Moratoria Access Waiver Demonstration (PEWD) which is designed to provide exceptions to the moratoria to ensure that beneficiary access to care is not adversely impacted.[16]

## III. Effect of Proposed Changes:

The bill removes a prohibition on the agency from issuing an initial home health agency license to an applicant that shares common controlling interests with another licensed home health

[10] The Florida Senate, *Review Regulatory Requirements for Home Health Agencies*, November 2007, http://archive.flsenate.gov/data/Publications/2008/Senate/reports/interim_reports/pdf/2008-135hr.pdf (last viewed March 30, 2017)
[11] *See* chs. 2008-246, 2009-193, and 2009-223, Laws of Fla.
[12] Joint Report by the AHCA and the Medicaid Fraud Control Unit with the Office of the Attorney General, The State's Efforts to Control Medicaid Fraud and Abuse FY 2015-16, December 16, 2016, page 57, available at: http://ahca.myflorida.com/Executive/Inspector_General/docs/Medicaid_Fraud_Abuse_Annual_Reports/2015-16_MedicaidFraudandAbuseAnnualReport.pdf (last viewed March 30, 2017).
[13] *Id.* at page 58.
[14] CMS *Provider Enrollment Moratorim*, available at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/ProviderEnrollmentMoratorium.html (last viewed March 30, 2017).
[15] The moratoria was imposed statewide to address problems in the effectiveness of the earlier moratorium because those did not prevent providers outside the moratoria area from billing for servicing beneficiaries within that area.
[16] *Supra*, note 13.

agency that is located in the same county and within 10 miles of the applicant. The bill also removes the directive for the agency to return the application and fees to the applicant.

The effective date of the bill is July 1, 2017.

## 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:

Applicants for an initial HHA license with common controlling interests with a currently licensed HHA will be able to obtain a new license within close proximity to the currently licensed HHA. A new license will enable the HHA to do business under a different license authority.

C. Government Sector Impact:

None.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends section 400.471 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.

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

**By** Senator Garcia

36-00455A-17 20171056__

A bill to be entitled

An act relating to home health care agency licenses; amending s. 400.471, F.S.; removing a prohibition against the issuance of an initial home health agency license to an applicant who shares common controlling interests with another licensed home health agency located within 10 miles of the applicant and in the same county; providing an effective date.

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

Section 1. Subsection (7) of section 400.471, Florida Statutes, is amended to read:

400.471 Application for license; fee.—

~~(7) The agency may not issue an initial license to an applicant for a home health agency license if the applicant shares common controlling interests with another licensed home health agency that is located within 10 miles of the applicant and is in the same county. The agency must return the application and fees to the applicant.~~

Section 2. This act shall take effect July 1, 2017.



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

# The Florida Senate

State Senator René García

36th District

**Please reply to:**

☐ **District Office:**

1490 West 68 Street
Suite # 201
Hialeah, FL. 33014
Phone# (305) 364-3100

April 4th, 2017

The Honorable Anitere Flores
Chair, Appropriations Subcommittee on Health and Human Services
201 The Capitol
404 S. Monroe Street
Tallahassee, FL 32399-1100

Dear Senator Flores,

Please have this letter serve as my formal request to have **SB 1056: Home Health Care Agency Licenses** be heard during the next scheduled Appropriations Subcommittee on Health and Human Services Meeting. Should you have any questions or concerns, please do not hesitate to contact my office.

Sincerely,

State Senator René García
District 36

CC: Phil Williams
Robin Jackson

**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.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

| | |
|---|---|
| BILL: | PCS/CS/SB 1406 (787872) |
| INTRODUCER: | Appropriations Subcommittee on Health and Human Services; Health Policy Committee; and Senator Powell and others |
| SUBJECT: | Stroke Centers |
| DATE: | April 19, 2017 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Rossitto-Van Winkle | Stovall | HP | **Fav/CS** |
| 2. | Forbes | Williams | AHS | **Recommend: Fav/CS** |
| 3. | | | AP | |

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

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

PCS/CS/SB 1406 requires the Agency for Health Care Administration (ACHA) to add acute stroke ready centers to the list of primary stroke centers and comprehensive stroke centers made available to emergency medical services providers. All three levels of stroke centers are treated similarly for purposes of being added to, or removed from, the list. The bill removes language instructing the ACHA to base stroke center rules on criteria established solely by the Joint Commission; and expands rule criteria to be substantially similar to any nationally recognized accrediting organization.

The Department of Health (DOH) is directed to contract with a private entity to establish and maintain a statewide stroke registry to ensure that the stroke performance measures required to be submitted are maintained and available for use to:

- Improve or modify the stroke care system;
- Ensure compliance with standards; and
- Monitor stroke patient outcomes.

Each acute ready stoke center, primary stroke center, and comprehensive stroke center, is required to regularly report to the statewide stroke registry information specified by the department. The contract provider is required to use a nationally recognized platform to collect data from each stroke center on the performance measures and provide regular reports to DOH.

Provides immunity from liability of any kind or character for damages against any acute ready stroke center, primary stroke center, or comprehensive stroke center for having provided such information to the statewide stroke registry.

The cost to create and maintain the statewide stroke registry required by this legislation is unknown. The DOH and AHCA will incur costs associated with rulemaking, but such costs should be absorbed within current resources.

The bill provides an effective date of July 1, 2017.

## II. Present Situation:

### What is a Stroke?

A stroke is a serious medical condition that occurs when the blood supply to the brain is interrupted or severely reduced, depriving brain tissue of oxygen and nutrients.[1] The brain needs a constant supply of oxygen and nutrients in order to function.[2] Even a brief interruption in blood supply from a stoke can cause significant problems.

During a stroke, brain cells begin to die after just a few minutes without blood or oxygen.[3] Brain cell death causes loss of brain function, including impaired ability with movement, speech, thinking and memory, bowel and bladder, eating, emotional control, and other vital bodily functions. A small stroke may result in problems such as weakness in an arm or leg, whereas larger strokes may cause paralysis, loss of speech, or even death.[4] A stroke is one of the leading causes of death in the United States.[5]

There are two main types of strokes: an ischemic stroke and a hemorrhagic stroke. The former, is the most common type, and occurs when an artery in the brain becomes blocked. The latter occurs when a brain artery leaks blood or ruptures.[6]

There are two types of ischemic strokes: thrombotic and embolic.[7] In a thrombotic stroke, a blood clot (thrombus) forms in an artery that supplies blood to the brain.[8] In an embolic stroke, a blood clot, or other substance such as plaque or fatty material, travels through the bloodstream to an artery in the brain.[9] With both types of ischemic stroke, the blood clot or other substance blocks the flow of oxygenated blood to a portion of the brain.[10]

---

[1] The Mayo Clinic, *Stroke*, *available at* http://www.mayoclinic.org/diseases-conditions/stroke/home/ovc-20117264, (last visited Mar. 22, 2017).
[2] UCLA Health, *What is a Stroke? available at* http://stroke.ucla.edu/what-is-a-stroke, (last visited Mar. 23, 2017).
[3] Id.
[4] Id.
[5] National Institutes of Health, National Heart, Lung and Blood Institute, *What Is a Stroke?* (updated Jan. 27, 2017) *available at* https://www.nhlbi.nih.gov/health/health-topics/topics/stroke, (last visited Mar. 23, 2017).
[6] Id.
[7] Id.
[8] Id.
[9] Id. The blood clot or other substance traveling through the bloodstream is called an embolus.
[10] Id.

The two types of hemorrhagic stroke are intracerebral and subarachnoid.[11] In an intracerebral hemorrhage, a blood vessel inside the brain leaks blood or ruptures.[12] In a subarachnoid hemorrhage, a blood vessel on the surface of the brain leaks blood or ruptures, and bleeding occurs between the inner and middle layers of the membrane that covers the brain.[13] In both types of hemorrhagic stroke, the leaked blood causes swelling of the brain and increased pressure in the skull. This swelling and pressure causes brain damage.[14]

***Signs and Symptoms of a Stroke***

The signs and symptoms of a stroke often develop quickly. However, they can develop over hours or even days as well. Signs and symptoms of a stroke may include:

- Sudden weakness;
- Paralysis (an inability to move) or numbness of the face, arms, or legs, especially on one side of the body;
- Confusion;
- Trouble speaking or understanding speech;
- Trouble seeing in one or both eyes;
- Problems breathing;
- Dizziness, trouble walking, loss of balance or coordination, and unexplained falls;
- Loss of consciousness; and
- Sudden and severe headache.[15]

***Stroke Treatment***

Time is of the essence in the treatment of a stroke. Medical personnel begin treatment in the ambulance on the way to the hospital.[16] Treatment for a stroke depends on how much time has elapsed since the symptoms began to appear; and whether the stroke is ischemic or hemorrhagic.[17]

Treatment for an ischemic stroke may include medicines,[18] such as antiplatelet medicines and blood thinners, and medical procedures, but a hemorrhagic stroke may require surgery to find and stop the bleeding.[19] In addition to emergency care to treat a stroke, an individual may also receive treatment to prevent another stroke and rehabilitation to treat the side effects of the stroke.[20] According to the Centers for Disease Control and Prevention (CDC), research indicates

[11] Id.
[12] Id.
[13] Id.
[14] Id.
[15] Id.
[16] Center for Disease Control and Prevention, *Stroke Treatment* (updated Feb. 10, 2017) *available at* https://www.cdc.gov/stroke/treatments.htm, (last visited Mar. 23, 2017).
[17] National Institutes of Health, National Heart, Lung and Blood Institute, *How Is a Stroke Treated?* (updated Jan. 27, 2017) *available at* https://www.nhlbi.nih.gov/health/health-topics/topics/stroke/treatment (last visited Mar. 23, 2017).
[18] Id. Such medication includes a tissue plasminogen activator (TPA), which dissolves, or breaks up the clot. TPA is an injection which must be given within 4 hours of stroke symptoms onset.
[19] Id.
[20] *Supra* note 16.

that patients receiving care at primary stroke centers have a higher incidence of survival and recovery than those treated in hospitals without this type of specialized care.[21]

**Stroke Centers in Florida**

Florida first enacted legislation relating to primary and comprehensive stroke centers in 2004.[22] The AHCA establishes the criteria for both the primary and comprehensive stroke centers.[23] There are 118 Florida hospitals designated as primary stroke centers in 37 counties, and 41 comprehensive stroke centers in 16 counties. [24]

***Primary Stroke Centers***

A primary stroke center certification recognizes hospitals that meet standards to support better outcomes for stroke care.[25] Such hospitals must have a dedicated stroke-focused program, be staffed by qualified medical professionals trained in stroke care, and provide individualized care to meet stroke patients' needs based on recommendations of the Brain Attack Coalition and guidelines published by the American Heart Association/American Stroke Association or equivalent guidelines.[26] These hospitals must also collect and utilize performance data to improve quality of care for stroke patients.[27]

In order for the AHCA to designate a hospital program as a primary stroke center, the hospital program must be certified by the Joint Commission as a primary stroke center, or meet the certification criteria applicable to primary stroke centers as outlined in the Joint Commission Disease-Specific Care Certification Manual, 2nd Edition.[28] The manual requires a primary stroke center to:[29]

- Use a standardized method of delivering care;
- Support patient self-management activities;
- Tailor treatment and intervention to individual needs;
- Promote the flow of patient information across settings and providers, while protecting patient rights, security and privacy;

---

[21] Centers for Disease Control and Prevention, A *Summary Of Primary Stroke Center Policy In The United States* (2011), *available at* https://www.cdc.gov/dhdsp/pubs/docs/primary_stroke_center_report.pdf, (last visited Mar. 23, 2017)
[22] Section 3, ch. 2004-325, Laws of Fla.
[23] Section 395.3038, F.S.
[24] Agency for Health Care Administration, *Senate Bill 1406 Analysis* (Feb. 17, 2017) (on file with the Senate Committee on Health Policy). Although stroke services is dependent upon the availability of qualified health care professionals, the majority of primary stroke centers have fewer than 300 inpatient beds and the majority of comprehensive stroke centers have more than 300 beds.
[25] American Heart Association, *Primary Stroke Center Certification, available at* https://www.heart.org/HEARTORG/Professional/HospitalAccreditationCertification/PrimaryStrokeCenterCertification/Primary-Stroke-Center-Certification_UCM_439155_SubHomePage.jsp, (last visited Mar. 23, 2017).
[26] Id.
[27] Id.
[28] Rule 59A-3.2085(15)(a) F.A.C.
[29] The standards are published in the Comprehensive Certification Manual for Disease-Specific Care. They incorporate the "Recommendations for the Establishment of Primary Stroke Centers" developed by the Brain Attack Coalition. The chapters address program management, delivering or facilitating clinical care, supporting self-management, clinical information management, and performance improvement and measurement.

- Analyze and use standardized performance measure data to continually improve treatment plans; and
- Demonstrate their application of and compliance with clinical practice guidelines published by the American Heart Association/American Stroke Association or equivalent evidence-based guidelines.[30]

***Comprehensive Stroke Centers***

A comprehensive stroke center certification recognizes hospitals that meet standards to treat the most complex stroke cases.[31] These hospitals must meet all the criteria of a primary stroke center; they must also have advanced imaging techniques and personnel trained in vascular neurology, neurosurgery and endovascular procedures available 24 hours a day, seven days a week, as well as neuroscience intensive care unit (ICU) and experience and expertise treating patients with large ischemic strokes, intracerebral hemorrhage and subarachnoid hemorrhage.

In order for the AHCA to designate a hospital program as a comprehensive stroke center, the hospital program must have received primary stroke center designation and also have the following:

- Personnel with clinical expertise in specified disciplines available;[32]
- Advanced diagnostic capabilities;[33]
- Neurosurgical and endovascular interventions available;[34]
- Specialized infrastructure; [35] and
- Quality improvement and clinical outcomes measurements.[36]

The specialized infrastructure includes extensive requirements that the emergency medical services (EMS) and comprehensive stroke center leadership are linked to ensure:

- EMS use a stroke triage assessment tool;
- EMS patient assessment and management at the scene is consistent with evidence-based practice;
- Inter-facility transfers; and
- On-going communication with EMS providers regarding availability of services; and
- A comprehensive stroke center maintains:
  - An acute stroke team available 24 hours per day, 7 days per week;
  - A system for facilitating inter-facility transfers;
  - Defined access telephone numbers in a system for accepting appropriate transfer;

[30] The Joint Commission, *Facts about Primary Stroke Center Certification* (Jan. 6, 2015), *available at* https://www.jointcommission.org/facts_about_primary_stroke_center_certification/ (last visited Mar. 23, 2017).
[31]The American Heart Association, *Comprehensive Stroke Center Certification, available at* https://www.heart.org/HEARTORG/Professional/HospitalAccreditationCertification/ComprehensiveStrokeCenterCertification/Comprehensive-Stroke-Center-Certification_UCM_455446_SubHomePage.jsp, (last visited Mar. 23, 2017).
[32] *See* Fla. Admin. Code R. 59A-3.2085(15)(b), for specific qualifications. Medical personnel with neurosurgical expertise must be available in a CSC on a 24 hours per day, seven days per week basis and in-house within two hours, and neurologist(s) with special expertise in the management of stroke patients should be available 24 hours per day, seven days per week.
[33] Id.
[34] Id.
[35] Id.
[36] Id.

- Specialized inpatient units including an ICU with medical and nursing personnel who have special training, skills and knowledge in the management of patients with all forms of neurological or neurosurgical conditions that require intensive care;
- An acute stroke unit with medical and nursing personnel who have training, skills and knowledge sufficient to care for patients with neurological conditions, particularly acute stroke patients, and who are appropriately trained in neurological assessment and management;
- Inpatient post-stroke rehabilitation and ensure continuing arrangements post-discharge for rehabilitation needs and medical management;
- Its medical and paramedical professionals education by offering ongoing professional education for all disciplines; and provide education to the public and inpatients and families on risk factor reduction or management, primary and secondary prevention, the warning signs and symptoms of stroke, and medical management and rehabilitation for stroke patients;
- Provide a career development track to develop neuroscience nursing, particularly in the area of cerebrovascular disease; and
- Professional and administrative infrastructure necessary to conduct clinical trials and should have participated in stroke clinical trials within the last year and actively participate in ongoing clinical stroke trials.[37]

***Stroke Patient Transportation***

The DOH has also developed a stroke assessment tool.[38] The tool is available on the DOH's website and is provided to emergency medical services providers.[39] Each licensed emergency medical services provider must use a stroke-triage assessment tool that is substantially similar to the DOH's stroke-triage assessment tool.[40] Annually, by June 1, each year the DOH sends the list of primary stroke centers and comprehensive stroke centers to the medical director of each licensed emergency medical services provider in Florida.[41]

***Stroke Center Inventory***

The AHCA maintains an inventory of hospitals offering stroke services.[42] A listing of hospitals meeting the criteria as either a primary stroke center or comprehensive stroke center is published on the AHCA's website.[43,44]

Currently, there are no data reporting requirements for stroke centers related to quality measures.[45] There are 274 emergency medical service providers, 222 acute care hospitals and 25 medical examiner districts that report patient data to the DOH.[46] However, the data is not

[37] Id.
[38] Section 395.3041(2), F.S.
[39] Section 395.3041(2), F.S.
[40] Id.
[41] Section 395.3041(1), F.S.
[42] Section 395.3038, F.S.
[43] *Supra* note 24.
[44] Id. A list of hospitals with a stroke center designation is also available through the facility locator tool on www.floridahealthfinder.gov, (last visited Mar. 23, 2017).
[45] Id.
[46] *Supra* note 24.

standardized and much of the data that the DOH currently collects comes from voluntary participation in the DOH's EMS Tracking and Reporting System (EMSTARS) program[47] and only includes data on response, provider impression, procedures and medication, and destination.[48]

**Acute Stroke Ready Centers**

Many patients with an acute stroke live in areas without ready access to a primary or comprehensive stroke center; more than half the U.S. population lives more than an hour away from a stroke center.[49] Hospitals in areas with low population densities and relatively small numbers of patients with strokes may be less likely to have the resources to become a stroke center and may lack the experience and expertise to provide ongoing care for a stroke.[50] In such settings, there is a need to distinguish between those that offer enhanced care and expertise for acute stroke versus those with only basic or no organized abilities and expertise.[51]

A recent study by the American Stroke Association proposed a new designation for hospitals that are not primary stroke centers, but can provide timely, evidence-based care to most patients with an acute stroke; these acute stroke-ready hospitals provide initial diagnostic services, stabilization, emergent care and therapies to patients with an acute stroke who are seen in their emergency department, and would then transfer these patients to a primary or comprehensive stroke center.[52]

**Accrediting Organizations**

The Joint Commission, the Healthcare Facilities Accreditation Program, and the DNV GL (formerly known as Det Norske Veritas) offer certification as an acute stroke ready centers, as well as primary and comprehensive stroke centers.[53]

## III. Effect of Proposed Changes:

**Acute Stroke Ready Centers**

**Section 1** amends s. 395.3038, F.S., to recognize a new level of stroke services: an acute stroke ready center. A hospital could receive an acute stroke ready center designation by attesting to the ACHA on the appropriate form that, among other things, it is accredited by a nationally recognized accrediting organization or meets the criteria for accreditation. A hospital with an acute stroke ready center designation is required to notify the ACHA if it no longer meets the criteria.

---

[47] The EMSTARS program allows emergency medical providers to capture incident level patient care records for every emergency activation.
[48] *Supra* note 46.
[49] Mark J. Alberts, et al, *Formation and Function of Acute Stroke–Ready Hospitals Within a Stroke System of Care Recommendations From the Brain Attack Coalition*, Stroke, Vol. 44, Issue 12 (Nov. 25, 2013), *available at* http://stroke.ahajournals.org/content/44/12/3382.full, (last visited Mar. 23, 2017).
[50] Id.
[51] Id.
[52] Id.
[53] *Supra* note 24.

The bill removes language instructing the ACHA to base stroke center rules on criteria established solely by the Joint Commission; and expands criteria to be substantially similar to any nationally recognized accreditation organization's criteria for the level of stroke center.

Acute stroke ready centers must be added to the list of stroke centers the DOH supplies to emergency medical services providers in the state. The bill requires the AHCA to develop and adopt by rule electronic standardized forms for stroke centers to report data to the DOH, including patient care quality assurance proceedings, records, or reports associated with any treatment or service provided to a person suffering a stroke.

Currently, there are approximately 60 acute care hospitals that do not have primary or comprehensive stroke center designation and may be eligible for an acute stroke ready center designation. The majority of these hospitals have less than 100 beds.[54]

**Statewide Stroke Registry**

**Section 2** creates the 395.3081, F.S., relating to statewide stroke registry, to require the DOH to contract, subject to an appropriation, with a private entity to establish and maintain a statewide stroke registry to ensure that the stroke performance measures required to be submitted are maintained and available for use to improve or modify the stroke care system. This provider is required to use a nationally recognized platform to collect data from each stroke center on the performance measures and provide regular reports to the department. Requires each stroke center, primary stroke center, and comprehensive stroke center to regularly report to the statewide stroke registry information specified by the department, including nationally recognized stroke performance measures. Provides immunity from liability of any kind or character for damages against any acute ready stroke center, primary stroke center, or comprehensive stroke center for having provided such information to the statewide stroke registry.

**Section 3** amends s. 395.3041, F.S., to removes obsolete deadlines for the DOH to implement the stroke-triage assessment tool. This section also directs the DOH to include the acute stroke ready centers on the list of stroke-related facilities to the licensed emergency medical services providers in the state.

The bill provides an effective date of July 1, 2017.

## IV. Constitutional Issues:

### A. Municipality/County Mandates Restrictions:

None.

[54] *See* The Joint Commission, *Certification for Primary Stroke Centers, available at* https://www.jointcommission.org/certification/primary_stroke_centers.aspx, *and Certification Comprehensive Stroke Centers, available at* https://www.jointcommission.org/certification/advanced_certification_comprehensive_stroke_centers.aspx (last visited Mar. 28, 2017); DNV-GL, *Healthcare, available at* http://dnvglhealthcare.com/search?q=stroke+centers&s=rank; and Healthcare Facilities Accreditation Program, *available at* http://www.hfap.org/AccreditationPrograms/stroke.aspx, (last visited Mar. 28, 2017).

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:

Public hospitals that are required to submit data to the DOH under the bill, may be required to purchase new software and incur labor costs to collect, maintain and send the required data to the DOH. The estimated cost of this is unknown at this time.

C. Government Sector Impact:

The DOH will incur rulemaking costs to implement the registry. The DOH may also incur costs to develop and maintain the registry or to contract with a private entity to establish and maintain the registry. There is no appropriation provided in the bill to establish the registry.

The AHCA will incur rulemaking costs related to updating criteria for acute stroke ready centers and comprehensive stroke centers. According to the AHCA, current resources can absorb these costs.[55]

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

A public records exemption (separate bill) may be necessary to protect the confidentiality of information in the statewide stroke registry.

## VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 395.3038 and 395.3041.

This bill creates section 395.30381 of the Florida Statutes.

[55] *Supra* note 24.

## IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

**Recommended CS/CS by Appropriations Subcommittee on Health and Human Services on April 18, 2017:**
The committee substitute:

- Creates 395.3081, F.S., related to statewide stroke registry.
- Requires that, subject to appropriation, the DOH is to contract with a private entity to establish and maintain a statewide stroke registry to ensure that the stroke performance measures required to be submitted are maintained and available for use to improve or modify the stroke care system. This provider is required to use a nationally recognized platform to collect data from each stroke center on the performance measures and provide regular reports to the department.
- Requires each stroke center, primary stroke center, and comprehensive stroke center to regularly report to the statewide stroke registry information specified by the department, including nationally recognized stroke performance measures.
- Provides immunity from liability of any kind or character for damages against any acute ready stroke center, primary stroke center, or comprehensive stroke center for having provided such information to the statewide stroke registry.

**CS by Health Policy on March 27, 2017:**
Deletes emergency medical services providers and medical examiners from the list of entities required to submit to the DOH patient care quality assurance proceedings, records, or reports associated with any treatment or services provided to a person suffering a stroke.

B. Amendments:

None.

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

374610

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 04/19/2017 | . | |
| | . | |
| | . | |
| | . | |

Appropriations Subcommittee on Health and Human Services (Powell) recommended the following:

**Senate Amendment (with title amendment)**

Delete lines 68 - 96
and insert:
Section 2. Section 395.30381, Florida Statutes, is created to read:
395.30381 Statewide stroke registry.—
(1) Subject to a specific appropriation, the department shall contract with a private entity to establish and maintain a statewide stroke registry to ensure that the stroke performance

374610

measures required to be submitted under subsection (2) are maintained and available for use to improve or modify the stroke care system, ensure compliance with standards, and monitor stroke patient outcomes.

(2) Each acute ready stroke center, primary stroke center, and comprehensive stroke center shall regularly report to the statewide stroke registry information specified by the department, including nationally recognized stroke performance measures.

(3) The department shall require the contracted entity to use a nationally recognized platform to collect data from each stroke center on the stroke performance measures required in subsection (2). The contracted entity shall provide regular reports to the department on the data collected.

(4) No liability of any kind or character for damages or other relief shall arise or be enforced against any acute ready stroke center, primary stroke center, or comprehensive stroke center by reason of having provided such information to the statewide stroke registry.

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

And the title is amended as follows:

Delete lines 6 - 14

and insert:

stroke centers; creating s. 395.30381, F.S.; requiring the department to contract with a private entity to establish and maintain a statewide stroke registry, subject to an appropriation; requiring stroke centers to provide certain information to the statewide stroke

374610

registry; requiring the contracted entity to use a nationally recognized platform to collect data; requiring the contracted entity to provide reports to the department on stroke performance measures; providing immunity from liability under certain circumstances; amending s. 395.3041, F.S.;

**By** the Committee on Health Policy; and Senators Powell, Passidomo, and Baxley

588-02959A-17 20171406c1

A bill to be entitled

An act relating to stroke centers; amending s. 395.3038, F.S.; directing the Agency for Health Care Administration to include hospitals that meet the criteria for acute stroke ready centers on a list of stroke centers; directing the agency to adopt rules governing such criteria and the development of certain electronic forms to provide reports to the Department of Health; creating s. 395.30381, F.S.; requiring stroke centers to provide certain information to the department; requiring the department to establish a statewide stroke registry; providing immunity from liability under certain circumstances; requiring the department to adopt rules; amending s. 395.3041, F.S.; conforming a provision and deleting obsolete dates; providing an effective date.

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

Section 1. Section 395.3038, Florida Statutes, is amended to read:

395.3038 State-listed ~~primary stroke centers and comprehensive~~ stroke centers; notification of hospitals.—

(1) The agency shall make available on its website and to the department a list of the name and address of each hospital that meets the criteria for an acute stroke ready center, a primary stroke center, or ~~and the name and address of each hospital that meets the criteria for~~ a comprehensive stroke center. The list of ~~primary and comprehensive~~ stroke centers



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



588-02959A-17 20171406c1

must include only those hospitals that attest in an affidavit submitted to the agency that the hospital meets the named criteria, or those hospitals that attest in an affidavit submitted to the agency that the hospital is certified as an acute stroke ready center, a primary stroke center, or a comprehensive stroke center by a nationally recognized ~~an~~ accrediting organization.

(2)(a) If a hospital no longer chooses to meet the criteria for an acute stroke ready center, a primary stroke center, or a comprehensive stroke center, the hospital shall notify the agency and the agency shall immediately remove the hospital from the list of stroke centers.

(b)1. This subsection does not apply if the hospital is unable to provide stroke treatment services for a period of time not to exceed 2 months. The hospital shall immediately notify all local emergency medical services providers when the temporary unavailability of stroke treatment services begins and when the services resume.

2. If stroke treatment services are unavailable for more than 2 months, the agency shall remove the hospital from the list of ~~primary or comprehensive~~ stroke centers until the hospital notifies the agency that stroke treatment services have been resumed.

(3) The agency shall adopt by rule criteria for an acute stroke ready center, a primary stroke center, and a comprehensive stroke center which are substantially similar to the certification standards for the same categories of ~~primary~~ stroke centers of a nationally recognized accrediting organization ~~the Joint Commission~~.



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

~~(4) The agency shall adopt by rule criteria for a comprehensive stroke center. However, if the Joint Commission establishes criteria for a comprehensive stroke center, agency rules shall be substantially similar.~~

(4)~~(5)~~ This act is not a medical practice guideline and may not be used to restrict the authority of a hospital to provide services for which it is licensed under chapter 395. The Legislature intends that all patients be treated individually based on each patient's needs and circumstances.

(5) The agency shall adopt by rule standardized electronic forms for each acute stroke ready center, primary stroke center, and comprehensive stroke center to report to the department such information as required in s. 395.30381.

Section 2. Section 395.30381, Florida Statutes, is created to read:

395.30381 Statewide stroke registry.—

(1) Each acute ready stroke center, primary stroke center, and comprehensive stroke center shall submit to the department patient care quality assurance proceedings, records, or reports associated with any treatment or service provided to a person suffering a stroke. Such information shall be used to evaluate stroke care system effectiveness, ensure compliance with standards established pursuant to s. 395.3038, and monitor patient outcomes.

(2) The department shall establish a statewide stroke registry to ensure that patient care quality assurance proceedings, records, and reports required to be submitted under subsection (1) are maintained and available for use to improve or modify the stroke care system, ensure compliance with





standards, and monitor stroke patient outcomes. The department may contract with a private entity to establish and maintain the registry. No liability of any kind or character for damages or other relief shall arise or be enforced against any acute ready stroke center, primary stroke center, or comprehensive stroke center by reason of having provided such information to the department.

(3) The department shall adopt rules to administer this section.

Section 3. Subsections (1), (2), and (4) of section 395.3041, Florida Statutes, are amended to read:

395.3041 Emergency medical services providers; triage and transportation of stroke victims to a stroke center.—

(1) By June 1 of each year, the department shall send the list of acute stroke ready centers, primary stroke centers, and comprehensive stroke centers to the medical director of each licensed emergency medical services provider in this state.

(2) The department shall develop a sample stroke-triage assessment tool. The department must post this sample assessment tool on its website and provide a copy of the assessment tool to each licensed emergency medical services provider ~~no later than June 1, 2005~~. Each licensed emergency medical services provider must use a stroke-triage assessment tool that is substantially similar to the sample stroke-triage assessment tool provided by the department.

(4) Each emergency medical services provider licensed under chapter 401 must comply with all sections of this act ~~by July 1, 2005~~.

Section 4. This act shall take effect July 1, 2017.

The Florida Senate

# Committee Agenda Request

**To:** Senator Antiere Flores, Chair
Appropriations Subcommittee on Health and Human Services

**Subject:** Committee Agenda Request

**Date:** April 5, 2017

---

I respectfully request that **Senate Bill #1406**, relating to Stroke Centers, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Bobby Powell
Florida Senate, District 30

File signed original with committee office

S-020 (03/2004)

# CourtSmart Tag Report

**Room:** SB 401 **Case No.:** **Type:**
**Caption:** Senate Appropriations Subcommittee on Health And Human Services **Judge:**

**Started: 4/13/2017 2:34:01 PM**
**Ends: 4/13/2017 3:30:56 PM Length: 00:56:56**

**2:34:03 PM** Sen. Flores (Chair)
**2:34:29 PM** CS/SB 682
**2:34:41 PM** Sen. Stargel
**2:35:17 PM** Sen. Flores
**2:35:24 PM** Am. 625180
**2:35:33 PM** Sen. Stargel
**2:35:41 PM** Sen. Flores
**2:35:56 PM** Geoff Fraser, Senior Vice President, Clear Choice Health Care, waives in support
**2:36:02 PM** Ron Reid, Administrator, Centre Pointe Health and Rehab, waives in support
**2:36:12 PM** Deborah Franklin, Senior Director of Quality, Florida Health Care Association, waives in support
**2:36:24 PM** Sen. Stargel
**2:36:25 PM** Sen. Flores
**2:36:48 PM** SB 916
**2:37:02 PM** Sen. Stargel
**2:38:08 PM** Sen. Flores
**2:38:18 PM** Sen. Baxley
**2:39:01 PM** Sen. Stargel
**2:39:21 PM** Sen. Flores
**2:39:27 PM** Am. 587308
**2:39:35 PM** Sen. Stargel
**2:39:47 PM** Sen. Flores
**2:39:58 PM** Am. 306190
**2:40:04 PM** Sen. Stargel
**2:40:17 PM** Sen. Flores
**2:40:21 PM** Sen. Powell
**2:40:37 PM** Sen. Stargel
**2:40:52 PM** Sen. Flores
**2:41:05 PM** Am.167498
**2:41:12 PM** Sen. Stargel
**2:41:20 PM** Sen. Flores
**2:41:58 PM** TAB- 3
**2:42:50 PM** Justin Senior, Secretary of Health Care Administration
**2:46:26 PM** Sen. Flores
**2:46:31 PM** Sen. Book
**2:47:00 PM** J. Senior
**2:47:34 PM** Sen. Book
**2:47:50 PM** J. Senior
**2:48:35 PM** Sen. Book
**2:48:48 PM** J. Senior
**2:50:14 PM** Sen. Powell
**2:50:26 PM** J. Senior
**2:51:07 PM** Sen. Powell
**2:51:33 PM** J. Senior
**2:53:06 PM** Sen. Powell
**2:53:42 PM** J. Senior
**2:54:54 PM** Sen. Powell
**2:55:14 PM** J. Senior
**2:55:21 PM** Sen. Flores
**2:55:25 PM** Sen. Rader
**2:55:41 PM** J. Senior
**2:56:10 PM** Sen. Flores
**2:56:37 PM** J. Senior

**2:57:51 PM** Sen. Rader
**2:58:18 PM** J. Senior
**3:05:17 PM** Sen. Flores
**3:05:20 PM** Sen. Book
**3:06:10 PM** J. Senior
**3:08:55 PM** Sen. Book
**3:09:19 PM** Sen. Flores
**3:10:08 PM** J. Senior
**3:11:54 PM** Sen. Flores
**3:12:52 PM** J. Senior
**3:15:13 PM** Sen. Flores
**3:15:18 PM** Sen. Baxley
**3:17:58 PM** J. Senior
**3:19:25 PM** Sen. Flores
**3:20:12 PM** TAB-4
**3:20:32 PM** Celeste Philip, State Surgeon General, Florida Department of Health
**3:26:47 PM** Sen. Flores
**3:26:50 PM** Sen. Rader
**3:27:40 PM** C. Philip
**3:29:13 PM** Sen. Flores
**3:29:15 PM** Sen. Rader
**3:29:47 PM** Sen. Flores
**3:30:04 PM** Sen. Rader
**3:30:14 PM** Sen. Flores
**3:30:55 PM** Meeting Adjourned