

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 Committee on Health Policy

BILL: SB 778

INTRODUCER: Senator Baxley

SUBJECT: Program of All-Inclusive Care for the Elderly

DATE: March 1, 2019

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Brown	HP	Pre-meeting
2.			AHS	
3.			AP	

I. Summary:

SB 778 codifies the Program of All-Inclusive Care for the Elderly (PACE) in s. 430.84, F.S. The PACE was first authorized in 1998 and became operational in 2003 in Miami-Dade County, but has not been codified in state law. With almost 2,000 Medicaid managed care eligible recipients already enrolled in seven counties, The bill establishes a statutory process for the review, approval, and oversight of future and current PACE organizations, including:

- Specifying funding and enrollment requirements;
- Providing notification requirements for PACE organization applications;
- Requiring the Agency for Health Care Administration (AHCA) and the Department of Elder Affairs (DOEA) to provide monitoring and oversight of PACE organizations;
- Directing PACE organizations to enroll participants at levels funded by the General Appropriations Act (GAA);
- Permitting retroactive enrollment at the discretion of a PACE organization; and
- Providing other eligibility guidelines and requirements for Medicaid recipients enrolled in PACE organizations.

The bill exempts all PACE organizations from the requirements of chapter 641, which regulates health maintenance organizations, prepaid health clinics, and other health care service programs.

The fiscal impact of the bill is unknown. The AHCA and DOEA are currently performing many of the tasks described in the bill. If additional funding were provided to expand the number of PACE sites, then additional resources may be necessary at the affected state agencies to adapt to the related, increased volume of applications and necessary oversight at the additional sites.

The effective date of the bill is July 1, 2019.

II. Present Situation:

Program of All-Inclusive Care for the Elderly (PACE)

The PACE is a capitated benefit model authorized by the federal Balanced Budget Act of 1997 (BBA)¹ that features a comprehensive service delivery system and integrated federal Medicare and state Medicaid financing. The model, which was tested through federal Centers for Medicare and Medicaid Services (CMS) demonstration projects beginning in the mid-1980s,² was developed to address the needs of long-term care clients, providers, and payers. The PACE operates as a three-way agreement between the federal government, the state administering agency, and a PACE organization. In Florida, the PACE is a Florida Medicaid long-term care managed care plan option providing comprehensive long-term and acute care services which supports Medicaid and Medicare enrollees who would otherwise qualify for Medicaid nursing facility services.³

The PACE is a unique federal/state partnership. The BBA established the PACE model of care as a permanent entity within the Medicare program and enabled states to provide PACE services to Medicaid beneficiaries as an optional state plan service without a Medicaid waiver.

The federal government established the PACE organization requirements and application process while the state Medicaid agency or other state agency is responsible for oversight of the application process, which includes reviewing the initial application and providing an on-site readiness review before a PACE organization can be authorized to serve patients. An approved PACE organization must sign a contract with CMS and the state Medicaid agency.

The DOEA serves as the operating entity and oversees the contracted PACE organizations but is not a party to the contract between CMS, the AHCA, and the PACE organizations.⁴ DOEA, AHCA, and CMS must approve any applications for new PACE organizations if expansion has been authorized by the Legislature through the necessary appropriation of the state matching funds.

A PACE organization must be part of either a city, county, state, or tribal government; a private not-for-profit 501(c)(3) organization; or for-profit entity that is primarily engaged in providing PACE services and must also:

- Have a governing board that includes participant representation;
- Be able to provide the complete service package regardless of frequency or duration of services;
- Have a physical site to provide primary care, social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals;

¹ Specifically, services under the PACE program are authorized under Section 1905(a)(26) of the Social Security Act.

² Department of Health and Human Services, Centers for Medicare and Medicaid Services, *CMS Manual System: Pub. 100-11 Programs of All-Inclusive Care for the Elderly (PACE) Manual* (issued 6-9-2011), available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pace111c01.pdf> (last visited Feb. 21, 2019).

³ Department of Elder Affairs and Agency for Health Care Administration, *Program of All-Inclusive Care for the Elderly and Statewide Medicaid Managed Care Long-term Care Program Comparison Report* (Jan. 14, 2014), p 3, available at http://ahca.myflorida.com/docs/PACE_Evaluation_2014.pdf (last visited Feb. 21, 2019).

⁴ *Id.*

- Have a defined service area;
- Have safeguards against conflicts of interest;
- Have a demonstrated fiscal soundness;
- Have a formal participant bill of rights; and
- Have a process to address grievances and appeals.⁵

Eligibility and Benefits

PACE participants must be at least 55 years of age, live in the PACE service area, and be certified eligible for nursing home care but able to live safely in the community. The PACE becomes the sole source of services for these Medicare and Medicaid eligible enrollees. Additionally, by electing to enroll in the PACE, the enrollee is agreeing to forgo other options for medical services and receive all of their services through the PACE organization.⁶

Under the PACE, an interdisciplinary team consisting of professional and paraprofessional staff assesses participants' needs, develops care plans, and delivers all services, including acute care and nursing facility services when necessary, which are integrated to provide a seamless delivery model. In most cases, a PACE organization provides social and medical services in a health center with supplemental services through in-home and referral services as necessary. The PACE service package must include all Medicare and Medicaid covered services and other services determined necessary by the multidisciplinary team for the care of the PACE participant.⁷

Before being approved to operate and deliver services, PACE organizations are required to provide evidence of the necessary financial capital to deliver the benefits and services, which include a combined adult day care center and primary care clinic, transportation, and full range of clinical and support staff with the interdisciplinary team of professionals.⁸

By federal law, the first three contract years for a PACE organization are considered a trial period, and the PACE organization is subject to annual reviews to ensure compliance.⁹ The site visit reviews include:

- A comprehensive assessment of an organization's fiscal soundness.
- A comprehensive assessment of the organization's capacity to provide all PACE services to all enrolled participants.
- A detailed analysis of the PACE organization's substantial compliance with all the federal statutory requirements and accompanying federal regulations.
- Compliance with any other elements the Secretary of the Department of Health and Human Services (secretary) or the state's administering agency considers necessary and appropriate.¹⁰

⁵ *Supra* note 2.

⁶ *Id.*

⁷ *Id.*

⁸ *Supra* note 3, at 4.

⁹ *See* 42 U.S.C. s. 1395eee(e)(4)(A)(2019).

¹⁰ *Id.*

Review of the PACE organization may continue after the trial period by the secretary or the administering state agency as appropriate, depending upon the PACE organization's performance and compliance with requirements and regulations.

No deductibles, copayments, coinsurance, or other cost-sharing can be charged by a PACE organization. No other limits relating to amount, duration, or scope of services that might otherwise apply in Medicaid are permitted.¹¹ The PACE enrollee must accept the PACE center physician as his or her new Medicare primary care physician, if enrolled in Medicare.¹²

Quality of Care Requirements

Each PACE organization is required to develop, implement, maintain, and evaluate an effective data-driven quality assurance, performance improvement (QAPI) program. The program must incorporate all aspects of the PACE organization's operations, which allows for the identification of areas that need performance improvement. The organization's written QAPI plan must be reviewed by the PACE organization's governing body at least annually. The plan should address at least the following areas:

- Utilization of services in the PACE organization, especially in key services.
- Participant and caregiver satisfaction with services.
- Data collected during patient assessments to determine if individual and organizational-level outcomes were achieved within a specified time period.
- Effectiveness and safety of direct and contracted services delivered to participants.
- Outcomes in the organization's non-clinical areas.¹³

Florida PACE

The Florida PACE project was initially authorized in ch. 98-327, Laws of Florida, under the administration of the DOEA operating in consultation with the AHCA.¹⁴ Florida's first PACE organization was located in Miami-Dade County and began serving enrollees in February 2003 with a total of 150 slots. Since then, the Legislature has approved additional slots either as part of the GAA or general law. Currently, PACE organizations with funded slots exist in these Florida counties: Baker, Broward, Charlotte, Clay, Collier, Desoto, Duval, Lee, Miami-Dade, Palm Beach, Pinellas, Manatee, Martin, Nassau, Sarasota, and St. John's.

In 2011, the Legislature moved administrative responsibility for the PACE program from the DOEA to the AHCA as part of the expansion of Medicaid managed care into the Statewide Medicaid Managed Care program (SMMC).¹⁵ Participation by PACE in SMMC is not subject to the procurement requirements or regional plan number limits normally applicable to SMMC

¹¹ *Supra* note 2.

¹² Dep't of Elder Affairs and Agency for Health Care Administration, *Program of All-Inclusive Care for the Elderly and Statewide Medicaid Managed Care Long-term Care Program Comparison Report* (Jan. 14, 2014), available at http://ahca.myflorida.com/docs/PACE_Evaluation_2014.pdf (last visited Mar. 27, 2014).

¹³ *Id.*

¹⁴ Chapter 2011-135, s. 24, L.O.F., repeals s. 430.707, F.S., effective Oct 1, 2013, as part of the expansion of Medicaid managed care.

¹⁵ Chapter 2011-135, s. 24, L.O.F., repeals s. 430.707, F.S., effective Oct. 1, 2013.

managed care plans. Instead, PACE plans may continue to provide services to individuals at such levels and enrollment caps as authorized by the GAA.¹⁶

The 2013 Legislature also directed the AHCA and the DOEA to provide a comprehensive report describing the PACE's organizational structure, scope of services, utilization, and costs; comparing those findings with similar information for managed long-term care, and evaluating alternative methods for integrating PACE with Long-Term Care Managed Care.¹⁷ The report's findings noted a difference in the average age (81.1 years in SMMC versus 75.5 in PACE),¹⁸ prevalence of severe emotional problems (PACE enrollees are more likely to report), and affliction with cognitive impairments such as dementia (higher with Long-Term Care Managed Care).¹⁹

The current PACE approval process requires any entity interested in becoming a PACE organization to submit a comprehensive PACE application to the AHCA, which sets forth details about the adult day care center, staffing, provider network, financial solvency and pro forma financial projections, and policies and procedures, among other elements. The application is similar in detail to the provider applications submitted by managed care plans seeking to provide medical care to Medicaid recipients. Providers operating in the same geographic region must establish that there is adequate demand for services so that each provider will be viable. The application requires that documentation be submitted demonstrating that neither provider is competing for the same potential enrollees.

The AHCA and the DOEA review the application and, when the entity has satisfied all requirements, conduct an on-site survey of the entity's readiness to serve PACE enrollees. Once all requirements are met, including full licensure of the center, staffing for key positions, and signed provider network contracts, the AHCA certifies to federal CMS that the PACE site is ready. At that time, CMS reviews the application and readiness certification and, if all requirements are satisfied, executes a three-way agreement with the PACE provider and the AHCA. The PACE provider may then begin enrolling members, subject to an appropriation to fund the slots.

Enrollment and Organizational Slots

Slots are authorized by the Legislature for a specific PACE area; however, those slots may not always be fully funded in the same year as the program is authorized. Some PACE providers need additional time to complete the application process, obtain necessary licensures, or to finalize operations. The chart below summarizes the current status of approved PACE organizations.

¹⁶ Section 409.981(4), F.S.

¹⁷ Chapter 2013-40, L.O.F., line 424.

¹⁸ Dep't of Elder Affairs, *Supra* note 2, at 20.

¹⁹ *Id* at 19.

SUMMARY OF PACE PROGRAMS ²⁰					
PACE ORGANIZATION			SLOT INFORMATION		
Area	Year	Organization	Auth. Slots	Funded Slots	Current Enrollment ²¹ (Jan. 2019)
Broward	2014	Florida PACE	150	125	65
Charlotte	2010	Hope Select	150	150	66
Collier	2010	Hope Select	120	120	37
Desoto, Manatee, and Sarasota	NA	Tidewell	150	0	0
Gadsden, Jefferson, Leon and Wakulla	NA	Elder Care Services	300	100	0
Hillsborough	2011	Suncoast Neighborly PACE	150	0	0
Lee	2010	Hope Select	380		213
Martin	2018	Morse PACE	150	75	0
Miami-Dade	2003	Miami-Dade	809	809	759
Northeast Florida (Clay, Duval, St. Johns, Baker, Nassau)	2018	Northeast Florida PACE	300	100	
Orange, Osceola, Lake and Sumter	NA	Cornerstone PACE	150	0	0
Palm Beach	2013	Morse PACE	656	656	493
Panhandle		Covenant	100	100	
Pinellas	2009	Suncoast Neighborly PACE	325	325	316
Seminole	NA	Cornerstone PACE	150	0	0
Total Enrollees - Statewide:			4,040	2,740	1,949

Funding and Rates

Each year since the PACE's inception, the Legislature has appropriated funds for PACE organizations through proviso language in the state's General Appropriations Act (GAA) or through one of the appropriation implementing or conforming bills.²² These directives provide specific slot increases or decreases by county or authorization for a county to implement a new program. In 2013, Governor Scott vetoed the allocations in all counties except Palm Beach, noting that the state's focus should be on the implementation of the SMMC and that effectiveness and the need for additional PACE slots should be re-evaluated after that transition was completed.²³

²⁰ Agency for Health Care Administration and Department of Elder Affairs, *SPB 7124 - Relating to the Program of All-Inclusive Care for the Elderly (PACE) Bill Analysis and Background Information* (Mar. 28, 2014) on file with the Senate Health Policy Committee.

²¹ Agency for Health Care Administration, *Florida Statewide Medicaid Monthly Enrollment Report Program Enrollment by Region* (January 2019) available at http://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited Feb. 25, 2019).

²² Chapter 2013-40, L.O.F.

²³ Governor Rick Scott, *Veto Message - SB 1500* (May 20, 2013), p. 28, available at <http://www.flgov.com/wp-content/uploads/2013/05/Message1.pdf> (last visited Feb. 21, 2019).

PACE organizations receive a capitated Medicaid payment for each enrolled Medicaid long-term care recipient and an enhanced Medicare payment for Medicare enrollees for acute care services from the federal government. The payment amount is established in the GAA and is based on estimates that have been forecast by the Social Services Estimating Conference (SSEC) for the PACE. The SSEC principals from the Office of Economic and Demographic Research, the Governor's Office of Planning and Budget, the budget staff of the House of Representatives and the Florida Senate, seek a consensus on an appropriate risk-adjusted rate for the program which takes into account the current membership, any statutory or regulatory changes that may affect health care utilization, and any other changes that may impact costs positively or negatively.

The current cost per eligible per month for the PACE is \$2,681.76.²⁴ In comparison, according to a 2016 survey by Genworth Financial, the national average cost for nursing home care cost \$92,000 per year for a private room or \$82,125 for a semi-private room.²⁵

Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid serves approximately 3.8 million people in Florida, with over half of those being children and adolescents 19 years of age or younger. Medicaid is a partnership between the federal and state governments where the federal government establishes the structure for the program and pays a share of the cost. Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare and Medicaid Services or CMS. The plan outlines current Medicaid eligibility standards, policies, and reimbursement methodologies.

To qualify for nursing home care under Medicaid, both an individual's income and assets will be reviewed. Additionally, a personal needs allowance will be applied as part of the eligibility determination process.²⁶ The current standard income limit in Florida for institutional care or services under the home and community based services waiver is \$2,313 for an individual and \$4,626 for a couple. There is also an asset limit for either category of \$2,000 for an individual or \$3,000 for a couple.²⁷

In Florida, the Medicaid program is administered by the AHCA. The AHCA; however, delegates certain functions to other state agencies, including the Department of Children, Families and Elder Affairs (DCF), the Agency for Persons with Disabilities (APD), and the DOEA. The AHCA has overall responsibility for the program and qualifies providers, sets payment levels, and pays for services.

²⁴ Office of Economic and Demographic Research, *Social Services Estimating Conference –Long Term Medicaid Services and Expenditures Forecast* (December 2018), p. 22, <http://edr.state.fl.us/Content/conferences/medicaid/medltexp.pdf> (last visited Feb. 25, 2019).

²⁵ Emily Mullin and Lisa Esposito, *How to Pay for Nursing Home Costs*, U.S. NEWS AND WORLD REPORT (Nov. 16, 2016) available at <https://health.usnews.com/wellness/articles/2016-11-16/how-to-pay-for-nursing-home-costs> (last visited Feb. 25, 2018).

²⁶ The personal needs allowance (PNA) of an individual is defined as that portion of an individual's income that is protected to meet the individual's personal needs while in an institution. See Department of Children, Families and Elder Affairs, *Glossary (Chapter 4600) "Personal Needs Allowance,"* pg. 19, <http://www.dcf.state.fl.us/programs/access/docs/esspolicymanual/4600.pdf> (last visited Feb. 25, 2019).

²⁷ Dep't of Children, Families and Elder Affairs, *SSI-Related Program-Financial Eligibility Standards: January 2019*, http://www.dcf.state.fl.us/programs/access/docs/esspolicymanual/a_09.pdf (last visited Feb. 25, 2019).

The DCF is responsible for determining financial eligibility for Medicaid recipients. The APD operates one of the larger waiver programs under Medicaid, the Home and Community Based (HCBS) Waiver program serving individuals with developmental disabilities.

The DOEA assesses Medicaid recipients to determine if they require nursing home care. Specifically, the DOEA determines whether an individual:

- Requires nursing home placement as evidenced by the need for medical observation throughout a 24-hour period and requires medically complex care to be performed on a daily basis under the direct supervision of a health professional because of mental or physical incapacitation;
- Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and requires care to be performed on a daily basis under the supervision of a health professional because of mental or physical incapacitation; or,
- Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and requires limited care to be performed on a daily basis under the supervision of a health professional because of mild mental or physical incapacitation.

Floridians who need nursing home care, but do not qualify for Medicaid, must pay from their own funds or through insurance.

Long-Term Care Managed Care

In 2011, the Legislature passed and the Governor signed into law HB 7107²⁸ to increase the use of managed care in Medicaid. The law required both Medicaid long-term care (LTC) services and Managed Medical Assistance (MMA) services to be provided through managed care plans.

Participating Long-Term Care Managed Care plans participating in SMMC are required to provide minimum benefits that include nursing home care as well as home and community based services. The minimum benefits include:

- Nursing home care
- Services provided in assisted living facilities
- Hospice
- Adult day care
- Medical equipment and supplies, including incontinence supplies
- Personal care
- Home accessibility adaptation
- Behavior management
- Home delivered meals
- Case management
- Therapies: physical, respiratory, speech, and occupational
- Intermittent and skilled nursing

²⁸ Chapter 2011-134, L.O.F.

- Medication administration
- Medication management
- Nutritional assessment and risk reduction
- Caregiver training
- Respite care
- Transportation
- Personal emergency response system

III. Effect of Proposed Changes:

Section 1 creates s. 430.84, F.S., and codifies the Program of All-Inclusive Care for the Elderly (PACE). Currently, the program does not have an implementing statute and has been operationalized through annual appropriations, proviso, or bills designed to implement the state budget or conform statute to provisions of the state budget.

Definitions

The bill creates the following definitions for the PACE program:

- Agency;
- Applicant;
- CMS;
- Department;
- PACE organization; and
- Participant;

Program Creation

SB 778 authorizes the AHCA, in consultation with the DOEA, to approve entities who have submitted the required application and data to the federal Centers for Medicare and Medicaid Services (CMS) as PACE organizations pursuant 42 U.S.C. s. 1395eee (2019). Applications, as required by CMS, will be reviewed by the AHCA on an ongoing basis, in consultation with the DOEA for initial approval as PACE organizations. Notice of applications must also be published in the Florida Administrative Register.

A prospective PACE organization must submit an application to the AHCA before submitting a request for program funding. An applicant for a PACE program must meet the following requirements:

- Provide evidence that the applicant can meet all of the federal regulations and requirements established by CMS by the proposed implementation date.
- Provide market studies which include an estimate of the potential number of participants and which show the geographic area the applicant proposes to serve.
- Develop a business plan of operation, including pro forma financial statement and projections based on the planned implementation date.
- Show evidence of regulatory compliance and meet market studies requirements, if applicant is an existing PACE organization which seeks to expand to an additional service area.
- Implement program within 12 months after date of initial state approval if granted authorization as a prospective PACE organization or such approval is void.

Funding and Enrollment

SB 778 directs PACE organizations to enroll participants at the level funded through the General Appropriations Act (GAA) which must reflect a reasonable level of growth to meet the needs of the community and be consistent with the financial projections periodically submitted by the PACE organizations. The AHCA is directed to consult with the DOEA and the Social Services Estimating Conference and to submit a report to the Legislature requesting the necessary funding for prospective PACE participants to have the PACE as an option in all authorized service areas.

The bill also permits the use of funds within any PACE organization's authorized geographic area, regardless of county lines. The DOEA is required to notify individuals who are determined eligible for nursing level of care under Medicaid that the PACE organization is an available service option and that enrollment into PACE is voluntary.

Quality and Reporting

All PACE organizations are required to meet specific quality and performance standards established by CMS. The AHCA has the responsibility to oversee and monitor Florida's PACE and the contracted organizations through the data and reports submitted periodically to the AHCA and CMS.

The bill exempts all PACE organizations from the requirements of chapter 641, the chapter of Florida law which regulates health maintenance organizations, prepaid health clinics, and other health care service programs.

Section 2 amends s. 409.981, F.S., relating to eligible long-term care plans in the Medicaid program, particularly the PACE. The bill modifies this section of law to provide a cross reference to the newly created section of law in Section 1 of the bill and to change the language from permissive participation in the Medicaid managed care program to mandatory participation in the program.

Additionally, new language is added to allow prospective participants who have applied for the PACE to have been determined eligible by the Comprehensive Assessment and Review (CARES) program to be medically eligible, but have not yet received their financial eligibility determination from the Department of Children and Families, to be enrolled in the PACE if PACE organizations have agreed to enroll participants pending this final determination.

The bill requires the CARES program to determine each applicant's medical eligibility within 21 days after receiving a complete application packet and requires the Department of Children, Families, and Elder Affairs to determine eligibility within state and federal requirements.²⁹ If the applicant is determined eligible, the AHCA is directed to pay the PACE organization the applicable Medicaid rate retroactive to the first of the month in which the financial eligibility was determined. If the applicant is not eligible for the PACE as a Medicaid recipient, the

²⁹ The timeliness standard for the processing of applications under Medicaid is found under 42 CFR 435.912 (a), (b), and (c). The federal requirement for processing of a Medicaid application based on a disability is 90 days for all other applicants, it is 45 days.

applicant may continue in the PACE as a private-pay PACE participant or may terminate services. In the latter case, the PACE organization may seek reimbursement from the applicant.

Section 3 provides an effective date of July 1, 2019.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Subject to the availability of funds and slots, additional private sector providers that meet the criteria to be a PACE organization and achieve eligibility confirmation status could be approved as PACE sites. Expansion of PACE sites would also mean additional individuals in the community would have access to these services.

PACE organizations represent 0.05 percent of the market share of Medicaid enrollees as of January 2019.³⁰ Current managed care plans that participate in the SMMC program may experience a loss of market share and/or profit margin if enrollment in PACE organizations were to grow beyond a certain percentage or if certain, less risky or less

³⁰ Agency for Health Care Administration, *Medicaid SMMC Market Share Report, SMMC-MMA Assignment* (as of January 31, 2019) available at http://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited Feb. 25, 2019).

costly segments of their current SMMC population were to depart SMMC enrollment and enroll in the PACE.

C. Government Sector Impact:

SB 778 codifies an existing program. If the bill were to result in the expansion of the PACE, then it may result in an increased workload for the AHCA and the DOEA. The bill reflects the structure and many of the current processes required of both entities to review applications, monitor performance, and make annual recommendations to the Legislature and the federal oversight agency which are undertaken today. By formalizing the process, some potential PACE organizations may be more likely to consider pursuing this option, leading to an increased workload and request for additional funding.

The fiscal impact of the bill to the state agencies is unknown. If additional funding were provided to expand the number of PACE sites, then additional resources may be necessary at the affected state agencies to adapt to the related, increased volume of applications and necessary oversight.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 409.981 of the Florida Statutes.

This bill creates section 430.84 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.