HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1503 Children's Medical Services Program
SPONSOR(S): Grant
TIED BILLS: **IDEN./SIM. BILLS:** SB 1548

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee	16 Y, 0 N	Guzzo	McElroy
2) Health Care Appropriations Subcommittee	14 Y, 0 N	Smith	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The Children's Medical Network (CMS Network) was created in 1978 within the Department of Health. It was established to provide children with special health care needs a family-centered, comprehensive, and coordinated statewide managed system of care. The Department of Health (DOH) was responsible for the administration of the CMS Network which was a provider-based fee-for-service program. In August 2014, the CMS Network was transitioned to a managed care model within the Agency for Health Care Administration (AHCA) and became known as the Children's Medical Services Managed Care Plan (CMS). DOH remains responsible for administering CMS.

AHCA contracts with DOH to administer CMS. DOH conducts the clinical eligibility determination for CMS and subcontracts with a private vendor for aspects of the plan's operation including case management. DOH provides vendor oversight in the areas of clinical operations, compliance, performance management, family level grievance remedies, and provider technical assistance.

HB 1503 transfers all statutory powers, duties, responsibilities and functions for the operation of CMS from DOH to AHCA, effective October 1, 2024. The bill requires AHCA to competitively procure one or more specialty plan contracts for service to children with special health care needs enrolled in Medicaid and CHIP beginning in the 2024-2025 plan year and requires DOH to assist AHCA with the procurement. DOH retains responsibility for clinical eligibility determination and must provide ongoing consultation to AHCA on services to children and youth with special health care needs.

The bill makes the following changes to the newborn screening program:

- Removes the requirement for the newborn screening program to coordinate with the Department of Education for consultation;
- Allows licensed genetic counselors to receive newborn screening results;
- Provides standardized requirements for hearing screening at hospitals, licensed birth facilities, and birthing centers; and
- Requires all newborn hearing screening providers, audiologists, and early childhood programs conducting hearing screening or diagnostic testing to report results to the Newborn Hearing Screening Program for infants and toddlers up to 36 months old.

The bill has no fiscal impact on state or local government.

The bill provides an effective date of July 1, 2023, except as otherwise expressly provided in the bill.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Florida Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds.

The structure of each state's Medicaid program varies and what states must pay for is largely determined by the federal government, as a condition of receiving federal funds.[1] Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states. The federal government sets the minimum mandatory populations to be included in every state Medicaid program. The federal government also sets the minimum mandatory benefits to be covered in every state Medicaid program.[2] States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, adult dental services, and dialysis.[3]

States have some flexibility in the provision of Medicaid services. Section 1915(b) of the Social Security Act provides authority for the Secretary of the U.S. Department of Health and Human Services (HHS) to waive requirements to the extent that he or she "finds it to be cost-effective and efficient and not inconsistent with the purposes of this title." Section 1115 of the Social Security Act allows states to implement demonstrations of innovative service delivery systems that improve care, increase efficiency, and reduce costs. These laws allow HHS to waive federal requirements to expand populations or services, or to try new ways of service delivery.

Florida operates under a Section 1115 waiver to use a comprehensive managed care delivery model for primary and acute care services, the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program.[4] Florida also has a waiver under Sections 1915(b) and (c) of the Social Security Act to operate the SMMC Long-Term Care (LTC) program.[5]

The Florida Medicaid program covers over 5.5 million low-income individuals, including approximately 2.5 million children, or 54%, of the children in Florida.[6]

Children's Medical Services Network (CMS)

The CMS Network was created in 1978 and was established to provide children with special health care needs a family-centered, comprehensive, and coordinated statewide managed system of care and to provide essential preventative, evaluative, and early intervention services for children at risk for or having special health care needs. Originally, the CMS Network, was a fee-for-service program serving children with special health care needs who were enrolled in either Medicaid or the Children's Health Insurance Program (CHIP). In August 2014, the CMS Network was transitioned to a managed care model referred to as the CMS Managed Care Plan. Current law has not been updated to reflect the change from the CMS Network to the CMS Managed Care Plan.

[1] Title 42 U.S.C. §§ 1396-1396w-5; Title 42 C.F.R. Part 430-456 (§§ 430.0-456.725) (2016).
[2] S. 409.905, F.S.
[3] S. 409.906, F.S.
[4] S. 409.964, F.S.
[5] *Id.*
[6] Agency for Health Care Administration, Presentation to the House Healthcare Regulation Subcommittee, Jan. 18, 2023, on file with the House Healthcare Regulation Subcommittee.

CMS Managed Care Plan

AHCA contracts with the Department of Health (DOH) to provide the state's specialty plan for children with chronic illness in the CMS Managed Care Plan (CMS). DOH conducts the clinical eligibility determination for CMS but subcontracts with a private vendor, Sunshine Health, for aspects of the plan's operation including case management. DOH provides vendor oversight in the areas of clinical operations, compliance, performance management, family level grievance remedies, and provider technical assistance. CMS must meet requirements of health plans for participation in the managed medical assistance program established in s. 409.974, F.S., except for the requirement to be competitively procured by AHCA.

Enrollment in CMS has continually increased, as families choose the value and quality of care the CMS Health Plan offers. In December 2022, the CMS Health Plan provided services to both Medicaid, 96,937 enrolled members, and CHIP, 7,167 enrolled members.

CMS Programs

Programs within CMS include:[7]

- Child Abuse Death Review;
- Child Protection Team and Special Technologies;
- Children's Medical Services Managed Care Plan;
- Children's Multidisciplinary Assessment Team;
- Early Steps;
- Medical Foster Care;
- Newborn Screening;
- Poison Information Center Network;
- Regional Perinatal Intensive Care Centers;
- Safety Net;
- Sexual Abuse Treatment Program;
- Specialty Contracts, including Statewide and Regional Networks for Access and Quality;
- State Systems Development Initiative; and
- Title V for children and youth with special health care needs.

Current law does not expressly name all of these programs or include any power or duties for the effective operation of some CMS programs. For example, section 391.028, F.S., requires CMS to implement a program to determine the level of care and medical complexity for pediatric long-term care services. This is a reference to the functions of the Children's Multidisciplinary Assessment Team, which is not expressly mentioned in the law. Another example is section 391.026(13), F.S., which allows DOH to administer the Children and Youth with Special Health Care Needs portion of the Maternal Child Health block grant, in accordance with Title V of the Social Security Act.[8]

Additional CMS programs or functions administered by DOH which are not expressly provided for in law, include the Medical Foster Care program (MFC) [9], the Safety Net program, CMS Clinical Eligibility Screening, Networks for Access and Quality (referred to as Specialty Contracts), the Child Protection Teams, the Child Abuse Death Review program, and the Sexual Abuse Treatment program.[10]

CMS Network Advisory Council and Technical Panels

[7] Department of Health, Agency Analysis of 2023 HB 1503 (February 24, 2023), On file with the House Health Care Regulation Subcommittee.
[8] *Supra* note 13.
[9] CMS is responsible for administering the MFC program which includes recruitment, training, assessment, and facilitating admission of eligible children into the program and designated MFC parent home. Current law does not include language for MFC program. The MFC program is a coordinated effort between CMS, AHCA, and the Department of Children and Families (DCF).
[10] *Id.*

Chapter 391, Part II, Sections 391.221 and 391.223, F.S., establish the Statewide CMS Network Advisory Council and technical advisory panels, respectively. These bodies served to advise the State Surgeon General on the operation of the CMS Network as a fee-for-service program. CMS Managed Care Plan conformity with the requirements in Chapter 409, F.S., in effect renders the role and responsibilities of councils and panels for the operation of CMS Managed Care Plan duplicative and obsolete. In accordance with section 20.43(6), F.S., the State Surgeon General retains the authority to implement ad hoc advisory committees, as needed, without this provision specifically existing for CMS.

Florida Newborn Screening Program

General

The Legislature created the Florida Newborn Screening Program (NSP) within DOH to promote the screening of all newborns for metabolic, hereditary, and congenital disorders known to result in significant impairment of health or intellect.[11] The NSP also promotes the identification and screening of all newborns in this state and their families for environmental risk factors such as low income, poor education, maternal and family stress, emotional instability, substance abuse, and other high-risk conditions associated with increased risk of infant mortality and morbidity to provide early intervention, remediation, and prevention services.[12]

The NSP involves coordination among several entities, including the Bureau of Public Health Laboratories Newborn Screening Laboratory in Jacksonville (state laboratory), DOH Children's Medical Services (CMS) Newborn Screening Follow-up Program in Tallahassee, and referral centers, birthing centers, and physicians throughout the state.[13] Health care providers in hospitals, birthing centers, perinatal centers, county health departments, and school health programs provide screening as part of the multilevel NSP screening process.[14] This includes a risk assessment for prenatal women, and risk factor analysis and screening for postnatal women and newborns as well as laboratory screening for selected disorders in newborns.[15] The NSP attempts to screen all newborns for hearing impairment and to identify, diagnose, and manage newborns at risk for selected disorders that, without detection and treatment, can lead to permanent developmental and physical damage or death.[16] While the NSP attempts to screen all prenatal women and newborns, parents and guardians may decline the screening.[17]

Health care providers perform non-laboratory NSP screening, such as hearing and risk factor analysis, and report the results to the Office of Vital Statistics. If necessary, health care providers refer patients to the appropriate health, education, and social services.[18] Health care providers in hospitals and birthing centers perform specimen collection for laboratory NSP screening by collecting a few drops of blood from the newborn's heel on a standardized specimen collection card.[19] The specimen card is then sent to the state laboratory for testing.[20] The results of the laboratory test are released to the newborn's health care provider. In the event that a newborn screen has an abnormal result, the baby's health care provider, or a nurse or specialist from NSP's Follow-up Program provides follow-up services and referrals for the child and his or her family.[21]

The Legislature established the Florida Genetics and Newborn Screening Advisory Council to advise DOH about which disorders to include in the NSP panel of screened disorders and the procedures for

[11] S. 383.14(1), F.S.
[12] *Id.*
[13] S. 383.14, F.S.
[14] *Supra* note 11.
[15] *Id.*
[16] Florida Department of Health, Florida Newborn Screening Protocols, 2022, available at https://floridanewbornscreening.com/wp-content/uploads/NBS-Protocols-2022-FINAL.pdf (last viewed April 4, 2023).
[17] S. 383.14(4), F.S.; Rule 64C-7.008, F.A.C.; The health care provider must attempt to get a written statement of objection to be placed in the medical record.
[18] *Id.*
[19] Florida Newborn Screening, What is Newborn Screening?, available at https://floridanewbornscreening.com/parents/what-is-newborn-screening/ (last visited April 4, 2023). *See also* Specimen Collection Card, available at http://floridanewbornscreening.com/wp-content/uploads/Order-Form.png (last visited April 4, 2023).
[20] *Id.*
[21] *Id.*

collecting and transmitting specimens.[22] Florida's NSP currently screens for 58 conditions, 55 of which are screened through the collection of blood spots. Screening of the other three conditions—hearing screening, critical congenital heart defect (CCHD) or pulse oximetry, and congenital cytomegalovirus (CCMV) targeted screening—are completed at the birthing facility through point of care (POC) testing.[23]

Florida statutes specify to whom the NBS Program may release NBS screening results. In 2021, the Florida Legislature passed a measure creating initial licensure and renewal for genetic counselors. Currently, the NBS Program is not permitted to release specimen results to genetic counselors which can prolong the time before an infant receives treatment.

The NBS Program has set quality benchmarks for collecting specimens and shipping NBS specimens to the Newborn Screening State Laboratory in Jacksonville, FL.[24]

Quality benchmarks for blood spot collection require:

- Less than 1 percent of specimens received by the Bureau of Public Health Laboratories (BPHL)-Jacksonville are unsatisfactory for testing; and
- At least 80 percent of specimens should be received at BPHL-Jacksonville no later than three days after collection. To achieve this, specimens should be shipped within 24 hours of collection to the BPHL-Jacksonville via overnight delivery.

Quality benchmarks for CCHD screening require:

- At least 90 percent of specimens submitted must have appropriate CCHD screening data included on the specimen card.

Quality benchmarks for hearing screening require:

- A hearing screening no later than 1 month of age;
- A diagnosis no later than 3 months of age; and
- Entry into early intervention services no later than 6 months of age.

These benchmarks were created using national standards and guidelines established by the Advisory Committee on Heritable Disorders in Newborns and Children, the U.S. Department of Health and Human Services (HHS), and the Joint Committee on Infant Hearing (JCIH). State statutes currently gives the NBS Program authority to create rules.[25]

Chapter 64C-7, Florida Administrative Code, requires the submitting entity ensure a satisfactory newborn screen has been collected. A review of data between 2018-2020, identified 5.5% (14,981) of specimens submitted to the NBS State Laboratory were unsatisfactory, which means the specimen cannot be tested and the family must return to the hospital, midwife, or pediatrician for another screening. Reviewing the same three years, 21% (56,664) specimens were received at the NBS State Laboratory after three days of collection. Both concerns result in a delay in receiving potentially lifesaving treatment.[26]

Section 383.14(3)(2), F.S., requires the office of the inspector general to certify the annual costs of the newborn screening program.

Newborn and Infant Hearing Screening

Section 383.145, F.S., requires a newborn hearing screening for all newborns in hospitals before discharge. When a newborn is delivered in a facility other than a hospital, the parents must be

[22] S. 383.14(5), F.S.
[23] *Supra* note 7.
[24] *Id.*
[25] *Id.*
[26] *Id.*

instructed on the importance of having the hearing screening performed and must be given information to assist them in having the screening performed within three months after the child's birth.[27]

Before a newborn is discharged from a hospital or other state-licensed birthing facility, and unless objected to by the parent or legal guardian, the newborn must be screened for the detection of hearing loss to prevent the consequences of unidentified disorders. However, if the screening is not completed before discharge due to scheduling or temporary staffing limitations, the screening must be completed within 21 days after the birth. Before a newborn is discharged from a licensed birth center, such facility must refer the newborn to a licensed audiologist, physician, or hospital for screening for detection of hearing loss and referral for appointment must be made within 30 days after discharge. If the birth is a home birth, the health care provider in attendance must provide a referral to a licensed audiologist, hospital, or other newborn hearing screening provider and the referral for appointment must be made within 7 days after the birth.[28]

All screenings must be conducted by a licensed audiologist, a licensed physician, or appropriately supervised individual who has completed documented training specifically for newborn hearing screening. When ordered by the treating physician, screening of a newborn's hearing must include auditory brainstem responses, or evoked otoacoustic emissions, or appropriate technology as approved by the United States Food and Drug Administration (FDA).[29]

A child who is diagnosed as having a permanent hearing impairment must be referred by the licensee or individual who conducted the screening to the primary care physician for medical management, treatment, and follow-up services. Furthermore, any child from birth to 36 months of age who is diagnosed as having a hearing impairment that requires ongoing special hearing services must be referred to the Children's Medical Services Early Intervention Program by the licensee or individual who conducted the screening serving the geographical area in which the child resides. Any person who is not covered through insurance and cannot afford the costs for testing must be given a list of newborn hearing screening providers who provide the necessary testing free of charge.[30]

Section 391.055(4), F.S., requires newborns with abnormal screenings be referred to the CMS local programs for additional testing and services. With the transition of the CMS Network to managed care, newborns with abnormal screenings are served by the Newborn Screening Program.

Effect of the Bill

Children's Medical Services Network (CMS)

The bill transfers all statutory powers, duties, responsibilities and functions for the operation of CMS Network from DOH to AHCA, effective October 1, 2024. The bill requires AHCA to competitively procure one or more specialty plan contracts for service to children with special health care needs enrolled in Medicaid and CHIP beginning in the 2024-2025 plan year and requires DOH to assist AHCA with the procurement. DOH retains responsibility for clinical eligibility determination and must provide ongoing consultation to AHCA on services to children and youth with special health care needs.

The bill removes obsolete references to the "CMS Network" and replaces them with "CMS Managed Care Plan." The bill also removes obsolete references to "area offices" and "local directors."

The bill amends children with special health care needs references to include youth. These changes do not impact any clinical or other criteria for program participation and would align the state's definitions with those used by federal grantors and national partners.

[27] S. 383.145(3), F.S.
[28] *Id*.
[29] *Id.*
[30] *Id*.

The bill provides express statutory authority to DOH to implement existing programs, including the Medical Foster Care program, Safety Net program, CMS Clinical Eligibility, and the Title V program for children and youth with special health care needs.

The bill removes duplicative language relating to provider qualification requirements.

Newborn Screening Program

The bill makes the following changes to the newborn screening program:

- Removes the requirement for the newborn screening program to coordinate with the Department of Education for consultation;
- Requires DOH to furnish screening forms to all physicians, county health departments, perinatal centers, birthing centers, and hospitals;
- Allows licensed genetic counselors to receive newborn screening results; and
- Deletes an obsolete requirement for the DOH Office of Inspector General to certify the financial operations of the newborn screening program.

Newborn and Infant Hearing Screening

The bill provides standardized requirements for hearing screening at hospitals, licensed birth facilities, and birthing centers. Additionally, the bill requires all newborn hearing screening providers, audiologists, and early childhood programs conducting hearing screening or diagnostic testing to report results to the Newborn Hearing Screening Program for infants and toddlers up to 36 months old.

B. SECTION DIRECTORY:

Section 1: Amends s. 383.14, F.S., relating to screening for metabolic disorders, other hereditary and congenital disorders, and environmental risk factors.
Section 2: Amends s. 383.145, F.S., relating to newborn and infant hearing screening.
Section 3: Amends s. 391.016, F.S., relating to purposes and functions.
Section 4: Amends s. 391.021, F.S., relating to definitions.
Section 5: Amends s. 391.025, F.S., relating applicability and scope.
Section 6: Amends s. 391.026, F.S., relating to powers and duties of the department.
Section 7: Amends s. 391.028, F.S., relating to administration.
Section 8: Amends s. 391.029, F.S., relating to program eligibility.
Section 9: Amends s. 391.0315, F.S., relating to benefits.
Section 10: Repeals s. 391.035, F.S., relating to provider qualifications.
Section 11: Amends s. 391.045, F.S., relating to reimbursement.
Section 12: Amends s. 391.055, F.S., relating to service delivery systems.
Section 13: Amends s. 391.097, F.S., relating to research and evaluation.
Section 14: Repeals part II of chapter 391, F.S., consisting of ss. 391.221 and 391.223, F.S., relating to Statewide Children's Medical Services Network Advisory Council and Technical advisory panels respectively.
Section 15: Provides legislative findings and intent.
Section 16: Provides for the transfer of operation of the Children's Medical Services Managed Care Plan.
Section 17: Provides reporting requirements.
Section 18: Amends s. 409.974, F.S., relating to Children's Medical Services Network.
Section 19: Amends s. 409.166, F.S., relating to children within the child welfare system; adoption assistance programs.
Section 20: Amends s. 409.811, F.S., relating to definitions relating to Florida Kidcare Act.
Section 21: Amends s. 409.813, F.S., relating to health benefits coverage; program components; entitlement and nonentitlement.
Section 22: Amends s. 409.8134, F.S., relating to program expenditure ceiling; enrollment.
Section 23: Amends s. 409.814, F.S., relating to eligibility.
Section 24: Amends s. 409.815, F.S., relating to health benefits coverage; limitations.
Section 25: Amends s. 409.8177, F.S., relating to program evaluation.

Section 26: Amends s. 409.818, F.S., relating to administration.
Section 27: Amends s. 409.912, F.S., relating to cos-effective purchasing of health care.
Section 28: Amends s. 409.9126, F.S., relating to children with special health care needs.
Section 29: Amends s. 409.9131, F.S., relating to special provisions relating to integrity of the Medicaid program.
Section 30: Amends s. 409.920, F.S., relating to Medicaid provider fraud.
Section 31: Amends s. 409.962, F.S., relating to definitions.
Section 32: Provides an effective date of July 1, 2023, except as otherwise expressly provided.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   The bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

DOH and AHCA have sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

None.