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 Fiscal Policy

BILL:	CS/SB 1548
INTRODUCER:	Health Policy Committee and Senator Bradley
SUBJECT:	Children's Medical Services Program
DATE:	April 24, 2023
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Brown	HP	**Fav/CS**
2.	Barr	Money	AHS	**Favorable**
3.	Rossitto-Van Winkle	Yeatman	FP	**Favorable**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1548 clarifies responsibilities of the Department of Health (DOH) Children's Medical Services (CMS) Program, transfers the Children's Medical Services Managed Care Plan (CMS MCP) from the DOH to the Agency for Health Care Administration (AHCA), and updates the Newborn Screening (NBS) Program and the Newborn Hearing Screening (NBHS) Program to reflect current and best practices.

The bill transfers Medicaid and Children's Health Insurance Program (CHIP) provider and operational contracting duties and responsibilities from the Department of Health (DOH) to the Agency for Health Care Administration (AHCA), effective October 24, 2024.

The bill requires the AHCA to competitively procure one or more specialty plan contracts for services to children with special health care needs enrolled in Medicaid and CHIP beginning in the 2024-2025. The DOH will retain responsibility for clinical eligibility determinations and must provide ongoing consultation to the AHCA on services to children and youth with special health care needs.

The bill clarifies and codifies the programs under the Children's Medical Services Program within the DOH.

The bill makes the following changes to the NBS Program:

- Updates language to include testing blood samples for multiple conditions, not just phenylketonuria;
- Removes the requirement that the NBS Program consult with the Department of Education (DOE);
- Authorizes licensed genetic counselors to receive newborn screening results; and
- Requires all specimens collected be submitted directly to the State Public Health Laboratory in accordance with adopted rules.

The bill makes the following changes to the NBHS Program:

- Defines and incorporates the term "toddler" into the program language;
- Provides standard requirements for hearing screening at hospitals, licensed birth facilities, and birthing centers; and
- Requires hearing screening or diagnostic testing results be reported to the NBHS Program for infants and toddlers up to 36 months of age.

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

II. Present Situation:

Agency for Health Care Administration

The Agency for Health Care Administration (AHCA) is the chief health policy and planning entity for the state and is primarily responsible for the state's Medicaid program; the licensure and regulation of the state's 48,500 health care facilities; and the sharing of health care data through the Florida Center for Health Information and Policy Analysis.[1]

The Department of Health

The Department of Health (DOH) is tasked with protecting and promoting the health of residents and visitors in the state and has been responsible for the administration of the Children's Medical Services (CMS) programs and the CMS Network since the program's inception in 1978.

Florida Medicaid

Medicaid is the medical assistance program that provides access to health care for low-income families and individuals. Medicaid also assists the elderly and people with disabilities with the costs of nursing facility care and other medical and long-term care expenses.[2] With federal approval, Florida has used a comprehensive managed care delivery program model for primary and acute care services since 2014, with the Statewide Medicaid Managed Care (SMMC), Managed Medical Assistance (MMA) program, and SMMC Long-Term Care (LTC) programs.[3]

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[1] Agency for Health Care Administration, *About*, available at https://ahca.myflorida.com/about (last visited Mar. 29, 2023).
[2] Agency for Health Care Administration, *Medicaid*, available at https://ahca.myflorida.com/medicaid (last visited Mar. 29, 2023).
[3] Agency for Health Care Administration, *Statewide Medicaid Managed Care*, available at https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care (last visited Apr. 12, 2023).

The Florida Medicaid program covers over 5.5 million low-income individuals, including approximately 2.5 million children, or 54 percent, of the children in Florida.[4]

Florida KidCare

The Florida KidCare Program provides low-cost health insurance for children in Florida. The program was created through Title XXI of the Social Security Act to provide a defined set of health benefits to uninsured, low-income children through the establishment of a variety of affordable health benefits coverage options from which families may select coverage and through which families may contribute financially to the health care of their children.[5]

Currently, more than 2.4 million Florida children are enrolled in Florida KidCare.[6]

Children's Medical Services

Children's Medical Services (CMS) is a compilation of programs that serve children and youth with special health care needs (CYSHCN). Administered by the CMS Program within the DOH, each program is responsible to either provide a managed system of care; preventive, evaluative, or early intervention services; or statewide children's services.[7]

The following programs are currently named in statute as part of the CMS programs:
- Children's Medical Services Managed Care Plan;
- Early Steps;
- Newborn Screening;
- Regional Perinatal Intensive Care Centers;

Additional functions and programs of the DOH CMS Program that are not currently named or outlined in statute include:
- Child Abuse Death Review;
- Child Protection Team and Special Technologies;
- Children's Multidisciplinary Assessment Team;
- Medical Foster Care;
- Newborn and Infant Hearing Screening Program;
- Poison Information Center Network;
- Safety Net;
- Sexual Abuse Treatment Program;
- Specialty Contracts, including Statewide and Regional Networks for Access and Quality;
- State Systems Development Initiative;

[4] House of Representatives Staff Analysis, *House Bill 1503, 2023 Legislative Session* (Mar. 28, 2023) referencing Agency for Health Care Administration, Presentation to the House Healthcare Regulation Subcommittee, Jan. 18, 2023, (on file in the Senate Committee on Health Policy).
[5] Section 409.9812, F.S.
[6] House of Representatives Staff Analysis, *House Bill 1503, 2023 Legislative Session* (Mar. 28, 2023) referencing Agency for Health Care Administration, Presentation to the House Healthcare Regulation Subcommittee, Jan. 18, 2023, (on file in the Senate Committee on Health Policy).
[7] Department of Health, 2023 Agency Legislative Bill Analysis, *House Bill 1503* (Feb. 24, 2023) (on file with the Senate Committee on Health Policy).

- Title V for CYSHCN;
- Research and evaluation projects to improve the delivery of services to CYSHCN; and
- Conducting clinical screening to determine the medical eligibility of CYSHCN for programs such as Medicaid, CHIP, and Safety Net.[8]

Children's Medical Services Network

The Children's Medical Services (CMS) Network provides children with special health care needs a family-centered, comprehensive, and coordinated statewide managed system of care and provides 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 under the purview of the AHCA and became known as the Children's Medical Services Managed Care Plan (CMS MCP). Current law has not been updated to reflect the name change.[9]

The AHCA contracts with the DOH, who remains responsible for administering the CMS MCP. The DOH conducts the clinical eligibility determination for CMS clients, subcontracts with private vendors for the plan's operation including case management, and provides vendor oversight in the areas of clinical operations, compliance, performance management, family level grievance remedies, and provider technical assistance. The DOH sends all contractors' and vendors' invoices to the AHCA for payment, often causing delays.[10]

The CMS MCP 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 the AHCA.

In December 2022, the CMS MCP provided services to 96,937 Medicaid enrollees and 7,167 members enrolled in CHIP.[11]

CMS Network Advisory Council and Technical Panels

Sections 391.221 and 391.223, F.S., establish the Statewide CMS Network Advisory Council and technical advisory panels, respectively. These bodies serve to advise the State Surgeon General on the operations of the CMS Network as a fee-for-service program. The CMS Managed Care Plan conformity with the requirements in ch. 409, F.S., renders the role and responsibilities of these councils and panels obsolete. In accordance with s. 20.43(6), F.S., the State Surgeon General retains the authority to implement ad hoc advisory committees, as needed, without the need for this provision specifically for the CMS MCP.

[8] Department of Health, 2023 Agency Legislative Bill Analysis, *House Bill 1503* (Feb. 24, 2023) (on file with the Senate Committee on Health Policy).
[9] Id.
[10] Id.
[11] Id.

Newborn Screening Program

Florida's Newborn Screening (NBS) Program within the DOH promotes the screening of all newborns for metabolic, hereditary, and congenital disorders known to result in significant impairment of health or intellect.[12] The NBS Program also promotes the screening of all newborns 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.[13] The NBS processes are governed by ss. 383.14 and 383.145, F.S.

The Florida Genetics and Newborn Screening Advisory Council (GNSAC) advises the DOH about which disorders to include in the NBS panel of screened disorders and the procedures for collecting and transmitting specimens.[14] Newborn Screening began with screening for phenylketonuria (PKU)[15] and now screens for 58 conditions prior to discharge. Fifty-five of these conditions are screened through the collection of blood spots. Screening of the three remaining conditions – hearing deficiencies, critical congenital heart defect (CCHD), and congenital cytomegalovirus (cCMV) targeted screening – are completed at a birthing facility through point-of-care testing.[16]

The GNSAC coordinates with the DOH Bureau of Public Health Laboratories (BPHL) and the DOH CMS Program as provided in s. 383.14(5), F.S. Historically, the NBS Program has not collaborated with the Department of Education (DOE); however, other programs in this statute, such as Healthy Start, have a longstanding relationship with DOE.[17]

Florida law specifies 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, a situation that can prolong the time before an infant receives treatment.[18]

The NBS Program has set quality benchmarks for collecting specimens and shipping NBS specimens to the state laboratory. These benchmarks were created using national standards and guidelines established by the Advisory Committee on Heritable Disorders in Newborns and Children, the US Department of Health and Human Services, and the Joint Committee on Infant Hearing (JCIH). [19]

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[12] S. 383.14(1), F.S
[13] Id.
[14] Section 383.14(5), F.S.
[15] See Mayo Clinic, Patient Care & Health Information Diseases & Conditions, *Phenylketonuria (PKU)*, available at https://www.mayoclinic.org/diseases-conditions/phenylketonuria/symptoms-causes/syc-20376302#:~:text=Phenylketonuria%20(fen%2Dul%2Dkey,needed%20to%20break%20down%20phenylalanine. (last visited Mar. 29, 2023) Phenylketonuria, also called PKU, is a rare inherited disorder that causes an amino acid called phenylalanine to build up in the body. Without treatment this can lead to severe brain damage.
[16] Department of Health, 2023 Agency Legislative Bill Analysis, *House Bill 1503* (Feb. 24, 2023) (on file with the Senate Committee on Health Policy).
[17] Id.
[18] Id.
[19] Id.

Quality benchmarks for blood spot collection require:

- Less than 1 percent of specimens received by the state laboratory 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 state laboratory 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 one month of age;
- A diagnosis no later than three months of age; and
- Entry into early intervention services no later than six months of age.

State statutes currently gives the NBS Program authority to create rules.[20]

Florida Administrative Code Rule 64C-7(2022), requires the submitting entity to ensure that a satisfactory newborn screening has been collected. A review of data between 2018-2020 identified 5.5 percent (14,981) of specimens submitted to the 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 percent (56,664) of the specimens were received at the state laboratory after three days of collection. Both concerns resulted in a delay in receiving potentially lifesaving treatment.[21]

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

Newborn and Infant Hearing Screening (NBHS)

The DOH Newborn and Infant Hearing and Screening (NBHS) Program supports a comprehensive statewide hearing screening and follow-up referral system. The NBHS Program is funded through donations, trust funds, and federal grants from the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA).

In 2022, the Florida Legislature mandated that a hospital or other state-licensed birthing facility test newborns for cCMV if the newborn fails his or her screening for hearing loss, before the newborn is 21 days old or before discharge, whichever is earlier. Statewide targeted cCMV screening began on January 1, 2023. Screening must be completed prior to 21 days of age to differentiate between congenital and acquired CMV. Newborns with congenital CMV may have birth defects and developmental disabilities. Individuals with acquired CMV typically have mild or no symptoms.[22]

[20] Id.
[21] Id.
[22] Id.

Section 383.145, F.S., requires a newborn hearing screening for all newborns in hospitals before the newborn is discharged from the hospital or other state-licensed birthing facility, unless objected to by the parent or legal guardian. 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 seven days after the birth.[23]

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, evoked otoacoustic emissions, or appropriate technology as approved by the federal Food and Drug Administration (FDA). Any person who is not covered through health 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.[24]

A child who is diagnosed with a permanent hearing impairment must be referred to the primary care physician for medical management, treatment, and follow-up services. Any child, from birth to 36 months of age who is diagnosed with a hearing impairment that requires ongoing special hearing services must be referred to the DOH CMS Early Intervention Program.[25]

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 the CMS Managed Care Plan, newborns with abnormal screenings are served by the NBS Program.

III. Effect of Proposed Changes:

Section 1 amends s. 383.14, F.S., to remove obsolete language and to update the statutes to reflect current practices in the Newborn Screening (NBS) Program:

- Remove the Department of Education (DOE) from parties with whom the Department of Health (DOH) must consult regarding screening and tests to be performed;
- Authorize the taking of a blood sample before one week of age for “screening,” rather than for testing for phenylketonuria only;
- Add genetic counselors to practitioners who can receive newborn screening test results;
- Change assessment billing language to allow for more efficient processing of fees;
- Delete the requirement that the DOH include an audited report of the costs of the NBS Program in its annual legislative budget request; and

[23] Id.
[24] Id.
[25] Id.

- Require all NBS Program specimen cards to be sent directly to the state laboratory.

Section 2 amends s. 383.145, F.S., which authorizes the Newborn and Infant Hearing Screening (NBHS) Program, to remove obsolete practices, update for legislative changes, and update to current practice standards:

- Define the term "toddler" as child from 12 months to 36 months of age, and integrate the term into program requirements to comply with federal grant requirements for the collection of hearing screening data;
- Require licensed birth centers providing maternity and newborn care services to ensure that all newborns are screened for the detection of hearing loss before discharge;
- Require birth centers to ensure that all newborns who do not pass the hearing screening are referred for a test to screen for congenital cytomegalovirus before the newborn becomes 21 days of age;
- Delete the requirement for providers to refer patients to audiologist or hospital for hearing screening; and
- Require early childhood programs to report screening results to the DOH CMS Program within seven days.

Section 3 amends s. 391.016, F.S., to update DOH CMS programs terminology to include "children and youth" and to delete the obsolete requirement that the DOH CMS Program coordinate and maintain a consistent medical home for participating children.

Section 4 amends s. 391.021, F.S., to rename "Children's Medical Services Network," to "Children's Medical Services Managed Care Plan (CMS MCP)" and to update terminology to include "children and youth" in place of "children."

Section 5 amends s. 391.025, F.S., to clarify the scope of the DOH CMS Program to include the following:

- The Newborn and Infant Hearing Screening Program;
- The Children's Medical Services Managed Care Plan;
- The Children's Multidisciplinary Assessment Team;
- The Medical Foster Care Program;
- The Title V program for children and youth with special health care needs;
- The Safety Net Program;
- The Networks for Access and Quality;
- Child Protection Teams and sexual abuse treatment programs established under s. 39.303, F.S.; and
- The State Child Abuse Death Review Committee and local child abuse death review committees established in s. 383.402, F.S.

Section 6 amends s. 391.026, F.S., relating to powers and duties of the DOH, to:

- Remove obsolete language granting the DOH authority and responsibility to serve as a provider and principal case manager for children with special health care needs under Titles XIX and XXI of the Social Security Act;
- Reflect the name change from CMS Network to CMS MCP; and
- Authorize the DOH to administer the Medical Foster Care program, including:

- Recruitment, training, assessment, and monitoring for the program;
- Monitoring access and facilitating admissions of eligible children and youth to the program and designated Medical Foster Care homes; and
- Coordination with the Department of Children and Families and the Agency for Health Care Administration, or their designees.

Section 7 amends s. 391.028, F.S., to modify the following CMS Program activities:
- Remove responsibility for case management services for network participants;
- Change local program activities to statewide program activities;
- Remove responsibility to develop treatment plans; and
- Remove requirements for CMS area office management.

Section 8 amends 391.029, F.S., outlining individuals who are eligible to receive CMS program services, to:
- Clarify a high-risk pregnant female enrolled in Medicaid is eligible when receiving services through a Regional Perinatal Intensive Care Centers (RIPCC); and
- Update terminology to include "children and youth" in place of "children".

Section 9 amends s. 391.0315, F.S., to specify that benefits provided under the CMS MCP are required to be equivalent to mandatory Medicaid benefits required under s. 409.905, F.S., and optional Medicaid benefits under s. 409.906, F.S.

Sections 10 repeals s. 391.035, F.S., removing the obsolete requirement for the DOH CMS Program to establish provider qualifications.

Section 11 amends s. 391.045, F.S., to reflect the name change from CMS Network to CMS MCP and to update terminology to include "children and youth" in place of "children."

Section 12 amends s. 391.055, F.S., to:
- Reflect name change from CMS Network to CMS MCP
- Delete language specifying components of the CMS network;
- Authorize CMS MCPs to contract with school districts; and
- Delete the requirement that newborns with abnormal screening results for metabolic or other hereditary and congenital disorders must be referred to the DOH CMS program for additional services.

Section 13 amends s. 391.097, F.S., which authorizes the DOH to initiate, fund, and conduct research to improve delivery of CMS, to reflect the name change from CMS Network to CMS MCP.

Section 14 repeals ss. 391.221 and 391.223, F.S., eliminating the CMS Statewide Network Advisory Council and Technical advisory panels.

Section 15 provides legislative intent that the operations of the CMS MCP be transitioned from the DOH to the AHCA and that the AHCA competitively procure and operate one or more specialty plan contracts starting the 2024-2025 plan year.

Section 16 requires the transfer of all duties, authority, functions, obligations, and resources for operations of the CMS MCP be transferred from the DOH to the AHCA, effective October 1, 2024. The DOH will retain responsibility for conducting clinical eligibility screening for children with special health care needs. The bill also directs the DOH CMS Program to assist the AHCA in developing requirements for the new specialty plan procurement and contracts.

Section 17 requires that by November 1, 2023, the AHCA and the DOH must submit to the Legislature a report specifying any legislative or administrative changes needed to effectively transfer operations of the CMS MCP from the DOH to the AHCA.

Section 18 amends s. 409.974, F.S., relating to eligible Medicaid plans, to reflect the transition from the CMS Network at the DOH to the CMS MCP at the AHCA. The AHCA must competitively procure one or more vendors to provide services for children with special health care needs who are enrolled in Medicaid and for children with special health care needs who are enrolled in CHIP for the 2024-2025 plan year. The DOH CMS Program must:

- Assist the AHCA in developing specifications for the procurement contract;
- Conduct clinical eligibility screening for children with special health care needs who are eligible for or are enrolled in Medicaid or CHIP; and
- Collaborate with the AHCA in the care of children with special health care needs.

Section 19 amends s. 409.166, F.S., effective October 1, 2024, to allow the adoptive parents of a child covered under CMS programs to also receive adoption assistance. The bill also amends s. 409.166, F.S., to replace the specific reference to CMS Network services with a broader reference to a specialty plan under contract with the AHCA to serve children with special heath care needs.

Sections 20 through 27 effective October 1, 2024, amend ss. 409.811, 409.813, 409.8134, 409.814, 409.815, 409.8177, 409.818, 409.912, 409.9126, F.S., respectively, to make technical changes to update obsolete references to CMS Network and to reflect the transfer of the CMS MCP from the DOH to the AHCA, which is effective October 1, 2024.

Section 28 amends s. 409.9126, F.S., effective October 1, 2024, deleting to the requirement that Medicaid-eligible children diagnosed with HIV/AIDS must be served through the CMS Network.

Sections 29 through 31 effective October 1, 2024, amend ss. 409.9131, 409.920, and 409.962, F.S., respectively, relating to Medicaid overpayments, Medicaid fraud and Medicaid eligible plans, and deletes references to Children's Medical Services Network.

Section 31 provides an effective date of July 1, 2023, except as otherwise expressly provided.

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:

The bill is designed to streamline the payment and reimbursement process for venders, providers, and the Agency for Health Care Administration.

C. Government Sector Impact:

The Department of Health (DOH) reports no fiscal impact to the state expenditures or revenue. The October 1, 2024 transfer of responsibility for the Children's Medical Services Managed Care Plan from DOH to Agency for Health Care Administration will be accompanied by the transfer of existing resources.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 383.14, 383.145, 391.016, 391.021, 391.025, 391.026, 391.028, 391.029, 391.0315, 391.045, 391.055, 391.097, 409.974, 409.166, 409.811, 409.813, 409.8134, 409.814, 409.815, 409.8177, 409.818, 409.912, 409.9126, 409.9131, 409.920, and 409.962.

This bill repeals the following sections of the Florida Statutes: 391.035, 391.221, and 391.223.

IX. Additional Information:

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

CS by Health Policy April 4. 2023:
The CS revises the bill's placement of children who meet clinical CMS eligibility within the KidCare program by providing that such children will be assigned to and may opt-out of a specialty plan under contract with the AHCA to serve children with special health care needs, instead of being assigned to the CMS Managed Care Plan or the CMS Network as provided under the bill and current law, respectively. The CS makes a similar revision to a separate statutory provision relating to a requirement to complete an application and a clinical screening.

B. Amendments:

None.