Health & Human Services Committee

Thursday, January 14, 2016
8:00 AM - 10:00 AM
Morris Hall

Steve Crisafulli
Speaker

Jason Brodeur
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health & Human Services Committee

Start Date and Time: Thursday, January 14, 2016 08:00 am

End Date and Time: Thursday, January 14, 2016 10:00 am

Location: Morris Hall (17 HOB)

Duration: 2.00 hrs

Consideration of the following bill(s):

HB 103 Transactions in Fresh Produce Markets by Fullwood, Campbell
HB 107 Physical Therapy by Cummings
CS/HB 127 Continuing Care Facilities by Health Innovation Subcommittee, Cummings
CS/HB 173 Medical Faculty Certification by Health Quality Subcommittee, Magar
HB 241 Children and Youth Cabinet by Harrell
HB 4007 Medical Assistant Certification by Pigman, Campbell
HB 4037 Licensure of Facilities and Programs for Persons with Developmental Disabilities by Rodrigues, R.

Presentations:
--AHCA Medicaid managed care implementation update - quality measures, drug issues, PMPM drop, etc.
--DOH briefing on CMS reforms - eligibility rule controversy, etc.

Pursuant to rule 7.12, the deadline for amendments to bills on the agenda by non-appointed members is 6:00 p.m., Wednesday, January 13, 2016.

By request of the chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Wednesday, January 13, 2016.

NOTICE FINALIZED on 01/12/2016 3:38PM by Iseminger.Bobbye

HB 103

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 103 Transactions in Fresh Produce Markets
SPONSOR(S): Fullwood
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	11 Y, 0 N	Tuszynski	Brazzell
2) Health & Human Services Committee		Tuszynski	Calamas

SUMMARY ANALYSIS

The Supplemental Nutrition Assistance Program (SNAP) is a federal program that offers nutrition assistance to low-income individuals and families. Individuals and families who meet eligibility standards receive an Electronic Benefits Transfer (EBT) card. Money is deposited on the EBT card for families and individuals to purchase certain types of food each month. To accept SNAP benefits from an EBT card, businesses selling food must have an EBT system and be licensed by the United States Department of Agriculture (USDA). The USDA licenses farmers' markets and allows farmers' markets to operate EBT systems, but not all farmers' markets accept SNAP benefits.

The bill allows the owner or operator of a market selling fresh produce, such as a farmer's market, that does not have an Electronic Benefits Transfer (EBT) system to allow certain specified groups to implement and operate an EBT system in the market on behalf of the sellers. The bill does not require farmers' markets to operate or maintain an EBT system, nor does it apply to markets that already accept SNAP benefits through an EBT system.

The bill has no fiscal impact.

The bill provides an effective date of July 1, 2016.

This document does not reflect the intent or official position of the bill sponsor or House of Representatives.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

History of the Food Stamp Program

The food stamp program began in 1939, providing a discount for surplus food to people on relief. From 1939-1943, those who qualified were able to purchase stamps redeemable for the purchase of food, and were given additional stamps redeemable only towards purchasing surplus food.[1] In 1961 the Pilot Food Stamp Program was created by President Kennedy. The pilot program used the original food stamp program, but did not limit the use of additional stamps toward surplus food; those stamps could be used for perishables as well.[2]

The Food Stamp Act of 1964 made the program permanent and expanded the use of food stamps to "all items eligible for consumption, with the exception of alcohol and imported foods."[3] Since then a number of changes and reforms to the program have taken place including changing the name of the program to the Supplemental Nutrition Assistance Program (SNAP), changing eligibility determinations and introducing the use of an Electronic Benefits Transaction (EBT).[4]

Supplemental Nutrition Assistance Program-SNAP

Today, SNAP is a federal program that is administered by the individual states. SNAP aims to "provide children and low-income people access to food, a healthful diet and nutrition education in a way that supports American agriculture and inspires public confidence."[5] The Food and Nutrition Act of 2008 defines "eligible food" as "any food or food product intended for human consumption except alcoholic beverages, tobacco, hot foods and hot food products prepared for immediate consumption."[6] Eligible food also includes seeds and plants to grow foods for personal consumption, as well as some additional exceptions to allow for hot food products ready for consumption in certain circumstances.[7]

State SNAP Administration

The Florida Department of Children and Families (DCF) administers and operates the SNAP program including the eligibility process for recipients.[8] The federal government pays 100 percent of the SNAP benefits, and the federal and state governments share the administrative costs.[9] The USDA determines the amount of food assistance benefits an individual or family receives, based on the individual's or family's income and resources.[10] Food assistance benefits are a supplement to a family's food budget. Households may need to spend some of their own cash, along with their food assistance benefits, to buy enough food for a month.[11] State law requires DCF to establish procedures in compliance with

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[1] A Short History of SNAP, USDA Food and Nutrition Service, *available at*: http://www.fns.usda.gov/snap/rules/Legislation/about.htm (last visited December 30, 2015).
[2] *Id.*
[3] *Id.*
[4] *Id.*
[5] About FNS, USDA Food and Nutrition Service, *available at*: http://www.fns.usda.gov/about-fns (last visited December 30, 2015).
[6] 7 C.F.R. s. 271.2.
[7] P.L. 110-246, provides that certain individuals because of age, disability or living arrangement may purchase hot foods with their SNAP EBT card.
[8] S. 414.31, F.S.
[9] SNAP/Food Stamps, Food Research and Action Center, accessible at: http://frac.org/federal-foodnutrition-programs/snapfood-stamps/ (last visited December 30, 2015).
[10] DCF Food Assistance Program Fact Sheet, *accessible at*: http://www.dcf.state.fl.us/programs/access/docs/fafactsheet.pdf (last visited December 30, 2015).
[11] *Id.*

federal law for notifying the appropriate federal and state agencies of any violation of law regarding the food assistance program and DCF must also notify the Department of Financial Services.[12]

Use of the Electronic Benefits Card

Food assistance monies are placed on an EBT card. Once an individual applies for cash assistance or food assistance with DCF, he or she will receive an EBT card in the mail.[13]

There are three ways for retailers to accept SNAP benefits using EBT: a point of sale (POS) system; a machine that processes EBTs, credit, and debit transactions; and a manual paper voucher process.

The POS system is electronic and free for retailers selling over $100 in SNAP benefits monthly. Retailers using POS systems usually receive payment within two banking days.

To use a machine that processes credit, debit, and EBT transactions, the retailer must arrange to have commercial equipment provided by a third-party processor. Commercial equipment is provided at a cost that the retailer negotiates with the third-party processor. Commercial equipment is often integrated, meaning that the POS terminal, cash register, and scanning device are all connected together in order to speed transactions and minimize errors.

The manual paper voucher process is a free way for retailers to accept EBT. The retailer must fill out a voucher and have the customer sign the form. Prior to completing the transaction, the retailer must call customer service to confirm that the customer has enough money in his or her SNAP account to purchase the items. At that point the transaction is complete. To collect money from the transaction, the retailer must electronically clear the voucher within 15 days or send the voucher to the state by the set expiration date.[14]

Retailers Accepting SNAP Benefits

Retailers accepting SNAP benefits as a form of payment must be licensed by the United States Department of Agriculture (USDA).[15] The Food and Nutrition Service (FNS), within the USDA, licenses and monitors retail food stores participating in SNAP.[16] A separate SNAP license is required for each store location and a SNAP permit is no longer valid if a store is closed, moved, or sold.[17] Licensed stores are fully reviewed for eligibility at least once every five years.[18]

To apply as a SNAP provider, retailers must meet basic eligibility requirements. For basic eligibility, the store must sell food for home preparation and consumption and must also meet ONE of the following conditions:

- Offer at least three varieties of qualifying foods in each of the following four stable food groups on a continuous basis[19]:
    - Meat, poultry, or fish;
    - Bread or cereal;
    - Vegetables or fruits; and
    - Dairy products.

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[12] S. 414.33, F.S.
[13] EBT Card Issuance, Department of Children and Families Access Program, *accessible at*: http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash/ebt-card-issuance (last visited December 30, 2015).
[14] SNAP Training guide for Retailers, USDA Food and Nutrition Service, *accessible at*: http://www.fns.usda.gov/snap/retailers/store-training.htm (last accessed December 30, 2015)
[15] Supplemental Nutrition Assistance Program-Retailers, USDA Food and Nutrition Service, *accessible at:* http://www.fns.usda.gov/snap/additional-information (last visited December 30, 2015).
[16] *Id.*
[17] *Id.*
[18] Supplemental Nutrition Assistance Program Training Guide for Retailers, USDA Food and Nutrition Service, *accessible at:* http://www.fns.usda.gov/supplemental-nutrition-assistance-program-training-guide-retailers (last visited December 30, 2015).
[19] The store must offer perishable goods in a least two of the categories.

- More than 50% of the total dollar amount of all retail sales sold in the store must be from the sale of eligible staple foods.[20]

Qualified retailers can then apply to be a SNAP provider, either online or with the use of a paper application.[21]

Once a retailer is licensed, the store will receive a seven digit FNS number, which is used to identify both the store and the owner.[22]

Farmers' Markets

Farmers' markets are eligible under federal law to collect SNAP benefits as a form of payment for the sale of food.[23] The USDA defines a farmers' market as "a multi-stall market at which farmer-producers sell agricultural products directly to the general public at a central or fixed location, particularly fresh fruit and vegetables (but also meat products, dairy products, and/or grains)."[24] Like traditional retailers, the USDA requires farmers' markets to obtain a license in order to accept SNAP benefits as a form of payment.[25]

Individual farmers may apply for and receive a license to accept SNAP benefits, but when individual farmers do not have a license, the farmers' markets, rather than the individual farmers, must hold an FNS license in order to accept SNAP.[26] In these cases, the farmers' markets can use a scrip[27] system for use and payment within the market and use a centralized POS device to process transactions.[28]

The FNS describes two basic scrip systems to be used in markets with a centralized POS device: a paper scrip (or token system) and a receipt system.[29]

The paper scrip system requires the farmers' markets to design and purchase tokens or print paper scrip.[30] With the paper scrip system, customers swipe their EBT card at a centrally located POS device and the market staff gives the customers paper scrip or tokens in exchange for the amount debited from the EBT card.[31] Customers can then use the paper scrip or tokens to purchase eligible food at booths throughout the market.[32]

With the receipt system, customers shop for eligible food, and individual vendors hold this food aside for the customer.[33] The vendor makes a list of the food and the customer takes the list to a centralized

[20] Supplemental Nutrition Assistance Program, USDA Food and Nutrition Service, *accessible at:* http://www.fns.usda.gov/snap/retail-store-eligibility-usda-supplemental-nutrition-assistance-program (last visited December 30, 2015).
[21] SNAP Retail Merchants. "Operating a CSA and SNAP Participation." *accessible at*: http://www.fns.usda.gov/ebt/what-farmers-market (last visited December 30, 2015).
[22] *Supra.* at FN 18.
[23] 7 U.S.C. s. 2012(o) and 7 CFR s. 271.2 – A Farmers' Market is included in the definition of Retail food store for the purposes of SNAP.
[24] What is a Farmers' Market, Supplemental Nutrition Assistance Program, USDA, *accessible at*: http://www.fns.usda.gov/ebt/what-farmers-market (last accessed December 30, 2015)
[25] Market Responsibilities, Supplemental Nutrition Assistance Program, USDA, *accessible at*: http://www.fns.usda.gov/ebt/market-responsibilities (last accessed December 30, 2015).
[26] Scrip System, Supplemental Nutrition Assistance Program, USDA *accessible at* http://www.fns.usda.gov/ebt/scrip-system-paper-scrip-token-or-receipts (last accessed December 30, 2015).
[27] A document used as evidence that the holder or bearer is entitled to receive something.
[28] *Id.*
[29] *Id.*
[30] Market Responsibilities, Supplemental Nutrition Assistance Program, USDA, *accessible at*: http://www.fns.usda.gov/snap/ebt/fm-scrip-market_responsibilities.htm (last accessed December 30, 2015).
[31] Scrip System, Supplemental Nutrition Assistance Program, USDA, *accessible at* http://www.fns.usda.gov/ebt/scrip-system-paper-scrip-token-or-receipts (last accessed December 30, 2015).
[32] *Id.*
[33] *Id.*

POS to pay with their EBT card.[34] After paying, the customer receives a receipt, which they take to the vendor in exchange for the food that has been held aside.[35]

The farmers' markets also must train farmers in scrip redemption rules and procedures, since the market's ability to accept SNAP benefits could be jeopardized if the farmer commits a SNAP violation while operating under the market's license.[36] In addition, the farmers' markets must develop an accounting system and method for reimbursing vendors.[37]

Only a small percentage of farmers' markets nationwide participate in SNAP EBT. In order to encourage greater EBT participation, the USDA provides grants to expand the use of SNAP benefits and EBT within farmers' markets.[38]

DCF announced a USDA grant on July 27, 2012, that would provide free wireless EBT equipment allowing up to 100 farmers' markets within the state to handle SNAP redemption.[39] As of October 10, 2015, 82 of Florida's farmers' markets are participating in EBT.[40]

Effect of Proposed Changes

The bill creates an unnumbered section of law that authorizes the owner or operator of a fresh produce market that does not have an EBT system to allow certain groups to implement and operate an EBT system in the market on behalf of the produce sellers. The bill lists groups authorized to set up the EBT operations and specifies that these groups must also be authorized by the FNS. The groups specified in the bill includes a food nutrition service group, association of produce sellers active in the market or a food nutrition service third party organization.

If an outside group establishes the EBT system, the bill requires that the market owner or operator must reasonably accommodate the group in the implementation and operation of the EBT system for accepting SNAP benefits.

This bill states that it does not:

- Apply to a market selling fresh produce whose owner or operator has an EBT system for accepting SNAP benefits in the market;
- Prohibit an authorized food and nutrition service produce seller in a market selling fresh produce from operating his or her own EBT system as part of his or her customer transaction options; or
- Require a market owner or operator to create, operate, or maintain an EBT system on behalf of his produces sellers.

The bill provides for an effective date of July 1, 2016.

Effect of Proposed Changes

The bill authorizes the owner or operator of a fresh produce market that does not have an EBT system to allow certain groups to implement and operate an EBT system in the market on behalf of the produce sellers. The bill lists groups authorized to set up the EBT operations and specifies that these

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[34] *Id.*
[35] *Id.*
[36] Market Responsibilities, Supplemental Nutrition Assistance Program, USDA, *accessible at*: http://www.fns.usda.gov/ebt/market-responsibilities (last accessed December 30, 2015).
[37] *Id.*
[38] Learn About SNAP Benefits at Farmers Markets, EBT, USDA, *accessible at:* http://www.fns.usda.gov/ebt/learn-about-snap-benefits-farmers-markets (last accessed December 30, 2015).
[39] More Farmers' Markets in Florida Will Soon Accept Food Assistance Cards, Florida Department of Children and Families, *accessible at:* http://www.myflfamilies.com/press-release/more-farmers-markets-florida-will-soon-accept-food-assistance-cards (last accessed December 30, 2015).
[40] SNAP Authorized Farmers' Markets, USDA *accessible at* Department of Agriculture, National Farmers Market Directory, *accessible at :* http://www.fns.usda.gov/ebt/learn-about-snap-benefits-farmers-markets (last accessed December 30, 2015).

groups must also be authorized by the Food and Nutrition Service. The groups specified in the bill includes a food nutrition service group, association of produce sellers active in the market or a food nutrition service third party organization.

If an outside group establishes the EBT system, the bill requires that the market owner or operator must reasonably accommodate the group in the implementation and operation of the EBT system for accepting SNAP benefits.

This bill states that the EBT system requirement does not apply to a market selling fresh produce whose owner or operator has an EBT system for accepting SNAP benefits in the market. The requirement also does not prohibit an authorized food and nutrition service produce seller in a market selling fresh produce from operating his or her own EBT system as part of his or her customer transaction options. The bill also does not require a market owner or operator to create, operate, or maintain an EBT system on behalf of his produces sellers.

B. SECTION DIRECTORY:

Section 1: Creates an unnumbered section of law, relating to the Fresh Produce Markets.
Section 2: Provides for an effective date.

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:

   Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to transactions in fresh produce
3 markets; providing definitions; authorizing certain
4 owners and operators of farmers' markets, community
5 farmers' markets, flea markets, and other open-air
6 markets selling fresh produce to allow authorized Food
7 and Nutrition Service groups, associations, and third-
8 party organizations to operate electronic benefits
9 transfer systems in such markets; providing
10 applicability; providing an effective date.
11
12 Be It Enacted by the Legislature of the State of Florida:
13
14 Section 1. (1) As used in this section, the term:
15 (a) "Market" means a farmers' market, community farmers'
16 market, flea market, or other open-air market.
17 (b) "SNAP" means the federal Supplemental Nutrition
18 Assistance Program established under 7 U.S.C. ss. 2011 et seq.
19 (2)(a) The owner or operator of a market selling fresh
20 produce who is not an authorized SNAP retailer may allow an
21 authorized Food and Nutrition Service group or association of
22 produce sellers that is actively participating in produce sales
23 in the market, or an authorized Food and Nutrition Service
24 third-party organization, to implement and operate an electronic
25 benefits transfer system for purposes of accepting SNAP benefits
26 in the market on behalf of the produce sellers to the extent and

27 manner allowed by federal law and regulation.
28 (b) The authorized Food and Nutrition Service group,
29 association, or third-party organization responsible for
30 implementation and operation of the electronic benefits transfer
31 system may not be another market that competes with the market
32 being served.
33 (c) The market owner or operator shall reasonably
34 accommodate the authorized Food and Nutrition Service group,
35 association, or third-party organization in the implementation
36 and operation of an electronic benefits transfer system for
37 purposes of accepting SNAP benefits.
38 (3) This section does not:
39 (a) Apply to a market selling fresh produce whose owner or
40 operator has an electronic benefits transfer system for
41 accepting SNAP benefits in the market.
42 (b) Prohibit an authorized Food and Nutrition Service
43 produce seller in a market selling fresh produce from operating
44 his or her own electronic benefits transfer system as part of
45 his or her customer transaction options.
46 (c) Require a market owner or operator to create, operate,
47 or maintain an electronic benefits transfer system on behalf of
48 its produce sellers.
49 Section 2. This act shall take effect July 1, 2016.

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

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED __ (Y/N)

ADOPTED AS AMENDED __ (Y/N)

ADOPTED W/O OBJECTION __ (Y/N)

FAILED TO ADOPT __ (Y/N)

WITHDRAWN __ (Y/N)

OTHER ____

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1 Committee/Subcommittee hearing bill: Health & Human Services
2 Committee
3 Representative Fullwood offered the following:
4
5 **Amendment (with title amendment)**
6 Remove line 14 and insert:
7 Section 1. Section 414.456, Florida Statutes, is created
8 to read:
9 414.456 Supplemental Nutrition Assistance Program in fresh
10 produce markets.—
11 (1) As used in this section, the term:
12
13 ---
14 **T I T L E A M E N D M E N T**
15 Remove line 3 and insert:
16 markets; creating s. 414.456, F.S.; providing definitions;
17 authorizing certain

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 107 Physical Therapy
SPONSOR(S): Cummings
TIED BILLS: **IDEN./SIM. BILLS:** SB 450

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	12 Y, 0 N	Siples	O'Callaghan
2) Health & Human Services Committee		Siples	Calamas

SUMMARY ANALYSIS

Physical therapists are regulated under ch. 486, F.S., the Physical Therapy Practice Act (Act), and by the Board of Physical Therapy (Board) under the Department of Health's Division of Medical Quality Assurance. Physical therapy is the assessment, treatment, prevention, and rehabilitation of any disability, injury, disease, or other health condition of a human being with the use of various modalities.

The bill requires a practitioner of record to review and sign a treatment plan for a patient when treatment is required beyond 30 days for a condition not previously assessed by a practitioner of record or by a physician licensed in another state. A practitioner of record includes allopathic or osteopathic physicians, chiropractors, podiatrists, or dentists.

The bill creates title protection for a licensed physical therapist who has obtained a doctoral degree in physical therapy by only allowing a person qualified as such to use the title "D.P.T." Additionally, the bill makes it unlawful for a person to use, in connection with his or her place of business, the title acronym "D.P.T.," unless the person holds a doctoral degree in physical therapy and an active license as a physical therapist. However, the bill prohibits a physical therapist who holds a doctoral degree in physical therapy from using the title "doctor," unless the physical therapist clearly informs the public that his or her profession is physical therapy.

The bill also deletes redundant language in statutes providing title protection for physical therapists and physical therapy assistants.

The bill has an insignificant, negative fiscal impact on the Department of Health and no fiscal impact on local governments.

The bill provides that it shall take effect upon becoming a law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Physical Therapy in the United States

Physical therapy practice is the performance of physical therapy assessments and treatment, or prevention of any disability, injury, disease, or other health condition of human beings and rehabilitation as it relates to the use of various modalities, such as exercise, massage, ultrasound, ice, heat, water, and equipment.[1]

Physical Therapists (PTs) are licensed in all 50 states. States utilize the National Physical Therapy Exam (NPTE), which was developed by the Federation of State Boards of Physical Therapy (FSBPT), to determine if a person has met competency standards for the safe provision of nationally accepted physical therapy procedural interventions.[2]

The NPTE provides a common element in the evaluation of candidates so that standards will be comparable from jurisdiction to jurisdiction, and protects the public interest in having only those persons who have the requisite knowledge of physical therapy be licensed to practice physical therapy.[3] To practice as a PT in the U.S., a person must earn a physical therapy degree from a state approved PT education program, pass the state approved licensure exam, and comply with other state specific licensure requirements. Currently, all entry-level PT education programs in the U.S. only offer the Doctor of Physical Therapy (D.P.T.) degree to all new students who enroll.[4]

Physical Therapy Practice in Florida

Physical therapy practitioners are regulated by ch. 486, F.S., the Physical Therapy Practice Act (Act) and the Board of Physical Therapy (Board) under the Department of Health's Division of Medical Quality Assurance.[5]

A licensed PT or a licensed physical therapist assistant (PTA) must practice physical therapy in accordance with the provisions of the Act and the Board rules. There are 15,234 PTs and 8,452 PTAs who hold active licenses in Florida.[6]

Licensure

To be licensed as a PT, an applicant must be at least 18 years old; be of good moral character; pay $180 in fees;[7] pass the Laws and Rules Examination offered by the FSBPT within 5 years before the

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[1] Section 486.021(11), F.S.

[2] American Physical Therapy Association, *About the National Physical Therapy Examination*, available at http://www.apta.org/Licensure/NPTE/ (last visited January 4, 2016).

[3] American Physical Therapy Association, *Licensure*, available at http://www.apta.org/Licensure/ (last visited January 4, 2016).

[4] American Physical Therapy Association, *Physical Therapist (PT) Education Overview*, available at http://www.apta.org/For_Prospective_Students/PT_Education/Physical_Therapist_(PT)_Education_Overview.aspx (last visited January 4, 2016).

[5] The Division of Medical Quality Assurance (MQA) regulates health care practitioners to ensure the health, safety, and welfare of the public. There are 22 boards and 6 councils under the MQA, and the MQA regulates 7 types of facilities and more than 200 occupations in over 40 health care professions. Department of Health, Division of Medical Quality Assurance, *Division of Medical Quality Assurance Annual Report and Long-Range Plan, Fiscal Year 2014-2015*, available at http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/_documents/annual-report-1415.pdf (last visited on January 4, 2016).

[6] Email correspondence with Florida Department of Health MQA staff on October 12, 2015. The number of active licensed PTs and PTAs provided include both in-state and out-of-state licensees as of June 30, 2015.

[7] Section 486.041, F.S., and Rule 64B17-2.001, F.A.C.

date of application for licensure;[8] meet the general requirements for licensure of all health care practitioners in ch. 456, F.S.; and meet one of the following requirements:

- Have graduated from an accredited PT training program and have passed the National Physical Therapy Examination (NPTE) for PTs offered by the FSBPT within 5 years before the date of application for licensure;[9]
- Have graduated from a PT training program in a foreign country, have had his or her credentials deemed by the Foreign Credentialing Commission on Physical Therapy or other board-approved credentialing agency to be equivalent to those of U.S.-educated PTs and have passed the NPTE for PTs within 5 years before the date of application for licensure;[10] or
- Have passed a board-approved examination and holds an active license to practice physical therapy in another state or jurisdiction if the board determines that the standards for licensure in that state or jurisdiction are equivalent to those of Florida.[11]

A PT's license is renewed every two years by submitting an application, paying an $80 renewal fee,[12] and submitting proof of completion of 24 hours of continuing physical therapy education. At least 1 hour of education must be on HIV/AIDS, and 2 hours must be on medical error prevention.[13]

Title Protection

Section 486.081(1), F.S., authorizes a licensed PT to use the words "physical therapist" or "physiotherapist," or the letters "P.T." in connection with his or her name or place of business to denote his or her licensure. False representation of a PT license, or willful misrepresentation or false representation to obtain a PT license is unlawful. A list of titles and title acronyms in s. 486.135, F.S., may only be used by a licensed PT.[14]

Referrals for Treatment and Treatment Plans

Every state, the District of Columbia, and the U.S. Virgin Islands allow for evaluation and some form of treatment without physician referral.[15] However, many states impose restrictions on a patient's direct access to physical therapy services, or only allow for treatment without referral under limited circumstances. Twenty-two states, including Florida, allow a PT to treat a patient without a physician's referral, for a limited amount of time.[16]

PTs are trained to recognize signs and symptoms that are outside the scope of their practice. If a patient's condition is outside the scope of physical therapy practice, PTs are often mandated by state law to refer patients to other providers who can provide appropriate care for a patient's condition.[17]

A physical therapy treatment plan establishes the goals and specific remediation techniques that a PT will use in the course of treating a patient.[18] In addition to a treatment plan developed by a PT for their

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[8] Rule 64B17-3.002, F.A.C.
[9] *Id.*
[10] Rule 64B17-3.001, F.A.C.
[11] Rule 64B17-3.003, F.A.C.
[12] The fees vary if a PT has an inactive license and is wishing to reactivate their license. Board of Physical Therapy, *Renewal Information*, available at http://floridasphysicaltherapy.gov/renewals/ (last visited January 4, 2016).
[13] Board of Physical Therapy, *Renewal Information*, available at http://floridasphysicaltherapy.gov/renewals/ (last visited January 4, 2016).
[14] Section 486.151, F.S., provides that it is a first-degree misdemeanor if a person fraudulently uses the title "physical therapist," "physical therapist assistant," or any other related title without holding a valid license. A first-degree misdemeanor is punishable by a term of imprisonment not to exceed 1 year and a $1,000 fine. Sections 775.082 and 775.083, F.S.
[15] American Physical Therapy Association, *FAQ: Direct Access at the State Level*, available at http://www.apta.org/StateIssues/DirectAccess/FAQs/ (last visited January 4, 2016).
[16] Federation of State Boards of Physical Therapy, *Jurisdiction Licensure Reference Guide: Direct Access*, last updated August 2014, available at https://www.fsbpt.org/Portals/0/documents/free-resources/JLRG_DirectAccess_201408.pdf (last visited December 21, 2015).
[17] *Supra* fn. 15.

own use, s. 486.021(11)(a), F.S., authorizes a PT to implement a treatment plan provided by a practitioner of record or an advanced registered nurse practitioner licensed under s. 464.012, F.S. Section 486.021(11)(a), F.S., provides that a health care practitioner who is an allopathic or osteopathic physician, chiropractor, podiatrist, or dentist, that is actively engaged in practice is eligible to serve as a practitioner of record.

Currently, a PT may implement a treatment plan for a patient without a written order from a practitioner of record if the recommended treatment plan is performed within a 21-day timeframe. If the treatment plan requires treatment beyond 21 days, the condition must be assessed by a practitioner of record who is required to review and sign the treatment plan.[19]

A PT is not allowed to implement any treatment plan that, in the PT's judgment, is contraindicated. If the treatment plan was requested by a referring practitioner, the PT must immediately notify the referring practitioner that he or she is not going to follow the request and the reasons for such refusal.[20]

Effect of Proposed Changes

Treatment Plan and Referral for Treatment

Currently, a PT must have a practitioner of record review and sign a patient's treatment plan if physical therapy treatment is required beyond 21 days for a condition not previously assessed by a practitioner of record.[21] The bill expands this timeframe from 21 days to 30 days. The bill also exempts a PT from this requirement when a patient has been physically examined by a physician licensed in another state and diagnosed by that physician as having a condition for which physical therapy is required.[22]

Title Protection

All of Florida's physical therapy educational programs are three-year doctoral programs.[23] The bill adds the new title acronym "D.P.T.," which may be used by a PT who has obtained a doctoral degree in physical therapy in connection with his or her name or place of business. However, this bill allows the title "doctor" to only be used by a PT who holds a physical therapy doctoral degree, and only if the public is informed that his or her profession is physical therapy.

Pursuant to s. 486.151, F.S., a person who uses any name or title which would lead the public to believe that the person using the name or title is licensed to practice physical therapy, and the person is not licensed to perform such practice, commits a first-degree misdemeanor. The bill amends s. 486.135, F.S., to make it unlawful for a person to use, in connection with his or her place of business, the title acronym "D.P.T.," unless the person holds an active license as a PT, and cross-references s. 486.151, F.S., to make the unlawful act a first degree misdemeanor.

Current law prohibits the use of any words, letters, abbreviations, or insignia indicating or implying that a person is a physical therapist or physical therapist assistant, unless licensed as such. Therefore, the bill deletes listed title abbreviations that may not be used by unlicensed persons, because the prohibition against the use of each listed title is redundant.

The bill provides that it shall take effect upon becoming a law.

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[18] Rule 64B17-6.001, F.A.C

[19] Section 486.021(11)(a), F.S.

[20] *Supra* fn. 18.

[21] A practitioner of record, includes allopathic (ch. 458, F.S.) or osteopathic physicians (ch. 459, F.S.), chiropractors (ch. 460, F.S.), podiatrists (ch. 461, F.S.), or dentists (ch. 466, F.S.).

[22] This allows physical therapy patients, who have a seasonal residence in Florida, to obtain uninterrupted physical therapy treatment if their out of state licensed physician has recommended physical therapy treatment for a certain condition.

[23] Florida has eleven Doctor of Physical Therapy educational programs. Florida Physical Therapy Association, *Florida PT Schools*, available at http://fpta.site-ym.com/?page=272 (last visited December 21, 2015).

B. SECTION DIRECTORY:

Section 1. Amends s. 486.021, F.S., relating to definitions.
Section 2. Amends s. 486.081, F.S., relating to physical therapist; issuance of license without examination to person passing examination of another authorized examining board; fee.
Section 3. Amends s. 486.135, F.S., relating to false representation of licensure, or willful misrepresentation or fraudulent representation to obtain license, unlawful.
Section 4. Amends s. 486.151, F.S., relating to prohibited acts; penalty.
Section 5. Provides an effective date of upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   DOH may incur a recurring increase in workload associated with additional practitioner complaints, which current resources are adequate to absorb.

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:

   Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to physical therapy; amending s.
3 486.021, F.S.; revising the definition of the term
4 "practice of physical therapy"; amending s. 486.081,
5 F.S.; providing that a licensed physical therapist who
6 holds a specified doctoral degree may use specified
7 letters in connection with her or his name or place of
8 business; prohibiting a physical therapist with a
9 specified doctoral degree from using the title
10 "doctor" without informing the public of his or her
11 profession as a physical therapist; amending s.
12 486.135, F.S.; revising the terms prohibited from
13 being used by certain unlicensed persons; providing a
14 criminal penalty; amending s. 486.151, F.S.;
15 prohibiting an unlicensed person from using specified
16 letters; providing an effective date.
17
18 Be It Enacted by the Legislature of the State of Florida:
19
20 Section 1. Paragraph (a) of subsection (11) of section
21 486.021, Florida Statutes, is amended to read:
22 486.021 Definitions.—In this chapter, unless the context
23 otherwise requires, the term:
24 (11) "Practice of physical therapy" means the performance
25 of physical therapy assessments and the treatment of any
26 disability, injury, disease, or other health condition of human

27 beings, or the prevention of such disability, injury, disease,
28 or other condition of health, and rehabilitation as related
29 thereto by the use of the physical, chemical, and other
30 properties of air; electricity; exercise; massage; the
31 performance of acupuncture only upon compliance with the
32 criteria set forth by the Board of Medicine, when no penetration
33 of the skin occurs; the use of radiant energy, including
34 ultraviolet, visible, and infrared rays; ultrasound; water; the
35 use of apparatus and equipment in the application of the
36 foregoing or related thereto; the performance of tests of
37 neuromuscular functions as an aid to the diagnosis or treatment
38 of any human condition; or the performance of electromyography
39 as an aid to the diagnosis of any human condition only upon
40 compliance with the criteria set forth by the Board of Medicine.
41 (a) A physical therapist may implement a plan of treatment
42 developed by the physical therapist for a patient or provided
43 for a patient by a practitioner of record or by an advanced
44 registered nurse practitioner licensed under s. 464.012. The
45 physical therapist shall refer the patient to or consult with a
46 practitioner of record if the patient's condition is found to be
47 outside the scope of physical therapy. If physical therapy
48 treatment for a patient is required beyond 30 ~~21~~ days for a
49 condition not previously assessed by a practitioner of record,
50 the physical therapist shall have ~~obtain~~ a practitioner of
51 record ~~who will~~ review and sign the plan. The requirement for a
52 physical therapist to have a practitioner of record review and

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

53 <u>sign a plan of treatment does not apply when a patient has been</u>
54 <u>physically examined by a physician licensed in another state,</u>
55 <u>the patient has been diagnosed by such physician as having a</u>
56 <u>condition for which physical therapy is required, and the</u>
57 <u>physical therapist is treating such condition.</u> For purposes of
58 this paragraph, a health care practitioner licensed under
59 chapter 458, chapter 459, chapter 460, chapter 461, or chapter
60 466 and engaged in active practice is eligible to serve as a
61 practitioner of record.
62 Section 2. Subsection (1) of section 486.081, Florida
63 Statutes, is amended to read:
64 486.081 Physical therapist; issuance of license without
65 examination to person passing examination of another authorized
66 examining board; fee.—
67 (1) The board may cause a license to be issued through the
68 department without examination to any applicant who presents
69 evidence satisfactory to the board of having passed the American
70 Registry Examination prior to 1971 or an examination in physical
71 therapy before a similar lawfully authorized examining board of
72 another state, the District of Columbia, a territory, or a
73 foreign country, if the standards for licensure in physical
74 therapy in such other state, district, territory, or foreign
75 country are determined by the board to be as high as those of
76 this state, as established by rules adopted pursuant to this
77 chapter. Any person who holds a license pursuant to this section
78 may use the words "physical therapist" or "physiotherapist~~,~~" or

CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

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79 the letters "P.T.~~,~~" in connection with her or his name or place
80 of business to denote her or his licensure hereunder. A person
81 who holds a license pursuant to this section and obtains a
82 doctoral degree in physical therapy may use the letters "D.P.T."
83 and "P.T." A physical therapist who holds a degree of Doctor of
84 Physical Therapy may not use the title "doctor" without also
85 clearly informing the public of his or her profession as a
86 physical therapist.
87 Section 3. Subsection (1) of section 486.135, Florida
88 Statutes, is amended, subsection (2) is renumbered as subsection
89 (3), and a new subsection (2) is added to that section, to read:
90 486.135 False representation of licensure, or willful
91 misrepresentation or fraudulent representation to obtain
92 license, unlawful.—
93 (1)(a) It is unlawful for any person who is not licensed
94 under this chapter as a physical therapist, or whose license has
95 been suspended or revoked, to use in connection with her or his
96 name or place of business the words "physical therapist,"
97 "physiotherapist," "physical therapy," "physiotherapy,"
98 "registered physical therapist," or "licensed physical
99 therapist"; ~~or~~ the letters "P.T.~~,~~" ~~"Ph.T.," "R.P.T.," or~~
100 ~~"L.P.T."~~; or any other words, letters, abbreviations, or
101 insignia indicating or implying that she or he is a physical
102 therapist or to represent herself or himself as a physical
103 therapist in any other way, orally, in writing, in print, or by
104 sign, directly or by implication, unless physical therapy

105 services are provided or supplied by a physical therapist
106 licensed in accordance with this chapter.
107 (b) It is unlawful for a person who is not licensed under
108 this chapter as a physical therapist and who does not hold a
109 doctoral degree in physical therapy to use the letters "D.P.T."
110 in connection with his or her name or place of business.
111 (c) ~~(b)~~ It is unlawful for any person who is not licensed
112 under this chapter as a physical therapist assistant, or whose
113 license has been suspended or revoked, to use in connection with
114 her or his name the words "physical therapist assistant,"
115 ~~"licensed physical therapist assistant," "registered physical~~
116 ~~therapist assistant," or "physical therapy technician"; or~~ the
117 letters "P.T.A.," ~~"L.P.T.A.," "R.P.T.A.," or "P.T.T.";~~ or any
118 other words, letters, abbreviations, or insignia indicating or
119 implying that she or he is a physical therapist assistant or to
120 represent herself or himself as a physical therapist assistant
121 in any other way, orally, in writing, in print, or by sign,
122 directly or by implication.
123 (2) An unlawful act under this section is a violation of
124 s. 486.151.
125 Section 4. Paragraph (d) of subsection (1) of section
126 486.151, Florida Statutes, is amended to read:
127 486.151 Prohibited acts; penalty.—
128 (1) It is unlawful for any person to:
129 (d) Use the name or title "Physical Therapist" or
130 "Physical Therapist Assistant" or any other name or title which

131 would lead the public to believe that the person using the name
132 or title is licensed to practice physical therapy, unless such
133 person holds a valid license; or use the letters "D.P.T.,"
134 unless such person holds a valid license under this chapter and
135 a doctoral degree in physical therapy.
136 Section 5. This act shall take effect upon becoming a law.

CS/HB 127

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 127 Continuing Care Facilities
SPONSOR(S): Health Innovation Subcommittee; Cummings
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	11 Y, 0 N, As CS	Guzzo	Poche
2) Health & Human Services Committee		Guzzo	Calamas

SUMMARY ANALYSIS

The Gold Seal Program (Program) is a recognition process and award program for nursing homes that demonstrate excellence in long-term care over a sustained period of time. Recipients of the Gold Seal Award (Award) may use the designation in their advertising and marketing. Of the 684 currently licensed nursing homes in Florida, 25 nursing homes hold the award.

A nursing home that wishes to be considered for the Award must submit an application to the Agency for Health Care Administration (AHCA). The Governor's Panel on Excellence in Long-Term Care reviews the applications and makes recommendations to the Governor for final approval of the Award.

To be considered for the Award, a nursing home must be licensed and operating for at least 30 months and must provide evidence of financial soundness and stability during the 30 months preceding application submission. To demonstrate the financial soundness requirement an applicant must:

- Submit a balance sheet, income statement, and a statement of cash flow for the three consecutive years immediately preceding the application;
- Submit a report from a certified public accountant who has audited or reviewed such financial statements; and
- Meet two of the following three requirements;
  - Have a positive assets to liabilities ratio;
  - Have a positive tangible net worth; or
  - Have a times interest earned ratio of at least 115 percent.

A nursing home that is part of the same corporate entity as a continuing care facility licensed under Chapter 651, F.S., can meet the financial soundness and stability requirement if:

- The facility meets the minimum liquid reserve requirements in s. 651.035, F.S.; and
- The facility is accredited by an organization recognized under statute and OIR rule, as long as the accreditation is not provisional.

CS/HB 127 provides two additional options for a nursing home to satisfy the financial soundness and stability requirement of the Program. First, the bill permits a nursing home which is part of an unaccredited continuing care facility to demonstrate that the facility, in its entirety, meets AHCA financial standards as proof of financial soundness and stability for purposes of qualifying for the Program. Second, the bill allows a nursing home that is part of a corporate entity that operates nursing homes, assisted living facilities, or independent living facilities to satisfy the financial soundness and stability requirement by submitting a consolidated corporate financial statement to AHCA and demonstrating that the corporate entity, in its entirety, meets the financial standards established by AHCA.

The bill does not appear to have a fiscal impact on state or local government.

The bill provides an effective date of upon becoming a law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Nursing Homes and Continuing Care Facilities

Nursing homes are regulated by the Agency for Health Care Administration (AHCA) under the Health Care Licensing Procedures Act (Act) in part II of chapter 408, F.S., which contains uniform licensing standards for 29 provider types including nursing homes. In addition, nursing homes must comply with the requirements contained in the individual authorizing statutes of part II of chapter 400, F.S., which includes unique provisions for licensure beyond the uniform criteria.

A continuing care facility is a facility that offers a continuum of services at a single location including skilled nursing care, independent living, assisted living, and memory support. Oversight of continuing care facilities is primarily shared between AHCA and the Office of Insurance Regulation (OIR), pursuant to ch. 651, F.S. ("the Act"). AHCA regulates aspects of continuing care facilities related to the provision of health care such as skilled nursing care, assisted living, quality of care, and concerns with medical facilities.

The Act gives OIR primary responsibility of licensing continuing care facilities, examining them for compliance with applicable laws and rules, and monitoring their financial condition for the protection of the public from insolvency risks and unethical practices.[1] In addition, the Department of Financial Services shares some solvency regulatory authority with OIR.[2]

Nursing Home Gold Seal Program

The Gold Seal Program (Program) was established in 1999 to develop an award and recognition program for nursing homes that demonstrate excellence in long-term care over a sustained period of time.[3] Recipients of the Gold Seal Award (Award) may use the designation in their advertising and marketing.[4] Of the 684 currently licensed nursing homes in Florida[5], 25 nursing homes hold the Award.[6]

Governor's Panel on Excellence in Long-Term Care

The Program is implemented by the Governor's Panel on Excellence in Long-Term Care (Panel) which is administratively housed within the Executive Office of the Governor.[7] The Panel consists of 13 members, including:

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[1] Office of Insurance Regulation, *Specialty Product Administration,* available at http://www.floir.com/Sections/Specialty/is_sp_index.aspx (last viewed January 7, 2016).
[2] S. 651.114(6), F.S., provides that OIR and the Department of Financial Services may intervene in continuing care facilities with all the necessary powers and duties they possess under the provisions of the Insurers Rehabilitation and Liquidation Act in part I of ch. 631, F.S.
[3] House Bill 1971, 1999 Florida Legislative Session, and ch. 99-394, Laws of Fla.
[4] S. 400.235(8)(a), F.S.
[5] Agency for Health Care Administration, *Facility Provider Locator; General Search, by Facility/Provider Type; Nursing Homes,* available at http://www.floridahealthfinder.gov/facilitylocator/FacilitySearch.aspx (last viewed January 7, 2016).
[6] Agency for Health Care Administration, *Facility Provider Locator; General Search, by Facility/Provider Type; Nursing Homes; Advanced Search, Gold Seal Award Recipient,* available at http://www.floridahealthfinder.gov/facilitylocator/FacilitySearch.aspx (last viewed January 7, 2016).
[7] S. 400.235(3)(a), F.S.

- Three members appointed by the Governor, including a consumer advocate for senior citizens and two persons with expertise in the fields of quality management, service delivery excellence, or public sector accountability;
- Three members appointed by the Secretary of Elder Affairs, including an active member of a nursing facility family and resident care council, a member of the University Consortium on Aging, and a representative of the State Long-Term Care Ombudsman Program;
- Two members appointed by the Secretary of the Agency for Health Care Administration (AHCA);
- One member appointed by the Florida Life Care Residents Association;
- One member appointed by the State Surgeon General; and
- One member appointed by the Florida Health Care Association.[8]

An individual with any ownership interest in a nursing home is prohibited from becoming a member of the Panel. Any member of the Panel who is employed by a nursing home in any capacity is prohibited from reviewing or voting on recommendations involving the facility by which the member is employed or any facility under common ownership with the facility.[9]

Program Requirements - General

To be considered for the Award, a nursing home must have a letter of recommendation from AHCA, a nursing home industry organization, a consumer, the State Long-Term Care Ombudsman Program, or a member of the community where the nursing home is located.[10] The nursing home must then submit the letter of recommendation and a completed application with supporting documentation to AHCA.[11] Only nursing homes with a quality of care ranking within the top 15 percent of facilities regionally, or top 10 percent of facilities statewide, and that have a five-star facility designation[12] overall are considered.[13]

In addition, applicants must meet the following criteria:

- Have no Class I or Class II deficiencies within the 30 months preceding the application for the Program;
- Participate in a consumer satisfaction process involving residents, family members and guardians;
- Provide evidence of the involvement of families of residents and members of the community in the facility on a regular basis;
- Have a stable workforce as evidenced by a low rate of turnover among certified nursing assistants and licensed nurses within the preceding 30 months;
- Provide evidence that verified complaints reported to the State Long-Term Care Ombudsman Program within the 30 months preceding application for the program have not resulted in a citation for licensure; and
- Provide targeted in-service training.[14]

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[8] Id.
[9] S. 400.235(3)(b), F.S.
[10] S. 400.235(6), F.S.
[11] Rule 59A-4.201(1), F.A.C.
[12] S. 400.191 F.S., requires AHCA to provide information to the public in consumer-friendly printed and electronic formats to assist consumers and their families in comparing and evaluating nursing home facilities. AHCA publishes a Nursing Home Guide, which includes facility-specific comparative information based on certain quality and performance measures, including a star ranking based upon deficiencies cited during inspections. The more stars (up to 5), the better the facility scored on that particular measure. The broadest measure of performance is Overall Inspection, available at http://www.floridahealthfinder.gov/CompareCare/MethodologyNH.aspx (last viewed January 7, 2016).
[13] Rule 59A-4.202, F.A.C.
[14] S. 400.235(5), F.S.

Program Requirements – Financial Soundness and Stability

An applicant for the Award is required to provide evidence of financial soundness and stability.[15] The financial soundness and stability requirements differ based on whether or not a nursing home is part of the same corporate entity as a continuing care facility.[16]

A nursing home that is not part of the same corporate entity as a continuing care facility is required to be licensed and operating for at least 30 months prior to the date of application submission and must provide evidence of financial soundness and stability during the 30 months preceding application submission.[17] To demonstrate financial soundness and stability, a nursing home must:

- Submit a balance sheet, income statement, and a statement of cash flow for the three consecutive years immediately preceding the application;
- Submit a report from a certified public accountant who has audited or reviewed such financial statements; and
- Meet two of the following three requirements;
  - Have a positive assets to liabilities ratio;
  - Have a positive tangible net worth; or
  - Have a times interest earned ratio[18] of at least 115 percent.[19]

A nursing home that is part of the same corporate entity as a continuing care facility demonstrates financial soundness and stability if:

- The facility meets the minimum liquid reserve requirements in s. 651.035, F.S.; and
- The facility is accredited by an organization recognized under statute and OIR rule[20], as long as the accreditation is not provisional.[21]

If a facility is accredited without stipulations or conditions by a process substantially equivalent to the requirements of Chapter 651, F.S., OIR may waive any requirement of Chapter 651, F.S., including the minimum liquid reserve requirements.[22]

Presently, a continuing care facility must maintain a statutorily-prescribed minimum liquid reserve under s. 651.035, F.S. The reserve is comprised of three separate reserves based on separate calculations. The first is the "debt service reserve," which is an amount equal to the aggregate amount of all principal and interest payments due during the fiscal year on any mortgage loan or other long term financing of the facility, including taxes and insurance.[23]

The second is the "operating reserve," represented as a function of a provider's total operating expenses. Each facility must maintain in reserve an amount equal to 30 percent of the total projected operating expenses for the first 12 fiscal months of operation, and 15 percent thereafter. Where a facility has been in operation for more than 12 months, the total operating expenses is determined by averaging the total annual operating expenses reported to OIR by the number of annual reports filed with OIR within the immediate preceding 3-year period.

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[15] Id.
[16] S. 400.235(5)(b), F.S.
[17] Rule 59A-4.203, F.A.C.
[18] A times interest earned ratio is determined by dividing interest expense into net income before deducting such interest and income tax. Net income is defined as revenues less expenses.
[19] Rule 59A-4.203, F.A.C.
[20] Rule 69O-193.055(1)(a), F.A.C., recognizes the National Continuing Care Accreditation Commission.
[21] S. 400.235(5)(b), F.A.C.
[22] S. 651.028, F.S.
[23] S. 651.035(1)(a), F.S.

The third is the “renewal and replacement reserve,” which is equal to 15 percent of the total accumulated depreciation based on the audited financial statement of a facility, but not to exceed 15 percent of the facility’s average operating expenses for the past 3 fiscal years based on a facility’s audited financial statement for each year.

Effect of Proposed Changes

For a nursing home which is part of a continuing care facility to qualify for the Program, current law requires the facility to meet the minimum liquid reserve requirements of s. 651.035, F.S., and be accredited by a recognized accrediting organization to satisfy the financial soundness and stability requirement of the Program.

CS/HB 127 provides two additional options for a nursing home to satisfy the financial soundness and stability requirement of the Program. First, the bill permits a nursing home which is part of an unaccredited continuing care facility to demonstrate that the facility, in its entirety, meets AHCA financial standards as proof of financial soundness and stability for purposes of qualifying for the Award. Second, the bill allows a nursing home that is part of a corporate entity that operates nursing homes, assisted living facilities, or independent living facilities to satisfy the financial soundness and stability requirement by:

- Submitting a consolidated corporate financial statement to AHCA; and
- Demonstrating that the corporate entity, in its entirety, meets the financial standards established by AHCA.

The bill potentially allows more nursing homes to qualify for the Program.

B. SECTION DIRECTORY:

Section 1: Amends s. 400.235, F.S., relating to nursing home quality and licensure status; Gold Seal Program.
Section 2: Provides an effective date of upon becoming a law.

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:

The bill may have a positive fiscal impact on unaccredited facilities that offer skilled nursing care and wish to apply for the Program by providing an alternative means to meet the financial soundness and stability requirement.

The bill may also have a positive fiscal impact on nursing homes that are part of corporate entities that operate a combination of nursing homes, assisted living facilities, or independent living facilities. Such nursing homes can meet the financial soundness and stability requirements of the Program by submitting a consolidated corporate financial statement to AHCA and demonstrating that the corporate entity, in its entirety, meets the financial standards established by AHCA. A nursing home that could not meet the financial soundness and stability standards on its own may become eligible for the Program as a result of the financial performance of other facilities owned by the corporate entity. In addition, the corporate entity will only incur the expenses resulting from the single consolidated corporate financial statement.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   None. The bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On December 2, 2015, the Health Innovation Subcommittee adopted one amendment and reported the bill favorably as a committee substitute. The amendment authorized a nursing home that is part of a corporate entity that operates nursing homes, assisted living facilities, or independent living facilities to satisfy the financial soundness and stability requirement of the Program by submitting a consolidated corporate financial statement to AHCA and demonstrating that the corporate entity, in its entirety, meets the financial standards established by AHCA.

The analysis is drafted to the committee substitute as passed by the Health Innovation Subcommittee.

A bill to be entitled

An act relating to continuing care facilities; amending s. 400.235, F.S.; providing financial requirements for certain nursing homes to be designated as a Gold Seal Program facility; providing an effective date.

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

Section 1. Paragraph (b) of subsection (5) of section 400.235, Florida Statutes, is amended to read:

400.235 Nursing home quality and licensure status; Gold Seal Program.—

(5) Facilities must meet the following additional criteria for recognition as a Gold Seal Program facility:

(b) Evidence financial soundness and stability according to standards adopted by the agency in administrative rule. Such standards must include, but not be limited to, criteria for the use of financial statements that are prepared in accordance with generally accepted accounting principles and that are reviewed or audited by certified public accountants.

1. A nursing home that is part of the same corporate entity as a continuing care facility licensed under chapter 651 which meets the minimum liquid reserve requirements specified in s. 651.035 satisfies the financial soundness and stability requirement if such continuing care facility ~~and~~ is accredited

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

27 by a recognized accrediting organization under s. 651.028 and
28 rules of the Office of Insurance Regulation, ~~satisfies this~~
29 ~~requirement~~ as long as the accreditation is not provisional, or
30 if such continuing care facility demonstrates that it meets in
31 its entirety the financial standards adopted by the agency.
32 2. A nursing home that is part of a corporate entity
33 operating nursing homes, assisted living facilities, or
34 independent living facilities, or a combination thereof,
35 satisfies the financial soundness and stability requirement if
36 the nursing home submits a consolidated corporate financial
37 statement to the agency and demonstrates that the corporate
38 entity in its entirety meets the financial standards adopted by
39 the agency.
40
41 For purposes of this paragraph, facilities operated by a federal
42 or state agency are deemed to be financially stable for purposes
43 of applying for the Gold Seal.
44
45 A facility assigned a conditional licensure status may not
46 qualify for consideration for the Gold Seal Program until after
47 it has operated for 30 months with no class I or class II
48 deficiencies and has completed a regularly scheduled relicensure
49 survey.
50 Section 2. This act shall take effect upon becoming a law.

CS/HB 173

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 173 Medical Faculty Certification
SPONSOR(S): Health Quality Subcommittee; Magar
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	12 Y, 0 N, As CS	Siples	O'Callaghan
2) Health & Human Services Committee		Siples	Calamas

SUMMARY ANALYSIS

A medical faculty certificate allows medical school faculty physicians to practice medicine in Florida without sitting for and successfully passing a licensure examination. A physician who receives a medical faculty certificate has all rights and responsibilities as other licensed physicians, except the certificateholder may only practice in conjunction with a full-time faculty position at an accredited medical school and its affiliated clinical facilities or teaching hospitals. Currently, medical faculty certificates are authorized for physicians teaching in one of seven Florida medical schools; Florida Atlantic University is not included in that list.

The bill expands the current medical faculty certificate eligibility criteria by allowing a medical faculty certificate to be issued to an individual who has been offered and has accepted a full-time faculty appointment to teach in a program of medicine at the Florida Atlantic University. The bill also limits the number of extended medical faculty certificateholders allowed at the Florida Atlantic University to 30 persons, which is consistent with limitations for all but one of the other institutions eligible for such certificates.

The bill also changes the name of the Mayo Medical School at the Mayo Clinic in Jacksonville, Florida, in s. 458.3145, F.S., to the Mayo Clinic College of Medicine in Jacksonville, Florida, to expand the eligibility of physicians who teach at the college to receive medical faculty certificates.

There is an insignificant, negative fiscal impact on the Department of Health and no fiscal impact on local governments.

The bill provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Medical Faculty Certificates

The Board of Medicine within the Department of Health's Division of Medical Quality Assurance may issue medical faculty certificates to physicians allowing them to practice medicine in Florida without sitting for and successfully passing a national examination.[1] These physicians have the same rights and responsibilities as other licensed physicians, except they may only practice in conjunction with a full-time faculty position at an accredited medical school and its affiliated clinical facilities or teaching hospitals.

To be eligible to receive a medical faculty certificate a physician must:[2]

- Be a graduate of an accredited medical school or its equivalent, or a graduate of a foreign medical school listed with the World Health Organization;
- Hold a valid, current license to practice medicine in another jurisdiction;
- Complete the application form and remit a nonrefundable application fee not to exceed $500;
- Complete an approved residency or fellowship of at least one year or equivalent training;
- Be at least 21 years of age;
- Be of good moral character;
- Not have committed any act in Florida or any other jurisdiction which would constitute the basis for disciplining a physician;
- Have completed, before medical school, the equivalent of 2 academic years of preprofessional, postsecondary education, as determined by the Board of Medicine;[3] and
- Have accepted a full-time faculty appointment to teach in a program of medicine at:
    - The University of Florida;
    - The University of Miami;
    - The University of South Florida;
    - The Florida State University;
    - The Florida International University;
    - The University of Central Florida; or
    - The Mayo Medical School at the Mayo Clinic in Jacksonville, Florida.

Currently, a medical faculty certificate holder is required to pay an application fee of $500, and $424 for the issuance of the initial certificate.[4] The initial certificate is valid for 2 years, or until the applicant terminates their relationship with the medical school or teaching institution. To renew (or extend) a certificate, an applicant must submit an approved form, remit a renewal fee of $360,[5] and submit a letter from the dean of the medical school stating that the applicant is a distinguished medical scholar and an outstanding practicing physician.[6]

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[1] There are several different types of national examinations for medical doctors: a State Board Examination, National Board of Medical Examiners, United States Medical Licensing Examination, Federation Licensing Examination (FLEX), and Special Purpose Examination (SPEX).
[2] Section 458.3145(1), F.S.
[3] This education requirement is only applicable to applicants who have graduated from medical school after October 1, 1992. Section 458.3145(1)(h), F.S.
[4] Rule 64B8-3.002, F.A.C.
[5] However, for a medical faculty certificate renewed during calendar years 2015 and 2016, the renewal fee is $250. Rule 64B8-3.003, F.A.C.
[6] Section 458.3145(2), F.S.

There is no limit on the number of initial certificates a medical school or teaching institution may receive. However, the number of medical faculty certificates that may be renewed by each medical school or teaching institution is statutorily limited.[7] All medical schools, except the Mayo Medical School at the Mayo Clinic in Jacksonville, Florida, are limited to 30 renewed medical faculty certificates. The Mayo Medical School is limited to 10 renewed medical faculty certificates. The H. Lee Moffitt Cancer Center and Research Institute is also permitted to have up to 30 renewed faculty certificates.[8]

An annual review of each medical faculty certificate recipient is made by the dean of the certificate recipient's accredited 4-year medical school and reported to the Board of Medicine within the Department of Health on an annual basis.[9] According to the Department of Health, as of October 12, 2015, the Board of Medicine oversees 46 active medical faculty certificates.[10]

Florida Atlantic University Charles E. Schmidt College of Medicine

The Florida Atlantic University Charles E. Schmidt College of Medicine (college) was recently established in Palm Beach County and is housed in a $20 million, 95,000-square-foot facility funded by a gift from the Schmidt Family Foundation and state matching funds. The college's inaugural class of 64 students, who were enrolled in August 2011, recently graduated in April 2015.[11] The college has approximately 256 currently enrolled students.[12] Tuition at the college is $27,292 a year for resident students and $60,710 a year for nonresident students.[13]

The college also hosts several researchers who are performing research on an array of health issues, including cardiovascular disease and stroke, cancer, Parkinson's disease, Alzheimer's disease, macular degeneration, autoimmune diseases, and HIV/AIDS.[14]

Currently, physicians teaching at the college may not obtain a medical faculty certificate, because Florida Atlantic University is not included in the list of institutions whose full-time physician employees are eligible to apply under s. 458.3145, F.S.

Mayo Clinic College of Medicine

The Mayo Clinic College of Medicine includes 5 different schools: Mayo Medical School, Mayo Graduate School, Mayo School of Graduate Medical Education, Mayo School of Health Sciences, and Mayo School of Continuous Professional Development.[15] To date, the Mayo Clinic has trained more than 23,000 physicians and scientists,[16] including at least 1,600 students who have completed medical school training at the Mayo Medical School.[17]

Under s. 458.3145, F.S., a physician hired by the Mayo Medical School at the Mayo Clinic in Jacksonville, Florida, is eligible to apply for a medical faculty certificate.

[7] Section 458.3145(4), F.S.
[8] *Id.*
[9] Section 458.3145(5), F.S.
[10] E-mail correspondence with Department of Health staff (October 12-13, 2015).
[11] Florida Atlantic University Charles E. Schmidt College of Medicine, *Message from the Dean*, available at http://med.fau.edu/home/deans_message.php (last visited on January 4, 2016).
[12] *Id.*
[13] The reflected tuition costs do not include any fees, including health insurance fees, which may be assessed by the college. AAMC, *Tuition and Student Fees Reports: Public Medical Schools-Tuition and Fees First Year Medical Students 2014-2015*, available at https://services.aamc.org/tsfreports/report.cfm?select_control=PUB&year_of_study=2015 (last visited on January 4, 2016).
[14] Florida Atlantic University Charles E. Schmidt College of Medicine, *About Charles E. Schmidt College of Medicine*, available at http://med.fau.edu/home/index.php (last visited on January 4, 2016).
[15] Mayo Clinic College of Medicine, *About*, available at http://www.mayo.edu/education/about (last visited on January 4, 2016).
[16] Mayo Clinic College of Medicine, *History*, available at http://www.mayo.edu/education/about/history (last visited on January 4, 2016).
[17] Mayo Medical School, *History*, available at http://www.mayo.edu/mms/about/history (last visited on January 4, 2016).

Effect of Proposed Changes

The bill expands the current medical faculty certificate eligibility criteria by allowing a medical faculty certificate to be issued without examination to an individual who has been offered and has accepted a full-time faculty appointment to teach in a program of medicine at the Florida Atlantic University. The bill also limits the number of extended medical faculty certificateholders allowed at the Florida Atlantic University to 30 persons, which is consistent with limitations for all but one of the other institutions eligible for such certificates.

The bill changes the name of one institution listed in s. 458.3145, F.S., from the "Mayo Medical School at the Mayo Clinic in Jacksonville, Florida," to the "Mayo Clinic College of Medicine in Jacksonville, Florida." The Mayo Medical School is only one of 5 schools within the Mayo Clinic College of Medicine.[18] Therefore, the bill would allow a physician hired to teach in any one of the five schools under the Mayo Clinic College of Medicine to be eligible for a medical faculty certificate.

The bill provides an effective date of July 1, 2016.

B. SECTION DIRECTORY:

Section 1. Amends s. 458.3145, F.S., relating to medical faculty certificates.
Section 2. Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The Division of Medical Quality Assurance within the Department of Health may see an increase in workload from processing additional medical faculty certificates and certificate renewals. However, the application fee of $500, the initial license fee of $424, and the renewal license fee of $360 should support the workload increase.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

[18] *Supra* fn. .

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

   None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

   None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On October 20, 2015, the Health Quality Subcommittee adopted an amendment to correct the name of The Mayo Clinic College of Medicine in Jacksonville, Florida, and includes the Florida Atlantic University as a recipient of the medical faculty certificates, instead of the medical school within the university, which is consistent with the other listed eligible institutions in current law.

A bill to be entitled

An act relating to medical faculty certification; amending s. 458.3145, F.S.; revising the list of schools at which certain faculty members are eligible to receive a medical faculty certificate; providing an effective date.

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

Section 1. Paragraph (i) of subsection (1) and subsection (4) of section 458.3145, Florida Statutes, are amended to read:

458.3145 Medical faculty certificate.—

(1) A medical faculty certificate may be issued without examination to an individual who:

(i) Has been offered and has accepted a full-time faculty appointment to teach in a program of medicine at:

1. The University of Florida;~~,~~

2. The University of Miami;~~,~~

3. The University of South Florida;~~,~~

4. The Florida State University;~~,~~

5. The Florida International University;~~,~~

6. The University of Central Florida;~~, or~~

7. The ~~Mayo Medical School at the~~ Mayo Clinic College of Medicine in Jacksonville, Florida; or

8. The Florida Atlantic University.

(4) In any year, the maximum number of extended medical

27 faculty certificateholders as provided in subsection (2) may not
28 exceed 30 persons at each institution named in subparagraphs
29 (1)(i)1.-6. <u>and 8.</u> and at the facility named in s. 1004.43 and
30 may not exceed 10 persons at the institution named in
31 subparagraph (1)(i)7.
32 Section 2. This act shall take effect July 1, 2016.

HB 241

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 241 Children and Youth Cabinet
SPONSOR(S): Harrell
TIED BILLS: **IDEN./SIM. BILLS:** SB 500

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Choice & Innovation Subcommittee	12 Y, 0 N	Dehmer	Healy
2) Health & Human Services Committee		Ives	Calamas
3) Education Committee			

SUMMARY ANALYSIS

The Florida Children and Youth Cabinet (Cabinet) consists of the Governor and 14 other members. These other members include the Secretary of the Department of Children and Families, the Secretary of Juvenile Justice, the director of the Agency for Persons with Disabilities, the director of the Office of Early Learning, the State Surgeon General, the Secretary of Health Care Administration, the Commissioner of Education, the director of the Statewide Guardian Ad Litem Office, the director of the Office of Child Abuse Prevention, and five members appointed by the Governor who represent children and youth advocacy organizations.

The bill expands the total membership of the cabinet to 16 by adding a superintendent of schools who is appointed by the Governor. The bill changes the title of the ninth member of the cabinet from "the director of the Office of Child Abuse Prevention" to "the director of the Office of Adoption and Child Protection."

The bill does not have a fiscal impact on state or local governments.

The bill takes effect July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

The Florida Children and Youth Cabinet (Cabinet) was created in 2007.[1] The Florida Legislature found a need to collaborate with the Governor to improve child and family outcomes in the state.[2] Among other things, the Cabinet was created to enable state agencies and programs that serve children to coordinate policy development and program implementation so services provided to children and youth are planned, managed, and delivered in a holistic and integrated manner.[3]

The Cabinet is comprised of the Governor and 14 other members. These other members include the Secretary of Children and Family Services, the Secretary of Juvenile Justice, the director of the Agency for Persons with Disabilities, the director of the Office of Early Learning, the State Surgeon General, the Secretary of Health Care Administration, the Commissioner of Education, the director of the Statewide Guardian Ad Litem Office, the director of the Office of Child Abuse Prevention, and five members representing children and youth advocacy organizations, who are not service providers and who are appointed by the Governor.[4]

During the 2007 Legislative Session the Office of Child Abuse Prevention was renamed the Office of Adoption and Child Protection. The name was changed to reflect the establishment of a comprehensive statewide approach for the promotion of adoption, support of adoptive families, and prevention of child abuse, abandonment, and neglect.[5]

Effect of Proposed Changes

The bill expands the membership of the Cabinet to include the Governor and 15 other members. The additional Cabinet position created by the bill will be a superintendent of schools who is appointed to the Cabinet by the Governor.

Current law states that the "Cabinet shall consist of 14 members including the Governor and the following persons . . . ." However, the law lists 14 specific members of the Cabinet in addition to the Governor, bringing the total membership of the Cabinet to 15 members. The bill changes the total membership figure to 16 members, thereby accounting for the member added by the bill and the Governor.

The bill changes the title of the ninth cabinet member from the "the director of the Office of Child Abuse Prevention" to "director of the Office of Adoption and Child Protection" to conform to current law.[6]

B. SECTION DIRECTORY:

Section 1: Amends s. 402.56, F.S., relating to the Children and Youth Cabinet.
Section 2: Provides an effective date of July 1, 2016.

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[1] Section 1, Ch. 2007-151, L.O.F.
[2] Section 402.56(2)(b), F.S.
[3] Section 402.56(3)(a), F.S.
[4] Section 402.56(4), F.S.
[5] Section 1. Ch. 2007-124, L.O.F.
[6] Section 39.001(9), F.S.

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:

   Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to the Children and Youth Cabinet; amending s. 402.56, F.S.; revising the membership of the cabinet; providing an effective date.

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

Section 1. Paragraph (a) of subsection (4) of section 402.56, Florida Statutes, is amended to read:

402.56 Children's cabinet; organization; responsibilities; annual report.—

(4) MEMBERS.—The cabinet shall consist of 16 ~~14~~ members including the Governor and the following persons:

(a)1. The Secretary of Children and Families;

2. The Secretary of Juvenile Justice;

3. The director of the Agency for Persons with Disabilities;

4. The director of the Office of Early Learning;

5. The State Surgeon General;

6. The Secretary of Health Care Administration;

7. The Commissioner of Education;

8. The director of the Statewide Guardian Ad Litem Office;

9. The director of the Office of Adoption and Child Protection ~~Child Abuse Prevention~~; ~~and~~

10. A superintendent of schools, appointed by the Governor; and

27 11.~~10.~~ Five members who represent ~~representing~~ children
28 and youth advocacy organizations and who~~, who~~ are not service
29 providers, ~~and who are~~ appointed by the Governor.
30 Section 2. This act shall take effect July 1, 2016.

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 4007 Medical Assistant Certification
SPONSOR(S): Pigman
TIED BILLS: **IDEN./SIM. BILLS:** SB 238

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	12 Y, 0 N	Ives	O'Callaghan
2) Health & Human Services Committee		Ives JI	Calamas CEC

SUMMARY ANALYSIS

Section 458.3485(3), F.S., currently states that medical assistants may be certified by the American Association of Medical Assistants or as a Registered Medical Assistant by the American Medical Technologists. There are other organizations that certify medical assistants which are not specified in statute. However, there is no statutory requirement that such practitioners be licensed, registered, certified, or otherwise regulated by a state agency.

The bill repeals s. 458.3485(3), F.S., pertaining to the permissive certification of medical assistants. Because certification is not required, this bill has no effect on the regulation of medical assistants.

The bill appears to have no fiscal impact on the state government or local governments.

The bill provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Section 458.3485, F.S., defines a medical assistant as a professional, multi-skilled person dedicated to assisting in all aspects of medical practice under the direct supervision and responsibility of a physician. A medical assistant assists with patient care management, executes administrative and clinical procedures, and often performs managerial and supervisory functions. Competence in the field requires that a medical assistant adhere to ethical and legal standards of professional practice, recognize and respond to emergencies, and demonstrate professional characteristics.[1]

Subsection 458.3485(2), F.S., lists the following duties that a medical assistant may perform under the direct supervision of a licensed physician:[2]

- Clinical procedures, including:
  - Aseptic procedures
  - Taking vital signs
  - Preparing patients for the physician's care
  - Performing venipunctures and nonintravenous injections
  - Observing and reporting patients' signs or symptoms;
- Basic first aid;
- Assisting with patient examinations or treatments;
- Operating office medical equipment;
- Collecting routine laboratory specimens as directed by the physician;
- Administering medication as directed by the physician;
- Performing basic laboratory procedures;
- Performing office procedures including all general administrative duties required by the physician; and
- Performing dialysis procedures, including home dialysis.

According to the United States Department of Labor, Bureau of Labor Statistics, there were approximately 40,770 medical assistants employed in Florida in 2014.[3] This figure is projected to increase to 49,866 by the year 2022.[4] Overwhelmingly, medical assistants find employment within the offices of physicians, health care practitioners, or medical and surgical hospitals.[5] By the year 2024, job growth in this occupation is expected to increase 23.5 percent nationally.[6]

<u>Certification of Medical Assistants</u>

The Florida Department of Health does not license, register, certify, or otherwise regulate medical assistants.[7] However, under s. 458.3485(3), F.S., a medical assistant may be certified by the American Association of Medical Assistants or as a Registered Medical Assistant by the American Medical

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[1] Section 458.3485, F.S.
[2] Section 458.3485(2), F.S.
[3] United States Dept. of Labor, Bureau of Labor Statistics, Occupational Employment and Wages, May 2014 (31-9092 Medical Assistants), available at http://www.bls.gov/oes/current/oes319092.htm (last visited Dec. 14, 2015).
[4] Florida Dept. of Economic Opportunity. Florida Jobs by Occupation. *Florida Department of Economic Opportunity*. Retrieved from <u>http://www.floridajobs.org/labor-market-information/data-center/statistical-programs/employment-projections</u>.
[5] *Supra*, FN 3.
[6] United States Department of Labor, Bureau of Labor Statistics, *Employment Projections (2014-2024),* available at http://data.bls.gov/projections/occupationProj (last visited Dec. 15, 2015).
[7] Florida Dept. of Health, 2016 Agency Legislative Bill Analysis, HB 4007, September 4, 2015 (on file with committee staff).

Technologists. There are other organizations that certify medical assistants; however, these and other organizations are not specified in statute. The specific inclusion of two organizations but not others may give the appearance that the specified organizations are state-sanctioned.

Although medical assistants are not required to be certified in Florida, employers prefer to hire certified assistants.[8] The National Commission for Certifying Agencies, part of the Institute for Credentialing Excellence, accredits the following certification programs for medical assistants:[9]

- Certified Medical Assistant (CMA) from the American Association of Medical Assistants;
- Registered Medical Assistant (RMA) from American Medical Technologists;
- National Certified Medical Assistant (NCMA) from the National Center for Competency Testing; and
- Certified Clinical Medical Assistant (CCMA) from the National Healthcareer Association.

The American Association of Medical Assistants (AAMA)

To be eligible for the AAMA certification examination, applicants must be one of the following:

- A completing student[10] or recent graduate[11] of a medical assisting program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or the Accrediting Bureau of Health Education Schools (ABHEP);
- A non-recent graduate of a CAAHEP or ABHES accredited medical assisting program; or
- An AAMA re-certificant.[12]

An accredited medical assisting program includes academic and clinical training in areas such as human anatomy, physiology, and pathology; medical terminology, record keeping and accounting; laboratory techniques; pharmacology; first aid; office practices and patient relations; and medical law and ethics. A practicum or an unpaid, supervised on-site work experience in an ambulatory health care setting is also a required component of the certification process.[13]

Certifications are current for 60 months and may be re-certified through either re-examination or by continuing education. Expired certifications greater than 60 months may only be re-certified through examination.[14]

The American Medical Technologists (AMT)

The AMT is accredited by the National Commission for Certifying Agencies (NCCA) through April 2018. In its 2012-13 Annual Report, the AMT reported certification of 38,518 members as RMAs.[15]

RMA applicants must meet one of the following five eligibility routes, with applicants applying under Routes 1, 2, 3 or 4 required to pass the AMT certification examination:[16]

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[8] Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2014-15 Edition*, Medical Assistants, on the Internet at http://www.bls.gov/ooh/healthcare/medical-assistants.htm (last visited October 12, 2015).
[9] *Id.*
[10] A completing student may take the exam no more than 30 days prior to completing their formal education and practicum.
[11] Recent graduates are defined by the AAMA as those students who apply for the exam within 12 months of graduation.
[12] American Association of Medical Assistants, *Exam Eligibility Requirements,* available at http://www.aama-ntl.org/cma-aama-exam/application-steps/eligibility (last visited Dec. 15, 2015).
[13] American Association of Medical Assistants, *CAAHEP and ABHEP Accredited Programs*, available at http://www.aama-ntl.org/medical-assisting/caahep-abhes-programs#.VlNcok3ouUk (last visited Dec. 15, 2015).
[14] American Medical Technologies, *Recertification Policies*, available at http://www.aama-ntl.org/continuing-education/recertification-policies#.VlNjxk3ouUk (last visited Dec. 15, 2015).
[15] American Medical Technologies, 2012-13 Annual Report, p. 4, available at http://www.americanmedtech.org/Portals/0/PDF/AMTIE-About%20Us/About%20Us/AMT_2013AnnualRpt_web.pdf (last visited Dec. 15, 2015).
[16] American Medical Technologists, RMA Eligibility, Medical Assistant, available at http://www.americanmedtech.org/GetCertified/RMAEligibility.aspx (last visited Dec. 15, 2015).

- Route 1: A recent graduate of, or be scheduled to graduate from, an accredited medical assisting program with a minimum of 720 clock hours, including 160 hours of clinical externship within the four years prior to application for certification. An applicant whose date of graduation is four years or more prior to the date of their application must provide evidence of relevant work experience for at least three of the last five years.
- Route 2: A recent graduate of, or be scheduled to graduate from, a formal medical services training program of the U.S. Armed Forces within the four years prior to application. An applicant whose date of graduation is four years or more prior to the date of their application must provide evidence of relevant work experience for at least three of the last five years.
- Route 3: Employed as a medical assistant for a minimum of five out of the last seven years, no more than two which have been as an instructor in a post-secondary medical assistant program. Work experience must include both clinical and administrative duties, and proof of high school graduation is required.
- Route 4: Currently employed as an instructor in an accredited medical assisting program, has completed a course of instruction in a healthcare discipline related to medical assisting, and has a minimum of five years of full-time teaching experience in a medical assisting discipline that includes both clinical and administrative competencies. An applicant, who has less than five years teaching experience, but more than one year, must provide documentation of at least three years of full-time clinical work experience in a healthcare profession in which the scope of practice is equal to the medical assisting scope of practice.
- Route 5: Passed another certification examination that has been approved by the AMT Board of Directors and has met one of the above eligibility routes.

Other Medical Assistant Certifying Organizations

At least two other organizations certify medical assistants, the National Healthcareer Association and the National Center for Competency Testing. The National Healthcareer Association allows individuals who have graduated high school and completed either a training program or possess relevant work experience, to take the certification examination for a Clinical Medical Assistant.[17]

The National Center for Competency Testing (NCCT) is also accredited by the NCCA and to be eligible for the NCCT exam, applicants must meet one of the following:[18]

- Current student, or a graduate of a medical assistant program from an NCCT authorized school within the past five years;
- Two years of verifiable full-time experience as a medical assistant practitioner within the past five years; or
- Completion of medical assistant training or its equivalent during U.S. military service within the past five years.

Effect of Proposed Changes

The bill repeals s. 458.3485(3), F.S., which authorizes the American Association of Medical Assistants and the American Medical Technologists to certify medical assistants. Removing this law, which permits but does not require certification of medical assistants, has no effect on the regulation of medical assistants.

The bill provides an effective date of July 1, 2016.

[17] National Healthcareer Association Candidate Handbook, p. 8, available at http://www.nhanow.com/docs/default-source/pdfs/handbooks/nha-candidate-handbook.pdf?sfvrsn=2 (last visited Dec. 15, 2015).

[18] National Center for Competency Testing, Medical Assistant (NCMA), available at https://www.ncctinc.com/Certifications/MA.aspx (last visited Dec. 15, 2015).

B. SECTION DIRECTORY:

Section 1: Repeals s. 458.3485(3), F.S., relating to certification of a medical assistant by the American Association of Medical Assistants or as a Registered Medical Assistant by the American Medical Technologists.
Section 2: Provides an effective date of July 1, 2016.

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:

   Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to medical assistant certification;
3 repealing s. 458.3485(3), F.S., relating to
4 certification of a medical assistant by the American
5 Association of Medical Assistants or as a Registered
6 Medical Assistant by the American Medical
7 Technologists; providing an effective date.
8
9 Be It Enacted by the Legislature of the State of Florida:
10
11 Section 1. Subsection (3) of section 458.3485, Florida
12 Statutes, is repealed.
13 Section 2. This act shall take effect July 1, 2016.

HB 4037

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 4037 Licensure of Facilities and Programs for Persons with Developmental Disabilities
SPONSOR(S): Rodrigues
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	11 Y, 0 N	Tuszynski	Brazzell
2) Health Care Appropriations Subcommittee	12 Y, 0 N	Clark	Pridgeon
3) Health & Human Services Committee		Tuszynski	Calamas

SUMMARY ANALYSIS

The Agency for Persons with Disabilities (APD) is required, pursuant to s. 393.067, F.S., to license residential facilities, defined by s. 393.063(28) F.S., as a facility providing room and board and personal care for persons who have developmental disabilities. The residential facilities that APD licenses consist of foster care facilities, group home facilities, residential habilitation centers, and comprehensive transitional education programs.

A Comprehensive Transitional Education Program (CTEP) is a group of jointly operating centers or units that provide a sequential series of educational care, training, treatment, habilitation, and rehabilitation services to persons who have developmental disabilities and who have severe or moderate maladaptive behaviors.

The 2015 General Appropriations Act Implementing Bill (Chapter 2015-222, Laws of Florida) amended s. 393.067, F.S., to remove a requirement that APD must contract for residential services with facilities licensed prior to October 1, 1989, if those facilities were in compliance with statute. The amendment to this statute will expire and revert to the original language on July 1, 2016.

Chapter 2015-222, Laws of Florida, also amended s. 393.18, F.S., to delete paragraphs detailing the licensing requirements that has restricted APD's ability to license new CTEP providers, and moved the 15 resident cap for residential units within a CTEP to s. 393.18(4), F.S, The amendment to this statute will expire and revert to the original language on July 1, 2016.

HB 4037 repeals those expiration and reversion clauses, allowing the amended language of ss. 393.067 and 393.18, F.S., from Chapter 2015-222, Laws of Florida, to remain law.

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

The bill provides for an effective date of June 30, 2016, or, if the act fails to become law until a later time, it shall take effect upon becoming law and operate retroactively to June 30, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

The Agency for Persons with Disabilities

The Agency for Persons with Disabilities (APD) was created to serve Floridians with developmental disabilities. APD works in partnership with local communities and private providers to assist people who have developmental disabilities and their families. Examples of services provided by APD include adult day training, personal care services, and specialized therapies.[1] APD serves more than 50,000 individuals with autism, cerebral palsy, spina bifida, intellectual disabilities, Down syndrome, and Prader-Willi syndrome.[2]

Residential Facilities

Persons with developmental disabilities reside in various types of residential settings. Some individuals with developmental disabilities live with family, some live in their own homes, while others may live in community-based residential facilities.[3] Pursuant to s. 393.067, F.S., APD is charged with licensing community-based residential facilities that serve and assist individuals with developmental disabilities; these include foster care facilities, group home facilities, residential habilitation centers, and comprehensive transitional education programs.[4]

In addition to its regulatory duties, APD contracts with licensed community-based residential facilities to provide services under the Medicaid Home and Community-Based Waiver (waiver). Prior to enactment of the 2015 General Appropriations Act Implementing Bill (Chapter 2015-222, Laws of Florida), APD was statutorily required to contract for residential services with residential facilities licensed prior to October 1, 1989, if those facilities complied with all provisions of s. 393.067, F.S[5, 6] This requirement was placed in statute as a response to residential facilities that were concerned about their continued business with APD after the waiver was enacted.[7]

In order to implement Specific Appropriation 251 of the 2015-2016 General Appropriations Act, Chapter 2015-222, Laws of Florida, amended s. 393.067, F.S. to remove this statutory procurement requirement with an expiration and reversion clause set for July 1, 2016.

Comprehensive Transitional Education Programs

A Comprehensive Transitional Education Program (CTEP) is a group of jointly operating centers or units that provide a sequential series of educational care, training, treatment, habilitation, and rehabilitation services to persons who have developmental disabilities and who have severe or moderate maladaptive behaviors.[8]

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[1] S. 393.006 (3), F.S.
[2] Agency for Persons with Disabilities, *About Us*, accessible at: http://apd.myflorida.com/about/ (last accessed 11/10/15).
[3] S. 393.063(28) defines residential facility as a facility providing room and board and personal care for persons who have developmental disabilities.
[4] Agency for Persons with Disabilities, *Planning Resources*, accessible at: http://apd.myflorida.com/planning-resources/ (last accessed 11/11/15).
[5] S. 393.067(15), F.S., (2014)
[6] Ch. 89-308, Laws of Fla.
[7] Email from Caleb Hawkes, Deputy Legislative Affairs Director, Agency for Persons with Disabilities, RE: Residential Facility Contracting Language (Nov. 13, 2015)(on file with Health and Human Services Committee staff).
[8] S. 393.18, F.S.

CTEPs serve individuals with developmental disabilities with the most intensive of behavioral needs.[9] A CTEP is designed to provide services to such individuals with the ultimate objective of allowing them to return to other less intensive settings within their own communities.[10] There are presently two CTEPs licensed in Florida, and both licenses are held by the same organization, Advoserv Inc., which operates the Carlton Palms Educational Center in Lake County.[11,12]

Previously, pursuant to s. 393.18, F.S., APD was authorized to license CTEPs that were already in operation by July 1, 1989, or owned real property zoned and registered with APD to operate a CTEP by July 1, 1989. Each residential unit within the CTEP could not exceed a capacity of 15 persons. The statute also authorized licensure of facilities that provided residential services for children if those children had developmental disabilities needing special behavioral services, and the residential facility served children with an open case in the child welfare system as of July 1, 2010. APD has interpreted this as a prohibition against licensing newer facilities.

In order to implement Specific Appropriation 251 of the 2015-2016 General Appropriations Act, Chapter 2015-222, Laws of Florida, amended s. 393.18, F.S., to delete the paragraphs detailing the licensing requirements that has restricted APD's ability to license new CTEP providers, and moved the 15 resident cap for residential units within a CTEP to s. 393.18(4), F.S. The amendment also includes an expiration and reversion clause for these amendments set for July 1, 2016.

Effect of Proposed Changes

HB 4037 repeals ss. 24 and 26 of chapter 2015-222, Laws of Florida (2015 General Appropriations Implementing Bill) that set the expiration and reversion of amendments to ss. 393.067(15) and 393.18, F.S., for July 1, 2016.

The bill reenacts s. 393.067(15) as amended in s. 23 of chapter 2015-222, Laws of Florida, which deletes obsolete language, and specifies that the Agency for Persons with Disabilities is not required to contract with residential facilities it licenses under s. 393.067, F.S., including foster care facilities, group home facilities, residential habilitation centers, and CTEPs.

The bill reenacts s. 393.18(4) as amended in s. 25 of chapter 2015-222, Laws of Florida, to include the requirement that each unit within the component centers may not exceed 15 residents, unless authorized prior to July 1, 2015.

The bill provides for an effective date of June 30, 2016, or upon becoming law after that date and operating retroactively to June 30, 2016.

B. SECTION DIRECTORY:

Section 1: Repeals ss. 24 and 26 of chapter 2015-222, Laws of Florida.
Section 2: Reenacts s. 393.067(15), F.S., relating to facility licensure.
Section 3: Reenacts s. 393.18(4), F.S., relating to comprehensive transitional education programs.

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[9] Agency for Persons with Disabilities, *2016 Agency Legislative Bill Analysis for HB 4037*, November 9, 2015 (on file with Children, Families, and Seniors Subcommittee staff).
[10] Id.
[11] Id.
[12] Carlton Palms has an extensive history of complaints and regulatory action. APD has filed 4 administrative complaints against the facility since 2011, detailing inadequate training of staff, physical violence, inadequate care, and inadequate supervision of residents while in the care and custody of Carlton Palms. APD has twice sought moratoria on new admissions to the facility, once in 2012 and most recently in September of 2014. In this most recent administrative complaint, DOAH Case No: 14-004853, APD sought the maximum fine allowed by law, $10,000, as well as a moratorium on new admissions. APD has settled each of these administrative complaints without the imposition of a moratorium. Due to the inability to license other providers, APD has no licensed facilities to place persons requiring this level of care if a moratorium were imposed or transfer residents if the facility were closed.

Section 4: Provides an effective date of June 30, 2016, or upon becoming law after that date and operating retroactively to June 30, 2016.

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:

APD may contract with additional organizations besides the current licensed CTEPs for services.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to licensure of facilities and
3 programs for persons with developmental disabilities;
4 repealing ss. 24 and 26 of chapter 2015-222, Laws of
5 Florida; abrogating the scheduled expiration and
6 reversion of amendments to ss. 393.067(15) and 393.18,
7 F.S.; reenacting s. 393.067(15), F.S.; deleting
8 obsolete provisions; specifying that the Agency for
9 Persons with Disabilities is not required to contract
10 with certain licensed facilities; reenacting s.
11 393.18(4), F.S.; revising residency limitations for
12 comprehensive transitional education programs;
13 providing applicability; deleting provisions relating
14 to licensure for such programs and certain facilities
15 providing residential services for children who need
16 behavioral services; providing for contingent
17 retroactive operation; providing an effective date.
18
19 Be It Enacted by the Legislature of the State of Florida:
20
21 Section 1. Sections 24 and 26 of chapter 2015-222, Laws of
22 Florida, are repealed.
23 Section 2. Subsection (15) of section 393.067, Florida
24 Statutes, is reenacted to read:
25 393.067 Facility licensure.—
26 (15) The agency is not required to contract with

27 facilities licensed pursuant to this chapter.
28 Section 3. Subsection (4) of section 393.18, Florida
29 Statutes, is reenacted to read:
30 393.18 Comprehensive transitional education program.—A
31 comprehensive transitional education program is a group of
32 jointly operating centers or units, the collective purpose of
33 which is to provide a sequential series of educational care,
34 training, treatment, habilitation, and rehabilitation services
35 to persons who have developmental disabilities and who have
36 severe or moderate maladaptive behaviors. However, this section
37 does not require such programs to provide services only to
38 persons with developmental disabilities. All such services shall
39 be temporary in nature and delivered in a structured residential
40 setting, having the primary goal of incorporating the principle
41 of self-determination in establishing permanent residence for
42 persons with maladaptive behaviors in facilities that are not
43 associated with the comprehensive transitional education
44 program. The staff shall include behavior analysts and teachers,
45 as appropriate, who shall be available to provide services in
46 each component center or unit of the program. A behavior analyst
47 must be certified pursuant to s. 393.17.
48 (4) For comprehensive transitional education programs, the
49 total number of residents who are being provided with services
50 may not in any instance exceed the licensed capacity of 120
51 residents and each residential unit within the component centers
52 of the program authorized under this section may not in any

53 instance exceed 15 residents. However, a program that was
54 authorized to operate residential units with more than 15
55 residents before July 1, 2015, may continue to operate such
56 units.
57 Section 4. This act shall take effect June 30, 2016, or,
58 if this act fails to become law until after that date, it shall
59 take effect upon becoming a law and operate retroactively to
60 June 30, 2016.

AHCA Presentation

Florida Medicaid: Statewide Medicaid Managed Care

Justin M. Senior

Florida Medicaid Director

Agency for Health Care Administration

House Health & Human Services

January 14, 2016

Better Health Care for All Floridians

AHCA.MyFlorida.com

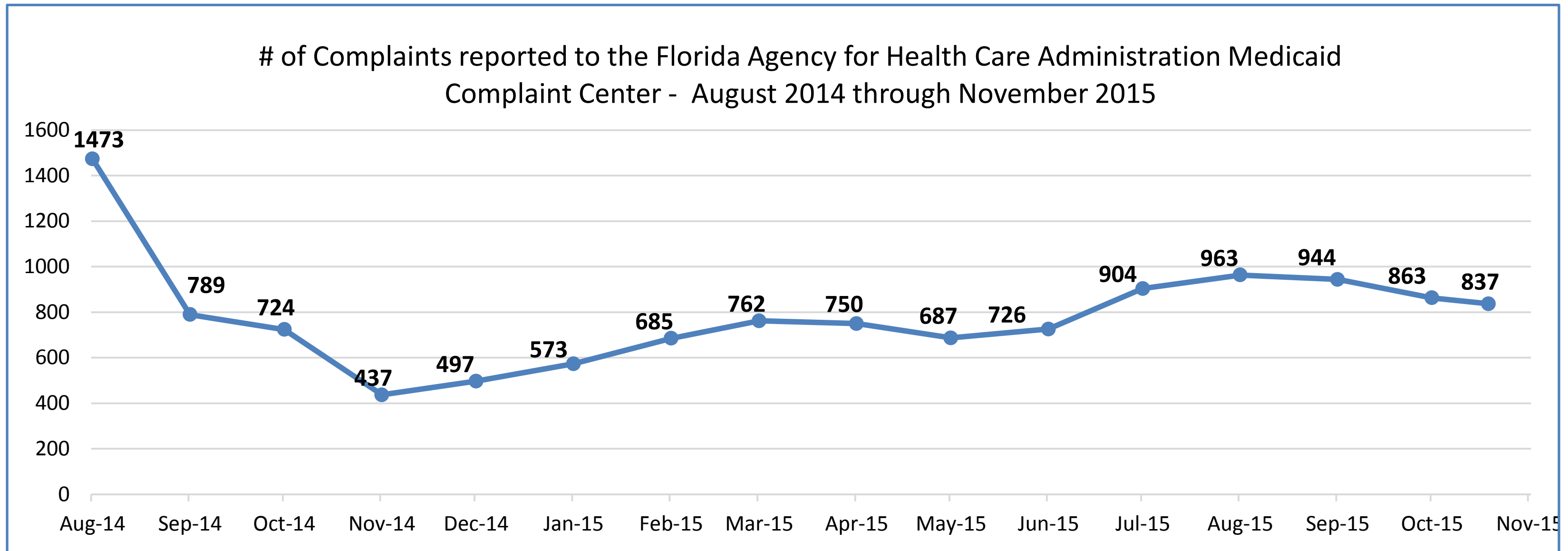
Statewide Medicaid Managed Care Program

- Most Florida Medicaid recipients are enrolled in one or both components of the Statewide Medicaid Managed Care (SMMC) program, Long-term Care program and Managed Medical Assistance program
- Now that the SMMC program is operational, program performance data is coming in:
  - Initial evidence shows
    - Florida's Medicaid program is currently operating at the highest level of quality in its history, and that it is doing so at a substantial per person savings to Florida's taxpayers.
    - Consumer satisfaction is high.

MMA Program Quality

- Medicaid recipients enrolled in Managed Medical Assistance plans now have access to the highest quality of care in the history of the Florida Medicaid program
  - HEDIS Scores
  - Health Plan Report Cards
  - Consumer Satisfaction Survey

Complaints reported since August 1, 2014
Statewide Medicaid Managed Care (both MMA & LTC)



SMMC Enrollment:	2,843,379	2,808,135	2,832,433	2,858,539	2,937,619	2,953,484	2,999,096	3,038,586	3,056,535	3,089,246	3,094,423	3,137,972	3,165,257	3,172,113	3,180,800	3,197,781
# Issues per 1,000 Enrollees:	0.518	0.281	0.256	0.153	0.169	0.194	0.228	0.251	0.245	0.222	0.235	0.288	0.304	0.298	0.271	0.262

Note - The Agency actively encourages all stakeholders to surface any potential issue, concern, or complaint regarding the SMMC Program to the SMMC Complaint Operations Center. All allegations and issues have been recorded, regardless of whether they were found to be accurate or substantiated.

Complaints can be reported by phone at 1-877-254-1055, or online at https://apps.ahca.myflorida.com/smmc_cirts/

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Focused Complaints reported since August 1, 2014
Statewide Medicaid Managed Care (Includes both MMA & LTC)

of Transportation, Durable Medical Equipment, Dental, Therapy and Home Health Complaints reported to the Florida Agency for Health Care Administration Medicaid Complaint Center - Aug. 2014 through Nov. 2015

120
100
80
60
40
20
0

Aug-14 Sep-14 Oct-14 Nov-14 Dec-14 Jan-15 Feb-15 Mar-15 Apr-15 May-15 Jun-15 Jul-15 Aug-15 Sep-15 Oct-15 Nov-15

# of Transportation Complaints
# of Therapy Complaints
# of DME Complaints
# of Home Health Complaints
# of Dental Complaints

Better Health Care for All Floridians
AHCA.MyFlorida.com

Complaints can be reported by phone at 1-877-254-1055, or online at https://apps.ahca.myflorida.com/smmc_cirts/

MMA Program Quality:
Overall HEDIS Scores Trend Upward

	Managed Care Calendar Year 2010	Managed Care Calendar Year 2011	Managed Care Calendar Year 2012	Managed Care Calendar Year 2013	MMA Calendar Year 2014
Scores at the National Average	9%	2%	21%	12%	10%
Scores better than the National Average	25%	32%	24%	29%	55%

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Note: If non-reform and Reform are separated when calculating the percentage of "the scores below the National Mean in calendar year 2014, but higher than managed care scores in calendar year 2013", the overall percentage would be 14%.

MMA Program Quality: Dental Visit Scores Trend Upward

Time Period	MMA	Reform Pilot Plans	Prepaid Dental Carve Out
CY 2007 (Reported in 2008)	N/A	*15.2%*	N/A
CY 2008 (Reported in 2009)	N/A	*28.5%*	N/A
CY 2009 (Reported in 2010)	N/A	*33.4%*	N/A
CY 2010 (Reported in 2011)	N/A	*34.0%*	N/A
CY 2011 (Reported in 2012)	N/A	*35.3%*	N/A
CY 2012 (Reported in 2013)	N/A	**40.40%**	**40.92%**
CY 2013 (Reported in 2014)	N/A	**42.3%**	**37.04%**
MMA Year 1	**43.1%**	N/A	N/A

Reform Pilot Plan Notes: Data above is the weighted mean across all plans.
Prepaid Dental Carve Out Notes: 2012 is the first year the PDHPs submitted data audited by an NCQA-certified HEDIS auditor. Data is weighted across all plans.
MMA Year 1 Notes: AHCA used the same parameters required to calculate the HEDIS children's dental care annual dental visit measure with two variations: 1) HEDIS requires that a calendar year be used; AHCA used an August through July; 2) HEDIS requires that individuals be enrolled in the plan on December 31 of the measurement year; the Agency's analysis required that they be enrolled on July 31 of the measurement year.

MMA Program Quality: Dental Visit Scores

- The Agency conducted an analysis to determine the percent of MMA enrollees ages 2-21 who received at least one dental service in the first year of MMA implementation (08/01/2014 through 07/31/2015).
  - The Agency used the same parameters required to calculate the HEDIS children's dental care annual dental visit measure, but changed the enrollment period measured to accommodate the 2014 transition year (from old Medicaid to MMA).

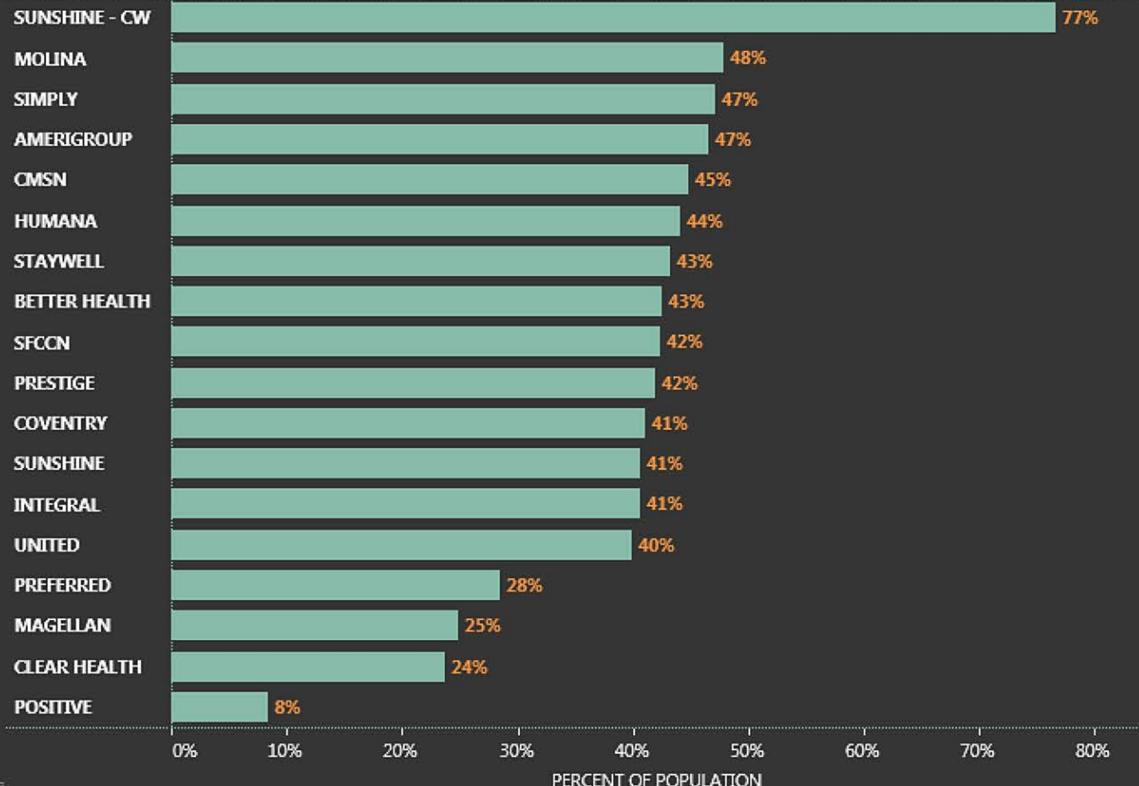
- Result: 43% of the children who qualified to be counted in this measure received dental services during this time period. This is slightly higher than the HEDIS scores achieved in 2013 by Medicaid Reform plans (42%).

MMA Program Quality: Dental Visit Scores

Florida Medicaid Data Visualization Series

Program Profiles: ***Managed Care -*** *Dental Services (Children Ages 2 - 21) for MMA Year 1 Aug 2014 - July 2015*

CLICK PLAN NAME TO SEE ASSOCIATED COUNTY PERFORMANCE
CLICK AGAIN TO RESET



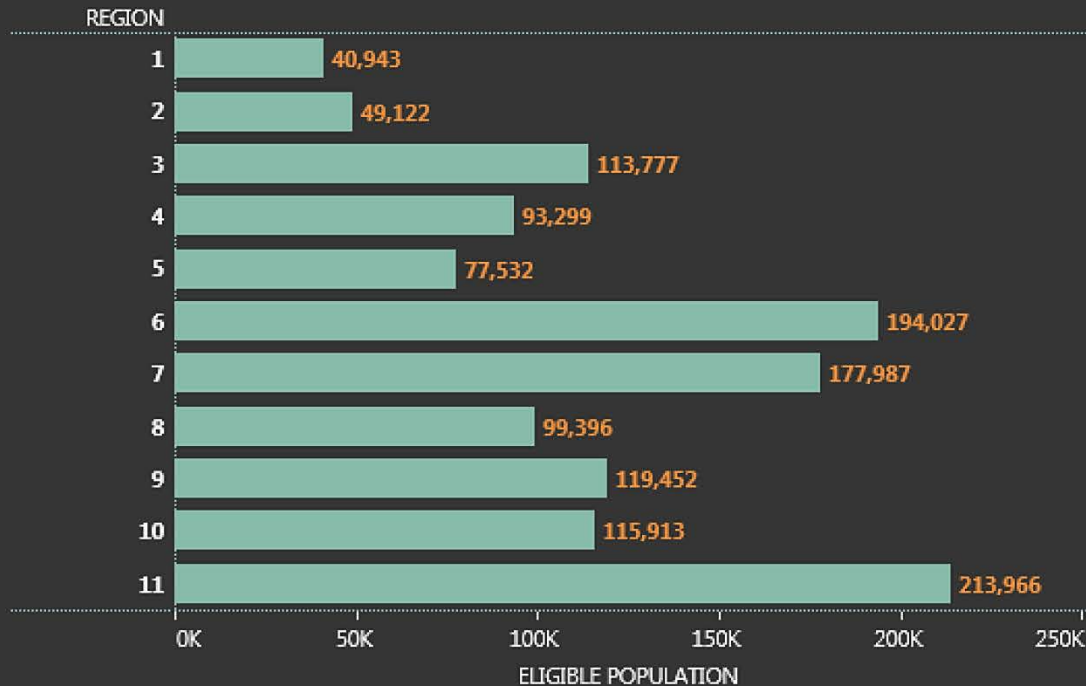
MEDICAID DATA ANALYTICS - DATA SCIENCE UNIT WORKBOOK: Dental Profile MMA Year 1 DATA SOURCE:D11_Tableau (WORKAPS) LAST UPDATE: 10/28/2015 3:54:21 PM

MMA Program Quality: Dental Visit Scores

Source: https://bi.ahca.myflorida.com/t/FLMedicaid/views/DentalProfileMMAYear1/DENTALSERVICES-MMA?:embed=y&:toolbar=no&:display_count=no

REGION: 1 34%
REGION: 2 43%
REGION: 3 39%
REGION: 4 44%
REGION: 5 45%
REGION: 6 42%
REGION: 7 43%
REGION: 8 41%
REGION: 9 48%
REGION: 10 45%
REGION: 11 45%

CLICK TO SEE ASSOCIATED REGION PERFORMANCE
CLICK AGAIN TO RESET



MMA Program Quality: Health Plan Report Cards

- Health Plan Report Cards: Enrollees can now choose plans based on quality.
- Measures include important topics such as Pregnancy Related Care, Children's Dental Care, Keeping Kids Healthy, etc.
- 2014 Report Card: Contains information all plans participating during the entire 12 month period (SMMC plans)

MMA Program Quality: Health Plan Report Cards

1. Navigate to FloridaHealthFinder.gov

2. Select "Medicaid Health Plan Report Card"

3. Select a county, or view all counties

4. View Results

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AHCA.MyFlorida.com

MMA Program Quality:
Health Plan Report Cards

Quality of Care Indicators - Ratings

All Florida Counties
Plan Type: Medicaid Health Plans
Data are for services received in 2014

◉ **Medicaid Health Plan Report Card**
To view individual measures in a category, click one of the following:

- ○ Pregnancy-related Care
- ○ Keeping Kids Healthy
- ○ Keeping Adults Healthy
- ○ Living with Illness
- ○ Mental Health Care

Sorting Options:

Sort By Column ◉ Ascending (A-Z, 0-9) ○ Descending (Z-A, 9-0)

View Results

Statewide Information for Plans Currently Operating in Florida Counties

Plan Name	Pregnancy-related Care	Keeping Kids Healthy	Keeping Adults Healthy	Living with Illness	Mental Health Care
Amerigroup Florida, Inc.	★★★★☆	★★★★☆	★★★★☆	★★★★☆	★★★★☆
Better Health, LLC	★★★☆☆	★★★★☆	★★★★☆	★★★☆☆	★★★☆☆
Children's Medical Services	N/A	★★★★☆	N/A	★★★★★	★★★★☆
Clear Health Alliance	N/A	N/A	★★★★★	★★★☆☆	★☆☆☆☆
Coventry Health Care of Florida	★★★★☆	★★★☆☆	★★★★☆	★★★★☆	★☆☆☆☆
Florida MHS (Magellan)	★☆☆☆☆	N/A	N/A	N/A	★☆☆☆☆
Humana Medical Plan, Inc.	★★★★☆	★★★★☆	★★★★☆	★★★★☆	★★☆☆☆
Molina Healthcare of Florida, Inc.	★★★☆☆	★★★☆☆	★★★☆☆	★★☆☆☆	★★★☆☆
Positive Healthcare Florida	N/A	N/A	★★★★★	★★★☆☆	★★☆☆☆
Prestige Health Choice	★★★★☆	★★☆☆☆	★★★☆☆	★★★☆☆	★★☆☆☆
Simply Healthcare Plans, Inc.	★★★☆☆	★★★☆☆	★★★★☆	★★★★☆	★★☆☆☆
South Florida Community Care Network	★★☆☆☆	★★★★☆	★★☆☆☆	★★★★☆	★★☆☆☆
Staywell	★★★★☆	★★★★☆	★★★★☆	★★★★☆	★★★☆☆
Sunshine State Health Plan, Inc.	★★★☆☆	★★★☆☆	★★★☆☆	★★★★☆	★★★★☆
Sunshine State Health Plan, Inc. - Child Welfare	N/A	★★★☆☆	N/A	N/A	★★★★☆
United Healthcare of Florida, Inc.	★★★★☆	★★★☆☆	★★★★☆	★★★☆☆	★★★★☆

Ratings Key:

★★★★★	**Best**	at or above 50% of all Medicaid health plans' scores
★★★★☆	**Good**	better than at least 40% of all Medicaid health plans' scores
★★★☆☆	**Fair**	better than at least 25% of all Medicaid health plans' scores
★★☆☆☆	**Poor**	better than at least 10% of all Medicaid health plans' scores
★☆☆☆☆	**Very Poor**	worse than 90% of all Medicaid health plans' scores
N/A		Not Measurable/Small Population

Change Health Plan Type | Change Location / County | Print | Save to Excel | Start Over

MMA Program Quality:
CAHPS Survey

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care.
  - Survey results were due to the Agency July 1, 2015.
  - Plans must use NCQA standards for conducting the survey and use NCQA CAHPs survey vendors.

MMA Program Quality: CAHPS Survey

- Parents reported the following regarding their experience with their children in the Medicaid program:
  - 81 % of enrollees have high overall plan satisfaction (rating 8, 9, 10)
  - 90 % of enrollees rate their personal doctor highly (rating 8, 9, 10)
  - 83% of enrollees rate their specialists highly (rating 8, 9, 10)
  - 82% of enrollees say that they usually or always find it easy to get care
  - 89 % of enrollees say that they usually or always find it easy to get care quickly
  - 93 % of enrollees say that their doctor usually or always explains things to them well, listened carefully, showed respect and spent enough time in communications

LTC Program Quality

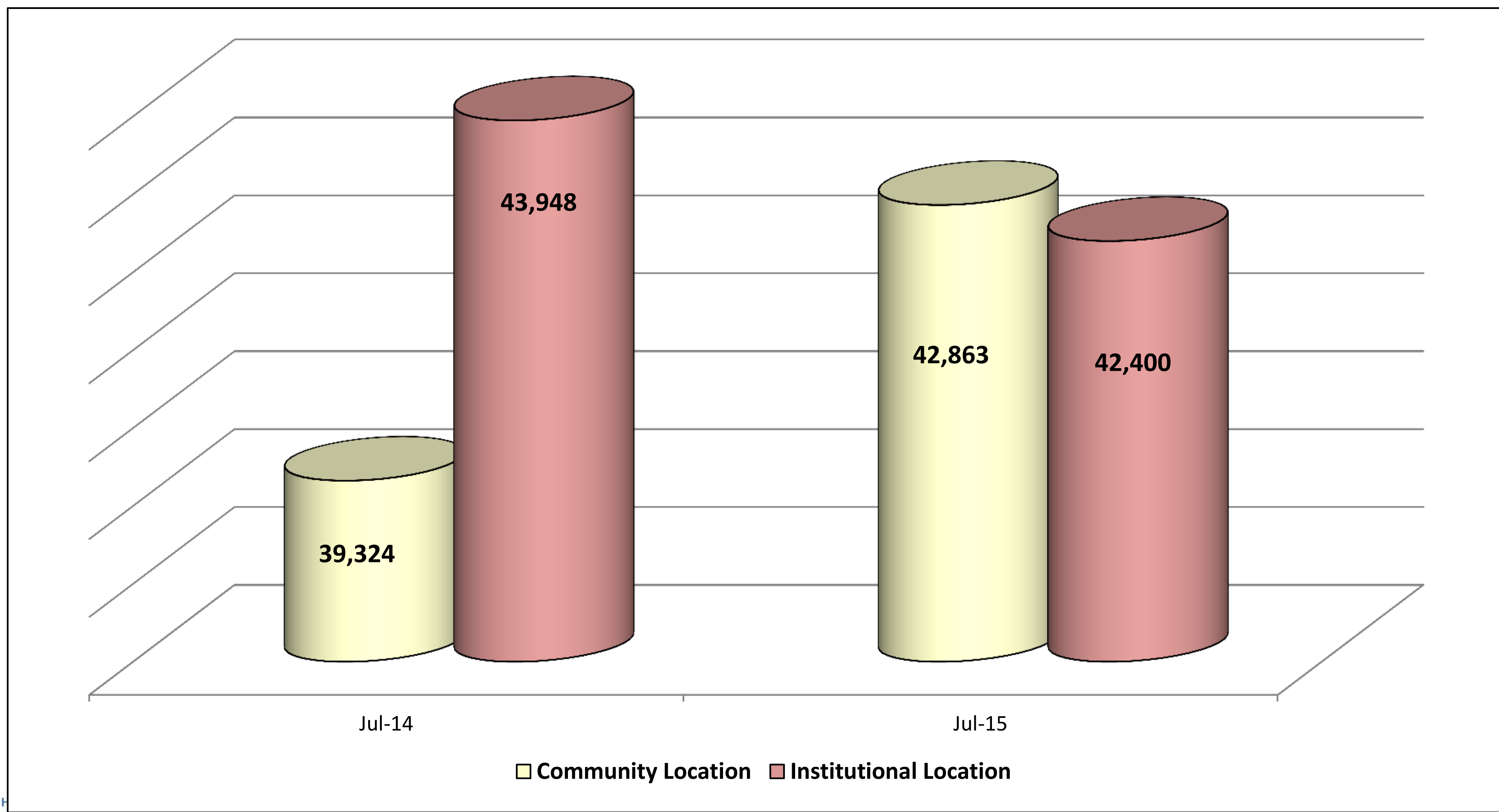
- The LTC program was designed with incentives to ensure patients are able to reside in the least restrictive setting possible and have access to home and community based providers and services that meet their needs.
- Three measures apply to the LTC Program:
  - Transition of individuals who wish to go home from institutional care such as nursing facility care to the community.
  - Patient Satisfaction survey results.
  - LTC Evaluation Report.

LTC Program Quality: HCBS Incentives

- The LTC program was designed with incentives to ensure patients are able to reside in the least restrictive setting possible and have access to home and community based providers and services that meet their needs.
  - The law requires AHCA to adjust managed care plan rates to provide an incentive to shift services from nursing facilities to community based care.
  - Transition percentages apply until no more than 35% of the plan’s enrollees are in nursing facilities.
- An enrollee who starts the year in a nursing home is treated as being in a nursing home for rate purposes for the entire year, even after transition.
- Plans “win” financially if they beat the target, “lose” if they do not meet the target.

LTC Program Quality: HCBS Incentives

Number of enrollees, July 2014 and July 2015, by Residential Setting

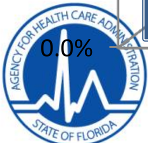


LTC Program Quality: HCBS Incentives

Percentage of LTC Enrollees by Residential Setting and Plan

Plan	Year	Home and Community	Institutional
Amerigroup	2014	73.9%	26.1%
Amerigroup	2015	76.0%	24.0%
Molina	2014	57.4%	42.6%
Molina	2015	60.9%	39.1%
American Eldercare	2014	57.3%	42.7%
American Eldercare	2015	58.8%	41.2%
Humana	2014	55.6%	44.4%
Humana	*2015	60.8%	39.2%
Coventry	2014	51.9%	48.1%
Coventry	2015	56.3%	43.7%
All Plans	2014	47.2%	52.8%
All Plans	2015	50.3%	49.7%
United	2014	41.7%	58.3%
United	2015	44.6%	55.4%
Sunshine	2014	38.8%	61.2%
Sunshine	2015	42.7%	57.3%

Note: Data is as of July 2014 and July 2015.
*Humana 2015 data is as of June 2015 due to Humana purchasing American Eldercare.



LTC Program Quality: LTC Enrollee Satisfaction Survey

- Developed by the Agency/Used by all plans.
- Satisfaction regarding:
  - LTC plan
  - Case manager
  - Services
  - Overall health
- Agency-approved independent survey vendor must be used.
- Results must be used by the plans to develop and implement activities to improve member satisfaction.
- The survey was completed in 2015.

LTC Program Quality:
LTC Enrollee Satisfaction Survey

- Survey respondents reported the following regarding their experience with the LTC Program:
  - 79.7% of respondents rated their Long-term Care plan an 8, 9, or 10.
  - 83.4% of respondents reported it usually or always being easy to get in contact with their case manager.
  - 84.4% of respondents rated their case manager an 8, 9, or 10.
  - 90% of respondents reported their long-term care services are usually or always on time.
  - 83.3% of respondents rated their LTC services an 8, 9, or 10.
  - 59.5% reported that their overall health had improved since enrolling in their LTC plan
  - **77.4% reported that their quality of life had improved since enrolling in their LTC plan**

LTC Program Quality:
LTC Evaluation Report

- Required by the federal government as part of waiver approval
- Evaluation covers the period from August 1, 2013 through August 31, 2014.
- Conducted by the FSU College of Medicine, College of Social Work and FSU's Claude Pepper Data Center.

LTC Program Quality: LTC Evaluation Report

- Access to Care Findings:
  - Diligent outreach conducted
  - Complex effort was coordinated successfully with no large scale access to care failures
  - Complaints related to access to care were fairly uncommon
  - Network of willing LTC providers appears to be robust.
- Quality of Care Findings:
  - Overall, quality levels remained the same or improved
  - 75 % of satisfaction survey respondents indicated that their quality of life had improved since enrolling in the LTC program

Other SMMC Program Enhancements

- Enhanced Access/ Provider Networks
  - Historically robust provider network requirements
  - Enhanced provider network transparency
- Added Benefits
  - Expanded Benefits
  - Benefit Package Flexibility

SMMC Program Enhancements: MMA Provider Networks

- Network requirements are the most comprehensive ever required by the Florida Medicaid program.
  - Time and distance standards
  - Ratios of patients to providers
  - Increasing the number of primary care and specialist providers accepting new Medicaid enrollees
  - Increasing the number of primary care providers that offer appointments after normal business hours
- The Agency has the highest accountability measures in place to ensure plan provider network information is up to date and accurate.
  - Provider Network File submitted weekly
  - Online provider directories
  - Secret Shopper program, and compliance actions for failure to meet requirements

SMMC Program Enhancements: MMA Provider Networks

MMA increased the number of providers participating in Medicaid

MDs & DOs, Dentists, PAs, ARNPs

Provider Type	Nov-13	Oct-15	Total % Change from Nov-2013 to Oct-2015
Total Participating MDs and DOs	39,699	43,350	9.20%
Total Participating Dentists	1,884	2,378	26.22%
Total Participating PAs	2,497	2,964	18.70%
Total Participating ARNPs	7,021	8,673	23.53%

Physician Specialty

Provider Type	Nov-13	Oct-15	Total % Change from Nov-2013 to Oct-2015
Total Participating CARDIOVASCULAR MEDICINE	1,989	2,163	8.7%
Total Participating DERMATOLOGY	405	472	16.5%
Total Participating ENDOCRINOLOGY	398	429	7.8%
Total Participating NEPHROLOGY	598	640	7.0%
Total Participating NEUROLOGY	849	939	10.6%
Total Participating NEUROLOGY/CHILDREN	134	146	9.0%
Total Participating PEDIATRICS, CARDIOLOGY	188	203	8.0%
Total Participating PEDIATRICS, NEPHROLOGY	46	53	15.2%
Total Participating SURGERY, NEUROLOGICAL	330	352	6.7%
Total Participating UROLOGY	3	25	733.3%
Total Participating OB-GYN	1,803	1,851	2.7%
Total Participating PEDIATRICS	3,941	4,213	6.9%
Total Participating PSYCHIATRY, CHILD	233	239	2.6%
Total Participating SURGERY, PEDIATRIC	119	121	1.7%

Source: Monthly DSS provider enrollment reports.

SMMC Program Enhancements: Added Benefits/ Benefit Package Flexibility

- Plans have added flexibility in services provision
  - Expanded benefits
  - Substitution services
  - Increased availability of Telemedicine

SMMC Program Enhancements: Added Benefits/ Expanded Benefits

- The Agency negotiated with health plans to provide extra benefits at no cost to the state. These benefits include:
  - Adult dental
  - Hearing and vision coverage
  - Outpatient hospital coverage
  - Physician coverage, among many others.

SMMC Program Enhancements: MMA Added Benefits/ Expanded Benefits

List of Expanded Benefits	Standard Plans											Specialty Plans					
	Amerigroup	Better Health	Coventry	Humana	Molina	Florida True Health/ DBA Prestige	SFCCN	Simply	Staywell	Sunshine	United	CMSN	Magellan (Serious Mental Illness)	Freedom (Chronic/ Duals)	Sunshine (Child Welfare)	Clear Health (HIV/AIDS)	PositiveHealth (HIV/AIDS)
Adult dental services (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y
Adult hearing services (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				Y	Y	Y
Adult vision services (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y
Art therapy	Y			Y	Y				Y	Y					Y		
Equine therapy									Y								
Home health care for non-pregnant adults (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y			Y	Y
Influenza vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y
Medically related lodging & food		Y		Y	Y	Y		Y	Y	Y			Y		Y	Y	Y
Newborn circumcisions	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				Y	Y	Y
Nutritional counseling	Y	Y	Y	Y	Y	Y		Y	Y	Y			Y		Y	Y	Y
Outpatient hospital services (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y
Over the counter medication and supplies	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y		Y		Y	Y	Y
Pet therapy				Y	Y				Y								
Physician home visits	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y				Y	Y	
Pneumonia vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y
Post-discharge meals	Y	Y	Y	Y	Y			Y	Y	Y	Y		Y		Y	Y	Y
Prenatal/Perinatal visits (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y
Primary care visits-non-pregnant adults (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y
Shingles vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y
Waived co-payments	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y
Home health care-non-pregnant adults (Expanded)													Y		Y	Y	
Intensive Outpatient Therapy													Y			Y	

NOTE: Details regarding scope of covered benefit may vary by managed care plan.

SMMC Program Enhancements: LTC Added Benefits/ Expanded Benefits

List of Expanded Benefits	Standard Plans					
	Amerigroup	Coventry	Humana	Molina	Sunshine	United
ALF/AFCH Bed Hold	Y	Y		Y	Y	
Cellular Phone Services	Y	Y			Y	
Dental Services	Y	Y		Y	Y	Y
Emergency Financial Assistance		Y				
Hearing Evaluation		Y			Y	
Mobile Personal Emergency Response System					Y	
Non-Medical Transportation					Y	Y
Over-The-Counter (OTC) Medications/Supplies	Y	Y		Y	Y	Y
Support to Transition Out of a Nursing Facility	Y	Y		Y	Y	Y
Vision Services	Y	Y		Y	Y	
Wellness Grocery Discount						
Emergency Meal Supply		Y				
NOTE: Details regarding scope of covered benefit may vary by managed care plan.						

SMMC Program Enhancements: Added Benefits/ Benefit Package Flexibility

- Telemedicine services are available to recipients in both MMA and fee-for-service programs for:
  - Behavioral health
  - Dental
  - Physician
  - Interpretation of diagnostic testing results by Florida licensed physicians.
- MMA plans are allowed to offer telemedicine for most covered services with Agency approval.
- Two plans have indicated interest in expanding their telemedicine programs; 1 plan has submitted a proposal.

SFY 2016-17 Low Income Pool

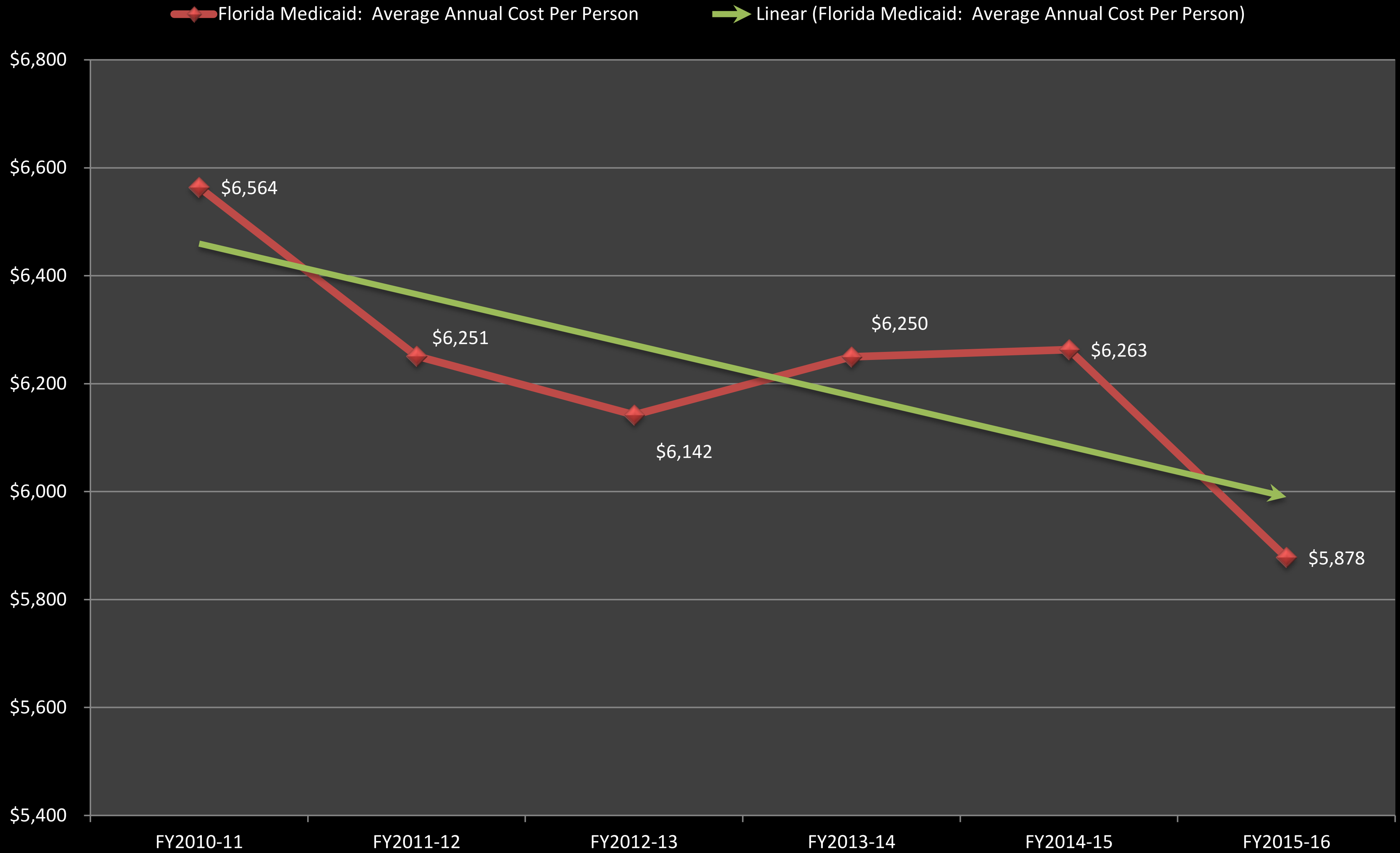
- The total amount of LIP funding for SFY 2016-2017 is approximately $608 million ($607,825,452).
- Funds may be used for health care costs that would be within the definition of medical assistance in the Social Security Act.
- For SFY 2016-2017 these health care costs may be incurred by the state or by providers to furnish uncompensated medical care as charity care for low-income individuals that are uninsured. The costs must be incurred pursuant to a charity care program that adheres to the principles of the Healthcare Financial Management Association.

SFY 2016-17 Low Income Pool

- Distribution **can** include both hospital providers and medical school faculty plan providers.
- For each provider type included, the LIP distribution model:
  - Must rank providers by their amount of uncompensated charity care costs or charges as a percentage of their privately insured patient care costs or charges (commercial pay).
  - Can include up to four tiers for distribution.
  - Must pay providers for the same percentage of their charity care cost within each tier.

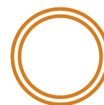
SFY 2016-17 Low Income Pool

- Florida has a few areas of flexibility in creating the distribution model for SFY 2016-2017. Questions that will need to be answered are:
  - Which providers to include?
  - What portion of the $608 million should be allocated to each provider type included?
  - How many tiers should the model include?
  - What should the thresholds be for each tier?
  - How much funding should be allocated to each individual tier?
  - Which dataset should be used for the charity care/ commercial care ratio?


Florida Medicaid: Average Annual Cost Per Person
Florida Medicaid: Average Annual Cost Per Person
Linear (Florida Medicaid: Average Annual Cost Per Person)
$6,800
$6,600
$6,400
$6,200
$6,000
$5,800
$5,600
$5,400
$6,564
$6,251
$6,142
$6,250
$6,263
$5,878
FY2010-11
FY2011-12
FY2012-13
FY2013-14
FY2014-15
FY2015-16
FY 2013-14 and prior data is from the final year end budgets.
FY 2014-15 Medicaid Expenditures data are from the March 4, 2015 Medicaid Expenditure SSEC and Caseload is from July 21, 2015 Medicaid Caseload SSEC
FY 2015-16 Medicaid Expenditures data are from the August 28, 2015 Medicaid Expenditure SSEC and Caseload is from July 21, 2015 Medicaid Caseload SSEC

Questions?

CMS Managed Care Plan



Presentation to the

House Health & Human Services Committee

January 14, 2016

Jennifer A. Tschetter, Chief Operating Officer

Overview

- Commitment to caring for Florida's children with serious and chronic medical conditions
- Statutory framework and clinical eligibility
- Development of new screening process and rescreening
- Rule Challenge and enrollment solution
- New clinical eligibility screening rule

Statutes: CMS Managed Care Plan

- Section 409.974(4), Florida Statutes
  - Identifies the CMS Managed Care Plan as a specialty plan for children with special health care needs
  - Exempts the CMS Managed Care Plan from competitive procurement
  - Requires CMS Managed Care Plan to meet all other managed care plan requirements

- Section 409.974(3), Florida Statutes
  - Limits the aggregate enrollment of specialty plans in a given region to 10 percent of the total enrollees in that region

Statutes: 2012 Amendments

- Section 391.016, Florida Statutes – Purposes and Functions

  ~~Serve as a principal provider for children with special health care needs under Titles XIX and XXI of the Social Security Act.~~

- Section 391.021(2), Florida Statutes – Definitions

  "Children with special health care needs" means those children younger than 21 years of age who have chronic <u>and serious</u> physical, developmental, behavioral, or emotional conditions and who ~~also~~ require health care and related services of a type or amount beyond that which is generally required by children.

2012 Clinical Eligibility Changes

Florida HEALTH

- Maintained diagnosis based clinical eligibility
- Required the diagnosis be serious
- Left to clinical judgment of screeners

2014: Acuity of CMS Plan Children

- 16.1%- Tier 0 (unscored or under age 1)
- 55.8%- Tier 1 (risk score >0 and <1.5)
- 22.2%- Tier 2 (risk score ≥1.5 and <4)
- 5.9%- Tier 3 (risk score ≥4)

*Tiers are based on the AHCA MMA Chronic Illness and Disability Payment System + Medicaid Rx (CDPS+Rx) risk adjustment model

*Percentages are based on a sample (n=41,589) of September 2014 CMS MMA Plan enrollment

Development of New Screening Process

Florida HEALTH

- November 2014: Workgroup formed and national experts consulted
- January 2015: Pilot of screening tool
  - Tampa Bay and Southeast Regions
  - Indeterminate results for 25% of children screened
- February 2015: Workgroup reconvened
- March 2015: Pilot of parent-based screening tool
  - No indeterminate results
  - 38.6% screened clinically ineligible/61.4% eligible

CMS Plan: Rescreening

Florida HEALTH

- Commenced May 4, 2015
- No eligible child denied services
- Enhanced continuity of care in place for all children more appropriately served by another managed care plan
  - Primary care physicians linked
  - Prescriptions transferred
  - Care coordinators connected
  - Service authorization and provider choices honored

Rule Challenge

- Filed June 25, 2015
- Alleged Department was required to promulgate clinical eligibility screening process by rule
- Arguments submitted to Administrative Law Judge
  - Eligibility screening process had never been in rule
  - Was an AHCA contractual requirement and exempt from rulemaking requirements
  - Not a statement of general applicability; an internal process for making decisions on individual cases
- September 22, 2015 Final Order issued requiring Department to cease all clinical eligibility screening activity until process promulgated by rule

Temporary AHCA Enrollment Solution

- Ensured enrollment of children in the CMS Plan during rulemaking
- Implemented through contract amendment
- List of diagnostic codes
- Physician attestation required

Results of Rescreening

- Status
  - 100% of Medicaid enrollees processed
  - 52% of KidCare enrollees processed
- Transitions
  - 12,102 Medicaid children transitioned to other managed care plans with the same required care coordination and access primary and specialty care services.
  - 972 children transitioned to Florida Healthy Kids

CMS Plan: Medicaid Enrollment

Member Count

80,000
70,000
60,000
50,000
40,000
30,000
20,000

Jan-14 Feb-14 Mar-14 Apr-14 May-14 Jun-14 Jul-14 Aug-14 Sep-14 Oct-14 Nov-14 Dec-14 Jan-15 Feb-15 Mar-15 Apr-15 May-15 Jun-15 Jul-15 Aug-15 Sep-15 Oct-15 Nov-15 Dec-15 Jan-16

Direct Service Network ←

→ MMA Plan

Clinical Eligibility Screening Rule

Florida HEALTH

- Effective January 11, 2016
- Two-paths for children to establish clinical eligibility
  - Physician-based attestation for automatic eligibility
  - Parent-based survey
- Will open the rule for necessary refinement in April 2016

Children's Medical Services Hotline Number: 855-901-5390

OPPAGA
research memorandum
THE FLORIDA LEGISLATURE'S OFFICE OF PROGRAM POLICY ANALYSIS & GOVERNMENT ACCOUNTABILITY

Children's Medical Services Screening Tool and Enrollment Trends

March 4, 2015

Summary

At the request of the Legislature, OPPAGA reviewed Children's Medical Services as administered by the Department of Health and answered four questions.

1. How are children with special health care needs identified, and how has the Children's Medical Services' screening process changed over time?
2. How has Children's Medical Services enrollment changed over time?
3. What types of chronic and serious medical diagnoses are most common for Children's Medical Services enrollees?
4. What are the monthly costs for the most common diagnoses for Children's Medical Services enrollees?

Background

The federal Social Security Act requires states to establish programs that assist children with special health care needs. Title V of the Social Security Act enables states to provide and promote family-centered, community-based, coordinated care for children with special health care needs and to facilitate the development of community-based systems for such children and their families. The U.S. Department of Health and Human Services' Health Resources and Services Administration, Maternal and Child Health Bureau defines children with special health care needs as those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

In Florida, the Department of Health's Division of Children's Medical Services serves children with special health care needs. Children's Medical Services (CMS) operates the CMS Network, a statewide specialty plan for children from birth to 21 years of age who have serious and chronic physical, developmental, behavioral, or emotional conditions.[1] Children who are clinically eligible can choose the CMS Network as a benefit plan option if they meet income eligibility requirements for Title 19 (Medicaid) or Title 21 (Florida's Children's Health Insurance Program, or CHIP).[2] Title 19 Medicaid and Title 21 CHIP eligibility are determined by the child's age and the family's income. (See Exhibit 1 for eligibility requirements.) For the purposes of this review, we will use Title 19 to refer to children eligible for CMS Network services funded through Medicaid and Title 21 to refer to children eligible for CMS Network services funded through CHIP. Referrals and cost sharing differ for Title 19 and Title 21 CMS enrollees, although service networks, benefit packages, care coordination, and service authorization processes are the same for both groups.[3]

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[1] In addition to administering the CMS Network, CMS also provides prevention and early intervention services through the Early Steps, Newborn Screening, and Child Protection Team programs.

[2] CMS contracts with two Integrated Care Systems to develop, maintain, and manage the provider network and deliver and coordinate primary and specialty care.

[3] Title 19 children are often referred by the Medicaid program while the Florida Healthy Kids Corporation most often refers children to CMS who are Title 21 eligible. For children eligible for Title 21, families must pay a monthly premium of $15 to $20, depending on income; Medicaid-eligible children have no cost-sharing requirements.

Exhibit 1
Children Must Be Financially Eligible for Medicaid or CHIP to Qualify for Children's Medical Services

	Family Income as a Percentage of the Federal Poverty Level	
Age of Child	Title 19 Medicaid Financial Eligibility	Title 21 CHIP Financial Eligibility
0 up to 1	up to 185%	185% to 200%
1 through 5	up to 133%	133% to 200%
6 up to 19	up to 133%	133% to 200%
19 to 21	up to 19%	N/A

Source: Florida Department of Health Division of Children's Medical Services.

Children are referred to CMS in several ways, including by Medicaid counselors, screening questions on the Florida Healthy Kids Corporation application, and medical professionals.[4] Care coordinators—nurses and social workers who assist families with organizing their child's care—located in the 22 CMS area offices throughout the state, receive referrals and complete the clinical screening process with the child's family using a multi-tiered tool. Care coordinators re-screen children annually or more often, as determined by a primary care physician. Title 19 enrollees choose the CMS Network as their Statewide Medicaid Managed Care Managed Medical Assistance plan. Title 21 is a non-entitlement plan, and thus, these enrollees are responsible for a monthly premium. CMS reimburses providers and plans on a fee-for-service basis.

There are more Title 19 enrollees than Title 21 enrollees in CMS. In Fiscal Year 2013-14, we identified an unduplicated count of 29,357 Title 21 enrollees and 70,513 Title 19 enrollees. Exhibit 2 presents the total claims expenditures for CMS enrollees by program for Fiscal Years 2009-10 through 2013-14. The greater number of Title 19 CMS enrollees contributes to higher total claims. In addition, Title 19 enrollment includes clients who qualify for Supplemental Security Income (SSI) due to being either blind or disabled and thus may have higher expenditures.[5] Medicaid SSI recipients account for nearly three-quarters ($2.88 billion) of the total $3.87 billion CMS Title 19 claims for the five-year period.

Exhibit 2
The Higher Number of CMS Title 19 Enrollees During Fiscal Years 2009-10 Through 2013-14 Results in Higher Total Claims Compared to Title 21 Enrollees[1]

Fiscal Year	Title 19 Medicaid Claims	Title 21 CHIP Claims
2009-10	$713,326,326	$96,723,741
2010-11	775,423,081	103,903,499
2011-12	760,833,762	118,648,647
2012-13	811,434,640	103,885,195
2013-14	811,178,540	97,531,092
Total	**$3,872,196,348[2]**	**$520,692,176**

[1] The costs in the exhibit include provider service claims only and do not include administrative services such as care coordination; totals do not include costs for the Safety Net Program.

[2] The total Title 19 CMS claims data does not include $471.2 million for children that we could not match to CMS enrollment data. This figure includes children that did not appear in the CMS enrollment data during a fiscal year, which varied from a low of 3,332 children in Fiscal Year 2009-10 to a high of 32,475 in Fiscal Year 2013-14. It also includes children enrolled in CMS who had claims outside of their enrollment period identified in CMS enrollment data.

Source: OPPAGA analysis of Florida Department of Health, Division of Children's Medical Services and Agency for Health Care Administration data.

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[4] The Florida Healthy Kids Corporation application includes three CMS Network screening questions. A yes answer to any of these questions generates a referral to CMS.

[5] In addition to SSI-eligible recipients, children also may qualify for Title 19 Medicaid due to eligibility for Temporary Assistance for Needy Families (TANF), the Medically Needy program, or under specific provisions of the Omnibus Budget Reconciliation Act of 1987.

How are children with special health care needs identified, and how has the Children's Medical Services' screening process changed over time?

Florida's definition of children with special health care needs differs from other states. As defined by s. 391.021, *Florida Statutes*, children with special health care needs are those younger than 21 years of age who have chronic and serious physical, developmental, behavioral, or emotional conditions and who require health care and related services of a type or amount beyond that which is generally required by children. Other states define children with special health care needs differently than Florida and may exclude certain illnesses or conditions from coverage. For example, Texas's definition includes children with medical conditions and does not cover children with only a mental, behavioral, or emotional condition or developmental delay. In Texas, the application must include medical diagnosis information submitted by a physician or dentist. Ohio excludes learning disabilities or behavior problems from its list of eligible conditions and also requires a physician to submit a medical application form on behalf of the child. To cover conditions such as asthma, Indiana regulations specify a severe asthma diagnosis that requires two medications daily and medical forms signed by a physician.

Screening of children with special health care needs occurs via telephone using an electronic screening tool. When a child is referred to CMS, a care coordinator contacts the family or caregiver by telephone to determine the child's clinical eligibility for CMS. Care coordinators use a computer-based tool to enter the information in the CMS computer system. The screening tool consists of four tiers.

- Tier I gathers information on a child's medical, behavioral, and developmental status.
- Tier II identifies any functional limitations the child may have.
- Tier III consists of a medical records request.
- Tier IV requires a direct medical evaluation.[6]

Steps in the screening process are successive—if a child meets the clinical eligibility criteria in a specific tier, the child is determined eligible and the screening stops. For example, Tier I prompts the care coordinator to ask the child's parent(s) whether the child has a medical problem or condition. If the parent answers yes, he or she is then asked the name of the condition. Because the screening process is successive, a yes answer regarding the presence of medical, behavioral, or developmental conditions stops the screening and the child is determined eligible. Department officials reported that most children are determined eligible in either Tier I or Tier II. Exhibit 3 provides examples of medical conditions that qualify a child for the CMS Network.

[6] The questions in Tier II are derived from the national Children with Special Health Care Needs Screener.

Exhibit 3
Medical Conditions Qualify Children as Clinically Eligible for the Children's Medical Services Network

Medical Diagnoses

- Asthma
- Cancer, including leukemia (if treated, has been in remission for less than five years)
- Cerebral palsy
- Chronic renal failure/kidney disease
- Congenital heart disease
- Craniofacial disorders
- Diabetes
- Genetic and/or metabolic disorders
- Hemophilia
- Hepatitis
- History of organ transplant
- HIV/AIDS
- Juvenile myasthenia gravis
- Juvenile rheumatoid arthritis
- Morbid obesity
- Muscular dystrophy or other progressive neuromuscular disorders
- Neurologic abnormalities and insults (e.g., epilepsy)
- Quadriplegia
- Spina bifida
- Spinal cord injury
- Other chronic condition that has lasted or is expected to last 12 months or longer

Developmental Conditions

- Severe attachment disorder, including autism spectrum
- Significant sensory impairment
- Other condition that has lasted or is expected to last 12 months or longer

Behavioral Health and Substance Abuse Diseases

- Behavioral health diseases and conditions
- Substance abuse diseases and conditions

Source: Florida Department of Health, Division of Children's Medical Services.

Over time, the CMS screening tool has undergone various changes; the tool does not currently take into account illness severity. In some instances, earlier versions of the CMS screening tool took into account the severity of a child's illness through questions that asked parents to provide specific treatment information. For example, Edition #7 of the tool, adopted in December 2000, specified eligibility for children with cancer and leukemia who had been in remission less than five years. Edition #7 also used guidelines developed by the National Institutes of Health (NIH) for classifying asthma severity. The NIH guidelines categorized asthma as mild intermittent, mild persistent, moderate persistent, and severe persistent. Edition #7 of the CMS screening tool required a diagnosis of moderate persistent or severe persistent asthma for children with an asthma diagnosis. The tool included the NIH guidelines and prompted care coordinators to reference the guidelines. By 2006, asthma severity questions were removed from the screening tool.

CMS screening also changed as a result of Florida's Medicaid reform pilot projects. Prior to the Medicaid reform pilot projects, the CMS screening tool granted categorical eligibility for children who qualified for Medicaid under an SSI assistance category or were enrolled in another CMS program. These children automatically were eligible for the CMS Network. Categorical eligibility questions were removed from screening for children in the initial Medicaid reform counties; the program applied this change statewide in 2012.[7] As directed by the 2012 Legislature, the program made additional changes to the screening tool to revise the statutory definition of children with special health care needs. Previously, statute only referred to children

[7] As directed by Ch. 2005-133, *Laws of Florida*, the Agency for Health Care Administration implemented the Medicaid Reform pilot program in Baker, Broward, Clay, Duval, and Nassau counties.

with chronic conditions; the language was changed so that the statute refers to children with both chronic and serious physical, developmental, behavioral, or emotional conditions.[8] In response to the statutory change, CMS changed the wording of the CMS screening questions to refer to chronic and serious conditions.

How has Children's Medical Services enrollment changed over time?

From Fiscal Years 2009-10 through 2013-14, the number of CMS enrollees has increased due to an increase in Medicaid enrollees. However, enrollment trends differ for Title 19 and Title 21 CMS children. As shown in Exhibit 4, Title 19 enrollees increased 19.8%, from 58,843 to 70,513. During this same period, CMS Title 21 enrollees decreased by 6,129 (17.3%). We also analyzed the average enrollment months for children in the program. For the five years in the study, Title 19 enrollees had an average of nine months of enrollment each year, while those enrolled in Title 21 had eight months of enrollment.

Exhibit 4
During Fiscal Years 2009-10 Through 2013-14, the Number of CMS Title 19 Enrollees Increased[1]

Fiscal Year	Title 19 Enrollees	Title 21 Enrollees	Total
2009-10	58,843	35,486	94,329
2010-11	64,712	34,928	99,640
2011-12	67,888	34,091	101,979
2012-13	69,550	33,057	102,607
2013-14	70,513	29,357	99,870
Total	**331,506**	**166,919**	**496,961**

[1] Children's whose financial eligibility changed during a year were counted in both programs.

Source: OPPAGA analysis of Florida Department of Health, Division of Children's Medical Services and Agency for Health Care Administration data.

As part of our review, we analyzed new enrollees over the five-year period from Fiscal Year 2009-10 through Fiscal Year 2013-14. As shown in Exhibit 5, using a child's first ever enrollment in the program, we identified new enrollees by program. The number of new Title 19 enrollees decreased by 9.3%, from 10,459 to 9,487. During this same period, the number of new Title 21 enrollees decreased by 5,028, a 51% decline. Program officials suggested the Title 21 enrollment decline is due in part to changes in federal health laws; some children with lower family incomes shifted to Title 19, while some with higher family incomes may have shifted to full pay status with the Florida Healthy Kids Corporation.

Exhibit 5
From Fiscal Year 2009-10 Through Fiscal Year 2013-14, New CMS Enrollees Decreased[1]

Fiscal Year	Title 19 Enrollees	Title 21 Enrollees	Total
2009-10	10,459	9,860	20,319
2010-11	10,861	8,070	18,931
2011-12	10,393	7,285	17,678
2012-13	10,792	6,844	17,636
2013-14	9,487	4,832	14,319
Total	**51,992**	**36,891**	**88,883**

[1] Children may gain and lose CMS eligibility due to changes in family circumstances. Rather than identifying new enrollees based on a certain number of months of non-enrollment, we identified new enrollees based on the child's original enrollment date in CMS.

Source: OPPAGA analysis of Florida Department of Health, Division of Children's Medical Services and Agency for Health Care Administration data.

[8] Chapter 2012-184, *Laws of Florida*.

Most CMS children range from age 6 up to age 19 and are male; approximately 60% live in one of three regions in the state. As shown in Exhibit 6, children served by CMS range in age from less than 1 year to 19 years of age and older. During Fiscal Year 2009-10 through Fiscal Year 2013-14, nearly three quarters (72.6%) of the CMS enrollees were age 6 up to age 19.

Exhibit 6
Children Served by CMS Range in Age from Less Than 1 Year to 19 and Older[1]

Fiscal Year	Child's Age				Total
	Less than 1	1 through 5	6 up to19	19 and older	
2009-10	2,089	19,455	62,534	3,207	87,348
2010-11	2,089	19,950	66,620	3,628	92,287
2011-12	2,223	19,970	68,783	3,822	94798
2012-13	2,394	19,762	70,112	3,833	96,101
2013-14	2,009	18,839	69,299	3,952	94,099
Total	**10,804**	**97,976**	**337,348**	**18,505**	**464,633**

[1] Age could not be determined for 1,462 (0.3%) of CMS enrollees.

Source: OPPAGA analysis of Florida Department of Health, Division of Children's Medical Services and Agency for Health Care Administration data.

Males make up about 60% of CMS enrollees in both Title 19 and Title 21. While CMS children are served throughout the state, nearly 60% are served in three CMS regions—21.0% in the Southeast region, 20.3% in the North Central region, and 17.4% in the Tampa Bay region. The North Central region includes Gainesville and Jacksonville, and the Southeast region includes Fort Lauderdale, Fort Pierce, and West Palm Beach.[9]

What types of chronic and serious medical diagnoses are most common for Children's Medical Services enrollees?

For Fiscal Years 2009-10 through 2013-14, the most common CMS diagnoses were asthma, attention deficit disorder, and congenital anomalies. Children enrolled in CMS have a range of medical conditions, including conditions that exist from birth such as heart defects, permanent disabilities that may result from an injury and a broad spectrum of diseases, as shown in Exhibit 7. Over the five fiscal years, 16.2% of CMS enrollees had an asthma diagnosis while 13.0% had a diagnosis of attention deficit disorder. Congenital anomalies, such as a heart valve defect, were the third most common diagnosis (11.3%). We examined the diagnoses of new CMS enrollees and found similar patterns with regard to asthma and attention deficit disorder. For more information on the diagnoses of new enrollees, see Appendix A.

[9] Miami-Dade, in the South region, has 11.0% of the CMS enrollees. The Central region includes Orlando and has 12.1% of enrollees.

Exhibit 7
The Most Frequent Diagnoses for CMS Enrollees are Asthma, Attention Deficit Disorder, and Congenital Anomalies[1]

Diagnosis[2]	Fiscal Year 2009-10	Fiscal Year 2010-11	Fiscal Year 2011-12	Fiscal Year 2012-13	Fiscal Year 2013-14	Average
Asthma	16.7%	16.6%	16.4%	16.0%	15.4%	16.2%
Attention deficit conduct and disruptive behavior disorders	12.5%	13.0%	13.2%	13.4%	13.2%	13.0%
Congenital anomalies	11.4%	11.2%	11.2%	11.2%	11.4%	11.3%
Other endocrine, nutritional, and metabolic diseases and immunity disorders (other than diabetes)	6.1%	6.1%	6.1%	5.9%	5.9%	6.0%
Developmental disorders	5.2%	5.5%	5.7%	6.0%	6.1%	5.7%
Disorders usually diagnosed in infancy, childhood, or adolescence	4.6%	5.1%	5.7%	6.2%	6.7%	5.7%
Epilepsy; convulsions	3.8%	3.6%	3.6%	3.5%	3.5%	3.6%
Certain conditions originating in the perinatal period	2.7%	2.6%	2.8%	3.0%	3.3%	2.9%
Other diseases of the nervous system and sense organs (other than paralysis, epilepsy, convulsions and ear and eye conditions)	2.9%	2.8%	2.7%	2.6%	2.6%	2.7%
Paralysis	2.9%	2.7%	2.6%	2.4%	2.4%	2.6%
Diseases of the blood and blood-forming organs	2.4%	2.4%	2.4%	2.3%	2.3%	2.4%
Diabetes	2.4%	2.4%	2.3%	2.3%	2.3%	2.3%
Ear conditions	2.2%	2.1%	2.1%	2.0%	2.1%	2.1%
Diseases of the circulatory system	2.1%	2.1%	2.1%	2.1%	2.0%	2.1%
No diagnosis record	2.0%	1.7%	1.7%	1.9%	2.8%	2.0%
Symptoms, signs, and ill-defined conditions and factors influencing health status[3]	2.2%	2.2%	2.0%	1.9%	1.7%	2.0%
Eye disorders	1.9%	2.1%	2.2%	2.1%	1.9%	2.0%
Mood disorders	2.0%	2.0%	1.9%	1.9%	1.8%	1.9%
Diseases of the musculoskeletal system and connective tissue	1.9%	1.8%	1.8%	1.7%	1.6%	1.8%
Neoplasms	1.8%	1.7%	1.6%	1.6%	1.6%	1.7%
Other diseases of the respiratory system (other than asthma)	1.8%	1.8%	1.8%	1.7%	1.6%	1.7%
Diseases of the digestive system	1.7%	1.7%	1.7%	1.7%	1.6%	1.7%
Other behavioral health (other than attention deficit conduct and disruptive behavior disorders and mood disorders)	1.5%	1.5%	1.6%	1.8%	1.8%	1.6%
Injury and poisoning	1.3%	1.4%	1.5%	1.6%	1.4%	1.5%
Diseases of the genitourinary system	1.5%	1.4%	1.4%	1.2%	1.2%	1.3%
Infectious and parasitic diseases	1.3%	1.2%	1.1%	1.1%	1.1%	1.2%
Residual codes, unclassified, all E codes[4]	1.1%	0.7%	0.5%	0.5%	0.4%	0.6%
Diseases of the skin and subcutaneous tissue	0.4%	0.3%	0.3%	0.3%	0.3%	0.3%
Complications of pregnancy, childbirth, and the puerperium	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%

[1] Children in CMS can have up to four different diagnoses. For the purposes of this exhibit, we identify a child's primary diagnosis in a given year.

[2] The Agency for Health Care Administration's contractors have used different models of disease diagnosis and procedure codes to predict Medicaid costs for capitation rates. We used the Clinical Classifications Software to combine CMS diagnoses into clinical categories to analyze the CMS population.

[3] The Clinical Classifications Software includes various diagnoses in this category including loss of consciousness, fever of unknown origin, shock, gangrene, allergic reactions, screening for suspected conditions, and rehabilitation care such as fitting of prostheses, etc. The specific diagnostic codes for the CMS children in this broad diagnostic group could have included any of these or other conditions.

[4] The category of residual codes includes diagnoses such as adverse effects of medical care and adverse effects of medical drugs, as well as codes for suffocation, overexertion, and other types of injuries from falls, burns, etc.

Source: OPPAGA analysis of Florida Department of Health, Division of Children's Medical Services and Agency for Health Care Administration data.

Title 19 and Title 21 enrollees differ with respect to the frequency of certain diagnoses. Exhibit 8 presents 11 diagnoses for children in the CMS population where at least a 1.3% difference exists in disease diagnosis between Title 19 and Title 21 enrollees. While 13.4% of Title 19 enrollees have an asthma diagnosis, 21.6% of Title 21 enrollees have this primary diagnosis. Similarly, while 10.8% of Title 19 enrollees have a primary diagnosis of attention deficit disorder, over 20% of Title 21 enrollees have this diagnosis. While 2.9% of Title 19 enrollees have paralysis as primary diagnosis, less than 1% of Title 21 enrollees have paralysis as a primary diagnosis. Four percent of Title 19 enrollees have a diagnosis of epilepsy while only 2% of Title 21 enrollees have this diagnosis.

Exhibit 8
In Fiscal Year 2013-14, a Higher Percentage of CMS Title 21 Enrollees had a Diagnosis of Asthma and Attention Deficit Disorder Compared to CMS Title 19 Enrollees[1]

Diagnosis	Percentage of Title 19 Enrollees with Diagnosis	Percentage of Title 21 Enrollees with Diagnosis	Population with Higher Percentage of Enrollees with Diagnosis—Title 19 or Title 21
Asthma	13.4%	21.6%	Title 21
Attention deficit conduct and disruptive behavior disorders	10.8%	20.4%	Title 21
Certain conditions originating in the perinatal period	4.1%	0.7%	Title 19
Congenital anomalies	13.4%	5.5%	Title 19
Developmental disorders	5.5%	7.5%	Title 21
Diseases of the blood and blood-forming organs	2.7%	1.3%	Title 19
Epilepsy; convulsions	4.0%	2.0%	Title 19
Injury and poisoning	1.8%	0.4%	Title 19
Other endocrine	6.4%	4.5%	Title 19
Paralysis	2.9%	0.7%	Title 19
Symptoms; signs; and ill-defined conditions and factors influencing health status[2]	1.3%	2.8%	Title 21

[1] Diagnoses in this exhibit are based on a child's primary diagnosis for Fiscal Year 2013-14. Children may have more than one diagnosis, and the primary diagnosis can change over time. Diagnoses were grouped for analysis purposes using the Clinical Classifications Software.

[2] The Clinical Classifications Software includes various diagnoses in this category including loss of consciousness, fever of unknown origin, shock, gangrene, allergic reactions, screening for suspected conditions, and rehabilitation care such as fitting of prostheses, etc. The specific diagnostic codes for the CMS children in this broad diagnostic group could have included any of these or other conditions.

Source: OPPAGA analysis of Florida Department of Health, Division of Children's Medical Services and Agency for Health Care Administration data.

Medicaid risk scores for the Title 19 children may provide information about disease severity. The CMS screening tool asks three initial questions regarding a child with an illness—these questions pertain to the existence of a medical, behavioral, or developmental condition. Neither the CMS screening tool nor CMS' enrollment information system gathers information about the severity of a child's condition. As a proxy, to examine severity we analyzed Medicaid risk scores for the Title 19 CMS children that are based on a child's age, gender, and certain Medicaid claims data.[10] The Agency for Health Care Administration (AHCA), through a third party, established risk scores for the entire Medicaid population. These risk scores were then

[10] Risk scores, which are intended to predict service costs, are available for the Title 19 CMS children because they were developed as part of the Medicaid capitated payment system under Medicaid Reform. Title 21 children are not included in the risk score analysis.

used to create the capitation payment schedule, first for Florida's Medicaid Reform Pilot areas and eventually for the Statewide Medicaid Managed Care Program.[11]

In developing the Medicaid risk scores to predict costs for managed care, AHCA's contracted actuary calculated the scores separately for the SSI population (adults and children) and the Temporary Assistance for Needy Families population (TANF adults and children). The distinction between TANF and SSI eligibility is important. Children identified as TANF are Medicaid eligible because their families meet the low-income requirements to qualify for TANF. To be eligible for SSI benefits, a child must be either blind or disabled, and the federal criteria for disabled or blind require that the child have a medically determinable physical or mental impairment(s) which results in marked and severe functional limitations, has lasted or is expected to last for a continuous period of at least 12 months, or be expected to result in death.[12] In Fiscal Year 2013-14, of the 70,513 Title 19 CMS enrollees, we identified 40.6% (28,642) who were eligible for Title 19 due to their SSI disability status.[13]

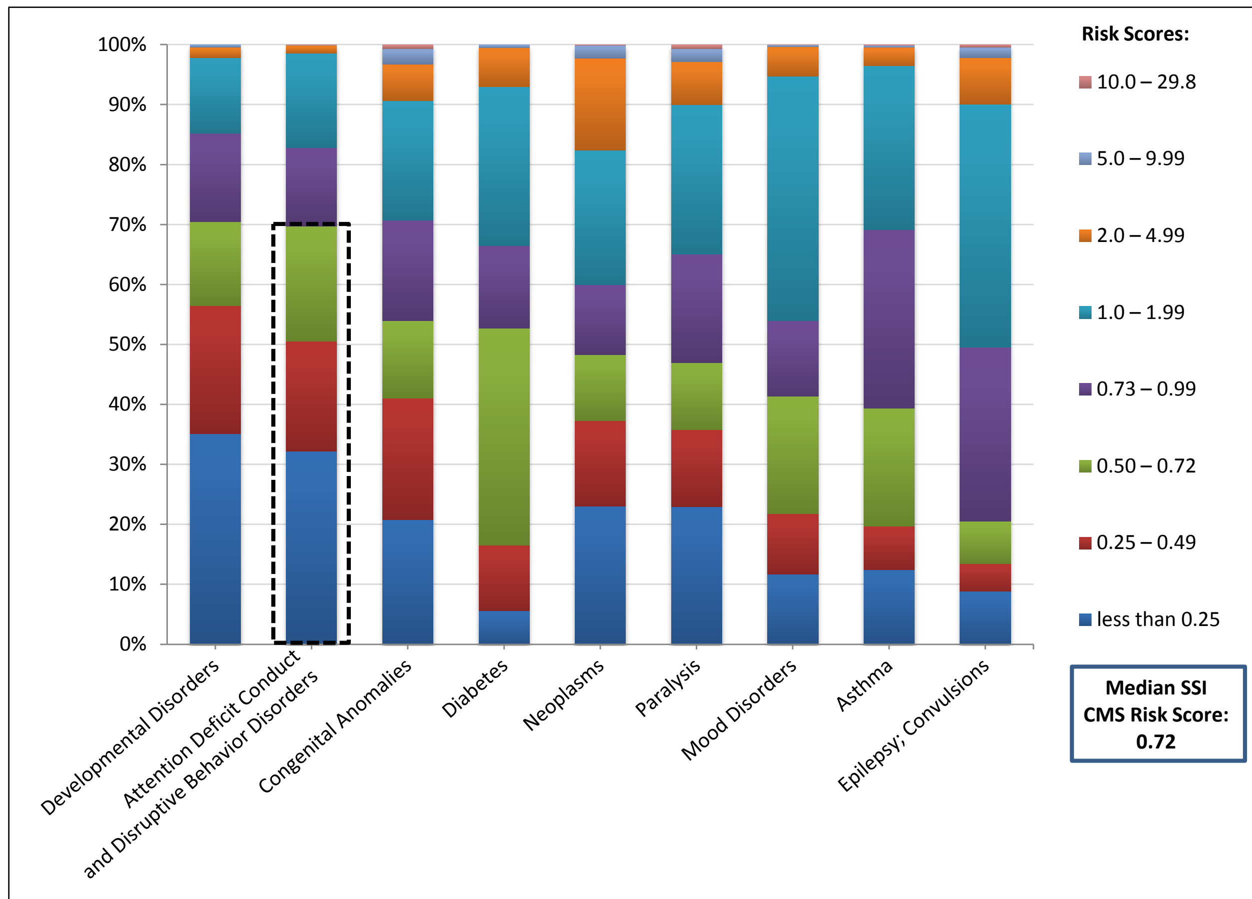
[11] For risk scores developed during Fiscal Year 2013-14, AHCA's contractor used a software system (CDPS+Rx) developed at the University of California, San Diego to establish the risk scores based on pharmacy and other medical claims and set the managed care capitation payments. For the prior years, the risk scores were created using the Medicaid Rx system that relies on pharmacy claims only. For the purposes of our analysis we used the Medicaid Rx scores, which provide a longer timeframe and larger numbers of children with specific diagnoses.

[12] Overall, 73% of SSI CMS children have multiple diagnoses compared to 53% of TANF CMS children.

[13] Any child with a Title 19 CMS claim within the year that was identified as SSI eligible is included in the total number of SSI children.

The median risk score for an SSI CMS child is 0.72 which means that half the SSI children enrolled in CMS have a risk score less than 0.72.[14] As shown in Exhibit 9, the proportion of SSI CMS children with low risk scores vary across diagnoses. For example, 69.7% of SSI CMS enrollees with a primary diagnosis of attention deficit disorder have risk scores less than 0.73, meaning that their overall costs are lower than the typical SSI CMS child. Of SSI CMS children, 47% with a primary diagnosis of paralysis and 52.7% with a primary diagnosis of diabetes have risk scores lower than 0.73. For SSI CMS children with asthma, 39.3% have risk scores less than 0.73, and 69.2% have risk scores less than 1.0.

Exhibit 9
Nearly 70% of SSI Eligible CMS Children with Attention Deficit Disorder Have Risk Scores Lower than 0.73

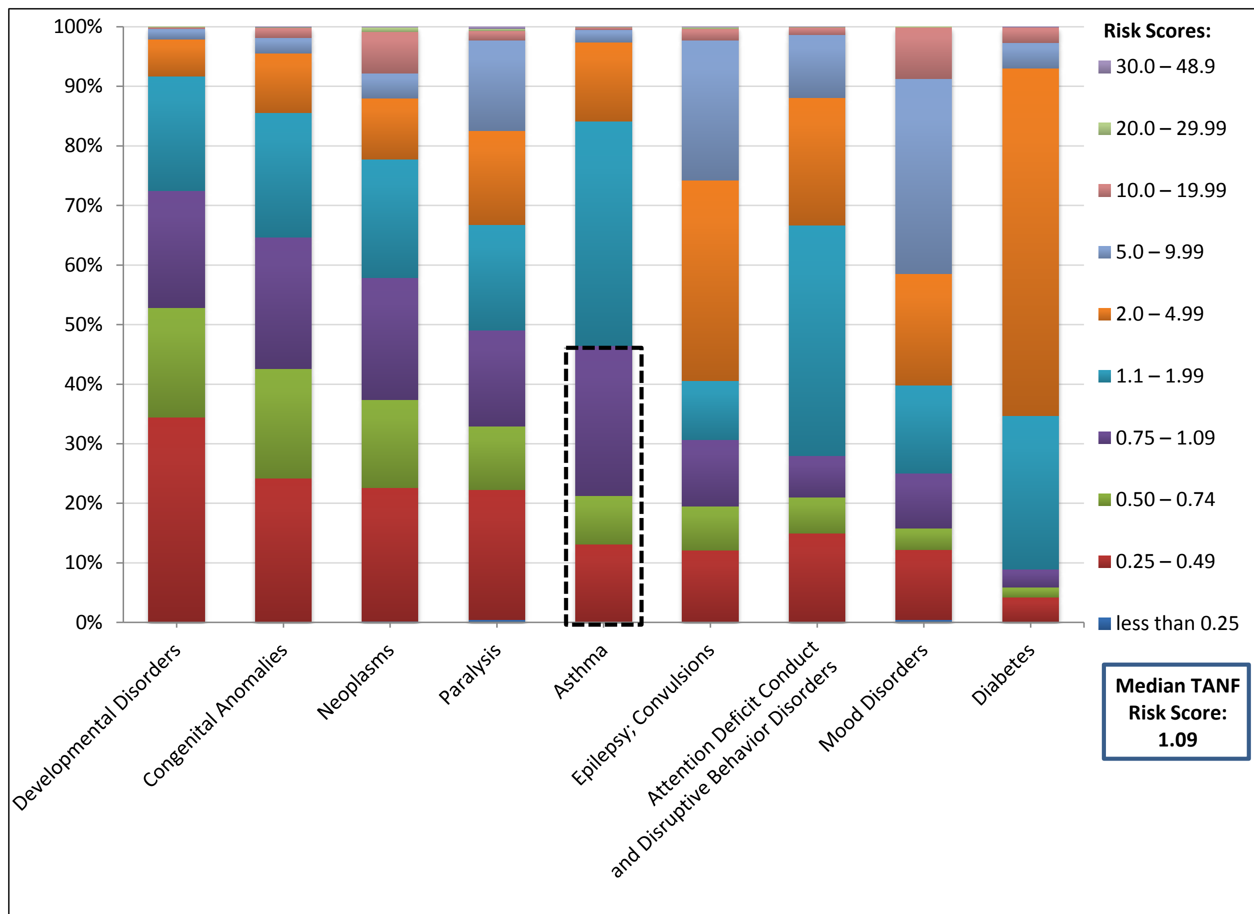


Source: OPPAGA analysis of Agency for Health Care Administration data.

[14] A risk score indicates how an enrollee's predicted service costs compare to predicted costs for average enrollees, who have risk scores of 1.0. A risk score less than 1.0 would mean that an enrollee's predicted costs are lower than average, and a risk score greater than 1.0 would mean that an enrollee's predicted costs are higher than average.

A TANF child enrolled in CMS has a median risk score of 1.09, slightly higher than the typical TANF Medicaid enrollee. A median risk score of 1.09 means that half the TANF CMS children have risk scores less than 1.09 and half have scores higher than 1.09. Exhibit 10 presents risk scores for TANF CMS children for a range of diagnoses. For certain diagnoses, a percentage of risk scores for TANF CMS children are lower than the median of 1.09. For example, of children with a primary diagnosis of asthma, 46.5% have risk scores less than 1.1. In addition, 28% of TANF CMS children with a primary diagnosis of attention deficit disorder and 30.6% with epilepsy have risk scores less than 1.1.

Exhibit 10
Nearly 50% of TANF Eligible CMS Enrollees with Asthma Have Risk Scores Less than 1.1



Source: OPPAGA analysis of Agency for Health Care Administration data.

What are the monthly costs for the most common diagnoses for Children's Medical Services enrollees?

Costs for the typical CMS child as well as average monthly costs vary widely based on eligibility. Costs for children with special health care needs can vary widely, even for children with the same diagnoses. For example, one child's illness may respond better to certain medications resulting in fewer emergency department visits or hospitalizations. Exhibit 11 presents the median (typical) and mean (average) monthly costs for the same CMS diagnoses groups shown in Exhibit 8 (where at least a 1.3% difference exists in disease diagnosis between Title 19 and Title 21 enrollees). For the diagnoses in Exhibit 11, we distinguish between TANF and SSI children eligible for Title 19 due to the potential increased medical complexity of SSI children with a disability compared to TANF children. For example, the range of average monthly costs for a child with a congenital anomaly varies from a low of $478 for a Title 21 enrollee and $732 for a Title 19 TANF enrollee, to a high of $2,298 for a Title 19 SSI enrollee.[15] Typical and average monthly costs across the different diagnoses in Exhibit 11 are highest for Title 19 SSI, followed by Title 19 TANF, and lowest for Title 21 children. We also found that Title 19 children had, on average, a higher rate of monthly claims than Title 21 children. Title 19 children had, on average, claims for 90% of their enrollment months compared to 60% on average for the Title 21 children.

Exhibit 11
Title 19 SSI Enrollees have Higher Median and Mean Monthly Claims than Title 21 Enrollees[1]

	Costs for a Typical Child Based on Diagnosis (Median Monthly Cost)			Average Costs for Child by Diagnosis (Mean Monthly Cost)		
Diagnosis	Title 19 SSI	Title 19 TANF	Title 21	Title 19 SSI	Title 19 TANF	Title 21
Paralysis	$917	$761	$227	$2,821	$2,326	$1,056
Epilepsy; convulsions	$618	$159	$115	$2,406	$882	$528
Injury and poisoning	$660	$186	$35	$4,105	$1,005	$836
Congenital anomalies	$458	$122	$59	$2,298	$732	$478
Certain conditions originating in the perinatal period	$461	$134	$68	$3,021	$786	$484
Attention deficit conduct and disruptive behavior disorders	$284	$177	$107	$587	$334	$262
Other endocrine (other than diabetes)	$451	$120	$80	$2,428	$776	$1,023
Diseases of the blood and blood-forming organs	$356	$111	$53	$3,803	$1,837	$2,041
Developmental disorders	$246	$125	$8	$818	$355	$208
Asthma	$287	$113	$45	$958	$314	$221
Symptoms; signs; and ill-defined conditions and factors influencing health status[2]	$211	$74	$34	$770	$211	$260

[1] This analysis is based on data covering five fiscal years (Fiscal Year 2009-10 through Fiscal Year 2013-14) for CMS Title 19 and Title 21.

[2] The Clinical Classifications Software includes various diagnoses in this category including loss of consciousness, fever of unknown origin, shock, gangrene, allergic reactions, screening for suspected conditions, and rehabilitation care such as fitting of prostheses, etc. The specific diagnostic codes for the CMS children in this broad diagnostic group could have included any of these or other conditions.

Source: OPPAGA analysis of Florida Department of Health, Division of Children's Medical Services and Agency for Health Care Administration data.

[15] Congenital anomalies include, for example, heart, spinal cord, kidney, and other defects existing from birth.

Appendix A

Diagnoses for New CMS Enrollees Show Similar Patterns to Existing Enrollees

Exhibit A-1 details the percentage of new CMS enrollees, by fiscal year, with specific diagnoses. The most common diagnoses for new enrollees during Fiscal Years 2009-10 through 2013-14 were asthma, attention deficit disorder, and congenital anomalies. During this same period, these three diagnoses were also the most common diagnoses among all CMS enrollees as shown in Exhibit 7.

Exhibit A-1
The Most Frequent Diagnoses for New CMS Enrollees are Asthma, Attention Deficit Disorder, and Congenital Anomalies

Diagnosis	Fiscal Year 2009-10	Fiscal Year 2010-11	Fiscal Year 2011-12	Fiscal Year 2012-13	Fiscal Year 2013-14	Average
Asthma	16.4%	15.6%	15.0%	13.3%	12.1%	14.6%
Attention deficit conduct and disruptive behavior disorders	14.5%	14.9%	14.6%	15.4%	13.6%	14.6%
Congenital anomalies	8.3%	8.6%	8.7%	9.2%	8.9%	8.7%
Developmental disorders	7.0%	6.6%	6.8%	7.0%	7.2%	6.9%
Disorders usually diagnosed in infancy childhood or adolescence	5.3%	6.1%	6.5%	7.2%	7.7%	6.5%
Other endocrine, nutritional, and metabolic diseases and immunity disorders (other than diabetes)	5.4%	5.8%	5.5%	5.0%	5.2%	5.4%
Certain conditions originating in the perinatal period	2.9%	3.2%	4.0%	4.3%	4.9%	3.8%
No diagnosis code	2.5%	1.8%	1.9%	3.0%	9.2%	3.4%
Epilepsy; convulsions	2.8%	2.9%	3.1%	2.7%	2.8%	2.9%
Other diseases of the nervous system and sense organs (other than paralysis, epilepsy, convulsions, and ear and eye conditions)	2.6%	2.3%	2.2%	2.5%	2.6%	2.5%
Symptoms, signs, and ill-defined conditions and factors influencing health status[1]	2.7%	2.6%	2.4%	2.3%	1.6%	2.4%
Mood disorders	2.4%	2.5%	2.3%	2.4%	1.8%	2.3%
Other behavioral health (other than attention deficit, conduct, disruptive behavior, and mood disorders)	2.1%	1.9%	2.3%	2.5%	2.3%	2.2%
Diabetes	2.0%	2.2%	2.1%	2.1%	2.1%	2.1%
Diseases of the circulatory system	2.1%	2.2%	2.0%	2.0%	2.1%	2.1%
Injury and poisoning	1.3%	2.3%	2.2%	2.8%	1.6%	2.0%
Eye disorders	2.1%	2.2%	2.5%	1.6%	1.3%	2.0%
Ear conditions	2.3%	2.0%	1.9%	1.9%	1.7%	2.0%
Diseases of the musculoskeletal system and connective tissue	1.9%	1.7%	2.0%	1.9%	1.7%	1.8%
Diseases of the blood and blood-forming organs	1.7%	1.7%	1.7%	1.7%	1.6%	1.7%
Diseases of the digestive system	1.7%	1.9%	1.6%	1.7%	1.6%	1.7%
Other respiratory diseases (other than asthma)	1.9%	1.9%	1.7%	1.4%	1.0%	1.6%
Neoplasms	1.6%	1.5%	1.4%	1.5%	1.3%	1.5%
Paralysis	1.4%	1.4%	1.3%	1.1%	1.3%	1.3%
Residual codes; unclassified; all E codes[2]	2.2%	1.3%	1.3%	0.8%	0.5%	1.3%
Diseases of the genitourinary system	1.4%	1.2%	1.2%	1.1%	1.0%	1.2%
Infectious and parasitic diseases	1.0%	1.1%	1.1%	1.4%	1.3%	1.2%
Diseases of the skin and subcutaneous tissue	0.5%	0.3%	0.4%	0.3%	0.2%	0.4%
Complications of pregnancy, childbirth, and the puerperium	0.1%	0.1%	0.0%	0.1%	0.1%	0.1%

[1] The Clinical Classifications Software includes various diagnoses in this category including loss of consciousness, fever of unknown origin, shock, gangrene, allergic reactions, screening for suspected conditions, and rehabilitation care such as fitting of prostheses, etc. The specific diagnostic codes for the CMS children in this broad diagnostic group could have included any of these or other conditions.

[2] The category of residual codes includes diagnoses such as adverse effects of medical care and adverse effects of medical drugs, as well as codes for suffocation, overexertion, and other types of injuries from falls, burns, etc.

Source: OPPAGA analysis of Florida Department of Health, Division of Children's Medical Services and Agency for Health Care Administration data.

Appendix A

Diagnoses for New CMS Enrollees Show Similar Patterns to Existing Enrollees

Exhibit A-1 details the percentage of new CMS enrollees, by fiscal year, with specific diagnoses. The most common diagnoses for new enrollees during Fiscal Years 2009-10 through 2013-14 were asthma, attention deficit disorder, and congenital anomalies. During this same period, these three diagnoses were also the most common diagnoses among all CMS enrollees as shown in Exhibit 7.

Exhibit A-1
The Most Frequent Diagnoses for New CMS Enrollees are Asthma, Attention Deficit Disorder, and Congenital Anomalies

Diagnosis	Fiscal Year 2009-10	Fiscal Year 2010-11	Fiscal Year 2011-12	Fiscal Year 2012-13	Fiscal Year 2013-14	Average
Asthma	16.4%	15.6%	15.0%	13.3%	12.1%	14.6%
Attention deficit conduct and disruptive behavior disorders	14.5%	14.9%	14.6%	15.4%	13.6%	14.6%
Congenital anomalies	8.3%	8.6%	8.7%	9.2%	8.9%	8.7%
Developmental disorders	7.0%	6.6%	6.8%	7.0%	7.2%	6.9%
Disorders usually diagnosed in infancy childhood or adolescence	5.3%	6.1%	6.5%	7.2%	7.7%	6.5%
Other endocrine, nutritional, and metabolic diseases and immunity disorders (other than diabetes)	5.4%	5.8%	5.5%	5.0%	5.2%	5.4%
Certain conditions originating in the perinatal period	2.9%	3.2%	4.0%	4.3%	4.9%	3.8%
No diagnosis code	2.5%	1.8%	1.9%	3.0%	9.2%	3.4%
Epilepsy; convulsions	2.8%	2.9%	3.1%	2.7%	2.8%	2.9%
Other diseases of the nervous system and sense organs (other than paralysis, epilepsy, convulsions, and ear and eye conditions)	2.6%	2.3%	2.2%	2.5%	2.6%	2.5%
Symptoms, signs, and ill-defined conditions and factors influencing health status[1]	2.7%	2.6%	2.4%	2.3%	1.6%	2.4%
Mood disorders	2.4%	2.5%	2.3%	2.4%	1.8%	2.3%
Other behavioral health (other than attention deficit, conduct, disruptive behavior, and mood disorders)	2.1%	1.9%	2.3%	2.5%	2.3%	2.2%
Diabetes	2.0%	2.2%	2.1%	2.1%	2.1%	2.1%
Diseases of the circulatory system	2.1%	2.2%	2.0%	2.0%	2.1%	2.1%
Injury and poisoning	1.3%	2.3%	2.2%	2.8%	1.6%	2.0%
Eye disorders	2.1%	2.2%	2.5%	1.6%	1.3%	2.0%
Ear conditions	2.3%	2.0%	1.9%	1.9%	1.7%	2.0%
Diseases of the musculoskeletal system and connective tissue	1.9%	1.7%	2.0%	1.9%	1.7%	1.8%
Diseases of the blood and blood-forming organs	1.7%	1.7%	1.7%	1.7%	1.6%	1.7%
Diseases of the digestive system	1.7%	1.9%	1.6%	1.7%	1.6%	1.7%
Other respiratory diseases (other than asthma)	1.9%	1.9%	1.7%	1.4%	1.0%	1.6%
Neoplasms	1.6%	1.5%	1.4%	1.5%	1.3%	1.5%
Paralysis	1.4%	1.4%	1.3%	1.1%	1.3%	1.3%
Residual codes; unclassified; all E codes[2]	2.2%	1.3%	1.3%	0.8%	0.5%	1.3%
Diseases of the genitourinary system	1.4%	1.2%	1.2%	1.1%	1.0%	1.2%
Infectious and parasitic diseases	1.0%	1.1%	1.1%	1.4%	1.3%	1.2%
Diseases of the skin and subcutaneous tissue	0.5%	0.3%	0.4%	0.3%	0.2%	0.4%
Complications of pregnancy, childbirth, and the puerperium	0.1%	0.1%	0.0%	0.1%	0.1%	0.1%

[1] The Clinical Classifications Software includes various diagnoses in this category including loss of consciousness, fever of unknown origin, shock, gangrene, allergic reactions, screening for suspected conditions, and rehabilitation care such as fitting of prostheses, etc. The specific diagnostic codes for the CMS children in this broad diagnostic group could have included any of these or other conditions.

[2] The category of residual codes includes diagnoses such as adverse effects of medical care and adverse effects of medical drugs, as well as codes for suffocation, overexertion, and other types of injuries from falls, burns, etc.

Source: OPPAGA analysis of Florida Department of Health, Division of Children's Medical Services and Agency for Health Care Administration data.