

COMMITTEE MEETING EXPANDED AGENDA

APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

Senator Grimsley, Chair
Senator Flores, Vice Chair

MEETING DATE: Wednesday, September 25, 2013
TIME: 1:00 —3:00 p.m.
PLACE: *Pat Thomas Committee Room, 412 Knott Building*

MEMBERS: Senator Grimsley, Chair; Senator Flores, Vice Chair; Senators Bean, Benacquisto, Galvano, Garcia, Gibson, Lee, Montford, Richter, Smith, Sobel, and Thrasher

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	Status Reports from the Agency for Health Care Administration:	Diagnosis Related Groups (DRGs) Implementation Statewide Medicaid Residency Program Implementation Status of Statewide Medicaid Managed Care Roll-out Status of Medically Needy Waiver Request Low Income Pool (LIP) Conversion and Waiver Request Lawsuits with Fiscal Implications	Presented
Other Related Meeting Documents			

Update on Diagnosis Related Groups (DRG) Implementation

Background:

The 2012 Legislature directed the Agency to convert Medicaid fee-for-service inpatient hospital reimbursement to a prospective payment system (PPS) which categorizes stays using Diagnosis Related Groups (DRGs) (s. 409.905(5)(f), F.S.).

The Agency was required to submit a Medicaid DRG plan by January 1, 2013. The plan was submitted on December 21, 2012. In addition, the Agency was required to implement DRG pricing by July 1, 2013. The DRG pricing was implemented July 1, 2013.

AHCA engaged MGT of America and its subcontractor Navigant Healthcare for implementation of the DRG system.

The previous rate setting methodology was a Cost-Based “Per Diem” methodology. Payments were based on hospitals’ spending. Rates for hospitals were set on a facility specific basis, based on each facility’s reported costs. The Hospital rates were all inclusive, “per diem” rates, based on reported costs for services provided by the hospital to Medicaid recipients on a fee-for-service basis.

Diagnosis Related Group (DRG) Methodology Overview:

Payments are based on patients’ needs. Higher payments are made for sicker patients.

Each discharge is assigned a DRG code based on information routinely submitted on medical claims (diagnosis codes, procedure codes, age, gender, and birth weight). DRGs categorize patients with similar clinical characteristics and requiring similar hospital resource intensity.

Each DRG has a relative weight factor, which recognizes the differences in resource requirements for patients assigned to the DRG. The DRG relative weight and a hospital base rate are the primary components in calculating DRG payment, which is per discharge.

Payment is generally a fixed amount based on the DRG assignment, thus rewarding hospitals that reduce costs. Payment is generally determined by multiplying a hospital’s “base rate” by the assigned DRG’s relative weight factor. An “outlier” payment provision is typically incorporated to provide additional payments where the base DRG amount is not appropriate – generally cases with extraordinarily high costs.

Payment models are also sometimes modified to affect payment for specialty services or providers to ensure fair reimbursement and access to care for Medicaid recipients. These are referred to as “policy adjusters”.

The DRG payment also includes additional per claim add-ons, tied to intergovernmental transfers (IGTs)

Update on Diagnosis Related Groups (DRG) Implementation

The goals of the DRG system are as follows:

- Efficiency: Aligns with incentives for providing efficient care
- Access: Promotes access to quality care, consistent with federal requirements
- Equity: Promotes equity of payment through appropriate recognition of resource intensity and other factors
- Predictability: Provides predictable and transparent payment for providers and the State
- Transparency and Simplicity: Enhances transparency, and contribute to an overall methodology that is easy to understand and replicate
- Quality: Promotes and rewards high value, quality-driven healthcare services

Impact of Change in Payment Methodology:

The move from a cost-based payment method (previous method) to an acuity-based payment method has a tendency to increase reimbursement for hospitals that have relatively low costs and decrease reimbursement for hospitals with relatively high costs.

Hospitals with relatively high costs can mitigate the projected changes in reimbursement level by reducing their costs. For example, a reduction in average length stay, which would reduce a hospital's revenue under the current payment method, will increase its pay-to-cost ratio under the new DRG payment method.

Implementation:

On July 1, 2013, the state implemented the new payment method utilizing DRGs. The Agency's fiscal agent, Hewlett-Packard (HP), began the implementation phase in February, 2013.

The effort was categorized into three main areas of focus:

- Systems: Updating the Florida Medicaid Management Information System (FMMIS) to process inpatient claims according to the Agency's direction.
- Training: Educating Agency and HP personnel on DRG changes.
- Provider Outreach: Supporting and educating the hospital provider community on the transition to DRG pricing.

DRG Information on the Web Portal:

A DRG-specific webpage was created on the Florida Medicaid Web Portal at <http://mymedicaid-florida.com> to house all public documents related to the transition. A variety of resources were published to the DRG page, including a presentation, FAQs, and a quick reference and awareness guide.

Update on Diagnosis Related Groups (DRG) Implementation

Provider Outreach Highlights:

A series of DRG webinars, consisting of general overview, payment methodology, and prior authorization impact, was created to provide an opportunity for hospitals to participate in electronic and virtual training. Thirteen (13) webinars were conducted with over 900 attendees.

HP's seven (7) dedicated DRG Field Services Representatives (FSRs) contacted all active participating hospital providers in the state of Florida and "border" hospitals. This contact resulted in 100 on-site provider visits.

Triage Support:

For the period of 07/01/13 – 09/30/13, a triage unit was implemented to monitor post-implementation issues, inpatient claims, and provide support to the submitting hospital providers.

As of September 12, 2013, as part of the triage provider outreach, 223 hospitals have been contacted to discuss initial DRG claims and outcomes.

Since implementation, ten (10) system change orders related to DRG were created and implemented. All change orders were expedited in order to lessen the impact to the Provider Community.

DRG Claim Metrics:

As of September 9, 2013 the DRG claim metrics had the following statistics:

- Hospitals with paid DRG claims: 230
- Total DRG claims paid: 41,993
 - Average per claim reimbursement: \$4,749.83
- Total DRG reimbursement: \$199,464,263.12

The top 100 most costly DRG claims reimbursed in August had an average relative weight of 9.70, an average length of stay of 17.71 days, and an average total reimbursement of \$79,885.05.

DSS Data:

Seventeen (17) DSS reports were created to gauge the impact of DRG, compare historical payments to new payments, and identify any areas of concern.

As of September 12, 2013, sixteen (16) reports have been completed. Results were distributed by HP to the Agency on a weekly basis during the Triage period.

Update on Diagnosis Related Groups (DRG) Implementation

One report compares total inpatient expenditures against the prior year. The chart below represents a monthly comparison of total inpatient expenditures for the month of July 2012 to the month of July 2013.

DOS Month / Year	07/2012	07/2013
Sum Of Covered Days	226,507	94,203
Sum Of Reimbursed Amount	\$246,852,933.43	\$100,445,027.38
Sum Of Billed Amount	\$1,692,201,263.86	\$638,788,953.88
Paid Claims Count	33,689	23,419
Denied Claims Count	9,003	4,183
Total Claims Count:	42,692	27,602

The 2013 reimbursed amount in the above chart is lower for several reasons:

- Hospitals are paid at discharge, not the daily per diem
- The simplest claims are billed first
- Daily bills from June still being paid in July
- Impact of the discontinuation of interim claims
- For 2013 this report only includes DRG admissions and excludes any inpatient claim with a date of admission of June 30 and prior

DRG Payment Monitoring:

Additional DRG payment monitoring reports will include:

- Overall Medicaid inpatient expenditures
- Payments by hospital compared to previous year and compared to prediction from DRG payment simulations
- Actual casemix
- Readmission rates
- Prevalence of outlier payments
- Average length of stay

Next Steps:

Self-Funded IGTs:

DRG add-ons related to IGTs include an add-on for automatic IGT distributions tied to special designations, and for self-funded IGTs provided by local governmental entities for rate enhancements. By October 31, 2013, the Agency will recalculate and update the DRG base rate and policy adjustors after the actual self-funded IGT letters of agreement are finalized.

Update on Diagnosis Related Groups (DRG) Implementation

When the new DRG payment parameters become effective, they will be retroactive back to July 1, 2013, and posted on the Medicaid cost reimbursement website. All inpatient claims with admissions beginning July 1, 2013 will be re-priced.

Casemix Reconciliation:

The Agency will review and potentially update the DRG payment parameters again effective March 1, 2014 based on actual measure casemix (average DRG relative weight)

Base rate was set under assumption that casemix will be 1.05 (5% above casemix from rate setting dataset). The 5% increase in casemix expected primarily because of improved documentation and coding on hospital claims

This DRG payment parameter adjustment will be prospective – covering admissions from March 1, 2014 through June 30, 2014. Adjustments will maintain budget neutrality for SFY 2013-14

Transitional Payment Reconciliation:

\$65 million was made available in FY 2013-14 for quarterly payments to hospitals expected to see Medicaid revenue decrease with move from per diem to DRG methodology.

- All rural hospitals are set budget neutral.
- Hospitals that were predicted to lose \$300,000 or more were provided additional funds to cover some of the revenue reduction.

Reconciliation of transitional funds will compare actual DRG reimbursement in FY 2013-14 to estimated reimbursement under per diem payment method.

Adjustments in transitional funds for individual hospitals must stay within the \$65 million in total.

Graduate Medical Education/Statewide Residency Program Overview

Background:

Prior to July 1, 2013, Medicaid's inpatient reimbursement methodology recognized costs associated with Graduate Medical Education (GME).

There was no specific dollar amount or portion of the hospital per diem rate specifically allocated for GME, but GME would be included in the total Hospital Inpatient services line item and would be made up of General Revenue as well as Medical Care Trust Fund dollars.

During the 2013 Legislative Session the 2013-14 General Appropriations Act (GAA) removed \$52 million from the Hospital Inpatient Line, Specific Appropriation 208, for Graduate Medical Education. This \$52 million was re-appropriated to line item 207A, Graduate Medical Education, and \$28 million in additional funds were added for a total appropriation for GME of roughly \$80 million.

In addition, Medicaid's 2013 Conforming bill, SB 1520, created the Statewide Medicaid Residency program and outlined the formula that will be used to derive hospital reimbursements for hospitals participating in the program going forward. The overall goal of the program is to improve the quality of care and access to care for Medicaid recipients, expand graduate medical education on an equitable basis, and increase the supply of highly trained physicians statewide.

Reimbursement under Statewide Residency Program:

Statute requires the Agency to calculate an allocation fraction to be used for distributing funds to hospitals participating in the program on or before September 15th of each year with the distributions occurring on a quarterly basis throughout the fiscal year with the first occurring by September 30th.

The Agency sent a letter to all hospitals on August 22, 2013, requesting data that would support the calculation of the allocation fraction that would be used for distributing funds to qualified hospitals. All hospitals licensed under part 1 of the chapter 395 were eligible to submit data. The allocation fraction for each participating hospital is based on the hospital's submission of the number of full-time equivalent (FTE) residents. The following data was requested:

- A.) List of residents by name and please also include the following:
 - Each resident's unique number, specialty,
 - The fraction of the year the resident will be in your facility, and
 - Residency year.
- B.) Copy of the Certification Letter for resident rotation location.
- C.) Accreditation letters from the Council of Graduate Medical Education, American Association of Osteopathic Medicine or American Osteopathic Association.

The number of residents submitted by facilities is based on the amount of FTE residents enrolled at the facility as of July 1, 2013. The qualifying residents were to be in their initial residency period in which they are being trained, not to exceed 5 years. A resident training beyond the initial residency period is counted as 0.5 FTE, unless his or her chosen specialty is in general surgery or primary care, in which case the resident is counted as 1.0 FTE. The Agency will not be funding a designated number of residency slots, but rather distributing funds based on the allocation fraction.

2013-14 GME

			1	2	3	4	5	6	7	8	9	10	11	
Provider County	Medicaid ID	Hospital	Resident Count Provided by the Hospitals	Baseline Payment - From FY 2013-14 GAA DRG Conference Model	Estimated Resident Allocation	Estimated Medicaid Allocation	Estimated Allocation Fraction	Initial Estimated Allocation	Initial Per Resident Cost	Over \$50,000 Cap	Final Estimated Allocation	Final Per Resident Cost	Final Estimated Quarterly Distribution	
1	Pinellas	101516	All Children's Hospital	46.7	\$99,224,989	1.19865%	5.84490%	1.66328%	\$1,330,298	\$28,485	\$0	\$1,330,888	\$28,498	\$332,722
2	Dade	116483	Anne Bates Leach Eye Hospital	66.1	\$102,984	1.69726%	0.00607%	1.52814%	\$1,222,215	\$18,483	\$0	\$1,222,754	\$18,491	\$305,689
3	Duval	100641	Baptist Medical Center	43.5	\$29,283,590	1.11655%	1.72497%	1.17739%	\$941,688	\$21,647	\$0	\$942,104	\$21,656	\$235,526
4	Pinellas	101567	Bayfront Medical Center	24.5	\$25,416,987	0.62882%	1.49720%	0.71566%	\$572,390	\$23,363	\$0	\$572,644	\$23,373	\$143,161
5	Broward	100129	Broward General Hospital	87.2	\$93,456,218	2.23758%	5.50509%	2.56433%	\$2,050,971	\$23,526	\$0	\$2,051,879	\$23,536	\$512,970
6	Broward	120405	Broward Health Coral Springs	1.4	\$16,729,460	0.03593%	0.98546%	0.13089%	\$104,683	\$74,774	\$34,683	\$70,000	\$50,000	\$17,500
7	Dade	100366	Cedars Medical Center, Inc.	121.6	\$24,834,434	3.12127%	1.46289%	2.95543%	\$2,363,775	\$19,437	\$0	\$2,364,819	\$19,446	\$591,205
8	Broward	102202	Cleveland Clinic Hospital	86.0	\$569,668	2.20730%	0.03356%	1.98992%	\$1,591,553	\$18,506	\$0	\$1,592,256	\$18,515	\$398,064
9	Palm Beach	120308	Columbia Hospital	18.5	\$5,911,835	0.47483%	0.34824%	0.46217%	\$369,644	\$19,981	\$0	\$369,807	\$19,990	\$92,452
10	Palm Beach	101460	Columbia JFK Medical Center	50.9	\$21,775,417	1.30641%	1.26269%	1.30404%	\$1,042,840	\$20,491	\$0	\$1,043,440	\$20,500	\$260,860
11	Orange	101290	Florida Hospital	145.6	\$116,610,822	3.73726%	6.86903%	4.05044%	\$3,239,567	\$22,248	\$0	\$3,241,000	\$22,258	\$810,250
12	Volusia	101842	Halifax Medical Center	29.0	\$26,784,314	0.74432%	1.57775%	0.82766%	\$661,971	\$22,827	\$0	\$662,264	\$22,837	\$165,566
13	Dade	120057	HealthSouth Larkin Hospital-Miami	180.6	\$2,549,356	4.63532%	0.15017%	4.18681%	\$3,348,637	\$18,542	\$0	\$3,350,114	\$18,550	\$837,529
14	Dade	100421	Jackson Memorial Hospital	630.0	\$321,103,773	16.17025%	18.91480%	16.44470%	\$13,152,581	\$20,876	\$0	\$13,158,393	\$20,886	\$3,289,598
15	Pinellas	119741	Largo Medical Center	111.5	\$4,158,693	2.86151%	0.24497%	2.59985%	\$2,079,379	\$18,651	\$0	\$2,080,297	\$18,659	\$520,074
16	Manatee	101168	Manatee Memorial Hospital	44.0	\$19,941,941	1.12931%	1.17469%	1.13385%	\$906,863	\$20,611	\$0	\$907,263	\$20,620	\$226,616
17	Duval	100722	Mayo Clinic Florida	122.3	\$2,831,346	3.13821%	0.16678%	2.84107%	\$2,272,305	\$18,584	\$0	\$2,273,308	\$18,593	\$568,327
18	Broward	100200	Memorial Hospital	17.4	\$78,716,034	0.44711%	4.63681%	0.86608%	\$692,694	\$39,764	\$0	\$693,002	\$39,782	\$173,250
19	Duval	101931	Memorial Medical Center	1.2	\$8,152,560	0.03080%	0.48023%	0.07574%	\$60,579	\$50,483	\$579	\$60,000	\$50,000	\$15,000
20	Dade	100609	Miami Children's Hospital	121.7	\$83,279,937	3.12230%	4.90565%	3.30063%	\$2,639,869	\$21,701	\$0	\$2,641,036	\$21,710	\$660,259
21	Hillsborough	120324	Moffitt Cancer Center	100.9	\$15,708,868	2.58844%	0.92534%	2.42213%	\$1,937,236	\$19,209	\$0	\$1,938,091	\$19,218	\$484,523
22	Pinellas	101583	Morton F. Plant Hospital	25.0	\$18,724,745	0.64166%	1.10299%	0.68779%	\$550,099	\$22,004	\$0	\$550,342	\$22,014	\$137,585
23	Dade	100463	Mt. Sinai Medical Center	145.1	\$21,538,528	3.72443%	1.26874%	3.47886%	\$2,782,415	\$19,175	\$0	\$2,783,643	\$19,183	\$695,911
24	Baker	260029	Northeast Florida State Hospital	3.0	\$3,111,911	0.07700%	0.18331%	0.08763%	\$70,087	\$23,362	\$0	\$70,118	\$23,373	\$17,529
25	Pinellas	115193	Northside Hospital	33.1	\$3,871,035	0.84930%	0.22803%	0.78717%	\$629,583	\$19,026	\$0	\$629,861	\$19,035	\$157,465
26	Orange	101338	Orlando Regional Medical Center	226.6	\$126,362,821	5.81674%	7.44347%	5.97941%	\$4,782,375	\$21,102	\$0	\$4,784,488	\$21,111	\$1,196,122
27	Palm Beach	120260	Palm West Hospital	19.0	\$16,297,740	0.48766%	0.96003%	0.53490%	\$427,813	\$22,516	\$0	\$428,002	\$22,526	\$107,001
28	Dade	104604	Palmetto General Hospital	68.5	\$18,953,897	1.75865%	1.11649%	1.69444%	\$1,355,220	\$19,778	\$0	\$1,355,819	\$19,787	\$338,955
29	Escambia	100765	Sacred Heart Hospital	50.2	\$39,896,446	1.28870%	2.35012%	1.39484%	\$1,115,606	\$22,219	\$0	\$1,116,099	\$22,229	\$279,025
30	Duval	100676	Shands Jacksonville Med Cntr	249.6	\$91,953,207	6.40707%	5.41656%	6.30801%	\$5,045,191	\$20,211	\$0	\$5,047,419	\$20,220	\$1,261,855
31	Alachua	100030	Shands Teaching Hospital	497.0	\$165,977,127	12.75613%	9.77698%	12.45821%	\$9,964,157	\$20,049	\$0	\$9,968,558	\$20,057	\$2,492,139
32	St. Lucie	119971	St. Lucie Medical Center	37.0	\$5,335,701	0.94965%	0.31430%	0.88612%	\$708,722	\$19,155	\$0	\$709,034	\$19,163	\$177,259
33	Pinellas	120103	St. Petersburg General Hospital	41.0	\$4,729,243	1.05232%	0.27858%	0.97494%	\$779,765	\$19,019	\$0	\$780,109	\$19,027	\$195,027
34	Duval	100731	St. Vincent's Hospital	30.0	\$9,344,272	0.76999%	0.55043%	0.74803%	\$598,281	\$19,943	\$0	\$598,545	\$19,951	\$149,636
35	Leon	101133	Tallahassee Memorial Rgnl Med Cntr	58.8	\$18,584,222	1.50892%	1.09471%	1.46750%	\$1,173,715	\$19,965	\$0	\$1,174,233	\$19,973	\$293,558
36	Hillsborough	100994	Tampa General Hospital	243.0	\$129,243,409	6.23690%	7.61316%	6.37452%	\$5,098,385	\$20,981	\$0	\$5,100,639	\$20,990	\$1,275,160
37	Hillsborough	100943	Univ Community Hosp Carrollwood	1.0	\$1,660,274	0.02567%	0.09780%	0.03288%	\$26,297	\$26,297	\$0	\$26,309	\$26,309	\$6,577
38	Hillsborough	101028	Univ Community Hosp-Tampa	5.5	\$8,190,672	0.14004%	0.48248%	0.17428%	\$139,393	\$25,548	\$0	\$139,455	\$25,559	\$34,864
39	Broward	112801	University Hospital & Medical Center	12.0	\$1,550,415	0.30799%	0.09133%	0.28633%	\$229,007	\$19,084	\$0	\$229,108	\$19,092	\$57,277
40	Dade	100471	University of Miami Hospital and Clinic	50.2	\$1,154,483	1.28845%	0.06801%	1.16640%	\$932,896	\$18,584	\$0	\$933,307	\$18,592	\$233,327
41	Palm Beach	102130	Wellington Regional Medical Center	18.0	\$10,455,141	0.46199%	0.61587%	0.47738%	\$381,811	\$21,212	\$0	\$381,980	\$21,221	\$95,495
42	Dade	032265	West Kendall Baptist Hospital	4.0	\$172,882	0.10266%	0.01018%	0.09342%	\$74,715	\$18,679	\$0	\$74,748	\$18,687	\$18,687
43	Dade	100625	Westchester General Hospital	28.0	\$3,380,848	0.71865%	0.19915%	0.66670%	\$533,235	\$19,044	\$0	\$533,470	\$19,052	\$133,367
			Total	3,896.2	\$1,697,632,249	100.00000%	100.00000%	100.00000%	\$79,980,644	\$20,528	\$35,262	\$79,980,644	\$20,528	\$19,995,161

GME Simulation (90-10) HAF = [0.9*(HFTE/FTFE)] + [(0.1)*(HMP/TMP)]

Statewide Medicaid Managed Care Update

Background:

The Agency is in the process of implementing the Statewide Medicaid Managed Care (SMMC) program. Part IV of Chapter 409, F.S., created in part by HB 7107 and HB 7109 during the 2011 Legislative Session.

The SMMC program has two key components, the Long-term Care (LTC) Managed Care program and the Managed Medical Assistance (MMA) program.

The goals of the Statewide Medicaid Managed Care Program are:

- improve coordination of care;
- a system that focuses on improving the health of recipients, not just paying claims when people are sick;
- enhanced accountability;
- recipient choice of plans and benefit packages;
- flexibility to offer services not otherwise covered; and
- enhanced fraud and abuse prevention through contract requirements.

Long-term Care Program:

Implementation:

On February 1, 2013, the Agency received federal approval of the waiver it needed to implement the LTC component of the SMMC program.

The Agency completed its competitive procurement in early 2013 and has already navigated the bid protest process. The Agency selected seven plans to participate in the LTC program – six HMOs and one PSN.

The LTC program began on August 1, 2013, in the Orlando area and is being rolled out on a regional basis. The Agency has the following goals during LTC rollout:

- No services missed;
- No recipients required to move.

LTC Enrollment:

Individuals must enroll in LTC managed care if they are 18 and older and **in a nursing facility** or enrolled in;

- Aged and Disabled Adult Waiver
 - Consumer-Directed Care Plus for individuals in the A/DA waiver
- Assisted Living Waiver
- Channeling Services for Frail Elders Waiver
- Nursing Home Diversion Waiver
- Frail Elder Option.

The Waivers listed above will end with implementation of the SMMC program.

Statewide Medicaid Managed Care Update

Individuals who are enrolled in the following programs are NOT required to enroll in the LTC program, although they may enroll if they choose to:

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

Recipient Choice/Plan Selection:

Prior to roll-out in each Region, recipients will receive plan selection materials from the choice counselor by mail.

All Medicaid recipients receiving services in a nursing facility, or through the waivers previously mentioned, will have the opportunity to receive choice counseling prior to enrollment.

Choice Counselors will assist recipients in selecting plans in their region that best meets their needs via telephone, online, or recipients can request an in person visit from a choice counselor.

The Agency continues to use certified choice counseling services to assist recipients.

We have a call center, located in Tallahassee, available to recipients, as well as 22 contracted field staff, and an additional 167 field office staff who will be certified choice counselors to assist in person.

If a recipient is currently receiving services from a LTC plan that will also be a LTC plan in the region where the recipient resides, the recipient can choose to remain with the original plan, or the recipient can choose to enroll with a different plan.

Statewide Medicaid Managed Care Update

Roll Out Schedule:

LTC recipients in Regions 7, 8, and 9 are now enrolled in LTC managed care plans.

Region	Date Enrolled in LTC Plans
1	March 1, 2014
2	November 1, 2013
3	March 1, 2014
4	March 1, 2014
5	February 1, 2014
6	February 1, 2014
7	August 1, 2013
8	September 1, 2013
9	September 1, 2013
10	November 1, 2013
11	December 1, 2013

The following plans have been selected for participation in the LTC program:

Region	LTC Plans						
	American Eldercare, Inc.	Amerigroup Florida, Inc.	Coventry Health Plan	Humana Medical Plan, Inc.	Molina Healthcare of Florida, Inc.	Sunshine State Health Plan	United Healthcare of Florida, Inc.
1	X					X	
2	X						X
3	X					X	X
4	X			X		X	X
5	X				X	X	X
6	X		X		X	X	X
7	X		X			X	X
8	X					X	X
9	X		X			X	X
10	X	X		X		X	
11	X	X	X	X	X	X	X

Statewide Medicaid Managed Care Update

Current LTC Enrollment by Plan:

August 1, 2013 and September 1, 2013		
	August 1, 2013	September 1, 2013
American Eldercare, Inc.	2,227	5,942
United Healthcare of Florida, Inc.	1,040	5,331
Coventry Health Plan	2,524	2,243
Sunshine State Health Plan	2,974	7,023
Total	8,765	20,539

LTC Outreach:

Created an interested parties list allowing individuals to sign up and receive email alerts when new information is available.

Hold webinars for potential long-term care providers on various subjects including eligibility and enrollee and provider protection.

Posted a FAQ document created from various stakeholder questions to the SMMC website.

Created an online complaint form allowing providers, recipients and others to quickly submit complaints allowing quick triage and handling.

Weekly Calls with LTC providers beginning 2 weeks prior to go-live in a region to provide a forum for specific provider types to ask questions relating to the program and to notify the Agency of any issues occurring during the transition period.

DOEA and Field office staff placing outbound calls to recipients to ensure services are being provided.

SMMC interested parties list currently has 4,290 individuals signed up to receive program updates.

The following statistics have been compiled from the 29 Webinars that have been held:

- 6,500 Live Webinar attendees
- Webinar Plays via YouTube: 2,281
- Slideshare Views: 64,367

In addition, below are statistics for the outreach efforts previously mentioned:

- More than 600 Providers have participated in weekly calls.
- More than 350 Questions responded to in the FAQ document.
- More than 4,600 Outbound calls.

Statewide Medicaid Managed Care Update

Finally, statistics relating to outreach efforts conducted by Choice Counseling are below:

- 112,860 letters mailed as of September 6, 2013.
- Face to Face Meetings:
 - 125,359 Total Miles logged by Choice Counselors
 - 2,905 Recipients
 - 332 Home Visits
 - 932 Partner staff
 - 752 Partner Site Visits
 - 539 Live Community/Provider Outreach Events

Managed Medical Assistance Program (MMA):

Florida Medicaid will implement the Managed Medical Assistance program second beginning in 2014.

The Managed Medical Assistance program is comprised of several types of health plans:

- Health Maintenance Organizations (HMOs);
- Provider Service Networks (PSNs); and
- Children's Medical Services Network.

Due to the competitive procurement, we are in a statutorily imposed "Blackout Period" until 72 hours after the award and cannot provide interpretation or additional information not included in the LTC or MMA ITN documents.

Federal Authority:

In order to implement the MMA component of the SMMC program, the Agency amended the 1115 Medicaid Reform Demonstration Waiver that currently operates in Baker, Broward, Clay, Duval, and Nassau counties:

- To mandatorily enroll certain previously voluntary populations in the Statewide Medicaid Managed Care MMA plans.
- To geographically expand the program statewide.
- To update programmatic operations and safeguards.
- To change the name of the demonstration to the Managed Medical Assistance program.

On June 14, 2013, the Agency received a letter from federal CMS approving our request to amend the 1115 Medicaid Reform Demonstration Waiver to allow the statewide rollout of this program.

MMA Plan Selection:

The MMA ITN was released on December 28, 2012, and the final bids were due from potential plans on March 29, 2013.

The Agency received 182 submissions from 27 health plans responding to the 11 Regional Statewide Medicaid Managed Care Managed Medical Assistance Invitations to Negotiate.

The anticipated posting of notice of intent of award is September 23, 2013.

[Medically Needy Program Update—September 2013](#)

Background:

Prior to the 2011 legislative session, section 409.904(2) (a), Florida Statutes (F.S.), authorized the Medically Needy program with an ending date for non-pregnant adults of June 30, 2011.

During the 2011 legislative session, the Legislature considered several alternative approaches to the Medically Needy program. As a result, the Legislature decided to continue the Medically Needy program while directing the Agency to seek Federal authority to make changes to the program. The Legislature also directed the Agency to implement the Statewide Medicaid Managed Care (SMMC) program which has two key components: the Long-term Care program and the Managed Medical Assistance program.

Provisions relating to the Medically Needy program are codified in s. 409.9122 (20), F.S. The SMMC program is codified at Part IV of Chapter 409, F.S. (409.961 – 409.985).

Section 409.9122 (20), F.S., sunsets on October 1, 2014, or upon full implementation of the SMMC program. Changes to the Medically Needy program outlined in s. 409.9122 were intended to serve as an interim program prior to the implementation of the SMMC program, while changes outlined in Part IV of Chapter 409 were intended as a permanent component of the SMMC program.

	Interim Program (s. 409.9122 (20), F.S.)	Permanent Program (Part IV of Chapter 409, F.S.)
Program Changes	Section 409.9122 (20), F.S, requires the Agency to contract with a single provider service network (PSN) to provide services to Medicaid enrollees enrolled in the Medically Needy program.	Sections 409.972 and 409.975, F.S., require the agency to contract, through a competitive procurement, with health plans to provide services to Medicaid enrollees including the medically needy population when the MMA component is implemented in 2014.
Federal Authorities	<p>A request for an amendment of the Florida Medicaid programs' 1115 MEDS AD Waiver was submitted on April 26, 2012.</p> <p>The 1115 MEDS AD Waiver amendment was submitted to implement the provisions of 409.9122 (20), to allow the Agency to enroll Medically Needy recipients into a provider service network (PSN) the month after their initial determination of eligibility. Under the amendment Florida Medicaid would revise the Medically Needy program to provide six additional months of coverage, to implement a premium that would not exceed the share of cost and</p>	<p>A request for a new section 1115 Research and Demonstration Waiver was submitted on November 21, 2012.</p> <p>The new section 1115 Research and Demonstration Waiver request was submitted to implement the provisions on ss. 409.972 and 409.975, F.S., to allow the Agency to enroll Medically Needy recipients into managed care plans under the Managed Medical Assistance component of the SMMC program. Under the waiver, Florida Medicaid would revise the Medically Needy program to provide 12 additional months of coverage, to implement a premium that would not</p>

Medically Needy Program Update—September 2013

	to provide care coordination and utilization management to achieve more cost-effective services. The program would sunset on October 1, 2014, or upon implementation of the SMMC program, whichever is sooner.	exceed the share of cost and to provide care coordination and utilization management to achieve more cost-effective services. The program would begin with implementation of the SMMC program.
Current Status	The Agency will submit a request to CMS to withdraw the pending amendment. The amendment has been pending since April 26, 2012. Since CMS has not approved at this time, the Agency does not have sufficient time to implement and then phase out this program prior to implementation of the Managed Medical Assistance program in 2014.	CMS has conveyed concern that the premium may not meet federal requirement that states pay Medicaid health plans actuarially sound rates in all rate cells. The Agency has been informed that CMS does not view the waiver request as approvable under federal law. The Agency will notify CMS in the fall if written denial of the waiver application is necessary.

Low Income Pool Update

History of Low Income Pool: Change for SFY 2014-2015

Current state and federal authority for the \$1 billion annually Low Income pool program is expiring.

The Florida Legislature established new program parameters during the 2011 session, to take effect during SFY 2014-15.

Federal authority (through the 1115 Waiver) expires June 30, 2014, and must be renewed.

Current Low Income Pool Program:

Florida had an Upper Payment Limit (UPL) Payment Methodology that was in place from July 1, 2000 until June 30, 2006. Payments were made to qualifying hospitals only. The methodology provided a mechanism to supplement fee-for-service inpatient payments to Medicaid hospital providers. UPL expenditures for SFY 2005-06 were \$631 million.

On October 19, 2005, the Centers for Medicare and Medicaid Services (CMS) approved the 1115 Research and Demonstration Waiver Application for the State of Florida, relating to Medicaid reform.

On December 8, 2005, the Florida Legislature authorized implementation of the waiver effective July 1, 2006.

- In the Waiver Special Terms and Conditions (STC), # 91, the Low Income Pool (LIP) was "established to ensure continued government support for the provision of health care services to Medicaid, underinsured and uninsured populations."
- The low-income pool consisted of a capped annual allotment of \$1 billion total computable for each year of the 5 year demonstration period.

Low Income Pool funds may be used for health care expenditures (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act. These health care expenditures may be incurred by the State, by hospitals, clinics, or by other provider types for:

- Uncompensated medical care costs of medical services for the uninsured
- Medicaid shortfall (after all other Title XIX payments are made)

Funding Source:

Local governments, such as counties, hospital taxing districts and other state agencies (e.g. Florida Department of Health) provide funding for the non-federal share of the \$1 billion LIP distributions. Federal funds are drawn down to match the non-federal funds.

Effective October 1, 2013, through September 30, 2014, the Federal Matching Assistance Percentage is 58.79%; and the non-federal share is 41.21%.

Low Income Pool Update

Funding Recipients:

Funding in the LIP Program allows many Provider Access Systems (PAS) in Florida to receive additional payments to cover the cost of providing services to Medicaid, uninsured, and underinsured individuals. PAS entities are defined in the waiver as providers with access to LIP funding and services funded from LIP.

PAS entities include entities such as hospitals, clinics, or other provider types and entities designated by Florida Statutes to improve health services access in rural communities, which incur uncompensated medical care costs in providing medical services to the uninsured and underinsured.

Federal and State Changes

State Changes:

In 2011, the Florida Legislature created the Statewide Medicaid Managed Care program, to be fully implemented by October 1, 2014.

- Section 409.97, F.S., directed the Agency to make changes to the operation of the low income pool program through contract with the Access to Care Partnership.
- Section 409.911, F.S., the Legislature amended section 409.911, F.S., to sunset the Low Income Pool Council effective October 1, 2014.

Section 409.97, Florida Statutes (a component of the Statewide Medicaid Managed Care (SMMC) statute):

Intergovernmental Transfers: In the SMMC statute, the Legislature authorized the Agency to accept voluntary transfers of local taxes and other qualified revenue from counties, municipalities, and special taxing districts that **must be contributed to advance the general goals of the Florida Medicaid program without restriction.**

Low Income Pool: The SMMC statute directed the Agency to establish and maintain a LIP program to support enhanced access to services by offsetting shortfalls in Medicaid reimbursement, paying for otherwise uncompensated care, and financing coverage for the uninsured.

- In accordance with the SMMC statute, the low income pool will be distributed in periodic payments to the Access to Care Partnership throughout the fiscal year. Distribution of low-income pool funds by the Access to Care Partnership to participating providers may be made through capitated payments, fees for services, or contracts for specific deliverables.

Access To Care Partnership: Florida law directs the Agency to contract with an administrative services organization to distribute LIP funds and be responsible for an ongoing program of activities that provides needed, but uncovered or undercompensated, health services to Medicaid enrollees and persons receiving charity care.

Low Income Pool Update

Hospital Rate Distribution: Florida law also directs the Agency to distribute IGTs not associated with the low income pool or the disproportionate share program through a tiered enhanced rate methodology.

Federal Changes:

As previously indicated current 1115 waiver authority that includes LIP expires June 30, 2014. The Agency will submit a 3-year extension request for 1115 Managed Medical Assistance Waiver on or before November 22, 2013. The Agency will request that the LIP be included as part of the renewed waiver.

The Agency intends to request additional federal funding for the LIP program, and anticipates that Federal CMS will expect the state to tie at least some of the additional funds to metric driven quality improvement projects.

Development of the LIP Distribution Model

Based on the changes directed in Section 409.97, F.S., the Agency developed a distribution model for SFY 2014-2015.

- This follows what is outlined in the Medicaid Supplemental Hospital Funding Programs Fiscal Year 2013-14 Final Conference Report for the GAA for the funding associated with the \$1 billion low income pool program.
- The Agency used current year parameters for this new model as outlined in Section 409.97, Florida Statutes, i.e., the statute will be applied to current year spending.
- The Agency provided the model to legislative staff for review on August 23, 2013.

Model 1 Assumptions

The Agency used the SFY 2013-14 distribution methodology for LIP and DSH. The Agency updated the SFY 2013-14 GAA Model for SFY 2014-15 FMAP. Due to the updated FMAP \$18.1 million is available for an additional LIP distribution.

In Addition, no more than 40% of IGT funding came from any single funding source and the Agency's model eliminates exemptions and buybacks in accordance with Florida law.

Statewide issues will continue. Statewide issues raises the cap on outpatient reimbursement per recipient from \$1,000 to \$1,500 per SFY. There will be a continued collection of Liver Global fee IGTs.

Model 1 Assumptions: Tiered IGT Distribution Methodology

The Agency will need to incorporate the steps for the tiered hospital rate distribution methodology as outlined in Section 409.97(4), Florida Statutes, into the Florida Title XIX Inpatient Hospital Reimbursement Plan component of the Florida Medicaid State Plan effective July 1, 2014 for approval from Federal CMS.

- The Agency will need to define and outline the tiers and the acronyms.

Low Income Pool Update

- It will need to state that the Agency will calculate this rate distribution using only IGTs unless the legislature provides GR for this distribution.
- The Agency anticipates that it will need to change the Florida Title XIX Outpatient Hospital Reimbursement Plan effective July 1, 2014 to reflect that IGTs will no longer be used in outpatient rates.

Model 1 Breakdown:

The Following is the LIP Model 1 breakdown funding levels for SFY 2014-15 (in millions):

Low Income Pool	\$1,000.2
Tier Funding	\$797.1
Liver Global Fee	\$9.9
Disproportionate Share	\$239.4
Statewide Issues	\$55.5
Total	\$2.10 Billion

Comparison of SFY 2013-14 Appropriation to this Model 1 for SFY 2014-15 (in millions):

Low Income Pool:	<u>SFY 2013-14 GAA</u>	<u>Model 1 SFY 2014-15</u>
• LIP Hospital	\$766.9	\$748.8
• Special LIP	\$116.0	\$116.0
• LIP Non-Hospital	\$117.3	\$117.3
• Distribution to be Determined	<u>0.0</u>	<u>\$ 18.1</u>
• Total LIP (millions)	\$1,000.2	\$1,000.2
Related Programs:		
• Disproportionate Share Hospital	\$ 239.4	\$239.4
• Exemptions	\$666.5	0.0
• Medicaid "Buy-Back" Program	\$130.5	0.0
• Tier Funding	<u>0.0</u>	<u>\$797.0</u>
• Total LIP Related (millions)	\$1,036.4	\$1,036.4
Total LIP and Related Programs	\$2,036.6	\$2,036.6

Below is a breakout of where the dollars come from:

State General Revenue	\$19.7 million
Local Taxes & Other Agencies	\$824.4 million
Federal Funds	\$1,192.5 million
Total	\$ 2,036.6 billion

Matching funds (all programs):

- \$19.7 million in total state GR match.
- \$824.4 million in local Intergovernmental Transfers (IGTs) are provided using local tax dollars, other Agencies' funds and public hospital operating funds. Thirty-one local governments contribute these funds.

Low Income Pool Update

Hospital IGT Contributors				
State and Local Government	Statewide Issues	DSH	LIP, Tier and Liver Global Fee	Total
General Revenue		-	250,000	250,000
General Revenue Recurring	-	750,000	10,506,000	11,256,000
Shands - GR			3,820,670	3,820,670
Moffitt - GR		706,826	5,803,255	6,510,081
Bay County	-	-	-	-
Citrus County Hospital Board	-	-	7,215,882	7,215,882
Collier County	-	-	-	-
Duval County	1,506,817	4,711,475	2,664,256	8,882,548
Gulf County	-	-	417,604	417,604
Halifax Hospital Medical Center Taxing District	-	2,143,644	18,109,172	20,252,816
Health Care District of Palm Beach County	-		3,500,000	3,500,000
Health Central			2,370,438	2,370,438
Hernando County			981,938	981,938
Highlands County			565,209	565,209
Hillsborough County	-	3,322,903	-	3,322,903
Hillsborough County - clerk of court				-
Indian River Taxing District	-	-	8,915,254	8,915,254
Lake Shore Hospital Authority	-	-	2,571,995	2,571,995
Lee Memorial Health System	-	5,808,616	16,377,741	22,186,357
Manatee County			2,039,290	2,039,290
Marion County	-		2,085,150	2,085,150
Marion County Hospital Board		734,471	-	734,471
Miami-Dade County	12,094,236	34,529,736	292,582,900	339,206,872
North Brevard Hospital District	-	-	1,055,929	1,055,929
North Broward Hospital District	4,216,371	18,701,037	153,290,372	176,207,780
North Lake Hospital Taxing District	-	-	1,597,947	1,597,947
Orange County	-	2,878,180	-	2,878,180
Pinellas County	-	-	-	-
Santa Rosa County			122,483	122,483
Sarasota County Public Hospital Board	-		19,232,905	19,232,905
South Broward Hospital District	2,761,135	13,451,683	102,874,740	119,087,558
South Lake Hospital Taxing District			-	-
St. Johns County			-	-
Suwannee County Board of County Commissioners			224,283	224,283
Doctor's Memorial of Perry				-
GME DSH		790,114	-	790,114
undetermined amounts	2,188,721	851,698	16,702,842	19,743,261
DSH (Shands-UF & FP GR)		5,852,899	-	5,852,899
Total Government Transfer (Hospitals)	22,767,280	95,233,282	675,878,255	793,878,817

Low Income Pool Update

Special LIP funding of \$116.0 million for the following initiatives shown in millions:

Rural	\$5.6
Primary Care	\$12.0
Specialty Pediatric	\$1.4
Trauma	\$8.8
STC 61 Quality Measures	\$15.0
Safety Net	\$73.1
Total Special LIP	\$116.0

LIP “Below the Line” Programs SFY 2014-2015 Model 1: \$117.3 Million:

Initiatives focused on primary care, emergency room diversion, disease management, poison control, and continued initiatives related to premium assistance programs for uninsured and underinsured individuals.

- Federally Qualified Health Centers, County Health Departments, Hospital based Primary Care Programs benefit from continued funding.
- Projects Include:
 - Poison Control Centers
 - Federally Qualified Health Centers
 - County Health Department Initiatives
 - Hospital Based Primary Care Initiatives
 - Premium Assistance Programs
 - Manatee, Sarasota, and Desoto County Emergency Room Diversion
 - STC 61 Tier One Milestone Distribution

Disproportionate Share Hospital Program (DSH) SFY 2014-2015 Model 1: \$239.3

DSH Program which provides financial support to hospitals serving a significant number of low-income patients.

- Federally capped program with limited allotments to each state.
- Seventy hospitals including the rural hospitals are recommended for Medicaid DSH payments.

The DSH Program distribution method remains the same as current policy and distribution.

DSH is authorized under federal law and not part of the 1115 Waiver LIP Pool.

Tier Distribution Funding SFY 2014-2015 Model 1: \$797.0 Million

In this model, payments are supplemental additions of dollars, not a policy adjustor. A provider can be in more than one tier – providers can be in tiers 1 and 3 or in tiers 2 and 3. A provider cannot be in both tiers 1 and 2.

Out of state providers participating in the Florida Medicaid program will not receive any IGT payments.

Low Income Pool Update

The Agency combined inpatient and outpatient automatic IGTs from FY 2013-14 to get the total figure for FY 2014-15.

IGT funds will only be distributed with inpatient claims. Assumed “total estimated inpatient spending” is total money spent from non-IGT sources – that is general revenue and PMATF. Assumed \$10 million from GR that is paid out with automatic IGTs in FY 2013-14 will continue to be paid out with IGTs in FY 2014-15.

Self-funded IGTs are no longer permitted.

Below is the total allocation by tier:

Total Automatic IGT Payment 2013/2014:	\$797,054,937		
	Tier 1	Tier 2	Tier 3
Percentage of IGT Funds:	35%	35%	30%
Tier Allocation (T*A):	\$278,969,228	\$278,969,228	\$239,116,481
Total General Revenue (T*TEIS):	\$663,287,387	\$191,749,102	\$1,599,062,772
Tier Percent Increase (T*PI):	0.421	1.455	0.150

THE FLORIDA SENATE
APPEARANCE RECORD

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

9/25/13

Meeting Date

Topic Medicaid

Bill Number _____
(if applicable)

Name Justin Senior

Amendment Barcode _____
(if applicable)

Job Title Deputy Secretary for Medicaid - AHCA

Address 2727 Mahan Drive, MS #8

Phone _____

Street

Tallahassee

FL

32308

City

State

Zip

E-mail _____

Speaking: For Against Information

Representing AHCA

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE
APPEARANCE RECORD

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

9/25
Meeting Date

Topic AHCA Pending Litigation

Bill Number _____
(if applicable)

Name Stuart Williams

Amendment Barcode _____
(if applicable)

Job Title AHCA General Counsel

Address 2727 Mahan Drive

Phone 412-3669

Tallahassee FL 32309
City State Zip

E-mail Stuart.Williams@AHCA.myflorida.com

Speaking: For Against Information

Representing AHCA

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE
APPEARANCE RECORD

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

9/25/13

Meeting Date

Topic Medicaid Managed Care

Bill Number
(if applicable)

Name Kyle Simon

Amendment Barcode
(if applicable)

Job Title Associate Director of Government Affairs

Address 3001 Aloma Ave Ste 202

Phone 407.520.6944

Street

Winter Park

FL

32792

City

State

Zip

E-mail Ksimon@bayada.com

Speaking: For Against Information

Representing BAYADA Home Health Care

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

9/25/13
Meeting Date

Topic Hospital Medicaid Funding

Bill Number _____
(if applicable)

Name Tony Carvalho

Amendment Barcode _____
(if applicable)

Job Title President

Address _____

Phone _____

T
Street
City

State Zip

E-mail _____

Speaking: For Against Information

Representing _____

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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CourtSmart Tag Report

Room: KN 412

Case:

Type:

Caption: Appropriations Subcommittee on Health and Human Services (412 Knott)

Judge:

Started: 9/25/2013 1:04:04 PM

Ends: 9/25/2013 2:23:49 PM

Length: 01:19:46

1:04:05 PM Meeting called to order
1:04:09 PM Roll call
1:04:46 PM Opening Remarks by Chairman
1:05:17 PM Tab 1 - Status Reports from the Agency for Health Care Administration:
1:05:31 PM Justin Senior, Deputy Secretary for Medicaid
1:14:50 PM Diagnosis Related Groups (DRGs) Implementation
1:15:04 PM Low Income Pool (LIP) Conversion and Waiver Request
1:27:57 PM Statewide Medicaid Residency Program Implementation
1:32:02 PM Status of Statewide Medicaid Managed Care Roll-out
1:47:16 PM Status of Medically Needy Waiver Request
1:52:35 PM Tab 1 - Status Reports from the Agency for Health Care Administration:
1:53:37 PM Stuart Williams, General Counsel
1:53:53 PM Lawsuits with Fiscal Implications
2:08:00 PM Public Testimonies:
2:09:00 PM Kyle Simon, Associate Director of Government Affairs, BAYADA Home Health Care
2:10:31 PM Tony Carvalho, President, Safetynet Hospital Alliance
2:22:43 PM Adjourned



THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:

Appropriations Subcommittee on Education, *Chair*
Agriculture
Appropriations
Appropriations Subcommittee on Health
and Human Services
Education
Gaming
Health Policy
Regulated Industries
Rules

SENATOR BILL GALVANO

26th District

September 25, 2013

Senator Denise Grimsley
306 Senate Office Building
404 South Monroe Street
Tallahassee, FL 32399

Dear Madam Chair Grimsley:

I am writing to request approval to be excused from the Appropriations Subcommittee on Health and Human Services meeting scheduled for September 25, 2013.

I appreciate your consideration in this matter.

Sincerely,

A handwritten signature in blue ink that reads "Bill".

Bill Galvano

cc.: Scarlet Pigott

REPLY TO:

- 1023 Manatee Avenue West, Suite 201, Bradenton, Florida 34205
- 326 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5026

Senate's Website: www.flsenate.gov

DON GAETZ
President of the Senate

GARRETT RICHTER
President Pro Tempore