The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Harrell, Chair
Senator Berman, Vice Chair

MEETING DATE: Tuesday, September 17, 2019
TIME: 9:00—10:30 a.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Harrell, Chair; Senator Berman, Vice Chair; Senators Baxley, Bean, Book, Cruz, Diaz, Hooper, Mayfield, and Rouson

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1		Introduction of State Health Officer and Surgeon General Scott A Rivkees	
2		Update on Hepatitis A Outbreak by Department of Health	
3		Health Care Facility Hurricane Preparedness by Agency for Health Care Administration	
4		Update on Rulemaking for Hospital Licensure by Agency for Health Care Administration	
5		Regional Perinatal Intensive Care Centers by John Curran, M.D.	
6		Update on Medicaid Behavior Analysis and Medical Foster Care Services by Agency for Health Care Administration	
7		Update on Children's Medical Services Program by Department of Health	
		Other Related Meeting Documents	

Florida Surgeon General, Dr. Scott A Rivkees

Dr. Scott A. Rivkees, the Florida Surgeon General, is focused on building a culture of health and prevention to protect, promote & improve the health of everyone who calls Florida home. As the Surgeon General, Dr. Rivkees also serves as State Health Officer for the Florida Department of Health. In this capacity, he oversees the operations of the state health office in Tallahassee, 67 County Health Departments, 22 Children's Medical Services area offices; 12 Medical Quality Assurance regional offices; nine Disability Determinations regional offices; and four public health laboratories.

Prior to his tenure as the Surgeon General, Scott A. Rivkees, M.D., served as chair of the Department of Pediatrics at the University of Florida College of Medicine and physician-in-chief of UF Health Shands Children's Hospital, part of UF Health Shands Hospital, the university's academic health center. He also served as academic chair of pediatrics at Orlando Health and the University of Florida College of Medicine pediatric chair at Studer Family Children's Hospital at Sacred Heart in Pensacola.

Dr. Rivkees is a graduate of Rutgers University and the University of Medicine and Dentistry. He received residency, fellowship, and postdoctoral training at Massachusetts General Hospital and Harvard Medical School, where he was also faculty. Before moving to Florida, Dr. Rivkees served as professor of pediatrics with tenure at Yale University, where he was Associate Chair for Research, and started and directed the Yale Pediatric Thyroid Center, one of the first of its kind in the United States.

Dr. Rivkees has worked for the National Institute of Health and the US Food and Drug Administration on drug safety issues. He is responsible for the safety alert about liver toxicity of the antithyroid drug propylthiouracil, which lead to major international treatment practice changes. For this effort, he was recognized as the 2018 recipient of the American Thyroid Association, Paul Starr Award.

During his career, Dr. Rivkees has been named "One of America's Best Doctors," "One of America's Top Pediatricians," and "One of New York's Best Doctors." He is a member of American Society for Clinical Investigation, the Connecticut Academy of Science and Fellow of the American Academy for the Advancement of Science. Dr. Rivkees is a recipient of the Pioneer Award from CARES as well as the Special Service Award from the American Academy of Pediatrics

He currently is Chair of the Board of Scientific Counselors for the Eunice Kennedy Shriver National Institute of Child Health and Human Development. He is the past Chair of the Advocacy Committee of Association of Medical School Pediatric Department Chairs, the past treasurer of the Florida Chapter of the American Academy of Pediatrics and was a member of the Pediatric Policy Council.

Dr. Rivkees has committed his career to building a culture of health that enables each adult and child in Florida to live a long and health life.

Department of Health

Hepatitis A
Public Health Emergency

Senate Committee on Health Policy
September 17, 2019

Department of Health

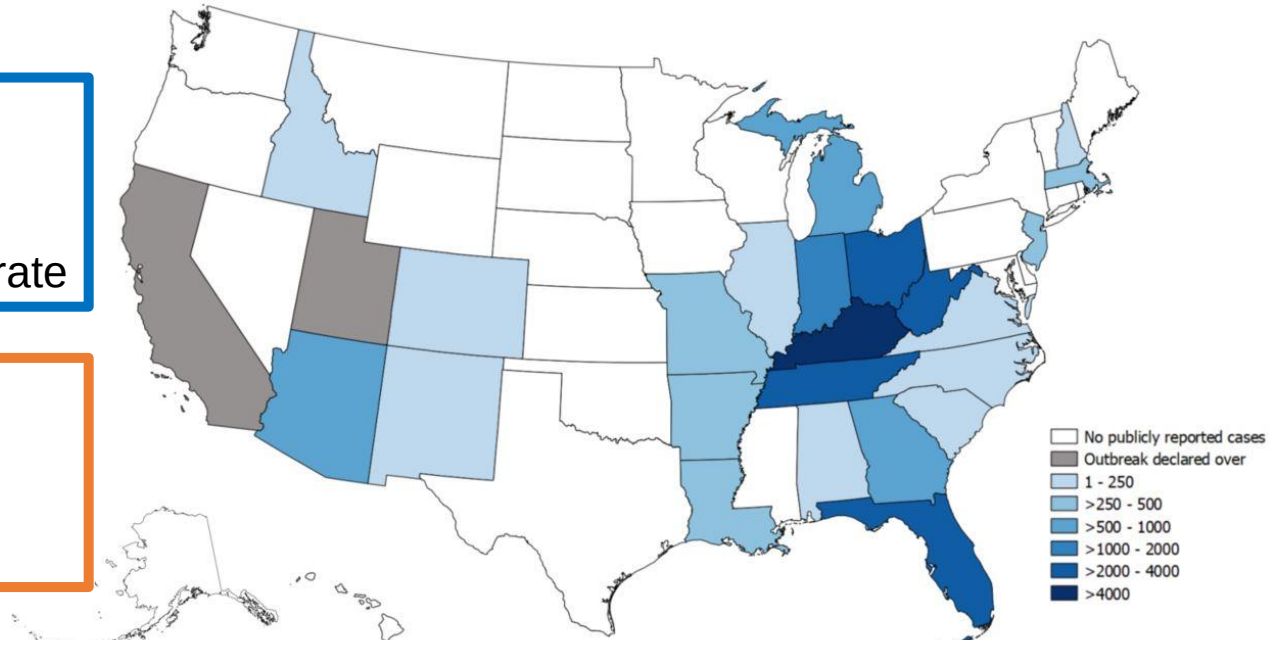
Scott A. Rivkees, M.D.
State Surgeon General

Department of Health

Hepatitis A: Part of a National Outbreak

NATIONAL DATA
- Cases: 25,484 as of 9/07/19
- Hospitalizations: 15,330 (60%)
- Deaths: 254, 1% case mortality rate

FLORIDA DATA
- Cases: 3,009 as of 9/07/19
- Hospitalizations: 2,357 (78%)
- Deaths: 40, 1.3% case mortality rate

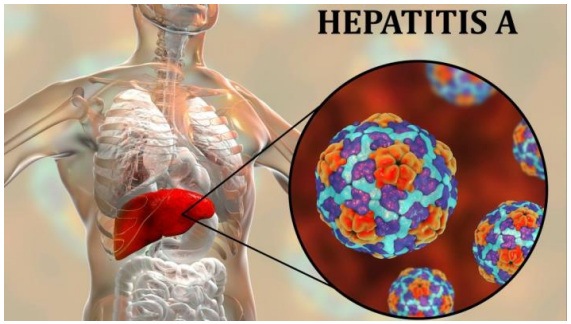


https://www.cdc.gov/hepatitis/outbreaks/2017March-HepatitisA.htm

Disease Overview

Hepatitis A is a highly contagious disease of the liver

- Transmitted through fecal-oral route that can be associated with poor hygiene
- Contagious two weeks before onset of symptoms and while symptomatic



- Symptoms may include fatigue, fever, decreased appetite, abdominal pain, nausea, diarrhea, jaundice and dark colored urine
- Disease usually starts 28 days after exposure, with a range of 15-50 days
- Preventable if vaccinated within 14 days of exposure
- 10% relapse rate

- ***Virus survives on surfaces for months: killed by bleach solutions***
- ***Not killed by alcohol-based hand sanitizers: handwashing is an important prevention component***

Department of Health

A Vaccine-Preventable Disease

- Children routinely vaccinated before their 2nd birthday since 2005
- 2-dose series, 6 months apart
- 1 dose, 93% of individuals are protected for 10 years
- 2 doses, ~100% protection
- Killed/inactivated virus
- Side effects are very rare

Department of Health

High-Risk & Vulnerable Patients in Florida

High-Risk Individuals

- Intravenous or non-intravenous illicit drug users
- Individuals who are homeless

Medically Vulnerable Individuals

- Individuals with underlying liver disease
- Individuals ≥60 years-of-age with a chronic medical condition

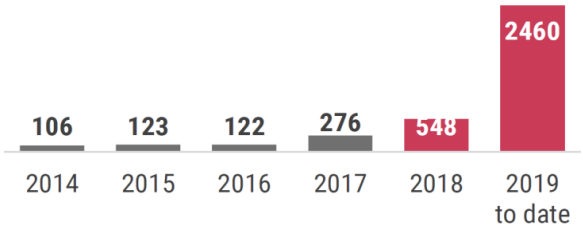
https://www.cdc.gov/hepatitis/hav/index.htm

Department of Health

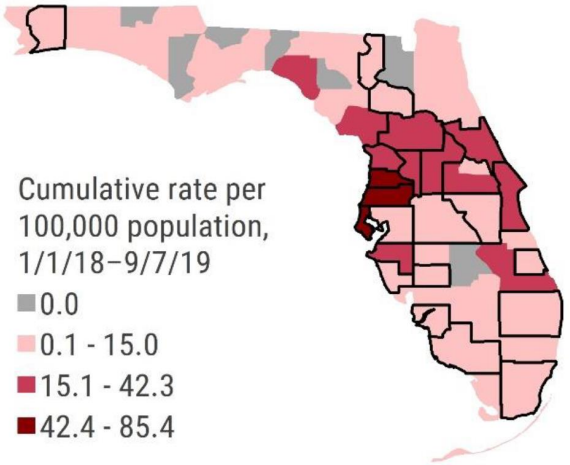
Tracking the Disease

The Department monitors Hepatitis A activity in Florida

- Surveillance is conducted across all 67 counties
- Weekly case reporting has occurred since October 8, 2018
- Since early 2018, Department staff have investigated over 3,077 persons for possible Hepatitis A
- 21 patron notifications have been made regarding cases associated with food handlers



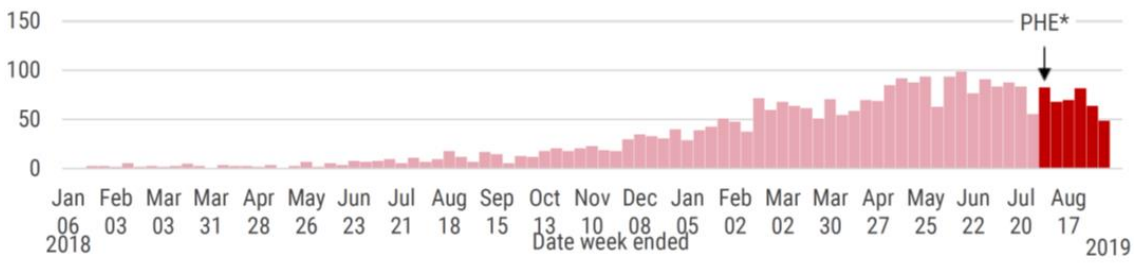
Through 09/07/2019



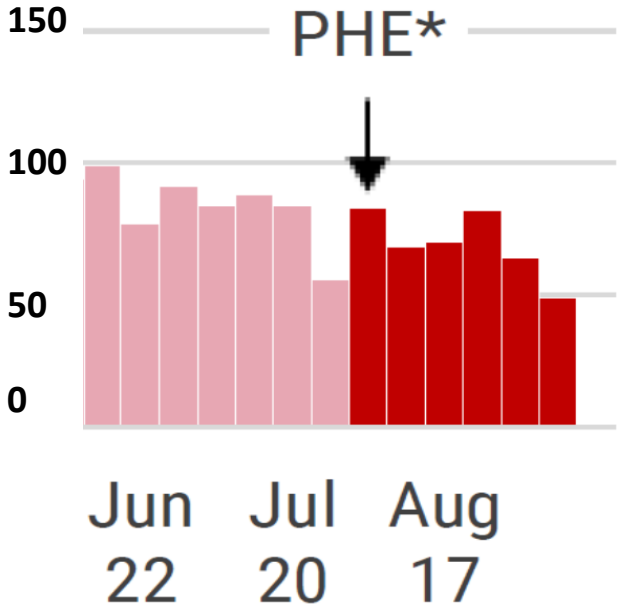
www.floridahealth.gov

Department of Health

Latest Update: New Hepatitis A Cases per Week



*PHE: Public Health Emergency Declared



Impact on Florida

40 deaths: 1.3% mortality rate vs. 1.0% nationally

- <60 years-of-age, 75% with underlying liver disease
- >60 years-of-age, 85% without underlying liver disease, but with a chronic medical condition

2,357 Hospitalizations

- 78% hospitalization rate vs. 60% nationally
- $77,000 in charges per admission
- $181,000,000 in estimated hospital charges

Department of Health

Public Health Emergency August 1, 2019

Includes all counties in Florida

Counties with a case rate greater than 10 per 100,000 persons or high case count (>100):

- Brevard
- Citrus
- Glades
- Hernando
- Hillsborough
- Lake
- Liberty
- Manatee
- Marion
- Martin
- Okeechobee
- Orange
- Pasco
- Pinellas
- Sumter
- Taylor
- Volusia

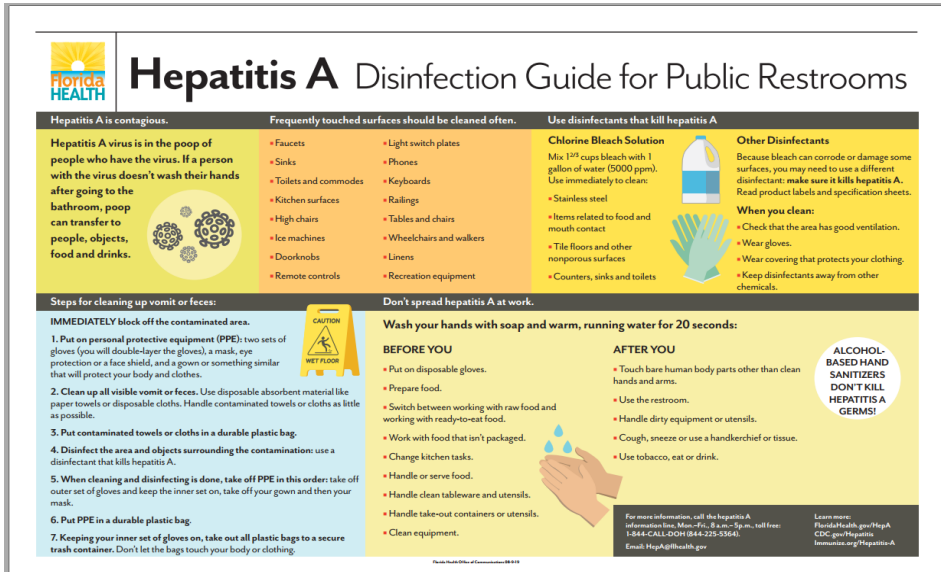
RECOMMENDATIONS

- Health care providers vaccinate high-risk patients
- Health care providers vaccinate medically vulnerable individuals
- Vaccinate individuals working with high-risk persons in a non-health care setting
- Health care providers report all cases of hepatitis A to county health departments
- Follow good handwashing procedures
- Cleaning of public shower, bathing, restroom facilities with bleach or other effective disinfectant solutions to kill the virus

Department of Health

Public Education Program: VEST

- **V**accination
- **E**ducation
- **S**anitation
- **T**racking



www.floridahealth.gov

Vaccination Strategy

CDC advises **80% vaccination of high-risk persons is necessary** to curtail a disease outbreak.
Estimated high-risk population of persons using illicit drugs and homelessness is 491,000 in Florida.

To achieve vaccination goals, the Department has:

- Increased resources to vaccinate high-risk individuals at county health departments (CHDs)
- Development of new approaches to reach high-risk individuals
- Enrolled 50 new partner organizations as vaccine providers with 35 additional enrollments in progress
- Partnered with county jails, homeless shelters and drug rehabilitation centers to conduct vaccination clinics
- Calls with hospital executives, Medicaid and commercial insurance providers, community groups, drug treatment centers
- Community education: web-based, print materials
- Agency partnerships: DCF, AHCA, DBPR, DOT, DEP
- Federal partnership: HHS/CDC

Department of Health

High-Risk and Vulnerable Population Estimates

High-Risk Population: CHD Primary Effort			Goal
Homeless	Illicit Drug Users	Total	80% of Total
64,000	427,000	491,000	392,000

Homeless Management Information System Data (provided by the CDC)
Substance Abuse and Mental Health Services (provided by the CDC)

Vulnerable Population	Liver Disease	>60 yrs Diabetes and/or Heart disease	Total Vulnerable Population
Estimated Numbers	338,500	>500,000	>838,500

FLHEALTHCHARTS.COM

Department of Health

Where to get vaccinated

- Health care provider
- Pharmacies
- County health departments
- Locations posted on www.floridahealth.gov
- Cost covered by commercial insurance
- Cost may be covered by Medicare Part D and Medicare Advantage plans
- Coverage being considered by some Medicaid plans
- County health departments will provide for free to high-risk, uninsured or underinsured individuals

Department of Health

Vaccines Administered

	January-December 2018	January-present 2019	Total Since 2018
CHD Administered Vaccine	17,940	82,875	100,815 83,733 High Risk
Non-CHD Administered Vaccine	31,384	121,667	153,051
Total Administered Vaccine	49,324	204,542	253,866

When can we expect control of the outbreak?

- Per CDC, need to vaccinate 80% of high-risk groups to begin to see major decline
- Gradual decline as target approached
- Outbreak will be declared over when it has been 100 days since the onset of illness of the last outbreak-associated case, which is two incubation cycles for hepatitis A

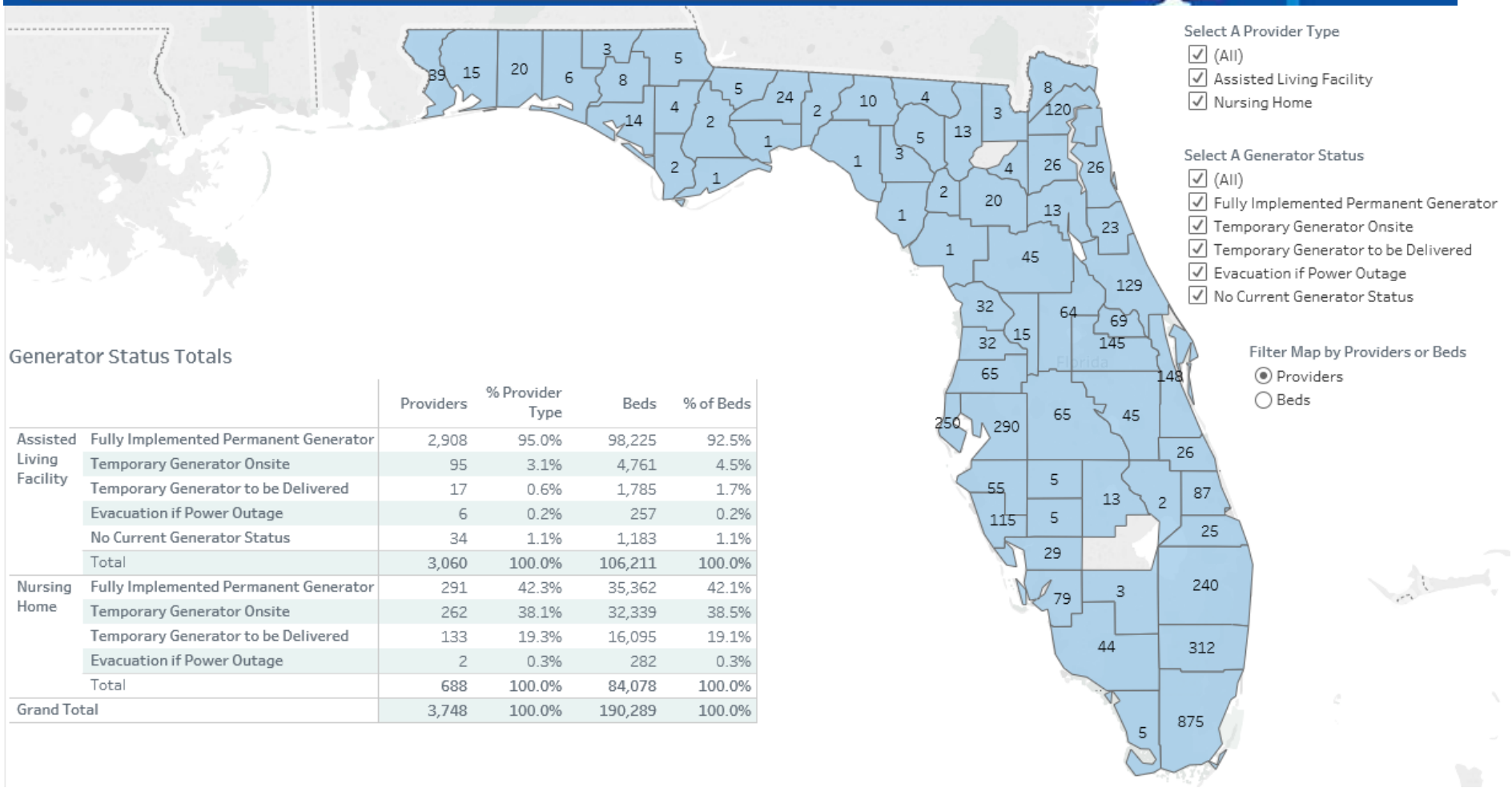
Thank you

Long Term Care Facility Emergency Power Status

Secretary Mary Mayhew
Agency for Health Care Administration

Senate Committee on Health Care
September 17, 2019

Generator Status Map



Select A Provider Type

- [x] (All)
- [x] Assisted Living Facility
- [x] Nursing Home

Select A Generator Status

- [x] (All)
- [x] Fully Implemented Permanent Generator
- [x] Temporary Generator Onsite
- [x] Temporary Generator to be Delivered
- [x] Evacuation if Power Outage
- [x] No Current Generator Status

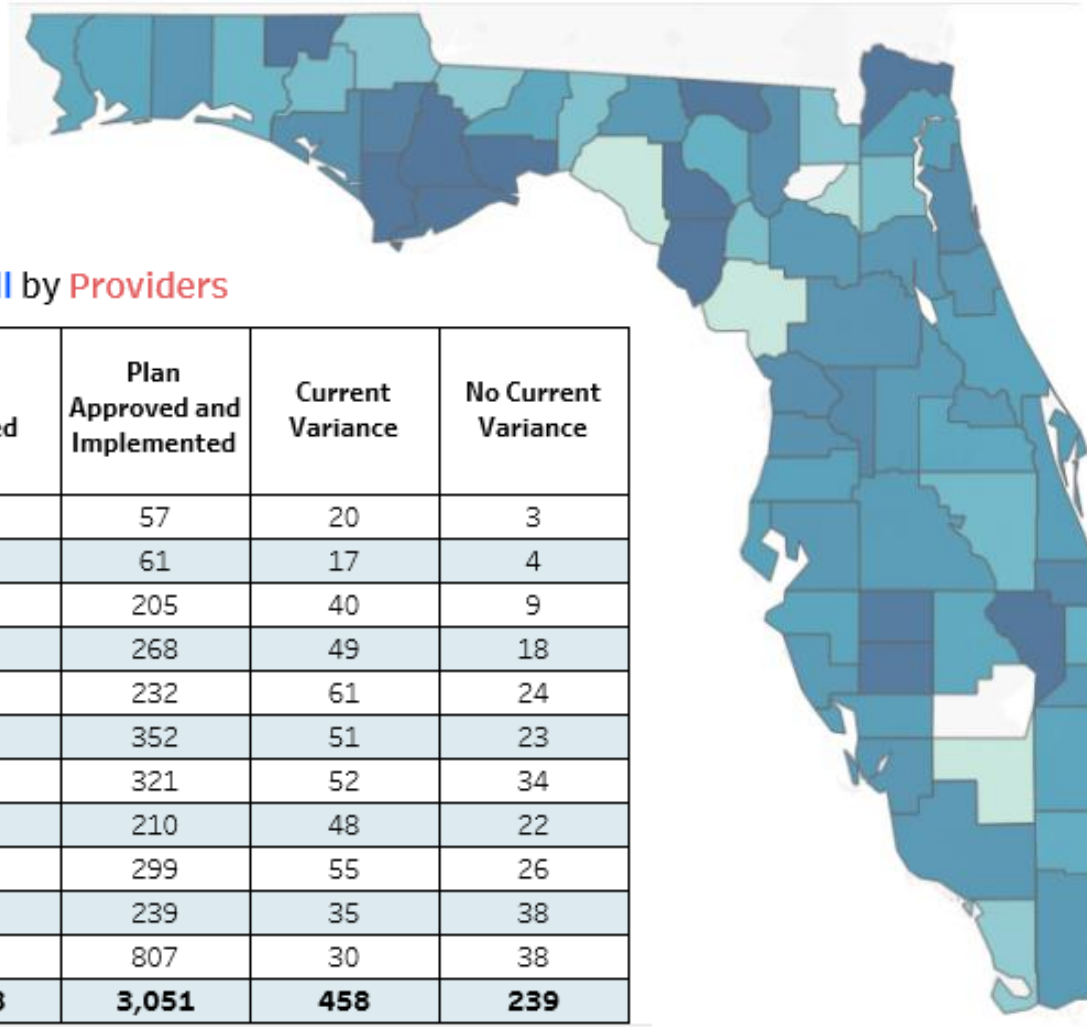
Filter Map by Providers or Beds

- (•) Providers
- ( ) Beds

Generator Status Totals

		Providers	% Provider Type	Beds	% of Beds
Assisted Living Facility	Fully Implemented Permanent Generator	2,908	95.0%	98,225	92.5%
	Temporary Generator Onsite	95	3.1%	4,761	4.5%
	Temporary Generator to be Delivered	17	0.6%	1,785	1.7%
	Evacuation if Power Outage	6	0.2%	257	0.2%
	No Current Generator Status	34	1.1%	1,183	1.1%
	Total	3,060	100.0%	106,211	100.0%
Nursing Home	Fully Implemented Permanent Generator	291	42.3%	35,362	42.1%
	Temporary Generator Onsite	262	38.1%	32,339	38.5%
	Temporary Generator to be Delivered	133	19.3%	16,095	19.1%
	Evacuation if Power Outage	2	0.3%	282	0.3%
	Total	688	100.0%	84,078	100.0%
Grand Total		3,748	100.0%	190,289	100.0%

Generator Compliance
Nursing Homes and Assisted Living Facilities



Region Totals for All by Providers

Region	Total Licensed	Plan Approved and Implemented	Current Variance	No Current Variance
01	80	57	20	3
02	82	61	17	4
03	254	205	40	9
04	335	268	49	18
05	317	232	61	24
06	426	352	51	23
07	407	321	52	34
08	280	210	48	22
09	380	299	55	26
10	312	239	35	38
11	875	807	30	38
Grand Total	**3,748**	**3,051**	**458**	**239**

Hospital Certificate of Need and Licensure

Molly McKinstry

Deputy Secretary

Agency for Health Care Administration

Senate Committee on Health Policy
September 17, 2019

Overview

- 2019 Certificate of Need (CON) Legislation HB 21
- Recent Hospital CON Decisions and Litigation
- Implementation of HB 21
- Current Hospital Licensure Process
- Remaining CON Programs

2019 Certificate of Need Repeal Effective July 1, 2019

- New general (Class I) hospitals (Acute Care, Long Term Care and Rural hospitals)
- Addition of new beds (any type) to an existing hospital
  - Licensure rules are being drafted specific to comprehensive medical rehabilitation (CMR) services, neonatal intensive care unit (NICU) services, psychiatric services and substance abuse services
  - Interim standards/requirements have been established based on CON Rules until licensure rules are adopted

2019 Certificate of Need Repeal Effective July 1, 2019

- New transplant programs in an existing hospital
  - Licensure rules are being drafted to establish licensure requirements related to transplant programs
  - Interim standards/requirements have been established based on CON Rules until licensure rules are adopted
- New tertiary services are special programs added to any existing hospital including Neonatal Intensive Care Units (NICU), comprehensive medical rehab (CMR), pediatric heart programs, and transplant programs including bone marrow
- Adding new beds for mental health or substance abuse to an existing hospital

2019 Certificate of Need Repeals Effective July 1, 2021

- New Specialty (Class II, III, IV) Hospitals Including:
  - Children's Hospitals
  - Rehabilitation Hospitals
  - Psychiatric Hospitals
  - Substance Abuse Hospitals
  - Intensive Residential Treatment Facilities for Children and Adolescents

Hospital Beds & Facilities CON Batching Cycle – February 2019

- Most recent hospital CON cycle (batch)
- 8 Applications
  - Freestanding Psychiatric – 1 applied / 1 approved
  - Freestanding Comprehensive Medical Rehab – 3 applied/ 2 approved
  - Comprehensive Medical Rehab Units* – 3 applied/ 3 approved
  - Level II NICU* - 1 applied / 1 approved

- Decisions issued June 7, 2019
- Challenge period ended July 1, 2019 -effective date of HB 21

Hospital CON Litigation

- February Hospital Batch (decisions June 2019)
  - 2 challenges originally filed - now withdrawn
    - Freestanding Psychiatric approval
    - Freestanding Comp Med Rehab (CMR) denial
- All acute care hospital cases have been dismissed as moot due to HB 21
- One appellate case pending

Transition to Licensure Requirements

- Enacting legislation (HB 21) retains the authority in specific CON rules for the sole purpose of maintaining licensure requirements until the agency has adopted rules for the corresponding services
- AHCA defined the sections of CON rules that apply and notified hospitals
- On July 3, 2019, AHCA posted notification of supplemental information expected with applications for tertiary services based upon the CON rules
- Applicants must describe their plan to meet these rules during licensure application

Comprehensive Medical Rehabilitation

Licensure expectations pending rule adoption:

- Separately organized units within a general hospital
- Provide services to Medicaid and Medicare recipients
- Medical director of rehabilitation must be board certified or board eligible physiatrist with at least two years of experience
- Services must be provided by qualified personnel and these services must include: rehabilitation nursing, physical therapy, occupational therapy, speech pathology, speech audiology, social services, psychological services, orthotic services and prosthetic services
- Must provide utilization reports to the agency/ Local Health Council

Neonatal Intensive Care Unit (NICU) Services

Licensure expectations pending rule adoption:

- Minimum NICU beds -10 Level II/15 Level III
- Minimum births - 1,000 Level II/ 1,500 Level III
- Staffing requirements for board certified/eligible neonatologists, physicians, nursing, and specialties
- Therapies and nurse ratios
- Key services available 24-hour basis
- Room size and equipment
- Emergency transportation
- Transfer agreements

Transplant Programs

Heart, Liver, Kidney, Bone Marrow, Lung and Others

Licensure expectations pending rule adoption:

- Qualified staff and specialties
- Staff and resources to support 24-hour transplant services
- Agreement with an organ procurement organization
- Age appropriate intensive care unit
- Detailed protocols for pre-, in-hospital and post-transplant
- Appropriate equipment,
- Lab, pathology and blood banking services
- Educational programs for staff and patients/families
- Data submission
- Volume requirements
  - Licensure rule volume evaluation in process
- Other requirements based including services for beds and research programs

Current Status

- Licensure Rules
  - Draft licensure rule language being developed
  - Anticipate formal rule development in October
    - Generally minimum six month process
    - Workshop with public comment
    - Proposed rules with public hearing
    - Adoption unless challenged
- No licensure applications submitted since repeal July 1, 2019

OPPAGA Study

- Authorizing legislation (HB 21) directed OPAGGA to study
  - Federal requirements and other state licensure of tertiary services
  - Make recommendations regarding minimum volume as applicable by November 1, 2019
  - May inform rule development

Pediatric Cardiac Service Rules

Recommendations of the Pediatric Cardiac Technical Advisory Panel

- Volume Requirements
- Personnel (Board-certified/eligible for select personnel)
- 24/7 staffing coverage
- 30 minute response time
- Specific service capabilities
- Onsite ambulatory care
- Physical plant (addressed in the Florida Building Code)
- Equipment (specific equipment attributes)
- Data reporting
- Society of Thoracic Surgeons participation for quality reporting

CON Condition Monitoring

- CON holders commit to providing certain services or certain levels of a service
- The most common CON condition is an agreement to serve a certain level of Medicaid residents
- Authority for CON conditions eliminated upon repeal

Acute Care Hospital Licensure Process

- **Applicants for new general** (acute care) hospitals
  - Required review and approval by the AHCA Office of Plans and Construction architects and electrical/mechanical engineers before facility construction is initiated and after construction is complete
  - Construction approvals must be completed before a hospital applicant can be licensed
- All same licensing requirements apply
  - Full application compliance
  - Inspections for licensure and Medicare/Medicaid

Hospital Licensure Steps

- Licensure applications must be submitted and include:
  - Neonatal Intensive Care Units (NICU) – Office of Plans and Construction, AHCA Life/Safety inspection
  - Comprehensive Medical Rehabilitation (CMR) – Office of Plans and Construction, AHCA Life/Safety inspection
  - Transplant Programs – Organ Procurement and Transplantation Network approval, Office of Plans and Construction, AHCA Life/Safety inspection, onsite survey for Medicare certification
  - Psychiatric and Substance Abuse programs – Office of Plans and Construction, AHCA Life/Safety inspection

Remaining Certificate of Need Programs

- CONs are required for:
  - New nursing homes and the addition of nursing home beds
  - New hospice, new hospice inpatient facility, add a new service area to a hospice
  - New intermediate care facilities for the developmentally disabled and the addition of beds
- CON includes
  - Competitive batched reviews
  - Expedited reviews
  - Exemptions
  - Annual monitoring of CON conditions
  - Biannual publications of utilization of services

THANK YOU

For more information:

http://ahca.myflorida.com/

http://ahca.myflorida.com/MCHQ/CON_FA/

Regional Perinatal Intensive Care Centers – John S. Curran MD

Proposed Statutory RPICC Amendments: Revision of F.S. 383.15 to 383.19

Senate Health Policy Committee – Sept. 17, 2019

The RPICC (Regional Perinatal Intensive Care Centers) Statute needs modification and update to contemporary health professional recommendations related to Florida's substantial population growth and standards most recently promulgated in Guidelines for Perinatal Care, 8th Edition (2017) of the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP). Florida as one of the most populous states should be a national leader in the deployment of these guidelines to enhance the quality of patient care, prevent maternal deaths, and decrease morbidity and mortality of newborn infants. Amendment of this statute provides an appropriate statutory vehicle to initiate efforts and collaboration by both the DOH and AHCA related to geographic access and evolving current health delivery systems and financing.

Rationale: The following cogent issues are identified

- Perinatal provisions in Chapter 383, F.S., passed in 1976 at a time when Health and Rehabilitative Services (HRS) was the responsible agency before the creation of either DOH or AHCA with the last technical modification in 2014; last revision of Department of Health RPICC rules was in 1996.
- There has been a substantial increase in Florida births from 115,113 in 1970 to 221,508 in 2018 – an increase of 92.4% in annual births! There are currently 115 hospitals delivering more than 100 babies/year in Florida.
- There are 11 RPICC's – 5 initiated in 1974 with last one added in Fort Myers in 1994.
- As of January 2019 Florida has 33 Licensed Level III NICU facilities with 909 beds and 69 Level II NICU facilities with 1,172 beds and **no** Licensed Level IV NICU Facilities
- Florida through AHCA does not currently define nor review separately Levels of Maternal Care. There are **no** designated licensed **levels of maternal care** commensurate with the RPICC or the recently published Perinatal Guidelines of ACOG/AAP 8th Edition.
- Maternal Mortality in Florida is above the national average (See Graphic on Reverse)
- Rule-making authority for the statutory designation of RPICC only exists for DOH; there is a need for Level IV Neonatal designation for complex neonatal surgery.
- Divided responsibility exists between DOH and AHCA for professional standards and resources (DOH) and licensure (AHCA) as tertiary services may be redefined.

Summary: ***Actions sought for proposed amendments which would grant authority to:***

- Add Level IV designation to certain RPICC facilities,
- Authorize additional RPICC facilities contemporary with Florida's doubling of births since enactment and to assure geographic access to needed services,

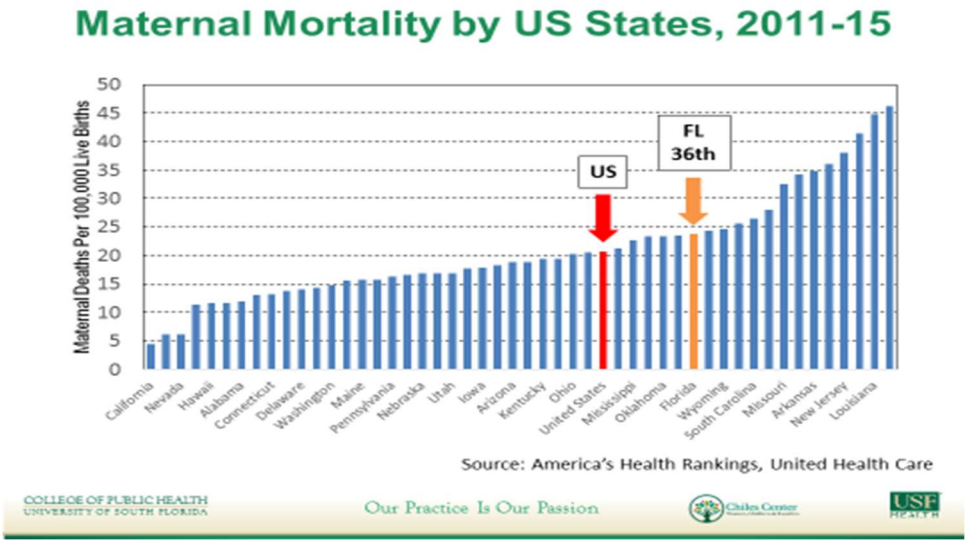
- Initiate a process to use ACOG Consensus Statement #9 to address and develop maternal levels of care with AHCA
- Direct DOH and AHCA to work together to mutually commence a not-longer-than-three-years process for defining levels of maternal care through a self-identification process using the CDC LOCATe template, followed by extramural verification, which would be consistent with national guidelines as supported by ACOG and the Society for Maternal Fetal Medicine,
- Require participation in a perinatal quality collaborative using active quality improve cycles with data reporting such as but not limited to the Florida Perinatal Quality Collaborative
- Periodically report patient quality and outcome data to both AHCA and DOH
- Ensure that any facility not continuing to maintaining such standards be subject to a corrective action plan or loss of such designation if not remedied within a reasonable period of time.

CDC Reference

The CDC template has been used successfully in a participative process for self-identification of Maternal Levels of Care. As of February 2019, a total of 15 states (California, Colorado, Delaware, Georgia, Illinois, Iowa, the southeast perinatal region of Michigan, Mississippi, New Hampshire, New Mexico, North Carolina, Oklahoma, Tennessee, Utah, and Wyoming) and Puerto Rico are participating in CDC LOCATe.

The CDC Levels of Care Assessment for Maternal Care is well documented at:
https://www.cdc.gov/reproductivehealth/maternalinfanthealth/LOCATe.html

Maternal Mortality Graphic



NO MATERIALS AVAILABLE

Children's Medical Services Health Plan

Senate Committee on Health Policy
September 17, 2019

Cheryl Young, Director
Office of Children's Medical Services Managed Care Plan & Specialty Programs

CMS Health Plan 3.0

- CMS 1.0 (1970s to 2014) – Where we started
  - Direct services through specialty clinics
  - Care coordination to clinically eligible children Chronically Medical Complexity (CMC) with state health insurance
- CMS 2.0 (Aug 2014) – Launching into managed care
  - Florida Department of Health/CMS as a Managed Care Organization (MCO)
  - 62,000 CSHCN in Florida choose the CMS Health Plan
- CMS 3.0 (Feb 2019) – Improved delivery system for Children and Youth with Special Health Care Needs (CYSHCN), Improved administration and governance by DOH
  - CMS as a (MCO) with an improved delivery system for CMC/CSHCN
  - **69,322 CSHCN in Florida choose the CMS Health Plan (as of August 2019 compared to 63,378 one year ago)**

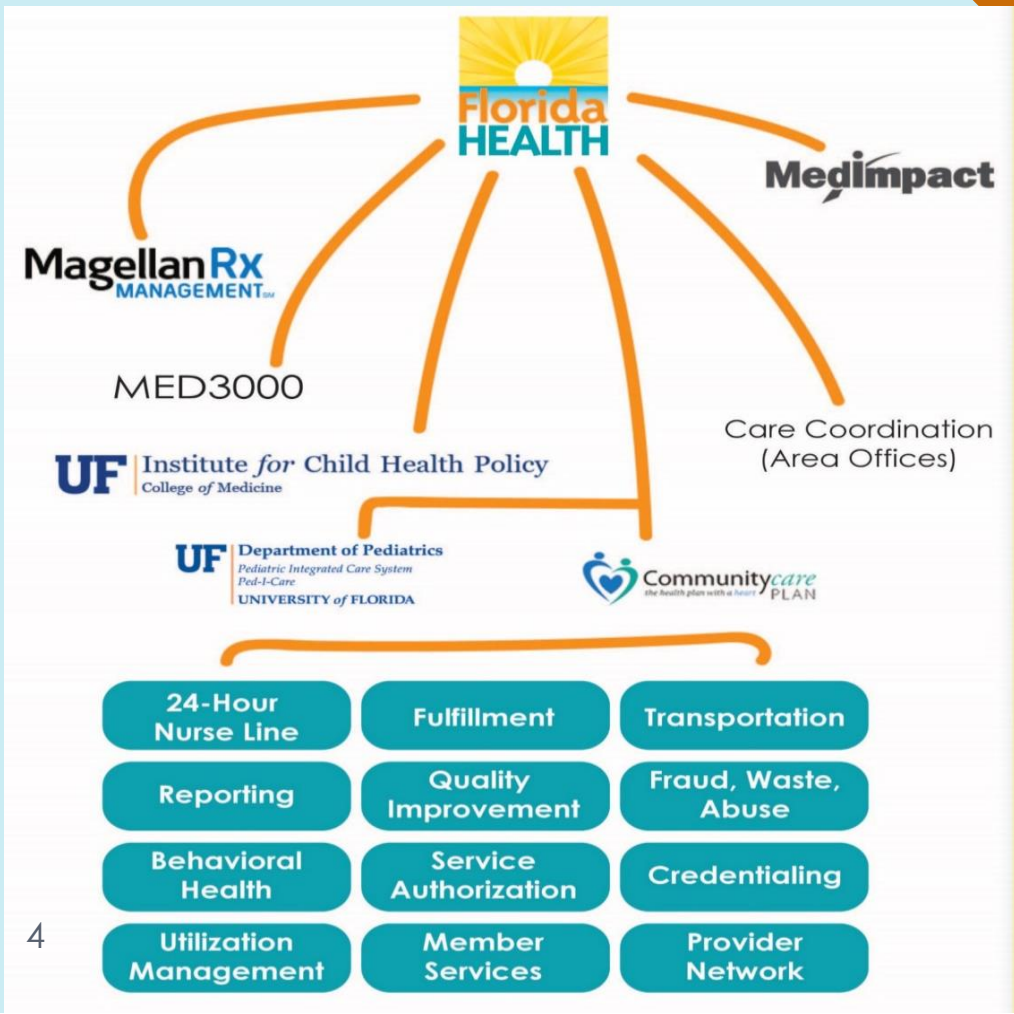
Children's Medical Services Health Plan
Enrollment Increases

Membership in the CMS Plan pre- and post- improved model. Marketing activities began June 2019.

Enrollment Month	Title XIX (Medicaid)	Title XXI (KidCare)
July 2018	51,646	11,732
August 2018	51,983	11,864
September 2018	52,495	12,233
October 2018	52,963	12,368
November 2018	53,197	12,543
December 2018	53,427	12,596
January 2019	54,174	12,623
February 2019	54,182	12,731
March 2019	54,561	12,613
April 2019	54,656	12,537
May 2019	55,150	12,713
June 2019	55,527	12,843
July 2019	55,932	12,834
August 2019	56,418	12,905
September 2019	57,011	~12,975

Nearly 70,000 Children and Youth with Special Health Care Needs (CYSHCN) in Florida choose the CMS Plan, compared to less than 65,000 one year ago

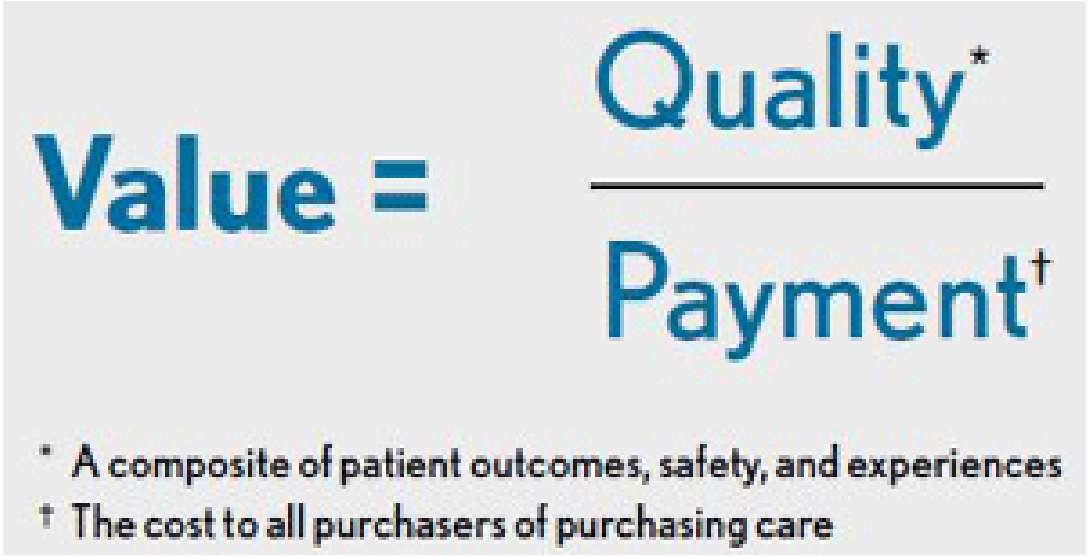
Yesterday



Today

"Value-Based Care"

- Physicians and hospitals are paid for improving the health of patients with chronic illnesses and for keeping healthy patients healthy
- Process is evidence-based, data driven
- Similar term: "value-based purchasing"
- Designed around patients and quality
- Coordinated care



Children's Medical Services Plan
Transition Facts

- CMS employees hired by WellCare
  - UF/Ped-O-Care pediatric medical director
  - Other DOH CMS leaders
  - >130 CMS care coordinators hired by WellCare– still hiring to reach 500+ CMS dedicated team
- MD provider network with 92% overlap
  - 16,000 plus providers, 11,000 plus eligible for enhanced payment
  - Specialists as Primary Care Physicians (PCPs) also, required telemedicine
- 180 day "continuity of care" provision
- DOH Oversight and Governance

Children's Medical Services Plan
FOCUS ON FAMILIES

- Goals met for transition for families and providers
- "Warm hand-offs" for especially fragile children
  - Technology dependent
  - Skilled nursing facility, private duty nursing
  - Medical Foster Care (MFC)
  - Partners in Care: Together for Kids (PIC:TFK) (Palliative Care)
- Regional and local office "transition" staff through June 2019
- Rapid issue resolution and partnership, ombudspersons and additional hotlines

Sample Family Info: New CMS Plan Model—*What Is Changing*

- Enhanced care coordination and better care coordination ratios
- Improved outcomes through physician payment
  - Quality outcomes
  - Mental/physical health
  - Telehealth
- In-lieu-of and expanded benefits for families

Children's Medical Services Plan
Physician Incentive Program

As of June 2019:

- Physicians enrolled as CMS providers: 16,761
- Physicians enrolled as CMS providers qualifying for enhanced payments: 11,539
- Comments:
  - 11,539 qualifying for enhanced payments reflects the Managed Medical Assistance (MMA) Physician Incentive Program (MPIP).
  - WellCare is also in the process of developing additional physician incentive programs for the CMS Health Plan, most notably the "Partnership for Quality" (P4Q) program which is typically offered to 100% of PCPs with assigned members.

New Benefits for Families

Enhanced Benefits

- Housing assistance
- Caregivers behavioral health assistance
- Carpet cleaning
- Over-the-counter products
- Tutoring services
- Swimming lessons

In-lieu-of Benefits

- Emergency respite
- Equine, art and music therapies
- Mobile crisis assessment and intervention
- Crisis stabilization units
- Transition from skilled nursing facility to private home setting

Subject to final approval

Care Coordination: Quality Enhancements

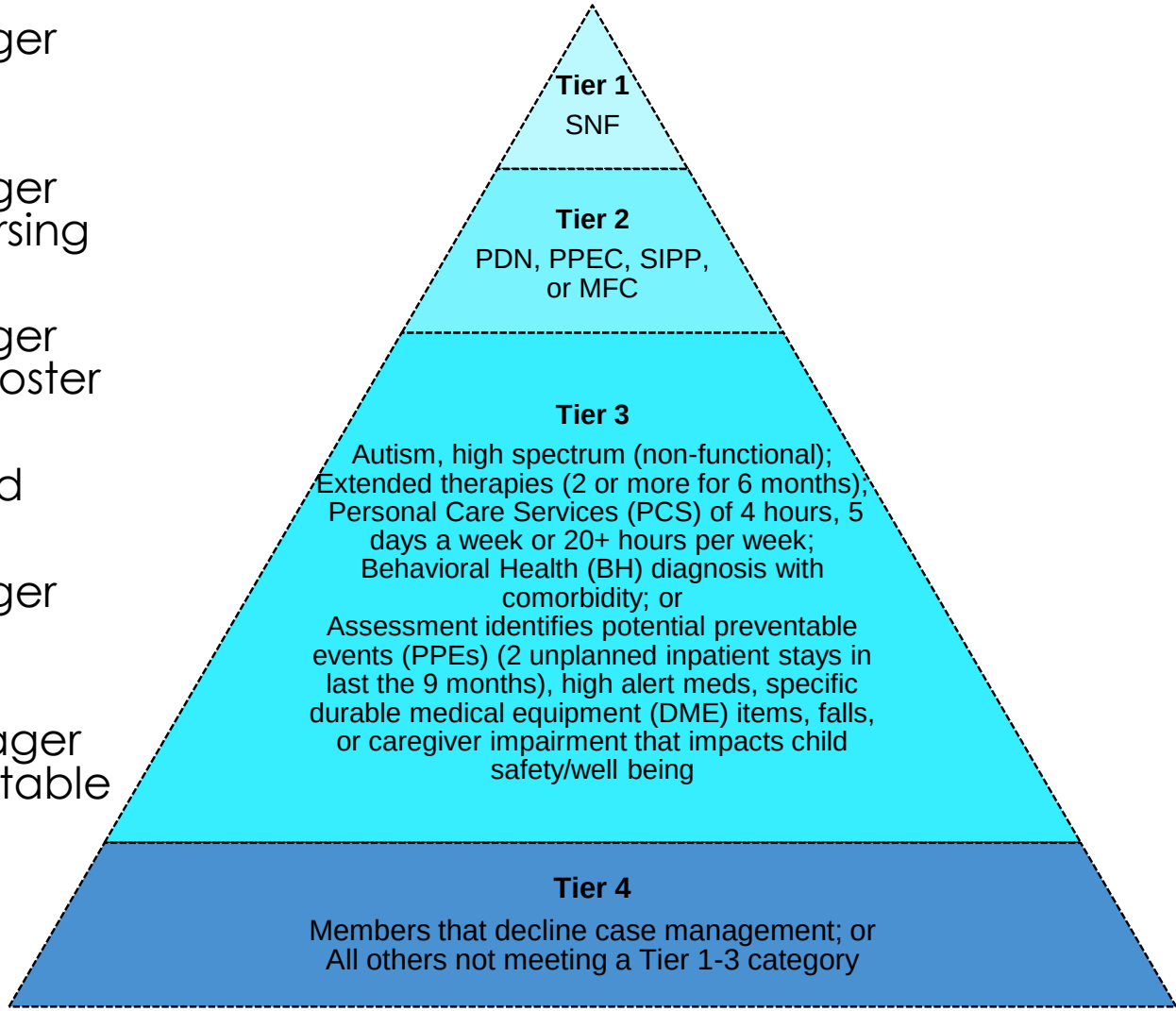
Health-related, community-based services offered and coordinated by WellCare, but not separately reimbursed include:

- A searchable database of community resources available to families and Care Coordinators/Care Managers
- Screens for signs of domestic violence and referral services
- Pregnancy prevention programs for adolescents
- Agreements with local Healthy Start Coalitions
- Nutritional assessment and counseling to all pregnant and postpartum enrollees and their children
- Outreach to enrollees in and at risk of juvenile justice system involvement

Care Management

Caseload/Staffing Ratios

- 15 members to one care manager for children residing in nursing facilities
- 40 members to one care manager for children with private duty nursing in the community
- 40 members to one care manager for children within the Medical Foster Care Program
- Care Plan must be reviewed and signed by Medical Director
- 90 members to one care manager for children stratified as high/moderate risk
- 200 members to one care manager for those whose conditions are stable or who are in a care monitoring status within care management



Children's Medical Services Plan
Care Management

Case Management Acuity	Tier 1 High	Tier 2 Medium	Tier 3 Low	Tier 4 Disease Management
Caseload Max per Care Manager	15	40	90	200
Face-to-Face	2/month	1/month	1/quarter	
Telephone contacts	2/month	1/month	1/month	1/quarter
Plan of Care Review	1/month	1/month	1/month	1/year
Plan of Care Update	3 months (quarterly)	6 months (semiannually)	6 months (semiannually)	12 months (annually)
Multidisciplinary Team (MDT) Meetings	6 months (semiannually)	6 months (semiannually)	As needed	As needed
Reassessment	12 months (annually)	12 months (annually)	12 months (annually)	12 months (annually)
Quality of Life Survey	Initially, Annually	Initially, Annually	Initially, Annually	Initially, Annually

Care Coordination / Care Management Overview – Special Programs

Building out specialized programs and initiatives for children with special needs and their families

Child-Focused Programs and Initiatives
Early Steps Dedicated to assisting the ~4,400 current CMS members 0-3 years
WellCare at School Dedicated to assisting the ~49,000 current school-age CMS children and youth
Transition Milestones Dedicated to assisting the ~25,000 current CMS youth who are 12 years of age or older
Community Connections Information and referrals for children and caregivers through CAL and QE database
Consumer and Provider Advisory Committees Allow us to gather children- and family-centered insights and experience from children, families and caregivers, providers, community-based organizations, and advocates.

Leveraging *WellCare at Home* fully integrated care model

- Ensures children and families are active, core partners in decision making
- Deliver services and supports in a culturally competent, linguistically appropriate, and accessible manner
- Access to affordable, comprehensive, and continuous care
- Facilitate access to evidence-based (or evidence-informed)
- Address physical, behavioral health, pharmacy, and social support needs of children and families across settings
- Features integrated, multi-disciplinary, regionally-based Care Management Teams (co-located where children and families reside)
- Specialized roles
- Person and family-centered care planning
- Fully integrated clinical platform
- Regionally-based *Welcome Rooms*
- Pharmacist-performed medication reconciliation

Quality Improvement: Performance Measures

Total of 42 Performance Measures across various domains including 10 new proposed Child Health measures. The ten new measures include:

- ED visits per 1,000 member months
- Percentage of children ages 10–17 months receiving a developmental screening
- Rate of hospitalization for non-fatal injury per 100,000 children ages 0–9 and adolescents 10–19
- Percentage of adolescents with a preventive medical visit in the past year
- Adolescent Screening for Depression
- New enrollees provided initial health assessment within 30 days and completed person-centered plan within 45 days of enrollment
- Use of PCMHs
- Proportion of children receiving services in a medical home
- Percentage of youth reporting transition in place
- Quality of Life Survey results reported

CMS Plan/Specialty Programs Vision

Every child with special health care needs (esp. CMC) has **access to high-quality, evidence-based, family-centered medical care, regardless of health insurance**.

- Appropriate quality measures (health plan, programs)
- Regional Networks for Access and Quality (R-NAQs)and Statewide Networks for Access & Quality (S-NAQs)
  - Essential infrastructure for quality improvement, team-based care
  - Health and well-being of ALL children – because CYSHCN are especially vulnerable to their environment
  - Community partnerships and other state programs

CMS Health Plan – Option of choice for families/CMC

Questions/For more information:

www.CMSPlanFlorida.gov

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Division of Children's Medical Services

Senate Committee on Health Policy
September 17, 2019

Cassandra G. Pasley, BSN, JD, Director
Division of Children's Medical Services
Early Steps Program

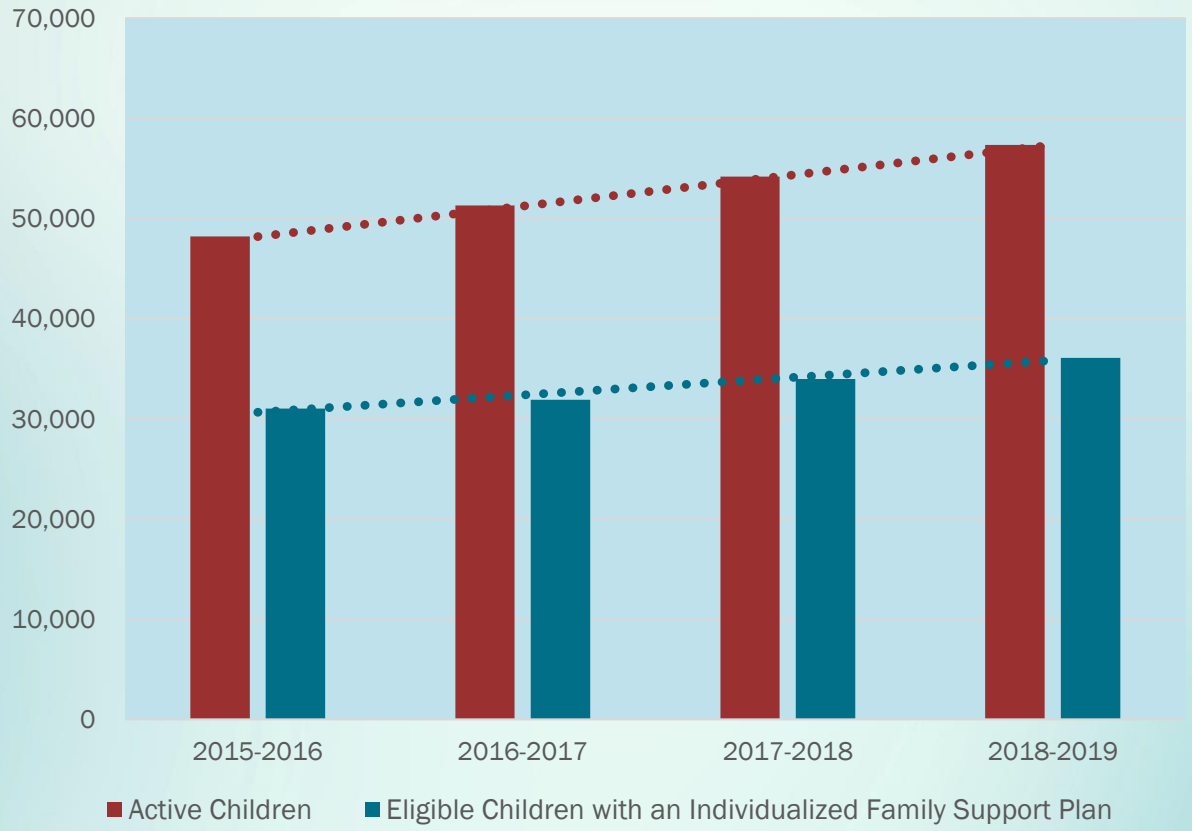
Florida HEALTH
Children's Medical Services

Early Steps Eligibility

Eligibility	
Age	Children birth to 36 months
Developmental Delay; OR	Children who do not meet developmental milestones at expected times in one or more of the following areas: cognitive, motor, communication, social/emotional, or adaptive/self help
Established Condition; OR	Children with conditions known to cause developmental delays, such as: Down Syndrome, Cerebral Palsy, or Spina Bifida
At-risk Condition	Children with conditions that have a high likelihood of causing a delay, such as: Traumatic Brain Injury, Neonatal Abstinence Syndrome, and Low Birth Weight

Florida HEALTH Children's Medical Services

Number of Children Served



*Active children are those for whom action was taken at some point during the fiscal year, including those eligible with an IFSP, referred and found not eligible, and those yet to complete the eligibility determination process.

**An IFSP is an Individualized Family Support Plan developed by the Local Early Steps evaluation team and the child's family after eligibility determination.

Early Steps Services

December 1, 2018; January 1, 2019; February 1, 2019
Services Transitioned into Managed Care

- Developmental Evaluations
- Developmental Screenings
- Targeted Case Management
- Early Intervention Sessions

August 2014
Services Transitioned into Managed Care

- Assistive Technology Devices and Services
- Audiology
- Health and Medical Services
- Nursing
- Nutrition
- Occupational, Physical, and Speech Therapies
- Psychological Services
- Social Work
- Hearing and Vision Services

Transition Priorities

- Services to children are not disrupted.
- Providers are paid.
- All Florida programs and providers remain in compliance with:
  - State laws.
  - Individuals with Disabilities Education Act (IDEA), Part C, and
  - Medicaid rules and regulations.

Transition Activities

- Claims
  - Provided technical assistance to Local Early Steps (LES) to address barriers to successful claims submission and payment, including linking existing Early Steps Data System to a claims processing clearinghouse.
  - Contracted with experienced-billing organization to provide support to LES and provided additional billing personnel to LES through a staffing agency.
  - The Agency for Health Care Administration (AHCA) initiated an expedited complaint resolution process and extended the Continuity of Care period.
- Technical Assistance
  - Federal technical assistance center provided resources on other states implementation of Managed Care.
  - Created a specialized team at the Department of Health to provide targeted technical assistance to LES.

Transition Activities (continued)

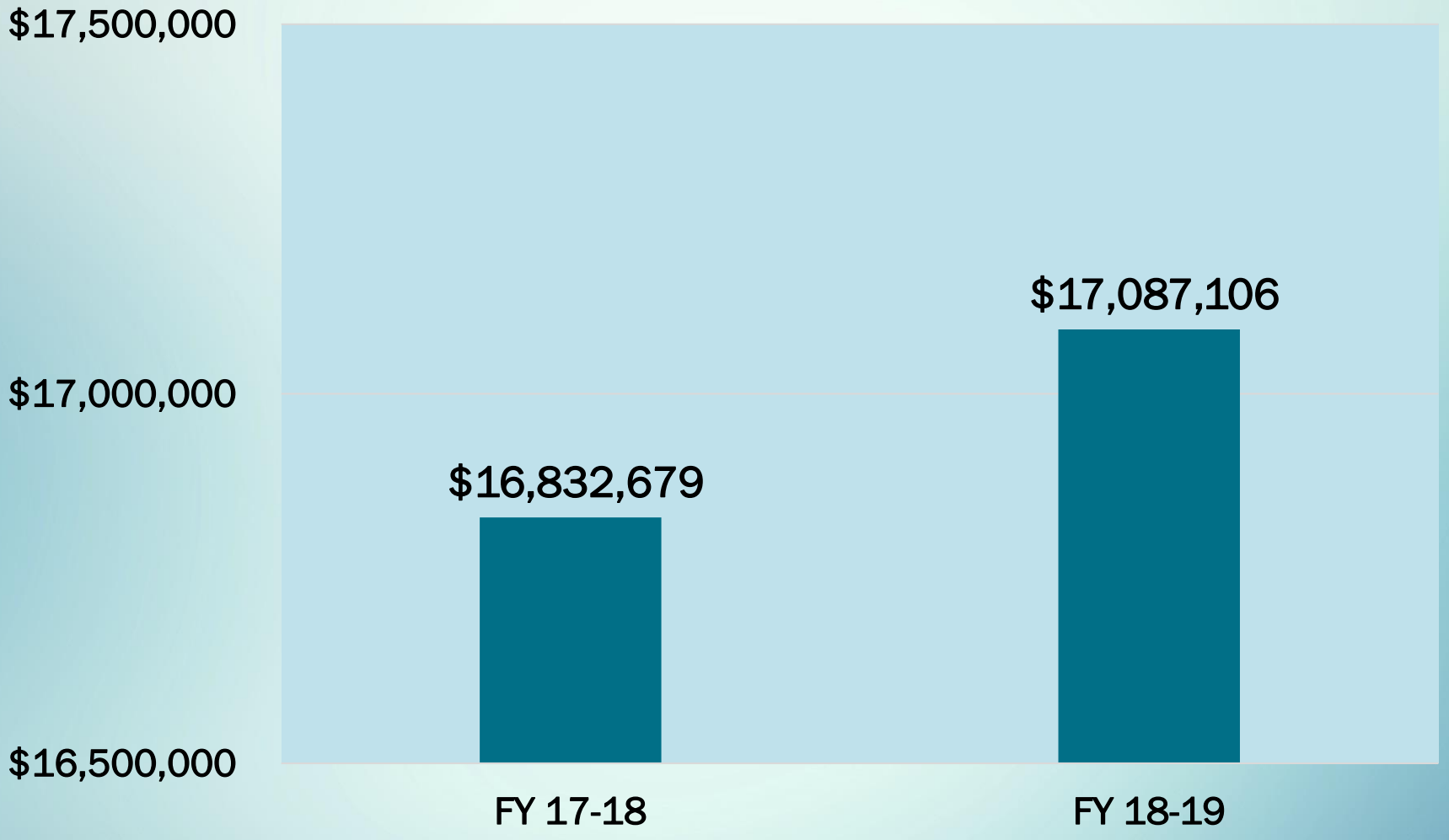
- Communication
  - Routine conference calls to identify and address any challenges during the transition and shared best practices.
  - In-person and web-based meetings including the Department of Health, AHCA, LES, community providers, and Managed Medical Assistance (MMA) Plans.
  - Updated the Florida Interagency Coordinating Council for Infants and Toddlers and received feedback.

Timely Eligibility Requirement

- Children referred to Early Steps must receive an initial evaluation, assessment, and Individualized Family Support Plan within 45 days of being referred (*34 CFR §303.310 (a)*).

	1/2018 - 6/2018	1/2019 - 6/2019
Eligible Infants and Toddlers Receive an Individualized Support Plan within 45 days of referral	88.7%	89.8%

Medicaid Early Intervention Services Payment to Providers



Lessons Learned

- Communication and coordination with partners is critical to ensure a holistic approach for integrated service delivery.
  - Early intervention providers have a unique set of skills and expertise; therefore, MMA Plans require LES providers to strengthen their provider networks.
  - LES continue to work with MMA Plans to ensure providers are paid for services rendered, which ensures compliance with the IDEA, Part C payor of last resort requirement.

Next Steps

- AHCA, in partnership with the Department of Health, is initiating a stakeholder group that includes providers and health plans to implement program enhancements based on lessons learned during the transition.
- Continue to ensure children are served, providers are paid, and programs remain in compliance with laws, rules, regulations, and policies.