

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL: PCS/SB 916 (188616)

INTRODUCER: Appropriations Subcommittee on Health and Human Services and Senator Grimsley

SUBJECT: Statewide Medicaid Managed Care Program

DATE: April 17, 2017

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	Favorable
2.	Forbes	Williams	AHS	Recommend: Fav/CS
3.			AP	
4.			RC	

I. Summary:

PCS/SB 916 modifies the Statewide Medicaid Managed Care program (SMMC) and deletes obsolete provisions from the implementation of the program. The bill specifically:

- Deletes the fee-for-service reimbursement option for provider service networks (PSNs);
- Revises the requirements for the contents of the databook used for rate setting to be consistent with actuarial rate-setting practices and standards;
- Collapses regions, re-groups counties within new regions, and revises the plan limitations within the regions for the procurement process for the Medicaid Managed Medical Assistance (MMA) and Long-Term Care (LTC) components; and
- Removes obsolete provisions.

The bill has no impact on state revenues or expenditures.

The effective date of the bill is July 1, 2017.

II. Present Situation:

Florida Medicaid

The Medicaid program is a partnership between the federal and state governments to provide medical care to low income pregnant women, children and disabled persons. Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare and Medicaid Services (CMS). The state plan outlines Medicaid eligibility standards, policies, and reimbursement methodologies.

Florida Medicaid serves as the safety net to Florida’s healthcare delivery system. Medicaid currently is the second largest expenditure in Florida’s budget behind education and covers 20 percent of all Floridians, including:

- 47 percent of Florida’s children;
- 63 percent of Florida’s births; and
- 61 percent of Florida’s nursing home days.¹

However, Florida Medicaid does not cover all low-income Floridians. The maximum income limits for programs are illustrated below as a percentage of the federal poverty level (FPL).

Florida’s Current Medicaid and CHIP Eligibility Levels in Florida ² (With Income Disregards and Modified Adjusted Gross Income)						
Children’s Medicaid			CHIP (Kidcare)	Pregnant Women	Parents Caretaker Relatives	Childless Adults
Age 0-1	Age 1-5	Age 6-18	Ages 0-18			
206% FPL	140% FPL	133% FPL	210% FPL	191% FPL	31% FPL	0% FPL

Florida Medicaid is administered by the AHCA and is financed with federal and state funds. The Department of Children and Families (DCF) determines Medicaid eligibility and transmits that information to the AHCA. As the single state agency for Medicaid, the AHCA has the lead responsibility for the overall program.³

Applicants for Medicaid must be United States citizens or qualified noncitizens, must be Florida residents, and must provide social security numbers for data matching. While self-attestation is permitted for a number of data elements on the application, most components are matched through the Federal Data Services Hub.⁴ Applicants must also agree to cooperate with Child Support Enforcement during the application process.⁵

The structures of state Medicaid programs vary from state to state, and each state’s share of expenditures varies and is largely determined by the federal government. Federal law and regulations set the minimum amount, scope, and duration of services offered in the program, among other requirements. State Medicaid benefits are provided in statute under s. 409.903, F.S. (Mandatory Payments for Eligible Persons) and s. 409.904, F.S. (Optional Payments for Eligible Persons).

¹ Agency for Health Care Admin., Senate Health and Human Services Appropriations Subcommittee Presentation, *Agency for Health Care Administration - Florida Medicaid* (January 11, 2017), slide 2, http://www.flsenate.gov/PublishedContent/Committees/2016-2018/AHS/MeetingRecords/MeetingPacket_3554.pdf (last visited Mar. 14, 2017).

² U.S. Centers for Medicare and Medicaid Services, Medicaid.gov, *Florida*, <http://www.medicare.gov/medicaid-chip-program-information/by-state/florida.html> (last visited Mar. 14, 2017).

³ See s. 409.963, F.S.

⁴ Florida Dep’t of Children and Families, *Family-Related Medicaid Programs Fact Sheet*, p. 3 (April 2016), <http://www.dcf.state.fl.us/programs/access/docs/Family-RelatedMedicaidFactSheet.pdf> (last visited Mar. 15, 2017).

⁵ Id.

Minimum eligibility coverage thresholds are established in federal law for certain population groups, such as children, as well as minimum benefits and maximum cost sharing. The minimum benefits include items such as physician services, hospital services, home health services, and family planning.⁶ States can add benefits, pending federal approval. Florida has added benefits, including prescription drugs, adult dental services, and dialysis.⁷ For children under age 21, the benefits must include the Early and Periodic Screening, Diagnostic and Treatment services, which are those health care and diagnostic services and treatment and measures that may be needed to correct or ameliorate defects or physical and mental illnesses and conditions discovered by screening services, consistent with federal law.⁸

Waivers to the state plan may be requested and negotiated by the state through the federal Centers for Medicare and Medicaid Services (CMS) by the AHCA. Florida has several such Medicaid waivers, including one that implemented the Statewide Medicaid Managed Care (SMMC) program. Current federal law requires the state to obtain a waiver to implement managed care. Through these waivers, the states have limited flexibility to design their Medicaid programs; however, even within waiver authorities, federal regulations prescribe requirements for benefits, delivery systems, cost sharing limitations, and population coverages.

Statewide Medicaid Managed Care (SMMC)

The SMMC program is currently designed for the AHCA to issue invitations to negotiate (ITN) and competitively procure contracts with managed care plans in 11 regions of the state to provide comprehensive Medicaid coverage for most of the state's enrollees in the Medicaid program. The 11 regions reflect areas that were initially set by the original Department of Health and Rehabilitative Services which was re-organized and downsized into several smaller agencies in the 1990s.

The SMMC has two components: managed medical assistance (MMA) and long-term care managed care (LTC). The MMA waiver expires on June 30, 2017, and the LTC waiver was recently extended through December 27, 2021.⁹

The LTC component began enrolling in August 2013 and completed its statewide roll-out in March 2014. The MMA component began enrolling Medicaid recipients in May 2014 and finished its roll-out in August 2014. These contracts will be re-procured in 2017 with contract execution and implementation expected during the last part of 2018, according to the AHCA.

The chart below shows the enrollment in each of these components as of March 1, 2017:

⁶ Section 409.905, F.S.

⁷ Section 409.906, F.S.

⁸ See Section 1905 9(r) of the Social Security Act.

⁹ The current Managed Medical Assistance waiver is approved as an 1115 waiver and was last approved for the time period of July 31, 2014 through June 30, 2017. The Long-Term Care Managed Care waiver is approved as a section 1915(b) and section 1915(c) combination waiver and was most recently approved through December 27, 2021 by the federal Centers for Medicare and Medicaid Services.

Statewide Medicaid Managed Care - March 2017			
Component	Enrollment Start Date	Budget¹⁰	Enrollment¹¹ (as of Mar. 2017)
Long-Term Care Plan	August 2013	\$3.97 billion	94,803
Managed Medical Assistance	May 2014	\$14.4 billion	3,233,235

The LTC program provides services in two settings: nursing facilities or home and community based services (HCBS) such as a recipient's home, an assisted living facility, or an adult family care home. Nursing facility services are an entitlement program for eligible enrollees and no waitlist exists; however, HCBS are delivered through waivers and are dependent on the availability of annual funding in the general appropriations act (GAA).

Enrollment in the HCBS portion of LTC is managed based on a priority system and wait list. For the 2016-2017 waiver year, the state is approved for 62,500 unduplicated recipients in the HCBS portion of the program.¹² In order to be eligible for the program, a recipient must be both clinically eligible as required under s. 409.979, F.S., and financially eligible for Medicaid under s. 409.904, F.S.

Eligibility and Enrollment

The AHCA is the single state agency for Medicaid; however through an interagency agreement with the Department of Elderly Affairs (DOEA), the DOEA is Florida's federally mandated pre-admission screening program for nursing home applicants through its Long-Term Care Services (CARES) program, including for the LTC component.¹³ The frailty-based assessment results in a priority score for an individual, who is then placed on the wait list based on his or her priority score.

Individuals are released from the wait list periodically, based on the availability of funding and their priority scores. The Legislature has specifically directed funding in the past several years through the GAA to serve elders off the waitlist who have a priority score of 4 or higher.¹⁴ Individuals who are more frail or have an immediate need for services receive a higher rank on the waitlist. Those who have resided in a nursing facility for more than 60 days receive prior enrollment into the HCBS portion of the program. Exemptions from the wait list also exist under s. 409.979(3)(f), F.S.

¹⁰ Agency for Health Care Admin., *Statewide Medicaid Managed Care (Presentation to House Health and Human Services Committee - Jan. 10, 2017)*, slide 2,

http://ahca.myflorida.com/medicaid/recent_presentations/House_Health_Human_Services_Med_101_2017-01-10.pdf (last visited Mar. 14, 2017).

¹¹ Agency for Health Care Administration, *SMMC MMA Enrollment by County by Plan (As of Mar. 1, 2017)*,

http://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited Mar. 14, 2017).

¹² Letter from U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services to Beth Kidder, Interim Deputy Secretary for Medicaid, Agency for Health Care Administration (Dec. 19, 2016), *available at* http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/LTC_Approval_Letter_2016-12-19.pdf (last visited Mar. 14, 2017).

¹³ Florida Dep't of Elderly Affairs, *Comprehensive Assessment and Review for Long-Term Care Services (CARES)*, <http://elderaffairs.state.fl.us/does/cares.php> (last visited Mar. 14, 2017).

¹⁴ See Ch. Law 2016-66, line item 232; Ch. Law 2015-232, line item 226; and Ch. Law 2014-51, line item 242. In state fiscal year 2013-14, GAA provided funding during first year of the LTCMC program for those on the wait list with priority scores of 5 or higher. (Ch. Law 2013-40, line item 414).

Individuals who are enrolled in the following programs may enroll in the LTC program, but are not required to:

- Developmental Disabilities waiver program;
- Traumatic Brain and Spinal Injury waiver;
- Project AIDS Care waiver;
- Adult Cystic Fibrosis waiver;
- Program of All-Inclusive Care for the Elderly (PACE);
- Familial Dysautonomia waiver; or
- Model waiver.¹⁵

Individuals, both those who are enrolled in LTC and those on the wait list, must be re-screened at least annually or whenever there is a significant change in circumstances, such as change in caregivers or medical condition.¹⁶

Delivery System and Benefits

The AHCA conducted a competitive procurement to select LTC and MMA plans in each of the 11 regions in 2012. Under the Invitation to Negotiate for MMA plans, the AHCA selected 10 different companies to serve as the health care delivery system. Of the plans selected, 11 of the awarded contracts went to general, non-specialty plans, of which five were PSNs.¹⁷ Five different specialty plans and the Children's Medical Services plan were also awarded contracts.^{18,19} Currently, MMA recipients receive services through 11 different managed care plans, of which two are PSNs.

In 2012, the AHCA awarded seven LTC contracts, including one statewide contract.²⁰ One of the original LTC contracts operated as a PSN; however, that plan is no longer participating in SMMC. The LTC services are now delivered through six managed care plans, which vary based on the recipient's region. Each region has at least two plans to allow for recipient choice. For nursing facilities and hospices, the plans are required to pay those designated providers a rate set by the AHCA. All six of the LTC plans also participate in the MMA program.

In addition to these plans, there are six specialty plans that serve unique populations: Children's Medical Services for children with chronic conditions; two plans for individuals with HIV/AIDS; a plan for child welfare enrollees; a plan for recipients eligible for both Medicaid and Medicare

¹⁵ *Id.*

¹⁶ Application for §1915(c) Home and Community-Based Services Waiver (Effective July 1, 2013), pp. 45-46, http://www.fdhc.state.fl.us/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/mma/LTC_1915c_Application.pdf (last visited Mar. 15, 2017).

¹⁷ Agency for Health Care Admin., *Florida Managed Medical Assistance Program - 1115 Research and Demonstration Waiver (3rd Quarter Progress Report: January 1, 2014 - March 31, 2014)*, p. 15, (on file with the Senate Committee on Health Policy).

¹⁸ *Id.*

¹⁹ Agency for Health Care Administration, *Medicaid and Managed Care* (Sept. 3, 2014), http://ahca.myflorida.com/Medicaid/recent_presentations/Child_Protection_Summit_2014-09-03.pdf (last visited Mar. 20, 2017).

²⁰ Agency for Health Care Administration, *Statewide Medicaid Managed Care Update* (Oct. 8, 2013) (on file with the Senate Committee on Health Policy).

with chronic conditions, such as diabetes or congestive heart failure; and a plan for individuals with serious mental illness. Recipients in both components of the program receive choice counseling services to assist them in selecting the plan that will best meet their needs.

The total enrollment in the specialty plans as of March 1, 2017 is shown in the chart below:²¹

Specialty Plan Enrollment - March 2017	
Component	Enrollment (As of March 1, 2017)
Child Welfare Plan	31,810
Specialty Plans (Capitated)	78,842
Children's Medical Services Network	50,924
Total:	161,576

The managed care plans under both components are required to cover a minimum level of benefits as prescribed under s. 409.973, F.S., for the MMA plans, and s. 409.98, F.S., for the LTC plans. However, the statutes also permit the plans to offer an expanded menu of optional benefits.

Mandatory Benefits - Statewide Medicaid Managed Care	
Managed Medical Assistance	Long-Term Care
Advanced registered nurse practitioner services	Nursing facility care
Ambulatory surgical treatment center services	Services provided in assisted living facility
Birthing center services	Hospice
Chiropractic services	Adult day care
Dental services	Medical equipment and supplies, including incontinence supplies
Early periodic screening diagnostic and treatment services for recipients under age 21	Personal care
Emergency services	Home accessibility adaption
Family planning services and supplies	Behavior management
Healthy Start services (with exceptions)	Home-delivered meals
Hearing services	Case management
Home health agency services	Therapies
Hospice services	Occupational therapy
Hospital inpatient services	Speech therapy
Hospital outpatient services	Respiratory therapy
Laboratory and imaging services	Physical therapy
Medical supplies, equipment, prostheses, and orthoses	Intermittent and skilled nursing
Mental health services	Medication administration
Nursing care	Medication management
Optical services and supplies	Nutritional assessment and risk reduction

²¹ Agency for Health Care Administration, SMMC MMA Specialty Capitated Enrollment Report (As of Mar. 1, 2017).

Mandatory Benefits - Statewide Medicaid Managed Care	
Managed Medical Assistance	Long-Term Care
Optometrist services	Caregiver training
Physical, occupational, respiratory, and speech therapy services	Respite care
Physician services, including physician assistant services	Transportation
Podiatric services	Personal emergency response system
Prescription drugs	
Renal dialysis services	
Respiratory equipment and supplies	
Rural health clinic services	
Substance abuse treatment services	
Transportation to access covered services	

The LTC enrollees who are not eligible for Medicare also receive their medical services through an MMA plan. Some plans participate in both components in the same regions, and a recipient may elect the same managed care plan for both components. These plans are referred to as comprehensive plans.

Provider Service Networks

The payment design of the SMMC was intended to facilitate a smooth transition from a mix of fee-for-service, primary care case management, and managed care delivery to a statewide system of Medicaid managed care. The statute permitted the PSNs to be reimbursed on a fee-for-service or prepaid basis, but only for the first two years of the plan’s operation or until the contract year beginning September 1, 2014, whichever is later. The AHCA is required to conduct cost reconciliations for the fee-for-service PSNs to determine cost reconciliations. All other managed care plans under SMMC are paid on a capitated basis meaning that a plan must pay for all covered services under the contract regardless of whether the capitated rate covers the cost of services for that recipient.

During the procurement process, at least one of the contract awards must be to a PSN if any PSNs submit a responsive bid. However, the AHCA must also issue an additional ITN following the end of a procurement, only for provider service networks, in those regions where no provider service networks submitted a responsive bid.

III. Effect of Proposed Changes:

Provider Service Networks (Sections 1, 3, 4, 6, 7, and 8)

The bill removes the option for PSNs, under both the MMA and LTC components, to be reimbursed on a fee-for-service basis. Prepaid PSNs shall be reimbursed only on a per-member, per month basis. Currently, PSNs could elect to receive payments for the first 2 years of a contract or until the contract year beginning September 1, 2014, whichever is later, under fee-for-service or on a capitated basis. The bill also deletes provisions relating to quality selection criteria specific to savings under PSNs, which are calculated under fee-for-service rates.

The reconciliation and cost savings review process sections relating to the PSN fee-for-service payment process are deleted from the MMA and LTC sections of the SMMC program. Provisions relating to how the cost reconciliations shall be conducted and the reconciliation deadline are removed to correspond to the removal of those now obsolete provisions.

The ITN process for both the MMA and LTC components is modified to no longer require the AHCA to conduct a separate procurement process within 12 months of the initial procurement process if no PSN is selected during the initial procurement.

Managed Care Plan Selection (Sections 3, 6, and 8)

The bill modifies the AHCA's responsibilities for compiling and publishing a databook as part of the ITN process to require a comprehensive set of utilization and spending data that is consistent with actuarial rate-setting practices and standards. The modification eliminates specific requirements that the data include the three most recent contract years for all Medicaid recipients by region or county. The source of the data in the databook report must include the most recent 24 months of validated data from the Medicaid Encounter Data System. The health care delivery regions for both the MMA and LTC components are also collapsed and changed to letters from numbers. These modifications provide for administrative streamlining and will enhance plan stability through increased market share by the plans, according to the AHCA. Since the original regions were created in the 1990s, the AHCA believes these revised regions more accurately reflect the health care market and current utilization patterns.²² The larger regions will also assist the AHCA in ensuring compliance with the access and appointment standards by the managed care plans as a wider choice of plans is likely to be available to recipients. The pooling of additional membership across the collapsed regions will likely draw more interested parties to some of the less populated areas of the state.

The table below shows the proposed re-groupings of counties and the minimum and maximum number of plans for the procurement. The same range of plan limitations apply for MMA and LTC.

²² Agency for Health Care Administration, *Senate Bill 916 Analysis* (Feb. 24, 2017), p. 3, (on file with the Senate Committee on Health Policy).

Proposed Region Changes and Plan Limitations							
Current Region	Counties	Plan Min.	Plan Max.	New Region	Counties	Plan Min.	Plan Max.
1	<i>Escambia, Okaloosa, Santa Rosa, Walton</i>	2	0	A	<i>Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, Washington</i>	3	4
2	<i>Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, Washington</i>	2	0	B	<i>Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, Volusia</i>	3	6
3	<i>Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, Union</i>	3	5	C	<i>Hardee, Highlands, Hillsborough, Manatee, Pasco, Pinellas, Polk</i>	5	10
4	<i>Baker, Clay, Duval, Flagler, Nassau, St. Johns, Volusia</i>	3	5	D	<i>Brevard, Orange, Osceola, Seminole</i>	3	6
5	<i>Pasco, Pinellas</i>	2	4	E	<i>Charlotte, Collier, Desoto, Glades, Hendry, Lee, Sarasota</i>	3	4
6	<i>Hardee, Highlands, Hillsborough, Manatee, Polk</i>	4	7	F	<i>Indian River, Martin, Okeechobee, Palm Beach, St. Lucie</i>	3	5
7	<i>Brevard, Orange, Osceola, Seminole</i>	3	6	G	<i>Broward</i>	3	6
8	<i>Charlotte, Collier, Desoto, Glades, Hendry, Lee, Sarasota</i>	2	4	H	<i>Miami-Dade and Monroe</i>	5	10
9	<i>Indian River, Martin, Okeechobee, Palm Beach, St. Lucie</i>	2	4				
10	<i>Broward</i>	2	4				
11	<i>Miami-Dade, Monroe</i>	5	10				

Obsolete Language (Sections 2, 5, 6, and 7)

Sections 2, 5, 6, and 7 amend ss. 409.964, 409.971, and 409.974(1), and 409.978(1), F.S., respectively, to remove obsolete language. These sections contain references to dates or activities associated with program implementation, the initial procurement process, and expired deadlines.

Effective Date (Section 9)

The effective date of the bill is July 1, 2017.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

PCS/SB 916 reorganizes the regions and the number of plans that may be selected in each region. The AHCA plans to re-procure the SMMC contracts in late 2017 giving the health plan industry, both those currently with contracts and those who wish to gain a contract, an opportunity to bid on the new ITN. The AHCA believes that collapsing regions will result in administrative streamlining and more accurately reflects today's health care utilization patterns. These changes may result in more competitive proposals from more managed care organizations during the upcoming procurement process, resulting in savings to the state and more choices for the consumer. In response to a voluntary Intent to Bid request, the AHCA received 41 responses from PSNs and HMOs that were interested in all three types of plans: long-term care, specialty, and managed medical assistance.²³

Any changes in which managed care organizations receive contracts under a new procurement will impact the health care provider community in 2017 and 2018. Not only will Medicaid managed care enrollees possibly be transitioning to new providers, but the provider community may have to adapt to a new group of managed care plans.

C. Government Sector Impact:

According to the AHCA, the bill has no impact on state revenues or expenditures.²⁴ However, the AHCA also believes, and notes in its bill analyses that collapsing regions will result in administrative streamlining and that these new regions will more accurately

²³ Agency for Health Administration, *Statewide Medicaid Managed Care (SMMC) Program Non-Binding Letters of Intent Received by 2/13/2017, in response to Intent to Bid Posted 2/3/2017*,

http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Intent_to_Bid_Responses.pdf (last visited Mar. 16, 2017).

²⁴ *Supra* note 20, at 4.

reflect today's health care utilization patterns. These changes in the regions may result in more competitive proposals from more managed care organizations during the upcoming procurement process, resulting in additional savings to the state and more choices for the consumer.

VI. Technical Deficiencies:

Strike the word, "Prepaid" from line 101.

VII. Related Issues:

The AHCA plans to release an ITN in the summer of 2017. Non-binding letters of Intent to Bid were requested from interested bidders by February 13, 2017, using the current 11 regions.²⁵ With changes to the current business process, an effective date of July 1, 2017, may keep the AHCA from maintaining their current deadlines.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.912, 409.964, 409.966, 409.968, 409.971, 409.974, 409.978, and 409.981.

IX. Additional Information:

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

Recommended CS by Appropriations Subcommittee on Health and Human Services on April 13, 2017:

- Requires that when selecting a plan for participation in the Medicaid program, the agency compile and publish a databook consisting of a comprehensive set of utilization and spending data consistent with actuarial rate-setting practices and standards. The source of the data in the databook report must include the most recent 24 months of validated data from the Medicaid Encounter Data System.
- Changes the following regions to the a new structure for the Managed medical assistance program: At least three plans and up to four plans for Region A; at least three plans and up to six plans for Region B; at least five and up to 10 plans for Region C; at least three and up to four plans for Region E; at least three plans and up to five plans for Region F; and at least three plans and up to five six plans for Region G.
- Changes the following regions to a new structure for the long-term care managed care program: At least three plans and up to four plans for Region A; at least three plans and up to six plans for Region B; at least five and up to eight plans for Region C; at least three and up to four plans for Region E; at least three plans and up to five plans for Region F; and at least three and up to four plans for Region G.

²⁵ Agency for Health Care Administration, *Non-binding Letters of Intent from Potential SMMC Plans*, http://ahca.myflorida.com/medicaid/statewide_mc/SMMC_LOI.shtml (last visited Mar. 16, 2017).

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.
