Commission on Mental Health and Substance Abuse

Agenda

February 15, 2023
9:00 a.m. to 1:00 p.m.

9:00 a.m. – Call to Order/Welcome/Opening Remarks
Jay Reeve, Chair

Chair Reeve expressed his appreciation for Sheriff Prummell' s leadership and hard work with this Commission for the past two years, thanked everyone else for their hard work and reminded that we are not done with the work of this Commission. He advised the interim report has been issued to the legislature and now the task is to gather feedback from the legislature and Governor's office and incorporate that feedback into the final report. Also provided a legislative update stating the commission is currently set to sunset in September. He doesn't think the work will be complete by then. In addition, there are some new things that have emerged that he will touch on.

Roll Call

Attendance Summary

Chair Reeve	Commissioner Mahon
Commissioner Hunschofsky	Commissioner Gadd
Commissioner Berner	Commissioner Secretary Harris
Commissioner Prummell	Commissioner Secretary Weida
Commissioner Moore	Commissioner Suryadevara
Commissioner Gray-Eurom	Commissioner Ficarrotta
Commissioner Rein	Commissioner Evans

Approval of the December 2, 2022, Commission Meeting Minutes
Jay Reeve, Chair
Motion to approve by: Commissioner Ficarrotta Seconded by: Commissioner Prummell

9:10 a.m. – AHCA Presentation – Florida Medicaid Program Overview
Commissioner Jason Weida, Tom Wallace, and Austin Noll

Commissioner Secretary Weida: Thanks everyone for being present and allowing this presentation on Florida Medicaid Program. The overall mission of the Agency for Healthcare Administration is better healthcare for all Floridians. We are the states chief healthcare policy and planning entity, and we really have two large operating divisions. One is administering the Florida Medicaid program and that is a responsibility that is split between Tom Wallace and Austin Null. The other large operating component within AHCA is the licensure and regulation of healthcare facilities, approximately 50,000 in Florida between hospitals, nursing homes and assisted living facilities. For these functions, we leverage technology to support them in all the agency operations and other components as well. As a large agency, we have a lot of different operating components, but we do our best to function as one team and we have people in place to make sure that the different silos are speaking to each other and that there's the required exchange of information that needs to occur to make a large agency run properly. The strategy for healthcare in Florida is one, healthcare should be cost effective. Two is transparency and we have several initiatives at the agency right now that support transparency and power consumers and making informed healthcare decisions. The third is high quality and we emphasize quality in all that we do to improve health outcomes and always putting the individual first. We are responsible

for administering the states $37/$38-billion-dollar Medicaid program and we serve more than 5.5 million recipients in Florida, which is a significant portion of the population and includes lots of children. Healthcare regulation and transparency, we are responsible for licensing and certifying 50,000 plus healthcare facilities, including hospitals, nursing homes, and assisted living facilities, and sharing the healthcare data through the Florida Center for Health Information Policy Analysis.

Austin Null: Medicaid is a federal program designed to be a partnership between the federal government and states who choose to participate. States are afforded the flexibility to design their Medicaid program, which fits the unique aspects of each state while remaining compliant with the federal rules. The program is funded by a split between the federal and state entity governments who will share that cost. Federal entities, such as Congress and the Department of Health and Human Services, have established the minimum requirements for the Medicaid program. Some include administrative requirements the state must meet, who is covered, and with what services, as well as the process for receiving federal funds. When we consider who is covered by Medicaid, there are two types of groups. There's a mandatory group and an optional group. Mandatory groups are those individuals that must be covered and include low-income children, families, and seniors, as well as Social Security recipients. Then optional groups are those that are at the discretion of the state and may include individuals with exceptional medical needs or breast and cervical cancer enrollees, as an example. Similar to the groups, federal requirements also have mandatory and optional services. Mandatory services are those that must be covered, whereas optional are those that states may choose to cover with federal approval. In the event the state chooses or selects optional, there are federal funds that would support those optional services as well. There hasn't been a lot of change to the mandatory services over the years. Instead, they've allowed states to adapt and adopt optional services. As an example, prescribed drugs were originally not in the mandatory group back in the 60s, as it wasn't as big of a deal as it is today but is one of our biggest spend categories. To establish a Medicaid program, each state is required to have a state plan outlining the components of the program. They must designate a single state Medicaid agency, the Agency for Healthcare Administration. We are then afforded the ability to delegate and shift some responsibilities to other entities, like the Department of Children and Families, and other state entities to help fulfill all the different Medicaid aspects. We rely on the Department of Children and Families to perform the eligibility review for our members. We will then go through and determine the benefits and services as well as set the appropriate payment rates, whether that's through the capitation rate with managed care or, the fee for service. Something to note is that the state plan services are required to be statewide and in the same amount, duration, and scope, regardless of where someone might live. We cannot put an overall limit on services or limit the number of people who can receive services. The state plan is approved by federal CMS along with any subsequent amendments. Waivers allow us to test different delivery models or payment mechanisms. Additionally, the federal program allows us to decide how we're going to deliver services. There are two main ways in which states will choose, and that's either fee for service or managed care. In Florida, along with many other states, we use a combination of both. Fee for service is a model that pays providers an amount for each service they provide. Managed care is slightly different in that we will contract with healthcare organizations or health plans. In the managed care environment, we do make payments through a capitated arrangement, which is a per member, per month fee that we pay to the managed care entities. Florida served just over 5.5 million Floridians. Most of those are adults or parents, elderly and disabled. We also represent over 50% of the children in Florida, 50% of the births, as well as over 60% of the nursing home days in Florida. We started the statewide Medicaid managed care program in 2013. Of those receiving full benefits, which means that they are completely in managed care, 95% are enrolled in the managed care program. Medicaid managed care is 3 aspects. It has the Managed Medical Assistance (MMA), Long-Term Care (LTC) and Dental. The statewide managed care program, as far as services, we identify all of them in the Medicaid state plan. There are also some expanded benefits in lieu of services as well as case management services. They include the behavior, health benefit as well as other services that you would normally see for prevention, diagnostic and treatment. We also have specific things laid

out for specialized therapeutic care, inpatient psychiatric programs, and behavioral on-site services. In lieu of services are something that is considered medically appropriate but cost less than the service or the place of service listed in the Medicaid state plan. Case Management Services are focused on individuals with serious mental illness or emotional disturbance impairments that help establish the minimum services or treatments that are needed to help provide these individuals with the care they need. This is one of the items that is required by federal government to make sure that we are providing these services to Medicaid enrollees. We have specialty programs that have individuals or a team/network that are focused on serious mental illness, they provide additional or enhanced case management. Further, we currently have a pilot program through housing support where it helps those with serious mental illness and assists them with housing as well as sustained tenancy.

Tom Wallace: In terms of federal funding, the states receive a federal matching dollars to support our Medicaid program. This funding is provided to each state based off a specific formula called the Federal Medical Assistance Percentage, or FMAP, also known as FFP - the federal financial participation - or just federal match. The FMAP is effective on a federal fiscal year basis, which is October through September of each year. The state does have a FMAP that it uses for budget purposes. It uses a blended FMAP because our state budget is based off a state fiscal year which begins July through June. The portion that the feds come up with to pay each state is based on a formula that looks at the ratio of a states per capita income compared to the national per capita income. It's looking at the most recent three years of data. The current FMAP in the state of Florida is 60.05%. For every dollar that is spent on Medicaid Services, the feds are putting in 60.05 cents on that dollar right now. Then all states receive at least a 50% FMAP on administration, 50% on salaries - except for certain specialized categories of 75% - and 90% on technology. A key thing about Medicaid that kind of makes us different than other agencies is that we do not receive a lump sum amount of money or grant for individual entities or individual provider types. Everything we have is based off expenditures. We receive federal funds based off the state expenditures for services provided to each individual Medicaid recipient. The state share must be funded with state dollars and most of those state dollars are general revenue funds where the legislature appropriates general revenue dollars to fund our Medicaid program. Then there's some other state sources as well, one of them being the public Medical Assistance Trust Fund. This is a trust fund that funds mostly hospital inpatient/outpatient services. Double budget is where there would be a particular item in another state agency where the state agency has the general revenue appropriated to them, but they use ACHA as us being the single state source with the federal government to draw down those federal dollars. To get the dollars to the Medicaid program, we do have to work with the federal government on this. Each quarter we must show the federal government what we anticipate spending, then we must report on those expenditures.

Question - Commissioner Prummell: During our research we have found a lot of the monies tend to follow programs and not the person as they go through the system of care. You were saying that you can move monies if someone is in a particular need. So, if someone needs a particular care program will Medicaid cover it and if so, how is it applied for if it’s not under one of your covered plans?

Answer - Tom Wallace: If a member is in a Medicaid plan, which a vast majority of them are, then all services that they need, get prior authorization, authorized by the Managed care plan. They go through that process, and they can get access to those services. Now the money is not necessarily moved from one program to the other. It's just any services that's available by that plan they can pay for. So, again we are appropriated certain dollar amounts for a managed care plan. We have fee for service programs as well that's appropriated by the legislature, but we're not necessarily moving dollars and funding around between the programs. Again, it's an expenditure for that individual that comes in to receive services.

Question – Commissioner Prummell: If I remember correctly from the earlier slide, you're managing like a $36.4 billion budget and those are expected expenses for the quarter or for the

year rather. Do you use every bit of that money or is some of that returned or not claimed?

Answer – Tom Wallace: Those numbers are estimated. We go through a social service estimating conference process where we go and present to the principles of the estimating conference, which are made-up of the governor's office, the House and Senate staff as well as EDR - economic and demographic research. We are working on that process right now. We project out what we think our current year expenditures will be. Where we are now using the most recent actual data, actual caseload information, and project out what we think the expenditures will be for the current year and for the next year, and what the legislature will use to craft their budgets. At the end of that state fiscal year any dollars that are not spent is essentially reverted into the state's coffers, but we project this out each time to try to get it on target where we think we'll end up each year.

Question – Chair Reeve: Commissioner Secretary Weida, in our interim report there was a recommendation for the development of a single entity to manage all behavioral health funds in a single county as a pilot towards integration. There was a comment by your predecessor in terms of what the process would be to allow that to happen and I wondered if you or any of your team had any comment on that?

Answer – Tom Wallace: What Secretary Marstiller was saying is that the pilot program is a statewide Medicaid managed care program that started in 13-14. The whole idea of that was all the Members now are going to be in one of these managed care plans with the managed care plans providing the services and doing the case management and care coordination for that Member to get the services they need.

Answer – Austin Noll: At one point the Medicaid program did have a carved out mental health program as part of the managed care aspect When we think about mental health issues it's not just the diagnosis or the treatment of that specific condition, but it's really what's going on holistically. Medical homes are something that we've been exploring and doing more with trying to look at individuals across the spectrum of their health needs rather than just mental health.

Question – Commissioner Ann Berner: I know you mentioned that the MA plans are allowed to keep a certain amount of profit. Do you what the amount of profit they are entitled to keep?

Answer – Tom Wallace: It’s called the achieved savings rebate, it's in statute. It's a profit-sharing mechanism that the states have with the managed care plans. Right now, in the capitation rates, when we go through that development, there is already a 2% profit built into the capitation rate. When our actuary sets these rates, they already built in 2%. Through the ASR process, the first 5% of profit the plans get to keep, the next 5% to 10% the plan splits that profit with the state, which is the profit-sharing mechanism. Then, any profits that the plans make that are over 10% all comes back to the state. This is looked at on a quarterly financial report. The rebate is what the plans must give back to us.

Question – Commissioner Ann Berner: Is there a cap on their administrative rate?

Answer – Tom Wallace: When we go through the rate setting process, there is an admin allowance that is allowed to the plans. So, there's not a cap on that. It just depends on what their admin is.

Question – Commissioner Ann Berner: Is there a typical range?

Answer – Tom Wallace: It's roughly around 9% to 10%.

Question – Commissioner Ann Berner: There was a 2001 report on behavioral health, there was the ability for the state to break out expenditures through Medicaid on behavioral health specifically. I think since 13-14 when the MMA plans rolled out, that doesn't really exist

anymore. Is there a way for you to tell what the amount of money is that's spent on behavioral health annually?

Answer – Tom Wallace: We do have a lot of data here at the agency, and we have encounter data. Encounter data is what comes from the managed care plans. Within those encounters, we can look at certain codes like if they're behavioral health codes, to kind of look at what that spend is for behavioral health, and we can look at data and pull that to look at what the expenditures might be.

Question – Commissioner Ann Berner: Is that something that can be requested by the Commission. There's just a lot of talk on the financing in general of behavioral health and all the different state agencies and it just seemed it would be helpful to kind of put that in perspective to what other federal and state monies go into behavioral health.

Answer – Commissioner Secretary Weida: I think that whatever mechanism is appropriate for the Commission to request that information, we would be happy to provide it. We have a lot of data scientists here and we work with data a lot in the Medicaid program and outside of the Medicaid program as well, which is one of our biggest assets here in the agency. I'm not sure the exact mechanism that request would be made, but we'd be happy to do that if requested.

10:00 a.m. – DJJ Presentation
Tracy Shelby, Ph.D. and Joy Bennink

Dr. Shelby: Today, we're going to tell you a little bit about the treatment services that we provide throughout our continuum of care. We're also going to let you know about our priorities, our barriers to treatment and some future ideas for treatment. We provide oversight of medical and mental health services to youth served throughout all our program areas and help to ensure that these services are delivered with efficacy. We provide clinical technical assistance and training to our contracted medical and mental health staff. All our medical and mental health treatment services are provided through contracted staff. Our services are offered throughout the continuum of care. That includes prevention, detention, probation, and residential services, screening, assessment, evaluation, individual therapy, group therapy, family therapy, crisis intervention, suicide prevention and supportive services, and psychiatric treatment services as needed based upon the youths' individual needs.

Joy Bennick: Once youth are detained and they're screened in a probation unit, if they score high enough, then they go to a detention center. Our detention centers are staffed with full time mental health clinical staff that are on site every day. Each detention center has at least two licensed mental health professionals that work there, and depending on the size of the facility, they may have additional therapists on site as well. All youth are provided mental health and substance abuse treatment services during their stay based upon their individualized needs. We're very proud of our track record with suicide prevention. We lead the nation in suicide prevention. All youth receive a comprehensive evaluation completed by a contracted provider for youth who are pending residential commitment. This allows the youth to be diagnosed and then placed into a specialized residential program to meet their needs.

Dr. Shelby: All our youth prior to going into a residential treatment program received a psychological evaluation and that's so we can identify those diagnosis and treatment needs and place that youth accordingly. Florida is one of the only states that does not have general offender programs. All of ours are treatment based. Residential Program types include treatment specializations such as mental health overlay, substance abuse overlay, juvenile sexual offender, development disability and borderline intellectual functioning, intense mental health, and comprehensive co-occurring disorders.

Joy Bennick: Last year, we had a legislative budget request approved to upgrade and enhance our

electronic health record. The two biggest parts of this project was revamping all the mental health forms. We're getting very close to being finished with that process and initiating the E scribe capability, so now our doctors can prescribe straight from our EHR. In the future we'll be able to collect aggregate data and share that with the Commission and any other kinds of entities that want to have that information. This will include clinical data, diagnostic data, frequency of services data. All these kinds of points of contact and information will be invaluable to the department and to our ability to lobby for support. Our EHR will ensure continuity of care, quality of care, the appropriateness of care, transitional community care and expand collaborative efforts with DCF to care for our dually served youth. The EHR allows for seamless transition of services throughout the program areas. For example, the residential provider will be able to see the youths' records of mental health services in the detention center for their clients, so they won't have to start from scratch.

Question – Commissioner Prummell: To clarify, as the system operates now, when a child is no longer under the supervision of the department, all the care they've been going through ceases, correct?

Answer – Dr. Shelby: In some cases, that's correct. In other cases, that is not. When a youth is discharged from our care, there is a discharge and referral that is completed for the youth and given to the parent with options for treatment services, contact for information, and the parent is encouraged to follow through with that. Unfortunately, when they're not under our care we can't force that. We try to make it as easy as possible for the parents to obtain the treatment services but when they're out of our care we can't force the issue.

Question – Commissioner Prummell: Do you communicate with the Department of Education? What about transitioning them back into school? There's managing entities, community-based providers; is any of this information about the child shared with them?

Answer – Dr. Shelby: It is with the schools. In our residential programs, oftentimes youth graduate, obtain their GED, and some of them are even in college courses. Our current Secretary, Dr. Hall, has worked very hard with expanding these vocational and higher-level education options for our youth so yes, there is a pipeline back into the education system.

Question - Chair Reeve: You mentioned that most of your clinical work is provided through contract staff. It sounds like they're contracting directly with DJJ, and they are not intermediary agencies as in AHCA or DCF funding. Is that accurate?

Answer – Dr. Shelby: Yes, that is correct.

Answer - Joy Bennick: In addition, when the youth are in residential care, Medicaid is dropped and that comes directly from the department's funding.

Question - Chair Reeve: Do you have a ballpark idea of what level of behavioral health funding overall we're talking about flowing through DJJ?

Answer – Dr. Shelby: I think that's something we'd have to look into to give you anywhere close to an accurate number. We could get that information to you if that's something that you want. But I don't feel comfortable even taking a stab at that.

Question - Chair Reeve: I think the Commission would be very interested in having a sense of the overall funding that was going into various behavioral health services through DJJ. I (Chair Reeve) will connect with you on this.

10:50 a.m. – 11:00am Break

11:00 a.m. – Legislative Update
Jay Reeve, Chair

Chair Reeve: I have started to meet with house and senate staff, and I've already met with the Governor's office staff to get feedback on the interim report. There are two bills right now that impact us. There is a HB655 and SB468. The text of those bills is directing the Commission to look at suicide prevalence and prevention within the state and to expand our look at emergency and crisis services, including things like mobile response teams, central receiving facilities, baker act facilities and the like. Looking at the previous commission report that was issued 22 years ago and looking at where we are with the interim report, we have sort of a vote of confidence in the Commission that the larger system of care would be brought into focus by the letters. The House bill has not been given any committee stops yet. The Senate bill has been referred to children and family and elders' affairs to health policy and rules. I'm confident that one will go through. If it's the intent for legislature to bring these additional tasks to bear for the Commission, we certainly need an extension beyond September of 2023.

Commissioner Representative Hunschofsky: I saw HB655 it has since been referenced to children, families and senior subcommittee and Health and Human Services Committee. I'm actually very familiar with it because I had it in drafting. I was going to file it, but since we're limited in the house to 7 bills, we were told it was DOA last session, I did not file it. I was very surprised when I heard from bill drafting that the bill I had in drafting was already filed. Having said that, I reached out to Representative Trabulsy on the wish to change the name of the Commission to The Commission on Mental Health and Substance Use Disorder, and that we use the term substance use disorder throughout the bill to make it more appropriate. Additionally, I had also mentioned that we had discussed extending it. I wasn't sure what the timeline was. I don't know if we're looking at a December 31st, 2024, or something like that to give additional time. I would love if we would also be adding something about dealing with workforce issues because that is becoming more and more an issue. There has been a lot of support for compacts right now in the legislature. I would hope that we would also have ample funding so that we have, as a Commission, the support we need. This Commission is often compared to the Marjory Stoneman Douglas Public Safety Commission, but we are a leaner machine here. I think it would be helpful to make sure that we have appropriate resources that we need as a Commission.

Chair Reeve: I want to make sure that we have comment from the Commission on the direction. Does anyone have a problem with the direction I am trying to go?

11:10 a.m. – Finance Subcommittee Update
Commissioner Senator Rouson

Commissioner Senator Rouson: At our last subcommittee meeting we talked about sending a letter out to the agencies to follow up the initial letter that was sent out requesting information because the information we got was incomplete. We decided that we needed to expand on what we were using. We needed precise information from the agencies so that we could fill out the matrix, which would give us measurements. I prepared a draft of the letter, submitted it to Aaron, and requested that it be sent out. We just wanted to get this letter out to receive the information and be ready to do recommendations.

Chair Reeve: I would be happy to send that out on behalf of the commission. Asked Aaron to help make that happen after this meeting.

Comments from Chair Reeve: Before we go into these subcommittees, status reports, I want to mention that we are at a mile marker with the issuance of the interim report. Between feedback from the legislature and the executive branch and the possibility of the new direction and possible extension. I think it's not impossible that we would want to reformulate and potentially add some subcommittees. I know there is going to be some shifting. There is substantial overlap between, some of the recommendations that came out of Business Operations and Data Analysis and between Finance and Business Operations. If we are charged to look at suicide prevention and the suicide risk and system of emergency care, that probably calls for a subcommittee level refocus. So, as we go into our subcommittee status reports, I'd be really interested in the Commissioners, and especially the Subcommittee chairs, sharing any thoughts that you might have about ways to refine or show the focus of or eliminate duplication along the subcommittees. This is a fluid process and if we can all be thinking about that over the course of the next few weeks. Any thoughts on that?

11:25 a.m. – Subcommittee Workgroup Discussion
Business Operations, Commissioner Christine Hunschofsky

Commissioner Berner, on behalf of Commissioner Hunschofsky: We met in January and, there was a spreadsheet that was developed for some of the recommendations that were in the interim final report. In that final report there were several recommendations that originated in the Business Operations Subcommittee. The first one we looked at was the master client index. I was at a committee meeting last week in Tallahassee, where AHCA and DCF presented on their updates to their data systems. I think the Secretary from AHCA alluded to the FX project; it's basically the tool that interfaces with eligibility and encounter data for the payment on whether it's the MMA plan or a fee for service. I think over the course of the next couple of years, it's about a $450 million IT project. DCF is also working on their eligibility side. As you were speaking, Chair Reeve, about some of the consolidation that may need to happen, it seems like there might be an opportunity to provide some request in the process. There were several questions that came from the committee members. A lot of it had to do around interoperability and being able to match data. I was thinking that maybe it's just a matter of putting together some of the needs or expectations as it's related to our requests and build off that. We were also looking at some core metrics. We've developed additional framework on how we would better define metrics across all the systems. There were some accountability and outcomes related to publicly funded behavioral health services so we're going to continue that line. Again, we are also looking for anyone who wants to be part of that sub-group, but we feel like that's important in being able to assess and evaluate the quality of care. We are also looking at the Medicaid income eligibility criteria for young adults 18 to 26. There's also been some work on the three-year pilot project. That was where one agency level entity manages all public behavioral funding in a specific geographic area. Lastly, we drafted some proposed statutory language that would help align public school mental health funding with the core state mental health plan that would better align expectations related to school funding for mental health. For the upcoming piece, and I know we're looking at some of the status reports, but maybe I could just put in a placeholder for looking at some of the statutory expectations related to the Commission. One of the areas that we haven't really tackled yet has to do with the responsibility of the Commission as it relates to looking at a permanent agency level entity to manage mental health and substance use in the state. Not advocating either way, but it is a specific task and requirement. There's also a reference to chapter 2020-107, which is also corresponds to the HB945, that addresses the children's system of care and the planning process. I think there's some interest in updating the language in that bill to move it into an implementation, to have more implementation language because it's kind of stalled at a planning process that's been pretty much completed. This may be another area for us to look at and I would request a placeholder to further discuss.

Commissioner Prummell: There is a large public school safety bill, that was filed in the house and senate, that might be a good place to try and get that attached if we want to if you can reach out to the bill sponsors.

Criminal Justice Update
Commissioner Mark Mahon

Judge Mahon: The first recommendation, number eight, is to limit the use of competency restoration process to cases where it's inappropriate for dismissal or diversion. That subgroup was shared by Judge Ficarrotta, they have in large measure completed their Excel spreadsheet and so the work of that subcommittee group is going along very well. Recommendation number nine which was to modernize the Baker and Marchman Act. We decided not to endorse any specific piece of legislation, but there is a bill that was filed last year, Heather Allman has volunteered to do that, and I have also asked my magistrate Brady, who agreed. At our subcommittee meeting, there was discussion of us drafting a commissioner, but we're still working on that. Finally, recommendation number ten is to establish pre and post diversion programs in every circuit throughout Florida for individuals who might be appropriate that meet certain criteria for mental health services. Our lead Commissioner on that is Sean Salamida, with the help of Peter Kennedy, John Newcomer, and Judge Ficarrotta. On recommendation number eight, they are planning a meet this afternoon. I think we'll be able to get these recommendations done and come up with our Excel spreadsheet and an action item. I think these three goals are concrete enough, and they're obtainable enough and they'll have a real significant impact, both on the delivery of services and to make sure that we're using the monies that go toward mental health services in an appropriate and useful area.

Data Analysis Update
Chair Jay Reeve

Chair Reeve: With the shift of the commission and my new role as chair Commissioner Moore has agreed to take on this subcommittee. Within the Data Analysis Subcommittee recommendations was the recommendation to form a statewide data steering committee that would work on the development of the public data repository.

Commissioner Moore: We took recommendations two and three, and then we expanded on those in terms of the impact on the behavioral health system, the objectives within each, and the key steps in the implementation process. We're suggesting that a cost analysis be done. We can't really put a dollar figure right now to that cost. We really want to look at what's been going on both county and state level. To create this statewide data repository, there's several things that need to be in place that go into these two recommendations. One is defining and determining the structure, including the authority, security, and then policies and procedures. Then, forming an ongoing oversight group and thinking about initial analytic metrics that go along with that. To do this statewide repository, we really need to have ongoing funding and leadership. We also have different objectives. Being able to secure administrative authority and commitment from stakeholders is important. We want to start out working with data from DCF and AHCA to establish the statewide system as kind of a pilot. There's also data sensitivity and we really need to kind of work through the legalities of HIPAA, FERPA and really thinking about ethical use of data. We want to implement innovative technology to address these privacy concerns and incorporate innovations. We want to do a cost analysis to think through carefully and thoughtfully how much this will cost, not only in the short term but in the long term. We're happy to collaborate on any sort of recommendation so that we can streamline the process.

12:55 p.m. Public Comment

John Newcomer: The only thing I would just comment on is obviously they'll have to be a lot of additional scrutiny regarding data systems as this is a very complicated topic. What's being talked about here is somehow a massive data integration project. The FBI tried to do that about 20 years ago and abandoned ship. It's a very, very complicated exercise. So, I would just caution the Commission to look very hard at proposals.

Commissioner Ann Berner: I was just wondering, going back the next iteration and some of the comments that I made during the business OPS, is there an opportunity now to talk about the additional steps or what else we might be working on in addition to closing out the interim report?

Chair Reeve: The next step for me is to seek legislative and executive feedback on what our progress has been so far and what they need from us going forward. Most importantly, secure an extension of the commission itself.

Secretary Harris: I stated my thoughts on this issue back in December when we met. I think that that's a huge undertaking and there are lots of moving pieces and parts that we really need to make sure we're making a thoughtful recommendation. So, I do agree, I think a separate group that is talking about that and I'm really contemplating that and whether that's in the best interests of the state and is going to move the needle forward. I think really unpacking what the issues are and how that solves for the issues of the day. I think is very prudent, so I'm happy to participate myself in those discussions.

1:00 p.m. – Closing Remarks

Chair Reeve – I will have conversation with Aaron to get with committee Chairs about refining the committee structure.

Motion to adjourn by: Commissioner Mahon Seconded by Secretary Harris