Health Innovation Subcommittee

Wednesday, December 2, 2015
11:30 AM – 1:30 PM
306 HOB

Steve Crisafulli
Speaker

Kenneth Roberson
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health Innovation Subcommittee

Start Date and Time:	Wednesday, December 02, 2015 11:30 am
End Date and Time:	Wednesday, December 02, 2015 01:30 pm
Location:	306 HOB
Duration:	2.00 hrs

Consideration of the following bill(s):

HB 127 Continuing Care Facilities by Cummings
HB 337 Vision Care Plans by Peters
HB 581 State Veterans' Nursing Homes by Magar
HB 595 Reimbursement to Health Access Settings for Dental Hygiene Services for Children by Plasencia

Pursuant to rule 7.12, the deadline for amendments to bills on the agenda by non-appointed members is 6:00 p.m., Tuesday, December 1, 2015.

By request of the chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Tuesday, December 1, 2015.

NOTICE FINALIZED on 11/24/2015 2:10PM by Ellerkamp.Donna

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

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

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Guzzo	Poche
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The Gold Seal Program is an award and recognition program for nursing homes that demonstrate excellence in long-term care over a sustained period of time. Recipients of the Gold Seal Award (Award) may use the designation in their advertising and marketing. Of the 683 currently licensed nursing homes in Florida, 26 nursing homes hold the award.

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

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

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

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

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

HB 127 provides an additional means for a nursing home that is part of the same corporate entity as a continuing care facility to meet the financial soundness and stability requirement. The bill permits the nursing home to demonstrate that the facility, in its entirety, meets AHCA financial standards as proof of financial soundness and stability for purposes of qualifying for the Award.

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

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Nursing Home Gold Seal Program

The Gold Seal Program (Program) was established in 1999 to develop an award and recognition program for nursing homes that demonstrate excellence in long-term care over a sustained period of time.[1] Recipients of the Gold Seal Award (Award) may use the designation in their advertising and marketing.[2] Of the 683 currently licensed nursing homes in Florida[3], 26 nursing homes hold the award.[4]

Governor's Panel on Excellence in Long-Term Care

The Program is implemented by the Governor's Panel on Excellence in Long-Term Care (Panel) which is administratively housed within the Executive Office of the Governor.[5] The Panel consists of 13 members, including:

- Three members appointed by the Governor, including a consumer advocate for senior citizens and two persons with expertise in the fields of quality management, service delivery excellence, or public sector accountability;
- Three members appointed by the Secretary of Elder Affairs, including an active member of a nursing facility family and resident care council, a member of the University Consortium on Aging, and a representative of the State Long-Term Care Ombudsman Program;
- Two members appointed by the Secretary of the Agency for Health Care Administration (AHCA);
- One member appointed by the Florida Life Care Residents Association;
- One member appointed by the State Surgeon General; and
- One member appointed by the Florida Health Care Association.[6]

An individual with any ownership interest in a nursing home is prohibited from becoming a member of the Panel. Any member of the Panel who is employed by a nursing home in any capacity is prohibited from reviewing or voting on recommendations involving the facility by which the member is employed or any facility under common ownership with the facility.[7]

Program Requirements - General

To be considered for the Award, a nursing home must have a letter of recommendation from AHCA, a nursing home industry organization, a consumer, the State Long-Term Care Ombudsman Program, or a member of the community where the nursing home is located.[8] The nursing home must then submit the letter of recommendation and a completed application with supporting documentation to AHCA.[9]

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[1] House Bill 1971, 1999 Florida Legislative Session, and ch. 99-394, Laws of Fla.
[2] S. 400.235(8)(a), F.S.
[3] Agency for Health Care Administration, *Facility Provider Locator; General Search, by Facility/Provider Type; Nursing Homes*, available at http://www.floridahealthfinder.gov/facilitylocator/FacilitySearch.aspx (last viewed November 23, 2015).
[4] Agency for Health Care Administration, *Facility Provider Locator; General Search, by Facility/Provider Type; Nursing Homes; Advanced Search, Gold Seal Award Recipient*, available at http://www.floridahealthfinder.gov/facilitylocator/FacilitySearch.aspx (last viewed November 23, 2015).
[5] S. 400.235(3)(a), F.S.
[6] Id.
[7] S. 400.235(3)(b), F.S.
[8] S. 400.235(6), F.S.
[9] Rule 59A-4.201(1), F.A.C.

Only nursing homes with a quality of care ranking within the top 15 percent of facilities regionally, or top 10 percent of facilities statewide, and that have a five-star facility designation[10] overall are considered.[11]

In addition, applicants must meet the following criteria:

- Have no Class I or Class II deficiencies within the 30 months preceding the application for the Program;
- Participate in a consumer satisfaction process involving residents, family members and guardians;
- Provide evidence of the involvement of families of residents and members of the community in the facility on a regular basis;
- Have a stable workforce as evidenced by a low rate of turnover among certified nursing assistants and licensed nurses within the preceding 30 months;
- Provide evidence that verified complaints reported to the State Long-Term Care Ombudsman Program within the 30 months preceding application for the program have not resulted in a citation for licensure; and
- Provide targeted in-service training.[12]

Program Requirements – Financial Soundness and Stability

An applicant for the Award is required to provide evidence of financial soundness and stability.[13] The financial soundness and stability requirements differ based on whether or not a nursing home is part of the same corporate entity as a continuing care facility.[14]

A nursing home that is not part of the same corporate entity as a continuing care facility is required to be licensed and operating for at least 30 months prior to the date of application submission and must provide evidence of financial soundness and stability during the 30 months preceding application submission.[15] To demonstrate financial soundness and stability, a nursing home must:

- Submit a balance sheet, income statement, and a statement of cash flow for the three consecutive years immediately preceding the application;
- Submit a report from a certified public accountant who has audited or reviewed such financial statements; and
- Meet two of the following three requirements;
    - Have a positive assets to liabilities ratio;
    - Have a positive tangible net worth; or
    - Have a times interest earned ratio[16] of at least 115 percent.[17]

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[10] S. 400.191 F.S., requires AHCA to provide information to the public in consumer-friendly printed and electronic formats to assist consumers and their families in comparing and evaluating nursing home facilities. AHCA publishes a Nursing Home Guide, which includes facility-specific comparative information based on certain quality and performance measures, including a star ranking based upon deficiencies cited during inspections. The more stars (up to 5), the better the facility scored on that particular measure. The broadest measure of performance is Overall Inspection, available at http://www.floridahealthfinder.gov/CompareCare/MethodologyNH.aspx (last viewed November 24, 2015).

[11] Rule 59A-4.202, F.A.C.

[12] S. 400.235(5), F.S.

[13] Id.

[14] S. 400.235(5)(b), F.S. A continuing care facility is a facility that offers a continuum of services and living arrangements at a single location including independent living apartments, assisted living, memory support care, and skilled nursing care.

[15] Rule 59A-4.203, F.A.C.

[16] A times interest earned ratio is determined by dividing interest expense into net income before deducting such interest and income tax. Net income is defined as revenues less expenses.

[17] Rule 59A-4.203, F.A.C.

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

- The facility meets the minimum liquid reserve requirements in s. 651.035, F.S.; and
- The facility is accredited by an organization recognized under statute and OIR rule[18], as long as the accreditation is not provisional.[19]

If a facility is accredited without stipulations or conditions by a process substantially equivalent to the requirements of Chapter 651, F.S., OIR may waive any requirement of Chapter 651, F.S., including the minimum liquid reserve requirements.[20]

Presently, a continuing care facility must maintain a statutorily-prescribed minimum liquid reserve under s. 651.035, F.S. The reserve is comprised of three separate reserves based on separate calculations. The first is the "debt service reserve," which is an amount equal to the aggregate amount of all principal and interest payments due during the fiscal year on any mortgage loan or other long term financing of the facility, including taxes and insurance.[21]

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

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

Effect of Proposed Changes

HB 127 provides an alternative means for a nursing home that is part of the same corporate entity as a continuing care facility to meet the financial soundness and stability requirement of the Gold Seal Program. Current law requires the continuing care facility to meet the minimum liquid reserve requirements of s. 651.035, F.S., and receive accreditation by a recognized accrediting organization to satisfy the financial soundness and stability requirement. The bill retains these requirements.

The bill allows a nursing home, which is part of an unaccredited continuing care facility, to demonstrate that the facility, in its entirety, meets the financial standards established by AHCA. If the nursing home can demonstrate such compliance with the standards, it satisfies the financial soundness and stability requirement for consideration under the Program. As a result, more nursing homes may become eligible for the Award.

B. SECTION DIRECTORY:

Section 1: Amends s. 400.235, F.S., relating to nursing home quality and licensure status; Gold Seal Program.

Section 2: Provides an effective date of upon becoming a law.

[18] Rule 69O-193.055(1)(a), F.A.C., recognizes the National Continuing Care Accreditation Commission.
[19] S. 400.235(5)(b), F.A.C.
[20] S. 651.028, F.S.
[21] S. 651.035(1)(a), F.S.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill may have a positive fiscal impact on unaccredited facilities that offer skilled nursing care and wish to apply for the Nursing Home Gold Seal Program by providing an alternative means to meet the financial soundness and stability requirement. If a facility can meet the other requirements of the Program, the bill allows a facility that may not have been eligible for the Award to seek recognition under the Program, which is not available under current law.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

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

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

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

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

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

(b) Evidence financial soundness and stability according to standards adopted by the agency in administrative rule. Such standards must include, but not be limited to, criteria for the use of financial statements that are prepared in accordance with generally accepted accounting principles and that are reviewed or audited by certified public accountants. A nursing home that is part of the same corporate entity as a continuing care facility licensed under chapter 651 which meets the minimum liquid reserve requirements specified in s. 651.035 satisfies this requirement if such nursing home:

1. ~~and~~ Is accredited by a recognized accrediting

organization under s. 651.028 and rules of the Office of Insurance Regulation satisfies this requirement as long as the accreditation is not provisional; or

2. Demonstrates that the continuing care facility in its entirety meets the financial standards adopted by the agency.

For purposes of this paragraph, facilities operated by a federal or state agency are deemed to be financially stable for purposes of applying for the Gold Seal.

A facility assigned a conditional licensure status may not qualify for consideration for the Gold Seal Program until after it has operated for 30 months with no class I or class II deficiencies and has completed a regularly scheduled relicensure survey.

Section 2. This act shall take effect upon becoming a law.

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	____

Committee/Subcommittee hearing bill: Health Innovation Subcommittee

Representative Cummings offered the following:

Amendment

Remove lines 21-31 and insert:

or audited by certified public accountants.

1. A nursing home that is part of the same corporate entity as a continuing care facility licensed under chapter 651 which meets the minimum liquid reserve requirements specified in s. 651.035 satisfies the financial soundness and stability requirement if such continuing care facility ~~and~~ is accredited by a recognized accrediting organization under s. 651.028 and rules of the Office of Insurance Regulation, ~~satisfies this requirement~~ as long as the accreditation is not provisional, or if such continuing care facility demonstrates that it meets in its entirety the financial standards adopted by the agency.

2. A nursing home that is part of a corporate entity operating nursing homes, assisted living facilities, or independent living facilities, or a combination thereof, satisfies the financial soundness and stability requirement if the nursing home submits a consolidated corporate financial statement to the agency and demonstrates that the corporate entity in its entirety meets the financial standards adopted by the agency.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 337 Vision Care Plans
SPONSOR(S): Peters
TIED BILLS: **IDEN./SIM. BILLS:** SB 340

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Langston	Poche
2) Insurance & Banking Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Ophthalmologists, optometrists, and opticians are health care practitioners, as defined in s. 456.001(4), F.S. They are regulated by their respective boards within the Division of Medical Quality Assurance and are overseen by the Department of Health (DOH).

The key difference between ophthalmologists, optometrists, and opticians is the scope of their practice. An optician designs, verifies, fits, and dispenses eyeglasses, contact lenses, and other optical devices upon the written prescription of a licensed ophthalmologist or optometrist; they do not diagnose or treat eye diseases. In addition to being able to dispense eyeglasses and contact lenses, an optometrist performs eye exams and vision tests to detect certain eye abnormalities, prescribes eyeglasses and contact lenses, and prescribes medications for eye diseases. An optometrist is not a medical doctor and is not authorized within the scope of practice to perform surgery or other invasive procedures. An ophthalmologist is a medical doctor or an osteopathic physician; therefore, in addition to being able to perform the duties of an optometrist, the ophthalmologist is licensed to perform eye surgeries.

Ophthalmologists, optometrists, and opticians routinely contract with health insurers, prepaid limited health services providers (PLHSOs), and health maintenance organizations (HMOs) for the provision of vision care services.

HB 337 prohibits health insurers, PLHSOs, and HMOs from requiring an ophthalmologist or optometrist to join a network solely for the purpose of credentialing the licensee for another insurer's vision network. The bill also prohibits a plan or insurer from restricting an ophthalmologist, optometrist, or optician to specific suppliers of materials or optical laboratories. Additionally, the bill requires health insurers, PLHSOs, and HMOs to update their online vision care network provider directories on a monthly basis to reflect current participation.

The bill renders a violation of these prohibitions an unfair insurance trade practice under s. 626.9541, F.S.

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

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Regulation of Ophthalmologists, Optometrists, and Opticians

Ophthalmologists, optometrists, and opticians are health care practitioners, as defined in s. 456.001(4), F.S., and are regulated by their respective boards within the Division of Medical Quality Assurance[1] within the Department of Health (DOH).[2] Ophthalmologists are governed by the practice act in Chapter 458 or 459, F.S.; optometrists are governed by the practice act in Chapter 463, F.S.; opticians are governed by the practice act in Chapter 484, Part I, F.S.

Ophthalmologists

Ophthalmology is a branch of medicine specializing in the anatomy, function, and diseases of the eye. Ophthalmologists provide a full spectrum of eye care. They perform functions of optometrists, such as annual eye exams and prescribing glasses and contact lenses. In addition, they are authorized within their scope of practice to perform delicate eye surgery. Ophthalmologists are either Medical Doctors (MDs) or Doctors of Osteopathic Medicine (DOs). They are regulated by the Board of Medicine and the Board of Osteopathic Medicine, respectively.

Optometrists

Optometrists, licensed by the Board of Optometry, are the primary health providers for normal vision care, including yearly checkups. They are licensed to practice optometry, which involves performing eye exams and vision tests, prescribing and dispensing glasses and contact lenses, detecting certain eye abnormalities, and prescribing medications for certain eye diseases.[3] Optometrists, or Doctors of Optometry, are not medical doctors and are not authorized within their scope of practice to perform surgery or other invasive techniques.[4]

Opticians

Opticians, licensed by Board of Opticianry, are technicians trained to design, verify and fit eyeglass lenses and frames, contact lenses, and other devices to correct eyesight.[5] Opticians are not permitted to test vision, diagnose or treat eye diseases, or write prescriptions for visual correction. Opticians rely on prescriptions supplied by ophthalmologists or optometrists to provide services.

Health Insurer Contracts

Health insurer provider contracts are regulated by the Office of Insurance Regulation (OIR) under Chapter 627, Part VI, F.S.

There are certain limitations placed on health insurer contracts. Section 627.6474(1), F.S., provides that a health insurer that requires a contracted health care practitioner to accept the terms of other practitioner contracts with the insurer, health maintenance organization (HMO) preferred provider, exclusive provider organization, prepaid limited health service organization (PLHSO), or other provider

[1] S. 456.001, F.S.
[2] S. 456.004, F.S.
[3] American Association for Pediatric Ophthalmology and Strabismus, *Differences between Ophthalmologist, Optometrist and Optician*, http://www.aapos.org/terms/conditions/132 (last visited November 24, 2015).
[4] S. 463.0055(1)(a), F.S.
[5] Supra, note 3.

contract is void. The only exception is for a practitioner in a group practice who must accept the terms of a contract negotiated for the practitioner by the group, as a condition of continuation or renewal of the contract. Additionally, s. 627.6474(2), F.S., provides that a contract between a health insurer and a dentist for the provision of dental services may not require the dentist to provide services to the insured under such contract at a fee set by the health insurer unless such services are covered services under the applicable contract.

Current Florida law does not prohibit health insurer provider contracts from requiring a licensed ophthalmologist or optometrist join a network or restricting an ophthalmologist, optometrist, or optician to specific suppliers of materials or optical laboratories. There are also no statutes that require health insurers to update network provider directories monthly.

Prepaid Limited Health Service Organization (PLHSO) Arrangements

PLHSOs provide limited health services to enrollees through an exclusive panel of providers in exchange for a prepayment, and are authorized in Part I, ch. 636, F.S. Limited health services are ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services, and pharmaceutical services. Provider arrangements for PLHSOs are authorized in s. 636.035, F.S., and must comply with the requirements in that section.

There are other limitations on PLHSO agreements. Section 636.035(12), F.S., provides that a contract is void if, as a condition of continuation or renewal of a contract, it requires a contracted limited health service provider to accept the terms of other practitioner contracts with the PLHSO or any insurer, preferred provider, exclusive provider organization, or other provider. There is an exception to this limitation for a practitioner in a group practice who must accept the terms of a contract negotiated for the practitioner by the group, as a condition of continuation or renewal of the contract. Additionally, s. 636.035(13), F.S., provides that a contract for dental services may not contain a provision that requires the dentist to provide services to the subscriber of the PLHSO at a fee set by the PLHSO unless such services are covered services under the applicable contract.

Section 636.035, F.S., does not prohibit PLHSO provider agreements from requiring a licensed ophthalmologist or optometrist join a network or restricting an ophthalmologist, optometrist, or optician to specific suppliers of materials or optical laboratories. There are also no statutes that require PLHSOs to update network provider directories monthly.

Health Maintenance Organization (HMO) Contracts

OIR regulates HMO contracts and rates under Chapter 641, Part I, F.S. The Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under Part III of ch. 641, F.S. Section 641.315, F.S., authorizes provider contracts with HMOs, and specifies the requirements for HMO provider contracts with "health care practitioners" as defined in s. 465.001(4), F.S.

Chapter 641, Part I, F.S., limits the provisions that may be in an HMO contract. Section 641.315(9), F.S., provides that a contract between an HMO and a contracted primary care or admitting physician may not contain any provision that prohibits the physician from providing inpatient services in a contracted hospital to a subscriber if such services are determined by the HMO to be medically necessary and covered services under the HMO's contract with the contracted physician. Also, s. 641.315(10), F.S., provides that an HMO contract that requires a contracted health care practitioner to accept the terms of another practitioner contract is void, except in cases where the practitioner is in a group practice and must accept the terms of a contract negotiated for the practitioner by the group, as a condition of continuation or renewal of the contract. Additionally, s. 641.315(11), F.S., provides that a contract for dental services may not contain a provision that requires the dentist to provide services to the subscriber of the HMO at a fee set by the HMO unless such services are covered services under the applicable contract.

Section 641.315, F.S., does not prohibit HMO provider contracts from requiring a licensed ophthalmologist or optometrist join a network or that restrict an ophthalmologist, optometrist, or optician to specific suppliers of materials or optical laboratories. There are also no statutes that require HMOs to update network provider agreements monthly.

Unfair Insurance Trade Practices

Chapter 626, Part IX, F.S., regulates insurance by defining practices that constitute unfair methods of competition or unfair or deceptive acts or practices and prohibits those activities.[6] Potential penalties under the Unfair Insurance Trade Practices Act include an amount not greater than:

- $5,000 for each nonwillful violation.
- $40,000 for each willful violation.
- An aggregate amount of $20,000 for all nonwillful violations arising out of the same action.
- An aggregate amount of $200,000 for all willful violations arising out of the same action.[7]

Fines may be imposed in addition to any other applicable penalty.[8] Additionally, OIR is authorized to conduct hearings,[9] issue cease and desist orders,[10] and assess a penalty of up to $50,0000 and suspend or revoke an entity's certificate of authority for engaging in an unfair insurance trade practice.[11]

Credentialing

Credentialing is a process for the collection and verification of a provider's professional qualifications, including academic background, relevant training and experience, licensure, and certification or registration to practice in a particular health care field.[12] Section 641.495(6), F.S., provides that each HMO must have a system for verification and examination of the credentials of each of its providers. If the HMO delegates the credentialing process to a contracted provider or entity, it must verify that the policies and procedures of the delegated provider or entity are consistent with the policies and procedures of the HMO and there is evidence of oversight activities to determine that required standards are maintained.[13]

Effect of the Proposed Changes

HB 337 amends ss. 627.6474, F.S., 636.035, F.S., and 641.315, F.S., to prohibit health insurers, PLHSOs, and HMOs, respectively, from requiring a licensed ophthalmologist or optometrist to join a network solely for the purpose of credentialing the licensee for another insurer's or organization's network. However, the bill provides that this provision does not prevent a health insurer, PLHSO, or

[6] S. 626.9541(1)(d), F.S., provides that entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion, or intimidation resulting in, or tending to result in, unreasonable restraint of, or monopoly in, the business of insurance are an unfair insurance trade practices.
[7] S. 656.9521(2), F.S.
[8] See s. 626.9631, F.S., the penalties under the insurance code are in addition to any other civil or administrative penalties.
[9] S. 626.9571, F.S.
[10] S. 626.9581, F.S.
[11] S. 626.6901, F.S.
[12] See, e.g. Aetna, *Health care professionals: Joining the Network FAQs*, https://www.aetna.com/faqs-health-insurance/health-care-professionals-join-network.html (last visited November 24, 2015); Florida Blue, *Manual for Physicians and Providers*, (2015), p. 14, available at https://www.floridablue.com/docview/provider-manual-2015/ (last visited November 24, 2015); UnitedHealthcare, *Physician Credentialing and Recredentialing Frequently Asked Questions*, available at https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools%20and%20Resources/Protocols/Credentialing_FAQ.pdf (last visited November 24, 2015).
[13] Bureau of Managed Health Care, Agency for Health Care Administration, *Interpretive Guidelines for Initial Health Care Provider Certificates: Health Maintenance Organizations and Prepaid Health Clinics*, (2010), page 48, available at https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Commercial_Managed_Care/docs/CHMO/Initial-IGs-withProbesJune2010.pdf (last visited November 24, 2015).

HMO from entering into a contract with another insurer's or organization's vision care plan to use their network.

The bill amends ss. 627.6474 F.S., 636.035, F.S., and 641.315, F.S., to prohibit health insurers, PLHSOs, and HMOs, respectively, from restricting a licensed ophthalmologist, optometrist, or optician to specific suppliers of material or optical laboratories. However, the bill provides that this provision does not restrict a health insurer, PLHSO, or HMO in determining specific amounts of coverage or reimbursement for the use of network or out-of-network suppliers or laboratories.

The bill specifies that any health insurer, PLHSO, or HMO who commits a knowing violation of either provision has committed an unfair insurance trade practice pursuant to s. 626.9541(1)(d), F.S. The violator is then subject to civil and administrative penalties under the Unfair Insurance Trade Practices Act.

The bill also requires health insurers, PLHSOs, and HMOs to update their online vision care network provider directory on a monthly basis to accurately reflect the providers currently participating in their networks.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 627.6474, F.S., relating to provider contracts.
Section 2: Amends s. 636.035, F.S., relating to provider arrangements.
Section 3: Amends s. 641.315, F.S., relating to provider contracts.
Section 4: Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

A health insurer, PLHSO, or HMO found to have violated the provisions of the bill is subject to civil and administrative fines under the Unfair Insurance Trade Practices Act.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The general rule of law is that legislation applies prospectively only. The Florida Constitution prohibits laws that retroactively impair the obligation of contracts already in existence.[14] To clarify its application, the bill may specify that the provisions only apply to contracts entered into or renewed on or after July 1, 2016.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[14] FLA. CONST. art I, s. 10.

A bill to be entitled

An act relating to vision care plans; amending ss. 627.6474, 636.035, and 641.315, F.S.; providing that a health insurer, a prepaid limited health service organization, and a health maintenance organization, respectively, may not require a licensed ophthalmologist or optometrist to join a network solely for the purpose of credentialing the licensee for another vision network; providing that such insurers and organizations are not prevented by the act from entering into a contract with another vision care plan; providing that such insurers and organizations may not restrict a licensed ophthalmologist, optometrist, or optician to specific suppliers of materials or optical laboratories; providing that such insurers and organizations are not restricted by the act in determining certain amounts of coverage or reimbursement; requiring such insurers' and organizations' online vision care network provider directories to be updated monthly; providing that a violation of certain prohibitions in the act constitutes a specified unfair insurance trade practice; providing an effective date.

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

Section 1. Subsection (3) is added to section 627.6474, Florida Statutes, to read:

627.6474 Provider contracts.—

(3)(a) A health insurer may not require an ophthalmologist licensed pursuant to chapter 458 or chapter 459 or an optometrist licensed pursuant to chapter 463 to join a network solely for the purpose of credentialing the licensee for another insurer's vision network. This paragraph does not prevent a health insurer from entering into a contract with another insurer's vision care plan to use the vision network.

(b) A health insurer may not restrict an ophthalmologist licensed pursuant to chapter 458 or chapter 459, an optometrist licensed pursuant to chapter 463, or an optician licensed pursuant to part I of chapter 484 to specific suppliers of materials or optical laboratories. This paragraph does not restrict a health insurer in determining specific amounts of coverage or reimbursement for the use of network or out-of-network suppliers or laboratories.

(c) A health insurer's online vision care network provider directory must be updated monthly to reflect the vision care providers currently participating in the health insurer's network.

(d) A knowing violation of paragraph (a) or paragraph (b) constitutes an unfair insurance trade practice under s. 626.9541(1)(d).

Section 2. Subsection (14) is added to section 636.035,

Florida Statutes, to read:

636.035 Provider arrangements.—

(14)(a) A prepaid limited health service organization may not require an ophthalmologist licensed pursuant to chapter 458 or chapter 459 or an optometrist licensed pursuant to chapter 463 to join a network solely for the purpose of credentialing the licensee for another organization's vision network. This paragraph does not prevent such organization from entering into a contract with another organization's vision care plan to use the vision network.

(b) A prepaid limited health service organization may not restrict an ophthalmologist licensed pursuant to chapter 458 or chapter 459, an optometrist licensed pursuant to chapter 463, or an optician licensed pursuant to part I of chapter 484 to specific suppliers of materials or optical laboratories. This paragraph does not restrict such organization in determining specific amounts of coverage or reimbursement for the use of network or out-of-network suppliers or laboratories.

(c) A prepaid limited health service organization's online vision care network provider directory must be updated monthly to reflect the vision care providers currently participating in the organization's network.

(d) A knowing violation of paragraph (a) or paragraph (b) constitutes an unfair insurance trade practice under s. 626.9541(1)(d).

Section 3. Subsection (12) is added to section 641.315,

Florida Statutes, to read:

641.315 Provider contracts.—

(12)(a) A health maintenance organization may not require an ophthalmologist licensed pursuant to chapter 458 or chapter 459 or an optometrist licensed pursuant to chapter 463 to join a network solely for the purpose of credentialing the licensee for another organization's vision network. This paragraph does not prevent such organization from entering into a contract with another organization's vision care plan to use the vision network.

(b) A health maintenance organization may not restrict an ophthalmologist licensed pursuant to chapter 458 or chapter 459, an optometrist licensed pursuant to chapter 463, or an optician licensed pursuant to part I of chapter 484 to specific suppliers of materials or optical laboratories. This paragraph does not restrict such organization in determining specific amounts of coverage or reimbursement for the use of network or out-of-network suppliers or laboratories.

(c) A health maintenance organization's online vision care network provider directory must be updated monthly to reflect the vision care providers currently participating in the organization's network.

(d) A knowing violation of paragraph (a) or paragraph (b) constitutes an unfair insurance trade practice under s. 626.9541(1)(d).

Section 4. This act shall take effect July 1, 2016.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 581 State Veterans' Nursing Homes
SPONSOR(S): Magar
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Guzzo	Poche
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

HB 581 creates a site selection process for new state veterans' nursing homes to be administered by the Florida Department of Veterans' Affairs (FDVA).

The State Veterans' Homes Program, administered by FDVA, provides care to eligible veterans in need of either long-term skilled nursing care or assisted living services. Currently, there are six state veterans' nursing homes in Florida. Because of the size and age of the veteran population, Florida is near the top of the list of states with a "Great Need" for veterans' nursing home beds as determined by the U.S. Department of Veterans' Affairs (VA). As a result, Florida will receive priority over other states applying to the VA for grants for the construction of new state veterans' nursing homes.

Currently, no Florida law governs FDVA's site selection process. FDVA's current process is two-tiered. First, FDVA contracts for a Site Selection Study (Study) to rank each county based on greatest need using certain measureable criteria. Second, FDVA sends applications to the top ten counties identified in the Study. Each county that wishes to be considered in the selection process must submit an application, which includes other measureable criteria, to FDVA by a specified date. The application is scored by a Site Selection Committee appointed by the Executive Director of FDVA. The county with the highest score is awarded the site, subject to approval by the Governor and the Cabinet.

The bill creates a single-step site selection process, in new s. 296.42, F.S. The bill requires FDVA to contract for a study to determine the most appropriate county for construction of a nursing home based on the greatest level of need. The study must be delivered to the Governor, the President of the Senate, and the Speaker of the House of Representatives by November 1, 2016, and a new study must be conducted and submitted every 4 years thereafter.

The bill requires that the study rank each county using the following criteria:

- The distance from the geographic center of the county to the nearest existing state veterans' nursing home;
- The number of veterans aged 65 years and older living in the county;
- The availability of emergency health care in the county;
- The presence of an existing Veterans' Health Administration Medical Center or Outpatient Clinic in the county;
- The number of existing nursing home beds per 1,000 elderly male residents of the county;
- The presence of accredited education institutions with health care programs in the county; and
- The county poverty rate.

FDVA must select the county with the highest ranking as the site for the new home, subject to approval by the Governor and the Cabinet. The bill requires the next highest ranked county to be selected if a higher ranked county cannot participate. The study must be used to determine the site of any new veterans' nursing home authorized before July 1, 2020. The bill requires the Site Selection Study dated February 7, 2014, to be used to select a county for a new veterans' nursing home before November 1, 2016, if authorized.

The bill has an insignificant fiscal impact on FDVA for the study.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

State Veterans' Homes Program

The Florida Department of Veterans' Affairs (FDVA) operates the State Veterans' Homes Program (Program) as authorized by Chapters 292 and 296, F.S.[1] The Program provides care to eligible veterans in need of either long-term skilled nursing care or assisted living services. Care is provided to veterans with qualifying war or peacetime service, who are residents of Florida and who require skilled care as certified by a U.S. Department of Veterans' Affairs (USDVA) physician.[2] There are over 700,000 veterans aged 65 years and older in the state.[3]

Currently, there are six state veterans' nursing homes in Florida. Five of the six homes have dementia-specific care.[4] The six nursing homes are located in Daytona Beach, Land O' Lakes, Pembroke Pines, Panama City, Port Charlotte, and St. Augustine. Currently, the Program has a total of 720 skilled-nursing beds and an average occupancy rate of 99%.[5] In 2014, St. Lucie County was selected as the site for the seventh nursing home. The home is currently in the initial planning stages.[6]

Funding

The construction of a new nursing home is subject to approval by the Governor and Cabinet. Funding is based on a 65% / 35% federal/state split of the cost.[7] Florida is near the top of the list of states with a "Great Need" for veterans' nursing home beds as determined by the USDVA.[8] As a result, Florida will receive priority over other states applying to USDVA for grants for the construction of new state veterans' nursing homes. The estimated cost to build a new nursing home can range from $37 million to $50 million, depending on style, land condition, materials used, weather resistance and energy efficiency.[9]

According to FDVA, the total cost of the seventh nursing home in St. Lucie County is $39.8 million.[10] The state pro-rata share of cost is $13.9 million and will be paid from the FDVA Operations and Maintenance Trust Fund.[11] Funding for future nursing homes will need to be supported by General Revenue funding.[12]

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[1] S. 292.05(7), F.S. "The Department shall administer this chapter and shall have the authority and responsibility to apply for and administer any federal programs and develop and coordinate such state programs as may be beneficial to the particular interests of the veterans of this state."; part II of ch. 296, F.S., titled "The Veterans' Nursing Home of Florida Act" provides for the establishment of basic standards by FDVA for the operation of veteran's nursing homes for eligible veterans in need of such services.

[2] S. 296.36, F.S.

[3] Florida Department of Veterans' Affairs, *Long Range Program Plan Fiscal Years 2016-17 through 2020-21*, page 10, available at http://floridavets.org/about-us/long-range-program-plan/ (last viewed on November 24, 2015).

[4] AHCA, Florida Health Finder.gov, *Facility Provider Locator; General Search by Nursing Home; Advanced Search (Special Programs and Services) by Alzheimer's*, available at http://www.floridahealthfinder.gov/facilitylocator/FacilitySearch.aspx (last viewed November 24, 2015).

[5] FDVA, Presentation to the House Health Care Appropriations Committee on November 3, 2015, *State Veterans' Homes Program and Fixed Capital Outlay Projects*, at pg. 3 (on file with Health Innovation Subcommittee staff).

[6] FDVA, *Fourth Quarter Report, Administrative Highlights, Current Issues Concerns, New State Veterans' Nursing Home*, (April 1 – June 30, 2015).

[7] 38 CFR §59.80

[8] 38 CFR §59.50(1)(iii); *see also* 38 CFR §§59.40 and .50.

[9] E-mail correspondence, FDVA, February 12, 2015, (on file with Health Innovation Subcommittee staff).

[10] Supra, FN 5 at pg. 10, "Changes in the construction schedule of state veteran' home number 7 may result in differences in actual expenditures by fiscal year. However, total cost of the project is not expected to vary from the total amount of $39.75 million.

[11] Id.

[12] Supra, at FN 8.

Site Selection Process for Recently Authorized State Veterans' Nursing Homes

State Veterans' Nursing Home Seven (St. Lucie County)

In 2013, the Legislature appropriated funds for FDVA to contract with a private entity to conduct a Site Selection Study (Study).[13] The purpose of the Study was to identify five communities, defined as single-county or multi-county areas, to be given priority for development of a new state veterans' nursing home.

Counties that did not meet certain minimum threshold criteria, including access to emergency care and the availability of health care professionals, were eliminated from consideration before the Study began. Counties with an existing state veterans' nursing home and those located within 25 miles of an existing home were also eliminated from consideration.

The Study used the following criteria to score the counties, rank ordered from greatest to least value assigned:

- Number of elderly veterans in the county;
- Ratio of existing nursing home beds per/1,000 elderly male residents in the county;
- County poverty rate;
- Distance to an existing state veterans' nursing home;
- Presence of an existing veterans' health care facility in the county; and
- Presence of nursing education programs in the county.

The Study identified the following top ten counties with the greatest need for a new state veterans' nursing home, ranked in order of greatest need based on the scoring criteria:

Study Ranking	County
1	Collier
2	Lee
3	Polk
4	Manatee
5	Marion
6	Putnam
7	St. Lucie
8	Hillsborough
9	Palm Beach
10	Sumter

FDVA sent applications to all ten counties listed in the Study. Six of the counties submitted applications: Collier County, Polk County, Manatee County, Marion County, Putnam County, and St. Lucie County. A Site Selection Committee (Committee) was created by the Executive Director of FDVA to evaluate each application.

The Committee established factors for consideration, and assigned a score of 0 to 50 points for each of the following criteria:

- Number of veterans aged 65 or older living within a 75 mile radius of the proposed site;
- Number of nursing home beds and assisted living facility beds located within 10 miles of the proposed site;

[13] Hoy & Stark Architects, *Site Selection Study; Phase I State Veterans' Nursing Homes Statewide*, February 7, 2014, (on file with the Health Innovation Subcommittee staff).

- Suitability of the donated site in terms of its general surroundings and support capabilities;
- Availability of emergency health care, as determined by:
  - Number of hospitals and/or emergency care centers within 25 miles of the proposed site;
  - Number of emergency room holding beds per facility;
  - Presence of in-house physicians on staff in the emergency room 24 hours/day, 7 days/week; and
  - The nursing workforce.
- Availability of health care professionals, as determined by the number of accredited educational institutions located within 50 miles of the proposed site; and
- Availability of infrastructure at the site, including roads, water, sewer, telephone lines, and electricity/natural gas services, all of which must link to the property line of the proposed site at no cost to the state.

The Committee's final rankings were:

Committee Ranking	County	Study Ranking
1	St. Lucie	7
2	Marion	5
3	Collier Site B	1
4	Collier Site A	1
5	Polk Site A	3
6	Polk Site B	3

St. Lucie County was selected as the site for the seventh nursing home, and approved by the Governor and Cabinet on September 23, 2014.

State Veterans' Nursing Home Six (St. Johns County)

The same site selection process was used to determine the site of the sixth nursing home. A Study[14] was conducted in 2004 and the home was built in 2010. The extended length of time between site selection and construction of the nursing home was due to a lack of funds caused by the economic recession in the mid-2000s.

The Study identified the following top twelve areas, which included counties and multi-county groups, with the greatest need for a veterans' nursing home:

Study Ranking	County or Area
1	Lake/Marion/Sumter
2	Duval
3	Brevard
4	Escambia/Santa Rosa/Okaloosa
5	Indian River/Martin/St. Lucie
6	Orange/Seminole
7	Collier/Lee
8	Palm Beach
9	Sarasota/Manatee
10	Polk
11	Citrus/Hernando
12	Pinellas

The Committee selected St. Johns County as the site for sixth veterans' nursing home. St. Johns County was not identified in the Study as an area of need.

[14] Health Strategies, Inc., *Nursing Home Site Selection Study*, February 2004, (on file with the Health Innovation Subcommittee staff).

Site Selection Process Workshop

In February 2015, FDVA conducted a state veterans' nursing home site selection process workshop (workshop). The goal of the workshop was to review the existing site selection process and determine if the process is valid and useful for future site selections.[15]

The final report from the workshop included the following recommendations:

- Follow the 2014 site selection study recommendations but allow up to three adjoining counties to combine and submit a single application;
- Revise weighting of the application, but not the site selection study;
- Outline weighted factors in the application packet;
- Limit counties to a single site proposal to ensure counties put their best product forward and apply resources to that site accordingly;
- Keep the site selection committee intact, but change the point of contact to a non-voting member;
- Redesign the application form;
- Revise the score sheet to add a scoring scale and train site selection committee members accordingly;
- Rank order sites in the next site selection process from one through four and award homes 8,9, and 10 to the top three sites with the fourth site being an alternate if site number three is disqualified by FDVA or the USDVA; and
- Allow runner-up sites in scoring to become alternate sites.[16]

On November 10, 2015, FDVA presented the recommendations to the Governor and Cabinet for approval. The Governor and Cabinet approved all but one of the recommendations. Specifically, the recommendation to rank order sites in the next site selection process from one through four and award homes 8,9, and 10 to the top three sites was not accepted.

Effect of Proposed Changes

The bill creates a single-step site selection process, in new s. 296.42, F.S. The bill requires FDVA to contract for a study to determine the most appropriate county for construction of a new nursing home based on the greatest level of need. The study must be delivered to the Governor, President of the Senate, and the Speaker of the House of Representatives by November 1, 2016, and a new study must be conducted and submitted every 4 years thereafter.

The bill requires the study to use the following criteria to rank each county:

- The distance from the geographic center of the county to the nearest existing state veterans' nursing home;
- The number of veterans aged 65 years and older living in the county;
- The availability of emergency health care in the county, as determined by:
    - The number of general hospitals;
    - The number of emergency room holding beds per hospital; and
    - The number of in-house physicians per hospital on staff in the emergency room 24 hours per day.
- The presence of an existing Veterans' Health Administration Medical Center or Outpatient Clinic in the county;
- The number of existing nursing home beds per 1,000 elderly male residents of the county;
- The presence of accredited education institutions with health care programs in the county; and

[15] FDVA, *State Veterans' Nursing Home Site Selection Process Workshop Results and Recommendations, Final Report,* (March 12, 2015).
[16] Id.

- The county poverty rate.

The county with the highest ranking must be selected as the site for the new home, subject to approval by the Governor and the Cabinet. The bill requires the next highest ranked county to be selected if a higher ranked county cannot participate. The study must be used to determine the site for any veterans' nursing home authorized before July 1, 2020. For any veterans' nursing home authorized before November 1, 2016, the bill requires the FDVA to use the 2014 Site Selection Study.

B. SECTION DIRECTORY:

Section 1: Creates s. 296.42, F.S., relating to the site selection process for state veterans' nursing homes.

Section 2: Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill requires FDVA to contract for a study to rank each county according to greatest need to determine the most appropriate site for a new veterans' nursing home. The Site Selection Study for the determination of the seventh state nursing home location was competitively procured and a contract was awarded to Hoy + Stark Architects, P.A. for a total cost of $38,692.[17]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

[17] E-mail correspondence, FDVA, March 19, 2015, (on file with Health Innovation Subcommittee staff).

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to state veterans' nursing homes; creating s. 296.42, F.S.; directing the Department of Veterans' Affairs to contract for a study to determine the need for additional state veterans' nursing homes and the most appropriate counties in which to locate the homes; directing the department to submit the study to the Governor and Legislature; providing study criteria for ranking each county according to need; requiring the department to use specified studies to select new nursing home sites; directing the department to contract for subsequent studies and submit the studies to the Governor and Legislature; providing an effective date.

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

Section 1. Section 296.42, Florida Statutes, is created to read:

296.42 Site selection process for state veterans' nursing homes.—

(1) The department shall contract for a study to determine the need for new state veterans' nursing homes and the most appropriate counties in which to locate the homes based on the greatest level of need. The department shall submit the study to the Governor, the President of the Senate, and the Speaker of

the House of Representatives by November 1, 2016.

(2) The study shall use the following criteria to rank each county according to need:

(a) The distance from the geographic center of the county to the nearest existing state veterans' nursing home.

(b) The number of veterans age 65 years or older residing in the county.

(c) The presence of an existing federal Veterans' Health Administration medical center or outpatient clinic in the county.

(d) Elements of emergency health care in the county, as determined by:

1. The number of general hospitals.

2. The number of emergency room holding beds per hospital.

3. The number of in-house physicians per hospital on staff in the emergency room 24 hours per day.

(e) The number of existing community nursing home beds per 1,000 males age 65 years or older residing in the county.

(f) The presence of an accredited educational institution offering health care programs in the county.

(g) The county poverty rate.

(3) The department shall use the study ranking to select each new state veterans' nursing home site authorized before July 1, 2020, subject to approval by the Governor and Cabinet. For each new nursing home, the department shall select the highest-ranked county in the study which does not have a

veterans' nursing home. If the highest-ranked county cannot serve as the site, the department shall select the next-highest-ranked county. The department shall use the 2014 Site Selection Study to select a county for any new state veterans' nursing home authorized before November 1, 2016, subject to approval by the Governor and Cabinet.

(4) The department shall contract for and submit a new study in accordance with this section by November 1, 2020, and every 4 years thereafter.

Section 2. This act shall take effect July 1, 2016.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 595 Reimbursement to Health Access Settings for Dental Hygiene Services for Children
SPONSOR(S): Plasencia
TIED BILLS: **IDEN./SIM. BILLS:** SB 580

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		McElroy CM	Poche MP
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

There is currently a conflict between s. 409.906(6), F.S., and s. 466.024(2), F.S., which limits the reimbursable scope of practice for dental hygienist providing dental services to children under the age of 21 in health access settings. Section 466.024(2), F.S., authorizes dental hygienists to perform a limited number of unsupervised remedial tasks in health access settings. These remedial tasks are reimbursable pursuant to s. 466.024(4), F.S. However, reimbursement for these unsupervised tasks is barred under the Managed Medical Assistance (MMA) program as s. 409.906(6), F.S., expressly authorizes reimbursement for dental services only if these tasks were performed under the supervision a licensed dentist. HB 595 eliminates this conflict by amending s. 409.906(6), F.S., to allow for the reimbursement of the remediable tasks that a licensed dental hygienist is authorized to perform under s. 466.024(2), F.S. Reimbursement is limited to only those remedial tasks which were performed on children under the age of 21.

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

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Oral Health

Oral health has a significant impact on an individual's physical and mental health. It can influence how individuals grow, enjoy life, look, speak, chew, taste food and socialize, as well as their feelings of social well-being.[1] It can also affect, be affected or contribute to various diseases and conditions including:[2]

- Endocarditis;
- Cardiovascular disease;
- Diabetes;
- HIV/AIDS;
- Osteoporosis; and
- Alzheimer's disease.

For children, poor oral health can result in pain, discomfort, disfigurement, acute and chronic infections, eating and sleep disruption and an overall reduction of quality of life.[3] Children with poorer oral health are also more likely to miss school, have a lower grade-point average and otherwise perform poorly in school.[4] In fact, one study concluded that visits or dental problems accounted for 117,000 hours of school lost per 100,000 children.[5]

Tooth decay is one of the most common, and easily preventable, chronic conditions of childhood in the United States.[6] About 20% of children aged 5-11 and 13% of adolescents aged 12-19 have at least one untreated tooth decay.[7] The prevalence of tooth decay is more than twice as high, 25% compared to 11%, for children from low-income families.[8]

Dental Workforce

Currently, there is a national workforce shortage of dentists, and it is projected to worsen in the future. In 2012, there were 190,800 dentists with an estimated need of 197,800 dentists, resulting in a shortage of 7,000 dentists.[9] By 2025, projections have 202,600 dentists in practice with a need for

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[1] *Oral Health, General Health and Quality of Life*, World Health Organization, Aubrey Sheiham, Volume 83, Number 9, September 2005, 641-720. http://www.who.int/bulletin/volumes/83/9/editorial30905html/en/ (last visited November 23, 2015).
[2] *What Conditions May be Linked to Oral Health*, Mayo Clinic. http://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475?pg=2 (last visited on November 23, 2015).
[3] Id.
[4] *Impact of Poor Oral Health on Children's School Attendance and Performance*, Stephanie L. Jackson, DDS, MS,corresponding author William F. Vann, Jr, DMD, PhD, Jonathan B. Kotch, MD, MPH, Bhavna T. Pahel, PhD, MPH, BDS, and Jessica Y. Lee, DDS, PhD, MPH, American Journal of Public Health, Am J Public Health. 2011 October; 101(10): 1900–1906. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3222359/ (last visited on November 23, 2015); *The Impact of Oral Health on the Academic Performance of Disadvantaged Children*, Hazem Seirawan, DDS, MPH, MS, Sharon Faust, DDS, and Roseann Mulligan, DDS, MS, American Journal of Public Health, Am J Public Health. 2012 September; 102(9): 1729–1734. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3482021/ (last visited on November 23, 2015).
[5] *Supra* footnote 1.
[6] *Children's Oral Health*, Centers for Disease Control and Prevention, Division of Oral Health, National Center for Chronic Disease Prevention and Health Promotion. http://www.cdc.gov/oralhealth/children_adults/child.htm (last visited November 23, 2015).
[7] Id.
[8] Id.
[9] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. National and State-Level Projections of Dentists and Dental Hygienists in the U.S., 2012-2025. Rockville, Maryland, 2015. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwjv-

211,200 dentists.[10] This projected shortage of 8,600 dentists, combined with the 2012 shortage, results in a shortage of 15,600 dentists by the year 2025. All 50 states and the District of Columbia are projected to have a shortfall of dentists with Florida projected to have the second highest shortfall in the nation (1,152) by 2025.[11]

Dental hygienists are trending in the opposite direction of dentists. There is currently an excess supply of dental hygienists and by 2025 the national excess supply is projected to be 28,100.[12] Florida again follows the national trend and is projected to have the third largest excess supply of dental hygienists (2,768) by 2025.[13] However, not all states are projected to have an excess supply.[14]

Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families, the Agency for Persons with Disabilities, and the Department of Elderly Affairs.

The structure of each state's Medicaid program varies and what states must pay for is largely determined by the federal government, as a condition of receiving federal funds. Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states: Some populations are entitled to enroll in the program; and enrollees are entitled to certain benefits.

The federal government sets the minimum mandatory benefits to be covered in every state Medicaid program. These benefits include physician services, hospital services, home health services, and family planning.[15] States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, dental services, and dialysis.[16]

Statewide Medicaid Managed Care[17]

In 2011, the Legislature established the Statewide Medicaid Managed Care (SMMC) program as Part IV of Chapter 409, F.S. The SMMC program is an integrated managed care program which provides all the mandatory and optional Medicaid benefits to enrollees. Within the SMMC program, the Managed Medical Assistance (MMA) program provides primary and acute medical assistance and related services, including dental services.[18]

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[10] Id.

[11] Id.

[12] Id.

[13] Id.

[14] Id.

[15] S. 409.905, F.S.

[16] S. 409.906, F.S.

[17] The delivery of Medicaid services through managed care is not expressly authorized by federal law. If a state wants to use a managed care delivery system, it must seek a waiver of certain requirements of Title XIX of the Social Security Act (Medicaid). To implement the SMMC program, AHCA applied for and obtained section 1115 waiver authority.

[18] The other component of the SMMC program is the Long-Term Care Managed Care Program.

In the SMMC program, each Medicaid recipient has one managed care organization to coordinate all health care services, rather than various entities.[19] Such coordinated care is particularly important in the area of oral health, which is connected to overall health outcomes.[20]

In December 2012, AHCA released an Invitation to Negotiate (ITN) to competitively procure managed care plans on a regional basis for the MMA program.[21] AHCA selected 19 managed care plans and executed 5-year contracts in February, 2014. The MMA program was fully implemented statewide as of August 1, 2014.

Dental Care in the MMA Program

Dental services are an optional Medicaid benefit. Florida provides full dental services for children and only dentures and medically necessary, emergency dental procedures to alleviate pain or infection for adults.[22] As of November 2015, approximately 3.1 million Medicaid recipients are enrolled in the MMA program and receive their dental services through managed care plans that offer a full array of medical, behavioral, and dental health benefits.[23]

Dental Service Accountability and Performance in the MMA Program

The MMA program contracts impose various accountability provisions and performance measures on the MMA plans specific to dental services, which include requirements for:[24]

- Network adequacy;
- Annual medical loss ratio for the first full year of MMA program operation;
- Preventive dental services rate for children enrolled for 90 continuous days;
- Transportation to and from the child's dental appointment, if needed; and
- Healthcare Effectiveness Data and Information Set scores.[25]

MMA plans are subject to corrective actions and liquidated damages for failure to meet accountability provisions and performance measures set forth in the contracts.

In addition, under federal terms and conditions, AHCA must work with MMA plans on an oral health quality improvement initiative. For this initiative, the MMA contracts[26] have specific performance goals for pediatric dental services and penalties for not reaching the performance standards.

Dental Care Reimbursement for Children's Dental Services

The MMA program authorizes reimbursement for children's dental services rendered by dentists, dental hygienists and dental assistants. A dentist may delegate remediable tasks[27] to dental hygienists or

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[19] This comprehensive coordinated system of care was successfully implemented in the 5-county Medicaid reform pilot program, 2006-2014.

[20] U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000. http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBJT/ (last visited on November 23, 2015).

[21] AHCA Invitation to Negotiate, *Statewide Medicaid Managed Care*, *Addendum 2* Solicitations Number: AHCA ITN 017-12/13; dated February 26, 2013 http://www.govcb.com/Statewide-Medicaid-Managed-Care-ADP13619273520001182.htm (last visited on November 23, 2015); AHCA Invitation to Negotiate, *Statewide Medicaid Managed Care*, Solicitation Number: AHCA ITN 017-12/13; dated December 28, 2012 http://www.govcb.com/Statewide-Medicaid-Managed-Care-ADP13619273520001182.htm (last visited on November 23, 2015).

[22] S. 409.906(1), (6), F.S.

[23] Comprehensive Medicaid Managed Care Enrollment Reports, AHCHA, November 2015. http://www.fdhc.state.fl.us/MCHQ/Managed_Health_Care/MHMO/med_data.shtml (last visited on November 23, 2015).

[24] The Managed Medical Assistance Model Contract is available at https://ahca.myflorida.com/medicaid/statewide_mc/plans.shtml (last visited on November 23, 2015).

[25] AHCA measures the performance of the MMA plans based on standards established by the National Committee for Quality Assurance called the Healthcare Effectiveness Data and Information Set (HEDIS).

[26] *Supra* footnote 25.

dental assistants when such tasks pose no risk to the patient.[28] ACHA is statutorily authorized to pay for diagnostic, preventive, or corrective procedures, including orthodontia in severe cases, provided to a recipient under age 21, by or under the supervision of a licensed dentist.[29] Thus, a dentist must supervise any delegable tasks performed by a dental hygienist or dental assistant if reimbursement is being sought under the MMA.

Dental Hygienists

Dental Hygienists are regulated by ch. 466, F.S., and by the Board of Dentistry (Board) within the Department of Health. Dental hygienists are focused on preventing dental disease. They are educated and trained to evaluate the patient's oral health; expose, process and interpret dental X-ray films; and remove calculus deposits, stains, and plaque above and below the gumline.[30] They also apply preventive agents such as fluorides and sealants to teeth when allowed by state regulations.[31] Dental hygienists may also perform certain tasks which are delegated by a licensed dentist. These delegable tasks are established either in statute or by rule and include:[32]

- Taking impressions for study casts but not for the purpose of fabricating any intraoral restorations or orthodontic appliance;
- Placing periodontal dressings;
- Removing periodontal or surgical dressings;
- Removing sutures;
- Placing or removing rubber dams;
- Placing or removing matrices;
- Placing or removing temporary restorations;
- Applying cavity liners, varnishes, or bases;
- Polishing amalgam restorations;
- Polishing clinical crowns of the teeth for the purpose of removing stains but not changing the existing contour of the tooth;
- Dental charting[33];
- Obtaining bacteriological cytological specimens not involving cutting of the tissue; and
- Administering local anesthesia pursuant to s. 466.017(5).

[27] "Remediable tasks" are those intraoral treatment tasks which are reversible and do not create unalterable changes within the oral cavity or the contiguous structures and which do not cause an increased risk to the patient. S. 466.003(12), F.S.
[28] S. 466.024(1), F.S.
[29] S. 409.906 (6), F.S.
[30] S. 466.023, F.S.
[31] See Rule 64B5-16.006, F.A.C.
[32] S. 466.024 (1), F.S.
[33] "Dental Charting" is a recording of visual observations of clinical conditions of the oral cavity without the use of X rays, laboratory tests, or other diagnostic methods or equipment, except the instruments necessary to record visual restorations, missing teeth, suspicious areas, and periodontal pockets. S. 466.0235.

The Board establishes by rule whether these tasks are to be performed under direct, indirect, or general supervision of the dentist.[34] A dental hygienist may perform these tasks in multiple settings, including:[35]

- In the office of a licensed dentist;
- In public health programs and institutions of the Department of Children and Families, Department of Health, and Department of Juvenile Justice under the general supervision of a licensed dentist; and
- In a health access setting.

Scope of Practice in Health Access Settings

In 2011, the Legislature expanded the scope of practice for dental hygienists providing dental services to children under the age of 21 in health access settings[36] in an effort to maximize the existing dental workforce. The legislation authorized licensed dental hygienists to perform certain remedial tasks in a health access setting without the physical presence, prior examination or authorization of a dentist.[37] These tasks include:

- Perform dental charting as defined in s. 466.0235 and as provided by rule;
- Measure and record a patient's blood pressure rate, pulse rate, respiration rate, and oral temperature;
- Record a patient's case history;
- Apply topical fluorides, including fluoride varnishes, which are approved by the American Dental Association or the Food and Drug Administration;
- Apply dental sealants; and
- Remove calculus deposits, accretions, and stains from exposed surfaces of the teeth and from tooth surfaces within the gingival sulcus. [38]

Numerous safeguards are in place to ensure patient safety when unsupervised services are provided in health access settings. For example, when a dental hygienist performs one of the above procedures, the patient must be notified that the visit with the dental hygienist is not a substitute for a comprehensive dental exam.[39] Additionally, a dentist is required to conduct an oral examination within 13 months of a dental hygienist removing calculus deposits, accretions, and stains from a patient's teeth.[40] Also, a dental hygienist providing such services must maintain professional malpractice insurance coverage that has minimum limits of $100,000 per occurrence and $300,000 in the aggregate through the employing health access setting or through an individual policy.[41]

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[34] S. 466.023(1), F.S. "Direct supervision" means supervision whereby a dentist diagnoses the condition to be treated, a dentist authorizes the procedure to be performed, a dentist remains on the premises while the procedures are performed, and a dentist approves the work performed before dismissal of the patient. "Indirect supervision" means supervision whereby a dentist authorizes the procedure and a dentist is on the premises while the procedures are performed. "General supervision" means supervision whereby a dentist authorizes the procedures which are being carried out but need not be present when the authorized procedures are being performed. The authorized procedures may also be performed at a place other than the dentist's usual place of practice. The issuance of a written work authorization to a commercial dental laboratory by a dentist does not constitute general supervision. S. 466.003 (8), (9) and (10), F.S.

[35] S. 466.023(2), F.S.

[36] "Health access setting" means a program or an institution of the Department of Children and Families, the Department of Health, the Department of Juvenile Justice, a nonprofit community health center, a Head Start center, a federally qualified health center or look-alike as defined by federal law, a school-based prevention program, a clinic operated by an accredited college of dentistry, or an accredited dental hygiene program in this state if such community service program or institution immediately reports to the Board of Dentistry all violations of s. 466.027, s. 466.028, or other practice act or standard of care violations related to the actions or inactions of a dentist, dental hygienist, or dental assistant engaged in the delivery of dental care in such setting. S. 466.003(14), F.S.

[37] S. 466.024 (2), F.S.

[38] Id.

[39] S. 466.024 (3)(a), F.S.

[40] S. 466.024 (2)(f) 2, F.S.

[41] S. 466.024 (5)(c), F.S.

The absence of dentist supervision of the tasks performed by a dental hygienist in a health access setting does not preclude reimbursement for those services. Specifically, s. 466.024(4), F.S., states:

> This section does not prevent a program operated by one of the health access settings as defined in s. 466.003 or a nonprofit organization that is exempt from federal income taxation under s. 501(a) of the Internal Revenue Code and described in s. 501(c)(3) of the Internal Revenue Code from billing and obtaining reimbursement for the services described in this section which are provided by a dental hygienist or from making or maintaining any records pursuant to s. 456.057 necessary to obtain reimbursement.

As such, programs providing dental care in health access settings may seek reimbursement for specified dental services provided by dental hygienists, irrespective of whether those services were supervised by a dentist.

Effect of Proposed Changes

There is currently a conflict between s. 409.906(6), F.S., and s. 466.024(2), F.S., which limits the reimbursable scope of practice for dental hygienist providing dental services to children under the age of 21 in health access settings. Section 466.024(2), F.S., authorizes dental hygienists to perform a limited number of unsupervised remedial tasks in health access settings. These remedial tasks are reimbursable pursuant to s. 466.024(4), F.S. However, reimbursement for these unsupervised tasks is barred under the Managed Medical Assistance (MMA) program as s. 409.906(6), F.S., expressly authorizes reimbursement for children's dental services only if these tasks were performed under the supervision a licensed dentist.

HB 595 eliminates this conflict by amending s. 409.906(6), F.S., to allow for the reimbursement of the remediable tasks that a licensed dental hygienist is authorized to perform under s. 466.024(2), F.S. Reimbursement is limited to only those remedial tasks which were performed on children under the age of 21.

B. SECTION DIRECTORY:

Section 1: Amending s. 409.906, F.S., relating to optional Medicaid services.
Section 2: Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   AHCA may reimburse health access settings for remedial tasks performed by licensed dental hygienists, as outlined in s. 466.024(2), F.S., on children under age 21.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Health access settings may be reimbursed for remedial tasks performed by licensed dental hygienists on children under age 21.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to reimbursement to health access settings for dental hygiene services for children; amending s. 409.906, F.S.; authorizing reimbursement for children's dental services provided by licensed dental hygienists in certain circumstances; providing an effective date.

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

Section 1. Subsection (6) of section 409.906, Florida Statutes, is amended to read:

409.906 Optional Medicaid services.—Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or

directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(6) CHILDREN'S DENTAL SERVICES.—The agency may pay for diagnostic, preventive, or corrective procedures, including orthodontia in severe cases, provided to a recipient under age 21, by or under the supervision of a licensed dentist, or the remediable tasks that a licensed dental hygienist is authorized to perform under s. 466.024(2). Services provided under this program include treatment of the teeth and associated structures of the oral cavity, as well as treatment of disease, injury, or impairment that may affect the oral or general health of the individual. However, Medicaid will not provide reimbursement for dental services provided in a mobile dental unit, except for a mobile dental unit:

(a) Owned by, operated by, or having a contractual agreement with the Department of Health and complying with Medicaid's county health department clinic services program specifications as a county health department clinic services provider.

(b) Owned by, operated by, or having a contractual

arrangement with a federally qualified health center and complying with Medicaid's federally qualified health center specifications as a federally qualified health center provider.

(c) Rendering dental services to Medicaid recipients, 21 years of age and older, at nursing facilities.

(d) Owned by, operated by, or having a contractual agreement with a state-approved dental educational institution.

Section 2. This act shall take effect July 1, 2016.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 595 (2016)

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health Innovation Subcommittee

Representative Plasencia offered the following:

Amendment

Remove lines 38-40 and insert:

21, by or under the supervision of a licensed dentist. The agency may also reimburse a health access setting as defined in s. 466.003 for the remediable tasks that a licensed dental hygienist is authorized to perform under s. 466.024(2). Services provided under this