The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Harrell, Chair
Senator Berman, Vice Chair

MEETING DATE: Monday, March 4, 2019
TIME: 1:00—3:00 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

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

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 192** Bean	Medicaid Eligibility; Requiring the Agency for Health Care Administration to seek authorization from the federal Centers for Medicare and Medicaid Services (CMS) to eliminate the Medicaid retroactive eligibility period for nonpregnant adults; requiring the agency to request such authorization to become effective no later than a certain date, etc. HP 03/04/2019 Favorable AHS AP	Favorable Yeas 6 Nays 4
2	**CS/SB 322** Banking and Insurance / Simpson	Preexisting Conditions; Defining the terms “operative date” and “preexisting medical condition” with respect to individual health insurance policies; requiring insurers, contingent upon the occurrence of either of two specified events, to make at least one comprehensive major medical health insurance policy available to all residents of this state within a specified timeframe; prohibiting such insurers from excluding, limiting, denying, or delaying coverage under such policies due to preexisting medical conditions, etc. BI 02/19/2019 Fav/CS HP 03/04/2019 Fav/CS RC	Fav/CS Yeas 10 Nays 0
3	**SB 778** Baxley (Similar H 1123)	Program of All-Inclusive Care for the Elderly; Authorizing the Agency for Health Care Administration, in consultation with the Department of Elderly Affairs, to approve entities applying to deliver Program of All-Inclusive Care for the Elderly (PACE) services in the state; requiring prospective PACE organizations that are granted initial state approval to submit a complete application to the agency and the Federal Government within a certain timeframe; exempting PACE organizations from specified provisions; specifying requirements for the agency in paying contractors providing services to eligible applicants, etc. HP 03/04/2019 Favorable AHS AP	Favorable Yeas 9 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**SB 648** Mayfield (Identical H 549)	Continuing Education for Dentists; Requiring a licensed dentist to complete a minimum of 2 hours of continuing education on the prescribing of controlled substances biennially, etc. HP 03/04/2019 Favorable IT RC	Favorable Yeas 9 Nays 0
5	**SB 716** Hooper (Similar H 465)	Dental Services; Citing this act as the "Donated Dental Services Act"; establishing the Dental Student Loan Repayment Program to support dentists who practice in public health programs located in certain underserved areas; requiring the Department of Health to establish the Donated Dental Services Program to provide comprehensive dental care to certain eligible individuals, etc. HP 03/04/2019 Favorable AHS AP	Favorable Yeas 9 Nays 0
6	**SB 374** Harrell (Similar H 1017)	Children and Youth Cabinet; Expanding the membership of the Children and Youth Cabinet within the Executive Office of the Governor to include a representative from the Florida Dental Association appointed by the Governor, etc. CF 02/11/2019 Favorable HP 03/04/2019 Favorable RC	Favorable Yeas 9 Nays 0
7	**SB 1026** Harrell (Identical H 1147, Compare H 383, Linked S 448)	Fees/Advanced Birth Centers; Providing applicability of licensure fee requirements to advanced birth centers; requiring an advanced birth center to pay an inspection fee to the agency; providing applicability of an assessment to advanced birth centers, etc. HP 03/04/2019 Favorable CF RC	Favorable Yeas 9 Nays 0
	Other Related Meeting Documents		

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 192
INTRODUCER:	Senator Bean
SUBJECT:	Medicaid Eligibility
DATE:	March 5, 2019
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Williams	Brown	HP	**Favorable**
2.			AHS	
3.			AP	

I. Summary:

SB 192 directs the Agency for Health Care Administration (AHCA) to seek authorization from the federal government to maintain Florida's current waiver authority that modifies the period of retroactive eligibility for certain Medicaid recipients. Pending federal approval, the current waiver authority allowing Florida's retroactive eligibility period for a non-pregnant adult to begin on the first day of the month in which the Medicaid recipient applies for Medicaid, would continue beyond its current expiration date of July 1, 2019. Otherwise, on that date, Florida's retroactive eligibility period will revert to 90 days, which is the norm under federal Medicaid regulations.

Consistent with the Terms and Conditions of the current Medicaid Managed Medical Assistance Program waiver, the bill also directs the AHCA to notify the federal government, before May 17, 2019, that this bill has been enacted by the Legislature during the 2019 Regular Session.

Florida's Medicaid program estimates that if the current waiver authority to limit retroactive eligibility is not extended, the Legislature will need to appropriate an additional $103.6 million to the AHCA for State Fiscal Year 2019-2020 to restore the reduction taken in the 2018-2019 General Appropriations Act. Of this total, $40.1 million is General Revenue, and $63.5 million is federal funding.

The bill is effective upon becoming law.

II. Present Situation:

The Medicaid Program

The Florida Medicaid program is a partnership between the federal and state governments. Each state operates its own Medicaid program under a state plan approved by the federal Centers for

Medicare & Medicaid Services (CMS). The state plan outlines Medicaid eligibility standards, policies, and reimbursement methodologies.

Florida Medicaid is administered by the AHCA, and financed with federal and state funds. Just under 4 million Floridians are currently enrolled in Medicaid, and the program has estimated expenditures for the 2019-2020 state fiscal year of $28.2 billion.[1]

Eligibility for Florida Medicaid is based on a number of factors, including age, household or individual income, and assets. State Medicaid payment guidelines are provided in s. 409.903, F.S., (Mandatory Payments for Eligible Persons) and s. 409.904, F.S., (Optional Payments for Eligible Persons). Minimum coverage thresholds are established in federal law for certain population groups, such as children.

Medicaid Retroactive Eligibility

The Social Security Act provides the requirements under which state Medicaid programs must operate. Federal law directs state Medicaid programs to cover, and provides federal matching funds for, medical bills up to three months prior to a recipient's application date.[2] The federal Medicaid statute requires that Medicaid coverage for most eligibility groups must include retroactive coverage for a period of 90 days prior to the date of the application for medical assistance, but, by federal regulations, this requirement can be waived.

An initial analysis by the AHCA indicated that approximately 39,000 non-pregnant adults were made retroactively eligible under the 90-day requirement of federal regulations in State Fiscal Year 2015-2016.[3] A more recent AHCA analysis corrects the erroneous counting of duplicate months of coverage for such recipients and indicates that 11,466 distinct individuals were granted such retroactive eligibility and utilized services during their retroactive period during State Fiscal Year 2017-2018.[4]

In compliance with the federal requirement for 90 days of retroactive eligibility, the Florida Medicaid State Plan previously provided that "[c]overage is available beginning the first day of the third month before the date of application if individuals who are aged, blind or disabled, or who are AFDC-related,[5] would have been eligible at any time during that month, had they

[1] Social Services Estimating Conference, Medicaid Caseloads and Expenditures, November 18, 2018 and December 10, 2018--Executive Summary http://edr.state.fl.us/Content/conferences/medicaid/execsummary.pdf (last visited Feb. 5, 2019.)
[2] 42 U.S.C. s. 1396a.
[3] See Agency for Health Care Administration, *Florida's 1115 Managed Medical Assistance (MMA) Prepaid Dental Health Program (PDHP), Low Income Pool (LIP), and Retroactive Eligibility Amendment Request* (March 28, 2018), Power Point presentation, *available at:* http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/MMA_PDHP_LIP-Retro_Elig_amendment_presentation_032818.pdf (last visited February 14, 2019).
[4] Agency for Health Care Administration, *Senate Bill 192 Analysis* (Feb. 27, 2019) (on file with Senate Committee on Health Policy).
[5] Aid to Families with Dependent Children (AFDC) was a federal assistance program in effect from 1935 to 1996 created by the Social Security Act and administered by the United States Department of Health and Human Services that provided financial assistance to children whose families had low or no income.

applied." These provisions had been applicable to the Florida Medicaid State Plan since at least October 1, 1991.[6]

In 2018, the Florida Legislature, via the General Appropriations Act (GAA)[7] and the Implementing Bill accompanying the GAA[8], approved a measure to direct the AHCA to seek a waiver from federal CMS to eliminate the 90-day retroactive eligibility period for non-pregnant adults aged 21 and older. For these adults, eligibility would become retroactively effective on the first day of the month in which their Medicaid application was filed, instead of the first day of the third month prior to the date of application.

Since this directive was enacted into law in the 2018 budget implementing bill, it is only applicable in the fiscal year for which it was enacted, which is State Fiscal Year 2018-2019, and does not have ongoing applicability beyond June 30, 2019.

Waiver Special Terms and Conditions

As directed by the 2018 Legislature, the AHCA sought to amend the federal waiver for Florida's section 1115 demonstration project, titled Managed Medical Assistance (MMA) Program (Project No. 11-W-00206/4). As a waiver amendment, there were comment periods at the state level prior to submission of the waiver request and at the federal level after submission of the waiver request. The waiver request that included the retroactive eligibility item was submitted to federal CMS by the AHCA on April 27, 2018, and was approved on November 30, 2018. The approval letter from federal CMS contained the following waiver authority:

> [Effective February 1, 2019], to enable Florida to not provide medical assistance for any month prior to the month in which a beneficiary's Medicaid application is filed, for adult beneficiaries who are not pregnant or within the 60-day period after the last day of the pregnancy, and are aged 21 and older. The waiver of retroactive eligibility does not apply to pregnant women (or during the 60-day period beginning on the last day of the pregnancy), infants under one year of age, or individuals under age 21. The state currently has state legislative authority for this waiver through June 30, 2019. The state must submit a letter to CMS by May 17, 2019, if it receives state legislative authority to continue the waiver past June 30, 2019. In the event the state does not receive legislative authority to continue this waiver through June 30, 2019 and timely submit a letter to CMS to this effect, this waiver authority ends June 30, 2019.[9]

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[6] See Florida Medicaid State Plan, page 373 of 431, *available at* http://www.fdhc.state.fl.us/medicaid/stateplanpdf/Florida_Medicaid_State_Plan_Part_I.pdf (last visited Feb. 27, 2019).

[7] See Specific Appropriation 199 of the General Appropriations Act for Fiscal Year 2018-2019, Chapter 2018-9, Laws of Florida, *available at* http://www.flsenate.gov/Session/Bill/2018/5001/Amendment/616813/pdf (last visited Feb. 1, 2019.

[8] See section 20 of the Implementing bill for Fiscal Year 2018-2019, Chapter 2018-10, Laws of Florida, *available at* http://www.flsenate.gov/Session/Bill/2018/5001/Amendment/616813/pdf (last visited Feb. 1, 2019).

[9] See the November 30, 2018, CMS letter and waiver approval document, including waiver Special Terms and Conditions, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-mma-ca.pdf (last visited Feb. 13, 2019).

An objective of the waiver authority is to encourage Medicaid recipients to obtain and maintain health coverage even when they are healthy, as opposed to applying for Medicaid only after they need and have obtained health care services. Obtaining and maintaining coverage in advance of illness should increase continuity of care and reduce gaps in coverage when recipients "churn" on and off of Medicaid enrollment by enrolling only when sick. Recipients should remain healthier on an ongoing basis and expenditures for treating acute illnesses should be mitigated if recipients obtain and maintain coverage in a more continuous fashion.[10]

Even though the federal waiver authority became effective only on February 1, 2019, the Legislature's direction to the AHCA to seek the waiver took effect July 1, 2018. The AHCA reports that skilled nursing facilities and hospitals have resultantly taken steps to ensure that Medicaid applications for their residents or patients are submitted expeditiously.[11]

Medicaid Retroactive Eligibility in Other States

At the time the Legislature considered the issue of changing Medicaid retroactive eligibility as part of the 2018 session, several states had already reduced retroactive eligibility periods so that retroactive eligibility begins on the first day of the month in which application is made. Iowa, New Hampshire, Arkansas, and Indiana made their changes in conjunction with Medicaid program expansion under the federal Patient Protection and Affordable Care Act (PPACA). Several other states had already modified retroactive eligibility prior to the enactment of the PPACA, including Delaware, Massachusetts, Maryland, Tennessee, and Utah.[12]

Based on a more recent analysis, Florida is one of eight states that has eliminated or is proposing to eliminate or place limits on retroactive eligibility for one or more eligibility groups in 2018 or 2019. The states in addition to Florida are Arkansas, New Hampshire, Iowa, Kentucky, Maine, New Mexico, and Utah.[13]

III. Effect of Proposed Changes:

Section 1 directs the AHCA to seek approval from federal CMS to maintain Florida's current waiver authority that modifies the period of retroactive eligibility for certain Medicaid recipients. Under the bill, pending federal approval, the current waiver authority allowing Florida's retroactive eligibility period for a non-pregnant adult to begin on the first day of the month in

[10] Id.
[11] *Supra* note 4
[12] Musumeci, MaryBeth, and Rudowitz, Robin, *Medicaid Retroactive Coverage Waivers; Implications for Beneficiaries, providers, and States,* Kaiser Family Foundation, *available at* https://www.kff.org/medicaid/issue-brief/medicaid-retroactive-coverage-waivers-implications-for-beneficiaries-providers-and-states/
(last visited Jan. 26, 2018).
[13] Gifford, Kathleen, et al., *States Focus on Quality and Outcomes Amid Waiver Changes, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2018 and 2019,* October 2019, *available at* https://www.kff.org/medicaid/report/states-focus-on-quality-and-outcomes-amid-waiver-changes-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2018-and-2019/ (last visited Feb. 13, 2019).

which the Medicaid recipient applies for Medicaid, would continue beyond its current expiration date of July 1, 2019.

Section 2 directs the AHCA to notify federal CMS, before May 17, 2019, that the bill has been enacted during the 2019 Regular Session of the Legislature, consistent with the Special Terms and Conditions of the current Managed Medical Assistance waiver program.

Section 3 provides for the bill to be effective upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Pending federal approval under SB 192, the retroactive eligibility waiver authority that has been in effect since February 1, 2019, will remain in effect beyond the current state fiscal year, meaning that Medicaid providers who provide services to newly-eligible, non-pregnant Medicaid recipients aged 21 or older, earlier than the first day of the month

in which the recipient applies for Medicaid, will continue to receive no Medicaid reimbursement for those services.

C. Government Sector Impact:

For the 2018-2019 state fiscal year, the AHCA originally estimated that, by reducing the period of retroactive Medicaid eligibility for non-pregnant adults from a period of 90 days prior to application to the first day of the month of application, the Medicaid program would avoid the payment of claims totaling $98.4 million. That sum represented $37.5 million from the General Revenue Fund and $60.9 million from federal funds. This was the amount originally calculated by the AHCA as part of the development of its schedule VIII-B reduction proposals that accompanied the Governor's Budget Recommendations for State Fiscal Year 2018-2019.[14]

The AHCA has provided a more recent fiscal impact estimate. If the waiver authority for retroactive eligibility granted by federal CMS on November 30, 2018, is not continued for the 2019-2020 state fiscal year, the AHCA estimates that the Legislature will need to appropriate an additional $103.6 million to the AHCA in order to restore the reduction made during the 2018 Regular Session. Of this total, $40.1 million is General Revenue and $63.5 million is federal funding.[15]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates two non-statutory sections of Laws of Florida.

IX. Additional Information:

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

None.

B. Amendments:

None.

[14] See AHCA's Schedule VIII-B reduction proposals for Fiscal Year 2018-2019, available on Florida Fiscal Portal at http://floridafiscalportal.state.fl.us/Document.aspx?ID=18102&DocType=PDF (last visited Feb. 4, 2019).
[15] *Supra* note 4

By Senator Bean

4-01292-19 2019192__

A bill to be entitled

An act relating to Medicaid eligibility; requiring the Agency for Health Care Administration to seek authorization from the federal Centers for Medicare and Medicaid Services (CMS) to eliminate the Medicaid retroactive eligibility period for nonpregnant adults; requiring the agency to request such authorization to become effective no later than a certain date; requiring the agency to provide certain notice to CMS before a specified date; providing an effective date.

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

Section 1. The Agency for Health Care Administration shall seek authorization from the federal Centers for Medicare and Medicaid Services to eliminate the Medicaid retroactive eligibility period for nonpregnant adults so that if a nonpregnant adult is deemed Medicaid-eligible, his or her eligibility begins on the first day of the month in which he or she applies for Medicaid. The agency shall request such federal authorization to become effective no later than July 1, 2019.

Section 2. In implementing this act, the Agency for Health Care Administration shall, before May 17, 2019, and in conformity with Special Term and Condition Number 20 of this state's Section 1115 demonstration project, titled Managed Medical Assistance (MMA) Program (Project No. 11-W-00206/4), officially notify the federal Centers for Medicare and Medicaid Services that this act has been enacted by the Florida Legislature as part of the 2019 Regular Session, which is

scheduled to conclude May 3, 2019.

Section 3. This act shall take effect upon becoming a law.

The Florida Senate

Committee Agenda Request

To: Senator Gayle Harrell, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: February 22, 2019

I respectfully request that **Senate Bill # 192**, relating to Medicaid Eligibility, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Aaron Bean

Senator Aaron Bean
Florida Senate, District 4

File signed original with committee office

S-020 (03/2004)

2019 AGENCY SUMMARY BILL ANALYSIS & ECONOMIC IMPACT STATEMENT

AGENCY: Agency for Health Care Administration

BILL#:	**Senate Bill 192**
RELATING TO:	**Medicaid Eligibility/ Retroactive**
SPONSOR(S):	**Senator Bean**
COMPANION BILLS:	**None**

ANALYST/REVIEWER NAME:	**Shevaun Harris**
DIVISION/UNIT:	**Medicaid**
CONTACT NUMBER:	**412-4000**

COORDINATED WITH:	
DIVISION/UNIT:	
CONTACT NUMBER:	

I. SUMMARY:

Retroactive eligibility allows a person applying for Medicaid eligibility to have their eligibility start prior to the month in which they applied. Prior to February 2019, Florida allowed retroactive eligibility for a period of up to 90 days prior to the month in which the Medicaid application is made. The Department of Children and Families (DCF), the Florida agency responsible for determining Medicaid eligibility, applied two periods of eligibility retroactively:

> (1) Grants eligibility automatically for all applicants' **retroactive back to the first day of the month in which a person applied**. For example, one person applies on April 5th, another on April 27th; both of them would be granted eligibility beginning April 1.
>
> (2) If those individuals had medical expenses in the 90 days prior to the month in which they applied, they can request and be granted **retroactive eligibility to pay for those expenses that occurred during the 90 days prior to the month in which they applied.** In the examples above, if either person had medical expenses, their eligibility could be granted back to January 1.

In Florida, a vast majority of individuals who received retroactive eligibility under #2 above gained it because they were hospitalized or in a nursing facility. They likely would have been eligible for Medicaid already, but did not apply. This means they did not have the advantage of accessing the full array of Medicaid benefits such as preventive care, care management for chronic conditions like diabetes and asthma, and expanded benefits offered by Medicaid health plans.

During the 2018 Legislative Session, the Agency was directed to seek federal approval to change the retroactive eligibility policy to only allow retroactive eligibility to go back to the first day of the month in which a person applied. This change does not apply to children or pregnant women. With the passage of this direction, a budget reduction was taken reflecting the savings estimated to occur with the implementation of this policy.

The Agency's waiver request has been approved, and, effective February 1, 2019, pregnant women and children will continue to have access to retroactive eligibility for a period of up to 90 days prior to the month in which the submitted their application to DCF. Adults who are not pregnant will have access to retroactive eligibility for only the period between their application date and the first day of this month in which they submitted their application to DCF.

Since the authorizing language was in the 2018 Appropriations Implementing bill, the language was only valid for the 2018-19 fiscal year, and the federally approved waiver requires the state Medicaid program to seek further legislative authority in order to continue the policy.

> Section 20. In order to implement Specific Appropriations 598 199, 203, 204, 206, 208, and 217 of the 2018-2019 General 599 Appropriations Act, the Agency for Health Care Administration 600 shall seek authorization from the federal Centers for Medicare 601 and Medicaid Services to eliminate the Medicaid retroactive 602 eligibility period for nonpregnant adults in a manner that 603 ensures that the elimination becomes effective on July 1, 2018. 604 Eligibility will continue to begin the first day of the month in 605 which a nonpregnant adult applies for Medicaid. This section 606 expires July 1, 2019.

The Agency has state legislative authority for this portion of the waiver through June 30, 2019. The Agency must submit a letter to CMS by May 17, 2019, if it receives state legislative authority to continue the retroactive eligibility portion of the waiver past June 30, 2019. In the event the state Legislature does not authorize the continuation of the waiver of retroactive eligibility, the authority for the waiver of retroactive eligibility will end July 1, 2019 and the former policy of allowing all Medicaid recipients to request up to 90 days of retroactive eligibility would be restored.

If this bill, or a similar directive, is not enacted, the Legislature will need to appropriate an additional $103.6 million to the Agency for Health Care Administration to restore the reduction taken during the 2018 Legislative session in order to cover the program costs incurred by reinstating the prior coverage policy. $40.1 million of this total is General Revenue.

II. Does this bill impact the Agency? If yes, please provide a brief explanation of the impact:

Senate Bill (SB) 192, related to Medicaid eligibility, requires the Agency for Health Care Administration (Agency) to seek authorization from the Centers for Medicare and Medicaid Services (CMS) to eliminate the 90-day Medicaid retroactive eligibility period for non-pregnant adults, effective July 1, 2019. The bill requires that the eligibility period for this population begin on the first day of the month in which the individual applies for Medicaid coverage. The provisions in this bill do not apply to pregnant women and children seeking Medicaid coverage; their eligibility period will continue to begin 90 days prior to the date in which they submitted their Medicaid application.

In practice, Senate Bill 192 directs the Agency to seek federal authority to continue the policy adopted by the 2018 Florida Legislature. If SB 192 or similar legislation is not adopted by the Legislature, the retroactive eligibility period will revert to including the 90 days prior to the month when a person submits their Medicaid eligibility application.

In Florida, the vast majority of individuals who receive retroactive eligibility gain it because they were hospitalized or in a nursing facility. They likely would have been eligible for Medicaid already, but did not apply. This means they did not have the advantage of accessing the full array of Medicaid benefits such as preventive care, care management for chronic conditions like diabetes and asthma, and expanded benefits offered by Medicaid health plans.

If this change is not authorized by statute to continue, the previous retroactive eligibility period will be reinstated and the Agency will be responsible for paying for those expenses that occurred during the 90 day period prior to the month in which a person applied. An additional $103.6 million will need to be

appropriated to the Agency for Health Care Administration to cover the additional program costs incurred by reinstating the prior coverage policy.

In addition, a return to the prior policy will have an adverse impact on persons eligible for Medicaid in Florida. No one has lost eligibility due to this change, in fact, the current policy has the effect of incentivizing Floridians to seek health care through the Medicaid program before they are in an emergency health care situation. This change has inspired changes in process on behalf of nursing facility and hospitals to ensure that applications for Medicaid are submitted timely by their residents/ patients. Florida Medicaid recipients who have a nursing facility level of care should be enrolled in the Statewide Medicaid Managed Care Long-Term Care program so that they can access the enhanced care management and assistance with transition to the community that those plans provide. The policy adopted by the 2018 Florida Legislature has incentivized nursing facilities to assist their residents in submitting these applications without delay and therefore facilitated increased access to the services provided under the Long-Term Care program.

The provisions in this bill do not pose an operational impact to the Medicaid program as the Agency has already implemented the proposed changes, so no further action is needed. Further, the notification letter that would be provided to CMS, as required by the bill, will take minimal effort to accomplish.

III. FISCAL COMMENTS:

Fiscal Impact:

If the policy adopted during the 2018 Legislative Session is not continued, the Legislature will need to appropriate an additional $103.6 million to the Agency for Health Care Administration to restore the reduction taken during the 2018 Legislative session in order to cover the program costs incurred by reinstating the prior coverage policy. $40.1 million of this total is General Revenue.

Florida Medicaid

Retroactive Eligibility[1] Fiscal Impact Report

(Non-Pregnant Adults Only)

State Fiscal Year 2017 - 2018 (SFY1718)		
RETRO MONTHS	TOTAL	
	Distinct Recipient Count[3]	Amount
1	9,568	$ 57,852,911
2	5,488	$ 27,912,164
3	3,595	$ 17,834,338
Retro 1-3 Total	11,466	$ 103,599,413

Note[1]: *Retroactive eligibility is defined as eligibility prior to a recipient's application date with the Department of Children and Families (DCF). DCF will grant retroactive eligibility up to three months prior to a recipient's application month. Additionally, DCF will grant retroactive eligibility to cover the full month of application.*

Note[2]: *The month of application. Amounts reflected in this row are expenditures during the application month that take place prior to the application date.*

Note[3]: *Distinct count of recipients eligible during a retroactive eligibility period and utilizing services.*

Source: Bureau of Medicaid Data Analytics, SQL Server Claims, Eligibility & DCF Application List

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/4/19
Meeting Date

SB 192
Bill Number (if applicable)

Topic Medicaid eligibility

Amendment Barcode (if applicable)

Name Karen Woodall

Job Title

Address 579 E. Call St.
Street

Phone 850-321-9386

Tallahassee FL 32301
City *State* *Zip*

Email fcfep@yahoo.com

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Fla. Center for Fiscal & Economic Policy

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/4/19
Meeting Date

192
Bill Number (if applicable)

Topic Medicaid

Amendment Barcode (if applicable)

Name Barbara DeVane

Job Title

Address 625 Brevard St.
Street
Tallahassee FL 32303
City *State* *Zip*

Phone 850-222-3969

Email barbaradevane1@yahoo.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

Representing Fla. National Organization for Women

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/4/19
Meeting Date

192
Bill Number (if applicable)

Topic Medicaid Eligibility

Amendment Barcode (if applicable)

Name Scott McCoy

Job Title Policy Director

Address P.O. Box 10788
Street

Tallahassee, FL 32302
City *State* *Zip*

Phone 334-224-4309

Email scott.mccoy@splcenter.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

Representing SPLC Action Fund

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/4/19	192
Meeting Date	*Bill Number (if applicable)*

Topic Medicaid Eligibility — *Amendment Barcode (if applicable)*

Name Bob Asztalos

Job Title Chief Lobbyist

Address 307 W. Park Avenue (*Street*) — Phone 850-224-3907

Tallahassee (*City*) FI (*State*) 32301 (*Zip*) — Email basztalos@fhca.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

Representing Florida Health Care Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3-4-19
Meeting Date

SB 192
Bill Number (if applicable)

Topic Retroactive Medicaid

Amendment Barcode (if applicable)

Name Anne Swerlick

Job Title Health Policy Analyst

Address 255 Primera Blvd.
Street
Lake Mary Fl. 32746
City *State* *Zip*

Phone 850-524-0602

Email aswerlick@fpi.institute

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Policy Institute

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/4/19
Meeting Date

192
Bill Number (if applicable)

Topic Medicaid

Amendment Barcode (if applicable)

Name Marco Paredes

Job Title Associate Director for Health

Address 201 W Park Ave
Street

Phone 850-205-7207

Tallahassee FL 32301
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

Representing FL Conference of Catholic Bishops

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

March 4, 2019
Meeting Date

192
Bill Number (if applicable)

Topic Medicaid Eligibility

Amendment Barcode (if applicable)

Name Brian Jogerst

Job Title

Address PO Box 11094
Street

Phone 850.222.0191

Tallahassee FL 32302
City *State* *Zip*

Email brian@bhandassociates.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

Representing Academy of Florida Elder Law Attorneys and Elder Law Section/Florida Bar

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3.4.19
Meeting Date

SB192
Bill Number (if applicable)

Topic Medicaid Eligibility

Amendment Barcode (if applicable)

Name Cliff Bauer

Job Title V.P Agreement Relation

Address 5200 NE 2nd
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Phone

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Speaking: ☐ For ☐ Against ☒ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Miami Jewish Health.

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

March 4, 2019
Meeting Date

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

SB 192
Bill Number (if applicable)

Topic Retroactive Medicaid Eligibility

Amendment Barcode (if applicable)

Name Dorene Barker

Job Title Associate State Director

Address 200 W. College Ave, Suite 304A
Street

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City *State* *Zip*

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Email dobarker@aarp.org

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing AARP Florida

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	CS/CS/SB 322
INTRODUCER:	Health Policy Committee; Banking and Insurance Committee and Senator Simpson
SUBJECT:	Preexisting Conditions
DATE:	March 5, 2019 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.	Lloyd	Brown	HP	**Fav/CS**
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/CS/SB 322 requires each insurer or health maintenance organization (HMO) issuing major medical policies or contracts in Florida to offer at least one comprehensive major medical policy or contract that does not exclude, limit, deny, or delay coverage due to one or more preexisting medical conditions. The operative date for such mandated offer is the enactment of a federal law that expressly repeals the Patient Protection and Affordable Care Act (PPACA) or the invalidation of the PPACA by the United States Supreme Court. Preexisting conditions affect an estimated 129 million Americans.[1]

The PPACA prohibits group and individual health insurance plans from imposing preexisting condition exclusions. This requirement of the PPACA preempts state laws that allow such insurers to utilize preexisting condition exclusions. The currently preempted Florida law prohibits individual health policies from excluding preexisting conditions for more than 24 months and that may relate to conditions that manifested themselves during the 24-month period. Individual health policies may exclude coverage for named or specific conditions without any time limit. Florida law prohibits group policies from excluding preexisting conditions for more than 12 months, or 18 months in the case of a late enrollee, and may only relate to conditions that manifested themselves during the six-month period prior to coverage.

[1] 80 FR 72192.

II. Present Situation:

PPACA

On March 23, 2010, the PPACA was signed into law.[2] Among its sweeping changes to the U.S. health insurance system are requirements for health insurers to make coverage available to all individuals and employers, without exclusions, for preexisting medical conditions and without basing premiums on any health-related factors. The PPACA imposes many insurance requirements, including an individual mandate of coverage, required benefits, rating and underwriting standards, mandatory review of rate increases, reporting of medical loss ratios and payment of rebates, internal and external appeals of adverse benefit determinations, and other requirements.[3] The PPACA preempts any state law that prevents the application of a provision of PPACA.[4]

Preexisting Condition Exclusions

The PPACA prohibits health insurance policies from excluding coverage for any preexisting condition.[5] A health insurer that offers individual or group health insurance coverage may not impose any preexisting condition exclusion.[6] Rules define the term, "preexisting condition exclusion" to include a denial of coverage.[7] Individual (but not group) grandfathered health plans are exempt from this requirement.[8]

Regulation of Insurance in Florida

Florida's Office of Insurance Regulation (OIR) is responsible for the regulation of all activities of insurers and other risk-bearing entities.[9]

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[2] Pub. Law No. 111-148, 124 Stat. 119-1945 (2010). PPACA was amended by Pub. Law No. 111-152, the Health Care and Education Reconciliation Act of 2010.

[3] Most of the insurance regulatory provisions in PPACA amend Title XXVII of the Public Health Service Act (PHSA), (42 U.S.C. s. 300gg et seq.).

[4] The PPACA preempts any state law that prevents the application of a provision of the PPACA. The PPACA effectively allows states to adopt and enforce laws that provide greater consumer protections than the PPACA, but any state law that does not meet the federal minimum standards will be preempted. PPACA s. 1321(d).

[5] PPACA s. 1201; PHSA s. 2704 (42 U.S.C. 300gg-3).

[6] 45 CFR 144.108.

[7] *Preexisting condition exclusion* means a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan or group or individual health insurance coverage…whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan, or group or individual health insurance coverage…such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period. *See* 45 C.F.R. s. 144.013.

[8] A grandfathered health plan can be an individual or group health insurance policy purchased on or before March 23, 2010. Such plans are not subject to the ACA prohibition on pre-existing conditions and other specified ACA requirements. A plan can lose its grandfathered status if it is significantly changed. See Healthcare.gov, Grandfathered Health Insurance Plans, available at https://www.healthcare.gov/health-care-law-protections/grandfathered-plans (last viewed Feb. 18, 2019).

[9] The OIR is under the Financial Services Commission, which is composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture, which serves as the agency head of the commission. Section 20.121(3), F.S.

2019 Individual and Small Group Markets

Nine health insurance companies writing individual policies or contracts submitted rate filings to the OIR in June 2018. In August 2018, the OIR announced that premiums for the individual PPACA-compliant plans would increase an average of 5.2 percent effective January 1, 2019.[10] The average approved rate changes on the exchange plans ranged from -1.5 percent to a +9.8 percent. Only one insurer, Blue Cross Blue Shield, offers individual coverage in all 67 counties.[11] During the 2019 open enrollment period, 1,786,679 individuals enrolled in Florida plans through the federally administered exchange.[12]

The OIR approved the 2019 rates for 14 small group insurers.[13] The weighted average change in approved rates from 2018 was 6.0 percent. The percentage change in approved rates from 2018 ranged from -11.8 percent to +14.5 percent. Florida Blue and United HealthCare (and affiliates) offer small group plans in every county.

Preexisting Condition Exclusions

The PPACA prohibits group and individual health insurance plans from imposing preexisting condition exclusions.[14] This requirement of the PPACA preempts state laws that allow such insurers to utilize preexisting condition exclusions. The currently preempted Florida law prohibits individual health policies from excluding preexisting conditions for more than 24 months and that may relate to conditions that manifested themselves during the 24-month period.[15] Individual health policies may exclude coverage for named or specific conditions without any time limit.[16] Florida law prohibits group policies from excluding preexisting conditions for more than 12 months, or 18 months in the case of a late enrollee and may only relate to conditions that manifested themselves during the six-month period prior to coverage.[17]

PPACA Legislation and Litigation

In recent years, major federal legislation has been filed to amend, repeal or replace the PPACA.[18] In 2017, the federal Tax Cuts and Jobs Act[19] reduced the tax penalty for individuals who fail to

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[10] Office of Insurance Regulation, Individual PPACA Market Monthly Premiums for Plan Year 2019, *available at* https://floir.com/siteDocuments/IndividualMarketPremiumSummary.pdf (last viewed Feb. 28, 2019). See also OIR Press Release, OIR Announces 2019 PPACA Individual Market Health Insurance Plan Rates, *available at* https://www.floir.com/PressReleases/viewmediarelease.aspx?id=2234 (last viewed Feb. 28, 2019).
[11] OIR, Individual Market County Offerings, available at https://www.floir.com/sitedocuments/IndividualMarketCountyOfferings.pdf, (last viewed Feb. 28, 2019).
[12] CMS.gov, *Final Weekly Enrollment Snapshot for the 2019 Enrollment Period* (January 3, 2019), *available at* https://edit.cms.gov/newsroom/fact-sheets/final-weekly-enrollment-snapshot-2019-enrollment-period (last viewed Feb 28, 2019).
[13] OIR, Small Group PPACA Market Monthly Premiums for Plan Year 2019 (August 22, 2018), *available at* https://www.floir.com/siteDocuments/SGMarketPremiumSummary.pdf (last viewed Feb. 14, 2019).
[14] 42 U.S.C. s. 300gg-3.
[15] Section 627.6045, F.S.
[16] Section 627.607(2), F.S.
[17] Prior creditable coverage reduces the exclusion period.
[18] Compare Proposals to Replace the Affordable Care Act, *available at* https://www.kff.org/interactive/proposals-to-replace-the-affordable-care-act/ (last viewed Feb. 28, 2019).
[19] Pub. Law No. 115-97, Stat. 2054 (2017).

comply with PPACA's individual mandate to maintain minimum essential health coverage to zero beginning tax year 2019.[20] However, the act did not repeal the individual mandate.

On December 14, 2018, the U.S. District Court for the Northern District of Texas, declared the individual mandate of the PPACA unconstitutional and the remaining provisions of the PPACA inseverable from the mandate, and thus invalid.[21] Subsequently, on December 31, 2018, the Court issued a stay that keeps the PPACA in force while the ruling is appealed.[22] In response to the ruling, the federal U.S. Department of Health and Human Services[23] stated, "The recent U.S. District Court decision regarding the Affordable Care Act is not an injunction that halts the enforcement of the law and not a final judgment. Therefore, HHS will continue administering and enforcing…"

III. Effect of Proposed Changes:

Section 1 creates s. 627.6046, F.S., to require insurers issuing or delivering individual health insurance policies in Florida to offer at least one comprehensive major medical health insurance policy that does not exclude or delay coverage under the policy or contract due to one or more preexisting medical conditions. This mandated offer is triggered by an operative date. The term, "operative date," means the date that either of the following occurs with respect to PPACA:

- A federal law is enacted that expressly repeals PPACA; or
- PPACA is invalidated by the United States Supreme Court.

Notwithstanding s. 627.6045, F.S.,[24] the bill requires every insurer to make such policy or contract available to all residents of the state within 30 days after the operative date. The comprehensive major medical health insurance policy that an insurer is required to offer under this section must be a policy that had been actively marketed in this state by the insurer as of the operative date and that was also actively marketed in this state during the year immediately preceding the operative date. An insurer may not limit or exclude benefits under such policy, including a denial of coverage applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage, or if coverage is denied, the date of the denial.

The term, "preexisting medical condition" is defined to mean:

- A condition that was present before the effective date of coverage under a policy, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the effective date of coverage; and

[20] Prior to tax year 2019, PPACA required that, for each month during the year, an individual must have minimum essential coverage (MEC) or individual mandate; qualify for an exemption; or pay a penalty or shared responsibility payment when filing the federal income tax return. 26 U.S.C. s. 5000A. See https://www.irs.gov/taxtopics/tc561 (last viewed Feb. 28, 2019).
[21] *Texas v. Azar*, available at https://benefitslink.com/src/ctop/Texas-v-US_NDTex_12142018.pdf (last viewed Feb. 28, 2019). The Court noted that the 2010 Congress memorialized that the mandate was the keystone to PPACA, *see* 42 U.S.C. s. 18091.
[22] *Texas v. Azar*, Order *available at* https://static.politico.com/17/86/6721f2eb435fb2512430e54c2904/220.pdf (last viewed Feb. 28, 2019).
[23] *See* Statement from the Department of Health and Human Services on Texas v. Azar (December 17, 2018), *available at* https://www.hhs.gov/about/news/2018/12/17/statement-from-the-department-of-health-and-human-services-on-texas-v-azar.html (last viewed Feb. 28, 2019).
[24] Florida law on preexisting conditions in individual market policies that is currently preempted by the PPACA.

- A condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.[25]

This section does not apply to an insurer issuing only limited benefit, disability income, specified disease, Medicare supplement, or hospital indemnity policies in this state.

Section 2 creates s. 627.65612, F.S., to require insurers issuing or delivering group health insurance policies in Florida to offer at least one comprehensive major medical health insurance policy that does not exclude or delay coverage under the policy due to one or more preexisting medical conditions, as required for individual policies and contracts in Section 1 of the bill. The terms, "operative date" and "preexisting medical condition," have the same meaning as provided in Section 1 of the bill.

Notwithstanding s. 627.6561, F.S.,[26] an insurer is required under the bill to make such coverage available within 30 days after the operative date. The comprehensive major medical health insurance policy that an insurer is required to offer under this section must be a policy that had been actively marketed in this state by the insurer as of the operative date and that was also actively marketed in this state during the year immediately preceding the operative date. An insurer may not limit or exclude benefits under such policy, including a denial of coverage applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage, or if coverage is denied, the date of the denial.

This section does not apply to an insurer issuing only limited benefit, disability income, specified disease, Medicare supplement, or hospital indemnity policies in this state.

Section 3 amends s. 641.31, F.S., to require health maintenance organizations (HMOs) issuing or delivering individual or group contracts in Florida to offer at least one comprehensive major medical health insurance policy or contract that does not exclude or delay coverage under the policy or contract due to one or more preexisting medical conditions, as required for individual policies and contracts in Section 1 of the bill. The terms, "operative date" and "preexisting medical condition," have the same meaning as provided in Section 1 of the bill.

Notwithstanding s. 641.31071, F.S.,[27] an HMO is required under the bill to make such coverage available within 30 days after the operative date. The comprehensive major medical HMO contract that the HMO is required to offer under this section must be a contract that had been actively marketed in this state by the HMO as of the operative date and that was also actively marketed in this state during the year immediately preceding the operative date. An HMO may not limit or exclude benefits under such contract, including a denial of coverage applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage, or if coverage is denied, the date of the denial.

Section 4 provides this act will take effect July 1, 2019.

[25] *See* 45 C.F.R. s. 144.013.
[26] Florida laws on preexisting conditions for group policies offered by insurers that are currently preempted by the PPACA.
[27] Florida laws on preexisting conditions for contracts offered by health maintenance organizations that are currently preempted by the PPACA.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

If the U.S. Supreme Court invalidates PPACA or a federal law expressly repeals PPACA, the bill would provide access for individuals and groups to at least one policy or contract for major medical coverage that did not exclude or delay coverage due to the applicant having one or more preexisting medical conditions. Currently, the Florida Insurance Code does not prohibit preexisting condition exclusions; however, it is preempted by PPACA.

CS/CS/SB 322 requires every insurer and HMO to offer at least one policy or contract without preexisting medical exclusions to all residents. Currently, only Florida Blue offers individual plans in every county. Florida Blue and United HealthCare (and affiliates) offer small group plans in every county.

Such coverage may be expensive for some individuals with preexisting medical conditions due to adverse selection. Many individuals purchasing such coverage would be expected to have some type of preexisting medical condition. Under Florida law, insurers would be allowed to pool policies or contracts covering preexisting conditions

separately from other policies that did not offer that benefit, as well as underwrite such policies that accounts for the losses experienced.

C. Government Sector Impact:

If implemented, the required changes to health maintenance organization contracts and group health insurance policies under contract with the state for state employee benefits would be required to comply with the mandatory eligibility and benefit changes under the bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates the following sections of the Florida Statutes: 627.6046, 627.65612, and 641.31.

IX. Additional Information:

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

CS/CS by Health Policy on March 4, 2019:
Due to a scrivener's error, a provision in Section 2 of the bill, as filed, was not included in the CS adopted by the Banking and Insurance Committee. The CS by the Health Policy Committee corrected this error by re-inserting the provision relating to the type of group policy an insurer is required to offer.

CS by Banking and Insurance on February 19, 2019:
The CS:
- Revises the definition of the term, "preexisting medical condition."
- Revises requirements relating to the offer of coverage without preexisting condition exclusions.

B. Amendments:

None.

200152

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/04/2019	.	
	.	
	.	
	.	

The Committee on Health Policy (Simpson) recommended the following:

Senate Amendment (with title amendment)

Delete line 109
and insert:
(3) The comprehensive major medical health insurance policy that the insurer is required to offer under this section must be a policy that had been actively marketed in this state by the insurer as of the operative date and that was also actively marketed in this state during the year immediately preceding the operative date.

200152

(4) This section does not apply to an insurer issuing only

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete line 26

and insert:

preexisting medical conditions; requiring such policies to have been actively marketed on a specified date and during a certain timeframe before that date; providing

By the Committee on Banking and Insurance; and Senator Simpson

597-02479-19 2019322c1

A bill to be entitled

An act relating to preexisting conditions; creating s. 627.6046, F.S.; defining the terms "operative date" and "preexisting medical condition" with respect to individual health insurance policies; requiring insurers, contingent upon the occurrence of either of two specified events, to make at least one comprehensive major medical health insurance policy available to all residents of this state within a specified timeframe; prohibiting such insurers from excluding, limiting, denying, or delaying coverage under such policies due to preexisting medical conditions; requiring such policies to have been actively marketed on a specified date and during a certain timeframe before that date; providing applicability; creating s. 627.65612, F.S.; defining the terms "operative date" and "preexisting medical condition" with respect to group health insurance policies; requiring insurers, contingent upon the occurrence of either of two specified events, to make at least one comprehensive major medical health insurance policy available to all residents of this state within a specified timeframe; prohibiting such insurers from excluding, limiting, denying, or delaying coverage under such policies due to preexisting medical conditions; providing applicability; amending s. 641.31, F.S.; defining the terms "operative date" and "preexisting medical condition" with respect to health maintenance

contracts; requiring health maintenance organizations, contingent upon the occurrence of either of two specified events, to make at least one comprehensive major medical health maintenance contract available to all residents of this state within a specified timeframe; prohibiting such health maintenance organizations from excluding, limiting, denying, or delaying coverage under such contracts due to preexisting medical conditions; requiring such contracts to have been actively marketed on a specified date and during a certain timeframe before that date; providing an effective date.

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

Section 1. Section 627.6046, Florida Statutes, is created to read:

627.6046 Limit on preexisting conditions.—

(1) As used in this section, the term:

(a) "Operative date" means the date on which either of the following occurs with respect to the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (PPACA):

1. A federal law is enacted which expressly repeals PPACA; or

2. PPACA is invalidated by the United States Supreme Court.

(b) "Preexisting medical condition" means a condition that was present before the effective date of coverage under a

policy, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the effective date of coverage. The term includes a condition identified as a result of a preenrollment questionnaire or physical examination given to the individual, or review of medical records relating to the preenrollment period.

(2)(a) Not later than 30 days after the operative date, and notwithstanding s. 627.6045 or any other law to the contrary, every insurer issuing, delivering, or issuing for delivery individual health insurance policies in this state shall make at least one comprehensive major medical health insurance policy available to all residents of this state, and such insurer may not exclude, limit, deny, or delay coverage under such policy due to one or more preexisting medical conditions.

(b) An insurer may not limit or exclude benefits under such policy, including a denial of coverage applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage, or if coverage is denied, the date of the denial.

(3) The comprehensive major medical health insurance policy that the insurer is required to offer under this section must be a policy that had been actively marketed in this state by the insurer as of the operative date and that was also actively marketed in this state during the year immediately preceding the operative date.

(4) This section does not apply to an insurer that issues only limited benefit, disability income, specified disease, Medicare supplement, or hospital indemnity policies in this

state.

Section 2. Section 627.65612, Florida Statutes, is created to read:

627.65612 Limit on preexisting conditions.—

(1) As used in this section, the terms "operative date" and "preexisting medical condition" have the same meanings as provided in s. 627.6046.

(2)(a) Not later than 30 days after the operative date, and notwithstanding s. 627.6561 or any other law to the contrary, every insurer issuing, delivering, or issuing for delivery group health insurance policies in this state shall make at least one comprehensive major medical health insurance policy available to all residents of this state, and such insurer may not exclude, limit, deny, or delay coverage under such policy due to one or more preexisting medical conditions.

(b) An insurer may not limit or exclude benefits under such policy, including a denial of coverage applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage, or if coverage is denied, the date of the denial.

(3) This section does not apply to an insurer issuing only limited benefit, disability income, specified disease, Medicare supplement, or hospital indemnity policies in this state.

Section 3. Subsection (45) is added to section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.—

(45)(a) As used in this subsection, the terms "operative date" and "preexisting medical condition" have the same meanings

as provided in s. 627.6046.

(b) Not later than 30 days after the operative date, and notwithstanding s. 641.31071 or any other law to the contrary, every health maintenance organization issuing, delivering, or issuing for delivery individual or group contracts in this state shall make at least one comprehensive major medical health maintenance contract available to all residents of this state, and such health maintenance organization may not exclude, limit, deny, or delay coverage under such contract due to one or more preexisting medical conditions. A health maintenance organization may not limit or exclude benefits under such contract, including a denial of coverage applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage, or if coverage is denied, the date of the denial.

(c) The comprehensive major medical health maintenance contract the health maintenance organization is required to offer under this section must be a contract that had been actively marketed in this state by the health maintenance organization as of the operative date and that was also actively marketed in this state during the year immediately preceding the operative date.

Section 4. This act shall take effect July 1, 2019.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 778
INTRODUCER:	Senator Baxley
SUBJECT:	Program of All-Inclusive Care for the Elderly
DATE:	March 1, 2019
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Brown	HP	**Favorable**
2.			AHS	
3.			AP	

I. Summary:

SB 778 codifies the Program of All-Inclusive Care for the Elderly (PACE) in s. 430.84, F.S. The PACE was first authorized in 1998 and became operational in 2003 in Miami-Dade County, but has not been codified in state law. With almost 2,000 Medicaid managed care eligible recipients already enrolled in seven counties, the bill establishes a statutory process for the review, approval, and oversight of future and current PACE organizations, including:

- Specifying funding and enrollment requirements;
- Providing notification requirements for PACE organization applications;
- Requiring the Agency for Health Care Administration (AHCA) and the Department of Elder Affairs (DOEA) to provide monitoring and oversight of PACE organizations;
- Directing PACE organizations to enroll participants at levels funded by the General Appropriations Act (GAA);
- Permitting retroactive enrollment at the discretion of a PACE organization; and
- Providing other eligibility guidelines and requirements for Medicaid recipients enrolled in PACE organizations.

The bill exempts all PACE organizations from the requirements of chapter 641, which regulates health maintenance organizations, prepaid health clinics, and other health care service programs.

The fiscal impact of the bill is unknown. The AHCA and DOEA are currently performing many of the tasks described in the bill. If additional funding were provided to expand the number of PACE sites, then additional resources may be necessary at the affected state agencies to adapt to the related, increased volume of applications and necessary oversight at the additional sites.

The effective date of the bill is July 1, 2019.

II. Present Situation:

Program of All-Inclusive Care for the Elderly (PACE)

The PACE is a capitated benefit model authorized by the federal Balanced Budget Act of 1997 (BBA)[1] that features a comprehensive service delivery system and integrated federal Medicare and state Medicaid financing. The model, which was tested through federal Centers for Medicare and Medicaid Services (CMS) demonstration projects beginning in the mid-1980s,[2] was developed to address the needs of long-term care clients, providers, and payers. The PACE operates as a three-way agreement between the federal government, the state administering agency, and a PACE organization. In Florida, the PACE is a Florida Medicaid long-term care managed care plan option providing comprehensive long-term and acute care services which supports Medicaid and Medicare enrollees who would otherwise qualify for Medicaid nursing facility services.[3]

The PACE is a unique federal/state partnership. The BBA established the PACE model of care as a permanent entity within the Medicare program and enabled states to provide PACE services to Medicaid beneficiaries as an optional state plan service without a Medicaid waiver.

The federal government established the PACE organization requirements and application process while the state Medicaid agency or other state agency is responsible for oversight of the application process, which includes reviewing the initial application and providing an on-site readiness review before a PACE organization can be authorized to serve patients. An approved PACE organization must sign a contract with CMS and the state Medicaid agency.

The DOEA serves as the operating entity and oversees the contracted PACE organizations but is not a party to the contract between CMS, the AHCA, and the PACE organizations.[4] DOEA, AHCA, and CMS must approve any applications for new PACE organizations if expansion has been authorized by the Legislature through the necessary appropriation of the state matching funds.

A PACE organization must be part of either a city, county, state, or tribal government; a private not-for-profit 501(c)(3) organization; or for-profit entity that is primarily engaged in providing PACE services and must also:

- Have a governing board that includes participant representation;
- Be able to provide the complete service package regardless of frequency or duration of services;
- Have a physical site to provide primary care, social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals;

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[1] Specifically, services under the PACE program are authorized under Section 1905(a)(26) of the Social Security Act.
[2] Department of Health and Human Services, Centers for Medicare and Medicaid Services, *CMS Manual System: Pub. 100-11 Programs of All-Inclusive Care for the Elderly (PACE) Manual* (issued 6-9-2011), *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pace111c01.pdf (last visited Feb. 21, 2019).
[3] Department of Elder Affairs and Agency for Health Care Administration, *Program of All-Inclusive Care for the Elderly and Statewide Medicaid Managed Care Long-term Care Program Comparison Report* (Jan. 14, 2014), p 3, *available at* http://ahca.myflorida.com/docs/PACE_Evaluation_2014.pdf (last visited Feb. 21, 2019).
[4] *Id.*

- Have a defined service area;
- Have safeguards against conflicts of interest;
- Have a demonstrated fiscal soundness;
- Have a formal participant bill of rights; and
- Have a process to address grievances and appeals.[5]

Eligibility and Benefits

PACE participants must be at least 55 years of age, live in the PACE service area, and be certified eligible for nursing home care but able to live safely in the community. The PACE becomes the sole source of services for these Medicare and Medicaid eligible enrollees. Additionally, by electing to enroll in the PACE, the enrollee is agreeing to forgo other options for medical services and receive all of their services through the PACE organization.[6]

Under the PACE, an interdisciplinary team consisting of professional and paraprofessional staff assesses participants' needs, develops care plans, and delivers all services, including acute care and nursing facility services when necessary, which are integrated to provide a seamless delivery model. In most cases, a PACE organization provides social and medical services in a health center with supplemental services through in-home and referral services as necessary. The PACE service package must include all Medicare and Medicaid covered services and other services determined necessary by the multidisciplinary team for the care of the PACE participant.[7]

Before being approved to operate and deliver services, PACE organizations are required to provide evidence of the necessary financial capital to deliver the benefits and services, which include a combined adult day care center and primary care clinic, transportation, and full range of clinical and support staff with the interdisciplinary team of professionals.[8]

By federal law, the first three contract years for a PACE organization are considered a trial period, and the PACE organization is subject to annual reviews to ensure compliance.[9] The site visit reviews include:

- A comprehensive assessment of an organization's fiscal soundness.
- A comprehensive assessment of the organization's capacity to provide all PACE services to all enrolled participants.
- A detailed analysis of the PACE organization's substantial compliance with all the federal statutory requirements and accompanying federal regulations.
- Compliance with any other elements the Secretary of the Department of Health and Human Services (secretary) or the state's administering agency considers necessary and appropriate.[10]

[5] *Supra* note 2.
[6] *Id.*
[7] *Id.*
[8] *Supra* note 3, at 4.
[9] *See* 42 U.S.C. s. 1395eee(e)(4)(A)(2019).
[10] *Id.*

Review of the PACE organization may continue after the trial period by the secretary or the administering state agency as appropriate, depending upon the PACE organization's performance and compliance with requirements and regulations.

No deductibles, copayments, coinsurance, or other cost-sharing can be charged by a PACE organization. No other limits relating to amount, duration, or scope of services that might otherwise apply in Medicaid are permitted.[11] The PACE enrollee must accept the PACE center physician as his or her new Medicare primary care physician, if enrolled in Medicare.[12]

Quality of Care Requirements

Each PACE organization is required to develop, implement, maintain, and evaluate an effective data-driven quality assurance, performance improvement (QAPI) program. The program must incorporate all aspects of the PACE organization's operations, which allows for the identification of areas that need performance improvement. The organization's written QAPI plan must be reviewed by the PACE organization's governing body at least annually. The plan should address at least the following areas:

- Utilization of services in the PACE organization, especially in key services.
- Participant and caregiver satisfaction with services.
- Data collected during patient assessments to determine if individual and organizational-level outcomes were achieved within a specified time period.
- Effectiveness and safety of direct and contracted services delivered to participants.
- Outcomes in the organization's non-clinical areas.[13]

Florida PACE

The Florida PACE project was initially authorized in ch. 98-327, Laws of Florida, under the administration of the DOEA operating in consultation with the AHCA.[14] Florida's first PACE organization was located in Miami-Dade County and began serving enrollees in February 2003 with a total of 150 slots. Since then, the Legislature has approved additional slots either as part of the GAA or general law. Currently, PACE organizations with funded slots exist in these Florida counties: Baker, Broward, Charlotte, Clay, Collier, Desoto, Duval, Lee, Miami-Dade, Palm Beach, Pinellas, Manatee, Martin, Nassau, Sarasota, and St. John's.

In 2011, the Legislature moved administrative responsibility for the PACE program from the DOEA to the AHCA as part of the expansion of Medicaid managed care into the Statewide Medicaid Managed Care program (SMMC).[15] Participation by PACE in SMMC is not subject to the procurement requirements or regional plan number limits normally applicable to SMMC

[11] *Supra* note 2.
[12] Dep't of Elder Affairs and Agency for Health Care Administration, *Program of All-Inclusive Care for the Elderly and Statewide Medicaid Managed Care Long-term Care Program Comparison Report* (Jan. 14, 2014), *available at* http://ahca.myflorida.com/docs/PACE_Evaluation_2014.pdf (last visited Mar. 27, 2014).
[13] *Id.*
[14] Chapter 2011-135, s. 24, L.O.F., repeals s. 430.707, F.S., effective Oct 1, 2013, as part of the expansion of Medicaid managed care.
[15] Chapter 2011-135, s. 24, L.O.F., repeals s. 430.707, F.S., effective Oct. 1, 2013.

managed care plans. Instead, PACE plans may continue to provide services to individuals at such levels and enrollment caps as authorized by the GAA.[16]

The 2013 Legislature also directed the AHCA and the DOEA to provide a comprehensive report describing the PACE's organizational structure, scope of services, utilization, and costs; comparing those findings with similar information for managed long-term care, and evaluating alternative methods for integrating PACE with Long-Term Care Managed Care.[17] The report's findings noted a difference in the average age (81.1 years in SMMC versus 75.5 in PACE),[18] prevalence of severe emotional problems (PACE enrollees are more likely to report), and affliction with cognitive impairments such as dementia (higher with Long-Term Care Managed Care).[19]

The current PACE approval process requires any entity interested in becoming a PACE organization to submit a comprehensive PACE application to the AHCA, which sets forth details about the adult day care center, staffing, provider network, financial solvency and pro forma financial projections, and policies and procedures, among other elements. The application is similar in detail to the provider applications submitted by managed care plans seeking to provide medical care to Medicaid recipients. Providers operating in the same geographic region must establish that there is adequate demand for services so that each provider will be viable. The application requires that documentation be submitted demonstrating that neither provider is competing for the same potential enrollees.

The AHCA and the DOEA review the application and, when the entity has satisfied all requirements, conduct an on-site survey of the entity's readiness to serve PACE enrollees. Once all requirements are met, including full licensure of the center, staffing for key positions, and signed provider network contracts, the AHCA certifies to federal CMS that the PACE site is ready. At that time, CMS reviews the application and readiness certification and, if all requirements are satisfied, executes a three-way agreement with the PACE provider and the AHCA. The PACE provider may then begin enrolling members, subject to an appropriation to fund the slots.

Enrollment and Organizational Slots

Slots are authorized by the Legislature for a specific PACE area; however, those slots may not always be fully funded in the same year as the program is authorized. Some PACE providers need additional time to complete the application process, obtain necessary licensures, or to finalize operations. The chart below summarizes the current status of approved PACE organizations.

[16] Section 409.981(4), F.S.
[17] Chapter 2013-40, L.O.F., line 424.
[18] Dep't of Elder Affairs, *Supra* note 2, at 20.
[19] *Id* at 19.

SUMMARY OF PACE PROGRAMS[20]					
PACE ORGANIZATION			SLOT INFORMATON		
Area	**Year**	**Organization**	**Auth. Slots**	**Funded Slots**	**Current Enrollment[21] (Jan. 2019)**
Broward	2014	Florida PACE	150	125	65
Charlotte	2010	Hope Select	150	150	66
Collier	2010	Hope Select	120	120	37
Desoto, Manatee, and Sarasota	NA	Tidewell	150	0	0
Gadsden, Jefferson, Leon and Wakulla	NA	Elder Care Services	300	100	0
Hillsborough	2011	Suncoast Neighborly PACE	150	0	0
Lee	2010	Hope Select	380		213
Martin	2018	Morse PACE	150	75	0
Miami-Dade	2003	Miami-Dade	809	809	759
Northeast Florida *(Clay, Duval, St. Johns, Baker, Nassau)*	2018	Northeast Florida PACE	300	100	
Orange, Osceola, Lake and Sumter	NA	Cornerstone PACE	150	0	0
Palm Beach	2013	Morse PACE	656	656	493
Panhandle		Covenant	100	100	
Pinellas	2009	Suncoast Neighborly PACE	325	325	316
Seminole	NA	Cornerstone PACE	150	0	0
Total Enrollees - Statewide:			4,040	2,740	1,949

Funding and Rates

Each year since the PACE's inception, the Legislature has appropriated funds for PACE organizations through proviso language in the state's General Appropriations Act (GAA) or through one of the appropriation implementing or conforming bills.[22] These directives provide specific slot increases or decreases by county or authorization for a county to implement a new program. In 2013, Governor Scott vetoed the allocations in all counties except Palm Beach, noting that the state's focus should be on the implementation of the SMMC and that effectiveness and the need for additional PACE slots should be re-evaluated after that transition was completed.[23]

[20] Agency for Health Care Administration and Department of Elder Affairs, *SPB 7124 - Relating to the Program of All-Inclusive Care for the Elderly (PACE) Bill Analysis and Background Information* (Mar. 28, 2014) on file with the Senate Health Policy Committee.
[21] Agency for Health Care Administration, *Florida Statewide Medicaid Monthly Enrollment Report Program Enrollment by Region* (January 2019) *available at* http://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited Feb. 25, 2019).
[22] Chapter 2013-40, L.O.F.
[23] Governor Rick Scott, *Veto Message - SB 1500* (May 20, 2013), p. 28, *available at* http://www.flgov.com/wp-content/uploads/2013/05/Message1.pdf (last visited Feb. 21, 2019).

PACE organizations receive a capitated Medicaid payment for each enrolled Medicaid long-term care recipient and an enhanced Medicare payment for Medicare enrollees for acute care services from the federal government. The payment amount is established in the GAA and is based on estimates that have been forecast by the Social Services Estimating Conference (SSEC) for the PACE. The SSEC principals from the Office of Economic and Demographic Research, the Governor's Office of Planning and Budget, the budget staff of the House of Representatives and the Florida Senate, seek a consensus on an appropriate risk-adjusted rate for the program which takes into account the current membership, any statutory or regulatory changes that may affect health care utilization, and any other changes that may impact costs positively or negatively.

The current cost per eligible per month for the PACE is $2,681.76.[24] In comparison, according to a 2016 survey by Genworth Financial, the national average cost for nursing home care cost $92,000 per year for a private room or $82,125 for a semi-private room.[25]

Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid serves approximately 3.8 million people in Florida, with over half of those being children and adolescents 19 years of age or younger. Medicaid is a partnership between the federal and state governments where the federal government establishes the structure for the program and pays a share of the cost. Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare and Medicaid Services or CMS. The plan outlines current Medicaid eligibility standards, policies, and reimbursement methodologies.

To qualify for nursing home care under Medicaid, both an individual's income and assets will be reviewed. Additionally, a personal needs allowance will be applied as part of the eligibility determination process.[26] The current standard income limit in Florida for institutional care or services under the home and community based services waiver is $2,313 for an individual and $4,626 for a couple. There is also an asset limit for either category of $2,000 for an individual or $3,000 for a couple.[27]

In Florida, the Medicaid program is administered by the AHCA. The AHCA; however, delegates certain functions to other state agencies, including the Department of Children, Families and Elder Affairs (DCF), the Agency for Persons with Disabilities (APD), and the DOEA. The AHCA has overall responsibility for the program and qualifies providers, sets payment levels, and pays for services.

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[24] Office of Economic and Demographic Research, *Social Services Estimating Conference –Long Term Medicaid Services and Expenditures Forecast* (December 2018), p. 22, http://edr.state.fl.us/Content/conferences/medicaid/medltexp.pdf (last visited Feb. 25, 2019).

[25] Emily Mullin and Lisa Esposito, *How to Pay for Nursing Home Costs,* U.S. NEWS AND WORLD REPORT (Nov. 16, 2016) *available at* https://health.usnews.com/wellness/articles/2016-11-16/how-to-pay-for-nursing-home-costs (last visited Feb. 25, 2018).

[26] The personal needs allowance (PNA) of an individual is defined as that portion of an individual's income that is protected to meet the individual's personal needs while in an institution. *See* Department of Children, Families and Elder Affairs, *Glossary (Chapter 4600) "Personal Needs Allowance," pg. 19,* http://www.dcf.state.fl.us/programs/access/docs/esspolicymanual/4600.pdf (last visited Feb. 25, 2019).

[27] Dep't of Children, Families and Elder Affairs, *SSI-Related Program-Financial Eligibility Standards: January 2019,* http://www.dcf.state.fl.us/programs/access/docs/esspolicymanual/a_09.pdf (last visited Feb. 25, 2019).

The DCF is responsible for determining financial eligibility for Medicaid recipients. The APD operates one of the larger waiver programs under Medicaid, the Home and Community Based (HCBS) Waiver program serving individuals with developmental disabilities.

The DOEA assesses Medicaid recipients to determine if they require nursing home care. Specifically, the DOEA determines whether an individual:

- Requires nursing home placement as evidenced by the need for medical observation throughout a 24-hour period and requires medically complex care to be performed on a daily basis under the direct supervision of a health professional because of mental or physical incapacitation;
- Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and requires care to be performed on a daily basis under the supervision of a health professional because of mental or physical incapacitation; or,
- Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and requires limited care to be performed on a daily basis under the supervision of a health professional because of mild mental or physical incapacitation.

Floridians who need nursing home care, but do not qualify for Medicaid, must pay from their own funds or through insurance.

Long-Term Care Managed Care

In 2011, the Legislature passed and the Governor signed into law HB 7107[28] to increase the use of managed care in Medicaid. The law required both Medicaid long-term care (LTC) services and Managed Medical Assistance (MMA) services to be provided through managed care plans.

Participating Long-Term Care Managed Care plans participating in SMMC are required to provide minimum benefits that include nursing home care as well as home and community based services. The minimum benefits include:

- Nursing home care
- Services provided in assisted living facilities
- Hospice
- Adult day care
- Medical equipment and supplies, including incontinence supplies
- Personal care
- Home accessibility adaptation
- Behavior management
- Home delivered meals
- Case management
- Therapies: physical, respiratory, speech, and occupational
- Intermittent and skilled nursing

[28] Chapter 2011-134, L.O.F.

- Medication administration
- Medication management
- Nutritional assessment and risk reduction
- Caregiver training
- Respite care
- Transportation
- Personal emergency response system

III. Effect of Proposed Changes:

Section 1 creates s. 430.84, F.S., and codifies the Program of All-Inclusive Care for the Elderly (PACE). Currently, the program does not have an implementing statute and has been operationalized through annual appropriations, proviso, or bills designed to implement the state budget or conform statute to provisions of the state budget.

Definitions

The bill creates the following definitions for the PACE program:
- Agency;
- Applicant;
- CMS;
- Department;
- PACE organization; and
- Participant;

Program Creation

SB 778 authorizes the AHCA, in consultation with the DOEA, to approve entities who have submitted the required application and data to the federal Centers for Medicare and Medicaid Services (CMS) as PACE organizations pursuant 42 U.S.C. s. 1395eee (2019). Applications, as required by CMS, will be reviewed by the AHCA on an ongoing basis, in consultation with the DOEA for initial approval as PACE organizations. Notice of applications must also be published in the Florida Administrative Register.

A prospective PACE organization must submit an application to the AHCA before submitting a request for program funding. An applicant for a PACE program must meet the following requirements:
- Provide evidence that the applicant can meet all of the federal regulations and requirements established by CMS by the proposed implementation date.
- Provide market studies which include an estimate of the potential number of participants and which show the geographic area the applicant proposes to serve.
- Develop a business plan of operation, including pro forma financial statement and projections based on the planned implementation date.
- Show evidence of regulatory compliance and meet market studies requirements, if applicant is an existing PACE organization which seeks to expand to an additional service area.
- Implement program within 12 months after date of initial state approval if granted authorization as a prospective PACE organization or such approval is void.

Funding and Enrollment

SB 778 directs PACE organizations to enroll participants at the level funded through the General Appropriations Act (GAA) which must reflect a reasonable level of growth to meet the needs of the community and be consistent with the financial projections periodically submitted by the PACE organizations. The AHCA is directed to consult with the DOEA and the Social Services Estimating Conference and to submit a report to the Legislature requesting the necessary funding for prospective PACE participants to have the PACE as an option in all authorized service areas.

The bill also permits the use of funds within any PACE organization's authorized geographic area, regardless of county lines. The DOEA is required to notify individuals who are determined eligible for nursing level of care under Medicaid that the PACE organization is an available service option and that enrollment into PACE is voluntary.

Quality and Reporting

All PACE organizations are required to meet specific quality and performance standards established by CMS. The AHCA has the responsibility to oversee and monitor Florida's PACE and the contracted organizations through the data and reports submitted periodically to the AHCA and CMS.

The bill exempts all PACE organizations from the requirements of chapter 641, the chapter of Florida law which regulates health maintenance organizations, prepaid health clinics, and other health care service programs.

Section 2 amends s. 409.981, F.S., relating to eligible long-term care plans in the Medicaid program, particularly the PACE. The bill modifies this section of law to provide a cross reference to the newly created section of law in Section 1 of the bill and to change the language from permissive participation in the Medicaid managed care program to mandatory participation in the program.

Additionally, new language is added to allow prospective participants who have applied for the PACE to have been determined eligible by the Comprehensive Assessment and Review (CARES) program to be medically eligible, but have not yet received their financial eligibility determination from the Department of Children and Families, to be enrolled in the PACE if PACE organizations have agreed to enroll participants pending this final determination.

The bill requires the CARES program to determine each applicant's medical eligibility within 21 days after receiving a complete application packet and requires the Department of Children, Families, and Elder Affairs to determine eligibility within state and federal requirements.[29] If the applicant is determined eligible, the AHCA is directed to pay the PACE organization the applicable Medicaid rate retroactive to the first of the month in which the financial eligibility was determined. If the applicant is not eligible for the PACE as a Medicaid recipient, the

[29] The timeliness standard for the processing of applications under Medicaid is found under 42 CFR 435.912 (a), (b), and (c). The federal requirement for processing of a Medicaid application based on a disability is 90 days for all other applicants, it is 45 days.

applicant may continue in the PACE as a private-pay PACE participant or may terminate services. In the latter case, the PACE organization may seek reimbursement from the applicant.

Section 3 provides an effective date of July 1, 2019.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Subject to the availability of funds and slots, additional private sector providers that meet the criteria to be a PACE organization and achieve eligibility confirmation status could be approved as PACE sites. Expansion of PACE sites would also mean additional individuals in the community would have access to these services.

PACE organizations represent 0.05 percent of the market share of Medicaid enrollees as of January 2019.[30] Current managed care plans that participate in the SMMC program may experience a loss of market share and/or profit margin if enrollment in PACE organizations were to grow beyond a certain percentage or if certain, less risky or less

[30] Agency for Health Care Administration, *Medicaid SMMC Market Share Report, SMMC-MMA Assignment* (as of January 31, 2019) *available at* http://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited Feb. 25, 2019).

costly segments of their current SMMC population were to depart SMMC enrollment and enroll in the PACE.

C. Government Sector Impact:

SB 778 codifies an existing program. If the bill were to result in the expansion of the PACE, then it may result in an increased workload for the AHCA and the DOEA. The bill reflects the structure and many of the current processes required of both entities to review applications, monitor performance, and make annual recommendations to the Legislature and the federal oversight agency which are undertaken today. By formalizing the process, some potential PACE organizations may be more likely to consider pursuing this option, leading to an increased workload and request for additional funding.

The fiscal impact of the bill to the state agencies is unknown. If additional funding were provided to expand the number of PACE sites, then additional resources may be necessary at the affected state agencies to adapt to the related, increased volume of applications and necessary oversight.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 409.981 of the Florida Statutes.

This bill creates section 430.84 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator Baxley

12-01151A-19 2019778__

A bill to be entitled

An act relating to the Program of All-Inclusive Care for the Elderly; creating s. 430.84, F.S.; defining terms; authorizing the Agency for Health Care Administration, in consultation with the Department of Elderly Affairs, to approve entities applying to deliver Program of All-Inclusive Care for the Elderly (PACE) services in the state; requiring the agency, in consultation with the department, to review and consider applications; requiring that notice of such applications be published in the Florida Administrative Register; specifying application requirements; requiring prospective PACE organizations that are granted initial state approval to submit a complete application to the agency and the Federal Government within a certain timeframe; specifying funding and enrollment requirements for PACE organizations; requiring the agency, in consultation with the department and the Social Services Estimating Conference, to submit a certain report to the Legislature; requiring the agency and department to provide certain notices to certain individuals; requiring PACE organizations to meet certain standards; requiring the agency to oversee and monitor the PACE program based on certain information; exempting PACE organizations from ch. 641, F.S.; amending s. 409.981, F.S.; conforming a provision to changes made by the act; providing that specified individuals may be enrolled in the PACE program under

certain circumstances; requiring the Comprehensive Assessment and Review for Long-Term Care Services program to determine a PACE applicant's eligibility within a certain timeframe; requiring the Department of Children and Families to determine a PACE applicant's financial eligibility; specifying requirements for the agency in paying contractors providing services to eligible applicants; authorizing certain actions by a contractor with respect to certain applicants; providing an effective date.

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

Section 1. Section 430.84, Florida Statutes, is created to read:

430.84 Program of All-Inclusive Care for the Elderly.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Agency" means the Agency for Health Care Administration.

(b) "Applicant" means an entity that has filed an application with the agency for consideration as a Program of All-Inclusive Care for the Elderly (PACE) organization.

(c) "CMS" means the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services.

(d) "Department" means the Department of Elderly Affairs.

(e) "PACE organization" means an entity under contract with the agency to deliver PACE services.

(f) "Participant" means an individual receiving PACE

services who the department has determined needs the level of care required under the state Medicaid plan for coverage of nursing facility services.

(2) PROGRAM CREATION.—The agency, in consultation with the department, may approve entities that have submitted the application the CMS requires to the agency for review and consideration. An entity must submit the data and information required in subsection (3) to provide benefits pursuant to the PACE program as established in 42 U.S.C. s. 1395eee and in accordance with the requirements set forth in this section.

(3) PACE ORGANIZATION SELECTION.—The agency, in consultation with the department, shall review and consider on a continuous basis applications the CMS requires for PACE which have been submitted to the agency by entities seeking initial state approval to become PACE organizations. Notice of such applications must be published in the Florida Administrative Register.

(a) A prospective PACE organization shall submit application documents to the agency before requesting program funding. Application documents submitted to and reviewed by the agency, in consultation with the department, must include all of the following:

1. Evidence that the applicant is able to meet all of the applicable federal regulations and requirements established by the CMS for participation as a PACE organization by the proposed implementation date.

2. Market studies, including an estimate of the number of potential participants and the geographic service area the applicant proposes to serve.

3. A business plan of operation, including pro forma financial statements and projections, based on the proposed implementation date.

(b) Each applicant must propose to serve a unique and defined geographic service area without duplication of services or target populations. No more than one PACE organization may be authorized to provide services within any unique and defined geographic service area.

(c) An existing PACE organization seeking authority to serve an additional geographic service area not previously authorized by the agency or Legislature must meet the requirements set forth in paragraphs (a) and (b).

(d) A prospective PACE organization granted initial state approval by the agency, in consultation with the department, shall submit its complete federal PACE application, in accordance with the application process and guidelines established by the CMS, to the agency and the CMS within 12 months after the date of initial state approval, or such approval is void.

(4) FUNDING AND ENROLLMENT.—

(a) PACE organizations shall enroll participants at such levels as funded by the General Appropriations Act, which must reflect a reasonable growth of capacity sufficient to meet community needs and which must be consistent with the pro forma or other projections submitted pursuant to paragraph (3)(a) or projections of PACE census and demand growth that are periodically submitted by PACE organizations. The agency, in consultation with the department and the Social Services Estimating Conference, shall submit a report to the Legislature

requesting the amount of funding necessary for prospective PACE participants to have access to PACE services as a program service option in all authorized geographic service areas.

(b) Funds may be used within any PACE organization's authorized geographic service area, regardless of county lines.

(c) The department shall notify individuals who are determined to need the level of care required under the state Medicaid plan for coverage of nursing facility services that the PACE program is a service plan option and that enrollment in the PACE program is voluntary.

(d) The agency shall notify individuals who are determined eligible for managed long-term care that the PACE program is available as a choice for a managed care plan pursuant to s. 409.969 in statewide Medicaid managed care regions wherein a PACE organization operates.

(5) ACCOUNTABILITY.—All PACE organizations must meet specific quality and performance standards established by the CMS for the PACE program. The agency shall oversee and monitor the PACE program and organizations based upon data and reports PACE organizations submit periodically to the agency and the CMS. A PACE organization is exempt from the requirements of chapter 641.

Section 2. Subsection (4) of section 409.981, Florida Statutes, is amended to read:

409.981 Eligible long-term care plans.—

(4) PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY.—

(a) Participation by the Program of All-inclusive Care for the Elderly (PACE) shall be pursuant to a contract with the agency and not subject to the procurement requirements or

regional plan number limits of this section. PACE organizations shall ~~plans may continue to~~ provide services to participants ~~individuals~~ at such levels ~~and enrollment caps~~ as authorized by the General Appropriations Act pursuant to s. 430.84.

(b) A prospective participant who applies for the PACE program and has been determined by the Comprehensive Assessment and Review for Long-Term Care Services (CARES) program to be medically eligible but has not been determined financially eligible for Medicaid by the Department of Children and Families, or who has been determined financially eligible for Medicaid by the Department of Children and Families but has not been determined medically eligible by the CARES program, may be enrolled in the PACE program if contractors elect to provide services to PACE program applicants pending final determination of eligibility. The CARES program shall determine each applicant's medical eligibility within 21 days after receiving the complete application packet. The Department of Children and Families shall determine each applicant's financial eligibility according to federal and state requirements. If the applicant is determined eligible, the Agency for Health Care Administration shall pay the contractor that provided the services the applicable Medicaid rate, retroactive to the first day of the month following the CARES program eligibility determination. If the applicant is not eligible for the PACE program with Medicaid as the payor, the contractor may continue to provide services as a private-pay PACE participant or terminate services and seek reimbursement from the applicant.

Section 3. This act shall take effect July 1, 2019.

THE FLORIDA SENATE

SENATOR DENNIS BAXLEY
12th District

COMMITTEES:
Ethics and Elections, *Chair*
Appropriations Subcommittee on Education
Education
Finance and Tax
Health Policy
Judiciary

JOINT COMMITTEE:
Joint Legislative Auditing Committee

February 19, 2019

The Honorable Chairwoman Gayle Harrell
310 Senate Office Building
404 South Monroe Street
Tallahassee, Florida 32399

Dear Chairwoman Harrell,

I would like to request SB 778 Program of All-Inclusive Care for the Elderly (PACE) be heard in your next Health Policy Committee meeting.

This bill defines what is a PACE organization and who is the individual receiving PACE services who the department has determined needs the level of care required under the state Medicaid plan for coverage of nursing facility services.

It also provides for application guidelines for organizations wanting to provide PACE services.

I appreciate your favorable consideration.

Onward & Upward,

Senator Dennis K Baxley
Senate District 12

DKB/dd

cc: Allen Brown, Staff Director

320 Senate Office Building, 404 South Monroe St, Tallahassee, Florida 32399-1100 • (850) 487-5012
Email: baxley.dennis@flsenate.gov

Bill Galvano
President of the Senate

David Simmons
President Pro Tempore

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SPB 7124
INTRODUCER:	For Consideration by the Health Policy Committee
SUBJECT:	Program of All-Inclusive Care for the Elderly
DATE:	March 27, 2014
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Pre-meeting**

I. Summary:

SPB 7124 creates the Program of All-Inclusive Care for the Elderly (PACE) in statute. The bill establishes definitions for the PACE program, authorizes the Department of Elder Affairs (DOEA), in consultation with the Agency for Health Care Administration (AHCA), to contract for services and creates a two-step selection process for providers.

The bill establishes an eligibility confirmation status requirement for both new providers and those in existence as of May 1, 2014. Documentation of compliance with federal requirements, accreditation status, financial stability, fidelity bond, insurance coverage, prior experience and a business plan of operation is required to achieve eligibility confirmation status. Each provider must serve a unique and defined service area without duplication of services or target populations.

The PACE providers will be selected on a regional basis using the regions under s. 409.966, F.S., and no more than one provider can be selected per 3,000 potential eligible enrollees in a region.

Annually, the AHCA and the DOEA will review the list of existing providers, the projected enrollment and costs for existing providers, and the list of entities with a confirmed eligibility status. The AHCA and the DOEA shall develop an annual funding priority list by January 1 for submission to the President of the Senate and the Speaker of the House of Representatives. Besides enrollment and cost projections, the priority funding list must also include recommendations for any discontinuation of providers or policy changes that require statute modifications. The AHCA and DOEA are also directed to take into consideration several factors when developing their recommendations, such as the services being offered, the proposed plan of operation, the outreach plan, the anticipated costs and enrollment and any supplemental benefits.

All PACE providers will be required to meet quality and performance standards developed by the AHCA and DOEA, as well as unique standards mutually developed between the provider and the DOEA.

Enrollment in PACE is voluntary and on a first-come, first served basis. Based on the General Appropriations Act (GAA), the AHCA shall define a cap on the number of PACE slots; however, the number available statewide may not exceed 3 percent of the total enrollees in the long-term care managed care program.

The bill provides for the negotiation of rates between the PACE provider and the AHCA as part of the application and contract renewal process. Capitation rates and enrollment caps are subject to the GAA. Payment rates will reflect historic utilization and case mix of PACE enrollees.

SPB 7124 requires the contract between the PACE provider and the AHCA include a lock-in provision that holds the PACE provider financially responsible for a designated period of time if an enrollee disenrolls and subsequently enrolls or transfers to a nursing home.

Annual capitation rates to a PACE provider may not result in an increase to the capitation rate paid under the Statewide Medicaid Managed Care Program - Long-Term Care (SMMC - LTC) by more than 3 percent over the prior fiscal year, as certified by the AHCA's chief financial officer.

II. Present Situation:

Program of All-Inclusive Care for the Elderly (PACE)

The PACE is a capitated benefit model authorized by the federal Balanced Budget Act of 1997 (BBA), that features a comprehensive service delivery system and integrated federal Medicare and state Medicaid financing. The model, which was tested through Centers for Medicaid and Medicare (CMS) demonstration projects beginning in the mid-1980s,[1] was developed to address the needs of long-term care clients, providers, and payers.

A PACE organization is a not-for-profit, private or public entity that is primarily engaged in providing PACE services and must:

- Have a governing board that includes community representation;
- Be able to provide the complete service package regardless of frequency or duration of services;
- Have a physical site to provide adult day services;
- Have a defined service area;
- Have safeguards against conflicts of interest;
- Have a demonstrated fiscal soundness; and,
- Have a formal participant bill of rights.

The PACE participants must be at least 55 years of age, live in the PACE service area, and be certified eligible for nursing home care, but able to live safely in the community. The PACE program becomes the sole source of services for these Medicare and Medicaid eligible enrollees.

Under the PACE program, an interdisciplinary team consisting of professional and paraprofessional staff assesses participants' needs, develops care plans, and delivers all services,

[1]CMS Manual *available at* http://www.cms.gov/Medicare/Health-Plans/pace/downloads/r1so.pdf (last visited Mar. 27, 2014)

including acute care and nursing facility services when necessary, which are integrated to provide a seamless delivery model. A PACE program provides social and medical services primarily in an adult day health center, which are supplemented by in-home and referral services as necessary. The PACE service package must include all Medicare and Medicaid covered services, and other services determined necessary by the multidisciplinary team for the care of the PACE participant. The PACE enrollee must accept the PACE center physician as their new Medicare primary care physician, if enrolled in Medicare.[2]

The BBA established the PACE model of care as a permanent entity within the Medicare program and enabled states to provide the PACE services to Medicaid beneficiaries as an optional state plan service without a Medicaid waiver. The state plan must include PACE as an optional Medicaid benefit before the state and the Secretary of the Department of Health and Human Services can enter into program agreements with PACE providers.

The PACE project is a unique federal/state partnership. The federal government establishes the PACE organization requirements and application process. The state Medicaid agency or other state agency is responsible for oversight of the entire application process, which includes reviewing the initial application and providing an on-site readiness review before a PACE organization can be authorized to serve patients. An approved PACE organization must sign a contract with CMS and the state Medicaid agency. Rates for PACE providers are developed based on a county level actuarial analysis of the costs associated with the service population.

Florida PACE Project

The Florida PACE project was initially authorized in ch. 98-327, Laws of Florida, and is codified in s. 430.707(2), F.S., under the administration of the DOEA, operating in consultation with the AHCA.[3] The initial program was located in Miami-Dade County and began serving enrollees in February 2003 with a total of 150 slots. Since then, the Legislature has approved additional slots either as part of the GAA or general law. Currently, active PACE programs exist in 6 Florida counties: Lee, Charlotte, Collier, Miami-Dade, Palm Beach, and Pinellas.

The 2006 GAA contained proviso language authorizing an additional 150 slots in the Miami-Dade County program and 200 slots each at new programs in Martin/St. Lucie Counties, and Lee County.[4] In 2008, the Legislature reallocated equally 150 unused PACE slots to Miami-Dade, Lee, and Pinellas Counties.[5] In 2009, the Legislature authorized 100 slots for a program in Hillsborough County.[6] The 2010 GAA funded an additional 100 slots in Pinellas County and authorized and funded a new program with 100 slots in Hillsborough County.[7] That same year, the Legislature, by general law, authorized an additional 50 slots in Miami-Dade and 150 slots

[2] Department of Elder Affairs and Agency for Health Care Administration, *Program of All-Inclusive Care for the Elderly and Statewide Medicaid Managed Care Long-term Care Program Comparison Report* (Jan. 14, 2014), http://ahca.myflorida.com/docs/PACE_Evaluation_2014.pdf (last visited Mar. 27, 2014).
[3] Chapter 2011-135, s. 24, L.O.F, repeals s. 430.707, F.S., effective Oct 1, 2013, as part of the expansion of Medicaid managed care.
[4] Chapter 2006-25, L.O.F.
[5] Chapter 2008-152, L.O.F.
[6] Chapter 2009-55, s. 20, L.O.F.
[7] Chapter 2010-152, L.O.F.

for a program serving Polk, Hardee, Highlands, and Hillsborough Counties.[8] In 2011, the Legislature authorized a program with 150 slots in Palm Beach County,[9] and funded, through the GAA, 50 additional slots in Lee County and 150 slots for a program serving Polk, Hardee, and Highlands Counties.[10] In 2012, the Legislature authorized two new programs of up to 150 slots each for a program in Broward County and a program serving Manatee, Sarasota, and DeSoto Counties.[11] The 2012–2013 GAA funded 100 additional slots in Miami-Dade and 150 additional slots in Lee County.[12]

The Legislature appropriated $30,402,775 for PACE in the 2013-2014 GAA.[13] The appropriation proviso language included specific slot increases in Lee County by 100, in Hillsborough County by 75, in Palm Beach County by 100, and in Broward County by 50. The Governor vetoed the allocations in all counties, except Palm Beach, noting that the state's focus should be on the implementation of the SMMC-LTC and that effectiveness and the need for additional PACE slots should be re-evaluated after that transition is completed.[14]

Slots are authorized by the Legislature for a specific PACE program area; however, those slots may not always be fully funded in the same year as the program is authorized. Some PACE providers need additional time to complete the application process, obtain necessary licensures or to finalize operations.

PACE Organizations and Enrollee Counts[15]

PACE Organization Name	Year Began Operating	County	Current Enrollees Mar-2014	Total Slots Funded
Hope Select Care	2010	Charlotte	37	100
Hope Select Care	2010	Collier	17	50
(No Provider Currently)[16]	2011	Hillsborough	0	150
Hope Select Care	2010	Lee	220	250
Florida PACE	NA	Broward	Vetoed	Vetoed
Florida PACE	2003	Miami-Dade	395	450
Suncoast Neighborly	2012	Pinellas	161	225
Morse PACE	2013	Palm Beach	35	100
TBA	NA	Manatee, Sarasota, DeSoto	0	0
Total Enrollees - Statewide:			865	1,325

[8] Chapter 2010-156, ss. 14 and 15, L.O.F.
[9] Chapter 2011-61, s. 17, L.O.F.
[10] Chapter 2011-69, L.O.F.
[11] Chapter 2012-33, ss.18 and 19, L.O.F.
[12] Chapter 2012-118, L.O.F.
[13] Chapter 2013-40, L.O.F.
[14] Governor Rick Scott, *Veto Message - SB 1500* (May 20, 2013), p.28, http://www.flgov.com/wp-content/uploads/2013/05/Message1.pdf (last visited Mar. 27, 2014).
[15] Agency for Health Care Administration and Department of Elder Affairs, *SPB 7124 - Relating to the Program of All-Inclusive Care for the Elderly (PACE) Bill Analysis and Background Information* (Mar. 28, 2014) on file with the Senate Health Policy Committee.
[16] The Hillsborough PACE provider, Chapters PACE, discontinued services as of August 31, 2013. Enrollees were transitioned to other home or community based setting options.

The 2013 Legislature also directed the AHCA and DOEA to provide a comprehensive report describing PACE's organizational structure, scope of services, utilization, and costs; comparing those findings with similar information for managed long-term care, and evaluating alternative methods for integrating PACE with SMMC-LTC.[17] The report's findings noted a difference in the average age (81.1 years in SMMC versus 75.5 in PACE),[18] prevalence of severe emotional problems (PACE enrollees are more likely to report) and affliction with cognitive impairments such as dementia (higher with SMMC-LTC).[19]

An entity that seeks to become a PACE provider must submit a comprehensive PACE application to the AHCA, which sets forth details about the adult day health care center, staffing, provider network, financial solvency and pro forma financial projections, and policies and procedures, among other elements. The application is similar in detail level to the provider applications submitted by managed care plans seeking to provide medical care to Medicaid recipients. Providers operating in the same geographic region must establish that there is adequate demand for services so that each provider will be viable. The application requires that documentation be submitted demonstrating that neither provider is competing for the same potential enrollees.

The AHCA and the DOEA review the application and, when the entity has satisfied all requirements, conduct an on-site survey of the entity's readiness to serve PACE enrollees. Once all requirements are met, including full licensure of the center, staffing for key positions, and signed provider network contracts, the AHCA certifies to CMS that the PACE site is ready. At that time, CMS reviews the application and readiness certification and, if all requirements are satisfied, executes a three-way agreement with the PACE provider and the AHCA. The PACE provider may then begin enrolling members, subject to an appropriation to fund the slots.

In 2011, the Legislature moved administrative responsibility for the PACE program from DOEA to AHCA as part of the expansion of Medicaid managed care.[20] Participation by PACE is not subject to the procurement requirements or regional plan number limits applicable to the statewide Medicaid Managed Care program. Instead, PACE plans may continue to provide services to individuals at such levels and enrollment caps as authorized by the GAA.[21]

Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid serves approximately 3.3 million people in Florida, with over half of those being children and adolescents 19 years of age or younger. Medicaid is a partnership between the federal and state governments where the federal government establishes the structure for the program and pays a share of the cost. Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare and Medicaid Services or CMS. The plan outlines current Medicaid eligibility standards, policies and reimbursement methodologies.

[17] Chapter 2013-40, L.O.F., line 424.
[18] Department of Elder Affairs, *Supra* note 2 at 20.
[19] *Id* at 19.
[20] Chapter 2011-135, s. 24, L.O.F., repeals Section 430.707, F.S., effective Oct. 1, 2013.
[21] Section 409.981(4), F.S.

In Florida, the program is administered by the AHCA. The AHCA delegates certain functions to other state agencies, including the Department of Children and Families (DCF), the Agency for Persons with Disabilities (APD), and the DOEA. The AHCA has overall responsibility for the program and qualifies providers, sets payment levels, and pays for services. The DCF is responsible for determining financial eligibility for Medicaid recipients. The APD operates one of the larger waiver programs under Medicaid, the Home and Community Based Waiver program serving individuals with disabilities. The DOEA assesses Medicaid recipients to determine if they require nursing home care. Specifically, the DOEA determines whether an individual:

- Requires nursing home placement as evidenced by the need for medical observation throughout a 24-hour period and requires medically complex care to be performed on a daily basis under the direct supervision of a health professional because of mental or physical incapacitation;
- Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and requires care to be performed on a daily basis under the supervision of a health professional because of mental or physical incapacitation; or,
- Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and requires limited care to be performed on a daily basis under the supervision of a health professional because of mild mental or physical incapacitation.

Floridians who need nursing home care, but do not qualify for Medicaid, must pay from their own funds or through insurance. According to the 2012 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs, the national average cost of a nursing home was $81,030 per year for a semi-private room in 2012.[22] Persons needing nursing home care are determined to be eligible for Medicaid based on financial assets and monthly income.

Long-Term Managed Care

In 2011, the Legislature passed and the Governor signed into law HB 7107[23] to increase the use of managed care in Medicaid. The law requires both long-term care services and Medicaid medical assistance to be provided through managed care plans. The Long-term Care Managed Care component was implemented first. Enrollment began in Region 7 effective August 1, 2013, and concluded with Regions 1, 3, and 4 on March 1, 2014.[24]

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[22] 2012 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs, https://www.metlife.com/assets/cao/mmi/publications/highlights/mmi-market-survey-long-term-care-costs-highlights.pdf (last visited Mar. 27, 2014).

[23] Chapter 2011-134, L.O.F.

[24] Agency for Health Care Administration, *Medicaid - Long Term Care Home*, http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#LTCMC (last visited Mar. 27, 2014). Region 1 includes Escambia, Okaloosa, Santa Rosa, and Walton. Region 3 includes Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union. Region 4 includes Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia. Region 7 includes Brevard, Orange, Osceola and Seminole.

The AHCA procured the long-term managed care plans through a competitive bid process. The AHCA considered many factors when selecting plans. The AHCA chose a certain number of long-term care managed care plans for each region to ensure that recipients have a choice between plans. PACE organizations were eligible to bid to become comprehensive long-term care program plans, but no PACE organizations elected to bid.[25] However, pursuant to s. 409.981, F.S., PACE plans are authorized to continue to provide services to individuals as authorized annually in the General Appropriations Act through a contract with the AHCA. Following the procurement process, seven different contracts were awarded and each region has at least two SMMC-LTC plans.

Participating managed care plans are required to provide minimum benefits that include nursing home as well as home and community based services. Plans were free to customize and offer additional services. The minimum benefits include:

- Nursing home
- Services provided in assisted living facilities
- Hospice
- Adult day care
- Medical equipment and supplies, including incontinence supplies
- Personal care
- Home accessibility adaptation
- Behavior management
- Home delivered meals
- Case management
- Therapies: physical, respiratory, speech, and occupational
- Intermittent and skilled nursing
- Medication administration
- Medication management
- Nutritional assessment and risk reduction
- Caregiver training
- Respite care
- Transportation
- Personal emergency response system

On February 1, 2013, the Federal Centers for Medicare and Medicaid Services, approved AHCA's request for a Home and Community Based Care Services waiver for individuals 65 and older and individuals with physical disabilities ages 18 through 64 years of age. This approval allows Florida to implement managed care for long-term care services under Medicaid.

III. Effect of Proposed Changes:

Section 1 creates s. 430.84, F.S., and establishes, in statute, the Program of All-Inclusive Care for the Elderly (PACE). Currently, the program does not have a specific implementing statute and has been operationalized through annual appropriations, proviso and implementing bill language. The bill creates the following definitions for the PACE program:

[25] Department of Elder Affairs, *See Supra* note 2, at 7.

- Agency;
- Applicant;
- Department;
- Eligible entity;
- Enrollee; and
- Provider.

The DOEA is authorized to contract, in consultation with the AHCA, with entities that have submitted applications to provide benefits pursuant to PACE under 42 U.S.C. s. 1395eee and that have met specific requirements. Provider selection is to be conducted through a two-step process developed by the AHCA and the DOEA for both new and existing PACE sites. A PACE provider is exempt from the requirements of chapter 641, requirements relating to health maintenance organizations, prepaid health clinics, and prepaid provider service networks.

Applications will be reviewed by the AHCA on an ongoing basis, in consultation with the DOEA. To be considered for funding, an applicant must receive an eligibility confirmation status and be placed on the annual funding priority list by the AHCA, in consultation with the DOEA. For PACE providers in existence as of May 1, 2014, the agency must document the provider's continued eligibility confirmation status in the provider's contract file by the provider's next contract renewal date, but no later than January 1, 2015.

The minimum components for an eligibility confirmation status are documentation by the applicant of the following:

- Ability to meet all federal requirements for participation as a PACE provider by the proposed implementation date;
- Confirmation of accreditation status or ability to attain the status within 1 year of the proposed implementation date;
- Evidence of financial stability, including insurance at a level determined by the AHCA or evidence that such level will be attained before the proposed implementation date;
- Evidence of a fidelity bond in the PACE provider's own name and in the name of its officers and employees in an amount to be established by the AHCA and the DOEA, or ability to acquire such coverage before the proposed implementation date;
- At least 20 years' prior experience in providing similar services to the frail elderly population; and
- Evidence of a business plan of operation, including pro forma financial statements and projections, based on the proposed implementation date.

If applications are received from more than one entity, the AHCA may notify the applicants and request that the parties collaborate on a single application if the region cannot support more than one PACE provider. Each provider must serve a unique and defined area without duplication of services or target population.

The AHCA will notify an applicant of their status and may request additional information for updates or to support its annual report. Providers will be selected based on the 11 regions under s. 409.966, F.S., and no more than one PACE provider per 3,000 eligible enrollees will be selected in a particular region.

The AHCA and DOEA must review the list of providers annually along with the projected enrollment and costs of existing providers and the list of entities with confirmed statuses seeking implementation. To remain on the priority funding list, a provider must continuously maintain its status. The AHCA and DOEA shall develop recommendations for the President of the Senate and Speaker of the House of Representatives no later than January 1 each year. The report must include, at a minimum, the following:

- Existing providers recommended for continuation;
- The estimated or proposed capitation rates and enrollment by existing provider for the next state fiscal year, including recommendations for discontinuation of any providers;
- A priority funding list for implementation of any new providers which includes, in priority order, all eligible entities with the estimated or proposed capitation rates and enrollment for each site; and
- Any recommended policy changes that require statutory modifications;

In developing the recommendations, the AHCA and DOEA are directed to take into consideration the following factors:

- The services being offered or proposed to be offered to the frail elderly population;
- The proposed plan of operation for implementation or continuation of services;
- An outreach plan to potentially eligible enrollees;
- The anticipated costs and enrollment projections; and,
- Any supplemental benefits offered to enrollees.

Every PACE provider will be required to meet specific quality and performance standards established by the DOEA. Each site will be monitored and additional quality standards unique to each site will be mutually developed.

The provisions of ss. 409.967 and 409.983, F.S., relating to Medicaid managed care accountability and long-term care plan payment are applicable to the PACE program, except to the extent that subsections (3) on the unique PACE selection process, (6) on the voluntary PACE plan enrollment process, and (7) on the PACE plan payment process have modified those requirements.

Enrollment in PACE is voluntary and will be based on a first-come, first-served basis until any enrollment cap is reached. The AHCA shall define any cap on PACE slots; however, the statewide cap shall not exceed 3 percent of the total number of enrollees in the SMMC-LTC program.

The PACE plan payments shall be negotiated between the provider and the AHCA as part of the negotiation and contract renewal process. Rates will be re-negotiated each year. Both capitation rates and enrollment caps are subject to the GAA. Payment rates must reflect historic utilization and spending for covered services and be adjusted based on the case mix of enrollees in each plan.

The contract between the AHCA and the PACE provider must include a lock-in provision that holds the provider financially responsible for a designated period of time for any PACE enrollee

that disenrolls and transfers to nursing home care within 6 months of disenrollment. The terms of the lock-in provision are to be negotiated between the AHCA and each provider.

Annual capitation rates paid under PACE may not result in a corresponding increase of more than 3 percent over the prior fiscal year in the SMMC-LTC program, as certified by the AHCA's chief financial officer.

Section 2 provides an effective date of July 1, 2014.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Subject to the availability of funds and slots, additional private sector providers that meet the criteria to be a PACE provider and achieve eligibility confirmation status could be approved as a PACE site. Expansion of PACE sites would also mean additional individuals in the community would have access to these services.

C. Government Sector Impact:

The potential expansion of the PACE program may result in an increased workload for the AHCA and the DOEA. The bill requires both entities to review applications, monitor performance and make annual recommendations to the Legislature.

The AHCA estimates that at least one additional FTE would be required to manage the new contracts with the PACE providers. The FTE requested by the AHCA has a fiscal impact, for salary only, of $40,948.18.

VI. Technical Deficiencies:

The bill references a contract with the PACE provider in several provisions but varies with whom the contract is with, either the AHCA or the DOEA. On Lines 41-42, the provision references a contract between the DOEA and the eligible entities, but on Line 151, the reference is to a contract between the AHCA and the provider. The bill should be consistent and since the AHCA is the lead agency for Medicaid and the SMMC-LTC, the contracting entity should be the AHCA.

VII. Related Issues:

The bill extends and potentially expands an existing long-term care services program separate from the SMMC-LTC program in an environment where the Legislature has sought to combine similar programs and eliminate waivers and carve outs. The SMMC-LTC program is expected to have an enrollment of over 90,000 once fully implemented while the PACE program currently has less than 800 enrollees statewide.

VIII. Statutes Affected:

This bill creates the following section of the Florida Statutes: 430.54.

IX. Additional Information:

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

None.

B. Amendments:

None.

Duplicate

THE FLORIDA SENATE

APPEARANCE RECORD

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

3-4-19
Meeting Date

748
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic PACE program

Name CLIFF BAUER

Job Title Pres. FL Pace Centers, Inc

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City *State* *Zip*

Email cbauer@miamijewishhealth.org

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FL Pace Centers

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/4/19
Meeting Date

SB 778
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic SB 778

Name Brett Bacot

Job Title Lobbyist

Address 101 N. Monroe St.
Street

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Tallahassee FL 32301
City *State* *Zip*

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Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Hope Healthcare Services

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/4/19
Meeting Date

778
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic SB 778

Name ~~PACE~~ Matt Hudson

Job Title Executive Director Florida PACE Providers Assoc

Address 9470 Healthpark Cir
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Email Matt.Hudson@FLPACE.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida PACE Providers Association (Here for Information if needed)

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 648
INTRODUCER:	Senator Mayfield
SUBJECT:	Continuing Education for Dentists
DATE:	March 1, 2019
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Brown	HP	**Favorable**
2.			IT	
3.			RC	

I. Summary:

SB 648 amends s. 466.0135, F.S., to mandate that dentists complete two hours of dental continuing education (CE), every biennial license renewal, on the safe and effective prescribing of controlled substances as part of his or her required 30 hours in general dental CE subjects.

The bill takes effect July 1, 2019.

II. Present Situation:

Health Care Practitioner Licensure

The mission of the Florida Department of Health (DOH) is to protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts. Working in conjunction with 22 boards and four councils, the DOH, Division of Medical Quality Assurance (MQA) licenses and regulates seven types of health care facilities and more than 200 license types in over 40 professions. Any person desiring to be a licensed health care professional in Florida must apply to the MQA and, for most professions, can apply in writing on line. Most health care professions are regulated by a board or council in conjunction with the DOH, and all profession have different requirements for initial licensure and licensure renewal. Currently, nearly 97 percent of health care practitioners are renewing their licenses online.[1]

Dentistry

Chapter 466, F.S., governs the practice of dentistry in Florida. The profession is governed by the Board of Dentistry (BOD), which is composed of 11 members who are appointed by the

[1] Florida Dep't of Health, Division of Medical Quality Assurance, *Annual Report and Long Range Plan, Fiscal Year 2017-2018* (pub Jan. 11, 2019), *available at*: http://mqawebteam.com/annualreports/1718/files/assets/common/downloads/publication.pdf (last visited Feb. 25, 2019).

Governor, subject to Senate confirmation, including seven licensed dentists actively practicing, two dental hygienists actively practicing, and two laypersons.[2]

Dentistry is concerned with the examination, diagnosis, treatment, and care of conditions within the human oral cavity and its adjacent tissues and structures. It encompasses dental examinations, dental operations, and oral or oral-maxillofacial surgery. It includes:

- The taking of impressions of human teeth or jaws, directly or indirectly by various methods;
- Supplying artificial substitutes for the natural teeth or furnishing, supplying, constructing, reproducing, or repairing any prosthetic denture, bridge, appliance, or any other structure designed to be worn in the human mouth on the written work order of a licensed dentist;
- The placing or delivering of an appliance or structure in the human mouth or the adjusting or attempting to adjust the same;
- Educating the public about the benefits of dental care and treatment, prosthetic dentures, bridge, appliances, or other structures designed to be worn in the human mouth;
- Diagnosing, prescribing, or treating, or professing to diagnose, prescribe, or treat disease, pain, deformity, deficiency, injury, or physical condition of the human teeth or jaws or oral-maxillofacial region;
- Extracting or attempting to extract human teeth;
- Correcting, or attempting to correct, malformations of human teeth or of human jaws; and
- Repairing or attempting to repair cavities in human teeth.[3]

Dental Licensure in Florida

The State of Florida does not have dental reciprocity with any other state; and does not issue licenses by endorsement or credentials. The requirements for a dental license by examination are found in s. 466.006, F.S.; and include:

- The applicant must be at least 18 years of age;
- The applicant must be:
  - A graduate of a dental school accredited by the American Dental Association Commission on Dental Accreditation or its successor, or any other dental accrediting entity recognized by the United States Department of Education;
  - A dental student in the final year of a program at such an accredited dental school who has completed all the coursework necessary to prepare the student to perform the clinical and diagnostic procedures required to pass the examinations;[4] or
  - A graduate of a dental college or school not accredited by the American Dental Association Commission on Dental Accreditation or the United States Department of Education, or a dental college or school not approved by the BOD, but meets one of the following criteria:
    - Has completed a program of study, as defined by BOD rule, at an accredited American dental school and demonstrates receipt of a D.D.S. or D.M.D. from said school; or

[2] Section 466.004, F.S.
[3] Section 466.003, F.S.
[4] With respect to a dental student in the final year of a program at a dental school, a passing score on the examinations is valid for 365 days after the date the examinations were completed. A dental school student who takes the licensure examinations during the student's final year of an approved dental school must have graduated before being certified for licensure pursuant to s. 466.011, F.S. *See* s. 466.006 (2)(b)2., F.S.

    - Submits proof of having successfully completed at least two consecutive academic years at a full-time supplemental general dentistry program accredited by the American Dental Association Commission on Dental Accreditation which has a didactic and clinical education program at the level of a D.D.S. or D.M.D. accredited by the American Dental Association Commission on Dental Accreditation; and
- The successful completion of the following examinations:
    - Dental National Board Examination;
    - Florida Laws and Rules Examination; and
    - ADEX Dental Licensing Examination.[5,6]

Renewal of Dental Licenses

Licensees of the BOD are required to renew their licenses biennially in order to maintain the right to practice. In order to renew his or her dental license a dentist must:

- Submit a renewal application and fee;
- Submit verification of current status relating to prescribing controlled substances for treatment of "chronic nonmalignant pain";[7]
- Submit a completed financial responsibility form;
- Have a current certification to perform cardiopulmonary resuscitation;[8]
- Have completed at least 30 hours of professional CE[9] in dental subjects every 2 years as follows:
    - 30 CE hours in general dental subjects;
    - 2 CE hours in medical errors;
    - 2 CE hours in domestic violence (due every third biennial renewal); and
    - 2 CE hours in HIV/AIDS (due for first renewal only).

Controlled Substance Prescribers

Effective July 1, 2018, the Legislature created s. 456.0301, F.S., requiring that each person registered with the United States Drug Enforcement Administration (DEA), and authorized to prescribe controlled substances, complete a 2-hour continuing education course from a statewide professional association of physicians in this state that is accredited to provide educational activities designated for the American Medical Association Physician's Recognition Award Category 1 Credit or the American Osteopathic Category 1-A medical CE on the safe and effective prescribing of controlled substances by January 31, 2019, and each biennial license renewal thereafter. The course is required to include information on the current standards for prescribing controlled substances, particularly opiates; alternatives to these standards; non-

[5] See Florida Dep't of Health, *Dentist*, available at https://floridasdentistry.gov/licensing/dentist/ (last visited Feb. 13, 2019). Scores from ADEX Dental Licensing examinations administered in Florida are valid for 365 days after the date the official examination results are published. Scores from ADEX Dental Licensing Examinations administered in a jurisdiction other than Florida must be completed on or after October 2, 2011.
[6] *See also* s. 466.006(2)(c)2., F.S., An applicant who holds an active Florida health access dental license is not required to take the National Dental Board examination if certain other conditions are met.
[7] "Chronic nonmalignant pain" has been defined as pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery. Section 456.44(1)(f), F.S.
[8] Rule 64B5-12.020, F.A.C.
[9] Section 466.0135, F.S.

pharmacological therapies; prescribing emergency opioid antagonists; and the risks of opioid addiction following all stages of treatment in the management of acute pain.[10,11]

The requirement in s. 456.0301, F.S., for persons registered with the DEA and authorized to prescribe controlled substances to receive CE on the prescribing of controlled substances from a statewide professional association of physicians in this state, does not apply to such a licensee who is required by his or her applicable practice act to complete a minimum of 2 hours of CE on the safe and effective prescribing of controlled substances.

The BOD amended Rule 64B5-12, F.A.C., *Continuing Professional Education*, adding subsection (5), which became effective August 6, 2018, requiring that, pursuant to s. 456.0301, F.S., all dental licensees who are registered with the DEA and authorized to prescribe controlled substances must complete a board-approved two hour course on prescribing controlled substances by January 31, 2019, and at each subsequent biennium renewal or for reactivation of a license.

III. Effect of Proposed Changes:

SB 648 amends s. 466.0135, F.S., to mandate that dentists complete 2 hours of dental CE on safe and effective prescribing of controlled substances as part of his or her required 30 hours of general dental CE subjects every biannual renewal. This mandate will grant the BOD statutory authority to adopt rules to implement this provision under s. 466.004(4), F.S., and approve of dental courses that meet all the mandates of s. 456.0301, F.S.

The bill takes effect July 1, 2019.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

[10] Section 456.0310, F.S.
[11] *See* Rules 64B8-13.005(1)(d), 64B15-13.001(1)(e) and 64B15-13.0025, and 64B-18-17.001(2)(d), F.A.C.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 466.0135 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator Mayfield

17-01055-19 2019648__

A bill to be entitled

An act relating to continuing education for dentists; amending s. 466.0135, F.S.; requiring a licensed dentist to complete a minimum of 2 hours of continuing education on the prescribing of controlled substances biennially; providing an effective date.

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

Section 1. Subsection (1) of section 466.0135, Florida Statutes, is amended to read:

466.0135 Continuing education; dentists.—

(1) In addition to the other requirements for renewal set out in this chapter, each licensed dentist shall be required to complete biennially at least ~~not less than~~ 30 hours of continuing professional education in dental subjects, with at least 2 hours of continuing education on the safe and effective prescribing of controlled substances. Programs of continuing education shall be programs of learning that contribute directly to the dental education of the dentist and may include, but shall not be limited to, attendance at lectures, study clubs, college postgraduate courses, or scientific sessions of conventions; and research, graduate study, teaching, or service as a clinician. Programs of continuing education shall be acceptable when adhering to the following general guidelines:

(a) The aim of continuing education for dentists is to improve all phases of dental health care delivery to the public.

(b) Continuing education courses shall address one or more of the following areas of professional development, including,

but not limited to:

1. Basic medical and scientific subjects, including, but not limited to, biology, physiology, pathology, biochemistry, and pharmacology;

2. Clinical and technological subjects, including, but not limited to, clinical techniques and procedures, materials, and equipment; and

3. Subjects pertinent to oral health and safety.

(c) The board may also authorize up to three hours of credit biennially for a practice management course that includes principles of ethical practice management, provides substance abuse, effective communication with patients, time management, and burnout prevention instruction.

(d) Continuing education credits shall be earned at the rate of one-half credit hour per 25-30 contact minutes of instruction and one credit hour per 50-60 contact minutes of instruction.

Section 2. This act shall take effect July 1, 2019.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 716
INTRODUCER:	Senator Hooper and others
SUBJECT:	Dental Services
DATE:	March 1, 2019
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Brown	HP	**Favorable**
2.			AHS	
3.			AP	

I. Summary:

SB 716 creates the Dental Student Loan Repayment Program (program) for Florida-licensed dentists who practice in specific public health programs located in designated dental health professional shortage areas (HPSAs) or medically underserved areas. Subject to the availability of funds, the Department of Health (DOH) will award funds from the program in an amount not to exceed $50,000 per eligible dentist per year. A participant is eligible to receive funds for a minimum of one year and a maximum of five years. The bill defines eligibility for the program and conditions for termination from the program.

SB 716 also creates the Donated Dental Services Program, which establishes a network of voluntary dentists and other dental providers for the purpose of providing comprehensive dental services to needy, disabled, elderly, and medically comprised individuals. The DOH is directed to contract with a nonprofit organization to administer the Donated Dental Services Program.

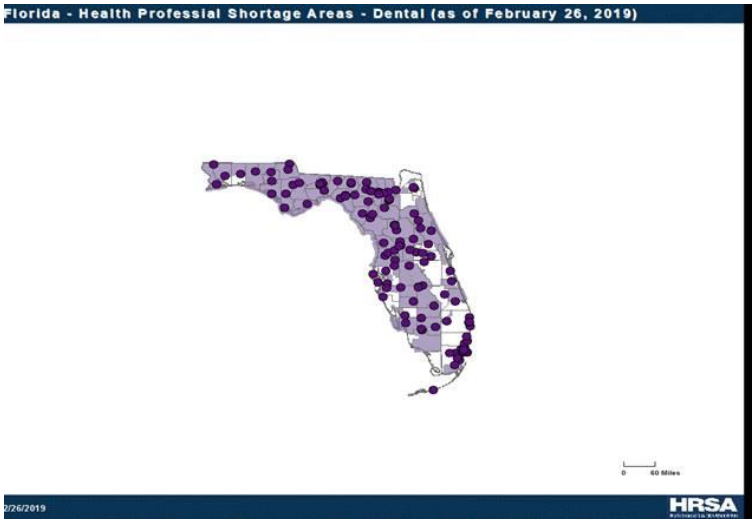
The bill directs DOH to adopt rules to administer both programs. The bill does not directly affect state revenues or expenditures as implementation of both programs is contingent upon the availability of funds. However, the DOH has expressed the need for administrative funding of $772,670 for the first year of implementation and $1,286,241 for the second year, if the programs are funded and implemented.

The bill is effective upon becoming law.

II. Present Situation:

The Health Resources and Services Administration, or HRSA, a federal agency within the U.S. Department of Health and Human Services (HHS), is charged with, among other responsibilities, improving health care for individuals who are geographically isolated, or economically or

medically vulnerable.[1] Four of the five HRSA goals focus on access to care through either building a healthy workforce or improvements in accessing quality care and services.[2]



Health Professional Shortage Areas (HPSAs)

Health Professional Shortage Areas (HPSAs) are designated by the HRSA according to criteria developed in accordance with section 332 of the Public Health Services Act. HPSA designations are used to identify areas and groups within the United States that are experiencing a shortage of health professionals. An HPSA can be a geographic area, a population group, or a health care facility. These areas have a shortage of health care professionals or have population groups who face specific barriers to health care. The map above shows the locations of the state's current dental HPSAs as of February 26, 2019.[3]

There are three categories for a HPSA designation: (1) primary medical care; (2) dental; and (3) mental health.

The primary factor used to determine a HPSA designation is the number of health professionals relative to the population, with consideration of high need. State Primary Care Offices, usually located within a state's main health agency, apply to HRSA for most designations of HPSAs in their states. HRSA will review provider-level data, whether providers are actively engaged in clinical practice, if a provider has any additional practice locations, the number of hours served at each location, the populations served, and the amount of time that a provider spends with

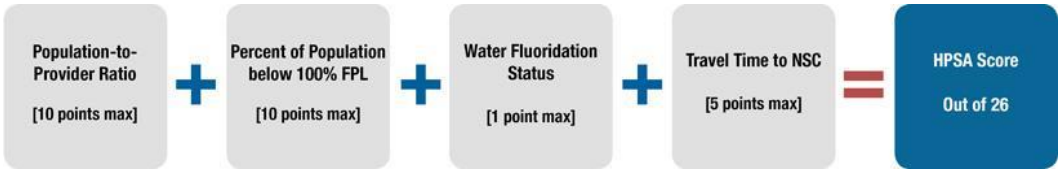
[1] U.S. Dep't of Health and Human Services, HRSA, *About HRSA*, https://www.hrsa.gov/about/index.html (last visited Feb. 26, 2019).
[2] *Id.*
[3] Map generated based on information held in the U.S. Dep't of Health and Human Services, HRSA Data Warehouse, *Dental Health Professional Shortage Areas (HPSAs) Primary Dataset*, https://datawarehouse.hrsa.gov/Tools/DataPortalResults.aspx (results last generated on Feb. 26, 2019).

specific populations.[4] Primary care and mental health HPSAs can score between 0-25 and dental health can score between 0-26.[5]

Three scoring criteria are common across all disciplines HPSA (primary care medical, dental, and mental health):

- The population to provider ratio;
- The percentage of the population below 100 percent of the federal poverty level[6]; and
- The travel time to the nearest source of care outside of the HPSA designation.[7]

The dental scoring system also reviews the water fluoridation status of the areas. The components of the dental scoring system are then calculated using the points system shown below to arrive at a total score of up to 26 points.[8]



Automatic Designations as HPSAs

Certain facilities are automatically designated as HPSAs based either on statute or regulations which govern shortages or the type of facility. For example, federally qualified health centers (FQHCs) have a different scoring structure. These facilities may often have multiple sites under one organization. In those instances, the scores of all the related organizations are averaged together to attain a single score for the overall organization.[9] Rural Health Clinics (RHCs) submit a Certificate of Eligibility form.[10] The form requires the RHC to include its RHC Certification letter from the federal Centers for Medicare and Medicaid Services, a copy of its sliding fee scale, agreement to accept Medicare beneficiaries, Medicaid, and CHIP patients, and to make every effort to collect patient fees.[11]

HRSA Workforce Programs

The HRSA's workforce programs are designed to strengthen and improve the health care workforce and to connect skilled professionals to communities in need. The HRSA's Bureau of

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[4] U.S. Dep't of Health and Human Services, HRSA Health Workforce, *Health Professional Shortage Area (HPSA) Shortage Application and Scoring Process*, Shortage Designation Management System, https://bhw.hrsa.gov/shortage-designation/application-scoring-process (last visited Feb. 26, 2019).
[5] U.S. Dep't of Health and Human Services, HRSA Health Workforce, *Health Professional Shortage Area (HPSA) Shortage Application and Scoring Process*, https://bhw.hrsa.gov/shortage-designation/hpsa-process (last visited Feb. 26, 2019)
[6] For a family of 4, the maximum income at 100 percent of the federal poverty level is approximately $25,750 annually. The 2019 federal Health and Human Services income guidelines can be found at https://aspe.hhs.gov/poverty-guidelines.
[7] U.S. Dep't of Health and Human Services, *supra*, note 5.
[8] *Id.*
[9] *Id.*
[10] U.S. Dep't of Health and Human Services, HRSA Health Workforce, *Certificate of Eligibility as an Automatic HPSA*, https://bhw.hrsa.gov/sites/default/files/bhw/shortagedesignation/BHW%20Certificate%20of%20Eligibility%20Form%20%2810.20.16%29%20v%200.1.3.pdf (last visited Feb. 26, 2019).
[11] *Id.*

Health Workforce (BHW) supports workforce training and seeks to expand the availability of clinicians in high-need areas, including in urban, rural, and frontier locations.[12] To determine the state's need, the chart below illustrates Florida's dental practitioner status, including the percentage of current need that is being met for Florida's dental HPSA compared to data nationwide.

Florida's Dental HPSA Snapshot Compared to National Data[13, 14]							
Number of Sites in Designations *(geographic area, population group, or facility)*		**Population Covered by Designation** *Low income population 200 percent FPL*		**Number of Practitioners Needed Projected - 2025[15]**		**Percent of Projected Need Met – 2025**	
Nat'l	*FL*	*Nat'l[16]*	*FL*	*Nat'l*	*FL*	*Nat'l*	*FL*
5,732	235	20,501,816	1,420,551	28,100	1,152	35.28%	13.28%

According to a February 2015 HRSA study of the dental workforce, all 50 states and the District of Columbia will face a shortage of dentists by 2025. At the national level, the demand for dentists shows a ten percent increase over the need from 2012, from 197,800 to 218,200.[17] Florida has the second highest level of projected demand, behind only California, with 1,152 dentists needed by 2025.[18]

Multiple national surveys of dentists since the 1950s through today have found significant shifts in the demographics of dentists. For example:[19]

- In the 1980s, less than 3 percent of the dental workforce were women. Now women represent 27 percent of the dental workforce.
- In 1975, less than 10 percent of all working dentists worked part-time. Now an estimated 14 percent of all working dentists in private practice and 12 percent of all dentists work part-time.
- In 1950, only 0.5 percent of all dentists were employed by another dentist; however, from 2007-2009 almost 17 percent of all active dentists were employees. Among private practitioners, 44 percent of dentists were employees.

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[12] U.S. Dep't of Health and Human Services, HRSA, *HRSA Fact Sheet – FY 2018 – Florida,* https://data.hrsa.gov/data/fact-sheets (last visited Feb. 26, 2019).
[13] *Id.*
[14] U.S. Dep't of Health and Human Services, HRSA, *HRSA Fact Sheet – FY 2018 – Nation,* https://data.hrsa.gov/data/fact-sheets (last visited Feb. 26, 2019).
[15] U.S. Dep't of Health and Human Services, HRSA, *National and State-Level Projections of Dentists and Dental Hygienists in the U.S., 2012-2025 (February 2015),* https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/nationalstatelevelprojectionsdentists.pdf (last visited Feb. 27, 2019).
[16] U.S. Dep't of Health and Human Services, HRSA, *Shortage Areas,* https://data.hrsa.gov/data/fact-sheets (last visited Feb. 26. 2019).
[17] U.S. Dep't of Health and Human Services, *supra* note 15.
[18] *Id.*
[19] Eric Soloman, DDS, MA, *Dental workforce trends and the future of dental practices,* DENTAL ECONOMICS https://www.dentaleconomics.com/articles/print/volume-105/issue-2/macroeconomics/dental-workforce-trends-and-the-future-of-dental-practices.html (last visited Feb. 27, 2018).

- In 1970, less than 10 percent of all active dentists were specialists. Today, approximately 22 percent of dentists are specialists.
- In 1975, the profile of a dentist indicated someone who was generally younger than age 45 and male (98 percent). Today, 42 percent of dentists are at least 55 years of age with only 31 percent younger than 45 years of age.

The HRSA has also begun plans for a national shortage designation update of certain elements of existing information and designations in its databases for late spring/early summer 2019.[20] The update will encompass the existing designations for national shortages based on geography, population, and other facility HPSA designations.[21]

Definitions have also been established for each of the auto HPSAs[22] to determine the population to provider ratio.

Scoring for the Population to Provider Ratio Determinations – Auto HPSAs[23]			
Definitions	**Community Health Clinics (CHC)**	**Rural Health Clinics (RHC)**	**Indian Health Service Facilities (IHSF)**
Service Area	Defined by the zip codes in which 75 percent of an Auto HPSA facility's patients reside to create a Zip Code Tabulation area.	Defined by census tracts intersecting with a 30 or 40 minute travel polygon to create service area.	Defined by census tracts intersecting with a 30 or 40 minute travel polygon to create service area.
Population	A low income population at or below 200 percent of the federal population level (FPL).	Low income population at or below 200 percent of the federal poverty level.	Total population of American Indian and Alaskan Native alone or in combination with one or more races (when available)
Providers	The count of eligible FTEs that serve Medicaid patients and/or provide services on a sliding scale in a service area.	The count of eligible FTEs that serve Medicaid patients and/or provide services on a sliding scale in a service area.	FTEs that serve American Indian or Alaskan Native populations within the service area.

Medically Underserved Area

Medically Underserved Areas (MUAs) are also designated by the HRSA. These areas are designated using one of three methods and can consist of a whole county, a group of contiguous counties, or census tracts having too few health care providers, high infant mortality, high poverty rates, or a high elderly population.[24] Nationally, there are 3,581 such designated areas, with 128 designated in Florida.[25]

[20] U.S. Dep't of Health and Human Services, HRSA, *Shortage Designation Modernization Project,* https://bhw.hrsa.gov/sdmp (last visited Feb. 26, 2019).
[21] *Id.*
[22] Based on statutes and regulations governing shortages, certain facilities can automatically be designated as HPSAs without having to apply for the designation.
[23] U.S. Dep't of Health and Human Services, *supra,* note 20.
[24] U.S. Dep't of Health and Human Services, HRSA Health Workforce, *Medically Underserved Areas and Populations (MUA/Ps),* https://bhw.hrsa.gov/shortage-designation/muap (last visited Feb. 28, 2019).
[25] U.S. Dep't of Health and Human Services, HRSA, *Shortage Areas,* https://data.hrsa.gov/topics/health-workforce/shortage-areas (last visited Feb. 27, 2019).

The first method, the Index of Medical Underservice (IMU), calculates a score based on the ratio of primary medical care physicians per 1,000 in population, percentage of the population with incomes below the federal poverty level, infant mortality rate, and percentage of population aged 65 or older.[26]

The second method, Medically Underserved Populations (MUP), is based on data collected under the MUA process and reviews the ratio of primary care physicians serving the population seeking the designation. A MUP is a group of people who encounter economic or cultural barriers to primary health care services.[27]

The third process, Exceptional MUP Designations, includes those population groups that do not meet the criteria of an IMU but may be considered for designation because of unusual conditions with a request by the governor or another senior executive level official and a local state health official.[28]

The Dental Workforce

The Health Policy Institute (HPI) for the American Dental Association (ADA) recently updated its estimates on the future supply of dentists and concluded Florida's per capita supply of dentists is projected to increase through 2035.[29] The unadjusted number of dentists per 100,000 population increases from 52.0 in 2015 to 56.9 in 2035.[30] The per capita calculation performed in this report is a headcount of total dentists in comparison to the state's total population. The study was based on a headcount of 10,781 dentists and a state population of 20.6 million.

One drawback to a per capita count of dentists is that the study does not consider the location of the providers and any access to care issues in particular regions or the needs of special populations. For example, a shortage could be only for participation by dental health providers in public programs such as Medicaid and the Children's Health Insurance Program (CHIP), two programs that serve high numbers of children and families from low and moderate income families. Florida's dental provider participation rate in these public programs is 30 percent while the national average is 39 percent.[31] The HPI's data indicates that 96 percent of publicly insured children live within 15 minutes of a Medicaid dentist.[32]

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[26] U.S. Dep't of Health and Human Services, HRSA, *Shortage Designation,* https://bhw.hrsa.gov/shortage-designation/muap-process (last visited Feb. 27, 2019).
[27] *Supra* note 24.
[28] *Id.*
[29] American Dental Association, Health Policy Institute, *Projected Supply of Dentists: Florida,* https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/ProjectedSupplyofDentists/Florida-Projected-Supply-of-Dentists.pdf?la=en (last visited Feb. 27, 2019).
[30] *Id*.
[31] American Dental Association, *Dentist Participation in Medicaid or CHIP,* https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIGraphic_0318_1.pdf?la=en (last visited Feb. 27, 2019).
[32] Health Policy Institute, American Dental Association, *Geographic Access to Dental Care: Florida,* https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/AccesstoDentalCare-StateFacts/Florida-Access-To-Dental-Care.pdf (last visited Feb. 27, 2019).

The chart below shows the current national participation rate by dental providers by type of provider.

Percentage of Dentists' Practices that Had Any Patients Covered by Public Assistance[33]			
Type of Provider	**2015**	**2016**	**2017**
National %	*% Public Assistance*	*% Public Assistance*	*% Public Assistance*
General Practitioner	36.4%	37.3%	32.9%
Specialists	35.5%	41.4%	33.5%
All Dentists	36.2%	38.2%	33.1%

Most dentists practice in general dentistry (157,676 dentists) followed by orthodontics as a distant second (10,779).[34] In many rural communities, the county health department may be the primary provider of health care services, including dental care. According to the Department of Health (DOH), Florida's current designated dental HPSAs have only enough dentists to serve 13.22 percent of the population living within them.[35] According to the DOH, there are seven currently vacant dentist positions in the DOH itself.[36] As of December 31, 2018, HRSA estimated that 1,266 additional dentists were required to meet the state's total need and eliminate the state's shortage.[37]

The ADA has also studied this issue and found that while there may be a sufficient number of dentists overall for the state's population or the national population, there may be an inadequate number available for certain populations or geographic areas.[38] Children are acutely affected by the shortage of dentists to serve low-income patients. For example in Florida for federal fiscal year 2016, 37.6 percent of all Medicaid-enrolled children and 42.8 percent of all CHIP-enrolled children received preventive dental services.[39] For Medicaid, this was an increase from 2012 when only 26 percent of Medicaid-enrolled children received at least one dental care service.[40]

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[33] Health Policy Institute, American Dental Association, *Dental Practice – 2017 Characteristics of Private Dental Practice – Table 4 – Percentage of Dentists' Practices That Had Any Patients Covered by Public Assistance, 1990-2017* (January 2016), http://www.ada.org/en/science-research/health-policy-institute/data-center/dental-practice (last visited Feb. 28, 2019).
[34] American Dental Association, *Supra,* note 29.
[35] U.S. Dep't of Health and Human Services, Bureau of Health Workforce – HRSA, *Designated Health Professional Shortage Areas Statistics* (as of December 31, 2017), https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Qtr_Smry_HTML&rc:Toolbar=false (last visited Feb. 28, 2019).
[36] E-Mail from Bryan Wendell, Office of Legislative Planning, Florida Dep't. of Health, (Feb. 27, 2019) (on file with the Senate Committee on Health Policy).
[37] U.S. Dep't of Health and Human Services, HRSA, *Shortage Areas – Explore MUSAs Dashboard-Florida*, https://data.hrsa.gov/topics/health-workforce/shortage-areas (report last generated Feb. 28, 2019).
[38] Bradley Munson, B.A., and Marko Vujicic, Ph.D.: Health Policy Institute Research Brief, American Dental Association, *Supply of Dentists in the United States Likely to Grow*, p.2. (October 2014) http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1014_1.ashx (last visited Feb. 27, 2019).
[39] Brishke, J., Gaskins, J., and Shenkman, B., *Florida KidCare: The Florida KidCare Program Evaluation Calendar Year 2016* (Dec. 1 2017), p. 141, http://ahca.myflorida.com/medicaid/Policy_and_Quality/Quality/performance_evaluation/MER/contracts/med147/FL_KidCare_MED147_Deliverable_66_12-2017_Final.pdf (last visited Feb. 27, 2019).
[40] Agency for Health Care Administration, *Statewide Medicaid Managed Care Dental Program Overview Presentation* (October 2018), Slide 8, https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/SMMC_Dental_Overview.pdf (visited Feb. 27, 2019).

Medicaid

In 2011, the Legislature passed HB 710741 creating the Statewide Medicaid Managed Care (SMMC) program as part IV of ch. 409, F.S. The program has two primary components: Managed Medical Assistance (MMA) and Long-Term Care Managed Care (LTCMC). To implement MMA, the law required the AHCA to create an integrated managed care program for the delivery of Medicaid primary and acute care services, including dental. Medicaid recipients who are enrolled in MMA initially received their dental services and other medical services through the same managed care plan. With the recent re-procurement of the SMMC contracts, the dental benefits were carved out of the MMA contracts and separately procured. Three statewide SMMC dental plans were selected as a result of that procurement: Managed Care of North America (MCNA), DentaQuest of Florida, and Liberty Dental Plan.

Medicaid dental benefits are now being delivered to recipients in MMA, fee-for-service reimbursement systems, iBudget waiver participants, and Medically Needy enrollees under the separately procured dental contracts.[42] Preexisting enrollees were required to select a dental plan as their regions were implemented, starting in December 2018. Most dental services are designated as a required benefit only for Medicaid recipients under age 21; however, the dental plans are also providing extensive adult benefits at no extra cost to the state.[43]

Future Outlook for Dentists

According to the United States Department of Labor, Bureau of Labor Statistics, the occupational outlook for dental students is growing much faster than the average for other occupations for the time period between 2016 through 2026, and an estimated 29,300 additional jobs are anticipated during this same time period.[44] Florida has one metropolitan area in the top 10 list of highest paying areas for dentists: Sebring, which pays an annual median wage of $269,300.[45]Below is a chart comparing the mean annual wages of different types of dentists nationally and for the state.

[41] *See* chapter 2011-134, Laws of Fla.
[42] Agency for Health Care Administration, *Statewide Medicaid Managed Care Dental Program Overview Presentation* (October 2018), Slides 21-30, https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/SMMC_Dental_Overview.pdf (visited Feb. 27, 2019).
[43] AHCA, Invitation to Negotiate 012-17/18 (Oct. 16, 2017). A copy of the ITN can be downloaded from http://www.myflorida.com/apps/vbs/vbs_www.ad_r2.view_ad?advertisement_key_num=137442 (last visited Feb. 27, 2019). See also Chapter 2016-109, Laws of Fla.
[44] U.S. Dep't of Labor, Bureau of Labor Statistics, *Occupational Outlook Handbook – Dentists,* https://www.bls.gov/ooh/healthcare/dentists.htm#tab-1 (last visited Feb. 27, 2019).
[45] U.S. Dep't of Labor, Bureau of Labor Statistics, *Occupational Employment Statistics, May 2017 (Florida),* https://www.bls.gov/oes/current/oes291021.htm#st (last visited Feb. 27, 2019).

Comparison of Dental Professions by Mean Annual Wages – May 2017		
Dental Profession Type	**Mean National Annual Wage**	**Mean State Annual Wage**
Dentist, generally[46]	$176,630	$166,610
Oral & Maxillofacial Surgeons[47]	$242,740	$288,450
Orthodontists[48]	$229,380	$221,990
Dentists, all other specialists[49]	$199,980	$166,610

Wages can also vary dramatically depending on the setting in which the provider is located. Generally, a provider located in a private office setting has higher wages, for example, an annual wage of $176,630, while a dentist located in a hospital setting or in the office of another health care practitioner who is not a dentist, might have a significantly lower average annual wage, from $138,480 to $132,990.[50]

The Cost of Dental Education

According to a survey of dental school students, the average debt for graduates in 2017 was $287,337,[51] a 72 percent increase in the last decade.[52] Over 30 percent of the Class of 2016 reported student loan debt in excess of $300,000.[53] For the Class of 2018, 40 percent of the graduates reported a student loan debt greater than $300,000.[54]

For in-state tuition at a state university, such as the University of Florida, one year's tuition is currently $41,720 and non-residents pay $68,202. When housing, books and other costs are added, three or four years of dental school for a DMD degree can result in a total dental school bill ranging from $226,042 to $291,836.[55] In comparison, a northern private school's tuition is listed at $73,364 per year and with other supplies, housing and fees, the total estimated costs over four years for 2018-2019 would be $463,490.[56]

In 2013, Congress enacted the Bipartisan Student Loan Certainty Act of 2013 (Public Law 113-28) that tied certain student loan interest rates to the 10-year Treasury Note plus 2.05 percent for

[46] U.S. Dep't of Labor, Bureau of Labor Statistics, *Occupational Employment and Wages, May 2017, Dentists, General,* https://www.bls.gov/oes/current/oes291021.htm#st (last visited Feb. 27. 2019).
[47] *Id*.
[48] *Id*.
[49] U.S. Dep't of Labor, Bureau of Labor Statistics, *Occupational Employment and Wages, May 2017, Dentists, All Other Specialists,* https://www.bls.gov/oes/current/oes291029.htm#st (last visited Feb. 27, 2019).
[50] *Supra* note 46.
[51] American Student Dental Education Association, *Dental Student Debt,* https://www.asdanet.org/index/get-involved/advocate/issues-and-legislative-priorities/Dental-Student-Debt (last visited Feb. 27, 2019).
[52] American Student Dental Education Association, *Paying for Dental School,* https://www.asdanet.org/index/get-into-dental-school/before-you-apply/paying-for-dental-school, (last visited Feb. 27, 2019).
[53] American Dental Education Association, *Education Debt,* http://www.adea.org/GoDental/Money_Matters/Educational_Debt.aspx#sthash.rYlqVawm.dpbs (last visited Feb. 27, 2019).
[54] *Id.*
[55] University of Florida, Office of Admissions – College of Dentistry, *Budgets & Costs of Attendance: DMD,* http://admissions.dental.ufl.edu/financial-aid-2/d-m-d/budgets-cost-of-attendance-d-m-d/ (last visited Feb. 27, 2019).
[56] Tufts School of Dental Medicine, *Financial Aid Application Forms and Costs of Attendance for D.M.D. and D.I.S. Programs,* https://dental.tufts.edu/academics/financial-aid/forms-and-costs-dmd-and-dis-programs (last visited Feb. 27, 2019).

undergraduates. For graduate and professional student loans, the interest rate is tied to the 10-year Treasury note plus 3.6 percent but may not exceed 9.5 percent in any given year.[57]

In June 2014, through a Presidential Memorandum, President Barack Obama directed the Secretary of Education to propose final regulations to allow additional students with student loan debt to cap their payments at 10 percent of their income, by December 31, 2015.[58] The Presidential Memorandum called the plan the "*Pay as You Earn Plan.*"[59] President Obama's memorandum also called for the Secretary to improve communication with vulnerable borrowers to help with loan rehabilitation, to encourage support and awareness of repayment options during tax filing season, and to promote collaboration between students and their families to ensure better borrowing decisions.[60] Two years after President Obama announced his debt relief plan, Florida had over 826,000 federal student loan borrowers with 188,613 borrowers enrolled in the *Pay as You Earn* or other income driven payment plans. The state had a total student federal loan debt outstanding of $23.9 billion.[61]

Loan forgiveness is also one of the top priorities of the American Student Dental Association (ASDA). Listed among the organization's priorities is for Congress and state legislatures to pass measures that include loan forgiveness, scholarship opportunities, and tax deductions or rebates for students that agree to practice in underserved areas after graduation.[62]

Florida does not have a current state program to address the dental health professional shortage areas or medically underserved areas.

Florida Health Services Corps

In 1992, the Legislature created the Florida Health Services Corps (FHSC), administered by the DOH, to encourage medical professionals to practice in locations that are underserved because of a shortage of qualified professionals.[63] The FHSC was defined[64] as a program that offered scholarships to allopathic, osteopathic, chiropractic, podiatric, dental, physician assistant, and nursing students, and loan repayment assistance and travel and relocation expenses to allopathic and osteopathic residents and physicians, chiropractic physicians, podiatric physicians, nurse practitioners, dentists, and physician assistants, in return for service in a public health care

[57] Bipartisan Student Loan Certainty Act of 2013, Pub. L. No. 113-28, §2, 127 Stat. 506, 506 (2013).
[58] *Id.*
[59] The White House, Office of the Press Secretary, *Presidential Memorandum - Federal Student Loan Repayments* (June 9, 2014) https://www.whitehouse.gov/the-press-office/2014/06/09/presidential-memorandum-federal-student-loan-repayments (last visited Feb. 27, 2019).
[60] The White House, Office of the Press Secretary, *Presidential Memorandum – Federal Student Loan Repayments* (June 9, 2014) https://obamawhitehouse.archives.gov/the-press-office/2014/06/09/presidential-memorandum-federal-student-loan-repayments (last visited Feb. 27, 2019).
[61] Jason Furman, Sandra Black, The White House, Office of Press Secretary, *Six Recent Trends in Student Debt* (April 28, 2016), https://obamawhitehouse.archives.gov/blog/2016/04/28/six-recent-trends-student-debt (last visited Feb. 27, 2018).
[62] American Student Dental Education Association, *supra* note 37.
[63] Chapter 92-33, s. 111, Laws of Fla. (creating s. 381.0302, F.S., effective July 1, 1992).
[64] Section 381.0302(2)(b)1., F.S. (2011).

program[65] or in a medically underserved area.[66] Membership in the FHSC could be extended to any health care practitioner who provided uncompensated care to medically indigent patients.[67] All FHSC members were required to enroll in Medicaid and to accept all patients referred by the DOH pursuant to the program agreement.[68] In exchange for this service, an FHSC member was made an agent of the state and granted sovereign immunity under s. 768.28(9), F.S., when providing uncompensated care to medically indigent patients referred for treatment by the DOH.[69]

The statute authorized the DOH to provide loan repayment assistance and travel and relocation reimbursement to allopathic and osteopathic medical residents with primary care specialties during their last two years of residency training or upon completion of residency training, and to physician assistants and nurse practitioners with primary care specialties, in return for an agreement to serve a minimum of two years in the FHSC. During the period of service, the maximum amount of annual financial payments was limited to no more than the annual total of loan repayment assistance and tax subsidies authorized by the National Health Services Corps (NHSC) loan repayment program.[70]

During the 20 years the program was authorized by law, it was funded only three times. A total of $3,684,000 was appropriated in three consecutive state fiscal years beginning with the 1994-1995 fiscal year for loan assistance payments to all categories of eligible health care practitioners. Of that amount, $971,664 was directed to 18 dentists for an average award of $25,570 per year of service in the program.[71] The 2007 Legislature attempted to reinvigorate the program by appropriating $700,000 to fund loan repayment assistance for dentists only.[72] However, the appropriation and a related substantive bill were vetoed.[73] The Legislature repealed the program in 2012.[74]

[65] "Public health program" was defined to include a county health department, a children's medical services program, a federally funded community health center, a federally funded migrant health center, or other publicly funded or nonprofit health care program designated by the department. Section 381.0302(2)(e), F.S. (2011).
[66] "Medically underserved area" was defined to include: a geographic area, a special population, or a facility that has a shortage of health professionals as defined by federal regulations; a county health department, community health center, or migrant health center; or a geographic area or facility designated by rule of the department that has a shortage of health care practitioners who serve Medicaid and other low-income patients. Section 381.0302(2)(c), F.S. (2011).
[67] "Medically indigent person" was defined as a person who lacks public or private health insurance, is unable to pay for care, and is a member of a family with income at or below 185 percent of the federal poverty level. Section 381.0302(2)(d), F.S. (2011).
[68] Section 381.0302(10), F.S. (2011).
[69] Section 381.0302(11), F.S. (2011).
[70] Section 381.0302(6), F.S. (2011).
[71] E-mail from Karen Lundberg, Florida Dept. of Health, to Joe Anne Hart, Florida Dental Association (Sept. 16, 2005) (on file with the Senate Committee on Health Policy).
[72] Chapter 2007-72, Laws of Fla. The funding was contained in Specific Appropriations 677A of the General Appropriation Act, but later vetoed pursuant to the Governor's line item veto authority.
[73] *Journal of the Florida Senate*, at 3 (June 12, 2007).
[74] Chapter 2012-184, s. 45, Laws of Fla.

National Health Service Corps (NHSC)

The NHSC programs provide scholarships and educational loan repayment to primary care providers[75] who agree to practice in areas that are medically underserved and are located in selected HPSAs. The chart below shows the different loan programs that dental students may be eligible for based on where the participant is placed (HPSA score) and whether the participant provides full (40 hours per week) or part-time (20 hours per week) service.

The NHSC-approved sites are community-based health care facilities that provide comprehensive outpatient, ambulatory, and primary health care services. Eligible dental facilities must be located in a dental HPSA and offer comprehensive primary dental health services. NHSC-approved sites (with the exception of correctional facilities and free clinics) are required to provide services free or on a sliding fee scale (SFS) or discounted fee schedule for low-income individuals.

Participants may be eligible to continue loan repayment beyond the initial term. If a participant breaches his or her LRP agreement, he or she will be subject to monetary damages, which are the sum of the amount of assistance received by the participant representing any period of obligated service not completed, a penalty, and interest. As of February 28, 2019, there were 42, full-time-equivalent NHSC dentists in Florida in the loan repayment program, all of which are located at federally qualified health centers.[76]

[75] Primary care physicians, nurse practitioners, certified nurse midwives, physician assistants, dentists, dental hygienists, and behavioral and mental health providers, including health service psychologists, licensed clinical social workers, marriage and family therapists, psychiatrist nurse specialists, and licensed professional counselors.
[76] E-Mail from John Rich, Office of Legislative Planning, Florida Dep't. of Health, (Feb. 28, 2019) (on file with the Senate Committee on Health Policy).

Federal Loan Programs Applicable for Dental Students – National Health Services Corps (NHSC)				
Program Name	**Time Commitment**	**Maximum Amount**	**Service Commitment Locations**	**Additional Time**
Loan Repayment Program (LRP) [77,78]	2 years	Vary based on where placed Range: $30,000 - $50,000 (Full-time) $15,000- $25,000 – (Part-time)	NHSC approved sites in HPSAs	Option to annually renew after 2 years
Student to Service LRP[79]	Students in last year of school must commit to serve 3 years	Up to $120,000	At an HPSA of greatest need	Option to annually renew after 3 year commitment to pay off loan remainder
Public Service Loan Forgiveness[80]	120 qualifying on time loan payments	Forgiveness of remainder of qualified federal loan	Qualified public service employment while making 120 loan payments	Remainder of qualified federal loan amounts forgiven at end of 120 payments

All of the NHSC programs require an application process. Some require a background check depending on the setting, and all require that the applicant be:

- A U.S. Citizen or U.S. National;
- Eligible to participate in the Medicare, Medicaid, and the State Children's Health Insurance Program, as appropriate; and
- Fully trained and licensed to practice in the NHSC-eligible primary care medical, dental, mental/behavioral health discipline for which the applicant seeks approval.

Additionally, the applicant must:

- Have unpaid student loans, taken before application to the NHSC's Loan Repayment Program to support undergraduate or graduate education and
- Be working at or have an accepted an offer of employment at an NHSC-approved site by the designated date (date determined each year).[81]

The State Loan Repayment Program (SLRP) offers cost-sharing grants to states to operate their own state educational loan repayment programs for primary care providers, including dental

[77] The definition of part-time and full-time vary by discipline. The guidelines for both can be found in the *Fiscal Year 2018 Application and Program Guidance (March 2018)* beginning on pg. 24, https://nhsc.hrsa.gov/downloads/loan-repayment/nhsc-LRP-application-program-guidance.pdf (last viewed Feb. 28, 2019).
[78] U.S. Dep't. of Health and Human Services, Loan Repayment Program - *Fiscal Year 2019 Application and Program Guidance* (December 2018) https://nhsc.hrsa.gov/sites/default/files/NHSC/loan-repayment/lrp-application-guidance.pdf (last viewed Feb. 27, 2019).
[79] U.S. Dep't of Health and Human Services, HRSA, *Loan Repayment – NHSC Loan Repayment Program*, https://www.nhsc.hrsa.gov/loanrepayment/index.html (last visited Feb. 27, 2019).
[80] *Id.* A qualifying public employer is a government organization at any level (federal, state, local, or tribal), not-for-profit organizations that are tax exempt under Section 501(c)(3) of the Internal Revenue Code, or other types of not-for-profit organizations that provide certain types of qualifying public services.
[81] National Health Services Corps, Loan Repayment Program, *Eligibility*, https://nhsc.hrsa.gov/loan-repayment/nhsc-loan-repayment-program.html#eligibility (last visited Feb. 27, 2019).

professionals, working in HPSAs within the state. The SLRP varies from state to state and may differ in eligible categories of providers, practice sites, length of required service commitment, and the amount of loan repayment assistance offered. However, there are certain statutory requirements SLRP grantees must meet. There is a minimum two-year service commitment with an additional one-year commitment for each year of additional support requested. Any SLRP program participant must practice at an eligible site located in a federally designated HPSA.

In addition, the SLRP requires a $1 state match for every $1 provided under the federal grant. While the SLRP does not limit award amounts, the maximum award amount per provider that the federal government will support through its grant is $50,000 per year, with a minimum service commitment of two years. Florida does not currently participate in SLRP.

Several other federal loan repayment programs are open to most borrowers, including dental, that have certain post-graduate working conditions such as a requirement to work as a faculty member at an approved health institution, as a biomedical researcher, as a provider at an Indian health program site, as a commissioned dental officer in the U.S. Public Health Service Commissioned Corps, or with the United States Army or Navy.[82]

III. Effect of Proposed Changes:

Section 1 provides that the legislative intent for the Dental Student Loan Repayment Program is to promote programs and initiatives that make preventive and educational dental services available to Floridians. It recognizes that better oral health leads to a more productive workplace and improves the cognitive abilities of schoolchildren, resulting in a reduction in the number of missed school days.

Section 2 creates the Dental Student Loan Repayment Program at the Department of Health (DOH) under s. 381.4019, F.S. The initiative is conditioned on the availability of funds and is intended to promote access to dental care, encourage dentists to practice in dental health professional shortage areas or medically underserved areas, or serve a medically underserved population. The bill defines several key terms:

- Dental health professional shortage area: A geographic area so designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services;
- Department: The Department of Health;
- Loan program: The Dental Student Loan Repayment Program.
- Medically underserved area: A geographic area, an area having a special population, or a facility which is designed by department rule as a designated health professional shortage area as defined by federal regulation and which has a shortage of dental health professionals to serve Medicaid and other low income patients; and
- Public health program: A county health department, the Children's Medical Services program, a federally qualified community health center, a federally funded migrant health center, or other publicly funded or not-for-profit health care program designated by the DOH.

[82] American Dental Education Association, *State and Federal Loan Forgiveness Programs* (November 1, 2017), www.adea.org/advocacy/state/loan-forgiveness-programs.aspx (last visited Feb. 27, 2019).

The DOH is required to establish a Dental Student Loan Repayment Program to benefit state-licensed dentists who demonstrate active employment in a public health program that serves Medicaid recipients and other low-income patients. The employment must be located in a dental health professional shortage area (HPSA) or a medically underserved area (MUA). Compliance with these requirements will be established by rule as determined by the DOH.

The DOH is directed to award funds from the loan program to repay student dental loans of a Florida-licensed dentist who meets these requirements; however, no award may exceed $50,000 per year, per dentist. The DOH must limit the number of new dentists participating in the loan program to no more than 10 per fiscal year. A dentist may receive funds for at least one year and up to a maximum of five years. The dentist's period of obligated service begins when the dentist who receives the funds begins his employment.

Only loans taken out to pay the costs of tuition, books, dental equipment and supplies, uniforms, and living expenses may be covered under the loan program. Loan repayments are contingent upon continued proof of eligibility and must be made directly to the holder of the loan.

A dentist is not eligible to benefit from program funding if the dentist:
- Is no longer employed by a public health program that meets the requirements;
- Ceases to participate in the Florida Medicaid program; or
- Has disciplinary action taken against his or her license by the Board of Dentistry for a violation of s. 466.028, F.S.[83]

The DOH is required to adopt rules to administer the loan program.

Section 3 creates the Donated Dental Services Program under s. 381.40195, F.S., in the DOH. The Donated Dental Services Program is intended to provide comprehensive dental care through a network of volunteer dentists and other dental providers to needy, disabled, elderly, and medically comprised individuals who are ineligible for public assistance programs such as Medicaid or CHIP. Services under the program may be provided in a private office location or at any other suitable location. The eligible individual is not required to pay any fees or costs associated with the services for any treatments received.

The DOH is responsible for the implementation and operation of the program. The DOH shall contract with a nonprofit organization that has experience providing and administering similar services and any such contract must delineate all of the vendor's responsibilities as provided in the statute. These responsibilities include, but are not limited to:
- Maintaining a network of volunteer providers who can provide a comprehensive range of dental services;
- Maintaining a referral system to an appropriate volunteer dentist or other participating provider;
- Developing a public awareness and marketing campaign to promote the program and to educate eligible individuals about the program;

[83] A violation of s. 466.028, F.S., constitutes grounds for denial of dental licensure or disciplinary action by the Board of Dentistry, as specified in s. 456.072(2), F.S.

- Providing the necessary administrative and technical support to administer the program;
- Submitting an annual report to the DOH with the required statutory components; and
- Performing any other program-related duties and responsibilities as required by the DOH.

The DOH is also required to adopt rules to administer this program.

Section 4 provides the bill shall take effect upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Floridians living in those areas identified as medically underserved with little or no access to dental care could benefit from this initiative. The program could bring additional dental professionals to underserved communities, populations, and facilities. The program could also be a reason that a dental graduate elects to stay in Florida instead of practicing in another state after graduation.

Dentists who qualify for the loan program will benefit from another option to reduce their student loan debt.

As a dentist practices in his or her public service employment program, the DOH will make payments on the dentist's previously incurred student loans. The DOH notes that

during the period that the state funded repayment assistance is in place, underwriters for the student loans will receive guaranteed repayments. The DOH will need to have financial arrangements in place to ensure timely payments to the loan guarantors and arrangements with the dentists who participate in the program to ensure continued eligibility while payments are being made.

C. Government Sector Impact:

If implemented, the DOH is requesting additional resources to implement the program in addition to funds for the loan repayment awards. The estimated cost is $772,670 for the first year of implementation and $1,286,241 for the second year of the program.

Dental Student Loan Repayment Program Fiscal Analysis		
Expenses:	**Year One**	**Year Two**
	FY 2019-2020	**FY 2020-2021**
OPS Medical /Health Care Program Analyst	$41,554.00	$41,554.00
Total OPS:	$41,554.00	$41,554.00
Expense:	$24,009.00	$19,580.00
Transfer to DMS:	$107.00	$107.00
Other Services:		
10 Students @$50,000 student	$500,000.00	
20 Students @$50,000 student		$1,000,000.00
Donated Dental Services with Lifeline Network	$200,000.00	$200,000.00
Development and Printing of Educational Pamphlets and materials for statewide student recruitment and Job Fair	$7,000.00	$7,000.00
GRAND TOTAL:	**$772,670**	**$1,272,6670**

VI. Technical Deficiencies:

None.

VII. Related Issues:

On lines 61 and 71, the term “other low income patients” is used to identify other clients that could be the focus of dental graduates who are the beneficiaries of the Dental Student Loan Repayment program. However, the term is not defined in the bill and it is unclear what the threshold is for “other low income patients.”

In Section 3 of the bill, a series of new terms to describe the target population for the Donated Dental Services Program are also introduced without being defined: needy, disabled, elderly, and medically compromised (lines 111-112). These terms may need further clarification to ensure that the DOH is accurately focusing its efforts on the populations desired under the legislation.

VIII. Statutes Affected:

This bill creates the following sections of the Florida Statutes: 381.4019, 381.40195

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator Hooper

16-00819A-19 2019716__

A bill to be entitled

An act relating to dental services; providing legislative intent; creating s. 381.4019, F.S.; establishing the Dental Student Loan Repayment Program to support dentists who practice in public health programs located in certain underserved areas; providing definitions; requiring the Department of Health to establish a dental student loan repayment program for specified purposes; providing for the award of funds; providing the maximum number of years funds may be awarded; providing eligibility requirements; requiring the department to adopt rules; creating s. 381.40195, F.S.; providing a short title; providing definitions; requiring the Department of Health to establish the Donated Dental Services Program to provide comprehensive dental care to certain eligible individuals; requiring the department to contract with a nonprofit organization to implement and administer the program; specifying minimum contractual responsibilities; requiring the department to adopt rules; providing an effective date.

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

Section 1. It is the intent of the Legislature to promote programs and initiatives that help make available preventive and educational dental services for the citizens of the state, as well as provide quality dental treatment services. The geographic characteristics among the citizens of the state are

distinctive and vary from region to region, with such citizens having unique needs regarding access to dental care. The Legislature recognizes that maintaining good oral health is integral to the overall health status of individuals and that the good health of the residents of this state is an important contributing factor in economic development. Better health, including better oral health, increases workplace productivity, reduces the burden of health care costs, and improves the cognitive development of children, resulting in a reduction of missed school days.

Section 2. Section 381.4019, Florida Statutes, is created to read:

381.4019 Dental Student Loan Repayment Program.—Subject to the availability of funds, the Legislature shall establish the Dental Student Loan Repayment Program to promote access to dental care by supporting qualified dentists who treat medically underserved populations in dental health professional shortage areas or medically underserved areas.

(1) As used in this section, the term:

(a) "Dental health professional shortage area" means a geographic area designated as such by the Health Resources and Services Administration of the United States Department of Health and Human Services.

(b) "Department" means the Department of Health.

(c) "Loan program" means the Dental Student Loan Repayment Program.

(d) "Medically underserved area" means a geographic area, an area having a special population, or a facility which is designated by department rule as a health professional shortage

area as defined by federal regulation and which has a shortage of dental health professionals who serve Medicaid recipients and other low-income patients.

(e) "Public health program" means a county health department, the Children's Medical Services program, a federally funded community health center, a federally funded migrant health center, or other publicly funded or nonprofit health care program designated by the department.

(2) The department shall establish a dental student loan repayment program to benefit Florida-licensed dentists who demonstrate, as required by department rule, active employment in a public health program that serves Medicaid recipients and other low-income patients and is located in a dental health professional shortage area or a medically underserved area.

(3) The department shall award funds from the loan program to repay the student loans of a dentist who meets the requirements of subsection (2).

(a) An award may not exceed $50,000 per year per eligible dentist.

(b) Only loans to pay the costs of tuition, books, dental equipment and supplies, uniforms, and living expenses shall be covered.

(c) All repayments shall be contingent upon continued proof of eligibility and shall be made directly to the holder of the loan. The state shall bear no responsibility for the collection of any interest charges or other remaining balances.

(d) A dentist is eligible to receive funds under the loan program for at least 1 year, up to a maximum of 5 years.

(e) The department shall limit the number of new dentists

participating in the loan program to no more than 10 per fiscal year.

(4) A dentist is no longer eligible to receive funds under the loan program if the dentist:

(a) Is no longer employed by a public health program that meets the requirements of subsection (2).

(b) Ceases to participate in the Florida Medicaid program.

(c) Has disciplinary action taken against his or her license by the Board of Dentistry for a violation of s. 466.028.

(5) The department shall adopt rules to administer the loan program.

Section 3. Section 381.40195, Florida Statutes, is created to read:

381.40195 Donated Dental Services Program.—

(1) This act may be cited as the "Donated Dental Services Act."

(2) As used in this section, the term:

(a) "Department" means the Department of Health.

(b) "Program" means the Donated Dental Services Program as established pursuant to subsection (3).

(3) The department shall establish the Donated Dental Services Program for the purpose of providing comprehensive dental care through a network of volunteer dentists and other dental providers to needy, disabled, elderly, and medically compromised individuals who cannot afford necessary treatment but are ineligible for public assistance. An eligible individual may receive treatment in a volunteer dentist's or participating dental provider's private office or at any other suitable location. An eligible individual is not required to pay any fee

or cost associated with the treatment he or she receives.

(4) The department shall implement and administer the program. The department shall contract with a nonprofit organization that has experience in providing similar services or administering similar programs. The contract must specify the responsibilities of the nonprofit organization, which may include, but are not limited to:

(a) Maintaining a network of volunteer dentists and other dental providers, including, but not limited to, dental specialists and dental laboratories, to provide comprehensive dental services to eligible individuals.

(b) Maintaining a system to refer eligible individuals to the appropriate volunteer dentist or participating dental provider.

(c) Developing a public awareness and marketing campaign to promote the program and educate eligible individuals about its availability and services.

(d) Providing the necessary administrative and technical support to administer the program.

(e) Submitting an annual report to the department which must include, at a minimum:

1. Financial data relating to administering the program.

2. Demographic data and other information relating to the eligible individuals who are referred to and receive treatment through the program.

3. Demographic data and other information relating to the volunteer dentists and participating dental providers who provide dental services through the program.

4. Any other data or information that the department may

require.

(f) Performing any other program-related duties and responsibilities as required by the department.

(5) The department shall adopt rules to administer the program.

Section 4. This act shall take effect upon becoming a law.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR ED HOOPER
16th District

COMMITTEES:
Governmental Oversight and Accountability, Chair
Appropriations Subcommittee on Agriculture, Environment, and General Government
Appropriations Subcommittee on Health and Human Services
Health Policy
Infrastructure and Security
Joint Select Committee on Collective Bargaining, Alternating Chair
Joint Administrative Procedures Committee

February 19th, 2019

The Honorable Gayle Harrell, Chair
Health Policy Committee
530 Knott Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Chair Harrell:

I am writing to request that Senate Bill 716, Dental Services, be placed on the agenda of the next meeting of the Health Policy Committee.

Should you have any questions regarding this bill, please do not hesitate to reach out to me. Thank you for your time and consideration.

Warm regards,

Ed Hooper

CC: Allen Brown, Staff Director
Celia Georgiades, Administrative Assistant

REPLY TO:
❒ 3450 East Lake Road, Suite 305, Palm Harbor, Florida 34685-2411 (727) 771-2102
❒ 326 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5016

Senate's Website: *www.flsenate.gov*

BILL GALVANO
President of the Senate

DAVID SIMMONS
President Pro Tempore

From: Lloyd, Jennifer
To: Georgiades, Celia
Subject: FW: SB 716
Date: Friday, March 1, 2019 12:20:12 PM

From: Wendel, Bryan P <Bryan.Wendel@flhealth.gov>
Sent: Wednesday, February 27, 2019 5:08 PM
To: Lloyd, Jennifer <LLOYD.JENNIFER@flsenate.gov>
Subject: RE: SB 716

The total vacancies as of 02/27/19 are:

- Dental Executive Director – 1
- Dentist – 5
- Senior Dentist – 1

From: Lloyd, Jennifer [mailto:LLOYD.JENNIFER@flsenate.gov]
Sent: Wednesday, February 27, 2019 3:38 PM
To: Wendel, Bryan P <Bryan.Wendel@flhealth.gov>
Subject: SB 716

Bryan – I am working on SB 716 – Dental Services. I am updating some numbers from last year's analysis and was looking for the total number of vacancies DOH had for dentists. Can you help me with that?

Thanks,
Jennifer

Jennifer Kiser Lloyd, J.D.
Chief Legislative Analyst
Health Policy Committee, Florida Senate
(850) 487-5824

From: Lloyd, Jennifer
To: Georgiades, Celia
Subject: FW: Question on SB 716
Date: Friday, March 1, 2019 12:20:00 PM

From: Rich, John P <John.Rich@flhealth.gov>
Sent: Thursday, February 28, 2019 4:31 PM
To: Lloyd, Jennifer <LLOYD.JENNIFER@flsenate.gov>
Subject: Question on SB 716

Evening Jennifer,

I hope this answers your question.

As of the field strength report run today, there are 42 dentist loan re-payers practicing at FQHC's.

John Rich
Office of Legislative Planning
(850) 245-4006
John.Rich@flhealth.gov

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/4/19
Meeting Date

SB 716
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Dentists

Name Joe Anne Hart

Job Title Chief Legislative Officer

Address 118 East Jefferson St
Street

Tall, FL 32301
City *State* *Zip*

Phone 850.224.1089

Email jahart@flowldental

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [X] In Support [ ] Against
(The Chair will read this information into the record.)

Representing Florida Dental Association

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [X] Yes [ ] No

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

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

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 374
INTRODUCER:	Senator Harrell
SUBJECT:	Children and Youth Cabinet
DATE:	March 1, 2019
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Preston	Hendon	CF	**Favorable**
2.	Williams	Brown	HP	**Favorable**
3.			RC	

I. Summary:

SB 374 adds a representative of the Florida Dental Association to the Children and Youth Cabinet. The representative will be appointed by the Governor.

The bill has an insignificant fiscal impact on the state.

The bill has an effective date of July 1, 2019.

II. Present Situation:

The Children and Youth Cabinet (Cabinet) was established in 2007 in the Executive Office of the Governor to ensure that Florida's public policy relating to children and youth is developed to promote interdepartmental collaboration and program implementation in order that services designed for children and youth are planned, managed, and delivered in a holistic and integrated manner to improve children's self-sufficiency, safety, economic stability, health, and quality of life.[1]

Currently the Cabinet has 16 members, and the President of the Senate, the Speaker of the House of Representatives, the Chief Justice of the Supreme Court, the Attorney General, and the Chief Financial Officer, or their appointed designees, serve as ex officio members. The total membership includes:

- The Governor;
- The secretary of the Department of Children and Families;
- The secretary of the Department of Juvenile Justice;
- The director of the Agency for Persons with Disabilities;
- The director of the Office of Early Learning;

[1] Section 402.56(4)(a), F.S.

- The State Surgeon General;
- The secretary of the Agency for Health Care Administration;
- The Commissioner of Education;
- The director of the Statewide Guardian Ad Litem Office;
- The director of the Office of Adoption and Child Protection;
- A superintendent of schools, appointed by the Governor; and
- Five members who represent children and youth advocacy organizations and who are not service providers, appointed by the Governor.

The enabling statute specifies that nongovernmental members of the cabinet shall serve without compensation but are entitled to receive per diem and travel expenses in accordance with s. 112.061, F.S., while in performance of their duties.[2]

The Florida Dental Association

The Florida Dental Association (FDA) is a trade organization representing the interests of licensed dentists in the state and is a state constituent of the American Dental Association (ADA), which represents dentists throughout the country.

The FDA was founded in 1884 and currently has a membership of more than 8,100 licensed dentists. According to the FDA's web site, its mission includes "delivering programs, services, continuing education, and advocacy" for its members.[3] The web site also includes information about programs designed to promote and advocate for oral health among Florida's residents, such as the "Florida's Action for Dental Health" program in conjunction with the American Dental Association.[4]

III. Effect of Proposed Changes:

Section 1 amends s. 402.56, F.S., to add a representative of the Florida Dental Association to the Children and Youth Cabinet, to be appointed by the Governor.

Section 2 provides an effective date of July 1, 2019.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

[2] Section 403.56(4)(d), F.S.
[3] *See* https://www.floridadental.org/about-us/who-we-are (last visited Feb. 28, 2019)
[4] *See* https://www.floridadental.org/public/florida's-action-for-dental-health (last visited Feb. 28, 2019)

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

Per statute, the non-governmental members of the Cabinet are entitled to travel expense reimbursement for Cabinet related travel. At present, the Executive Office of the Governor provides that reimbursement. There will be an insignificant increase in such expenses associated with this bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

The bill amends s. 402.56 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator Harrell

25-00579A-19 2019374__

A bill to be entitled

An act relating to the Children and Youth Cabinet; amending s. 402.56, F.S.; expanding the membership of the Children and Youth Cabinet within the Executive Office of the Governor to include a representative from the Florida Dental Association appointed by the Governor; providing an effective date.

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

Section 1. Subsection (4) of section 402.56, Florida Statutes, is amended to read:

402.56 Children's cabinet; organization; responsibilities; annual report.—

(4) MEMBERS.—The cabinet shall consist of 17 ~~16~~ members including the Governor and the following persons:

(a)1. The Secretary of Children and Families;

2. The Secretary of Juvenile Justice;

3. The director of the Agency for Persons with Disabilities;

4. The director of the Office of Early Learning;

5. The State Surgeon General;

6. The Secretary of Health Care Administration;

7. The Commissioner of Education;

8. The director of the Statewide Guardian Ad Litem Office;

9. The director of the Office of Adoption and Child Protection;

10. A superintendent of schools, appointed by the Governor;

11. A representative of the Florida Dental Association,

appointed by the Governor; and

12.~~11.~~ Five members who represent children and youth advocacy organizations and who are not service providers, appointed by the Governor.

(b) The President of the Senate, the Speaker of the House of Representatives, the Chief Justice of the Supreme Court, the Attorney General, and the Chief Financial Officer, or their appointed designees, shall serve as ex officio members of the cabinet.

(c) The Governor or the Governor's designee shall serve as the chair of the cabinet.

(d) Nongovernmental members of the cabinet shall serve without compensation, but are entitled to receive per diem and travel expenses in accordance with s. 112.061 while in performance of their duties.

Section 2. This act shall take effect July 1, 2019.

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/4/19
Meeting Date

SB 374
Bill Number (if applicable)

Topic Children and Youth Cabinet

Amendment Barcode (if applicable)

Name Joe Anne Hart

Job Title Chief Financial Officer

Address 118 East Jefferson Str.
Street

Phone

Tally FL 3234
City *State* *Zip*

Email

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [X] In Support [ ] Against
(The Chair will read this information into the record.)

Representing Florida Dental Association

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [X] Yes [ ] No

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

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

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 1026
INTRODUCER:	Senator Harrell
SUBJECT:	Fees/Advanced Birth Centers
DATE:	March 1, 2019
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Favorable**
2.			CF	
3.			RC	

I. Summary:

SB 1026 applies certain existing statutory fees to a new type of license for advanced birth centers (ABC) created by SB 448 (2019). Specifically, the bill applies license and inspection fees imposed on birth centers[1] to ABCs and adds ABCs to the list of selected health care facilities that must pay fees to fund local health councils.

The Florida Constitution requires that legislation imposing or authorizing new state taxes or fees[2] and legislation that raises existing state taxes or fees[3] to be passed by a two-thirds vote of the membership of each house of the Legislature, and the tax or fee provisions must be passed in a separate bill.[4] SB 1026 applies existing statutory fees, which are not being increased, to a new type of licensee created by SB 448. As such, the Florida Constitution may require that the fees be passed in a separate bill by a two-thirds vote of the membership of each house of the Legislature.

The provisions of the bill take effect on the same date that SB 448, or other similar legislation, takes effect if such legislation is passed in the same legislative session or extension thereof.

II. Present Situation:

Advanced Birth Centers

The bill defines an ABC as "a birth center that may perform trial of labor after cesarean deliveries for screened patients who qualify, planned low-risk cesarean deliveries, and

[1] A birth center is current license type that is established in ss. 383.30-383.332, F.S. A birth center is "any facility, institution, or place, which is not an ambulatory surgical center or a hospital or in a hospital, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy." See s. 383.302, F.S.

[2] FLA. CONST. art. VII, s. 19(a).

[3] FLA. CONST. art. VII, s. 19(b).

[4] FLA. CONST. art. VII, s. 19(e).

anticipated vaginal deliveries for laboring patients from the beginning of the 37th week of gestation through the end of the 41st week of gestation." For more information on ABCs and on the specifics of SB 448, see the analysis of SB 448.

Licensure and Inspection Fees for Birth Centers

Section 383.305, F.S., requires birth centers to pay fees for initial licensure. The amount of the fee is established by the Agency for Health Care Administration (AHCA) in Rule 59A-11.003 of the Florida Administrative Code, is $392.80.

Section 383.324, F.S., requires birth centers to pay an inspection fee to the AHCA. The AHCA conducts two types of inspections of birth centers: licensure inspections and life safety inspections. Birth centers that are accredited by the Accreditation Association for Ambulatory Health Care, the Commission for the Accreditation of Birth Centers, or the Joint Commission are exempt from the requirement to be inspected for licensure. The fees for licensure and life safety inspections are $250 each.[5]

Fees for Local Health Councils

Local health councils are a network of non-profit agencies that conduct regional health planning and implementation activities.

Each council's district is designated in s. 408.032, F.S. The boards of directors of these councils are composed of health care providers, purchasers, and non-governmental consumers. Members serve for two years and are eligible for reappointment. Local health councils develop district health plans containing data, analysis, and recommendations that relate to health care status and needs in the community. The recommendations are designed to improve access to health care, reduce disparities in health status, assist state and local governments in the development of sound and rational health care policies, and advocate on behalf of the underserved.

Local health councils study the impact of various initiatives on the health care system, provide assistance to the public and private sectors, and create and disseminate materials designed to increase their communities' understanding of health care issues.[6]

Section 408.033, F.S., provides that the Legislature intends for the cost of local health councils to be borne by assessments on selected health care facilities.[7] Hospitals, nursing homes, and assisted living facilities pay a tax per bed while all other facilities are assessed an annual fee of $150.[8]

[5] See Rule 59A-11.004, F.A.C.
[6] See *Florida's Local Health Councils* (Dec 19, 2017), *available at* http://www.floridahealth.gov/provider-and-partner-resources/health-councils/index.html (last visited on Feb. 26, 2019).
[7] These health care facilities include abortion clinics, assisted living facilities, ambulatory surgical centers, birth centers, home health agencies, hospices, hospitals, intermediate care facilities for the developmentally disabled, nursing homes, health care clinics, and multiphasic testing centers
[8] Section 408.033(2)(b)1. and 2., F.S.

III. Effect of Proposed Changes:

SB 1026 applies certain existing fees to the new Advanced Birth Center license type that is established in SB 448. The bill amends:

- Section 383.305, F.S., to apply current-law licensing fees for birth centers to ABCs;
- Section 383.324, F.S., to apply current-law fees for inspections of birth centers to ABCs; and
- Section 408.033, F.S., to apply a current-law annual fee to fund local health councils to ABCs.

The provisions of the bill take effect on the same date that SB 448, or other similar legislation, takes effect if such legislation is passed in the same legislative session or extension thereof.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

Article VII, s. 19, of the Florida Constitution requires that a new state tax or fee, as well as an increased state tax or fee, must be approved by two-thirds of the membership of each house of the Legislature and must be contained in a separate bill that contains no other subject. Article VII, s. 19(d)(1), of the Florida Constitution defines "fee" to mean "any charge or payment required by law, including any fee for service, fee or cost for licenses, and charge for service."

SB 1026 applies existing statutory fees, which are not being increased, to a new type of licensee created by SB 448. As such, the Florida Constitution may require that the fees be passed in a separate bill by a two-thirds vote of the membership of each house of the Legislature.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 383.305, 383.324, and 408.033.

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator Harrell

25-00540A-19 20191026__

A bill to be entitled

An act relating to fees; amending s. 383.305, F.S.; providing applicability of licensure fee requirements to advanced birth centers; amending s. 383.324, F.S.; requiring an advanced birth center to pay an inspection fee to the agency; amending s. 408.033, F.S.; providing applicability of an assessment to advanced birth centers; providing a contingent effective date.

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

Section 1. Section 383.305, Florida Statutes, is amended to read:

383.305 Licensure; fees.—

(1) In accordance with s. 408.805, an applicant <u>for licensure as a birth center or an advanced birth center</u> or a licensee shall pay a fee for each license application submitted under ss. 383.30-383.332 and part II of chapter 408. The amount of the fee shall be established by rule.

(2) Each applicant for licensure and each licensee must comply with the requirements of this chapter and part II of chapter 408.

Section 2. Section 383.324, Florida Statutes, is amended to read:

383.324 Inspections and investigations; inspection fees.—Each <u>birth center and advanced birth center</u> ~~facility~~ licensed under s. 383.305 shall pay to the agency an inspection fee established by rule of the agency. In addition to the

requirements of part II of chapter 408, the agency shall coordinate all periodic inspections for licensure made by the agency to ensure that the cost to the birth center or advanced birth center ~~facility~~ of such inspections and the disruption of services by such inspections is minimized.

Section 3. Paragraph (a) of subsection (2) of section 408.033, Florida Statutes, is amended to read:

408.033 Local and state health planning.—

(2) FUNDING.—

(a) The Legislature intends that the cost of local health councils be borne by assessments on selected health care facilities subject to facility licensure by the Agency for Health Care Administration, including abortion clinics, assisted living facilities, ambulatory surgical centers, birth centers, advanced birth centers, home health agencies, hospices, hospitals, intermediate care facilities for the developmentally disabled, nursing homes, health care clinics, and multiphasic testing centers and by assessments on organizations subject to certification by the agency pursuant to chapter 641, part III, including health maintenance organizations and prepaid health clinics. Fees assessed may be collected prospectively at the time of licensure renewal and prorated for the licensure period.

Section 4. This act shall take effect on the same date that SB 448 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes a law.