SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

BILL: CS/SB 400

SPONSOR: Health, Aging, and Long-Term Care Committee and Senator Peaden

SUBJECT: Health Programs

DATE: April 21, 2003 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Parham	Wilson	HC	Favorable/CS
2.			AHS	
3.			AP	
4.			RC	
5.				
6.				

I. Summary:

This bill makes technical and clarifying changes relating to health programs administered through the Agency for Health Care Administration (Agency). The bill:

- Authorizes the Agency to establish and conduct fair hearings requested by Medicaid recipients unrelated to eligibility determinations and fair hearings relating to nursing home resident transfers and discharges.
- Changes the requirement from a 100 percent class review by the Pharmaceutical and Therapeutics Committee to an annual review of the top 75 percent of therapeutic classes and a biennial review of all other classes.
- Provides that appeals of preferred drug list (PDL) decisions can be heard through the Office of Fair Hearings.
- Modifies the Quality of Long-Term Care Facility Improvement Trust Fund, allowing the federal civil monetary penalty revenues to be deposited in the fund and to expand the programs that can be supported through the fund to include nursing home consumer satisfaction, evaluation of special resident needs, initiatives authorized by the Centers for Medicare and Medicaid Services (CMS), and projects recommended through the Medicaid Up or Out demonstration program.
- Requires nursing homes to provide proof of legal right to occupy the property as part of an application for licensure or change of ownership.
- Revises the grounds for denial, revocation, or suspension of a license of an assisted living facility.
- Provides for the imposition of administrative fines and grounds for the fines for assisted living facilities.
- Eliminates the requirement that the Agency send renewal notices by certified mail to assisted living facilities, adult day care centers, and adult family care homes.

- Reinstates background screening for Health Care Services Pools.
- Eliminates the nursing home financial reporting requirement.
- Authorizes the Agency to require that fines be paid prior to approval of a change of ownership to a new licensee.
- Authorizes the Agency to enroll MediKids beneficiaries in managed care plans as defined in s. 409.811, F.S.
- Repeals the requirement for specialty prepaid health plans to be licensed under chapter 641, F.S., and provides that the Agency shall issue a request for proposal or intent to implement a contract with a prepaid health plan to pay them on a prepaid basis to provide benefits to Medicaid-eligible recipients who have HIV or AIDS.
- Eliminates the requirement that the Agency must issue an intent to negotiate to implement an outpatient specialty services pilot project.
- Revises the definition of "third-party" for purposes of the Medicaid program to include third-party administrators and pharmacy benefit managers and revises the definition of "third-party benefit" to include the Neurological Injury Compensation Association.
- Removes a requirement that administrative hearings be reinstated within 90 days following assignment of an administrative law judge in Medicaid cases involving recovery of overpayments.
- Provides specific rulemaking authority to the Agency as it pertains to cooperative efforts between the Medicaid program and other Departments.
- Provides that children born in a family practice teaching hospital shall not be considered for the purposes of making assessments for the Florida Birth-Related Neurological Injury Compensation Plan.
- Revises the definition of companion or sitter to a person who provides companionship to an elderly, handicapped or convalescent individual.
- Increases the penalty for violating home health agency licensure requirements to a third degree felony for the first violation and a second degree felony for the second or subsequent violation.
- Provides that an individual who owns, operates, or maintains an unlicensed home health agency or nurse registry who fails to cease operation and apply for a license within 10 working days of being notified by the Agency, commits a third degree felony, and that each day of continued operation is a separate offense.
- Provides that a home health agency or nurse registry may be fined $500 per day for each day of noncompliance.
- Provides that the completion of volume data questions on the home health agency application is required information for an application for license, provisional license, or temporary permit.

This bill amends ss. 120.80, 400.0255, 408.15, 409.91195, 400.0239, 400.071, 400.414, 400.419, 400.417, 400.557, 400.619, 408.061, 408.831, 400.91188, 409.811, 409.8132, 409.912, 409.901, 409.905, 409.913, 409.919, 766.314, 400.462, 400.464, 400.471, 400.487, 400.491, 400.512, and 400.515, Florida Statutes.

This bill repeals ss. 400.509, 400.980(4)(h), and 408.062(2), Florida Statutes.

II. Present Situation:

Medicaid Fair Hearings

Federal law requires that a state plan provide an opportunity for a fair hearing to any Medicaid recipient whose claim for assistance is denied or otherwise limited. The Office of Appeals Hearings of the Department of Children and Families (DCF) presently conducts these fair hearings for the Agency. By agreement between the Agency and DCF, the Agency has agreed to assume fair hearing responsibilities for recipient requests that are unrelated to eligibility determinations.

Pharmaceutical and Therapeutics Committee

The Medicaid Pharmaceutical and Therapeutics Committee developed and implemented a voluntary Medicaid preferred prescribed drug designation program, as mandated in the 2000 Session of the Florida Legislature, SB 2034. This legislation enacted several prescribed drug program spending controls. Florida Medicaid implemented a mandatory preferred drug list (PDL) with prior authorization effective July 1, 2002. The committee, comprised of five physicians, five pharmacists and one consumer representative, meets quarterly to review the effectiveness and cost of drugs within each therapeutic class to recommend which drugs to include or remove from the PDL. Of the nearly 600 therapeutic classes of drugs, 75 percent of Medicaid drug use is represented by 50 therapeutic classes.

The Quality of Long-Term Care Facility Improvement Trust Fund

Federal civil monetary penalties (CMP) imposed against certified nursing homes are collected by the Centers for Medicare and Medicaid Services (CMS) for violations of Medicare and Medicaid regulations. A portion of these fines is returned to the states based upon the proportion of Medicaid residents served by the facility. The state funds are currently placed in the Resident Protection Trust Fund (RPTF) and used for resident relocation or placement of a receiver to operate a nursing home pending closure. There has been a recent federal emphasis that CMP funds should be used for projects that involve improvements and are focused on nursing homes found to be deficient. Many of the goals of the Quality of Long-Term Care Facility Improvement Trust Fund are consistent with the intent expressed by CMS for use of the federal CMP funds returned to Florida.

Assisted Living Facilities Administrative Fines

Historically, the Agency has imposed administrative fines under either s. 400.414 or s. 400.419, F.S., with the assumption that either statute provides legal authority to impose administrative fines, and without regard to any potential conflicts between the statutes when fines are assessed. Section 400.414, F.S., provides clear authority to impose administrative fines. In contrast, s. 400.419, defines the four classifications of deficiencies and the range of fines for each. Currently, s. 400.414, F.S., requires that a minimum number of violations by class must exist prior to imposing a fine. In contrast, s. 400.419, F.S., has been used by the Agency to impose fines for a single violation. The application of these two statutes is confusing and difficult given the lack of clarity.

Nursing Home Financial Reporting System

The Nursing Home Financial Data program was created to address the scarcity of information on nursing home revenues, the change in such revenues, and the distribution of charity care throughout the industry. The program is designed to evaluate the ability of Florida citizens to purchase nursing home services, and to measure the impact of nursing home care on state Medicaid budgets. The data is collected using Agency forms and is reported 120 days subsequent to the close of the fiscal year. Data elements include revenues by payer, contractual allowances by payer, and operating expenses by category, and patient days by payer. An annual report is prepared for public distribution.

Licensed nursing homes are required to submit audited financial statements to the Agency each year under the Nursing Home Financial Data program. This information is separate from information submitted to Medicaid.

According to the Agency, the nursing home financial analysis system is largely duplicative of the Medicaid cost reporting system for nursing homes. The nursing home financial analysis system has become a stand-alone system of interest primarily to researchers, consultants and others. Continuation of the system would require a major update in reporting requirements to better track current and future nursing home spending, as well as a significant allocation of information technology resources.

Facility Change of Ownerships

Currently, if a licensee of a facility owes fines to the state or federal government, in most programs the Agency has no authority to deny the application or withhold approval of another entity to purchase the facility from the licensee who owes fines. Once the ownership changes, the Agency has little or no leverage to require the old licensee to pay outstanding fines. In 2002, legislation was passed giving the Agency authority to deny, suspend or revoke a license for failure to pay fines due. However, the legislation does not provide sufficient authority to require payment of these past-due fines before a change of ownership is approved. Facilities have been able to change ownership without fines being paid, leaving the Agency with little recourse to collect the fines.

Florida KidCare Act

MediKids is a component of the Florida KidCare program and provides services to children from ages 1 up to 5 who qualify for Title XXI with incomes up to 200 percent of FPL. Medikids uses the Medicaid infrastructure, offering the same provider choices and package of benefits. The definition for “managed care” in s. 409.901, F.S., is applicable to ss. 409.901-409.920, F.S. Adding that definition to the section, Definitions Relating to the Florida Kidcare Act, will give MediKids beneficiaries additional managed care options.

Pre-Paid Health Plans for Persons with HIV/AIDS

Florida Medicaid is a major provider of health care coverage to low-income persons with HIV/AIDS. In addition to mandatory and optional benefits available to all beneficiaries, Florida Medicaid operates a number of special programs for beneficiaries with HIV/AIDS.

The Project AIDS Care (PAC) waiver provides home and community based services to Medicaid recipients with a diagnosis of AIDS. Medicaid recipients that meet eligibility criteria for the Project AIDS Care (PAC) waiver are given a choice of enrolling in the program that is operated by approximately 65 PAC waiver case management agencies (CMAs) across the state or being institutionalized. Home and community based services are provided to enrollees for the purpose of preventing or delaying hospitalization or placement in a nursing facility. The Agency administers this statewide program under authority of a federal Medicaid waiver.

The Florida Medicaid Disease Management Initiative includes disease management (DM) programs for beneficiaries with HIV/AIDS that are enrolled in MediPass, Medicaid's primary care case management program. HIV/AIDS DM programs provide beneficiary services (e.g., care coordination, education), provider services (e.g., education, consultation) and certain administrative services (e.g., reporting and data analysis). Since 1999, the Agency has contracted with a single vendor, AIDS Healthcare Foundation (AHF), to operate the DM program in 65 of Florida's 67 counties. More recently, the Agency has executed a single contract with multiple parties (AHF, the Public Health Trust of Miami-Dade County, and the North Broward Hospital District) to operate the program in Dade and Broward counties. Both contracts resulted from an Invitation to Negotiate (ITN) issued by the Agency in August 1998. HIV/AIDS DM is a statewide effort authorized as part of a broader federal waiver authority for MediPass.

In 2000, CS/HB 591 established s. 409.91188, F.S., which authorized the Agency to implement a specialty prepaid plan for persons with HIV/AIDS. The Agency worked with various stakeholders through an established advisory group to develop a general program design and specification for the development of a federal waiver. This forum was developed in conjunction with the Florida Department of Health, in part through funding from the federal Health Services and Resources Administration (HRSA). The Agency submitted a Medicaid waiver application to CMS in March 2001. The Agency responded to numerous requests for additional information from CMS following the submission of the waiver application. In August 2001, the Agency informed CMS that adequate responses to questions raised related to the cost-effectiveness of the waiver application would require additional data and fiscal analysis. Since that time, the Agency has contracted with independent consultants to assist in developing actuarially sound payment rates necessary to demonstrate the cost-effectiveness required for federal waiver authority.

Currently, chapter 641, F.S., applies to specialty prepaid health plans. Pursuant to this chapter, health maintenance organizations and prepaid health clinics are required to have a certificate of authority to do business in Florida from the Department of Financial Services and to obtain a health care provider certificate from the agency as a condition precedent to obtaining a certificate of authority. Additionally, s. 409.91188, F.S., requires all specialty prepaid health plans for Medicaid recipients with HIV or AIDS to be licensed under Chapter 641, F.S., meaning that they must be licensed as HMOs.

Provider Service Networks

Florida law mandates that Medicaid recipients (low- income family and child recipients and SSI recipients without Medicare) eligible for managed care must enroll with a MediPass provider, in a Medicaid health maintenance organization (HMO), Provider Service Network (PSN), or the Children's Medical Services (CMS) Network. Eligible recipients are given 30 days from the date that Medicaid eligibility begins to select a managed care option. If recipients do not select MediPass, an HMO, a PSN, or the CMS Network, AHCA assigns them to MediPass, an HMO, or a PSN.

A PSN is an integrated health care delivery system owned and operated by Florida hospitals and physician groups. The PSN is a Medicaid managed care option for Medicaid recipients in Miami-Dade and Broward Counties, along with HMOs, MediPass, and the CMS Network. The South Florida Community Care Network (SFCCN) PSN is composed of the Public Health Trust of Miami-Dade County (PHT), Memorial Healthcare System (MHS), and the North Broward Hospital District (NBHD). The PSN is paid a monthly administrative allocation payment for the management of its enrollees. PSN primary care providers are paid a monthly case management fee of $3. Providers rendering services to PSN enrollees are reimbursed on a fee-for-service basis.

Pre-Enrollment by Managed Care Organizations

Managed care is the cornerstone of the Florida's efforts to control Medicaid acute care expenditures. The state requires mandatory enrollment in managed care for most recipients. Two-thirds of Medicaid beneficiaries participate in either MediPass or capitated managed care plans. Health maintenance organizations have been investigated and sanctioned by the Agency on numerous occasions for abusive activities involving the pre-enrollment process.

Managed care plans may currently perform "pre-enrollment" by providing assistance to a Medicaid recipient in completing application forms. The Agency has received complaints about some HMO marketing practices, and the forms used by plan marketing representatives contain HIPAA regulated information concerning Medicaid beneficiaries and individuals who may not be currently eligible for Medicaid benefits. Such information includes Medicaid numbers, social security numbers, addresses, phone numbers, dates of birth and medical information. This information should not be used by sales agents because it is not directly related to administration of the state plan, which is the use permitted by the Privacy Act.

Medicaid Pharmacy Services and Prior Authorization

Beginning in August 2001, Florida Medicaid limited the number of brand name prescriptions to four per month for all adult beneficiaries. A prescriber may request a brand name drug over the four per month limit through the Therapeutic Consultation Program. Following a clinical discussion, which includes a discussion of preferred drug list (PDL) or generic options that may be as clinically effective and less costly, the prescriber decides which drug is most appropriate and a prior authorization is granted. The Florida Medicaid Preferred Drug List (PDL) is a listing of prescription products selected by the Pharmaceutical and Therapeutics Committee as efficacious, safe, and cost effective choices when prescribing for Medicaid patients. Current law

also allows an institutional or community pharmacy to call for a prior authorization on a brand name drug override for PDL drugs.

Third Party Liability

Third party liability (TPL) refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a State plan. The Medicaid program by law is intended to be the payer of last resort; that is, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. Examples of third parties which may be liable to pay for services include employment-related health insurance, court-ordered health insurance derived by noncustodial parents, workers' compensation, long-term care insurance, and other state and federal programs (unless specifically excluded by Federal statute).

The Medicaid program is responsible for billing insurance companies for services paid by Medicaid in which the insurance company may have been liable. Many insurance companies contract their claims processing functions to either Third Party Administrators (TPA) or Pharmacy Benefit Managers (PBM). Many TPAs and PBMs claim they are not "third parties" therefore, are exempt from federally required data matching and billing.

The Neurological Injury Compensation Association (NICA) through the litigation process has argued they are not a "third-party benefit" and are therefore secondary to Medicaid for payment of medical services.

Prior Authorization of Inpatient Hospital Medical Services

The state is required to monitor health care services provided to Medicaid beneficiaries to safeguard against unnecessary or inappropriate use of Medicaid services. Medical services and/or records are reviewed for medical necessity, quality of care, appropriateness of place of service and length of stay (i.e. inpatient hospital). The state contracts with a Peer Review Organization (PRO) to provide this service, which is accomplished through a prior authorization program.

There are currently 233 acute care hospitals enrolled as Medicaid providers in the state of Florida. Medicaid reimburses hospital services prospectively. This is done by establishing per-diem rates based on cost reports from the hospitals. The rates are subject to caps. Medicaid reimbursement for inpatient hospital care for adults age 21 and older is limited to 45 days per fiscal year. The only exception to the 45 day cap is when a patient requires inpatient care due to an emergency condition. There is no limit on the number of days that Medicaid can reimburse for recipients under age 21. The agency has contracted with federally designated peer review organizations to perform utilization review oversight of Medicaid hospital admissions since 1985.

Section 409.905, F.S., requires that the PRO make a determination on whether the services were medically necessary, within four hours of receipt of information. However, when a case is referred to a physician for potential denial, the PRO cannot adhere to the four-hour turnaround

because of difficulty in accessing referral physicians, especially during the night and early morning hours.

Administrative Hearings

Currently, s. 409.913(30), F.S., provides for an administrative hearing to be held within 90 days of the assignment of an administrative law judge. The Division of Administrative Hearings' policy is to not grant extensions or continuances of these cases. The 90-day timeframe further impedes a proper and reasonable discovery schedule and increases litigation costs to the state as a result of the need for accelerated deposition transcripts and expert witness reviews.

Agency Rulemaking Authority

Interagency agreements allow for cooperative efforts between the Agency and Departments, but fail to provide specific legislative authority necessary for proper rulemaking in overlapping areas. This problem was first brought to light by the Joint Administrative Procedures Committee (JAPC) when it reviewed the Developmental Services Waiver Handbook that was promulgated by the Agency in a cooperative effort with the Department of Children and Families (DCF). However, the services covered by the handbook are almost exclusively delivered by DCF. The necessary statutory authority for the Agency to promulgate language governing another department was deemed lacking by JAPC, despite the existing interagency agreements between the Agency and DCF.

Application of Sanctions against Providers

Subsections 12, 14 and 15 of s. 409.913, F.S., provide differing methodologies for the application of sanctions against providers. Section 409.913(12), F.S., "may"; s. 409.913(14), F.S., "may"; and s. 409.913(15), F.S., "shall", with an optional override at the discretion of the Agency secretary. There is a need to improve the clarity and consistency of statutory language to eliminate confusion and possible challenge. If the mandatory "shall" is changed to an optional "may", there will be no need for the language allowing for an override by the Agency secretary.

Homemaker Companions and Sitters

Definition
Homemaker companion agencies are agencies that employ individuals to do housekeeping, cook, run errands, and provide companionship. The words are in conflict with the last sentence of the definition in s. 400.462(5), F.S., that says, "a companion may not provide hands-on personal care."

Registration
Before any entity or individual shall directly or indirectly provide homemaker, companion, or sitter services for adults, not including personal care, it has to become registered by the Agency. The Agency registers non-health care businesses that provide homemaker companion services for a fee of $25 per year as required in s. 400.509, F.S. Homemaker and companion services are household chores, shopping assistance, accompanying persons on outings and preparing meals. There are 600 businesses registered to provide homemaker companion services. The Agency has

no authority to inspect the businesses prior to registration. The Agency may investigate complaints but there are no standards or requirements to be met in law other than background screening. Thus, if complaints are confirmed, the Agency has no authority to fine or take administrative action.

Home Health Agencies

Licensure
The Agency receives complaints of unlicensed home health activity throughout the state. Businesses found to be providing home health services without a license are given a notice of violation and are requested to get licensed. Some disregard the notices and continue operating. The existing laws do not provide the Agency with sufficient enforcement authority to require the businesses to get licensed. The Agency does not have the authority to impose an administrative fine specifically to prevent or discourage the operation of an unlicensed home health agency or nurse registry. The Agency may seek an injunction only when there is an emergency affecting the immediate health and safety of a patient.

Data Collection
Currently, state licensed home health agencies are not required to collect data on the number of admissions, visits, and revenues received by home health agencies, to quantify the work that they do. There is no authority to collect such data now and the information would be beneficial to the Agency, other agencies, researchers and the public.

Plans of Care
There are no federally required time frames for physicians to sign orders now for Medicare home health agencies. Medicare allows home health plans of care to be signed before the claim is submitted for payment. The 30-day time limit has been difficult for home health agencies to meet, as physicians have been slow at returning the signed documents. Home health agencies already have to have signed orders prior to reimbursement from Medicare, Medicaid and private insurance. The Agency allows claims to be submitted to managed care plans before the plan of care is signed if the managed care contract for payment so permits.

III. Effect of Proposed Changes:

Section 1. Amends s. 120.80(7), F.S., to authorize the Agency for Health Care Administration to conduct fair hearings for Medicaid recipients unrelated to eligibility determinations. Eligibility related fair hearings would remain the responsibility of DCF.

Section 2. Amends s. 400.0255(8), (15), and (16), F.S., to reflect the responsibility of the Agency for fair hearings related to nursing home resident transfers or discharges that were previously conducted by the Office of Appeals Hearings of DCF.

Section 3. Amends s. 408.15, F.S., adding subsection (13), authorizing the Agency to establish and conduct Medicaid fair hearings unrelated to eligibility determinations. Eligibility related fair hearings would remain the responsibility of DCF.

Section 4. Amends s. 409.91195(4) and (11) F.S., changing the requirement from a 100 percent class review by the Pharmaceutical and Therapeutics Committee to an annual review of the top 75 percent of therapeutic classes based on the number of prescriptions and a biennial review of all other classes. The bill also provides that appeals of preferred drug list (PDL) decisions can be heard through the office of fair hearings.

Section 5. Amends s. 400.0239(1) and (2), F.S., relating to the Quality of Long-Term Care Facility Improvement Trust Fund, to allow the federal civil monetary penalty revenues to be deposited in the fund, to expand the programs that can be supported through the fund. This section expands programs that may be supported by the fund to include nursing home consumer satisfaction, evaluation of special resident needs, and initiatives authorized by CMS as well as projects recommended through the Medicaid Up or Out demonstration program.

Section 6. Amends s. 400.071, F.S., relating to nursing home proof of occupancy, to require nursing homes to provide proof of legal right to occupy the property as part of an application for licensure or change of ownership. Proof may include leases, deeds or other legal documentation.

Section 7. Amends s. 400.414, F.S., to revise the grounds for denial, revocation, or suspension of an assisted living facility license and to delete imposition of administrative fines from this section.

Section 8. Amends s. 400.419, F.S., to require the Agency to impose administrative fines in the manner provided in chapter 120, enabling the Agency to consistently, efficiently, and effectively pursue assisted living facility cases involving administrative fines.

Sections 9. Amends s. 400.417(1), F.S., to eliminate the requirement that the Agency send renewal notices by certified mail to assisted living facilities.

Section 10. Amends s. 400.557, F.S., to eliminate the requirement that the Agency send renewal notices by certified mail to adult day care centers.

Section 11. Amends s. 400.619, F.S., to require the Agency to send renewal notices to adult family care homes at least 120 days prior to the expiration of licenses.

Section 12. Repeals s. 400.980(4)(h), F.S., to reinstate background screening for Health Care Services Pools repealed by a sunset provision. All other background screening for health care providers was reinstated.

Section 13. Amends s. 408.061(4) and (6), F.S., to repeal requirements for financial data submission by nursing homes and continuing care facilities.

Section 14. Repeals s. 408.062(2), F.S., to eliminate the nursing home financial reporting requirement which will result in the reduction of 3 FTEs.

Section 15. Amends s. 408.831, F.S., to require all regulated providers to pay fines before change of ownerships can be approved. This proposal closes a loophole in current law that does not provide the Agency with sufficient authority to collect past-due fines and authorizes the

Agency to require that fines be paid prior to approval of a change of ownership to a new licensee. Similar language exists in the nursing home statute and has been very helpful in facilitating payments of past-due fines.

Sections 16. Amends s. 409.811, F.S., to define a managed care plan to be a health maintenance organization authorized pursuant to chapter 641, F.S., or a prepaid health plan authorized pursuant to s. 409.912, F.S., for purposes of the Florida Kidcare program.

Section 17. Amends s. 409.8132, F.S., to authorize the agency to enroll MediKids beneficiaries in managed care plans as defined in s. 409.811, F.S.

Section 18. Amends s. 409.91188, F.S., relating to specialty prepaid health plans for Medicaid recipients with HIV or AIDS. Subsection (1) repeals the requirement for specialty prepaid health plans to be licensed under chapter 641, F.S., and provides that the Agency shall issue a request for proposal or intent to implement a contract with a prepaid health plan to pay them on a prepaid basis to provide benefits to Medicaid-eligible recipients who have HIV or AIDS.

Subsection (2) adds provisions for qualifying as a specialty prepaid capitated health plan for AIDS and HIV populations. These qualifications would be reviewed by the Agency. Also added are provisions for risk sharing between the specialty prepaid capitated health plan and the Agency. This arrangement could make it more difficult to obtain the necessary federal waiver for implementation of the specialty prepaid health plan for the HIV and AIDS population. This section also provides for review by the Agency of specialty prepaid health plan facilities, services, insurance coverage and financial operations.

Section 19. Amends s. 409.912, F.S., to remove the limit on the number of Medicaid provider service networks and to add "adult's" provider networks. This section eliminates the opportunity for preenrollment (defined as providing marketing and educational materials to a Medicaid recipient and assistance in completing application forms) of Medicaid recipients by managed care plans. While preventing breaches of HIPAA rules, the deletion of this language would not prohibit the plans from distributing educational materials. The requirement that the Agency must issue an intent to negotiate to implement an outpatient specialty services pilot project is deleted.

Section 20. Amends s. 409.901(25) and (26), F.S., to revise the definition, for Medicaid purposes, of "third-party" in s. 409.901(25), F.S., to include third-party administrators and pharmacy benefit managers and to revise the definition of "third-party benefit" in s. 409.901(26), F.S., to include the Neurological Injury Compensation Association.

Section 21. Amends s. 409.905(5)(a), F.S., to increase, from four hours to twenty-four hours, the time allotted to grant prior authorization for Medicaid hospital services. This will enhance the quality of reviews.

Section 22. Amends ss. 409.913(30) F.S., to remove the requirement for administrative hearings to be conducted within 90 days following assignment of an administrative law judge in cases involving Medicaid recovery of overpayments, thus allowing for better case management and decreased litigation expenses. Administrative law judges would retain their ability to accelerate

the scheduling of hearings as they deem reasonable under the circumstances, and AHCA would still have the ability to request that a hearing be expedited where necessary.
Section 23. Amends s. 409.919, F.S., to provide specific rulemaking authority to the Agency as it pertains to cooperative efforts between the Medicaid program and other Departments.

Section 24. Amends s. 766.314, F.S., to provide that children born in a family practice teaching hospital shall not be considered for the purposes of making assessments for the Florida Birth-Related Neurological Injury Compensation Plan.

Section 25. Amends s. 400.462(5), F.S., to revise the definition of companion or sitter to a person who provides companionship to an elderly, handicapped, or convalescent individual. The term is amended to clarify the function of homemaker companions and to make clear that a companion does not provide personal care services.

Section 26. Amends s. 400.464 (4) and (5), F.S., to remove "registration", "registrant" and "regulation number," as section 32 of the bill repeals the homemaker companion registration program. This section revises the penalty for violating home health agency licensure requirements from a second degree misdemeanor to a third degree felony for the first violation and a first degree misdemeanor to a second degree felony for the second or subsequent violation. An individual who owns, operates or maintains an unlicensed home health agency or nurse registry who fails to cease operation and apply for a license within 10 working days of being notified by the Agency, commits a third degree felony, and each day of continued operation is a separate offense. The home health agency or nurse registry may be charged a $500 per-day fine by the Agency for each day of noncompliance. The requirement that companion and sitter organizations must be registered under s. 400.509(1), F.S., on January 1, 1999 is removed.

Section 27. Amends s. 400.471(2), F.S., to provide that the completion of volume data questions on the renewal application is required information needed for an application for license, provisional license, or temporary permit for a home health agency.

Section 28. Amends s. 400.487 (2), F.S., to require home health agency physician treatment orders to be signed in the time allowed by the provider agreement if the claim is submitted to a managed care organization. The 30-day deadline to review treatment orders from the start of care date is removed. This revision allows managed care procedures to continue as they are today.

Section 29. Amends s. 400.491, F.S., to remove the requirement of a service provision plan and the maintenance of plan records for home health clients who receive non-skilled care.

Section 30. Amends s. 401.512, F.S., to remove companions and homemakers registered under 400.509, F.S., from the screening requirements

Section 31. Amends s. 400.515, F.S, relating to injunction proceedings to authorize the Agency to maintain an action in the name of the state for injunction or other process to enforce home health agency licensure requirements notwithstanding the existence or pursuit of any other remedy.

Section 32. Repeals s. 400.509, F.S., relating to the exemption of organizations providing homemaker and companion services from licensure.

Section 33. This act shall take effect July 1, 2003.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Art. I, s. 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Home health agencies and nurse registries who do not comply with licensure requirements will be required to pay a $500 fine for each day of noncompliance once notified by the Agency.

Homemaker companion agencies will no longer be required to register with the Agency. They can still provide the housekeeping, chores and errand type services that they currently provide, as do other maid and errand type services around the state.

C. Government Sector Impact:

Elimination of the nursing home financial reporting system will result in the reduction of three FTE's from the Agency's budget.

The Agency will save money by not using certified mail to send renewal notices to assisted living facilities, adult day care centers, and adult family care homes.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.