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 Banking and Insurance Committee

BILL:	CS/CS/SB 1374
INTRODUCER:	Banking and Insurance Committee; Heath Regulation Committee; Health Regulation Committee and Senator Jones
SUBJECT:	Home Health Care
DATE:	March 18, 2008 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Stovall	Wilson	HR	**Fav/CS**
2.	Emrich	Deffenbaugh	BI	**Fav/CS**
3.			HA	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

The bill revises the regulation of home health care to:

- Authorize nurse registries to refer appropriately licensed professionals to provide home infusion therapy;
- Require applicants for an initial home health agency license to submit additional business and financial information and to maintain for four years a $50,000 surety bond or equivalent security;
- Provide a methodology to limit the number of new home health agency licensure applications that the Agency for Health Care Administration (AHCA) may accept for processing;
- Restrict the AHCA from issuing an initial license to a home health agency under common control with another licensee that is located within 20 miles of the applicant, restrict applicants from transferring pending applications, and require an initial application for a change of address to a different geographic service area;
- Place the burden of proof on a home health agency licensure applicant to demonstrate that a factual determination made by the AHCA is incorrect;
- Require that a home health agency licensee actively provide home health services;

- Increase existing administrative fines and make them mandatory as opposed to discretionary, and establish administrative fines for additional proscribed activities;
- Impose greater limitations on the span of control for home health agency administrators and directors of nursing;
- Prohibit a home health agency that provides skilled nursing care from operating in excess of 30 days without a qualified director of nursing, and require administrative fines and authorize additional enforcement for a violation of this provision;
- Require notifications to the AHCA within 10 days after termination and replacement of the director of nursing and require administrative fines for the failure to notify the AHCA;
- Require the AHCA to adopt rules for certain functions of the home health agency's director of nursing;
- Require a home health agency to ensure that each certified nursing assistant and home health aide used by the home health agency is adequately trained;
- Require home health agencies to maintain the client service provision plan for 3 years;
- Delete the authority for unlicensed persons to assist home health agency patients with the self-administration of medication, but authorize licensed home health agency nurses to delegate tasks to unlicensed persons; and
- Require the AHCA to survey newly licensed home health agencies within 15 months after initial licensure.

The bill establishes additional proscribed activities for nurse registries and imposes additional criteria for Medicaid-enrolled durable medical equipment and medical supply provider.

The bill further requires the AHCA to review the precertification process related to the authorization of home health services in excess of 60 visits over a Medicaid recipient's lifetime, and report to the Legislature on the feasibility and costs of accessing the Medicare system in order to deny Medicaid payments for services already paid for by Medicare.

This bill substantially amends the following sections of the Florida Statutes: 400.462, 400.464, 400.471, 400.474, 400.484, 400.488, 400.491, 400.497, 400.506, 400.518, and 409.906. The bill creates a new section 400.476, F.S., and two undesignated sections of law.

II. Present Situation:

Home Health Services/Home Health Agencies

Home health agencies are organizations that are licensed by the AHCA to provide home health services and staffing service. Home health services are health and medical services and medical supplies furnished to an individual in the individual's home or place of residence. The services include:

- Nursing care;
- Physical, occupational, respiratory, or speech therapy;
- Home health aide services (assistance with daily living such as bathing, dressing, eating, personal hygiene, and ambulation);
- Dietetics and nutrition practice and nutrition counseling; and

- Medical supplies, restricted to drugs and biologicals prescribed by a physician.[1]

Staffing services are provided to health care facilities or other business entities on a temporary basis by licensed health care personnel and by certified nursing assistants and home health aides who are employed by, or work under the auspices of, a licensed home health agency.[2]

A home health agency may also provide homemaker and companion services without additional licensing or registration. These services do not involve hands-on personal care to a client and typically include housekeeping, meal planning and preparation, shopping assistance, routine household activities, and accompanying the client on outings.

Home health agency personnel are employed by or under contract with a home health agency.

Licensure Provisions

Since 1975, home health agencies operating in Florida have been required to obtain a state license.[3] The licensure requirements for home health agencies are found in the general health care licensing provisions of part II of ch. 408, F.S., the specific home health agency licensure provisions of part III of ch. 400, F.S., and the minimum standards for home health agencies in chapter 59A-8, Florida Administrative Code.

As of December 31, 2007, there were 1,985 licensed home health agencies in Florida.[4] A home health agency license is valid for 2 years, unless sooner suspended or revoked.[5] If a home health agency operates related offices, each related office outside the county where the main office is located must be separately licensed.[6]

The issuance of an initial license to a home health agency is based on the submission of a signed and notarized, complete and accurate home health agency application, submission of the $1,660 biennial licensure fee, and the results of a survey conducted by the AHCA. The application identifies the geographic service areas and counties in which the home health agency will provide services. For licensure renewal, the home health agency must submit a signed and notarized renewal application and licensure fee of $1,660.

The AHCA conducts unannounced licensure surveys every 36 months, unless a home health agency has requested an exemption from state licensure surveys based on accreditation by an approved accrediting organization. The Home Health Agency State Regulation Set that is used in conducting surveys contains over 100 standards and surveyor guidelines, which are based on Rule 59A-8, Florida Administrative Code. The AHCA also conducts inspections related to complaints.

[1] Section 400.462(13), F.S.
[2] Section 400.462(25), F.S.
[3] Sections 36 – 51 of ch. 75-233, Laws of Florida (L.O.F.).
[4] Source: AHCA Home Care Unit, Bureau of Health Facility Regulation, reported on 1/2/2008.
[5] Section 408.808(1), F.S.
[6] Section 400.464(2), F.S

Each home health agency is required to employ an administrator. The administrator must be a licensed physician, physician assistant, or registered nurse licensed to practice in this state or an individual having at least one year of supervisory or administrative experience in home health care in a facility licensed under ch. 395, F.S.,[7] part II of ch. 400, F.S.,[8] or part I of ch. 429, F.S.[9] The administrator may manage a maximum of five licensed home health agencies if the home health agencies are located within one geographic service area or within an immediately contiguous county. An employee of a retirement community that provides multiple levels of care may administer a home health agency and up to a maximum of four entities licensed under ch. 400, F.S.,[10] or ch. 429, F.S.,[11] if they are owned, operated, or managed by the same corporate entity. The administrator must designate an alternate administrator to serve during the administrator's absence.

A home health agency providing skilled services is required to employ a director of nursing who is a Florida licensed registered nurse with at least 1 year of supervisory experience as a registered nurse.[12] The director of nursing is responsible for overseeing the delivery of professional nursing and home health aide services and must be readily available at the home health agency or by phone for any 8 consecutive hours between 7 a.m. to 6 p.m. The director of nursing is also responsible for establishing and conducting an ongoing quality assurance program for services provided by the home health agency.[13] A home health agency that offers only home health aide and homemaker/companion services is not required to have a director of nursing.[14]

A director of nursing may be the director for a maximum of five licensed home health agencies if the home health agencies are operated by a related business entity and are located within one geographic service area or within an immediately contiguous county. An employee of a retirement community that provides multiple levels of care may serve as the director of nursing of a home health agency and of up to four entities licensed under ch. 400, F.S., or ch. 429, F.S., if they are owned, operated, or managed by the same corporate entity.

A change in the administrator or alternate administrator requires notification to the AHCA prior to or on the date of change and submission of documentation evidencing the statutory qualifications as well as background screening clearance documentation of the replacement.[15] No notification is required for changes in the director of nursing in between renewals of the home health agency's license.[16] The AHCA licensure staff has had conversations with nurses who

[7] Facilities licensed under ch. 395, F.S., include hospitals, ambulatory surgical centers, and mobile surgical facilities.
[8] Facilities licensed under part II of ch. 400, F.S., include nursing homes.
[9] Facilities licensed under part I of ch. 429, F.S., include assisted living facilities.
[10] Entities licensed under ch. 400, F.S., include nursing homes, home health agencies, nurse registries, hospices, intermediate care facilities, homes for special services, transitional living facilities, prescribed pediatric extended care centers, home medical equipment providers, intermediate care facilities for developmentally disabled persons, health care services pools, and health care clinics.
[11] Entities licensed under ch. 429, F.S., include assisted living facilities, adult family care homes, and adult day care centers.
[12] Section 400.462(10), F.S.
[13] Rule 59A-8.0095(2), F.A.C.
[14] Rule 59A-8.0095(5), F.A.C.
[15] Rule 59A-8.0095(1)(b), F.A.C.
[16] Source: AHCA Most Frequently Asked Questions / Home Health Agencies - Question 28c., found at <http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Home_Care/definitions.shtml#a> (Last visited on March 3, 2008).

resigned shortly after the home health agency license was issued. Home health agencies may operate for months, perhaps until license renewal, without a qualified director of nursing.[17]

There is no requirement in state or federal law for a home health agency to have a medical director. Federal regulations for Medicare and Medicaid certified home health agencies require that a physician be on the group of professional personnel that is to establish and annually review the agency's policies.[18]

Medicare Certification Requirements

To receive reimbursement from Medicare, a home health agency must apply to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), for certification as a Medicare provider. Certification is based on the home health agency meeting the conditions of participation set forth in 42 Code of Federal Regulations, Ch. IV, Part 484 (Subparts A, B, and C), and demonstrating compliance with minimum standards during an on-site survey inspection. A home health agency must be operational and have a minimum of 10 patients receiving skilled care before the survey is conducted. Historically, the federal government has contracted with the AHCA to perform the certification surveys. However, due to recent funding shortfalls at the federal level, CMS notified the AHCA that CMS would not be able to fund those inspections at this time. In October 2007, the AHCA released guidance to home health agencies explaining the AHCA's discontinuation of initial certification surveys and provided information for obtaining certification surveys from private accrediting organizations. The initial certification survey generally occurred 9-12 months after the home health agency submitted the application to Medicare. The AHCA will continue to conduct the ongoing Medicare re-certification surveys and usually they are performed concurrently with a state licensure survey approximately every 3 years.

As of August 23, 2007, of the 1,865 licensed home health agencies in Florida, 873 were certified for Medicare (47 percent of the licensed home health agencies).[19]

Medicaid Provider Enrollment

To enroll as a Medicaid provider, a home health agency must be licensed under part III of ch. 400, F.S., and meet the Medicare conditions of participation.[20] In addition, the home health agency must meet the general Medicaid provider enrollment requirements contained in the Florida Medicaid Provider General Handbook[21] and the specific home health agency

[17] Source: AHCA Home Health Unit.
[18] Source: AHCA 2008 Bill Analysis and Economic Impact Statement for SB 1374.
[19] The Florida Senate Interim Project Report 2008-135, *Review Regulatory Requirements for Home Health Agencies*, available at <http://www.flsenate.gov/data/Publications/2008/Senate/reports/interim_reports/pdf/2008-135hr.pdf> (Last visited on March 3, 2008).
[20] *Florida Medicaid, Home Health Services Coverage and Limitations Handbook*, Agency for Health Care Administration, found at <http://floridamedicaid.acs-inc.com/XJContent/CL_07_070701_Home_Health_ver1.1.pdf?id=000005500052> (Last visited on March 3, 2008).
[21] *Florida Medicaid, Provider General Handbook*, Agency for Health Care Administration, found at <http://floridamedicaid.acs-inc.com/XJContent/GH_07_070101_Provider_General_ver1.1.pdf?id=000004590898> (Last visited on March 3, 2008).

qualifications in the Home Health Services Coverage and Limitations Handbook. All parent offices, branch offices and subunits are required to enroll in Medicaid and receive their own unique Medicaid provider numbers. Unless exempt, a surety bond is required for home health agencies if there have been (within the past 5 years) or currently are sanctions or terminations (voluntary or involuntary) involved. It takes approximately 6-9 months from submission of the application for a home health agency to become enrolled as a Medicaid provider.

As of August 23, 2007, there were 524 licensed home health agencies enrolled as providers in the Florida Medicaid program (28 percent of the licensed home health agencies).[22]

Growth in the Number of Licensed Home Health Agencies

As of December 31, 2007, there were 1,985 licensed home health agencies in the state,[23] an increase of 797 (67 percent) new agencies since August 1999. The growth has been uneven around the state. Seventeen counties experienced a reduction in the number of licensed home health agencies during this period. Almost all of these counties are rural. However, despite the reduction in the number of licensed home health agencies in the rural counties, there is no indication that requested home health services are unavailable in these areas as a home health agency licensed in one county may serve clients in multiple counties. The population of persons over the age of 64 increased 16 percent statewide from 1999 – 2007 and 20 percent for all ages during that same period.[24]

In Miami-Dade County, the number of licensed home health agencies increased from 216 in August 1999 to 733 on December 31, 2007 (517 newly licensed home health agencies - a 239 percent increase). The increase in Miami-Dade County represents 65 percent of the statewide increase in licensed home health agencies.

Miami-Dade and Broward counties comprise 19 percent of the state's population of persons over age 64, yet host 48 percent of the licensed home health agencies in the state.[25] Although home health services are not limited to persons over the age of 64, this population predominates the market. Based on population data for 2007 and the number of licensed home health agencies in each geographic service area on December 31, 2007, in Miami-Dade and Monroe Counties, there was one licensed home health agency for every 470 residents over the age of 64; for Broward County, the ratio was one agency for every 1156 residents over the age of 64. For all other counties, the average was one home health agency for every 2537 residents over the age of 64.

The AHCA received 431 new licensure applications for home health agencies during 2007. Two hundred fifty-two (58.5 percent) of those were for new home health agency licenses in Miami-Dade County.

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[22] *Supra: note 19.*
[23] Source: AHCA Home Care Unit, Bureau of Health Facility Regulation.
[24] Source: Office of Economic & Demographic Research website, found at <http://edr.state.fl.us/population.htm> (Last visited on March 3, 2008).
[25] Source of population data: Office of Economic & Demographic Research website on 9/11/2007; Source of licensee data: AHCA Home Care Unit, Bureau of Health Facility Regulation, as of 8/23/2007.

Home Health Agency Deficiencies

The AHCA received 663 complaints related to various allegations against home health agencies during the 2-year period 2001-2002. During the 2-year period 2005-2006, the AHCA received 897 complaints, a 36-percent increase. Not all of these complaints were confirmed after investigation by the AHCA. The number of home health agencies fined by the AHCA for serious and uncorrected violations of state laws and rules has increased over the past 5 years as follows: 14 in 2001; 25 in 2002; 43 in 2003; 35 in 2004, 43 in 2005; and 50 in 2006. For the fiscal year ending June 30, 2007, home health agencies paid the AHCA $74,836 in administrative fines.

The AHCA conducts surveys of Florida licensed home health agencies that are enrolled in Medicaid and Medicare for compliance with federal conditions of participation based on the federal set of survey standards. There has been an increasing number of federal conditions of participation not met yearly from 2001 to 2006. Annually the number of federal conditions of participation not met has been 7 in 2001; 31 in 2002; 40 in 2003; 63 in 2004; 68 in 2005; and 84 in 2006. The number of home health agencies in Florida that are enrolled in Medicare has increased from 349 in 2001 to 729 in 2006.

Section 400.484, F.S., requires the AHCA to impose fines for various classes of deficiencies as follows:

Description	Current Administrative Fine Authorized
Class I – any act, omission, or practice that results in a patient's death, disablement, or permanent injury, or places a patient at imminent risk of death, disablement, or permanent injury.	$5,000
Class II – any act, omission, or practice that has a direct adverse effect on the health, safety, or security of a patient.	$1,000
Class III – any act, omission, or practice that has an indirect adverse effect on the health, safety, or security of a patient. The fine may be imposed only for an uncorrected or repeated Class III deficiency.	$500
Class IV – any act, omission, or practice related to required reports, forms, or documents which does not have the potential of negatively affecting patients. There must be a finding of an uncorrected or repeated class IV deficiency.	$200

Medicare/Medicaid Fraud

The AHCA's Bureau of Medicaid Program Integrity (MPI) is responsible for preventing and detecting fraud and abuse and performing inspections and investigations related to the Florida Medicaid program. If the MPI suspect's fraud or another criminal violation of state law is involved, the case is referred to the Office of the Attorney General Medicaid Fraud Control Unit

(MFCU) for further investigation and prosecution, if appropriate. The following chart depicts the number of investigations relating to home health agencies opened by the MPI for the last 3 state fiscal years.

Medicaid Program Integrity Investigations			
County	2004-2005	2005-2006	2006-2007
Miami-Dade	26	45	113
Broward	5	6	4
All other	16	21	27
Total	47	72	144

Nineteen home health agencies have been terminated from the Medicaid program in Miami-Dade County since July 1, 2004.[26]

Any Medicaid recipient requiring more than 60 visits in a lifetime must have the additional visits authorized through a precertification process.[27] The AHCA contracts with a private entity for these precertification determinations. Utilization reports prepared by the AHCA indicate that in Miami–Dade County for fiscal years 2005-06 and 2006-07, Medicaid paid for an average number of visits per recipient by home health aides without associated skilled nursing services of 278.1 and 297.7, respectively. Medicaid paid on average for 124 and 162.6 visits for the same services during the same periods for all other counties in the state.

Some Medicaid-related fraud and abuse observations by the AHCA that could translate into quality of care issues include:

- The same home health aide being employed by multiple home health agencies and cumulative billings for that aide exceed 24 hours per day;
- Home health aides providing services to two recipients at the same time in different locations;
- Billing for services not rendered; and
- No changes in the patient condition from one assessment/re-certification period to the next.

The AHCA referred 3 cases to the MFCU in 2004, 7 in 2005, 13 in 2006, and 19 in 2007 (through November 30) for suspected Medicaid fraud. The MFCU opened seven home health agency cases in 2004, 17 in 2005, 17 in 2006, and 17 in 2007. The MFCU reports that from 2005–2007, Miami-Dade County centered cases accounted for approximately 70 percent of the new MFCU home health agency cases opened.

Durable Medical Equipment and Medical Supply Providers

Durable medical equipment and medical supply providers (DME providers) are licensed and regulated by the AHCA as home medical equipment providers in part VII of ch. 400, F.S., and part II of ch. 408, F.S. Home medical equipment includes any products:

[26] Provided by AHCA's Medicaid Program Integrity Unit.
[27] *Florida Medicaid, Home Health Services Coverage and Limitations Handbook*, Agency for Health Care Administration, *supra: note 18.*

- As defined by the Federal Food and Drug Administration,
- Reimbursed under Medicare Part B Durable Medical Equipment benefits, or
- Reimbursed under the Florida Medicaid durable medical equipment program.[28]

Home medical equipments includes:

- Oxygen and related respiratory equipment;
- Manual, motorized, or customized wheelchairs and related seating and positioning, but does not include prosthetics or orthotics or any splints, braces, or aids custom fabricated by a licensed health care practitioner;
- Motorized scooters;
- Personal transfer systems; and
- Specialty beds, for use by a person with a medical need.

The AHCA is the single state agency that administers or supervises the administration of the state Medicaid plan under federal law.[29] According to the Medicaid program, the ACHA must pay eligible providers for the provision of certain medically-necessary services to eligible recipients. Under federal and state law, certain other services are optional under the Medicaid program. Durable medical equipment and supplies is an optional service. Florida law authorizes the AHCA to pay for certain medically-necessary durable medical equipment and supplies provided to an eligible Medicaid recipient.[30]

The *Florida Medicaid, Durable Medical Equipment/Medical Supply Services Coverage and Limitations Handbook* provides that a DME entity must meet the following criteria to enroll as a Medicaid DME provider:[31]

- Be licensed by the local government agency as a business or merchant or provide documentation from the city or county authority that no licensure is required;
- Be licensed by the Department of Health, Board of Orthotics and Prosthetics, if providing orthotics and prosthetic devices;
- Be licensed by the AHCA with a Home [Medical] Equipment license;
- Be in compliance with all applicable laws relating to qualifications or licensure;
- Have an in-state business location or be located not more than fifty miles from the Florida state line;
- Meet all the general Medicaid provider requirements and qualifications;
- Be fully operational;

[28] Section 400.925(6), F.S.
[29] Sections 409.901(2) and (14), F.S. The Medicaid DME and medical supplies program is authorized by Title XIX of the Social Security Act and 42 C.F.R. Part 440.70. The program was implemented through ch. 409, F.S., and Chapter 59G, F.A.C.
[30] Section 409.906(10), F.S.
[31] *Florida Medicaid, Durable Medical Equipment/Medical Supply Services Coverage and Limitations Handbook*, Agency for Health Care Administration, found at < http://floridamedicaid.acs-inc.com/XJContent/Durable_Medical_Equipment-Medical_SuppliHB.pdf?id=000000182419> (Last visited on March 6, 2008).

- Submit a surety bond as part of the enrollment application unless the provider is owned and operated by a governmental entity. One $50,000 bond is required for each provider location up to a maximum of five bonds statewide or an aggregate bond of $250,000;[32] and
- Pass a site visit unless the applicant is associated with a pharmacy or rural health clinic, or provides only orthotic or prosthetic devices and is licensed by the Board of Orthotics and Prosthetics.

On October 2, 2007, the AHCA presented to the House Health Innovation Committee that there has been an increase in Medicaid Program Integrity investigations of Medicaid-enrolled DME providers as well as an increase in the number of referrals to the MFCU over the last several years related to Medicaid-enrolled DME providers.

Nurse Delegation

Nurses are licensed and regulated under ch. 464, F.S., and rules in Chapter 64B9, F.A.C. The practice of professional nursing means the performance of those acts requiring substantial specialized knowledge, judgment, and nursing skill based upon applied principles of psychological, biological, physical, and social sciences which shall include but not be limited to:

- The observation, assessment, nursing diagnosis, planning, intervention, and evaluation of care; health teaching and counseling of the ill, injured, or infirm; and the promotion of wellness, maintenance of health, and prevention of illness of others.
- The administration of medications and treatments as prescribed or authorized by a duly licensed practitioner authorized by the laws of this state to prescribe such medications and treatments.
- The supervision and teaching of other personnel in the theory and performance of any of the above acts.

Section 464.022(5), F.S., provides that no provision of the Nurse Practice Act shall be construed to prohibit the rendering of services by nursing assistants acting under the direct supervision of a registered professional nurse. Rules related to nurses delegating tasks are in ch. 64B9-14, F.A.C. Direct supervision is defined in those rules to mean the supervisor is on the premises but not necessarily immediately physically present where the tasks and activities are being performed. There are also other levels of supervision defined in the rule. For example, “indirect supervision” is defined as the supervisor is not on the premises but is accessible by two way communication, is able to respond to an inquiry when made, and is readily available for consultation.

Assistance with self-administration of medicine

In 1999, the Legislature enacted s. 400.488, F.S.,[33] authorizing an unlicensed person who has been trained in this area, to assist a patient who receives home health services in his or her home or place of residence with the self-administration of medications. The patient or patient’s representative must provide written informed consent for this assistance.

[32] *Ibid at page 1-7.*
[33] Section 7, ch. 99-332, L.O.F.

Assistance with the self-administration of medication may involve taking a properly dispensed and labeled container to the patient; in the presence of the patient reading the label, removing the prescribed amount of the medication from the container, and placing it in the patient's hand or another container from which the patient will consume the medication; and helping the patient by lifting that container to his or her mouth in order to take the medication. It may also involve applying topical medications.

Assistance with self-administration of medication does not include:

- Any form of preparing the medication, except for measuring the prescribed amount of a liquid or breaking a scored tablet or crushing a tablet as prescribed;
- The preparation of syringes of injection or the administration of medications by any injectable route;
- Administration of medications through intermittent positive pressure breathing machines or a nebulizer;
- Administration of medications by way of a tube inserted in a body cavity;
- Administration of parenteral preparations;
- Irrigations or debriding agents used in the treatment of a skin condition;
- Rectal, urethral, or vaginal preparations;
- Medications ordered to be given "as needed," unless there are specific parameters that preclude independent judgment on the part of the unlicensed person; and
- Medications for which any type of judgment or discretion on the part of the unlicensed person is needed.

This law was enacted as a means to contain costs for mentally competent patients who are aware of their medicine regime, but are physically unable to administer medication that normally can be self-administered by accessing care of trained assistants rather than more costly personnel licensed to administer medications.[34] This law specifies that the assistance with the self-administration of medication as described in this section does not constitute administration under the Florida Pharmacy Act.

Senate Interim Project 2008-135

During the 2007-2008 legislative interim, professional staff of the Senate Committee on Health Regulation reviewed the regulatory requirements for home health agencies. This bill addresses, among other things, the recommendations in the Interim Project Report 2008-135, *Review Regulatory Requirements for Home Health Agencies*,[35] recommendations from the AHCA and testimony to the Health Regulation Committee on December 12, 2007, January 9 and 23, 2008, and committee member's comments during the interim committee meetings.

[34] House of Representatives Committee on Health Care Licensing and Regulation Final Analysis for HB 1983, dated June 21, 1999 (Passed in CS/SB 2360).
[35] *Supra: note 19.*

III. Effect of Proposed Changes:

Section 1. Amends s. 400.462, F.S., to remove substantive provisions from the definitions of "administrator," "certified nursing assistant," "director of nursing," "home health aide," and "staffing services." The substantive provisions are moved to other sections of the Florida Statutes in the bill. Definitions are added to support terms used in new prohibited acts. The new terms defined are fair market value, immediate family member, medical director, and remuneration. In addition, the definition of "staffing services" is modified to include a school as a recipient of staffing services and to require a written contract for all staffing services provided by a home health agency or persons registered with a nurse registry.

Section 2. Amends s. 400.464, F.S., to allow a nurse registry to refer an appropriately licensed health care professional to provide home infusion therapy without having to become licensed as a home health agency. Unnecessary language related to reimbursements under the Medicare DME-Part B program is deleted.

Section 3. Amends s. 400.471, F.S., to modify the application requirements and procedures for home health agency licensure applicants.

Additional information or other requirements for applicants include:

- A business plan detailing the methods to obtain patients and recruit and maintain staff;
- Evidence of contingency funding equal to 1 month's average operating expense over the first year of operation;
- A balance sheet, income and expense statement, and statement of cash flows for the first 2 years of operation that demonstrate the initial applicant's financial ability to operate. These statements may not project an operating margin for any month in the first year of operation of 15 percent or greater, must be prepared in accordance with generally accepted accounting principles, and be signed by a certified public accountant;
- Disclosure of all other ownership interests in health care entities for each controlling interest,
- Submitting a $50,000 surety bond or other equivalent means of security, e.g., irrevocable letter of credit or deposit in a trust account or financial instituiton, acceptable and payable to the AHCA for applicants for an initial home health agency license. However, a surety bond is the only form of security that may be initially submitted until AHCA has adopted a rule providing for other equivalent means of security. The bill provides that the bond (or equivalent security) must remain in effect for the first four years of the license. The articulated purpose of the bond or security is to secure payment of any administrative penalties, costs, or fees imposed or incurred by the AHCA that are not paid by the licensed home health agency to the AHCA within 30 days after the fine or costs become final. The bill specifies the timeframe under which the AHCA may make a claim against the bond or security. This timeframe is the later of: one year after the license ceases to be valid if the license is not renewed for a second biennial period, one year after the license has been renewed a second time, or 60 days after any proceeding involving the licensed home health agency is concluded, including any appeal.

This section also imposes a cap on the number of applications for a new home health agency license that the AHCA may accept quarterly from the effective date of the bill until July 1, 2011.

The number of new licensure applications the AHCA may receive each quarter depends upon the geographic service area in which the home health agency is to be located. For each geographic service area, the AHCA will determine the number of residents over the age of 64 per licensed home health agency. The range within which this result falls determines the number of applications that the agency may accept for processing quarterly. The bill specifies the sources of data for determining the cap.

- The number of residents over the age of 64 will come from the Florida Population Estimates for Counties and Municipalities, April 1, 2007, published by the Office of Economic and Demographic Research of the Legislature.[36] The following chart depicts this population.

Geographic Service Area	# residents over age 64 as of 4/1/2007
1	97,127
2	87,150
3	347,542
4	286,328
5	304,867
6	353,203

Geographic Service Area	# residents over age 64 as of 4/1/2007
7	287,998
8	414,498
9	424,603
10	257,793
11	345,126

- The number of licensed home health agencies will be the number of valid, licensed home health agencies in each geographic service area on June 1, 2008.

The number of residents over the age of 64 in each geographic service area per licensed home health agency in that geographic service area will fall into a range between 0–999; 1000–1999, and 2000–2999. It was determined that the AHCA could accept five applications quarterly for new home health agency licenses in most of the state and meet recent licensure demand based on the number of new home health agency licenses issued during the nine-month period from April – December 2007. Accordingly, in the bill, the AHCA is authorized to receive five applications for new home health agency licenses quarterly in each geographic service area that falls within the 2000–2999 range; four applications for new home health agency licenses quarterly in each geographic service area that falls within the 1000–1999 range, and three applications for new home health agency licenses quarterly in each geographic service that falls within the 0–999 range. This allows for a controlled number of new home health agencies to enter the market throughout the three-year period that the cap will be in place, which will allow the AHCA staff to devote more time to surveys of already licensed home health agencies in order to ensure the quality of home health services being delivered.

For illustration purposes, the following table reflects the number of residents over the age of 64 in 2007 in each AHCA geographic service area per licensed home health agency in that geographic service area as of December 31, 2007. Geographic service areas 1 and 3–9 fall within the 2000–2999 range, geographic service areas 2 and 10 fall within the 1000–1999 range, and geographic service area 11 falls within the 0–999 range.

[36]See <http://edr.state.fl.us/population.htm> (Last visited on March 6, 2008).

Geographic Service Area	# residents over age 64 per HHA
1	2857
2	1981
3	2737
4	2512
5	2628
6	2419

Geographic Service Area	# residents over age 64 per HHA
7	2717
8	2801
9	2223
10	1156
11	470

The bill provides for an exemption from the cap for a home health agency that is part of a retirement community that provides multiple levels of care and that will provide home health services only to residents of the retirement community. If a licensee exempted under this provision provides home health services to persons outside that retirement community, the AHCA is to impose a moratorium on that home health agency and revoke that home health agency license. A home health agency whose license is revoked pursuant to this process is authorized to reapply for a new home health agency license and will be subject to the cap imposed on the AHCA's acceptance of new licensure applications.

The bill establishes a process for the AHCA to accept applications for a new home health agency license during the first five business days of a calendar quarter. Applications for a new home health agency license received during this period must be grouped according to the geographic service area in which the home health agency is to be located. When the number of applications received for a geographic service area exceeds the number of applications authorized to be accepted for processing, the AHCA must use a lottery system to select applications to be accepted for processing for that geographic service area as follows:

- A number must be assigned to each application received for the geographic service area;
- For each such area, the AHCA must put the numbers assigned to each application in an opaque container;
- The AHCA must select the applicable quantity of numbers for that geographic service area without viewing the contents of the container; and
- The application that corresponds to the selected number shall be accepted for processing.

The selection of applications to be accepted for processing must be a public process conducted in Tallahassee and noticed for a date during the first 6 through 10 business days of the calendar quarter.

The AHCA is to return to the sender those applications and fees for a new home health agency license that are received in excess of the quarterly number allowed to be accepted or an application for a new home health agency license that is received outside of the first five-business-days window.

The limitation expires July 1, 2011.

Additional provisions related to licensure include:

- The AHCA may not issue an initial license to a home health agency licensure applicant if the applicant shares common controlling interests with another licensed home health agency that is located within 20 miles of the applicant. The AHCA must return the application and licensure fees.
- An applicant may not transfer its application to another home health agency or controlling interest while the application is pending.
- A licensed home health agency must submit an initial application to relocate to a different geographic service area.
- An applicant has the burden of proof to demonstrate that a factual determination made by the AHCA is not supported by the preponderance of the evidence if the applicant alleges that a factual determination made by the AHCA is incorrect.

Section 4. Amends s. 400.474, F.S., to prohibit certain activities by a home health agency and to provide for the AHCA to take disciplinary action against a home health agency that violates these provisions:

- A home health agency or its employees preparing or maintaining fraudulent patient records. Examples of fraudulent patient records provided in the bill include charting ahead, recording vital signs or symptoms that were not personally obtained or observed by the home health agency's staff at the time indicated, borrowing patients or patient records from another home health agency to pass a survey or inspection, and falsifying signatures;
- Failing to provide at least one service directly to a patient for a period of 60 days;
- A pattern, as demonstrated by at least three fraudulent entries or documents, of falsifying documents of training for home health aides or certified nursing assistants, or health statements for staff providing direct care to patients. The AHCA is to impose a $1,000 fine for each fraudulent entry;
- A pattern of billing any payor for services not provided, as demonstrated by at least three billings for services not provided within a 12-month period. The AHCA is to impose a $5,000 fine for each incident that is falsely billed and the AHCA may also require payback of all funds, revoke the license, or issue a moratorium against the home health agency; and
- A pattern of failing to provide a service specified in the home health agency's written agreement with a patient, or the patient's legal representative, or the plan of care for that patient, as demonstrated by at least three incidences where a service was not provided during a 3-month period. The AHCA is to impose a $5,000 fine for each occurrence, and may also impose additional administrative fines for the direct or indirect harm to a patient, or deny, revoke, or suspend the license of the home health agency for this violation, unless a reduction in service is mandated by a federal or state program or in emergency situations that make it impossible to provide the service.

The AHCA may deny, revoke, or suspend the license of a home health agency and shall impose a fine of $5,000 against a home health agency that:

- Gives remuneration for staffing services to another home health agency or health services pool, with which the home health agency has a patient referral arrangement; however, this provision does not apply to a continuing care retirement facility which provides home health

agency services to its residents and receives payment for those services from another home health agency that has lawfully billed Medicare for the services;
- Provides services to residents in an assisted living facility or staffing to an assisted living facility without receiving fair market value remuneration;
- Fails to provide copies of all contracts with an assisted living facility upon AHCA's request;
- Gives remuneration to a person involved in discharge planning for referrals;
- Fails to submit to the AHCA, within 10 days after the end of a quarter, a report of the number of insulin-dependent diabetic patients receiving insulin-injection services from the home health agency, the number of patients receiving both home health services and hospice services, the number of patients receiving home health services from that agency, and the names and nursing license numbers of nurses receiving more than $25,000 in remuneration during the quarter;
- Gives cash, or its equivalent, to a Medicare or Medicaid beneficiary;
- Has multiple medical directors;
- Gives remuneration to a physician without a one-year contract in effect that specifies remuneration will be based on a fair-market-value hourly rate supported by a detailed invoice;
- Gives remuneration to a member of a physician's office staff, an immediate family member of a physician, or a physician who does not have the required contract in effect or who is in excess of the number of authorized medical directors and the home health agency has received a patient referral in the preceding 12 months from that physician or physician's office staff; and
- Fails to provide copies of all contracts with medical directors upon AHCA's request.

Section 5. Creates s. 400.476, F.S., to establish requirements related to home health agency staff and staffing services. Currently an administrator may manage a maximum of five licensed home health agencies, if the home health agencies are located within one geographic service area or within an immediately contiguous county. The bill restricts an administrator to managing only one home health agency except that the administrator may manage up to five home health agencies within the same geographic service area, or within an immediately contiguous county, if all the home health agencies have identical controlling interests.[37] The bill also authorizes an employee of a retirement community that provides multiple levels of care to administer a home health agency and up to a maximum of four entities, other than home health agencies, licensed under ch. 400, F.S., or ch. 429, F.S., if all entities have identical controlling interests.

The bill reinstates two provisions that were removed from the definitions. The first provision requires an administrator to designate in writing an alternate administrator to serve during the administrator's absence. The second provision authorizes a licensed physician, physician assistant, or registered nurse licensed to practice in this state to serve as both an administrator of a home health agency and the director of nursing for that home health agency. An administrator may serve as a director of nursing for up to the number of entities authorized below, but only if

[37] Controlling interest is referenced to and defined in s. 408.803, F.S., to mean the applicant or licensee; a person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the applicant or licensee; or a person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member.

there are 10 or fewer full-time equivalent employees and contracted personnel in each home health agency.

Currently a director of nursing may be the director for a maximum of five licensed home health agencies, if the home health agencies are operated by a related business entity and are located within one geographic service area or within an immediately contiguous county. The bill restricts a director of nursing to serve as the director of nursing of a maximum of two home health agencies, if the two agencies are located within the same geographic service area, or within an immediately contiguous county, and have identical controlling interests. However, a director of nursing may serve as the director of nursing of up to five licensed home health agencies if all of the agencies have identical controlling interests, all of the agencies are located within one agency geographic service area or within an immediately contiguous county, and each home health agency has a registered nurse with a written delegation to serve as the director of nursing for that agency when the director of nursing is not present. The bill also authorizes an employee of a retirement community that provides multiple levels of care to serve as the director of nursing of a home health agency and up to a maximum of four entities, other than home health agencies, licensed under ch. 400, F.S., or ch. 429, F.S., if all entities have identical controlling interests.

The bill prohibits a home health agency that provides skilled nursing care from operating more than 30 days without a director of nursing, and provides for a $5,000 administrative fine and authorizes the AHCA to issue a moratorium or revoke the license for violating this provision. Both the licensed home health agency and the director of nursing must notify the AHCA within 10 business days after the director of nursing terminates serving as the director of nursing for that home health agency. However, the agency may not be subject to administrative enforcement if the nurse fails to notify the AHCA. The home health agency must also notify the AHCA within 10 days after hiring a new director of nursing. The specified notification includes the identity and qualifications of the director of nursing. A home health agency that provides skilled nursing care that fails to notify the AHCA as required will be fined $1,000 for the first violation and $2,000 for a repeat violation. The bill further provides that a home health agency that provides only physical, occupational, or speech therapy is not required to have a director of nursing and is exempt from these provisions.

The bill reinstates a provision removed from the definitions related to requiring a home health agency to ensure that each certified nursing assistant and each home health aide who is either employed by or under contract with the home health agency is adequately trained to perform the tasks of a home health aide.

The bill reinstates a provision removed from the definitions that allows a home health agency to provide staffing services anywhere within the state.

Section 6. Amends s. 400.484, F.S., to mandate the AHCA conduct an unannounced survey of each home health agency within 15 months after it becomes licensed initially and to increase administrative fines and make them mandatory as follows:

Deficiency Classification	Current Administrative Fine	Administrative Fine in the Bill
Class I	$5,000	$15,000
Class II	$1,000	$5,000
Class III	$500	$1,000
Class IV	$200	$500

Section 7. Amends s. 400.488, F.S., to authorize a home health agency nurse to delegate nursing tasks as provided in the statutes and rules regulating nurses. Also, the language providing for assistance with the self-administration of medication by unlicensed persons is deleted.

Section 8. Amends s. 400.491, F.S., to extend from one year to three years the record retention period for records related to a client who has a service provision plan for nonskilled care.

Section 9. Amends s. 400.497, F.S., to require the AHCA to adopt rules related to standards for a director of nursing. These standards must address:

- The oversight of skilled nursing and personal care services provided by the home health agency,
- Requirements for responding to a request from the AHCA for a certified log of services provided by a specified direct employee or contracted staff member providing home health services for the home health agency, and
- The quality assurance program for home health services provided by the home health agency.
- Conditions for using a recent unannounced licensure inspection for the inspection required in s. 408.806, F.S., related to a licensure application associated with a change in ownership of a licensed home health agency.

Section 10. Amends s. 400.506, F.S., to reinstate a provision removed from the definitions related to requiring a nurse registry to ensure that each certified nursing assistant and each home health aide that is referred by the nurse registry has been adequately trained to perform the tasks of a home health aide. The bill also prohibits additional conduct by nurse registries and authorizes the AHCA to impose sanctions against the nurse registry's license and impose a $5,000 fine if a nurse registry engages in any of the following proscribed conduct:

- Provides services to residents in an assisted living facility or staffing to an assisted living facility without receiving fair market value remuneration;
- Fails to provide copies of all contracts with an assisted living facility upon the AHCA's request;
- Gives remuneration to a person involved in discharge planning for referrals; and
- Gives remuneration to a physician, a member of the physician's office staff, or an immediate family member of the physician, and the nurse registry received a patient referral in the last 12 months from that physician or the physician's office staff.

The AHCA is required to impose an administrative fine of $15,000 if a nurse registry refers nurses, CNAs, home health aides, or other staff without charge to a facility licensed under

ch. 429, F.S., in return for patient referrals. Collections of fines imposed for these violations are to be deposited into the Health Care Trust Fund.

Section 11. Amends s. 400.518, F.S., to prohibit a home health agency from providing nurses, CNAs, home health aides, or other staff on a complimentary basis to a facility licensed under ch. 429, F.S., in return for patient referrals. The AHCA is required to impose an administrative fine not to exceed $15,000 for this prohibited action and deposit the fines collected into the Health Care Trust Fund.

Section 12. Amends s. 409.906, F.S., to establish additional criteria, effective January 1, 2009, for Medicaid-enrolled DME providers to be reimbursed for services under the Medicaid program, including:

- Be accredited, and periodically re-accredited, by an AHCA-approved accreditation organization. Accrediting reviews may be unannounced.
- Have a physical business location that meets these criteria:
  - Has substantial inventory;
  - Has exterior signage that can be read from 20 feet away which readily identifies the business as one providing durable medical equipment, medical supplies, or both;
  - Has a functional landline business telephone;
  - Is not located within or at the same number street address (this includes unique suite or storefront numbers assigned by the United States Postal Services or building's owner) as another Medicaid-enrolled DME provider or Medicaid pharmacy that is also a DME provider;
  - If located outside of Florida's border, be no more than 50 miles from the Florida state line. Exceptions to this requirement may be made for a manufacturer of a unique type of durable medical equipment that is not otherwise available from a provider located within the state; and
  - Unless an excepted out-of-state location, be easily accessible to the public no less than 5 hours a day, 5 days a week, with the exception of scheduled and posted holidays.
- Obtain a $50,000 surety bond for each location up to a maximum of five bonds statewide or an aggregate bond of $250,000 statewide. All locations that are covered by the bond are to be identified in an enrollment application or bond renewal. Proof that the bond has been renewed or is a continuous bond must be provided to the AHCA annually; and
- Have a level 2 background screening for staff in direct contact with and providing direct services to recipients. This requirement applies to, but is not limited to, repair and service technicians, fitters, and delivery staff.

The requirement for accreditation and the surety bond does not apply to a DME provider that is owned and operated by a governmental entity; operating within a pharmacy that is currently enrolled as a Medicaid pharmacy provider; and an active Medicaid-enrolled orthopedic physician's group, primarily owned by physicians, and which only provides orthotic and prosthetic devices.

Section 13. Requires the AHCA to review the Medicaid precertification process and the contractor's performance related to authorizing home health visits in excess of 60 visits over a recipient's lifetime to determine whether opportunities exist to detect and deter payment for

home health services that are not medically necessary. The bill further requires the AHCA to amend the contract related to the contractor's performance of precertification determinations if such opportunities exist.

Section 14. Requires the AHCA to report to the Legislature by January 1, 2009, on the feasibility and costs of the Medicaid system communicating with the Medicare system so that the Medicaid system can disallow a claim for payment of a home health service that has already been paid for under the Medicare prospective payment system.

Section 15. Provides an effective date of July 1, 2008.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

The law imposing a cap on the number of applications for an initial home health agency license that the AHCA may accept for processing may be subject to challenge due to the disparate treatment of different geographical areas within the state. It is not clear that such a challenge would succeed on equal protection or due process grounds, given the public purpose that prompted the time-limited caps and that all applicants similarly situated within a geographical service area are subject to the same standards.

Provisions limiting the span of control for administrators and directors of nursing could result in impairment of contract challenges. However, it is not clear that such challenges would be successful under existing case law.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill imposes a cap on the number of applications for a new home health agency license that the AHCA may accept (from 3–5 quarterly depending on the location within the state). This cap will be in place until July 1, 2011, unless otherwise modified by the

Legislature. Currently there is no restriction on the number of licensure applications AHCA may accept for processing or the number of licenses that may be issued if all conditions of licensure are satisfied. As a result, it is foreseeable, especially in Miami-Dade and Monroe Counties, that some businesses will not be able to enter the market to provide home health agency services. The cap could also affect the ability of currently licensed home health agencies to sell their businesses since this cap will also apply to changes in ownership[38] of currently licensed home health agencies.

The bill also requires an applicant for a new home health agency license to obtain and maintain throughout the first four years of licensure, a surety bond, irrevocable letter of credit or equivalent security in the amount of $50,000. The purpose of the bond is to secure payment of any administrative penalties imposed by the AHCA against the home health agency. A surety bond is a contractual arrangement between the surety company, the principal, e.g., home health agency licensee, and the obligee, e.g., the AHCA, whereby the surety company agrees to pay the ACHA if the home health agency defaults on paying any administrative penalties. According to surety and banking representatives, the annual average cost of a $50,000 bond is from $1,000 to $2,500. The average annual fee to obtain an irrevocable letter of credit ranges from $700 to $800. Home health agencies licensed as of June 30, 2007, or applicants that have submitted an application for a new home health agency license by June 30, 2007, are not subject to this requirement.

C. Government Sector Impact:

The bill requires the AHCA to draft rules, receive reported information from home health agencies, and conduct a survey of each home health agency licensee within the first 15 months after the home health agency is initially licensed.

The AHCA is requesting a total of 10 positions: 3 additional surveyors and a support position for South Florida, 2 positions for rulemaking and other ongoing activities related to implementation of the regulatory enhancements in this bill, and 4 positions in Medicaid Program Integrity. The first year fiscal impact is $891,408 and the second year fiscal impact is $773,008, which would be funded from trust funds.

The AHCA estimates that the limit in the number of initial licensure applications accepted will result in a loss of $434,240 in application fee collections for state fiscal year 2008-09, which will be offset by a projected increase of $445,500 in fines collected per provisions in the bill. The AHCA further notes that the home health agency renewal license application fee and other fee revenues in the Health Care Trust Fund have exceeded costs each year and should continue to do so.

There may be additional costs to the AHCA depending upon the outcome of the review of the Medicaid pre-certification process and the study of the Medicare/Medicaid system

[38] A change in ownership is defined in s. 408.803(5), F.S., as an event in which the licensee changes to a different legal entity or in which 45 percent or more of the ownership, voting shares, or controlling interest in a corporation whose shares are not publicly traded on a recognized stock exchange is transferred or assigned, including the final transfer or assignment of multiple transfers or assignments over a 2-year period that cumulatively total 45 percent or greater. A change solely in the management company or board of directors is not a change of ownership.

interface mandated in sections 13 and 14 of the bill. These costs and the potential savings from cost avoidance cannot be determined at this time.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The AHCA indicated in its analysis of the bill that the limitation on the number of applications that can be accepted by the AHCA is of some concern, both conceptually and in the possible barriers to its implementation.[39]

Eliminating the current authority in s. 400.488, F.S., for unlicensed persons to assist home health patients with the self-administration of medication may impose an additional burden on licensed professionals if this task cannot be delegated by a home health agency nurse under general or indirect supervision.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Banking and Insurance on March 18, 2008:

Provides that a surety bond is the only form of security that may be submitted by a home health agency applicant until AHCA has adopted a rule providing for other equivalent securities.

Authorizes the cap limiting the number of new home health agencies to take effect immediately without requiring AHCA to adopt rules establishing the lottery system for selecting applicants.

Allows a continuing care retirement facility to provide home health agency services to its residents and receive payment for those services from another home health agency that has lawfully billed Medicare for the services.

Corrects the placement of the word “only” in a sentence to clarify that an administrator may serve as a director of nursing for up to the number of entities authorized in the bill, but only if there are 10 or fewer full-time equivalent employees and contracted personnel in each home health agency.

Authorizes AHCA to adopt a rule to use a recent inspection of a home health agency to satisfy the inspection requirement associated with a change in ownership of a licensed home health agency.

Deletes an anti-kickback provision which subjected a nurse registry to administrative sanctions if the registry gave remuneration to an insurance agent, a member of the agent’s staff, or immediate

[39] *Supra: note 18.*

family, and the registry received a patient referral within the last 12 months from the agent or agent's staff.

CS by Health Regulation on March 5, 2008:

Changes in Section 2. This section is added to the original bill. It eliminates an inconsistency in the law so that a nurse registry may refer an appropriately licensed health care professional to provide home infusion therapy without having to become licensed as a home health agency and removes unnecessary language related to reimbursements under the Medicare DME – Part B program.

Changes in Section 3. Requires additional information for the home health agency licensure application including:

- A business plan detailing the methods to obtain patients and staff,
- Disclosure of contingency funding,
- Demonstration of financial ability to operate with a threshold on projected profit margins, and
- Other ownership interests in health care entities of controlling interests.

Specifies the methodology for the cap on the number of home health agency licensure applications that the AHCA may accept for processing quarterly rather than the calculated result for each geographic service area. This will allow for more recent licensure counts, as of June 1, 2008, to be used to determine the cap for each geographic service area when the law takes effect.

Requires the AHCA to return the application fees submitted if the application is returned because of the cap.

Prohibits the AHCA from issuing a home health agency license to an applicant if another licensed home health agency with a common controlling interest is located within 20 miles of the applicant.

Prohibits an applicant from transferring its application to another home health agency or controlling interest prior to issuance of the license.

Requires a home health agency that wants to relocate to a different geographic service area to submit an initial application for the new geographic service area.

Provides that the burden of proof is on an applicant to demonstrate that a factual determination made by the AHCA is incorrect.

Changes in Section 4. Requires a licensed home health agency to provide services to at least one patient within a 60-day period.

Clarifies for disciplinary purposes that a patient's legal representative may be a party to the written agreement setting forth the required plan of care for the patient.

Requires a home health agency to report to the AHCA the name and nursing license number of all nurses, not just registered nurses, who received remuneration from the home health agency in excess of $25,000 during the calendar quarter.

Changes in Section 5. Incorporates rule language that an administrator may also be the director of nursing if each home health agency that the administrator manages has no more than 10 staff.

Clarifies that the requirements related to a director of nursing apply to home health agencies that provide skilled nursing services.

Provides that a home health agency that only provides physical, occupational, or speech therapy is not required to have a director of nursing.

Changes in Section 6. Moves language requiring the AHCA to conduct an unannounced licensure survey within the first 15 months after the initial license is issued from an undesignated section of law to s. 400.484, F.S. This language was in section 10 in the original bill.

Changes in Section 7. This section is added to the original bill. It strikes the section of law authorizing unlicensed persons who have been trained to do so to assist patients with self-administration of medication and authorizes licensed nurses to delegate tasks pursuant to their authority in ch. 464, F.S., and applicable rules.

Changes in Section 10. Provides for disciplinary action against nurse registries that engage in similar prohibited conduct to that prohibited for home health agencies, including:

- Providing services or staffing in assisted living facilities without receiving fair market value remuneration,
- Failing to provide to the agency copies of contracts with assisted living facilities,
- Giving remuneration to certain persons providing referrals, and
- Referring staff without charge in exchange for patient referrals.

Changes in Section 12. This section is added to the original bill. It requires additional criteria, as well as exemptions, for Medicaid-enrolled DME providers including:

- Accreditation,
- Physical business location meeting specific criteria,
- $50,000 surety bond, and
- Level II background screening for certain employees.

Deletes the undesignated section of the bill related to initial unannounced surveys.

B. Amendments:

None.