

**HOUSE OF REPRESENTATIVES
FINAL BILL ANALYSIS**

BILL #:	CS/CS/HB 597	FINAL HOUSE FLOOR ACTION:		
SUBJECT/SHORT TITLE	Health Care Facility Regulation	112	Y's 0	N's
SPONSOR(S):	Health & Human Services Committee; Health Care Appropriations Subcommittee; Yarborough	GOVERNOR'S ACTION:	Approved	
COMPANION BILLS:	CS/CS/SB 622			

SUMMARY ANALYSIS

CS/CS/HB 597 passed the House on March 5, 2018, as CS/CS/SB 622.

The bill amends various authorizing and licensing statutes for entities regulated by the Agency for Health Care Administration (AHCA). The bill clarifies existing licensure and enforcement requirements, amends certain provisions to eliminate conflict between part I of ch. 395, F.S., ch. 400, F.S., and part II of ch. 408, F.S., increases administrative efficiency at AHCA, and repeals redundant or obsolete statutes. Specifically, the bill:

- Repeals part I of ch. 483, F.S. regulating clinical laboratories. Clinical laboratories that perform testing on specimens derived from within Florida will no longer be required to obtain state licensure. Clinical laboratories will continue to be certified by the federal Clinical Laboratory Improvement Amendments program.
- Repeals the health care risk manager licensure requirements and the Health Care Risk Manager Advisory Council.
- Addresses unlicensed assisted living facilities (ALFs) by strengthening the enforcement capabilities of AHCA.
- Defines the assistance an ALF must provide a resident under the Resident Bill of Rights.
- Repeals the Subscriber Assistance Program, which resolves disputes between health maintenance organizations and subscribers. Subscribers have several other options in state and federal law to resolve such disputes.
- Eliminates the mobile surgical facility license. To date, no license has been issued for a mobile surgical facility.
- Repeals obsolete special designations of rural hospitals.
- Eliminates conflict and duplicative provisions between part II of ch. 408, F.S., and authorizing statutes.
- Repeals the Statewide Managed Care Ombudsman Committee. The last activity on record was in 2010, and there are currently no active committees.
- Eliminates the special procedures for investigating emergency access complaints against hospitals, allowing AHCA to use the existing hospital complaint investigation procedures used for all other types of complaints.
- Repeals an exemption to licensure for any facility that was providing obstetrical and gynecological surgical services and was owned and operated by a board-certified obstetrician on June 15, 1984. No providers currently meet this criteria.
- Removes language that prevents nurse registries from marketing their services.
- Excludes individuals from employment with licensees if they have a pending domestic violence offense and excludes providers from participation in the Medicaid program for criminal offenses including offenses related to the provision of health care services, fraud, and controlled substances.
- Establishes requirements for pediatric cardiac programs.
- Revises requirements for qualifications for Adult Cardiac Service providers.
- Establishes the authority of a county with a public health trust over the trust's facility.
- Makes necessary conforming changes throughout the statutes to reflect the changes proposed in the bill.

The bill has a negative fiscal impact on AHCA due to a decrease in revenues from the repeal of certain licensure application fees; however, regulatory trust fund revenues are sufficient to absorb this loss. In addition, AHCA should experience a positive fiscal impact due to administrative efficiencies, including a decreased need for full-time equivalent positions.

The bill was approved by the Governor on March 19, 2018, ch. 2018-24, L.O.F., and will become effective on July 1, 2018.

This document does not reflect the intent or official position of the bill sponsor or House of Representatives.

STORAGE NAME: h0597z2.HIS

DATE: March 30, 2018

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Agency for Health Care Administration – Division of Health Quality Assurance

The Division of Health Quality Assurance (HQA), housed within the Agency for Health Care Administration (AHCA), licenses, certifies, and regulates 40 different types of health care providers. In total, HQA regulates more than 49,500 individual providers.¹ Regulated providers include:

- Laboratories performing testing under the Drug-Free Workplace program, s. 440.102(9), F.S.
- Birth centers, ch. 383, F.S.
- Abortion clinics, ch.390, F.S.
- Crisis stabilization units, parts I and IV of ch. 394, F.S.
- Short-term residential treatment facilities, parts I and IV of ch. 394, F.S.
- Residential treatment facilities, as provided under part IV of ch. 394, F.S.
- Residential treatment centers for children and adolescents, part IV of ch. 394, F.S.
- Hospitals, part I of ch. 395, F.S.
- Ambulatory surgical centers, part I of ch. 395, F.S.
- Mobile surgical facilities, part I of ch. 395, F.S.
- Health care risk managers, part I of ch. 395, F.S.
- Nursing homes, part II of ch. 400, F.S.
- Assisted living facilities, part I of ch. 429, F.S.
- Home health agencies, part III of ch. 400, F.S.
- Nurse registries, part III of ch. 400, F.S.
- Companion services or homemaker services providers, part III of ch. 400, F.S.
- Adult day care centers, part III of ch. 429, F.S.
- Hospices, part IV of ch. 400, F.S.
- Adult family-care homes, part II of ch. 429, F.S.
- Homes for special services, part V of ch. 400, F.S.
- Transitional living facilities, part XI of ch. 400, F.S.
- Prescribed pediatric extended care centers, part VI of ch. 400, F.S.
- Home medical equipment providers, part VII of ch. 400, F.S.
- Intermediate care facilities for persons with developmental disabilities, part VIII of ch. 400, F.S.
- Health care services pools, part IX of ch. 400, F.S.
- Health care clinics, part X of ch. 400, F.S.
- Clinical laboratories, part I of ch. 483, F.S.
- Multiphasic health testing centers, part II of ch. 483, F.S.
- Organ, tissue, and eye procurement organizations, part V of ch. 765, F.S.

Health Care Facility Licensing

Background

Certain health care providers² are regulated under part II of ch. 408, F.S., which is the Health Care Licensing Procedures Act (Act), or core licensing statutes. The Act provides uniform licensing procedures and standards for 29 provider types.³ In addition to the Act, each provider type has an

¹ Agency for Health Care Administration, *Health Quality Assurance*, 2017, available at <http://ahca.myflorida.com/MCHQ/> (last visited February 6, 2018).

² "Provider" means any activity, service, agency, or facility regulated by the agency and listed in s. 408.802, F.S.

³ S. 408.802, F.S.

authorizing statute which includes unique provisions for licensure beyond the uniform criteria. In the case of conflict between the Act and an individual authorizing statute, the Act prevails.⁴

Relatives

The term “relative” is not currently defined in the Act. The Act makes portions of patient records that contain the name, residence or business address, telephone number, social security or other identifying number, or photograph of the patient’s relative confidential and exempt from public records.⁵ The Act also requires a provider furnish any relative of a person who has applied to be admitted by the provider with a copy of its last inspection report upon request.⁶

Unlicensed Activity

It is unlawful for any person or entity to own, operate, or maintain an unlicensed provider. Unlicensed activity constitutes harm that materially affects the health, safety, and welfare of clients.⁷ AHCA works closely with the Department for Children and Families (DCF), The Attorney General’s Medicaid Fraud Control Unit, Medicaid Program Integrity, and the Department of Elder Affairs when unlicensed activity is discovered. Currently, some cases AHCA receives from the DCF concerning a victim of unlicensed activity do not currently fall under DCF’s current statutory authority for the protection of vulnerable adults⁸, so the DCF does not have the authority to open a case or move residents from an unlicensed facility.

Ownership

Current law requires an application for change of ownership of a provider to comply with all aspects of an initial license application, including submitting proof of financial ability to operate.⁹

Current law requires an applicant for licensure to disclose each controlling interest.¹⁰ A controlling interest is an applicant or licensee, a person or entity that serves as an officer or on the board of directors, or a person or entity with 5% or greater ownership interest. Over time, organizations have reorganized to move owners outside the disclosure requirements, such as through a parent corporation that wholly owns a subsidiary that owns a licensee. This arrangement enables persons with an adverse criminal or regulatory history to control health care provider operations without disclosure.

Hospice Licensure

Hospice authorizing statutes require initial and change of ownership applicants to submit a copy of the most recent profit-loss statement and licensure inspection if the applicant is an existing licensed health care provider.¹¹ The Act also requires certificate of need applicants that are existing licensed health care providers to submit a profit-loss statement for the two previous fiscal years’ operation.¹² Hospices are subject to certificate of need review.¹³ The Act also requires applicants and licensees to provide

⁴ S. 408.832, F.S.

⁵ S. 408.061(7), F.S.

⁶ S. 408.811(6)(b), F.S.

⁷ S. 408.812, F.S.

⁸ Ch. 415, F.S. provides DCF with authority to investigate complaints alleging abuse, neglect or exploitation of vulnerable adults and to provide protective services to vulnerable adults.

⁹ S. 408.806, F.S.

¹⁰ Id.

¹¹ S. 400.606, F.S.

¹² S. 408.037(1)(c), F.S.

¹³ A certificate of need is a written statement issued by AHCA evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility or health service. See S. 408.036, F.S.

proof of financial ability to operate in order to obtain and maintain a license.¹⁴ Applicants and licensees must submit a pro forma balance sheet, a pro forma cash flow statement and a pro forma income and expense statement for the first 2 years of operation that provide evidence of having sufficient assets, credit, and projected revenues to cover liabilities and expenses.¹⁵

Background Investigations

At the time of licensure, a level 2 background screening¹⁶ must be conducted on the following persons:

- The licensee, if an individual;
- The administrator or similarly titled individual who is responsible for the day-to-day operation of the provider;
- The financial officer or similarly titled individual who is responsible for the financial operation of the provider;
- Any person who has a controlling interest if AHCA has reason to believe that such person has been convicted of a prohibited offense;¹⁷ and
- Any person, as required by authorizing statutes, seeking employment with a licensee or provider and who is expected to provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person contracting with a licensee to provide such service or have such access.

All electronically submitted fingerprints retained by the Department of Law Enforcement (FDLE) are checked against all incoming arrest fingerprints.¹⁸ If there is a match with a retained fingerprint submission, FDLE notifies AHCA of the arrest. Currently, FDLE may only search against incoming Florida arrest fingerprints. If an arrest occurs in another state or by the federal government, the arrest will not be included in the arrest notifications. The screening is valid for 5 years, after which an individual must be re-screened.

The Federal Bureau of Investigations (FBI) provides the “Rap Back” services that allows authorized agencies to receive ongoing status notifications of any criminal history reported to the FBI on certain individuals.¹⁹ Currently, the national background screening is a one-time snapshot of an individual’s criminal history background.

Effect of the Bill – Health Care Facility Licensing

Relatives

The bill defines “relative” for purposes of the Act. The term “relative” is not currently defined in the Act. The proposed definition clarifies who qualifies as a relative for the public records exemption for information related to a patient’s relative in a patient’s record and for receiving a copy of facility’s inspection report.

¹⁴ S. 408.810(8), F.S.

¹⁵ Rule 59A-35.062, F.A.C.

¹⁶ Under s. 435.04, F.S., a level 2 screening includes fingerprinting for statewide criminal history checks through the Department of Law Enforcement and national criminal history records check through the Federal Bureau of Investigations, and may include local criminal records checks through local law enforcement agencies.

¹⁷ S. 435.04(2), F.S., provides a list of prohibited offenses.

¹⁸ FDLE, *Criminal History Records Checks/Background Checks Fact Sheet*, (Feb. 14, 2017), available at https://www.fdle.state.fl.us/cms/Criminal-History-Records/Documents/BackgroundChecks_FAQ.aspx (last visited November 27, 2017)

¹⁹ FBI, “Next Generation Identification (NGI),” available at <https://www.fbi.gov/services/cjis/fingerprints-and-other-biometrics/ngi> (last visited November 27, 2017).

Additionally, the bill grants AHCA rule-making authority to govern the circumstances under which a controlling interest of a licensed facility, an administrator, an employee, a contractor, or a representative thereof, who is not a relative of the patient or client, can act as the patient's or client's legal representative, agent, health care surrogate, power of attorney, or guardian. The bill requires the rules to include disclosure requirements, bonding, restrictions, and patient or client protections.

Unlicensed Activity

The bill deems any unlicensed activity, which constitutes harm that materially affects the health, safety, and welfare of clients, as abuse and neglect as defined under ch. 415, F.S. The change allows vulnerable adults receiving health or custodial care from an unlicensed provider to be eligible for adult protective services from DCF.

Ownership

The bill exempts a change of ownership applicant from demonstrating proof of financial ability to operate if the current licensee has been operational for five years and:

- Due to a corporate reorganization, the controlling interest does not change, or
- Due to the death of a controlling interest, the licensee changes but the remaining ownership holds more than 51 percent after the change.

The bill requires a licensee, during the license application process, to ensure that no person applying for a license has held or currently holds ownership interest in another licensed provider that has had a license or change of ownership application denied, revoked, or excluded. This patient safety provision allows AHCA to exclude bad actors from owning, directly or indirectly, a licensed facility.

Hospice Licensure

The bill removes the requirement for an existing licensed health care provider to provide a copy of the most recent profit-loss statement and licensure inspection report with his or her application for hospice licensure. Profit-loss statements and proof of financial ability are already required to be collected pursuant to the Act and licensure inspection reports for all health care providers are readily available via the internet.

Expiration Dates

The bill allows a licensee that holds a license for multiple providers to request alignment of all license expiration dates. AHCA is permitted to prorate a licensure fee for an abbreviated licensure period resulting from the alignment. AHCA and licensees with multiple provider licenses should realize greater efficiency in the licensure process.

The bill makes conforming changes to ss. 400.933 and 400.980, F.S., to reflect the new requirements of health care facility licensing proposed by the bill.

Background Investigations

Currently, a background screening for an employee of a licensee that is a controlling interest is only initiated if AHCA has evidence of a conviction of a disqualifying offense. This provision limits AHCA's ability to properly vet potential facility operators and conflicts with Medicaid screening requirements. The bill amends the language for background screening requirements to include background screenings for all employees of a licensee that are a controlling interest.

The bill excludes from employment with licensees persons who have been arrested for and are awaiting final disposition of domestic violence offense. Under current law, to be excluded from employment for a domestic violence offense, a person must have been found guilty of or have entered a plea of nolo contendere or guilty to such offense.²⁰

The bill also amends language to require contractors who work 20 or more hours a week and provide personal care or service and have access to client funds or personal property, or living area to have a Level 2 screening. This change allows for consistency in screening standards for contractors who are performing the same duties as employees of facilities, but are currently not required to be screened.

Clinical Laboratories

Background

A clinical laboratory is the physical location in which services are performed to provide information or materials for use in the diagnosis, prevention, or treatment of a disease or the identification or assessment of a medical or physical condition.²¹ Services performed in clinical labs include:

- The examination of fluids or other materials taken from the human body;²²
- The examination of tissue taken from the human body;²³ and
- The examination of cells from individual tissues or fluid taken from the human body.²⁴

Clinical laboratories are regulated under part I of ch. 483, F.S. In keeping with federal law and regulations, clinical laboratories must meet appropriate standards.²⁵ Such standards include overall standards of performance that comply with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA), and the federal rules adopted thereunder, for a comprehensive quality assurance program²⁶ and standards of performance in the examination of specimens for clinical laboratory proficiency testing programs using external quality control procedures.²⁷ AHCA may impose an administrative fine of up to \$1,000 per violation of any statute or rule.²⁸ In determining the penalty to be imposed for a violation, AHCA must consider the following factors:

- The severity of the violation.
- Actions taken by the licensee to correct the violation or to remedy the complaint.
- Any previous violation by the licensee.
- The financial benefit to the licensee of committing or continuing the violation.²⁹

In 1993, Florida enacted legislation requiring all facilities, including doctor's offices, performing clinical laboratory testing to be licensed.³⁰ AHCA previously issued two types of clinical laboratory licenses: one for laboratories that only performed waived testing and one for laboratories that performed non-waived testing.³¹ Waived tests are simple laboratory examinations and procedures that have an

²⁰ S. 435.04(3), F.S.

²¹ S. 483.041, F.S.

²² S. 483.041(2)(a), F.S.

²³ S. 483.041(2)(b), F.S.

²⁴ S. 483.041(2)(c), F.S.

²⁵ S. 483.021, F.S.

²⁶ S. 483.051(2)(a), F.S.

²⁷ S. 483.051(2)(b), F.S.

²⁸ S. 483.221(1), F.S.

²⁹ S. 483.221(2)(a)-(d), F.S.

³⁰ Id.

³¹ Agency for Health Care Administration, *Clinical Laboratory Regulation in Florida*, pg. 2, available at http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Laboratory_Licensure/docs/clin_lab/OverviewBrochure_lab.pdf (last visited November 20, 2017).

insignificant risk of erroneous result; any other tests are considered non-waived.³² In 2009, the requirement for laboratories that performed waived testing to obtain a state license was repealed. However, facilities performing any non-waived clinical laboratory testing or testing using microscopes must obtain a clinical laboratory license before the laboratory is authorized to perform testing.³³ Currently, all clinical laboratories performing non-waived testing in Florida must hold both a valid state license and federal CLIA certificate.³⁴

Clinical Laboratory Improvement Amendments of 1988

The federal Centers for Medicare & Medicaid Services (CMS), within the United States Department of Health and Human Services, regulates all laboratory testing performed on humans in the United States through the CLIA.³⁵ The purpose of the CLIA program is to establish quality standards for all laboratory testing to ensure accuracy, reliability, and timeliness of test results regardless of where the test was performed.³⁶ The Division of Laboratory Services, within the Survey and Certification Group, under the Center for Clinical Standards and Quality in CMS has the responsibility for implementing the CLIA Program, including laboratory registration, fee collection, onsite surveys, and enforcement.³⁷ In total, CLIA covers approximately 254,000 laboratory entities.³⁸

In 1992, the federal government required all facilities, including doctor's offices, performing clinical laboratory testing to register with the CLIA program.³⁹ The CLIA program issues five types of certificates:

- Certificate of Waiver – Issued to a laboratory that performs only waived tests;
- Certificate of Provider-Performed Microscopy Procedures⁴⁰ - Issued to a laboratory in which a physician, midlevel practitioner, or dentist performs specific microscopy procedures during the course of a patient's visit. This certificate permits the laboratory to also perform waived tests;
- Certificate of Registration – Issued to a laboratory to allow the laboratory to conduct nonwaived testing until the laboratory is inspected to determine its compliance with CLIA regulations;
- Certificate of Compliance - Issued to a laboratory after a survey is conducted and the laboratory is found to be in compliance with all applicable CLIA requirements; and
- Certificate of Accreditation - Issued to a laboratory on the basis of the laboratory's accreditation by an accreditation organization approved by the CMS.⁴¹

³² Examples of waived tests include urine dipstick, blood glucose, etc. A full list of waived tests can be found at <https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/analyteswaived.cfm> (last visited November 20, 2017).

³³ Agency for Health Care Administration, *Clinical Laboratories*, 2017, available at http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Laboratory_Licensure/non-waived_apps.shtml (last visited November 20, 2017).

³⁴ Id. In an effort to streamline the licensing process, Florida enacted comprehensive basic licensure requirements under part II of ch. 408, F.S. that impacted all facilities licensed by AHCA, including clinical laboratories. Health care facility licensing procedures can also be found in Chapter 59A-35, F.A.C.

³⁵ Centers for Medicare & Medicaid Services, *Clinical Laboratory Improvement Amendments (CLIA)*, available at https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html?redirect=/CLIA/10_Categorization_of_Tests.asp (last visited November 20, 2017).

³⁶ Department of Health and Human Services, Office of the Inspector General, *Enrollment and Certification Processes in the Clinical Laboratory Improvement Amendments Program*, (Aug. 2001), available at <https://oig.hhs.gov/oei/reports/oei-05-00-00251.pdf> (last visited November 20, 2017)

³⁷ Id.

³⁸ Supra, FN 31.

³⁹ Supra, FN 31.

⁴⁰ Center for Surveillance, Epidemiology, and Laboratory Services, *Provider-Performed Microscopy Procedures: A Focus on Quality Practices*, February 2016, available at https://wwwn.cdc.gov/clia/Resources/PPMP/pdf/15_258020-A_Stang_PPMP_Booklet_FINAL.pdf (last visited November 20, 2017). PPMPs are a select group of moderately complex microscopy tests commonly performed by health care providers during patient office visits. Tests included in PPMP do not meet the criteria for waiver because they are not simple procedures, but rather require training and specific skills to conduct such tests.

⁴¹ Centers for Medicare and Medicaid Services, *Clinical Laboratory Improvement Amendments (CLIA): How to Obtain a CLIA Certificate*, (March 2006), available <https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html>

Alternate Site Laboratory Testing

Generally, a hospital's main or central laboratory or satellite laboratories that are licensed clinical laboratories established on the same or adjoining grounds of a hospital licensed under ch. 395, F.S., may perform clinical laboratory testing.⁴² Testing at satellite labs must be done by licensed clinical laboratory personnel. Section 483.051(9), F.S., allows for alternate-site testing, which is any laboratory testing done under the administrative control of a hospital, but performed out of the physical or administrative confines of the hospital's central laboratory. This allows tests to be performed bedside, at a nurse station, in an operating room or the emergency room, or anywhere else under the administrative control of a hospital. AHCA has rulemaking authority, in consultation with the Board of Clinical Laboratory Personnel, to adopt criteria for alternate-site testing to be performed under the supervision of a clinical laboratory director.

Effect of the Bill – Clinical Laboratories

The bill repeals part I of ch. 483, F.S., which regulates clinical laboratories. Clinical laboratories that perform testing on specimens from within the state will no longer be required to obtain state licensure. Clinical laboratories will continue to be certified by the CLIA program under federal law.⁴³ Such certification is required for a clinical laboratory to provide testing services in Florida.

The bill defines clinical laboratory and clinical laboratory examination for clinical laboratory personnel by relocating the existing definitions from the provisions being repealed.

The bill moves language which grants AHCA rulemaking authority to adopt criteria for alternate-site testing to be performed under the supervision of a clinical laboratory director, to s. 395.0091, F.S.

The bill moves language being struck in s. 483.245(1), F.S., prohibiting clinical laboratory rebates, to the section on general authority concerning kickbacks, s. 456.054, F.S.

The bill also makes conforming changes to the following statutes to reflect the repeal of state licensure requirements for clinical laboratories: ss. 20.43(3)(g), 381.0034, 381.0031(2), 381.004, 383.313(1), 384.31, 395.009, 395.7015(2)(b), 400.9905(4), 400.0625(1), 408.033(2)(a), 408.07(11), 408.802, 408.806, 408.820(26), 409.905(7), 456.001, 456.057, 483.294, 483.801(3), 483.803, 483.813, 491.003, F.S., 627.351(4)(h), 766.202(4), and 945.36(1), F.S.

Health Care Risk Managers

Background

A health care risk manager assesses and minimizes various risks to staff, patients, and the public in a health care organization,⁴⁴ and can play a role in reducing safety, finance, and patient problems in the organization or facility.⁴⁵ Health care risk managers may perform such duties as event and incident risk management; clinical, financial, legal, and general business responsibilities; statistical analysis; and

[Guidance/Legislation/CLIA/Downloads/HowObtainCLIACertificate.pdf](#) (last visited November 20, 2017). All certificates are effective for two years.

⁴² Rule 59A-7.034, F.A.C.

⁴³ Agency for Health Care Administration, *2018 Agency Legislative Bill Analysis*, November 14, 2017 (on file with the Health and Human Services Committee).

⁴⁴ Healthcare Administration Degree Programs, *What is a Health Care Risk Manager?*, available at <http://www.healthcare-administration-degree.net/faq/what-is-a-health-care-risk-manager/> (last viewed November 20, 2017).

⁴⁵ *Id.*

claims management.⁴⁶ However, the job description of a health care risk manager is unique to the organization at which he or she is employed.

Every hospital and ambulatory surgical center (ASC) licensed under part I of ch. 395, F.S., is required to establish and maintain an internal risk management program that is overseen by a health care risk manager.⁴⁷ The purpose of the risk management program is to control and prevent medical accidents and injuries.⁴⁸ The internal risk management program must include:

- A process to investigate and analyze the frequency and causes of adverse incidents to patients;
- Appropriate measures to minimize the risk of adverse incidents to patients;
- The analysis of patient grievances that relate to patient care and the quality of medical services;
- A system for informing a patient or an individual that she or he was the subject of an adverse incident; and
- An incident reporting system which allows for the reporting of adverse incidents to the risk manager within 3 business days after their occurrence.⁴⁹

Licensure of Health Care Risk Managers

Florida is the only state to require the licensure of health care risk managers.⁵⁰ Health care risk managers are licensed by AHCA. To qualify for licensure, an applicant must demonstrate competence, by education or experience, in:

- Applicable standards of health care risk management;
- Applicable federal, state, and local health and safety laws and rules;
- General risk management administration;
- Patient care;
- Medical care;
- Personal and social care;
- Accident prevention;
- Departmental organization and management;
- Community interrelationships; and
- Medical terminology.⁵¹

AHCA must issue a license to an applicant who affirmatively proves that he or she is:

- 18 years of age or over; and
- A high school graduate or equivalent; and
 - Has fulfilled the requirements of a 1-year program or its equivalent in health care risk management training which may be developed or approved by AHCA;
 - Has completed 2 years of college-level studies which would prepare the applicant for health care risk management, to be further defined by rule; or
 - Has obtained 1 year of practical experience in health care risk management.⁵²

⁴⁶ American Society for Healthcare Risk Management, *Overview of the Healthcare Risk Management Profession*, available at http://www.ashrm.org/about/HRM_overview.dhtml (last visited November 20, 2017).

⁴⁷ S. 395.0197(1)-(2), F.S.

⁴⁸ S. 395.10971, F.S.

⁴⁹ S. 395.0197(1)(a)-(d), F.S.

⁵⁰ American Society for Healthcare Risk Management, *A Brief History of ASHRM 1980-2010... 30 Years and Counting!*, 2010, pg. 7., available at http://www.ashrm.org/about/files/A_Brief_History_of_ASHRM.pdf (last visited November 20, 2017).

⁵¹ S. 395.10974(1), F.S.

⁵² S. 395.10974(2), F.S.

AHCA currently licenses 2,458 health care risk managers and 602, or 24.5 percent, report working in a licensed capacity for at least one hospital or ASC.⁵³ On average, for the past five years, approximately 174 initial applications for licensure are received and 181 licensees fail to renew each year.⁵⁴

Denial, Suspension, or Revocation of a License

AHCA may deny, suspend, revoke, or refuse to renew or continue the license of an applicant or health care risk manager for various grounds, including submitting false information in a license application, unlicensed practice, various criminal disqualifications, and the following:

- Repeatedly acting in a manner inconsistent with the health and safety of the patients of the licensed facility in which the licensee is the health care risk manager;
- Being unable to practice health care risk management with reasonable skill and safety to patients by reason of illness; drunkenness; or use of drugs, narcotics, chemicals, or any other material or substance or as a result of any mental or physical condition;
- Willfully permitting unauthorized disclosure of information relating to a patient or a patient's records; or
- Discriminating against patients, employees, or staff on account of race, religion, color, sex, or national origin.⁵⁵

When a health care risk manager fails to complete his or her tasks, the licensed facility is cited for any applicable violations, not the health care risk manager. Health care risk managers are exempt from monetary liability for any act or proceeding performed within the scope of the internal risk management program if the risk manager acts without intent to defraud.⁵⁶ In the last 5 years, AHCA received three complaints against health care risk managers. The complaints involved allegations for which AHCA does not have regulatory and disciplinary authority such as practicing law without a license and activities of the individuals as claims adjusters for an insurance company not as the risk manager of a licensed facility.⁵⁷

Health Care Risk Manager Advisory Council

Current law authorizes AHCA to establish a seven-member Health Care Risk Manager Advisory Council (Council) to advise AHCA on health care risk manager issues.⁵⁸ If the Council is established, it must consist of:

- Two active health care risk managers, including one risk manager who is recommended by and a member of the Florida Society of Healthcare Risk Management.
- One active hospital administrator.
- One employee of an insurer or self-insurer of medical malpractice coverage.
- One public representative.
- Two licensed health care practitioners, one of whom must be a physician licensed under ch. 458 or ch. 459.⁵⁹

Currently, there are no appointed Council members and there have been no Council meetings for at least ten years.⁶⁰

⁵³ Supra, FN 43.

⁵⁴ Id.

⁵⁵ S. 395.10975(1), F.S.

⁵⁶ S. 395.0197(16), F.S.

⁵⁷ E-mail correspondence with AHCA staff, December 14, 2017 (on file with the Health and Human Services Committee).

⁵⁸ S. 395.10972, F.S.

⁵⁹ S. 395.10972(1)-(5), F.S.

⁶⁰ Supra, FN 43.

Effect of the Bill – Health Care Risk Managers

The bill repeals health care risk manager licensure requirements and the Council. Licensed facilities must maintain an internal risk management program, but may hire any risk manager to run the program who meets criteria established by each facility. Repeal of the Council is appropriate if the health care risk manager licensure requirements are repealed.

The bill also makes conforming changes to the following statutes to reflect the repeal of the health care risk manager program and the Council: ss. 395.0197(2)(c), 395.10973, 408.802, 408.820(10) & (11), 458.307, and 641.55, F.S.

Assisted Living Facilities

Background

Licensure

An assisted living facility (ALF) is a residential establishment, or part of a residential establishment, that provides housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.⁶¹ A personal service is direct physical assistance with, or supervision of, the activities of daily living and the self-administration of medication.⁶² Activities of daily living include ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks.⁶³

ALFs are licensed and regulated by AHCA under part I of ch. 429, F.S., and part II of ch. 408, F.S.⁶⁴ In addition to a standard license, an ALF may have one or more specialty licenses that allow the ALF to provide additional care. These specialty licenses include limited nursing services,⁶⁵ limited mental health services,⁶⁶ and extended congregate care services.⁶⁷ The Department of Elder Affairs (DOEA) is responsible for establishing training requirements for ALF administrators and staff.⁶⁸

As of November 20, 2017, there are 3,108 licensed ALFs in Florida with 98,833 beds.⁶⁹

⁶¹ S. 429.02(5), F.S. An ALF does not include an adult family-care home or a non-transient public lodging establishment.

⁶² S. 429.02(16), F.S.

⁶³ S. 429.02(1), F.S.

⁶⁴ Under s. 429.04, F.S., the following are exempt from licensure: ALFs operated by an agency of the federal government; facilities licensed under ch. 393, F.S., relating to individuals with developmental disabilities; facilities licensed under ch. 394, F.S., relating to mental health; licensed adult family care homes; a person providing housing, meals, and one or more personal services on a 24-basis in the person's own home to no more than 2 adults; certain facilities that have been incorporated in this state for 50 years or more on or before July 1, 1983; certain continuing care facilities; certain retirement facilities; and residential units located within a community care facility or co-located with a nursing home or ALF in which services are provided on an outpatient basis.

⁶⁵ S. 429.07(3)(c), F.S. Limited nursing services include acts that may be performed by a person licensed nurse but are not complex enough to require 24-hour nursing supervision and may include such services as the application and care of routine dressings, and care of casts, braces, and splints (s. 429.02(13), F.S.)

⁶⁶ S. 429.075, F.S. A facility that serves one or mental health residents must obtain a licensed mental health license. A limited mental health ALF must assist a mental health patient in carrying out activities identified in the resident's community support living plan. A community support plan is written document that includes information about the supports, services, and special needs of the resident to live in the ALF and a method by which facility staff can recognize and respond to the signs and symptoms particular to that resident which indicate the need for professional services (s. 429.02(7), F.S.)

⁶⁷ S. 429.07(3)(b), F.S. Extended congregate care facilities provide services to an individual that would otherwise be ineligible for continued care in an ALF. The primary purpose is to allow a resident the option of remaining in a familiar setting from which they would otherwise be disqualified for continued residency as they become more impaired.

⁶⁸ S. 429.52, F.S.

⁶⁹ Agency for Health Care Administration, *Facility/Provider Search Results-Assisted Living Facilities*, available at <http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx> (report generated on November 20, 2017).

An ALF administrator is responsible for the operation and maintenance of an ALF.⁷⁰ Administrators must meet minimum training and education requirements established by DOEA. The training and education requirements allow administrators to assist ALFs to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements.⁷¹ The required training and education must cover, at least, the following topics:

- State law and rules applicable to ALFs;
- Resident rights and identifying and reporting abuse, neglect, and exploitation;
- Special needs of elderly persons, persons with mental illness, and persons with developmental disabilities, and how to meet those needs;
- Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food;
- Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication;
- Fire safety requirements, including fire evacuation drill procedures and other emergency procedures; and
- Care of persons with Alzheimer's disease and related disorders.⁷²

All ALF administrators and managers must successfully complete ALF core training course and pass a competency test within 3 months from the date of becoming an ALF administrator.⁷³ Administrators must complete at least 12 contact hours of continuing education every 2 years.⁷⁴ Effective October 1, 2015, each new ALF administrator or manager, who has not previously completed core training, must attend a preservice orientation provided by the ALF before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of ALF residents.⁷⁵

An ALF must provide appropriate care and services to meet the needs of the residents admitted to the facility.⁷⁶ The owner or facility administrator determines whether an individual is appropriate for admission to the facility based on certain criteria.⁷⁷ If a resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, as determined by the facility administrator or a health care provider, the resident must be discharged in accordance with the Resident Bill of Rights.⁷⁸

Unlicensed Assisted Living Facilities

All facilities that meet the definition of an ALF must be licensed except:

- A facility, institution, or other place operated by the federal government;
- A facility licensed under ch. 393, F.S.,⁷⁹ or ch. 394, F.S.;⁸⁰
- A facility licensed as an adult family-care home;
- Any person who provides housing, meals, and one or more personal services⁸¹ on a 24-hour basis in the person's own for to not more than two adults who do not receive optional state

⁷⁰ S. 429.02(2), F.S.

⁷¹ S. 429.52(2), F.S.

⁷² S. 429.52(3), F.S.

⁷³ Rule 58A-5.0191(a), F.A.C.

⁷⁴ S. 429.52(5), F.S.

⁷⁵ S. 429.52(1), F.S.

⁷⁶ For specific minimum standards, see Rule 58A-5.0182, F.A.C.

⁷⁷ S. 429.26, F.S., and Rule 58A-5.0181, F.A.C.

⁷⁸ S. 429.28, F.S.

⁷⁹ These include facilities licensed by the Agency for Persons with Disabilities for individuals with developmental disabilities.

⁸⁰ These include mental health facilities licensed by AHCA, in consultation with the Department of Children and Families.

supplementation.⁸² The person providing the housing, meals, and personal services must own or rent the home and reside therein;

- Certain homes or facilities approved by the U.S. Department of Veterans Affairs;
- Certain facilities that have been incorporated in this state for 50 years or more on or before July 1, 1983;
- Any facility licensed under ch. 651, F.S., as a continuing care retirement community, or a retirement community that provide certain services to its residents who live in single-family homes, duplexes, quadraplexes, or apartments on its campus under certain conditions; and
- A residential unit for independent living located within a facility certified under ch. 651, F.S., or co-located with a licensed nursing home.⁸³

A person who owns, operates, or maintains an unlicensed ALF commits a felony of the third degree.⁸⁴ Any person found guilty of operating an unlicensed ALF a second or subsequent time commits a felony of the second degree.⁸⁵ Health care practitioners must report an unlicensed ALF to AHCA.⁸⁶ Any provider who knowingly discharges a patient to an unlicensed ALF is subject to sanction by AHCA.⁸⁷ AHCA works with the Department of Children and Families, the Attorney General's Medicaid Fraud Control Unit,⁸⁸ Medicaid Program Integrity, and DOEA when unlicensed activity is discovered.⁸⁹

If a person operates an unlicensed ALF due to a change in the law or rules adopted thereunder within 6 months after the effective date of the change, a facility must apply for a license or cease operation within 10 working days of receiving notification from AHCA.⁹⁰ Failure to comply is a felony of the third degree.⁹¹ Each day of continued operation is considered a separate offense.⁹²

In the last 5 years, AHCA conducted 632 investigations involving unlicensed ALFs, 238 of which were substantiated.⁹³

Inspections, Surveys and Monitoring Visits

Current law authorizes AHCA to inspect each licensed ALF at least once every 24 months to determine compliance with statutes and rules. Section 408.813, F.S. categorizes violations into four classes according to the nature and gravity of its probable effect on residents. If an ALF is cited for a class I violation or three or more class II violations arising from separate surveys within a 60-day period or due to unrelated circumstances during the same survey, AHCA must conduct an additional licensure

⁸¹ S. 429.02(17), F.S. defines personal services as "direct physical assistance with supervision of the activities of daily living, and the self-administration of medicine, and other similar services which the department may define by rule."

⁸² Optional State Supplementation is a cash assistance program that supplements the income of eligible individuals to help them pay for room and board. The program is funded entirely by state general revenue. In most instances, the maximum monthly payment is \$78.40. AHCA, *Optional State Supplementation*, available at http://www.fdhc.state.fl.us/SCHS/ALWG/archived/docs/2011/2011-11-07_08/OSSFACT-102011.pdf (last visited November 20, 2017).

⁸³ S. 429.04, F.S.

⁸⁴ S. 429.08(1)(b), F.S.

⁸⁵ S. 429.08(1)(c), F.S.

⁸⁶ S. 429.08(2)(a), F.S.

⁸⁷ S. 429.08(2)(b), F.S.

⁸⁸ The Medicaid Fraud Control Unit investigates and prosecutes Medicaid provider fraud, as well as allegations of patient, abuse, neglect, and exploitation in facilities receiving payments under the Medicaid program, such as nursing homes and assisted living facilities. Office of the Attorney General, *Medicaid Fraud Control Unit*, available at <http://www.myfloridalegal.com/pages.nsf/Main/EBC480598BBF32D885256CC6005B54D1> (last visited November 20, 2017).

⁸⁹ Supra, FN 43.

⁹⁰ S. 429.08, F.S.

⁹¹ Id. A felony in the third degree is punishable by a term of imprisonment of up to 5 years (s. 775.082, F.S.), and a fine of up to \$5,000 (s. 775.083, F.S.)

⁹² S. 429.08(1)(d), F.S.

⁹³ Supra, FN 43.

inspection within six months.⁹⁴ Similarly, the Resident Bill of Rights requires AHCA to perform a biennial survey to determine whether a facility is adequately protecting residents' rights.⁹⁵

During any calendar year in which no survey is performed, AHCA may conduct at least one monitoring visit of a facility, as necessary, to ensure compliance of a facility with a history of certain violations that threaten the health, safety, or security of residents. If warranted, AHCA will perform an inspection as a part of a complaint investigation of alleged noncompliance with the Resident Bill of Rights.⁹⁶

Facilities with limited nursing services (LNS) or extended congregate care (ECC) licenses are subject to monitoring visits by AHCA to inspect the facility for compliance with the requirements of the specialty license type. An LNS licensee is subject to monitoring inspections at least twice a year. At least one registered nurse must be included in the inspection team to monitor residents receiving LNS and to determine if the facility is complying with applicable regulatory requirements. An ECC licensee is subject to quarterly monitoring inspections. At least one registered nurse must be included in the inspection team. AHCA may waive one of the required yearly monitoring visits for an ECC facility that has been licensed for at least 24 months, if the registered nurse who participated in the monitoring inspections determines that the ECC services are being provided appropriately and there are no serious violations or substantiated complaints about the quality of service or care.

Penalties

Under s. 408.813, F.S., ALFs are subject to administrative fines imposed by AHCA for certain types of violations. In addition, AHCA can take other actions against a facility. AHCA may deny, revoke, or suspend any license for any of the actions listed in s. 429.14(1)(a)-(k), F.S., such as an intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility or a determination by AHCA that the owner lacks the financial responsibility to provide continuing adequate care to residents. AHCA must deny or revoke the license of an ALF with two or more class I violations that are similar to violations identified during a survey, inspection, monitoring visit, or complaint investigation occurring within the previous 2 years.⁹⁷ AHCA may also impose an immediate moratorium or emergency suspension on any provider if it determines that any condition presents a threat to the health, safety, or welfare of a client.⁹⁸ AHCA is required to publicly post notification of a license suspension or revocation, or denial of a license renewal, at the facility.⁹⁹ Finally, ch. 825, F.S., provides criminal penalties for the abuse, neglect, and exploitation of elderly persons¹⁰⁰ and disabled adults.¹⁰¹

Resident Contracts

All residents of an ALF must be covered by a contract, executed at or before the time of admission, between the resident and the ALF.¹⁰² Each contract must specifically describe the services and accommodations to be provided by the facility, along with the charges and rates. The contract must also include provision that requires the ALF to give at least 30 days written notice of a rate increase.

⁹⁴ S. 429.34(2), F.S.

⁹⁵ S. 429.28(3), F.S.

⁹⁶ Id.

⁹⁷ S. 429.14(4), F.S.

⁹⁸ S. 408.814(1), F.S.

⁹⁹ S. 429.14(7), F.S.

¹⁰⁰ "Elderly person" means a person 60 years of age or older who is suffering from the infirmities of aging as manifested by advanced age or organic brain damage, or other physical, mental, or emotional dysfunction, to the extent that the ability of the person to provide adequately for the person's own care or protection is impaired. S. 825.101(5), F.S. It does not constitute a defense to a prosecution for any violation of ch. 825, F.S., that the accused did not know the age of the victim. S. 825.104, F.S.

¹⁰¹ "Disabled adult" means a person 18 years of age or older who suffers from a condition of physical or mental incapacitation due to a developmental disability, organic brain damage, or mental illness, or who has one or more physical or mental limitations that restrict the person's ability to perform the normal activities of daily living. S. 825.101(4), F.S.

¹⁰² S. 429.24, F.S.

Assistance to Residents

An ALF may provide assistance to a resident who is medically stable with self-administration of a routine, regularly scheduled medication that is intended to be self-administered if there is a documented request by and the written informed consent of the resident.¹⁰³ This assistance includes, among other things:

- Taking a medication from where it is stored and bring it to the resident;
- In the presence of the resident, reading the label, opening the container, removing the prescribed amount from the container, and closing the container;
- Placing the dosage in the resident's hand or in another container and lifting the container to the resident's mouth;
- Returning medication to proper storage; and
- Maintaining a record of when a resident receives assistance with self-administration.¹⁰⁴

Under the Resident's Bill of Rights, the ALF must provide its residents with access to adequate and appropriate health care. An ALF may not be able to provide all health care needed for a resident but may facilitate the provision of such health care services.

Effect of the Bill – Assisted Living Facilities.

ALF Licensure Compliance

Currently, a facility administrator must complete core educational requirements prior to or within a reasonable time of assuming his or her position. The bill requires administrators complete the core educational requirements within 90 days of the date of employment at an ALF. The bill prohibits a facility from operating for more than 120 consecutive days without an administrator who has completed core educational requirements.

Current law exempts from ALF licensure an individual who provides housing, meals, and one or more personal services on a 24-hour basis in the individual's own home to two or more adults who do not receive optional state supplementation.¹⁰⁵ The bill requires that the individual must establish the home as his or her permanent residence. The bill establishes a presumption that if the individual asserts a homestead exemption at an address other than the address used for the exemption from licensure, that the address is not his or her permanent residence. This exemption does not apply to an individual or entity that previously held a license that was revoked, denied renewal, or voluntarily relinquished during an enforcement proceeding.

ALF Unlicensed Activity

Under current law, there are several exemptions from ALF licensure. The bill creates additional exemptions:

- Hospitals licensed under ch. 395, F.S.;
- Nursing homes licensed under part II of ch. 400, F.S.;
- Inpatient hospices licensed under part IV of ch. 400, F.S.;

¹⁰³ S. 429.256(2), F.S.

¹⁰⁴ S. 429.256(3)(a), F.S. A resident may also receive assistance with applying topical medications, using a nebulizer, using a glucometer to perform blood-glucose level checks, putting on and taking off anti-embolism stockings, applying and removing an oxygen cannula, the use of a continuous airway pressure device, measuring vital signs, and colostomy bags.

¹⁰⁵ S. 429.04(1)(d), F.S.

- Homes for special services licensed under part V of ch. 400, F.S.;
- Intermediate care facilities licensed under part VIII of ch. 400, F.S.; and
- Transitional living facilities licensed under part XI of ch. 400, F.S.

In an AHCA investigation of a complaint of unlicensed activity, the bill places the burden of proving that an individual or entity is exempt from licensure on the individual or entity claiming the exemption.

The bill makes it a third degree felony to own, operate, or maintain an unlicensed ALF after receiving notice from AHCA. Under current law, a person has 10 days from the date of notification to apply for a license or cease operations before he or she is regarded as committing a felony of the third degree. The bill eliminates the 10-day waiting period.

The bill modifies the definition of “personal services” to close loopholes taken advantage of by unlicensed providers. Because s. 429.02(17), F.S., defines personal services as “direct physical assistance with supervision of the activities of daily living, *and* the self-administration of medicine, *and* other similar services which the department may define by rule,” the statute could be interpreted to require all of the criteria be met in order to meet the definition of personal services. As an example, an unlicensed provider giving multiple patients assistance with medication would not meet the definition because the unlicensed provider was also not giving direct physical assistance with the activities of daily living. The bill changes the definition of “personal services” to direct physical assistance with supervision of the activities of daily living, *or* the self-administration of medicine, *or* other similar services which the department may define by rule.” The change allows AHCA to prosecute unlicensed providers who meet any of the criteria in the definition rather than only providers that meet all of the criteria.

ALF Inspections and Surveys

Currently, AHCA must inspect an ALF every 24 months. The bill aligns the inspection schedule with the core licensing statute (ch. 408, F.S.), by requiring that re-licensure inspections be conducted biennially. This will provide AHCA with more flexibility in scheduling inspections. The bill retains and relocates the authority to conduct monitoring visits in calendar years in which a survey is not performed from the Resident Bill of Rights to the statutory section on inspections.

ALF Resident Contracts

Current law requires an ALF to provide a resident a 30-day written notice of a rate increase; however, it is unclear whether the notice requirement also applies to service changes. Under the bill, a facility does not have to provide a resident 30-day written notice if it offers a new service or if an accommodation is amended or implemented in a resident’s contract for which the ALF did not previously charge the resident. For example, if a resident returns from a hospital stay with a new need for wound care, the resident’s personal services plan would be amended immediately and the resident would begin receiving the new care immediately, while the assisted living facility would be able to begin charging immediately.

ALF Assistance to Residents

Current law governing assistance with self-administered medications requires that the ALF employee to read the medication label every time the assistance is provided. The bill authorizes an ALF resident to decline the reading of a label at each time of assistance.

Currently, the Resident Bill of Rights states that a resident has the right to assistance from the ALF in obtaining access to adequate and appropriate health care. The bill clarifies this right by defining such assistance as the management of medication, assistance in making appointments for health care

services, providing transportation to health care appointments, and performing certain other health care services by appropriately licensed personnel or volunteers, including:

- Taking resident vital signs;
- Managing pill organizers for residents who self-administer medication;
- Give prepackaged enemas ordered by a physician;
- Observe and document residents and report such observations to the resident's physician;
- In an emergency, exercise professional duties until emergency medical personnel assume responsibility for care; and
- For facilities with 17 or more beds, have a functioning automated external defibrillator on the premises at all times.

Current law requires an ALF to provide a copy of the resident's complete records within 10 days, upon the request of a resident or his or her representative. The bill requires an ALF to respond to such requests in the same timeframe as required for nursing homes, which is within 14 working days of a request for a current resident and within 30 days for a request relating to a former resident.¹⁰⁶

Mobile Surgical Facilities

Background

Section 395.002(21), F.S., defines a "mobile surgical facility" as:

[A] mobile facility in which licensed health care professionals provide elective surgical care under contract with the Department of Corrections or a private correctional facility operating pursuant to ch. 957 and in which inmate patients are admitted to and discharged from said facility within the same working day and are not permitted to stay overnight. However, mobile surgical facilities may only provide health care services to the inmate patients of the Department of Corrections, or inmate patients of a private correctional facility operating pursuant to ch. 957, and not to the general public.

In addition, section 395.002(3), F.S., defines "mobile surgical facility", along with "ambulatory surgical center", as:

[A] facility the primary purpose of which is to provide elective surgical care, in which the patient is admitted to and discharged from such facility within the same working day and is not permitted to stay overnight, and which is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy, an office maintained by a physician for the practice of medicine, or an office maintained for the practice of dentistry shall not be construed to be an ambulatory surgical center, provided that any facility or office which is certified or seeks certification as a Medicare ambulatory surgical center shall be licensed as an ambulatory surgical center pursuant to s. 395.003. Any structure or vehicle in which a physician maintains an office and practices surgery, and which can appear to the public to be a mobile office because the structure or vehicle operates at more than one address, shall be construed to be a mobile surgical facility.

¹⁰⁶ S. 400.145, F.S.

AHCA licenses and regulates mobile surgical facilities.¹⁰⁷ The initial application for licensure must include:

- Proof of fictitious name registration, if applicable;
- Articles of Incorporation or a similarly titled document registered by the applicant with the Florida Department of State; and
- The center's zoning certificate or proof of compliance with zoning requirements.¹⁰⁸

After the initial application is filed, AHCA will perform an initial licensure inspection. The documents that must be available for during the initial licensure inspection include:

- The governing board bylaws, rules and regulations, or other written organizational plan;
- A roster of medical staff members;
- A roster of registered nurses and licensed practical nurses with current license numbers; and
- The Comprehensive Emergency Management Plan, pursuant to Rule 59A-5.018, F.A.C.¹⁰⁹

A license fee of \$1,679.82 must accompany an application for an initial, renewal, or change of ownership license for a mobile surgical facility.¹¹⁰ Upon receipt of the required information, AHCA will conduct a licensure inspection to determine compliance with the applicable statutes and rules.¹¹¹ Once the mobile surgical facility is in compliance and has received all approvals, AHCA will issue a license, which identifies the licensee and the name and location of the center.¹¹² AHCA may revoke or deny a license if there has been substantial failure to comply with the applicable statutes and rules.¹¹³

Rule 59A-3.081, F.A.C., sets out the physical plant requirements for a mobile surgical facility, which include staying in compliance with the requirements of the National Fire Protection Association, site requirements, architectural design requirements, mechanical requirements, and electrical system requirements.

Since the enactment of the mobile surgical facility license in statute, no such license has been issued and no applications for the license are anticipated.¹¹⁴

Effect of the Bill – Mobile Surgical Facilities

The bill eliminates the “mobile surgical facility” license from statute by deleting the definition of mobile surgical facility and all other references to such a facility.

The bill also makes conforming changes to the following statutes to reflect the repeal of “mobile surgical facility” definitions from statute: ss. 385.211(2), 395.001, 394.4787(7),

¹⁰⁷ S. 395.003, F.S. and Rule 59A-5.003, F.A.C., contain the licensure provisions for mobile surgical facilities.

¹⁰⁸ Rule 59A-5.003(4)(a)-(c), F.A.C.

¹⁰⁹ Rule 59A-5.003(5), F.A.C.

¹¹⁰ Rule 59A-5.003(7), F.A.C.

¹¹¹ Rule 59A-5.003(12), F.A.C.

¹¹² Rule 59A-5.003(13), F.A.C.

¹¹³ Rule 59A-5.003(15), F.A.C. A “substantial failure to comply” means that there has been a major, or significant, breach of a requirement in law or rule. If a licensee fails to pay its renewal fee after receiving notice, AHCA may find that there is a substantial failure to comply and may suspend or revoke the license.

¹¹⁴ Supra, FN 43.

395.0161(1)(f), 395.0163(3), 395.1055(2), 395.7015(2)(b), 408.036(3)(e), 408.802, and 408.820(10) & (11), 409.975(1), 627.64194(1), 766.118(6)(b), and 766.202(4), F.S.

Hospital Regulation

Background

Hospitals in Florida must be licensed by AHCA. Hospital licensure is governed by part II of ch. 408, F.S., part I of ch. 395, F.S., and associated rules.

State-Operated Hospitals

State-operated hospitals are subject to the same licensure and reporting requirements as other licensed hospitals in the state, except hospitals operated by AHCA and the Department of Corrections are exempt from the requirement to file an annual financial statement. Hospitals operated by the Department of Children and Families (DCF) are not exempt. A primary purpose of the financial statement is to determine the payment each hospital must pay to the Public Medical Assistance Trust Fund (PMATF), which is used to fund health care services to indigent persons.¹¹⁵ An assessment of 1.5% of the annual net operating revenue for inpatient services and 1% for outpatient services is collected.¹¹⁶ Hospitals operated by AHCA and the Department of Corrections are exempt from paying this tax.¹¹⁷

DCF operates seven hospitals and treatment centers statewide:

- Florida State Hospital in Chattahoochee;
- Northeast Florida State Hospital in Macclenny;
- South Florida State Hospital in Pembroke Pines;
- North Florida Evaluation and Treatment Center in Gainesville;
- South Florida Evaluation and Treatment Center in Florida City;
- Treasure Coast Forensic Treatment Center in Indiantown; and
- West Florida Community Care Center in Milton.¹¹⁸

The Department of Corrections (DOC) operates the Reception and Medical Center in Lake Butler, where newly committed male inmates are processed into the corrections system and medical care is provided to inmates.¹¹⁹

Specialty Hospitals

A specialty hospital¹²⁰ is a hospital that offers:

- The range of medical services offered by general hospitals, but restricted to a defined age or gender group of the population; or
- A restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical or psychiatric illnesses or disorders; or
- Intensive residential treatment programs for children and adolescents.¹²¹

¹¹⁵ S. 409.918, F.S.

¹¹⁶ S. 395.701, F.S.

¹¹⁷ Id.

¹¹⁸ Department of Children and Families, *State Mental Health Treatment Facilities*, available at <http://www.myflfamilies.com/service-programs/mental-health/state-mental-health-treatment-facilities> (last visited November 20, 2017).

¹¹⁹ Department of Corrections, *Reception and Medical Center (RMC)*, 2014, available at <http://www.dc.state.fl.us/facilities/region2/209.html> (last visited November 20, 2017).

¹²⁰ S. 395.002(28), F.S.

Specialty hospitals may not provide any service or regularly serve any population group other than those services or groups specified in its license.¹²² However, a specialty-licensed children's hospital that is authorized to provide pediatric cardiac catheterization and pediatric open-heart surgery services may provide cardiovascular service to adults who, as children, were previously served by the hospital for congenital heart disease, or who are referred for a specialized procedure only for congenital heart disease by an adult hospital.¹²³

Also, a specialty-licensed children's hospital that has licensed neonatal intensive care unit beds and is located in a county with a population of 1,750,000 or more may provide obstetrical services for certain high-risk pregnancies. The obstetrical services provided are restricted to the diagnosis, care, and treatment of pregnant women of any age who have documentation by an examining physician that includes information regarding:

- At least one fetal characteristic or condition diagnosed intra-utero that would characterize the pregnancy or delivery as high risk including structural abnormalities of the digestive, central nervous, and cardiovascular systems and disorders of genetic malformations and skeletal dysplasia, acute metabolic emergencies, and babies of mothers with rheumatologic disorders; or
- Medical advice or a diagnosis indicating that the fetus may require at least one perinatal intervention.¹²⁴

There are currently four specialty-licensed children's hospitals in Florida: John Hopkins All Children's Hospital, Nemours Children's Hospital, Nicklaus Children's Hospital, and Shriners Hospitals for Children-Tampa.¹²⁵ All but Shriners Hospitals for Children-Tampa have neonatal intensive care unit beds.¹²⁶ Currently, only Nicklaus Children's Hospital in Miami-Dade County meets the criteria to provide obstetrical services.

Complaint Investigation Procedures

Under the core licensing statute (ch. 408, F.S.), AHCA may inspect or investigate a facility to determine the state of compliance with the core licensing statute, the facility authorizing statutes, and applicable rules.¹²⁷ Inspections must be unannounced, except for those performed pursuant to initial licensure and license renewal. If at the time of the inspection, AHCA identifies a deficiency, the facility must file a plan of correction within 10 calendar days of notification, unless an alternative timeframe is required.

For any violation of the core licensing statute, the facility authorizing statutes, or applicable rules, AHCA may impose administrative fines.¹²⁸ Violations are classified according to the nature of the violation and the gravity of its probable effect on clients:

- Class I violations are those conditions that AHCA determines presents an immediate danger to clients or there is a substantial probability of death or serious physical or emotional harm. These violations must be abated or eliminated within 24 hours unless a fixed period is required for correction.

¹²¹ "Intensive residential treatment programs for children and adolescents" means a specialty hospital accredited by an accrediting organization as defined in subsection (1) which provides 24-hour care and which has the primary functions of diagnosis and treatment of patients under the age of 18 having psychiatric disorders in order to restore such patients to an optimal level of functioning. See S. 395.002(15), F.S.

¹²² S. 395.003(6)(a), F.S.

¹²³ Id.

¹²⁴ S. 395.003(6)(b), F.S.

¹²⁵ E-mail correspondence with AHCA staff, February 19, 2018 (on file with the Health and Human Services Committee).

¹²⁶ Id.

¹²⁷ S. 408.811, F.S.

¹²⁸ S. 408.813, F.S.

- Class II violations are those conditions that AHCA determines directly threaten the physical and emotional health, safety, or security of clients.
- Class III violations are those conditions that AHCA determines indirectly or potentially threaten the physical or emotional health, safety, or security of clients.
- Class IV violations are those conditions that do not have the potential of negatively affecting clients.

AHCA may also impose an administrative fine for a violation that is not designated in one of the classes listed above.

Emergency Services

The federal Emergency Medical Treatment and Labor Act (EMTALA)¹²⁹ passed in 1986 after “patient dumping,” the practice of refusing to treat uninsured patients in need of emergency care, came to the attention of the U.S. Congress.¹³⁰ In 1987, Florida enacted the first statute requiring some degree of emergency services to be provided to a patient regardless of the patient’s ability to pay.¹³¹

Currently, in Florida, every general hospital which has an emergency department must provide emergency services and care for any emergency medical condition when:

- A person requests emergency services and care; or
- Emergency services and care are requested on behalf of a person by:
 - An emergency medical services provider who is rendering care to or transporting the person; or
 - Another hospital, when such hospital is seeking a medically necessary transfer.¹³²

If a medically necessary transfer is made, it must be made to the geographically closest hospital with the service capability, unless another prior arrangement is in place or the geographically closest hospital is at service capacity.¹³³ Each hospital must retain records of each transfer made or received for a period of five years.¹³⁴ Decisions about services and care provided to an individual cannot be based upon the individual’s:

- Race;
- Ethnicity;
- Religion;
- National origin;
- Citizenship;
- Age;
- Sex;
- Preexisting medical condition;
- Physical or mental handicap;
- Insurance status;
- Economic status; or

¹²⁹ 42 U.S.C. §1395

¹³⁰ Richard E. Mills, *Access to Emergency Services and Care in Florida*, The Florida Bar Journal, January 1998, available at <https://www.floridabar.org/news/tfb-journal/?durl=/DIVCOM/JN/journal01.nsf/cb53c80c8fabd49d85256b5900678f6c/1C3429F6216E4EA985256ADB005D6190!opendocument> (last viewed November 20, 2017).

¹³¹ Id.

¹³² S. 395.1041(3)(a), F.S.

¹³³ S. 395.1041(3)(e), F.S.

¹³⁴ S. 395.1041(4)(a)1., F.S.

- Ability to pay for medical services.¹³⁵

AHCA may deny, revoke, or suspend a hospital's license or impose an administrative fine, not to exceed \$10,000 per violation, for any violation of access to emergency service and care laws.¹³⁶

Section 395.1046, F.S., provides the procedures for complaints against hospitals regarding emergency access issues, such as a person being denied emergency services and care.¹³⁷ AHCA must investigate any complaint against a hospital for any violation which AHCA reasonably believes to be legally sufficient. A complaint is legally sufficient if it contains facts showing that a violation of ch. 395, F.S., or any rule adopted under ch. 395, F.S., has occurred.¹³⁸ AHCA may investigate emergency access complaints even if the complaint is withdrawn.¹³⁹ When the investigation is complete, AHCA prepares a report making a probable cause determination.¹⁴⁰

Section 408.811, F.S. in the licensure act also provides procedures for investigating complaints and applies to all AHCA-regulated facilities. The investigative procedures in s. 395.1046, F.S. are the same as those in s. 408.811, F.S. However, s. 408.811, F.S. provides broader authority to AHCA to open an investigation whenever the agency deems necessary to determine compliance with the Act, authorizing statutes, and applicable rules, whereas s. 395.1046, F.S. provides authority for only complaint-based investigations.

Adult Cardiovascular Services

In 2007, certificate of need (CON)¹⁴¹ review was eliminated for adult cardiovascular services and such services are currently only subject to licensure requirements.¹⁴² Section 408.0361, F.S., establishes two levels of hospital program licensure for Adult Cardiovascular Services (ACS). A Level I program is authorized to perform adult percutaneous cardiac intervention (PCI)¹⁴³ without onsite cardiac surgery and a Level II program is authorized to perform PCI with onsite cardiac surgery.¹⁴⁴

Level I ACS Programs

Licensed Level I ACS programs provide diagnostic and therapeutic cardiac catheterization services, including PCI, on a routine and emergency basis, but do not have on-site open-heart surgery capability.¹⁴⁵ For a hospital seeking a Level I ACS program license, it must demonstrate that, for the most recent 12-month period as reported to AHCA, it has:

- Provided a minimum of 300 adult inpatient and outpatient diagnostic cardiac catheterizations; or
- Discharged or transferred at least 300 inpatients with the principal diagnosis of ischemic heart disease;¹⁴⁶ and that it has formalized, written transfer agreement with a hospital that has a Level II program.¹⁴⁷

¹³⁵ S. 395.1041(3)(f), F.S.

¹³⁶ S. 395.1041(5)(a), F.S.

¹³⁷ S. 395.1041(1), F.S.

¹³⁸ S. 395.1046(1), F.S.

¹³⁹ Id.

¹⁴⁰ S. 395.1046(2), F.S.

¹⁴¹ A certificate of need is a written statement issued by AHCA evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility or health service. See S. 408.036, F.S.

¹⁴² Ch. 2007-214, Laws of Fla.

¹⁴³ Percutaneous cardiac intervention (PCI), commonly known as coronary angioplasty or angioplasty, is a nonsurgical technique for treating obstructive coronary artery disease.

¹⁴⁴ S. 408.0361(3)(a), F.S.

¹⁴⁵ Rule 59A-3.2085(16)(a), F.A.C. Level I programs are prohibited from performing any therapeutic procedure requiring trans-septal puncture, any lead extraction for a pacemaker, biventricular pacer or implanted cardioverter defibrillator.

¹⁴⁶ Heart condition caused by narrowed heart arteries. This is also called "coronary artery disease" and "coronary heart disease."

Licensed Level I ACS programs must comply with the guidelines that apply to diagnostic cardiac catheterization services¹⁴⁸ and PCI, including guidelines for staffing, physician training and experience, operating procedures, equipment, physical plant, and patient selection criteria to ensure patient quality and safety.¹⁴⁹ Additionally, they must comply with the reporting requirements of the ACC-National Cardiovascular Data Registry.¹⁵⁰

Level I ACS programs must meet the following staffing requirements:

- Each cardiologist shall be an experienced physician who has performed a minimum of 75 interventional cardiology procedures, exclusive of fellowship training, within the previous 12 months from the date of the Level I ACS application or renewal application.
- Physicians with less than 12 months experience shall fulfill applicable training requirements prior to being allowed to perform emergency PCI in a hospital that is not licensed for a Level II ACS program.
- Nursing and technical catheterization laboratory staff must:
 - Be experienced in handling acutely ill patients requiring intervention or balloon pump;
 - Have at least 500 hours of previous experience in dedicated cardiac interventional laboratories at a hospital with a Level II adult cardiovascular services program;
 - Be skilled in all aspects of interventional cardiology equipment; and
 - Participate in a 24-hour-per-day, 365 day-per-year call schedule.
- A member of the cardiac care nursing staff who is adept in hemodynamic monitoring and Intra-aortic Balloon Pump management shall be in the hospital at all times.¹⁵¹

As of October 1, 2017, there are 56 general acute care hospitals with a Level I ACS program in Florida.¹⁵²

Level II ACS Programs

Licensed Level II ACS programs provide diagnostic and therapeutic cardiac catheterization services on a routine and emergency basis, but have on-site open-heart surgery capability.¹⁵³ For a hospital seeking a Level II program license, it must demonstrate that, for the most recent 12-month period as reported to AHCA, it has:

- Performed a minimum of 1,100 adult inpatient and outpatient cardiac catheterizations, of which at least 400 must be therapeutic catheterizations; or

¹⁴⁷ S. 408.0361(3)(b), F.S.

¹⁴⁸ Rule 59A-3.2085(16)(a)5., F.A.C.

¹⁴⁹ Rule 59A-3.2085(16)(a)2., F.A.C., requires compliance with the American College of Cardiology/Society for Cardiac Angiography and Interventions Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards: Bashore, et al., *ACC/SCA&I Clinical Expert Consensus Document on Catheterization Laboratory Standards*, Journal of the American College of Cardiology, Vol. 37, No. 8, June 2001: 2170-214. The rule also requires compliance the *ACC/AHA/SCAI 2005 Guideline Update for Percutaneous Coronary Intervention A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (ACC/AHA/SCAI Writing Committee to Update the 2001 Guidelines for Percutaneous Coronary Intervention)* available at <http://circ.ahajournals.org/content/113/1/156.full.pdf+html> (last visited November 20, 2017), which revises the guidelines for procedural complications, quality assurance, volume of elective procedures, the role of on-site cardiac surgical back-up, treatment of patients with certain diagnoses or medical history, the use of specified procedures and devices, and the use of certain drugs.

¹⁵⁰ Rule 59A-3.2085(16)(a)8., F.A.C. The reporting requirements include patient demographics; provider and facility characteristics; history/risk factors, cardiac status, treated lesions; intracoronary device utilization and adverse event rates; appropriate use criteria for coronary revascularization; and compliance with ACC/AHA clinical guideline recommendations.

¹⁵¹ Rule 59A-3.2085(16)(b), F.A.C.

¹⁵² Supra FN 43.

¹⁵³ Rule 59A-3.2085(17)(a), F.A.C.

- Discharged at least 800 patients with the principal diagnosis of ischemic heart disease.¹⁵⁴

In addition to the licensure requirements for a Level I ACS program, Level II ACS programs must also comply with the ACC/AHA 2004 Guideline Update for Coronary Artery Bypass Graft Surgery: A Report of the ACC/AHA Task Force on Practice Guidelines (Committee to Update the 1999 Guidelines for Coronary Artery Bypass Graft Surgery) Developed in Collaboration With the American Association for Thoracic Surgery and the Society of Thoracic Surgeons, which includes standards regarding staffing, physician training and experience, operating procedures, equipment, physical plant, and patient selection criteria to ensure patient quality and safety.¹⁵⁵ Level II ACS programs must also document an ongoing quality improvement plan to ensure that their cardiac catheterization, PCI, and cardiac surgical programs meet or exceed national quality and outcome benchmarks reported by the ACC-National Cardiovascular Data Registry and the Society of Thoracic Surgeons.¹⁵⁶ In addition to the reporting requirements for Level I ACS Programs, Level II ACS programs must meet the reporting requirements for the Society of Thoracic Surgeons National Database.¹⁵⁷

As of October 1, 2017, there are 79 general acute care hospitals¹⁵⁸ with a Level II ACS program in Florida.¹⁵⁹

Pediatric Cardiac Services

Currently, pediatric cardiac catheterization¹⁶⁰ and pediatric open-heart surgery¹⁶¹ are subject to CON review and approval prior to implementation of services pursuant to ss. 408.036(1) and 408.032(17), F.S. As conditions of CON approval, AHCA requires that:

- The program director for a pediatric cardiac catheterization program be board-eligible or board-certified in pediatric cardiology;¹⁶²
- Pediatric cardiac catheterization programs be located in a hospital in which pediatric open-heart surgery is being performed;¹⁶³ and
- Pediatric open-heart surgery programs have at least one physician who is board-eligible or board-certified as a pediatric cardiac surgeon on the staff of a hospital.¹⁶⁴

Licensure standards do not include pediatric cardiac service standards that exist within the certificate of need (CON) process. In 2017, the Legislature imposed a requirement for AHCA to adopt rules for

¹⁵⁴ S. 408.0361(3)(c), F.S.

¹⁵⁵ Rule 59A-3.2085(16)(a)5., F.A.C.

¹⁵⁶ Id. Eligible professionals must satisfactorily report 50 percent performance on at least nine quality measures for the annual reporting period. The measures address topics such as preoperative screenings, length of postoperative intubation, and length of postoperative stay.

¹⁵⁷ Rule 59A-3.2085(16)(a)5., F.A.C. The data collection form is available at https://www.ncdr.com/WebNCDR/docs/default-source/tvt-public-page-documents/tvt-registry_2_0_tavr_data-collection-form.pdf (last visited February 7, 2017).

¹⁵⁸ 64 Level II ACS programs were licensed pursuant to the grandfathering provisions of Chapters 2004-382 and 2004-383, Laws of Fla.; Agency for Health Care Administration, *Agency Analysis of SB 58 2017 Legislative Session*, Nov. 28, 2016 (on file with Health Innovation Subcommittee staff).

¹⁵⁹ Supra, FN 43.

¹⁶⁰ Pediatric cardiac catheterization is a nonsurgical procedure used in infants, children, and teens to determine if there is a problem with the heart or repair a problem. Nemours, Cardiac Catheterization in Children, <https://www.nemours.org/service/medical/delaware-valley-pediatric-cardiac-center/treatment-and-testing/cardiac-catheterization-in-children.html?location=naidhc>, (last visited on February 2, 2018).

¹⁶¹ Pediatric cardiovascular surgery may treat either congenital heart defects, which are heart diseases present at birth, or heart problems developed later in childhood, called acquired heart disease. Nemours, Pediatric Cardiac Surgery, <https://www.nemours.org/service/medical/delaware-valley-pediatric-cardiac-center/treatment-and-testing/pediatric-cardiac-surgery.html> (last visited February 2, 2018).

¹⁶² Rule 59C-1.032(5)(b)1., F.A.C.

¹⁶³ Rule 59C-1.032(6)(c)., F.A.C.

¹⁶⁴ 59C-1.003(5)(b), F.A.C.

pediatric cardiac catheterization programs and pediatric cardiovascular surgery programs, which, at a minimum, were required to include:

- Outcome standards specifying expected levels of performance in pediatric cardiac programs, using a risk adjustment procedure that accounts for the variations in severity and case mix. Such standards may include, but are not limited to, in-hospital mortality, infection rates, nonfatal myocardial infarctions, length of postoperative bleeds, and returns to surgery; and
- Specific steps to be taken by the agency and licensed facilities that do not meet the outcome standards within specified time periods, including time periods for detailed case reviews and development and implementation of corrective action plans.

Pediatric Cardiac Technical Advisory Panel

In 2017, the Legislature created the Pediatric Cardiac Technical Advisory Panel to recommend licensure standards for pediatric cardiac programs to AHCA.

The panel includes three at-large members appointed by the Secretary of AHCA who meet certain criteria, including one cardiologist who is board-certified in caring for adults with congenital heart disease, two board-certified pediatric cardiologists, and 10 members, each of whom is a pediatric cardiologist or a pediatric cardiovascular surgeon, from the following pediatric cardiac centers:

- Johns Hopkins All Children's Hospital in St. Petersburg;
- Arnold Palmer Hospital for Children in Orlando;
- Joe DiMaggio Children's Hospital in Hollywood;
- Nicklaus Children's Hospital in Miami;
- St. Joseph's Children's Hospital in Tampa;
- University of Florida Health Shands Hospital in Gainesville;
- University of Miami, Holtz Children's Hospital in Miami;
- Wolfson Children's Hospital in Jacksonville;
- Florida Hospital for Children in Orlando; and
- Nemours Children's Hospital in Orlando.

The panel sunsets on July 1, 2022.

Background Screening - Distinct Part Nursing Units

Some hospitals operate distinct part nursing units that provide long-term care. A distinct part nursing unit is a unit of a hospital certified for participation in the Medicare and Medicaid nursing facility program.¹⁶⁵ Skilled nursing units operate under the hospital's license and are not currently subject to the background screening requirements of nursing homes even though they provide skilled nursing care.

¹⁶⁵ A distinct part nursing unit is a unit of a hospital certified for participation in the Medicare and Medicaid nursing facility program (s. 395.1055(3), F.S. A distinct part must be physically distinguishable from the larger institution and fiscally separate for cost reporting purposes. *Medicare Provider Reimbursement Manual (2000)* available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R418PR1.pdf> (last visited December 14, 2017).

Tertiary Services

Certain tertiary health services provided by hospitals are subject to certificate of need review.¹⁶⁶ The following tertiary health services must undergo certificate of need review:

- Pediatric cardiac catheterization;
- Pediatric open-heart surgery;
- Neonatal intensive care units;
- Adult open heart surgery;
- Comprehensive medical rehab (CMR) services; and
- Organ transplantation, including
 - Heart;
 - Kidney;
 - Liver;
 - Bone marrow;
 - Lung; and
 - Pancreas.¹⁶⁷

The certificate of need process includes standards for pediatric cardiovascular, neonatal intensive care units (NICU), transplant, psychiatric and comprehensive medical rehab services. Current licensure statutes, as opposed to certificate of need statutes, do not contain specific authority for AHCA to adopt or enforce through the facility's license on an ongoing basis. Additionally, licensure requirements are included in the survey process whereas certificate of need requirements are not.

Effect of the Bill – Hospital Regulation

State-Operated Hospitals

The bill exempts all state-operated hospitals from the requirement to pay the annual assessment to the PMATF and to file an annual financial statement.

Specialty Hospitals

The bill removes the current law's requirement that a specialty-licensed children's hospital with neonatal intensive care unit beds be located in a county with a population of 1,750,000 in order to provide obstetrical services for certain high-risk pregnancies. Instead, the bill imposes a requirement that the specialty-licensed children's hospital be located in the certificate of need service areas of District 5 or District 11.¹⁶⁸ District 5 includes Pasco and Pinellas Counties.¹⁶⁹ District 11 includes Miami-Dade and Monroe Counties.¹⁷⁰ Only John Hopkins All Children's Hospital in Pinellas County and Nicklaus Children's Hospital in Miami-Dade County meet the new location requirement under the bill.

Emergency Access Complaints

The bill eliminates redundant procedures for investigating hospital emergency access complaints and allows AHCA to employ existing hospital complaint investigation procedures used for all other types of complaints. Section 395.1046, F.S., duplicates the complaint investigation procedure found in s. 408.811, F.S. Section 408.811, F.S., authorizes AHCA to inspect or investigate a licensed facility to ensure compliance with licensing requirements.

¹⁶⁶ S. 408.032, F.S.

¹⁶⁷ Id.

¹⁶⁸ Section 408.032(5), F.S., establishes 11 district service areas in Florida for purposes of certificate of need review.

¹⁶⁹ Id.

¹⁷⁰ Id.

Adult Cardiovascular Services

The bill removes exemptions from certificate of need review for adult cardiovascular services made obsolete by the 2007 repeal of certificate of need review for these services.

The bill provides an exception to the qualifications for a Level I ASC program, which will allow the Lower Keys Medical Center to become a Level I ACS provider. The facility would have to meet the physician qualification requirements for Level I ACS providers currently in rule, and meet lower annual volume requirements. Currently, Level I ACS providers must provide a minimum of 300 adult inpatient and outpatient diagnostic cardiac catheterizations. The facility must provide a minimum of 100 adult inpatient and outpatient diagnostic cardiac catheterizations. The facility will not have to meet the transfer time requirements to a Level II hospital.

Additionally, the bill adds an option for meeting staffing qualifications for all ASC providers. Nurses working in a Level I hospital will be able to obtain the required training and experience within their hospital instead of training at a Level II hospital if the hospital has an annual volume of 500 or more percutaneous coronary interventions in which balloon angioplasty, stenting, rotational atherectomy, cutting balloon atheroma remodeling, and procedures relating to left ventricular support are performed with a 95% or more success rate and less than 5% complication rate.

Pediatric Cardiovascular Services

The bill requires members of the pediatric cardiac technical advisory panel (panel) to have technical expertise in pediatric cardiac medicine, serve without compensation, and not be reimbursed for per diem and travel expenses. The bill requires the panel to meet at least biennially and allows meetings to be conducted telephonically or by other electronic means.

The bill authorizes the AHCA Secretary authority to appoint nonvoting members to the panel, which may include the AHCA Secretary, the Surgeon General, the Deputy Secretary of CMS, any current or past Division Director of CMS, a parent of a child with congenital heart disease, an adult with congenital heart disease, and a representative from each of the following organizations:

- Florida Chapter of the American Academy of Pediatrics;
- Florida Chapter of the American College of Cardiology;
- Greater Southeast Affiliate of the American Heart Association;
- Adult Congenital Heart Association;
- March of Dimes;
- Florida Association of Children's Hospitals; and
- Florida Society of Thoracic and Cardiovascular Surgeons.

The bill requires the panel to submit an annual report to the Governor, the President of the Senate, the Speaker of the House of Representatives, the AHCA Secretary, and the State Surgeon General that summarizes its activities and includes data and performance measures on surgical morbidity and mortality for all pediatric cardiac programs.

The bill requires pediatric cardiac programs to:

- Have a pediatric cardiology clinic affiliated with a licensed hospital;
- Have a pediatric cardiac catheterization laboratory and a pediatric cardiovascular surgery program located in the hospital;
- Have a risk adjustment surgical procedure protocol that follows national guidelines;

- Have quality assurance and quality improvement processes in place to enhance clinical operation and patient satisfaction with services; and
- Participate in clinical outcome reporting systems.

The bill revises the requirements for AHCA pediatric cardiac program rules to include standards for pediatric cardiac catheterization services and pediatric cardiovascular surgery.

The bill requires AHCA to contract with the Society of Thoracic Surgeons¹⁷¹ and the American College of Cardiology¹⁷² to obtain and publish data reported by pediatric cardiac programs that will allow consumers to compare pediatric cardiac programs.

Background Screening - Distinct Part Nursing Units

The bill requires level 2 background screenings for personnel of a distinct part nursing unit of a hospital. This is consistent with the requirement for nursing facilities personnel in long-term care units in s. 400.215, F.S.

Tertiary Services

The bill directs AHCA to implement minimum standards for neonatal intensive care units, transplant, psychiatric, and comprehensive medical rehab services. AHCA has rulemaking authority to implement the certificate of need review process for those services but does not currently have rulemaking authority under licensure standards for those services. The addition of these rules will require facilities who obtain a certificate of need to provide these services to continue to meet the licensure standards adopted by rule.

Rural Hospitals

Background

A rural hospital is an acute care hospital that has 100 or fewer licensed beds and an emergency room that is:¹⁷³

- The sole provider within a county with a population density of up to 100 persons per square mile;¹⁷⁴
- An acute care hospital in a county with a population density of up to 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county;¹⁷⁵
- A hospital supported by a tax district or subdistrict whose boundaries encompass a population of up to 100 persons per square mile;¹⁷⁶
- A hospital classified as a sole community hospital under 42 C.F.R. § 412.92 regardless of the number of licensed beds;¹⁷⁷

¹⁷¹ The Society of Thoracic Surgeons National Database collects data on 25 different pediatric heart operations from more than 100 hospitals nationwide. There are currently 11 hospitals in Florida reporting to its Congenital Heart Surgery Database. Society of Thoracic Surgeons, *Society for Thoracic Surgeons (STS) National Database: Congenital Heart Surgery Database Participants*, available at <http://www.sts.org/sites/default/files/files/PDF/STSNationalDatabaseParticipantMaps.pdf> (last visited February 2, 2018).

¹⁷² The American College of Cardiology operates cardiovascular data registries that assess the prevalence, demographics, management and outcomes of pediatric and adult congenital heart disease patients who undergo diagnostic catheterizations and catheter-based interventions. American College of Cardiology, *About NCDR*, <https://cvquality.acc.org/NCDR-Home/about-ncdr> (last visited February 2, 2018).

¹⁷³ S. 395.602(2)(e), F.S.

¹⁷⁴ S. 395.602(2)(e)1., F.S.

¹⁷⁵ S. 395.602(2)(e)2., F.S.

¹⁷⁶ S. 395.602(2)(e)3., F.S.

- A hospital with a service area that has a population of up to 100 persons per square mile,¹⁷⁸ or
- A hospital designated as a critical access hospital, as defined in s. 408.07.¹⁷⁹

Special Designations for Rural Hospitals

AHCA licenses four classes of hospital.¹⁸⁰ Class I licenses include rural hospitals.¹⁸¹ All licensed hospitals must have:

- Inpatient beds;
- A governing authority legally responsible for the conduct of the hospital;
- A chief executive officer or others similarly titled official to who the governing authority delegates the full-time authority for the operation of the hospital in accordance with the established policy of the governing authority;
- An organized medical staff to which the governing authority delegates responsibility for maintaining proper standards for medical and other health care;
- A current and complete medical record for each patient admitted to the hospital;
- A policy requiring that all patients be admitted on the authority of and under the care of a member of the organized medical staff;
- Facilities and professional staff available to provide food to patients to meet their nutritional needs;
- A procedure for providing care in emergency cases;
- A method and policy for infection control; and
- An on-going organized program to enhance the quality of patient care and review the appropriateness of utilization of services.¹⁸²

In addition, Class I hospitals must have:

- One licensed registered nurse on duty at all times on each floor or similarly titled part of the hospital for rendering patient care services;
- A pharmacy supervised by a licensed pharmacist either in the facility or by contract sufficient to meet patient needs;
- Diagnostic imaging services either in the facility or by contract sufficient to meet patient needs;
- Clinical laboratory services either in the facility or by contract sufficient to meet patient needs;
- Operating room services; and
- Anesthesia service.¹⁸³

Though not used in rule or statute for licensure of hospitals or otherwise, there are several designations of “rural hospitals” based on their services, bed capacity, and location. These designations are “emergency care hospital,” “essential access community hospital,” and “rural primary care hospital.”

An emergency care hospital is a medical facility which provides:

- Emergency medical treatment; and

¹⁷⁷ S. 395.602(2)(e)4., F.S.

¹⁷⁸ S. 395.602(2)(e)5., F.S. As used in this subparagraph, the term “service area” means the fewest number of zip codes that account for 75 percent of the hospital’s discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database at the Florida Center for Health Information and Transparency.

¹⁷⁹ S. 395.602(2)(e)6., F.S.

¹⁸⁰ Rule 59A-3.252(1), F.A.C.

¹⁸¹ Rule 59A-3.252(1)(a)3., F.A.C.

¹⁸² Rule 59A-3.252(2), F.A.C.

¹⁸³ Rule 59A-3.252(3), F.A.C.

- Inpatient care to ill or injured person prior to their transportation to another hospital; or
- Inpatient medical care to persons needing such care up to 96 hours.¹⁸⁴

An essential access community hospital is a facility which:

- Has at least 100 beds;
- Is located more than 35 miles from any other essential access community hospital, rural referral center, or urban hospital meeting the criteria for classification as a regional referral center;¹⁸⁵
- Is part of a network that includes rural primary care hospitals;
- Provides emergency and medical backup services to rural primary care hospitals in its rural health network;
- Extends staff privileges to rural primary care hospital physicians in its network; and
- Accepts patients transferred from rural primary care hospitals in its network.¹⁸⁶

A rural primary care hospital is any facility meeting the criteria for a rural hospital or emergency care hospital which:

- Provides twenty-four-hour emergency medical care;
- Provides temporary inpatient care for 72 hours or less to patients requiring stabilization before discharge or transfer to another hospital; and
- Has no more than six licensed acute care inpatient beds.¹⁸⁷

The essential access community hospital and rural primary care hospital designations were established under federal programs that were implemented in 1993 and subsequently replaced in 1997 by the Critical Access Hospital program.¹⁸⁸ The designations of “emergency care hospital,” “essential access community hospital,” and “rural primary care hospital are redundant or obsolete since the implementation of the Critical Access Hospital program.¹⁸⁹

Effect of the Bill – Rural Hospitals

The bill repeals the emergency care hospital, essential access community hospital, and rural primary care hospital designations. There are no rural hospitals with those designations, and the federal Critical Access Hospital program has replaced the essential access community hospital and rural primary care hospital designations. A hospital currently meeting the definition of rural hospital will continue to be classified as a rural hospital.

An inactive rural hospital bed is a licensed acute care hospital bed, as defined in s. 395.002(13), that cannot be occupied by an acute care inpatient.¹⁹⁰ There is no longer a need for hospitals to track inactive beds because AHCA no longer maintains a list of facilities with inactive beds for the purpose of publishing the need for additional acute care beds under the Certificate of Need (CON) program.¹⁹¹

¹⁸⁴ S. 395.602(2)(a), F.S.

¹⁸⁵ Rural Referral Centers are high-volume acute care rural hospitals that treat a large number of complicated cases.

¹⁸⁶ S. 395.602(2)(b), F.S.

¹⁸⁷ S. 395.602(2)(f), F.S.

¹⁸⁸ Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation; Final Rule. 77 Fed.

Reg. 95 (May 16, 2012). *Federal Register: The Daily Journal of the United States*, available at: <https://www.gpo.gov/fdsys/pkg/FR-2012-05-16/pdf/2012-11548.pdf> (last visited December 14, 2017). The Critical Access Hospital program is a federal program that pays certain state-designated rural hospitals an enhanced, cost-based rate for Medicare services. See, 42 U.S.C. 1395i-4; 42 U.S.C. 1395x; et al; and ss. 395.002, 395.602, 408.07, F.S.

¹⁸⁹ Id.

¹⁹⁰ S. 395.602(2)(c), F.S.

¹⁹¹ Supra, FN 43.

The bill also makes conforming changes to the following statutes to reflect the repeal of “emergency care hospital,” “essential access community hospital,” “inactive rural hospital bed,” and “rural primary care hospital” definitions from statute, as well as the repeal of other rural hospital programs and emergency care hospitals: ss. 395.603, 409.9116(6), 409.975(1), 458.345(1), 1009.65(2)(b), F.S.

Home Health Agencies

Background

Home health agencies (HHAs) are organizations licensed by AHCA to provide home health and staffing services.¹⁹² Home health services are health and medical services and medical supplies furnished to an individual in the individual’s home or place of residence. These 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.¹⁹³

Staffing services are provided to health care facilities, schools, or other business entities on a temporary or school-year basis by licensed health care personnel and by certified nursing assistants and home health aides who are employed by, or work under the umbrella of, a licensed HHA.¹⁹⁴

A HHA may also provide homemaker¹⁹⁵ and companion¹⁹⁶ 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. Personnel providing homemaker or companion services are employed by or under contract with a HHA.¹⁹⁷

Licensure and Exceptions

Since 1975, HHAs operating in Florida have been required to obtain a state license.¹⁹⁸ HHAs must meet the general health care licensing provisions¹⁹⁹ and specific HHA licensure provisions and standards.²⁰⁰ A HHA license is valid for 2 years, unless revoked.²⁰¹ If a HHA operates related offices, each related office outside the health service planning district where the main office is located must be separately licensed.²⁰² As of November 20, 2017, there are 1,917 licensed HHAs in Florida.²⁰³

A HHA may obtain an initial license by submitting to AHCA a signed, complete, and accurate application and the \$1,705 licensure fee.²⁰⁴ The HHA must also submit the results of a survey

¹⁹² S. 400.462(12), F.S.

¹⁹³ S. 400.462(14), F.S.

¹⁹⁴ S. 400.462(30), F.S.

¹⁹⁵ S. 400.462(16), F.S.

¹⁹⁶ S. 400.462(7), F.S.

¹⁹⁷ S. 400.462(13), F.S.

¹⁹⁸ SS. 36 – 51 of ch. 75-233, Laws of Fla.

¹⁹⁹ Part II of ch. 408, F.S.

²⁰⁰ Part III of ch. 400, F.S., and Rule 59A-8, F.A.C.

²⁰¹ S. 408.808(1), F.S.

²⁰² S. 400.464(2), F.S. There are eleven health service planning districts grouped by county.

²⁰³ Florida Health Finder, *Facility/Provider Search Results-Home Health Agencies*, available at <http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx> (report generated April 2, 2017).

²⁰⁴ S. 400.471(5) and Rule 59A-8.003(12).

conducted by AHCA.²⁰⁵ The application must identify the geographic service areas²⁰⁶ and counties in which the HHA will provide services. An initial licensure applicant must be fully accredited to obtain a license to provide skilled nursing services, however, accreditation is not required if, after initial licensure, a home health agency requests to begin providing skilled nursing services.

Section 400.464, F.S., exempts certain entities, individuals, and services from the HHA licensure requirements, including:

- A HHA operated by the federal government;
- A home health aide or certified nursing assistant who is acting in his or her individual capacity, within the definitions and standards of his or her occupation, and who provides hands-on care to patients in their homes;
- The delivery of nursing home services for which the nursing home is licensed under part II of ch. 400, F.S., to serve its residents; and
- A not-for-profit, community-based agency that provides early intervention services to infants and toddlers.²⁰⁷

For licensure renewal, the HHA must submit a signed renewal application, licensure fee and report the volume of patients serviced during the previous licensure period.²⁰⁸ The requirement to report patient volume is found in both ss. 400.474(7), F.S. and 400.471(2)(c), F.S.

In addition to the requirements of the core licensing statute in s. 408.813, F.S.,²⁰⁹ a HHA is also subject to inspections and investigations under its authorizing statute, s. 400.484, F.S. In conducting an inspection or investigation, AHCA may cite an HHA for violations of laws and rules and may impose administrative fines. Both s. 408.813, F.S., and s. 400.484, F.S., categorize violations into four defined classes according to the nature of the violation. Section 408.813, F.S., authorizes AHCA to impose fines for those violations “as provided by law”, referring to s. 400.484, F.S., which specifies the fines AHCA may impose.

Sections 400.484 and 408.813, F.S., although quite similar, have a few slight differences and redundancies. For example, under s. 408.813, F.S., a Class I deficiency presents an imminent danger or a substantial probability of harm, and must be corrected within 24 hours (or within some other timeframe determined by AHCA). A Class I deficiency under s. 400.484, F.S., is one that results in *actual* harm or presents a *risk* of harm, and that section is silent on the timeframe in which a Class I deficiency must be corrected. Similarly, a Class II violation in s. 408.813, F.S., threatens physical and emotional health, while a Class II violation in s. 400.484, F.S., merely refers to “health”. The definitions for Class III and Class IV violations appear to be largely redundant.

A HHA providing skilled nursing services for more than 30 days is required to employ a director of nursing²¹⁰ who is a Florida licensed registered nurse with at least one year of supervisory experience.²¹¹ However, HHAs that are not Medicaid or Medicare certified and do not provide skilled care, or provide only physical, occupational, or speech therapy are not required to employ a director of nursing.

The director of nursing is responsible for overseeing the delivery of professional nursing and home health aide services²¹² and must be readily available at the HHA or by phone for any eight consecutive

²⁰⁵ Id.

²⁰⁶ S. 408.032(5), F.S. lists the eleven health service planning districts grouped by county.

²⁰⁷ S. 400.464(5)(a)-(n), F.S.

²⁰⁸ Ss. 400.474(7), F.S. and 400.471(2)(c), F.S. Rules 59A-8.003(2) and (12), F.A.C.

²⁰⁹ S. 408.813, F.S.

²¹⁰ S. 400.462(10), F.S.

²¹¹ S. 400.476(2), F.S.

²¹² S. 400.462(10), F.S.

hours between 7 a.m. to 6 p.m.²¹³ The director of nursing is also responsible for establishing and conducting an ongoing quality assurance program for services provided by the HHA.²¹⁴

A director of nursing may be the director for a maximum of five licensed HHAs if the HHAs have identical controlling interests, are located within one geographic service area or within an immediately contiguous county, and each HHA has a registered nurse who meets the qualifications of a director of nursing and has been delegated by the director of nursing to serve in the stead of the director. An employee of a retirement community that provides multiple levels of care may serve as the director of nursing of a HHA 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.²¹⁵

Effect of the Bill – Home Health Agencies

The bill requires that any HHA license issued on or after July 1, 2018, must specify the home health services the HHA is authorized to perform and whether such services are considered “skilled care.” Currently, an initial licensure applicant must be fully accredited to obtain a license to provide skilled nursing services, however, accreditation is not required if, after initial licensure, a home health agency requests to begin providing skilled nursing services. The bill closes the loophole by which a home health agency could forgo full accreditation after initial licensure by requiring proof of accreditation when seeking approval to begin providing skilled nursing services.

In addition, the bill authorizes AHCA to issue a certificate of exemption to any person or HHA providing home health services that is exempt. The certificate of exemption is voluntary and expires after two years, at which time the exempt HHA may voluntarily reapply for a certificate. AHCA is authorized to charge \$100 or the actual cost to process the certificate. This provides the industry an option for demonstrating to clients and payor sources that they are exempt from licensure.

The bill removes the exemption for HHAs that are not Medicaid or Medicare certified and do not provide skilled care, or provide only physical, occupational, or speech therapy to have a director of nursing. The provision ensures that skilled nursing care services are overseen by a registered nurse, and ensures recipients of such services are receiving appropriate care.

The bill removes the definitions of Class I, II, III, and IV violations from s. 400.484(2), F.S., and instead references the definitions of the violations found in s. 408.813, F.S. This eliminates redundancy and resolves differences between the two sections of law. The bill retains the specified administrative fines that may be charged for each class of violations.

An HHA that wishes to provide services to Medicare or Medicaid patients must meet the certification standards for each program. However, if a home health agency does not provide services to Medicare or Medicaid patients, it does not need to meet the certification standards. Currently, AHCA lists a HHA as Medicare-certified or Medicaid-certified on the HHA’s license. The bill deletes the requirement that a home health license states that it is Medicare-certified or Medicaid-certified. According to ACHA, the proposed changes should eliminate confusion among providers and consumers, and should not have an adverse effect on AHCA or home health agency licensees.²¹⁶

The bill repeals duplicative language that a HHA, for purpose of license renewal, report the volume of patients serviced during the previous licensure period.

²¹³ Rule 59A-8.003(11)(a), F.A.C.

²¹⁴ Rule 59A-8.0095(2)(e), F.A.C.

²¹⁵ S. 400.476(2), F.S.

²¹⁶ Supra, FN 43.

The bill also makes conforming changes to s. 400.497(4), F.S., to reflect the provisions of the bill.

Birth Centers

Background

A birth center is any facility, institution, or place, which is not an ambulatory surgical center, a hospital or in a hospital, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy.²¹⁷ A birth center must include:

- Birthing rooms;
- Bath and toilet facilities;
- Storage areas for supplies and equipment;
- Examination areas; and
- Reception or family areas.²¹⁸

A birth center must be equipped with those items needed to provide low-risk maternity care and readily available equipment to initiate emergency procedures in life-threatening events to a mother and baby.²¹⁹

Current law provides an exemption to birth center licensure for any facility that was providing obstetrical and gynecological surgical services and was owned and operated by a board-certified obstetrician on June 15, 1984.²²⁰ According to AHCA, there are currently no providers who meet these criteria.²²¹

Effect of the Bill – Birth Centers

The bill repeals the exemption to birth center licensure for any facility that was providing obstetrical and gynecological surgical services and was owned and operated by a board-certified obstetrician on June 15, 1984.

Nurse Registries

Background

A nurse registry refers to any person that procures, offers, promises, or attempts to secure healthcare-related contracts for registered nurses, licensed practical nurses, certified nursing assistants, home health aides, companions, or homemakers, who are compensated by fees as independent contractors, including, but not limited to, contracts for the provision of services to patients and contracts to provide private duty or staffing services to hospitals, nursing homes, hospices, ALFs, and other business entities.²²² A nurse registry is exempt from the licensing requirements of a HHA, but must be licensed as a nurse registry.²²³

A nurse registry is prohibited from providing remuneration to health care providers, health care provider office staff, immediate family members of a health care providers, and vendors for patient referrals.²²⁴ The nurse registry is also prohibited from providing remuneration to a case manager, discharge

²¹⁷ S. 383.302(2), F.S.

²¹⁸ S. 383.308(1), F.S.

²¹⁹ S. 383.308(2)(a), F.S.

²²⁰ S. 383.335, F.S.

²²¹ Supra, FN 43.

²²² S. 400.462(21), F.S.

²²³ S. 400.506(1)(a), F.S. A licensed nurse registry may operate a satellite office.

²²⁴ S. 400.506(15)(a)4., F.S.

planner, facility-based staff, or other third-party vendor who is involved in the discharge planning process.²²⁵ However, if a nurse registry does not bill the Medicaid or Medicare programs or does not share a controlling interest in a licensed entity or facility that bills Medicaid or Medicare, this provision does not apply. Nurse registries are not eligible for participation in the Medicare program and are only authorized to participate in Florida Medicaid through the Long Term Care Waiver program. AHCA has received three complaints in the last 5 years against nurse registries for providing remuneration in violation of law.²²⁶ However, the complaints were not substantiated and AHCA did not take any disciplinary action.

In accordance with s. 400.506(5)(a), F.S., the continued operation of an unlicensed nurse registry for more than 10 days after Agency notification is considered a second degree misdemeanor. Each day of continued non-compliance is considered a separate offense, with each offense carrying the potential for imprisonment of up to 60 days. In addition to the criminal actions, s. 400.506(5)(b), F.S., authorizes the Agency to impose a \$500.00 fine for each day of continued non-compliance. However, s. 408.812, F.S., authorizes the Agency to impose a \$1000.00 per day fine for each day of continued operation after Agency notification.

Agency records show that 37 complaints alleging nurse registry unlicensed activity were filed between January 1, 2012, and present and upon investigation, only 11 of the complaints were substantiated.²²⁷ Of the 11 substantiated complaints, the Agency imposed an administrative fine of \$46,000.00 for one unlicensed nurse registry who failed to discontinue operations after notification.

Effect of the Bill – Nurse Registries

The bill specifies that caregivers referred for contract by a nurse registry are not employees of the nurse registry under any chapter of Florida law. The bill prohibits nurse registries from monitoring, supervising, managing or training the independent contractors referred to the client by the nurse registry. The bill also requires nurse registries to advise clients that the nurse registry may not monitor, supervise, manage or train the independent contractors referred to the client by the nurse registry.

The bill repeals the two prohibitions on nurse registries that relate to remuneration by the registry to health care providers, facility staff, or third party vendors. However, nurse registries will continue to be subject to criminal penalties for patient brokering as provided for in s. 817.505, F.S.

Additionally, the bill resolves the conflict between ss. 400.606 and 408.812, F.S., for penalties of unlicensed facilities, referring to provisions in s. 408.812, F.S., so all licensed facilities will be subject to the same penalties. Unlicensed nurse registries will be subject to criminal penalties and administrative fines of \$1000.00 per day for each day of continued operation after Agency notification.

Home Medical Equipment

A home medical equipment provider sells or rents, or offers to sell or rent, home medical equipment²²⁸ and services or home medical equipment services²²⁹ to or for a consumer. A home medical equipment

²²⁵ S. 400.506(15)(a)5., F.S.

²²⁶ Supra, FN 43.

²²⁷ Id.

²²⁸ S. 400.925(6), F.S., defines home medical equipment as any product as defined by the Federal Drug Administration, any products reimbursed under the Medicare Part B Durable Medical Equipment benefits or the Florida Medicaid durable medical equipment program. Such equipment includes oxygen and related respiratory equipment, wheelchairs and related seating and positioning, but does not include motorized scooters, personal transfer systems, specialty beds, prosthetics, orthotics, or custom-fabricated splints, braces, or aids.

²²⁹ S. 400.925(9), F.S., defined home medical equipment services as equipment management and consumer instruction, including selection, delivery, setup, and maintenance of equipment, and other related services for the use of home medical equipment in the consumer's place of residence.

provider must be licensed by AHCA.²³⁰ Medical oxygen is defined as oxygen USP²³¹ which must be labeled in compliance with labeling requirements for oxygen under the federal act.²³² The Department of Business and Professional Regulation (DBPR) regulates medical equipment, including medical oxygen.²³³ In 2014, part III of ch. 499, F.S., was created to regulate of medical gas, including medical oxygen, separate from other drugs and medical equipment.

The bill requires a licensee to notify AHCA within 21 days, rather than 45 days, when a change in the general manager of a home medical equipment provider occurs. The reduced notification timeframe matches other notification provision timeframes in part II of ch. 408, F.S., resulting in regulatory uniformity. The bill makes changes to the home medical equipment exemption for a medical oxygen permit by correcting the reference in s. 400.933, F.S., from Department of Health (DOH) to DBPR, which is now responsible for such regulation.

The bill modifies the definition of home medical equipment in s. 400.925(6), F.S., by restructuring and providing clarification of which items require home medical equipment licensure in order to sell and/or rent those items. The placement of the semi-colons in the current statutory definition is often misinterpreted to mean none of the items that are listed after “but does not include” are considered home medical equipment.²³⁴

Health Care Service Pools

A health care services pool is any person, firm, corporation, partnership, or association which provides temporary employment in health care facilities, residential facilities, and agencies for licensed, certified, or trained health care personnel, including nursing assistants, nurses’ aides, and orderlies.²³⁵ Registration or a license issued by AHCA is required for the operation of a health care services pool.²³⁶ Currently, if a health care services pool must change information contained its original registration application, it must notify AHCA 14 days prior to the change.²³⁷

The bill requires a health care services pool to notify AHCA of a change of ownership at least 60 days before the effective date of the change. For any other change of information contained in a registration application, AHCA must be notified at least 60 days, but no more than 120 days, before the requested effective date. Health care service pools will be subject to the same reporting timeframe for these changes as other health care facilities licensed by AHCA.

Health Care Clinics

Health care clinics are licensed by AHCA under the Health Care Clinic Act (Act), ss. 400.990 - 400.995, F.S.²³⁸ The Act creates many exceptions to this requirement.²³⁹ Health care clinics exempt from licensure include:

²³⁰ See generally s. 400.931, F.S.

²³¹ The United States Pharmacopoeia (USP) is a list of drugs licensed for use in the U.S. with standards necessary to determine purity suitable for persons.

²³² S. 499.82(10), F.S.

²³³ Ch. 499, F.S.

²³⁴ Supra, FN 43.

²³⁵ S. 400.980(1), F.S.

²³⁶ S. 400.980(2), F.S.

²³⁷ Id.

²³⁸ The Health Care Clinic Act was enacted in 2003 to reduce fraud and abuse in the personal injury protection insurance system. A health care clinic is an entity where health care services are provided to individuals and which tenders charges for reimbursement of such services (s. 400.9905(4), F.S.)

²³⁹ Section 400.9905(4), F.S.

- Entities owned, operated, or licensed by certain licensed facilities, licensed health care practitioners; and certain non-profit entities;
- Clinical facilities affiliated with an accredited medical school or an accredited college of chiropractic;
- Clinical entities that only provide oncology or radiation therapy services by licensed physicians which are owned by a publicly-traded corporation;
- Entities that provide licensed practitioners to staff emergency room departments or to deliver anesthesia services in hospitals and derive at least 90 percent of their gross annual revenues from the provision of those services;
- Orthotic, prosthetic, pediatric cardiology, or perinatology clinical facilities or anesthesia clinical facilities that are not otherwise exempt and are a publicly-traded company or wholly owned by a publicly-traded company;
- Entities owned by certain corporations that have \$250 million or more in total annual sales of health care services provided by licensed health care practitioners; and
- Certain entities that employ 50 or more licensed health care practitioners billing for medical services under a single tax identification number.²⁴⁰

A health care clinic may voluntarily apply for a certificate of exemption, and the fee for issuance of the certificate is \$100.²⁴¹ There are currently 10,239 entities with certificates of exemption²⁴² under the Health Care Clinic Act. Certificates of exemption have no expiration date, and AHCA does not know if all of these entities still qualify for an exemption or whether the entity still exists.

The bill limits the health care clinic license exemption to two years. Therefore, an entity holding a voluntary certificate of exemption would need to renew the exemption biennially.

Nursing Home Guide

Under the §1864 Agreement of the Social Security Act, the Agency serves as an agent of the federal Centers for Medicare and Medicaid Services to provide regulatory oversight and perform certification functions for nursing homes in the state of Florida. Nursing homes are subject to a standard survey that is completed no later than 15.9 months after the previous survey. The Agency typically combines the standard federal survey with the standard state licensure survey, and many surveys may occur well before the 15.9-month mark.

Section 400.191, F.S. requires AHCA to publish a quarterly Nursing Home Guide in electronic form to assist consumers and their families in comparing and evaluating nursing home facilities. The Nursing Home Guide that includes survey and deficiency information, including federal and state recertification, licensure, revisit, and complaint survey information for the past 30 months.

However, if a provider's survey period were to be extended beyond the 15-month window, but still within the permissible 15.9-month window, it could possibly place them outside of the 30-month period preceding the release of the publication of the Guide. As a result, the provider could potentially be impacted with a rating of "NR" (Not Rated). According to the Nursing Home Guide Methodology²⁴³, the deficiencies cited on an inspection are used to compute a score for the nursing home. The Nursing Home Guide was intended to consider at least two standard surveys and the loss of 1.8 months of data may result in the unintentional exclusion of some providers from being rated in the Nursing Home Guide.

²⁴⁰ S. 400.9905(4), F.S.

²⁴¹ Rule 59A-33.006, F.A.C.

²⁴² Supra, FN 43.

²⁴³ AHCA, *Nursing Home Guide Methodology*, available at: <http://www.floridahealthfinder.gov/CompareCare/MethodologyNH.aspx> (last visited December 14, 2017).

The bill removes the 30-month time-frame for surveys to be included in the guide. The change would afford providers whose survey period may have exceeded 15 months the opportunity to receive a rating in the Nursing Home Guide.

Florida Consortium of National Cancer Institute Programs

Background

The National Cancer Institute (NCI) is the federal government's principal agency for cancer research and training.²⁴⁴ NCI leads the National Cancer Program, which is the largest funder of cancer research in the world.²⁴⁵ NCI designates cancer centers as either comprehensive cancer centers, which demonstrate significant research activities in each of 3 major areas—laboratory-based research, population-based research, and clinical research—and which have substantial multidisciplinary research efforts or cancer centers, which are primarily focused in one or more of these scientific areas.²⁴⁶ There are currently 69 NCI-designated cancer centers, located in 35 states and the District of Columbia.²⁴⁷ Moffitt Cancer Center is currently the only NCI-designated cancer center in Florida.²⁴⁸

Section 381.915, F.S. creates the Florida Consortium of National Cancer Institute Centers Program (Program), which provides funding, subject to appropriation, to Florida-based NCI-designated cancer centers or NCI-designated comprehensive cancer centers, and cancer centers working toward achieving NCI designation. To participate in the Program, cancer centers must have achieved or be prepared to achieve NCI designation by July 1, 2019.²⁴⁹

The Program designates three tiers of cancer centers as follows²⁵⁰:

- Tier 1: Florida-based NCI-designated comprehensive cancer centers.
- Tier 2: Florida-based NCI-designated cancer centers.
- Tier 3: Florida-based cancer centers seeking designation as either a NCI-designated cancer center or NCI-designated comprehensive cancer center.

To be eligible for Tier 3 designation, a cancer center must²⁵¹:

- Conduct cancer-related basic scientific research and cancer-related population scientific research;
- Offer and provide the full range of diagnostic and treatment services on site, as determined by the Commission on Cancer of the American College of Surgeons;
- Host or conduct cancer-related interventional clinical trials that are registered with the NCI's Clinical Trials Reporting Program;
- Offer degree-granting programs or affiliate with universities through degree-granting programs accredited or approved by a nationally recognized agency and offered through the center or

²⁴⁴ National Cancer Institute, *National Cancer Institute Overview and Mission*, available at: <https://www.cancer.gov/about-nci/overview> (last visited March 6, 2018).

²⁴⁵ Id.

²⁴⁶ In Haejin, et. al, *The Role of National-Cancer Institute-Designated Cancer Center Status: Observed Variation in Surgical Care Depends of the Level of Evidence*, *Annals of Surgery* 255(5):890-895, May 2012, available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3428029/> (last visited March 6, 2018).

²⁴⁷ National Cancer Institute, *NCI-Designated Cancer Centers*, available at: <https://www.cancer.gov/research/nci-role/cancer-centers> (last visited March 6, 2018).

²⁴⁸ National Cancer Center Institute, *Find a Cancer Center*, available at: <https://www.cancer.gov/research/nci-role/cancer-centers/find#Florida> (last visited March 6, 2018).

²⁴⁹ 381.915(3)(b)

²⁵⁰ 381.915(4)

²⁵¹ 381.915(4)(c)

through the center in conjunction with another institution accredited by the Commission on Colleges of the Southern Association of Colleges and Schools;

- Provide training to clinical trainees, medical trainees accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, and postdoctoral fellows recently awarded a doctorate degree; and
- Have more than \$5 million in annual direct costs associated with their total NCI peer-reviewed grant funding.

A cancer center's participation in Tier 3 is limited to 5 years.²⁵² A cancer center that qualified as a designated Tier 3 center by July 1, 2014, may pursue NCI designation as a cancer center or a comprehensive cancer center for 5 years after qualification.²⁵³

The General Appropriations Act or accompanying legislation may limit the number of cancer centers that receive Tier 3 designations or provide additional criteria for such designation.²⁵⁴

Effect of the Bill - Florida Consortium of National Cancer Institute Programs

The bill increases the number of years a cancer center may participate in the Tier 3 designation of the Program from 5 years to 6 years. The bill also increases the number of years a cancer center that qualifies as a Tier 3 center may pursue NCI designation from 5 years to 6 years. This will allow more time for Florida-based cancer centers to pursue NCI designation and be able to participate in the Program.

Public Health Trusts

Current law authorizes each county to create a public corporate body known as a public health trust.²⁵⁵ A public health trust may only be created if the governing body of the county of a public health trust declares that there is a need for the trust to function.²⁵⁶ The governing body of the county must then designate health care facilities to be operated and governed by the trust and appoint a board of trustees (board).²⁵⁷

The purpose of a public health trust is to exercise supervisory control over the operation, maintenance, and governance of the designated health care facilities. A designated facility is any county-owned or county-operated facility used in connection with the delivery of health care.²⁵⁸ Designated facilities include:²⁵⁹

- Sanatoriums;
- Clinics;
- Ambulatory care centers;
- Primary care centers;
- Hospitals;
- Rehabilitation centers;
- Health training facilities;
- Nursing homes;
- Nurses' residence buildings;

²⁵² 381.915(4)(c)3., F.S.

²⁵³ 381.915(4)(c)4., F.S.

²⁵⁴ 381.915(4)(c)2., F.S.

²⁵⁵ Section 154.07, F.S.

²⁵⁶ Id.

²⁵⁷ Section 154.08, F.S., and s. 154.09, F.S.

²⁵⁸ Section 154.08, F.S.

²⁵⁹ Id.

- Infirmaries;
- Outpatient clinics;
- Mental health facilities;
- Residences for the aged;
- Rest homes;
- Health care administration buildings; and
- Parking facilities and areas serving health care facilities.

Current law authorizes the board of each public health trust to be the operator of, and governing body for, any designated facility.²⁶⁰ The governing body of the county where the trust is located selects the board, which consists of between 7 and 21 members.²⁶¹ The members must be residents of the county in which the trust is located and are appointed on staggered terms which may not exceed 4 years.²⁶² The members serve without compensation, but are entitled to necessary expenses incurred in the discharge of their duties.²⁶³

The board's authority is subject to the limitation of the governing body of the county where the trust is located and includes the authority to:²⁶⁴

- Sue and be sued;
- Make and adopt bylaws and rules and regulations for the board's guidance and for the operation, governance, and maintenance of designated facilities;
- Make and execute contracts;
- Appoint and remove a chief executive officer of the trust;
- Appoint, remove, or suspend employees or agents of the board;
- Cooperate with and contract with any governmental agency or instrumentality, federal, state, municipal, or county;
- Employ legal counsel; and
- Lease, either as lessee or lessor, or rent for any number of years and upon any terms and conditions real property, except that the board shall not lease or rent, as lessor, any real property except in accordance with the requirements of s. 125.35, F.S.

Miami-Dade County is the only county to have created a public health trust, Public Health Trust of Miami-Dade County (Trust), created in 1973.²⁶⁵ The Trust's designated facilities include Jackson Memorial Hospital and all related facilities and real and personal property.

The bill grants a county with a public health trust exclusive jurisdiction over a designated facility owned or operated by that public health trust if it is located within the boundaries of a municipality.

²⁶⁰ Id.

²⁶¹ Section 154.09, F.S.

²⁶² Id.

²⁶³ Id.

²⁶⁴ Id.

²⁶⁵ Chapter 25A of the Miami-Dade County Code.

Subscriber Assistance Program

Background

Managed Health Care

Managed care refers to a variety of methods of financing and organizing the delivery of comprehensive health care in an effort to control costs and improve quality by controlling the provision of services. Managed care, in varying degrees, integrates the financing and delivery of medical care through contracts with selected physicians, hospitals, and other health care providers that provide comprehensive health care services to enrolled members for a predetermined monthly premium. The term “managed care organization” or “entity” includes health maintenance organizations, exclusive provider organizations, prepaid health clinics and Medicaid prepaid health plans. In addition, a health insurer that sells a preferred provider contract may be considered to be a “managed care” plan.²⁶⁶ Since 1973, under federal law,²⁶⁷ HMOs have been required to establish and provide meaningful procedures for hearing and resolving grievances between the HMO and members of the organization. Medical groups and other health care delivery entities providing health care services for the organization must also be afforded grievance procedures under the federal law. Grievance procedures provide a mechanism to ensure that subscribers have a means of receiving further consideration of a HMO’s decisions that deny care, treatment, or services. Under state law, such mechanisms are extended to adverse decisions of other types of managed care entities.²⁶⁸

Health insurance regulators have also had a substantial role in helping to resolve disputes arising between consumers and their health insurance carriers and health plans.²⁶⁹ The types of disputes that regulators consider relate to decisions to deny or limit coverage and judgments about medical necessity or appropriateness of care.²⁷⁰

External Review Process

Section 641.47(1), F.S., defines the term “adverse determination” to mean a coverage determination by a HMO or prepaid health clinic that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the organization’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and coverage for the requested service is therefore denied, reduced, or terminated. An adverse determination may be the basis for a grievance. A subscriber who chooses to challenge an adverse determination or file another type of grievance is required to first go through the managed care entity’s internal grievance procedure. Once a final decision is rendered through this process, if the decision is unsatisfactory to the subscriber, then the subscriber may appeal through a binding arbitration process provided by the managed care entity or to the Subscriber Assistance Program (SAP).²⁷¹

²⁶⁶ The Florida Senate, *Review of the Implementation of the Statewide Provider and Subscriber Assistance Program*, September 2001, pg. 1-2, available at http://archive.flsenate.gov/data/Publications/2002/Senate/reports/interim_reports/pdf/2002-138hc.pdf (last visited November 27, 2017).

²⁶⁷ Health Maintenance Organization Act of 1973, Title 42, Sec. 300e, et seq.

²⁶⁸ Id.

²⁶⁹ Pollitz, K., Dallek, G., et al., *External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare*, (prepared for Kaiser Family Foundation) Institute for Health Care Research and Policy, November 1998.

²⁷⁰ Id.

²⁷¹ Supra, FN 266.

Subscriber Assistance Program

In 1985, Florida became the second state, following Michigan, to provide a mechanism for consumers to resolve managed care disputes through a state-administered external review process. The Florida program was moved from the Department of Health and Rehabilitative Services (HRS) to AHCA in 1993, and renamed the Statewide Provider and Subscriber Assistance Program (SAP).²⁷²

Section 408.7056, F.S., requires AHCA to implement the SAP to assist consumers of managed care entities with grievances that have not been satisfactorily resolved through the managed care entity's internal grievance process. The program can hear grievances of subscribers of HMOs, prepaid health clinics and exclusive provider organizations.²⁷³

The panel must consist of:

- Members employed by AHCA and members employed by the Office of Insurance Regulation (OIR), chosen by their respective agencies;
- A consumer appointed by the Governor;
- A physician appointed by the Governor, as a standing member; and
- Physicians who have expertise relevant to the case to be heard, on a rotating basis.²⁷⁴

AHCA may contract with a medical director and a primary care physician who may provide additional expertise. The medical director must be selected from a Florida licensed HMO.²⁷⁵

SAP hearings are public, unless a closed hearing is requested by the subscriber. A portion of a hearing may be closed by the panel when deliberating information of a sensitive personal nature, such as medical records.²⁷⁶ In addition to hearings, the panel must meet as often as necessary to timely review, consider, and hear grievances about disputes between a subscriber, or a provider on behalf of a subscriber, and a managed care entity. Following its review, the panel must make a recommendation to AHCA or Office of Insurance Regulation (OIR). The recommendation may include specific actions the managed care entity must take to comply with state laws or rules. AHCA or OIR may adopt all or some of the panel's recommendations and may impose administrative sanctions on the managed care entity.²⁷⁷ The following chart shows the number of cases received by the SAP, the number of cases heard by the panel, and the outcome of each case heard since FY 2009-2010.

²⁷² Id.

²⁷³ Id.

²⁷⁴ S. 408.7056(11), F.S.

²⁷⁵ S. 408.7056(11)(a), F.S.

²⁷⁶ S. 408.7056(14)(b), F.S.

²⁷⁷ S. 408.7056 (9), F.S.

SAP Cases FY 2009-2010 through FY 2016-2017 (YTD)²⁷⁸

SAP Cases	FY 2009-2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016	FY 2016-2017
Total Cases Received (MCD - # Medicaid cases)	498 (70 MCD)	506 (75 MCD)	415 (50 MCD)	213 (57 MCD)	160 (50 MCD)	238 (114 MCD)	350 (204 MCD)	253 (101 MCD)
Total Cases Heard (MCD - # Medicaid cases)	124 (7 MCD)	96 (9 MCD)	74 (3 MCD)	17 (2 MCD)	19 (8 MCD)	29 (12 MCD)	53 (37 MCD)	28 (12 MCD)
Case Outcomes								
Determined Non-Jurisdictional	246	260	224	145	115	166	221	165
Incomplete Application	39	37	40	24	11	27	31	24
Request Withdrawn	27	21	20	9	6	11	26	10
Resolved Before Hearing	68	82	55	18	9	7	19	26
Panel Found for Subscriber	23	23	19	5	7	7	27	6
Panel Found for Plan	95	83	57	12	12	17	25	22

The Patient Protection and Affordable Care Act (PPACA) governs how insurance companies handle initial appeals and how consumers can request reconsideration of a payment denial.²⁷⁹ If an insurance company upholds its decision to deny payment, the law provides consumers with the right to appeal the decision to an outside, independent decision-maker. Insurance companies may choose to participate in a process administered by the federal Department of Health and Human Services (HHS) or contract with independent review organizations in states where the federal government oversees the process.²⁸⁰ Managed care plans that elected to participate in the federal program established by PPACA are no longer required to participate in the SAP.²⁸¹ Following enactment of PPACA, the majority of the health plans elected to use the federal program and, as a result, the SAP is no longer an external appeal option for the majority of their members.²⁸²

Effect of the Bill – Subscriber Assistance Program

The bill repeals s. 408.7056, F.S. that established the SAP. Consumers will no longer be able to use the SAP as an alternative appeal option after exhausting the managed care entity’s grievance process. However, consumers have access to the grievance resolution program provided by PPACA, through either the federally administered process or independent contractor review. Further, the number of cases received by the SAP and the number of cases heard by the panel have steadily decreased over the past eight years. There will be an insignificant adverse effect to consumers as a result of repeal of the SAP because of the small percentage of people currently taking advantage of the program.

The bill also makes conforming changes to the following statutes to reflect repeal of the SAP: ss. 220.1845(2)(k), 376.30781(3)(f), 376.86(1), 627.602(1)(h), 627.6513, 641.185, 641.312, 641.3154, 641.51(5), 641.511, and 641.515(1), F.S.

²⁷⁸ Supra, FN 43.

²⁷⁹ 42 U.S.C. 300gg-19.

²⁸⁰ What are my rights in an external review, Department of Health and Human Services. Available at: <https://www.healthcare.gov/appeal-insurance-company-decision/external-review/> (last visited January 3, 2018).

²⁸¹ Centers for Medicaid and Medicare Services, *The Center for Consumer Information & Insurance Oversight*, available at <https://www.cms.gov/ccio/Programs-and-Initiatives/Consumer-Support-and-Information/External-Appeals.html> (last visited November 20, 2017).

²⁸² Supra, FN 43.

Medicaid Provider Background Investigations

Current law excludes from participation in the Medicaid program, providers who have been convicted of a federal or state criminal offense relating to²⁸³:

- The delivery of goods or services under Medicare, Medicaid, or any other public or private health care or insurance program;
- Neglect or abuse of a patient in connection to the delivery of any health care good or service;
- Unlawful manufacture, distribution, prescription, or dispensing of a controlled substance;
- Fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;
- Moral turpitude, if punishable by imprisonment by a year or more;
- Criminal use of a public record or public records information;
- Unlawful compensation of reward for official behavior;
- Corruption by threat against a public servant;
- Official misconduct;
- Bid tampering;
- Falsifying records;
- Misuse of confidential information; or
- Interfering with or obstructing an investigation into any of the above-listed criminal offenses.

Current law does not provide those who have a disqualifying offense the ability to request an exemption from disqualification.

Effect of the bill – Medicaid Provider Background Investigations

The bill moves the disqualifying offenses for Medicaid providers from s. 409.907(10), F.S., to ch. 435, F.S., which provides those who have a disqualifying offense the ability to request an exemption from disqualification.

Managed Care Ombudsman Committees

Background

The Statewide Managed Care Ombudsman Committee (Committee) is established by s. 641.60, F.S., and was created to serve as a consumer protection and advocacy organization on behalf of health care consumers receiving services through managed care organizations.²⁸⁴ In addition to the statewide Committee, district committees are established to protect consumers receiving managed care services at a more local level. The districts are established by each health service planning district, composed of the following counties:

- District 1—Escambia, Santa Rosa, Okaloosa, and Walton Counties.
- District 2—Holmes, Washington, Bay, Jackson, Franklin, Gulf, Gadsden, Liberty, Calhoun, Leon, Wakulla, Jefferson, Madison, and Taylor Counties.
- District 3—Hamilton, Suwannee, Lafayette, Dixie, Columbia, Gilchrist, Levy, Union, Bradford, Putnam, Alachua, Marion, Citrus, Hernando, Sumter, and Lake Counties.
- District 4—Baker, Nassau, Duval, Clay, St. Johns, Flagler, and Volusia Counties.
- District 5—Pasco and Pinellas Counties.
- District 6—Hillsborough, Manatee, Polk, Hardee, and Highlands Counties.

²⁸³ s. 409.907(10), F.S.

²⁸⁴ S. 641.60(2), F.S.

- District 7—Seminole, Orange, Osceola, and Brevard Counties.
- District 8—Sarasota, DeSoto, Charlotte, Lee, Glades, Hendry, and Collier Counties.
- District 9—Indian River, Okeechobee, St. Lucie, Martin, and Palm Beach Counties.
- District 10—Broward County.
- District 11—Miami-Dade and Monroe Counties.²⁸⁵

Each district committee must have at least nine members and no more than 16 members,²⁸⁶ with the AHCA secretary appointing the first three committee members in each district.²⁸⁷ Each committee is required to have:

- Multiple licensed physicians:
 - one physician licensed under ch. 458;
 - one osteopathic physician licensed under ch. 459;
 - one chiropractor licensed under ch. 460; and
 - one podiatrist licensed under ch. 461;
- One licensed psychologist;
- One registered nurse;
- One clinical social worker;
- One attorney; and
- One consumer.²⁸⁸

Each district committee or member of the committee:

- Must serve to protect the health, safety, and rights of all enrollees participating in managed care programs in this state.
- Must receive complaints regarding quality of care from the agency, and may assist the agency with the resolution of complaints.
- May conduct site visits with the agency, as the agency determines is appropriate.
- Must submit an annual report to the statewide committee concerning activities, recommendations, and complaints reviewed or developed by the district committee during the year.
- Must conduct meetings as required at the call of its chairperson, the call of the agency director, the call of the statewide committee, or by written request of a majority of the district committee members.²⁸⁹

Effect of the Bill - Managed Care Ombudsman Committees

The bill repeals the Statewide Managed Care Ombudsman Committee and district managed care ombudsman committees. Due to the very stringent committee requirements, the Committee could not meet the requirements in the majority of the districts and the program was never fully implemented. The last activity on record was in 2010, and there are currently no active committees.²⁹⁰

The bill provides an effective date of July 1, 2018.

²⁸⁵ S. 408.032(5), F.S.

²⁸⁶ S. 641.65(2), F.S.

²⁸⁷ S. 641.65(3)(a), F.S.

²⁸⁸ S. 641.65(2), F.S.

²⁸⁹ S. 641.65(6), F.S.

²⁹⁰ Supra, FN 43.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

AHCA will realize an annual decrease in revenue of approximately \$64,866 from the repeal of the risk manager application licensure and licensure fees. There will be an annual decrease in revenue of approximately \$1,540,000 from the repeal of AHCA's clinical laboratory licensure requirement and subsequent licensure application fees.²⁹¹

2. Expenditures:

AHCA will no longer expend funds to administer the SAP, health care risk manager licensure, and clinical laboratory licensure programs. AHCA will see an increased workload due to the new background screening requirements for distinct part nursing units and enforcement, issuance of certificates of exemption for health care clinics and home health agencies, and enforcement of rules regarding NICU, transplant, psychiatric and CMR services. However, AHCA will be able to absorb these costs and employees from the eliminated SAP, health care risk manager licensure, and clinical laboratory licensure programs will be reassigned to handle the increased workload.²⁹² The chart below shows the decreased need in FTEs, as well as the decrease in the number of licensure application reviews that will take place due to the elimination of the programs. Conversely, the chart also shows the new need for FTEs and the increased licensure application reviews due to the new programs that will be added.

PROGRAMS BEING ELIMINATED			
Program	Portion of FTE Time on Project	Application Reduction	Application Increase
SAP Program	-1.10		
Health Care Risk Manager Program	-1.00	-600/year	
Clinical Laboratory Program	-2.75	-2,200/year	
Totals	-4.85	-2,800/year	
PROGRAMS TO BE ADDED			
Health Care Clinic Exemption Applications	2.04		5,000/year
Home Health Agency Exemption Application	2.25		1,500/year
Totals	4.29		6,500/year

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

²⁹¹ Supra, FN 43.

²⁹² E-mail correspondence with AHCA staff, January 9, 2018 (on file with the Health and Human Services Committee).

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill will have a positive economic impact to certain providers, including clinical laboratories and health care risk managers that no longer need to be licensed by the state or pay state licensure fees. Also, provisions in the bill that streamline the licensure process for various providers should ease the administrative burden on those providers to comply with licensing laws.

To the extent that health care clinics and home health agencies apply for voluntary certificates of exemption, these entities will have to pay biennial renewal fees.

D. FISCAL COMMENTS:

None.