HOUSE OF REPRESENTATIVES STAFF FINAL BILL ANALYSIS

BILL #: CS/CS/HB 731 Agency for Health Care Administration
SPONSOR(S): Health & Human Services Committee and Health Market Reform Subcommittee, Perez
TIED BILLS: **IDEN./SIM. BILLS:** CS/CS/SB 1726

FINAL HOUSE FLOOR ACTION: 100 **Y's** 14 **N's** **GOVERNOR'S ACTION:** Approved

SUMMARY ANALYSIS

CS/CS/HB 731 passed the House on March 9, 2020, as amended. The bill was amended in the Senate on March 10, 2020, and was returned to the House. The House concurred in the Senate amendment to the House Bill and subsequently passed the bill as amended on March 12, 2020. The bill includes portions of CS/CS/CS/HB 713.

The bill amends various authorizing and licensing statutes for entities regulated by the Agency for Health Care Administration (AHCA), and laws governing the Medicaid program, administered by AHCA. Specifically, the bill:

- Updates requirements for approval of comprehensive emergency management plans for newly licensed facilities;
- Allows a health care facility employee, who has previously qualified with background screening requirements, to apply for an exemption if the law is changed to add a disqualifying offense for which the employee committed prior to being screened;
- Allows AHCA to issue provisional licenses to all regulated providers/facilities;
- Authorizes risk-based, less frequent, licensure inspections for nuse registires, HME providers, and clinics;
- Allows AHCA to use extended inspection periods for high performing hospices and adult day care centers;
- Revises inspection frequency for nursing homes with poor performance from every six months for two years to two surveys a year until the facility has two consecutive surveys without a citation for a class I or a class II deficiency;
- Increases the period of time to obtain designation as a Tier 3 Cancer Center under the Florida Consortium of National Cancer Institute Centers Program from 6 years to 10 years;
- Exempts from clinic licensure federally certified providers, community mental health center-partial hospitalization programs, portable x-ray providers, and rural health clinics;
- Exempts from clinic licensure all Medicaid providers;
- Repeals licensure of multiphasic health testing centers;
- Repeals several statutorily mandated annual reports, and instead directs AHCA to publish the information online;
- Repeals an unenforceable annual assessment on diagnostic imaging centers and ASCs;
- Amends the definition of home health agency to clarify that an agency that provides only home health services, but not staffing services, must be licensed as a home health agency;
- Increases the range of services defined as "shoppable" for purposes of earning shared saving incentives from insurers;
- Extends the rural hospital designation from 2021 to 2025 for a rural hospital licensed during FY 2010-11 or FY 2011-12;
- Removes AHCA authority to establish an alternative methodology to the diagnosis related group-based prospective payment system for class III psychiatric hospitals;
- Allows AHCA to collect legal fees for Medicaid cases in which AHCA prevails;
- Requires AHCA to re-procure contracts with Medicaid managed care plans every 6 years instead of every 5 years, beginning with the contract procurement process initiated in 2023;
- Requires AHCA to extend the existing plan contracts for the prepaid dental health program until December 31, 2024;
- Specifies that Medicaid anti-kickback prohibitions do not apply to any discount, payment, waiver of payment, or payment practice not prohibited under the federal anti-kickback law;
- Requires background screening for Medicaid providers, applicable to individuals who will have direct access to recipients, recipient living areas, or recipient financial, medical, or service records, or who supervise the delivery of goods or services to a recipient;
- Provides that drivers providing transportation to Medicaid recipients through a transportation broker or a transportation network company are required to undergo only level I background screening, consistent with current law; and
- Allows AHCA to conduct retrospective review of Medicaid hospital payments to allow AHCA to recover all overpayments.

The bill has an indeterminate, but likely insignificant, fiscal impact on AHCA. The bill has no fiscal impact to local governments.

The bill was approved by the Governor on June 30, 2020, ch. 2020-157, L.O.F., and the effective date is July 1, 2020, except as otherwise expressly provided.

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 48,000 individual providers.[1] Regulated providers include, for example,

- Birth centers, ch. 383, F.S.
- Crisis stabilization units, parts I and IV of ch. 394, F.S.
- Hospitals, part I of ch. 395, F.S.
- Ambulatory surgical centers, part I of ch. 395, F.S.
- Nursing homes, part II of ch. 400, F.S.
- Assisted living facilities (ALFs), 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.
- Adult day care centers, part III of ch. 429, F.S.
- Hospices, part IV of ch. 400, F.S.
- Home medical equipment providers, part VII of ch. 400, F.S.
- Health care clinics, part X of ch. 400, F.S.
- Multiphasic health testing centers, part II of ch. 483, F.S.

Certain health care providers[2] 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 26 provider types.[3] In addition to the Act, each provider type has an 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]

Provisional Licensure

Current Situation

Section 408.808, F.S., provides the uniform licensing requirements for all health care facilities regulated by AHCA. There are three types of licenses issued by AHCA, including, standard, inactive, and provisional licenses. A standard license is valid for two years and is issued to an applicant at the time of initial licensure, licensure renewal, or a change of ownership.[5] An inactive license is issued to a health care provider subject to certificate of need (CON) review when the provider is licensed, but does not have a provisional license, and will be temporarily unable to provide services but is reasonably expected to resume services within 12 months.[6]

A provisional license is issued to an applicant for licensure renewal when a proceeding is pending to deny or revoke their license.[7] A provisional license may also be issued to an applicant applying for a change of ownership. Provisional licensure must be limited to a specific period of time, up to 12 months, as determined by AHCA. ALF statutes allow AHCA to issue a provisional license to an applicant for initial licensure for a specific period of time not to exceed 6 months. Current law does not allow AHCA to issue a provisional license for initial licensure for any other facility regulated by AHCA.

Effect of the Bill – Provisional Licensure

[1] Agency for Health Care Administration, *Health Quality Assurance*, 2017, available at http://ahca.myflorida.com/MCHQ/ (last visited March 17, 2020).
[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.
[4] S. 408.832, F.S.
[5] S. 408.808(1), F.S.
[6] S. 408.808(3), F.S.
[7] S. 408.808(2), F.S.

The bill amends s. 408.808, F.S., to allow AHCA to issue a provisional license for initial licensure to all regulated providers. According to AHCA, there have been instances when a provider's license is revoked because they forgot to renew their license, so they have to go through the process of applying for initial licensure, which can often take a long time.[8] In such instances, residents or patients have to be moved and other accommodations must be made. Allowing AHCA to issue a provisional license in such instances will allow the provider to go through the licensure process while avoiding an interruption in client services.

Comprehensive Emergency Management Plans

Current Situation

Different provider types are subject to different comprehensive emergency management plan submission requirements in their authorizing statutes. ALFs are required to get plan approval by local emergency management officials prior to being licensed.[9] According to AHCA, some local jurisdictions refuse to review a plan until the provider is licensed, making it impossible for providers within those jurisdictions to become lawfully licensed.[10]

Effect of the Bill – Comprehensive Emergency Management Plans

The bill amends s. 408.821, F.S., to require providers that are required by authorizing statutes and AHCA rule to have a comprehensive emergency management plan to:

- Submit the plan within 30 days after initial licensure and change of ownership, and notify AHCA within 30 days after submission of the plan;
- Submit the plan annually and within 30 days after any significant modification to a previously approved plan;
- Submit necessary plan revisions within 30 days after notification that plan revisions are required; and
- Notify AHCA within 30 days after approval of its plan by the local emergency management agency, county health department, or DOH.

Birth Centers

Current Situation

A birth center is any facility, institution, or place, which is not an ambulatory surgical center or a hospital, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy.[11] Birth centers are licensed and regulated by AHCA under ch. 383, F.S., and part II of ch. 408, F.S.

AHCA is required to adopt rules establishing minimum standards for birth centers, which ensure:

- Sufficient numbers and qualified types of personnel and occupational disciplines are available at all times to provide necessary and adequate patient care and safety;
- Infection control, housekeeping, sanitary conditions, disaster plan, and medical record procedures that will adequately protect patient care and provide safety are established and implemented; and

[8] Supra FN 9.
[9] S. 429.41(1)(b), F.S.
[10] Supra FN 9.
[11] S. 383.302(2), F.S. Section 383.302(8), F.S.

- Licensed facilities are established, organized, and operated consistent with established programmatic standards. [12]

Section 383.327, F.S., requires birth centers to submit an annual report to AHCA, the contents of which are to be prescribed by AHCA rule. Current law does not expressly authorize AHCA to adopt rules to change the frequency for submission of the report. Rule 59A-11.019, F.A.C., requires birth centers to submit the annual report using an electronic form, which includes reportable data fields on:

- The number of deliveries by birth weight;
- The number of maternity clients accepted for care and length of stay;
- The number of surgical procedures performed at the birth center by type;
- Maternal transfers, including the reason for the transfer, whether it occurred intrapartum or postpartum, and the length of the hospital stay;
- Newborn transfers, including the reason for the transfer, birth weight, days in hospital, and APGAR score[13] at five and ten minutes;
- Newborn deaths; and
- Stillborn/Fetal deaths. [14]

Effect of the Bill – Birth Centers

The bill amends s. 383.327, F.S., to remove the statutory requirement for the report to be submitted annually. Instead, the bill authorizes AHCA to adopt rules to establish the frequency at which the report is submitted. According to AHCA, this will allow the Agency to change the annual reporting requirement in AHCA rule to require more frequent submission.[15]

Birth centers are also required to immediately report each maternal death, newborn death, and stillbirth to the medical examiner. However, current law does not require birth centers to immediately report such deaths to AHCA. The bill requires birth centers to immediately report to AHCA each maternal death, newborn death, and stillbirth.

[12] Section 383.309, F.S.; The minimum standards for birth centers are contained in Chapter 59A-11, F.A.C.
[13] The AGPAR score is the result of a test given by the delivering physician, midwife or nurse to measure a baby's heart rate, muscle tone, and other signs to determine if extra medical attention is needed. A newborn is scored on a scale of 0 to 2, with 2 being the best score for each of the following: appearance (skin color), pulse (heart rate), grimace response (reflexes), activity (muscle tone), and respiration (breathing rate).
[14] Rule 59A-11.019, F.A.C., and AHCA Form 3130-3004, (Apr. 2019).
[15] Agency for Health Care Administration, 2020 Legislative Bill Analysis-HB 731, January 28, 2020 (on file with Health & Human Services committee staff).

Hospital Licensure

Current Situation

In 2019, the Legislature eliminated certificate of need (CON) review for general hospitals.[16] Section 395.003, F.S., requires AHCA to include certain information on a license issued to a hospital, including the service categories and the number of hospital beds in each bed category. Current law in this section includes an outdated CON provision directing AHCA to identify hospital beds as general beds on the face of the hospital's license, when not covered by any specialty-bed-need methodology. Beds covered by a specialty-bed-need methodology include neonatal intensive care beds, comprehensive medical rehabilitation beds, adult psychiatric beds, child/adolescent psychiatric beds, and adult substance abuse beds. Currently, these specialty hospital beds might be incorrectly reported as general beds on the face of the hospital's license.

Effect of the Bill – Hospital Licensure

The bill removes this obsolete language to allow hospital licenses to correctly reflect the actual bed categories provided by a licensee.

Adult Cardiovascular Services in Hospitals

Current Situation

Current AHCA rules require a hospital with a level I or level II adult cardiovascular services program[17] to report certain data on clinical outcomes to the American College of Cardiology National Cardiovascular Data Registry.[18] When the Legislature repealed certificate of need review for general hospitals in 2019, it moved licensure requirements and rulemaking authority for adult cardiovascular services from part II of ch. 408, F.S., to the hospital licensing statutes in part I of ch. 395, F.S. However in doing so, it inadvertently did not include the authority for AHCA to develop rules on the reporting of data on clinical outcomes to the American College of Cardiology National Cardiovascular Data Registry. AHCA is currently in the process of revising the rules for adult cardiovascular service programs, and the draft rule deletes the requirement for hospitals with adult cardiovascular service programs to report data to the registry because AHCA no longer has the authority to implement such rules due to the inadvertent repeal of the rulemaking authority.

Effect of the Bill – Adult Cardiovascular Services in Hospitals

The bill reinstates authority for AHCA to adopt rules to require hospitals with adult cardiovascular service programs to report data on clinical outcomes to national data registries operated by the American College of Cardiology or the American Heart Association to ensure these licensed programs meet or exceed national quality and outcome benchmarks. The bill also requires hospitals licensed to provide level II adult cardiovascular services to participate in the clinical outcome reporting systems operated by the Society for Thoracic Surgeons.

[16] Ch. 2019-136, L.O.F.
[17] S. 395.1055(18)(a), F.S. Level I adult cardiovascular services programs are authorized to perform adult percutaneous cardiac interventions without onsite cardiac surgery. Level II programs are authorized to perform adult percutaneous cardiac interventions with onsite cardiac surgery.
[18] Rule 59A-3.246(2) and (3), F.A.C.

Rural Hospitals

Current Situation

A rural hospital is an acute care hospital that has 100 or fewer licensed beds and an emergency room that is:[19]

- The sole provider within a county with a population density of up to 100 persons per square mile;[20]
- 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;[21]
- A hospital supported by a tax district or subdistrict whose boundaries encompass a population of up to 100 persons per square mile;[22]
- A hospital classified as a sole community hospital under 42 C.F.R. § 412.92 regardless of the number of licensed beds;[23]
- A hospital with a service area that has a population of up to 100 persons per square mile;[24] or
- A hospital designated as a critical access hospital, as defined in s. 408.07.[25]

There are currently 28 hospitals in Florida that are designated as rural hospitals.[26]

Currently, a hospital designated as a rural hospital by meeting one of the criteria above during the 2010-11 or 2011-12 fiscal years does not have to continue to meet any of the criteria above to be considered a rural hospital. However, pursuant to s. 395.602(2)(b), F.S., on June 30, 2021, they will be required to continuously meet one of the qualifying criteria to retain designation as a rural hospital.

Section 409.9116, F.S., requires AHCA to administer a federally-matched disproportionate share hospital funding program[27] and a state-funded financial assistance program for rural hospitals. AHCA is required to make disproportionate share payments to rural hospitals that qualify for such payments, and it must make financial assistance payments to rural hospitals that do not qualify for disproportionate share payments.[28] The same formula is used to calculate both of these payments, so in effect, rural hospitals are guaranteed to receive payments equal to disproportionate share payments whether they qualify for them or not.[29] AHCA must distribute the funds quarterly in each fiscal year in which an appropriation is made.

[19] S. 395.602(2)(b), F.S.
[20] S. 395.602(2)(b)1., F.S.
[21] S. 395.602(2)(b)2., F.S.
[22] S. 395.602(2)(b)3., F.S.
[23] S. 395.602(2)(b)4., F.S.
[24] S. 395.602(2)(b)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.
[25] S. 395.602(2)(b)6., F.S.
[26] AHCA, Florida Health Finder, *Facility/Provider Search, Hospitals, Rural Hospitals,* available at https://www.floridahealthfinder.gov/facilitylocator/facloc.aspx (search conducted March 17, 2020).
[27] 42 U.S.C. ss. 1396a and 1396r-4. Federal law requires state Medicaid programs to make Disproportionate Share Hospital (DSH) payments to qualifying hospitals that serve a large number of Medicaid recipients and uninsured individuals. The federal government annually provides a limited DSH allotment to each state. States may appropriate these federal funds based on the amount of state dollars appropriated as matching funds, up to but not exceeding the federal limit.
[28] S. 409.9116, F.S.
[29] S. 409.9116(1), F.S.

Effect of the Bill – Rural Hospitals

The bill extends the rural hospital designation from 2021 to 2025 for a hospital licensed as a rural hospital during the 2010-11 or 2011-12 fiscal years. According to AHCA, this would only impact Putnam Medical Center in Palatka.[30] As a result, Putnam Medical Center will be eligible to receive disproportionate share program reimbursements of up to $3.47 million for inpatient services and $1.73 million for outpatient services based on 2019-20 FY models.[31]

Annual Assessments on Health Care Facilities

Current Situation

Section 395.7015, F.S., imposes an annual assessment on ambulatory surgical centers and certain diagnostic imaging centers[32], to be deposited into the Public Medical Assistance Trust Fund (PMATF). These assessments were ruled unconstitutional in 2002, and are no longer collected.[33]

Effect of the Bill – Annual Assessments on Health Care Facilities

The bill repeals s. 395.7015, F.S., to remove unenforceable statutory authority for AHCA to collect the annual assessments. The bill also amends s. 395.7016, F.S., to make a conforming change by removing a cross-reference to s. 395.7015, F.S.

Nursing Home Inspections

Current Situation

Uniform licensing requirements in s. 408.811, F.S., require all facilities licensed by AHCA to be inspected biennially unless otherwise specified in statute or rule.

Section 400.19, F.S., requires AHCA to conduct at least one unannounced inspection of licensed nursing homes every 15 months. Federal law also requires AHCA to inspect nursing homes every 15 months.[34]

Current law in s. 400.19, F.S., also requires AHCA to conduct additional inspections of nursing homes that are cited for multiple deficiencies within specified timeframes. Specifically, AHCA is required to inspect a nursing home every six months for two years if the facility has been cited for a class I deficiency[35], has been cited for two or more class II deficiencies[36] arising from separate surveys or investigations within a 60-day period, or has had three or more substantiated complaints within a six-month period that resulted in at least one class I or class II deficiency. Current law also requires nursing homes to pay a $6,000 fine for falling under the additional inspection cycle.

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[30] Supra FN 9.
[31] Id.
[32] Diagnostic imaging centers that are freestanding outpatient facilities that provide specialized services for the identification or determination of a disease through examination and also provide sophisticated radiological services, and in which services are rendered by a licensed physician or a licensed osteopathic physician.
[33] *Agency for Health Care Administration v. Hameroff,* 816 So. 2d 1145, 1149-1150 (Fla. 1st DCA 2002).
[34] 42 C.F.R. §. 488.308(a).
[35] S. 408.813(2)(a), F.S. Class "I" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines present an imminent danger to the clients of the provider or a substantial probability that death or serious physical or emotional harm would result therefrom. The condition or practice constituting a class I violation shall be abated or eliminated within 24 hours, unless a fixed period, as determined by the agency, is required for correction. The agency shall impose an administrative fine as provided by law for a cited class I violation. A fine shall be levied notwithstanding the correction of the violation.
[36] S. 408.813(2)(b), F.S. Class "II" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines directly threaten the physical or emotional health, safety, or security of the clients, other than class I violations. The agency shall impose an administrative fine as provided by law for a cited class II violation. A fine shall be levied notwithstanding the correction of the violation.

Effect of the Bill – Nursing Home Inspections

The bill amends s. 400.19, F.S., to remove the 15-month inspection requirement. However, AHCA will still be required to inspect nursing homes every 15 months as required by federal law.

The bill revises the requirement for AHCA to additionally inspect nursing homes every six months for two years as detailed above. Instead, if a facility has been cited for a class I deficiency, has been cited for two or more class II deficiencies arising from separate surveys or investigations within a 60-day period, or has had three or more substantiated complaints within a six-month period that resulted in at least one class I or class II deficiency, the bill requires AHCA to conduct biannual inspections until the facility has two consecutive licensure surveys without a citation for a class I or a class II deficiency under those circumstances.

Hospice Inspections

Current Situation

Section 400.605, F.S., requires AHCA to conduct annual inspections of hospices, with the exception that inspections may be conducted biennially for hospices having a three-year record of substantial compliance.

Effect of the Bill – Hospice Inspections

The bill amends s. 400.605, F.S., removing the requirement for AHCA to inspect hospices annually, or biennially for hospices having a three-year record of substantial compliance. Instead, the bill requires AHCA to inspect hospices biennially in accordance with the uniform licensing requirements in s. 408.811, F.S. In addition, the bill authorizes AHCA to conduct inspections less frequently than biennially. The bill requires AHCA to consider certain measures reflective of quality and safety in granting an extended inspection period to a hospice, including whether the facility has:

- A favorable regulatory history of deficiencies, sanctions, complaints, and other regulatory measures;
- Outcome measures that demonstrate quality performance;
- Successful participation in a recognized, quality program; and
- Accreditation status.

The bill requires AHCA to continue to conduct unannounced licensure inspections on at least 10 percent of providers that qualify for the extended inspection period.

Adult Day Care Center Inspections

Current Situation

Adult day care centers are inspected biennially by AHCA in accordance with the uniform licensing requirements in s. 408.811, F.S. Adult day care center programs that are collocated in an ALF or a nursing home are also required to be inspected biennially by AHCA pursuant to the adult day care center licensing statute in s. 429.905, F.S.

Section 429.929, F.S., authorizes AHCA to conduct, in lieu of a full inspection, an abbreviated biennial inspection of key quality of care standards if the adult day care center has a record of good performance.

Effect of the Bill – Adult Day Care Center Inspections

The bill amends s. 429.905, F.S., to remove the biennial inspection requirement for adult day care center programs collocated in an ALF or a nursing home. As a result, AHCA will be required to inspect adult day care center programs collocated in an ALF or a nursing home in accordance with the inspection requirements for ALFs and nursing homes. For nursing homes, the inspection frequency is once every 15 months. For adult day care centers collocated in an ALF, the inspections will be in accordance with the new ALF inspection requirements detailed in the ALF section above. This will have no measurable effect because both settings in which an adult day care center may be collocated will be inspected more frequently than biennially.

The bill removes the authority for AHCA to conduct abbreviated biennial inspections of adult day care centers. Instead, the bill requires AHCA to inspect adult day care centers biennially in accordance with the uniform licensing requirements in s. 408.811, F.S. In addition, the bill authorizes AHCA to conduct inspections less frequently than biennially. The bill requires AHCA to consider certain measures reflective of quality and safety in granting an extended inspection period to an adult day care center, including whether the facility has:

- A favorable regulatory history of deficiencies, sanctions, complaints, and other regulatory measures;
- Outcome measures that demonstrate quality performance;
- Successful participation in a recognized, quality program; and
- Accreditation status.

The bill requires AHCA to continue to conduct unannounced licensure inspections on at least 10 percent of providers that qualify for the extended inspection period.

Inspections of Health Care Clinics, Home Medical Equipment Providers and Nurse Registries

Current Situation

Health care clinics, home medical equipment providers, and nurse registries are all subject to initial licensure inspections and biennial inspections pursuant to the uniform licensing requirements of s. 408.811, F.S.

According to AHCA, the inspection history for these three provider types have been good compared to other provider types, which indicates to AHCA that they are low-risk providers as compared to other providers.[37]

The results of inspections of these three provider types conducted during Fiscal Years 2017-18 and 2018-19 found that:

- 87 percent of health care clinics were deficiency free;
- 79 percent of home medical equipment providers were deficiency free; and
- 59 percent of nurse registries were deficiency free.[38]

Effect of the Bill – Inspections of Health Care Clinics, Home Medical Equipment Providers and Nurse Registries

The bill exempts health care clinics, home medical equipment providers, and nurse registries from initial licensure inspections and biennial inspections. Instead, the bill authorizes AHCA to conduct verification of compliance inspections for health care clinics, home medical equipment providers, and nurse registries. The bill requires AHCA to continue to conduct unannounced licensure inspections on at least 10 percent of providers to verify regulatory compliance. According to ACHA, this will provide the agency

[37] Id.
[38] Id.

the flexibility to conduct fewer inspection visits to providers with a good regulatory history, and allow them to spend more time and resources inspecting poorly performing providers.[39]

Home Health Agencies

Current Situation

A "home health agency" is an organization that provides home health services and staffing services.[40] According to AHCA, there is concern that the definition could be interpreted to mean a provider is exempt from licensure as a home health agency if they provide home health services but not staffing services.[41]

Home health services are health and medical services and supplies furnished by an organization[42] to an individual in the individual's home or place of residence, including organizations that provide one or more of the following:

- Nursing care:
- Physical, occupational, respiratory, or speech therapy;
- Home health aide services;
- Dietetics and nutrition practice and nutrition counseling; or
- Medical supplies, restricted to drugs and biologicals prescribed by a physician.[43]

According to AHCA, the current definition of organization is problematic because it only refers to entities and does not include an individual person, which creates a loophole for an individual to employ health care personnel for the provision of home health services without having to obtain a license.[44]

Current law, requires an applicant for initial home health agency licensure to provide proof of accreditation and a survey demonstrating compliance with survey standards prior to the addition of skilled care or services. However, current law does include such requirements for a change of ownership or licensure renewal.[45]

[39] Supra FN 9.
[40] S. 400.462(12), F.S.
[41] Id.
[42] S. 400.462(22), F.S. Organization means a corporation, government or governmental subdivision or agency, partnership or association, or any other legal or commercial entity, any of which involve more than one health care professional discipline; a health care professional and a home health aide or certified nursing assistant; more than one home health aide; more than one certified nursing assistant; or a home health aide and a certified nursing assistant. The term does not include an entity that provides services using only volunteers or only individuals related by blood or marriage to the patient or client.
[43] S. 400.462(14), F.S.
[44] Supra FN 9.
[45] S. 400.471((2)(g), F.S.

Effect of the Bill – Home Health Agencies

The bill amends the definition of home health agency by removing the reference to staffing services to clarify that a home health agency that provides only home health services, but not staffing services, is required to be licensed as a home health agency.

The bill also deletes the definition of organization to exclude programs that offer home visits for a single profession. According to AHCA, this change will clarify that current law only requires a home health license when an organization offers multiple professional disciplines in the home.[46] The bill amends various sections of home health agency statute to replace the term "organization" with "person".

The bill retains an exemption from home health agency licensure for a person that provides skilled care by health care professionals licensed solely under part I of ch. 464, F.S. (nursing), part I, part III, or part V of ch. 468, F.S. (speech, operational or respiratory therapy), or part V of ch. 486, F.S. (physical therapy). According to AHCA, this exemption indirectly exists within the current definition of "organization", which is deleted by the bill.[47] AHCA states that by adding this exemption, a person or entity would be able to voluntarily apply for a certificate of exemption from home health agency licensure as documentation of exempt status.[48]

The bill requires applicants for, not only initial licensure, but also for a change of ownership or license renewal to provide proof to AHCA of accreditation and a survey demonstrating compliance with survey standards prior to the addition of skilled care or services.

Health Care Clinic Act

The Health Care Clinic Act (Act), ss. 400.990 – 400.995, F.S., was enacted in 2003 to reduce fraud and abuse in the personal injury protection (PIP) insurance system.[49] Pursuant to the Act, AHCA licenses health care clinics, ensures that clinics meet basic business and billing related standards, and provides administrative oversight.

Pursuant to the uniform licensure requirements of part II of ch. 408, F.S., applicants for licensure as a health care clinic are required to demonstrate financial ability to operate by showing that the applicant's assets, credits, and projected revenues will meet or exceed projected liabilities and expense[50] As an alternative to submitting proof of financial ability to operate, s. 400.991, F.S., allows a health care clinic to submit a surety bond to AHCA of at least $500,000. According to AHCA, no clinic has ever submitted a surety bond instead of submitting proof of financial ability to operate.[51]

The bill amends s. 400.991, F.S., to remove the alternative option for a health care clinic to prove their financial ability to operate.

[46] Supra FN 9
[47] Id.
[48] Id.
[49] Chapter 2003-411, Laws of Fla. PIP insurance is no fault auto insurance that provides certain benefits for individuals injured as a result of a motor vehicle accident. All motor vehicles registered in this state must have PIP insurance.
[50] S. 408.8065, F.S., and s. 408.810, F.S.
[51] Supra FN 9.

Healthcare Clinic Exemptions

Federally Certified Providers

Current Situation

Any entity that meets the definition of a health care clinic must be licensed as a health care clinic. However, the Act creates many exceptions from the health care clinic licensure requirements.[52] A health care clinic may voluntarily apply for a certificate of exemption for a fee of $100.[53] Certificates of exemption are valid for up to two years.[54] Among many other exemptions, certain federally certified entities are exempt from licensure under the Act, including:

- Entities federally certified as end-stage renal disease providers, comprehensive outpatient rehabilitation facilities, outpatient physical therapy and speech-language pathology providers, and clinical laboratories;
- Entities that own, directly or indirectly, entities federally certified as end-stage renal disease providers, comprehensive outpatient rehabilitation facilities, outpatient physical therapy and speech-language pathology providers, and clinical laboratories;
- Entities that are owned, directly or indirectly, by an entity federally certified as end-stage renal disease providers, comprehensive outpatient rehabilitation facilities, outpatient physical therapy and speech-language pathology providers, and clinical laboratories; and
- Entities that are under common ownership, directly or indirectly, with an entity federally certified as end-stage renal disease providers, comprehensive outpatient rehabilitation facilities, outpatient physical therapy and speech-language pathology providers, and clinical laboratories.

Federal certification requirements are more stringent than the licensure standards of the Health Care Clinic Act. Current Florida law does not include exemptions from health care clinic licensure for federally certified community mental health center-partial hospitalization programs[55], portable x-ray providers[56], or rural health care clinics[57].

Effect of the Bill – Federally Certified Providers

The bill creates exemptions for federally certified community mental health center-partial hospitalizatioin programs, portable x-ray providers, and rural health care clinics similar to current exemptions for other federally certified providers. Approximately 200 providers will qualify for this exemption.[58]

Ownership

Current Situation

In 2019, SB 2502 (Implementing the 2019-2020 General Appropriations Act (GAA)), provided two exemptions from health care clinic licensure in order to implement specific appropriations[59], of the GAA. The exemptions expire on July 1, 2020. Specifically, the bill provided an exemption for entities:

[52] S. 400.9905(4), F.S.
[53] S. 400.9935(6), F.S.
[54] Id.
[55] 42 C.F.R. §§. 485.900-485.920.
[56] 42 C.F.R. §§. 486.100-486.110.
[57] 42 C.F.R. §§. 491.1-491.12.
[58] Supra FN 9.
[59] 2019, HB 5001, General Appropriations Act, lines 208, 25-236, 368. Funds in specific appropriation 208 are for the inclusion of freestanding dialysis clinics in the Medicaid Program. Funds in specific appropriation 368 are to fund the following projects: Citrus Health Network; Apalachee Center Forensic Treatment Services; Mental Health Care-Forensic Treatment Services; Apalachee Center-Civil Treatment Services; New Horizons of the Treasure Coast-Civil Treatment Services.

- Under the common ownership or control by a mutual insurance holding company with an entity licensed or certified under chapter 624, F.S., or chapter 641, F.S., that has $1 billion or more in total annual sales in this state; or
- Owned by an entity who is a behavioral health service provider in at least 5 states other than Florida and that, together with its affiliates, have $90 million or more in total annual revenues associated with the provision of behavioral health care services and where one or more of the persons responsible for the operations of the entity is a health care practitioner who is licensed in this state and who is responsible for supervising the business activities of the entity and is responsible for the entity's compliance with state law for purposes of part X of chapter 400, F.S.

Effect of the Bill - Ownership

The bill makes permanent the exemptions above that are set to expire on July 1, 2020.

Medicaid Providers

Current Situation

In December, 2019, AHCA amended the Medicaid Provider Enrollment Policy rule to require certain providers to be licensed as health care clinics or show proof of exemption from licensure as health care clinics as a condition of enrolling as Medicaid providers.[60] Providers enrolling in Medicaid and providers already enrolled in Medicaid as a provider type listed in the table below must show proof of health care clinc licensure or exemption by the dates listed in the table below.[61]

Medicaid Provider Health Care Clinic License or Proof of Exemption Compliance Dates

Provider Type	Compliance Date
Advanced Practice Registered Nurse	March 1, 2021
Audiologist	September 1, 2020
Behavior Analysis	December 1, 2020
Chiropractor	September 1, 2020
Community Behavioral Health Services	December 1, 2020
Dentist	September 1, 2020
Hearing Aid Specialist	September 1, 2020
Independent Laboratory	September 1, 2020
Midwife	September 1, 2020
Optician	July 1, 2020
Optometrist	July 1, 2020
Physician (M.D.)	June 1, 2021
Physician (D.O.)	June 1, 2021
Physician Assistant	July 1, 2020
Podiatrist	July 1, 2020
Portable X-ray Company	September 1, 2020
Registered Nurse	September 1, 2020
Rural Health Clinic	September 1, 2020
Specialized Therapeutic Services	July 1, 2020
Therapies: Physical, Occupational, Speech, Respiratory	March 1, 2021

[60] Rule 59G-1.060
[61] Agency for Health Care Administration, *Florida Medicaid Provider Enrollment Policy, December 2019,* at pg. 86, available at https://ahca.myflorida.com/medicaid/review/General/59G-1.060_Enrollment.pdf (last visited March 17, 2020).

AHCA estimates 20,000 providers may be required to be licensed as a health care clinic or obtain an exemption from licensure as a health care clinic as a result of this policy.[62] After adopting this policy in rule, AHCA requested statutory changes to override it.

Effect of the Bill – Medicaid Providers

The bill creates an exemption from health care clinic licensure for all Medicaid providers. AHCA estimates that approximately 20,000 providers would qualify for the exemption.[63]

Public Posting of a Schedule of Charges

Current Situation

Current law in s. 400.9935, F.S., requires health care clinics to publish a schedule of charges for the medical services offered to patients. The schedule must include the prices charged to an uninsured person paying for services by cash, check, credit card, or debit card. The schedule may group services by three price levels, listing services in each price level. The schedule may be a sign that must be at least 15 square feet in size or an electronic messaging board that is at least three square feet in size. A health care clinic that does not publish and post a schedule of charges may be assessed a fine of up to $1,000 per day.

Further, the statute requires the schedule to be posted in a conspicuous place in the reception area of an urgent care center. The specific reference to an urgent care center complicates the interpretation as to whether the posting requirements apply only to urgent care centers or to all health care clinics. AHCA interprets the provision as creating authority to enforce the posting requirements on all health care clinics, including urgent care centers.[64]

Effect of the Bill – Public Posting of a Schedule of Charges

The bill removes the ambiguity of the current law by specifically requiring an urgent care center to post a schedule of charges in their reception area. The bill is silent as to the means by which all other health care clinics will be required to publish a schedule of charges; however, AHCA has indicated that the Agency will continue to require clinics to publish them on the clinic's website, in a document available at the clinic, in a scanned document that can be emailed upon request, or in posted signage of an undetermined size.[65]

AHCA Reports

Current law requires AHCA to publish numerous reports on health care data. Some of the reports are obsolete, and others are no longer necessary because the data is readily available online.

Hospice Annual Report

Current Situation

Section 400.60501, F.S., provides reporting requirements for AHCA on certain hospice data. AHCA is required to make available to the public the national hospice outcome measures and survey data in a format that is comprehensible by a layperson and that allows a consumer to compare such measures of one or more hospices. Further, AHCA is required to develop an annual report that analyzes and evaluates the national hospice outcome measures and survey data.

[62] Supra FN 9.
[63] Id.
[64] Id.
[65] Id.

Effect of the Bill – Hospice Annual Report

The bill removes the requirement for AHCA to develop an annual report, but retains the requirement for AHCA to make the national hospice outcome measures and survey data available to the public. AHCA already publishes the outcome measures and survey data on FloridaHealthFinder.gov.[66]

Electronic Prescribing Annual Report

Current Situation

Electronic prescribing is the electronic review of a patient's medication history, the electronic generation of the patient's prescription, and the electronic transmission of the patient's prescription to a pharmacy.[67] Current law requires AHCA to work with electronic prescribing initiatives and relevant stakeholders to create a clearinghouse of information on electronic prescribing for health care practitioners, health care facilities, and pharmacies.[68] AHCA must monitor the implementation of electronic prescribing and provide an annual report on the progress of implementation to the Governor and the Legislature. The report is also required to include information on federal and private sector electronic prescribing initiatives and, to the extent that data is readily available from organizations that operate electronic prescribing networks, the number of health care practitioners using electronic prescribing and the number of prescriptions electronically submitted.[69] AHCA publishes the electronic prescribing data online[70], and it is updated quarterly.

Effect of the Bill – Electronic Prescribing Annual Report

The bill removes the requirement for AHCA to provide an annual report on the progress of implementation to the Governor and the Legislature. Instead, the bill requires AHCA to annually publish the report online.

Emergency Department Utilization Annual Report

Current Situation

Section 408.062, F.S., requires AHCA to conduct research, analyses, and studies relating to health care costs and access to and quality of health care services, which must include the use of emergency department services by patient acuity level and the implication of increasing hospital cost by providing non-urgent care in emergency departments. Based on this monitoring and assessment, AHCA must submit an annual report to the Governor and the Legislature, and substantive Legislative committees. Most of, but not all, of the information required to be in the annual report is available anytime by using the emergency department query tool on FloridaHealthFinder.gov. Not included on the website is the use of emergency department services by patient acuity level and its impact on increasing hospital cost by providing non-urgent care in emergency departments.

Effect of the Bill – Emergency Department Utilization Annual Report

The bill repeals annual report on emergency department utilization required to be sent to the Governor and the Legislature. Instead, the bill requires AHCA to annually publish online, information on the use of emergency department services by patient acuity level.

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[66] AHCA, FloridaHealthFinder.gov, Hospice Quality Reporting Program, CAHPS (Patient and Family Experience Measures-Consumer Assessment of Healthcare Providers and Systems), and HIS (Quality of Patient Care Measures-Hospice Item Set), available at https://www.floridahealthfinder.gov/Hospice/Hospice.aspx (last visited March 17, 2020).
[67] S. 408.0611(2)(a), F.S.
[68] Ch. 2007-156, Laws of Fla.
[69] S. 408.0611(4), F.S.
[70] AHCA, ePrescribing Dashboard, Quarterly Metrics Summary and Data Charts, available at http://fhin.net/eprescribing/dashboard/index.shtml (last visited March 17, 2020).

Florida Center for Health Information and Transparency Annual Report

Current Situation

Section 408.062, F.S., requires AHCA to publish on its website, and make available in a hard copy format upon request, data on patient charges, volumes, length of stay, and performance indicators from data collected from hospitals, for specific procedures, medical conditions, surgeries, and procedures provided in inpatient and outpatient facilities. The data must be updated quarterly. AHCA is also required to submit an annual report on the status of the collection of data and publication of health care quality measures to the Governor and the Legislature, and substantive Legislative committees. All of this information is easily accessible on FloridaHealthFinder.gov[71], and the data is updated bi-weekly.

Effect of the Bill – Florida Center for Health Information and Transparency Annual Report

The bill retains the requirement for AHCA to publish data currently contained in the annual report, but removes the requirement for the annual report to be submitted to the Governor, and the Legislature. According to AHCA, if the bill passes, all of the data that is currently required to be published will still be easily accessible for consumers and others.[72]

State Health Expenditures Annual Report

Current Situation

Section 408.063, F.S., requires AHCA to annually publish a comprehensive report of state health expenditures, which must identify the contribution of health care dollars made by all payers, and the dollars expended by type of health care service. According to AHCA, the data used to generate the Expenditure Report is not available until several years after the reporting period. AHCA publishes the current year report utilizing the available data from three years prior. The report includes information collected from the Department of Economic Opportunity, the U.S. Census Bureau, CMS, the Florida Office of Insurance Regulation (OIR), and the U.S. Bureau of Economic Analysis. All data is publicly available on relevant government agency websites. The dashboard associated with this report received only 14 website hits over the course of a year.[73]

Effect of the Bill – State Health Expenditures Annual Report

The bill removes the requirement for AHCA to publish the State Health Expenditures Annual Report. Should the bill pass, AHCA will no longer collect this information or publish it in any manner.

[71] AHCA, Research Studies and Reports, Florida Center for Health Information and Transparency Annual Report, available at https://www.floridahealthfinder.gov/researchers/studies-reports.aspx (last visited March 17, 2020).
[72] Supra FN 9
[73] Id.

Health Flex Plan Annual Report

Current Situation

The health flex plan began as a pilot program[74] to cover basic and preventative health care services to low-income families not eligible for public assistance programs and not covered by private insurance. Health flex plans are unique compared to the common health insurance plan. A health flex plan may limit or exclude benefits otherwise required by law, or they can cap the total amount of claims paid per year to an enrollee.[75] The pilot program began with three health flex plans in the three areas of the state with the highest number of uninsured individuals. Today, there is only one remaining health flex plan with less than 300 members.[76]

Section 408.909(9), F.S., requires AHCA and OIR to jointly submit an annual report to the Governor and the Legislature, which must include:

- An evaluation of the entities that seek approval as health flex plans;
- The number of enrollees and the scope of health care coverage offered;
- An assessment of the health flex plans and their potential applicability in other settings; and
- Information to evaluate low-income consumer driven benefit packages

According to AHCA, the online report has received no website hits in over a year.[77]

Effect of the Bill – Health Flex Plan Annual Report

The bill repeals the health flex plan evaluation and annual reporting requirements. Should the bill pass, AHCA and OIR will still be required to collect certain data on health flex plans.

Cover Florida Health Care Access Program Annual Report

Current Situation

In 2008, the Legislature created the Cover Florida Health Access Program to provide affordable health care options for uninsured residents. A Cover Florida plan must have two alternate benefit option plans having different cost and benefit levels, including at least one plan that provides catastrophic coverage. Plans without catastrophic coverage must provide coverage options for certain services like preventive health services, behavioral health services, durable medical equipment, inpatient hospital stays, hospital emergency services, urgent care and more.[78]

Section 408.9091, F.S., requires AHCA and OIR to:

- Evaluate the Program and its effect on the entities that seek approval, the number of enrollees, and on the scope of the health care coverage offered;
- Provide an assessment of the plans and their potential applicability in other settings;
- Use plans to gather more information to evaluate low-income, consumer-driven benefit packages; and
- Jointly submit an annual report to the Governor and the Legislature, which must include the gathered information above, and must include recommendations relating to the successful implementation and administration of the program.

[74] Ch. 2002-389, Laws of Fla.
[75] S. 409.909(3), F.S.
[76] Supra FN 9.
[77] Id.
[78] S. 408.9091(4)(a), F.S.

Currently, there are no plans participating in the Cover Florida Health Care Access Program, and the last participating plan terminated its coverage policies in 2015.[79]

Effect of the Bill – Cover Florida Health Care Access Program Annual Report

The bill removes the requirement for AHCA and OIR to submit an annual report on the Cover Florida Health Care Access Program to the Governor and the Legislature. The bill retains current law requiring AHCA and OIR to evaluate and assess the program.

ALF Sanctions Annual Report

Current Situation

Section 429.19(9), F.S., requires AHCA to annually develop a list of all facilities that were sanctioned or fined, which must include the number and class of violations involved, the penalties imposed, and the current status of the cases. Upon developing the list, AHCA must annually disseminate it to the Department of Elder Affairs, the Department of Health, the Department of Children and Families, the Agency for Persons with Disabilities, the area agencies on aging, the Florida Statewide Advocacy Council, the State Long-Term Ombudsman Program, and state and local ombudsman councils.

The Department of Children and Families must then disseminate the list to their contracted service providers who are responsible for referring individuals to an ALF for residency. The list may be provided electronically or through AHCA's website. The statutory requirement for AHCA to annually disseminate the list of ALF sanctions was adopted in 1993. Since that time, AHCA has committed significant resources towards moving information online that may be used by a consumer in selecting a health care provider, including the history of an ALF's citations and violations. The provider-specific information on FloridaHealthFinder.gov is updated nightly to reflect licensure status, inspection details, and legal case activities.[80] However, aggregate data on the ALF industry is not provided on the website.

Effect of the Bill

The bill repeals s. 419.19(9), F.S. As a result, AHCA would no longer be required to annually compile or disseminate a list on facilities that were sanctioned or fined. Information on sanctions and fines is available online by specific provider.[81] Further, DCF would no longer be required to disseminate the list to their contracted service providers.

Background Screening

Current Situation

In 2012, the Legislature created the Care Provider Background Screening Clearinghouse (Clearinghouse) to create a single "program" of screening individuals and allow for the results of criminal history checks of persons acting as covered care providers to be shared among the specified agencies.[82] Designated agencies include AHCA, the Department of Health, the Department of Children and Families, the Department of Elder Affairs, the Agency for Persons with Disabilities, Vocational Rehabilitation within the Department of Education, and the Department of Juvenile Justice.

Section 408.809(2), F.S., allows providers to provide proof of screening from agencies joining the Clearinghouse to meet screening requirements until such time until such time as the specified agency

[79] Supra FN 9.
[80] Id.
[81] AHCA, FloridaHealthFinder.gov, ALF compare, available at https://www.floridahealthfinder.gov/CompareSC/SCSelectFilters.aspx (last visited March 17, 2020).
[82] Ch. 2014-84, Laws of Fla.

is fully implemented in the Clearinghouse. Final implementation of the Clearinghouse by the designated state agencies was required by October 1, 2013.

The Clearinghouse was initially implemented by AHCA on January 1, 2013. It included language that allowed a person currently employed as of June 30, 2014, who was screened and qualified prior to employment, to apply for an exemption in the event that a disqualifying offense, that the employee committed prior to screening, is later added to the law. Because statute still includes the date of June 30, 2014, the exemption is unenforceable.

Section 408.809(5), F.S., requires a controlling interest, employee, or individual under contract with a licensee to be rescreened by July 31, 2015. This provision is now obsolete.

Section 409.907, F.S., provides background screening requirements for Medicaid providers. According to AHCA, the background screening requirements are only intended to apply to staff having direct access to patients, but some Medicaid managed care plans have been screening all staff beyond those with access to clients.[83]

Current law requires drivers providing transportation to Medicaid recipients through a transportation broker or a transportation network company to undergo a level I background screening through the Florida Department of Law Enforcement or, for transportation network companies, an AHCA-approved equivalent background screening.[84] Current law does not require level II background screening for transportation providers.

Effect of the Bill – Background Screening

The bill allows an employee who previously qualified for employment under the background screening requirements to apply for an exemption if the law is changed to add a disqualifying offense which the employee committed prior to being screened previously.

Section 408.809(2), F.S., allows providers to provide proof of screening from agencies joining the Clearinghouse to meet screening requirements until such time until such time as the specified agency is fully implemented in the Clearinghouse. Final implementation of the Clearinghouse by the designated state agencies was required by October 1, 2013. The bill amends s. 408.809(2), F.S., to delete expired provisions related to implementation of the Clearinghouse. All specified agencies are now fully implemented in the Clearinghouse.

The bill also amends s. 408.809(5), F.S., to delete an obsolete background screening schedule.

The bill amends s. 409.907, F.S., clarify that background screening requirements for Medicaid providers apply to individuals who will have direct access to Medicaid recipients, recipient living areas, or the financial, medical, or service records of a Medicaid recipient, or who supervise the delivery of goods or services to a Medicaid recipient. The bill clarifies that drivers providing transportation to Medicaid recipients through a transportation broker or a transportation network company are required to undergo only level I background screening, consistent with current law.

Multiphasic Health Testing Centers

Current Situation

Multiphasic health testing centers are regulated by AHCA under part I of ch. 483, F.S. A multiphasic health testing center is a facility where specimens are taken from the human body for delivery to

[83] Supra FN 9.
[84] S. 316.87, F.S.

registered clinical laboratories for analysis and certain measurements and tests are taken, such as height and weight, blood pressure, limited audio and visual, and electrocardiograms.[85]

The federal Clinical Laboratory Improvement Amendments Act (CLIA) requires a clinical laboratory to receive CLIA certification if it examines materials derived from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, a human being. 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.[86] 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.[87] 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 inspections, and enforcement.[88] In addition to CLIA inspections, AHCA is required to conduct biennial inspections of all licensed multiphasic health testing centers.

As of March 17, 2020, there were 230 multiphasic health testing centers licensed in Florida.[89] Of these, 180 are CLIA certified, which means they are subject to federal inspections by CMS. The other 7 centers, although currently licensed, are not required to be licensed because they are not providing services that necessitate licensure as a multiphasic health testing center.[90]

Since 2011, AHCA has imposed only six fines against multiphasic health testing centers, and received only 10 complaints, with none substantiated.[91]

Effect of the Bill – Multiphasic Health Testing Centers

The bill repeals licensure of multiphasic health testing centers. Currently, 180 licensed centers are CLIA-certified and will continue to be regulated and inspected by federal CMS.

[85] S. 483.288(2), F.S.
[86] 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 March 17, 2020).
[87] 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 March 17, 2020)
[88] Id.
[89] AHCA, Florida Health Finder, *Facility/Provider Search, Multiphasic Health Testing Centers,* available at https://www.floridahealthfinder.gov/facilitylocator/facloc.aspx (search conducted March 17, 2020).
[90] Supra FN 9.
[91] Id.

Medicaid Program Integrity Hospital Retrospective Review Program

Current Situation

Section 409.905(5), F.S., requires AHCA to pay for all covered services for the medical care of a Medicaid recipient who is admitted to a hospital as an inpatient by a licensed physician or dentist. However, AHCA may limit the payment for inpatient hospital services, for a Medicaid recipient 21 years of age or older, to 45 days or the number of days necessary to comply with the GAA. This statute authorizes AHCA to implement reimbursement and utilization management reforms in order to comply with any limitations or directions in the GAA, including:

- Prior authorization for inpatient psychiatric days;
- Prior authorization for non-emergency hospital inpatient admissions for individuals at least 21 years of age;
- Authorization of emergency and urgent-care admissions within 24 hours after admission;
- Enhanced utilization and concurrent review programs for highly utilized services;
- Reduction or elimination of covered days of service;
- Adjusting reimbursement ceilings for variable costs;
- Adjusting reimbursement ceilings for fixed and property costs; and
- Implementing target rates of increase.

Pursuant to s. 409.905(5)(a), F.S., AHCA must discontinue its hospital retrospective review program once it has implemented its prior authorization program for hospital inpatient services.

AHCA's hospital retrospective review program, within the AHCA's Bureau of Medicaid Program Integrity (MPI), performs routine pre-claim and post-claim reviews to determine the appropriateness of historical, existing, and future provider reimbursement. Since the inception of MPI, AHCA's claim review processes have recovered in excess of one billion dollars.[92]

MPI also conducts provider audits based on probable cause through the Alien Audit Program, which was created in 2010[93]. The Alien Audit Program is part of the hospital retrospective review program and was developed after an audit report from the Health and Human Services Office of Inspector General directed the state to return the federal share of erroneous payment for certain hospital claims related to Emergent Medicaid. Since its inception, the Alien Audit Program has closed 668 cases and collected $57,056,455.79.

In February, 2019, the First District Court of Appeal ruled that s. 409.9905(5)(a), F.S., precludes post-payment audits, including the Alien Audit Program audits, to determine the appropriateness of reimbursement, including whether prior authorization was obtained under false pretenses.[94] As a result, AHCA lost $13,449,595.12 related to 42 cases that have been or will be closed at zero overpayment due to the court ruling.[95]

Federal regulations require AHCA to have a post-payment review process for all Medicaid services.[96] State plans are also required, pursuant to Federal regulations, to have processes relating to identification, investigation, and referral of suspected fraud and abuse cases, which includes the requirement to have a post-payment review process.[97]

Effect of the Bill – Medicaid Program Integrity Hospital Retrospective Review Program

[92] Id.
[93] Ch. 2009-223 Laws of Fla.
[94] *Lee Mem'l Health Sys. Gulf Coast Med. Ctr. v. State of Fla., Agency for Health Care Admin.*, 272 So.3d 431 (Fla. 1st DCA 2019).
[95] Supra FN 9.
[96] 42 C.F.R. § 456.23.
[97] 42 C.F.R. § 455.12.

According to AHCA, the directive in s. 409.905(5)(a), F.S., to discontinue an inpatient retrospective review program was intended to refer to a specific program conducted in the Division of Medicaid when the Division shifted to a prior authorization review.[98] The bill removes this obsolete language and adds language to clarify that AHCA may conduct reviews to determine fraud, abuse and overpayment in the Medicaid program. As a result, MPI would be able continue conducting retrospective reviews of hospital claims.

The bill makes these changes effective upon the bill becoming a law.

Medicaid Program Integrity Legal Fees

Current Situation

Current law authorizes AHCA to recover legal costs upon prevailing in a provider overpayment case, but does not specifically reference costs for outside legal counsel. However, in 2019, the Division of Administrative Hearings (DOAH) ruled that s. 409.913(23)(a), F.S., does not authorize AHCA to recover full attorney's fees on MPI legal cases involving outside counsel.[99]

Effect of the Bill – Medicaid Program Integrity Legal Fees

The bill amends s. 409.913(23)(a), F.S., to provide legal authority for AHCA to collect all legal fees incurred while defending a case if AHCA prevails, including the cost of outside counsel.

Medicaid Class III Psychiatric Hospitals

Current Situation

Current law authorizes AHCA to establish an alternative methodology to the diagnosis related group[100] (DRG) payment methodology for state-owned hospitals, newborn hearing screening services, certain transplant services, recipients who have tuberculosis, and class III psychiatric hospitals.[101] However, class III psychiatric hospitals[102] are excluded from the DRG payment methodology under federal law. Federal law prohibits state Medicaid programs from receiving federal matching funds for services provided by facilities described in 42 CFR 435.1010 as institutions for mental diseases (IMDs) under the fee-for-service (FFS) program. As a result, AHCA has not established the alternative methodology currently allowed under s. 409.908, F.S.[103]

However, in Medicaid managed care programs, states have slightly more flexibility as health plans may pay for services in an IMD in lieu of more costly services. For example, Florida Medicaid cannot pay for services in a behavioral health crisis stabilization unit (CSU) under the FFS program. However, Medicaid contracts allow health plans to pay for services in a CSU because CSUs provide a less costly service equivalent to inpatient psychiatric hospitalization.[104]

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[98] Supra FN 9.
[99] State of Florida, Division of Administrative Hearings, Case No. 18-5986F, June 12, 2019, the case had an overpayment of $637,973.10 and a sanction of $127,594.62 and AHCA was seeking fees and costs of $330,186.14, but DOAH ruled that AHCA has the ability to collect the "costs" but not the "fees".
[100] S. 409.905(5)(b), F.S. AHCA uses DRGs to implement a prospective payment methodology to establish reimbursement rates for inpatient hospital services. The prospective payment methodology categorizes each inpatient admission into a DRG and assigns a relative payment weight to the base rate according to the average relative amount of hospital resources used to treat a patient in a specific diagnosis-related group.
[101] S. 409.908(1), F.S.
[102] Rule 59A-3.065(41), F.A.C. A class III psychiatric hospital is a class III specialty hospital that is primarily restricted to treating persons with a sole diagnosis, or principal diagnosis, of a psychiatric disorder.
[103] Supra FN 9.
[104] Id.

Effect of the Bill – Medicaid Class III Psychiatric Hospitals

The bill amends s. 409.908, F.S., to remove AHCA's authority to establish an alternative methodology to the DRG-based prospective payment system for class III psychiatric hospitals.

Statewide Medicaid Managed Care

Current Situation

Section 409.967, F.S., requires AHCA to establish a 5-year contract with each managed care plan selected during the procurement process.

Section 409.973, F.S., requires AHCA to establish 5-year contracts with managed care plans in the prepaid dental health program during the procurement process.

Effect of the Bill – Statewide Medicaid Managed Care

The bill requires AHCA to re-procure contracts with managed care plans in the Statewide Medicaid Managed Care program and the prepaid dental health program every 6 years instead of every 5 years, beginning with the contract procurement process initiated during the 2023 calendar year. The bill requires AHCA to extend the term of existing plan contracts for the prepaid dental health program until December 31, 2024.

Medicaid Provider Fraud

Current Situation

New technology and innovative online platforms allow patients to access doctor appointment schedules through a web portal hosted by an online service, and health care professionals contract with these platforms for a fee. Federal law authorizes these fee-based scheduling services under other health insurance programs, including Medicare, Tricare, and commercial programs.[105]

Federal law prohibits payment for the referral of an individual to a person for furnishing or arranging to furnish any item or service for which payment may be made under a federal health care program.[106] A federal health care program is any plan or program that provides health benefits, in whole or in part, by the United States government or any state health care program. State health care programs include Medicaid, maternal and child health services block grants, block grants and programs for social services and elder justice, and state children's health insurance programs.[107] Violation of the federal anti-kickback statute is a felony that is punishable by a fine of up to $25,000 or up to 5 years in prison, or both.[108] However, similar to Florida's patient brokering statute, there are several exceptions to the federal statute, such as:[109]

- Discounts properly disclosed and appropriately reflected in the costs claimed and charges made by the provider or entity;
- Payments between employers and employees for employment in the provision of covered items or services;
- Certain payments to a group purchasing organization;
- Waivers of co-insurance;
- Certain risk-sharing agreements; and
- The waiver of any cost-sharing provisions by a pharmacy.

[105] 42 U.S.C. s. 1320a-7b(b).
[106] 42 U.S.C. s. 1320a-7b(b).
[107] Id.
[108] Id.
[109] Id.

Federal law allows other payment arrangements that are not specifically listed in law. Payment arrangements that do not squarely meet one of the exceptions are reviewed on a case-by-case basis to determine if the parties have the requisite criminal intent.[110] The Office of the Inspector General, within the U.S. Department of Health and Human Services, is proposing additional exceptions to the anti-kickback statute, including payment arrangements that are currently used by health care practitioners but are not specifically authorized under the statute.[111]

Current Medicaid statutes include anti-kickback provisions that prohibit a person from knowingly soliciting, offering, paying, or receiving any remuneration, including any kickback, bribe, or rebate, directly or indirectly, in cash or in kind, in return for referring an individual to a person for the arranging of any item or service for which payment may be made under the Medicaid program.[112]

Effect of the Bill – Medicaid Provider Fraud

The bill aligns the state Medicaid anti-kickback law with the federal anti-kickback law by specifying that the Medicaid anti-kickback prohibitions in Medicaid statute do not apply to any discount, payment, waiver of payment, or payment practice not prohibited under the federal anti-kickback law. This may clarify for providers and AHCA that the Medicaid anti-kickback law is not more restrictive than the federal law.

Patient Savings Act

Current Situation

In 2019, the Legislature enacted the Patient Savings Act [113] (Act), which allows health insurers and health maintenance organizations (HMOs) to create shared savings incentive programs (Programs) to encourage insured individuals to shop for high quality, lower cost health care services and share any savings realized as a result of the insured's choice. The Act authorized implementation of these incentive programs for plan years beginning January 1, 2020.

Health insurers and HMOs that choose to offer a Program must develop a website outlining the range of shoppable health care services available to insureds. This website must provide patients with an inventory of participating health care providers and an accounting of the shared savings incentives available for each shoppable service. The Act provides a list of nonemergency services that qualify as "shoppable health care services". These include, but are not limited to:

- Clinical laboratory services.
- Infusion therapy.
- Inpatient and outpatient surgical procedures.
- Obstetrical and gynecological services.
- Outpatient nonsurgical diagnostic tests and procedures.
- Physical and occupational therapy services.
- Radiology and imaging services.
- Prescription drugs.
- Services provided through telehealth.

The Act defines a "shared savings incentive" as an optional financial incentive that may be paid to an insured for choosing certain shoppable health care services under a Program. When a patient obtains a

[110] U.S. Department of Health and Human Services, *HHS Office of Inspector General Fact Sheet: Notice of Proposed Rulemaking OIG-0936-AA10-P*, (Oct. 2019), available at https://oig.hhs.gov/authorities/docs/2019/CoordinatedCare_FactSheet_October2019.pdf (last visited Feb. 5, 2020).
[111] Id.
[112] S. 409.920(2)(a), F.S.
[113] Ss. 627.6387, 627.6648, and 641.31076, F.S.

shoppable health care service for less than the average price for the service, the bill requires the savings to be shared by the health insurer and the patient. A patient is entitled to a financial incentive that is no less than 25 percent of the savings that accrue to the insurer as a result of the patient's participation.

The bill provides a range of methods by which a Program may financially reward patients who save money by shopping for health care services. Patients may receive financial incentives in the form of premium reductions, or deposits into a flexible spending account, health savings account, or health reimbursement account.[114]

Effect of the Bill – Patient Savings Act

The bill requires AHCA to publish an annual report identifying health care services with the most significant price variation at statewide and regional levels. This report will be due on July 1 of each year.

The bill also amends the Patient Savings Act by increasing the range of services defined as "shoppable" for purposes of earning a shared savings incentive under a Program. In addition to the examples of specific services outlined in the Act, the bill extends the "shoppable" service designation to those services identified by the Florida Center's annual report as having the most significant price variation at statewide and regional levels.

Under current law, insurers and HMOs operating a Program may reward participants through deposits to health-related accounts or through premium reductions. The bill expands the range of rewards to include cash or cash-equivalent incentives.[115]

Except for the bill's amendments to s. 409.905, F.S., which take effect upon becoming law, the bill provides an effective date of July 1, 2020. Section 409.905, F.S., allows AHCA to continue conducting retrospective reviews of hospital claims.

[114] Id.

[115] To the extent that a cash incentive paid to an insured increases that insureds total income, he or she will be responsible for income-related taxes that may be due on this additional income.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

AHCA estimates a loss in annual revenue of $489,071.84 resulting from the repeal of multiphasic health testing center licensure ($89,071.84) and the new exemptions from health care clinic licensure for community mental health partial-hospitalization programs, portable x-ray providers, and rural health care clinics ($400,000). These losses are offset by a commensurate workload reduction.

Exempting all Medicaid providers from health care clinic licensure will result in a cost avoidance to AHCA. AHCA previously asked for 13 full-time equivalent (FTE) positions in a legislative budget request to process the approximately 20,000 anticipated applications that will be submitted by July 1, 2020.[116]

AHCA lost approximately $13.5 million in revenue related to 42 cases that have been or will be closed at zero overpayment due to the court ruling on retrospective hospital audits.[117] The MPI retrospective alien audit case was an isolated example; however, according to AHCA, the bill could protect the Agency from not being able to recoup significant amounts of revenue in the future.[118]

The bill provides authority for AHCA to collect all legal fees incurred while defending a Medicaid Program integrity case if AHCA prevails, including the cost of outside counsel. AHCA's tracking system for Medicaid recovery amounts does not distinguish legal fees, so they are unable to determine the future impact of the proposed change; however, AHCA has incurred over $300,000 in legal fees for a single case.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

[116] Id.
[117] Id.
[118] Id.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill repeals licensure for multiphasic health testing center. Currently there are 187 licensed multiphasic health testing centers. As a result, multiphasic health testing centers will no longer be required to pay the biennial license renewal fee of $952.64.

The bill exempts from health care clinic licensure, community mental health partial-hospitalization programs, and portable x-ray providers, and rural health care clinics. These providers will no longer be required to pay the $2,000 biennial license renewal fee. AHCA estimates that approximately 200 providers would qualify for the exemption.[119]

The bill also exempts Medicaid providers, including behavior analysis providers, from health care clinic licensure. These providers are not currently required to be licensed, but licensure will be required effective July 1, 2020.[120] According to AHCA, an estimated 20,000 providers have been identified as possibly being required to be licensed as a health care clinic or obtain an exemption from licensure as a health care clinic.[121] Providers who qualify for the exemption would not have to pay the $2,000 initial licensure fee.

D. FISCAL COMMENTS:

The net fiscal impact of other licensure changes is indeterminate. However, the fiscal impact is expected to be minimal because any loss in revenue will likely be offset by gains in savings and workload reductions. Specifically, the loss of revenue from licensure repeals and exemptions coupled with the potential saving in funds recouped from Medicaid overpayments and attorney fees.

[119] Supra FN 9.
[120] Florida Medicaid, Provider Enrollment Policy, at pg. 86, available at https://ahca.myflorida.com/medicaid/review/Rules_in_Process/Proposed/59G-1.060_Enrollment_ProposedRule.pdf (last visited March 17, 2020).
[121] Supra FN 9.