HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 7083 PCB HCC 08-19 Health Care

SPONSOR(S): Policy & Budget Council; Healthcare Council; Garcia
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.: Healthcare Council	17 Y, 0 N	Calamas/Massengale	Gormley
1) Policy & Budget Council	29 Y, 0 N, As CS	Leznoff	Hansen
2)			
3)			
4)			
5)			

SUMMARY ANALYSIS

HB 7083 revises several sections of Florida law related to home health agency and nurse registry licensure to reduce Medicaid fraud and improve quality and accountability. The bill:

- Imposes additional licensure application requirements for home health agencies to better ensure financial viability, and prohibits transferring an application to another entity prior to the license being issued;
- Makes falsifying patient records and staff training records a basis for action by the Agency for Health Care Administration (AHCA) on a home health agency license, and imposes a specific fine for a pattern of offenses;
- Creates and amends home health agency staffing requirements to ensure greater accountability by limiting the number of facilities an administrator or nursing director may supervise, with some exceptions, requiring notice to AHCA of a change or loss of a nursing director and imposing a specific fine for failing to do so, and requiring staff training and documentation of that training;
- Makes fines for licensure deficiencies mandatory, rather than discretionary on the part of AHCA, and raises fine amounts for each class of deficiencies;
- Requires home health agencies to maintain patient records for 3 years rather than one; and
- Requires nurse registries to ensure adequate staff training for all certified nursing assistants and home health aides referred by the registries.

The bill revises several sections of Chapter 409, Florida Statutes, relating to Medicaid provider changes of ownership and Medicaid durable medical equipment (DME) providers to reduce fraud and improve accountability. The bill:

- Defines “change of ownership” to include events when a provider changes to a different legal entity under certain circumstances, specifies liability for moneys owed to AHCA when a provider changes ownership, requires notice of a change of ownership, and clarifies the effective dates of provider agreements.
- Requires AHCA to limit its network of DME providers to those which are accredited, meet certain requirements for a physical location, directly provide the durable medical equipment to the Medicaid recipient (with certain exceptions), provide a surety bond, and obtain background screening for employees in direct contact with Medicaid recipients.

The bill appears to have no fiscal impact on state or local government.

The bill provides an effective date of July 1, 2008.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

None of the House Principles appear to be implicated in the present legislation.

B. EFFECT OF PROPOSED CHANGES:

Background

Home Health Services/Home Health Agencies[1]

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

- Nursing care;
- Physical, occupational, respiratory, or speech therapy;
- Home health aide services (assistance with daily living such as bathing, dressing, eating, personal hygiene, and ambulation);
- Dietetics and nutrition practice and nutrition counseling; and
- Medical supplies, restricted to drugs and biologicals prescribed by a physician.[2]

Staffing services are provided to health care facilities or other business entities on a temporary basis by licensed health care personnel and by certified nursing assistants and home health aides who are employed by, or work under the auspices of, a licensed home health agency.[3]

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

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

Licensure Provisions[4]

Since 1975, home health agencies operating in Florida have been required to obtain a state license.[5] The licensure requirements for home health agencies are found in the general health care licensing provisions of part II of ch. 408, F.S., the specific home health agency licensure provisions of part III of

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[1] The Florida Senate Bill Analysis and Fiscal Impact Statement, CS/CS/CS/SB 1374, on file with the Health and Human Services Appropriations Committee, April 2, 2008.
[2] Section 400.462(13), F.S.
[3] Section 400.462(25), F.S.
[4] The Florida Senate Bill Analysis and Fiscal Impact Statement, CS/CS/CS/SB 1374, on file with the Health and Human Services Appropriations Committee, April 2, 2008.
[5] Sections 36 – 51 of ch. 75-233, Laws of Florida (L.O.F.).

ch. 400, F.S., and the minimum standards for home health agencies in chapter 59A-8, Florida Administrative Code.

As of December 31, 2007, there were 1,985 licensed home health agencies in Florida.[6] A home health agency license is valid for 2 years, unless sooner suspended or revoked.[7] If a home health agency operates related offices, each related office outside the county where the main office is located must be separately licensed.[8]

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

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

Each home health agency is required to employ an administrator. The administrator must be a licensed physician, physician assistant, or registered nurse licensed to practice in this state or an individual having at least one year of supervisory or administrative experience in home health care in a facility licensed under ch. 395, F.S.,[9] part II of ch. 400, F.S.,[10] or part I of ch. 429, F.S.[11] The administrator may manage a maximum of five licensed home health agencies if the home health agencies are located within one geographic service area or within an immediately contiguous county. An employee of a retirement community that provides multiple levels of care may administer a home health agency and up to a maximum of four entities licensed under ch. 400, F.S.,[12] or ch. 429, F.S.,[13] if they are owned, operated, or managed by the same corporate entity. The administrator must designate an alternate administrator to serve during the administrator's absence.

A home health agency providing skilled services is required to employ a director of nursing who is a Florida licensed registered nurse with at least 1 year of supervisory experience as a registered nurse.[14] The director of nursing is responsible for overseeing the delivery of professional nursing and home health aide services and must be readily available at the home health agency or by phone for any 8 consecutive hours between 7 a.m. to 6 p.m. The director of nursing is also responsible for establishing and conducting an ongoing quality assurance program for services provided by the home health agency.[15] A home health agency that offers only home health aide and homemaker/companion services is not required to have a director of nursing.[16]

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[6] Source: AHCA Home Care Unit, Bureau of Health Facility Regulation, reported on 1/2/2008.
[7] Section 408.808(1), F.S.
[8] Section 400.464(2), F.S
[9] Facilities licensed under ch. 395, F.S., include hospitals, ambulatory surgical centers, and mobile surgical facilities.
[10] Facilities licensed under part II of ch. 400, F.S., include nursing homes.
[11] Facilities licensed under part I of ch. 429, F.S., include assisted living facilities.
[12] Entities licensed under ch. 400, F.S., include nursing homes, home health agencies, nurse registries, hospices, intermediate care facilities, homes for special services, transitional living facilities, prescribed pediatric extended care centers, home medical equipment providers, intermediate care facilities for developmentally disabled persons, health care services pools, and health care clinics.
[13] Entities licensed under ch. 429, F.S., include assisted living facilities, adult family care homes, and adult day care centers.
[14] Section 400.462(10), F.S.
[15] Rule 59A-8.0095(2), F.A.C.
[16] Rule 59A-8.0095(5), F.A.C.

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

A change in the administrator or alternate administrator requires notification to AHCA prior to or on the date of change and submission of documentation evidencing the statutory qualifications as well as background screening clearance documentation of the replacement.[17] No notification is required for changes in the director of nursing in between renewals of the home health agency's license.[18] AHCA licensure staff has had conversations with nurses who resigned shortly after the home health agency license was issued. Home health agencies may operate for months, perhaps until license renewal, without a qualified director of nursing.[19]

There is no requirement in state or federal law for a home health agency to have a medical director. Federal regulations for Medicare and Medicaid certified home health agencies require that a physician be on the group of professional personnel that is to establish and annually review the agency's policies.[20]

Growth in the Number of Licensed Home Health Agencies[21]

As of December 31, 2007, there were 1,985 licensed home health agencies in the state,[22] an increase of 797 (67 percent) new agencies since August 1999. The growth has been uneven around the state. Seventeen counties experienced a reduction in the number of licensed home health agencies during this period. Almost all of these counties are rural. However, despite the reduction in the number of licensed home health agencies in the rural counties, there is no indication that requested home health services are unavailable in these areas as a home health agency licensed in one county may serve clients in multiple counties. The population of persons over the age of 64 increased 16 percent statewide from 1999 – 2007 and 20 percent for all ages during that same period.[23]

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

Miami-Dade and Broward counties comprise 19 percent of the state's population of persons over age 64, yet host 48 percent of the licensed home health agencies in the state.[24] Although home health services are not limited to persons over the age of 64, this population predominates the market. Based on population data for 2007 and the number of licensed home health agencies in each geographic service area on December 31, 2007, in Miami-Dade and Monroe Counties, there was one licensed home health agency for every 470 residents over the age of 64; for Broward County, the ratio was one

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[17] Rule 59A-8.0095(1)(b), F.A.C.
[18] Source: AHCA Most Frequently Asked Questions / Home Health Agencies - Question 28c., found at <http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Home_Care/definitions.shtml#a> (Last visited on March 3, 2008).
[19] Source: AHCA Home Health Unit.
[20] Source: AHCA 2008 Bill Analysis and Economic Impact Statement for SB 1374.
[21] The Florida Senate Bill Analysis and Fiscal Impact Statement, CS/CS/CS/SB 1374, on file with the Health and Human Services Appropriations Committee, April 2, 2008.
[22] Source: AHCA Home Care Unit, Bureau of Health Facility Regulation.
[23] Source: Office of Economic & Demographic Research website, found at <http://edr.state.fl.us/population.htm> (Last visited on March 3, 2008).
[24] Source of population data: Office of Economic & Demographic Research website on 9/11/2007; Source of licensee data: AHCA Home Care Unit, Bureau of Health Facility Regulation, as of 8/23/2007.

agency for every 1156 residents over the age of 64. For all other counties, the average was one home health agency for every 2537 residents over the age of 64.

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

Home Health Agency Deficiencies[25]

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

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

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

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

Home Health Medicaid Fraud and Abuse

On October 2, 2007, AHCA and the Medicaid Fraud Control Unit in the Office of the Attorney General (MFCU) presented to the House Committee on Health Innovation information indicating there has been an increase in Medicaid Program Integrity investigations of Medicaid-enrolled home health agency providers as well as an increase in the number of referrals to MFCU over the last several years related to Medicaid-enrolled home health agencies.

MFCU opened an average of 7 home health agency cases per year between 2002 and 2004, but opened 17 each year between 2005 and 2007, 70 percent of which were in Miami-Dade County. According to MFCU, fraudulent home health activity includes kickbacks, patient recruiting, and false billing. AHCA's Bureau of Medicaid Program Integrity (MPI) reports that investigations of home health agency providers have risen from 47 in FY 2005-2006 to 144 in FY 2006-2007. Identified overpayments are on an upward trend, from about $10,000 in FY 2004-2005 to about $1.3 million in FY 2006-2007.

[25] Florida Senate Bill Analysis and Fiscal Impact Statement, CS/CS/CS/SB 1374, on file with the Health and Human Services Appropriations Committee, April 2, 2008.

Change of Ownership by a Medicaid Provider

Presently, under s. 409.907(6), F.S., the agency is authorized to revoke a Medicaid provider agreement following the change of ownership of any facility, association, partnership, or other entity named as the provider in the provider agreement.

Additionally, such a provider is required to give the agency 60 days notice before making any change in ownership of the entity named in the provider agreement as the provider.

Durable Medical Equipment and Medical Supply Providers

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

- As defined by the Federal Food and Drug Administration,
- Reimbursed under Medicare Part B Durable Medical Equipment benefits, or
- Reimbursed under the Florida Medicaid durable medical equipment program.[26]

Home medical equipment includes:

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

AHCA is the single state agency that administers or supervises the administration of the state Medicaid plan under federal law.[27] According to the Medicaid program, the ACHA must pay eligible providers for the provision of certain medically-necessary services to eligible recipients. Under federal and state law, certain other services are optional under the Medicaid program. Durable medical equipment and supplies is an optional service in the state. Florida law authorizes AHCA to pay for certain medically-necessary durable medical equipment and supplies provided to an eligible Medicaid recipient.[28]

The *Florida Medicaid, Durable Medical Equipment/Medical Supply Services Coverage and Limitations Handbook* provides that a DME entity must meet the following criteria to enroll as a Medicaid DME provider:[29]

- Be licensed by the local government agency as a business or merchant or provide documentation from the city or county authority that no licensure is required;
- Be licensed by the Department of Health, Board of Orthotics and Prosthetics, if providing orthotics and prosthetic devices;
- Be licensed by AHCA with a Home [Medical] Equipment license;
- Be in compliance with all applicable laws relating to qualifications or licensure;

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

- Have an in-state business location or be located not more than fifty miles from the Florida state line;
- Meet all the general Medicaid provider requirements and qualifications;
- Be fully operational;
- Submit a surety bond as part of the enrollment application unless the provider is owned and operated by a governmental entity. One $50,000 bond is required for each provider location up to a maximum of five bonds statewide or an aggregate bond of $250,000;[30] and
- Pass a site visit unless the applicant is associated with a pharmacy or rural health clinic, or provides only orthotic or prosthetic devices and is licensed by the Board of Orthotics and Prosthetics.

On October 2, 2007, AHCA and the Medicaid Fraud Control Unit in the Office of the Attorney General (MFCU) presented to the House Committee on Health Innovation information indicating there has been an increase in Medicaid Program Integrity investigations of Medicaid-enrolled DME providers as well as an increase in the number of referrals to the Medicaid Fraud Control Unit over the last several years related to Medicaid-enrolled DME providers. MFCU worked 117 DME cases between 2002 and 2007, 64 of which were in Miami-Dade County, resulting in 78 arrests. According to MFCU, fraudulent DME activity includes changes of ownership with strawman purchasers and kickback schemes. AHCA's Bureau of Medicaid Program Integrity (MPI) reports that investigations of DME providers have risen from 148 in FY 2005-2006 to 354 in FY 2006-2007. However, identified overpayments are on a downward trend, from about $449,000 in FY 2004-2005 to about $349,000 in FY 2006-2007.

Effect of Proposed Changes

Nursing Facility Adverse Incidents

The bill amends s. 400.179, F.S., to change the definition of "adverse incident" related to nursing facility reporting. The current definition provides that an adverse incident includes events reported to law enforcement. The bill amends this part of the definition to exclude events reported to law enforcement that are requests for transportation.

Home Health Agency Licensure

The bill amends s. 400.462, F.S., to remove substantive provisions from definitions of "administrator", "certified nursing assistant", "director of nursing", and "home health aide". These substantive provisions are amended and moved into the body of the statute in s. 400.476, F.S.

The bill amends s. 400.464, F.S., to require that a home infusion therapy provider must be licensed as either a home health agency or nurse registry, which will allow nurse registries to refer providers of home infusion therapy without being licensed as a home health agency.

The bill makes substantial changes to home health licensure, both in the initial application process and in licensure discipline. The bill amends s. 400.471, F.S., to prohibit initial licensure of a home health agency if another agency owned by the applicant is located within 10 miles of and within the same county as the applicant. Applicants are also prohibited from transferring an application to another entity prior to AHCA issuing the license. The bill substantially increases the documentation requirements for new home health agency licenses. Applicants must:

- Submit a business plan;
- Provide evidence of contingency funding equivalent to 1 month's average operating expenses;
- Provide evidence of sufficient assets, credit, and projected revenues to cover liabilities and expenses; and

[30] *Ibid at page 1-7.*

- Disclose of all ownership interests.

These changes may slow the sharp growth in the number of licensure applicants and new licensees.

The bill creates new bases for action on a home health agency license, amending s. 400.474, F.S., to require AHCA to fine an agency that falsifies patient records or records on staff training or health statements, and to fine an agency that fails to provide at least one service directly to a patient for a period of 60 days. The bill sets the mandatory fine amount at $1000 for each fraudulent document or each fraudulent entry on a document.

The bill addresses quality issues by creating s. 400.476, F.S. This section contains amended substantive provisions moved from definitions in s. 400.462, F.S., addressing home health agency staffing requirements and limitations on staffing services. The bill limits the number of home health agencies one administrator can supervise to one, but provides an exception for up to five if all five agencies have identical controlling interests and are in the same geographic area. Similarly, the bill limits the number of home health agencies one director of nursing may direct to two, if the two have identical controlling interests and are in the same geographic area, and limits the number of home health agencies one director of nursing may direct to five, if the five have identical controlling interests, are in the same geographic area, and each home health agency has a registered nurse who meets the qualifications for a director of nursing to serve as the director when the director is not present. The bill also provides an exception to these limits for home health agencies that are part of retirement communities providing multiple levels of care. Directors of nursing for these agencies may serve up to four entities licensed under chapter 429, if they all have the same controlling interests.

The bill requires home health agencies to notify AHCA if they change or lose their nursing director, and to cease operating if they don't have a director of nursing for more than 30 days. Failure to notify AHCA will result in a $1000 fine for a first violation and $2000 for a subsequent violation. The bill imposes additional requirements for the functions of the director of nursing, and gives AHCA rulemaking authority to implement them. The director of nursing must provide AHCA, on request, certified daily reports of services provided for up to two years prior to the request.

The bill also requires home health agencies to ensure staff are properly trained, and requires AHCA to promulgate rules related to quality assurance programs and inspections related to changes in ownership.

The bill amends s. 400.484, F.S., to makes fines for deficiencies mandatory, instead of discretionary, and increase the amount of the fine for each class of deficiencies, as follows:

- Class I – raised from $5,000 to $15,000
- Class II – raised from $1,000 to $5,000
- Class III – raised from $500 to $1000
- Class IV – raised from $200 to $500

To facilitate surveys and complaint inspections, the bill amends s. 400.491, F.S., to extend the length of time that a home health agency must maintain client records from 1 to 3 years following termination of services.

Finally, the bill briefly addresses nurse registries licensed under ss. 400.506-512, F.S., to require nurse registries to ensure adequate training for certified nursing assistants and home health aides referred for contract by the nurse registry.

Medicaid Provider Change of Ownership

Proposed Council Bill Health Care Council 08-19 revises several sections of Chapter 409, Florida Statutes relating to Medicaid provider change of ownership. The bill:

- Provides a definition of "Change of Ownership" to include events when a provider changes to a different legal entity under certain circumstances;
- Specifies transferor liability upon a change of ownership, and provides that a transferor shall remain liable for all outstanding overpayments before administrative fines and other moneys owed to AHCA owed prior to the transfer of ownership;
- In addition to the continuing liability of the transferor, the bill provides that the transferee shall be liable to the agency for all outstanding overpayments identified by the agency on of before the effective date of the change of ownership;
- Clarifies that the liabilities of nursing facilities will be governed by existing licensure statute, s. 400.179, F.S.
- Requires the transferee of a change of ownership for a skilled nursing facility or an intermediate care facility to satisfy all other Medicaid provider qualifications prior to assuming ownership;
- Provides that, in the event a change ownership occurs without compliance with the notice requirements imposed by the bill, the transferor and transferee are jointly and severally liable for all overpayments, administrative fines and other moneys due to the agency; and
- Specifies enrollment effective dates for providers requiring a Medicare certification survey, providers completing changes of ownership, and providers of emergency medical services transportation or emergency services and care.

Medicaid Durable Medical Equipment Providers

The bill amends s. 409.912, F.S., to require AHCA to limit its network of durable medical equipment (DME) providers and imposing a list of provider enrollment requirements. In order to obtain a Medicaid provider agreement and be reimbursed for equipment and supplies provided to Medicaid recipients on dates of service after January 1, 2009, DME providers must:

- Be accredited and maintain accreditation by a Centers for Medicare and Medicaid Services (CMS) Deemed Accreditation Organization for suppliers of durable medical equipment, prosthetics, orthotics and supplies. Accrediting reviews may be unannounced.
- Provide services or supplies directly to the Medicaid recipient or caregiver, or provide the services or supplies by mail, and may not subcontract or consign the function to a third party.
  - The bill includes an exception to the direct provision requirement to allow DME providers to store nebulizers at a physician's office for the purpose of having the physician staff issue the equipment, if: it is medically necessary to do so; the DME provider and the physician staff have been appropriately trained and document such training; and the physician's office maintains an inventory including source documentation. The bill prohibits the physician from having a financial relationship with the nebulizer provider, and prohibits any financial gain from the delivery of nebulizers to patients.
- Have a physical business location that meets these criteria:
  - Has exterior signage that can be read from 20 feet away which readily identifies the business as one providing durable medical equipment, medical supplies, or both;
  - Is easily accessible to the public no less than 5 hours a day, 5 days a week, with the exception of scheduled and posted holidays;
  - Has a functional landline business telephone;
  - Is not located within or at the same number street address as another Medicaid-enrolled DME provider or Medicaid pharmacy that is also a DME provider;
  - Is located within the state of Florida or no more than 50 miles from the Florida state line.

  The bill includes an exception to these physical location requirements for DME providers of equipment or supplies not otherwise available from enrolled providers located within the state
- Maintain a stock of equipment and supplies readily available to meet the needs of customers;

- Obtain a $50,000 surety bond for each location up to a maximum of five bonds statewide or an aggregate bond of $250,000 statewide. All locations that are covered by the bond are to be identified in an enrollment application or bond renewal. Proof that the bond has been renewed or is a continuous bond must be provided to AHCA annually; and
- Obtain a level 2 background screening for staff in direct contact with or providing direct services to recipients. This requirement applies to, but is not limited to, repair and service technicians, fitters, and delivery staff. The cost of the background screening is to be borne by the provider.

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

Section 1. Amends s. 400.147, F.S., relating to nursing facility internal risk management and quality assurance programs.

Section 2. Amends s. 400.462, F.S., relating to definitions.

Section 3. Amends s. 400.464, F.S., relating to home health agency licensure.

Section 4. Amends s. 400.471, F.S., relating to home health agency licensure applications.

Section 5. Amends s. 400.474, F.S., relating to home health agency administrative penalties.

Section 6. Creates s. 400.476, F.S., relating to staffing requirements, notifications, and limitations on staffing services.

Section 7. Amends s. 400.484, F.S., relating to home health agency inspections, deficiencies and fines.

Section 8. Amends s. 400.491, F.S., relating to home health agency clinical records.

Section 9. Amends s. 400.497, F.S., relating to rules establishing minimum standards.

Section 10. Amends s. 400.506, F.S., relating to licensure of nurse registries.

Section 11. Amends s. 400.901, F.S., relating to definitions for the Medicaid program.

Section 12. Amends s. 400.907, F.S., relating to Medicaid provider agreements.

Section 13. Amends s. 409.910, F.S., conforming a cross-reference

Section 14. Amends s. 409.912, F.S., relating to cost-effective purchasing of Medicaid services.

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

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None

2. Expenditures:

   None

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None

2. Expenditures:

   None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The requirement for a $50,000 surety bond for each DME provider location, up to a maximum of five bonds statewide or an aggregate bond of $250,000 statewide could lead to increased costs for DME providers. In addition, the requirement for Level Two background screenings, as described in s. 435.04, F.S. for each provider employee in direct contact with or providing direct services to recipients of DME and medical supplies in their homes will lead to increase provider costs.

D. FISCAL COMMENTS:

None

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   The legislation does not appear to require counties or municipalities to spend funds or take any action requiring the expenditure of funds; reduce the authority that municipalities or counties have to raise revenue in the aggregate; or reduce the percentage of a state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

N/A

C. DRAFTING ISSUES OR OTHER COMMENTS:

None

D. STATEMENT OF THE SPONSOR

N/A

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

On April 8, 2008, the Healthcare Council adopted one strike-all amendment to the bill and three amendments to the strike-all amendment. The strike-all amendment, as amended, adds provisions governing licensure of home health agencies and nurse registries, as follows:

Amends s. 400.462, F.S., to remove substantive provisions from definitions of “administrator”, “certified nursing assistant”, “director of nursing”, and “home health aide”. These provisions are amended and moved into the body of the statute in s. 400.474, F.S. (below).

Amends s. 400.464, F.S., to require a home infusion therapy provider to be licensed as either a home health agency or nurse registry.

Amends s. 400.471, F.S., to prohibit initial licensure of a home health agency if another agency owned by the applicant is located within 10 miles of the applicant, prohibit applicants from transferring an application to another entity prior to AHCA issuing the license, and to increase the documentation requirements for new home health agency licenses. Requires applicants to:

- Submit a business plan;
- Provide evidence of contingency funding equivalent to 1 month’s average operating expenses;
- Provide evidence of sufficient assets, credit, and projected revenues to cover liabilities and expenses; and
- Disclose of all ownership interests.

Amends s. 400.474, F.S., to create new authority to act on a home health agency license for falsifying patient records and falsifying records on staff training, and imposing a $1000 fine for those violations.

Creates s. 400.476, F.S., to provide home health agency staffing requirements and limitations on staffing services, to:

- Limit the number of home health agencies one administrator or nursing director can supervise, which varies depending on controlling interests and location;
- Require home health agencies to notify AHCA if they change or lose their nursing director, and cease operating if they don’t have a director of nursing for more than 30 days. Failure to notify AHCA will result in a $1000 fine for a first violation and $2000 for a subsequent violation.
- Provide an exemption from director of nursing requirements for agencies that provide only certain services; and
- Require home health agencies to ensure their staff are properly trained.

Amends s. 400.484, F.S., to makes fines for deficiencies mandatory, instead of discretionary, and increase the amount of the fine for each class of deficiencies, as follows:

- Class I – raised from $5,000 to $15,000
- Class II – raised from $1,000 to $5,000
- Class III – raised from $500 to $1000
- Class IV – raised from $200 to $500

Amends s. 400.491, F.S., to extend the length of time that a home health agency must maintain client records from 1 to 3 years following termination of services.

Amends s. 400.497, F.S., to require AHCA to adopt home health agency rules related to director of nursing oversight and inspections related to a change in ownership.

Amends s. 400.506, F.S., to require nurse registries to ensure adequate training for certified nursing assistants and home health aides referred for contract by the nurse registry.

The strike-all amendment, as amended, amends s. 400.910, F.S., to correct a cross-reference related to responsibility for payments on behalf of Medicaid eligible persons when other parties are liable.

The strike-all amendment, as amended, amends various sections of law addressing changes in ownership by Medicaid providers, and Medicaid durable medical equipment providers, as follows.

Amends s. 409.901, F.S., to define "change of ownership" for purposes of Medicaid provider contracting.

Amends s. 409.907, F.S., to require that providers must notify AHCA 60 days prior to a change in ownership, to provide that transferors are liable for certain moneys owed to AHCA prior to the effective date of the change of ownership and that transferees are liable for outstanding overpayments owed to AHCA identified prior to the date of the change of ownership, requiring the provider to pay or agreed to a payment plan for all outstanding moneys owed to AHCA prior to AHCA approval of the transferee's new provider agreement, and to clarify the effective dates of provider agreements for various situations.

Amends s. 409.912, F.S., to require AHCA to limit its network of durable medical equipment (DME) providers as of January 1, 2009, and imposing a list of provider enrollment requirements:

- Must be accredited by a federally-approved accreditation organization.
- Must post a $50,000 surety bond for each location, up to $250,000 total.
  Exemption: Providers that are government owned and operated, operating in a pharmacy that is currently enrolled as a Medicaid provider, an active orthopedic physician group that only provides orthotic or prosthetic devices, or that have been approved through the federal Medicare competitive bid process to provide services in Florida, are not subject to the surety bond requirement.
- DME products must be delivered directly to the Medicaid recipient and subcontracting or assignment of services is prohibited.
- Allows DME providers to store nebulizers at a physician's office for the purpose of having the physician staff issue the equipment, if it is medically necessary to do so, the DME provider and the physician staff have been appropriately trained and document such training, and the DME provider provides services under contract with the physician.
- DME providers must meet some physical location requirements. They must legally occupy a business location and that location must:
  - Be clearly identified as a DME provider by a sign readable from 20 feet away
  - Be readily accessible to the public at least 5 hours a day and 5 days a week (excluding scheduled and posted holidays)
  - Not share a street address with another DME provider or enrolled Medicaid pharmacy that is also a DME provider
  - Be within 50 miles of the state line
  - Have an inventory of products that can meet the demands of its customer base
- AHCA can make exceptions for out-of-state providers if their products are not available from other providers in the state.
- Must obtain a Level II background screening for each employee that will have direct contact with or provides direct services to Medicaid recipients at their homes.

PCB HCC 08-19 was reported favorably with one amendment. This analysis reflects the PCB as amended.

On April 10, 2008, the Policy and Budget Council adopted six amendments to House Bill 7083/PCB HCC 08-19. The amendments:

- Add a new section to the bill to amend s. 400.147, F.S., related to nursing facility risk management and quality assurance programs, changing the definition of "adverse incident" to exclude requests to law enforcement for transportation of residents.

- Amend provisions of the bill related to home health agency licensure to limit their prohibition on licensure of an applicant that shares common controlling interest with another licensed home health agency located within 10 miles to such applicants also in the same county as that other licensed home health agency.

- Amend provisions of the bill related to liabilities of Medicaid providers engaged in a change of ownership to clarify nursing facilities' liabilities will be governed by existing licensure statute, s. 400.179, F.S.

- Amend the Medicaid DME provider provisions of the bill related to storage of nebulizers in physician offices to require the physicians' offices to maintain inventory records of stored nebulizers, including documentation of the DME provider source. Physicians are also prohibited from having any financial relationship with the DME provider, or receive any financial gain from the delivery of nebulizers to patients.

- Amend provisions of the bill exempting certain providers from the bill's accreditation and surety bond requirements for Medicaid DME providers by deleting the exemption for providers approved through the federal Medicare competitive procurement process to provide services in any metropolitan area in Florida.

House Bill 7083 was reported favorably with six amendments. The analysis reflects the Council Substitute for House Bill 7083.