The Florida Senate

# BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Appropriations

BILL: CS/CS/SB 1254

INTRODUCER: Rules Committee; Health Policy Committee; and Senator Grimsley

SUBJECT: Health Care Services

DATE: April 21, 2014 REVISED:

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Looke | Stovall | HP | **Fav/CS** |
| 2. | Looke | Phelps | RC | **Fav/CS** |
| 3. | Brown | Kynoch | AP | **Pre-meeting** |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

CS/CS/SB 1254 amends various sections of the Florida Statutes to delete unused, obsolete, and redundant rulemaking authority granted to the Agency for Health Care Administration (AHCA) and the Department of Elder Affairs (DOEA) and make other technical and conforming changes.

The bill also:
- Changes “certification” to “licensure” for organ, eye, and tissue procurement organizations and amends the procurement groups specified in statute;
- Moves Medicaid recipients under the age of 21 who are not receiving waiver services but who are authorized to reside in certain group home facilities from the mandatory enrollment group to the voluntary group for statewide Medicaid managed care;
- Amends the definition of “provider service network” (PSN), and requires the AHCA to terminate its contract with a PSN that no longer meets that definition under certain conditions;
- Allows all hospitals, rather than only specialty-licensed children’s hospitals, that are authorized to provide certain pediatric cardiovascular services, to provide cardiovascular services to adults who the hospital treated as children for congenital heart disease; and
- Amends the parameters for certain reports made by a home health agency.

The bill has no fiscal impact.

## II. Present Situation:

The Agency for Health Care Administration (AHCA) has a number of regulatory responsibilities, among these being the licensure of health care facilities, including abortion clinics, nursing homes, and clinical laboratories.

In recent years, many of the facilities licensed by the AHCA have come under increasing regulatory control of federal law relating to Medicaid and Medicare, with state laws providing greater specificity than previously provided. At the same time, frequent changes to many of these overlapping legal environments have made it difficult for the AHCA to maintain rules consistent with current law. Some of this difficulty has related to unnecessary rulemaking mandates, particularly relating to statutes that provide sufficient specificity to enforce without the need for rulemaking.

Rulemaking is required by Florida's Administrative Procedure Act (APA) whenever an agency has express authority to make rules, and must resort to rulemaking in order to implement, interpret, or prescribe law, policy, or requirements, including mandatory forms.[1] Rulemaking is not discretionary under the APA.[2]

In 2009, and again in 2013, the Joint Administrative Procedures Committee held hearings focusing on 2007 legislation that, on its face, requires the AHCA to make rules that have yet to be finally adopted. In some cases, that legislation and similar legislation contemplated rulemaking that was either unnecessary under the APA or already promulgated under previously enacted law.

**Statewide Medicaid Managed Care**

Part IV of ch. 409, F.S., was created in 2011 by ch. 2011-134, L.O.F., and governs the Statewide Medicaid Managed Care program (SMMC). The program, authorized by a federal Medicaid waiver, is designed for the AHCA to issue invitations to negotiate[3] and competitively procure contracts with managed care plans in 11 regions of the state to provide comprehensive Medicaid coverage for most of the state's enrollees in the Medicaid program. SMMC has two components: managed medical assistance (MMA) and long-term care managed care (LTCMC).

The LTCMC component began enrolling Medicaid recipients in August 2013 and is scheduled to complete its statewide roll-out in March 2014.[4] The MMA component is scheduled to begin enrolling Medicaid recipients in May 2014 and finish its roll-out in August 2014.[5]

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[1] Section 120.52(16), F.S., defines "rule" to mean "each agency statement of general applicability that implements, interprets, or prescribes law or policy or describes the procedure or practice requirements of an agency and includes any form which imposes any requirement or solicits any information not specifically required by statute…"
[2] Section 120.54(1)(a), F.S.
[3] An "invitation to negotiate" is a written or electronically posted solicitation for vendors to submit competitive, sealed replies for the purpose of selecting one or more vendors with which to commence negotiations for the procurement of commodities or contractual services. *See* s. 287.012(17), F.S.
[4] *See* < http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#LTCMC >, last visited March 20, 2014.
[5] *See* < http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#MMA >, last visited March 20, 2014.

***Provider Service Networks***

Types of managed care plans that are eligible for SMMC include health insurers, exclusive provider organizations, health maintenance organizations, provider service networks (PSNs), and federally-authorized accountable care organizations, among other entities.[6]

A PSN is defined as a type of managed care plan of which a controlling interest is owned by a health care provider, or group of affiliated providers, or a public agency or entity that delivers health services. For the purpose of this definition, "health care provider" includes Florida-licensed health care professionals or licensed health care facilities, federally qualified health care centers, and home health care agencies.[7]

The AHCA is required to procure a specified number of managed care plans per region or a number of plans that range between a minimum and maximum specified for each region. At least two plans per region must be procured, and at least one plan per region must be a PSN, if a PSN submits a responsive bid during the procurement. If no PSN submits a responsive bid for a region, the AHCA is required to procure no more than one less than the maximum number of plans for that region during the initial procurement and, within 12 months after the initial invitation to negotiate, attempt once again to procure a PSN for that region.[8]

SMMC allows for contracted managed care plans to be paid via one of two methods. A managed care plan that is not a PSN is required to be a "prepaid plan," which is a plan licensed or certified in Florida as a risk-bearing entity and paid a prospective per-member-per-month payment by the AHCA known as a capitation. A PSN may qualify as a prepaid plan under s. 409.912(4)(d), F.S., which provides that a PSN may be reimbursed on a prepaid basis by complying with the solvency requirements for health maintenance organizations under s. 641.2261(2), F.S., and by meeting appropriate financial reserve, quality assurance, and patient rights requirements established by the AHCA.[9]

Managed care plans that provide for services on a prepaid, capitated basis agree to accept the capitation payment and assume financial risk for delivering all covered services, regardless of whether the capitation fully covers the cost for all services that need to be provided. Capitation is designed to provide the state with less risk and more predictability for Medicaid expenditures and to incent the capitated entities to manage the provision of services in a cost-effective manner. Capitation rates must be certified as actuarially sound by a third-party actuary in compliance with federal guidelines.

SMMC gives PSNs the option for their network providers to be paid on a fee-for-service basis by the state's Medicaid fiscal agent instead of the PSN being paid by capitation. The fee-for-service option is available to a PSN only for the first two years of its operation under the SMMC, at which point the PSN is required to convert to a prepaid PSN.[10]

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[6] *See* s. 409.962(6), F.S.
[7] *See* s. 409.962(13), F.S.
[8] *See* s. 409.974(1), F.S.
[9] *See* s. 409.962(12), F.S.
[10] *See* s. 409.968(2), F.S.

***Group Home Facilities for Persons with Developmental Disabilities***

The Agency for Persons with Disabilities (APD) is responsible for providing all services for persons with developmental disabilities that are provided under ch. 393, F.S., including the operation of all state-related institutional programs and the programmatic management of Medicaid waivers established to provide services to persons with developmental disabilities.[11] A person determined eligible by the APD to receive APD services is known as a “client,”[12] and the term includes persons receiving APD services and those on a waiting list to receive APD services.

The AHCA has been granted waiver authority from the federal Medicaid program for the state to implement a four-tiered system to serve eligible clients through a Developmental Disabilities Waiver (DD waiver). For the purpose of this waiver program, eligible clients include individuals with a diagnosis of Down syndrome or a developmental disability. The APD is required to assign all clients receiving services through this waiver to a tier, based on financial eligibility guidelines and APD assessments.[13]

Under the DD waiver, the APD operates four tier-based programs that provide home and community-based supports and services to clients living at home or in a home-like setting. DD waiver services are funded by state revenue and federal Medicaid matching dollars. APD operates the DD waiver under the authorization of the AHCA’s Division of Medicaid.

The purpose of the DD waiver is to promote, maintain, and restore the health of APD clients; to minimize the effects of illness and disabilities through the provision of needed supports and services in order to delay or prevent institutionalization; and to foster the principles of self-determination as a foundation for services and supports. The intent of the waiver is to provide a viable choice of services that allow clients to live as independently as possible in their own home or in the community and to achieve productive lives as close to normal as possible, as opposed to residing in an institutional setting.[14]

Under ch. 393, F.S., the Legislature declared that all persons with developmental disabilities who live in licensed community homes will have a living environment comparable to other Floridians and that such residences will be considered and treated as a functional equivalent of a family unit and not as an institution, business, or boarding home.[15]

The APD regulates group home facilities for persons with developmental disabilities. A “group home facility” is an APD-licensed residential facility that provides a family living environment, including supervision and care necessary to meet the physical, emotional, and social needs of its residents. The capacity of a group home facility is limited to at least four but not more than 15

[11] *See* s. 20.197(3), F.S.
[12] *See* s. 393.063(5), F.S.
[13] *See* s. 393.0661(2), F.S.
[14] Agency for Health Care Administration, *Developmental Disabilities Waiver Services Coverage and Limitations Handbook,* November 2010, sec. 1, p. 8, available at < http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/DD_Waiver_Handbook_Final_Rule_Nov_2010.pdf >, last visited March 20, 2014.
[15] *See* s. 393.062, F.S.

residents.[16] "Residential facilities" provide room and board and personal care for persons with developmental disabilities.[17] "Personal care services" are defined as individual assistance with or supervision of essential activities of daily living for self-care, including ambulation, bathing, dressing, eating, grooming, toileting, and other similar services that are incidental to the care furnished and essential to the health, safety, and welfare of a person with developmental disabilities if no one else is available to perform those services.[18]

Not all residents of APD-licensed group homes are APD clients. Some are private-pay residents. Some are eligible for Medicaid without being eligible for DD waiver services. The APD currently issues licenses to 1,661 group homes statewide in which approximately 8,000 persons with developmental disabilities reside. Approximately 250 of these residents are not APD clients while 7,673 APD clients in group home settings are enrolled in Medicaid for health care services. The number of group home residents who are not APD clients but are Medicaid-eligible is unknown.[19]

Under SMMC, all Medicaid recipients are required to receive covered Medicaid services through managed care plan enrollment, except for certain groups of individuals that are exempt from participation in SMMC.[20] Other Medicaid-eligible individuals are not required to enroll in managed care plans but may do so voluntarily, including Medicaid recipients who are receiving DD waiver services or are on a waiting list to receive DD waiver services,[21] which includes all APD clients. However, a resident of an APD-licensed group home who is not an APD client is not included in this "voluntary" category for managed care plan enrollment and is therefore required to join a Medicaid managed care plan under SMMC if he or she is Medicaid eligible and enrolls in Medicaid.

**Organ Donations in Florida**

Over 3,500 people in Florida are registered and waiting for organ transplants, and thousands more wait for tissue donations.[22] The most common types of organ transplants include the kidneys, liver, heart, lungs, and pancreas, but many other organs and tissues can be transplanted or used for various other medical procedures.[23] Nationwide, nearly 6,000 people die each year waiting for an organ donation.[24]

Four major organ and tissue procurement agencies operate in Florida to facilitate the process of organ donation. These agencies are certified by the U.S. Centers for Medicare and Medicaid Services (CMS) and operate in Florida to increase the number of registered donors and

[16] *See* s. 393.063(17), F.S.
[17] *See* s. 393.063(28), F.S.
[18] *See* s. 393.063(24), F.S.
[19] Email from APD staff to Senate Appropriations Committee staff, March 20, 2014, on file with staff of the Senate Health and Human Services Appropriations Subcommittee.
[20] *See* s. 409.965, F.S.
[21] *See* s. 409.972(2), F.S.
[22] *See* Donate Life Florida, 2009, *FAQs About Donation*, available at: http://www.donatelifeflorida.org/content/about/facts/faq/#faq_22 (last visited Mar. 26, 2013).
[23] Id.
[24] Id.

coordinate the donation process when organs become available.[25] Each agency serves a different region of the state.[26] In addition to federal certification of organ procurement organizations, the AHCA also certifies these organ procurement organizations and other eye and tissue organizations.[27]

The Organ Procurement and Transplantation Network (OPTN) is the unified network established by Congress in 1984. The OPTN is a public-private partnership of professionals involved in the donation and transplantation system. The main goals of the OPTN are to increase the effectiveness and efficiency of organ sharing, increase the equity of the national system of organ allocation, and increase the supply of donated organs.[28]

The Association of Organ Procurement Organizations (AOPO) is the national representative of the 58 federally-designated organ procurement organizations. The AOPO's main goal is to help member OPOs maximize the availability of organs and tissues for transplantation and enhance the quality, effectiveness, and integrity of the donation process. The AOPO also works closely with the OPTN and has two seats on the OPTN Board of Directors.[29]

The Eye Bank Association of America (EBAA) is the oldest transplant association in the United States. The EBAA is also a nationally-recognized accrediting body for eye banks, and the EBAA Medical Advisory Board develops standards to ensure consistently acceptable levels of quality, proficiency, and ethics in dealing with ocular tissue for transplantation and defines the minimum standards of practice in the recovery, preservation, storage, and distribution of eye tissue for transplantation and research, as determined by the ophthalmological medical community. The EBAA Medical Standards are reviewed semi-annually and are endorsed by the American Academy of Ophthalmology (AAO).[30]

**Specialty-Licensed Children's Hospitals**

Presently, s. 395.003, F.S., states that a specialty hospital may not provide any service or regularly serve any population group beyond those that are specified in its license, with an exception made for specialty-licensed children's hospitals to allow them to treat certain adult patients with cardiovascular issues who the hospital treated as children. The AHCA licenses all hospital types in the state of Florida either as a Class I general acute care hospital or as a Class II specialty hospital. The options for a class II specialty hospital are a women's hospital or a children's hospital. To offer services to the population as a whole, a hospital must be licensed as a class I general acute care hospital. A hospital must also obtain a Certificate of Need (CON) from the AHCA before offering specialized types of services, including routine adult cardiac surgery.

[25] *See* Donate The Gift of Life, *Organ Procurement Organizations*, available at http://organdonor.gov/materialsresources/materialsopolist.html (last visited Mar. 26, 2014).

[26] Id.; LifeLink of Florida serves west Florida, LifeQuest Organ Recovery Services serves north Florida, TransLife Organ and Tissue Donation Services serves east Florida, and LifeAlliance Organ Recovery Services serves south Florida.

[27] *See* AHCA's authority for certifying organ, eye, and tissue banks can be found in s. 765.542, F.S., and a list of organ, eye and tissue banks, *FloridaHealthFinder* at www.floridahealthfinder.gov (last visited on Mar. 26, 2013).

[28] *See* http://optn.transplant.hrsa.gov/optn/, (last visited on Mar. 26, 2013) and http://www.aopo.org/about-aopo, for the OPTN's policies (last visited Mar. 26, 2014).

[29] *See* http://www.aopo.org/about-aopo (last visited on Mar. 26, 2014).

[30] *See* http://www.restoresight.org/about-us/ (last visited on Mar. 26, 2014).

In addition to the three hospitals in Florida that qualify as specialty-licensed children's hospitals,[31] some Class I general acute care hospitals offer specialty services for children but are not technically considered specialty-licensed children's hospitals. One example of such an embedded children's hospital is the Palm Beach Children's Hospital located within St. Mary's Medical Center in West Palm Beach. Currently, St. Mary's Hospital is authorized to perform pediatric cardiac surgeries, including pediatric open heart surgery and pediatric cardiac catheterization. However, since St. Mary's Medical Center does not have a CON for routine adult cardiac surgery and since the present exception in s. 395.003, F.S., only applies to specialty-licensed children's hospitals, St. Mary's Medical Center may not continue to treat children for the same congenital heart conditions once they reach adulthood without obtaining a waiver from the AHCA for each instance.

**Home Health Agencies**

A Home Health Agency (HHA) is an organization that provides home health services and staffing services.[32] Home health services provided by an HHA include health and medical services and medical equipment provided to an individual in his or her home, such as nursing care, physical and occupational therapy, and home health aide services.[33] Home health agencies are regulated by the AHCA under Part III of ch. 400, F.S.

In 2008 the Florida Legislature passed ch. 2008-246, L.O.F., with anti-fraud measures, including the requirement for an HHA quarterly report to be submitted to the AHCA within 15 days following the end of each quarter. The Legislature passed ch. 2008-246, L.O.F., to combat an increase in Medicaid fraud in HHAs during the early to mid 2000s. In Fiscal Year 2004-2005, the AHCA's Bureau of Medicare Program Integrity (MPI) opened 47 investigations of HHAs for Medicaid fraud, 72 in Fiscal Year 2005-2006, and 144 in Fiscal Year 2006-2007.[34] Between 2004 and 2007, 19 HHAs were terminated from the Medicaid program in Miami-Dade County alone.[35]

Section 400.474(6)(f), F.S., enacted in ch. 2008-246, L.O.F., requires HHAs to report data as it existed on the last day of the quarter for four items that are markers for possible fraudulent activity. These items include:

- The number of insulin-dependent diabetic patients receiving insulin injection services;
- The number of patients receiving both home health services from the HHA and hospice services;
- The number of patients receiving HHA services; and
- Name and license number of nurses whose primary job responsibility is to provide home health services to patients and who received remuneration from the HHA in excess of $25,000 during the quarter.

[31] All Children's Hospital in Saint Petersburg, Miami Children's Hospital in Miami, and Nemours Children's Hospital in Orlando. See AHCA bill analysis for SB 1264, dated Mar. 15, 2013, on file with the Senate Health Policy Committee.
[32] S. 400.462(12), F.S.
[33] S. 400.462(14)(a)-(c), F.S.
[34] Staff analysis of SB 1374 (2008), dated Mar. 7, 2008, on file with the Senate Health Policy Committee.
[35] Id.

The AHCA is required to impose a fine of $200 per day, up to $5,000 per reporting period, if the report is not submitted within the first 15 days following the close of the quarter. From January 1, 2009, through December 31, 2012, there were a total of 1,407 fines imposed.[36] For the 2012-2013 state fiscal year, fines of $932,750 were imposed by final order. Also, the number of HHAs that fail to submit the reports each quarter has decreased. For the quarter ending December 31, 2012, 42 of the 2,250 licensed HHAs failed to submit their reports.[37]

The AHCA uses the data on the number of patients on the last day of the quarter as an indicator of the number of patients when a home health agency is closing. In addition, the data on numbers of patients is used as an indicator that the home health agency may not be operational, along with other information. Failing to provide at least one service directly for a period of 60 days is grounds to deny or revoke a license under s. 400.474(1)(2)(e), F.S. The AHCA already collects the number of patients admitted over a 12-month period, from each home health agency on the biennial license renewal application as required by s. 400.471(2)(c), F.S.[38]

## III. Effect of Proposed Changes:

**Section 1** amends s. 390.012, F.S., relating to the disposal of fetal remains, to repeal the requirement that the AHCA must adopt rules to require that abortion clinics be in compliance with s. 390.0111, F.S., relating to termination of pregnancies. This rule requirement is not necessary since abortion clinics must already comply with that section of law.

**Section 2** amends s. 395.003, F.S., to allow all hospitals, rather than only specialty-licensed children's hospitals, that are authorized to provide pediatric cardiac catheterization and pediatric open-heart surgery to provide cardiovascular services to adults that the hospital treated as children for congenital heart disease. This change will allow St. Mary's Medical Center in West Palm Beach to continue to offer cardiac services to adult patients that were by the Medical Center treated for congenital cardiac disorders as children without obtaining a waiver from the AHCA.

**Sections 3, 4, and 5** amend ss. 400.021, 400.0712, and 400.23, F.S., relating to the regulation of nursing homes, to repeal specific mandatory rule requirements and replace them with general authority allowing the AHCA to adopt rules to implement part II of ch. 400, F.S.

**Section 6** amends 400.474, F.S., to reduce the frequency of reports that HHAs are required to submit to the AHCA from quarterly to every six months, adjusting the remuneration amount required to be reported from $25,000 to $50,000 to account for the extended reporting period, and to require that the reports be submitted electronically. The bill also exempts from the reporting requirements HHAs that share a controlling interest with a licensee that bills Medicaid or Medicare so long as the HHA is not a Medicaid or Medicare provider itself.

**Sections 7, 8, 9, and 10** amend ss. 400.487, 400.497, 400.506, and 400.509, F.S., relating to home health agencies, to repeal specific mandatory rule requirements and replace them with general authority allowing the AHCA to adopt rules to implement part III of ch. 400, F.S.

[36] AHCA analysis of HB 4031 (SB 1094), dated Mar. 14, 2013, on file with the Senate Health Policy Committee.
[37] Id.
[38] Supra n. 19

**Sections 11, 23, and 24** amend ss. 400.6095, 429.255, and 429.73, F.S., respectively, to repeal the requirement to adopt rules to implement "do not resuscitate" orders under s. 401.45, F.S., in hospice, assisted living facilities, and adult family-care homes. These grants of rulemaking authority are unnecessary since the statute is self-executing.

**Sections 12 and 13** amend s. 400.914, F.S., and create s. 400.9141, F.S., respectively, to substitute mandatory rulemaking with discretionary rulemaking authority as needed to administer part VI of ch. 400, F.S., relating to prescribed pediatric extended care centers. Section 400.9141, F.S., is created with language moved from s. 400.914, F.S., to make the conditions self-executing.

**Sections 14 and 15** amend ss. 400.934 and 400.935, F.S., relating to home medical equipment providers, to repeal certain specific mandatory rule requirements and replace them with general authority allowing the AHCA to adopt rules to administer part VII of ch. 400, F.S. In addition s. 400.934, F.S., requires the comprehensive emergency management plan of a home medical equipment provider to include criteria for a patient's equipment and supply list to accompany a patient who is transported from his or her home.

**Sections 16 and 17** amend ss. 400.962 and 400.967, F.S., relating to intermediate care facilities for developmentally disabled persons, to repeal specific mandatory rule requirements and replace them with general authority allowing the AHCA to adopt rules to administer part VIII of ch. 400, F.S.

**Section 18** amends s. 400.980, F.S., relating to health care service pools, to repeal a mandate that the AHCA adopt rules for the registration of health care services pools.

**Section 19** amends s. 409.912, F.S., relating to the cost-effective purchasing of health care in the Medicaid program, to repeal the requirement for the AHCA to adopt rules to administer subsection 409.912(43), F.S., related to provider lock-in programs. The subsection expires on October 1, 2014.

**Section 20** amends s. 409.962(13), F.S., to revise the definition of "provider service network" (PSN) within the Statewide Medicaid Managed Care program (SMMC). The bill requires that a group of affiliated health care providers that owns a controlling interest in a PSN must be affiliated for the purpose of providing health care. The bill also provides that the term "health care providers" includes Florida-licensed health care "practitioners," as opposed to Florida-licensed health care "professionals," among other entities.

**Section 21** amends s. 409.972, F.S., to exempt from mandatory enrollment in Medicaid managed care Medicaid recipients under the age of 21 who are not receiving waiver services but who are authorized by the Agency for Persons with Disabilities or the Department of Children and Families to reside in a group home facility, and instead make enrollment in Medicaid managed care voluntary.

**Section 22** amends s. 409.974(1), F.S., to require the AHCA to procure and contract with managed care plans in each SMMC region under specified parameters regarding the number of PSNs and total plans per region. The bill also provides that in a region containing only one

contracted PSN, if changes in the PSN's ownership or business structure result in the PSN no longer meeting the definition of a PSN, the AHCA is required, within 12 months, to terminate that plan's contract, provide notice of another invitation to negotiate, and procure and contract with another PSN in that region

**Section 25** amends s. 440.102, F.S., to clarify the AHCA's rulemaking responsibilities pertaining to drug-free workplace laboratories.

**Section 26** amends s. 483.245, F.S., to repeal the requirement that the AHCA adopt rules to assess administrative penalties for clinical laboratories that pay or receive kickbacks.

**Sections 27 and 28** amend ss. 765.541 and 765.544, F.S., relating to organ and tissue procurement agencies, to repeal specific mandatory rule requirements and replace them with general authority allowing the AHCA to adopt rules to administer ss. 765.541 - 765.546, F.S. The bill also changes "certification" to "licensure" for organ, eye, and tissue procurement organizations and amends the procurement groups specified in statute. The AHCA must substantially base its procurement organizations licensure program on the standards and guidelines of the specified organizations.

The bill also makes technical, clarifying, and conforming changes as necessary throughout the sections of law amended by the bill.

**Section 29** establishes an effective date of July 1, 2014.

## IV. Constitutional Issues:

### A. Municipality/County Mandates Restrictions:

None.

### B. Public Records/Open Meetings Issues:

None.

### C. Trust Funds Restrictions:

None.

## V. Fiscal Impact Statement:

### A. Tax/Fee Issues:

None.

### B. Private Sector Impact:

None.

### C. Government Sector Impact:

None.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 390.012, 395.003, 400.021, 400.0712, 400.23, 400.474, 400.487, 400.497, 400.506, 400.509, 400.6095, 400.914, 400.934, 400.935, 400.962, 400.967, 400.980, 409.912, 409.962, 409.972, 409.974, 429.255, 429.73, 440.102, 483.245, 765.541, and 765.544.

This bill creates section 400.9141 of the Florida Statutes.

## IX. Additional Information:

### A. Committee Substitute – Statement of Substantial Changes:

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

**CS/CS by Rules on April 2, 2014:**
The CS:

- Allows all hospitals, rather than only specialty-licensed children's hospitals, that are authorized to provide pediatric cardiac catheterization and pediatric open-heart surgery to provide cardiovascular services to adults that the hospital treated as children for congenital heart disease; and
- Reduces the frequency of reports that HHAs are required to submit to the AHCA from quarterly to every six months and to require that the reports be submitted electronically. The CS also exempts from the reporting requirements HHAs that share a controlling interest with a licensee that bills Medicaid or Medicare so long as the HHA is not a Medicaid or Medicare provider itself.

**CS by Health Policy on March 25, 2014:**
The CS:

- Reinstates some of the minimum standards the AHCA is required to adopt in rule to regulate home medical equipment providers;
- Changes certification to licensure for organ, eye, and tissue procurement organizations and amend which groups are specified in statute. The AHCA must substantially base its procurement organizations licensure program on the standards and guidelines of the specified organizations as well as federal and state laws;
- Makes technical changes to the rulemaking authority over nurse registries and drug-free workplace laboratories.

- Allows voluntary enrollment in statewide Medicaid managed care for Medicaid recipients under the age of 21 who are not receiving waiver services but who are authorized by the Agency for Persons with Disabilities or the Department of Children and Families to reside in a group home facility; and
- Amends the definition of "provider service network" and requires the AHCA to terminate the contract of a Medicaid managed care plan if the plan was contracted as the only PSN in a region but no longer meets the definition of a PSN. The AHCA must re-procure another PSN in such a region within 12 months after the first PSN no longer meets the definition of a PSN.

## B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.