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:	PCS/CS/SB 1726 (233364)
INTRODUCER:	Appropriations Committee (Recommended by Appropriations Subcommittee on Health and Human Services); Health Policy Committee; and Senator Bean
SUBJECT:	Agency for Health Care Administration
DATE:	March 2, 2020 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Kibbey	Brown	HP	**Fav/CS**
2.	McKnight	Kidd	AHS	**Recommend: Fav/CS**
3.	McKnight	Kynoch	AP	**Pre-meeting**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

PCS/CS/SB 1726 addresses statutory duties and responsibilities of the Agency for Health Care Administration (AHCA) relating to the regulation of health care facilities and providers. The bill:

- Modifies annual birth center reporting to the AHCA.
- Removes outdated language relating to certificate of need, to allow hospital licenses to correctly reflect the actual bed categories provided by a licensee.
- Reinstates the AHCA's authority to require hospital adult cardiac programs to participate in national reporting and quality registries.
- Extends the current rural hospital designation to 2025 (set to expire June 30, 2021).
- Repeals an unenforceable annual assessment ruled unconstitutional.
- Removes provisions requiring fixed inspection time frames for nursing home facilities, hospices, assisted living facilities, and adult family care homes.
- Revises definitions and licensure requirements related to home health agencies.
- Creates an exemption to health care clinic licensure for federally certified providers.
- Removes the ability of a health care clinic to submit a surety bond instead of submitting certain documents as proof of financial ability to operate to satisfy initial licensure requirements.
- Creates risked-based licensure inspections for nurse registries, home medical equipment providers, and health care clinics to provide the AHCA the flexibility to inspect high-performing providers less frequently than poor performers.

- Authorizes the AHCA to adopt rules to waive a routine inspection, to waive an inspection for relicensure, or to allow an extended period between inspections for any provider type based upon specified factors.
- Authorizes the AHCA to issue a provisional license to all provider types.
- Revises requirements for the approval of comprehensive emergency management plans for newly-licensed facilities.
- Authorizes the AHCA to collect all legal fees incurred while defending a Medicaid case if the AHCA prevails.
- Clarifies the AHCA's authority to conduct retrospective reviews of Medicaid hospital inpatient claims and recover overpayments.
- Revises background screening regulations for health care provider staff.
- Removes class III psychiatric facilities from the diagnosis-related group (DRG) payment methodology.
- Removes the nursing home unit cost rate freeze.
- Aligns the state Medicaid anti-kickback law with the federal anti-kickback law.
- Requires the AHCA to extend the term of contracts awarded to Statewide Medicaid Managed Care plans (the Managed Medical Assistance Program, Long-term Care Program, and Dental Program) from five- to six-years, effectively extending current contracts through December 31, 2024.
- Requires the Florida Center for Health Information and Transparency to publish an annual report identifying health care services with the most significant price variation at statewide and regional levels.
- Expands the list of shoppable health care services that qualify for a shared savings incentive for patients to include services with the most significant price variation. Allows cash and cash equivalent incentives in shared savings incentives.
- Repeals multiphasic health testing center licensure.
- Replaces several legislatively mandated reports with online publications and repeals obsolete reports.

The bill has an indeterminate yet likely insignificant fiscal impact to the AHCA. See Section V.

The bill takes effect on July 1, 2020, except as otherwise expressly provided in the bill and except for the effective date section, which takes effect upon this bill becoming a law.

II. Present Situation:

The Agency for Health Care Administration (AHCA) is created in s. 20.42, F.S. It is the chief health policy and planning entity for the state and is responsible for, among other things, health facility licensure, inspection, and regulatory enforcement. It licenses or certifies and regulates 40 different types of health care providers, including hospitals, nursing homes, assisted living facilities, and home health agencies. In total, the AHCA licenses, certifies, regulates or provides exemptions for more than 48,000 providers.[1]

[1] *See* the Agency for Health Care Administration, Division of Health Quality Assurance http://ahca.myflorida.com/MCHQ/index.shtml (last visited Jan. 23, 2020).

Generally applicable provisions of health care provider licensure are addressed in the Health Care Licensing Procedures Act in part II of ch. 408, F.S. Additional chapters or sections in the Florida Statutes provide specific licensure or regulatory requirements pertaining to health care providers in this state.[2]

Due to the many diverse issues within the bill, pertinent background information is provided within the effect of proposed changes for the reader's convenience.

III. Effect of Proposed Changes:

Birth Center Reporting

Section 1 amends s. 383.327, F.S. Birth centers are required under current law to immediately report each maternal death, newborn death, and stillbirth to the medical examiner. Changes to subsection (2) of this section require birth centers to immediately report this information to the AHCA as well. Changes to subsection (4) of this section remove the requirement that birth centers submit a report to the AHCA annually and instead require reports to be submitted at a frequency adopted by the AHCA in rule. These changes could enable the AHCA to have the most current information to review during the inspection of a birth center.

Hospital Licensure and Registries

Chapter No. 2019-136, L.O.F. (enacted by the Legislature in 2019 as CS/HB 21) removes certificate of need (CON) review requirements for hospitals over time, with the final change occurring on July 1, 2021. The Legislature also repealed s. 408.0361(5)(b), F.S., that required hospitals with adult cardiovascular programs to participate in clinical outcome reporting systems.[3,4]

Section 2 amends s. 395.003(4), F.S., to remove the requirement that all beds not covered by any specialty-bed-need methodology be specified as general beds on the face of the hospital's license. If this subsection is not updated to reflect recent changes to CON requirements, specialty hospital beds such as neonatal intensive care beds will incorrectly be reported as general acute care beds on the face of the hospital's license.

Section 3 amends s. 395.1055, F.S., to reinstate the AHCA's authority to require hospital adult cardiac programs to participate in national reporting and quality registries. Adult diagnostic cardiac catheterization programs and Level I or Level II cardiovascular programs must participate in either the American college of Cardiology or American Heart Association registry to document quality improvement plans. Hospitals licensed for Level II adult cardiovascular services must participate in the Society for Thoracic Surgeons clinical outcome reporting systems.[5]

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[2] *See* s. 408.802, F.S., for the health care provider types and applicable licensure statutes.
[3] Chapter No. 2019-136, Laws of Fla.
[4] Florida House of Representatives, *CS/HB 21 Final Bill Analysis* (June 26, 2019), *available at* https://www.flsenate.gov/Session/Bill/2019/21/Analyses/h0021z1.HMR.PDF (last visited Feb. 25, 2020).
[5] Agency for Health Care Administration, *Analysis for Amendments to SB 1726* (February 25, 2020) (on file with the Senate Appropriations Subcommittee on Health and Human Services).

Rural Hospitals

There are currently 28 hospitals in Florida that are recognized as meeting the definition of "rural hospital" as defined in 395.602(2)(b), F.S.[6] The hospital must have 100 or fewer beds and an emergency room and meet one of the six additional criteria in order to be considered a rural hospital. Several of the criteria are based on the population density of up to 100 persons per square mile as well as distance from another acute care hospital. Hospitals licensed as a rural hospital during the 2010-2011 or 2011-2012 fiscal year are designated as a rural hospital through June 30, 2021.[7]

Section 4 amends s.395.602, F.S., to extend the current rural hospital designation through June 30, 2025.

Repeal of an Unenforceable Assessment

Section 5 repeals s. 395.7015, F.S., which imposes an annual assessment on ambulatory surgical centers and certain diagnostic-imaging centers that are freestanding outpatient facilities. These assessments were ruled to be unconstitutional in 2002, and are no longer collected. [8]

Section 6 amends s. 395.7016, F.S., to conform a cross-reference to this section.

Licensure Inspections for Nursing Home Facilities, Hospices, Assisted Living Facilities, and Adult Day Care Centers

Uniform licensing requirements in s. 408.811, F.S., require the biennial inspection of health care facilities unless otherwise specified in statute or in rule. Sections of the bill listed below remove the frequency required in statute for nursing home facilities, hospices, assisted living facilities, and adult day care centers.

Federal law currently requires the AHCA to inspect a nursing home facility, at a minimum, every 15 months.[9] Section 400.19, F.S., also requires the AHCA to inspect a nursing home facility every 15 months. The AHCA is required to inspect a nursing home facility every six months for two years if the facility has been cited for a class I deficiency, has been cited for two or more

[6] Section 395.602(2)(b), F.S., defines "rural hospital" as an acute care hospital licensed under ch. 395, F.S., having 100 or fewer licensed beds and an emergency room, which is: the sole provider within a county with a population density of up to 100 persons per square mile; 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; a hospital supported by a tax district or subdistrict whose boundaries encompass a population of up to 100 persons per square mile; a hospital classified as a sole community hospital under 42 C.F.R. s. 412.92, regardless of the number of licensed beds; a hospital with a service area that has a population of up to 100 persons per square mile. 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 in the Florida Center for Health Information and Transparency at the agency; or a hospital designated as a critical access hospital, as defined in s. 408.07, F.S.

[7] *Supra* note 5.

[8] *Agency for Health Care Admin. v. Hameroff*, 816 So. 2d 1145, 1149-1150 (Fla. 1st DCA 2002).

[9] 42 C.F.R. s. 488.308(a).

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, each resulting in at least one class I or class II deficiency. Those nursing home facilities are required to pay a $6,000 fine for the two additional inspections.

Section 7 amends s. 400.19, F.S., to remove the 15-month inspection requirement from state law and instead requires the AHCA to conduct periodic unannounced licensure inspections. This provision would require the AHCA to conduct licensure surveys every six months for a facility that has been cited for a class I or two or more class II deficiencies within a 60-day period until the facility has two consecutive licensure surveys without a class I or class II deficiency citation. The AHCA maintains current statutory authority to assess a fine of $6,000 for the additional six month licensure survey.

Section 14 amends s. 400.605(3), F.S., to remove the requirement that the AHCA must inspect hospices annually or biennially for hospices having a three-year record of substantial compliance and instead requires the AHCA to conduct inspections and investigations of hospices as necessary to determine compliance.

Sections 48 and 49 amend ss. 429.35(2) and 429.905(2), F.S., to remove the requirement (and related provisions) that the AHCA inspect assisted living facilities biennially.

Section 50 amends s. 429.929, F.S., to remove a provision authorizing the AHCA to conduct an abbreviated biennial inspection of an adult day care center that has a record of good performance. It also removes a provision requiring the AHCA to conduct a full inspection of an adult day care center that has had one or more confirmed complaints.

Home Health Agencies

Section 400.462(12), F.S., defines the term "home health agency" as an organization that provides home health services and staffing services. An organization that provides only home health services does not meet the definition of a home health agency.

Subsection (30) of that section defines the term "staffing services" as services provided to a health care facility, school, or other business entity on a temporary or school-year basis pursuant to a written contract 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 or who are registered with a licensed nurse registry.

Subsection (14) of that section defines "home health services" as the following services that are provided by an organization:

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

Subsection (22) of that section defines the term "organization" as 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.

Section 8 amends s. 400.462, F.S., to revise the definitions of the terms "home health agency," "home health services," "home infusion therapy provider," and "nurse registry" and delete the definition of the term "organization."

- "Home health agency" is redefined to mean a person that provides one or more home health services, as opposed to an organization that provides home health services (plural) and staffing services as under current law. As a result, the word "person" (as defined in s.1.01(3), F.S.) includes individuals, children, firms, associations, joint adventures, partnerships, estates, trusts, business trusts, syndicates, fiduciaries, corporations, and all other groups or combinations..
- "Home infusion therapy provider" is redefined to pertain to "a person," as opposed to "an organization" that meets the definition's criteria.
- "Home health services" is redefined to conform to elimination of the term "organization" in other definitions, and the definition of "organization" itself is eliminated since that term becomes obsolete under the bill for this section of statute.

The current definition of organization only refers to entities and does not include individual persons, which creates a potential loophole for an individual person to employ health care personnel for the provision of home health services without having to obtain a license.[10] Under the bill, such an individual must obtain a license if they are not currently exempt from licensure as a home health agency pursuant to s. 400.464(5), F.S.

The AHCA has interpreted the provision of home health services to be an activity that requires licensure as a home health agency and does not believe changes to this section will impact services that require licensure.[11] However, it is unclear if there are unlicensed individuals that employ or may seek to employ health care personnel for the provision of home health services that would be required to obtain a license under the bill and not qualify for licensure exemption. Under the bill, such an individual would be subject to the provisions of s. 400.471(5), F.S., which requires an applicant or licensee for home health agency licensure to pay a fee for each submitted application. The fee must be established by the AHCA in rule at an amount sufficient to cover the AHCA's costs in carrying out its responsibilities, not to exceed $2,000 per biennium. Under this statutory authority in current law, the AHCA is imposing a $1,705 fee for initial licensure, change of ownership, or licensure renewal.[12] See Sections IV.D. and VI.

[10] Agency for Health Care Administration, *Senate Bill 1726 Agency Analysis* (on file with the Senate Committee on Health Policy).
[11] Email from the Agency for Health Care Administration (February 5, 2020) (on file with the Senate Appropriations Subcommittee on Health and Human Services).
[12] 59A-8.003, F.A.C.

Section 9 amends s. 400.464, F.S., to make conforming changes and to make exemptions from licensure as a home health agency 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 therapy, occupational therapy, or respiratory therapy); or ch. 486, F.S., (physical therapy). Skilled care services are currently defined in s. 400.462(29), F.S. This exemption currently indirectly exists within the definition of "organization" that is being stricken in Section 8 of the bill. The section also clarifies that the exemption does not authorize an individual to perform home health services without the required professional license.

Section 10 amends s. 400.471(2)(g), F.S., to require applicants for change of ownership or license renewal to provide proof of accreditation and a survey demonstrating compliance with the applicable licensure requirements prior to licensure for the addition of skilled services.

Sections 11-13 amend ss. 400.492, 400.506, and 400.509, F.S., to conform provisions to changes made to the definitions section for part III of ch. 400, F.S., in Section 8 of the bill.

AHCA Reporting Requirements

Section 15 amends s. 400.60501, F.S., to delete a requirement that the AHCA develop an annual report that analyzes and evaluates the information collected under the Health Care Clinic Act. It also removes an obsolete date. Hospice outcome and quality information is currently published on FloridaHealthFinder.gov.

Section 22 amends s. 408.0611, F.S., to require the AHCA to report on its website information on the implementation of electronic prescribing rather than issuing an annual report to the Governor and the Legislature. The AHCA already updates this information quarterly on the ePrescribing dashboard of its website.[13]

Section 23 amends s. 408.062, F.S., to require the AHCA to report on its website information relating to the use of hospital emergency department services by patient acuity level and on health care quality measures rather than issuing an annual status report to the Governor and the Legislature. Most information that is required to be in the report is available on FloridaHealthFinder.gov.

Section 24 amends s. 408.063, F.S., to remove the requirement that the AHCA publish an annual comprehensive report of state health expenditures. This report currently identifies the contribution of health care dollars made by all payors and the dollars expended by the type of health care service. The AHCA indicates that this report has little value because of a three-year delay in reporting information.[14]

Section 35 amends s. 408.909, F.S., to delete a provision requiring the AHCA to evaluate and provide an annual assessment to the Governor and the Legislature relating to the Health Flex Plan. The Health Flex Plan program was a pilot program established to benefit low-income families who were not eligible for public assistance programs and not covered by private

[13] Agency for Health Care Administration, *ePrescribing Clearinghouse*. https://ahca.myflorida.com/SCHS/ePrescribing/metrics.shtml (last visited Jan. 24, 2020).
[14] *Supra* note 10.

insurance.[15] There were initially only three plans in limited service areas available for consumers. There is currently only one remaining Health Flex Plan with fewer than 300 members.[16]

Section 36 amends s. 408.9091, F.S., to remove the requirement that the AHCA and the Office of Insurance Regulation of the Financial Services Commission jointly submit an annual report to the Governor and the Legislature relating to the implementation of the Cover Florida Health Care Access Program. There are currently no plans participating in the Cover Florida Health Care Access Program.[17] The last participating health plan terminated its Cover Florida policies in January of 2015.[18]

Section 42 amends s. 409.913, F.S., to move the Medicaid Program Integrity Annual Report due date from January 1, which is a national holiday, to January 15. Other changes made to this section of statute are discussed below.

Section 47 amends s. 429.19(9), F.S., to remove the requirement that the AHCA develop and disseminate a list of all assisted living facilities sanctioned or fined for violations of state standards, the number and class of violations involved, the penalties imposed, and the current status of cases. The AHCA is required by s. 429.55(2), F.S., to create an accessible website containing this information and has done so with FloridaHealthFinder.gov.[19]

Health Care Clinics

Section 16 amends s. 400.9905, F.S., to provide exemptions from health care clinic licensure for Medicaid providers, for certain federally certified providers, for entities under common ownership by a mutual insurance holding company, and for certain entities that are owned by an entity that is a behavioral health service provider.

There are currently over 14 exemptions listed in the health care clinic licensure laws.[20] Most of these exemptions are for health care providers that are already licensed and regulated by the AHCA, an establishment or profession regulated by the Department of Health (DOH), a provider that is federally certified, a non-profit entity, or an entity with substantial financial commitment.

Comprehensive outpatient rehabilitation facilities (42 C.F.R. part 485, subpart B), outpatient physical therapy and speech-language pathology providers (42 C.F.R. part 485, subpart H), end stage renal diseases (42 C.F.R. part 494), and clinical laboratories are all federally certified providers that are regulated by the AHCA. These providers qualify for an exemption from health care clinic licensure.

Changes made in this section of the bill provide exemptions for other federally certified providers that are regulated by the AHCA, including community mental health center-partial

[15] *Id.*
[16] *Id.*
[17] *Id.*
[18] *Id.*
[19] *Id.*
[20] *Id.*

hospitalization programs (42 C.F.R. part 485, subpart J), portable X-ray providers (42 C.F.R. part 486, subpart C) and rural health care clinics (42 C.F.R. part 491, subpart A).

The Fiscal Year 2019-2020 Implementing Bill created two additional exemptions from clinic licensure for entities owned by an insurance holding company with over $1 billion in annual sales and entities owned by a behavioral health provider in at least five states with $90 million in annual revenues from behavioral health.[21] These exemptions are in effect until June 30, 2020.[22] Language in this section of CS/SB 1726 provides that those two exemptions will be permanent.

Providers that meet the definition of health care clinic who do not qualify for an exemption must obtain a license, and providers that participate in Medicaid must meet all requirements in applicable state laws. Medicaid recently initiated rule-making to add licensure as a health care clinic when required by law to be a pre-requisite to enrollment as a Medicaid provider. Over 20,000 providers have been identified as possibly requiring a health care clinic license to remain in Medicaid, though some will likely qualify for an exemption.[23] An estimated 13,000 may require licensure to meet Medicaid requirements by December 2020.[24] The AHCA asked for 13 positions to support this workload through a legislative budget request.[25]

Section 17 amends s. 400.991(3)(c), F.S., to remove the option for a health care clinic to file a surety bond of at least $500,000 as an alternative to submitting proof of financial ability to operate with its application for initial licensure or a change in ownership. No health care clinics have submitted the surety bond in lieu of proof of financial ability to operate.[26]

Section 18 amends s. 400.9935(1)(i), F.S., to authorize a health care clinic's schedule of charges to group services by price level. This section of the bill revises the requirement that the schedule must be posted in the reception area of the urgent care center of a clinic to only require posting in the reception area of a clinic that meets the definition of an "urgent care center" as defined in s. 395.002(29)(b), F.S.

Deleting a Reference to a Specific Data Collection Rule

Section 21 amends s. 408.061, F.S., to remove a reference to a repealed Rule 59E-7.012, F.A.C. Rules 59E-7.011-7.020, F.A.C., were repealed and replaced with Rules 59E-7.021-7.030, F.A.C.

Low-Risk Providers and Licensure Inspections

Section 26 amends s. 408.803, F.S., to define the term "low-risk provider" as nurse registries, home medical equipment providers, and health care clinics. The AHCA has determined these specific provider types to be low-risk with infrequently cited deficiencies.[27] This section of the bill also conforms a provision to changes made in Section 49 of the bill.

[21] Chapter No. 2019-116, s. 38, Laws of Fla.
[22] *Id.*
[23] *Supra* note 10.
[24] *Id.*
[25] *Id.*
[26] *Id.*
[27] *Id.*

Section 27 amends s. 408.806, F.S., to exempt low-risk providers from an initial licensure inspection as required under s. 408.811, F.S.

Section 30 amends s. 408.811, F.S., to authorize the AHCA to exempt a low-risk provider from licensure inspections if the provider or controlling interest has an excellent regulatory history with regard to deficiencies, sanctions, complaints, and other regulatory actions, as defined by the AHCA in rule. Under the bill, the AHCA is required to conduct unannounced licensure inspections for at least 10 percent of exempt low-risk providers.

The bill also authorizes the AHCA to adopt rules to waive routine inspections and inspections for relicensure or to allow for an extended period between relicensure inspections for specific providers based upon:

- A favorable regulatory history with regard to deficiencies, sanctions, complaints, and other regulatory measures.
- Outcome measures that demonstrate quality performance.
- Successful participation in a recognized quality assurance program.
- Accreditation status.
- Other measures reflective of quality and safety.
- The length of time between inspections.

With these changes, a provider will not necessarily have to meet any specific statutory requirement for the AHCA to waive the routine inspection. The AHCA's rules must base the decision to grant a waiver upon one or all of the factors listed above.

As it does with low-risk providers, the bill also requires the AHCA to conduct unannounced licensure inspections for at least 10 percent of providers that qualify for a waiver or extended period between licensure inspections.

Provisional Licenses for Health Care Facilities

Section 408.808(2), F.S., currently authorizes the AHCA to issue a provisional license for health care providers regulated under ch. 408, F.S., to a provider applying for a change of ownership or to a provider that is in litigation with the AHCA regarding the denial or revocation of its license.

Section 429.11(6), F.S., currently authorizes the AHCA to issue a provisional license for an assisted living facility when the provider is making an initial application for licensure.

Section 28 amends s. 408.808(2), F.S., to authorize the AHCA to issue a provisional license to an applicant for initial licensure as a health care provider under ch. 408, F.S., in addition to applicants for a change of ownership.

Section 46 amends s. 429.11(6), F.S., to remove provisions authorizing the AHCA to issue a provisional license to an assisted living facility because the AHCA would be authorized to issue a provisional licensed to an assisted living facility through the bill's changes to s. 408.808, F.S.

Background Screening Requirements for Health Care Providers and Employees

Seven state agencies participate in the Care Providers Background Screening Clearinghouse authorized in ch. 435, F.S. **Section 29** amends s. 408.809(2), F.S., to remove an obsolete provision relating to agencies that were once in the process of joining the Clearinghouse. All seven agencies are now fully implemented in the Clearinghouse.

Section 29 also amends s. 408.809(5), F.S., to remove an expired provision that allowed for an employee who becomes disqualified from employment because of legislation that created a new disqualifying offense, to continue to work pending the employee's request for an exemption from disqualification. That authority expired in 2014.

Federal regulations require state Medicaid programs to conduct criminal background checks including fingerprinting when required to do so under state law or by the level of screening based on risk of fraud, waste or abuse as determined for that category of providers.[28] State Medicaid programs are also required to conduct a criminal background check and require the submission of a set of fingerprints in accordance with 42 C.F.R. s. 455.434 for providers designated as a high categorical risk.[29] The AHCA designates high categorical risk providers in the Florida Medicaid Provider Enrollment Policy handbook incorporated in Rule 59G-1.060, F.A.C.[30]

Section 39 amends s. 409.907, F.S., to revise background screening requirements for Medicaid providers and codify federal requirements. This section of the bill requires a level 2 background screening to be conducted through the AHCA for certain persons who render services to Medicaid recipients, who have direct access to Medicaid recipients, recipient living areas, or the financial, medical or service records of a Medicaid recipient, or who supervises the delivery of goods or services to a Medicaid recipient. This change does not impose additional screening requirements on any providers licensed under part II of ch. 408, F.S. See Sections IV.D. and VI. Drivers providing transportation to Medicaid recipients through a transportation broker or a transportation network company are required to undergo a level 1 background screening through the Florida Department of Law Enforcement or, for Transportation Network Companies, an AHCA-approved equivalent background screening. The AHCA does not require level 2 screening for transportation drivers.[31] **Section 39** clarifies that these drivers are required to undergo only the level 1 background (or equivalent) screening, not the required level 2 background screening.

Comprehensive Emergency Management Plans

Different provider types are subject to different comprehensive emergency management plan requirements in their authorizing statutes. Assisted living facilities are required to get plan

[28] 42 CFR s. 455.434
[29] 42 CFR s. 455.450
[30] Providers and suppliers designated as "high" categorical risk include: behavior analysis practitioners, mental health targeted case management providers, physical therapists, physician groups owned by non-physicians, prospective (newly enrolling) home health agencies and other home health service providers, prospective (newly enrolling) durable medical equipment, and prosthetics, orthotics, and supplies suppliers. Agency for Health Care Administration, *Florida Medicaid Provider Enrollment Policy* (December 2019), *available at* https://ahca.myflorida.com/medicaid/review/General/59G-1.060.pdf (last visited Feb. 25, 2020).
[31] *Supra* note 5.

approval by local emergency management officials before they may be licensed. The AHCA indicates that some local jurisdictions refuse to review a plan until the provider is licensed.[32] This makes it impossible for providers within those jurisdictions to become lawfully licensed.

Section 32 amends s. 408.821, F.S., to require providers that are required by authorizing statutes and the AHCA rule to have a comprehensive emergency management plan to:

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

These changes establish consistent timeframes for the submission and review of comprehensive emergency management plans among provider types. This change allows for the licensure of a facility before its comprehensive emergency management plan is approved.

The Medicaid Program's Retrospective Review of Hospital Inpatient Admissions

The AHCA performs routine pre- and post-payment claim reviews to determine the appropriateness of Medicaid provider reimbursement.[33]

Section 37 amends s. 409.905(5), F.S., to clarify that a specific provision in paragraph (a) of that subsection may not be construed to prevent the AHCA from conducting retrospective reviews in its efforts to combat Medicaid fraud and abuse and to recoup overpayments in the Medicaid Program.

The provision of current law that the bill seeks to clarify was enacted under ch. 2001-104, L.O.F. Before the enactment of that law, the AHCA had statutory authority to prior authorize inpatient hospital admissions for Medicaid patients with psychiatric and substance abuse diagnoses. However, there was no specific authority for the AHCA to prior authorize inpatient hospital admissions for any other diagnoses.[34]

In lieu of prior authorization of inpatient hospital admissions for general acute care Medicaid services, the Medicaid Program was under contract in 2001 with a peer review organization for retrospective review of such admissions. If those retrospective reviews encountered inpatient admissions that should have been denied or inpatient services that were provided outside of

[32] *Id.*
[33] *Id.*
[34] *See* Chapter 2001-104, L.O.F., *available at* http://laws.flrules.org/files/Ch_2001-104.pdf (last visited Jan. 30, 2020).

medical necessity, the AHCA would require the hospital to repay the Medicaid program for the associated costs.[35]

Under ch. 2001-104, L.O.F., the Legislature amended s. 409.905(5)(a), F.S., to give the Medicaid Program authority to prior authorize nonemergency hospital inpatient admissions for individuals 21 years of age or older. The statute was also amended to allow Medicaid to require authorization of emergency and urgent-care admissions within 24 hours after Medicaid patients were admitted under such conditions.

Along with this new authority, the statute was further amended in 2001, in the same paragraph, to require the AHCA, upon implementing the prior authorization program for hospital inpatient services, to discontinue the Medicaid Program's hospital retrospective review efforts. CS/SB 1726 specifically addresses this latter provision of the 2001 law to clarify that the required discontinuation of the Medicaid Program's preexisting retrospective review program, which was being conducted in 2001 in lieu of prior authorization, may not be construed to prevent the AHCA's Office of Medicaid Program Integrity (MPI)[36] from conducting retrospective reviews under s. 409.913, F.S.

The Office of Medicaid Program Integrity

Section 409.913, F.S., is entitled, "Oversight of the integrity of the Medicaid program." This section of statute requires the AHCA to:

- Operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate;
- Conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and shall report the findings of any overpayments in audit reports as appropriate; and
- Conduct reviews of provider exceptions to peer group norms and, using statistical methodologies, provider profiling, and analysis of billing patterns, detect and investigate abnormal or unusual increases in billing or payment of claims for Medicaid services and medically unnecessary provision of services.

Section 409.913, F.S., further provides that a Medicaid provider is subject to having goods and services that are paid for by the Medicaid program reviewed by an appropriate peer-review organization designated by the AHCA. The written findings of the applicable peer-review organization are admissible in any court or administrative proceeding as evidence of medical necessity or the lack of medical necessity.

[35] Senate Committee on Health Care, *Senate Staff Analysis and Economic Impact Statement for CS/SB 792* (April 5, 2001), *available at* http://www.flsenate.gov/Session/Bill/2001/792/Analyses/20010792SHC_2001s0792.hc.pdf (last visited Jan. 30, 2020).

[36] *See* the Office of Medicaid Program Integrity's web page at https://ahca.myflorida.com/MCHQ/MPI/ (last visited Jan. 30, 2020).

MPI and the Medicaid Fraud Control Unit of the Department of Legal Affairs must submit a joint report to the Legislature each January, documenting the results of their work to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report for State Fiscal Year 2018-2019 indicates that overpayments of approximately $32.7 million were identified in that fiscal year, with approximately $13.4 million in accounts-receivable collections and reversals. MPI also prevented approximately $385.2 million in overpayments from occurring during the fiscal year, according to the 2018-2019 report.[37]

The bill clarifies that the Legislature's direction to the AHCA in 2001 to discontinue the Medicaid Program's hospital retrospective review efforts, upon implementing its newly-granted authority to prior authorize Medicaid hospital inpatient admissions, may not be construed to prevent MPI from conducting retrospective reviews under s. 409.913, F.S. This provision of the bill takes effect upon becoming law.[38]

Section 38 provides that it is the intent of the Legislature that the amendment to s. 409.905(5)(a), F.S., in Section 37 of the bill, is intended to confirm and clarify existing law. This section takes effect upon becoming a law.

Reimbursement of Medicaid Providers

Class III psychiatric facilities are excluded in statute from the diagnosis related group (DRG) payment methodology. Federal law prohibits state Medicaid programs from receiving federal matching funds for services provided by facilities described in 42 CFR 435.1010 as an institution for mental diseases[39] (IMDs) under the fee-for-service program and therefore, the AHCA has not established the alternative methodology currently allowed under s. 409.908, F.S. However, in Medicaid managed care programs, states have slightly more flexibility; 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 crisis stabilization unit under the fee-for-service program. However, Medicaid managed care contracts allow health plans to pay for services in a crisis stabilization unit for a plan enrollee, as crisis stabilization units provide a less costly service equivalent to inpatient psychiatric hospitalization.[40]

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[37] The Agency for Health Care Administration and the Department of Legal Affairs, *Florida's Efforts to Control Medicaid Fraud & Abuse: Fiscal Year 2018-2019* (December 30, 2019) *available at* https://ahca.myflorida.com/MCHQ/MPI/docs/FraudReports/FraudReport2018-19.pdf (last visited Jan. 30, 2020).

[38] In February 2019, Florida's First District Court of Appeal construed the discontinuation provision in s. 409.905(5)(a), F.S., to mean that the AHCA is "barred from conducting a retrospective review of prior authorization claims" under s. 409.913, F.S., or any other existing statutory authority. See *Lee Memorial Health System Gulf Coast Medical Center v. State of Florida, Agency for Health Care Administration*, 272 So.3d 431 (Fla. 1st DCA 2019). The AHCA reports that, under this ruling: (1) The AHCA is at risk of being required to repay overpayments that have already been recouped by MPI from hospitals, and (2) MPI is prohibited from conducting any hospital retrospective audits, except those relating to suspected fraud or abuse. Email from the Agency for Health Care Administration to the Senate Committee on Healthy Policy (January 30, 2020) (on file with the Senate Appropriations Subcommittee on Health and Human Services). See Section V.C.

[39] 42 CFR 435.1010 defines an "institution for mental diseases" as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases.

[40] *Supra* note 5.

During the 2008 Session, the Legislature amended s. 409.908, F.S., to implement a two-year unit cost rate freeze, effective July 1, 2009, for nursing facilities, hospitals, county health departments, intermediate care facilities for the developmentally disabled, and prepaid health plans.[41] The unit cost rate freeze was set to expire July 1, 2011. However, during the 2011 Session, the Legislature repealed the sunset date, capped unit costs at July 1, 2011 rates, and established reimbursement rates would be as provided in the General Appropriations Act. In effect, automatic annual Medicaid increase payments to nursing homes were capped at 2011 levels.[42] In Fiscal Years 2018-2019 and 2019-2020, the Implementing Bill[43,44] removed the unit cost rate freeze for one year.

Section 40 and 41 amend s. 409.908, F.S., to remove the nursing home unit cost rate freeze and remove class III psychiatric facilities from the DRG payment methodology, thereby eliminating the AHCA's authority to establish an alternative methodology to the DRG-based prospective payment system to set reimbursement rates for class III psychiatric hospitals.

Legal Fees in Medicaid Program Integrity Cases

Section 42 amends s. 409.913, F.S., to authorize the AHCA to recover legal fees in Medicaid Program Integrity and licensure cases. The AHCA has indicated that it spends significant funds defending Medicaid overpayment cases. The Division of Administrative Hearings (DOAH) ruled that s. 409.913(23)(a), F.S., does not authorize the AHCA to recover full legal fees on Medicaid Program Integrity legal cases.[45] The specific ruling came in the DOAH case number 18-5986F involving Covenant Hospice.[46] The case had an overpayment of $637,973.10 and sanction of $127,594.62. As of February 7, 2019, the AHCA was seeking to recover fees in the amount of $330,186.14 and costs in the amount of $14,466.52 as of February 7, 2019.[47] Currently, the AHCA only has the ability to collect the "costs" of $14,466.52.[48]

Multiphasic Health Testing Centers

Multiphasic health testing centers, regulated under part I of ch. 483, F.S., are facilities where, in addition to taking specimens from the human body for delivery to registered clinical laboratories for analysis, certain measurements such as height and weight determinations, blood pressure determinations, limited audio and visual tests, and electrocardiograms are also made. These additional services are not required to be provided by licensed personnel but can be provided by a medical assistant that is certified or registered through a national organization. These clinics would also fall under the definition of a health care clinic in part X of ch. 400, F.S., but are exempt since they are already regulated by the AHCA.

[41] Chapter 2008-143, s. 5, Laws of Fla.
[42] Chapter 2011-61, s. 4, Laws of Fla.
[43] Chapter 2018-10, s. 18-19
[44] Chapter 2019-116, s. 18-19
[45] *Agency for Health Care Administration v. Covenant Hospice, Inc.,* Case No.18-5986F (Fla. DOAH 2018).
[46] *Id.*
[47] *Id.*
[48] *Id.*

Section 54 repeals part I of ch. 483, F.S., relating to multiphasic health testing centers, which thereby repeals the requirements for and the licensing of multiphasic health testing centers as a provider type. Current multiphasic health testing centers would need to become licensed as health care clinics, in accordance with part X of ch. 400, F.S., unless they otherwise qualify for an exemption from health care clinic licensure.

As of January 21, 2020, there were 187 multiphasic health testing centers licensed in Florida. Of these, 69 were owned and operated by Laboratory Corporation of America and 111 were owned and operated by Quest Diagnostics, including one out-of-state center.[49] Both Laboratory Corporation of America and Quest Diagnostics also own and operate several clinical laboratories throughout the state that are regulated under the federal Clinical Laboratory Improvement Amendments (CLIA).[50] The remaining seven multiphasic health testing centers are owned by Professional Health Examiners, Inc.[51] Services are provided by licensed personnel under the direction of a medical director, and the company does not bill insurance and thus would also be exempt from health care clinic licensure as would those centers owned and operated by clinical laboratories regulated under the federal CLIA.[52]

Under current law, the AHCA assesses multiphasic health testing centers with a biennial licensure fee of $652.64 and a biennial health care assessment fee of $300 on multiphasic health testing centers. The AHCA collects an estimated $89,071.84 annually ($178,143.68 biennially) from 187 multiphasic health testing centers, roughly half of which renew each year.[53]

Since 2011, the AHCA has imposed only six fines against multiphasic health testing centers.[54] In this timeframe, only 10 complaints were received with none substantiated while 195 deficiencies have been cited since 2011.[55]

Sections 19, 25, 31, 33, and 34 amend ss. 408.033, 408.802, s. 408.820, 408.831, and 408.832, F.S., to delete references to multiphasic health testing centers or chapter 483, to conform to changes made by Section 54 of the bill, which repeals part I of ch. 483, F.S., relating to multiphasic health testing centers.

Medicaid Provider Fraud

New technology and innovative online platforms allow Medicaid patients to access doctor appointment schedules through a web portal hosted by an online service. Health care professionals may contract with such services for a fee. There is concern that this relationship may conflict with anti-kickback provisions in the Florida Medicaid law. These fee-based scheduling services can operate within other health insurance programs such as Medicare, Tricare, and commercial programs. The federal Anti-Kickback Statute[56] prohibits the knowing

[49] *Supra* note 10.
[50] *Id.*
[51] *Id.*
[52] *Id.*
[53] *Id.*
[54] *Id.*
[55] *Id.*
[56] 42 U.S.C. s. 1320a-7b(b).

and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs. The bill seeks to ensure Florida law mirrors federal law and does not apply a stricter standard than the federal Anti-Kickback Statute.[57]

Section 43 amends s. 409.920(2)(a), F.S., to align the state Medicaid anti-kickback law with the federal anti-kickback law so that Medicaid recipients can utilize innovations and technological advances to access medical appointments and care, similar to services that are currently used by Medicare, TriCare, and commercial patients.

Managed Care Plan Contracts

The AHCA is currently authorized to contract with plans for Statewide Medicaid Managed Care to provide managed medical assistance (MMA), long-term care (LTC) and dental services for a period of 5-years and to extend those contracts to cover any delays during the transition to a new plan following a re-procurement.

The AHCA re-procured these contracts during 2017 and awarded contracts in spring of 2018. Pursuant to statute, those contracts are effective from December of 2018 through December of 2023. While each procurement has presented the AHCA with the opportunity to negotiate significant program gains, included additional benefits for enrollees, enhanced processes to reduce administrative burdens for providers participating in the program, as well as significantly increased quality and performance benchmarks and savings that can be redirected to reward high performing providers, a longer contract period would provide the AHCA with more time to assess program performance as negotiated during the 2017 procurement and allow the collection of additional complete data years that could be considered when the contract is next procured. In addition, a longer contract period would provide the AHCA with additional opportunities to work with stakeholders and the Legislature on substantive program design.

Sections 44 and 45 amend ss. 409.967 and s. 409.973, F.S., to require the AHCA to establish a 6-year, rather than a 5-year, contract with each Medicaid managed care plan selected through the procurement process. It also requires the AHCA to extend the term of contracts awarded to managed care plans pursuant to the invitation to negotiate published in July 2017, through December 31, 2024, effectively extending the duration of those contracts by one year.

Health Insurance Benefits

The Florida Center for Health Information and Transparency (Florida Center), housed within the AHCA, provides a comprehensive health information system (information system) that includes the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of health-related data.[58] The Florida Center identifies existing health-related data and collects data for use in the information system, including information on health care costs and financing, trends in health care prices and costs, the sources of payment for health care services, and federal, state, and local expenditures for health care.[59]

[57] *Supra* note 5.
[58] Section 408.05(1), F.S.
[59] Section 408.05(2), F.S.

The Florida Center maintains www.FloridaHealthFinder.gov, which was established by law in 2016[60], to assist consumers in making informed health care decisions and lead to improvements in quality of care in Florida.

In 2019, the Legislature enacted the Patient Savings Act[61] (Act), which allows (but does not mandate) health insurers and health maintenance organizations (HMOs) to create a shared savings incentive program (Shared Savings Program) 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 authorizes implementation of these incentive programs for plan years beginning January 1, 2020.

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 Shared Savings Program. When a patient obtains a 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 law provides a range of methods by which a Shared Savings 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.[62]

Sections 20 and 51-53 amend ss. 408.05, 627.6387, 627.6648, and 641.31076, F.S., to increase the range of services defined as "shoppable" for purposes of earning shared savings incentives under a Shared Savings Program. In addition to the specific services outlined in the Patient Savings Act, the bill extends the "shoppable" service designation to those services identified by the Florida Center as having the most significant price variation at statewide and regional levels. The bill also allows a Shared Savings Program to provide cash or a cash-equivalent reward to a program participant who earns a shared savings incentive.

Cross-references

Sections 55-60 amend ss. 20.43, 381.0034, 456.001, 456.057, 456.076, and 456.47, F.S., to conform cross-references to changes made by the bill.

Effective Date

Section 61 provides that except as otherwise expressly provided in the bill and except for this section, which will take effect upon the bill becoming a law, the bill will take effect July 1, 2020.

[60] Chapter 2016-234, Laws of Fla.; *see also* s. 408.05(3), F.S.
[61] Sections 627.6387, 627.6648, and 641.31076, F.S.
[62] Section 627.6387, F.S.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

Article VII, s. 19 of the State Constitution requires that a new state tax or fee, as well as an increased state tax or fee, be approved by two-thirds of the membership of each house of the Legislature and be contained in a separate bill that contains no other subject. Article VII, s. 19(d)(1) of the State Constitution defines "fee" to mean "any charge or payment required by law, including any fee for service, fee or cost for licenses, and charge for service."

Currently, an individual could employ health care personnel for the provision of home health services without having to obtain a license. Section 6 of the bill amends s. 400.462, F.S., to require such an individual to obtain a home health agency license by paying the licensure fee required in s. 400.471(5), F.S., unless exempt from licensure pursuant to s. 400.464(5), F.S. This fee is an existing statutory fee that is not being increased. However, the bill expands the scope of licensure for home health agencies, which expands the application of the licensure fee (i.e., thereby requiring persons not subject to the fee to pay the fee).

Section 36 of the bill amends s. 409.907(8), F.S, to require a level 2 background screening to be conducted through the AHCA for certain persons who render services to Medicaid recipients, who have direct access to Medicaid recipients, recipient living areas, or the financial, medical or service records of a Medicaid recipient, or who supervises the delivery of goods or services to a Medicaid recipient. Accordingly, additional persons will be required to pay the fees for a level 2 background screening, who currently are not subject to that screening.

It is unclear if Article VII, s. 19 of the State Constitution applies to these provisions of the bill. As such, the State Constitution may require that the fees be passed in a separate bill by a two-thirds vote of the membership of each house of the Legislature.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

Currently, an individual could employ health care personnel for the provision of home health services without having to obtain a license. Section 8 of the bill amends s. 400.462, F.S., to require such an individual to obtain a home health agency license if they are not currently exempt from licensure as a home health agency pursuant to s. 400.464(5), F.S., and pay the licensure fee required in s. 400.471(5), F.S. The AHCA has interpreted the provision of home health services to be an activity that requires licensure as a home health agency and does not believe changes to this section will impact services that require licensure. However, it is unclear if there are unlicensed individuals that employ or may seek to employ health care personnel for the provision of home health services that would be required to obtain a license under the bill and not qualify for licensure exemption. The fee is established by the AHCA in rule at an amount sufficient to cover the AHCA's costs in carrying out its responsibilities, not to exceed $2,000 per biennium. Under the statutory authority in current law, the AHCA is imposing a $1,705 fee for initial licensure, change of ownership, or licensure renewal.[63] The number of individuals impacted by this requirement is indeterminate.

Section 39 of the bill amends s. 409.907(8), F.S. to require level 2 background screenings, in accordance with ch. 435, F.S., for individuals who have direct access to Medicaid recipients, recipient living areas, or the financial, medical or service records of a Medicaid recipient, or who supervises the delivery of goods or services to a Medicaid recipient. This does not impose additional screening requirements on any providers licensed under part II of ch. 408. According to the Florida Department of Law Enforcement (FDLE), the cost for a level 2 background screening with five years of Clearinghouse retention is $61.25 ($13.25 for the national criminal record check; $24 for the state criminal record check; and $24 paid up front for five years of state fingerprint Clearinghouse retention).[64] The number of individuals impacted by this requirement is indeterminate.[65]

B. Private Sector Impact:

Under CS/SB 1726:

- The bill exempts community mental health partial-hospitalization programs, portable x-ray providers, and rural health care clinics from health care clinic licensure. Those providers will no longer be required to pay the $2,000 biennial license renewal fee. The AHCA estimates that approximately 200 providers would qualify for the exemption.
- Low-risk Medicaid providers are exempt from health care clinic licensure. These providers are not currently required to be licensed, but licensure will be required

[63] *Supra* note 10.[64] Email from the Department of Law Enforcement (February 5, 2020) (on file with the Senate Appropriations Subcommittee on Health and Human Services).
[64] Email from the Department of Law Enforcement (February 5, 2020) (on file with the Senate Appropriations Subcommittee on Health and Human Services).
[65] *Supra* note 10.

effective July 1, 2020. The AHCA expects 28,291 providers to qualify for the exemption. Providers who qualify for the exemption would not have to pay the $2,000 initial licensure fee.
- The bill repeals licensure for 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, although some of these centers will need to pay licensure fees to become licensed as a health care clinic. There are currently 187 multiphasic health testing centers licensed in Florida.
- See Section V.A. for additional fees that may impact individuals not currently required to pay licensure fees now required in s. 400.471.(5), F.S., as amended, and fees associated with a level 2 background screening required in s. 409.907(8), F.S., as amended. The number of individuals impacted by the new requirements is indeterminate.

C. Government Sector Impact:

Under CS/SB 1726:
- Exempting Medicaid providers from health care clinic licensure will result in a cost avoidance. The exemptions created in the bill eliminate the need for the 13 full-time equivalent employees requested in the AHCA's Fiscal Year 2020-2021 legislative budget request to process health care clinic licensure applications.[66]
- The AHCA will be able to conduct retrospective reviews of hospital inpatient claims and recover all overpayments in the Medicaid program. The 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 on retrospective hospital audits. The AHCA would likely experience a significant positive fiscal impact from clarification, although the amount recovered from future retrospective reviews is indeterminate.
- The AHCA will be able to recover all legal fees in Medicaid Program Integrity legal cases in which the AHCA prevails. Although the AHCA's tracking system for Medicaid recovery amounts does not distinguish legal fees, the AHCA has incurred over $300,000 in legal fees for a single case.[67] The AHCA would likely experience a significant positive fiscal impact from this, although the amount of legal costs arising from future litigation is indeterminate.
- The bill exempts certain providers from health care clinic licensure and repeals licensure for multiphasic health testing centers. As a result, a loss in annual revenue of $489,071.84 and a commensurate workload reduction will occur 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 program, portable x-ray providers, and rural health care clinics ($400,000).[68]

The AHCA will also experience a reduction in workload from removing requirements that the AHCA submit various reports to the Governor and the Legislature.

[66] *Id.*
[67] *Id*.
[68] *Id.*

VI. Technical Deficiencies:

The provisions of section 8 and 39 of the bill, amending s. 400.462 and 409.907, F.S., could result in the application of new fees or assessments.

- Section 8 amends s. 400.462, F.S., to require certain individuals to obtain a home health agency license by paying the licensure fee required in s. 400.471(5), F.S.
- Section 39 amends s. 409.907, F.S., to require level 2 background screenings, in accordance with ch. 435, F.S., for individuals who have direct access to Medicaid recipients, recipient living areas, or the financial, medical or service records of a Medicaid recipient, or who supervises the delivery of goods or services to a Medicaid recipient.

See Section IV.D. and Section V.A. A separate fee bill should be considered to address the applicable fees and assessments.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 20.43, 381.0034, 383.327, 395.003, 395.1055, 395.602, 395,7015, 395.7016, 400.19, 400.462, 400.464, 400.471, 400.492, 400.506, 400.509, 400.605, 400.60501, 400.9905, 400.991, 400.9935, 408.033, 408.05, 408.061, 408.0611, 408.062, 408.063, 408.802, 408.803, 408.806, 408.808, 408.809, 408.811, 408.820, 408.821, 408.831, 408.832, 408.909, 408.9091, 409.905, 409.907, 409.908, 409.913, 409.920, 409.967, 409.973, 429.11, 429.19, 429.35, 429.905, 429.929, 456.001, 456.057, 456.076, 456.47, 627.6387, 627.6648, and 641.31076.

This bill repeals the following sections of the Florida Statutes: 395.7015 and part I of chapter 483 and 19 of chapter 2019-116, Laws of Florida, relating to the abrogation of the scheduled expiration of an amendment to 408.908.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

Recommended CS/CS by Appropriations Subcommittee on Health and Human Services on February 25, 2020:
The committee substitute:

- Reinstates the AHCA's authority to require hospital adult cardiac programs to participate in national reporting and quality registries.
- Extends the current rural hospital designation to 2025 (set to expire June 30, 2021).
- Modifies surveys for nursing home with a Class I or two Class II deficiencies in 60 days, to clarify that the AHCA will continue to conduct licensure surveys every six months until a facility has two consecutive licensure surveys without a citation for a

Class I or Class II deficiency. Reinstates current law and maintains the $6,000 fine for the additional surveys.
- Replaces the term "organization" for home health agencies to align with the AHCA uniform licensing requirements.
- Clarifies the current level 1 background screening requirements for non-emergency transportation providers and brokers remain in place.
- Amends directory language to provide the statutory clarification of retrospective hospital reviews is effective upon becoming a law.
- Removes class III psychiatric facilities from (DRG) payment methodology.
- Removes the nursing home unit cost rate freeze.
- Aligns the state Medicaid anti-kickback law with the federal anti-kickback law.
- Extends the Medicaid statewide dental contracts from five years to six years.
- Requires the Florida Center to publish an annual report identifying health care services with the most significant price variation at statewide and regional levels.
- Expands the list of shoppable health care services that qualify for a shared savings incentive for patients to include services with the most significant price variation. Allows cash and cash equivalent incentives in shared savings incentives.

CS by Health Policy on January 28, 2020:
The CS:
- Changes a reference from chapter 624 to chapter 627 to revise and make permanent an exemption from health care clinic licensure for entities owned by an insurance holding company with over $1 billion in annual sales.
- Clarifies that the Legislature's 2001 direction to the AHCA under s. 409.905(5)(a), F.S., to discontinue the Medicaid Program's hospital retrospective review program upon implementing its new authority (also granted in 2001) to prior authorize Medicaid hospital inpatient admissions, may not be construed to prevent MPI from conducting retrospective reviews under s. 409.913, F.S. This provision of the bill takes effect upon becoming law.
- Provides that it is the intent of the Legislature that the bill's amendment to s. 409.905(5)(a), F.S., is intended to confirm and clarify existing law
- Requires the AHCA to establish a six-year, rather than a five-year, contract with each managed care plan selected through the procurement process. Requires the AHCA to extend the term of contracts awarded to managed care plans pursuant to the invitation to negotiate published in July 2017, through December 31, 2024.
- Changes the effective date of the bill to allow for certain sections to take effect upon becoming a law as expressly provided. Unless expressly provided, the bill takes effect on July 1, 2020.

B. Amendments:

None.