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 Health Policy

BILL:	CS/SB 1726
INTRODUCER:	Senator Bean
SUBJECT:	Agency for Health Care Administration
DATE:	January 31, 2020
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Kibbey	Brown	HP	**Fav/CS**
2.			AHS	
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

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:

- Removes provisions requiring fixed inspection time frames for nursing home facilities, hospices, assisted living facilities, and adult family care homes.
- Authorizes the AHCA to exempt specified low-risk providers from licensure inspection.
- 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.
- Establishes that health care clinic licensure is not required for Medicaid providers.
- Creates an exemption to health care clinic licensure for federally-certified providers.
- Repeals multiphasic health testing center licensure.
- Authorizes the AHCA to issue a provisional license to all provider types.
- Increases the frequency of birth center reports to the AHCA.
- Revises background screening regulations for health care provider staff.
- Authorize the collection of legal fees on Medicaid overpayment and licensure cases.
- Clarifies the AHCA's authority to retrospectively review Medicaid inpatient hospital admissions and payments.
- Revises definitions and licensure requirements related to home health agencies.
- Revises language for listing hospital beds on license.
- Repeals an unenforceable annual assessment.

- Revises requirements for the approval of comprehensive emergency management plans for newly-licensed facilities.
- Replaces legislatively-mandated reports with online publications and repeals specified reports.

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 act becoming a law.

II. Present Situation:

The 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]

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 the reports to be submitted at a frequency adopted by the AHCA in rule. These changes could enable the AHCA to have more current information to review during the inspection of a birth center.

Listing Hospital Beds on a License

Chapter No. 2019-136, L.O.F. (enacted by the Legislature in 2019 as CS/HB 21) removes certificate of need review requirements for hospitals over time, with the final change occurring on July 1, 2021. **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 certificate of

[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).
[2] *See* s. 408.802, F.S., for the health care provider types and applicable licensure statutes.

need 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.

Repeal of an Unenforceable Assessment

Section 3 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 and are no longer collected. [3] **Section 4** 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 inspections 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.[4] 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 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 5 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 only one additional licensure survey for a facility that has been cited for a class I deficiency or for two or more class II deficiencies within a 60-day period. The $6,000 fine for the two additional inspections is removed and is replaced with a $3,000 fine for each additional licensure survey.

Section 12 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 41 and 42 amend ss. 429.35 and 429.905(2), F.S., to remove the requirement (and related provisions) that the AHCA inspect assisted living facilities biennially.

Section 43 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

[3] *Agency for Health Care Admin. v. Hameroff*, 816 So. 2d 1145, 1149-1150 (Fla. 1st DCA 2002).
[4] 42 C.F.R. s. 488.308(a).

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.

Section 6 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 deletes the definition of the term "organization."
- "Home health agency" is redefined to mean a person or an entity 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. The new definition will include individuals who provide one or more types of home health service, and the provision of staffing services will no longer be necessary in order to meet the definition.
- "Home infusion therapy provider" is redefined to pertain to "a person or an entity," as opposed to "an organization" that meets the definition's criteria.
- "Nurse registry" is redefined to include an "entity" that meets the definition of the term, as opposed to only a person who does so.
- "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.

Currently, an individual could employ health care personnel for the provision of home health services without having to obtain a license. Under the bill, such an individual must obtain a license. Section 400.471(5), F.S., 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.[5]

Section 7 amends s. 400.464, F.S., to make conforming changes and to make exemptions from licensure as a home health agency for a person or entity 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 6 of the bill.

Section 8 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 9-11 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 6 of the bill.

AHCA Reporting Requirements

Section 13 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 19 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.[6]

Section 20 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 21 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.[7]

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[5] 59A-8.003, F.A.C.
[6] Agency for Health Care Administration, *ePrescribing Clearinghouse* https://ahca.myflorida.com/SCHS/ePrescribing/metrics.shtml (last visited Jan. 24, 2020).
[7] Agency for Health Care Administration, *Senate Bill 1726 Agency Analysis* (on file with the Senate Committee on Health Policy).

Section 32 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 insurance.[8] 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.[9]

Section 33 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.[10] The last participating health plan terminated its Cover Florida policies in January of 2015.[11]

Section 37 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 40 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.[12]

Health Care Clinics

Section 14 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.[13] Most of these exemptions are made for health care providers that are already licensed and regulated by the AHCA, an establishment or profession regulated by the Department of Health, 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.

[8] *Id.*
[9] *Id.*
[10] *Id.*
[11] *Id.*
[12] *Id.*
[13] *Id.*

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 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 Implementing Bill accompanying the 2019 General Appropriations Act 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.[14] These exemptions are in effect until June 30, 2020.[15] 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 meet an exemption.[16] An estimated 13,000 may require licensure to meet Medicaid requirements by December 2020.[17] The AHCA asked for 13 positions to support this workload through a legislative budget request.[18]

Section 15 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.[19]

Section 16 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 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 18 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.

[14] Chapter No. 2019-116, s. 38, Laws of Fla.
[15] *Id.*
[16] Agency for Health Care Administration, *Senate Bill 1726 Agency Analysis* (on file with the Senate Committee on Health Policy).
[17] *Id.*
[18] *Id.*
[19] *Id.*

Low-Risk Providers and Licensure Inspections

Section 23 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.[20] This section of the bill also conforms a provision to changes made in Section 42 of the bill.

Section 24 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 27 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, complains, 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.

[20] *Id.*

Section 25 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 39 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 26** 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 26 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.

Section 36 amends s. 409.907, F.S., to revise background screening requirements for Medicaid providers. This section of the bill requires a new 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 aligns the background screening requirements of this chapter with those for licensees in ch. 408, F.S.

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 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.[21] This makes it impossible for providers within those jurisdictions to become lawfully licensed.

Section 29 amends s. 408.821, F.S., to require providers that are required by authorizing statutes and AHCA rule to have a comprehensive emergency management plan to:

- Submit the plan to the local emergency management agency, county health department, or Department of Health 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 Department of Health annually and within 30 days after any significant modification, as defined by AHCA rule, to a previously approved plan.

[21] *Id.*

- Respond to the local emergency management agency, county health department, or Department of Health 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 Department of Health.

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.[22]

Section 34 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.[23]

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 medical necessity, the AHCA would require the hospital to repay the Medicaid program for the associated costs.[24]

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.

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[22] *Id.*
[23] *See* Chapter 2001-104, L.O.F., *available at* http://laws.flrules.org/files/Ch_2001-104.pdf (last visited Jan. 30, 2020).
[24] 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).

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)[25] 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 shall, 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.

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.[26]

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

[25] See the Office of Medicaid Program Integrity's web page at https://ahca.myflorida.com/MCHQ/MPI/ (last visited Jan. 30, 2020).
[26] 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).

prevent MPI from conducting retrospective reviews under s. 409.913, F.S. This provision of the bill takes effect upon becoming law.[27]

Section 35 provides that it is the intent of the Legislature that the amendment to s. 409.905(5)(a), F.S., in Section 34 of the bill, is intended to confirm and clarify existing law.

Legal Fees in Medicaid Program Integrity Cases

Section 37 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.[28] The specific ruling came in DOAH case number 18-5986F involving Covenant Hospice.[29] The case had an overpayment of $637,973.10 and sanction of $127,594.62, and the AHCA was seeking fees and costs in the amount of $330,186.14 as of February 7, 2019.[30] The AHCA has the ability to collect the "costs" amount of the $330,186.14 but not the "fees" amount.[31]

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.

Section 44 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

[27] 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.
[28] *Agency for Health Care Administration v. Covenant Hospice, Inc.,* Case No.18-5986F (Fla. DOAH 2018).
[29] *Id.*
[30] *Id.*
[31] *Id.*

and operated by Quest Diagnostics, including one out-of-state center.[32] 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).[33] The remaining seven multiphasic health testing centers are owned by Professional Health Examiners, Inc.[34] 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.[35]

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.[36]

Since 2011, there have been six fine cases imposed against multiphasic health testing centers.[37] In this timeframe, only 10 complaints were received with none substantiated while 195 deficiencies have been cited since 2011.[38]

Sections 17, 22, 28, 30, and 31 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 42 of the bill, which repeals part I of ch. 483, F.S., relating to multiphasic health testing centers.

Managed Care Plan Contracts

Section 38 amends s. 409.967, F.S. to require the AHCA to establish a 6-year, rather than a 5-year, contract with each 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.

Cross-references

Sections 45-50 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 51 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.

[32] Agency for Health Care Administration, *Senate Bill 1726 Agency Analysis* (on file with the Senate Committee on Health Policy).
[33] *Id.*
[34] *Id.*
[35] *Id.*
[36] *Id.*
[37] *Id.*
[38] *Id.*

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, section 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, section 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. This fee is an existing statutory fee that is not being increased; however, the bill expands the scope of licensure of a home health agency which expands the application of the licensure fee.

It is unclear if Article VII, section 19, applies to this 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:

None.

B. Private Sector Impact:

By excluding additional providers from health care clinic licensure, those providers will not be required to pay the $2,000 biennial clinic licensure fee.

Multiphasic health testing centers would no longer have to pay licensure fees to be licensed as a multiphasic health testing center, although some of these centers will need to pay licensure fees to become licensed as a heath care clinic.

Nursing home facilities that are cited for certain deficiencies and require additional inspections would only be required to pay a $3,000 fine for an additional inspection rather than the $6,000 fine for two additional inspections as under current law.

C. Government Sector Impact:

Under CS/SB 1726:

- Exempting Medicaid providers from health care clinic law will result in a cost avoidance. The exemptions created in the bill would eliminate the need for the 13 employees requested by the AHCA in its legislative budget request to process health care clinic licensure applications.[39]
- The AHCA will be able to recover legal fees in Medicaid Program Integrity and licensure cases. The AHCA would likely experience a positive fiscal impact from this, although the amount of legal fees arising from future litigation is indeterminate.
- A loss of $89,071.84 per year will occur in licensure fees from the repeal of multiphasic health testing center licensure.[40]

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

VI. Technical Deficiencies:

Section 27 of the bill amends s. 408.811, F.S., to authorize 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 list of factors. It is unclear as to whether one or all of the listed factors are intended to be included in the decision to grant a waiver under the bill.

The bill's amendment to s. 409.905(5)(a), F.S., in Section 34 of the bill, takes effect upon becoming a law. Section 35 of the bill provides legislative intent for the changes made in Section 34; however, Section 35 will not take effect until July 1, 2020. Sections 34 and 35 should take effect at the same time.

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, 395.7016, 400.19, 400.462, 400.464, 400.471, 400.492, 400.506, 400.509,

[39] *Id.*
[40] *Id.*

400.605, 400.60501, 400.9905, 400.991, 400.9935, 408.033, 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, 409.913, 429.11, 429.19, 429.35, 429.905, 429.929, 456.001, 456.057, 456.076, and 456.47.

This bill repeals section 395.7015 and part I of chapter 483 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 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.