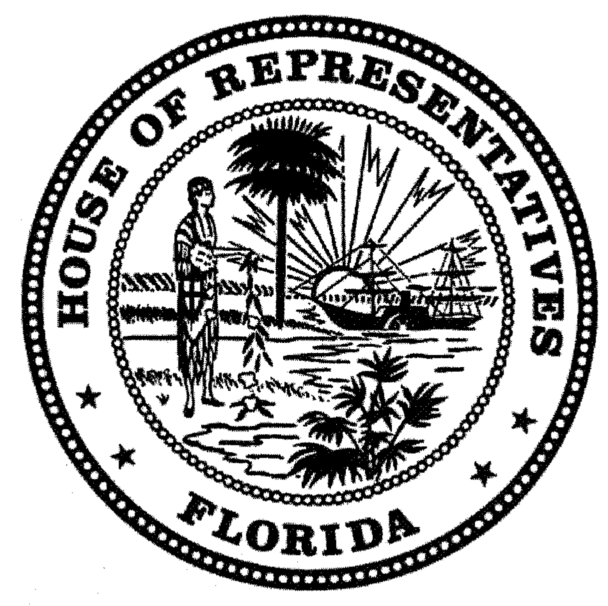

Health Innovation Subcommittee

Thursday, March 28, 2013
8:00 AM - 10:00 AM
306 HOB

Will Weatherford
Speaker

John Wood
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health Innovation Subcommittee

Start Date and Time:	Thursday, March 28, 2013 08:00 am
End Date and Time:	Thursday, March 28, 2013 10:00 am
Location:	306 HOB
Duration:	2.00 hrs

Consideration of the following bill(s):

HB 791 Audits of Pharmacy Records by Diaz, M.
HB 793 Cost-effective Purchasing of Health Care by Diaz, J.
HB 919 Hospital Licensure by Gonzalez
HB 1159 Skilled Nursing Facilities by O'Toole
HB 1195 Medicaid Managed Care by Pritchett
HB 1237 Payment For Services Provided By Licensed Psychologists by Schwartz
HB 4031 Home Health Agencies by Diaz, J.

Consideration of the following proposed committee substitute(s):

PCS for HB 1071 -- Health Care Accrediting Organizations

Pursuant to rule 7.12, the deadline for amendments to bills on the agenda by non-appointed members is 6:00 p.m., Wednesday, March 27, 2013.

By request of the chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Wednesday, March 27, 2013.

NOTICE FINALIZED on 03/26/2013 16:19 by Villar.Melissa

HB 791

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 791 Audits of Pharmacy Records
SPONSOR(S): Diaz, Jr.
TIED BILLS: **IDEN./SIM. BILLS:** SB 1358

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Poche	Shaw
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Section 465.188, F.S., establishes requirements for the conduct of an audit of the Medicaid-related records of a pharmacy licensed under ch. 465, F.S. The audit must meet certain criteria, including, but not limited to the following provisions:

- The agency conducting the audit must give the pharmacist at least one week's prior notice of the initial audit for each audit cycle.
- An audit must be conducted by a pharmacist licensed in Florida.
- Any clerical or recordkeeping error, such as a typographical error, scrivener's error, or computer error regarding a document or record required under the Medicaid program does not constitute a willful violation and is not subject to criminal penalties without proof of intent to commit fraud.
- A pharmacist may use the physician's record or other order for drugs or medicinal supplies written or transmitted by any means of communication for purposes of validating the pharmacy record with respect to orders or refills of a legend or narcotic drug.
- A finding of an overpayment or underpayment must be based on the actual overpayment or underpayment and may not be a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs.
- Each pharmacy shall be audited under the same standards and parameters.

House Bill 791 permits the application of the audit criteria and audit program contained in s. 465.188, F.S., to audits of pharmacies conducted by third-party payers or third-party administrators, such as pharmacy benefits managers, for claims filed after July 1, 2011. The bill requires third-party payers or third-party administrators to establish a process to allow a pharmacist to obtain a preview of the audit results and to allow for an appellate process, which includes establishing an ad hoc peer review counsel. If the peer review counsel finds an unfavorable to be unsubstantiated, the bill requires the third-party payer or administrator to dismiss the audit without further action.

The bill provides the audit criteria may not subject a claim to an action for financial recoupment, unless recoupment is required by law given certain circumstances. The bill provides that a clerical or recordkeeping error is not a willful violation that would subject the claim to criminal penalties without additional proof of intent to commit fraud. Lastly, the bill provides that a claim is not subject to an action for financial recoupment if it is a valid claim, but for a clerical or recordkeeping error.

The bill may have a fiscal impact on state government. See Fiscal Comments.

The bill provides an effective date upon becoming a law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Medicaid

Medicaid is the medical assistance program that provides access to health care for low-income families and individuals. Medicaid also assists aged and disabled people with the costs of nursing facility care and other medical expenses. The Agency for Health Care Administration (AHCA) is responsible for administering the Medicaid program. Medicaid serves approximately 3.3 million people in Florida, and costing nearly $20.7 billion in program expenditures.[1]

Medicaid reimburses health care providers that have a provider agreement with the AHCA only for goods and services that are covered by the Medicaid program and only for individuals who are eligible for medical assistance from Medicaid. Each provider agreement is a voluntary contract between the AHCA and the provider, in which the provider agrees to comply with all laws and rules pertaining to the Medicaid program.[2] A Medicaid provider has a contractual obligation to comply with Medicaid policy which requires that a claim must be true and correct or payments may be recouped.[3]

Section 409.906, F.S., identifies the services for which Florida has, at its option, decided to make payments under the Medicaid program. Prescribed drug services are optional services under the Medicaid program. Under s. 409.906(20), F.S., the AHCA may pay for medications that are prescribed for a recipient by a physician or other licensed practitioner of the healing arts authorized to prescribe medication and that are dispensed to the recipient by a licensed pharmacist or physician in accordance with applicable state and federal law.

Section 409.908(14), F.S., establishes policies regarding Medicaid reimbursement of providers of prescribed drugs. Section 409.912(37), F.S., requires the AHCA to implement a Medicaid prescribed-drug spending-control program that includes several specified components.

Section 409.913, F.S., provides for the oversight of the integrity of the Medicaid program to ensure that fraudulent and abusive behavior occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. Overpayment is defined to include any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.[4]

Under s. 409.913(2), F.S., the AHCA is required to conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination of these, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and to report the findings of any overpayments in audit reports as appropriate.

Section 409.913(32), F.S., authorizes agents and employees of the AHCA to inspect, during normal business hours, the records of any pharmacy, wholesale establishment or manufacturer, or any other place in which drugs and medical supplies are manufactured, packed, packaged, made, stored, sold or kept for sale, for the purpose of verifying the amount of drugs and medical supplies ordered, delivered,

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[1] Office of Economic and Demographic Research, Social Services Estimating Conference, *Medicaid Caseloads and Expenditures, Executive Summary*, February 15 and 25, 2013, available at http://edr.state.fl.us/Content/conferences/Medicaid/medsummary.pdf (last viewed on March 22, 2013).
[2] S. 409.907(2), F.S.
[3] S. 409.913(7), F.S.
[4] S. 409.913(1)(e), F.S.

or purchased by a Medicaid provider. The AHCA must provide at least 2 business days' prior notice of an inspection. The notice must identify the provider whose records will be inspected, and the inspection shall include only records specifically related to that provider.

Medicaid Pharmacy Audits

Section 465.188, F.S., establishes requirements for the conduct of an audit of the Medicaid-related records of a pharmacy licensed under ch. 465, F.S. The audit must meet the following requirements:

- The agency conducting the audit must give the pharmacist at least one week's prior notice of the initial audit for each audit cycle.[5]
- An audit must be conducted by a pharmacist licensed in Florida.[6]
- Any clerical or recordkeeping error, such as a typographical error, scrivener's error, or computer error regarding a document or record required under the Medicaid program does not constitute a willful violation and is not subject to criminal penalties without proof of intent to commit fraud.[7]
- A pharmacist may use the physician's record or other order for drugs or medicinal supplies written or transmitted by any means of communication for purposes of validating the pharmacy record with respect to orders or refills of a legend or narcotic drug.[8]
- A finding of an overpayment or underpayment must be based on the actual overpayment or underpayment and may not be a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs.[9]
- Each pharmacy shall be audited under the same standards and parameters.[10]
- A pharmacist must be allowed at least 10 days in which to produce documentation to address any discrepancy found during an audit.[11]
- The period covered by an audit may not exceed one calendar year.[12]
- An audit may not be scheduled during the first five days of any month due to the high volume of prescriptions filled during that time.[13]
- The audit report must be delivered to the pharmacist within ninety days after conclusion of the audit.[14]
- A final audit report must be delivered to the pharmacist within six months after receipt of the preliminary audit report or final appeal, whichever is later.[15]
- The agency conducting the audit may not use the accounting practice of extrapolation in calculating penalties for Medicaid audits.[16]

The law requires the AHCA to establish a process that allows a pharmacist to obtain a preliminary review of an audit report and to appeal an unfavorable audit report without the necessity of obtaining legal counsel.[17] The preliminary review and appeal may be conducted by an ad hoc peer review panel, appointed by the AHCA, which consists of pharmacists who maintain an active practice.[18] If, following the preliminary review, the AHCA or the review panel finds that an unfavorable audit report is unsubstantiated, the AHCA must dismiss the audit report without the necessity of any further proceedings.[19]

[5] S. 465.188(1)(a), F.S.
[6] S. 465.188(1)(b), F.S.
[7] S. 465.188(1)(c), F.S.
[8] S. 465.188(1)(d), F.S.
[9] S. 465.188(1)(e), F.S.
[10] S. 465.188(1)(f), F.S.
[11] S. 465.188(1)(g), F.S.
[12] S. 465.188(1)(h), F.S.
[13] S. 465.188(1)(i), F.S.
[14] S. 465.188(1)(j), F.S.
[15] Id.
[16] S. 465.188(1)(k), F.S.
[17] S. 465.188(2), F.S.
[18] Id.
[19] Id.

These requirements do not apply to investigative audits conducted by the Medicaid Fraud Control Unit of the Department of Legal Affairs or to investigative audits conducted by the AHCA when there is reliable evidence that the claim that is the subject of the audit involves fraud, willful misrepresentation, or abuse under the Medicaid program.[20]

Medicaid Program Integrity

Medicaid Program Integrity, a unit of the AHCA, recovers overpayments, which are payments made in a manner inconsistent with Medicaid policy, through MPI-conducted audits, paid claims reversals and vendor-assisted audits.[21] MPI audits include comprehensive investigations involving reviews of professional records, generalized analyses involving computer-assisted reviews of paid claims and focused audits involving reviews of certain types of providers in specific geographic areas.[22] MPI audits utilize generally-accepted accounting principles and statistical analysis methods.[23] Paid claims reversals are effected within MPI by Florida licensed pharmacists who review pharmacy paid claims and identify apparent mis-billings.[24] The pharmacies are notified and claims corrected, resulting in recoveries of Medicaid overpayments. Vendor-assisted audits are conducted, under MPI supervision, by contracted firms who perform work that would otherwise not be possible due to staffing limitations.[25] In fiscal year 2011-2012, 44 pharmacy site visits were conducted.[26]

Third-Party Payer/Third-Party Administrator Pharmacy Audits

Advances in pharmaceuticals have transformed health care over the last several decades. Many health care problems are prevented, cured, or managed effectively for years through the use of prescription drugs. As a result, national expenditures for retail prescription drugs have grown from $120.9 billion in 2000 to $263 billion in 2011.[27] This has brought about increased scrutiny of pharmaceutical dispensing and reimbursement processes.

Health insurers, including Medicare and Medicaid, and other third party payers spent $208.6 billion on prescription drugs in 2011 and consumers paid $45 billion out of pocket for prescription drugs that year.[28] As expenditures for drugs have increased, insurers have looked for ways to control that spending. Among other things, they have turned to pharmacy benefit managers, which are third party administrators of prescription drug programs. Pharmacy benefit managers process prescriptions for the groups that pay for drugs, usually insurance companies or corporations, and use their size to negotiate with drug makers and pharmacies. They are primarily responsible for processing and paying prescription drug claims. They are also responsible for maintaining the formulary of covered drugs, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

Pharmacy benefit managers build networks of retail pharmacies to provide consumers convenient access to prescriptions at discounted rates. The audit process is one means used by pharmacy benefit

[20] S. 465.188(3) and (4), F.S.

[21] Florida Agency for Health Care Administration, Office of the Inspector General, *Annual Report 2011-2012*, September 2012, page 14, available at www.fdhc.fl.us/Executive/Inspector_General/docs/OIG%20Annual%20Report%20FY%202011-12[1].pdf (last viewed March 22, 2013).

[22] Id.

[23] Id.

[24] Id.

[25] Id.

[26] Florida Agency for Health Care Administration and the Office of the Attorney General, *The State's Efforts to Control Medicaid Fraud and Abuse- FY 2011-2012*, December 31, 2012, page 36, available at www.ahca.myflorida.com/docs/FinalReportSignedand Certified.pdf (last viewed on March 22, 2013) (on file with Health Innovation Subcommittee staff).

[27] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *National Health Expenditures; Aggregate and Per Capita Amounts, Annual Percent Change and Percent Distribution, by Type of Expenditure: Selected Calendar Years 1960-2011*, Table 2, available at www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NaturalHealthAccountsHistorical.html (last viewed on March 22, 2013).

[28] Id. at Table 4.

managers and third-party payors to review pharmacy programs. The audits ensure that procedures and reimbursement mechanisms are consistent with contractual and regulatory requirements. Pharmacies have increasingly complained about the onerous and burdensome nature of these audits.[29]

Effect of Proposed Changes

The bill expands the application of requirements for Medicaid audits of pharmacies, contained in s. 465.188, F.S., to audits of pharmacy permittees conducted by a third-party payer or third-party administrator, such as a pharmacy benefits manager, under the third party's program. The bill creates a consistent standard for pharmacy audits under the Medicaid program and third-party payer or administrator programs.

The bill provides that any clerical or recordkeeping error, without proof of intent to commit fraud, revealed during the audit is not subject to criminal penalties. The bill also provides that a claim for payment is not subject to a recoupment action if, but for the recordkeeping or clerical error, the claim is otherwise valid under the program.

The audit criteria made applicable to third-party claims by the bill apply only to third-party claims submitted for payment after July 1, 2011. The bill prohibits the use of the accounting practice of extrapolation in calculating penalties or financial recoupment of a paid claim for the Medicaid program or a third-party payer or third-party administrator program. Also, the bill states that audit criteria may not create a claim for financial recoupment where it did not otherwise exists, unless recoupment is required by law as a result of the application of audit criteria to a claim.

Lastly, the bill requires the third-party payer or administrator contracting with the pharmacy under audit to establish a process that allows a pharmacist to obtain a preliminary review of an audit report and to appeal an unfavorable audit report without the necessity of obtaining legal counsel. The bill permits the third-party payer or administrator to appoint the ad hoc peer review counsel to conduct the preliminary review and appeal. If the ad hoc peer review counsel finds an unfavorable audit is unsubstantiated, the third-party payer or administrator must dismiss the audit report without further proceedings.

B. SECTION DIRECTORY:

Section 1: Amends s. 465.188, F.S., relating to Medicaid audits of pharmacies.
Section 2: Provides an effective date of upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   See Fiscal Comments.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

[29] National Community Pharmacists Association, *Survey: Pharmacists Say Patient Care Undermined by Auditing, Payment Practices*, available at www.ncpanet.org/index.php/new-releases/2012-news-releases/1470-survey-pharmacists-say-patient-care-undermined-by-auditing-payment-practices (last viewed on March 22, 2013).

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

The bill states that a claim is not subject to financial recoupment if, except for typographical, scrivener's, computer, clerical, or recordkeeping error, the claim is an otherwise valid claim. This provision may have a negative impact on the AHCA's ability to combat fraud and abuse in the Florida Medicaid program. Although providers may not be committing fraud, they may be committing abuse and collecting overpayments from the Medicaid program through computer and recordkeeping errors.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill does not require rule-making.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to audits of pharmacy records;
3 amending s. 465.188, F.S.; revising requirements for
4 the audit of Medicaid-related pharmacy records;
5 authorizing audits of third-party payor and third-
6 party administrator records of pharmacy permittees;
7 providing that claims containing certain clerical or
8 recordkeeping errors are not subject to financial
9 recoupment under certain circumstances; specifying
10 that certain audit criteria apply to third-party
11 claims submitted after a specified date; prohibiting
12 certain accounting practices used for calculating the
13 recoupment of claims; prohibiting the audit criteria
14 from requiring the recoupment of claims except under
15 certain circumstances; providing procedures for review
16 and appeal of third-party payor and third-party
17 administrator audits; providing an effective date.
18
19 Be It Enacted by the Legislature of the State of Florida:
20
21 Section 1. Section 465.188, Florida Statutes, is amended
22 to read:
23 465.188 Financial ~~Medicaid~~ audits of pharmacies.—
24 (1) Notwithstanding any provision of ~~other~~ law, when an
25 audit of ~~the~~ Medicaid-related, third-party payor, or third-party
26 administrator records of a pharmacy permittee ~~licensed~~ under
27 this chapter ~~465~~ is conducted, such audit must be conducted as
28 provided in this section.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

29 (a) The agency or other entity conducting the audit must
30 give the pharmacist at least 1 week's prior notice of the
31 initial audit for each audit cycle.
32 (b) An audit must be conducted by a pharmacist licensed in
33 this state.
34 (c) Any clerical or recordkeeping error, such as a
35 typographical error, scrivener's error, or computer error
36 regarding a document or record required under the third-party
37 payor, third-party administrator, or Medicaid program does not
38 constitute a willful violation and, without proof of intent to
39 commit fraud, is not subject to criminal penalties ~~without proof~~
40 ~~of intent to commit fraud~~. A claim is not subject to financial
41 recoupment if, except for such typographical, scrivener's,
42 computer, or other clerical or recordkeeping error, the claim is
43 an otherwise valid claim.
44 (d) A pharmacist may use the physician's record or other
45 order for drugs or medicinal supplies written or transmitted by
46 any means of communication for purposes of validating the
47 pharmacy record with respect to orders or refills of a legend or
48 narcotic drug.
49 (e) A finding of an overpayment or underpayment must be
50 based on the actual overpayment or underpayment and may not be a
51 projection based on the number of patients served having a
52 similar diagnosis or on the number of similar orders or refills
53 for similar drugs.
54 (f) Each pharmacy shall be audited under the same
55 standards and parameters.
56 (g) A pharmacist must be allowed at least 10 days in which

57 to produce documentation to address any discrepancy found during
58 an audit.
59 (h) The period covered by an audit may not exceed 1
60 calendar year.
61 (i) An audit may not be scheduled during the first 5 days
62 of any month due to the high volume of prescriptions filled
63 during that time.
64 (j) The audit report must be delivered to the pharmacist
65 within 90 days after conclusion of the audit. A final audit
66 report shall be delivered to the pharmacist within 6 months
67 after receipt of the preliminary audit report or final appeal,
68 as provided for in subsection (2), whichever is later.
69 (k) The audit criteria set forth in this section apply
70 ~~applies~~ only to audits of Medicaid claims submitted for payment
71 after ~~subsequent to~~ July 11, 2003, and to third-party claims
72 submitted for payment after July 1, 2011. Notwithstanding any
73 ~~other~~ provision of ~~in~~ this section, the agency or other entity
74 conducting the audit shall not use the accounting practice of
75 extrapolation in calculating penalties or recoupment for
76 Medicaid, third-party payor, or third-party administrator
77 audits.
78 (l) The audit criteria may not subject a claim to
79 financial recoupment except in those circumstances when
80 recoupment is required by law.
81 (2) The Agency for Health Care Administration, in the case
82 of a Medicaid-related audit, or the third-party payor or third-
83 party administrator contracting with the pharmacy, in the case
84 of a third-party payor or third-party administrator audit, shall

85 establish a process under which a pharmacist may obtain a
86 preliminary review of an audit report and may appeal an
87 unfavorable audit report without the necessity of obtaining
88 legal counsel. The preliminary review and appeal may be
89 conducted by an ad hoc peer review panel, appointed by the
90 agency, in the case of a Medicaid-related audit, or appointed by
91 the third-party payor or third-party administrator contracting
92 with the pharmacy, in the case of a third-party payor or third-
93 party administrator audit, which consists of pharmacists who
94 maintain an active practice. If, following the preliminary
95 review, the ~~agency or~~ review panel finds that an unfavorable
96 audit report is unsubstantiated, the agency, in the case of a
97 Medicaid-related audit, or the third-party payor or third-party
98 administrator contracting with the pharmacy, in the case of a
99 third-party payor or third-party administrator audit, shall
100 dismiss the audit report without the necessity of any further
101 proceedings.
102 (3) This section does not apply to investigative audits
103 conducted by the Medicaid Fraud Control Unit of the Department
104 of Legal Affairs.
105 (4) This section does not apply to any investigative audit
106 conducted by the Agency for Health Care Administration when the
107 agency has reliable evidence that the claim that is the subject
108 of the audit involves fraud, willful misrepresentation, or abuse
109 under the Medicaid program.
110 Section 2. This act shall take effect upon becoming a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 793 Cost-effective Purchasing of Health Care
SPONSOR(S): Diaz
TIED BILLS: **IDEN./SIM. BILLS:** SB 896

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		McElroy CM	Shaw JS
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Presently dental services are delivered to Medicaid recipients through prepaid dental health plans (PDHP) in counties not participating in Medicaid Reform. The Agency for Health Care Administration (ACHA) contracts on a prepaid or fixed-sum basis with appropriately licensed prepaid dental health plans to provide dental services. This authorization expires on October 1, 2014. This general authority does not include Miami-Dade. Section 409.912(41)(b), F.S., authorizes the AHCA to provide a Medicaid prepaid dental program in Miami-Dade for the fiscal year 2012-2013. This authorization expires on July, 1, 2013.

In 2011, the Legislature passed HB 7107 creating the Statewide Medicaid Managed Care (SMMC) program as part IV of ch. 409, F.S. The SMMC requires the AHCA to create an integrated managed care program for Medicaid enrollees that incorporates all of the minimum benefits for the delivery of primary and acute care, including dental. The AHCA began implementing the SMMC in January 2012.

On December 28, 2012, the ACHA released an Invitation to Negotiate (ITN) to competitively procure managed care plans on a statewide basis. Since dental services is a required benefit of SMMC, the ITN lists dental services as one of the core provisions of the scope of services to be offered in the managed care plans. Statewide implementation of the SMMC is expected to be completed by October 1, 2014.

The bill postpones the scheduled repeal of ACHA's general authority to contract with PDHPs until October 1, 2017. The bill directs the AHCA to provide a Medicaid prepaid dental program in Miami-Dade on a permanent basis.

The bill appears to have an indeterminate fiscal impact on state government.

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Medicaid

Medicaid is a joint federal and state funded program that provides health care for low income Floridians. The program is administered by the AHCA and financed with federal and state funds. The statutory authority for the Medicaid program is contained in ch. 409, F.S.

Federal law establishes the minimum benefit levels to be covered in order to receive federal matching funds. Benefit requirements can vary by eligibility category. For example, more benefits are required for children than for the adult population. Florida's mandatory and optional benefits are prescribed in state law under ss. 409.905, and 409.906 F.S., respectively.

Presently Florida Medicaid recipients receive their benefits through a number of different delivery systems including both fee-for-services and managed care models. Dental services are delivered through prepaid dental health plans (PDHP). The PDHPs are classified as prepaid ambulatory health plans by 42 CFR Part 438.[1] Prepaid plans are further defined in state law under s. 409.962, F.S., as:

> A managed care plan that is licensed or certified as a risk-bearing entity, or qualified pursuant to s. 409.912(4)(d), F.S., in the state and is paid a prospective per-member, per-month payment by the agency.

Prepaid Dental Health Plans – Florida Medicaid

In 2001, proviso language in the General Appropriations Act (GAA) authorized the AHCA to initiate a PDHP pilot program in Miami-Dade County.[2] The 2003 Legislature directed the AHCA to contract on prepaid or fixed sum basis for dental services for Medicaid-eligible recipients using PDHPs.[3] The AHCA implemented the program in Miami-Dade County in July 2004 to Medicaid children age 21 years of age or younger.[4] In the 2010-2011 General Appropriations Act (GAA), the Legislature directed the AHCA to provide enrollees with a choice of at least two licensed plans in Miami-Dade County and updated this number to three in the 2011-2012 GAA. Currently, two PDHPs serve Medicaid members in Miami-Dade County.[5]

The 2010-2011 GAA proviso directed the AHCA to contract separately on prepaid or fixed sum basis with prepaid dental plans on either a regional or statewide basis to achieve better outcomes for Medicaid recipients.[6] The contract was not to exceed 2 years. The directive excluded Miami-Dade County from this contracting process but did permit the AHCA the option of including the Medicaid reform counties in the procurement.[7] The AHCA elected not to include those counties in the

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[1] *See* Agency for Health Care Administration, *Model Statewide Prepaid Dental Health Plan (SPDHP) Contract, Attachment II-Core Contract Provisions*, p. 17, http://ahca.myflorida.com/medicaid/pdhp/docs/120120_Attachment_II_Core.pdf (last visited Mar. 24, 2013).
[2] *See* Specific Proviso 135A, General Appropriations Act 2001-2002 (Conference Report on CS/SB 2C).
[3] Chapter 2003-405, s. 18.
[4] Agency for Health Care Administration, *Statewide Prepaid Dental Program,* http://ahca.myflorida.com/Medicaid/index.shtml#pdhp (last visited: Mar. 24, 2013).
[5] Id.
[6] *See* Specific Proviso 204, General Appropriations Act 2010-2011 (Conference Report on HB 5001).
[7] In 2005, the Legislature enacted laws to reform the delivery and payment of services through the Medicaid program and directed AHCA to seek a federal waiver for a Medicaid managed care pilot program over five years. The program began in Broward and Duval counties in 2006 and later expanded to Baker, Clay and Nassau counties in 2007, as authorized in statute. The five year waiver was set to expire June 30, 2011, but has been renewed through June 30, 2014.

procurement process. Children enrolled in managed care plans in the reform counties receive their dental benefits through their health care plans and not directly through these PDHPs.[8]

The proviso language for the statewide effort was repeated in the 2011-2012 GAA.[9] Additionally, statutory changes made it mandatory, rather than discretionary, for the AHCA to contract on a prepaid or fixed sum basis for dental services.[10] An expiration date on the statutory subsection was added for October 1, 2014, to coincide with other non-managed care related statutory sunset provisions concerning the Medicaid program and to align with the implementation of the Statewide Medicaid Managed Care (SMMC) program.[11]

Changes made during the 2012 Legislative Session as part of the appropriations implementing bill modified the Statewide Prepaid Dental Program to reinstate the fee for service reimbursement option providing Medicaid recipients the option of either a prepaid dental plan or coverage through the traditional fee for service network of providers in all but Miami-Dade County. This subsection has a sunset date of July 1, 2013.

Statewide Medicaid Managed Care (SMMC)

In 2011, the Legislature passed HB 7107 creating the SMMC program as part IV of ch. 409, F.S. The SMMC requires the AHCA to create an integrated managed care program for Medicaid enrollees that incorporates all of the minimum benefits for the delivery of primary and acute care, including dental.[12] Instead of being delivered as a separate benefit under a separate contract, dental services would be incorporated by and be the responsibility of the managed care organization. Medicaid recipients who are enrolled in the SMMC program will receive their dental services through the fully integrated managed care plans as the plans are implemented.[13] The AHCA began implementing the SMMC in January 2012.

On December 28, 2012, the ACHA released an Invitation to Negotiate (ITN) to competitively procure managed care plans on a statewide basis.[14] The deadline for written inquires on the ITN was February 12, 2013, and the deadline for the ACHA's responses is March 29, 2013.[15] The negotiations for the plans will be conducted from July 8, 2013, through September 6, 2013.[16] The ACHA anticipates that the Notice of Intent to Award will be posted by September 16, 2013.[17] The ITN lists dental services as one of the core provisions of the scope of services to be offered in the managed care plans.[18]

The ITN is currently in a statutorily imposed "Blackout Period" until 72 hours after the award and the ACHA cannot provide interpretation or additional information not included in the managed medical assistance (MMA) ITN documents. Specifically, s. 287.057(23), F.S., provides as follows:

> Respondents to this solicitation or persons acting on their behalf may not contact, between the release of the solicitation and the end of the 72-hour period following the agency posting the notice of intended award, excluding Saturdays, Sundays, and state holidays, any employee or

[8] Agency for Health Care Administration, Capitated Health Plan Contract, Scope of Services, Attachment I, http://ahca.myflorida.com/mchq/Managed_Health_Care/MHMO/docs/contract/1215_Contract/2012-2015/Sept1-Versions/2012-15_HP-ContractAtt-I-CAP-CLEAN-SEPT2012.pdf (last visited: Mar. 24, 2013).
[9] *See* Chapter 2011-69; Specific Proviso for Line Item 192, General Appropriations Act 2011-2012, (Conference Report on SB 2000).
[10] Chapter 2011-135, s. 17.
[11] Id.
[12] Health and Human Services Committee, Fla. House of Representatives, *PCB HHSC 11-01 Staff Analysis*, p.25, (Mar. 25, 2011).
[13] AHCA, *supra* note 6, at 2.
[14] ACHA Invitation to Negotiate, *Statewide Medicaid Managed Care*, *Addendum 2* Solicitations Number: ACHA ITN 017-12/13; dated February 26, 2013. http://myflorida.com/apps/vbs/vbs_www.ad.view_ad?advertisement_key_num=105774 (last visited March 24, 2013).
[15] ACHA Invitation to Negotiate, *Statewide Medicaid Managed Care*, Solicitation Number: ACHA ITN 017-12/13; dated December 28, 2012. http://myflorida.com/apps/vbs/vbs_www.ad.view_ad?advertisement_key_num=105774 (last visited March 24, 2013).
[16] Id.
[17] Id.
[18] AHCA, *supra* note 16.

officer of the executive or legislative branch concerning any aspect of this solicitation, except in writing to the procurement officer or as provided in the solicitation documents. Violation of this provision may be grounds for rejecting a response.

Statewide implementation of the SMMC is expected to be completed by October 1, 2014. Final approval of the necessary Medicaid waiver by the federal government has not yet been received; however on February 20, 2013, the AHCA and the Centers for Medicare and Medicaid Services reached an "Agreement in Principle" on the proposed plan.[19]

Section 409.961, F.S., provides that it is the intent of the Legislature that if any conflict exists between the provisions contained in this part and in other parts of this chapter, the provisions in this part control.

Effect of the Proposed Changes

Section 409.912 (41)(a), F.S., provides that the ACHA shall contract on a prepaid or fixed-sum basis with appropriately licensed prepaid dental health plans to provide dental services. This provision is set expires October 1, 2014.[20] The bill amends section to postpone the scheduled repeal date to October 1, 2017.

Section 409.912(41)(b), F.S., authorizes the AHCA to provide a Medicaid prepaid dental program in Miami-Dade for the fiscal year 2012-2013. This provision expires on July, 1, 2013.[21] The bill deletes the current fiscal year reference which will become obsolete and authorizes the AHCA to provide a Medicaid prepaid dental program in Miami-Dade County on a permanent basis. This action would allow the AHCA to continue to provide a separate Medicaid prepaid dental plan in Miami-Dade County.

B. SECTION DIRECTORY:

Section 1. Amends s. 409.912, F.S., relating to the cost effective purchasing of health care under the Medicaid program.

Section 2. Provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The fiscal impact of this bill is indeterminate at this time.[22] Any potential savings which might occur if the Fee for Services option is eliminated would become a minor component of capitation rate calculations under SMMC.[23]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

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[19] *See* Correspondence between Agency for Health Care Administration and the Centers for Medicare and Medicaid Services, http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/Letter_from_CMS_re_Agreement_in_Principal_2013-02-20.pdf (last visited Mar. 24, 2013).
[20] Section 409.912 (41)(a), F.S.
[21] Section 409.912(41)(b), F.S.
[22] Agency for Health Care Administration, *House Bill 793 Bill Analysis and Economic Impact Statement*,(Mar. 14, 2013) (on file with the House of Representatives Health and Human Services Committee).
[23] Id.

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Statewide implementation of the Statewide Medicaid Managed Care program is expected to be completed by October 1, 2014. Dental benefits are a required benefit under both s. 409.973(1)(e), F.S., and the integrated managed care model. Thus, extending the requirement that the AHCA contract on a fixed-sum or pre-paid basis for dental services to October 1, 2017, may result in the possible overlap of dental services contracts between those contracts executed under s. 409.912, F.S., and those procured under SMMC.

Dental services are one of the ITN's core provisions of services to be offered in the managed care plans. The changes proposed by the bill create a conflict between s. 409.912, F.S., and the ITN. Specifically, the bill creates a question as to whether dental services are to be provided as part of the managed care services under the ITN or whether they are to be provided pursuant to s. 409.912, F.S. Parties interested in responding to the ITN cannot ask for clarification on this issue as the ITN is currently in a statutorily imposed "Blackout Period". Thus, the potential for an ITN protest exists as the bill potentially creates a material change to the terms and conditions of the ITN. Alternatively, the ACHA could reissue the ITN and address this issue. This however could potentially delay the expected date for the implementation of the SMMC.

Dental services are required to be included in the SMMC. It is unclear if the bill creates an exemption from this requirement. If it does not create an exemption, the bill potentially conflicts with the requirements of s. 409.973, F.S. Section 409.961, F.S., provides that it is the intent of the Legislature that if any conflict exists between the provisions contained in Part IV and in other parts of this chapter, the Part IV provisions control. The provisions addressed in the bill are contained within Part III. Thus, any of the bill's provisions which conflict with the SMMC provisions could be deemed invalid.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to cost-effective purchasing of health
3 care; amending s. 409.912, F.S.; extending the
4 authorization period for the Agency for Health Care
5 Administration to enter into contracts on a prepaid or
6 fixed-sum basis with appropriately licensed prepaid
7 dental health plans to provide dental services;
8 limiting agency authorization for the provision of
9 prepaid dental health programs to Miami-Dade County;
10 providing an effective date.
11
12 Be It Enacted by the Legislature of the State of Florida:
13
14 Section 1. Paragraphs (a) and (b) of subsection (41) of
15 section 409.912, Florida Statutes, are amended to read:
16 409.912 Cost-effective purchasing of health care.—The
17 agency shall purchase goods and services for Medicaid recipients
18 in the most cost-effective manner consistent with the delivery
19 of quality medical care. To ensure that medical services are
20 effectively utilized, the agency may, in any case, require a
21 confirmation or second physician's opinion of the correct
22 diagnosis for purposes of authorizing future services under the
23 Medicaid program. This section does not restrict access to
24 emergency services or poststabilization care services as defined
25 in 42 C.F.R. part 438.114. Such confirmation or second opinion
26 shall be rendered in a manner approved by the agency. The agency
27 shall maximize the use of prepaid per capita and prepaid
28 aggregate fixed-sum basis services when appropriate and other

29 alternative service delivery and reimbursement methodologies,
30 including competitive bidding pursuant to s. 287.057, designed
31 to facilitate the cost-effective purchase of a case-managed
32 continuum of care. The agency shall also require providers to
33 minimize the exposure of recipients to the need for acute
34 inpatient, custodial, and other institutional care and the
35 inappropriate or unnecessary use of high-cost services. The
36 agency shall contract with a vendor to monitor and evaluate the
37 clinical practice patterns of providers in order to identify
38 trends that are outside the normal practice patterns of a
39 provider's professional peers or the national guidelines of a
40 provider's professional association. The vendor must be able to
41 provide information and counseling to a provider whose practice
42 patterns are outside the norms, in consultation with the agency,
43 to improve patient care and reduce inappropriate utilization.
44 The agency may mandate prior authorization, drug therapy
45 management, or disease management participation for certain
46 populations of Medicaid beneficiaries, certain drug classes, or
47 particular drugs to prevent fraud, abuse, overuse, and possible
48 dangerous drug interactions. The Pharmaceutical and Therapeutics
49 Committee shall make recommendations to the agency on drugs for
50 which prior authorization is required. The agency shall inform
51 the Pharmaceutical and Therapeutics Committee of its decisions
52 regarding drugs subject to prior authorization. The agency is
53 authorized to limit the entities it contracts with or enrolls as
54 Medicaid providers by developing a provider network through
55 provider credentialing. The agency may competitively bid single-
56 source-provider contracts if procurement of goods or services

57 results in demonstrated cost savings to the state without
58 limiting access to care. The agency may limit its network based
59 on the assessment of beneficiary access to care, provider
60 availability, provider quality standards, time and distance
61 standards for access to care, the cultural competence of the
62 provider network, demographic characteristics of Medicaid
63 beneficiaries, practice and provider-to-beneficiary standards,
64 appointment wait times, beneficiary use of services, provider
65 turnover, provider profiling, provider licensure history,
66 previous program integrity investigations and findings, peer
67 review, provider Medicaid policy and billing compliance records,
68 clinical and medical record audits, and other factors. Providers
69 are not entitled to enrollment in the Medicaid provider network.
70 The agency shall determine instances in which allowing Medicaid
71 beneficiaries to purchase durable medical equipment and other
72 goods is less expensive to the Medicaid program than long-term
73 rental of the equipment or goods. The agency may establish rules
74 to facilitate purchases in lieu of long-term rentals in order to
75 protect against fraud and abuse in the Medicaid program as
76 defined in s. 409.913. The agency may seek federal waivers
77 necessary to administer these policies.
78 (41)(a) The agency shall contract on a prepaid or fixed-
79 sum basis with appropriately licensed prepaid dental health
80 plans to provide dental services. This paragraph expires October
81 1, 2017 ~~2014~~.
82 (b) Notwithstanding paragraph (a) ~~and for the 2012-2013~~
83 ~~fiscal year only~~, the agency is authorized to provide a Medicaid
84 prepaid dental health program in Miami-Dade County. ~~For all~~

85 ~~other counties, the agency may not limit dental services to~~
86 ~~prepaid plans and must allow qualified dental providers to~~
87 ~~provide dental services under Medicaid on a fee-for-service~~
88 ~~reimbursement methodology. The agency may seek any necessary~~
89 ~~revisions or amendments to the state plan or federal waivers in~~
90 ~~order to implement this paragraph. The agency shall terminate~~
91 ~~existing contracts as needed to implement this paragraph. This~~
92 ~~paragraph expires July 1, 2013.~~
93 Section 2. This act shall take effect July 1, 2013.

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED ___ (Y/N)

ADOPTED AS AMENDED ___ (Y/N)

ADOPTED W/O OBJECTION ___ (Y/N)

FAILED TO ADOPT ___ (Y/N)

WITHDRAWN ___ (Y/N)

OTHER ______

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1 Committee/Subcommittee hearing bill: Health Innovation
2 Subcommittee
3 Representative Diaz, J. offered the following:
4
5 **Amendment (with title amendment)**
6 Remove lines 78-84 and insert:
7 (41)(a) Notwithstanding s. 409.961, the agency shall
8 contract on a prepaid or fixed-sum basis with appropriately
9 licensed prepaid dental health plans to provide dental services.
10 This paragraph expires October 1, 2017 ~~2014~~.
11 (b) Notwithstanding paragraph (a) ~~and for the 2012-2013~~
12 ~~fiscal year only~~, the agency is authorized to provide a Medicaid
13 prepaid dental health program in Miami-Dade County. The agency
14 shall provide an annual report by January 15 to the Governor,
15 the President of the Senate, and the Speaker of the House of
16 Representatives which compares the combined reported annual
17 benefits utilization and encounter data from all contractors,
18 along with the agency's findings as to projected and budgeted
19 annual program costs, the extent to which each contracting
20 entity is complying with all contract terms and conditions, the

21 effect that each entity's operation is having on access to care
22 for Medicaid recipients in the contractor's service area, and
23 the statistical trends associated with indicators of good oral
24 health among all recipients served in comparison with the
25 state's population as a whole. ~~For all~~
26
27
28
29 ---
30 **T I T L E A M E N D M E N T**
31 Remove line 10 and insert:
32 requiring an annual report to the Governor and presiding
33 officers of the Legislature; providing an effective date.
34

HB 919

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 919 Hospital Licensure
SPONSOR(S): Gonzalez
TIED BILLS: **IDEN./SIM. BILLS:** SB 1264

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Guzzo	Shaw
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The Agency for Health Care Administration (AHCA) licenses all hospital types in Florida. Hospitals with a class II specialty license must be designated as either a women's hospital or a children's hospital. To offer services to women and children, a hospital must be licensed as a class I general acute care hospital. Currently, a licensed children's hospital wanting to offer services outside of their previously defined patient base would be required to obtain a Certificate of Need to establish a new hospital or apply to change their classification to a class I general acute care hospital. Currently, there are three hospitals in Florida that qualify as specialty-licensed children's hospitals.

The bill allows specialty-licensed children's hospitals that have licensed neonatal intensive care beds to provide obstetrical services, including labor and delivery care, up to 10 patients, under the following conditions:

- The services must be restricted to the diagnosis, care, and treatment of pregnant women of any age;
- The patient must have documentation by an examining physician, including information regarding:
  - At least one fetal characteristic or condition that would characterize the pregnancy or delivery as high risk; or
  - Medical advice or a diagnosis indicating that the fetus may require at least one perinatal intervention.

The bill does not appear to have a significant fiscal impact on state or local government.

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Section 395.003, F.S., states that a specialty hospital may not provide any service or regularly serve any population group beyond those that are specified in its license. However, a specialty-licensed children's hospital may treat certain adult patients with cardiovascular issues that the hospital treated as children.

The Agency for Health Care Administration (AHCA) licenses all hospital types in Florida. Hospitals with a class II specialty license must be designated as either a women's hospital or a children's hospital. To offer services to women and children, a hospital must be licensed as a class I general acute care hospital. Currently, a licensed children's hospital wanting to offer services outside of their previously defined patient base would be required to obtain a Certificate of Need to establish a new hospital or apply to change their classification to a class I general acute care hospital.

Effect of Proposed Changes

The bill allows specialty-licensed children's hospitals that have licensed neonatal intensive care beds to provide obstetrical services, including labor and delivery care, up to 10 patients, under the following conditions:

- The services must be restricted to the diagnosis, care, and treatment of pregnant women of any age;
- The patient must have documentation by an examining physician, including information regarding:
    - At least one fetal characteristic or condition that would characterize the pregnancy or delivery as high risk; or
    - Medical advice or a diagnosis indicating that the fetus may require at least one perinatal intervention.

Currently, there are three hospitals in Florida that would qualify under the provisions of the bill: All Children's Hospital in Saint Petersburg, Miami Children's Hospital in Miami, and Nemours Children's Hospital in Orlando.[1]

B. SECTION DIRECTORY:

Section 1: Amends s. 395.003, F.S., relating to licensure; denial, suspension, and revocation.
Section 2: Provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

[1] AHCA bill analysis for HB 919, dated Mar. 15, 2013, on file with the Health Innovation Subcommittee.

None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to affect county or municipal government.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The Agency for Health Care Administration has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to hospital licensure; amending s. 395.003, F.S.; authorizing certain specialty-licensed children's hospitals to provide obstetrical services under certain circumstances; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (6) of section 395.003, Florida Statutes, is amended to read:

395.003 Licensure; denial, suspension, and revocation.—

(6) A specialty hospital may not provide any service or regularly serve any population group beyond those services or groups specified in its license.

(a) A specialty-licensed children's hospital that is authorized to provide pediatric cardiac catheterization and pediatric open-heart surgery services may provide cardiovascular service to adults who, as children, were previously served by the hospital for congenital heart disease, or to those patients who are referred for a specialized procedure only for congenital heart disease by an adult hospital, without obtaining additional licensure as a provider of adult cardiovascular services. The agency may request documentation as needed to support patient selection and treatment. This paragraph ~~subsection~~ does not apply to a specialty-licensed children's hospital that is already licensed to provide adult cardiovascular services.

(b) A specialty-licensed children's hospital that has

29 licensed neonatal intensive care unit beds may provide
30 obstetrical services, including labor and delivery care, to up
31 to ten patients, which services are restricted to the diagnosis,
32 care, and treatment of pregnant women of any age who have
33 documentation by an examining physician that includes
34 information regarding:
35 1. At least one fetal characteristic or condition that
36 would characterize the pregnancy or delivery as high risk; or
37 2. Medical advice or a diagnosis indicating that the fetus
38 may require at least one perinatal intervention.
39 Section 2. This act shall take effect July 1, 2013.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	____	

1 Committee/Subcommittee hearing bill: Health Innovation
2 Subcommittee
3 Representative Gonzalez offered the following:
4
5 **Amendment**
6 Remove lines 29-38 and insert:
7 licensed neonatal intensive care unit beds and is located in a
8 county with a population of 1,750,000 or more may provide
9 obstetrical services, in compliance with the agency's rules
10 pertaining to the obstetrical department in a hospital and offer
11 mothers all necessary critical care equipment, services, and
12 capabilities, up to 10 beds for labor and delivery care, which
13 services are restricted to the diagnosis, care, and treatment of
14 pregnant women of any age who have documentation by an examining
15 physician that includes information regarding:
16 1. At least one fetal characteristic or condition
17 diagnosed intra-utero that would characterize the pregnancy or
18 delivery as high risk including structural abnormalities of the
19 digestive, central nervous and cardiovascular systems and
20 disorders of genetic malformations and skeletal dysplasia, acute

21 metabolic emergencies and babies of mothers with rheumatologic
22 disorders; or
23 2. Medical advice or a diagnosis indicating that the fetus
24 may require at least one perinatal intervention.
25
26 This paragraph shall not preclude a specialty-licensed
27 children's hospital from complying with s. 395.1041, F.S. or the
28 Emergency Medical Treatment and Active Labor Act, 42 U.S.C.
29 1395dd.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 919 (2013)

Amendment No. 2

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	___	(Y/N)
ADOPTED AS AMENDED	___	(Y/N)
ADOPTED W/O OBJECTION	___	(Y/N)
FAILED TO ADOPT	___	(Y/N)
WITHDRAWN	___	(Y/N)
OTHER	_____	

1 Committee/Subcommittee hearing bill: Health Innovation
2 Subcommittee
3 Representative Gonzalez offered the following:
4
5 **Amendment (with title amendment)**
6 Between lines 38 and 39, insert:
7 Section 2. Section 395.1051, Florida Statutes, is amended
8 to read:
9 395.1051 Duty to notify ~~patients~~.—
10 <u>(1)</u> An appropriately trained person designated by each
11 licensed facility shall inform each patient, or an individual
12 identified pursuant to s. 765.401(1), in person about adverse
13 incidents that result in serious harm to the patient.
14 Notification of outcomes of care that result in harm to the
15 patient under this section shall not constitute an
16 acknowledgment or admission of liability, nor can it be
17 introduced as evidence.
18 <u>(2) Notice shall be provided to obstetrical physicians</u>
19 <u>with privileges at a hospital at least 120 days prior to the</u>

20 hospital closing an obstetrics department or ceasing to provide
21 obstetrical services.
22
23
24
25 ---
26 **T I T L E A M E N D M E N T**
27 Remove lines 2-6 and insert:
28 An act relating to hospitals; amending s. 395.003, F.S.;
29 authorizing certain specialty-licensed children's hospitals to
30 provide obstetrical services under certain circumstances;
31 amending s. 395.1051, F.S.; requiring hospitals to provide
32 advance notice to obstetrical physicians with privileges at the
33 hospital before closing an obstetrics department or ceasing to
34 provide obstetrical services; providing an effective date.
35

HB 1159

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1159 Skilled Nursing Facilities
SPONSOR(S): O'Toole
TIED BILLS: **IDEN./SIM. BILLS:** SB 1482

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Guzzo	Shaw
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The bill provides an exemption from certificate of need (CON) requirements for the construction of a skilled nursing facility and the addition of skilled nursing home beds within a retirement community that meets certain qualifying specifications.

In 2001, the legislature enacted a moratorium on the issuance of new CONs for skilled nursing beds. The moratorium was originally set for five years, but in 2006 the legislature extended it another five years. In 2011, the legislature again extended the moratorium, but provided that the moratorium will expire on June 30, 2016, or upon the statewide implementation of Medicaid managed care, whichever is earlier.

Specifically, the bill provides a CON exemption for the construction of a skilled nursing facility within a retirement community that:

- Is deed-restricted for older persons;
- Has a population of at least 20,000 residents;
- Provides within its boundaries a continuum of health care services for older persons; and
- Has an agreement with a state university to coordinate and assist in providing comprehensive health care services to the retirement community residents.

As written, it appears that only one community, *The Villages*, meets the qualifying specifications of the CON exemption.

The bill has an indeterminate fiscal impact on the private sector, and does not appear to have a significant fiscal impact on state or local government.

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

A certificate of need (CON) is a written statement issued by the Agency for Health Care Administration (AHCA) evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility, health service, or hospice.[1] Under this regulatory program, the Agency must provide approval through the CON review and approval process prior to a provider establishing a new nursing home or adding nursing home beds.

Florida's CON program has been in operation since July 1973. From 1974 through 1986, the specifics of the program were largely dictated by the federal National Health Planning and Resources Development Act, which established minimum requirements regarding the type of services subject to CON review, review procedures, and review criteria. Each state was required to have a CON program in compliance with those standards as a condition for obtaining federal funds for health programs. The federal health planning legislation was repealed in 1986.

In 2001, the Legislature enacted the first moratorium on the issuance of CONs for additional community nursing home beds until July 1, 2006.[2] In 2006, the Legislature extended the moratorium until July 1, 2011.[3] In addition, the Legislature provided for additional exceptions to the moratorium to address occupancy needs that might arise.

The Florida CON program has three levels of review: full, expedited, and the granting of an exemption.[4]

Projects Subject to Full Comparative Review

- Adding beds in community nursing homes; and
- Constructing or establishing new health care facilities, which include skilled nursing facilities (SNFs).[5]

Expedited Reviews

Certain exceptions to the moratorium allow existing nursing home beds to be moved from one facility to another within small geographic regions. Section 408.036(2), F.S., provides expedited review of applications for nursing home replacement and relocation of beds from one nursing home to another, as follows:

- Replacing a nursing home within the same district, if the proposed project site is located within a geographic area that contains at least 65 percent of the facility's current residents and is within a 30-mile radius of the replaced nursing home.
- Relocating a portion of a nursing home's licensed beds to a facility within the same district.

[1] Section 408.032(3), F.S.
[2] Chapter 2001-45, L.O.F. s. 52.
[3] Chapter 2006-161, L.O.F.
[4] Section 408.036, F.S.
[5] Section 408.032(16), F.S., defines a SNF as an institution, or a distinct part of an institution, which is primarily engaged in providing, to inpatients, skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

Exemptions

Section 408.036(3), F.S., provides several exemptions to CON review for skilled nursing facility projects, including:

- Combining licensed beds from two or more licensed nursing homes within a district into a single nursing home within that district if 50 percent of the beds are transferred from the only nursing home in a county and that nursing home had less than a 75 percent occupancy rate;[6]
- State veteran's nursing homes operated by or on behalf of the Florida Department of Veterans' Affairs;
- Combining into one nursing home, the beds or services authorized by two or more CONs issued in the same planning subdistrict;
- Separating into two or more nursing homes in the subdistrict, the beds or services that are authorized by one CON;
- Adding the greater of no more than 10 total beds or 10 percent of the number of licensed nursing home beds if:[7]
    - The facility has not had any class I or class II deficiencies within the 30 months preceding the request for addition;
    - The prior 12-month average occupancy rate for the nursing home beds at the facility meets or exceeds 96 percent;
    - The prior 12-month occupancy rate for the nursing home beds in the subdistrict is 94 percent or greater; and
    - Any beds authorized for the facility under this exception in a prior request have been licensed and operational for at least 12 months.[8]
- Replacing a licensed nursing home on the same site, or within 3 miles, if the number of licensed beds does not increase.
- Adding the greater of no more than 10 total beds or 10 percent of the licensed nursing home beds of a nursing home located in a county having up to 50,000 residents, if:[9]
    - The nursing home has not had any class I or class II deficiencies[10] within the 30 months preceding the request for addition;
    - The prior 12-month average occupancy rate for the nursing home beds at the facility meets or exceeds 94 percent and the facility has not had any class I or class II deficiencies since its initial licensure; and
    - The prior 6-month average occupancy rate for the nursing home beds, at a facility that has been licensed for less than 24 months, meets or exceeds 94 percent and the facility has not had any class I or class II deficiencies since its initial licensure.

Determination of Need

A CON is predicated on a determination of need. The future need for community nursing home beds is determined twice a year and published by the agency as a fixed bed need pool for the applicable planning horizon. The planning horizon for CON applications is 3 years. Need determinations are

[6] This exemption is repealed upon the expiration of the moratorium by operation of s. 408.036(3)(f), F.S.
[7] Section 408.036(3)(k), F.S.
[8] The request to add beds under the exception to the moratorium is subject to the procedures related to an exemption to the CON requirements.
[9] Section 408.0435(5), F.S.
[10] Deficiencies in nursing homes are classified according to the nature and scope of the deficiency. A class I deficiency is a deficiency that the Agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility. A class II deficiency is a deficiency that the Agency determines has compromised a resident's ability to maintain or reach his or her highest practicable physical, mental, and psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. *See* s. 400.23(8), F.S.

calculated for subdistricts within AHCA's 11 service districts[11] based on estimates of current and projected population as published by the Executive Office of the Governor.

The need formula[12] links the projected subdistrict need to a projected increase in the district need for nursing home beds. The district increase is based on the expected increase in the district population age 65 to 74 and age 75 and over, with the age group 75 and over given 6 times more weight in projecting the population increase. The projected district bed need total is then allocated to its subdistricts. The result for a given subdistrict is adjusted to reflect the current subdistrict occupancy of beds, and a desired standard of 94 percent occupancy. The subdistrict net need is the excess of the allocated beds over the licensed or approved beds in the subdistrict. If current occupancy of licensed beds is less than 85 percent, the net need in the subdistrict is zero regardless of whether the formula otherwise shows a net need.

AHCA is required to issue a CON to the holder of a provisional certificate of authority to construct nursing home beds for the exclusive use of the prospective residents of the proposed continuing care facility under a different bed-need assessment scheme.[13] AHCA is required to approve at least one sheltered nursing home bed[14] for every four proposed residential units. Additional sheltered nursing home beds must be approved based on actual utilization and demand by current residents. Sheltered nursing home beds are not included in the need formula for community nursing home beds.

Application Process

Nursing home bed projects subject to competitive review are included in the batching cycle for "other beds and programs." The review process takes approximately 120 days.[15] The fixed bed need determination is published in the Florida Administrative Weekly. A letter of intent describing the applicant, the project type including the number of beds, and its location must be submitted to AHCA at least 30 days prior to the applicable batching cycle application due date.[16] A grace period after the initial letter of intent deadline provides an opportunity for other applicants to compete with an initial letter of intent. The grace period extends this initial phase by an additional 16 days for the submission of a competitor's letter of intent.

The CON application must be submitted to AHCA by the date published for that batching cycle. AHCA must perform a completeness review of the application within 15 calendar days of the application submission deadline.[17] The applicant has 21 calendar days after receiving a request from AHCA for additional information, to provide the information, otherwise the application is withdrawn from further consideration. AHCA must determine whether the application is complete or withdrawn within 7 calendar days after receipt of the requested information.

AHCA will conduct public hearings on the applications, if requested, to determine that a proposed project involves issues of great local public interest.[18]

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[11] The nursing home subdistricts are set forth in Rule 59C-2.200, F.A.C.
[12] Rule 59C-1.036, F.A.C.
[13] Section 651.118, F.S.
[14] A sheltered nursing home bed is a nursing home bed located within a continuing care facility for which a CON is issued pursuant to s. 651.118(2), F.S. Generally these beds must be used for residents of the continuing care facility. However, the beds may be used for persons who are not residents of the continuing care facility for a period of up to 5 years after the date of issuance of the initial nursing home license. A continuing care community may request an extension of this timeframe for up to 30 percent of the sheltered nursing home beds based on demonstrated financial need.
[15] Presentation by AHCA on Florida CONs to the House Health Quality Subcommittee on October 4, 2011, (on file with the Health Innovation Subcommittee) .
[16] Rule 59C-1.008, F.A.C.
[17] Rule 59C-1.010, F.A.C.
[18] Section 408.039, F.S.

AHCA reviews CON applications for additional nursing home beds in context with the need for the health care facilities and health services being proposed.[19] An application for nursing facility beds will not be approved in the absence or insufficiency of a numeric need unless the absence or insufficiency of numeric need is outweighed by other information presented in a CON application showing special circumstances consistent with the following additional criteria;[20]

- The availability, quality of care, accessibility, and extent of utilization of existing health care facilities and health services in the service district of the applicant;
- The ability of the applicant to provide quality of care and the applicant's record of providing quality of care;
- The availability of resources, including health personnel, management personnel, and funds for capital and operating expenditures, for project accomplishment and operation;
- The extent to which the proposed services will enhance access to health care for residents of the service district;
- The immediate and long-term financial feasibility of the proposal;
- The extent to which the proposal will foster competition that promotes quality and cost-effectiveness;
- The costs and methods of the proposed construction, including the costs and methods of energy provision and the availability of alternative, less costly, or more effective methods of construction;
- The applicant's past and proposed provision of health care services to Medicaid patients and the medically indigent; and
- The applicant's designation as a Gold Seal Program nursing facility pursuant to s. 400.235, F.S., when the applicant is requesting additional nursing home beds at that facility.

AHCA issues a State Agency Action Report which states the intent to grant or deny a CON for projects in their entirety or for identifiable portions thereof and states the conditions required, if any, of the CON holder. If there is no challenge to all or any part of the decision embodied in the State Agency Action Report within 21 days after publication in the Florida Administrative Weekly, the decision becomes final and the CON is issued.[21]

Applicants in the same batching cycle and exiting health care facilities in the same district that will be substantially affected by the issuance of any CON may challenge the issuance or denial of a CON. The Division of Administrative Hearings conducts the hearing, which must commence within 60 days after the administrative law judge has been assigned except upon unanimous consent of the parties or pursuant to a motion of continuance granted by the administrative law judge.[22] A party to an administrative hearing for an application for a CON may seek judicial review of the final order issued by the administrative law judge to the District Court of Appeal.

Effect of Proposed Changes

The bill amends s. 408.036, F.S., providing an exemption from CON review for the addition of a nursing home with an unknown number of beds in one or more of the state's retirement communities that is deed-restricted for older persons.[23] In addition, the retirement community must have a population of at least 20,000 residents, provide a continuum of health care services for older persons, and have an agreement with a state university to coordinate and assist in providing comprehensive health care services to the retirement community residents.

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[19] Section 408.035, F.S.
[20] Rule 59C-1.036, F.A.C.
[21] *Supra* fn. 12.
[22] *Supra* fn. 13.
[23] Section 760.29(3)(b), F.S., "housing for older persons" means housing: Intended for, and solely occupied by, persons 62 years of age or older; or Intended and operated for occupancy by persons 55 years of age or older where at least 80 percent of the occupied units are occupied by at least one person 55 years of age or older.

It appears that only one retirement community, *The Villages*, meets the qualifying specifications of the bill.

B. SECTION DIRECTORY:

Section 1: Amends s. 408.036, F.S., relating to projects subject to review; exemptions.
Section 2: Provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The fiscal impact to the private sector is "indeterminate" due to the uncertainty of the affect the bill will have on competition within the marketplace.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   A general law operates universally throughout the state, or uniformly upon subjects as they may exist throughout the state, or uniformly within permissible classifications by population of counties or otherwise, or is a law relating to a state function or instrumentality.[24] Conversely, special and local laws operate within a very narrow classification of persons or on a limited geographic region of the state. The Florida Supreme Court defines special and local laws as:

[24] *St. Vincent's Medical Center, Inc. v. Memorial HealthCare Group, Inc., 967 So.2d 794(Fla. 2007).*

> [A] special law is one relating to, or designed to operate upon, particular persons or things, or one that purports to operate upon classified persons or things when classification is not permissible or the classification adopted is illegal; a local law is one relating to, or designed to operate only in, a specifically indicated part of the state, or one that purports to operate within classified territory when classification is not permissible or the classification adopted is illegal.[25]

General laws are enacted through the ordinary legislative process. A "special or local" law however is required to meet additional notification requirements before it can be validly enacted. Specifically, Article III, s. 10 of the Florida Constitution states:

> No special law shall be passed unless notice of intention to seek enactment thereof has been published in the manner provided by general law.[26] Such notice shall not be necessary when the law, except the provision for referendum, is conditioned to become effective only upon approval by vote of the electors of the area affected.

The bill provides that a skilled nursing facility for the addition of skilled nursing homes beds may be constructed if it is located in a retirement community which meets all of the following criteria:

1. Is deed restricted for older persons;
2. Has a population of at least 20,000 residents;
3. Provides within its boundaries a continuum of health care services for older persons; and,
4. Has an agreement with a state university to coordinate and assist in providing comprehensive health care services to its residents.

Given the specific nature of these criteria it is unclear as to how many retirement communities currently qualify, or who may have a reasonable possibility to qualify in the future[27], for the exemption. As such, it is unclear whether the bill creates a general or special law.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[25] Id. Additionally, Article X s. 10 of the Florida Constitution defines "special law" as "a special or local law.

[26] Section 11.02, F.S., establishes the notice requirements for special laws.

[27] *St. Vincent's Medical Center, Inc. v. Memorial HealthCare Group, Inc.*, 967 So.2d 794(Fla. 2007)(any determination of possible future applications of a statute must be done with a realistic and reasonable assessment).

1 A bill to be entitled
2 An act relating to skilled nursing facilities;
3 amending s. 408.036, F.S.; providing an exemption from
4 certificate-of-need requirements for the construction
5 of specified licensed skilled nursing facilities;
6 providing an effective date.
7
8 Be It Enacted by the Legislature of the State of Florida:
9
10 Section 1. Paragraphs (d) through (s) of subsection (3) of
11 section 408.036, Florida Statutes, are redesignated as
12 paragraphs (e) through (t), respectively, and a new paragraph
13 (d) is added to that subsection, to read:
14 408.036 Projects subject to review; exemptions.—
15 (3) EXEMPTIONS.—Upon request, the following projects are
16 subject to exemption from the provisions of subsection (1):
17 (d) For the construction of skilled nursing facilities
18 licensed under chapter 400 for the addition of such skilled
19 nursing home beds located within a retirement community that is
20 deed-restricted for older persons as defined in part II of
21 chapter 760 with a population of at least 20,000 residents,
22 which community provides within its boundaries a continuum of
23 health care services for older persons and which has an
24 agreement with a state university to coordinate and assist in
25 providing comprehensive health care services to the retirement
26 community residents.
27 Section 2. This act shall take effect July 1, 2013.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED __ (Y/N)
ADOPTED AS AMENDED __ (Y/N)
ADOPTED W/O OBJECTION __ (Y/N)
FAILED TO ADOPT __ (Y/N)
WITHDRAWN __ (Y/N)
OTHER ____

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1 Committee/Subcommittee hearing bill: Health Innovation
2 Subcommittee
3 Representative O'Toole offered the following:
4
5 **Amendment (with title amendment)**
6 Remove everything after the enacting clause and insert:
7 Section 1. Section 408.0362, Florida Statutes, is created
8 to read:
9 408.0362 Skilled nursing facility in retirement community;
10 exempt from review.—
11 (1) Upon request by a deed-restricted retirement
12 community, the construction of a skilled nursing facility
13 licensed under part II of chapter 400 for the addition of
14 community skilled nursing home beds located within the
15 retirement community is exempt from s. 408.036 if:
16 (a) The retirement community is located in a county that
17 has 25 percent or more of its population consisting of persons
18 aged 65 and older;
19 (b) The retirement community is located in a county that
20 has a rate of no more than 16.1 beds per thousand persons aged

21 65 years or older. The rate shall be determined by using the
22 current number of licensed and approved community skilled
23 nursing home beds in the agency's most recent published
24 inventory;
25 (c) The retirement community is zoned for a mix of
26 residential and nonresidential uses;
27 (d) The residential use area of the retirement community
28 is deed-restricted as housing for older persons as defined in s.
29 760.29; and
30 (e) The retirement community has a population of at least
31 8,000 residents, based on a population data source accepted by
32 the agency.
33 (2) The number of community skilled nursing home beds
34 allowed in a retirement community under the exemption shall be
35 calculated at a rate of 16.1 beds per thousand persons aged 65
36 years and older in the county in which the retirement community
37 is located. To determine whether or not the county in which the
38 retirement community is located is at or above the rate of 16.1
39 beds per 1,000 elderly, the agency must use a prospective county
40 population estimate three years in the future to demonstrate:
41 (a) That the number of persons aged 65 years and older
42 will comprise at least 25 percent of the county's population at
43 the end of the three years. From this result, the current
44 number of licensed community skilled nursing home beds in the
45 agency's published inventory shall be subtracted to determine
46 the net number of additional community skilled nursing home beds
47 that the agency shall grant for development under the exemption;
48 and

49 (b) That the rate of community skilled nursing home beds
50 in the county will either remain at 16.1 beds per thousand
51 persons aged 65 years or older or will be less after three
52 years, prior to approval of additional community skilled nursing
53 home beds under the exemption.
54 (3) A retirement community that qualifies for the
55 exemption provided in this section shall provide a written
56 request for an exemption in accordance with the applicable
57 rules. In the request, the retirement community shall provide
58 evidence of population, mixed-use status, and the results of the
59 calculation showing the gross and net numbers of community
60 skilled nursing home beds in the county.
61 (4) The number of community skilled nursing home beds that
62 are added pursuant to the exemption shall at no time exceed 240
63 in any qualifying retirement community.
64 (5) Any skilled nursing home facility built pursuant to
65 the exemption shall be certified under both the Medicare and
66 Medicaid programs. All beds in the skilled nursing home
67 facility shall be certified under both the Medicare and Medicaid
68 programs.
69 Section 2. This act shall take effect upon becoming law.
70
71
72
73 ---
74 **T I T L E A M E N D M E N T**
75 Remove everything before the enacting clause and insert:
76 A bill to be entitled

77 An act related to skilled nursing facilities; creating s.
78 408.0362, F.S.; providing an exemption from certificate-of-need
79 requirements for construction of a licensed skilled nursing
80 facility in a retirement community; providing an effective date.
81

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1195 Medicaid Managed Care
SPONSOR(S): Pritchett and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1346

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		McElroy CYL	Shaw JS
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

By October 1, 2014, all Florida Medicaid recipients are required to receive covered services through the Statewide Medicaid Managed Care (SMMC) program. There are two types of exemptions from this requirement. The first is comprised of groups of individuals who are completely exempt from participation in the SMMC program. These groups are delineated in s. 409.965, F.S. The second is comprised of groups of individuals who are exempt but who may voluntarily participate in the in the SMMC program. These groups are delineated in s. 409.972, F.S.

The Agency for Health Care Administration (AHCA) is required to create an integrated managed care program for Medicaid enrollees that incorporates all of the minimum benefits for the delivery of primary and acute care, including behavioral health services. The AHCA began implementing the SMMC in January 2012. Statewide implementation of the SMMC is expected to be completed by October 1, 2014.

On December 28, 2012, the ACHA released an Invitation to Negotiate (ITN) to competitively procure managed care plans on a statewide basis. The ITN lists behavioral health services as one of the core provisions of the scope of services to be offered in the managed care plans.

The bill amends s. 409.972, F.S. to create an exemption for children residing in a Department of Children and Families licensed residential program approved as a Medicaid behavioral health overlay services provider. These children will be exempt from the mandatory enrollment requirement however; they may elect to voluntarily participate in the SMMC.

The bill does not appear to have a fiscal impact on state government.

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Medicaid

Medicaid is a joint federal and state funded program that provides health care for low income Floridians. The program is administered by the AHCA and financed with federal and state funds. The statutory authority for the Medicaid program is contained in ch. 409, F.S.

Federal law establishes the minimum benefit levels to be covered in order to receive federal matching funds. Florida's mandatory and optional benefits are prescribed in state law under ss. 409.905, and 409.906 F.S., respectively. Currently, Florida Medicaid recipients receive their benefits through a number of different delivery systems.

Behavioral Health Services in Child Welfare Settings

Behavioral health overlay services in child welfare settings are mental health, substance abuse, and supportive services designed to meet the behavioral health treatment needs of recipients who are placed in the care of Medicaid enrolled, certified residential group care agencies under contract with the Department of Children and Families (DCF).[1] The purpose of behavioral health overlay services in child welfare settings are to address on-site and on a child specific basis, medically necessary mental health and substance abuse treatment needs of children who are placed in a residential group care setting.[2]

Statewide Medicaid Managed Care (SMMC)

In 2011, the Legislature passed HB 7107 creating the SMMC program as part IV of ch. 409, F.S. All Florida Medicaid recipients are required to receive covered services through the Statewide Medicaid Managed Care (SMMC) program.[3] There are two types of exemptions from this requirement. The first is comprised of groups of individuals who are completely exempt from participation in the SMMC program and consists of the following:

- Women who are eligible only for family planning services;
- Women who are eligible only for breast and cervical cancer services;
- Persons who are eligible for emergency Medicaid for aliens; and,
- Children receiving services in a prescribed pediatric extended care center.[4]

The second is comprised of groups of individuals who are exempt but who may voluntarily participate in the in the SMMC program and consists of the following:

- Medicaid recipients who have other creditable health care coverage, excluding Medicare;
- Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or mental health treatment facilities as defined by s. 394.455(32);
- Persons eligible for refugee assistance;

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[1] ACHA, Florida Medicaid: *Community Behavioral Health Services Coverage and Limitations Handbook.* https://portal.flmmis.com/.../Community_Behavioral_HealthHB.pdf (last visited on March 24, 2013
[2] Id.
[3] Section 409.965, F.S
[4] Id.

- Medicaid recipients who are residents of a developmental disability center, including Sunland Center in Marianna and Tacachale in Gainesville; and,
- Medicaid recipients enrolled in the home and community based services waiver pursuant to chapter 393, and Medicaid recipients waiting for waiver services.[5]

AHCA is required to create an integrated managed care program for Medicaid enrollees that incorporates all of the minimum benefits for the delivery of primary and acute care, including behavioral health services.[6] The AHCA began implementing the SMMC in January 2012. Statewide implementation of SMMC is expected to be completed by October 1, 2014.

On December 28, 2012, the ACHA released an Invitation to Negotiate (ITN) to competitively procure managed care plans on a statewide basis.[7] The deadline for written inquires on the ITN was February 12, 2013, and the deadline for the ACHA's responses is March 29, 2013.[8] The negotiations for the plans will be conducted from July 8, 2013, through September 6, 2013.[9] The ACHA anticipates that the Notice of Intent to Award will be posted by September 16, 2013.[10] The ITN lists behavioral health services as one of the core provisions of the scope of services to be offered in the managed care plans.[11]

The ITN is currently in a statutorily imposed "Blackout Period" until 72 hours after the award and the ACHA cannot provide interpretation or additional information not included in the MMA ITN documents. Specifically, s.287.057(23), F.S., provides as follows:

> Respondents to this solicitation or persons acting on their behalf may not contact, between the release of the solicitation and the end of the 72-hour period following the agency posting the notice of intended award, excluding Saturdays, Sundays, and state holidays, any employee or officer of the executive or legislative branch concerning any aspect of this solicitation, except in writing to the procurement officer or as provided in the solicitation documents. Violation of this provision may be grounds for rejecting a response.

Effects of Proposed Changes

The bill creates an exemption for children residing in a Department of Children and Families licensed residential program approved as a Medicaid behavioral health overlay services provider. Persons eligible for Medicaid but exempt from mandatory participation who do not choose to enroll in managed care shall be served in the Medicaid fee-for-service program.[12] Thus, these children will be exempt from the mandatory enrollment requirement however, they may elect to voluntarily participate in the SMMC.

B. SECTION DIRECTORY:

Section 1. Amends s. 409.972, F.S., relating to mandatory and voluntary enrollment.

Section 2. Provides an effective date of July 1, 2013.

[5] Section 409.972, F.S.
[6] Health and Human Services Committee, Fla. House of Representatives, *PCB HHSC 11-01 Staff Analysis*, p.25, (Mar. 25, 2013).
[7] ACHA Invitation to Negotiate, *Statewide Medicaid Managed Care*, *Addendum 2* Solicitations Number: ACHA ITN 017-12/13; dated February 26, 2013. http://myflorida.com/apps/vbs/vbs_www.ad.view_ad?advertisement_key_num=105774 (last visited March 24, 2013).
[8] ACHA Invitation to Negotiate, *Statewide Medicaid Managed Care*, Solicitations Number: ACHA ITN 017-12/13; dated December 28, 2012. http://myflorida.com/apps/vbs/vbs_www.ad.view_ad?advertisement_key_num=105774 (last visited March 24, 2013).
[9] Id.
[10] Id.
[11] Id..
[12] Section 409.972, F.S.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

With limited exceptions, all Florida Medicaid recipients are required to receive covered services through the SMMC program.[13] Behavioral health services are one of the ITN's core provisions of services to be offered in the managed care plans. Specifically, the ITN requires that the managed Medicaid Assistance (MMA) program include services for behavioral health overlay services in child welfare settings and services for residential care. Although the bill does not eliminate these requirements, it potentially creates a material change to the terms of the ITN. Parties interested in responding to the ITN cannot ask for clarification on this issue as the ITN is currently in a statutorily imposed "Blackout Period". Thus, the potential for an ITN protest exists as the bill potentially creates a material change to the terms and conditions of the ITN. Alternatively, the ACHA could reissue the ITN and address this

[13] Section 409.965, F.S.

issue. This however could potentially delay the expected date for the statewide implementation of the SMMC.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to Medicaid managed care; amending s.
3 409.972, F.S.; providing an exemption from mandatory
4 enrollment in managed care for children residing in
5 certain licensed residential programs approved by the
6 Department of Children and Families; providing an
7 effective date.
8
9 Be It Enacted by the Legislature of the State of Florida:
10
11 Section 1. Paragraph (f) is added to subsection (2) of
12 section 409.972, Florida Statutes, to read:
13 409.972 Mandatory and voluntary enrollment.—
14 (2) The following Medicaid-eligible persons are exempt
15 from mandatory managed care enrollment required by s. 409.965,
16 and may voluntarily choose to participate in the managed medical
17 assistance program:
18 (f) Children residing in a Department of Children and
19 Families licensed residential program approved as a Medicaid
20 behavioral health overlay services provider.
21 Section 2. This act shall take effect July 1, 2013.

HB 1237

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1237 Payment for Services Provided By Licensed Psychologists
SPONSOR(S): Schwartz
TIED BILLS: **IDEN./SIM. BILLS:** SB 144

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Poche	Shaw
2) Insurance & Banking Subcommittee			
3) Appropriations Committee			
4) Health & Human Services Committee			

SUMMARY ANALYSIS

In general, after a payment is made to a health care provider for services rendered to an insured, health insurers and HMOs are time-limited to making a claim for overpayment to the provider within 30 months from the date of that payment. If a claim for overpayment is made, the health care provider has a certain timeframe within which to pay it, or contest the claim for overpayment. Claims of overpayment by health insurers and HMOs for services rendered by allopathic physicians, osteopathic physicians, chiropractic physicians, and dentists, however, must be submitted to the provider within 12 months after the health insurer's payment of the claim.

House Bill 1237 adds psychologists, licensed under chapter 490, F.S., to the list of providers from which claims for overpayment, by insurers or health maintenance organizations, cannot be made more than 12 months after payment for services rendered to an insured or subscriber. The bill also adds psychologists to the list of providers limited to making claims for underpayment up to 12 months after the date of payment for services rendered to an insured or subscriber. Lastly, the bill permits an insured to authorize direct payment to a psychologist for services rendered and requires an insurer to make the payment as directed.

The bill appears to have an insignificant negative fiscal impact on state government.

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Psychologists and Payment for Services

Chapter 490, F.S., the "Psychological Services Act," governs the practice of psychology and school psychology in Florida. A person desiring to practice psychology or school psychology in Florida must be licensed by the Department of Health. "Practice of psychology" means the observations, description, evaluation, interpretation, and modification of human behavior, by the use of scientific and applied psychological principles, methods, and procedures, for the purpose of describing, preventing, alleviating, or eliminating symptomatic, maladaptive, or undesired behavior and of enhancing interpersonal behavioral health and mental or psychological health.[1] "Practice of school psychology" means the rendering or offering to render to an individual, a group, an organization, a government agency, or the public any of the following services- assessment, counseling, consultation, and development of programs.[2]

After payment is made to most preferred providers, including psychologists, for services rendered to an insured, health insurers, and health maintenance organizations (HMOs) are time-limited to making a claim for overpayment within 30 months from the date of that payment.[3] If a claim for overpayment is made, the preferred provider has a certain timeframe within which to pay the overpayment, or deny or contest the claim.[45] In comparison, claims of overpayment by health insurers and HMOs for services rendered by allopathic physicians, osteopathic physicians, chiropractic physicians, and dentists must be submitted to the provider within 12 months after the health insurer's payment of the claim.[6]

Psychologists who contract as preferred providers[7] or network providers with an insurer receive payment directly from the insurer, instead of the insured, for services rendered.[8] In contrast, non-network psychologists are generally paid by the insured. After paying the psychologist, the insured then files a claim for reimbursement with the insurer. In comparison, non-network recognized hospitals, licensed ambulance providers, physicians, dentists, and other persons who provided services to the insured, in accordance with the provisions of the policy between the insured and the insurer, are directly reimbursed by the insurer if the insured specifically authorizes payment of benefits to the provider of services.[9]

Assignment of Benefits to Health Care Providers

Prior to the 2009 Legislative Session, s. 627.638(2), F.S., required direct payment by health insurers to certain health care providers if the patient authorized assignment of benefits, unless otherwise provided in the insurance contract.[10] Statutory amendments by the 2009 Legislature in ch. 2009-124, L.O.F., to

[1] S. 490.003(4), F.S.
[2] S. 490.003(5), F.S.
[3] SS. 627.6131(6)(a)(1), F.S. and 641.3155, F.S.
[4] S. 627.6131(6)(a)(1), F.S.
[5] S. 627.6131(6)(a)(2), F.S.
[6] SS. 627.6131(18), F.S. and 641.3155(14), F.S.
[7] S. 627.6471(1)(b), F.S. defines preferred provider as, "any licensed health care provider with which the insurer has directly or indirectly contracted for an alternative or a reduced rate of payment..."
[8] S. 627.638(3), F.S.
[9] S. 627.638(2), F.S.
[10] An exception existed that the insurance contract could not prohibit the assignment of benefits and direct payment for emergency services and care.

s. 627.638(2), F.S., required health insurers and HMOs to directly pay non-network hospitals, licensed ambulance providers, physicians, dentists, and other persons who provide services to an insured, in accordance with the provisions of the policy between the insured and the insurer, if the insured specifically authorizes payment of benefits to the provider of services.

Due to concerns that this would lead to increased costs to the state's group health plan as a result of providers leaving the network, language was included in ch. 2009-124, L.O.F., providing for the amendments to be automatically repealed on July 1, 2012, and the language in s. 627.638(2), F.S., to revert to the language that existed on June 30, 2009, if the Office of Program Policy Analysis and Government Accountability (OPPAGA) made certain findings in a study to be published on or before March 1, 2012. The amendments would repeal if the OPPAGA found that:

- The amendments have caused the third-party administrator of the state's group health plan to suffer a net loss of physicians from its preferred provider plan network; and
- As a direct result, the state's group health plan incurred an increase in costs.[11]

In January 2012, the OPPAGA issued the requisite report, which found that the statutory changes made in 2009:

- That the statutory changes made in 2009 did not result in a loss of network physicians in the state's group health plan; and
- That no cost increase in the state's group health plan could be directly attributed to the 2009 changes.[12]

Effect of Proposed Changes

The bill adds psychologists, licensed under chapter 490, F.S., to the list of providers to whom claims of overpayment of services rendered made by insurers or HMOs must be sent within 12 months after payment of the claim. The bill also adds psychologists to the list of providers who must file a claim of underpayment with an insurer or HMO within 12 months after payment of the claim.

The bill contains two sections of proposed language for s. 627.638(2), F.S., that are contingent upon the findings of the OPPAGA report, required by the 2009 statutory changes. If the report finds that the changes caused a loss in network physicians and increased costs to the state group health insurance plan, the language for the subsection reverts back to its form prior to the statutory changes. If the report does not find that the changes caused both issues, the language in the subsection remains the same as it existed on July 1, 2009. The two sections each permit an insured to authorize direct payment to a psychologist on any health insurance form and require the insurer to make the payment as directed.

The bill provides an effective date of July 1, 2013.

B. SECTION DIRECTORY:

Section 1: Amends s. 627.6131, F.S., relating to payment of claims.
Section 2: Amends s. 641.3155, F.S., relating to prompt payment of claims.
Section 3: Amends s. 627.638, F.S., relating to direct payment for hospital, medical services, contingent upon the Office of Program Policy Analysis and Government Accountability not presenting the finding specified in section 2 of chapter 2009-124, Laws of Florida.

[11] S. 2, ch. 2009-124, L.O.F.
[12] The Florida Legislature, Office of Program Policy Analysis and Government Accountability, *Negative Effects on the State's Third Party Provider Network from 2009 Law Not Apparent*, Report No. 12-01, January 2012, pages 2 and 4, available at http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1201rpt.pdf (last viewed March 21, 2013) (on file with Health Innovation Subcommittee staff).

Section 4: Amends s. 627.638, F.S., relating to direct payment for hospital, medical services, contingent upon the Office of Program Policy Analysis and Government Accountability presenting the finding specified in section 2 of chapter 2009-124, Laws of Florida.
Section 5: Provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   OIR anticipates an increase in health form review as a result of the additional category of provider eligible for direct payment on any health insurance form, but the increased form review can absorbed within current resources.[13]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Health insurance carriers and HMOs will incur some administrative costs to revise health insurance forms to allow for the selection of a psychologist for direct payment for services rendered for hospital and emergency medical services.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

   None.

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[13] Florida Office of Insurance Regulation, Legislative Affairs, *HB 1237*, March 13, 2013, page 3 (on file with Health Innovation Subcommittee staff).

B. RULE-MAKING AUTHORITY:

OIR has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill includes contingent language that revises s. 627.638(2), F.S., depending upon the findings of the OPPAGA report required by chapter 2009-124, L.O.F. The language appears to assume that the report has not yet been issued. However, the report was issued in January 2012 and found that the 2009 changes to s. 627.6131, F.S., and s. 641.3155, F.S., regarding prompt payments of claims, did not result in a loss of network physicians in the state group health insurance plan. The report also found that no cost increase could be directly attributed to the 2009 statutory changes.

Based on the findings of the report, section 4 of the bill, providing contingent language effective if the OPPAGA report found that the statutory changes referenced above caused a loss in network physicians, and caused increased costs, to the state group health insurance plan, can be deleted. Also, the contingency language contained in the directory of section 3 of the bill can be deleted due to the fact that the contingency has been met.

Section 627.638(1), F.S., permits payment by an insurer for benefits under a health insurance policy to be made directly to any recognized hospital, licensed ambulance provider, doctor, or other person who provided the services, in accordance with the terms of the policy. The term "other person who provided the services" appears to be a catch-all provision that allows for direct payment of benefits to any health care provider who provided covered services under the policy to the insured.

Further, s. 627.638(2), F.S., permits the insured to direct payment to, among others, "...any...other person who provided the services in accordance with the provisions of the policy,..." and requires the insurer to make the payment as directed. These statutory provisions, taken together, do not require specific health care providers to be listed in the statute in order to permit an insured to authorize direct payment, and require an insurer to acknowledge the authorization and make direct payment, to any health care provider, as long as services were provided in a manner consistent with the terms of the policy. Therefore, it appears that the addition of "psychologists" to the statute is not necessary in order to permit an insured to authorize direct payment to a psychologist and require the insurer to make direct payment to a psychologist.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to payment for services provided by licensed psychologists; amending ss. 627.6131 and 641.3155, F.S.; adding licensed psychologists to the list of health care providers who are protected by a limitations period from claims for overpayment being sought by health insurers or health maintenance organizations; adding licensed psychologists to the list of health care providers who are subject to a limitations period for submitting claims to health insurers or health maintenance organizations for underpayment; amending s. 627.638, F.S.; adding licensed psychologists to the list of health care providers who are eligible for direct payment for medical services by a health insurer under certain circumstances; making technical and grammatical changes; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsections (18) and (19) of section 627.6131, Florida Statutes, are amended to read:

627.6131 Payment of claims.—

(18) Notwithstanding the 30-month period provided in subsection (6), all claims for overpayment submitted to a provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, ~~or~~ chapter 466, or chapter 490 must be submitted to the provider within 12 months after the health insurer's payment

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

29 of the claim. A claim for overpayment is ~~may~~ not ~~be~~ permitted
30 ~~beyond~~ 12 months after the health insurer's payment of a claim,
31 except that claims for overpayment may be sought after ~~beyond~~
32 that time from providers convicted of fraud pursuant to s.
33 817.234.
34 (19) Notwithstanding any other provision of this section,
35 all claims for underpayment from a provider licensed under
36 chapter 458, chapter 459, chapter 460, chapter 461, ~~or~~ chapter
37 466, or chapter 490 must be submitted to the insurer within 12
38 months after the health insurer's payment of the claim. A claim
39 for underpayment is ~~may~~ not ~~be~~ permitted ~~beyond~~ 12 months after
40 the health insurer's payment of a claim.
41 Section 2. Subsections (16) and (17) of section 641.3155,
42 Florida Statutes, are amended to read:
43 641.3155 Prompt payment of claims.—
44 (16) Notwithstanding the 30-month period provided in
45 subsection (5), all claims for overpayment submitted to a
46 provider licensed under chapter 458, chapter 459, chapter 460,
47 chapter 461, ~~or~~ chapter 466, or chapter 490 must be submitted to
48 the provider within 12 months after the health maintenance
49 organization's payment of the claim. A claim for overpayment is
50 ~~may~~ not ~~be~~ permitted ~~beyond~~ 12 months after the health
51 maintenance organization's payment of a claim, except that
52 claims for overpayment may be sought after ~~beyond~~ that time from
53 providers convicted of fraud pursuant to s. 817.234.
54 (17) Notwithstanding any other provision of this section,
55 all claims for underpayment from a provider licensed under
56 chapter 458, chapter 459, chapter 460, chapter 461, ~~or~~ chapter

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

57 466, or chapter 490 must be submitted to the health maintenance
58 organization within 12 months after the health maintenance
59 organization's payment of the claim. A claim for underpayment is
60 ~~may~~ not ~~be~~ permitted ~~beyond~~ 12 months after the health
61 maintenance organization's payment of a claim.
62 Section 3. Contingent upon the Office of Program Policy
63 Analysis and Government Accountability not presenting the
64 finding specified in section 2 of chapter 2009-124, Laws of
65 Florida, and the text of subsection (2) of section 627.638,
66 Florida Statutes, not reverting to that in existence on June 30,
67 2009, that subsection is amended to read:
68 627.638 Direct payment for hospital, medical services.—
69 (2) For ~~Whenever, in~~ any health insurance claim form, if
70 an insured specifically authorizes payment of benefits directly
71 to a ~~any~~ recognized hospital, licensed ambulance provider,
72 physician, dentist, psychologist, or other person who provided
73 the services in accordance with ~~the provisions of~~ the policy,
74 the insurer shall make such payment to the designated provider
75 of such services. The insurance contract may not prohibit, and
76 claims forms must provide an option for, the payment of benefits
77 directly to a licensed hospital, licensed ambulance provider,
78 physician, dentist, psychologist, or other person who provided
79 the services in accordance with ~~the provisions of~~ the policy for
80 care provided. The insurer may require written attestation of
81 assignment of benefits. Payment to the provider from the insurer
82 may not be more than the amount that the insurer would otherwise
83 have paid without the assignment.
84 Section 4. Contingent upon the Office of Program Policy

85 Analysis and Government Accountability presenting the finding
86 specified in section 2 of chapter 2009-124, Laws of Florida, and
87 the text of subsection (2) of section 627.638, Florida Statutes,
88 reverting to that in existence on June 30, 2009, that subsection
89 is amended to read:
90 627.638 Direct payment for hospital, medical services.—
91 (2) For ~~Whenever, in~~ any health insurance claim form, if
92 an insured specifically authorizes payment of benefits directly
93 to a ~~any~~ recognized hospital, licensed ambulance provider,
94 physician, ~~or~~ dentist, or psychologist, the insurer shall make
95 such payment to the designated provider of such services, unless
96 otherwise provided in the insurance contract. The insurance
97 contract may not prohibit, and claims forms must provide an
98 option for, the payment of benefits directly to a licensed
99 hospital, licensed ambulance provider, physician, ~~or~~ dentist, or
100 psychologist for care provided pursuant to s. 395.1041 or part
101 III of chapter 401. The insurer may require written attestation
102 of assignment of benefits. Payment to the provider from the
103 insurer may not be more than the amount that the insurer would
104 otherwise have paid without the assignment.
105 Section 5. This act shall take effect July 1, 2013.

HB 4031

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 4031 Home Health Agencies
SPONSOR(S): Diaz
TIED BILLS: **IDEN./SIM. BILLS:** SB 1094

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Poche´ MP	Shaw JS
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

A home health agency is an organization that provides home health services and staffing services. Home health services provided by a home health agency include health and medical services and medical equipment provided to an individual in his or her home, such as nursing care, physical and occupational therapy, and home health aide services. Home health agencies are regulated by the Agency for Health Care Administration (AHCA) pursuant to part III of chapter 400, F.S.

House Bill 4031 deletes the requirement that a home health agency submit a report, on a quarterly basis to the AHCA, which provides the following information:

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

As a result of the elimination of the report, a home health agency will no longer face a fine of $5,000 for failing to submit the report on a quarterly basis.

The bill has an indeterminate fiscal impact on state government.

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Home Health Agencies and Regulation

A home health agency is an organization that provides home health services and staffing services.[1] Home health services provided by a home health agency include health and medical services and medical equipment provided to an individual in his or her home, such as nursing care, physical and occupational therapy, and home health aide services.[2] Home health agencies are regulated by the Agency for Health Care Administration (AHCA) pursuant to part III of chapter 400, F.S.

AHCA is authorized to deny, revoke, or suspend the license of a home health agency.[3] AHCA is required to impose a fine against a home health agency that commits certain acts.[4] One of these acts is the failure of the home health agency to submit a report to AHCA, within 15 days after the end of each calendar quarter, which includes the following information:

- The number of insulin dependent diabetic patients receiving insulin-injection services from the home health agency;
- The number of patients receiving both home health services from the home health agency and hospice services;
- The number of patients receiving home health services from that home health agency; and
- The names and license numbers of nurses whose primary job responsibility is to provide home health services to patients and who received remuneration from the home health agency in excess of $25,000 during the calendar quarter.[5]

These data items help identify possible fraud, such as billing for a high number of injection visits for insulin-dependent patients who could self-inject insulin, fraudulent billing for patients who did not receive the visits, possible duplicate payment for patients receiving both hospice and home health services, and nurses earning well above the average salary that could indicate false billing. The results of each quarter's reporting are shared with the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services" Medicare Program Integrity Miami Satellite Division, the AHCA"s Medicaid Program Integrity Office, and the Medicare Fraud Investigations Manager at SafeGuard Services, LLC.[6] The data is also provided to the public in response to public records requests.[7]

The amount of the fine for failing to submit the report to AHCA is $5,000.[8] From January 1, 2009 to December 31, 2012, 1,407 fines have been imposed.[9] For fiscal year 2011-2012, fines totaling $932,750 were imposed by final order.[10] AHCA has seen a decrease in the number of home health agencies that have failed to submit the report in a timely manner; for the fourth quarter of 2012, 41 of the 2,250 licensed home health agencies, or less than 2 percent, failed to submit the report.[11]

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[1] S. 400.462(12), F.S.
[2] S. 400.462(14)(a)-(c), F.S.
[3] S. 400.474(1), F.S.
[4] S. 400.474(3)-(6), F.S.
[5] S. 400.474(6)(f), F.S.
[6] Agency for Health Care Administration, *2013 Bill Analysis & Economic Impact Statement-HB 4031*, page 1 (on file with Health Innovation Subcommittee staff).
[7] Id.
[8] S. 400.474(6), F.S.
[9] See supra, FN 4.
[10] Id.
[11] Id.

Effect of Proposed Changes

The bill eliminates the requirement that a licensed home health agency submit a report every calendar quarter. As a result of the elimination of the report, a home health agency will no longer face a fine of $5,000 each quarter for failing to submit the report.

B. SECTION DIRECTORY:

Section 1: Amends s. 400.474, F.S., relating to administrative penalties.
Section 2: Provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   AHCA will see the elimination of the collection of fines from home health agencies for failing to submit the required report.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Licensed home health agencies will no longer be subject to a fine of $5,000 for failing to submit the report in a timely fashion at the end of each calendar quarter.

D. FISCAL COMMENTS:

AHCA will see a decrease in staff workload to provide technical assistance to home health agencies in completing the quarterly reports. AHCA will also see a decrease in preparation of fine notices, responding to inquiries from home health agencies that receive fine notices, the number of litigation appeals, and the necessity to testify at administrative hearings when the fine is challenged.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

AHCA has appropriate rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to home health agencies; amending s. 400.474, F.S.; deleting requirements for the quarterly reporting by a home health agency of certain data submitted to the Agency for Health Care Administration; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (6) of section 400.474, Florida Statutes, is amended to read:

400.474 Administrative penalties.—

(6) The agency may deny, revoke, or suspend the license of a home health agency and shall impose a fine of $5,000 against a home health agency that:

(a) Gives remuneration for staffing services to:

1. Another home health agency with which it has formal or informal patient-referral transactions or arrangements; or

2. A health services pool with which it has formal or informal patient-referral transactions or arrangements,

unless the home health agency has activated its comprehensive emergency management plan in accordance with s. 400.492. This paragraph does not apply to a Medicare-certified home health agency that provides fair market value remuneration for staffing services to a non-Medicare-certified home health agency that is part of a continuing care facility licensed under chapter 651 for providing services to its own residents if each resident

29 receiving home health services pursuant to this arrangement
30 attests in writing that he or she made a decision without
31 influence from staff of the facility to select, from a list of
32 Medicare-certified home health agencies provided by the
33 facility, that Medicare-certified home health agency to provide
34 the services.
35 (b) Provides services to residents in an assisted living
36 facility for which the home health agency does not receive fair
37 market value remuneration.
38 (c) Provides staffing to an assisted living facility for
39 which the home health agency does not receive fair market value
40 remuneration.
41 (d) Fails to provide the agency, upon request, with copies
42 of all contracts with assisted living facilities which were
43 executed within 5 years before the request.
44 (e) Gives remuneration to a case manager, discharge
45 planner, facility-based staff member, or third-party vendor who
46 is involved in the discharge planning process of a facility
47 licensed under chapter 395, chapter 429, or this chapter from
48 whom the home health agency receives referrals.
49 ~~(f) Fails to submit to the agency, within 15 days after~~
50 ~~the end of each calendar quarter, a written report that includes~~
51 ~~the following data based on data as it existed on the last day~~
52 ~~of the quarter:~~
53 ~~1. The number of insulin-dependent diabetic patients~~
54 ~~receiving insulin-injection services from the home health~~
55 ~~agency;~~
56 ~~2. The number of patients receiving both home health~~

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

57 ~~services from the home health agency and hospice services;~~
58 ~~3. The number of patients receiving home health services~~
59 ~~from that home health agency; and~~
60 ~~4. The names and license numbers of nurses whose primary~~
61 ~~job responsibility is to provide home health services to~~
62 ~~patients and who received remuneration from the home health~~
63 ~~agency in excess of $25,000 during the calendar quarter.~~
64 (f) ~~(g)~~ Gives cash, or its equivalent, to a Medicare or
65 Medicaid beneficiary.
66 (g) ~~(h)~~ Has more than one medical director contract in
67 effect at one time or more than one medical director contract
68 and one contract with a physician-specialist whose services are
69 mandated for the home health agency in order to qualify to
70 participate in a federal or state health care program at one
71 time.
72 (h) ~~(i)~~ Gives remuneration to a physician without a medical
73 director contract being in effect. The contract must:
74 1. Be in writing and signed by both parties;
75 2. Provide for remuneration that is at fair market value
76 for an hourly rate, which must be supported by invoices
77 submitted by the medical director describing the work performed,
78 the dates on which that work was performed, and the duration of
79 that work; and
80 3. Be for a term of at least 1 year.
81
82 The hourly rate specified in the contract may not be increased
83 during the term of the contract. The home health agency may not
84 execute a subsequent contract with that physician which has an

85 increased hourly rate and covers any portion of the term that
86 was in the original contract.
87 (i) ~~(j)~~ Gives remuneration to:
88 1. A physician, and the home health agency is in violation
89 of paragraph (g) ~~(h)~~ or paragraph (h) ~~(i)~~;
90 2. A member of the physician's office staff; or
91 3. An immediate family member of the physician,
92
93 if the home health agency has received a patient referral in the
94 preceding 12 months from that physician or physician's office
95 staff.
96 (j) ~~(k)~~ Fails to provide to the agency, upon request,
97 copies of all contracts with a medical director which were
98 executed within 5 years before the request.
99 (k) ~~(l)~~ Demonstrates a pattern of billing the Medicaid
100 program for services to Medicaid recipients which are medically
101 unnecessary as determined by a final order. A pattern may be
102 demonstrated by a showing of at least two such medically
103 unnecessary services within one Medicaid program integrity audit
104 period.
105
106 Nothing in paragraph (e) or paragraph (i) ~~(j)~~ shall be
107 interpreted as applying to or precluding any discount,
108 compensation, waiver of payment, or payment practice permitted
109 by 42 U.S.C. s. 1320a-7(b) or regulations adopted thereunder,
110 including 42 C.F.R. s. 1001.952 or s. 1395nn or regulations
111 adopted thereunder.
112 Section 2. This act shall take effect July 1, 2013.

PCS for HB 1071

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 1071 Health Care Accrediting Organizations
SPONSOR(S): Health Innovation Subcommittee; Antone
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Innovation Subcommittee		Guzzo	Shaw

SUMMARY ANALYSIS

The primary purpose of an accrediting organization is to assist providers, through private enterprise, with establishing policies and procedures to meet various local, state and federal regulations and national standards of practice. Accrediting organizations are referred to in current law, which affects a variety of state agencies and departments, including, but not limited to, the Agency for Health Care Administration, the Department of Health, the Department of Children and Families, and the Office of Insurance Regulation.

The proposed committee substitute amends several sections of statute to provide a standard definition of the term "accrediting organization" to consistently be applied among the various statutes in which the term is referenced.

Prior to 2012, s. 395.002, F.S., defined "accrediting organizations" as:

- The Joint Commission on Accreditation of Healthcare Organizations (now known as the Joint Commission);
- The American Osteopathic Association;
- The Commission on Accreditation of Rehabilitation Facilities; and
- The Accreditation Association for Ambulatory Health Care, Inc.

In 2012, the legislature amended s. 395.002, F.S., to change the definition of the term "accrediting organizations" to:

> National accreditation organizations that are approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state.

As a result, the term can now encompass a broad number of accrediting organizations, thus negating the need to refer to accrediting organizations individually in statute, while retaining the same level of regulatory compliance.

Currently, there are still several statutes that have different variations of the term "accrediting organizations".

The bill amends 16 sections of statute to provide a uniform interpretation and application of the term "accrediting organizations".

The bill does not appear to have a significant fiscal impact on state or local government.

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

The primary purpose of an accrediting organization is to assist providers, through private enterprise, with establishing policies and procedures to meet various local, state and federal regulations and national standards of practice. Generally, licensure statutes do not require participation with an accrediting organization, but often allow for the recognition of accreditation organizations as appropriate means of certification. There are several sections of Florida Statute that provide such references to accrediting organizations.

Prior to 2012, s. 395.002, F.S., defined "accrediting organizations" as the Joint Commission on Accreditation of Healthcare Organizations (now known as the Joint Commission), the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities (CARF), and the Accreditation Association for Ambulatory Health Care, Inc.

In 2012, the legislature amended[1] s. 395.002, F.S., to change the definition of the term "accrediting organizations" to national accreditation organizations that are approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state. As a result, the term can now be interpreted to encompass a broad number of accrediting organizations, including, but not limited to, those specifically mentioned in the prior definition of accrediting organizations.

Accrediting organizations are referred to in current law, which affects a variety of state agencies and departments, including, but not limited to, the Agency for Health Care Administration, the Department of Health, the Department of Children and Families, and the Office of Insurance Regulation.

<u>The Joint Commission</u>

The Joint Commission is a non-profit organization that accredits and certifies more than 20,000 health care organizations and programs in the United States.[2] The Joint Commission was established in 1951 as the Joint Commission on Accreditation of Hospitals. In 1987, the organization changed its name to the Joint Commission on Accreditation of Healthcare Organizations in order to reflect an expanded scope of activities. In 2007, the Joint Commission on Accreditation of Healthcare Organizations shorted its name to the Joint Commission in order to refresh its brand identity.[3] Currently, the Florida Statutes refer to the Joint Commission on Accreditation of Healthcare Organizations.

<u>The American Osteopathic Association – Healthcare Facilities Accreditation Program</u>

The Healthcare Facilities Accreditation Program (HFAP) is a program that is authorized by the Centers for Medicare and Medicaid Services (CMS) to survey hospitals for compliance with the Medicare Conditions of Participation. HFAP has maintained its authority to survey hospitals for compliance with the Medicare Conditions of Participation and Coverage since 1965 and meets or exceeds the standards required by CMS/Medicare to provide accreditation to hospitals, ambulatory care/surgical facilities, mental health facilities, physical rehabilitation facilities, clinical laboratories and critical access hospitals. The HFAP also provides certification reviews for Primary Stroke Centers.[4] The HFAP facility

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[1] Chapter 2012-66, L.O.F.
[2] About the Joint Commission, found at: http://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx, last visited on Mar. 27, 2013.
[3] The Joint Commission History, found at: http://www.jointcommission.org/assets/1/6/Joint_Commission_History.pdf, last visited on Mar. 27, 2013
[4] HFAP Overview, found at http://www.hfap.org/about/overview.aspx, last visited on Mar. 27, 2013.

accreditation process consists of five basic steps including application, survey, reporting deficiencies, creating a plan of corrections/correct action response, and accreditation.[5]

CARF International

What is now known as CARF International was founded in 1966 as the Commission on Accreditation of Rehabilitation Facilities when the National Association of Sheltered Workshops and Homebound Programs and the Association of Rehabilitation Centers agreed to pool their interests.[6] The CARF International is a nonprofit accreditor of health and human services providers in multiple areas including aging services, behavioral health, and medical rehabilitation. The CARF family of organizations currently accredits close to 50,000 programs in countries across the globe.[7] Currently, the Florida Statutes still refer to CARF as the Commission on Accreditation of Rehabilitation Facilities or something similar.

Effect of Proposed Changes

The bill amends 16 sections of statute to provide a standard definition of the term "accrediting organization" to consistently be applied among the various statutes in which the term is referenced.

Specifically, the bill inserts language from the current definition of "accrediting organizations", as appropriate, to clarify that the accrediting organization is "an accrediting organization whose standards incorporate comparable licensure regulations required by the state". As a result, the term can now be interpreted to encompass a broad number of accrediting organizations, thus negating the need to refer to accrediting organizations individually in statute, while retaining the same level of regulatory compliance.

B. SECTION DIRECTORY:

Section 1: Amends s. 154.11, F.S., relating to powers of the board of trustees.
Section 2: Amends s. 394.741, F.S., relating to accreditation requirements for providers of behavioral health care services.
Section 3: Amends s. 395.3038, F.S., relating to state-listed primary stroke centers and comprehensive stroke centers; and notification of hospitals.
Section 4: Amends s. 397.403, F.S., relating to license application.
Section 5: Amends s. 400.925, F.S., relating to definitions.
Section 6: Amends s. 400.9935, F.S., relating to clinic responsibilities.
Section 7: Amends s. 402.7306, F.S., relating to administrative monitoring of child welfare providers, and administrative, licensure, and programmatic monitoring of mental health and substance abuse service providers.
Section 8: Amends s. 408.05, F.S., relating to the Florida Center for Health Information and Policy Analysis.
Section 9: Amends s. 430.80, F.S., relating to implementation of a teaching nursing home pilot project.
Section 10: Amends s. 440.13, F.S., relating to medical services and supplies; penalty for violations; and limitations.
Section 11: Amends s. 627.645, F.S., relating to denial of health insurance claims restricted.
Section 12: Amends s. 627.668, F.S., relating to optional coverage for mental and nervous disorders required; and exceptions.
Section 13: Amends s. 627.669, F.S., relating to optional coverage required for substance abuse impaired persons, and exceptions.
Section 14: Amends s. 627.736, F.S., relating to required personal injury protection benefits; exclusions; priority; and claims.

[5] Accreditation by HFAP, found at http://www.hfap.org/WhyHfap/workingwithhfap.aspx, last visited on Mar. 27, 2013.
[6] History of CARF International, found at: http://www.carf.org/About/History/, last visited on Mar. 27, 2013.
[7] CARF International, found at: http://www.carf.org/About/WhoWeAre/, last visited on Mar. 27, 2013.

Section 15: Amends s. 641.495, F.S., relating to requirements for issuance and maintenance of certificate.
Section 16: Amends s. 766.1015, F.S., relating to civil immunity for members of or consultants to certain boards, committees, or other entities.
Section 17: Provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

B. RULE-MAKING AUTHORITY:

No additional rule-making authority is necessary to carry out the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to health care accrediting
3 organizations; amending ss. 154.11, 394.741, 395.3038,
4 397.403, 400.925, 400.9935, 402.7306, 408.05, 430.80,
5 440.13, 627.645, 627.668, 627.669, 627.736, 641.495,
6 and 766.1015, F.S.; conforming provisions to a
7 redefinition of the term "accrediting organizations"
8 in s. 395.002, F.S., relating to hospital licensing
9 and regulation; providing an effective date.
10
11 Be It Enacted by the Legislature of the State of Florida:
12
13 Section 1. Paragraph (n) of subsection (1) of section
14 154.11, Florida Statutes, is amended to read:
15 154.11 Powers of board of trustees.—
16 (1) The board of trustees of each public health trust
17 shall be deemed to exercise a public and essential governmental
18 function of both the state and the county and in furtherance
19 thereof it shall, subject to limitation by the governing body of
20 the county in which such board is located, have all of the
21 powers necessary or convenient to carry out the operation and
22 governance of designated health care facilities, including, but
23 without limiting the generality of, the foregoing:
24 (n) To appoint originally the staff of physicians to
25 practice in a ~~any~~ designated facility owned or operated by the
26 board and to approve the bylaws and rules to be adopted by the
27 medical staff of a ~~any~~ designated facility owned and operated by
28 the board, such governing regulations ~~to be in accordance with~~

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29 ~~the standards of the Joint Commission on the Accreditation of~~
30 ~~Hospitals~~ shall ~~which~~ provide, among other things, for the
31 method of appointing additional staff members and for the
32 removal of staff members.
33 Section 2. Subsection (2) of section 394.741, Florida
34 Statutes, is amended to read:
35 394.741 Accreditation requirements for providers of
36 behavioral health care services.—
37 (2) Notwithstanding any provision of law to the contrary,
38 accreditation shall be accepted by the agency and department in
39 lieu of the agency's and department's facility licensure onsite
40 review requirements and shall be accepted as a substitute for
41 the department's administrative and program monitoring
42 requirements, except as required by subsections (3) and (4),
43 for:
44 (a) An ~~Any~~ organization from which the department
45 purchases behavioral health care services which ~~that~~ is
46 accredited by an accrediting organization whose standards
47 incorporate comparable licensure regulations required by this
48 state ~~the Joint Commission on Accreditation of Healthcare~~
49 ~~Organizations or the Council on Accreditation for Children and~~
50 ~~Family Services, or has those services that are being purchased~~
51 ~~by the department accredited by CARF—the Rehabilitation~~
52 ~~Accreditation Commission~~.
53 (b) A ~~Any~~ mental health facility licensed by the agency or
54 a ~~any~~ substance abuse component licensed by the department which
55 ~~that~~ is accredited by an accrediting organization whose
56 standards incorporate comparable licensure regulations required

57 by this state ~~the Joint Commission on Accreditation of~~
58 ~~Healthcare Organizations, CARF—the Rehabilitation Accreditation~~
59 ~~Commission, or the Council on Accreditation of Children and~~
60 ~~Family Services~~.
61 (c) A ~~Any~~ network of providers from which the department
62 or the agency purchases behavioral health care services
63 accredited by an accrediting organization whose standards
64 incorporate comparable licensure regulations required by this
65 state ~~the Joint Commission on Accreditation of Healthcare~~
66 ~~Organizations, CARF—the Rehabilitation Accreditation Commission,~~
67 ~~the Council on Accreditation of Children and Family Services, or~~
68 ~~the National Committee for Quality Assurance~~. A provider
69 organization that~~, which~~ is part of an accredited network~~,~~ is
70 afforded the same rights under this part.
71 Section 3. Section 395.3038, Florida Statutes, is amended
72 to read:
73 395.3038 State-listed primary stroke centers and
74 comprehensive stroke centers; notification of hospitals.—
75 (1) The agency shall make available on its website and to
76 the department a list of the name and address of each hospital
77 that meets the criteria for a primary stroke center and the name
78 and address of each hospital that meets the criteria for a
79 comprehensive stroke center. The list of primary and
80 comprehensive stroke centers must ~~shall~~ include only those
81 hospitals that attest in an affidavit submitted to the agency
82 that the hospital meets the named criteria, or those hospitals
83 that attest in an affidavit submitted to the agency that the
84 hospital is certified as a primary or a comprehensive stroke

85 center by an accrediting organization ~~the Joint Commission on~~
86 ~~Accreditation of Healthcare Organizations~~.
87 (2)(a) If a hospital no longer chooses to meet the
88 criteria for a primary or comprehensive stroke center, the
89 hospital shall notify the agency and the agency shall
90 immediately remove the hospital from the list.
91 (b)1. This subsection does not apply if the hospital is
92 unable to provide stroke treatment services for a period of time
93 not to exceed 2 months. The hospital shall immediately notify
94 all local emergency medical services providers when the
95 temporary unavailability of stroke treatment services begins and
96 when the services resume.
97 2. If stroke treatment services are unavailable for more
98 than 2 months, the agency shall remove the hospital from the
99 list of primary or comprehensive stroke centers until the
100 hospital notifies the agency that stroke treatment services have
101 been resumed.
102 ~~(3) The agency shall notify all hospitals in this state by~~
103 ~~February 15, 2005, that the agency is compiling a list of~~
104 ~~primary stroke centers and comprehensive stroke centers in this~~
105 ~~state. The notice shall include an explanation of the criteria~~
106 ~~necessary for designation as a primary stroke center and the~~
107 ~~criteria necessary for designation as a comprehensive stroke~~
108 ~~center. The notice shall also advise hospitals of the process by~~
109 ~~which a hospital might be added to the list of primary or~~
110 ~~comprehensive stroke centers.~~
111 (3)~~(4)~~ The agency shall adopt by rule criteria for a
112 primary stroke center which are substantially similar to the

113 certification standards for primary stroke centers of the Joint
114 Commission ~~on Accreditation of Healthcare Organizations~~.
115 (4)~~(5)~~ The agency shall adopt by rule criteria for a
116 comprehensive stroke center. However, if the Joint Commission ~~on~~
117 ~~Accreditation of Healthcare Organizations~~ establishes criteria
118 for a comprehensive stroke center, ~~the~~ agency rules shall be
119 ~~establish criteria for a comprehensive stroke center which are~~
120 substantially similar ~~to those criteria established by the Joint~~
121 ~~Commission on Accreditation of Healthcare Organizations~~.
122 (5)~~(6)~~ This act is not a medical practice guideline and
123 may not be used to restrict the authority of a hospital to
124 provide services for which it is licenses ~~has received a license~~
125 under chapter 395. The Legislature intends that all patients be
126 treated individually based on each patient's needs and
127 circumstances.
128 Section 4. Subsection (3) of section 397.403, Florida
129 Statutes, is amended to read:
130 397.403 License application.—
131 (3) The department shall accept proof of accreditation by
132 an accrediting organization whose standards incorporate
133 comparable licensure regulations required by this state ~~the~~
134 ~~Commission on Accreditation of Rehabilitation Facilities(CARF)~~
135 ~~or the joint commission~~, or through another ~~any other~~ nationally
136 recognized certification process that is acceptable to the
137 department and meets the minimum licensure requirements under
138 this chapter, in lieu of requiring the applicant to submit the
139 information required by paragraphs (1)(a)-(c).
140 Section 5. Subsection (1) of section 400.925, Florida

141 Statutes, is amended to read:
142 400.925 Definitions.—As used in this part, the term:
143 (1) "Accrediting organizations" means an organization ~~the~~
144 ~~Joint Commission on Accreditation of Healthcare Organizations or~~
145 ~~other national accreditation agencies~~ whose standards
146 incorporate licensure regulations ~~for accreditation are~~
147 ~~comparable to those~~ required by this state ~~this part for~~
148 ~~licensure~~.
149 Section 6. Paragraph (g) of subsection (1) and paragraph
150 (a) of subsection (7) of section 400.9935, Florida Statutes, is
151 amended to read:
152 400.9935 Clinic responsibilities.—
153 (1) Each clinic shall appoint a medical director or clinic
154 director who shall agree in writing to accept legal
155 responsibility for the following activities on behalf of the
156 clinic. The medical director or the clinic director shall:
157 (g) Conduct systematic reviews of clinic billings to
158 ensure that the billings are not fraudulent or unlawful. Upon
159 discovery of an unlawful charge, the medical director or clinic
160 director shall take immediate corrective action. If the clinic
161 performs only the technical component of magnetic resonance
162 imaging, static radiographs, computed tomography, or positron
163 emission tomography, and provides the professional
164 interpretation of such services, in a fixed facility that is
165 accredited by a national accrediting organization that is
166 approved by the Centers for Medicare and Medicaid Services for
167 magnetic resonance imaging and advanced diagnostic imaging
168 services ~~the Joint Commission on Accreditation of Healthcare~~

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169 ~~Organizations or the Accreditation Association for Ambulatory~~
170 ~~Health Care, and the American College of Radiology;~~ and if, in
171 the preceding quarter, the percentage of scans performed by that
172 clinic which was billed to all personal injury protection
173 insurance carriers was less than 15 percent, the chief financial
174 officer of the clinic may, in a written acknowledgment provided
175 to the agency, assume the responsibility for the conduct of the
176 systematic reviews of clinic billings to ensure that the
177 billings are not fraudulent or unlawful.
178 (7)(a) Each clinic engaged in magnetic resonance imaging
179 services must be accredited by a national accrediting
180 organization that is approved by the Centers for Medicare and
181 Medicaid Services for magnetic resonance imaging and advanced
182 diagnostic imaging services ~~the Joint Commission on~~
183 ~~Accreditation of Healthcare Organizations, the American College~~
184 ~~of Radiology, or the Accreditation Association for Ambulatory~~
185 ~~Health Care,~~ within 1 year after licensure. A clinic that is
186 accredited ~~by the American College of Radiology~~ or that is
187 within the original 1-year period after licensure and replaces
188 its core magnetic resonance imaging equipment shall be given 1
189 year after the date on which the equipment is replaced to attain
190 accreditation. However, a clinic may request a single, 6-month
191 extension if it provides evidence to the agency establishing
192 that, for good cause shown, such clinic cannot be accredited
193 within 1 year after licensure, and that such accreditation will
194 be completed within the 6-month extension. After obtaining
195 accreditation as required by this subsection, each such clinic
196 must maintain accreditation as a condition of renewal of its

197 license. A clinic that files a change of ownership application
198 must comply with the original accreditation timeframe
199 requirements of the transferor. The agency shall deny a change
200 of ownership application if the clinic is not in compliance with
201 the accreditation requirements. When a clinic adds, replaces, or
202 modifies magnetic resonance imaging equipment and the
203 accrediting ~~accreditation~~ agency requires new accreditation, the
204 clinic must be accredited within 1 year after the date of the
205 addition, replacement, or modification but may request a single,
206 6-month extension if the clinic provides evidence of good cause
207 to the agency.
208 Section 7. Subsections (1) and (2) of section 402.7306,
209 Florida Statutes, are amended to read:
210 402.7306 Administrative monitoring of child welfare
211 providers, and administrative, licensure, and programmatic
212 monitoring of mental health and substance abuse service
213 providers.—The Department of Children and Family Services, the
214 Department of Health, the Agency for Persons with Disabilities,
215 the Agency for Health Care Administration, community-based care
216 lead agencies, managing entities as defined in s. 394.9082, and
217 agencies who have contracted with monitoring agents shall
218 identify and implement changes that improve the efficiency of
219 administrative monitoring of child welfare services, and the
220 administrative, licensure, and programmatic monitoring of mental
221 health and substance abuse service providers. For the purpose of
222 this section, the term "mental health and substance abuse
223 service provider" means a provider who provides services to this
224 state's priority population as defined in s. 394.674. To assist

225 with that goal, each such agency shall adopt the following
226 policies:
227 (1) Limit administrative monitoring to once every 3 years
228 if the child welfare provider is accredited by <u>an accrediting</u>
229 <u>organization whose standards incorporate comparable licensure</u>
230 <u>regulations required by this state</u> ~~the Joint Commission, the~~
231 ~~Commission on Accreditation of Rehabilitation Facilities, or the~~
232 ~~Council on Accreditation~~. If the accrediting body does not
233 require documentation that the state agency requires, that
234 documentation shall be requested by the state agency and may be
235 posted by the service provider on the data warehouse for the
236 agency's review. Notwithstanding the survey or inspection of an
237 accrediting organization specified in this subsection, an agency
238 specified in and subject to this section may continue to monitor
239 the service provider as necessary with respect to:
240 (a) Ensuring that services for which the agency is paying
241 are being provided.
242 (b) Investigating complaints or suspected problems and
243 monitoring the service provider's compliance with ~~any~~ resulting
244 negotiated terms and conditions, including provisions relating
245 to consent decrees that are unique to a specific service and are
246 not statements of general applicability.
247 (c) Ensuring compliance with federal and state laws,
248 federal regulations, or state rules if such monitoring does not
249 duplicate the accrediting organization's review pursuant to
250 accreditation standards.
251
252 Medicaid certification and precertification reviews are exempt

253 from this subsection to ensure Medicaid compliance.
254 (2) Limit administrative, licensure, and programmatic
255 monitoring to once every 3 years if the mental health or
256 substance abuse service provider is accredited by an accrediting
257 organization whose standards incorporate comparable licensure
258 regulations required by this state ~~the Joint Commission, the~~
259 ~~Commission on Accreditation of Rehabilitation Facilities, or the~~
260 ~~Council on Accreditation~~. If the services being monitored are
261 not the services for which the provider is accredited, the
262 limitations of this subsection do not apply. If the accrediting
263 body does not require documentation that the state agency
264 requires, that documentation, except documentation relating to
265 licensure applications and fees, must be requested by the state
266 agency and may be posted by the service provider on the data
267 warehouse for the agency's review. Notwithstanding the survey or
268 inspection of an accrediting organization specified in this
269 subsection, an agency specified in and subject to this section
270 may continue to monitor the service provider as necessary with
271 respect to:
272 (a) Ensuring that services for which the agency is paying
273 are being provided.
274 (b) Investigating complaints, identifying problems that
275 would affect the safety or viability of the service provider,
276 and monitoring the service provider's compliance with ~~any~~
277 resulting negotiated terms and conditions, including provisions
278 relating to consent decrees that are unique to a specific
279 service and are not statements of general applicability.
280 (c) Ensuring compliance with federal and state laws,

281 federal regulations, or state rules if such monitoring does not
282 duplicate the accrediting organization's review pursuant to
283 accreditation standards.
284
285 Federal certification and precertification reviews are exempt
286 from this subsection to ensure Medicaid compliance.
287 Section 8. Paragraph (k) of subsection (3) of section
288 408.05, Florida Statutes, is amended to read:
289 408.05 Florida Center for Health Information and Policy
290 Analysis.—
291 (3) COMPREHENSIVE HEALTH INFORMATION SYSTEM.—In order to
292 produce comparable and uniform health information and statistics
293 for the development of policy recommendations, the agency shall
294 perform the following functions:
295 (k) Develop, in conjunction with the State Consumer Health
296 Information and Policy Advisory Council, and implement a long-
297 range plan for making available health care quality measures and
298 financial data that will allow consumers to compare health care
299 services. The health care quality measures and financial data
300 the agency must make available includes ~~shall include~~, but is
301 not limited to, pharmaceuticals, physicians, health care
302 facilities, and health plans and managed care entities. The
303 agency shall update the plan and report on the status of its
304 implementation annually. The agency shall also make the plan and
305 status report available to the public on its Internet website.
306 As part of the plan, the agency shall identify the process and
307 timeframes for implementation, ~~any~~ barriers to implementation,
308 and recommendations of changes in the law that may be enacted by

309 the Legislature to eliminate the barriers. As preliminary
310 elements of the plan, the agency shall:
311 1. Make available patient-safety indicators, inpatient
312 quality indicators, and performance outcome and patient charge
313 data collected from health care facilities pursuant to s.
314 408.061(1)(a) and (2). The terms "patient-safety indicators" and
315 "inpatient quality indicators" have the same meaning as that
316 ascribed ~~shall be as defined~~ by the Centers for Medicare and
317 Medicaid Services, an accrediting organization whose standards
318 incorporate comparable regulations required by this state, ~~the~~
319 ~~National Quality Forum, the Joint Commission on Accreditation of~~
320 ~~Healthcare Organizations, the Agency for Healthcare Research and~~
321 ~~Quality, the Centers for Disease Control and Prevention,~~ or a
322 ~~similar~~ national entity that establishes standards to measure
323 the performance of health care providers, or by other states.
324 The agency shall determine which conditions, procedures, health
325 care quality measures, and patient charge data to disclose based
326 upon input from the council. When determining which conditions
327 and procedures are to be disclosed, the council and the agency
328 shall consider variation in costs, variation in outcomes, and
329 magnitude of variations and other relevant information. When
330 determining which health care quality measures to disclose, the
331 agency:
332 a. Shall consider such factors as volume of cases; average
333 patient charges; average length of stay; complication rates;
334 mortality rates; and infection rates, among others, which shall
335 be adjusted for case mix and severity, if applicable.
336 b. May consider such additional measures that are adopted

337 by the Centers for Medicare and Medicaid Studies, an accrediting
338 organization whose standards incorporate comparable regulations
339 required by this state, National Quality Forum, the Joint
340 Commission on Accreditation of Healthcare Organizations, the
341 Agency for Healthcare Research and Quality, Centers for Disease
342 Control and Prevention, or a similar national entity that
343 establishes standards to measure the performance of health care
344 providers, or by other states.
345
346 When determining which patient charge data to disclose, the
347 agency shall include such measures as the average of
348 undiscounted charges on frequently performed procedures and
349 preventive diagnostic procedures, the range of procedure charges
350 from highest to lowest, average net revenue per adjusted patient
351 day, average cost per adjusted patient day, and average cost per
352 admission, among others.
353 2. Make available performance measures, benefit design,
354 and premium cost data from health plans licensed pursuant to
355 chapter 627 or chapter 641. The agency shall determine which
356 health care quality measures and member and subscriber cost data
357 to disclose, based upon input from the council. When determining
358 which data to disclose, the agency shall consider information
359 that may be required by either individual or group purchasers to
360 assess the value of the product, which may include membership
361 satisfaction, quality of care, current enrollment or membership,
362 coverage areas, accreditation status, premium costs, plan costs,
363 premium increases, range of benefits, copayments and
364 deductibles, accuracy and speed of claims payment, credentials

365 of physicians, number of providers, names of network providers,
366 and hospitals in the network. Health plans shall make available
367 to the agency ~~any~~ such data or information that is not currently
368 reported to the agency or the office.
369 3. Determine the method and format for public disclosure
370 of data reported pursuant to this paragraph. The agency shall
371 make its determination based upon input from the State Consumer
372 Health Information and Policy Advisory Council. At a minimum,
373 the data shall be made available on the agency's Internet
374 website in a manner that allows consumers to conduct an
375 interactive search that allows them to view and compare the
376 information for specific providers. The website must include
377 such additional information as is determined necessary to ensure
378 that the website enhances informed decisionmaking among
379 consumers and health care purchasers, which shall include, at a
380 minimum, appropriate guidance on how to use the data and an
381 explanation of why the data may vary from provider to provider.
382 4. Publish on its website undiscounted charges for no
383 fewer than 150 of the most commonly performed adult and
384 pediatric procedures, including outpatient, inpatient,
385 diagnostic, and preventative procedures.
386 Section 9. Paragraph (b) of subsection (3) of section
387 430.80, Florida Statutes, is amended to read:
388 430.80 Implementation of a teaching nursing home pilot
389 project.—
390 (3) To be designated as a teaching nursing home, a nursing
391 home licensee must, at a minimum:
392 (b) Participate in a nationally recognized <u>accrediting</u>

393 ~~accreditation~~ program and hold a valid accreditation, such as
394 the accreditation awarded by the Joint Commission ~~on~~
395 ~~Accreditation of Healthcare Organizations~~, or, at the time of
396 initial designation, possess a Gold Seal Award as conferred by
397 the state on its licensed nursing home;
398 Section 10. Paragraph (a) of subsection (2) of section
399 440.13, Florida Statutes, is amended to read:
400 440.13 Medical services and supplies; penalty for
401 violations; limitations.—
402 (2) MEDICAL TREATMENT; DUTY OF EMPLOYER TO FURNISH.—
403 (a) Subject to the limitations specified elsewhere in this
404 chapter, the employer shall furnish to the employee such
405 medically necessary remedial treatment, care, and attendance for
406 such period as the nature of the injury or the process of
407 recovery may require, which is in accordance with established
408 practice parameters and protocols of treatment as provided for
409 in this chapter, including medicines, medical supplies, durable
410 medical equipment, orthoses, prostheses, and other medically
411 necessary apparatus. Remedial treatment, care, and attendance,
412 including work-hardening programs or pain-management programs
413 accredited by <u>an accrediting organization whose standards</u>
414 <u>incorporate comparable regulations required by this state</u> ~~the~~
415 ~~Commission on Accreditation of Rehabilitation Facilities or~~
416 ~~Joint Commission on the Accreditation of Health Organizations~~ or
417 pain-management programs affiliated with medical schools, shall
418 be considered ~~as~~ covered treatment only when such care is given
419 based on a referral by a physician as defined in this chapter.
420 Medically necessary treatment, care, and attendance does not

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421 include chiropractic services in excess of 24 treatments or
422 rendered 12 weeks beyond the date of the initial chiropractic
423 treatment, whichever comes first, unless the carrier authorizes
424 additional treatment or the employee is catastrophically
425 injured.
426
427 Failure of the carrier to timely comply with this subsection
428 shall be a violation of this chapter and the carrier shall be
429 subject to penalties as provided for in s. 440.525.
430 Section 11. Subsection (1) of section 627.645, Florida
431 Statutes, is amended to read:
432 627.645 Denial of health insurance claims restricted.—
433 (1) A ~~No~~ claim for payment under a health insurance policy
434 or self-insured program of health benefits for treatment, care,
435 or services in a licensed hospital that ~~which~~ is accredited by
436 an accrediting organization whose standards incorporate
437 comparable regulations required by this state may not ~~the Joint~~
438 ~~Commission on the Accreditation of Hospitals, the American~~
439 ~~Osteopathic Association, or the Commission on the Accreditation~~
440 ~~of Rehabilitative Facilities shall~~ be denied because such
441 hospital lacks major surgical facilities and is primarily of a
442 rehabilitative nature, if such rehabilitation is specifically
443 for treatment of physical disability.
444 Section 12. Paragraph (c) of subsection (2) of section
445 627.668, Florida Statutes, is amended to read:
446 627.668 Optional coverage for mental and nervous disorders
447 required; exception.—
448 (2) Under group policies or contracts, inpatient hospital

449 benefits, partial hospitalization benefits, and outpatient
450 benefits consisting of durational limits, dollar amounts,
451 deductibles, and coinsurance factors shall not be less favorable
452 than for physical illness generally, except that:
453 (c) Partial hospitalization benefits shall be provided
454 under the direction of a licensed physician. For purposes of
455 this part, the term "partial hospitalization services" is
456 defined as those services offered by a program that is
457 accredited by an accrediting organization whose standards
458 incorporate comparable regulations required by this state ~~the~~
459 ~~Joint Commission on Accreditation of Hospitals (JCAH) or in~~
460 ~~compliance with equivalent standards~~. Alcohol rehabilitation
461 programs accredited by an accrediting organization whose
462 standards incorporate comparable regulations required by this
463 state ~~the Joint Commission on Accreditation of Hospitals~~ or
464 approved by the state and licensed drug abuse rehabilitation
465 programs shall also be qualified providers under this section.
466 In a given ~~any~~ benefit year, if partial hospitalization services
467 or a combination of inpatient and partial hospitalization are
468 used ~~utilized~~, the total benefits paid for all such services may
469 ~~shall~~ not exceed the cost of 30 days after ~~of~~ inpatient
470 hospitalization for psychiatric services, including physician
471 fees, which prevail in the community in which the partial
472 hospitalization services are rendered. If partial
473 hospitalization services benefits are provided beyond the limits
474 set forth in this paragraph, the durational limits, dollar
475 amounts, and coinsurance factors thereof need not be the same as
476 those applicable to physical illness generally.

477 Section 13. Subsection (3) of section 627.669, Florida
478 Statutes, is amended to read:
479 627.669 Optional coverage required for substance abuse
480 impaired persons; exception.—
481 (3) The benefits provided under this section are ~~shall be~~
482 applicable only if treatment is provided by, or under the
483 supervision of, or is prescribed by, a licensed physician or
484 licensed psychologist and if services are provided in a program
485 that is accredited by an accrediting organization whose
486 standards incorporate comparable regulations required by this
487 state ~~the Joint Commission on Accreditation of Hospitals~~ or that
488 is approved by this ~~the~~ state.
489 Section 14. Paragraph (a) of subsection (1) of section
490 627.736, Florida Statutes, is amended to read:
491 627.736 Required personal injury protection benefits;
492 exclusions; priority; claims.—
493 (1) REQUIRED BENEFITS.—An insurance policy complying with
494 the security requirements of s. 627.733 must provide personal
495 injury protection to the named insured, relatives residing in
496 the same household, persons operating the insured motor vehicle,
497 passengers in the motor vehicle, and other persons struck by the
498 motor vehicle and suffering bodily injury while not an occupant
499 of a self-propelled vehicle, subject to subsection (2) and
500 paragraph (4)(e), to a limit of $10,000 in medical and
501 disability benefits and $5,000 in death benefits resulting from
502 bodily injury, sickness, disease, or death arising out of the
503 ownership, maintenance, or use of a motor vehicle as follows:
504 (a) Medical benefits.—Eighty percent of all reasonable

505 expenses for medically necessary medical, surgical, X-ray,
506 dental, and rehabilitative services, including prosthetic
507 devices and medically necessary ambulance, hospital, and nursing
508 services if the individual receives initial services and care
509 pursuant to subparagraph 1. within 14 days after the motor
510 vehicle accident. The medical benefits provide reimbursement
511 only for:
512 1. Initial services and care that are lawfully provided,
513 supervised, ordered, or prescribed by a physician licensed under
514 chapter 458 or chapter 459, a dentist licensed under chapter
515 466, or a chiropractic physician licensed under chapter 460 or
516 that are provided in a hospital or in a facility that owns, or
517 is wholly owned by, a hospital. Initial services and care may
518 also be provided by a person or entity licensed under part III
519 of chapter 401 which provides emergency transportation and
520 treatment.
521 2. Upon referral by a provider described in subparagraph
522 1., followup services and care consistent with the underlying
523 medical diagnosis rendered pursuant to subparagraph 1. which may
524 be provided, supervised, ordered, or prescribed only by a
525 physician licensed under chapter 458 or chapter 459, a
526 chiropractic physician licensed under chapter 460, a dentist
527 licensed under chapter 466, or, to the extent permitted by
528 applicable law and under the supervision of such physician,
529 osteopathic physician, chiropractic physician, or dentist, by a
530 physician assistant licensed under chapter 458 or chapter 459 or
531 an advanced registered nurse practitioner licensed under chapter
532 464. Followup services and care may also be provided by ~~any of~~

533 the following persons or entities:
534 a. A hospital or ambulatory surgical center licensed under
535 chapter 395.
536 b. An entity wholly owned by one or more physicians
537 licensed under chapter 458 or chapter 459, chiropractic
538 physicians licensed under chapter 460, or dentists licensed
539 under chapter 466 or by such practitioners and the spouse,
540 parent, child, or sibling of such practitioners.
541 c. An entity that owns or is wholly owned, directly or
542 indirectly, by a hospital or hospitals.
543 d. A physical therapist licensed under chapter 486, based
544 upon a referral by a provider described in this subparagraph.
545 e. A health care clinic licensed under part X of chapter
546 400 which is accredited by an accrediting organization whose
547 standards incorporate comparable regulations required by this
548 state ~~the Joint Commission on Accreditation of Healthcare~~
549 ~~Organizations, the American Osteopathic Association, the~~
550 ~~Commission on Accreditation of Rehabilitation Facilities, or the~~
551 ~~Accreditation Association for Ambulatory Health Care, Inc.~~, or
552 (I) Has a medical director licensed under chapter 458,
553 chapter 459, or chapter 460;
554 (II) Has been continuously licensed for more than 3 years
555 or is a publicly traded corporation that issues securities
556 traded on an exchange registered with the United States
557 Securities and Exchange Commission as a national securities
558 exchange; and
559 (III) Provides at least four of the following medical
560 specialties:

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

V

561 (A) General medicine.
562 (B) Radiography.
563 (C) Orthopedic medicine.
564 (D) Physical medicine.
565 (E) Physical therapy.
566 (F) Physical rehabilitation.
567 (G) Prescribing or dispensing outpatient prescription
568 medication.
569 (H) Laboratory services.
570 3. Reimbursement for services and care provided in
571 subparagraph 1. or subparagraph 2. up to $10,000 if a physician
572 licensed under chapter 458 or chapter 459, a dentist licensed
573 under chapter 466, a physician assistant licensed under chapter
574 458 or chapter 459, or an advanced registered nurse practitioner
575 licensed under chapter 464 has determined that the injured
576 person had an emergency medical condition.
577 4. Reimbursement for services and care provided in
578 subparagraph 1. or subparagraph 2. is limited to $2,500 if a ~~any~~
579 provider listed in subparagraph 1. or subparagraph 2. determines
580 that the injured person did not have an emergency medical
581 condition.
582 5. Medical benefits do not include massage as defined in
583 s. 480.033 or acupuncture as defined in s. 457.102, regardless
584 of the person, entity, or licensee providing massage or
585 acupuncture, and a licensed massage therapist or licensed
586 acupuncturist may not be reimbursed for medical benefits under
587 this section.
588 6. The Financial Services Commission shall adopt by rule

589 the form that must be used by an insurer and a health care
590 provider specified in sub-subparagraph 2.b., sub-subparagraph
591 2.c., or sub-subparagraph 2.e. to document that the health care
592 provider meets the criteria of this paragraph. Such~~, which~~ rule
593 must include a requirement for a sworn statement or affidavit.
594
595 Only insurers writing motor vehicle liability insurance in this
596 state may provide the required benefits of this section, and
597 such insurer may not require the purchase of any other motor
598 vehicle coverage other than the purchase of property damage
599 liability coverage as required by s. 627.7275 as a condition for
600 providing such benefits. Insurers may not require that property
601 damage liability insurance in an amount greater than $10,000 be
602 purchased in conjunction with personal injury protection. Such
603 insurers shall make benefits and required property damage
604 liability insurance coverage available through normal marketing
605 channels. An insurer writing motor vehicle liability insurance
606 in this state who fails to comply with such availability
607 requirement as a general business practice violates part IX of
608 chapter 626, and such violation constitutes an unfair method of
609 competition or an unfair or deceptive act or practice involving
610 the business of insurance. An insurer committing such violation
611 is subject to the penalties provided under that part, as well as
612 those provided elsewhere in the insurance code.
613 Section 15. Subsection (12) of section 641.495, Florida
614 Statutes, is amended to read:
615 641.495 Requirements for issuance and maintenance of
616 certificate.—

617 (12) The provisions of part I of chapter 395 do not apply
618 to a health maintenance organization that, on or before January
619 1, 1991, provides not more than 10 outpatient holding beds for
620 short-term and hospice-type patients in an ambulatory care
621 facility for its members, provided that such health maintenance
622 organization maintains current accreditation by an accrediting
623 organization whose standards incorporate comparable regulations
624 required by this state ~~the Joint Commission on Accreditation of~~
625 ~~Health Care Organizations, the Accreditation Association for~~
626 ~~Ambulatory Health Care, or the National Committee for Quality~~
627 ~~Assurance~~.
628 Section 16. Subsection (2) of section 766.1015, Florida
629 Statutes, is amended to read:
630 766.1015 Civil immunity for members of or consultants to
631 certain boards, committees, or other entities.—
632 (2) Such committee, board, group, commission, or other
633 entity must be established in accordance with state law, or in
634 accordance with requirements of an applicable accrediting
635 organization whose standards incorporate comparable regulations
636 required by this state, ~~the Joint Commission on Accreditation of~~
637 ~~Healthcare Organizations,~~ established and duly constituted by
638 one or more public or licensed private hospitals or behavioral
639 health agencies, or established by a governmental agency. To be
640 protected by this section, the act, decision, omission, or
641 utterance may not be made or done in bad faith or with malicious
642 intent.
643 Section 17. This act shall take effect July 1, 2013.

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