
# Select Committee on Health Innovation

**Friday, February 2, 2024**
**9:00 AM – 11:00 AM**
**Morris Hall (17 HOB)**

**Meeting Packet**

**Paul Renner**
**Speaker**

**Kaylee Tuck**
**Chair**

# Committee Meeting Notice

## HOUSE OF REPRESENTATIVES

### Select Committee on Health Innovation

**Start Date and Time:** Friday, February 02, 2024 09:00 am

**End Date and Time:** Friday, February 02, 2024 11:00 am

**Location:** Morris Hall (17 HOB)

**Duration:** 2.00 hrs

**Consideration of the following bill(s):**

HB 309 Rural Emergency Hospitals by Shoaf
HB 639 Coverage For Out-of-network Ground Ambulance Emergency Services by Yeager
CS/HB 739 North Brevard County Hospital District, Brevard County by Local Administration, Federal Affairs & Special Districts Subcommittee, Fine
HB 783 Medicaid Managed Care Plan Performance Metrics by Berfield
HB 935 Home Health Care Services by Franklin
HB 1259 Provider of Cardiovascular Services by Andrade
HB 1387 Adult Day Care Centers by Silvers, Rizo
HB 1591 Medicaid Billing for Behavioral Health Services by Gonzalez Pittman

**Consideration of the following proposed committee substitute(s):**

PCS for HB 773 -- Coverage for Diagnostic and Supplemental Breast Examinations
PCS for HB 891 -- Health Care Provider Accountability
PCS for HB 1343 -- Patient Protection

Pursuant to rule 7.11, the deadline for amendments to bills on the agenda by non-appointed members shall be 6:00 p.m. Thursday, February 1, 2024.

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. Thursday, February 1, 2024

To submit an electronic appearance form, and for information about attending or testifying at a committee meeting, please see the “Visiting the House” tab at www.myfloridahouse.gov.

**NOTICE FINALIZED on 01/31/2024 4:19PM by Killings.Anola**

**HB 309**

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 309 Rural Emergency Hospitals
**SPONSOR(S):** Shoaf
**TIED BILLS:** **IDEN./SIM. BILLS:**

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Select Committee on Health Innovation | | Lloyd | Calamas |
| 2) Health Care Appropriations Subcommittee | | | |
| 3) Health & Human Services Committee | | | |

## SUMMARY ANALYSIS

Rural hospital closures result in patients having to travel farther for medical care, which delays or reduces their health care access. Since 2020, five rural hospitals in Florida have closed. In response to rural hospital closures, in 2020, Congress created a special Rural Emergency Hospital (REH) licensure provision in Medicare. Once designated as an REH, the facility qualifies for a supplemental monthly payment which is re-calibrated every year based on hospital market basket pricing, as well as a five percent increase over Medicaid rates compared to rates for a general, acute care hospital.

Hospitals, including rural hospitals, are licensed by the Agency for Health Care Administration under Ch. 395, F.S. Current law does not recognize rural emergency hospitals as a licensure category. In addition, under Ch. 395, licensed hospitals must provide inpatient and other non-emergency services; not just emergency services.

HB 309 changes Florida licensure requirements to allow rural hospitals complying with federal REH requirements to be licensed as a hospital by AHCA. The bill updates statutory definitions to conform to the federal law and authorizes AHCA to seek federal approval for reimbursement under Medicaid for services received by Medicaid recipients at an REH.

The bill also mandates insurance coverage of REH services. It requires all policies issued on or after July 1, 2024, by group insurers; blanket, franchise, accident or health; or health maintenance organizations to require reimbursement for services at the REHs.

The bill has indeterminate, insignificant negative impact on the state Medicaid program and no fiscal impact on local government.

The bill provides an effective date of July 1, 2024.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Background**

**Rural Hospitals**

More than 60 million Americans live in what is defined as "rural America".[1] As a population, rural residents tend to be sicker and older, therefore needing more health care services. However, access to these services in a rural area can be difficult and often require travel of greater than 20 miles. Since 2020, at least 120 rural hospitals have closed, with the worst year occurring in 2019, when there were 19 rural hospital closures nationwide.[2] Many other hospitals nationally, and some in Florida, are considered "vulnerable" to closure. In Florida, one report identified 10 vulnerable hospitals and of those, 5 were considered the "most vulnerable"[3] and the other 5 were designated as "at risk". [4]

Hospital Licensure

Chapter 395, F.S. and Part II of Chapter 408, F.S., govern licensure of hospitals in Florida, including tasking the Agency for Health Care Administration (AHCA) to provide administrative oversight. Under s. 395.002, F.S., a "hospital" is any establishment that:

> (a) Offers services more intensive than those required for room, board, personal services, and general nursing care, and offers facilities and beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care for illness, injury, deformity, infirmity, abnormality, disease, or pregnancy; and
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> (b) Regularly makes available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment of similar extent, except that a critical access hospital, as defined in s. 408.07, shall not be required to make available treatment facilities for surgery, obstetrical care, or similar services as long as it maintains its critical access hospital designation and shall be required to make such facilities available only if it ceases to be designated as a critical access hospital.[5]

An applicant for a hospital license may apply online or through a hardcopy application, whether seeking initial licensure or renewal or re-activation of a license. However, before AHCA will accept an

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[1] United States Government Accountability Office, *Why Health Care is Harder to Access in Rural America,* available at: Why Health Care Is Harder to Access in Rural America | U.S. GAO (May 16, 2023 Blog) (last visited January 30, 2024). The definition of "rural" varies based on its purpose and which federal or state agency is using the word as a measurement. For hospitals, rural is defined by the Health Resources and Services Administration and means a non-metropolitan county; or a census tract that is a Rural Urban Community Code (RUCA) of 4 or greater; or a census tract in a metropolitan county that is (a) at least 400 square miles, (b) has a population density of 35 or fewer persons per square mile, and (c) has a RUCA code of 2 or 3; or an outlying county in a metropolitan area that does not have an urbanized area. This last criterion was added in 2022, causing several dozen hospitals to be reclassified as rural instead of urban.

[2] The Chartis Center for Rural Health, *The Rural Health Safety Net Under Pressure,* available at https://www.chartis.com/insights/rural-health-safety-net-under-pressure-rural-hospital-vulnerability last visited January 30, 2024).

[3] Id. The report defined the "most vulnerable" group as those hospitals whose median percentage change in total revenue was -1.4 percent, the median occupancy rate was 20,7, the median capital efficiency was -6.3, the percentage of outpatient revenue was 75.9 percent, and the median operating margin was -8.6 percent.

[4] Id. The report defined the "at risk" group as those hospitals have a lower likelihood of closure compared to the most vulnerable group. This group had a median change in total revenue of 1.7 percent, median occupancy 26.9 percent, the median capital efficiency was -1.1 percent, the median percentage of outpatient revenue is 77.6, and the median operating margin was -2.6 percent.

[5] Exceptions include any institution conducted by or for the adherents of any well-recognized church or religious denomination that depends exclusively upon prayer or spiritual means to heal, care for, or treat any person. Additionally, for purposes of local zoning matters, the term "hospital" includes a medical office building located on the same premises as a hospital facility, provided the land on which the medical office building is constructed is zoned for use as a hospital; provided the premises were zoned for hospital purposes on January 1, 1992.

application for initial licensure, an applicant must either have a current project order under review by AHCA's Office of Plans and Construction (OPC) for a new facility.[6]

The OPC reviews the plans to ensure compliance with ch. 395, F.S., including standards for the delivery of the minimum-level of required services and a physical review for the capacity, security and sufficiency of the building itself.[7] In addition to providing this evidence, the applicant organization must also submit financial information. The financial component includes detailed information about management of cash flow, staffing levels and salary costs, anticipated billing hours and billing charges for professional health care services, and expected budgets by department.[8]

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An applicant must identify the hospital's classification from one of four categories:

- Class I is a general hospital category which includes general acute care, long term care, rural hospitals, and a subcategory of rural hospitals, critical access hospitals.
- Class II Hospitals are the Specialty Hospitals for Children and the Specialty Hospitals for Women.
- Class III Specialty Hospitals include the specialty medical, rehabilitation, psychiatric, and substance abuse hospitals.
- Class IV Specialty Hospitals are intensive residential treatment facilities for children and adolescents.[9]

All Class I hospitals are considered general acute care hospitals, and as licensed hospital facilities, are required to have at least:

- Inpatient beds.
- A governing authority legally responsible for the conduct of the hospital.
- A chief executive officer or other similarly titled official to whom the governing authority delegates full-time authority for the operation of the hospital in accordance with the policy of the governing authority.
- An organized medical staff which maintains proper standards of care.
- Maintenance of a complete and accurate medical record for each admitted patient.
- A policy requirement that patients be admitted under the authority and care of a member of the organized medical staff;
- Facilities and staff with ability to provide patients with food that meets patients' nutritional needs.
- Procedures for provisions of emergency care.
- Methods for infection control.
- An ongoing organized program to enhance quality of patient care.[10]

Class I hospitals are also required to have certain professional staff and services either in the facility or by contract to meet patient needs, including access to clinical laboratory, diagnostic, operating room, anesthesia, and pharmaceutical services.[11] Hospitals can also seek exemptions from providing designated services or requirements if they meet certain conditions, such as when a required medical professional is not available in a region and cannot be contracted for coverage in the emergency room or hospital staff, or if a hospital seeks an exemption from the requirement for an emergency department.[12]

*Rural Hospital Licensure*

One type of Class I is a rural hospital. A rural hospital is an acute care hospital that has 100 or fewer beds and an emergency room, and also meets at least one of the following criteria:

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[6] 59A-3.066, F.A.C., Licensure Procedures.
[7] Agency for Health Care Administration, *Hospital and Outpatient Care Unit, available at Hospitals (myflorida.com) (last visited January 29, 2024).*
[8] Agency for Health Care Administration, *Health Care Policy and Oversight – Licensure and Forms,* Health Care Policy and Oversight Application for Licensure Forms (myflorida.com) (last visited January 29, 2024).)
[9] 59A-3.252, F.A.C., Classification of Hospitals.
[10] Id.
[11] Id.
[12] S. 395.1041, F.S.

- Is the sole provider within a county with a population density of up to 100 persons per square mile;
- Is an acute care hospital, in a county with a population density of up to 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county;
- Is a hospital supported by a tax district or sub-district whose boundaries encompass a population of up to 100 persons per square mile;
- Is a hospital classified as a sole community hospital under 42 C.F.R. s. 412.92, regardless of the number of licensed beds;
- Is a hospital with a service area[13] that has a population of up to 100 persons per square mile or
- Is a hospital designated as a critical access hospital, as defined in s. 408.07, F.S.[14]

However, the current definitions and provisions do not allow a rural hospital to seek an exclusion from any of the mandatory elements of being a hospital, such as providing inpatient services.[15]

According to AHCA, there are currently 22 licensed rural hospitals in Florida accounting for 948 licensed beds.[16] Of these,10 are critical access hospitals, and an additional 7 have 50 beds or fewer.[17]

*Closure of Rural Hospitals*

Rural hospitals face operational challenges due to low patient volumes, which can make it harder to meet fixed operating costs and performance standards, and because many of the patients treated in rural hospitals are older, sicker, and poorer when compared with the national average.[18]

Between 2017 and 2021, nationally, the total number of rural hospitals declined by 75.[19] In 2020 alone, a record number of 19 U.S. rural hospitals shuttered.[20] More than 100 rural hospitals have closed in the past 10 years, and another 400-600 rural hospitals are deemed "at risk" or vulnerable to closure by different health care analysts.[21]

The chart below shows closures of rural hospitals in Florida since 2000.

[13] The term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital discharge database in the Florida Center for Health Information and Transparency at the agency.
[14] A "critical access hospital" means a hospital that meets the definition of "critical access hospital" in s. 1861(mm)(1) of the Social Security Act and that is certified by the Secretary of Health and Human Services as a critical access hospital.
[15] Agency for Health Care Administration, *2024 Legislative Bill Analysis – HB 309* (November 7, 2023)(on file with Select Committee on Health Innovation).
[16] Id.
[17] Id.
[18] Rural Hospital Closures Threaten Access – Solutions to Preserve Care in Local Communities, The American hospital, September 2022, available at https://www.aha.org/system/files/media/file/2022/09/rural-hospital-closures-threaten-accessreport.pdf (last visited January 30, 2024).
[19] American Hospital Association, *Fast Facts: U.S. Rural Hospitals Infographic, available at* *Fast Facts: U.S. Rural Hospitals Infographic | AHA* (last visited January 30, 2024).
[20] Id.
[21] Center for Healthcare Quality and Reform, *Saving Rural Hospitals,* available at https://ruralhospitals.chqpr.org/ (last visited January 30, 2024). *See also Supra,* n. 3.

| Rural Hospital Closures in Florida since 2000[22] | | |
|---|---|---|
| **Hospital** | **City** | **Year Closed** |
| Gadsden Community Hospital | Quincy | 2005 |
| Gulf Pines Hospital | Port St Joe | 2000 |
| Trinity Community Hospital | Jasper | 2008 |
| Campbellton Graceville Hospital | Graceville | 2017 |
| Regional General - Williston | Williston | 2019 |
| Shands Lake Shore Regional | Starke | 2019 |
| Lake City Medical Center Suwanee | Lake City | 2020 |
| North Florida Regional Medical Ctr | Starke | 2020 |

In addition to the patient-side issues, rural hospitals also suffer from increased staffing shortages. For instance, only 10% of physicians practice in rural areas, despite 20% of the population residing in those areas.[23] The COVID-19 pandemic increased the severity of staffing shortages, increased costs, and worsened health outcomes.[24]

Medicare Rural Emergency Hospitals

To respond to a number of rural hospital closures, Congress created a new Medicare provider type, the Rural Emergency Hospital (REH),[25] through the federal Consolidated Appropriations Act of 2021 (Act).[26] REH's are eligible for enhanced reimbursements through Medicare.

Federal rule further defines an REH. An REH is an entity that operates for the purpose of providing emergency department services, observational care, and other outpatient medical and health services specified by the Secretary of the Department of Health and Human Services in which the annual per patient length of stay does not exceed 24 hours.[27] However, the Act and regulations specify that an REH must provide emergency care and observation services, but they may *not* provide inpatient services.[28] Only rural hospitals with 50 or fewer beds and critical access hospitals that were enrolled and certified to participate in Medicare on or before the date of the enactment of the Act (December 27, 2020), qualify for certification as a REH.[29]

To be recognized as an REH, the Act requires the following:

- Compliance with applicable Federal laws and regulations related to the health and safety of patients.
- Licensed in the state as an REH; or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals.
- Assurances that personnel are licensed or meet other applicable standards that are required by state or local laws to provide services within the applicable scope of practice.
- Maintain a Medicare provider agreement with the Centers for Medicare and Medicaid Services (CMS) as provided for in 42 CFR s. 485.5 through 42 CFR s. 485.546.
- Have an organized medical staff that operates under bylaws approved by the governing body of the REH and which is responsible for the quality of medical care provided to patients in the REH. The medical staff must be composed of medical or osteopathic doctors, and may include other categories of physicians. Additionally, an REH may supplement the care provided through

[22] Data run from *Saving Rural Hospitals, Data on Rural Hospitals, Size and Financial Status of Rural Hospitals,* (Center for Healthcare Quality and Reform), available at Saving Rural Hospitals - Data on Rural Hospitals (chqpr.org) (last visited January 30, 2024).
[23] *Supra,* note 18.
[24] Id.
[25] 42 U.S.C. s.1395x(kkk).
[26] Pub. Law 116-260 (December 27, 2020).
[27] 42 CFR s, 485.502.
[28] *Supra,* note 30, and Id.
[29] *Rural Emergency Hospitals MLN Fact Sheet (November 2023),* Centers for Medicare and Medicaid Services, available at https://www.cms.gov/files/document/mln2259384-rural-emergency-hospitals.pdf (last visited January 30, 2024).

the use of telemedicine services provided by a distant site hospital as long as the distant-site hospital meets specified requirements.[30]
- Have an organized nursing service that is available to provide 24 hour care to patients of the REH.[31]
- Provide emergency, laboratory, radiological, pharmaceutical, and outpatient medical and other health services as detailed in the rule.[32] The Act specifically excludes inpatient services as a required component.
- Maintain an infection control program and a quality assessment and performance improvement program.[33]

Any REHs and Critical Access Hospitals that have been closed or let licenses go inactive since December 27, 2020, would also be eligible to reactivate their licenses after completion of a special review by the Medicare Administrative Contractor and CMS[34].

An REH is eligible for payment through the Medicare program for services at the amount that would be paid to a hospital providing the equivalent outpatient service, increased by five percent.[35] An REH also receives a supplemental monthly facility payment.[36] Starting October 1, 2023, for CY 2024 the monthly facility payment is $276,233.58.[37] Each year, the supplemental facility payment increases based on the hospital market basket percentage increase.[38] The hospitals are required to maintain detailed information on how these supplemental payments are used.[39]

Currently, Florida rural hospitals are ineligible to become Medicare Rural Emergency Hospitals because Florida law does not include a licensure category for REHs. In addition, current law requires licensed hospitals to regularly make available inpatient services, facilities for surgery or obstetrical care clinical laboratory services, and similar services; whereas Medicare prohibits these types of services at REHs.

Mandated Health Insurance Coverages

*Federal Requirements*

Under the federal Patient Protection and Affordable Care Act (ACA), individuals and small businesses can shop for health insurance coverage on the federal marketplace. All non-grandfathered plans[40] must include minimum essential coverage (MEC),19 including an array of services that includes the 10 essential health benefits (EHBs). These 10 EHBs are further defined each year through the federal rulemaking process and are open for public comment before taking effect.

The 10 general categories for the EHBs are:

[30] 42 CFR s. 485.512.
[31] 42 CFR s. 485.530.
[32] 42 CFR s. 485.516 – 485.524.
[33] 42 CFR 485.508.
[34] *Supra,* note 33.
[35] 42 CFR s. 419.92.
[36] Id.
[37] U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, *CMS Manual System, Pub. 100-04, Medicare Claims Processing*; Subject: January 2024 Annual Rural Emergency Hospital (REH) Monthly Facility Payment Amount, https://www.cms.gov/files/document/r12373cp.pdf (last visited January 31, 2024).
[38] *Supra,* note 29. The term "hospital market basket" means all of the components in the overall costs of healthcare used to determine the consumer price index. Produced by the Office of the Chief Actuary at CMS, the calculation measures the change in price, over time, of the same mix of goods and services purchased in the base period. *See also FAQs Market Basket Based Definitions and General Information,* Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group (September 2023) available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/info.pdf (last visited January 30, 2024).
[39] Id.
[40] "Grandfathered health plans" are those health plans, both individual and employer plans, that maintain coverage that was in place prior to the passage of the PPACA or in which the enrollee was enrolled on March 23, 2010, while complying with the consumer protection components of the PPACA. If a group health plan enters a new policy, certificate, or contract of insurance, the group must provide the new issuer the documentation from the prior plan so it can be determined whether there has been a change sufficient to lose grandfather status. See 26 U.S.C. 7805 and 26 C.F.R. s. 2590.715-1251(a).

- Ambulatory services (outpatient care);
- Emergency services;
- Hospitalization (inpatient care);
- Maternity and newborn care.
- Mental health and substance abuse disorder services;
- Prescription drugs.
- Rehabilitative services and rehabilitative services and devices;
- Laboratory services;
- Preventive care and chronic disease management; and
- Pediatric services, including oral and vision care.[41]

A state may change the EHBs offered in that state; however, under the ACA, the state must pay for the coverage costs. As a result, the State of Florida may be required to defray the costs of any additional benefits beyond the required EHBs put in place after 2011[42]. Examples of health insurance benefits currently mandated under Florida law include:

- Coverage for certain diagnostic and surgical procedures involving bones or joints of the jar and facial region (s. 627.419(7), F.S.);
- Coverage for bone marrow transplants (s. 627.4236, F.S.);
- Coverage for certain cancer drugs (s. 627.4239, F.S.);
- Coverage for any service performed in an ambulatory surgical center (s. 627.6616, F.S.);
- Diabetes treatment services (s. 627.6408, F.S.);
- Osteoporosis (s. 627.6409, F.S.);
- Certain coverage for newborn children (s. 627.641, F.S.);
- Child health supervision services (s. 627.6416, F.S.);
- Certain coverages related to mastectomies (s. 627.6417, F.S.);
- Mammograms (s. 627.6418, F.S.); and
- Treatment of cleft lip and cleft palate in children (s. 627.64193, F.S.)

*State Requirements*

Every person or organization seeking consideration of a legislative proposal which would mandate a health coverage or the offering of a health coverage by an insurance carrier must submit a report to the AHCA and the legislative committees having jurisdiction that assesses the social and financial impacts of the proposed coverage.[43] As of January 31, 2024, the House Select Committee on Health Innovation had not received a report for this coverage expansion.

## Effect of Proposed Changes

Rural Emergency Hospital Licensure

HB 309 changes state hospital licensure requirements for rural hospitals, which removes a barrier to those hospitals qualifying to become Medicare Rural Emergency Hospitals. This change in turn makes available an opportunity for those rural hospitals to gain a higher rate of federal reimbursement for the emergency and outpatient services they provide.

The bill creates a hospital licensure type of a "rural emergency hospital." This is a hospital that meets the requirements under federal regulation and is certified by the U.S. Secretary of Health and Human Services as a rural emergency hospital. This hospital will be also be classified as a "rural hospital" under state law.

HB 309 requires AHCA to implement a new licensure category and revise current rules to reflect the new licensure category as well as remove any other references to rural hospitals that may create a

[41] 42 U.S.C. s. 18022(b)(1)(A)-(J).
[42] See 42 U.S.C. s. 18031(d)(3)(B)(ii).
[43] S. 624.215, F.S.

conflict with the bill's intentions relating to a separate licensure category for the REHs. It also allows a licensed rural emergency hospital to enter into any contract required to be eligible for federal reimbursement as a rural emergency hospital. The bill subjects rural emergency hospitals to requirements for agency review of plans and specifications.

As federal regulations allows eligible closed rural hospitals to receive enhanced payments if they become re-licensed and meet other requirements, if a rural hospital license is re-activated, the AHCA would have to conduct a physical site visit of the location and the building would also need to pass a building inspection.

If licensed as an REH, the hospital would have to meet the staffing and personnel requirements established by CMS, which may be different than what the hospital meets currently as a rural hospital. It may mean an adjustment to staffing regarding physician and other roles at a facility that will not include any inpatient services.

The bill also authorizes AHCA to seek federal approval to provide Medicaid reimbursement to licensed REHs. Updates to AHCA's technology and provider payment schedule would be required if Medicaid implemented reimbursement under the provision.

Mandated Health Insurance Coverage

Additionally, the bill requires all policies issued on or after July 1, 2024 by health insurers, health maintenance organizations, and group health plans to cover services provided at REHs, to the extent not pre-empted by federal law, and in the same manner as if those services had been provided at a general hospital.

The bill makes conforming changes.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

**Section 1:** Amends s. 395.002, F.S.; relating to definitions.
**Section 2:** Amends s. 395.0163, F.S.; relating to construction inspections; plan submission and approval; fees.
**Section 3:** Creates s. 395.01933, F.S.; relating to licensure for rural emergency hospitals.
**Section 4:** Amends s. 395.602, F.S.; relating to rural hospitals.
**Section 5:** Creates s. 395.60613, F.S.; relating to eligibility for federal reimbursement as rural emergency hospitals
**Section 6:** Creates: s. 409.90803, F.S.; relating to reimbursement of licensed rural emergency hospitals.
**Section 7:** Creates s. 627.4423, F.S.; relating to coverage for services provided by licensed rural emergency hospitals.
**Section 8:** Amends s. 409.9116, F.S.; relating to disproportionate share/financial assistance for rural hospitals.
**Section 9:** Amends s. 1009.65, F.S.; relating to medical education reimbursement and loan repayment.
**Section 10:** Provides an effective date.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

Applicants for the new type of licensure will be required to pay fees to the AHCA for the processing of their application and other associated costs, as provided in existing law.

2. Expenditures:

Indeterminate impact on Medicaid expenditures.

The workload impact on AHCA to create the new licensure category and process any applications is indeterminate but likely can be absorbed within existing resources.

If Medicaid begins paying for services provided by REH's, the FMMIS system would need to be programmed with the new provider type and the payment methodologies. The impact is indeterminate but can likely be absorbed within existing resources.[44]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

To the extent that a rural hospital is being supported with local government funds, the ability to consider this new licensure category and the supplemental monthly facility fee and additional reimbursements under Medicare may provide some fiscal relief to local governments. The additional funds may allow local governments an opportunity to re-allocate those funds into other health care resources in the community.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Private rural hospitals that achieve designation as an REH may receive an increase in Medicare payments for outpatient services of five percent and a monthly supplemental facility payment that is modified each year based on the hospital market basket rate.

A previously closed or inactive licensed entity may be able to reopen.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

The county/municipality mandates provision of Art. VII, section 18, of the Florida Constitution may apply because this bill requires local governments to provide an additional health insurance coverage item. However, the cost of the additional coverage is likely to be insignificant, based upon the low number of residents in each of the potential impact areas and the AHCA's report of only one closed hospital which would likely qualify for conversion, and of the existing rural hospitals, only 10 are both critical access hospitals and rural hospitals, and only seven have 50 beds or fewer.[45] In addition, counties and municipalities can expect to be made whole by the state for any increased expenditures under the bill, based on application of current federal law requiring states to defray the costs of additional health insurance coverage mandates.

2. Other:

[44] *Supra,* note 15.
[45] *Supra,* note 17.

None.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rulemaking 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 rural emergency hospitals; amending s. 395.002, F.S.; revising the definition of the term "hospital" to include rural emergency hospitals; amending s. 395.0163, F.S.; requiring rural emergency hospitals that are to be licensed to submit plans and specifications of the facilities to the Agency for Health Care Administration for review; deleting obsolete language; creating s. 395.01933, F.S.; providing that facilities that meet the definition of rural emergency hospitals are eligible to apply for licensure as rural emergency hospitals; amending s. 395.602, F.S.; defining the term "rural emergency hospital"; revising the definition of the term "rural hospital" to include rural emergency hospitals; deleting obsolete language; creating s. 395.60613, F.S.; authorizing licensed rural emergency hospitals to enter into certain contracts for a specified purpose; creating s. 409.90803, F.S.; authorizing the agency to seek federal approval to apply Medicaid reimbursement to licensed rural emergency hospitals; creating s. 627.4423, F.S.; requiring entities transacting accident and health insurance and prepaid health care to provide benefits for services performed by licensed rural emergency hospitals under certain

circumstances; amending ss. 409.9116 and 1009.65, F.S.; conforming a cross-reference; providing an effective date.

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

Section 1. Subsection (12) of section 395.002, Florida Statutes, is amended to read:

395.002 Definitions.—As used in this chapter:

(12) "Hospital" means any establishment that:

(a)1. Offers services more intensive than those required for room, board, personal services, and general nursing care, and offers facilities and beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care for illness, injury, deformity, infirmity, abnormality, disease, or pregnancy; and

2. ~~(b)~~ Regularly makes available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment of similar extent, except that a critical access hospital, as defined in s. 408.07, shall not be required to make available treatment facilities for surgery, obstetrical care, or similar services as long as it maintains its critical access hospital designation and shall be required to make such facilities available only if it ceases to be designated as a

critical access hospital; or.

(b) Is designated as a rural emergency hospital as defined in s. 395.602(2).

However, the provisions of this chapter do not apply to any institution conducted by or for the adherents of any well-recognized church or religious denomination that depends exclusively upon prayer or spiritual means to heal, care for, or treat any person. For purposes of local zoning matters, the term "hospital" includes a medical office building located on the same premises as a hospital facility, provided the land on which the medical office building is constructed is zoned for use as a hospital; provided the premises were zoned for hospital purposes on January 1, 1992.

Section 2. Paragraph (b) of subsection (1) of section 395.0163, Florida Statutes, is amended to read:

395.0163 Construction inspections; plan submission and approval; fees.—

(1)

(b) All outpatient facilities that provide surgical treatments requiring general anesthesia or IV conscious sedation, that provide cardiac catheterization services, or that are to be licensed as rural emergency hospitals or ambulatory surgical centers shall submit plans and specifications to the agency for review under this section. All other outpatient

facilities must be reviewed under this section, except that those that are physically detached from, and have no utility connections with, the hospital and that do not block emergency egress from or create a fire hazard to the hospital are exempt from review under this section. ~~This paragraph applies to applications for which review is pending on or after July 1, 1998.~~

Section 3. Section 395.01933, Florida Statutes, is created to read:

395.01933 Licensure for rural emergency hospitals.—A facility is eligible to apply for a license as a rural emergency hospital if the facility meets the definition of a rural emergency hospital in s. 395.602(2).

Section 4. Paragraphs (b) and (c) of subsection (2) of section 395.602, Florida Statutes, are redesignated as paragraphs (c) and (d), respectively, present paragraph (b) of subsection (2) is amended, and a new paragraph (b) is added to subsection (2) of that section, to read:

395.602 Rural hospitals.—

(2) DEFINITIONS.—As used in this part, the term:

(b) "Rural emergency hospital" means a hospital that meets the definition of the term "rural emergency hospital" in 42 U.S.C. s. 1395x(kkk)(2) and that is certified by the United States Secretary of Health and Human Services as a rural emergency hospital.

(c) ~~(b)~~ "Rural hospital" means an acute care hospital licensed under this chapter, having 100 or fewer licensed beds and an emergency room, which is:

1. The sole provider within a county with a population density of up to 100 persons per square mile;

2. An acute care hospital, in a county with a population density of up to 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county;

3. A hospital supported by a tax district or subdistrict whose boundaries encompass a population of up to 100 persons per square mile;

4. A hospital classified as a sole community hospital under 42 C.F.R. s. 412.92, regardless of the number of licensed beds;

5. A hospital with a service area that has a population of up to 100 persons per square mile. As used in this subparagraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Transparency at the agency; ~~or~~

6. A hospital designated as a critical access hospital, as defined in s. 408.07; or~~.~~

7. A hospital designated as a rural emergency hospital.

Population densities used in this paragraph must be based upon the most recently completed United States census. ~~A hospital that received funds under s. 409.9116 for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2021, if the hospital continues to have up to 100 licensed beds and an emergency room.~~ An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this paragraph shall be granted such designation upon application, including supporting documentation, to the agency. A hospital that was licensed as a rural hospital during the 2010-2011 or 2011-2012 fiscal year shall continue to be a rural hospital from the date of designation through June 30, 2025, if the hospital continues to have up to 100 licensed beds and an emergency room.

Section 5. Section 395.60613, Florida Statutes, is created to read:

395.60613 Eligibility for federal reimbursement as rural emergency hospitals.—A licensed rural emergency hospital may enter into any contract required to be eligible for federal reimbursement as a rural emergency hospital.

Section 6. Section 409.90803, Florida Statutes, is created to read:

409.90803 Reimbursement of licensed rural emergency hospitals.—The agency may seek federal approval to apply Medicaid reimbursement to licensed rural emergency hospitals, as defined in s. 395.602(2).

Section 7. Section 627.4423, Florida Statutes, is created to read:

627.4423 Coverage for services provided by licensed rural emergency hospitals.—Each insurer, health maintenance organization, nonprofit hospital or medical service plan corporation, and self-funded employee benefit plan transacting individual or group, blanket, or franchise accident or health insurance or providing prepaid health care in the state shall, to the extent not preempted by federal law or exempted by state law, provide benefits for services performed by a licensed rural emergency hospital, as defined in s. 395.602(2), if such services would be covered under the policy, contract, or plan when provided by a general hospital.

Section 8. Subsection (6) of section 409.9116, Florida Statutes, is amended to read:

409.9116 Disproportionate share/financial assistance program for rural hospitals.—In addition to the payments made under s. 409.911, the Agency for Health Care Administration shall administer a federally matched disproportionate share program and a state-funded financial assistance program for statutory rural hospitals. The agency shall make

disproportionate share payments to statutory rural hospitals that qualify for such payments and financial assistance payments to statutory rural hospitals that do not qualify for disproportionate share payments. The disproportionate share program payments shall be limited by and conform with federal requirements. Funds shall be distributed quarterly in each fiscal year for which an appropriation is made. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(6) This section applies only to hospitals that were defined as statutory rural hospitals, or their successor-in-interest hospital, prior to January 1, 2001. Any additional hospital that is defined as a statutory rural hospital, or its successor-in-interest hospital, on or after January 1, 2001, is not eligible for programs under this section unless additional funds are appropriated each fiscal year specifically to the rural hospital disproportionate share and financial assistance programs in an amount necessary to prevent any hospital, or its successor-in-interest hospital, eligible for the programs prior to January 1, 2001, from incurring a reduction in payments because of the eligibility of an additional hospital to participate in the programs. A hospital, or its successor-in-interest hospital, which received funds pursuant to this section

before January 1, 2001, and which qualifies under s. 395.602(2)(c) ~~s. 395.602(2)(b)~~, shall be included in the programs under this section and is not required to seek additional appropriations under this subsection.

Section 9. Paragraph (a) of subsection (1) of section 1009.65, Florida Statutes, is amended to read:

1009.65 Medical Education Reimbursement and Loan Repayment Program.—

(1) To encourage qualified medical professionals to practice in underserved locations where there are shortages of such personnel, there is established the Medical Education Reimbursement and Loan Repayment Program. The function of the program is to make payments that offset loans and educational expenses incurred by students for studies leading to a medical or nursing degree, medical or nursing licensure, or advanced practice registered nurse licensure or physician assistant licensure. The following licensed or certified health care professionals are eligible to participate in this program:

(a) Medical doctors with primary care specialties, doctors of osteopathic medicine with primary care specialties, physician assistants, licensed practical nurses and registered nurses, and advanced practice registered nurses with primary care specialties such as certified nurse midwives. Primary care medical specialties for physicians include obstetrics, gynecology, general and family practice, internal medicine,

pediatrics, and other specialties which may be identified by the Department of Health. From the funds available, the Department of Health shall make payments as follows:

1. Up to $4,000 per year for licensed practical nurses and registered nurses, up to $10,000 per year for advanced practice registered nurses and physician assistants, and up to $20,000 per year for physicians. Penalties for noncompliance shall be the same as those in the National Health Services Corps Loan Repayment Program. Educational expenses include costs for tuition, matriculation, registration, books, laboratory and other fees, other educational costs, and reasonable living expenses as determined by the Department of Health.

2. All payments are contingent on continued proof of primary care practice in an area defined in s. 395.602(2)(c) ~~s. 395.602(2)(b)~~, or an underserved area designated by the Department of Health, provided the practitioner accepts Medicaid reimbursement if eligible for such reimbursement. Correctional facilities, state hospitals, and other state institutions that employ medical personnel shall be designated by the Department of Health as underserved locations. Locations with high incidences of infant mortality, high morbidity, or low Medicaid participation by health care professionals may be designated as underserved.

Section 10. This act shall take effect July 1, 2024.

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 | _____ |

Committee/Subcommittee hearing bill: Select Committee on Health Innovation

Representative Shoaf offered the following:

**Amendment (with title amendment)**

Remove everything after the enacting clause and insert:

Section 1. Paragraph (a) of subsection (3) of section 395.1041, Florida Statutes, is amended to read:

395.1041 Access to and ensurance of emergency services; transfers; patient rights; diversion programs; reports of controlled substance overdoses.—

(3) EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF FACILITY OR HEALTH CARE PERSONNEL.—

(a) Every general hospital which has an emergency department, and every rural emergency hospital, shall provide

emergency services and care for any emergency medical condition when:

1. Any person requests emergency services and care; or

2. Emergency services and care are requested on behalf of a person by:

a. An emergency medical services provider who is rendering care to or transporting the person; or

b. Another hospital, when such hospital is seeking a medically necessary transfer, except as otherwise provided in this section.

Section 2. Paragraph (b) of subsection (2) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.—

(2) DEFINITIONS.—As used in this part, the term:

(b) "Rural hospital" means an acute care hospital licensed under this chapter, having 100 or fewer licensed beds and an emergency room, which is:

1. The sole provider within a county with a population density of up to 100 persons per square mile;

2. An acute care hospital, in a county with a population density of up to 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county;

3. A hospital supported by a tax district or subdistrict whose boundaries encompass a population of up to 100 persons per square mile;

4. A hospital classified as a sole community hospital under 42 C.F.R. s. 412.92, regardless of the number of licensed beds;

5. A hospital with a service area that has a population of up to 100 persons per square mile. As used in this subparagraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Transparency at the agency; or

6. A hospital designated as a critical access hospital, as defined in s. 408.07.

Population densities used in this paragraph must be based upon the most recently completed United States census. ~~A hospital that received funds under s. 409.9116 for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2021, if the hospital continues to have up to 100 licensed beds and an emergency room.~~ An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this paragraph shall be granted such designation

upon application, including supporting documentation, to the agency. A hospital that was licensed as a rural hospital during the 2010-2011 or 2011-2012 fiscal year shall continue to be a rural hospital from the date of designation through June 30, 2031~~2025~~, if the hospital continues to have up to 100 licensed beds and an emergency room.

Section 3. Section 395.607, Florida Statutes, is created to read:

395.607 Rural Emergency Hospitals.--

(1) As used in this section:

(a) "Rural emergency hospital" means a licensed rural hospital or critical access hospital as defined in s. 408.07 designated by the agency under this section.

(b) "Rural emergency services" means emergency services and care services and care that not require more than 24 hours on average in a rural emergency hospital; observation care; and, at the election of the hospital, outpatient services specified in regulations adopted by the United States Secretary of Health and Human Services.

(2) A qualifying hospital may apply to the agency for designation as a rural emergency hospital on a form adopted by the agency. The agency may designate a hospital as a rural emergency hospital if it demonstrates that it:

(a) Meets the requirements of the Consolidated Appropriations Act of 2021 (Pub. L. No. 116-260), and of regulations adopted and guidance issued thereunder.

(b) Has no more than 50 beds.

(c) Can adequately provide rural emergency services in the facility 24 hours a day and seven days a week.

(d) Is sufficiently staffed and equipped to provide rural emergency services of the types indicated by the applicant.

(e) Has a transfer agreement in effect with a Level I or Level II trauma center.

(3) Designated rural emergency hospitals are exempt from the requirements of s. 395.002 to offer acute inpatient care or care beyond 24 hours, or to make available treatment facilities for surgery, obstetrical care, or similar services, and shall be required to make such services available only if it ceases to be designated as a rural emergency hospital.

(4) The agency shall suspend or revoke the rural emergency hospital designation if at any time such a hospital fails to meet the requirements of this section.

Section 5. This act shall take effect July 1, 2024.

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**T I T L E A M E N D M E N T**

Remove everything before the enacting clause and insert:

An act relating to rural emergency hospitals; amending s. 395.1041, F.S.; making rural emergency hospitals subject to certain emergency services requirements for general hospitals; creating s. 395.607, F.S.; providing definitions; authorizing certain entities to apply to the Agency for Health Care Administration for designation as a rural emergency hospital; establishing requirements for emergency rural hospitals; providing exemptions from certain requirements for general hospitals; providing for administrative enforcement; providing an effective date.

**HB 639**

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 639 Coverage For Out-of-network Ground Ambulance Emergency Services
**SPONSOR(S):** Yeager
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 568

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Select Committee on Health Innovation | | Lloyd | Calamas |
| 2) Insurance & Banking Subcommittee | | | |
| 3) Health Care Appropriations Subcommittee | | | |
| 4) Health & Human Services Committee | | | |

## SUMMARY ANALYSIS

Congress adopted the federal *No Surprises Act* in 2021 to address balance billing in health care, except in the area of ground transportation, emergency and non-emergency. Emergency transportation companies do not get a choice in their patients and must answer every 911 call received for a medical emergency. Whether or not a patient has insurance, what insurance, or ability to pay is not a consideration at the time a ground ambulance responds to the emergency call. In the same manner, patients in need of an emergency transport are not able to shop around for services or to research which ambulance to call.

The vast majority of ground ambulance emergency services are owned or operated by a county or local municipality such as fire departments (37 percent) or other government entities (25 percent) with remainder being held by private businesses (30 percent) and hospital owned ambulances. When there is a choice of ambulance providers in an area, the 911 operator typically picks the provider based on its proximity to the scene and the patient's injury severity.

Florida established its own balance billing law in 2016. The law prohibits nonparticipating providers, including hospitals, ambulatory surgical centers, and urgent care centers, from balance billing members of a preferred provider organization (PPO) or exclusive provider organization (EPO) for emergency services or for nonemergency services when the nonemergency services are provided in a network hospital and the patient had no ability and opportunity to choose a network provider.

HB 639 addresses the gap left by the two laws through establishment of a set of options for payment of out-of-network claims by group health plans and individual health plan policies to be the greater of:

- The rate set or approved, whether it is established in a contract or local government ordinance, in the jurisdiction in which the covered services occurred.
- 350 percent of the current published rate by federal CMS for ambulance services under Title XVIII of the Social Security Act for the same geographic area; or the ambulance's billed charges whichever is less.
- The contracted rate at which the health care provider would reimburse an in-network ambulance provider for providing the covered service.

The bill also establishes that payment from the insurer is considered payment in full. Cost sharing from the patient may not exceed the in-network amounts that would have been charged for the same service.

The bill has an insignificant, negative fiscal impact potentially on state government of an indeterminate amount and a potentially significant, positive fiscal impact on local governments depending on how the local entity currently charges and collects for emergency services.

The bill has an effective date of July 1, 2024.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Background**

Emergency Ground Transportation

Ground emergency medical transportation is a life-saving service that may affect anyone, including the uninsured, privately insured, and those covered by governmental health care programs. In 2020, 37 percent[1] of emergency ground ambulance rides were provided through local fire departments[2] , 25 percent through other government agencies, 30 percent through private companies, and 8 percent through hospitals.[3] Federal laws and current Florida laws do not provide balance billing protections for insured consumers that use a non-participating or out-of-network emergency ground ambulance service.

About 51 percent of all ground ambulance calls require Advanced Life Support (ALS)[4] services compared to Basic Life Support (BLS) services[5, 6]. Emergency ambulance fees usually include two components: a base fee and a mileage fee. According to FAIR Health report, the average charge for ALS emergency ground ambulance services has increased from $1,042 in 2017 to $1,277 in 2020 which represents a 22.6 percent increase. In Medicare, the average increase for these same services was $441 to $463, a five percent increase.[7] The average charge for BLS emergency ground ambulance services increased 17.5 percent from $800 in 2017 to $940 in 2020. The average Medicare amount for these services increased 4.8 percent from $372 to $390.[8] The second component of the billing rate, mileage fees can vary greatly as well from $20 per mile to $90 per mile.[9] And, depending on where a patient lives in relation to the closest emergency facility, the cost per mile can quickly add up. In urban Florida, the hospital ride may be less than 10 miles, but in more rural areas of Florida, it could be 50 or more miles to the closest or most appropriate hospital for the patient. In 2019, Florida has one of the lowest averages for mileage for ground ambulance emergency transportation at 7.2 miles compared to the highest state of Wyoming at 29.2 miles.[10]

One study found that 71 percent of all ambulance rides had the potential to incur surprise medical bills.[11] While this study occurred in 2000, prior to the implementation of the federal legislation addressing most types of balance billing, it still speaks to the percentage of ambulance rides that end up as balance billing cases, whether ground or air, and the costs involved for such transportation. The

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[1] *Ground ambulance rides and potential for surprise billing* - Peterson-KFF Health System Tracker (June 24, 2021), available at Ground ambulance rides and potential for surprise billing - Peterson-KFF Health System Tracker (last visited January 31, 2024).
[2] *What are the differences between public and private ambulance services?* (ems1.com) (Oct. 23, 2017), available at What are the differences between public and private ambulance services? (ems1.com) (last visited January 31, 2024).
[3] *Protecting Consumers from Surprise Ambulance Bills* | Commonwealth Fund (Nov. 15, 2021), available at https://www.commonwealthfund.org/blog/2021/protecting-consumers-surprise-ambulance-bills (last visited January 31, 2024).
[4] Advanced Life Support Services (ALS) includes basic life support but must have a paramedic on board. The technicians on an ALS ambulance have a higher level of training. Typically, to treat a patient during an ALS ambulance service, an invasive procedure is done, for example, with needles or other devices that make cuts in the skin. An ALS provider can give injections, do very limited surgical procedures (e.g., a tracheotomy) and administer medicine. ALS ambulances are typically outfitted with airway equipment, cardiac life support, cardiac monitors and glucose testing devices.
[5] Also called "first step treatment," these services can be provided by either a paramedic or an emergency medical technician (EMT). They typically include fractures or injuries, psychiatric patients or medical and surgical patients who do not need cardiac monitoring or respiratory interventions.
[6] Ground Ambulance Services in the United States (2022), FAIR HEALTH, available at: Ground Ambulance Services in the United States - A FAIR Health White Paper.pdf (last visited January 30, 2024).
[7] Id.
[8] Id.
[9] PBS News Hour, *The No Surprises Act left out ground ambulances. Here is what is happening now, (August 17, 2023), available at* The No Surprises Act left out ground ambulances. Here's what's happening now | PBS NewsHour (last visited January 29, 2024).
[10] *Supra, note 6.*
[11] Karan R. Chhabra, Keegan McGuire, et al., "Most Patients Undergoing Ground and Air Ambulance Transportation Receive Sizeable Out-Of-Network Bills, HEALTH AFFAIRS (April 15, 2020), available at :Most Patients Undergoing Ground And Air Ambulance Transportation Receive Sizable Out-Of-Network Bills | Health Affairs

study found the median range in 2020 for surprise ground emergency transportation bill to be $450.[12] In balance billing for emergency ground transportation, which was not included in either the state or national balance billing laws, the Florida ambulance providers are reimbursed, on average, for 56 percent of their billed charges.

An ambulance may also arrive to a call, treat the patient, and not transport the patient to a facility. Nationally, from 2017 to 2019, the percentage has dropped for the number of cases from one percent of all calls to .7 percent, and then bounced back to one percent of all calls for emergency ground transportation.[13] For the five year period of 2017-2020, the top five reasons for emergency ground transportation calls, but no transport to a facility have remained the same, if out of order. For 2020, the number one reason for a call was for general, non-specific reasons, followed by circulatory and respiratory issues, injury to the body, endocrine and metabolic issues, and signs and symptoms related to cognition.[14]

Balance Billing

Balance billing occurs when an insured patient accesses out of network services at an emergency facility or while receiving non-emergency services at in-network hospital or facility for covered services.[15] With balance billing, a provider bills a patient for the difference between the amounts the provider charges and the amount that the patient's insurance company pays. This does not include cost-sharing requirements such as copayments that are typically paid by a patient. As a result, a consumer may incur an average balance billing or out of pocket cost of $450.[16] In some states, the average is more than $1,000. [17]

*Statewide Provider and Health Plan Claim Dispute Resolution Program*

When there is a billing dispute between the provider and the ground emergency transportation The Statewide Provider and Health Plan Claim Dispute Resolution Program was established by the 2000 Florida Legislature to assist to contracted and non-contracted providers and managed care organizations reach a resolution of claim disputes that were not resolved by the provider and the managed care organization without litigation. The statute requires the Agency to contract with a resolution organization to timely review and consider claim disputes and submit its recommendation to the AHCA.

As of June 30, 2023, no provider and health plan claim disputes are being reviewed as the contract with the resolution organization ended at the end of the fiscal year. The AHCA is soliciting a new third party vendor, but until then claims are not being resolved. According to figures from AHCA, 563 claims were received last year and 443 claims were reviewed. The difference between the claims accepted and those reviewed may be attributed to several factors, including lack of follow up for additional information, or failure to submit a complete application.

Emergency Medical Treatment and Active Labor Act (EMTALA)

In 1986, Congress enacted EMTALA[18] to ensure public access to emergency services regardless of ability to pay. The EMTALA imposes specific obligations on hospitals participating in the Medicare program, which offer emergency services. Any patient who comes to the emergency department must be provided with a medical screening examination within the hospital's capabilities to determine if the

[12] Id.
[13] Id.
[14] Id.
[15] *Supra,* note *1.*
[16] *Role of States in Exclusion of Ground Ambulances from NSA*, Medicalbillersandcoders.com, available at: Role of States in Exclusion of Ground Ambulances from NSA (medicalbillersandcoders.com) (July 22, 2022) (last visited January 29, 2024).
[17] *EMERGENCY: The high cost of ambulance surprise bills (pirg.org)* (Oct. 26, 2023), available at EMERGENCY: The high cost of ambulance surprise bills (pirg.org) (last visited January 29, 2024).
[18] 42 U.S.C. 1395dd; Section 1867 of the Social Security Act.

patient has an emergency medical condition. If an emergency medical condition exists, the hospital must provide treatment within its service capability to stabilize the patient. [19]

If a hospital is unable to stabilize a patient or, if the patient requests, the hospital must transfer the patient to another appropriate facility.[20] A hospital that violates EMTALA is subject to civil monetary penalty[21] or civil suit by a patient who suffers personal harm.[22]

Florida law imposes a similar duty.[23] The law requires AHCA to maintain an inventory of the service capability of all licensed hospitals that provide emergency care in order to assist emergency medical services (EMS or ambulance) providers and the public in locating appropriate medical care. Hospitals must provide all listed services when requested, whether by a patient, an emergency medical services provider, or another hospital, regardless of the patient's ability to pay. If the hospital is at capacity or does not provide the requested emergency service, the hospital may transfer the patient to the nearest facility with appropriate available services. Each hospital must ensure the services listed can be provided at all times either directly or through another hospital. A hospital is prohibited from basing emergency treatment and care on a patient's insurance status, economic status, or ability to pay.

Florida No Surprises Act

In 2016, the Florida Legislature passed and Governor Scott signed CS\CS\CS\HB 221[24] which, among provisions, prohibited out of network providers for preferred provider organizations (PPOs)[25] and exclusive provider organizations (EPOs)[26] from balance billing its enrollees for emergency services or for nonemergency services when the nonemergency services are provided in a network hospital and the patient had no ability and opportunity to choose a network provider. Effective July 1, 2016, the 2016 legislation set standards for determining reimbursement to the providers and authorized providers and insurers to settle disputed claims under the statewide provider and health plan claim dispute resolution program.[27]

An HMO is an organization that provides a wide range of health care services, including emergency care, inpatient hospital care, physician care, ambulatory diagnostic treatment and preventive health care pursuant to contractual arrangements with preferred providers in a designated service area. The network is made up of providers who have agreed to supply services to members at pre-negotiated rates. Traditionally, an HMO member must use the HMO's network of health care providers in order for the HMO to make payment of benefits. The use of a health care provider outside the HMO's network generally results in the HMO limiting or denying the payment of benefits for out-of-network services rendered to the member. Current statutes governing HMOs already prohibit balance billing for covered emergency services at an out of network provider.

CS\CS\CS\HB 221 also required PPOs to publish a list of their network providers on their websites, and to update the list monthly. All PPOs must give their subscribers notice regarding the potential for

[19] Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. §1395dd; see also CENTERS FOR MEDICARE & MEDICAID SERVICES, Emergency Medical Treatment & Labor Act (EMTALA), (last visited January 29, 2024).
[20] 42 U.S.C. 1395dd(b)(2).
[21] 42 U.S.C. 1395dd(d)(1).
[22] 42 U.S.C. 1395dd(d)(2).
[23] *See* s. 395.1041, F.S. A hospital that violates Florida's access to care statute is subject to administrative penalties; denial, revocation, or suspension of its license; or civil action by another hospital or physician suffering financial loss. In addition, hospital administrative or medical staff are subject to civil suit by a patient who suffers personal harm and may be found guilty of a second-degree misdemeanor for a knowing or intentional violation. Physicians who violate the statute are also subject to disciplinary action against their license or civil action by another hospital or physician suffering financial loss.
[24] ch. 2016-222, L.O.F.
[25] A PPO is a health plan that contracts with providers, such as hospitals and doctors, to create a network of providers who participate for an alternative or reduced rate of payment. A PPO is an insurance product. PPO plan members generally see specialists without prior referral or authorization from the insurer. Generally, the member is only responsible for the policy co-payment, deductible, or coinsurance amounts if covered services are obtained from network providers. However, if a member chooses to obtain services from an out-of-network provider, those out-of-pocket costs likely will be higher. *See generally s. 627.6471, F.S.*
[26] In an EPO arrangement, an insurance company contracts with hospitals, physicians, and other medical facilities. Insured members must use the participating hospitals or providers to receive covered benefits, subject to limited exceptions. See generally s. 627.6472, F.S
[27] S. 627.64194, F.S.

balance billing when using out-of-network providers. Disciplinary action for violations may be assessed on certain facilities and licensed health care practitioners for violations on balance billing.

Florida's *No Surprises Act* further requires hospitals publish information on their websites regarding their contracts with plans and providers of hospital-based services to keep consumers informed proactively of which hospitals participate with which PPOs and EPOs.

*Florida Health Insurance Advisory Board*

Repeating from its 2022 and 2023 list of Legislative Recommendations, the Florida Health Insurance Advisory Board (FHIAB) lists prohibition against balance billing for ground emergency medical transportation as Proposal five out of eight proposals.[28] When the proposal was discussed and added to the FHIAB's list of recommendations in 2022, the proposal was adopted by the board unanimously.[29] The proposal was re-adopted and placed on the 2023 Legislative Recommendations list without discussion during FHIAB's 2022 November meeting.[30]

Federal No Surprises Act

The federal *No Surprises Act of 2022*[31] (Act) eliminated the practice of health care practitioners balance billing for most provider types with the exception of ground ambulance services beginning in 2022. Because of the complications involved with how ground ambulance services, emergency and non-emergency, are currently delivered with most delivered by municipalities and other local governments and concerned about how national actions may impact those existing relationships and contracts, Congress deferred action and created an advisory committee.

The Act established the advisory committee to continue discussions on how to address surprise billings and balance billings with ground ambulance and emergency ground ambulance services.[32] The Charter for the Advisory Committee on Ground Ambulance and Patient Billing (GAPB) was signed by the Health and Human Services Secretary on November 16, 2021. The Committee held three public meetings between May 2, and November 1, 2023.[33]

Recommendations by the Committee were released following the November 2023 meeting, including the renewal of the Committee's Charter. The Committee's 15 recommendations ranged from inclusion of standard definitions relating to ground ambulance services to reimbursement policies and fell into the general categories relating to:

- Adopt standard definitions relating to ground emergency services.
- Protect patients from patient billing.
- Limit copays for ground ambulance rides.
- Make ambulance bills more transparent and easier for patients to understand.
- Guarantee payment to the ambulance crews.
- Avoid the independent dispute resolution process.
- Recommend the incorporation of Ground Ambulance Emergency Medical Services in the definition of emergency services under the essential health benefits requirements.[34]

[28] Florida Health Insurance Advisory Board, *2024 Legislative Recommendations,* available at fhiablegrecommendations2024.pdf (floir.com) (last visited January 29, 2024).
[29] Florida Health Insurance Advisory Board, *2023 Legislative Recommendations,* available at board-minutes-(approved-9-28-23).pdf (floir.com) (last visited January 29, 2024).
[30] Florida Health Insurance Advisory Board, Board Meeting Minutes, November 17, 2023, available at board-minutes-(approved-9-28-23).pdf (floir.com) (last visited January 29, 2024).
[31] 42 U.S.C. 1395dd; Section 1867 of the Social Security Act.
[32] Advisory Committee on Ground Ambulance and Patient Billing Advisory Committee, Title I (No Surprises Act) and Title II (Transparency) of Division BB of the Consolidated Appropriations Act, 2021 (CAA), Advisory Committee on Ground Ambulance and Patient Billing (GAPB) | CMS (last visited January 31, 2024).
[33] Centers for Medicare and Medicaid Services, *Advisory Committee on Ground Ambulance and Patient Billing*, available at: https://www.cms.gov/medicare/regulations-guidance/advisory-committees/advisory-committee-ground-ambulance-and-patient-billing-gapb (last visited January 31, 2024).
[34] Centers for Medicare and Medicaid Services, *Advisory Committee on Ground Ambulance and Patient Billing,* Meeting Materials for October 31, and November 1, 2023 meeting, available at https://www.cms.gov/medicare/regulations-guidance/advisory-committees/advisory-committee-ground-ambulance-and-patient-billing-gapb (last visited January 30, 2024).

All of the Committee's recommendations will be forwarded to Congress with a report which will notate which recommendations received a majority vote of the Committee.[35] The Secretary of HHS has acted on one of the recommendations and renewed the Committee's charter on November 16, 2023.[36]

Regulation of Insurers and Health Maintenance Organizations

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, health maintenance organizations (HMOs), and other risk bearing entities in Florida.[37] The Agency for Health Care Administration (AHCA) regulates the quality of care by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from AHCA.[38]

All persons who transact insurance in this state must comply with the Code.[39] The OIR has the authority to collect, propose, publish, and disseminate any information relating to the subject matter of the Code,[40] and may investigate any matter relating to insurance.[41]

Patient Protection and Affordable Care Act

Under the Patient Protection and Affordable Care Act (PPACA)[42], all non-grandfathered health plans in the non-group and small group private health insurance markets must offer a core package of health care services known as the essential health benefits (EHBs). While not specifying the benefits within PPACA, 10 general categories of benefits and services are identified that must be covered. The details of those benefits were left to the Secretary of the Department of Health and Human Services to define through regulatory guidance.[43]

The 10 EHB categories are:

- Ambulatory patient services.
- Emergency services.
- Hospitalization.
- Maternity and newborn care.
- Mental health and substance use disorder services, including behavioral health treatment.
- Prescription drugs.
- Rehabilitation and habilitation services.
- Laboratory services.
- Preventive and wellness services and chronic disease management.
- Pediatric services, including oral and vision care.

PPACA requires each state to select its own reference benchmark plan as its EHB benchmark plan which all other health plans in the state use as a model. Florida selected its EHB plan before 2012 and has not modified that selection.[44]

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[35] Laura Santhanam, PBS News Hour, *New recommendations outline how Congress could lower ground ambulance costs,* available at: https://www.pbs.org/newshour/health/new-recommendations-outline-how-congress-could-lower-ground-ambulance-costs (last visited January 30, 2024).
[36] Centers for Medicare and Medicaid Services, Advisory Committee on Ground Ambulance and Patient Billing Advisory Committee, *Charter Renewal (November 16, 2023),* available at: https://www.cms.gov/files/document/gapb-charter-renewal-november-16-2023.pdf (last visited January 31, 2024).
[37] S. 20.121(3)(a), F.S.
[38] S. 641.21(1)(1), F.S.
[39] S. 624.11, F.S.
[40] S. 624.307(4), F.S.
[41] S. 624.307(3), F.S.
[42] Affordable Care Act (March 23, 2010), P.L. 111-141, as amended.
[43] 45 CFR 156.100 et. seq.
[44] Centers for Medicare and Medicaid Services, State Essential Health Benchmark Plans – Florida, https://www.cms.gov/cciio/resources/data-resources/downloads/updated-florida-benchmark-summary.pdf (last visited January 31, 2024).

State Health Insurance Mandates

A health insurance mandate is a legal requirement that an insurance company or health plan cover specific benefits, or services by particular health care providers, or specific patient groups. A contingent coverage mandate requires coverage of a service, condition, or provider's care *only if* coverage is provided for a certain other service, condition, or provider's care. In general, coverage mandates increase the cost of health coverage in varying amounts depending on the cost of the mandated care and the amount of patient utilization of that care.

Current Florida law requires every person or organization seeking consideration of a legislative proposal which would mandate a health coverage or the offering of a health coverage by an insurer, to submit to AHCA and the legislative committees having jurisdiction, a report that assesses the social and financial impacts of the proposed coverage.[45] To the extent information is available, the report should address:

- The extent to which the treatment or service is generally used by a significant portion of the population.
- The extent to which insurance coverage is generally available; or, if not generally available, results in persons avoiding necessary health care treatment.
- The extent to which lack of coverage results in unreasonable financial hardship.
- The level of public demand for the treatment or service.
- The level of public demand for insurance coverage of the treatment or service.
- The level of interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts.
- The extent to which coverage will increase or decrease the cost of the treatment or service.
- The extent to which coverage will increase the appropriate uses of the treatment or service.
- The extent to which the treatment or service will be a substitute for a more expensive treatment or service.
- The extent to which the coverage will increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.
- The impact of this coverage on the total cost of health care.

The House Select Committee on Health Innovation has not received a report for HB 639.

**Effect of Proposed Changes:**

The bill creates two new section of law to require health insurers and health maintenance organizations under ch. 627 and ch. 641, F.S., respectively, to reimburse for claims incurred for out-of-network ambulance services using a specific formula. Currently, Florida law does not specify how claims for out of network ground ambulance services are to be reimbursed. Coverage issues and coverage benefits decisions are usually left up to the two parties involved in contracting for health care services, the employer, for example, and the insurer or insurer's representative ,as part of the contract negotiation process, made determinations about what is or is not covered, and at what cost.

If there is not an agreement between the provider and the out of network of emergency ground ambulance provider, then HB 639 would establish the reimbursement for services as the greater amount of any of the following:

- The rate set or approved, whether it is established in a contract or local government ordinance, in the jurisdiction in which the covered services occurred.
- 350 percent of the current published rate by federal CMS for ambulance services under Title XVIII of the Social Security Act for the same geographic area; or the ambulance's billed charges whichever is less.
- The contracted rate at which the health care provider would reimburse an in-network ambulance provider for providing the covered service.

[45] S. 624.215, F.S.

Definitions are created for the new section for "ambulance services provider," "clean claim," "covered services," and "out of network" to ensure terms used in these newly created sections of law are understood uniformly and have the specific meaning intended when referencing these provisions.

Under both new sections, the payments would be considered payment in full for the services rendered, except for any copayment, coinsurance, deductible, or other cost sharing responsibilities of the insured. The ambulance service is prohibited from balance billing the patient for any unpaid amounts. Out of network ambulance providers would not be allowed to seek out any additional payments from patients through balance billing for any differences between what may have been the provider's initial billed charged compared to final payments under this provision. The out of network ambulance provider may accept the insurer's payment for the services as payment in full

Payments from the insurers are due within 30 days after receipt of a clean claim to the ground ambulance service. Insurers are prohibited from sending any payment to the insured. If the ground transportation was requested by a first responder[46] or a health care practitioner as defined in s. 456.001,[47] a health insurer is required to pay for the transportation of those patients.

If the claim is considered to not be a clean claim, within 30 days of receipt of the claim the health insurer must send a written notice that acknowledges the date of claim receipt and informs the ambulance services provider one of the following:

- Insurer is declining to pay all or part of this claim and the specific reason for the denial.
- Additional information is necessary to determine if all or part of the claim is payable, and the specific information that is required.

HB 639 does not mandate a new coverage as emergency services and emergency ground transportation are already covered benefits as essential health benefits when provided by a covered provider; however, the bill does establish a requirement on health plans and individual health insurance policies, a requirement to reimburse a specific group of providers who do not contract with a patient's provider by a statutorily established formula. Currently, ground ambulance emergency rates are set mainly by local municipalities which run the vast majority of the emergency ambulance services in the state. The provisions of HB 639 would still allow for local governments to establish rates within certain guardrails which may or may not be lower than the rates currently charged. Additionally, the bill would end the ability of the emergency ground transportation services to seek additional payments from the patient after receipt of the payment from the insurer. Any out of pocket costs owed by the patient could not exceed the amounts the patient would have paid for an in-network service provider.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

**Section 1:** Creates s. 627.42398, F.S., relating to coverage for out-of-network ground ambulance emergency services.
**Section 2:** Creates s. 641.31078, F.S.; relating to coverage for out-of-network ground ambulance emergency services.
**Section 3:** Provides an effective date.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

[46] The term "first responder" is defined at s. 112.1815, F.S., and refers to law enforcement officer as defined in s. 943.10, a firefighter as defined in s. 633.102, or an emergency medical technician or paramedic as defined in s. 401.23 employed by state or local government. A volunteer law enforcement officer, firefighter, or emergency medical technician or paramedic engaged by the state or a local government is also considered a first responder of the state or local government for purposes of this section.
[47] A health care practitioner under s. 456.001(4), F.S. includes practitioners licensed under chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 462; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part I, part II, or part III of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491.

1. Revenues:

   None.

2. Expenditures:

   If it is determined that mandating payment options for the coverage of non-network ground ambulance emergency services is considered an expansion of benefits that generates an increase in premiums, then the state would be required to pay for the impact on all affected health insurance premiums for that benefit changes. The amount, if any, of that impact is indeterminate; however, the amount is not expected to be significant as both the Medicaid program and the State Group Health Insurance program have indicated no fiscal impact.

   The Agency for Health Care Administration reports no impact on the Florida Medicaid program.[48]

   The Department of Management Services for the Division of State Group Insurance reported no fiscal impact to the State Group Insurance Program.[49]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   Depending on what local governments that own and operate their own emergency ground transportation services charge and receive now, the impact on their revenue could increase or decrease. If the payment options are lower than what the counties are currently charging, the counties and local governments may still see an increase in revenue due to an increase in the percentage of claims being paid. The total impact on local governments cannot be determined as it may vary from municipality to municipality.

2. Expenditures:

   Depending on what percentage of local governments own and operate their own emergency ground transportation services and the difference in what those entities charge and receive now as compared to the options under bill, expenditures by local governments to maintain their emergency services could be less or more than the amounts currently needed to support these services beyond billed charges collected for those services now. The total impact on local governments cannot be determined as it may vary from municipality to municipality.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   The county/municipality mandates provision of Art. VII, section 18, of the Florida Constitution may apply because this bill requires those local governments which operate their own emergency ground ambulance services to provide such services in amount based on the rate options

[48] Agency for Health Care Administration, Letter from P. Steele, Legislative Affairs Director (January 11, 2024)(on file with Select Committee on Health Innovation).
[49] Department of Management Services, email from J. Holmgreen, Deputy Legislative Affairs Director (January 30, 2024)(on file with Select Committee on Health Innovation).

established in HB 639. These rate options may or may not be less than the amount being charged by local municipalities for these services. The bill still permits the counties and local governments to negotiate for rates with insurers, but establishes guardrails should the two parties fail to reach an agreement to ensure that patients are not caught with a surprise emergency ground transportation bill. Because the bill provides rate options, including the continued negotiations between the parties to reach a mutually agreeable amount, the bill may not trigger the mandate provision.

Based on responses from the DMS and Medicaid indicating that the changes proposed would have no fiscal impact on their program, any premium impact to health insurance coverage provided by local governments to their employees is likely to be insignificant. In addition, counties and municipalities can expect to be made whole by the state for any increased expenditures under the bill, based on application of current federal law requiring states to defray the costs of additional health insurance coverage mandates should other information suggest this interpretation is incorrect.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The OIR and AHCA has sufficient rulemaking to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Most health insurer contracts and policies begin on January 1st and the bill provides an effective date of July 1, 2024. To align this change in contract terms with providers and with policyholders, consideration should be given to including language making any provisions requiring changes in health insurance contract terms or policies to be effective for policies issued or renewed on or after January 1, 2025.

## IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to coverage for out-of-network ground ambulance emergency services; creating ss. 627.42398 and 641.31078, F.S.; defining terms; requiring health insurers and health maintenance organizations, respectively, to reimburse out-of-network ambulance service providers at specified rates for providing emergency services; specifying that such payment is payment in full; providing exceptions; prohibiting cost-sharing responsibilities paid for an out-of-network ambulance service provider from exceeding those of an in-network ambulance service provider for covered services; requiring health insurers and health maintenance organizations, respectively, to remit payment for covered services if such transportation was requested by a first responder or a health care professional; providing procedures for claims; providing an effective date.

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

Section 1. Section 627.42398, Florida Statutes, is created to read:

627.42398 Coverage for out-of-network ground ambulance emergency services.—

(1) As used in this section, the term:

(a) "Ambulance service provider" means a ground ambulance service licensed pursuant to s. 401.25.

(b) "Clean claim" means a claim that has no defect of impropriety, including lack of required substantiating documentation or particular circumstances requiring special treatment which prevent timely payment from being made on the claim.

(c) "Covered services" means those emergency ambulance services that an enrollee is entitled to receive under the terms of a health insurance policy. The term does not include air ambulance services.

(d) "Out-of-network" means a provider that does not contract with the health insurer of the enrollee receiving the covered health care services.

(2) A health insurance policy must require a health insurer to reimburse an out-of-network ambulance service provider for providing covered services at a rate that is the greater of any of the following:

(a) The rate set or approved, whether in contract, in ordinance, or otherwise, by a local governmental entity in the jurisdiction in which the covered services originated.

(b) Three hundred and fifty percent of the current published rate for ambulance services as established by the federal Centers for Medicare and Medicaid Services under Title

XVIII of the Social Security Act for the same service provided in the same geographic area; or the ambulance service provider's billed charges, whichever is less.

(c) The contracted rate at which the health insurer would reimburse an in-network ambulance provider for providing such covered services.

(3) Payment made in compliance with this section is payment in full for the covered services provided, except for any copayment, coinsurance, deductible, or other cost-sharing responsibilities required to be paid by the enrollee. An ambulance service provider may not bill the enrollee any additional amount for such paid covered services.

(4) Copayment, coinsurance, deductible, and other cost-sharing responsibilities paid for an out-of-network ambulance service provider's covered service may not exceed the in-network copayment, coinsurance, deductible, and other cost-sharing responsibilities for covered services received by the enrollee.

(5) A health insurer shall, within 30 days after receipt of a clean claim for covered services, promptly remit payment for covered services directly to the ambulance service provider and may not send payment to an enrollee. A health insurer must remit payment for the transportation of any patient by ambulance as a medically necessary service if the transportation was requested by a first responder or a health care practitioner as defined in s. 456.001.

(6) If the claim is not a clean claim, the health insurer must, within 30 days after receipt of the claim, send a written notice acknowledging the date of receipt of the claim and informing the ambulance service provider of one of the following:

(a) That the insurer is declining to pay all or part of the claim, and the specific reason or reasons for the denial.

(b) That additional information is necessary to determine if all or part of the claim is payable, and the specific additional information that is required.

Section 2. Section 641.31078, Florida Statutes, is created to read:

641.31078 Coverage for out-of-network ground ambulance emergency services.—

(1) As used in this section, the term:

(a) "Ambulance service provider" means a ground ambulance service licensed pursuant to s. 401.25.

(b) "Clean claim" means a claim that has no defect of impropriety, including lack of required substantiating documentation or particular circumstances requiring special treatment which prevent timely payment from being made on the claim.

(c) "Covered services" means those emergency ambulance services that a subscriber is entitled to receive under the terms of a health maintenance contract. The term does not

include air ambulance services.

(d) "Out-of-network" means a provider that is not a provider under contract with the health maintenance organization of the subscriber receiving the covered health care services.

(2) A health maintenance contract must require a health maintenance organization to reimburse an out-of-network ambulance service provider for providing covered services at a rate that is the greater of the following:

(a) The rates set or approved, whether in contract, in ordinance, or otherwise, by a local governmental entity in the jurisdiction in which the covered services originated.

(b) Three hundred and fifty percent of the current published rate for ambulance services as established by the federal Centers for Medicare and Medicaid Services under Title XVIII of the Social Security Act for the same service provided in the same geographic area; or the ambulance service provider's billed charges, whichever is less.

(c) The contracted rate at which the health maintenance organization would reimburse an in-network ambulance provider for providing such covered services.

(3) Payment made in compliance with this section is payment in full for the covered services provided, except for any copayment, coinsurance, deductible, or other cost-sharing responsibilities required to be paid by the subscriber. An ambulance service provider may not bill the subscriber any

additional amount for such paid covered services.

(4) Copayment, coinsurance, deductible, and other cost-sharing responsibilities paid for an out-of-network ambulance service provider's covered services may not exceed the in-network copayment, coinsurance, deductible, and other cost-sharing responsibilities for covered services received by the subscriber.

(5) A health maintenance organization shall, within 30 days after receipt of a clean claim for covered services, promptly remit payment for covered services directly to the ambulance service provider and may not send payment to a subscriber. A health maintenance organization must remit payment for the transportation of any patient by ambulance as a medically necessary service if the transportation was requested by a first responder or a health care practitioner as defined in s. 456.001.

(6) If the claim is not a clean claim, the health maintenance organization must, within 30 days after receipt of the claim, send a written notice acknowledging the date of receipt of the claim and informing the ambulance service provider of one of the following:

(a) That the health maintenance organization is declining to pay all or part of the claim, and the specific reason or reasons for the denial.

(b) That additional information is necessary to determine

if all or part of the claim is payable, and the specific additional information that is required.

Section 3. This act shall take effect July 1, 2024.

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 | _____ | |

Committee/Subcommittee hearing bill: Select Committee on Health Innovation

Representative Yeager offered the following:

**Amendment**

Remove line 44 and insert:

lesser of:

# CS/HB 739

# HOUSE OF REPRESENTATIVES LOCAL BILL STAFF ANALYSIS

**BILL #:** CS/HB 739 North Brevard County Hospital District, Brevard County
**SPONSOR(S):** Local Administration, Federal Affairs & Special Districts Subcommittee, Fine
**TIED BILLS:** **IDEN./SIM. BILLS:**

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Local Administration, Federal Affairs & Special Districts Subcommittee | 9 Y, 4 N, As CS | Roy | Darden |
| 2) Select Committee on Health Innovation | | DesRochers | Calamas |
| 3) State Affairs Committee | | | |

## SUMMARY ANALYSIS

A "special district" is a unit of local government created for a particular purpose, with jurisdiction to operate within a limited geographic boundary. A special district may be created by general law, special act, local ordinance, or rule of the Governor and Cabinet. A special district has only those powers expressly provided by, or reasonably implied from, the authority provided in the district's charter. Special districts provide specific municipal services in addition to, or in place of, those provided by a municipality or county.

The North Brevard County Hospital District (NBHD) is an independent special district in Brevard County created in 1953. The charter of the district was recodified in 2003. The district was created for the purpose of establishing and operating hospitals in the county. The district operates Parrish Medical Center, a 210-bed hospital in the City of Titusville.

The district board consists of nine members: three members appointed by the Titusville City Council; three members appointed by the Brevard County Board of County Commissioners; and three members appointed by the Brevard County Board of County Commissioners, subject to confirmation by the Titusville City Council. Members serve a four-year term and must reside within the boundaries of the district.

The bill revises the NBHD charter by:

- Replacing the current board of the district with a five-member board appointed by the Governor;
- Providing appointment procedures for board members;
- Removes the district's ability to levy an ad valorem tax;
- Revises dissolution procedures for the district, providing that the assets and liabilities of the district will be transferred to the Brevard County Board of County Commissioners; and
- Requiring the district, on or after October 1, 2024, to adopt a resolution to commence a valuation of the district's assets and provides qualifications for who may conduct the evaluation. After the receiving the evaluation report, the bill requires the district to solicit bids for the district's assets. If the district's assets are sold, the proceeds are transferred to the Brevard County Board of County Commissioners.

The bill restricts current board members from relating selling, disposing of, encumbering, transferring, or expending the assets of the district as such assets existed as of October 1, 2023, other than in the ordinary course of business.

The Economic Impact Statement filed with the bill indicates that the bill will not have a fiscal impact.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Present Situation**

Special Districts

A "special district" is a unit of local government created for a particular purpose, with jurisdiction to operate within a limited geographic boundary.[1] A special district may be created by general law, special act, local ordinance, or rule of the Governor and Cabinet.[2] A special district has only those powers expressly provided by, or reasonably implied from, the authority provided in the district's charter.[3] Special districts provide specific municipal services in addition to, or in place of, those provided by a municipality or county.[4]

A "dependent special district" is a special district meeting at least one of the following criteria:

- The membership of the district's governing body is identical to the governing body of a single county or municipality;
- All members of the district's governing body are appointed by the governing body of a single county or municipality;
- Members of the district's governing body are removable at will by the governing body of a single county or municipality; or
- The district's budget is subject to approval by the governing body of a single county or municipality.[5]

An "independent special district" is any district that is not a dependent special district or one that includes more than one county unless the district lies wholly within a single municipality.[6]

Hospital Districts

Hospital districts are a type of independent special district specializing in the provision of health care services. As of January 15, 2024, there are 30 special districts classified as hospital or health care districts.[7] The charters of hospital districts generally possess a set of core features: a board appointed by the Governor, the authority to build and operate hospitals, the power of eminent domain; the ability to issue bonds payable from ad valorem taxes; the use of ad valorem revenue to be used for operating and maintaining hospitals, and a provision that the facilities be established for the benefit of the indigent sick.[8]

All special districts must operate within a defined geographic boundary absent an "express and unambiguous" grant of extraordinary authority.[9] For example, the Sarasota County Public Hospital

[1] S. 189.012(6), F.S. *See also Halifax Hospital Medical Center v. State of Fla., et al.*, 278 So. 3d 545, 547-48 (Fla. 2019).
[2] S. 189.012(6), F.S.
[3] *See* ss. 189.02(4)-(5) and 189.031(3), F.S. Counties and municipalities have "home rule" powers allowing them to enact ordinances not inconsistent with general or special law for governmental, corporate, or proprietary purposes. Special districts do not possess home rule powers and are permitted to impose only those taxes, assessments, or fees authorized by special or general law. *See* art. VIII, ss. 1(f) and (g), 2(b), s. 6(e), Fla. Const. and ss. 125.01 and 166.021, F.S. *See also Local Gov't Formation Manual* 62, *available at* https://myfloridahouse.gov/Sections/Committees/committeesdetail.aspx?CommitteeId=3227 (last visited Jan. 16, 2024).
[4] *Local Gov't Formation Manual* at 62.
[5] S. 189.012(2), F.S.
[6] S. 189.012(3), F.S. Independent special districts are created by the Legislature, unless another mechanism is authorized by general law. *See, e.g.* s. 190.005, F.S. (community development districts may be created by a county, municipality, or the Florida Land and Water Adjudicatory Commission, depending on the size and location of the district).
[7] Dept. of Commerce, *Official List of Special Districts Online*, available at http://specialdistrictreports.floridajobs.org/webreports/mainindex.aspx (last visited Jan. 15, 2024).
[8] Florida TaxWatch, *Florida's Fragmented Hospital Taxing District System in Need of Reexamination*, Briefings (Feb. 2009), *available at* https://floridataxwatch.org/Research/Full-Library/ArtMID/34407/ArticleID/16012/Floridas-Fragmented-Hospital-Taxing-District-System-in-Need-of-Reexamination (last visited Jan. 17, 2023).
[9] *Halifax Hosp. Med. Center v. State*, 278 So. 3d 545, 548 (Fla. 2019).

District is authorized to operate hospitals and other types of health care facilities "both within and beyond the boundaries of the District."[10] The district is prohibited from using any funds derived from ad valorem taxation to establish or provide any health care facility or health care service beyond its boundaries. Meanwhile, the Cape Canaveral Hospital District is responsible for "support[ing] the health and welfare of all those in the District's boundaries and the surrounding communities by providing health care facilities and services to all those in need regardless of ability to pay."[11] The charter for the Halifax Hospital Medical Center empowers the district to operate hospitals and other types of health care facilities, as well as provide health services, in Brevard, Flagler, Lake, and Volusia Counties.[12]

Lease or Sale of Local Government Hospitals or Hospital Systems

Current law authorizes the sale or lease of local government owned hospitals.[13] The governing board of the hospital or hospital system must find that the sale or lease of the hospital is in the best interest of the affected community[14] and must state the basis of the finding. The governing board is responsible for determining the terms of the lease, sale, or contract. The hospital or hospital system may be leased or sold to a for-profit or a not-for-profit Florida entity, but the lease, contract, or agreement must:

- Subject the articles of incorporation of the lessee or buyer to approval by the board of the hospital;
- Require that not-for-profit lessees or buyers become qualified under s. 501(c)(3) of the United States Internal Revenue Code;
- Provide for orderly transition of operations and management;
- Provide for return of the facility upon termination of the lease, contract, or agreement; and
- Provide for continued treatment of the indigent sick.[15]

The lease, sale, or contract must be done through a public process that includes:

- Consideration of proposals by and negotiations with all qualified buyers or lessees following public notice to identify them;[16]
- Detailed, written board findings regarding the accepted proposal that meets specified requirements and disclosure of all information and documents relevant to the board's determination must occur;[17]
- A 120-day timeline for conclusion of the lease, sale, or agreement measured in advance of the anticipated closing date that:
    - Begins with publishing all findings, information, and documents specified by law and a public notice of the proposed transaction;[18]
    - Allows receipt of public comment;[19]
    - Is subject to approval by the Secretary of the Agency of Health Care Administration (AHCA), unless law requires approval by the registered voters of the local government where the hospital or hospital system is located;[20]
    - Requires a petition for approval of and a final order by AHCA;[21]
    - Provides a right of appeal for any interested party;[22]

[10] Ch. 2005-304, Laws of Fla.
[11] S. 1 of the Charter of the Cape Canaveral Hospital District, as codified in s. 3, ch. 2003-337, Laws of Fla.
[12] Ch. 2003-374, Laws of Fla., as amended by ch. 2019-172, Laws of Fla.
[13] S. 155.40, F.S.
[14] "Affected community" means those persons residing within the geographic boundaries defined by the charter of the county, district, or municipal hospital or health care system, or if the boundaries are not specifically defined by charter, by the geographic area from which 75 percent of the county, district, or municipal hospital's or health care system's inpatient admissions are derived. S. 155.40(4)(a), F.S.
[15] Continued treatment of the indigent sick must comply with the Florida Health Care Responsibility Act and pursuant to chapter 87-92, Laws of Florida. S. 155.40(2)(e), F.S. Ss. 154.301-154.316, F.S., are the Florida Health Care Responsibility Act. S. 154.301, F.S.
[16] S. 155.40(6), F.S.
[17] S. 155.40(7)(a), F.S.
[18] S. 155.40(8), F.S.
[19] S. 155.40(9), F.S.
[20] S. 155.40(10), F.S.
[21] S. 155.40(11), F.S. The AHCA final order is limited to whether the board complied with law and must require the board to approve or reject the proposal based on specified findings by AHCA.
[22] S. 155.40(12), F.S. "Interested party" includes a person submitting a proposal for sale or lease of the county, district, or municipal hospital or health care system, as well as the governing board. S. 155.40(4)(c), F.S.

- Makes the costs the responsibility of the board, unless any interested party appeals, then the costs can be equitably assigned to the parties;[23] and
- Allows voiding of the transaction by any party if specified provisions are not followed.[24]

If a hospital is sold, all tax authority associated with the hospital ceases.[25] Fifty percent of the proceeds from the sale or lease must be deposited into a health care economic development trust fund serving specified health care related purposes.[26] The district board must appropriate the other 50 percent to funding to care for the indigent sick.[27] Other taxing, financial, and liability considerations are provided by the law, including prohibitions on the transfer of government functions.[28] A streamlined process is provided if the property represents less than 20 percent of the hospital's net revenue.[29]

North Brevard County Hospital District (NBHD)

The NBHD is an independent special district in Brevard County created in 1953.[30] The district was created for the purpose of establishing, constructing, equipping, operating and maintaining, repairing, or leasing a hospital or hospitals in the county.[31] The NBHD's charter was recodified in 2003.[32] The district operates Parrish Medical Center, a 210-bed hospital in the City of Titusville.[33]

The district is governed by a nine-member board: three members appointed by the Titusville City Council; three members appointed by the Brevard County Board of County Commissioners; and three members appointed by the Brevard County Board of County Commissioners, subject to confirmation by the Titusville City Council.[34] Board members serve four-year terms and must reside within the boundaries of the district.[35]

The board is required to determine by July 15 of each year the amount of revenue the district will need for operations during the following fiscal year.[36] The board submits a certified copy of the board's adopted resolution documenting the amount required for the fiscal year to the Brevard County Board of County Commissioners, which may levy an ad valorem tax of up to five mills on behalf of the NBHD.[37] The county did not levy an ad valorem tax in the most recent fiscal year and "has a legacy of providing affordable health care without doing so."[38]

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[23] S. 155.40(13), F.S.
[24] S. 155.40(14), F.S. If any board member negligently or willfully violates specified provisions, they are subject to penalty by the Commission on Ethics.
[25] S. 155.40(15), F.S.
[26] S. 155.40(16)(a), F.S. The trust fund is controlled by the local government where the leased or sold property is located. The net proceeds in trust fund shall be distributed, in consultation with the Department of Economic Opportunity, to promote job creation in the health care sector of the economy through new or expanded health care business development, new or expanded health care services, or new or expanded health care education programs or commercialization of health care research within the affected community.
[27] S. 155.40(16)(b), F.S. Funding the delivery of indigent care, includes, but not limited to, primary care, physician specialty care, out-patient care, in-patient care, and behavioral health, to hospitals within the boundaries of the district with consideration given to the levels of indigent care provided.
[28] S. 155.40(17)-(21), F.S.
[29] S. 155.40(22), F.S.
[30] Ch. 2003-362, s. 1, Laws of Fla.
[31] Ch. 2003-362, s. 3(1), Laws of Fla.
[32] Ch. 2003-362, Laws of Fla.
[33] Parrish Healthcare, *History & Facts*, https://parrishhealthcare.com/about-us/history-facts/ (last visited Jan. 14, 2024). Jess Parrish and the Parrish family made a major land donation to help establish NBHD and North Brevard Hospital. In 1961, North Brevard Hospital rebranded as Jess Parrish Memorial Hospital after a hospital expansion. The hospital became officially known as Parrish Medical Center in 1990. In addition, the Jess Parrish Medical Foundation, Inc. is a Florida 501(c)(3) corporation that fundraises to support NBHD's programs and to advance health care organizations and objectives. North Brevard County Hospital District, *Financial Statements and Supplementary Information for the Year Ended September 20, 2022 and Independent Auditor's Report*, p. 37 (Feb. 27, 2023) https://www.parrishhealthcare.com/documents/FS_22-Parrish-Medical-Final.pdf (last visited Jan. 29, 2024).
[34] Ch. 2003-362, s. 3(2), Laws of Fla.
[35] *Id*.
[36] Ch. 2003, s. 3(6), Laws of Fla.
[37] Ch. 2003-362, s. 3(6), Laws of Fla.
[38] North Brevard County Hospital District, *Financial Statements and Supplementary Information For the Year Ended September 30, 2022 and Independent Auditor's Report* at 4, https://www.parrishhealthcare.com/documents/FS_22-Parrish-Medical-Final.pdf (last visited Jan. 14, 2024).

The NBHD charter provides that in the event of dissolution of the district, the assets of the district must be distributed to an entity organized under s. 501(c)(3) or s. 170(c)(2) of the Internal Revenue Code whose primary purpose is the same health care responsibilities as those performed by the district, together with other public needs of the district.[39] The entity must provide the same annual percentage of charity care, indigent care, and Medicaid care, based on gross revenues, that was provided by the public hospital and reported to the Health Care Cost Containment Board in its most recent reporting cycle.[40] The transfer of the assets must be approved by the member of the Brevard County Board of County Commissioners representing the area, as well as a four-fifths vote of the Titusville City Council.

The charter also requires any sale of hospital facilities to be subject to a referendum of the electors of the district.[41]

## Effect of Proposed Changes

Board Membership

The bill reduces the size of the NBHD board from nine members to five and provides that all members shall be appointed by the Governor. Board members must be qualified electors of the district. For the initial appointment, the Governor must issue a public notice soliciting citizen nominations for board members within 120 days after the effective date of the bill. The nomination solicitation period will remain open for at least 30 days after the notice, and the Governor must appoint initial members to the board from among the nominees within 60 days after the close of the nomination solicitation period. The initial terms of office for board members commence upon appointment, with three members serving until October 1, 2026 and two members serving until October 1, 2028.

For subsequent appointments, the Governor must have a citizen nomination solicitation period for at least 30 days, and appointed members serve for 4-year terms commencing on October 1 of the year in which they are appointed. If there is a vacancy for an unexpired portion of a term, the Governor must fill the vacancy within 60 days if the remainder of the term exceeds 90 days. If a member is appointed to complete an unexpired term, the member's terms starts at the time of appointment and continues through the remainder of the unexpired term.

The bill provides the offices and terms of current members of the NBHD board terminate as of the effective date of the bill. Members may continue to serve until a successor in office is appointed and qualified. Until successors are appointed and qualified to replace all the members of the board, the district may not sell, dispose of, encumber, transfer, or expend the assets of the district as such assets existed as of October 1, 2023, other than in the ordinary course of business.

[39] Ch. 2003-362, s. 3(17), Laws of Fla.
[40] The Health Care Cost Containment Board was abolished in 1992 and its duties transferred to the Agency for Health Care Administration. Ch. 92-33, Laws of Fla.
[41] *Id*.

Budget and Finance

The bill requires the NBHD board to submit a report its operating budget and projected revenues to the Brevard County Board of County Commissioners by July 15th of each year and removes the district's power to levy ad valorem taxes.

Dissolution Procedures

The bill removes provisions of the current charter specifying the distribution of the district's assets, instead requiring all assets and liabilities of the NBHD be transferred to the Brevard County Board of County Commissioners.

Valuation and Sale

The bill requires that, on or after October 1, 2024, the board must adopt a resolution to commence a valuation of the district's assets. The board must contract with an independent entity that has at least five years of experience conducting comparable evaluations of hospital organizations similar in size and function in accordance to applicable industry best practices. The bill provides that the independent entity may not have any current affiliation with or financial involvement with the district, any support corporation of the district, the Jess Parrish Medical Foundation, Inc., or any member of the NBHD board.

The valuation must be completed and a final report presented to the board no later than 180 days after the date the valuation commenced. The report must be published to the district's website and include a statement signed by the chair of the board and the chief executive officer of the independent entity based on each person's reasonable knowledge and belief the contents and conclusion of the valuation are true and correct.

The board must adopt a resolution commencing the process of soliciting bids for the district's assets no later than 30 days after the date the board received the final valuation report. The report must be made available to all potential bidders, include the time and date for the receipt of bids and of the public opening, and include all applicable contractual terms and conditions. The resolution must establish a minimum acceptable bid for the district's assets based on a commercially reasonable value and require bidders to enter into an enforceable commitment that programs and services provided by the district for indigent care must be continued in perpetuity, unless otherwise agreed to by the Brevard County Board of County Commissioners.

Upon completion of the sale of the district's assets, all liabilities and proceeds shall be transferred to the Brevard County Board of County Commissioners. Proceeds received by the board must first be used to satisfy all liabilities of the former district. No later than 30 days after the complete transfer of assets and liabilities, the district must notify the Florida Department of Commerce. The district is dissolved automatically upon receipt of the notice by the department.

The Economic Impact Statement filed with the bill indicates the bill will not have a fiscal impact.

B. SECTION DIRECTORY:

Section 1: Amends ch. 2003-362, Laws of Fla., relating to the North Brevard Hospital District, Brevard County.

Section 2: Provides the terms of current board members end as of the effective date of the bill, allows those members to continue to serve until the appointment of their successors, and prohibits district board members, officers, and employees from undertaking certain actions outside of the ordinary course of business with district assets as of the effective date of the bill.

Section 3: Provides an effective date of upon becoming a law.

## II. NOTICE/REFERENDUM AND OTHER REQUIREMENTS

A. NOTICE PUBLISHED? Yes [x] No []

IF YES, WHEN? November 1, 2023.

WHERE? *Florida Today*, a daily newspaper of general circulation published in Brevard County, Florida.

B. REFERENDUM(S) REQUIRED? Yes [] No [x]

IF YES, WHEN?

C. LOCAL BILL CERTIFICATION FILED? Yes [x] No []

D. ECONOMIC IMPACT STATEMENT FILED? Yes [x] No []

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

None.

B. RULE-MAKING AUTHORITY:

The bill neither provides authority for nor requires rulemaking by executive branch agencies.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On January 19, 2024, the Local Administration, Federal Affairs & Special Districts Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment clarifies who is responsible for notifying the Department of Commerce after the complete transfer of the district's assets and liabilities.

The analysis is drafted to the committee substitute as passed by the Local Administration, Federal Affairs & Special Districts Subcommittee.

A bill to be entitled

An act relating to the North Brevard County Hospital District, Brevard County; amending chapter 2003-362, Laws of Florida; revising the appointment and membership of the district board; requiring the board to determine the operating budget and estimated revenues of the district; removing provisions relating to ad valorem taxation; revising disposition of assets and liabilities in the event of dissolution of the district; requiring the district to conduct a valuation; requiring the district to solicit bids for the sale of district assets; providing for transfer; providing for dissolution of the district; providing that offices and terms of members of the board shall end on a certain date; providing an exception; prohibiting certain actions relating to district assets; providing an effective date.

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

Section 1. Sections 2, 6, and 17 of section 3 of chapter 2003-362, Laws of Florida, are amended, and section 24 is added to that section, to read:

Section 2. The governing body authority of the district shall be known as the North Brevard County Hospital District

Board. The board shall constitute a body politic and a body corporate; it may adopt and use a common seal; it may contract and be contracted with; and it may sue and be sued in its corporate name or in the corporate name of the district.

The board shall be composed of five ~~nine~~ members appointed by the Governor. All members shall be qualified electors of the district. The Governor shall issue a public notice soliciting citizen nominations for board members within 120 days after the effective date of this act. The nomination solicitation period shall remain open for at least 30 days after the date of the public notice. The Governor shall appoint initial members to the board from among the nominees within 60 days after the close of the nomination solicitation period. The initial terms of office for the five members shall commence at upon their appointment, with terms designated as follows: three members shall serve until October 1, 2026, and two members shall serve until October 1, 2028. The Governor shall have a citizen nomination solicitation period for at least 30 days and appoint members for subsequent terms from among the nominees. Members appointed for subsequent terms shall be appointed for 4-year terms commencing on October 1 of the year in which they are appointed. If a member is appointed to complete an unexpired term, the member's term shall commence at the time of appointment and shall continue through the remainder of the unexpired term. The

Governor shall fill any vacancy for the unexpired portion of a term within 60 days after the vacancy occurs if the remainder of the term exceeds 90 days. ~~The office of each member shall be designated specifically by number as member one through nine. The office of each member shall be for a term of 4 years beginning on the first day of January. Each member shall serve until his or her successor is appointed by the appropriate governing body as hereinafter provided. Any vacancy occurring in any office of a member shall be filled by the appropriate governing body in the manner provided herein for regular appointments for the remainder of the unexpired term of office. All board members shall reside within the boundaries of the district.~~

~~Board members one, two, and three shall be appointed by the City Council of the City of Titusville.~~

~~Board members four, five, and seven shall be appointed by the Board of County Commissioners of Brevard County.~~

~~Board members six, eight, and nine shall be appointed by the Board of County Commissioners of Brevard County subject to confirmation by the City Council of the City of Titusville.~~

~~In the event any board member ceases to reside within the~~

~~boundaries of the district, the office of such member shall be deemed vacant as of the date of such change in residence.~~

~~Any board member may be removed from office in the event a request for removal for violation of policies and procedures established by the board is approved by two-thirds of the membership of the board and in the event the majority of the governing body responsible for appointing such member approves of such removal without the necessity of any requirement of advice and consent as provided herein for an appointment.~~

Section 6. It shall be the duty of the board, no ~~not~~ later than July 15, to determine the operating budget and estimated revenues for ~~amount required during~~ the ensuing fiscal year for the purpose of establishing, constructing, equipping, operating, maintaining, repairing, or leasing of the hospital or hospitals, or for the payment of debt service and reserves on bonds, notes, or other obligations issued by the district, or reserves therefor, or for any one or more of the above purposes. Such determination shall be by resolution of the board and it shall be the duty of the chair and the secretary of the board to certify to the Board of County Commissioners of Brevard County the amount required~~, which shall be provided by an ad valorem tax levied by the Board of County Commissioners of Brevard County on all taxable real and personal property in the district for the ensuing fiscal year for the hospital fund. The Board of~~

~~County Commissioners of Brevard County, upon being furnished a certified copy of the resolution of the board regarding the amount required for its stated purposes, shall levy the necessary ad valorem taxes on all the taxable real and personal property within the district to raise the required amount, provided such millage shall not exceed 5 mills on the dollar of the assessed valuation of the taxable real and personal property situated in the district in Brevard County, less all such property exempt from taxation by the Florida Constitution; and further provided that the board, in issuing any bonds, notes, or other obligations as hereinafter provided, may covenant with the holders of such bonds, notes, or other obligations that such holders shall have a first lien on all such ad valorem taxes levied for the payment of such bonds, notes, or other obligations~~. The resolution of the board ~~above~~ shall be adopted and a certified copy thereof shall be filed with the Board of County Commissioners of Brevard County no later ~~not less~~ than 10 days from the adoption of the resolution ~~prior to the time fixed by law for the levy of general county taxes~~.

Section 17. In the event of dissolution of the district, the ~~residual~~ assets and liabilities of the district shall ~~may only~~ be transferred to ~~one or more organizations which are exempt organizations as described in Section 501(c)(3) or Section 170(c)(2) of the Internal Revenue Code of 1986 (or any other corresponding provisions of any future Internal Revenue~~

~~Law) and which shall have as their primary purpose those same health care responsibilities as then performed by the district, together with other public needs of the district, and shall be required to provide the same annual percentage of charity care, indigent care, and Medicaid care, based on gross revenues, that was provided by the public hospital and reported to the Health Care Cost Containment Board in its most recent reporting cycle, and which shall be jointly approved by the district One (1) Commissioner of~~ the Brevard County Board of County Commissioners ~~and four-fifths vote of the City Council of the City of Titusville~~.

~~Notwithstanding the foregoing, in no event shall the board sell the hospital facilities without first receiving the approval by a majority vote of the duly qualified electors who reside within the district and who vote in the election. Prior to any such sale, such qualified electors shall, by affirmative vote, consent to such sale of the hospital facilities, which consent must also approve the terms and conditions of the sale, and the disposition of the sale proceeds. The vote on this issue may be received at a general or special election to be held within the district, which shall not be called until notice thereof has been published in a newspaper of general circulation within the district once a week for 4 consecutive weeks next prior to the week during which the general or special election~~

~~will be held. If a majority of the electors who vote in the general or special election vote in favor of the sale of the hospital facilities and if they approve the terms and conditions of the sale, then in that event, the board shall have the authority to consummate the sale upon the terms and conditions thus approved by the electors. In the event that the duly qualified electors do not ratify and approve the sale along with its terms and conditions, the board shall not have the authority to consummate the sale of the hospital facilities.~~

Section 24. (a) On or after October 1, 2024, the board shall adopt a resolution to commence a valuation of the district's assets. The board shall contract with an independent entity that has at least 5 years of experience conducting comparable evaluations of hospital organizations similar in size and function to conduct the valuation according to applicable industry best practices. The independent entity may not have any current affiliation with or financial involvement in the district, any support corporation of the district, the Jess Parrish Medical Foundation, Inc., or any member of the board. The valuation must be completed and a final report presented to the board no later than 180 days after the date on which the valuation is commenced. The final report shall be published on the district's website. The final report must include a statement signed by the chair of the board and the chief executive officer of the independent entity conducting the

valuation that, based on each person's reasonable knowledge and belief, the contents and conclusions of the valuation are true and correct.

(b) No later than 30 days after the date on which the board receives the final report, the board must adopt a resolution commencing the process of soliciting bids for the district's assets. The resolution must be made available simultaneously to all potential bidders, must include the time and date for the receipt of bids and of the public opening, and must include all applicable contractual terms and conditions, including the criteria to be used in determining acceptability and relative merit of the bid. The resolution shall establish a minimum acceptable bid for the district's assets based on a commercially reasonable value and require bidders to enter into an enforceable commitment that programs and services provided by the district for indigent care must be continued in perpetuity, unless otherwise agreed to by the Board of County Commissioners of Brevard County.

(c) Upon completion of the sale of the district's assets, all liabilities and any proceeds from the sale shall be transferred to the Board of County Commissioners of Brevard County. Proceeds received by the board of county commissioners pursuant to this section shall first be used to satisfy all liabilities of the former district.

(d) No later than 30 days after the complete transfer of

assets and liabilities as provided in paragraph (c), the district Memorial Health System shall notify the Florida Department of Commerce. The district shall be dissolved automatically upon receipt of the notice by the department.

Section 2. The offices and terms of all members of the North Brevard County Hospital District Board existing as of the effective date of this act shall end as of the effective date of this act, but such members may continue to serve until a successor in office is appointed and qualified. Until successors are appointed and qualified to replace all of the members of the board existing as of the effective date of this act, board members, officers, and employees of the district may not sell, dispose of, encumber, transfer, or expend the assets of the district as such assets existed as of October 1, 2023, other than in the ordinary course of business.

Section 3. This act shall take effect upon becoming a law.

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 783 Medicaid Managed Care Plan Performance Metrics
**SPONSOR(S):** Berfield and others
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 794

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Select Committee on Health Innovation | | Lloyd | Calamas |
| 2) Health Care Appropriations Subcommittee | | | |
| 3) Health & Human Services Committee | | | |

## SUMMARY ANALYSIS

The Medicaid program is a medical assistance program for low-income people and disabled people funded jointly by the state and federal governments. The Agency for Health Care Administration (AHCA) administers the Medicaid program, primarily through a managed care model under contracts with managed care plans. The Statewide Medicaid Managed Care Program (SMMC) operates under a federal waiver to deliver primary and acute care services as the Managed Medical Assistance (MMA) program, and under a second federal waiver to deliver comprehensive long-term care services.

Current law requires AHCA to monitor plan performance, including requiring the managed care plans to report various data related to provider interactions and provider network administration. Currently, AHCA must report enrollment metrics, prepare annual evaluations, and maintain a health plan quality scorecard. AHCA imposes detailed reporting requirements for the plans through their contracts, including data not currently published or analyzed by AHCA in a systematic manner.

HB 783 establishes detailed requirements for plans to submit data on their administrative performance related to providers, including data on provider credentialing, prior authorization processing and claims payment.

The bill also requires AHCA to compile the data submitted by the plans and publish it in detail on a dashboard developed by a third-party vendor. The bill also requires AHCA to include recipient complaint data on the dashboard. AHCA must publish the data by plan and by provider category.

The bill has a significant negative fiscal impact on AHCA and no fiscal impact on local government.

The bill has an effective date of July 1, 2024.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Background**

**Medicaid**

The Medicaid program is a medical assistance program funded jointly between the state and federal governments. The program provides health care coverage for over 4.8 million low-income families and individuals, the elderly, and individuals with disabilities in Florida, including 3.4 million recipients who receive their services through a managed care plan.[1] In Florida, two in every five Florida children receive Medicaid and 45 percent of all births in the state are covered by the program.[2]

The Agency for Health Care Administration (AHCA) administers the Florida Medicaid program authorized under Title XIX of the federal Social Security Act and Ch. 409, F.S. The AHCA administers the program through the managed care model,[3] under contracts with managed care plans. The program operates under two separate federal Medicaid waivers: Section 1115 waiver for primary and acute care services called the Managed Medical Assistance (MMA) program and Long Term Care (LTC) services waiver under Sections 1915(b) and (c) of the Social Security Act.[4] Currently, the AHCA is conducting its third procurement process under these waivers with the selection of new contracts anticipated at the end of February, 2024.[5] The existing SMMC contracts have been effective for almost seven years and will expire December 31, 2024.

Managed Care Plan Accreditation

Accreditation is a "seal of approval" given to an organization by an independent evaluator which has reviewed the practices and performances of the managed care plan. An accreditation rating indicates that a plan meets or exceeds certain quality criteria based on the level or rating that a plan has earned. Accreditation status is one of the statutorily-designated quality selection criteria that the AHCA must consider in the selection of eligible plans during the procurement process. Plans must be accredited by the National Committee for Quality Assurance[6], the Joint Commission[7] or another nationally recognized accrediting body, or have initiated the accreditation process, within one year after the contract is executed.

Each accrediting organization has its own standards and assesses those standards against the health plan's performance and organizational structure to determine if its established standards and performance standards meet the accrediting body's requirements. The plan may be reviewed for its provider credentialing processes, prior authorization procedures, and prompt payment of provider claims record. Accreditation can be awarded for different lengths of time and then must be renewed.

Provider Network Credentialing

[1] Agency for Health Care Administration, *Comprehensive Medicaid Managed Care Enrollment Reports (December 31, 2023)* available at https://ahca.myflorida.com/medicaid/medicaid-finance-and-analytics/medicaid-data-analytics/medicaid-monthly-enrollment-report (last visited January 25, 2024).
[2] Kaiser Family Foundation, *Medicaid in Florida (June 2023),* available at https://files.kff.org/attachment/fact-sheet-medicaid-state-FL (last visited January 25, 2024).
[3] The vast majority of Medicaid enrollees receive services through the managed care model; those with limited benefits (such as the family planning program) are not, and some populations (such as enrollees in the home and community-based waiver for persons with developmental disabilities) may choose managed care or the fee-for-services model. S. 409.965, F.S.
[4] S. 409.964, F.S.
[5] *See* AHCA ITN 23/24 010 for Statewide Medicaid Managed Care (MMA and LTC) available at MyFloridaMarket Place Vendor Information Portal (last visited January 26, 2024) and the AHCA ITN for Statewide Medicaid Prepaid Dental Services available at MyFloridaMarket Place Vendor Information Portal (last visited January 26, 2024).
[6] National Committee on Quality Assurance (NCQA), *About NCQA,* Health Care Accreditation, Health Plan Accreditation Organization - NCQA - NCQA (last visited January 27, 2024).
[7] The Joint Commission, *Who We Are, A Trusted Partner in Patient Care | The Joint Commission* (last visited January 26, 2024).

*Medicaid Provider Identification Number*

To deliver health care services to a Medicaid recipient and be paid for that service, an individual provider must be an enrolled provider through AHCA's provider enrollment system. The credentialing process ensures that health care workers and organizations have the proper education, training, qualifications, and licenses to care for patients. The provider enrollment system also reduces improper payments in Medicaid by minimizing the risk of allowing unscrupulous providers to bill the Medicaid program, according to AHCA. [8]

For providers who only need to enroll for a Medicaid Provider Identification Number for billing under a Medicaid managed care contract and will only be paid through the plan and not through FFS, AHCA established a streamlined credentialing process that includes basic credentialing, licensure verification, review of background screening history, and a check with the federal exclusion database checks.[9] If a provider contracts with more than one SMMC plan, the basic credentialing by AHCA reduces the amount of time it takes for a provider to complete each plan's unique or supplemental credentialing requirements.

The limited provider enrollment option is only for those providers participating with the managed care plans and is not a sufficient process for a provider who is reimbursed as an individual provider in the FFS delivery system.[10] Providers credentialed through the limited process do not have access to all off the necessary web portal tools, including the ability to submit claims, upload or download files, or view reports.[11] A Limited Enrollment Provider can always submit a new application to become an Enrolled Provider later to have his or her access upgraded to direct billing and other options.[12]

*Managed Care Plan Network Credentialing*

A plan may conduct its own credentialing process or contract with an accreditation credential verification organization(s) to conduct the process on its behalf. While the managed care plan's credentialing process may be conducted concurrently with the Medicaid provider enrollment process, which could shorten the length of the credentialing period, most of the current plans require a prospective provider to obtain its Medicaid provider ID *prior to* submitting its credentialing application to the managed care plan for credentialing.[13]

The *Medicaid Provider Enrollment Application Guide* sets out example timeframes for provider application processing based on stages and if there are no deficiencies with the application. The following stages and timeframes would likely apply for a new application:[14]

- In Process: Application is being reviewed for accuracy and compliance with all provider eligibility requirements (a*pproximately 14 business days*).
- Background Screening: Application processing has been completed. Results of the background screening have not yet been received from Background Screening Clearinghouse (*approximately 5 business days*)
- Clearinghouse Screening: The application has no deficiencies and is awaiting the results of the background screening (*less than 15 calendar days*). If screening results are not received within 14 days, the provider receives a deficiency letter.
- State Review: Applications pending verification by AHCA will show a status of "State Review." State Review means validating the information on the application, such as certification and expiration dates, search for any prior history with the applicant and Medicaid or any other state agencies, and a review of the applicant's financial history.

[8] *Supra*, note 5.
[9] Agency for Health Care Administration. *An Overview of Streamlined Credentialing (Limited Enrollment), February 2, 2022,* available at https://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/Managed%20Care/Streamlined%20Credentialing%20(Limited%20Enrollment).pdf (last visited January 26, 2024).
[10] *Id.*
[11] *Id.*
[12] *Id.*
[13] *Id.*
[14] Agency for Health Care Administration, *Florida Medicaid Provider Enrollment Application Guide (October 2022)* available at Florida Medicaid Provider Enrollment App Guide.pdf (flmmis.com) (last visited January 25, 2024).

- Enrolled: Enrollment approved. A Welcome letter is mailed within 2 business days after the activation of the new provider (*activated within 5 business days*).

The timeframes for activation of a new provider identification number depend on the sufficiency of the application submitted and if additional documentation becomes necessary as part of the review process. Ensuring that an applicant's name and identification number are clearly marked on items helps with the matching of supplemental materials and the return of documents after the review.

Prior Authorization

Prior authorization one method of managing health care utilization and quality. Insurers and managed care plans may require providers to obtain coverage and reimbursement authorization prior to providing certain services or prescribing certain drugs. Prior authorization is often used to help identify under- and over- utilization of services, identify clinical risks such as drug-drug interactions, and to prevent fraud and abuse. In Medicaid managed care, both federal regulations and AHCA plan contracts establish maximum timelines for plans to resolve both urgent and non-urgent prior authorization requests.

| **Prior Authorization Timeline Comparison** | | |
|---|---|---|
| | **Federal Regulations** 42 CFR 438.210(d) | **AHCA Contract** |
| Standard Request (Non-Urgent) | 14 calendar days | 7 days |
| Standard Request Allowable Extension | 14 calendar days | 4 days |
| Standard Request Maximum Allowed | 28 calendar days | 11 days |
| Urgent Request | 72 hours | 2 days |
| Urgent Request - Allowable Extension | 14 calendar days | 1 day |
| Urgent Request - Maximum Extension | 17 calendar days | 3 days |

The AHCA reports that when the current SMMC contracts were renewed, a reduced response time for non-urgent and urgent requests was agreed upon by the parties. The non-urgent prior request maximum time was modified from the federal limit of 28 calendar days to the contractual standard of 11 days.[15] For urgent requests, the current contractual standard is two days with an extension period of one additional day which reduces the length of the maximum possible review time from 17 review days to three days.[16]

The plans currently report monthly on all service authorization requests completed during the previous reporting month. Service authorization requests are categorized as standard, extended standard, expedited, or extended expedited authorizations.[17] Plans are specifically prohibited from requiring prior authorization for emergency services; however, prior authorization for specific Medicaid services or benefits may be applicable for higher utilized or higher cost services. In some instances, there are procedural limitations in state statute if a prior authorization process is applied, including a requirement that access to the prior authorization system be accessible 24 hours a day, 7 days a week for approval of hospital inpatient services[18] or that responses to authorization requests be initially made within 24 hours.[19] Other prior authorization directives are focused on the entity requesting authorization and the

[15] *Supra,* note 5.
[16] *Supra,* note 5.
[17] *Id.*
[18] S. 409.905(5), F.S.
[19] S. 409.912(5)(1)(a), F.S.

items necessary for a determination such as clinical and medical records, prior use of a treatment or prescription, a recipient's plan of care, and documentation that supports the recipient's diagnosis.[20]

Prompt Payment

Federal Medicaid regulations establish standards for the prompt payment of provider claims for Medicaid beneficiaries.[21] The regulation defines a "claim" to mean a bill for services, a line item of service, or all services for one beneficiary within a bill." A "clean claim" is considered to be a claim that can be processed without obtaining additional information from the provider of the service or from a third party.[22]

State law also requires the plan to have a claims payment system which ensures the timely payment of clean claims within state standards under s. 641.3155, F.S.[23] With the receipt of a clean electronic claim, the plan may either dispute or deny the claim or pay the claim within 20 days after the claim has been received. If requested, a provider must submit additional information and documentation within 35 days of receipt of request for additional information. The claim must be paid or denied with 90 days of receipt. [24]

For nonelectronic or paper claims, a plan must pay the provider also in accordance with federal and state regulations. Paper claims must be denied or paid within 40 days after receipt of the claim; however, the time can be extended if supplemental documentation is required. If the claim is not denied or paid within 120 days of the original receipt date, the Plan is obligated to pay the claim within 140 days.[25]

Contractually, the AHCA and the MMA plan agreed to tighter prompt payment standards in the renewal of their contracts in 2018. With notice periods significantly less than statutory requirements, AHCA reports that the managed care plans must pay or notify a provider that a claim is denied or contested within 10 business days of receipt of a clean claim from either a nursing home or hospice and within 15 days if received from a non-nursing home/hospice facility. If contested or denied, the claim must be paid or denied within 90 days after receipt, but if the claim is neither denied nor paid, the plan has a maximum time period to pay of 120 days.

For non-electronically submitted claims, the plan must pay the paper claim or notify the provider that the claim is denied or contested within 20 days after receipt of the claim.[26] The chart below shows the existing authorities and standards for Medicaid contracts and prompt payment of claims.

**Comparison of Time Standards – Prompt Payment of Claims**
Maximum Time Measured from First Receipt of Claim

| | **Federal** CFR 42.447(d)* | **FL Insurance Code** §641.3155, F.S. | **Medicaid Contract** §409.966(3)(c)6, F.S. | |
|---|---|---|---|---|
| | **Based on a percentage of claims paid within this standard* | | Nursing Home Hospice | Non-Nursing Home Hospice |
| **Electronic Clean Claims** | | | | |
| #Days to acknowledge receipt | NA | NA | Next business day | |
| #Days to pay, notify denial or contest | 30 days | 20 days | 10 business days | 15 business days |
| #Days to provide additional information > denial | NA | 35 days | 35 days | 35 days |
| #Days to pay > additional information | NA | NA | 90 days | 90 days |
| **Paper Claims** | | | | |

[20] *See* ss. 409.905(4) and(5), 409.906(8), (13), (23), and 24 409.912(5)(a), 409.91195(5) and (9), F.S.
[21] 42 CFR 447.45.
[22] *Supra,* note 5.
[23] ss. 409.966(3)(c)(6), F.S. and 641.3155(3), F.S.
[24] *Supra,* note 5.
[25] Agency for Health Care Administration, *Florida Medicaid Provider Enrollment Application Guide (October 2022),* available at Florida Medicaid Provider Enrollment App Guide.pdf (flmmis.com) (last visited January 27, 2024).
[26] *Supra,* note 5.

| | | | | |
|---|---|---|---|---|
| #Days to acknowledge receipt | NA | 40 days | 20 days | 20 days |
| #Days to pay, notify denial, or contest | 30 days | 35 days | 20 days | 20 days |
| **All Claims Types** | | | | |
| #Days to pay or deny claim | 90 days | 90 days | 20 days | 20 days |
| #Days before Plan must pay if no payment, or a denial or contest | 90 days | 120 days | 90 days | 90 days |
| **Maximum time to pay any claim** | 12 months | 140 days | 120 days | 120 days |

Quality Strategies

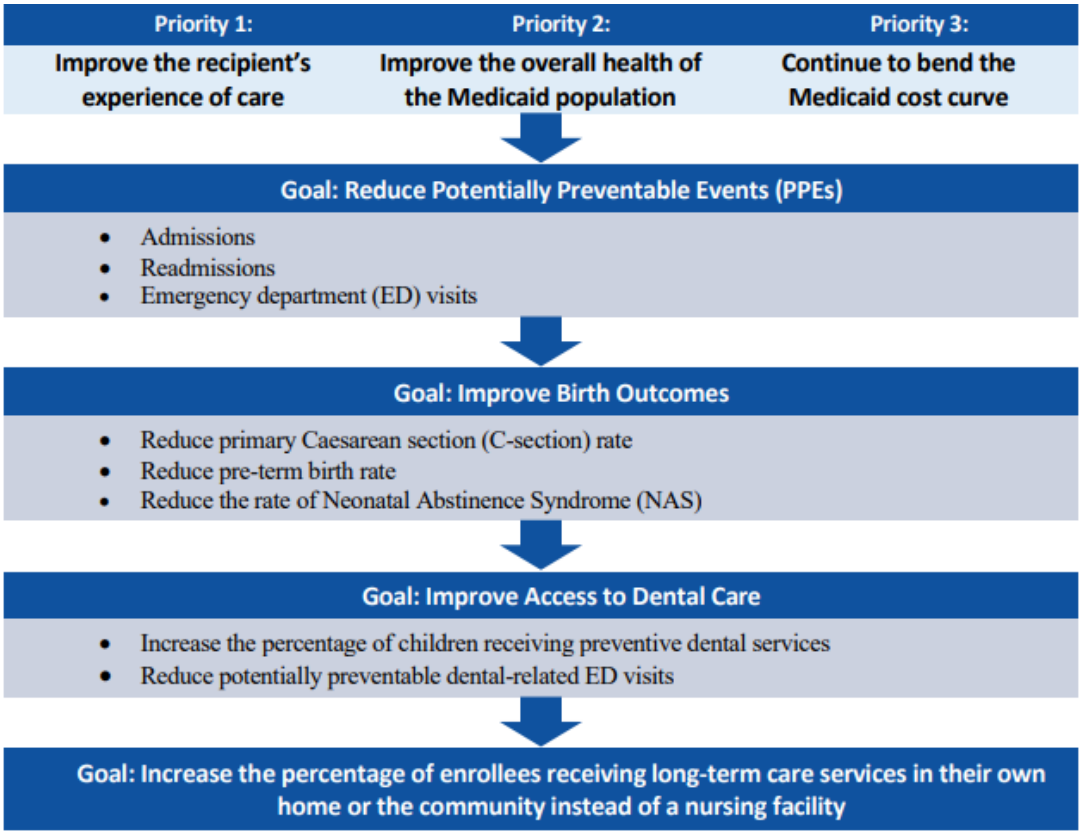
In 2016, the federal Centers for Medicare & Medicaid Services (CMS) re-vamped the Medicaid standards for contracting with managed care plans. States that contract with managed care plans must have a monitoring plan in place which includes:

- Standards for access to care, structure and operations, and quality measurement and improvement;
- Procedures for regularly monitoring and evaluating plan compliance with state standards;
- National performance measures identified and developed by CMS;
- External independent reviews of quality outcomes and access to services;
- Allowance for Intermediate sanctions for plans;
- Operation and review of the state's quality strategy;
- State-defined network adequacy and availability of services standards for managed care;
- Measurable goals and objectives for continuous quality improvement, with consideration of the existing population's health status;
- Performance targets, performance measures, quality measures, and performance outcomes that will be measured and reported;
- Performance improvement projects and other interventions proposed to improve access, quality, or timeliness of care;
- Description of the state's care transition policy;
- Description of the state's plan to address health care disparities; and
- Mechanisms to identify persons who need long term services and supports or persons with special health care needs.[27]

In addition to these ongoing requirements, the plans must continually demonstrate ongoing compliance with state contractual requirements for being nationally accredited, having experience with the population to be served, offering sufficient primary care and specialty care physicians, and processing of uncontested claims in a timely manner.[28] The plans were required before the federal regulation to maintain accurate and complete databases of their provider networks and display data and patient feedback on the provider in such a manner that it allowed patients to easily make provider comparisons.[29]

The federal regulations[30], also require states to develop and implement a written quality strategy and to re-assess that strategy every three years. The AHCA last updated these goals during the 2019-2020 state fiscal year and identified three priorities tied to four specific program goals.[31]

[27] 42 CFR 438.340.
[28] S. 409.966(3), F.S.
[29] ss. 409.967(2)(c)(1) and 409.967(2)(e), F.S.
[30] 42 CFR section 438.340
[31] Agency for Health Care Administration, Health Services Advisory Group, *SFY 2021-2022 External Quality Review Technical Report (April 2023),* available at SFY 2021–2022 External Quality Review Technical Report (myflorida.com) (last visited January 24, 2024).




The state may implement performance improvement projects (PIP) as another quality improvement strategy. A PIP includes four elements:

- Performance measurement;
- Implementation of interventions;
- Evaluation of the interventions' impact using the performance measures; and
- Activities to increase/sustain improvement.[32]

A PIP may be focused on a specific improvement need of a plan or a region, or it could be a PIP that is shared among all plans as a systematic goal of the Medicaid program. In a few cases, CMS has mandated a national PIP to see improvements in specific areas of health care, such as a focus on children's oral health. At this time, the MMA plans have three shared PIP topics incorporated into their contracts relating to maternal health, potentially preventable events, administration issues of the transportation benefit. In addition, the contracts require plans to add a PIP of their choosing in behavioral health or integrating behavioral health and primary care.[33]

An External Quality Review Organization (EQRO) is also required for each state's Medicaid program.[34] An EQRO acts to validate the data behind the performance measurements and other mandatory state and federal reporting requirements the state is held accountable for, review of the performance and measurement of the PIPs of the managed care plans, and to assist in the development of the state's quality rating system.

Complaints and Grievances

[32] 42 CFR 438.330(d)
[33] Agency for Health Care Administration, *Medicaid Managed Care, 2018-2024 Model Contracts, Managed Medical Assistance, Attachment II, Exhibit II-A, Section IX (Quality),* available at https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care/2018-2024-smmc-plans (last visited January 27, 2021).
[34] Section 1932(c)(1) of the Social Security Act.

The AHCA uses a centralized approach to resolve Medicaid complaints and to determine if Medicaid managed care plans are meeting their contractual obligations. All complaints are recorded whether the complaint is later substantiated or not.[35]

Complaint and grievance are defined in state statute in several places and while sometimes used interchangeably, the two words are statutorily and procedurally different. Federal laws and rules which govern the Medicaid program do not define complaint, but do define grievances.[36] By contract, the SMMC contract defines both "complaint" and "grievance." The SMMC contract defines "complaint" as "any oral or written expression of dissatisfaction by an enrollee submitted to the Managed Care Plan or to a State Agency and resolved by close of business the following business day." A complaint is considered to be a subcomponent by a grievance by the AHCA as any unresolved complaint at the end of the following business day becomes a grievance.

A "grievance" is then defined by the federal regulation definition. As a grievance, the managed care plan must provide the beneficiary with a written notice of the resolution within 90 days from the date of the receipt of the grievance. Unresolved grievances can then lead to a plan appeal, the Medicaid fair hearing process, the District Court of Appeal, and ultimately the Florida Supreme Court. The maximum time frames for these processes are established in the Code of Federal Regulations.[37]

Quarterly, the managed care plans submit a report to AHCA on the total number, description, and outcome of the grievances filed by beneficiaries. This internal review process is part of each plan's quality review process.

## Effect of Bill

HB 783 creates a new section of statute relating to Medicaid managed care contracts and data collection related to provider credentialing, prior authorization, and the prompt claims payment. Under the new requirements, managed care plans would be required to submit monthly to AHCA or a third-party vendor of AHCA, data which would show:

- Provider Credentialing volume, including:
  - Percentage and total number of provider applications processed and loaded for provider billing within the last 60 days;
  - Percentage and total number of provider applications processed and loaded for provider billing within the last 90 days
  - Percentage and total number of provider applications processed and loaded for provider billing within the last 120 days.
- Prior authorization requests
  - Percentage and total number of standard prior authorization requests approved;
  - Percentage and total number of standard prior authorization requests denied;
  - Percentage and total number of expedited prior authorization requests approved;
  - Percentage and total number of expedited prior authorization requests denied.
  - For each of the approvals, the standard length of time for an approval.
  - For each of the appeals, the percentage of appeals granted and the length of time from appeal to granting of request.
- Average and median time between submission of requests and decisions, for:
  - Standard authorizations
  - Expedited authorizations.
  - Prompt payment
- Prompt payment of claims:
  - Percentage and total number of claims that are rejected before review.
  - Percentage and total number of claims that are rejected before Paid.
  - Percentage and total number of claims that are rejected before Partially paid
  - Percentage and total number of claims that are rejected before Denied.

[35] *Id.*
[36] 42 CFR 438.400(b) defines grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination.
[37] *Supra,* note 5.

    - Percentage and total number of claims that are rejected before Suspended.
    - Average length of time to pay clean claims.
    - The percentage of clean claims paid within:
        - Seven days
        - 10 days
        - 20 days
        - In excess of 120 days.
    - Top 10 reasons for claim denial, with the percentage and the total number of claims for each reason cited.
- Number of managed care recipients enrolled in the statewide Medicaid Managed Medical Assistance program.
    - Number of complaints per 1,000 beneficiaries;
    - Number of complaints by managed care plan;
    - Number of complaints received by region;
    - Number of complaints by provider category (physicians, hospitals, outpatient services; skilled nursing facilities, assisted living facilities, therapy services, transportation; services, laboratories, home care services, and community based services);
    - Number of complaints resolved by region;
    - Number of complaints pending for resolution by region;
    - Average length of time to resolve provider complaint by region; and
    - Average length of time to resolve Medicaid recipient complaint by region.

The AHCA is directed to contract with a third party vendor to develop and display on the agency's public website the managed care performance metrics relating to provider credentialing, prior authorizations, and claims processing. For the performance metric data relating to grievances, the AHCA is responsible for creating a dashboard and the quarterly reports which are due under the bill.

Most of the data required by the bill relating to claims payment, prior authorization, and complaints are already being collected by AHCA. Not all of the data *calculations* required by the bill are included in today's reporting; however, the agency would be able to perform those calculations.

HB 783 requires AHCA to create and make publicly available a quarterly report containing the information in this newly created section of statute beginning October 1, 2024. A copy of the report is also due to the Medical Care Advisory Committee, the Governor, the President of the Senate, and the Speaker of the House of Representatives.

The effective date of the bill is July 1, 2024.

SECTION DIRECTORY:

**Section 1:** Creates s. 409.9673, relating to managed care plan performance metrics.
**Section 2:** Provides and effective date.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   AHCA indicates HB 783 would have an operational and fiscal impact on the Medicaid program. AHCA would be required to contract with a third-party vendor to create a dashboard to display the required reports of plan data. AHCA estimates the third-party vendor contract would cost $500,000, and $5,556 in non-recurring expenditures in the first year and $78,685 recurring expenditures in the following years.

In addition, AHCA estimates a need for one FTE at a cost of $84,241.

The total estimated cost for FY 2024-2025 is $584,241 with $292,121 in General Revenue.

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:
   None.

B. RULE-MAKING AUTHORITY:
The AHCA has sufficient rulemaking authority to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:
None.

## IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to Medicaid managed care plan performance metrics; creating s. 409.9673, F.S.; requiring Medicaid managed care plans to submit each month certain performance metrics to the Agency for Health Care Administration; providing requirements for such performance metrics; requiring the agency to contract with a third party to develop and display a public dashboard with certain information; requiring the agency to update the information each month; requiring the agency to create a quarterly report, make it available to the public, and submit it to certain entities; providing an effective date.

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

Section 1. Section 409.9673, Florida Statutes, is created to read:

409.9673 Managed care plan performance metrics.—

(1) Each managed care plan shall submit to the agency each month the managed care plan performance metrics by region and by county in a format prescribed by the agency. Each manage care plan shall provide, at a minimum, the following:

(a) Credentialing:

1. The percentage and total number of providers for which

a submitted provider application has been fully loaded and processed for provider billing within 60 days.

2. The percentage and total number of providers for which a submitted provider application has not been fully loaded and processed for provider billing in excess of:

a. Sixty days.

b. Ninety days.

c. One hundred twenty days.

(b) Prior authorization:

1.a. The percentage and total number of standard prior authorizations requests approved.

b. The percentage and total number of standard prior authorizations requests denied.

c. The percentage and total number of standard prior authorization requests approved after appeal and the length of time of the appeal process, from the beginning of the appeal until the approval.

2. The percentage and total number of expedited prior authorization requests approved and the length of time to receive approval.

3. The average and median time between submissions of requests and decisions for:

a. Standard prior authorizations.

b. Expedited prior authorizations.

(c) Prompt payment:

1. The percentage and total number of claims that are:

a. Rejected before review.

b.(I) Paid.

(II) Partially paid.

(III) Denied.

(IV) Suspended.

2. The average length of time to pay clean claims.

3. The percentage of clean claims paid within:

a. Seven days.

b. Ten days.

c. Twenty days.

d. In excess of 120 days.

4. The top 10 reasons for claims denial, with the percentage and total number of claims for each reason cited.

(2) The agency shall contract with a third party to develop and display on the agency's public website a dashboard with the data provided by each managed care plan under subsection (1) to show managed care plan performance and utilization management. In addition to the data provided under subsection (1), the agency shall publish on the dashboard the following information, accessible to the public, regarding managed care plan complaints:

(a) The number of Medicaid recipients enrolled in the statewide managed medical assistance program.

(b) The number of complaints per 1,000 Medicaid

recipients.

(c) By each managed care plan:

1. By provider category, the number of complaints received by physicians, hospitals, outpatient services, skilled nursing facilities, assisted living facilities, therapy services, transportation services, laboratories, home care services, and community-based services.

2. The number of Medicaid recipient complaints for each region.

3. The number of Medicaid recipient complaints resolved for each region.

4. By provider category:

a. The number of provider complaints resolved for each region.

b. The number of complaints pending for resolution for each region.

d. The average length of time to resolve provider complaints for each region.

e. The average length of time to resolve Medicaid recipient complaints for each region.

(3) The agency shall update each month on the dashboard the information described in subsections (1) and (2).

(4) Beginning July 31, 2025, the agency shall create a quarterly report containing the information described in subsections (1) and (2) and shall make the report publicly

available no later than 30 days after the close of each quarter. The agency shall also submit the report to the Medical Care Advisory Committee, the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Section 2. This act shall take effect July 1, 2024.

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 | _____ |

Committee/Subcommittee hearing bill: Select Committee on Health Innovation

Representative Berfield offered the following:

**Amendment (with title amendment)**

Remove everything after the enacting clause and insert:

Section 1. Section 409.9673, Florida Statutes, is created to read:

409.9673 Managed care plan performance metrics. —

The agency shall produce managed care plan performance data related to the administration of provider contracts. Agency reports shall include data reported by the plans to the agency pursuant to statutory and contract requirements related to provider credentialing, service prior authorization, claims payment and consumer complaints. The agency shall contract with a third party to analyze data and develop a dashboard on the

agency website to display the data, and shall publish the data by plan and by region on the dashboard quarterly beginning October 1, 2024. An annual report of the data analyses beginning January 1, 2026 shall be submitted to the Medical Care Advisory Committee, the Governor, the President of the Senate, and the Speaker of the House of Representatives and published on the website. The analyses shall include the following:

(1) Credentialing.

(a) The percentage and total number of providers for which a submitted provider application has been fully loaded and processed for provider billing within 60 days.

(b) The percentage and total number of providers for which a submitted provider application has not been fully loaded and processed for provider billing in excess of:

1. Sixty days.

2. Ninety days.

3. One hundred twenty days.

(2) Prior authorization.

(a) The percentage and total number of standard prior authorizations requests approved by service type.

1. The percentage and total number of standard prior authorizations requests denied.

2. The percentage and total number of standard prior authorization requests approved after appeal and the length of

time of the appeal process, from the beginning of the appeal until the approval.

(b) The percentage and total number of expedited prior authorization requests approved and the length of time to receive approval by service type.

(c) The average and median time between submissions of requests and decisions for:

1. Standard prior authorizations.

2. Expedited prior authorizations.

(3) Prompt payment.

(a) The percentage and total number of claims that are:

1. Rejected before review.

2. Paid, partially paid, denied or suspended.

(b) The average length of time to pay clean claims.

(c) The percentage of clean claims paid within:

1. Seven days.

2. Ten days.

3. Twenty days.

4. In excess of 120 days.

(d) The top 10 reasons for claims denial, with the percentage and total number of claims for each reason cited.

(4) Managed care plan complaints.

(a) The number of Medicaid recipients enrolled in the statewide managed medical assistance program.

(b) The number of complaints per 1,000 Medicaid recipients.

(c) By each managed care plan, per 1,000 Medicaid recipients:

1. By provider category, the number of complaints received by physicians, hospitals, outpatient services, skilled nursing facilities, assisted living facilities, therapy services, transportation services, laboratories, home care services, and community-based services.

2. The number of Medicaid recipient complaints for each region.

3. The number of Medicaid recipient complaints resolved for each region.

4. By provider category:

a. The number of provider complaints resolved for each region.

b. The number of complaints pending for resolution for each region.

d. The average length of time to resolve provider complaints for each region.

e. The average length of time to resolve Medicaid recipient complaints for each region.

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**T I T L E A M E N D M E N T**

Remove everything before the enacting clause and insert:
An act relating to Medicaid managed care plan performance metrics; creating s. 409.9673, F.S.; requiring the Agency for Health Care Administration to analyze certain Medicaid managed care performance data; requiring the agency to contract with a third party vendor to publish data on a dashboard quarterly; requiring an annual report and requiring the agency to submit it to certain entities; providing an effective date.

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 935 Home Health Care Services
**SPONSOR(S):** Franklin
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 1798

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

## SUMMARY ANALYSIS

A home health agency (HHA) is an organization that delivers skilled nursing and other services to a patient's home rather than in a traditional health facility setting. Home health care includes skilled physician and nursing care, physical, occupational, respiratory, or speech therapy, and homemaker/companion services; these services are given by a variety of health care professionals. The Agency for Health Care Administration (AHCA) regulates HHAs to develop, establish, and enforce basic standards that will ensure the safe and adequate care of persons receiving health services in their homes.

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons and is administered by the AHCA. Federal law requires state Medicaid programs to cover nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home. AHCA has certain requirements to pay for these services.

Current licensure law requires that initial admission, service evaluation, and discharge visits be provided by a direct employee of a home health agency. In addition, Medicaid reimbursement is not available for home health services ordered by any practitioner other than a physician, such as a nurse.

HB 935 allows home health agency contract staff to conduct initial admission, service evaluation, and discharge visits.

The bill expands the definition of health care facility to include home health agency. The bill also allows Medicaid to pay for home health services ordered by advanced practice registered nurses.

The bill has an indeterminate, likely insignificant negative fiscal impact on state government and no fiscal impact on local government.

The bill provides an effective date of July 1, 2024.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Background**

**Home Health Agencies**

A home health agency (HHA) is an organization that delivers skilled nursing and other services to a patient's home rather than in a traditional health facility setting. In Florida, an HHA is a person[1] that provides one or more home health services.[2]

Licensure

The Florida Agency for Health Care Administration (AHCA) is responsible for administering the Medicaid Program, licensing and regulating health facilities, and providing health care quality and price information to Floridians.[3] The AHCA regulates HHAs to develop, establish, and enforce basic standards that will ensure the safe and adequate care of persons receiving health services in their homes. [4]

To operate in Florida, an HHA must be licensed by the AHCA according to the Health Licensing Procedures Act[5] (Act). [6] The Act provides a streamlined and consistent set of basic licensing requirements for health care providers.[7] The Act provides minimum licensure requirements, with which applicants and licensees must comply to obtain and maintain a license.[8] HHAs operated by the federal government and home health services provided by a state agency or through a contractor[9] are exempt from licensure.[10] Any license or registration issued on or after July 1, 2018, must specify the services the HHA performs and indicate if the services are considered skilled care.[11]

Home Health Services

Home health is skilled care delivered directly to a patient's home. Health care services offered in the home may include:[12]

- Doctor care;
- Nursing care;
- Physical, occupational, respiratory, or speech therapy;
- Home health aide services;
- Medical social services;
- Medical social services; and
- Homemaker/companion services.

[1] "Person" includes individuals, children, firms, associations, joint adventures, partnerships, estates, trusts, business trusts, syndicates, fiduciaries, corporations, and all other groups or combinations. S. 1.01 (3), F.S.
[2] S. 400. 462 (15), F.S.
[3] S. 499.026 (1), F.S.
[4] S. 400.461 (2), F.S.
[5] Ch. 408, Part II, F.S.; *see also* s. 408.801(1), F.S. (providing a short title).
[6] s. 400.464 (1), F.S.
[7] S. 408.801(2), F.S.
[8] *See generally* s. 408.810, F.S.
[9] The Department of Elderly Affairs, the Department of Health, services provided to persons with developmental disabilities, companion and sitter organization registered under s. 400.509, F.S. and the Department of Children and Families.
[10] S. 400.464 (6), F.S.
[11] S. 400.464 (1), F.S.
[12] John Hopkins Medicine, *What are the different types of home health care services?* available at https://www.hopkinsmedicine.org/health/caregiving/types-of-home-health-care-services (last visited January 30, 2024).

Skilled care is nursing or therapeutic services delivered by a health care professional.[13] The health care professional must be licensed under part I of ch. 464, F.S.; part I, part III, or part V of ch. 468, F.S.; or ch. 486, F.S. and who is employed by or under contract with a licensed HHA or is referred by a licensed nurse registry.[14] Under current law, when nursing services are ordered, the HHA must provide the initial admission visit, all service evaluation visit, and discharge visit by direct a direct employee. Services provided by contract staff must be monitored and managed by the admitting HHA. [15]

**Florida Medicaid**

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the AHCA and financed by federal and state funds.

The structure of each state's Medicaid program varies and what states must pay for is largely determined by the federal government, as a condition of receiving federal funds.[16] Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states. The federal government sets the minimum mandatory populations to be included in every state Medicaid program. The federal government also sets the minimum mandatory benefits to be covered in every state Medicaid program. These benefits include home health care services.[17]

Medicaid Home Health Coverage

Medicaid pays for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home.[18] Under current law, AHCA may not pay for these services unless they are medically necessary and:[19]

- The services are ordered by a physician.
- The written prescription for the services is signed and dated by the recipient's physician before the development of a plan of care and before any request requiring prior authorization.
- The physician ordering the services is not employed, under contract with, or otherwise affiliated with the home health agency rendering the services.
- The physician ordering the services has examined the recipient within the 30 days preceding the initial request for the services and biannually thereafter.
- The written prescription for the services includes the recipient's acute or chronic medical condition or diagnosis, the home health services required, and for skilled nursing services, the frequency and duration of the services.
- The national provider identifier, Medicaid identification number, or medical practitioner license number of the physician ordering the services is listed on the written prescription for the services, the claim for home health reimbursement, and the prior authorization request.

Under current law, Medicaid requirements, reimbursement is not available for home health services ordered by any practitioner other than a physician, such as a nurse.

*Home Health Aide Visits – Children*

Florida Medicaid covers home health aide visits for recipients under the age of 21 who have a medical condition or disability that substantially limits their ability to perform activities of daily living or

[13] S.400.462 (32), F.S.
[14] *Id.*
[15] S. 400.487 (5), F.S.
[16] Title 42 U.S.C. §§ 1396-1396w-5; Title 42 C.F.R. Part 430-456 (§§ 430.0-456.725) (2016).
[17] S. 409.905, F.S.
[18] S. 409.905, F.S.
[19] *Id.*

instrumental activities of daily living.[20] The home health visit coverage policy includes up to four hours of intermittent home health visits per day for any combination of skilled nursing or home health aide services.[21]

*Personal Care Services – Children*

Personal care services are for Medicaid recipients who require more extensive care than can be provided through a home health visit. They are provided by unlicensed HHA personnel to assist Medicaid recipients under the age of 21 with activities of daily living and instrumental activities of daily living to enable recipients to accomplish tasks they would be able to do for themselves if they did not have a medical condition or a disability. A recipient may receive up to 24 hours of personal care services per day that have been determined to be medically necessary and that can be safely provided in the recipient's home or in the community.[22]

*Private Duty Nursing Services – Adults*

PDN services are skilled nursing services provided to recipients under the age of 21 by a registered nurse or licensed practical nurse. A recipient may receive up to 24 hours of private duty nursing services per day if they have a physician's order for PDN services that are medically necessary and can be safely provided in their home or their community. The PDN coverage policy also allows for reimbursement of up to 40 hours per week of an HHA provider for PDN services provided by the parent or legal guardian of a recipient.[23] The parent or legal guardian must be employed by an HHA and have a valid license as a registered nurse or licensed practical nurse.

**Effect of the Bill**

HB 935 amends HHA licensure law to allow contractors, rather than only employees, to provide the initial admission, service evaluation, and discharge visits for patients. The bill expands the definition of health care facility provided in ch. 408 to include home health agency.

The bill also allows Medicaid to pay for home health services ordered by an advanced practice registered nurse (APRN). When ordering services, the bill requires that the APRN not be employed, under contract with, or otherwise affiliated with the home health agency rendering the services. The APRN must also include their national provider identifier, Medicaid identification number, or medical practitioner license number when ordering the services listed on the written prescription for the services, the claim for home health reimbursement, and the prior authorization request.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

**Section 1:** Amends s. 400.487, F.S., relating to home health service agreements; physician's, physician assistant's, and advanced practice registered nurse's treatment orders; patient assessment; establishment and review of plan of care; provision of services; orders not to resuscitate.

**Section 2:** Amends s. 408.032, F.S., relating to definitions relating to Health Facility and Services Development Act.

[20] Activities of daily living include bathing, dressing, eating, maintaining continence, toileting, and transferring. Instrumental activities of daily living include grocery shopping, laundry, light housework, meal preparation, medication management, money management, personal hygiene, transportation, and using the telephone to take care of essential tasks.
[21] *Florida Medicaid Home Health Visit Services Coverages Policy* (November 2016), available at https://ahca.myflorida.com/content/download/7034/file/59G-4-130_Home_Health_Visit_Services_Coverage_Policy.pdf (last visited January 31, 2024).
[22] *Florida Medicaid Personal Care Services Coverage Policy* (November 2016), available at https://ahca.myflorida.com/content/download/7035/file/59G-4-215_Personal_Care_Services_Coverage_Policy.pdf (last visited January 31, 2024).
[23] *Florida Medicaid Private Duty Nursing Services Coverage Policy* (November 2016), available at https://ahca.myflorida.com/content/download/7036/file/59G-4-261_Private_Duty_Nursing_Services_Coverage_Policy.pdf (last visited January 31, 2024).

**Section 3:** Amends s. 409.905, F.S., relating to mandatory Medicaid services.
**Section 4:** Provides an effective date of July 1, 2024.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill has an indeterminate, likely insignificant negative fiscal impact on state government.

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 impact county or municipal government.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill does not appear to create a need for rulemaking or rulemaking authority.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to home health care services; amending s. 400.487, F.S.; authorizing contract staff to provide specified visits for a home health agency under certain circumstances; amending s. 408.032, F.S.; revising the definition of "health care facility" to include a home health agency; amending s. 409.905, F.S.; authorizing an advanced practice registered nurse to order or write prescriptions for certain Medicaid services; providing an effective date.

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

Section 1. Subsection (5) of section 400.487, Florida Statutes, is amended to read:

400.487 Home health service agreements; physician's, physician assistant's, and advanced practice registered nurse's treatment orders; patient assessment; establishment and review of plan of care; provision of services; orders not to resuscitate.—

(5) When nursing services are ordered, the home health agency to which a patient has been admitted for care must provide the initial admission visit, all service evaluation visits, and the discharge visit by a direct employee or contract

staff. Services provided by others under contractual arrangements to a home health agency must be monitored and managed by the admitting home health agency. The admitting home health agency is fully responsible for ensuring that all care provided through its employees or contract staff is delivered in accordance with this part and applicable rules.

Section 2. Subsection (8) of section 408.032, Florida Statutes, is amended to read:

408.032 Definitions relating to Health Facility and Services Development Act.—As used in ss. 408.031-408.045, the term:

(8) "Health care facility" means a skilled nursing facility, hospice, ~~or~~ intermediate care facility, or home health agency for the developmentally disabled. A facility relying solely on spiritual means through prayer for healing is not included as a health care facility.

Section 3. Paragraph (c) of subsection (4) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law.

Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(4) HOME HEALTH CARE SERVICES.—The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home. An entity that provides such services must be licensed under part III of chapter 400. These services, equipment, and supplies, or reimbursement therefor, may be limited as provided in the General Appropriations Act and do not include services, equipment, or supplies provided to a person residing in a hospital or nursing facility.

(c) The agency may not pay for home health services unless the services are medically necessary and:

1. The services are ordered by a physician or an advanced practice registered nurse.

2. The written prescription for the services is signed and dated by the recipient's physician or an advanced practice registered nurse before the development of a plan of care and before any request requiring prior authorization.

3. The physician or advanced practice registered nurse ordering the services is not employed, under contract with, or otherwise affiliated with the home health agency rendering the services. However, this subparagraph does not apply to a home health agency affiliated with a retirement community, of which the parent corporation or a related legal entity owns a rural health clinic certified under 42 C.F.R. part 491, subpart A, ss. 1-11, a nursing home licensed under part II of chapter 400, or an apartment or single-family home for independent living. For purposes of this subparagraph, the agency may, on a case-by-case basis, provide an exception for medically fragile children who are younger than 21 years of age.

4. The physician or advanced practice registered nurse ordering the services has examined the recipient within the 30 days preceding the initial request for the services and biannually thereafter.

5. The written prescription for the services includes the recipient's acute or chronic medical condition or diagnosis, the home health service required, and, for skilled nursing services, the frequency and duration of the services.

6. The national provider identifier, Medicaid identification number, or medical practitioner license number of the physician or advanced practice registered nurse ordering the services is listed on the written prescription for the services, the claim for home health reimbursement, and the prior

authorization request.

Section 4. This act shall take effect July 1, 2024.

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 | _____ | |

Committee/Subcommittee hearing bill: Select Committee on Health Innovation

Representative Franklin offered the following:

**Amendment (with title amendment)**

Remove lines 15-41

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**T I T L E A M E N D M E N T**

Remove lines 3-7 and insert:

s.

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 1259 Provider of Cardiovascular Services
**SPONSOR(S):** Andrade and others
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 1612

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Select Committee on Health Innovation | | Guzzo | Calamas |
| 2) Constitutional Rights, Rule of Law & Government Operations Subcommittee | | | |
| 3) Health & Human Services Committee | | | |

## SUMMARY ANALYSIS

The Agency for Health Care Administration (AHCA) licenses three levels of hospital programs for Adult Cardiovascular Services (ACS), including adult inpatient diagnostic cardiac catheterization, Level I ACS, and Level II ACS.

Diagnostic cardiac catheterization is a procedure to diagnose but not treat congenital or acquired cardiovascular diseases, or for determining measurement of blood pressure flow. Such procedures require the passage of a catheter into one or more cardiac chambers of the left and right heart, with or without coronary arteriograms.

Licensed Level I ACS programs provide diagnostic and therapeutic cardiac catheterization services, including percutaneous cardiac intervention (PCI involves placing a stent in an artery to allow the flow of blood), on a routine and emergency basis. Level I ACS programs must have written transfer agreements with at least one hospital licensed as a Level II ACS program, which must allow the safe transfer of a patient within 60 minutes. Level I ACS programs are not allowed to perform open heart surgery, use rotational or other atherectomy devices, or treat chronic total occlusions.

HB 1259 eliminates licensure for adult diagnostic cardiovascular services programs. As a result, hospitals will no longer be required to obtain a license from AHCA to provide adult diagnostic cardiovascular services, and existing hospitals will no longer be required to comply with the guidelines of the ACC or AHA for continued licensure.

The bill amends licensure requirements for Level I ACS programs. Specifically, it authorizes programs to perform adult PCI for treatment of chronic total occlusions, and to use rotational or other atherectomy devices, or electrophysiology when performing PCI.

The bill removes the volume requirements and all nursing and technical staffing requirements for Level I ACS program licensure. The bill retains the requirement for Level I ACS programs to have a written transfer agreement with a hospital that has a Level II ACS program, but it removes the requirement for the transfer agreement to be with a hospital to which a patient can be transferred within 60 minutes.

The bill allows Level I ACS programs to follow the guidelines of the Society for Cardiac Angioplasty and Intervention as a source of compliance with requirements for staffing, physician training and experience, operating procedures, equipment, physical plant, and patient selection criteria.

The bill requires AHCA to update its rules as new standards and guidelines are published.

The bill has no fiscal impact on state or local government.

The bill provides an effective date of July 1, 2024.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Background**

**Hospital Licensure**

The Agency for Health Care Administration (AHCA) regulates hospitals under chapter 395, F.S., and the general licensure provisions of part II, of chapter 408, F.S. Hospitals offer a range of health care services with beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care.[1] Hospitals must make regularly available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, and other definitive medical treatment.[2]

Section 395.1055, F.S., authorizes AHCA to adopt rules for hospitals which must include minimum standards to ensure:[3]

- A sufficient number of qualified types of personnel and occupational disciplines are on duty and available at all times to provide necessary and adequate patient care;
- Infection control, housekeeping, sanitary conditions, and medical record procedures are established and implemented to adequately protect patients;
- A comprehensive emergency management plan is prepared and updated annually;
- Licensed facilities are established, organized, and operated consistent with established standards and rules;
- Licensed facility beds conform to minimum space, equipment, and furnishing standards;
- Each hospital has a quality improvement program designed according to standards established by their current accrediting organization;
- Licensed facilities make available on their websites, and in hard copy format upon request, a description of and a link to their patient charge and performance outcome data;
- All hospitals providing organ transplantation, neonatal intensive care services, inpatient psychiatric services, inpatient substance abuse services, or comprehensive medical rehabilitation meet the minimum licensure requirements adopted by AHCA.

Separate standards may be provided for general and specialty hospitals, ambulatory surgical centers, and statutory rural hospitals.[4] The minimum standards for hospital licensure are contained in Chapter 59A-3, F.A.C.

Percutaneous Cardiac Intervention

Percutaneous cardiac intervention (PCI), commonly known as coronary angioplasty or angioplasty, is a nonsurgical technique for treating obstructive coronary artery disease.[5] PCI uses a catheter to insert a stent in the heart to reopen blood vessels that have been narrowed by plaque build-up, a condition known as atherosclerosis.[6] The catheter is threaded through blood vessels into the heart where the coronary artery is narrowed.[7] Once in place, a balloon tip covered with a stent is inflated to compress

[1] S. 395.002(12), F.S.
[2] *Id.*
[3] S. 395.1055(1), F.S.
[4] S. 395.1055(2), F.S.
[5] George A Stouffer, III, and Pradeep K Yadav, *Percutaneous Coronary Intervention (PCI)*, MEDSCAPE, Oct. 12, 2016, available at http://emedicine.medscape.com/article/161446-overview (last visited January 31, 2024).
[6] Percutaneous coronary intervention (PCI or angioplasty with stent), Heart and Stroke, available at https://www.heartandstroke.ca/heart/treatments/surgery-and-other-procedures/percutaneous-coronary-intervention (last visited January 31, 2024).
[7] *Id.*

the plaque and expand the stent.[8] When the plaque is compressed and the stent is in place, the balloon is deflated and withdrawn, leaving the stent to hold the artery open.[9]

In 2014, the Society for Cardiovascular Angiography and Interventions, the American College of Cardiology (ACC) and the American Heart Association (AHA) issued an Expert Consensus document on PCI without on-site surgical backup, which acknowledged advances and best practices in PCI performed in hospitals without on-site surgery (Level I adult cardiovascular services facilities).[10] The Expert Consensus document noted that while PCI peaked in 2006, PCIs at hospitals without on-site surgery have increased since 2007.[11] The Expert Consensus document recommends the PCI programs without on-site surgery have experienced nursing and technical laboratory staff with training in interventional laboratories.[12] The Expert Consensus document continues to recommend PCI procedures should not be performed in facilities performing fewer than 200 procedures, with few exceptions.[13] The Expert Consensus document also recommends that a 95% success rate and a less than 5% complication rate are more important factors than overall volume of procedures performed.[14]

Increasingly, these types of procedures are being done outside of a hospital setting, in office-based cardiac catheterization laboratories and ambulatory surgical centers (ASCs). In 2020, the US Centers for Medicare & Medicaid Services expanded coverage to include PCI in an ASC setting.[15] The new rule also removed the requirements for ASCs to have transfer agreements with acute care hospitals, and for physicians practicing at ASCs to have privileges at the acute care hospital with which they have a transfer agreement.

There are no state regulations for ASCs regarding these types of procedures other than compliance with building codes for treatment rooms. Studies have demonstrated that PCIs performed at sites without Level II surgery support have low rates of complications and similar outcomes to PCIs performed with surgery on site.[16]

Adult Cardiovascular Services

In 2007, certificate of need (CON)[17] review was eliminated for adult cardiovascular services (ASC) and such services are currently only subject to licensure requirements.[18] Section 395.1055, F.S., establishes three levels of hospital program licensure for ACS, including adult inpatient diagnostic cardiac catheterization, Level I ACS, and Level II ACS.

*Diagnostic Cardiac Catheterization Programs*

[8] *Id.*
[9] *Id.*
[10] Gregory J. Dehmer, et al., *SCAI/ACC/AHA Expert Consensus Document: 2014 Update on Percutaneous Coronary Intervention Without On-Site Surgical Backup*, Society for Cardiovascular Angiography and Interventions, the American College of Cardiology Foundation, and the American Heart Association, Inc., (Mar. 17, 2014) available at https://www.ahajournals.org/doi/10.1161/CIR.0000000000000037 (last visited January 31, 2024).
[11] *Id.*
[12] *Id.*
[13] *Id.* The Expert Consensus document cites data from a 2010-2011 National Cardiovascular Data Registry showing that half (49%) of reporting facilities performed fewer than 400 PCIs annually and of these, 65% of the facilities without on-site surgery backup had an annual case volume of less than 200 PCIs.
[14] *Supra*, note 10.
[15] 42 C.F.R. § 410.49.
[16] Alice K. Jacobs, M.D., Sharon-Lise T. Normand, Ph.D., Joseph M. Massaro, Ph.D., et al., *Nonemergency PCI at Hospitals with or without On-Site Cardiac Surgery*, New England Journal of Medicine (April 2013), available at https://www.nejm.org/doi/full/10.1056/nejmoa1300610 (last visited January 31, 2024), *see also* Thomas Aversano, M.D., Cynthia C. Lemmon, R.N., B.S.N., M.S., and Li Liu, M.D., *Outcomes of PCI at Hospitals with or without On-Site Cardiac Surgery*, New England Journal of Medicine (May 2012), available at https://www.nejm.org/doi/full/10.1056/nejmoa1114540 (last visited January 31, 2024).
[17] A certificate of need is a written statement issued by AHCA evidencing community need for a new, converted, or expanded nursing home, intermediate care facility for the developmentally disabled, or hospice. *See* s. 408.036, F.S.
[18] Ch. 2007-214, Laws of Fla.

Diagnostic cardiac catheterization is a procedure to diagnose but not treat congenital or acquired cardiovascular diseases, or for determining measurement of blood pressure flow.[19] Such procedures require the passage of a catheter into one or more cardiac chambers of the left and right heart, with or without coronary arteriograms.[20] Hospitals providing adult inpatient diagnostic cardiac catheterization programs must comply with rules adopted by AHCA which establish minimum licensure standards. The rules must ensure that such programs:

- Comply with the most recent guidelines of the American College of Cardiology and American Heart Association Guidelines for Cardiac Catheterization and Cardiac Catheterization Laboratories;
- Maintain sufficient appropriate equipment and health care personnel to ensure quality and safety;
- Maintain appropriate times of operation and protocols to ensure availability and appropriate referrals in the event of emergencies; and
- Demonstrate a plan to provide services to Medicaid and charity care patients.

Providers of adult inpatient diagnostic cardiac catheterization programs may not provide therapeutic cardiac catheterization or any other cardiology services.

As of January 10, 2024, there were 16 hospitals licensed to provide adult inpatient diagnostic cardiac catheterization programs.[21]

*Level I ACS Programs*

General Requirements

Licensed Level I ACS programs provide diagnostic and therapeutic cardiac catheterization services, including PCI, on a routine and emergency basis, but do not have on-site open-heart surgery capability.[22] Level I ACS programs must have written transfer agreements with at least one hospital licensed as a Level II ACS program, which must allow the safe transfer of a patient within 60 minutes.[23]

Licensed Level I ACS programs must comply with the most recent guidelines of the American College of Cardiology and American Heart Association Guidelines for Cardiac Catheterization and Cardiac Catheterization Laboratories.[24] Additionally, they must comply with the reporting requirements of the American College of Cardiology-National Cardiovascular Data Registry.[25]

Level I ACS programs are prohibited from performing the following procedures:[26]

- Any therapeutic procedure requiring transseptal puncture;
- Any lead extraction for a pacemaker, biventricular pacer or implanted cardioverter defibrillator;
- Any rotational or other atherectomy devices; and
- Treatment of chronic total occlusions.

Patient Volume Requirements

For a hospital seeking a Level I ACS program license, it must demonstrate that, for the most recent 12-month period as reported to AHCA, it has:[27]

[19] Rule 59A-3.246(1)(b)1., F.A.C.
[20] *Id.*
[21] Agency for Health Care Administration, Agency Analysis of 2024 HB 1259 (Jan. 10, 2024).
[22] S. 395.1055(18)(b)1.
[23] Rule 59A-3.246(2)(c), F.A.C.
[24] Rule 59A-3.246(2)(a)5., F.A.C.
[25] Rule 59A-3.246(2)(a)7., F.A.C.
[26] Rule 59A-3.246(2)(a)10., F.A.C.

- Provided a minimum of 300 adult inpatient and outpatient diagnostic cardiac catheterizations; or
- Discharged or transferred at least 300 inpatients with the principal diagnosis of ischemic heart disease;[28] and that it has formalized, written transfer agreement with a hospital that has a Level II program.

Staffing Requirements

Level I ACS programs must meet the following staffing requirements: [29]

- At initial licensure, each cardiologist shall be an experienced physician who has performed a minimum of 50 interventional cardiology procedures, including at least 11 primary cardiology interventional procedures, exclusive of fellowship training, within the previous 12 months from the date of the Level I ACS application.
- At licensure renewal, interventional cardiologists shall perform a minimum of 50 interventional cardiology procedures per year averaged over a 2-year period.
- Technical catheterization laboratory staff must be credentialed as a Registered Cardiovascular Invasive Specialist or complete a hospital-based education and training program at a hospital providing Level I or Level II ACS. The training must include:
    - A minimum of 500 hours of proctored clinical experience, including participation in a minimum of 120 interventional cardiology procedures and didactic education components of hemodynamics, pharmacology, arrhythmia recognition, radiation safety, and interventional equipment.
- Coronary care unit nursing staff must be trained and experienced with invasive hemodynamic monitoring, operation of temporary pacemaker, management of intra-aortic balloon pump, management of in-dwelling arterial/venous sheaths and identifying potential complications.
- All staff participating as members of the catheterization team, including physicians, nurses, and technical catheterization laboratory staff must maintain Advanced Cardiac Life Support certification, and must participate in a 24-hour-per-day, 365 day-per-year call schedule.
- Nursing and technical staff must have demonstrated experience handling acutely ill patients requiring intervention, based on the staff member's previous experience in dedicated cardiac interventional laboratories or surgical centers. If a staff member's previous experience is in a dedicated cardiac interventional laboratory at a hospital that does not have an approved adult open heart surgery program, the staff member's previous experience qualifies only if, at the time the staff member acquired their experience, the dedicated cardiac interventional laboratory:[30]
    - Had an annual volume of 500 or more percutaneous cardiac intervention procedures;
    - Achieved a demonstrated success rate of 95 percent or greater for percutaneous cardiac intervention procedures;
    - Experienced a complication rate of less than 5 percent for percutaneous cardiac intervention procedures; and
    - Performed diverse cardiac procedures, including, balloon angioplasty and stenting, rotational atherectomy, butting balloon atheroma remodeling, and procedures relating to left ventricular support capability.

As of January 10, 2024, there were 69 hospitals licensed to provide Level I ACS.[31]

*Level II ACS Programs*

General Requirements

Licensed Level II ACS programs provide diagnostic and therapeutic cardiac catheterization services on a routine and emergency basis, and have on-site open-heart surgery capability.

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[27] S. 395.1055(18)(b)1., F.A.C.
[28] Heart condition caused by narrowed heart arteries. This is also called "coronary artery disease" and "coronary heart disease."
[29] Rule 59A-3.246(2)(b), F.A.C.
[30] S. 395.1055(18)(b)3., F.S.
[31] *Supra* note 21.

Like Level I ACS programs, Level II ACS programs must comply with the most recent guidelines of the American College of Cardiology and the American Heart Association for staffing, physician training and experience, operating procedures, equipment, physical plant, and patient selection criteria, to ensure patient quality and safety.

Patient Volume Requirements

For a hospital seeking a Level II program license, it must demonstrate that, for the most recent 12-month period as reported to AHCA, it has:[32]

- Performed a minimum of 1,100 adult inpatient and outpatient cardiac catheterizations, of which at least 400 must be therapeutic catheterizations; or
- Discharged at least 800 patients with the principal diagnosis of ischemic heart disease.

Staffing Requirements

Each cardiac surgeon must be Board certified. At initial licensure and licensure renewal, interventional cardiologists must have performed a minimum of 50 coronary interventional procedures per year averaged over a 2-year period which must include at least 11 primary cardiology interventional procedures per year.

The requirements for technical catheterization laboratory staff and coronary care unit nursing staff are the same as those for Level I ACS programs.

As of January 10, 2024, there were 78 hospitals licensed to provide Level II ACS.[33]

**Effect of the Bill**

HB 1259 eliminates licensure for adult diagnostic cardiovascular services programs. As a result, hospitals will no longer be required to obtain a license from AHCA to provide adult diagnostic cardiovascular services, and existing hospitals will no longer be required to comply with the guidelines of the ACC or AHA for continued licensure.

The bill authorizes Level I ACS programs to perform adult PCI for treatment of chronic total occlusions,[34] and to use rotational or other atherectomy devices,[35] or electrophysiology[36] when performing PCI.

The bill removes the volume requirements for Level I ACS program licensure.

The bill retains the requirement for Level I ACS programs to have a written transfer agreement with a hospital that has a Level II ACS program, but it removes the requirement for the transfer agreement to be with a hospital to which a patient can be transferred within 60 minutes.

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[32] S. 395.1055(18)(c), F.S.
[33] *Supra* note 21.
[34] When a coronary artery becomes completely blocked – not simply narrowed – it is called a total occlusion, and if complete blockage lasts for three months or longer, it is referred to as "chronic total occlusion." *See* Yale Medicine, Chronic Total Occlusion Overview, available at https://www.yalemedicine.org/conditions/chronic-total-occlusion (last visited January 31, 2024).
[35] An atherectomy device is a catheter with a blade or laser on its end used to remove plaque from an artery. Types of atherectomy devices include: rotational atherectomy (tiny blades cut plaque in a circular motion); excisional atherectomy (a single blade cuts plaque in one direction); laser ablation atherectomy (a laser removes the plaque); and orbital atherectomy (a spinning tool that works like sandpaper to remove plaque). *See* Cleveland Clinic, PAD: Atherectomy; Overview What is Atherectomy for PAD?, available at https://my.clevelandclinic.org/health/treatments/17310-pad-atherectomy (last visited January 24, 2024).
[36] Electrophysiologic studies or "EP testing" is used to diagnose and treat abnormal heart rhythms. It involves the insertion of a catheter into a blood vessel that leads to the heart which inserts electrodes in the heart to measure electrical activity in the heart. *See* Cleveland Clinic, Electrophysiology (EP) Study, available at https://my.clevelandclinic.org/health/diagnostics/23054-electrophysiology-study (last visited January 31, 2024).

The bill removes all nursing and technical staffing requirements for Level I ACS programs. Specifically, the bill removes the following requirements:

- Nursing and technical staff must have demonstrated experience handling acutely ill patients requiring intervention, based on the staff member's previous experience in dedicated cardiac interventional laboratories or surgical centers. If a staff member's previous experience is in a dedicated cardiac interventional laboratory at a hospital that does not have an approved adult open heart surgery program, the staff member's previous experience qualifies only if, at the time the staff member acquired their experience, the dedicated cardiac interventional laboratory:[37]
  - Had an annual volume of 500 or more percutaneous cardiac intervention procedures;
  - Achieved a demonstrated success rate of 95 percent or greater for percutaneous cardiac intervention procedures;
  - Experienced a complication rate of less than 5 percent for percutaneous cardiac intervention procedures; and
  - Performed diverse cardiac procedures, including, balloon angioplasty and stenting, rotational atherectomy, butting balloon atheroma remodeling, and procedures relating to left ventricular support capability.

The bill allows Level I ACS programs to follow the guidelines of the Society for Cardiac Angioplasty and Intervention as a source of compliance with requirements for staffing, physician training and experience, operating procedures, equipment, physical plant, and patient selection criteria.

The bill requires AHCA to update their rules as new standards and guidelines are published.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

**Section 1:** Amends s. 395.1055, F.S., relating to rules and enforcement.
**Section 2:** Provides an effective date of July 1, 2024.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   AHCA may experience an indeterminate workload reduction.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

[37] S. 395.1055(18)(b)3., F.S.

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:

The bill provides sufficient rule-making authority to AHCA to implement the provisions of the bill. Sufficient existing rule-making authority is retained to allow AHCA to continue to adopt rules for Level I and Level II ACS programs.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to providers of cardiovascular services; amending s. 395.1055, F.S.; revising provisions relating to certain rules for providers of specified cardiovascular services; requiring the Agency for Health Care Administration to update agency rules under certain circumstances; providing an effective date.

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

Section 1. Subsections (17), (18), and (19) of section 395.1055, Florida Statutes, are renumbered as subsections (16), (17), and (18), respectively, and paragraphs (a), (b), and (d) of present subsection (18) and present subsection (19) are amended to read:

395.1055 Rules and enforcement.—

~~(16) Each provider of diagnostic cardiac catheterization services shall comply with rules adopted by the agency which establish licensure standards governing the operation of adult inpatient diagnostic cardiac catheterization programs. The rules must ensure that such programs:~~

~~(a) Comply with the most recent guidelines of the American College of Cardiology and American Heart Association Guidelines for Cardiac Catheterization and Cardiac Catheterization~~

~~Laboratories.~~

~~(b) Perform only adult inpatient diagnostic cardiac catheterization services and will not provide therapeutic cardiac catheterization or any other cardiology services.~~

~~(c) Maintain sufficient appropriate equipment and health care personnel to ensure quality and safety.~~

~~(d) Maintain appropriate times of operation and protocols to ensure availability and appropriate referrals in the event of emergencies.~~

~~(e) Demonstrate a plan to provide services to Medicaid and charity care patients.~~

(17) ~~(18)~~ In establishing rules for adult cardiovascular services, the agency shall include provisions that allow for:

(a) The establishment of two hospital program licensure levels, a Level I program that authorizes the performance of adult percutaneous cardiac intervention without onsite cardiac surgery, including rotational or other atherectomy devices, electrophysiology, and treatment of chronic total occlusions, and a Level II program that authorizes the performance of percutaneous cardiac intervention with onsite cardiac surgery.

(b)1. For a hospital seeking a Level I program, have a ~~demonstration that, for the most recent 12-month period as reported to the agency, the hospital has provided a minimum of 300 adult inpatient and outpatient diagnostic cardiac catheterizations or, for the most recent 12-month period, has~~

~~discharged or transferred at least 300 patients with the principal diagnosis of ischemic heart disease and that it has a formalized,~~ written transfer agreement with a hospital that has a Level II program, including written transport protocols to ensure safe and efficient transfer of a patient ~~within 60 minutes~~.

~~2.a. A hospital located more than 100 road miles from the closest Level II adult cardiovascular services program is not required to meet the diagnostic cardiac catheterization volume and ischemic heart disease diagnosis volume requirements in subparagraph 1. if the hospital demonstrates that it has, for the most recent 12-month period as reported to the agency, provided a minimum of 100 adult inpatient and outpatient diagnostic cardiac catheterizations or that, for the most recent 12-month period, it has discharged or transferred at least 300 patients with the principal diagnosis of ischemic heart disease.~~

2.~~b.~~ A hospital located more than 100 road miles from the closest Level II adult cardiovascular services program must have ~~does not need to meet the 60-minute transfer time protocol requirement in subparagraph 1. if the hospital demonstrates that it has~~ a formalized, written transfer agreement with a hospital that has a Level II program which~~. The agreement~~ must include written transport protocols to ensure the safe and efficient transfer of a patient, taking into consideration the patient's clinical and physical characteristics, road and weather

conditions, and viability of ground and air ambulance service to transfer the patient.

~~3. At a minimum, the rules for adult cardiovascular services must require nursing and technical staff to have demonstrated experience in handling acutely ill patients requiring intervention, based on the staff member's previous experience in dedicated cardiac interventional laboratories or surgical centers. If a staff member's previous experience is in a dedicated cardiac interventional laboratory at a hospital that does not have an approved adult open heart surgery program, the staff member's previous experience qualifies only if, at the time the staff member acquired his or her experience, the dedicated cardiac interventional laboratory:~~

~~a. Had an annual volume of 500 or more percutaneous cardiac intervention procedures.~~

~~b. Achieved a demonstrated success rate of 95 percent or greater for percutaneous cardiac intervention procedures.~~

~~c. Experienced a complication rate of less than 5 percent for percutaneous cardiac intervention procedures.~~

~~d. Performed diverse cardiac procedures, including, but not limited to, balloon angioplasty and stenting, rotational atherectomy, cutting balloon atheroma remodeling, and procedures relating to left ventricular support capability.~~

(d) Compliance with the most recent guidelines of the American College of Cardiology, ~~and~~ the American Heart

Association, and the Society for Cardiac Angiography and Intervention guidelines for staffing, physician training and experience, operating procedures, equipment, physical plant, and patient selection criteria, to ensure patient quality and safety.

(18) ~~(19)~~ The agency may adopt rules to administer the requirements of part II of chapter 408 and shall update agency rules as new standards and guidelines are published.

Section 2. This act shall take effect July 1, 2024.

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 | | |

Committee/Subcommittee hearing bill: Select Committee on Health Innovation

Representative Andrade offered the following:

**Amendment (with title amendment)**

Remove everything after the enacting clause and insert:

Section 1. Paragraph (a) of subsection (18) of section 395.1055, Florida Statutes, is amended to read:

395.1055 Rules and enforcement.—

(18) In establishing rules for adult cardiovascular services, the agency shall include provisions that allow for:

(a) The establishment of two hospital program licensure levels, a Level I program that authorizes the performance of adult percutaneous cardiac intervention without onsite cardiac surgery, including rotational or other atherectomy devices, electrophysiology, and treatment of chronic total occlusions,

and a Level II program that authorizes the performance of percutaneous cardiac intervention with onsite cardiac surgery.

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**T I T L E  A M E N D M E N T**

Remove everything before the enacting clause and insert:
An act relating to providers of cardiovascular services; amending s. 395.1055, F.S.; requiring the Agency for Health Care Administration to adopt rules that allow a Level I Adult Cardiovascular Services program to use certain additional tools in the treatment of adult percutaneous cardiac intervention; providing an effective date.

**HB 1387**

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 1387 Adult Day Care Centers
**SPONSOR(S):** Silvers and others
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 412

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

## SUMMARY ANALYSIS

An adult day care center (ADC) is a venue providing services (such as therapeutic programs, social and health activities and services, leisure activities, self-care training, rest, nutritional services, respite care, etc.) to three or more adults. Participants may utilize a variety of services offered during any part of a day totaling less than 24 hours.

HB 1387 requires Medicaid Long-term Care Managed Care plans to reimburse ADC providers based on a 2-tiered fee schedule that categorizes an ADC based on their quality of care, facilities, compliance with established standards, and level of service. The bill also requires an annual increase in the rates.

The bill also sets Medicaid Managed Care plan rates for transportation provided by ADCs.

The bill establishes continuing education requirements for operators of adult day care centers. Specifically, the bill requires each operator to annually complete a 9-hour continuing education course developed and offered by the Florida Adult Day Services Association and approved by the Department of Elder Affairs.

The bill has a significant negative fiscal impact of approximately $19 million annually on the state Medicaid program and no fiscal impact on local government.

The bill provides an effective date of July 1, 2024.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Background**

**Adult Day Care Centers**

An adult day care center is a venue where the owner-operator provides basic services (e.g., therapeutic programs of social and health activities and services, leisure activities, self-care training, rest, nutritional services, respite care, etc.) to three or more persons who are at least 18 years of age. Participants may utilize a variety of services offered during any part of a day totaling less than 24 hours.[1] The owner-operator may organize the adult day care center as a for-profit or non-profit entity.[2]

Licensure

The Florida Agency for Health Care Administration (AHCA) regulates adult day care centers to develop, establish, and enforce basis standards to assure that therapeutic social and health activities and services are provided to adults experiencing functional impairments in a noninstitutional environment.[3]

To operate in Florida, an adult day care center must be licensed by AHCA according to the Health Care Licensing Procedures Act[4] (Act).[5] The Act provides a streamlined and consistent set of basic licensing requirements for health care providers.[6] The Act provides minimum licensure requirements, with which applicants and licensees must comply to obtain and maintain a license.[7] The licensure fee for adult day care centers must not exceed $150, and county-operated or municipally operated centers are exempt from the licensure fee.[8]

In addition to the Act, current law sets additional licensure requirements specific to adult day care centers. When an applicant first applies for licensure, he or she must furnish a description of the physical and mental capacities and needs of the participants to the served and the availability, frequency, and intensity of basic services and of supportive and optional services to be provided and proof of adequately liability insurance coverage.[9] Current law requires separate licenses for adult day care centers located on separate premises even if the centers operate under the same management.[10]

An adult day care center may not claim to be licensed or designated to provide specialized Alzheimer's services unless AHCA designates the adult day care center's license as a "specialized Alzheimer's services adult day care center".[11] To obtain and maintain this special Alzheimer's designation, the owner, operator, and staff must possess prerequisite experience and educational credentials, receive the training and supervision, and complete Level II background checks.[12] Amongst other requirements, a specialized Alzheimer's services adult day care center must care for each Alzheimer participant according to an individualized care plan that accounts for cognitive deficits and personal needs.[13] The Department of Elderly Affairs may adopt rules specific to these designated centers.[14] Notwithstanding the tightly regulated environment of specialized Alzheimer's services adult day care centers, current

[1] Ss. 429.901(1), (3), F.S
[2] S. 429.901(1), F.S.
[3] Ss. 429.90, 429.903 F.S.
[4] Ch. 408, Part II, F.S.; *see also* s. 408.801(1), F.S. (providing a short title).
[5] S. 429.907(1), F.S.
[6] S. 408.801(2), F.S.
[7] *See generally* s. 408.810, F.S.
[8] S. 429.907(3)-(4), F.S.
[9] S. 429.909, F.S.
[10] S. 429.907(2), F.S.
[11] Ss. 429.917(2), 429.918(3), F.S.
[12] Ss. 429.918(5)-(6), 429.919, F.S.
[13] S. 429.918(4), F.S.
[14] S. 429.918(12), F.S.

law allows adult day care centers to serve persons experiencing Alzheimer's as part of the general population of participants at a non-designated center.[15]

Current law exempts three classes of facilities from adult day care center licensure. First, any facility, institution, or other place operated by the federal government is exempt. Second, any freestanding, Florida-licensed inpatient hospice facility that provides day care services exclusively to hospice patients is exempt.[16] Third, licensed assisted living facilities, licensed hospitals, and licensed nursing homes that provide adult day care services are generally exempt; however, if a facility from this class holds itself out to the public as an adult day care center, they must be licensed by AHCA as an adult day care center.[17]

Enforcement Action

AHCA may deny, revoke, or suspend the licensure of an adult day care center when the owner, operator, or an employee does any of the following acts:[18]

- An intentional or negligent act materially affecting the health or safety of center participants.
- A violation of the standards or administrative rules governing adult day care centers.
- Failure to comply with statutory background screening standards.
- Failure to follow statutory criteria and procedures relating to the transportation, voluntary admission, and involuntary examination of center participants.
- Multiple or repeated violations.

Current law makes AHCA responsible for all investigations and inspections of adult day care centers.[19] AHCA may impose an immediate moratorium or emergency suspension on an adult care day center provider when AHCA determines that a condition at the center presents a threat to the health, safety, or welfare of a participant.[20]

AHCA may also impose an administrative fine for licensure violations.[21] Before AHCA assesses a fine, AHCA must make a reasonable attempt to discuss with ownership each violation and may request a corrective action plan so that the owner can demonstrate a good faith effort to remedy violations by an AHCA-set deadline. Current law classifies an owner's failure to comply with a corrective action plan or to meet the deadline as a separate violation for each day the failure continues. In determining whether to assess a fine, AHCA must consider the gravity of the violation, the actions taken by the owner or operator to correct violations, any previous violations, and the financial benefit to the center of committing or continuing the violation. AHCA may assess a maximum fine of $500 per violation, not to exceed $5,000 in the aggregate. [22]

If violations occur during the course of a licensure renewal or a change in ownership, AHCA may issue a six-month conditional license to accompany an approved corrective action plan.[23]

[15] S. 429.918(11), F.S.
[16] S. 429.905(1), F.S.
[17] S. 429.905(2), F.S. Even if a facility from this class is not licensed as an adult day care center, AHCA must monitor these facilities through regular inspections to ensure adequate space and sufficient staff.
[18] S. 429.911(1)-(2), F.S.
[19] S. 429.911(3), F.S.
[20] Ss. 429.911(1); 408.814, F.S.
[21] S. 429.911(1), F.S.
[22] S. 429.913(1), F.S.
[23] S. 429.915, F.S.

Continuing Education Requirements

Current law does not require operators of adult day care centers to complete general training, however, operators are required to complete training on Alzheimer's disease and related disorders (ADRD).

Adult day care centers are required to provide basic written information to new employees, upon beginning employment, about interacting with individuals with ADRD.[24] Adult day care centers are required to ensure that all employees complete one hour of initial ADRD training within 30 days of beginning employment.[25] Employees adult day care centers who provide direct care to individuals with ADRD are required to complete three hours of additional ADRD training within seven months of beginning employment.[26]

Employees in adult day care centers that provide special care for individuals with ADRD, who have regular contact with residents are required to complete three hours of ADRD training within three months of beginning employment, and each employee who provides personal care must complete four hours of ADRD training within six months of beginning employment.[27] Thereafter each employee who provides personal care must participate in at least four hours of continuing education annually.[28]

**Florida Medicaid**

Medicaid is the health care safety net for low-income Floridians. The Medicaid program is a medical assistance program funded jointly between the state and federal governments. The program provides health care coverage for over 4.8 million low-income families and individuals, the elderly, and individuals with disabilities in Florida, including 3.4 million recipients who receive their services through a managed care plan.[29]

AHCA administers the Florida Medicaid program authorized under Title XIX of the federal Social Security Act and Ch. 409, F.S. The AHCA administers the program through the managed care model,[30] under contracts with managed care plans in the 11 regions across the state. The program operates under two separate federal Medicaid waivers: Section 1115 waiver for primary and acute care services called the Managed Medical Assistance (MMA) program and Long-Term Care (LTC) services waiver under Sections 1915(b) and (c) of the Social Security Act.[31]

Subject to specific appropriations, AHCA must reimburse Medicaid providers of home-based and community-based services rendered according to a federally approved waiver based on an established or negotiated rate for each service.[32] With the federal LTC services waiver, current law requires AHCA to make payments for long-term care, including home and community-based services, using the managed care model.[33] Payment rates to plans participating in the long-term care managed care program must reflect historic utilization and spending for covered services projected forward and adjusted to reflect the level of care profile for enrollees in each plan. AHCA must adjust payments to incentivize the increased utilization of home and community-based services.[34]

[24] Ss. 429.917(1), F.S., and 430.525(4)(a), F.S.
[25] Ss. 429.917(1), F.S., and 430.525(4)(b), F.S.
[26] Ss. 429.917(1), F.S., and 430.525(4)(d), F.S.
[27] Ss. 429.917(1), F.S., and 430.525(4)(e), F.S.
[28] *Id.*
[29] Agency for Health Care Administration, *Comprehensive Medicaid Managed Care Enrollment Reports (December 31, 2023)* available at https://ahca.myflorida.com/medicaid/medicaid-finance-and-analytics/medicaid-data-analytics/medicaid-monthly-enrollment-report (last visited January 31, 2024).
[30] The vast majority of Medicaid enrollees receive services through the managed care model; those with limited benefits (such as the family planning program) are not, and some populations (such as enrollees in the home and community-based waiver for persons with developmental disabilities) may choose managed care or the fee-for-services model. S. 409.965, F.S.
[31] S. 409.964, F.S.
[32] S. 409.908(8), F.S.
[33] S. 409.978(2), F.S.
[34] S. 409.983(3), F.S.

Medicaid LTC plans must cover adult day care services.[35] Current law does not set adult day care payment rates; these are set by contracts between the adult day care centers and the managed care plans.

Transportation Services

Long-term care plans are also required to cover both emergency and non-emergency transportation services.[36] Medicaid covers medically necessary non-emergency transportation services for Medicaid eligible recipients who have no other means of transportation to a Medicaid covered service.[37] Under current law, managed care plans may subcontract for transportation services, but are not required to contract with any specific provider.

## Effect of the Bill

Medicaid Managed Care Rates

HB 1387 requires Medicaid LTC managed care plans to reimburse adult day care services on a set fee schedule established pursuant to a two-tiered payment model that categorizes an adult day care center based on the center's quality of care, facilities, compliance with established standards, and level of service.

For reimbursement as a Tier I center, the bill requires the center to meet all of the basic requirements for a licensed adult day care center as provided in part III of chapter 429, with the exception of the provision of specialized Alzheimer's services as described in s. 429.918. The reimbursement rate for a Tier I center shall be the minimum rate per day set by the United States Department of Veterans Affairs for adult day health care services, but not less than $90 per day. The reimbursement rate shall be adjusted on January 1 of each year, except that such adjustment may not exceed the lesser of 3 percent or the increase in the Consumer Price Index for All Urban Consumers for the South.

For reimbursement as a Tier II center, the bill requires the center to meet all of the requirements of a Tier I center and must be designated as a specialized Alzheimer's services adult day care center, as provided in s. 429.918. The reimbursement rate for a Tier II center shall be the minimum rate per day set by the United States Department of Veterans Affairs for adult day health care services, plus 30 percent rate difference over the standard contracted rate or set fee schedule rate for a Tier 1 Adult Day Center; however, the reimbursement rate may not be less than $110 per day. The reimbursement rate shall be adjusted on January 1 of each year, except that such adjustment may not exceed the lesser of 3 percent or the increase in the Consumer Price Index for All Urban Consumers for the South.

The bill also requires Medicaid to reimburse adult day care centers that provide transportation services to Medicaid recipients at the rates that are the greater of:

- At least $25 per day each way for 10 miles or less from the recipient's starting point and $1.53 for each additional mile, or, for a nonambulatory wheelchair user, $35 per day each way for 10 miles or less from the recipient's starting point and $1.64 for each additional mile; or
- The rates paid by the applicable managed care plan to its contracted nonemergency medical transportation vendor or, if the adult day care center directly contracts with a nonemergency medical transportation vendor of a managed care plan, the rates paid by the nonemergency medical transportation vendor to the nonemergency medical transportation provider.

Further, the bill provides that the reimbursement rates for transportation services that an adult day care center provides to a Medicaid recipient are subject to an annual adjustment reflecting the cost-of-living increase to ensure that such rates remain fair and competitive.

Adult Day Care Center Licensure

[35] S. 409.98(4), F.S.
[36] S. 409.98(18), F.S.
[37] S. 409.905(12), F.S.

*Continuing Education*

The bill also establishes continuing education requirements for operators of adult day care centers. Specifically, the bill requires each operator to annually complete a 9-hour continuing education course developed and offered by the Florida Adult Day Services Association and approved by the Department of Elder Affairs (DOEA), or any other educational provider approved by DOEA.

The course must include training in the following subject areas:

- One hour on compliance with the Agency for Health Care Administration;
- One hour on Alzheimer's disease and related disorders;
- One hour on the state comprehensive emergency management plan;
- One hour on anti-fraud, abuse, and neglect;
- One hour on nonemergency medical transportation;
- One hour on daily management;
- One hour on staff compliance with participant care standards; and
- One hour on the Health Insurance Portability and Accountability Act.

The continuing education course may be offered in person or online. Upon completion of the online course, an operator must pass a department-approved online examination with a minimum score of 80 percent. An operator attending an in-person course is exempt from the examination requirement. A person who teaches an approved course of instruction, or lectures at any approved course, and who attends the entire course shall qualify for the same number of classroom hours as a person who takes and successfully completes such course. Credit is limited to the number of hours actually taught or lectured unless the person attends the entire course.

Each person or entity providing a course for continuing education credit must furnish, within 30 days after completion of the course, in a form satisfactory to the department or its designee a roster showing the adult day care center license numbers and the names of the operators who have successfully completed the continuing education course and who request the continuing education credits.

An operator's compliance with the continuing education requirements of this section is a condition precedent to the issuance, continuation, reinstatement, or renewal of an adult day care center license. The department may, for good cause shown, grant an operator an extension of time during which the continuing education requirements must be completed, except that any such extension may not exceed 1 year.

Unless the DOEA has granted an operator a waiver or an extension, DOEA may not issue a renewal license to an adult day care center whose operator fails to complete continuing education until the operator successfully completes the continuing education course.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

**Section 1:** Amending s. 409.908, F.S., relating to reimbursement of Medicaid providers.
**Section 2:** Creating s. 429.924, F.S., relating to continuing education requirements for operators.
**Section 3:** Providing an effective date.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The bill has a significant negative fiscal impact on AHCA resulting from the creation of the fee schedule for adult day care centers. Specifically, the bill is expected to result in increased Medicaid expenditures of approximately $19 million annually.

There are 4,381 Medicaid enrollees receiving adult day care services. The average cost per day, per enrollee is $70 but will increase to $100 ($30 increase). The average number of service days is 144 per enrollee/per year.

Calculated: 4,381 enrollees x $30 increase x 144 days = $18,925,920

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:

The bill does not provide rule-making authority to DOEA to implement the continuing education requirements, however, rule-making may not be necessary for implementation.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to adult day care centers; amending s. 409.908, F.S.; providing fee schedules for Medicaid reimbursement for services provided by adult day care centers; defining the term "tiered payment system"; creating s. 429.924, F.S.; providing purpose; authorizing requests for a waiver of the continuing education requirements under a specified circumstance; providing continuing education requirements for adult date care center operators; providing the required subject areas for such continuing education courses; authorizing such courses to be offered in person or online; requiring operators to pass certain online examinations with a specified minimum score under certain circumstances; providing continuing education credit hours under certain circumstances; requiring continuing education course providers to furnish specified rosters to the Department of Elderly Affairs or its designee; providing that compliance with continuing education requirements is a condition precedent to the issuance, continuation, reinstatement, and renewal of adult day care center licenses; authorizing the department to grant extensions of time for completion of continuation education requirements under certain circumstances;

prohibiting the department from issuing renewal licenses to adult day care centers under a specified circumstance; providing exceptions; providing an effective date.

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

Section 1. Subsection (8) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost

reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid-eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(8)(a) Except as otherwise provided in paragraph (b), a provider of home-based or community-based services rendered pursuant to a federally approved waiver shall be reimbursed based on an established or negotiated rate for each service. These rates shall be established according to an analysis of the expenditure history and prospective budget developed by each contract provider participating in the waiver program, or under any other methodology adopted by the agency and approved by the Federal Government in accordance with the waiver. Privately owned and operated community-based residential facilities which meet agency requirements and which formerly received Medicaid reimbursement for the optional intermediate care facility for the intellectually disabled service may participate in the

developmental services waiver as part of a home-and-community-based continuum of care for Medicaid recipients who receive waiver services.

(b) A provider of adult day care services rendered pursuant to a federally approved waiver shall be reimbursed on a set fee schedule established pursuant to a tiered payment system. As used in this paragraph, the term "tiered payment system" means a two-tiered payment model that categorizes an adult day care center based on the center's quality of care, facilities, compliance with established standards, and level of service.

1. For purposes of reimbursement as a Tier I center, the center must meet all of the basic requirements for a licensed adult day care center as provided in part III of chapter 429, with the exception of the provision of specialized Alzheimer's services as described in s. 429.918. The reimbursement rate for a Tier I center shall be the minimum rate per day set by the United States Department of Veterans Affairs for adult day health care services, but not less than $90 per day. The reimbursement rate shall be adjusted on January 1 of each year, except that such adjustment may not exceed the lesser of 3 percent or the increase in the Consumer Price Index for All Urban Consumers for the South.

2. For purposes of reimbursement as a Tier II center, the center must meet all of the requirements of a Tier I center and

must be designated as a specialized Alzheimer's services adult day care center, as provided in s. 429.918. The reimbursement rate for a Tier II center shall be the minimum rate per day set by the United States Department of Veterans Affairs for adult day health care services, plus 30 percent rate difference over the standard contracted rate or set fee schedule rate for a Tier 1 Adult Day Center; however, the reimbursement rate may not be less than $110 per day. The reimbursement rate shall be adjusted on January 1 of each year, except that such adjustment may not exceed the lesser of 3 percent or the increase in the Consumer Price Index for All Urban Consumers for the South.

3.a. An adult day care center that provides transportation services to a Medicaid recipient shall be reimbursed for such services at the rates that are the greater of the rates under sub-sub-subparagraph (I) or sub-sub-subparagraph (II):

(I) At least $25 per day each way for 10 miles or less from the recipient's starting point and $1.53 for each additional mile, or, for a nonambulatory wheelchair user, $35 per day each way for 10 miles or less from the recipient's starting point and $1.64 for each additional mile; or

(II) The rates paid by the applicable managed care plan to its contracted nonemergency medical transportation vendor or, if the adult day care center directly contracts with a nonemergency medical transportation vendor of a managed care plan, the rates paid by the nonemergency medical transportation vendor to the

nonemergency medical transportation provider.

b. Notwithstanding sub-sub-subparagraphs (I) and (II), the reimbursement rates for transportation services that an adult day care center provides to a Medicaid recipient are subject to an annual adjustment reflecting the cost-of-living increase to ensure that such rates remain fair and competitive.

Section 2. Section 429.924, Florida Statutes, is created to read:

429.924 Continuing education requirements for operators.—

(1) The purpose of this section is to establish the requirements and standards for a continuing education course for operators managing the day-to-day operations of licensed adult day care centers in the state. An operator who cannot comply with the continuing education requirements of this section due to active duty in the military may submit a written request for a waiver to the department.

(2) In addition to any existing adult day care center staff training required by department rule or established under this part, each operator must complete every year a 9-hour continuing education course developed and offered by the Florida Adult Day Services Association and approved by the department. The course may also be provided by any other educational provider that is approved by the department. The course must include training in the following subject areas:

(a) One hour on compliance with the Agency for Health Care

Administration.

(b) One hour on Alzheimer's disease and related disorders.

(c) One hour on the state comprehensive emergency management plan.

(d) One hour on anti-fraud, abuse, and neglect.

(e) One hour on nonemergency medical transportation.

(f) One hour on daily management.

(g) One hour on staff compliance with Participant Care Standards, rule 59A-16.103, Florida Administrative Code.

(h) One hour on the Health Insurance Portability and Accountability Act.

(3) The continuing education course described in subsection (2) may be offered in person or online. Upon completion of the online course, an operator must pass a department-approved online examination with a minimum score of 80 percent. An operator attending an in-person course is exempt from the examination requirement. A person who teaches an approved course of instruction, or lectures at any approved course, and who attends the entire course shall qualify for the same number of classroom hours as a person who takes and successfully completes such course. Credit is limited to the number of hours actually taught or lectured unless the person attends the entire course.

(4) Each person or entity providing a course for continuing education credit must furnish, within 30 days after

completion of the course, in a form satisfactory to the department or its designee a roster showing the adult day care center license numbers and the names of the operators who have successfully completed the continuing education course and who request the continuing education credits.

(5)(a) An operator's compliance with the continuing education requirements of this section is a condition precedent to the issuance, continuation, reinstatement, or renewal of an adult day care center license. The department may, for good cause shown, grant an operator an extension of time during which the continuing education requirements must be completed, except that any such extension may not exceed 1 year.

(b) Unless the department has granted an operator a waiver or an extension under paragraph (a), the department may not issue a renewal license to an adult day care center whose operator fails to complete the requirements of this section until the operator successfully completes the continuing education course.

Section 3. This act shall take effect July 1, 2024.

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 | _____ |

Committee/Subcommittee hearing bill: Select Committee on Health Innovation

Representative Silvers offered the following:

**Amendment (with title amendment)**

Remove everything after the enacting clause and insert:

Section 1. Subsection (6) is added to section 409.982, Florida Statutes, to read:

409.982 Long-term care managed care plan accountability.—In addition to the requirements of s. 409.967, plans and providers participating in the long-term care managed care program must comply with the requirements of this section.

(6) An adult day care center holding a contract with a managed care plan may provide nonemergency transportation services for its clients to and from the center. A managed care plan contracting with an adult day care center shall reimburse

for such transportation services at rates negotiated between the adult day care center and the managed care plan.

Section 2. Section 429.924, Florida Statutes, is created to read:

429.924 Continuing education requirements for operators.—

(1) The purpose of this section is to establish the requirements and standards for a continuing education course for operators managing the day-to-day operations of licensed adult day care centers in the state. An operator who cannot comply with the continuing education requirements of this section due to active duty in the military may submit a written request for a waiver to the department.

(2) In addition to any existing adult day care center staff training required by department rule or established under this part, each operator must complete every year an 8-hour continuing education course developed and offered by the Florida Adult Day Services Association and approved by the department. The course may also be provided by any other educational provider that is approved by the department. The course must include training in the following subject areas:

(a) One hour on compliance with the Agency for Health Care Administration.

(b) One hour on Alzheimer's disease and related disorders.

(c) One hour on the state comprehensive emergency management plan.

(d) One hour on anti-fraud, abuse, and neglect.

(e) One hour on nonemergency medical transportation.

(f) One hour on daily management.

(g) One hour on staff compliance with Participant Care Standards, rule 59A-16.103, Florida Administrative Code.

(h) One hour on the Health Insurance Portability and Accountability Act.

(3) The continuing education course described in subsection (2) may be offered in person or online. Upon completion of the online course, an operator must pass a department-approved online examination with a minimum score of 80 percent. An operator attending an in-person course is exempt from the examination requirement. A person who teaches an approved course of instruction, or lectures at any approved course, and who attends the entire course shall qualify for the same number of classroom hours as a person who takes and successfully completes such course. Credit is limited to the number of hours actually taught or lectured unless the person attends the entire course.

(4) Each person or entity providing a course for continuing education credit must furnish, within 30 days after completion of the course, in a form satisfactory to the department or its designee a roster showing the adult day care center license numbers and the names of the operators who have

successfully completed the continuing education course and who request the continuing education credits.

(5)(a) An operator's compliance with the continuing education requirements of this section is a condition precedent to the issuance, continuation, reinstatement, or renewal of an adult day care center license. The department may, for good cause shown, grant an operator an extension of time during which the continuing education requirements must be completed, except that any such extension may not exceed 1 year.

(b) Unless the department has granted an operator a waiver or an extension under paragraph (a), the department may not issue a renewal license to an adult day care center whose operator fails to complete the requirements of this section until the operator successfully completes the continuing education course.

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**T I T L E A M E N D M E N T**

Remove everything before the enacting clause and insert:
An act relating to adult day care centers; amending s. 409.982, F.S.; extending a licensure expiration date for rural hospitals; creating s. 429.924, F.S.; providing purpose; authorizing requests for a waiver of the continuing education requirements under a specified circumstance; providing continuing education requirements for adult date care center operators; providing the

required subject areas for such continuing education courses; authorizing such courses to be offered in person or online; requiring operators to pass certain online examinations with a specified minimum score under certain circumstances; providing continuing education credit hours under certain circumstances; requiring continuing education course providers to furnish specified rosters to the Department of Elderly Affairs or its designee; providing that compliance with continuing education requirements is a condition precedent to the issuance, continuation, reinstatement, and renewal of adult day care center licenses; authorizing the department to grant extensions of time for completion of continuation education requirements under certain circumstances; prohibiting the department from issuing renewal licenses to adult day care centers under a specified circumstance; providing exceptions; providing an effective date.

# PCS for HB 773

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** PCS for HB 773 Coverage for Diagnostic and Supplemental Breast Examinations
**SPONSOR(S):** Select Committee on Health Innovation
**TIED BILLS:** **IDEN./SIM. BILLS:**

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| Orig. Comm.: Select Committee on Health Innovation | | Lloyd | Calamas |

## SUMMARY ANALYSIS

Breast cancer is the second most common form of cancer diagnosed in women and it is estimated that one in eight women will be diagnosed with breast cancer in her lifetime. It accounts for 30 percent of all new cancers in the United States each year. The median age at which a woman is diagnosed in age 62 with a very small percentage of women who are diagnosed under the age of 45. Survival rates have been increasing steadily since 1989 which many believe is tied to increases in awareness as well as advances in treatment options. For Florida, over 3,200 Floridians died of breast cancer in 2022, for a five-year impact adding up to 15,666 deaths. The number of new breast cancer diagnoses far outpaces that of any other cancer.

Biennial breast cancer screenings are included in mandatory coverage requirements under federal law; insured women within the recommended age range are currently eligible to receive a preventive screening every other year without any out of pocket costs. Should more detailed testing or diagnostic mammograms be necessary, however, those services are not federally mandated and, depending on the patient's health care coverage plan, would likely be subject to out of pocket costs similar to any other kind of diagnostic testing.

The state employee group health plan, administered by the Department of Management Services, provides health coverage for state employees, retirees, and their dependents. Currently, enrollees have no out of pocket cost for diagnostic and preventive imaging performed by an in-network provider. However, out of pocket costs for supplemental or diagnostic imaging may vary by contractor.

The PCS for HB 773 prohibits copayments and other cost sharing for supplemental or diagnostic breast imaging within the state employee group health plan, for plans that cover such services. The prohibition is effective January 1, 2025, consistent with the start of the new plan year.

The bill has a significant negative fiscal impact on the state employee group health plan, and no fiscal impact on state government.

The bill has an effective date of January 1, 2025.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

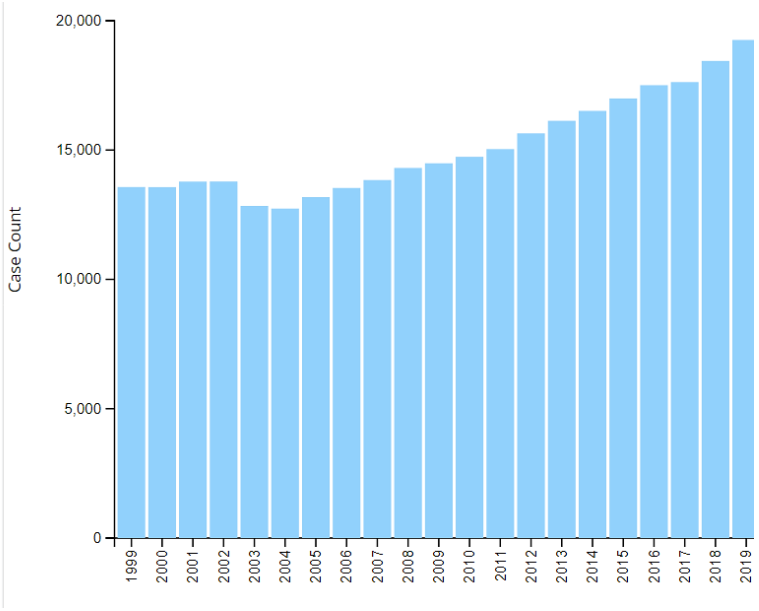
**Background**

**Breast Cancer**

Breast cancer is the second most common form of cancer diagnosed in women and it is estimated that one in eight women will be diagnosed with breast cancer in her lifetime.[1] It accounts for 30 percent of all new cancers in the United States each year.[2] The median age at which a woman is diagnosed is age 62 with a very small percentage of women who are diagnosed under the age of 45.[3] In its 2016 review of the screening guidelines, the United States Preventive Services Task Force (USPSTF) noted that the national mean age at diagnosis has remained virtually unchanged at 64 years since the late 1970s and the median age at time of death is 68 years during the same time as technology and screening percentages have increased significantly.[4]

The number of new diagnoses from 2022 data far outpaces the rate of any other types of new cancer cases. Female breast cancer cases were diagnosed at a rate of 114.9 per 100,000 women in Florida. The next closest diagnosis rate was for lung and bronchus cancer at 44 cases per 100,000 women.[5] The chart below shows the number of new female breast cancer diagnoses annually for the most recent 10-year period in which data is available.[6]

Annual Number of New Breast Cancers, Female, all Races and Ethnicities – Florida 1999-2020

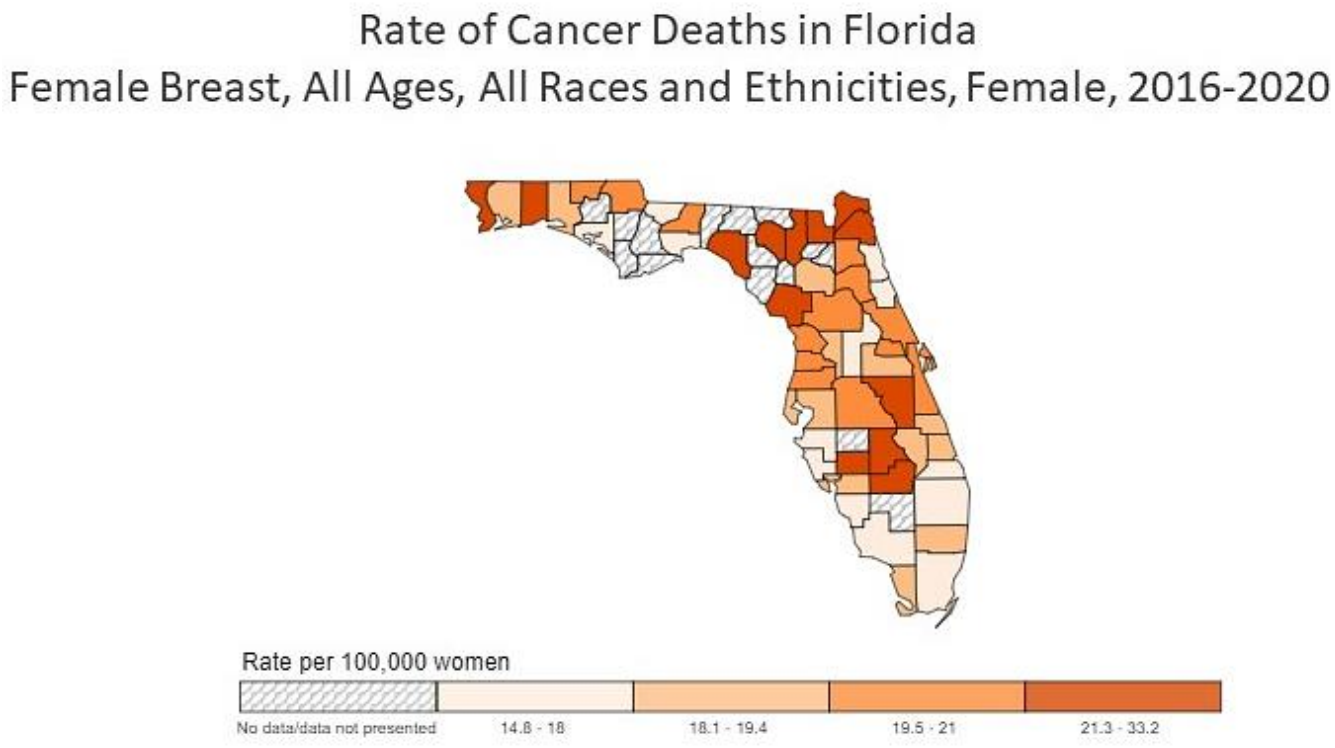



[1] American Cancer Society, *Key Statistics for Breast Cancer,* Breast Cancer Statistics | How Common Is Breast Cancer? | American Cancer Society (last visited January 27, 2024).
[2] *Id.*
[3] *Id.*
[4] Albert L. Siu, M.D. MSPH, on behalf of the U.S. Preventive Services Task Force, *Screening for Breast Cancer: U.S. Preventive Services Task Force Recommendation Statement, ANNALS OF INTERNAL MED.,(February 16, 2016, Clinical Guideline) available at* Recommendation: Breast Cancer: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org) (last visited January 28, 2027).
[5] *Supra,* note 1.
[6] Centers for Disease Control and Prevention, *U.S. Cancer Statistics Data Visualizations Tool*, (1999-2020 data), U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute (released in November 202 3); available at USCS Data Visualizations - CDChttps://gis.cdc.gov/Cancer/USCS/ - /Trends/ (last visited January 27, 2024).

The survival rate for female breast cancer is high. At five years, the relative survival rate for all races and ethnicities is 90 percent.[7] When broken down by race and ethnicity, the five-year survival rate shows an almost 10-point difference between Black, non-Hispanic women and several other race and ethnicity groups, as shown below.

| 5-Year Relative Survival: Female Breast Cancer By Race and Ethnicity – National Rates | |
|---|---|
| **Race, Ethnicity** | **5-Year Survival %** |
| White, Non-Hispanic | 91.5 |
| Black, Non-Hispanic | 82.9 |
| American Indian and Alaska Native, Non-Hispanic | 88.4 |
| Asian and Pacific Islander, Non-Hispanic | 91.7 |
| Hispanic | 88.8 |
| **All Races, All Ethnicities** | **90.3** |

Over 3,200 Floridians died of breast cancer in 2022, for a five-year impact adding up to 15,666 deaths.[8] For 2020, the rate of cancer deaths, all races and ethnicities for Florida, was 17.8 per 100,000 women. Higher rates of breast cancer deaths appear in small clusters in many rural areas of the Panhandle having insufficient numbers to provide a range for reporting purposes. For 2020, the statewide rate of breast cancer deaths was 17.8 per 100,000 women.[9]




[7] *Id.*
[8] Florida Department of Health, *FLHealthCharts, Deaths Counts Query* (query run January 28, 2024) available at: https://www.flhealthcharts.gov/FLQUERY_New/Death/Count (last visited January 28, 2024).
[9] *Supra,* note 5.

Risks and Risk Factors

There are no absolute ways to prevent breast cancer as there might be with other forms of cancer; however, there are some risk factors that may increase a woman's chances of receiving a diagnosis. Some risk factors that are out of an individual's control are:

- Being born female;
- Aging beyond 55;
- Inheriting certain gene changes;
- Having a family or personal history of breast cancer;
- Being of certain race or ethnicity;
- Being taller;
- Having dense breast tissue;
- Having certain benign breast conditions;
- Starting menstrual periods early, usually before age 12;
- Having radiation to the chest; and
- Being exposed to the drug, diethylstilbestrol (DES).[10]

For many of the factors above, it is unclear why these particular characteristics make an individual more susceptible to a cancer diagnosis other than perhaps being female. Other risk factors can be related to personal behaviors such as drinking alcohol excessively, being overweight or obese, not having children, or being less physically active.[11]

However, men can and do receive breast cancer diagnoses, just in very small numbers. About one in every 100 breast cancers diagnosed in the United States is found in a man.[12] For men, unique risk factors from those listed above may include genetic mutations, liver disease, conditions which affect the testicles, and the genetic condition known as Klinefelter syndrome.[13]

The USPSTF has called out advancing age as the most important risk factor for breast cancer in most women.[14] Age is also key in the factors cited by the USPSTF for when the net benefit of a regular biennial or annual mammogram screening for a person at regular risk may no longer be positive. For women between the ages of 70 to 74,the risks begin to outweigh the benefit, especially if the woman has other co-existing health conditions.[15] For those aged 75 and older, the USPSTF found insufficient evidence to be able to assess whether screening mammograms for those age 75 offered a net benefit. While a screening mammogram's risks as a procedure is considered to be a low risk, the principal harms identified were concerns of both over-diagnosis and under-diagnosis coupled with the anxiety caused by the follow-up procedures and false positives.

Beyond age, the next greatest risk factors are tied to hereditary and familial factors. About 5 to 10 percent of women who develop breast cancer have a mother or sister who also has breast cancer.[16] Additionally, while white women have had historically higher incident rates of cancer than African-American women; however, significantly more African American women die annually.

Prevention and Screenings

Having regular screenings for breast cancer are important as screenings aid in finding cancer early. Early detection with breast cancer gives an individual the best chance at successful treatment and higher incidences of survival.

[10] American Cancer Society, Breast Cancer Risk Factors You Cannot Change, available at Breast Cancer Risk Factors You Can't Change | American Cancer Society (last visited January 28, 2027).
[11] American Cancer Society, Lifestyle -related Breast Cancer Risk Factors, available at Lifestyle-related Breast Cancer Risk Factors | American Cancer Society (last visited January 28, 2024).
[12] Centers for Disease Control and Prevention, Breast Cancer in Men, available at https://www.cdc.gov/cancer/breast/men/ (last visited January 27, 2024).
[13] *Id.*
[14] *Supra,* note 4.
[15] *Id.*
[16] *Supra,* note 4.

A mammogram is an x-ray picture of the breast which may be able to detect breast cancer up to three years before it can be felt.[17] A screening mammography can often find evidence before there is any other evidence or symptoms of the cancer.

In October 2015, the American Cancer Society (ACS) modified its screening guidelines for women at average risk to start annual screenings at age 45, instead of age 40. Under the revised guidelines, it was recommended that women could still begin getting mammograms yearly from age 40 to 44 if they chose that screening pattern. The ACS guideline further recommended that beginning at age 55, women at average risk could transition to biennial screening. The change in the guideline was based on the ACS' finding that the evidence showed that the risk of cancer for women ages 40 to 44 was lower than the risk of harm associated with unnecessary biopsies.[18]

The accuracy of mammography is not 100 percent; however, detection through mammography does improve with a woman's age and has an overall accuracy rate of 85 percent.[19] Women should also be prepared by their health care practitioners of the chances of a callback back for a supplemental test. Approximately 10 percent of women are recalled for further testing or evaluation with an additional mammography, an ultrasound, or sometimes a biopsy.[20]

Biennial breast cancer screenings are included on the USPSTF list of recommended preventive services as part of the Essential Health Benefits coverages for women ages 50 to 74 years old with a "B" score.[21] With inclusion in the EHB package, preventive breast cancer screenings for insured women within the recommended age range qualify for the service from a network provider at no cost sharing. Should more detailed testing or diagnostic mammograms be necessary; however, those services are generally no longer considered to be preventive. Depending on the insured's insurance coverage plan, the additional diagnostic services, if covered, would incur the insured's regular out of pocket costs for diagnostic testing and be subject potentially to the insured's co-insurance or deductible requirements.

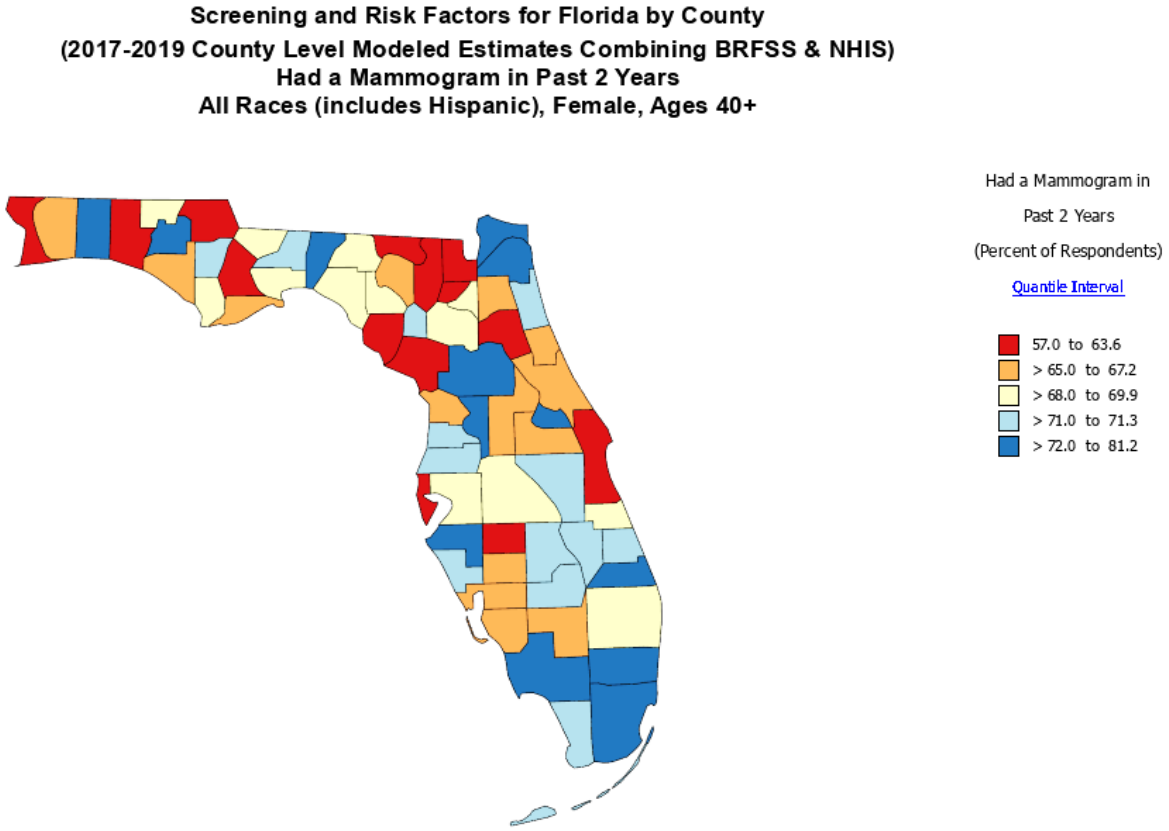
A health care provider may order additional tests like these below to make a further evaluation of a screening mammogram or to make additional treatment decisions:[22]

- **A breast ultrasound** uses machine-generated sound waves, called sonograms, to make pictures of areas inside the breast.
- **Diagnostic mammogram** may be used if a problem such as a lump, or an abnormal area has been located on a screening mammogram. The diagnostic mammogram is more a detailed x-ray of the breast.
- **Breast magnetic resonance imaging (MRI)** scans the body with a magnet linked to a computer. The MRI can make detailed pictures of areas inside the breast.
- **Biopsy** is a test that removes tissue or fluid from the breast to looked at under a microscope and to perform more testing. A biopsy can be done as a fine-needle, aspiration, core biopsy, or an open biopsy.

The percentage of Florida women over the age of 50 who undergo breast cancer screenings has steadily increased. However, women in certain Florida communities and women who are uninsured or underinsured women face challenges in accessing breast cancer screenings. Florida's overall

[17] Centers for Disease Control and Prevention, *What is a Mammogram?* available at: What Is a Mammogram? | CDC What Is a Mammogram? | CDC, (last visited January 28, 2024).
[18] American Cancer Society, *Frequently Asked Questions About the American Cancer Society's Breast Cancer Screening Guidelines,* available at What Is a Mammogram? | CDC (last visited January 28, 2024).
[19] *Id.*
[20] *Id.*
[21] Under the Affordable Care Act, benefits identified by the United States Preventive Services Task Force as having an "A" or B" effectiveness rating must be covered as an essential health benefit with no cost sharing to an individual insured under a qualified health plan with in-network providers.
[22] Centers for Disease Control and Prevention, *How is Breast Cancer Diagnosed?* Available at How Is Breast Cancer Diagnosed? | CDC (last visited January 27, 2028).

screening rate for women over the age of 40 is 73.27 percent which is slightly higher than the national average of 71.5 percent.[23]




**State Employee Health Plan**

The State of Florida offers its eligible employees, retirees, and their dependents a rich benefits package which includes comprehensive health insurance coverage. The Division of State Group Insurance (DSGI) within the Department of Management Services (DMS) administers the state group health insurance program (Program) under Ch. 110, F.S. The Program is a cafeteria plan managed consistent with section 125 of the Internal Revenue Service Code.[24] To administer the program, DSGI contracts with third party administrators for self-insured plans and fully insured HMOs to offer both standard and high deductible policies. For the 2024 Plan Year which began January 1, 2024, the HMO plans under contract with DSGI are Aetna, Capital Health Plan, and United Healthcare, and the PPO plan is Florida Blue.[25]

Breast Cancer Screening Coverage

Currently, the Program covers 100 percent of the costs of screening, preventive mammograms, (consistent with federal requirements related to essential health benefits coverage). Out of pocket costs, such as copayments, may vary for supplemental and diagnostic imaging based on the enrollee's plan and the provider selected.

**Effects of Proposed Changes**

[23] National Cancer Institute, *State Cancer Profiles – Florida (map and data generated on January 28, 2024)* available at State Cancer Profiles > Screening and Risk Factors Table (last visited January 28, 2024).
[24] A section 125 cafeteria plan is a type of employer offered, flexible health insurance plan that provides employees a menu of pre-tax and taxable qualified benefits to choose from, but employees must be offered at least one taxable benefit such as cash, and one qualified benefit, such as a Health Savings Account.
[25] Department of Management Services, Division of State Group Insurance, *2024 Open Enrollment Brochure for Active State Employee Participants*

PCS for HB 773 requires state group health insurance products which provide coverage for diagnostic and supplemental breast examinations to provide that coverage without imposing any cost sharing liability on the insured, such as a deductible, copayment, coinsurance, or cost-sharing. While current plans provide diagnostic breast examinations without cost sharing, cost sharing for supplemental examinations vary. The bill provides parameters for what constitutes supplemental breast examinations, prohibiting cost sharing for examinations that are:

- Medically necessary and appropriate examinations which may include magnetic resonance imaging and ultrasounds and other types of examinations;
- Used when no abnormality is seen or suspected; and
- Based on family medical history or other increased risk factors.

Under the bill, the state group plan will be responsible for the entire payment to the diagnostic and supplemental breast examination provider.

The effective date of the bill is January 1, 2025.

B. SECTION DIRECTORY:

**Section 1:** Amends s. 110.123, F.S., relating to state group insurance program.
**Section 2:** Provides an effective date.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The bill's prohibition on out of pocket costs for diagnostic and supplemental breast examinations in will reduce revenue to the program, generating a need cover the additional costs with increased premiums.

2. Expenditures:

   This benefit change has the potential to generate a higher insurance premium for the state group health plan. Historically, the state has covered premium inflation in the Program with General Revenue, rather than pass on premium increases to employees.

   The DSGI estimated the fiscal impact would be $4.1 million annually based on reductions in out of pocket costs.[26] DSGI did not estimate the cost of increased utilization.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill's prohibition on cost sharing may increase business revenue for diagnostic imaging providers, if state group health plan enrollees increase their utilization of breast exams as a result of the bill.

[26] Department of Management Services, 2023 Legislative Bill Analysis – SB 460 (February 8, 2023) (on file with the Select Committee on Health Innovation).

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:

None.

B. RULE-MAKING AUTHORITY:

The DSGI has sufficient rule-making authority under current law to implement the bill's provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to coverage for diagnostic and supplemental breast examinations; amending s. 110.123, F.S.; defining the terms "cost sharing requirement" "diagnostic breast examination" and "supplemental breast examination"; prohibiting the state group insurance program from imposing any enrollee cost-sharing liability with respect to coverage for diagnostic breast examinations and supplemental breast examinations; providing applicability; providing an effective date.

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

Section 1. Paragraphs (s), (t), and (u) are added to subsection (2) of section 110.123, Florida Statutes, to read:

110.123 State group insurance program.—

(2) DEFINITIONS.—As used in ss. 110.123-110.1239, the term:

(s) "Cost-sharing requirement" means an insured's deductible, coinsurance, copayment, or similar out-of-pocket expense.

(t) "Diagnostic breast examination" means a medically necessary and appropriate examination of the breast, including, but not limited to, an examination using diagnostic mammography,

breast magnetic resonance imaging, or breast ultrasound, which is used to evaluate an abnormality that is seen or suspected from a screening examination for breast cancer.

(u) "Supplemental breast examination" means a medically necessary and appropriate examination of the breast, including, but not limited to, an examination using breast magnetic resonance imaging or breast ultrasound, which is:

1. Used to screen for breast cancer when there is no abnormality seen or suspected; and

2. Based on personal or family medical history or additional factors that may increase the person's risk of breast cancer.

Section 2. Subsection (5) is added to section 110.12303, Florida Statutes, to read:

110.12303 State group insurance program; additional benefits; price transparency program; reporting.—

(5) In any contract or plan for state employee health benefits which provides coverages for diagnostic breast examinations or supplemental breast examinations, the state group insurance program may not impose any enrollee cost-sharing liability. If, under federal law, the application of this subsection would result in health savings account ineligibility under s. 223 of the Internal Revenue Code, the prohibition under this subsection applies only to health savings account qualified high-deductible health plans with respect to the deductible of

such a plan after the person has satisfied the minimum deductible under s. 223 of the Internal Revenue Code, except with respect to items or services that are preventive care pursuant to s. 223(c)(2)(C) of the Internal Revenue Code, in which case the requirements of s. 223(c)(2)(A) of the Internal Revenue Code apply regardless of whether the minimum deductible under s. 223 of the Internal Revenue Code has been satisfied.

Section 3. This act shall take effect January 1, 2025.

**PCS for HB 891**

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** PCS for HB 891 Health Care Provider Accountability
**SPONSOR(S):** Select Committee on Health Innovation
**TIED BILLS:** **IDEN./SIM. BILLS:**

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| Orig. Comm.: Select Committee on Health Innovation | | Guzzo | Calamas |

## SUMMARY ANALYSIS

Nursing homes provide 24-hour a day nursing care, case management, health monitoring, personal care, social activities, respite care, and physical, occupational, and speech therapy to those who are ill or physically infirm. Nursing homes are regulated by the Agency for Health Care Administration (AHCA) under the Health Care Licensing Procedures Act in part II of chapter 408, F.S., and under the individual authorizing statutes for nursing homes in part II of chapter 400, F.S.,

PCS for HB 891 requires nursing homes to report to AHCA any common ownership the facility or its parent company shares with a staffing or management company, a vocational or physical rehabilitation company, or any other entity that conducts business within the facility. Common ownership means, in relevant part, an ownership interest of 5 percent or more held by the entity in the facility or by the facility in the entity. The PCS requires facilities to report this information electronically as an element of the data required to be reported in the Florida Nursing Home Uniform Reporting System. AHCA must annually publish on its website all common ownership reported in the preceding year.

PCS for HB 891 also requires AHCA to submit an annual report to the Governor and the Legislature on the success of the Personal Care Attendant (PCA) training program, which was created by the Legislature in 2021, to create an additional path for an individual to become a certified nursing assistant (CNA). The report must include:

- The number of PCAs who take and subsequently pass the CNA exam after the four months of initial employment with a facility;
- Any adverse actions related to patient care involving PCAs; and
- The number of new CNAs employed and remaining each year after being employed as PCAs.

The bill has no fiscal impact on state or local government.

The bill provides an effective date of July 1, 2024.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Background**

Nursing Homes

Nursing homes are regulated by the Agency for Health Care Administration (AHCA) under the Health Care Licensing Procedures Act (Act) in part II of chapter 408, F.S., which contains uniform licensing standards for all 29 types of facilities and providers licensed by AHCA. In addition, nursing homes must comply with the requirements contained in the individual authorizing statutes of part II of chapter 400, F.S., which includes unique provisions beyond the uniform criteria.

*Nursing Home Uniform Reporting System*

Nursing homes are required to annually submit actual audited, financial experience including expenditures, revenues, and statistical measures to AHCA's Florida Nursing Home Uniform Reporting System (NHURS).[1] The data may be based on internal financial reports that are certified to be complete and accurate by the chief financial officer of the nursing home, and must include the fiscal year-end balance sheet, income statement, statement of cash flow, and statement of retained earnings.[2]

*Disclosure of Ownership Interest (State)*

The Act requires applicants for licensure, including applicants for nursing home licensure, to submit to AHCA the name, address, and social security number, or individual taxpayer identification number if a social security number cannot be legally obtained, of:[3]

- The applicant;
- The administrator or a similarly titled person who is responsible for the day-to-day operation of the facility;
- The financial officer or similarly titled person who is responsible for the financial operation of the licensee or provider;
- Each person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the applicant or licensee; and
- Each person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider.

Current Florida law does not require nursing homes to report to AHCA any common ownership the facility or its parent company shares with staffing or management companies, vocational or physical rehabilitation companies, or any other companies that conduct business within the facility.

*Disclosure of Ownership Interest (Federal)*

The federal Centers for Medicare and Medicaid Services (CMS) recently published a final rule implementing additional disclosure requirements for nursing homes certified to provide Medicare or Medicaid.[4] According to CMS, "over the years CMS has become increasingly concerned about the quality of care at nursing homes, especially those owned by private equity companies and other types of investment firms. Academic research suggests that ownership of nursing homes by private equity

[1] S. 408.061(5), F.S.
[2] *Id.*
[3] Ss. 408.806(1), F.S., and 408.803(7), F.S.
[4] 42 C.F.R., § 424.502 (Nov. 17, 2023).

companies and other types of investment firms can be associated with worse resident outcomes, and merits closer scrutiny."[5]

The rule requires all Medicare and Medicaid certified nursing homes to report to CMS and the relevant state Medicaid agencies additional information about their ownership and management structures. Specifically, nursing homes must submit certain information with their application for initial enrollment and upon revalidation, including information on any person or entity who does any of the following:[6]

- Exercises operational, financial, or managerial control over the facility or a part thereof;
- Provides policies or procedures for any of the operations of the facility;
- Provides financial or cash management services to the facility;
- Leases or subleases real property to the facility;
- Owns a whole or part interest equal to or exceeding five percent of the total value of such real property;
- Provides management or administrative services;
- Provides management or clinical consulting services; or
- Provides accounting or financial services to the facility.

For each disclosable party above, the nursing facilities must report the organizational structure of such entity. This requirement varies by business structure, as follows: [7]

- For a corporation – the officers, directors, and shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds five percent.
- For a limited liability company – the members and managers of the limited liability company including, as applicable, what percentage each member and manager has of the ownership interest in the limited liability company.
- For a general partnership – The partners of the general partnership.
- For a limited partnership – The general partners and any limited partners of the limited partnership who have an ownership interest in the limited partnership which is equal to or exceeds 10 percent.
- For a trust – The trustees of the trust.

Personal Care Attendant Training Program

In the initial stages of the COVID-19 pandemic, nursing homes struggled to maintain adequate staffing levels.[8] To address the staffing challenges caused by the pandemic, AHCA temporarily approved the creation of the personal care attendant (PCA) training program.[9] A PCA is an individual who has not fulfilled the necessary requirements to become a certified nursing assistant (CNA), but may assist nursing home residents with certain tasks after completion of required training.[10] This allows them to develop the skills to become a CNA while receiving on the job experience. Like all applicants for certification as a CNA, a PCA is required to pass the CNA competency exam, but their PCA training

[5] Centers for Medicare & Medicaid Services, *Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities and Nursing Facilities; Definitions of Private Equity Companies and Real Estate Investment Trusts for Medicare Providers and Suppliers* (Nov. 15, 2023), available at https://www.cms.gov/newsroom/fact-sheets/disclosures-ownership-and-additional-disclosable-parties-information-skilled-nursing-facilities-and-0 (last visited January 30, 2024).
[6] 42 C.F.R., § 424.502 *"Additional Disclosable Party"* (1)-(3).
[7] 42 C.F.R., § 424.502 *"Organizational Structure"*
[8] Noelle Denny-Brown, Denise Stone, Burke Hays, and Dayna Gallaghe/U.S. Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation, *COVID-19 Intensifies Nursing Home Workforce Challenges* (Oct. 19, 2020), available at https://aspe.hhs.gov/basic-report/covid-19-intensifies-nursing-home-workforce-challenges (last visited January 30, 2024).
[9] Memorandum from the Agency for Health Care Administration to the Florida Health Care Association and Florida Leading Age (Mar. 28, 2020), available at https://www.fhca.org/images/uploads/pdf/Personal_Care_Attendent.pdf (last visited January 30, 2024). *See also* Memorandum from the Agency for Health Care Administration to the Florida Health Care Association and Florida Leading Age (Sep. 9, 2020), available at https://www.fhca.org/images/uploads/pdf/PCA_letter_9-8-20_1.pdf (last visited January 30, 2024).
[10] S. 400.211(2)(d), F.S.

substitutes for the 120-hour CNA training program.[11] A PCA must become certified within four months of initial employment.[12]

In 2021, the Legislature codified the temporary PCA training program, with modifications to align it with current practice for CNAs.[13] The goal of the PCA training program is to enable the PCA to further obtain skills and training from their employer toward successfully passing the CNA exam.[14] The PCA must attain certification as a CNA within four months of initial employment.[15]

Completion of all training and documentation requirements for PCA candidates is the ultimate responsibility of the nursing home.[16] Training must consist of 16 hours of classroom instruction and eight hours of supervised simulation in which the PCA candidate is required to demonstrate competency in all areas of training.[17] The facility must maintain a record of all PCA candidates who complete training and must provide the names of all PCAs working in the facility to AHCA upon request.[18]

**Effect of the Bill**

PCS for HB 891 requires nursing homes to report to AHCA any common ownership the facility or its parent company shares with a staffing or management company, a vocational or physical rehabilitation company, or any other entity that conducts business within the facility. Common ownership means, in relevant part, an ownership interest of 5 percent or more held by the entity in the facility or by the facility in the entity. The PCS requires facilities to report this information electronically as an element of the data required to be reported in the NHURS. AHCA must annually publish on its website all common ownership reported in the preceding year.

PCS for HB 891 also requires AHCA to submit an annual report to the Governor and the Legislature on the success of the PCA training program, which must include:

- The number of PCAs who take and subsequently pass the CNA exam after the four months of initial employment with a facility;
- Any adverse actions related to patient care involving PCAs; and
- The number of new CNAs employed and remaining each year after being employed as PCAs.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

**Section 1:** Amends s. 400.141, F.S., relating to administration and management of nursing home facilities.
**Section 2:** Amends s. 400.211, F.S., relating to persons employed as nursing assistants; certification requirements; qualified medication aide designation and requirements.
**Section 3:** Provides an effective date of July 1, 2024.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

[11] S. 400.141(1)(w), F.S., and rule 59A-4.1081, F.A.C.
[12] S. 400.211(2)(d), F.S.
[13] Chapter 2021-163, Laws of Fla.
[14] Rule 59A-4.1081(2), F.A.C.
[15] S.400.211(2)(d), F.S.
[16] Rule 59A-4.1081(6), F.A.C.
[17] *Id.*
[18] *Id.*

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:

The bill does not necessitate rule-making for implementation.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to health care provider accountability; amending s. 400.141, F.S.; requiring nursing home facilities to report to the Agency for Health Care Administration common ownerships they or their parent companies share with certain entities; requiring the agency to work with stakeholders to determine how such reporting shall be conducted; requiring the agency to submit a report of such reported common ownerships to the Governor and Legislature by a specified date each year; requiring the agency to adopt rules; amending s. 400.211, F.S.; requiring the agency to submit a report on the success of the personal care attendant program to the Governor and Legislature by a specified date each year; providing requirements for the report; providing an effective date.

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

Section 1. Paragraph (x) is added to subsection (1) of section 400.141, Florida Statutes, to read:

400.141 Administration and management of nursing home facilities.—

(1) Every licensed facility shall comply with all

applicable standards and rules of the agency and shall:

(x) Report to the agency any common ownership the facility or its parent company shares with a staffing or management company, a vocational or physical rehabilitation company, or any other entity that conducts business within the nursing home facility. For the purposes of this paragraph, "common ownership" means an ownership interest of 5 percent or more held by the entity in the facility or by the facility in the entity. Facilities shall report this information electronically as an element of the data reporting required by s. 408.061(5). The agency shall annually, by January 15, publish on its website all common ownerships reported to the agency in the preceding year.

Section 2. Subsection (2) of section 400.211, Florida Statutes, is amended to read:

400.211 Persons employed as nursing assistants; certification requirement; qualified medication aide designation and requirements.—

(2) The following categories of persons who are not certified as nursing assistants under part II of chapter 464 may be employed by a nursing facility for a single consecutive period of 4 months:

(a) Persons who are enrolled in, or have completed, a state-approved nursing assistant program.

(b) Persons who have been positively verified as actively certified and on the registry in another state with no findings

of abuse, neglect, or exploitation in that state.

(c) Persons who have preliminarily passed the state's certification exam.

(d) Persons who are employed as personal care attendants and who have completed the personal care attendant training program developed pursuant to s. 400.141(1)(w). As used in this paragraph, the term "personal care attendants" means persons who meet the training requirement in s. 400.141(1)(w) and provide care to and assist residents with tasks related to the activities of daily living.

The certification requirement must be met within 4 months after initial employment as a nursing assistant in a licensed nursing facility. On January 1 of each year, the agency shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the success of this program including, but not limited to, how many personal care attendants take and subsequently pass the certified nursing assistant exam after the 4 months of initial employment with a single nursing facility, any adverse actions related to patient care involving personal care attendants, how many new certified nursing assistants are employed and remain employed each year after being employed as personal care attendants, and the turnover rate of personal care attendants in nursing facilities.

Section 3. This act shall take effect July 1, 2024.

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** PCS for HB 1343 Health Care Patient Protection
**SPONSOR(S):** Altman
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 798

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Select Committee on Health Innovation | | Guzzo | Calamas |
| 2) Health & Human Services Committee | | | |

## SUMMARY ANALYSIS

General hospital EDs (nonchildren's hospitals) primarily treat adults and may not be prepared to treat children because of low pediatric patient volume. More than 97 percent of EDs caring for children are general hospital EDs, accounting for 82 percent of pediatric ED visits. Currently, Florida laws do not require hospital EDs to meet minimum standards of care for pediatric patients.

The National Pediatric Readiness Project (NPRP) is a quality improvement initiative to empower all EDs to provide effective emergency care to children. The NPRP developed an assessment to measure a hospital ED's pediatric readiness. The NPRP Assessment is voluntary and is conducted every five years. Recent studies prove that hospital EDs with high pediatric readiness scores have lower mortality rates among children.

The bill requires all hospitals with EDs to develop and implement policies and procedures for pediatric patient care in the ED, which reflect evidence-based best practices related to, at a minimum: triage; measuring and recording vital signs; weighing and recording weights in kilograms; calculating medication dosages; and using pediatric instruments. Additionally, each hospital with an ED must conduct training on their policies and procedures, which must include, at a minimum: the use of pediatric instruments, as applicable to each licensure type, and using clinical simulation and drills that simulate emergency situations. Each ED must conduct drills at least annually and each clinical employee of the ED must receive training at least annually.

The bill requires each hospital with an ED to designate a physician or nurse to serve as the pediatric emergency care coordinator in the ED. The pediatric emergency care coordinator is responsible for implementation of, and ensuring fidelity to, the policies and procedures for pediatric patient care in the ED.

The bill requires AHCA, in consultation with the Florida Emergency Medical Services for Children State Partnership Program, to adopt rules that establish minimum standards for pediatric patient care in hospital EDs, including, but not limited to, availability and immediate access to pediatric specific equipment and supplies. The bill also requires AHCA to adopt rules to require a hospital's comprehensive emergency management plan to include components that address the needs of pediatric and neonatal patients.

The bill requires all hospital EDs to conduct the National Pediatric Readiness Assessment, in accordance with the timelines established by the National Pediatric Readiness Project. The next pediatric readiness assessment will be conducted in 2026 and every five years thereafter. Each hospital ED must submit the results of the assessment to AHCA by December 31, 2026. The bill requires AHCA to publish the results of the assessment score for each hospital ED and provide a comparison to the national average score. AHCA must publish the results of the 2026 assessment by April 1, 2027, and must publish the results of subsequent assessments by April 1 following a year in which the assessment is conducted.

The bill has no fiscal impact on state or local government.

The bill provides an effective date of July 1, 2024.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Background**

Hospital Licensure

Hospitals are regulated by the Agency for Health Care Administration (AHCA) under chapter 395, F.S., and the general licensure provisions of part II, of chapter 408, F.S. In Florida, emergency departments (EDs) are either located in a hospital or on separate premises of a licensed hospital. Any licensed hospital which has a dedicated ED may provide emergency services in a location separate from the hospital's main premises, known as a hospital-based off-campus emergency department.[1]

Current law requires each hospital with an ED to screen, examine, and evaluate a patient who presents to the ED to determine if an emergency medical condition exists and, if it does, provide care, treatment, or surgery to relieve or eliminate the emergency medical condition.[2] Each hospital with an ED must provide emergency services and care[3] 24 hours a day and must have at least one physician on-call and available within 30 minutes.[4]

*Inventory of Hospital Emergency Services*

Each hospital offering emergency services and care must report to AHCA the services which are within the service capability of the hospital.[5] AHCA is required to maintain an inventory of hospitals with emergency services, including a list of the services within the service capability of the hospital, to assist emergency medical services providers and the general public in locating appropriate emergency medical care.[6] If a hospital determines it is unable to provide a service on a 24 hour per day, 7 day per week basis, either directly or indirectly through an arrangement with another hospital, the hospital must request a service exemption from AHCA.[7]

*Policies and Procedures*

Each hospital offering emergency services and care is required to maintain written policies and procedures specifying the scope and conduct of their emergency services. The policies and procedures must be approved by the organized medical staff, reviewed at least annually, and must include:[8]

- A process to designate a physician to serve as the director of the ED;
- A written description of the duties and responsibilities of all other health care personnel providing care within the ED;
- A planned formal training program on emergency access laws for all health care personnel working in the ED; and
- A control register to identify all persons seeking emergency care.

[1] S. 395.002(13), F.S.
[2] S. 395.1041, F.S.
[3] S. 395.002(9), F.S., "emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility.
[4] Rule 59A-3.255(6), F.A.C.
[5] S. 395.1041(2), F.S.
[6] Medical services listed in the inventory include: anesthesia; burn; cardiology; cardiovascular surgery; colon & rectal surgery; emergency medicine; endocrinology; gastroenterology; general surgery; gynecology; hematology; hyperbaric medicine; internal medicine; nephrology; neurology; neurosurgery; obstetrics; ophthalmology; oral/maxilla-facial surgery; orthopedics; otolaryngology; plastic surgery; podiatry; psychiatry; pulmonary medicine; radiology; thoracic surgery; urology; and vascular surgery.
[7] Rule 59A-3.255(4), F.A.C. AHCA Form 3000-1 Emergency Services Exemption Request available at https://www.flrules.org/Gateway/reference.asp?No=Ref-04607 (last visited December 22, 2023).
[8] Rule 59A-3.255(6)(e), F.A.C.

Current law does not require EDs to have pediatric-specific policies and procedures.

*Equipment and Supplies*

Each hospital ED is required to provide diagnostic radiology services and clinical laboratory services and must ensure that an adequate supply of blood is available at all times. Hospitals EDs are also required to have certain equipment available for immediate use at all times, including:[9]

- Oxygen and means of administration;
- Mechanical ventilatory assistance equipment, including airways, manual breathing bags, and ventilators;
- Cardiac defibrillators with synchronization capability;
- Respiratory and cardiac monitoring equipment;
- Thoracentises and closed thoracotomy sets;
- Tracheostomy or cricothyrotomy sets;
- Tourniquets;
- Vascular cutdown sets;
- Laryngoscopes and endotracheal tubes;
- Urinary catheters with closed volume urinary systems;
- Pleural and pericardial drainage sets;
- Minor surgical instruments;
- Splinting devices;
- Emergency obstetrical packs;
- Standard drugs as determined by the facility;
- Common poison antidotes;
- Syringes, needles, and surgical supplies;
- Parenteral fluids and infusion sets;
- Refrigerated storage for biologicals and other supplies; and
- Stable examination tables.

Currently, there are no pediatric-specific equipment or supply standards for EDs.

*Comprehensive Emergency Management Plans*

All hospitals are required to develop and adopt comprehensive emergency management plan for emergency care during an internal or external disaster or an emergency.[10] Each hospital must review, update, and submit their plans annually to their county office of emergency management. A hospital's comprehensive emergency management plan must include the following:[11]

- Provisions for the management of staff, including the distribution and assignment of responsibilities and functions.
- Education and training of personnel in carrying out their responsibilities in accordance with the adopted plan;
- Information about how the hospital plans to implement specific procedures outlined in the plan;
- Precautionary measures, including voluntary cessation of hospital admissions, to be taken in preparation and response to warnings of inclement weather, or other potential emergency conditions;
- Provisions for the management of patients, including the discharge of patients in the event of an evacuation order;
- Provisions for coordinating with other hospitals;
- Provisions for the individual identification of patients, including the transfer of patient records;

[9] Rule 59A-3.255(6)(g), F.A.C.
[10] S. 395.1055(1)(c), F.S.
[11] Rule 59A-3.078, F.A.C.

- Provisions to ensure that relocated patients arrive at designated hospitals;
- Provisions to ensure that medication needs will be reviewed and advance medication for relocated patients will be forwarded to the appropriate hospitals;
- Provisions for essential care and services for patients who may be relocated to the facility during a disaster or an emergency, including staffing, supplies, and identification of patients;
- Provisions for the management of supplies, communications, power, emergency equipment, and security;
- Provisions for coordination with designated agencies including the Red Cross and the county emergency management office; and
- Plans for the recovery phase of the operation.

Current law does not require hospitals to include any pediatric-specific provisions in their comprehensive emergency management plans.

Pediatric Care in Hospital Emergency Departments

Children represent approximately 20 percent of all emergency department visits in the U.S. each year.[12] A recent analysis by the Wall Street Journal indicated that general hospital EDs are often unprepared to care for children, citing examples of failures to have pediatric equipment and supplies on hand, drug dosing errors, and lack of staff training on pediatric implements.

The analysis inferred that pediatric emergency care provided by hospital EDs in the U.S. is unsatisfactory to the extent that children are dying because of their ill-preparedness.[13] Specifically, according to the analysis, 1,440 children died from 2012 to 2017 because the ERs that treated them "weren't well prepared". The study cited as the source for this claim, however, estimates that if all 983 EDs in the study were in the highest quartile of pediatric readiness 1,442 deaths may have been prevented. While some in the industry do not agree with the negative tenor of the report, they agree that there is room for improvement.[14]

General hospital EDs (nonchildren's hospitals) primarily treat adults and may not be prepared to treat children because of low pediatric patient volume. More than 97 percent of EDs caring for children are general hospital EDs, accounting for 82 percent of pediatric ED visits.[15] Most of these hospitals see less than 15 pediatric patients per day.[16] Therefore, according to a joint policy statement issued by the American Academy of pediatrics (AAP), the American College of Emergency Physicians (ACEP), and the Emergency Nurses Association (ENA), "it is imperative that all hospital EDs have the appropriate resources (medications, equipment, policies, and education) and staff to provide effective emergency care for children."[17]

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[12] Remick KE, Hewes HA, Ely M, et al. *National Assessment of Pediatric Readiness of US Emergency Departments During the COVID-19 Pandemic*. JAMA Network (July, 2023) available at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2807059 (last visited December 22, 2023).

[13] Liz Essley Whyte and Melanie Evans, *Children are Dying in Ill-Prepared Emergency Rooms Across America*, Wall Street Journal (Oct. 2023), available at https://www.wsj.com/health/healthcare/hospitals-emergency-rooms-cost-childrens-lives-d6c9fc23 (last visited December 22, 2023).

[14] Amy Wimpey Knight and Torey Mack MD, *In Response to the Wall Street Journal: We Can Improve Pediatric Emergency Care,* Children's Hospital Association (Oct. 2023), available at https://www.childrenshospitals.org/news/childrens-hospitals-today/2023/10/in-response-to-the-wall-street-journal-we-can-improve-pediatric-emergency-care (last visited December 22, 2023) *see also* Chris DeRienzo, *Kids Deserve our Best: What the WSJ Got Wrong about Pediatric Readiness*, American Hospital Association (Oct. 2023), available at https://www.aha.org/news/blog/2023-10-02-kids-deserve-our-best-what-wsj-got-wrong-about-pediatric-readiness (last visited December 22, 2023).

[15] *Id.*

[16] The National Pediatric Readiness Project, Pediatric Readiness Saves Lives, available at https://media.emscimprovement.center/documents/EMS220628_ReadinessByTheNumbers_220830_ZekNYVF.pdf (last visited December 22, 2023).

[17] American Academy of Pediatrics, Committee on Pediatric Emergency Medicine; American College of Emergency Physicians, Pediatric Committee; Emergency Nurses Association, Pediatric Committee. Joint policy statement--guidelines for care of children in the emergency department (Oct. 2009), available at https://doi.org/10.1542/peds.2009-1807 (last visited December 22, 2023).

The 2009 joint policy statement by the AAP, ACEP, and ENA also included guidelines for care of children in the emergency department.[18] In 2012, the Emergency Medical Services for Children (EMSC) Program, under the U.S. Department of Health and Human Services, used the guidelines to launch the National Pediatric Readiness Project, in partnership with the AAP, ACEP, and ENA.

*The National Pediatric Readiness Project*

The National Pediatric Readiness Project (NPRP) is a quality improvement initiative offering state partnership grants to state governments and accredited schools of medicine to expand and improve emergency medical services for children in hospital emergency departments (EDs).[19] The NPRP measures the performance of hospital EDs based on the following 4 metrics and includes program goals for each:[20]

- Pediatric Readiness Recognition Programs – Program Goal: To increase the percent of hospitals with an ED recognized through a statewide, territorial, or regional standardized program that are able to stabilize and manage pediatric emergencies;
- Pediatric Emergency Care Coordinators – Program Goal: To increase the percent of hospitals with an ED that have a designated nurse, physician, or both who coordinates pediatric emergency care;
- Weigh and Record Children's Weight in Kilograms – Program Goal: To increase the percent of hospitals with an ED that weigh and record children in kilograms; and
- Disaster Plan Resources – Program Goal: To increase the percent of hospitals with an ED that have a disaster plan that addresses the needs of children.

Performance is measured based on the NPRP Assessment,[21] a voluntary survey accessed via invitation from the NPRP. The NPRP has conducted two nationwide assessments. The first NPRP Assessment occurred in 2013 and the second was in 2021. According to current Program plans, the expectation is that the NPRP Assessment will occur every 5 years, so the next assessment will be in 2026.[22]

In comparing participation rates in the NPRP Assessment in Florida from 2013[23] to 2021[24], participation dropped slightly, as did the average scores of participating hospitals in Florida. National participation dropped significantly from 2013 to 2021, while the average national score saw a slight increase.

Not all hospitals choose to participate in the NPRP Assessment. Florida Participation rates are below the national average, and dropped from 2013 to 2021. National participation rates dropped significantly from 2013 to 2021.

[18] *Id.*
[19] The program is also used to improve emergency medical care for children in prehospital settings and to advance family partnerships and leadership in efforts to improve EMSC systems of care, *see* https://www.grants.gov/search-results-detail/340371 .
[20] EMSC Innovation and Improvement Center, Performance Measures, available at https://emscimprovement.center/programs/partnerships/performance-measures/ .
[21] National Pediatric Readiness Project, Pediatric Readiness Assessment, available at https://www.pedsready.org/docs/PedsReady%20Survey-QI%20Assessment.pdf (last visited December 22, 2023).
[22] Emergency Medical Services for Children, National Pediatric Readiness Project Assessment, available at https://emscdatacenter.org/sp/pediatric-readiness/national-pediatric-readiness-project-nprp-assessment/ (last visited December 22, 2023).
[23] Florida versus National Pediatric Readiness Project Results from 2013 Survey, available at https://www.floridahealth.gov/provider-and-partner-resources/emsc-program/_documents/fl-pediatricreadiness-summary091013.pdf (last visited December 22, 2023).
[24] Florida Versus National Pediatric Readiness Project Results from 2021 Survey, available at https://emlrc.org/wp-content/uploads/National-Pediatric-Readiness-Assessment-2021-Results_07.19.2023_Final.pdf (last visited December 22, 2023).

| Florida Participation Rates | |
|---|---|
| 2013 Rate | 2021 Rate |
| 61 %<br>126 of 209 | 58%<br>170 of 295 |

| National Participation Rates | |
|---|---|
| 2013 Rate | 2021 Rate |
| 83 %<br>4,150 of 5,017 | 71 %<br>3,647 of 5,150 |

Recent studies associate high pediatric readiness scores with:[25]

- 76 percent lower mortality rate in ill children;
- 60 percent lower mortality rate in injured children; and
- 1,400 children's lives saved across the U.S. each year.

*Florida Emergency Medical Services for Children State Partnership Program*

The Florida Emergency Medical Services for Children State Partnership Program[26] (program) is a quality improvement initiative administered by the University of Florida College of Medicine — Jacksonville, and is funded by a state partnership grant from the national EMSC Program.[27] The purpose of the program is to expand and improve emergency medical services for children who need treatment for trauma or critical care by partnering with EDs, emergency medical service agencies, and disaster preparedness organizations to enhance pediatric readiness. The program provides outreach and information to hospital EDs to help improve their pediatric readiness by, among other things, increasing awareness of, and participation in, the NPRP Assessment.

**Effect of the Bill**

The bill requires all hospitals with EDs to develop and implement policies and procedures for pediatric patient care in the ED, which reflect evidence-based best practices related to, at a minimum:

- Triage;
- Measuring and recording vital signs;
- Weighing and recording weights in kilograms;
- Calculating medication dosages; and
- Using pediatric instruments.

Further, each hospital with an ED must conduct training on their policies and procedures, which must include, at a minimum: the use of pediatric instruments, as applicable to each licensure type, and using clinical simulation and drills that simulate emergency situations. Each ED must conduct drills at least annually and each clinical employee of the ED must receive training at least annually.

The bill requires each hospital with an ED to designate a physician or nurse to serve as the pediatric emergency care coordinator in the ED. The pediatric emergency care coordinator is responsible for

[25] Stefanie G. Ames, MD, MS; Billie S. Davis, PhD; Jennifer R. Marin, MD, MSc; Ericka L. Fink, MD, MS; Lenora M. Olson, PhD, MA; Marianne Gausche-Hill, MD; Jeremy M. Kahn, MD, MS, Emergency Department Pediatric Readiness and Mortality in Critically Ill Children, *American Academy of Pediatrics* (Sept. 2019), available at https://doi.org/10.1542/peds.2019-0568 and Newgard CD, Lin A, Malveau S, et al. Emergency Department Pediatric Readiness and Short-term and Long-term Mortality Among Children Receiving Emergency Care. JAMA Netw Open. 2023;6(1):e2250941. doi:10.1001/jamanetworkopen.2022.50941 (last visited December 22, 2023).
[26] Florida Emergency Medical Services for Children State Partnership Program (Florida PEDREADY), available at https://emlrc.org/flpedready/ (last visited December 22, 2023).
[27] EMSC Innovation and Improvement Center, EMSC State Partnership Grants Database, Florida – State Partnership, April 1, 2023 – March 31, 2027, available at https://emscimprovement.center/programs/grants/236/florida-state-partnership-20230401-20270331-emsc-state-partnership/ (last visited December 22, 2023).

implementation of, and ensuring fidelity to, the policies and procedures for pediatric patient care in the ED.

The bill requires AHCA, in consultation with the Florida Emergency Medical Services for Children State Partnership Program, to adopt rules that establish minimum standards for pediatric patient care in hospital EDs, including, but not limited to, availability and immediate access to pediatric specific equipment and supplies. The bill also requires AHCA to adopt rules to require a hospital's comprehensive emergency management plan to include components that address the needs of pediatric and neonatal patients.

The bill requires all hospital EDs to conduct the National Pediatric Readiness Assessment, in accordance with the timelines established by the National Pediatric Readiness Project. The next pediatric readiness assessment will be conducted in 2026 and every five years thereafter. Each hospital ED must submit the results of the assessment to AHCA by December 31, 2026. The bill requires AHCA to publish the results of the assessment score for each hospital ED and provide a comparison to the national average score. AHCA must publish the results of the 2026 assessment by April 1, 2027, and must publish the results of subsequent assessments by April 1 following a year in which the assessment is conducted.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

**Section 1:** Amends s. 395.1012, F.S., relating to patient safety.
**Section 2:** Amends s. 395.1055, F.S., relating to rules and enforcement.
**Section 3:** Amends s. 408.05, F.S., relating to Florida Center for Health Information and Transparency.
**Section 4:** Provides an effective date of July 1, 2024.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

2. Expenditures:

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 local or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rule-making authority to AHCA 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 health care patient protection; amending s. 395.1012, F.S.; requiring hospital emergency departments to develop and implement policies and procedures, conduct training, record weights in a certain manner, designate a pediatric emergency care coordinator, and conduct specified assessments; requiring each hospital emergency department to submit a specified report to the Agency for Health Care Administration by specified dates; amending s. 395.1055, F.S.; requiring the agency to adopt certain rules for comprehensive emergency management plans, and, in consultation with the Florida Emergency Medical Services for Children State Partnership Program, establish minimum standards for pediatric patient care in hospital emergency departments; amending s. 408.05, F.S.; requiring the agency to collect and publish the results of specified assessments submitted by hospitals by specified dates; providing an effective date.

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

Section 1. Section 1. Subsection (5) is added to section 395.1012, Florida Statutes, to read:

395.1012 Patient safety.—

(5)(a) Each hospital with an emergency department must:

1. Develop and implement policies and procedures for pediatric patient care in the emergency department which reflect evidence-based best practices relating to, at a minimum:

a. Triage.

b. Measuring and recording vital signs.

c. Weighing and recording weights in kilograms.

d. Calculating medication dosages.

e. Use of pediatric instruments.

2. Conduct training at least annually on the policies and procedures developed under this subsection. The training must include, at a minimum:

a. The use of pediatric instruments, as applicable to each licensure type, using clinical simulation as defined in s. 464.003.

b. Drills that simulate emergency situations. Each emergency department must conduct drills at least annually.

(b) Each hospital emergency department must:

1. Designate a pediatric emergency care coordinator. The pediatric emergency care coordinator must be a physician licensed under chapter 458 or chapter 459, or a nurse licensed under chapter 464. The pediatric emergency care coordinator is responsible for implementation of and ensuring fidelity to the policies and procedures adopted under this subsection.

2. Conduct the National Pediatric Readiness Assessment developed by the National Pediatric Readiness Project, in accordance with timelines established by the National Pediatric Readiness Project. Each hospital emergency department shall submit the results of the assessment to the agency by December 31, 2026, and each December 31 during a year in which the National Pediatric Readiness Assessment is conducted thereafter.

Section 2. Subsections (4) through (19) of section 395.1055, Florida Statutes, are renumbered as subsections (5) through (20), respectively, paragraph (c) of subsection (1) is amended, and a new subsection (4) is added to that section to read:

395.1055 Rules and enforcement.—

(1) The agency shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part, which shall include reasonable and fair minimum standards for ensuring that:

(c) A comprehensive emergency management plan is prepared and updated annually. Such standards must be included in the rules adopted by the agency after consulting with the Division of Emergency Management. At a minimum, the rules must provide for plan components that address emergency evacuation transportation; adequate sheltering arrangements; postdisaster activities, including emergency power, food, and water; postdisaster transportation; supplies; staffing; emergency

equipment; individual identification of residents and transfer of records, ~~and~~ responding to family inquiries, and the needs of pediatric and neonatal patients. The comprehensive emergency management plan is subject to review and approval by the local emergency management agency. During its review, the local emergency management agency shall ensure that the following agencies, at a minimum, are given the opportunity to review the plan: the Department of Elderly Affairs, the Department of Health, the Agency for Health Care Administration, and the Division of Emergency Management. Also, appropriate volunteer organizations must be given the opportunity to review the plan. The local emergency management agency shall complete its review within 60 days and either approve the plan or advise the facility of necessary revisions.

(4) The agency, in consultation with the Florida Emergency Medical Services for Children State Partnership Program, shall adopt rules that establish minimum standards for pediatric patient care in hospital emergency departments, including, but not limited to, availability and immediate access to pediatric specific equipment and supplies.

Section 3. Paragraph (n) is added to subsection (3) of section 408.05, Florida Statutes, to read:

408.05 Florida Center for Health Information and Transparency.—

(3) HEALTH INFORMATION TRANSPARENCY.—In order to

disseminate and facilitate the availability of comparable and uniform health information, the agency shall perform the following functions:

(n)1. Collect the results of National Pediatric Readiness Assessments submitted by hospitals pursuant to s. 395.1012(5).

2. By April 1, 2027, and each April 1 following a year in which the National Pediatric Readiness Assessment is conducted thereafter, publish the overall assessment score for each hospital emergency department, and provide a comparison to the national average score when it becomes available.

Section 4. This act shall take effect July 1, 2024.