Health Innovation Subcommittee

Tuesday, March 7, 2017
4:00 PM – 5:00 PM
Mashburn Hall

Richard Corcoran
Speaker

MaryLynn Magar
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health Innovation Subcommittee

Start Date and Time:	Tuesday, March 07, 2017 04:00 pm
End Date and Time:	Tuesday, March 07, 2017 05:00 pm
Location:	Mashburn Hall (306 HOB)
Duration:	1.00 hrs

Consideration of the following bill(s):

HB 577 Discount Plan Organizations by Pigman
HB 619 Consolidation of Medicaid Waiver Programs by Pigman
HB 6021 Home Health Agency Licensure by Rommel

Pursuant to rule 7.11, the deadline for amendments to bills on the agenda by non-appointed members shall be 6:00 p.m., Monday, March 6, 2017.

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., Monday, March 6, 2017.

NOTICE FINALIZED on 03/03/2017 4:00PM by Ellerkamp.Donna

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 577 Discount Plan Organizations
SPONSOR(S): Pigman
TIED BILLS: **IDEN./SIM. BILLS:** SB 430

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

SUMMARY ANALYSIS

The regulatory oversight of insurance companies is generally reserved to the states. In Florida, the Office of Insurance Regulation (OIR), within the Department of Financial Services (DFS), is responsible for regulating all activities concerning insurers and other risk bearing entities under the Insurance Code.

Discount Medical Plan Organizations (DMPOs) and Discount Medical Plans, in exchange for fees, dues, charges, or other consideration, provide access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. Discount Medical Plans are not considered insurance under chapter 627, F.S., health maintenance organizations under chapter 641, F.S., or prepaid limited health plans under part I of chapter 636, F.S.

The Legislature established a comprehensive regulatory scheme for DMPOs in 2004. Regulation involves licensure, forms and rate filings and approval, disclosure requirements, and penalties.

HB 577 renames a "Discount Medical Plan" and a "Discount Medical Plan Organization" to a "Discount Plan" and a "Discount Plan Organization." The bill also clarifies the definition of a "Discount Plan" to exclude any plan that does not charge a fee to members. To increase flexibility in marketing and reduce administrative barriers on DMPOs, the bill:

- Defines "first page", upon which certain disclosures must appear, to mean the first page of any marketing material that first includes information describing benefits;
- Removes certain OIR rate and form approval requirements;
- Allows DMPOs to delegate functions to marketers and binds DMPOs to the actions of those marketers within the scope of the delegation;
- Allows marketers to commingle certain information on forms, advertisements, marketing materials, or brochures; and
- Specifies that OIR's form approval authority only pertains to medical services.

To maintain consumer protections for potential members and members of Discount Plans, the bill:

- Makes changes to the disclosure requirements, requiring acknowledgement and acceptance of the disclosures and plan terms and conditions before enrollment;
- Requires any provider that provides discounted services, in exchange for fees, dues, charges, or other consideration, to obtain and maintain a license as a Discount Plan Organization; and
- Requires Discount Plans that participate in open enrollment through an employer or association to provide refunds for cancellation equal to the full amount of all periodic charges paid by a member.

The bill also makes extensive conforming changes to the chapter to reflect the proposed changes.

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

The bill provides an effective date of upon becoming a law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Office of Insurance Regulation

The regulatory oversight of insurance companies is generally reserved to the states. In Florida, the Office of Insurance Regulation (OIR), within the Department of Financial Services (DFS), is responsible for all activities relating to insurers and other risk bearing entities, including licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the Insurance Code (Code).[1]

All persons who transact insurance in the state must comply with the Code.[2] OIR has the power to collect, propose, publish, and disseminate any information relating to the subject matter of the Code,[3] and may investigate any matter relating to insurance.[4] The specific chapters that comprise the Code are:

Chapter 624, F.S. – Insurance Code: Administration and General Provisions
Chapter 625, F.S. – Accounting, Investments, and Deposits by Insurers
Chapter 626, F.S. – Insurance Field Representatives and Operations
Chapter 627, F.S. – Insurance Rates and Contracts
Chapter 628, F.S. – Stock and Mutual Insurers; Holding Companies
Chapter 629, F.S. – Reciprocal Insurers
Chapter 630, F.S. – Alien Insurers: Trusteed Assets; Domestication
Chapter 631, F.S. – Insurer Insolvency; Guaranty of Payment
Chapter 632, F.S. – Fraternal Benefit Societies
Chapter 634, F.S. – Warranty Associations
Chapter 635, F.S. – Mortgage Guaranty Insurance
Chapter 636, F.S. – Prepaid Limited Health Service Organizations and Discount Medical Plan Organizations
Chapter 641, F.S. – Health Care Service Programs
Chapter 648, F.S. – Bail Bond Agents
Chapter 651, F.S. – Continuing Care Contracts

Discount Medical Plans and Organizations

Discount Medical Plan Organizations (DMPOs)[5] offer Discount Medical Plans,[6] in exchange for fees, dues, charges, or other consideration, that provide access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. For example, a member pays a DMPO a monthly fee of $25 to access a network of providers that have contracted with the DMPO to offer discounts on certain procedures; the member chooses one of these contracted providers and has a $500 procedure done for $425, which is the 15% discounted rate provided in the plan. Discount Medical Plans are not considered insurance under chapter 627, F.S., health maintenance organizations under chapter 641, F.S., or prepaid limited health plans under part I of chapter 636, F.S.[7]

[1] S. 20.121(3)(a)1., F.S. The OIR's commissioner is the agency head for purposes of final agency action, and its rulemaking body is the Financial Services Commission (the Governor and the Cabinet).
[2] S. 624.11, F.S. The Insurance Code consists of chapters 624-632, 634, 635, 636, 641, 642, 648, and 651, F.S.
[3] S. 624.307(4), F.S.
[4] S. 624.307(3), F.S.
[5] S. 636.202(2), F.S.
[6] S. 636.202(1), F.S.
[7] Id.

Regulation of DMPOs

The Legislature established a comprehensive regulatory scheme for DMPOs in 2004, creating part II of ch. 636, titled "Discount Medical Plan Organizations."[8] Regulation of DMPOs involves licensure, form and rate filings and approval, procedures for examinations and investigations by OIR, prohibited activities, required disclosures to plan members, tracking of providers, annual report filing, minimum capital requirements, a process for suspension and revocation of licenses, and other penalties.[9]

To obtain a license, a prospective DMPO must file an application with OIR for approval and pay a $50 licensure fee.[10] The application must include corporate formation documents, a copy of the form of all contracts for the provision of services, financial statements, and other information OIR may reasonably require.[11] If approved, OIR must issue a license for 1 year, and each year thereafter the DMPO must renew their license and pay a $50 fee.[12] The statute exempts from DMPO licensure requirements a provider who provides discounts to his or her own patients, such as a dentist who discounts routine procedures for current active patients.[13]

A DMPO must file all charges to members with OIR, and member rates more than $30 per month or $360 per year must be approved by OIR.[14] A DMPO is also required to file and get approval by OIR for all forms, including advertisements, marketing materials, and brochures, before using them.[15] DMPOs must make the following disclosures on the first page, written in 12-point font, of any advertisement, marketing material, and brochure, to any prospective member:

- The plan is not insurance.
- The plan provides discounts at certain health care providers for medical services.
- The plan does not make payments directly to the providers of medical services.
- The plan member is obligated to pay for all health care services but will receive a discount from those providers who have contracted with the DMPO.
- The name and address of the licensed DMPO.

If a member cancels his or her membership in a plan within the first 30 days of the effective date of enrollment, the DMPO must reimburse all periodic charges upon return of the discount card to the DMPO and any portion of a one-time processing fee in excess of $30.[16] If a DMPO fails to comply with the provisions of part II of ch. 636, F.S., OIR may levy administrative penalties of $100 per penalty, not to exceed $75,000 in aggregate,[17] or $500 per day for the first 10 days and $1,000 for each day after the 10th day for failure to file the required annual report.[18] OIR may also suspend a DMPO's authority to enroll new members, or revoke a DMPO's license.[19]

[8] Ch. 2004-297, Laws of Fla.
[9] Part II of Ch. 636, F.S.
[10] Ss. 636.204(2) and (6), F.S.
[11] Ss. 636.204(2)(a),(b),(c),(f),(i), and (m), F.S.
[12] S. 636.204(3), F.S.
[13] S. 636.204(6), F.S.
[14] S. 636.216(1), F.S.
[15] Ss. 636.216(3) and 228(1), F.S.
[16] S. 636.208, F.S.
[17] S. 636.223, F.S.
[18] S. 636.218, F.S.
[19] Ss. 636.222, F.S.

Complaints against DMPOs

Between 2014 and 2016, there were 35 complaints filed against DMPOs.[20] The majority of these complaints concerned refunds after cancellation of a plan, confusion regarding the difference in insurance and a Discount Medical Plan, and provider network adequacy.[21]

Effect of the Bill

HB 577 renames a "Discount Medical Plan" and a "Discount Medical Plan Organization" to a "Discount Plan" and a "Discount Plan Organization" (DPO). Plans may use the old plan and organization monikers until June 30, 2018, allowing such plans and organizations enough time to make changes to plan and marketing materials. The bill also clarifies the definition of a "Discount Plan" to exclude from licensure requirements any plan that does not charge a fee to its members.

The bill requires providers that offer discounts to their own patients in exchange for fees, dues, charges or other consideration to obtain and maintain a Discount Plan license. This would mean that the dentist or doctor who provides discounted services to his or her patients for a periodic fee, and is currently exempt from DMPO licensure requirements, would be required to obtain and maintain a DPO license.

The bill makes changes to the disclosure requirements of DPOs. The bill:

- Defines "first page", upon which the disclosures must appear, to be the page of any advertisement, marketing material, or brochure that first includes information describing benefits.
- Deems the disclosure requirement met if the member is unable to enroll in the plan without being presented with the required disclosures and must acknowledge and accept the plan terms and conditions before enrollment. This requires members to affirmatively acknowledge and accept the required disclosures and plan terms and conditions before being enrolled in a Discount Plan.
- Allows additional disclosures beyond the statutory requirement and deletes the requirement that disclosures for contracts made by telephone must be made orally and then provided in the initial written materials provided to the prospective or new member. This requirement is no longer necessary if members must acknowledge and accept the disclosures and plan terms and conditions before enrollment.

These changes in disclosure requirements allow DPOs more flexibility in the design and presentation of advertising and marketing materials. The changes maintain consumer protections by requiring acknowledgment and acceptance of the disclosures before allowing enrollment. The bill provides further consumer protection by requiring Discount Plans that participate in an open enrollment period through an employer or association to provide refunds for cancellation of a membership equal to the full amount of all periodic charges paid by the member.

The bill makes changes to charge and form filing requirements of DPOs. The bill:

- Removes the requirement for DPOs to file all charges to members with OIR and that all charges greater than $30 per month or $360 per year be approved by OIR.
- Removes the requirement that DPOs have the burden of proof to show the charges are reasonable, as approval is no longer required.
- Requires that only membership applications and fulfillment materials that describe medical services must be filed and approved by OIR.

[20] Email from Elizabeth Boyd, Legislative Affairs Director, Office of Chief Financial Officer, FW: DMPO Complaints, (Feb. 13, 2017).
[21] Redacted Consumer Requests for Assistance from the Department of Financial Services (on file with Health Innovation Subcommittee staff).

- Exempts DPOs from filing any form previously approved by OIR that has not been materially changed. For purposes of determining a material change, the following changes are not considered material: a change in charge; a change in the name of the marketer or entity distributing the plan; deletion of a benefit; or addition of a benefit that is not a medical service.

These changes will streamline the form and rate filing process, removing administrative burdens on DPOs and OIR. Removing the burden on a DPO of proving charges are reasonable reduces administrative burdens on DPOs. Removing the requirement for the approval of charges over certain levels by OIR further reduces administrative burdens on DPOs and OIR and introduces a free-market approach to the determination of charges for Discount Plan products.

The bill changes how Discount Plans can be marketed. The bill explicitly allows a DPO to delegate functions to a marketer and states the DPO will be bound to the actions of marketers within the scope of that delegation, which do not comply with statute. The bill also allows a marketer or Discount Plan Organization selling a Discount Plan with medical services and other services to commingle those products on a single page of forms, advertisements, marketing materials, or brochures. The bill also specifies that OIR's approval of forms only pertains to medical services regulated by part II of chapter 636, F.S. These changes allow DPOs and Discount Plan marketers to offer multiple products within one form or on the same marketing materials, further reducing administrative burdens on DPOs.

The bill makes extensive conforming changes to the chapter to reflect the provisions of the bill.

The bill is effective upon becoming a law.

B. SECTION DIRECTORY:

Section 1: Retitles chapter 636, F.S., from "Prepaid Limited Health Service Organizations and Discount Medical Plan Organizations" to "Prepaid Limited Health Service Organizations and Discount Plan Organizations."
Section 2: Retitles part II of chapter 636, F.S., from "Discount Medical Plan Organizations" to "Discount Plan Organizations."
Section 3: Amends s. 636.202, F.S., relating to definitions.
Section 4: Amends s. 636.204, F.S., relating to license required.
Section 5: Amends s. 636.208, F.S., relating to fees; charges; reimbursement.
Section 6: Amends s. 636.212, F.S., relating to disclosures.
Section 7: Amends s. 636.214, F.S., relating to provider agreements.
Section 8: Amends s. 636.216, F.S., relating to form filings.
Section 9: Amends s. 636.228, F.S., relating to marketing of discount medical plans.
Section 10: Amends s. 636.230, F.S., relating to bundling discount medical plans with other products.
Section 11: Amends s. 408.9091, F.S., relating to Cover Florida Health Care Access Program.
Section 12: Amends s. 408.910, F.S., relating to Florida Health Choices Program.
Section 13: Amends s. 627.64731, F.S., relating to leasing, renting, or granting access to participating provider.
Section 14: Amends s. 636.003, F.S., relating to definitions.
Section 15: Amends s. 636.205, F.S., relating to issuance of license; denial.
Section 16: Amends s. 636.206, F.S., relating to examinations and investigations.
Section 17: Amends s. 636.207, F.S., relating to applicability of part.
Section 18: Amends s. 636.210, F.S., relating to prohibited activities of a discount medical plan organization.
Section 19: Amends s. 636.218, F.S., relating to annual reports.
Section 20: Amends s. 636.220, F.S., relating to minimum capital requirements.
Section 21: Amends s. 636.222, F.S., relating to suspension or revocation of license; suspension of enrollment of new members; terms of suspension.
Section 22: Amends s. 636.223, F.S., relating to administrative penalty.

Section 23: Amends s. 636.224, F.S., relating to notice of change of name or address of discount medical plan organization.
Section 24: Amends s. 636.226, F.S., relating to provider name listing.
Section 25: Amends s. 636.232, F.S., relating to rules.
Section 26: Amends s. 636.234, F.S., relating to service of process on a discount medical plan organization.
Section 27: Amends s. 636.236, F.S., relating to surety bond or security deposit.
Section 28: Amends s. 636.238, F.S., relating to penalties for violation of this part.
Section 29: Amends s. 636.240, F.S., relating to injunctions.
Section 30: Amends s. 636.244, F.S., relating to unlicensed discount medical plan organizations.
Section 31: Provides an effective date of upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

DPOs should realize administrative efficiencies from the elimination of several filing requirements and other regulations.

Currently exempt healthcare providers who provide discounted services to current patients for a fee would incur new administrative costs associated with licensure, including the $50 licensure fee, the $50 annual renewal fee, and administrative costs associated with certain filings and regulations.

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:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to discount plan organizations; revising the titles of ch. 636, F.S., and part II of ch. 636, F.S.; amending s. 636.202, F.S.; revising definitions; amending s. 636.204, F.S.; conforming provisions to changes made by the act; requiring a provider to be licensed as a discount plan organization if the provider charges patients fees, dues, charges, or other consideration to receive discounted medical services; amending s. 636.208, F.S.; conforming provisions to changes made by the act; revising a specified condition for a member to receive a reimbursement of certain charges after cancelling a membership in a discount plan organization; amending s. 636.212, F.S.; conforming provisions to changes made by the act; specifying what a first page is for the purpose of a disclosure requirement on certain materials relating to a discount plan; providing for construction; deleting certain requirements that apply if the initial contract is made by telephone; amending s. 636.214, F.S.; making a technical change; conforming provisions to changes made by the act; amending s. 636.216, F.S.; deleting a provision that requires filing charges to members with the Office of Insurance Regulation, that

requires approval of the office for specified charges, and that provides for the burden of proving the reasonable relation of charges to benefits received by the members; conforming provisions to changes made by the act; specifying certain forms that must be filed and approved by the office; providing an exception from approval by the office; specifying what is not included in a material change; amending s. 636.228, F.S.; conforming provisions to changes made by the act; authorizing a discount plan organization to delegate functions to its marketers; providing that the discount plan organization is bound to acts of its marketers within the scope of delegation; amending s. 636.230, F.S.; conforming provisions to changes made by the act; authorizing a marketer or discount plan organization to commingle certain products on a single page of certain documents; providing for applicability; deleting a requirement for discount medical plan fees to be provided in writing under certain circumstances; amending ss. 408.9091, 408.910, 627.64731, 636.003, 636.205, 636.206, 636.207, 636.210, 636.218, 636.220, 636.222, 636.223, 636.224, 636.226, 636.232, 636.234, 636.236, 636.238, 636.240, and 636.244, F.S.; conforming provisions to changes made by the act; providing an effective date.

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

Section 1. Chapter 636, Florida Statutes, entitled "Prepaid Limited Health Service Organizations and Discount Medical Plan Organizations," is retitled "Prepaid Limited Health Service Organizations and Discount Plan Organizations."

Section 2. Part II of chapter 636, Florida Statutes, entitled "Discount Medical Plan Organizations," is retitled "Discount Plan Organizations."

Section 3. Section 636.202, Florida Statutes, is amended to read:

636.202 Definitions.—As used in this part, the term:

(1) "Discount ~~medical~~ plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. The term ~~"discount medical plan"~~ does not include any product regulated under chapter 627, chapter 641, or part I of this chapter;~~, or~~ any medical services provided through a telecommunications medium that does not offer a discount to the plan member for those medical services; or any plan that does not charge a fee to plan members. Until June 30, 2018, a discount plan may also be referred to as a discount medical

plan.

(2) "Discount ~~medical~~ plan organization" means an entity that ~~which~~, in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. Until June 30, 2018, a discount plan organization may also be referred to as a discount medical plan organization.

(3) "Marketer" means a person or entity that ~~which~~ markets, promotes, sells, or distributes a discount ~~medical~~ plan, including a private label entity that ~~which~~ places its name on and markets or distributes a discount ~~medical~~ plan but does not operate a discount ~~medical~~ plan.

(4) "Medical services" means any care, service, or treatment of illness or dysfunction of, or injury to, the human body, including, but not limited to, physician care, inpatient care, hospital surgical services, emergency services, ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services, laboratory services, and medical equipment and supplies. The term does not include pharmaceutical supplies or prescriptions.

(5) "Member" means any person who pays fees, dues, charges, or other consideration for the right to receive the purported benefits of a discount ~~medical~~ plan.

(6) "Provider" means any person or institution that ~~which~~ is contracted, directly or indirectly, with a discount ~~medical~~ plan organization to provide medical services to members.

(7) "Provider network" means an entity that ~~which~~ negotiates on behalf of more than one provider with a discount ~~medical~~ plan organization to provide medical services to members.

Section 4. Subsections (1), (2), (4), and (6) of section 636.204, Florida Statutes, are amended to read:

636.204 License required.—

(1) Before doing business in this state as a discount ~~medical~~ plan organization, an entity must be a corporation, a limited liability company, or a limited partnership, incorporated, organized, formed, or registered under the laws of this state or authorized to transact business in this state in accordance with chapter 605, part I of chapter 607, chapter 617, chapter 620, or chapter 865, and must be licensed by the office as a discount ~~medical~~ plan organization or be licensed by the office pursuant to chapter 624, part I of this chapter, or chapter 641.

(2) An application for a license to operate as a discount ~~medical~~ plan organization must be filed with the office on a form prescribed by the commission. Such application must be sworn to by an officer or authorized representative of the applicant and be accompanied by the following, if applicable:

(a) A copy of the applicant's articles of incorporation or other organizing documents, including all amendments.

(b) A copy of the applicant's bylaws.

(c) A list of the names, addresses, official positions, and biographical information of the individuals who are responsible for conducting the applicant's affairs, including, but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers, contracted management company personnel, and any person or entity owning or having the right to acquire 10 percent or more of the voting securities of the applicant. Such listing must fully disclose the extent and nature of any contracts or arrangements between any individual who is responsible for conducting the applicant's affairs and the discount ~~medical~~ plan organization, including any possible conflicts of interest.

(d) A complete biographical statement~~,~~ on forms prescribed by the commission, an independent investigation report, and a set of fingerprints, as provided in chapter 624, with respect to each individual identified under paragraph (c).

(e) A statement generally describing the applicant, its facilities and personnel, and the medical services to be offered.

(f) A copy of the form of all contracts made or to be made between the applicant and any providers or provider networks

regarding the provision of medical services to members.

(g) A copy of the form of any contract made or arrangement to be made between the applicant and any person listed in paragraph (c).

(h) A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any function, including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of health services to members.

(i) A copy of the applicant's most recent financial statements audited by an independent certified public accountant. An applicant that is a subsidiary of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity and the subsidiary may petition the office to accept, in lieu of the audited financial statement of the applicant, the audited financial statement of the parent entity and a written guaranty by the parent entity that the minimum capital requirements of the applicant required by this part will be met by the parent entity.

(j) A description of the proposed method of marketing.

(k) A description of the subscriber complaint procedures to be established and maintained.

(l) The fee for issuance of a license.

(m) Such other information as the commission or office may reasonably require to make the determinations required by this part.

(4) Before ~~Prior to~~ licensure by the office, each discount ~~medical~~ plan organization must establish an Internet website so as to conform to the requirements of s. 636.226.

(6) This part does not require ~~Nothing in this part requires~~ a provider who provides discounts to his or her own patients to obtain and maintain a license as a discount ~~medical~~ plan organization unless the provider charges patients fees, dues, charges, or other consideration to receive medical services from the provider at a discount.

Section 5. Section 636.208, Florida Statutes, is amended to read:

636.208 Fees; charges; reimbursement.—

(1) A discount ~~medical~~ plan organization may charge a periodic charge as well as a reasonable one-time processing fee for a discount ~~medical~~ plan.

(2) If the member cancels his or her membership in the discount ~~medical~~ plan organization within the first 30 days after the effective date of enrollment in the plan or cancels his or her membership consistent with the open enrollment rules established by an employer or association for a plan having an open enrollment period, the member shall receive a reimbursement of all periodic charges upon return of the discount card to the

discount ~~medical~~ plan organization.

(3) If the discount ~~medical~~ plan organization cancels a membership for any reason other than nonpayment of fees by the member, the discount ~~medical~~ plan organization must ~~shall~~ make a pro rata reimbursement of all periodic charges to the member.

(4) In addition to the reimbursement of periodic charges for the reasons stated in subsections (2) and (3), a discount ~~medical~~ plan organization shall also reimburse the member for any portion of a one-time processing fee that exceeds $30 per year.

Section 6. Section 636.212, Florida Statutes, is amended to read:

636.212 Disclosures.—The following disclosures must be made in writing to any prospective member and must be on the first page of any advertisements, marketing materials, or brochures relating to a discount ~~medical~~ plan. The first page is the page that first includes the information describing benefits. The disclosures must be printed in not less than 12-point type:

(1) That the plan is not insurance.

(2) That the plan provides discounts at certain health care providers for medical services.

(3) That the plan does not make payments directly to the providers of medical services.

(4) That the plan member is obligated to pay for all

health care services but will receive a discount from those health care providers who have contracted with the discount plan organization.

(5) The name and address of the licensed discount ~~medical~~ plan organization.

The requirements of this section are met if the prospective member cannot enroll without being presented with the required disclosures and if the prospective member must acknowledge acceptance of the plan terms and conditions before enrollment. This section does not prohibit the discount plan organization from making additional disclosures to a prospective member ~~If the initial contract is made by telephone, the disclosures required by this section shall be made orally and provided in the initial written materials that describe the benefits under the discount medical plan provided to the prospective or new member~~.

Section 7. Section 636.214, Florida Statutes, is amended to read:

636.214 Provider agreements.—

(1) All providers offering medical services to members under a discount ~~medical~~ plan must provide such services pursuant to a written agreement. The agreement may be entered into directly by the provider or by a provider network to which the provider belongs.

(2) A provider agreement between a discount ~~medical~~ plan organization and a provider must provide the following:

(a) A list of the services and products to be provided at a discount.

(b) The amount or amounts of the discounts or, alternatively, a fee schedule which reflects the provider's discounted rates.

(c) A statement that the provider will not charge members more than the discounted rates.

(3) A provider agreement between a discount ~~medical~~ plan organization and a provider network must ~~shall~~ require that the provider network have written agreements with its providers which:

(a) Contain the terms described in subsection (2).

(b) Authorize the provider network to contract with the discount ~~medical~~ plan organization on behalf of the provider.

(c) Require the network to maintain an up-to-date list of its contracted providers and to provide that list on a monthly basis to the discount ~~medical~~ plan organization.

(4) The discount ~~medical~~ plan organization shall maintain a copy of each active provider agreement into which it has entered.

Section 8. Section 636.216, Florida Statutes, is amended to read:

636.216 ~~Charge or~~ Form filings.—

~~(1) All charges to members must be filed with the office and any charge to members greater than $30 per month or $360 per year must be approved by the office before the charges can be used. The discount medical plan organization has the burden of proof that the charges bear a reasonable relation to the benefits received by the member.~~

~~(2)~~ There must be a written agreement between the discount ~~medical~~ plan organization and the member specifying the benefits under the discount ~~medical~~ plan and complying with the disclosure requirements of this part.

(2)~~(3)~~ ~~All forms used, including~~ The written agreement pursuant to subsection (1)~~(2)~~, membership applications, and fulfillment materials that describe medical services as defined in this part must first be filed with and approved by the office. Every form filed shall be identified by a unique form number placed in the lower left corner of each form. A form previously approved by the office is not required to be approved unless the form is materially changed. For purposes of this subsection, a material change does not include a change in charges, a change to the name of the marketer or entity distributing the plan, the deletion of benefits, or the addition of benefits that are not medical services as defined in this part.

(3)~~(4)~~ A ~~charge or~~ form is considered approved on the 60th day after its date of filing unless it has been previously

disapproved by the office. The office shall disapprove any form that does not meet the requirements of this part or that is unreasonable, discriminatory, misleading, or unfair. If such filings are disapproved, the office must ~~shall~~ notify the discount ~~medical~~ plan organization and must ~~shall~~ specify in the notice the reasons for disapproval.

Section 9. Section 636.228, Florida Statutes, is amended to read:

636.228 Marketing of discount ~~medical~~ plans.—

(1) All advertisements, marketing materials, brochures, and discount cards used by marketers must be approved in writing for such use by the discount ~~medical~~ plan organization.

(2) The discount ~~medical~~ plan organization must ~~shall~~ have an executed written agreement with a marketer before ~~prior to~~ the marketer's marketing, promoting, selling, or distributing the discount ~~medical~~ plan. Such agreement must ~~shall~~ prohibit the marketer from using marketing materials, brochures, and discount cards without the approval in writing by the discount ~~medical~~ plan organization. The discount ~~medical~~ plan organization may delegate functions to its marketers but shall be bound by any acts of its marketers, within the scope of the delegation, which ~~marketers' agency, that~~ do not comply with ~~the provisions of~~ this part.

Section 10. Section 636.230, Florida Statutes, is amended to read:

636.230 Bundling discount ~~medical~~ plans with other products.—A marketer or discount plan organization selling a discount plan with medical services and other services may commingle those products on a single page of forms, advertisements, marketing materials, or brochures. The office's approval of forms only pertains to the medical services regulated by this part ~~When a marketer or discount medical plan organization sells a discount medical plan together with any other product, the fees for the discount medical plan must be provided in writing to the member if the fees exceed $30~~.

Section 11. Paragraph (b) of subsection (5) of section 408.9091, Florida Statutes, is amended to read:

408.9091 Cover Florida Health Care Access Program.—

(5) PLAN PROPOSALS.—The agency and the office shall announce, no later than July 1, 2008, an invitation to negotiate for Cover Florida plan entities to design a Cover Florida plan proposal in which benefits and premiums are specified.

(b) The agency and the office may announce an invitation to negotiate for the design of Cover Florida Plus products to companies that offer supplemental insurance, discount ~~medical~~ plan organizations licensed under part II of chapter 636, or prepaid health clinics licensed under part II of chapter 641.

Section 12. Paragraph (d) of subsection (2) and paragraph (d) of subsection (4) of section 408.910, Florida Statutes, are amended to read:

408.910 Florida Health Choices Program.—

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

(d) "Insurer" means an entity licensed under chapter 624 which offers an individual health insurance policy or a group health insurance policy, a preferred provider organization as defined in s. 627.6471, an exclusive provider organization as defined in s. 627.6472, ~~or~~ a health maintenance organization licensed under part I of chapter 641, or a prepaid limited health service organization or discount ~~medical~~ plan organization licensed under chapter 636.

(4) ELIGIBILITY AND PARTICIPATION.—Participation in the program is voluntary and shall be available to employers, individuals, vendors, and health insurance agents as specified in this subsection.

(d) All eligible vendors who choose to participate and the products and services that the vendors are permitted to sell are as follows:

1. Insurers licensed under chapter 624 may sell health insurance policies, limited benefit policies, other risk-bearing coverage, and other products or services.

2. Health maintenance organizations licensed under part I of chapter 641 may sell health maintenance contracts, limited benefit policies, other risk-bearing products, and other products or services.

3. Prepaid limited health service organizations may sell

products and services as authorized under part I of chapter 636, and discount ~~medical~~ plan organizations may sell products and services as authorized under part II of chapter 636.

4. Prepaid health clinic service providers licensed under part II of chapter 641 may sell prepaid service contracts and other arrangements for a specified amount and type of health services or treatments.

5. Health care providers, including hospitals and other licensed health facilities, health care clinics, licensed health professionals, pharmacies, and other licensed health care providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.

6. Provider organizations, including service networks, group practices, professional associations, and other incorporated organizations of providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.

7. Corporate entities providing specific health services in accordance with applicable state law may sell service contracts and arrangements for a specified amount and type of health services or treatments.

A vendor described in subparagraphs 3.-7. may not sell products that provide risk-bearing coverage unless that vendor is authorized under a certificate of authority issued by the Office

of Insurance Regulation and is authorized to provide coverage in the relevant geographic area. Otherwise eligible vendors may be excluded from participating in the program for deceptive or predatory practices, financial insolvency, or failure to comply with the terms of the participation agreement or other standards set by the corporation.

Section 13. Subsection (11) of section 627.64731, Florida Statutes, is amended to read:

627.64731 Leasing, renting, or granting access to a participating provider.—

(11) This section does not apply to a contract between a contracting entity and a discount ~~medical~~ plan organization licensed or exempt under part II of chapter 636.

Section 14. Paragraph (c) of subsection (7) of section 636.003, Florida Statutes, is amended to read:

636.003 Definitions.—As used in this act, the term:

(7) "Prepaid limited health service organization" means any person, corporation, partnership, or any other entity which, in return for a prepayment, undertakes to provide or arrange for, or provide access to, the provision of a limited health service to enrollees through an exclusive panel of providers. Prepaid limited health service organization does not include:

(c) Any person who is licensed pursuant to part II as a discount ~~medical~~ plan organization.

Section 15. Paragraphs (c) and (d) of subsection (1) of

section 636.205, Florida Statutes, are amended to read:

636.205 Issuance of license; denial.—

(1) Following receipt of an application filed pursuant to s. 636.204, the office shall review the application and notify the applicant of any deficiencies contained therein. The office shall issue a license to an applicant who has filed a completed application pursuant to s. 636.204 upon payment of the fees specified in s. 636.204 and upon the office being satisfied that the following conditions are met:

(c) The ownership, control, and management of the entity are competent and trustworthy and possess managerial experience that would make the proposed operation beneficial to the subscribers. The office may ~~shall~~ not grant or continue to grant authority to transact the business of a discount ~~medical~~ plan organization in this state at any time during which the office has good reason to believe that the ownership, control, or management of the organization includes any person whose business operations are or have been marked by business practices or conduct that is detrimental to the public, stockholders, investors, or creditors.

(d) The discount ~~medical~~ plan organization has a complaint procedure that will facilitate the resolution of subscriber grievances and that includes both formal and informal steps available within the organization.

Section 16. Section 636.206, Florida Statutes, is amended

to read:

636.206 Examinations and investigations.—

(1) The office may examine or investigate the business and affairs of any discount ~~medical~~ plan organization. The office may order any discount ~~medical~~ plan organization or applicant to produce any records, books, files, advertising and solicitation materials, or other information and may take statements under oath to determine whether the discount ~~medical~~ plan organization or applicant is in violation of the law or is acting contrary to the public interest. The expenses incurred in conducting any examination or investigation must be paid by the discount ~~medical~~ plan organization or applicant. Examinations and investigations must be conducted as provided in chapter 624.

(2) Failure by the discount ~~medical~~ plan organization to pay the expenses incurred under subsection (1) is grounds for denial or revocation.

Section 17. Section 636.207, Florida Statutes, is amended to read:

636.207 Applicability of part.—Except as otherwise provided in this part, discount ~~medical~~ plan organizations are governed by ~~the provisions of~~ this part and are exempt from the Florida Insurance Code unless specifically referenced.

Section 18. Section 636.210, Florida Statutes, is amended to read:

636.210 Prohibited activities of a discount ~~medical~~ plan

organization.—

(1) A discount ~~medical~~ plan organization may not:

(a) Use in its advertisements, marketing material, brochures, and discount cards the term "insurance" except as otherwise provided in this part or as a disclaimer of any relationship between discount ~~medical~~ plan organization benefits and insurance;

(b) Use in its advertisements, marketing material, brochures, and discount cards the terms "health plan," "coverage," "copay," "copayments," "preexisting conditions," "guaranteed issue," "premium," "PPO," "preferred provider organization," or other terms in a manner that could reasonably mislead a person into believing the discount ~~medical~~ plan was health insurance;

(c) Have restrictions on free access to plan providers, including, but not limited to, waiting periods and notification periods; or

(d) Pay providers any fees for medical services.

(2) A discount ~~medical~~ plan organization may not collect or accept money from a member for payment to a provider for specific medical services furnished or to be furnished to the member unless the organization has an active certificate of authority from the office to act as an administrator.

Section 19. Subsection (1), paragraphs (b), (c), and (d) of subsection (2), and subsection (3) of section 636.218,

Florida Statutes, are amended to read:

636.218 Annual reports.—

(1) Each discount ~~medical~~ plan organization shall ~~must~~ file with the office, within 3 months after the end of each fiscal year, an annual report.

(2) Such reports must be on forms prescribed by the commission and must include:

(b) If different from the initial application or the last annual report, a list of the names and residence addresses of all persons responsible for the conduct of the organization's affairs, together with a disclosure of the extent and nature of any contracts or arrangements between such persons and the discount ~~medical~~ plan organization, including any possible conflicts of interest.

(c) The number of discount ~~medical~~ plan members in the state.

(d) Such other information relating to the performance of the discount ~~medical~~ plan organization as is reasonably required by the commission or office.

(3) Every discount ~~medical~~ plan organization that ~~which~~ fails to file an annual report in the form and within the time required by this section shall forfeit up to $500 for each day for the first 10 days during which the neglect continues and shall forfeit up to $1,000 for each day after the first 10 days during which the neglect continues; and, upon notice by the

office to that effect, the organization's authority to enroll new members or to do business in this state ceases while such default continues. The office shall deposit all sums collected by the office under this section to the credit of the Insurance Regulatory Trust Fund. The office may not collect more than $50,000 for each report.

Section 20. Section 636.220, Florida Statutes, is amended to read:

636.220 Minimum capital requirements.—

(1) Each discount ~~medical~~ plan organization shall ~~must~~ at all times maintain a net worth of at least $150,000.

(2) The office may not issue a license unless the discount ~~medical~~ plan organization has a net worth of at least $150,000.

Section 21. Section 636.222, Florida Statutes, is amended to read:

636.222 Suspension or revocation of license; suspension of enrollment of new members; terms of suspension.—

(1) The office may suspend the authority of a discount ~~medical~~ plan organization to enroll new members, revoke any license issued to a discount ~~medical~~ plan organization, or order compliance if the office finds that any of the following conditions exist:

(a) The organization is not operating in compliance with this part.

(b) The organization does not have the minimum net worth

as required by this part.

(c) The organization has advertised, merchandised, or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading, or unfair practices with respect to advertising or merchandising.

(d) The organization is not fulfilling its obligations as a ~~medical~~ discount ~~medical~~ plan organization.

(e) The continued operation of the organization would be hazardous to its members.

(2) If the office has cause to believe that grounds for the suspension or revocation of a license exist, the office must ~~shall~~ notify the discount ~~medical~~ plan organization in writing specifically stating the grounds for suspension or revocation and shall pursue a hearing on the matter in accordance with ~~the provisions of~~ chapter 120.

(3) When the license of a discount ~~medical~~ plan organization is surrendered or revoked, such organization must proceed, immediately following the effective date of the order of revocation, to wind up its affairs transacted under the license. The organization may not engage in any further advertising, solicitation, collecting of fees, or renewal of contracts.

(4) The office shall, in its order suspending the authority of a discount ~~medical~~ plan organization to enroll new

members, specify the period during which the suspension is to be in effect and the conditions, if any, which must be met by the discount ~~medical~~ plan organization before ~~prior to~~ reinstatement of its license to enroll new members. The order of suspension is subject to rescission or modification by further order of the office before ~~prior to~~ the expiration of the suspension period. Reinstatement may not be made unless requested by the discount ~~medical~~ plan organization; however, the office may not grant reinstatement if it finds that the circumstances for which the suspension occurred still exist or are likely to recur.

Section 22. Section 636.223, Florida Statutes, is amended to read:

636.223 Administrative penalty.—In lieu of suspending or revoking a certificate of authority whenever any discount ~~medical~~ plan organization has been found to have violated any provision of this part, the office may:

(1) Issue and cause to be served upon the organization charged with the violation a copy of such findings and an order requiring such organization to cease and desist from engaging in the act or practice that constitutes the violation.

(2) Impose a monetary penalty of not less than $100 for each violation, but not to exceed an aggregate penalty of $75,000.

Section 23. Section 636.224, Florida Statutes, is amended to read:

636.224 Notice of change of name or address of discount ~~medical~~ plan organization.—Each discount ~~medical~~ plan organization must provide the office at least 30 days' advance notice of any change in the discount ~~medical~~ plan organization's name, address, principal business address, or mailing address.

Section 24. Section 636.226, Florida Statutes, is amended to read:

636.226 Provider name listing.—Each discount ~~medical~~ plan organization must maintain on an Internet website an up-to-date list of the names and addresses of the providers with which it has contracted~~, on an Internet website page~~, the address of which must ~~shall~~ be prominently displayed on all its advertisements, marketing materials, brochures, and discount cards. This section applies to those providers with whom the discount ~~medical~~ plan organization has contracted directly, as well as those who are members of a provider network with which the discount ~~medical~~ plan organization has contracted.

Section 25. Section 636.232, Florida Statutes, is amended to read:

636.232 Rules.—The commission may adopt rules to administer this part, including rules for the licensing of discount ~~medical~~ plan organizations; establishing standards for evaluating forms, advertisements, marketing materials, brochures, and discount cards; providing for the collection of data; relating to disclosures to plan members; and defining

terms used in this part.

Section 26. Section 636.234, Florida Statutes, is amended to read:

636.234 Service of process on a discount ~~medical~~ plan organization.—Sections 624.422 and 624.423 apply to a discount ~~medical~~ plan organization as if the discount ~~medical~~ plan organization were an insurer.

Section 27. Section 636.236, Florida Statutes, is amended to read:

636.236 Surety bond or security deposit.—

(1) Each discount ~~medical~~ plan organization licensed pursuant to ~~the provisions of~~ this part shall ~~must~~ maintain in force a surety bond in its own name in an amount not less than $35,000 to be used at the discretion of the office to protect the financial interests of members who may be adversely affected by the insolvency of a discount ~~medical~~ plan organization. The bond must be issued by an insurance company that is licensed to do business in this state.

(2) In lieu of the bond specified in subsection (1), a licensed discount ~~medical~~ plan organization may deposit and maintain deposited in trust with the department securities eligible for deposit under s. 625.52 having at all times a value of not less than $35,000. If a licensed discount ~~medical~~ plan organization substitutes its deposited securities under this subsection with a surety bond authorized in subsection (1), such

deposited securities must ~~shall~~ be returned to the discount ~~medical~~ plan organization no later than 45 days following the effective date of the surety bond.

(3) A ~~No~~ judgment creditor or other claimant of a discount ~~medical~~ plan organization, other than the office or department, does not ~~shall~~ have the right to levy upon any of the assets or securities held in this state as a deposit under subsections (1) and (2).

Section 28. Subsections (2) and (3) of section 636.238, Florida Statutes, are amended to read:

636.238 Penalties for violation of this part.—

(2) A person who operates as or willfully aids and abets another operating as a discount ~~medical~~ plan organization in violation of s. 636.204(1) commits a felony punishable as provided for in s. 624.401(4)(b), as if the unlicensed discount ~~medical~~ plan organization were an unauthorized insurer, and the fees, dues, charges, or other consideration collected from the members by the unlicensed discount ~~medical~~ plan organization or marketer were insurance premium.

(3) A person who collects fees for purported membership in a discount ~~medical~~ plan but purposefully fails to provide the promised benefits commits a theft, punishable as provided in s. 812.014.

Section 29. Subsection (1) of section 636.240, Florida Statutes, is amended to read:

636.240 Injunctions.—

(1) In addition to the penalties and other enforcement provisions of this part, the office may seek both temporary and permanent injunctive relief when:

(a) A discount ~~medical~~ plan is being operated by any person or entity that is not licensed pursuant to this part.

(b) Any person, entity, or discount ~~medical~~ plan organization has engaged in any activity prohibited by this part or any rule adopted pursuant to this part.

Section 30. Section 636.244, Florida Statutes, is amended to read:

636.244 Unlicensed discount ~~medical~~ plan organizations.—

Sections ~~The provisions of ss.~~ 626.901-626.912 apply to the activities of an unlicensed discount ~~medical~~ plan organization as if the unlicensed discount ~~medical~~ plan organization were an unauthorized insurer.

Section 31. This act shall take effect upon becoming a law.

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: Health Innovation Subcommittee

Representative Pigman offered the following:

Amendment (with title amendment)

Remove lines 185-626 and insert:

plan organization. If a provider contracts with a third-party entity to administer or provide a platform for a discount plan, the third-party entity must be licensed as a discount plan organization.

Section 5. Section 636.208, Florida Statutes, is amended to read:

636.208 Fees; charges; reimbursement.—

(1) A discount ~~medical~~ plan organization may charge a periodic charge as well as a reasonable one-time processing fee for a discount ~~medical~~ plan.

(2)(a) If the member cancels his or her membership in the discount ~~medical~~ plan organization within the first 30 days after the effective date of enrollment in the plan, the member shall receive a reimbursement of all periodic charges upon return of the discount card to the discount ~~medical~~ plan organization.

(b) If the member cancels his or her membership in the discount plan organization after the first 30 days, the discount plan organization:

1. Must cancel the membership on or before 30 days after receipt of the member's cancellation request.

2. May not charge the member any fees after the effective date of the cancellation of the membership.

3. Must provide a pro rata reimbursement of periodic charges made for months after cancellation date.

(c) If the member cancels his or her membership in the discount plan organization consistent with the open enrollment rules established by an employer or association for a plan having an open enrollment period, the member shall receive a pro rata reimbursement of all periodic charges upon return of the discount card to the discount plan organization.

(3) If the discount ~~medical~~ plan organization cancels a membership for any reason other than nonpayment of fees by the member, the discount ~~medical~~ plan organization must ~~shall~~ make a pro rata reimbursement of all periodic charges to the member.

(4) In addition to the reimbursement of periodic charges for the reasons stated in subsections (2) and (3), a discount ~~medical~~ plan organization shall also reimburse the member for any portion of a one-time processing fee that exceeds $30 per year.

Section 6. Section 636.212, Florida Statutes, is amended to read:

636.212 Disclosures.—A discount plan organization or marketer must provide disclosures to a prospective member and the prospective member must acknowledge the acceptance of such disclosures before enrolling in a discount plan. A discount plan organization or marketer may make additional disclosures to those described in paragraph (1)(a). ~~The following disclosures must be made in writing to any prospective member and must be on the first page of any advertisements, marketing materials, or brochures relating to a discount medical plan. The disclosures must be printed in not less than 12-point type:~~

(1)(a) A disclosure must include:

1. That the plan is not insurance.

2.~~(2)~~ That the plan provides discounts at certain health care providers for medical services.

3.~~(3)~~ That the plan does not make payments directly to the providers of medical services.

4.~~(4)~~ That the plan member is obligated to pay for all health care services but will receive a discount from those

health care providers who have contracted with the discount plan organization.

5.~~(5)~~ The name and address of the licensed discount ~~medical~~ plan organization.

(b) The first page of any written advertisements, marketing materials, or brochures relating to a discount plan must include the required disclosures in paragraph (a). The first page is the page that first includes the information that describes benefits of the discount plan. The disclosures must be printed in not less than 12-point type.

(c) Disclosures provided by electronic means must include disclosures required in paragraph (a). The disclosures must be in a font size and color that is readable.

(d) Disclosures made by telephone must include the disclosures in paragraph (a) and the prospective or new member must be provided with written disclosures in accordance with paragraph (b) in the initial written materials provided. ~~If the initial contract is made by telephone, the disclosures required by this section shall be made orally and provided in the initial written materials that describe the benefits under the discount medical plan provided to the prospective or new member~~.

Section 7. Section 636.214, Florida Statutes, is amended to read:

636.214 Provider agreements.—

(1) All providers offering medical services to members under a discount ~~medical~~ plan must provide such services pursuant to a written agreement. The agreement may be entered into directly by the provider or by a provider network to which the provider belongs.

(2) A provider agreement between a discount ~~medical~~ plan organization and a provider must provide the following:

(a) A list of the services and products to be provided at a discount.

(b) The amount or amounts of the discounts or, alternatively, a fee schedule which reflects the provider's discounted rates.

(c) A statement that the provider will not charge members more than the discounted rates.

(3) A provider agreement between a discount ~~medical~~ plan organization and a provider network must ~~shall~~ require that the provider network have written agreements with its providers which:

(a) Contain the terms described in subsection (2).

(b) Authorize the provider network to contract with the discount ~~medical~~ plan organization on behalf of the provider.

(c) Require the network to maintain an up-to-date list of its contracted providers and to provide that list on a monthly basis to the discount ~~medical~~ plan organization.

(4) The discount ~~medical~~ plan organization shall maintain a copy of each active provider agreement into which it has entered.

Section 8. Section 636.216, Florida Statutes, is amended to read:

636.216 Written agreement ~~Charge or Form Filings~~.—

~~(1) All charges to members must be filed with the office and any charge to members greater than $30 per month or $360 per year must be approved by the office before the charges can be used. The discount medical plan organization has the burden of proof that the charges bear a reasonable relation to the benefits received by the member.~~

~~(2)~~ There must be a written agreement between the discount ~~medical~~ plan organization and the member specifying the benefits under the discount ~~medical~~ plan and complying with the disclosure requirements of this part.

~~(3) All forms used, including the written agreement pursuant to subsection (2), must first be filed with and approved by the office. Every form filed shall be identified by a unique form number placed in the lower left corner of each form.~~

~~(4) A charge or form is considered approved on the 60th day after its date of filing unless it has been previously disapproved by the office. The office shall disapprove any form that does not meet the requirements of this part or that is~~

~~unreasonable, discriminatory, misleading, or unfair. If such filings are disapproved, the office shall notify the discount medical plan organization and shall specify in the notice the reasons for disapproval.~~

Section 9. Section 636.228, Florida Statutes, is amended to read:

636.228 Marketing of discount ~~medical~~ plans.—

(1) All advertisements, marketing materials, brochures, and discount cards used by marketers must be approved in writing ~~for such use~~ by the discount ~~medical~~ plan organization.

(2) The discount ~~medical~~ plan organization must ~~shall~~ have an executed written agreement with a marketer before ~~prior to~~ the marketer's marketing, promoting, selling, or distributing the discount ~~medical~~ plan. Such agreement must ~~shall~~ prohibit the marketer from using marketing materials, brochures, and discount cards without the approval in writing by the discount ~~medical~~ plan organization. The discount ~~medical~~ plan organization may delegate functions to its marketers but shall be bound by any acts of its marketers, within the scope of the delegation, which ~~marketers' agency, that~~ do not comply with ~~the provisions of~~ this part.

Section 10. Section 636.230, Florida Statutes, is amended to read:

636.230 Bundling discount ~~medical~~ plans with other products.—A marketer or discount plan organization selling a

discount plan with medical services and other services may commingle those products on a single page of forms, advertisements, marketing materials, or brochures ~~When a marketer or discount medical plan organization sells a discount medical plan together with any other product, the fees for the discount medical plan must be provided in writing to the member if the fees exceed $30~~.

Section 11. Paragraph (b) of subsection (5) of section 408.9091, Florida Statutes, is amended to read:

408.9091 Cover Florida Health Care Access Program.—

(5) PLAN PROPOSALS.—The agency and the office shall announce, no later than July 1, 2008, an invitation to negotiate for Cover Florida plan entities to design a Cover Florida plan proposal in which benefits and premiums are specified.

(b) The agency and the office may announce an invitation to negotiate for the design of Cover Florida Plus products to companies that offer supplemental insurance, discount ~~medical~~ plan organizations licensed under part II of chapter 636, or prepaid health clinics licensed under part II of chapter 641.

Section 12. Paragraph (d) of subsection (2) and paragraph (d) of subsection (4) of section 408.910, Florida Statutes, are amended to read:

408.910 Florida Health Choices Program.—

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

(d) "Insurer" means an entity licensed under chapter 624 which offers an individual health insurance policy or a group health insurance policy, a preferred provider organization as defined in s. 627.6471, an exclusive provider organization as defined in s. 627.6472, ~~or~~ a health maintenance organization licensed under part I of chapter 641, or a prepaid limited health service organization or discount ~~medical~~ plan organization licensed under chapter 636.

(4) ELIGIBILITY AND PARTICIPATION.—Participation in the program is voluntary and shall be available to employers, individuals, vendors, and health insurance agents as specified in this subsection.

(d) All eligible vendors who choose to participate and the products and services that the vendors are permitted to sell are as follows:

1. Insurers licensed under chapter 624 may sell health insurance policies, limited benefit policies, other risk-bearing coverage, and other products or services.

2. Health maintenance organizations licensed under part I of chapter 641 may sell health maintenance contracts, limited benefit policies, other risk-bearing products, and other products or services.

3. Prepaid limited health service organizations may sell products and services as authorized under part I of chapter 636,

and discount ~~medical~~ plan organizations may sell products and services as authorized under part II of chapter 636.

4. Prepaid health clinic service providers licensed under part II of chapter 641 may sell prepaid service contracts and other arrangements for a specified amount and type of health services or treatments.

5. Health care providers, including hospitals and other licensed health facilities, health care clinics, licensed health professionals, pharmacies, and other licensed health care providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.

6. Provider organizations, including service networks, group practices, professional associations, and other incorporated organizations of providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.

7. Corporate entities providing specific health services in accordance with applicable state law may sell service contracts and arrangements for a specified amount and type of health services or treatments.

A vendor described in subparagraphs 3.-7. may not sell products that provide risk-bearing coverage unless that vendor is authorized under a certificate of authority issued by the Office of Insurance Regulation and is authorized to provide coverage in

the relevant geographic area. Otherwise eligible vendors may be excluded from participating in the program for deceptive or predatory practices, financial insolvency, or failure to comply with the terms of the participation agreement or other standards set by the corporation.

Section 13. Subsection (11) of section 627.64731, Florida Statutes, is amended to read:

627.64731 Leasing, renting, or granting access to a participating provider.—

(11) This section does not apply to a contract between a contracting entity and a discount ~~medical~~ plan organization licensed or exempt under part II of chapter 636.

Section 14. Paragraph (c) of subsection (7) of section 636.003, Florida Statutes, is amended to read:

636.003 Definitions.—As used in this act, the term:

(7) "Prepaid limited health service organization" means any person, corporation, partnership, or any other entity which, in return for a prepayment, undertakes to provide or arrange for, or provide access to, the provision of a limited health service to enrollees through an exclusive panel of providers. Prepaid limited health service organization does not include:

(c) Any person who is licensed pursuant to part II as a discount ~~medical~~ plan organization.

Section 15. Paragraphs (c) and (d) of subsection (1) of section 636.205, Florida Statutes, are amended to read:

636.205 Issuance of license; denial.—

(1) Following receipt of an application filed pursuant to s. 636.204, the office shall review the application and notify the applicant of any deficiencies contained therein. The office shall issue a license to an applicant who has filed a completed application pursuant to s. 636.204 upon payment of the fees specified in s. 636.204 and upon the office being satisfied that the following conditions are met:

(c) The ownership, control, and management of the entity are competent and trustworthy and possess managerial experience that would make the proposed operation beneficial to the subscribers. The office may ~~shall~~ not grant or continue to grant authority to transact the business of a discount ~~medical~~ plan organization in this state at any time during which the office has good reason to believe that the ownership, control, or management of the organization includes any person whose business operations are or have been marked by business practices or conduct that is detrimental to the public, stockholders, investors, or creditors.

(d) The discount ~~medical~~ plan organization has a complaint procedure that will facilitate the resolution of subscriber grievances and that includes both formal and informal steps available within the organization.

Section 16. Section 636.206, Florida Statutes, is amended to read:

636.206 Examinations and investigations.—

(1) The office may examine or investigate the business and affairs of any discount ~~medical~~ plan organization. The office may order any discount ~~medical~~ plan organization or applicant to produce any records, books, files, advertising and solicitation materials, or other information and may take statements under oath to determine whether the discount ~~medical~~ plan organization or applicant is in violation of the law or is acting contrary to the public interest. The expenses incurred in conducting any examination or investigation must be paid by the discount ~~medical~~ plan organization or applicant. Examinations and investigations must be conducted as provided in chapter 624. For the duration of the agreement with a member and for 5 years thereafter, a discount plan organization must maintain an accurate record of each member, including the membership materials provided to the member, the discount plan issued to the member, and the charges billed and paid by the member, in a form accessible to the office during an examination or investigation.

(2) Failure by the discount ~~medical~~ plan organization to pay the expenses incurred under subsection (1) is grounds for denial or revocation.

Section 17. Section 636.207, Florida Statutes, is amended to read:

636.207 Applicability of part.—Except as otherwise provided in this part, discount ~~medical~~ plan organizations are governed by ~~the provisions of~~ this part and are exempt from the Florida Insurance Code unless specifically referenced.

Section 18. Section 636.210, Florida Statutes, is amended to read:

636.210 Prohibited activities of a discount ~~medical~~ plan organization.—

(1) A discount ~~medical~~ plan organization may not:

(a) Use in its advertisements, marketing material, brochures, and discount cards the term "insurance" except as otherwise provided in this part or as a disclaimer of any relationship between discount ~~medical~~ plan organization benefits and insurance;

(b) Use in its advertisements, marketing material, brochures, and discount cards the terms "health plan," "coverage," "copay," "copayments," "preexisting conditions," "guaranteed issue," "premium," "PPO," "preferred provider organization," or other terms in a manner that could reasonably mislead a person into believing the discount ~~medical~~ plan was health insurance;

(c) Have restrictions on free access to plan providers, including, but not limited to, waiting periods and notification periods; or

(d) Pay providers any fees for medical services.

(2) A discount ~~medical~~ plan organization may not collect or accept money from a member for payment to a provider for specific medical services furnished or to be furnished to the member unless the organization has an active certificate of authority from the office to act as an administrator.

Section 19. Subsection (1), paragraphs (b), (c), and (d) of subsection (2), and subsection (3) of section 636.218, Florida Statutes, are amended to read:

636.218 Annual reports.—

(1) Each discount ~~medical~~ plan organization shall ~~must~~ file with the office, within 3 months after the end of each fiscal year, an annual report.

(2) Such reports must be on forms prescribed by the commission and must include:

(b) If different from the initial application or the last annual report, a list of the names and residence addresses of all persons responsible for the conduct of the organization's affairs, together with a disclosure of the extent and nature of any contracts or arrangements between such persons and the discount ~~medical~~ plan organization, including any possible conflicts of interest.

(c) The number of discount ~~medical~~ plan members in the state.

(d) Such other information relating to the performance of the discount ~~medical~~ plan organization as is reasonably required by the commission or office.

(3) Every discount ~~medical~~ plan organization that ~~which~~ fails to file an annual report in the form and within the time required by this section shall forfeit up to $500 for each day for the first 10 days during which the neglect continues and shall forfeit up to $1,000 for each day after the first 10 days during which the neglect continues; and, upon notice by the office to that effect, the organization's authority to enroll new members or to do business in this state ceases while such default continues. The office shall deposit all sums collected by the office under this section to the credit of the Insurance Regulatory Trust Fund. The office may not collect more than $50,000 for each report.

Section 20. Section 636.220, Florida Statutes, is amended to read:

636.220 Minimum capital requirements.—

(1) Each discount ~~medical~~ plan organization shall ~~must~~ at all times maintain a net worth of at least $150,000.

(2) The office may not issue a license unless the discount ~~medical~~ plan organization has a net worth of at least $150,000.

Section 21. Section 636.222, Florida Statutes, is amended to read:

636.222 Suspension or revocation of license; suspension of enrollment of new members; terms of suspension.—

(1) The office may suspend the authority of a discount ~~medical~~ plan organization to enroll new members, revoke any license issued to a discount ~~medical~~ plan organization, or order compliance if the office finds that any of the following conditions exist:

(a) The organization is not operating in compliance with this part.

(b) The organization does not have the minimum net worth as required by this part.

(c) The organization has advertised, merchandised, or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading, or unfair practices with respect to advertising or merchandising.

(d) The organization is not fulfilling its obligations as a ~~medical~~ discount ~~medical~~ plan organization.

(e) The continued operation of the organization would be hazardous to its members.

(2) If the office has cause to believe that grounds for the suspension or revocation of a license exist, the office must ~~shall~~ notify the discount ~~medical~~ plan organization in writing specifically stating the grounds for suspension or revocation

and shall pursue a hearing on the matter in accordance with ~~the provisions of~~ chapter 120.

(3) When the license of a discount ~~medical~~ plan organization is surrendered or revoked, such organization must proceed, immediately following the effective date of the order of revocation, to wind up its affairs transacted under the license. The organization may not engage in any further advertising, solicitation, collecting of fees, or renewal of contracts.

(4) The office shall, in its order suspending the authority of a discount ~~medical~~ plan organization to enroll new members, specify the period during which the suspension is to be in effect and the conditions, if any, which must be met by the discount ~~medical~~ plan organization before ~~prior to~~ reinstatement of its license to enroll new members. The order of suspension is subject to rescission or modification by further order of the office before ~~prior to~~ the expiration of the suspension period. Reinstatement may not be made unless requested by the discount ~~medical~~ plan organization; however, the office may not grant reinstatement if it finds that the circumstances for which the suspension occurred still exist or are likely to recur.

Section 22. Section 636.223, Florida Statutes, is amended to read:

636.223 Administrative penalty.—In lieu of suspending or revoking a certificate of authority whenever any discount

~~medical~~ plan organization has been found to have violated any provision of this part, the office may:

(1) Issue and cause to be served upon the organization charged with the violation a copy of such findings and an order requiring such organization to cease and desist from engaging in the act or practice that constitutes the violation.

(2) Impose a monetary penalty of not less than $100 for each violation, but not to exceed an aggregate penalty of $75,000.

Section 23. Section 636.224, Florida Statutes, is amended to read:

636.224 Notice of change of name or address of discount ~~medical~~ plan organization.—Each discount ~~medical~~ plan organization must provide the office at least 30 days' advance notice of any change in the discount ~~medical~~ plan organization's name, address, principal business address, or mailing address.

Section 24. Section 636.226, Florida Statutes, is amended to read:

636.226 Provider name listing.—Each discount ~~medical~~ plan organization must maintain on an Internet website an up-to-date list of the names and addresses of the providers with which it has contracted~~, on an Internet website page~~, the address of which must ~~shall~~ be prominently displayed on all its advertisements, marketing materials, brochures, and discount cards. This section applies to those providers with whom the

458 discount ~~medical~~ plan organization has contracted directly, as
459 well as those who are members of a provider network with which
460 the discount ~~medical~~ plan organization has contracted.
461 Section 25. Section 636.232, Florida Statutes, is amended
462 to read:
463 636.232 Rules.—The commission may adopt rules to
464 administer this part, including rules for the licensing of
465 discount ~~medical~~ plan organizations; ~~establishing standards for~~
466 ~~evaluating forms, advertisements, marketing materials,~~
467 ~~brochures, and discount cards;~~ providing for the collection of
468 data; relating to disclosures to plan members; and defining
469 terms used in this part.
470
471 ----------
472 **T I T L E A M E N D M E N T**
473 Remove lines 6-48 and insert:
474 provisions to changes made by the act; providing an exception
475 for providers under certain circumstances; amending s. 636.206,
476 F.S.; conforming provisions to changes made by the act;
477 providing record keeping requirements for discount plan
478 organizations; amending s. 636.208, F.S.; conforming provisions
479 to changes made by the act; revising a specified condition for a
480 member to receive a reimbursement of certain charges after
481 cancelling a membership in a discount plan organization;
482 amending s. 636.212, F.S.; requiring discount plan organizations

or marketers to provide prospective members with certain disclosures; requiring prospective members to acknowledge the receipt of and the acceptance of such disclosures before enrolling in a discount plan; specifying what a first page is for the purpose of a disclosure requirement on certain materials relating to a discount plan; providing requirements for disclosures made in writing, by electronic means, and by telephone; amending s. 636.214, F.S.; making a technical change; conforming provisions to changes made by the act; amending s. 636.216, F.S.; deleting provisions relating to requirements to file with and obtain approval from the Department of Financial Services of certain charges and forms; conforming a provision to changes made by the act; amending s. 636.228, F.S.; conforming provisions to changes made by the act; authorizing a discount plan organization to delegate functions to its marketers; providing that the discount plan organization is bound to acts of its marketers within the scope of delegation; amending s. 636.230, F.S.; conforming provisions to changes made by the act; authorizing a marketer or discount plan organization to commingle certain products on a single page of certain documents; deleting a requirement for discount medical plan fees to be provided in writing under certain circumstances; amending s. 636.232, F.S.; revising the authority for the Financial Services Commission to adopt rules; amending ss. 408.9091, 408.910, 627.64731, 636.003, 636.205, 636.207, 636.210, 636.218,

508 636.220, 636.222, 636.223, 636.224, 636.226, 636.234, 636.236,
509 636.238, 636.240,

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 619 Consolidation of Medicaid Waiver Programs
SPONSOR(S): Pigman
TIED BILLS: **IDEN./SIM. BILLS:** SB 694

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

SUMMARY ANALYSIS

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 Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Health and Department of Elder Affairs (DOEA).

States have some flexibility in the provision of Medicaid services. Section 1915(b) of the Social Security Act provides authority for the Secretary of the U.S. Department of Health and Human Services to waive requirements to the extent that he or she "finds it to be cost-effective and efficient and not inconsistent with the purposes of this title." Also, Section 1115 of the Social Security Act allows states to use innovative service delivery systems that improve care, increase efficiency, and reduce costs.

States may also ask the federal government to waive federal requirements to expand populations or services, or to try new ways of service delivery. Florida has a Section 1115 waiver to use a comprehensive managed care delivery model for primary and acute care services, the Statewide Medicaid Managed Care Managed Medical Assistance (MMA) program. In addition, Florida also has a waiver under Sections 1915(b) and (c) of the Social Security Act to operate the Medicaid Managed Care Long-term Care (LTC) program. The LTC program provides services for elderly and disabled individuals who require long-term nursing facility level of care.

Florida also operates multiple Home and Community Based Services (HCBS) waivers to provide services, not otherwise available through Medicaid, intended to prevent or delay institutional placement. The HCBS waivers vary: some waivers are limited to persons with specific diseases or physical conditions (such as cystic fibrosis); others serve broader groups (such as persons who are elderly and/or have disabilities).

HB 619 requires the consolidation of individuals enrolled in three HCBS waivers into the LTC program by January 1, 2018: the Project AIDS Care (PAC) waiver, Adult Cystic Fibrosis (ACF) waiver, and Traumatic Brain Injury and Spinal Cord Injury waiver. The bill requires AHCA to seek federal approval to terminate those waivers once all eligible Medicaid beneficiaries have transitioned into the LTC program.

The bill expands eligibility requirements for the MMA and LTC programs to accommodate the PAC and ACF waiver populations and deletes language relating to waiver consolidation that would be obsolete upon passage. The bill also deletes the requirement for AHCA to operate a prescription drug management program that has become duplicative of services available in the Medicaid managed care model.

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

The bill provides for an effective date of July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

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 Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families, the Department of Health (DOH), the Agency for Persons with Disabilities, and the Department of Elderly Affairs (DOEA).

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.[1] 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 physician services, hospital services, home health services, and family planning.[2] States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, adult dental services, and dialysis.[3]

The Florida Medicaid program covers approximately 4 million low-income individuals, including approximately 2.3 million, or 58.6%, of the children in Florida.[4] Medicaid is the second largest single program in the state, behind public education, representing 31 percent of the total FY 2016-2017 budget. Medicaid expenditures represent over 19 percent of the total state funds appropriated in FY 2016-2017. Florida's program is the 4th largest in the nation by enrollment, and the 6th largest in terms of expenditures.[5]

Medicaid Waivers

States have some flexibility in the provision of Medicaid services. Section 1915(b) of the Social Security Act provides authority for the Secretary of the U.S. Department of Health and Human Services to waive requirements to the extent that he or she "finds it to be cost-effective and efficient and not inconsistent with the purposes of this title." Also, Section 1115 of the Social Security Act allows states to use innovative service delivery systems that improve care, increase efficiency, and reduce costs.

States may also ask the federal government to waive federal requirements to expand populations or services, or to try new ways of service delivery. For example, Florida has a Section 1115 waiver to use a comprehensive managed care delivery model for primary and acute care services, the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program.[6] In addition to the

[1] Title 42 U.S.C. §§ 1396-1396w-5; Title 42 C.F.R. Part 430-456 (§§ 430.0-456.725) (2016).
[2] S. 409.905, F.S.
[3] S. 409.906, F.S.
[4] Agency for Health Care Administration, *Florida Statewide Medicaid Monthly Enrollment Report*, February 2017, available at http://www.fdhc.state.fl.us/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last accessed February 28, 2017).
[5] The Henry J. Kaiser Family Foundation, State Health Facts, Total Medicaid Spending FY 2015 and Total Monthly Medicaid and CHIP Enrollment Nov. 2016, available at http://kff.org/statedata/ (last viewed March 3, 2017).
[6] S. 409.964, F.S.

Section 1115 waiver for the MMA program, Florida also has a waiver under Sections 1915(b) and (c) of the Social Security Act to operate the SMMC Long-term Care (LTC) program.[7]

Approximately 82% of the Medicaid population in Florida is enrolled in the MMA and LTC programs.[8]

Florida's Medicaid Managed Care Long-term Care Program

The LTC program provides long-term care services to eligible Medicaid beneficiaries. Individuals must enroll in the LTC program if they are age 65 or older and eligible for Medicaid, age 18 or older and eligible for Medicaid by reason of a disability, or determined by the Comprehensive Assessment and Review of Long-term Care Services (CARES) unit[9] at DOEA to need nursing facility level of care[10] and also meets one or more established criteria, such as receiving TANF or enrolled in hospice care.[11]

The LTC program also allows individuals who are eligible for various other Home and Community-based Services (HCBS) waivers[12] to enroll. Such waivers include:

- Developmental Disabilities Waiver (iBudget);
- Traumatic Brain and Spinal Cord Injury Waiver;
- Project AIDS Care Waiver; and
- Adult Cystic Fibrosis Waiver.[13]

The following chart details the minimum covered services available to individuals enrolled in the LTC program:

LTC Program Minimum Covered Services[14]		
Adult Companion Care	Home accessibility adaptation	Nursing facility
Adult day health care	Home-delivered meals	Nutritional assessment / risk reduction
Assisted living	Homemaker	Personal care

[7] Id.
[8] Supra, FN 4.
[9] CARES is a federally mandated pre-admission screening program to assess each individual who requests Medicaid reimbursement for nursing facility placement, or who seeks to receive home and community-based services through other Medicaid waivers.
[10] S. 409.985(3), F.S.; "Nursing facility care" means the individual:
(a) Requires nursing home placement as evidenced by the need for medical observation throughout a 24-hour period and care required to be performed on a daily basis by, or under the direct supervision of, a registered nurse or other health care professional and requires services that are sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse because of a mental or physical incapacitation by the individual;
(b) Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and care and the constant availability of medical and nursing treatment and requires services on a daily or intermittent basis that are to be performed under the supervision of licensed nursing or other health professionals because the individual is incapacitated mentally or physically; or
(c) Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and care and the constant availability of medical and nursing treatment and requires limited services that are to be performed under the supervision of licensed nursing or other health professionals because the individual is mildly incapacitated mentally or physically.
[11] Agency for Health Care Administration, Statewide Medicaid Managed Care, *Long-term Care Program Snapshot*, December 6, 2016, available at https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/SMMC_LTC_Snapshot.pdf (last accessed February 27, 2017).
[12] Infra, FN 16; Medicaid HCBS waivers are authorized by Section 2176 of the Omnibus Budget Reconciliation Act of 1981 and incorporated into Title XIX of the Social Security Act as Section 1915(c). States can use this authority to offer a broad array of services not otherwise available through Medicaid that are intended to prevent or delay institutional placement. Florida's HCBS waivers vary on a number of dimensions. Some waivers are limited to persons with specific diseases or physical conditions (such as cystic fibrosis); others serve broader groups (such as persons who are elderly and/or have disabilities). Waivers also differ with respect to the number and types of services provided, payment method, and whether waiver services are available statewide or limited to a few counties.
[13] Supra, FN 11.
[14] Id.

LTC Program Minimum Covered Services[14]		
Assistive care services	Hospice	Personal emergency response system
Attendant nursing care	Intermittent and Skilled Nursing	Respite care
Behavioral management	Medical equipment and supplies	Occupational, physical, respiratory and speech therapy
Care coordination / Case management	Medication administration	Non-emergency Transportation
Caregiver training	Medication Management	

LTC plan providers also cover some expanded benefits, such as dental, emergency financial assistance, non-medical transportation, over-the-counter medications/supplies, and vision services.[15]

Traumatic Brain and Spinal Cord Injury Waiver

The Traumatic Brain and Spinal Cord Injury (TB/SCI) waiver is an HCBS waiver operated by DOH that provides services for individuals with traumatic brain injuries and spinal cord injuries.[16] For purposes of the waiver, "traumatic brain injury" is an injury that produces an altered state of consciousness or anatomic, motor, sensory, or cognitive/behavioral deficits and "spinal cord injury" is an injury that has significant involvement of two of the following: motor deficit, sensory deficit, or bowel and bladder dysfunction.[17] To be eligible, individuals must be 18 years of age or older, be Medicaid eligible, have one of the conditions previously described, and meet nursing home level of care as determined by CARES.[18]

The TB/SCI waiver includes services such as assistive technologies, attendant care, adult companion, counseling, personal care, and support coordination. Currently, the TB/SCI waiver has approximately 350 individuals enrolled with 350 on the waitlist.[19]

Adult Cystic Fibrosis Waiver

The Adult Cystic Fibrosis (ACF) waiver is an HCBS waiver operated by DOH that provides services for individuals with a diagnosis of cystic fibrosis; a chronic, progressive, and terminal genetic disorder that affects a person's lungs and digestive system.[20] To be eligible, individuals must 18 years of age or older, be Medicaid eligible, have a diagnosis of cystic fibrosis, and meet nursing home level of care as determined by CARES.[21]

The ACF waiver includes services such as case management, counseling, personal care, prescription drugs, respite care, and respiratory therapy. Currently, the ACF waiver has approximately 140 individuals enrolled with none on the waitlist.[22]

Project AIDS Care Waiver

The Project AIDS Care (PAC) waiver is an HCBS waiver operated by AHCA that provides services for individuals with a diagnosis of acquired immune deficiency syndrome (AIDS). To be eligible, individuals

[15] Id.
[16] Office of Program Policy Analysis and Government Accountability, *Profile of Florida's Medicaid Home and Community-Based Services Waivers*, Report No. 13-07, March 2013, available at http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1307rpt.pdf (last accessed February 27, 2017).
[17] Id.
[18] Id.
[19] Agency for Health Care Administration, Agency Analysis of 2017 House Bill 619, p. 3 (Feb. 6, 2017).
[20] Supra, FN 16.
[21] Id.
[22] Supra, FN 19

must be Medicaid eligible, have a diagnosis of AIDS, have an AIDS-related opportunistic infection, be at risk for hospitalization, meet income eligibility requirements of the Social Security Administration for SSI,[23] and not be enrolled in the MMA or LTC programs.[24] To meet SSI income requirements, an individual must not earn more than $2,205 per month, or 300% of the Federal Benefits Rate (FBR).[25]

The PAC waiver includes services such as case management, home-delivered meals, personal care, restorative massage, specialized medical equipment, and skilled nursing. Currently, the PAC waiver has approximately 7,800 individuals enrolled with none on the waitlist.

Medication Therapy Management Program

Section 409.912(8)(a)11., F.S., requires AHCA to implement a Medicaid prescription drug management system that determines appropriate practice patterns and clinical guidelines to improve prescribing, dispensing, and use of prescription drugs for certain Medicaid beneficiaries. The system must improve quality of care and prescribing practices using best practice guidelines to improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs.[26]

AHCA contracts with the University of Florida College Of Pharmacy to administer the Medication Therapy Management (MTM) program. The MTM program uses a delivery model that allows pharmacists to work collaboratively with the patient and his or her health care provider to develop treatment plans and optimize drug treatment and therapeutic outcomes.[27] The MTM program uses telephonic follow-up assessments, customized interventions, member engagement, and intermediary services to connect patients, pharmacists, and providers.[28]

To be eligible for MTM services, a recipient must not be enrolled in a health plan and receive their prescribed drug and other medical care through the Medicaid fee-for-service delivery system. The MTM program has an annual capacity of 250 individuals. Currently, the program has 50 individuals enrolled.

Effect of Proposed Bill

HB 619 requires PAC, ACF, and TB/SCI waiver beneficiaries to transition to the LTC program by January 1, 2018. Once all eligible Medicaid beneficiaries have transitioned, AHCA must seek federal approval to terminate the waivers. Waiver consolidation removes administrative burdens on AHCA and DOH by transferring Medicaid beneficiaries from these HCBS waivers into the LTC program. Similar services, and in some cases expanded services, are available to the waiver beneficiaries in the LTC program as were available through the waivers.

Project AIDS Care Waiver Consolidation

The bill transfers approximately 7,800 individuals from the PAC waiver to the LTC program.

The bill amends eligibility requirements, subject to federal approval, for individuals who would otherwise be eligible for the PAC waiver but do not meet the eligibility requirements for the LTC program. The bill

[23] SSI is the Supplemental Security Income program, a federal income supplement program designed to help aged, blind, and disabled people with little to no income by providing cash to meet basic needs such as food, clothing and shelter; *See* Social Security Administration, Supplemental Security Income Home Page – 2016 Edition, *What is Supplemental Security Income?*, available at https://www.ssa.gov/ssi/ (last accessed February 27, 2017).
[24] Supra, FN 16.
[25] Current FBR is $735 per month; Department of Children and Families, *SSI-Related Programs – Financial Eligibility Standards*, available at http://www.dcf.state.fl.us/programs/access/docs/esspolicymanual/a_09.pdf (last accessed February 26, 2017).
[26] S. 409.912(8)(a)11.b., F.S.
[27] University of Florida College of Pharmacy, Services, *Medication Therapy Management*, available at http://mmc.pharmacy.ufl.edu/services/mtm/ (last accessed February 28, 2017).
[28] University of Florida College of Pharmacy, Services, *Performance Improvement Interventions*, available at http://mmc.pharmacy.ufl.edu/services/mtm/ (last accessed March 2, 2017).

makes those individuals with a diagnosis of AIDS, an AIDS-related opportunistic infection, at risk of hospitalization as determined by AHCA, and income at or below 300% of the FBR eligible for Medicaid. This change in the eligibility requirement would allow an individual otherwise eligible for the PAC waiver, who does not meet the nursing home level of care requirement for the LTC program, to be eligible for the MMA program.

The LTC program offers similar services to those offered under the PAC waiver. Some services will not be available, such as massage therapy, but other services available under the LTC program will replace those services.[29]

Adult Cystic Fibrosis Waiver Consolidation

The bill transfers approximately 140 individuals from the ACF waiver to the LTC program.

The bill amends CARES screening requirements to include "hospital level of care" for individuals diagnosed with cystic fibrosis. Currently, to meet LTC eligibility requirements, CARES must determine an individual requires "nursing facility care." This change will allow those individuals diagnosed with cystic fibrosis who do not meet the nursing facility level of care requirement to be eligible for the LTC program.

The LTC program offers similar services to those offered under the ACF waiver, but certain services are not available, such as nutritional supplements and the amount of sterile saline needed by individuals with ACF. AHCA will require LTC program plans to cover over-the-counter benefits to fill the gap in available services.[30]

Traumatic Brain Injury and Spinal Cord Injury Waiver

The bill transfers approximately 350 individuals from the TB/SCI waiver to the LTC program, and 350 individuals from the TB/SCI waiver waitlist to the LTC program waitlist. It is likely those individuals transferred onto the LTC waitlist will transition into the LTC program faster than they would have moved into the TB/SCI waiver due to their high level of acuity and the large number of people enrolled per year from the waitlist into the LTC program.

The LTC program offers services similar to those available through the TB/SCI waiver and expanded benefits will be available to individuals who transfer.

Medication Therapy Management Program

The bill removes the requirement for AHCA to operate a prescription drug management program, and ends the MTM program. Approximately 50 individuals will be impacted. Most Medicaid eligible individuals are already enrolled in the MMA or LTC programs. There are very few individuals eligible for the MTM program that do not otherwise have coverage in the SMMC program and enrolling those who are eligible in the MTM would duplicate services. The evaluation component of the MTM has become less reliable and not statistically significant due to the low participation numbers.[31]

AHCA uses the MTM program to satisfy a federally required research and demonstration component of another Medicaid waiver, the MEDS-AD waiver.[32] In the absence of the MTM program, AHCA will use

[29] Supra, FN 19 at pg. 4.
[30] Supra, FN 19 at pg. 5.
[31] Supra, FN 19 at pg. 6.
[32] The MEDS-AD waiver is another Section 1115 demonstration waiver which serves elderly or disabled individuals with incomes at or below 88% of the Federal Poverty Level and is designed to prevent premature institutionalization by providing access to health care services and medication therapy management. The waiver is limited to those individuals in hospice, home and community based services, or institutional care services that are not eligible for Medicare. See Agency for Health Care Administration, *Florida MEDS-AD Waiver Annual Report, Demonstration Year 9*, available at https://ahca.myflorida.com/medicaid/MEDS-AD/docs/FINAL_MEDS-AD_ANNUAL_RPT-DY9_Jan-Dec_2014.pdf (last accessed February 28, 2017).

its current authority under the MMA program Section 1115 waiver to comply with the research and demonstration requirement of the MEDS-AD waiver.[33]

The bill also deletes s. 409.906(13)(b), F.S., a section of law that allows AHCA to consolidate certain waiver programs that will become obsolete upon passage of the bill.

The bill provides for an effective date of July 1, 2017.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.904, F.S., relating to optional payments for eligible persons.
Section 2: Amends s. 409.906, F.S., relating to optional Medicaid services.
Section 3: Amends s. 409.912, F.S., relating to cost-effective purchasing of health care.
Section 4: Amends s. 409.979, F.S., relating to eligibility.
Section 5: Provides an effective date of July 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

The bill will require a transfer of General Revenue funds from DOH to AHCA relating to the TB/SCI and ACF waivers. DOH has worked with AHCA on this requirement and has not identified any issues with the transfer of General Revenue funds for this purpose.[34]

[33] Supra, FN 19 at pg. 6. AHCA uses this authority to satisfy similar requirements for the Healthy Start and Hemophilia programs.
[34] Email from Paul Runk, Director of Legislative Planning, Department of Health, RE: HB 619, (February 28, 2017)(on file with Health Innovation Subcommittee staff).

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:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

At line 35, the phrase "or its designee" is unnecessary.

At lines 442-443, the bill expands eligibility for the LTC program for adults diagnosed with cystic fibrosis to include "hospital level of care." The bill does not define or cross-reference a definition for this phrase.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to consolidation of Medicaid waiver programs; amending s. 409.904, F.S.; providing eligibility for optional payments for medical assistance and related services for certain persons with AIDS; amending s. 409.906, F.S.; deleting a provision relating to consolidation of waiver services made obsolete by changes made by the act; amending s. 409.912, F.S.; eliminating a prescription drug management program operated by the Agency for Health Care Administration; amending s. 409.979, F.S.; revising eligibility criteria for certain long-term care services; providing for the transition of certain home and community-based services waiver participants into long-term care managed care programs; providing for the termination of certain programs by a specified date after such transition is complete; providing an effective date.

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

Section 1. Subsection (11) is added to section 409.904, Florida Statutes, to read:

409.904 Optional payments for eligible persons.—The agency may make payments for medical assistance and related services on

behalf of the following persons who are determined to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(11) Subject to federal waiver approval, a person diagnosed with acquired immune deficiency syndrome (AIDS), who has an AIDS-related opportunistic infection and is at risk of hospitalization as determined by the agency or its designee, and whose income is at or below 300 percent of the federal benefit rate.

Section 2. Paragraph (b) of subsection (13) of section 409.906, Florida Statutes, is amended to read:

409.906 Optional Medicaid services.—Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited 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, 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 or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(13) HOME AND COMMUNITY-BASED SERVICES.—

~~(b) The agency may consolidate types of services offered in the Aged and Disabled Waiver, the Channeling Waiver, the Project AIDS Care Waiver, and the Traumatic Brain and Spinal Cord Injury Waiver programs in order to group similar services under a single service, or continue a service upon evidence of the need for including a particular service type in a particular waiver. The agency is authorized to seek a Medicaid state plan amendment or federal waiver approval to implement this policy.~~

Section 3. Paragraph (a) of subsection (8) of section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery

of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. s. 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization.

The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers

are not entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(8)(a) The agency shall implement a Medicaid prescribed-drug spending-control program that includes the following components:

1. A Medicaid preferred drug list, which shall be a listing of cost-effective therapeutic options recommended by the Medicaid Pharmacy and Therapeutics Committee established pursuant to s. 409.91195 and adopted by the agency for each therapeutic class on the preferred drug list. At the discretion of the committee, and when feasible, the preferred drug list should include at least two products in a therapeutic class. The agency may post the preferred drug list and updates to the list on an Internet website without following the rulemaking procedures of chapter 120. Antiretroviral agents are excluded from the preferred drug list. The agency shall also limit the amount of a prescribed drug dispensed to no more than a 34-day supply unless the drug products' smallest marketed package is

greater than a 34-day supply, or the drug is determined by the agency to be a maintenance drug in which case a 100-day maximum supply may be authorized. The agency may seek any federal waivers necessary to implement these cost-control programs and to continue participation in the federal Medicaid rebate program, or alternatively to negotiate state-only manufacturer rebates. The agency may adopt rules to administer this subparagraph. The agency shall continue to provide unlimited contraceptive drugs and items. The agency must establish procedures to ensure that:

a. There is a response to a request for prior consultation by telephone or other telecommunication device within 24 hours after receipt of a request for prior consultation; and

b. A 72-hour supply of the drug prescribed is provided in an emergency or when the agency does not provide a response within 24 hours as required by sub-subparagraph a.

2. Reimbursement to pharmacies for Medicaid prescribed drugs shall be set at the lowest of: the average wholesale price (AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC) plus 1.5 percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge billed by the provider.

3. The agency shall develop and implement a process for managing the drug therapies of Medicaid recipients who are using significant numbers of prescribed drugs each month. The

management process may include, but is not limited to, comprehensive, physician-directed medical-record reviews, claims analyses, and case evaluations to determine the medical necessity and appropriateness of a patient's treatment plan and drug therapies. The agency may contract with a private organization to provide drug-program-management services. The Medicaid drug benefit management program shall include initiatives to manage drug therapies for HIV/AIDS patients, patients using 20 or more unique prescriptions in a 180-day period, and the top 1,000 patients in annual spending. The agency shall enroll any Medicaid recipient in the drug benefit management program if he or she meets the specifications of this provision and is not enrolled in a Medicaid health maintenance organization.

4. The agency may limit the size of its pharmacy network based on need, competitive bidding, price negotiations, credentialing, or similar criteria. The agency shall give special consideration to rural areas in determining the size and location of pharmacies included in the Medicaid pharmacy network. A pharmacy credentialing process may include criteria such as a pharmacy's full-service status, location, size, patient educational programs, patient consultation, disease management services, and other characteristics. The agency may impose a moratorium on Medicaid pharmacy enrollment if it is determined that it has a sufficient number of Medicaid-

participating providers. The agency must allow dispensing practitioners to participate as a part of the Medicaid pharmacy network regardless of the practitioner's proximity to any other entity that is dispensing prescription drugs under the Medicaid program. A dispensing practitioner must meet all credentialing requirements applicable to his or her practice, as determined by the agency.

5. The agency shall develop and implement a program that requires Medicaid practitioners who prescribe drugs to use a counterfeit-proof prescription pad for Medicaid prescriptions. The agency shall require the use of standardized counterfeit-proof prescription pads by Medicaid-participating prescribers or prescribers who write prescriptions for Medicaid recipients. The agency may implement the program in targeted geographic areas or statewide.

6. The agency may enter into arrangements that require manufacturers of generic drugs prescribed to Medicaid recipients to provide rebates of at least 15.1 percent of the average manufacturer price for the manufacturer's generic products. These arrangements shall require that if a generic-drug manufacturer pays federal rebates for Medicaid-reimbursed drugs at a level below 15.1 percent, the manufacturer must provide a supplemental rebate to the state in an amount necessary to achieve a 15.1-percent rebate level.

7. The agency may establish a preferred drug list as

described in this subsection, and, pursuant to the establishment of such preferred drug list, negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the Social Security Act and at no less than 14 percent of the average manufacturer price as defined in 42 U.S.C. s. 1936 on the last day of a quarter unless the federal or supplemental rebate, or both, equals or exceeds 29 percent. There is no upper limit on the supplemental rebates the agency may negotiate. The agency may determine that specific products, brand-name or generic, are competitive at lower rebate percentages. Agreement to pay the minimum supplemental rebate percentage guarantees a manufacturer that the Medicaid Pharmaceutical and Therapeutics Committee will consider a product for inclusion on the preferred drug list. However, a pharmaceutical manufacturer is not guaranteed placement on the preferred drug list by simply paying the minimum supplemental rebate. Agency decisions will be made on the clinical efficacy of a drug and recommendations of the Medicaid Pharmaceutical and Therapeutics Committee, as well as the price of competing products minus federal and state rebates. The agency may contract with an outside agency or contractor to conduct negotiations for supplemental rebates. For the purposes of this section, the term "supplemental rebates" means cash rebates. Value-added programs as a substitution for supplemental rebates are prohibited. The agency may seek any federal waivers to implement this initiative.

8. The agency shall expand home delivery of pharmacy products. The agency may amend the state plan and issue a procurement, as necessary, in order to implement this program. The procurements must include agreements with a pharmacy or pharmacies located in the state to provide mail order delivery services at no cost to the recipients who elect to receive home delivery of pharmacy products. The procurement must focus on serving recipients with chronic diseases for which pharmacy expenditures represent a significant portion of Medicaid pharmacy expenditures or which impact a significant portion of the Medicaid population. The agency may seek and implement any federal waivers necessary to implement this subparagraph.

9. The agency shall limit to one dose per month any drug prescribed to treat erectile dysfunction.

10.a. The agency may implement a Medicaid behavioral drug management system. The agency may contract with a vendor that has experience in operating behavioral drug management systems to implement this program. The agency may seek federal waivers to implement this program.

b. The agency, in conjunction with the Department of Children and Families, may implement the Medicaid behavioral drug management system that is designed to improve the quality of care and behavioral health prescribing practices based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed

drug costs and the rate of inappropriate spending on Medicaid behavioral drugs. The program may include the following elements:

(I) Provide for the development and adoption of best practice guidelines for behavioral health-related drugs such as antipsychotics, antidepressants, and medications for treating bipolar disorders and other behavioral conditions; translate them into practice; review behavioral health prescribers and compare their prescribing patterns to a number of indicators that are based on national standards; and determine deviations from best practice guidelines.

(II) Implement processes for providing feedback to and educating prescribers using best practice educational materials and peer-to-peer consultation.

(III) Assess Medicaid beneficiaries who are outliers in their use of behavioral health drugs with regard to the numbers and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of behavioral health drugs.

(IV) Alert prescribers to patients who fail to refill prescriptions in a timely fashion, are prescribed multiple same-class behavioral health drugs, and may have other potential medication problems.

(V) Track spending trends for behavioral health drugs and deviation from best practice guidelines.

(VI) Use educational and technological approaches to promote best practices, educate consumers, and train prescribers in the use of practice guidelines.

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

(IX) Implement a disease management program with a model quality-based medication component for severely mentally ill individuals and emotionally disturbed children who are high users of care.

~~11. The agency shall implement a Medicaid prescription drug management system.~~

~~a. The agency may contract with a vendor that has experience in operating prescription drug management systems in order to implement this system. Any management system that is implemented in accordance with this subparagraph must rely on cooperation between physicians and pharmacists to determine appropriate practice patterns and clinical guidelines to improve the prescribing, dispensing, and use of drugs in the Medicaid program. The agency may seek federal waivers to implement this program.~~

~~b. The drug management system must be designed to improve the quality of care and prescribing practices based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid prescription~~

~~drugs. The program must:~~

~~(I) Provide for the adoption of best practice guidelines for the prescribing and use of drugs in the Medicaid program, including translating best practice guidelines into practice; reviewing prescriber patterns and comparing them to indicators that are based on national standards and practice patterns of clinical peers in their community, statewide, and nationally; and determine deviations from best practice guidelines.~~

~~(II) Implement processes for providing feedback to and educating prescribers using best practice educational materials and peer-to-peer consultation.~~

~~(III) Assess Medicaid recipients who are outliers in their use of a single or multiple prescription drugs with regard to the numbers and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of prescription drugs.~~

~~(IV) Alert prescribers to recipients who fail to refill prescriptions in a timely fashion, are prescribed multiple drugs that may be redundant or contraindicated, or may have other potential medication problems.~~

11.~~12.~~ The agency may contract for drug rebate administration, including, but not limited to, calculating rebate amounts, invoicing manufacturers, negotiating disputes with manufacturers, and maintaining a database of rebate collections.

12.~~13.~~ The agency may specify the preferred daily dosing form or strength for the purpose of promoting best practices with regard to the prescribing of certain drugs as specified in the General Appropriations Act and ensuring cost-effective prescribing practices.

13.~~14.~~ The agency may require prior authorization for Medicaid-covered prescribed drugs. The agency may prior-authorize the use of a product:

a. For an indication not approved in labeling;

b. To comply with certain clinical guidelines; or

c. If the product has the potential for overuse, misuse, or abuse.

The agency may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug. The agency shall post prior authorization, step-edit criteria and protocol, and updates to the list of drugs that are subject to prior authorization on the agency's Internet website within 21 days after the prior authorization and step-edit criteria and protocol and updates are approved by the agency. For purposes of this subparagraph, the term "step-edit" means an automatic electronic review of certain medications subject to prior authorization.

14.~~15.~~ The agency, in conjunction with the Pharmaceutical and Therapeutics Committee, may require age-related prior

authorizations for certain prescribed drugs. The agency may preauthorize the use of a drug for a recipient who may not meet the age requirement or may exceed the length of therapy for use of this product as recommended by the manufacturer and approved by the Food and Drug Administration. Prior authorization may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug.

15.~~16.~~ The agency shall implement a step-therapy prior authorization approval process for medications excluded from the preferred drug list. Medications listed on the preferred drug list must be used within the previous 12 months before the alternative medications that are not listed. The step-therapy prior authorization may require the prescriber to use the medications of a similar drug class or for a similar medical indication unless contraindicated in the Food and Drug Administration labeling. The trial period between the specified steps may vary according to the medical indication. The step-therapy approval process shall be developed in accordance with the committee as stated in s. 409.91195(7) and (8). A drug product may be approved without meeting the step-therapy prior authorization criteria if the prescribing physician provides the agency with additional written medical or clinical documentation that the product is medically necessary because:

a. There is not a drug on the preferred drug list to treat

the disease or medical condition which is an acceptable clinical alternative;

b. The alternatives have been ineffective in the treatment of the beneficiary's disease; or

c. Based on historic evidence and known characteristics of the patient and the drug, the drug is likely to be ineffective, or the number of doses have been ineffective.

The agency shall work with the physician to determine the best alternative for the patient. The agency may adopt rules waiving the requirements for written clinical documentation for specific drugs in limited clinical situations.

16.~~17.~~ The agency shall implement a return and reuse program for drugs dispensed by pharmacies to institutional recipients, which includes payment of a $5 restocking fee for the implementation and operation of the program. The return and reuse program shall be implemented electronically and in a manner that promotes efficiency. The program must permit a pharmacy to exclude drugs from the program if it is not practical or cost-effective for the drug to be included and must provide for the return to inventory of drugs that cannot be credited or returned in a cost-effective manner. The agency shall determine if the program has reduced the amount of Medicaid prescription drugs which are destroyed on an annual basis and if there are additional ways to ensure more

prescription drugs are not destroyed which could safely be reused.

Section 4. Subsections (1) and (2) of section 409.979, Florida Statutes, are amended to read:

409.979 Eligibility.—

(1) PREREQUISITE CRITERIA FOR ELIGIBILITY.—Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) preadmission screening program to require:

1. Nursing facility care as defined in s. 409.985(3); or

2. Hospital level of care for individuals diagnosed with cystic fibrosis.

(2) ENROLLMENT OFFERS.—Subject to the availability of funds, the Department of Elderly Affairs shall make offers for enrollment to eligible individuals based on a wait-list prioritization. Before making enrollment offers, the agency and the Department of Elderly Affairs shall determine that sufficient funds exist to support additional enrollment into plans.

(a) A Medicaid recipient enrolled in one of the following Medicaid home and community-based service waiver programs is eligible to participate in the long-term care managed care program when all eligibility requirements established in subsection (1) are met and shall be transitioned into the long-term care managed care program by January 1, 2018:

1. Traumatic Brain and Spinal Cord Injury Waiver.

2. Adult Cystic Fibrosis Waiver.

3. Project AIDS Care Waiver.

(b) The agency shall seek federal approval to terminate the Traumatic Brain and Spinal Cord Injury Waiver, the Adult Cystic Fibrosis Waiver, and the Project AIDS Care Waiver once all eligible Medicaid recipients have transitioned into the long-term care managed care program.

Section 5. This act shall take effect July 1, 2017.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 619 (2017)

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health Innovation Subcommittee

Representative Pigman offered the following:

Amendment

Remove line 35 and insert:

hospitalization as determined by the agency, and

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 6021 Home Health Agency Licensure
SPONSOR(S): Rommel
TIED BILLS: **IDEN./SIM. BILLS:**

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

SUMMARY ANALYSIS

Home health agencies (HHAs) are organizations licensed by the Agency for Healthcare Administration (AHCA) to provide home health services and staffing services. Home health services are health and medical services and medical supplies furnished to an individual in the individual's home or place of residence. The licensure requirements for HHAs are found in the general health care licensing provisions of part II of ch. 408, F.S., the specific HHA licensure provisions of part III of ch. 400, F.S., and the minimum standards for HHAs in chapter 59A-8, F.A.C.

After the total repeal of the certificate of need (CON) program for HHAs in July 2000, the number of HHAs rapidly increased, as did the amount of Medicare and Medicaid fraud found within HHAs. In June 2008, HB 7083 was signed into law, creating subsection (7) of s. 400.471, F.S., which prohibits the initial licensure of a HHA if another agency owned by the applicant is located within 10 miles of the applicant and in the same county.

HB 6021 repeals the "10-mile" rule found in s. 400.471(7), F.S., thereby permitting an entity that currently owns or has a controlling interest in a licensed HHA to apply for and obtain an initial license to operate a HHA within 10 miles and in the same county as the existing HHA. This would include an entity applying for a change of ownership of a currently licensed HHA.

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

The bill provides an effective date of July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Home Health Agencies

Home Health Agencies (HHAs) are organizations licensed by the Agency for Health Care Administrations (AHCA) to provide home health services and staffing services.[1] Home health services are health and medical services and medical supplies furnished to an individual in the individual's home or place of residence. The services include:

- Nursing care;
- Physical, occupational, respiratory, or speech therapy;
- Home health aide services (assistance with daily living such as bathing, dressing, eating, personal hygiene, and ambulation);
- Dietetics and nutrition practice and nutrition counseling; and
- Medical supplies, restricted to drugs and biologicals prescribed by a physician.[2]

Staffing services are provided to health care facilities, schools, or other business entities on a temporary or school-year basis by licensed health care personnel and by certified nursing assistants and home health aides who are employed by, or work under the umbrella of, a licensed HHA.[3]

A HHA may also provide homemaker[4] and companion[5] services without additional licensing or registration. These services do not involve hands-on personal care to a client and typically include housekeeping, meal planning and preparation, shopping assistance, routine household activities, and accompanying the client on outings. Personnel providing homemaker or companion services are employed by or under contract with a HHA.[6]

Licensure

Since 1975, HHAs operating in Florida have been required to obtain a state license.[7] HHAs must meet the general health care licensing provisions of part II of ch. 408, F.S., the specific HHA licensure provisions in part III of ch. 400, F.S., and the minimum standards for HHAs in chapter 59A-8, F.A.C. A HHA license is valid for 2 years, unless revoked.[8] If a HHA operates related offices, each related office outside the health service planning district where the main office is located must be separately licensed.[9] As of February 27, 2017, there are 1,948 licensed HHAs in Florida.[10]

A HHA may obtain an initial license by submitting to AHCA a signed, complete, and accurate application and the $1,705 licensure fee.[11] The HHA must also submit the results of a survey conducted

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[1] S. 400.462(12), F.S.
[2] S. 400.462(14), F.S.
[3] S. 400.462(30), F.S.
[4] S. 400.462(16), F.S.
[5] S. 400.462(7), F.S.
[6] S. 400.462(13), F.S.
[7] SS. 36 – 51 of ch. 75-233, Laws of Fla.
[8] S. 408.808(1), F.S.
[9] S. 400.464(2), F.S. There are eleven health service planning districts grouped by county.
[10] Florida Health Finder, *Facility/Provider Search Results-Home Health Agencies*, available at http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx (report generated February 27, 2017).
[11] S. 400.471(5) and 59A-8.003(12).

by AHCA.[12] The application must identify the geographic service areas[13] and counties in which the HHA will provide services.

An applicant for initial or renewal licensure must file with the application:

- A listing of services to be provided.
- The number and discipline of professional staff to be employed.
- Information concerning volume data on the renewal application, as determined by rule.
- A business plan, which details the HHAs methods to obtain patients and its plan to recruit and maintain staff.
- Evidence of contingency funding equal to 1 month's average operating expenses during the first year of operation.
- A balance sheet, income and expense statement, and statement of cash flow for the first 2 years of operation showing evidence of sufficient assets, credit, and projected revenues to cover liabilities and expenses.
- All other ownership interests in health care entities for each controlling interest, as defined in part II of chapter 408.
- For initial licensure, documentation of accreditation, or an application for accreditation, from an accrediting organization that is recognized by the agency as having standards comparable to those required by this part and part II of chapter 408.[14]

A HHA must obtain malpractice and liability insurance for at least $250,000 per claim, and submit proof of coverage with its initial application for renewal.[15]

Section 400.464, F.S., exempts certain entities, individuals, and services from the HHA licensure requirements, including:

- A HHA operated by the Federal Government.
- A home health aide or certified nursing assistant who is acting in his or her individual capacity, within the definitions and standards of his or her occupation, and who provides hands-on care to patients in their homes.
- The delivery of nursing home services for which the nursing home is licensed under part II of Chapter 400, F.S., to serve its residents.
- A not-for-profit, community-based agency that provides early intervention services to infants and toddlers.[16]

For licensure renewal, the HHA must submit a signed renewal application and licensure fee.[17] AHCA may not issue a renewal license to a HHA in any county where there is at least one licensed HHA and that has more than one HHA per 5,000 persons, if the applicant has been sanctioned by AHCA within 2 years prior to submitting the license renewal application for one or more of the following acts:

- An intentional or negligent act that materially affects the health or safety of a client;
- Preparing or maintaining fraudulent patient records, such as, but not limited to, charting ahead, recording vital signs or symptoms which were not personally obtained or observed by the HHA's staff at the time indicated, borrowing patients or patient records from other HHAs to pass a survey or inspection, or falsifying signatures;

[12] Id.
[13] S. 408.032(5), F.S. lists the eleven health service planning districts grouped by county.
[14] S. 400.471(2), F.S.
[15] S. 400.471(3), F.S.
[16] S. 400.464(5)(a)-(n), F.S.
[17] Rules 59A-8.003(2) and (12), F.A.C.

- Demonstrating a pattern of falsifying documents relating to the training of home health aides or certified nursing assistants or demonstrating a pattern of falsifying health statements for staff who provide direct care to patients; and
- Giving cash, or its equivalent, to a Medicare or Medicaid beneficiary.[18]

AHCA conducts unannounced licensure surveys every 36.9 months, unless a HHA has requested an exemption from such surveys based on accreditation by an approved accrediting organization.[19] The Home Health Agency State Regulation Set that is used in conducting surveys contains over 100 standards and surveyor guidelines, which are based on Rule 59A-8, F.A.C.[20] AHCA also conducts inspections related to complaints.[21]

Each HHA is required to employ an administrator.[22] The administrator[23] must be a licensed physician, physician assistant, or registered nurse licensed to practice in this state or an individual having at least one year of supervisory or administrative experience in home health care in a facility licensed under ch. 395, F.S.,[24] part II of ch. 400, F.S.,[25] or part I of ch. 429, F.S.[26] The administrator may manage a maximum of five licensed HHAs if the HHAs have identical controlling interests and are located within one geographic service area or within an immediately contiguous county.[27] An employee of a retirement community that provides multiple levels of care may administer a HHA and up to a maximum of four entities licensed under ch. 400, F.S.,[28] or ch. 429, F.S.,[29] if they are owned, operated, or managed by the same corporate entity. The administrator must designate an alternate administrator to serve during the administrator's absence.[30]

A HHA providing skilled services is required to employ a director of nursing[31] who is a Florida licensed registered nurse with at least 1 year of supervisory experience.[32] The director of nursing is responsible for overseeing the delivery of professional nursing and home health aide services[33] and must be readily available at the HHA or by phone for any 8 consecutive hours between 7 a.m. to 6 p.m.[34] The director of nursing is also responsible for establishing and conducting an ongoing quality assurance program for services provided by the HHA.[35]

A director of nursing may be the director for a maximum of five licensed HHAs if the HHAs have identical controlling interests, are located within one geographic service area or within an immediately contiguous county, and each HHA has a registered nurse who meets the qualifications of a director of nursing and has been delegated by the director of nursing to serve in the stead of the director. An employee of a retirement community that provides multiple levels of care may serve as the director of nursing of a HHA and of up to four entities licensed under ch. 400, F.S., or ch. 429, F.S., if they are owned, operated, or managed by the same corporate entity.[36]

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[18] S. 400.471(10), F.S.
[19] Rule 59A-8.003(3)(a), F.A.C.
[20] Agency for Health Care Administration, *ASPEN: Regulation Set (RS): Home Health Agencies*, available at, http://ahca.myflorida.com/MCHQ/Current_Reg_Files/Home_Health_Agencies_ST_H.pdf (last viewed March 1, 2017).
[21] Rule 59A-8.003(4), F.A.C.
[22] S. 400.476(1)(a), F.S.
[23] S. 400.462(1), F.S.
[24] Facilities licensed under ch. 395, F.S., include hospitals, ambulatory surgical centers, and mobile surgical facilities.
[25] Facilities licensed under part II of ch. 400, F.S., include nursing homes.
[26] Facilities licensed under part I of ch. 429, F.S., include assisted living facilities.
[27] S. 400.476(1), F.S.
[28] Entities licensed under ch. 400, F.S., include nursing homes, home health agencies, nurse registries, hospices, intermediate care facilities, homes for special services, transitional living facilities, prescribed pediatric extended care centers, home medical equipment providers, intermediate care facilities for developmentally disabled persons, health care services pools, and health care clinics.
[29] Entities licensed under ch. 429, F.S., include assisted living facilities, adult family care homes, and adult day care centers.
[30] S. 400.476(1)(a), F.S.
[31] S. 400.462(10), F.S.
[32] S. 400.476(2), F.S.
[33] S. 400.462(10), F.S.
[34] Rule 59A-8.003(11)(a), F.A.C.
[35] Rule 59A-8.0095(2)(e), F.A.C.
[36] S. 400.476(2), F.S.

Repeal of CON Program and Licensed HHA Growth[37]

HHAs were made subject to certificate of need (CON) regulation in 1977.[38] Under the CON program, a HHA was required to submit to the Department of Health (DOH) its application for a CON, along with a statement of the purpose and need for the project and the reasons for the proposed:

- Construction;
- Expansion;
- Renovations;
- Substantial change in service;
- Conversion;
- Acquisition; or
- Establishment of a new HHA.[39]

DOH would not issue a license to a HHA which failed to receive a CON.[40]

In 1983, the CON requirement was repealed for HHAs that were not certified or seeking certification as a Medicare home health service provider.[41] The Legislature later repealed the requirement that Medicare-certified HHAs receive CON approval, effective July 1, 2000.[42]

After the total repeal of the CON program for HHAs in July 2000, the number of HHAs rapidly increased. For example, in Miami-Dade County, the number of licensed HHAs increased from 216 in August 1999 to 733 by December 31, 2007, which was a 239 percent increase. The increase in Miami-Dade County represented 64 percent of the statewide increase in licensed HHAs over the same time period.

In 2007, Miami-Dade and Broward counties comprised 19 percent of the state's population of persons over age 64, yet hosted 46 percent of the licensed HHAs in the state.[43] Although home health services are not limited to persons over the age of 64, this population dominates the market. Based on population data from 2007 and the number of licensed HHAs in each geographic service area on December 31, 2007, in Miami-Dade County, there was one licensed HHA for every 505 residents over the age of 64; for Broward County, the ratio was one agency for every 1,196 residents over the age of 64. For all other counties in Florida, the average was one HHA for every 2,571 residents over the age of 64.

In 2007, there were 1,916 licensed HHAs in Florida.[44] The number of licensed HHAs grew to 2,419 HHAs by 2009 before gradually decreasing each year to the current amount of 1,948 licensed HHAs.[45]

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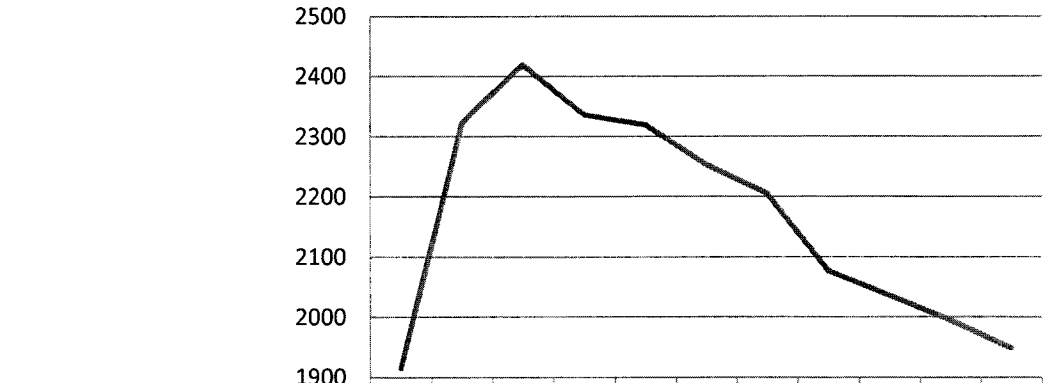
[37] The Florida Senate, *Review Regulatory Requirements for Home Health Agencies*, November 2007, pgs. 4-5, available at http://archive.flsenate.gov/data/Publications/2008/Senate/reports/interim_reports/pdf/2008-135hr.pdf (last viewed March 1, 2017).
[38] S. 2 of ch. 77-400, Laws of Fla.
[39] Supra, FN 37
[40] S. 7 of ch. 77-400, Laws of Fla.
[41] S. 1 of ch. 83-244, Laws of Fla.
[42] S. 7 of ch. 2000-256, Laws of Fla., and s. 8 of ch. 2000-318, Laws of Fla.
[43] Source of population data: Office of Economic & Demographic Research website on 9/11/2007; Source of licensee data: AHCA Home Care Unit, Bureau of Health Facility Regulation, as of 8/23/2007.
[44] Email from Orlando Pryor, Legislative Affairs Director, Agency for Health Care Administration, RE: HB 6021/HHA (March 1, 2017)(on file with the Health Innovation Subcommittee staff).
[45] Id.

Number of Licensed HHAs in Florida from 2007-2017



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Number of Licensed HHAs in Florida	1916	2323	2419	2336	2319	2253	2206	2077	2036	1995	1948

Some of the factors contributing to the decline of licensed HHAs since 2009 are the implementation of legislative regulatory reforms focused on fraud and abuse prevention in 2008 and 2009 and the Centers for Medicare and Medicaid Services (CMS) moratoria on new enrollment of HHAs in Miami-Dade County in 2013, Broward County in 2014, and statewide in 2016.[46]

Medicare and Medicaid Fraud[47]

AHCA's Bureau of Medicaid Program Integrity (MPI) is responsible for preventing and detecting fraud and abuse and performing inspections and investigations related to the Florida Medicaid program. If MPI suspects fraud, or another criminal violation of state law, the case is referred to the Office of the Attorney General Medicaid Fraud Control Unit (MFCU) for further investigation and prosecution, if appropriate.[48]

The MFCU has two primary areas of enforcement responsibility: fraud perpetrated against the Medicaid program and Patient Abuse, Neglect and Exploitation (PANE). Enforcement activities in these areas, which includes both criminal and civil enforcement actions, helps prevent, detect, prosecute, and deter misconduct.[49] MFCU's Control and Enforcement Strategy focuses on the following:

- Medicaid provider fraud;
- PANE investigations;
- Civil recoveries;
- Community outreach; and
- Intelligence.[50]

[46] Id.
[47] Supra, FN 37 at pgs. 4-5.
[48] Joint Report by the Agency for Health Care Administration and the Medicaid Fraud Control Unit with the Office of the Attorney General, *The State's Efforts to Control Medicaid Fraud and Abuse FY 2015-16*, December 16, 2016, pg. 1, available at http://ahca.myflorida.com/Executive/Inspector_General/docs/Medicaid_Fraud_Abuse_Annual_Reports/2015-16_MedicaidFraudandAbuseAnnualReport.pdf (last viewed March 1, 2017).
[49] Id.
[50] Id. at pgs. 1-2.

In an effort to mitigate Medicaid fraud, rule 59G-4.130, F.A.C., requires all providers of home health visit services to Medicaid recipients to comply with the provisions of the Medicaid Home Health Visit Service Coverage Policy (Policy). Under the Policy, Medicaid reimburses providers for:

- Four intermittent home health visits per day for qualifying recipients younger than 21 years and pregnant recipients who are 21 years or older; or
- Three intermittent home health visits per day for non-pregnant recipients age 21 years or older.[51]

In order to qualify for home health services, a recipient must be under the care of a physician, have a physician's order for such services, and require services that can be safely provided in the home.[52] Medicaid does not reimburse for other services provided in the home, including:

- Services provided at a skill level other than what is prescribed in the physician order and approved plan of care;
- Assistance with homework;
- Babysitting;
- Care, grooming, or feeding of pets;
- Companion sitting or leisure activities; and
- Intermittent home health visits rendered less than an hour apart.[53]

In 2007, the MFCU reported that the type of fraudulent activities and schemes seen in Florida related to both Medicaid and Medicare home health services included:[54]

- Kickbacks to physicians to sign plans of treatment;
- Recruiting recipients to fake or exaggerate symptoms to qualify for home health services;
- Paying recipients for participating in billing of unnecessary or non-rendered services; and
- Collaborative arrangements between Medicare and Medicaid certified HHAs to pass off some services (primarily home health aide services) provided to dually eligible recipients to providers enrolled in Medicaid.

Additionally, MPI reported that investigations of HHA providers rose from 47 in FY 2005-2006 to 144 in FY 2006-2007. MPI identified an increase in overpayments during the same time period, from about $10,000 in FY 2004-2005 to about $1.3 million in FY 2006-2007.[55]

In 2008 the Legislature passed, and the Governor signed HB 7083, which created s. 400.471(7), F.S., prohibiting the initial licensure of a HHA if another HHA owned by the applicant is located within 10 miles of the applicant and in the same county. The statute was intended to slow the sharp growth in the number of licensure applicants and new licensees during a time when Medicaid and Medicare HHA fraud investigations were on the rise.[56]

In 2009, the Legislature passed SB 1986 addressing regulatory reforms and fraud and abuse prevention. AHCA reports to the Senate detailing the implementation of provisions within SB 1986. The June 2016 report stated that, in the past, HHAs which have demonstrated a pattern of billing the Medicaid program for medically unnecessary services have either received an administrative penalty or were denied a renewal application. However, in FY 2015-16, no HHAs were identified as being

[51] Agency for Health Care Administration, *Florida Medicaid Home Health Visit Services Coverage Policy*, November 2016, pg. 3, available at https://www.flrules.org/Gateway/reference.asp?No=Ref-07500 (last viewed March 1, 2017).
[52] Id.
[53] Id. at pg. 4.
[54] MFCU's report to the Florida House of Representatives on October 2, 2007.
[55] Florida House of Representatives Bill Analysis for CS/HB 7083, April 10, 2008 (on file with the Health Innovation Subcommittee staff).
[56] Id.

penalized or denied a renewal for licensure because of a pattern of billing for medically unnecessary services.[57]

In FY 2015-2016, HHAs were sixth on the list of Medicaid provider types with the most MFCU fraud cases.[58] An example of a recent MFCU case concerning a HHA occurred in February 2015. Two individuals in Miami were arrested for Medicare and Medicaid fraud totaling more than $2.4 million. The defendants were charged with receiving kickbacks in return for providing false and fraudulent home health prescriptions and plans of care to patient recruiters.[59]

Also in FY 2015-2016, twenty-four HHAs were terminated from participation in the Medicaid program as a result of fraud and abuse,[60] and twenty-six HHAs were denied enrollment or reenrollment in the Medicaid program because of suspected fraud and abuse.[61]

Federal Moratoria on HHAs in Medicare and Medicaid

In July 2013, in an effort to target fraud, CMS implemented a moratorium on the enrollment of new HHAs in the Miami area. CMS extended the moratorium in 2014 to the metropolitan areas of Fort Lauderdale. The moratoria have since been extended at 6 month intervals and remain in place in both Miami and Ft. Lauderdale.[62]

Since implementing the moratoria, CMS has been able to identify and evaluate problems with their effectiveness. Because the current moratoria are geographically defined by county, providers and suppliers are not prohibited from opening new locations or creating a new enrollment outside of the areas under the moratoria and moving it into the area to provide services. Moreover, CMS is unable to prevent existing providers and suppliers from outside of a moratoria area from servicing beneficiaries within that area. CMS has analyzed data showing that providers and suppliers who are located several hundred miles outside of a moratorium area are billing for services provided to beneficiaries located within that moratorium area. In order to mitigate the vulnerabilities of the moratoria, CMS expanded the moratoria statewide on HHA providers in Medicare, Medicaid, and the Children's Health Insurance Program, effective July 29, 2016.[63] [64]

Effect of Proposed Changes

HB 6021 repeals the "10-mile" rule found in s. 400.471(7), F.S., thereby permitting an entity that currently owns or has a controlling interest in a licensed HHA to apply for and obtain an initial license to operate a HHA within 10 miles and in the same county as the existing agency. Also, an entity applying for a change of ownership of an existing HHA will no longer be subject to "10-mile" rule.

The removal of the restriction will allow an existing HHA to establish additional locations, under the same ownership or controlling interest, within the same city or county as the HHA. Such concentration of HHAs may allow for greater access to services for consumers. Larger HHA companies could group their operations within a smaller area than is currently permissible, potentially increasing competition in the market. Smaller HHAs may see an increase in competition within a city or county where previously there was none.

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[57] Supra, FN 44.
[58] Supra, FN 48 at pg. 3.
[59] Id. at pg. 8.
[60] Id. at pg. 57.
[61] Id. at pg. 58.
[62] Centers for Medicare and Medicaid Services, *Provider Enrollment Moratorium*, August 2016, available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/ProviderEnrollmentMoratorium.html (last viewed February 27, 2017).
[63] Id.
[64] Agency for Healthcare Administration, *Medicare/Medicaid*, available at http://www.fdhc.state.fl.us/mchq/health_facility_regulation/home_care/hha/medicare_medicaid.shtml (last viewed March 1, 2017).

Though the removal of the restriction may increase the number of HHAs, it is not likely that there will be a surge of HHAs, like after the repeal of the CON program, because of the statewide moratoria on new enrollments to provide services to Medicare, Medicaid, and CHIP beneficiaries. In addition, the active role of MPI and MFCU is likely to deter and prevent the types and volume of fraud seen after the repeal of the CON program.

The bill provides an effective date of July 1, 2017.

B. SECTION DIRECTORY:

Section 1: Amends s. 400.471, F.S., relating to application for license; fee.
Section 2: Provides an effective date of July 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The bill may result in an increase of licensure fees to AHCA for new HHAs within 10 miles of another HHA owned by the same entity. However, the number of licenses that AHCA will receive and the impact to license revenue is unknown.

2. Expenditures:

   The bill may result in an increase in licensure application reviews, inspections, and legal cases handled by AHCA. However, the increase in application reviews, inspections, and legal costs is unknown, as is the fiscal impact to AHCA resulting from those activities.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill permits HHAs to establish additional locations in smaller areas, such as cities and counties. As a result, there may be business growth, additional job opportunities for home health service providers, and greater access to home health services.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rulemaking authority necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to home health agency licensure; amending s. 400.471, F.S.; repealing a provision prohibiting the Agency for Health Care Administration from issuing an initial license to an applicant for a home health agency license which is located within a certain distance of a licensed home health agency that has common controlling interests; providing an effective date.

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

Section 1. Subsection (7) of section 400.471, Florida Statutes, is amended to read:

400.471 Application for license; fee.—

~~(7) The agency may not issue an initial license to an applicant for a home health agency license if the applicant shares common controlling interests with another licensed home health agency that is located within 10 miles of the applicant and is in the same county. The agency must return the application and fees to the applicant.~~

Section 2. This act shall take effect July 1, 2017.