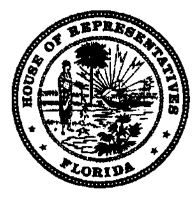
Health Care Appropriations Subcommittee

March 24, 2015
3:30 PM – 5:30 PM
Webster Hall

Steve Crisafulli
Speaker

Matt Hudson
Chair



The Florida House of Representatives

Appropriations Committee

Health Care Appropriations Subcommittee

Steve Crisafulli
Speaker

Matt Hudson
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March 24, 2015

AGENDA
3:30 PM – 5:30 PM
Webster Hall

I. Call to Order/Roll Call

II. HB 1001—Assisted Living Facilities by Ahern

III. CS/HB 999—Recovery Care Services by Fitzenhagen

IV. HB 7045—State Veterans' Nursing Homes by Sprowls

V. HB 1305—Home Medical Equipment by Eagle

VI. HB 309—Patient Admission Status Notification by Harrison

VII. Closing/Adjourn

HB 309

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 309 Patient Admission Status Notification
SPONSOR(S): Harrison
TIED BILLS: **IDEN./SIM. BILLS:** SB 786, SB 820

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	13 Y, 0 N	Guzzo	Poche
2) Health Care Appropriations Subcommittee		Clark	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

When a patient enters a hospital, a physician must decide whether or not to admit the individual for inpatient care. The term "observation status" means a hospital patient who is currently considered an outpatient, but is receiving observation services to determine if admission as an inpatient is necessary.

During an observation stay in a hospital, a treating physician may order a variety of outpatient services, including laboratory tests, medication, minor procedures, x-rays, and other imaging services. Observation stays can occur anywhere in the hospital.

A patient on "observation status" may experience higher costs than a patient on admission status for time spent in a hospital because Medicare covers inpatient and outpatient hospital services differently. Medicare Part A covers inpatient hospital services, which requires a one-time deductible covering all hospital services for the first 60 days a patient is in the hospital. A patient on "observation status" is covered under Medicare Part B, which covers outpatient hospital services and requires the patient to pay a copayment for each individual service.

In addition, observation status may affect Medicare coverage for care in a skilled nursing facility (SNF). A patient must have a qualifying inpatient hospital stay, defined as three consecutive days of inpatient care, to be covered by Medicare for SNF care. A patient who qualifies for Medicare and Medicaid will not be responsible for the copayment. A patient under "observation status" in a hospital does not meet the requirements for a qualifying inpatient hospital stay for Medicare coverage for SNF care.

In Florida, hospitals are not required to inform patients of their observation status under current law.

HB 309 requires a hospital to notify a patient that he or she has been placed on observation status rather than admission status before the patient is discharged from the hospital. The bill requires that notice be given to the patient orally and in writing. The written notice must be signed and dated by the patient or the patient's legal guardian and include:

- A statement that the patient is not admitted to the facility but is under observation status;
- A statement that observation status may affect the patient's Medicare, Medicaid, or private insurance coverage; and
- A recommendation that the patient contact his or her health insurance provider to determine the implications of placement in observation status and his or her right to appeal the determination.

The bill appears to have a positive, yet indeterminate fiscal impact and is anticipated to be insignificant.

The bill provides an effective date of July 1, 2015.

This document does not reflect the intent or official position of the bill sponsor or House of Representatives.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Hospital Billing Transparency

Hospitals are licensed and regulated by the Agency for Health Care Administration (AHCA) under part I of ch. 395, F.S.[1] Current law requires hospitals to notify each patient, upon admission and discharge, of the right to receive an itemized bill. Upon request, the hospital must provide the patient an itemized statement detailing the specific nature of the charges or expenses incurred by the patient.[2]

A hospital must also give a patient, prior to providing any non-emergent medical services, within 7 days of a written request, a good faith estimate of reasonably anticipated charges for the facility to treat the patient's condition.[3] Upon request, the hospital must also provide revisions to the estimate.[4] A facility that fails to provide the estimate may be fined $500 for each instance of the facility's failure to provide the requested information.[5]

Patient Status

When a patient enters a hospital, a physician must decide whether or not to admit the individual for inpatient care. Factors to be considered when making a decision to admit a patient include:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of an adverse event;
- The need for diagnostic studies to access whether the patient should be admitted;
- The availability of diagnostic procedures at the time when, and at the location where, the patient presents; and
- Whether the patient is expected to need at least 24 hours of hospital care.[6]

A patient in "observation status" in a hospital is considered an outpatient and receives observation services to determine if admission is necessary.[7] Observation services are commonly ordered for a patient who presents to the emergency department and requires a period of treatment or monitoring in order to make a decision between admission and discharge.[8] Outpatient services can include laboratory tests, medication, minor procedures, x-rays, and other imaging services. Observation stays can occur anywhere in the hospital, including the emergency department, a separate observation unit, or an inpatient unit. The federal Medicare program does not expressly limit the number of days a patient may be on "observation status," but assumes the decision whether to admit or discharge a patient from the hospital can often be made in less than 48 hours; only in rare cases are outpatient observation services required beyond 48 hours.[9]

[1] S. 395.002(16), F.S., defines "licensed facility" as a hospital, ambulatory surgical center, or mobile surgical facility licensed in accordance with ch. 395, F.S. The bill applies to all three facility types because it amends part I of ch. 395, F.S., but will only affect hospitals because ambulatory surgical centers and mobile surgical facilities serve patients who are receiving elective outpatient services and know in advance that they are not going to be admitted to a hospital, barring any complications.
[2] S. 395.301(1), F.S.
[3] S. 395.301(7), F.S.
[4] Id.
[5] Id.
[6] Centers for Medicare and Medicaid Services (CMS), *Medicare Benefit Policy Manual* (MBPM), ch. 1, § 10.
[7] Id. at ch. 6, § 20.6.
[8] Id.
[9] Id.

A patient on "observation status" may experience higher costs than a patient on admission status for time spent in a hospital because Medicare covers inpatient and outpatient hospital services differently. Medicare Part A covers inpatient hospital services, which requires a one-time deductible covering all hospital services for the first 60 days a patient is in the hospital. A patient on "observation status" is covered under Medicare Part B, which covers outpatient hospital services and requires the patient to pay a 20-percent copayment for each individual outpatient hospital service.[10]

In addition, a patient's hospital status may affect their Medicare coverage for care in a skilled nursing facility (SNF). The patient must have a qualifying inpatient hospital stay, defined as three consecutive days of inpatient care, to be covered by Medicare for SNF care.[11] A patient who qualifies for Medicare and Medicaid will not be responsible for the copayment.[12] A patient under "observation status" in a hospital does not meet the requirements for a qualifying inpatient hospital stay for Medicare coverage for SNF care.

Four states have recently enacted legislation to require a hospital to notify a patient within 24 hours of being placed on "observation status".[13] Currently, a Florida hospital is not required to inform a patient of his or her "observation status".

Effect of Proposed Changes

The bill requires hospitals to notify a patient that he or she has been placed on "observation status" rather than "admission status" before the patient is discharged from the hospital. The written notice must be signed and dated by the patient or the patient's legal guardian and include:

- A statement that the patient is not admitted to the facility but is under observation status;
- A statement that "observation status" may affect the patient's Medicare, Medicaid, or private insurance coverage; and
- A recommendation that the patient contact his or her health insurance provider to determine the implications of placement in "observation" status and his or her right to appeal the determination.

The signed written notice must be included in the patient's medical record.

The bill provides an effective date of July 1, 2015.

B. SECTION DIRECTORY:

Section 1: Amends s. 395.301, F.S., relating to itemized patient bill; form and consent prescribed by the agency.
Section 2: Provides an effective date of July 1, 2015.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

[10] 42 CFR § 419.40(b)
[11] 42 CFR § 409.30
[12] 42 CFR § 440.20 Outpatient hospital services are a mandatory Medicaid benefit. For services that both Medicare and Medicaid cover, Medicare pays first, and Medicaid pays second by covering an individual's remaining costs for Medicare coinsurances and copayments.
[13] Connecticut (2014), Substitute House Bill No. 5535, Public Act No. 14-180; Maryland (2013), Senate Bill 195, Chapter 202; New York (2013), Bill S3926A-2013; and Pennsylvania (2013), House Bill No. 1907.

1. Revenues:

   The bill is expected to have a positive, yet indeterminate fiscal impact on AHCA. The bill requires hospitals to provide written notice to a patient that he or she has been placed on "observation status". The hospital must also include the written notification in the patient's medical record. Section 395.1065(2), F.S., authorizes AHCA to impose an administrative fine, not to exceed $1,000 per violation, per day, for a violation of part I of ch. 395, F.S., part II of ch. 408, F.S., or applicable rules. The number of violations and the amount of fines that may be collected are unknown.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Hospitals may realize a minimal increase in administrative costs associated with providing the written notice to a patient on "observation status". Hospitals may also realize an increase in fines for failing to provide the written notice to a patient or include it in a patient's medical record.

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:

The bill requires hospitals to notify a patient that he or she has been placed on "observation status" rather than "admission status" before the patient is discharged from the hospital. A patient is likely to have already incurred charges prior to discharge. A requirement that the hospital notify the patient, within a certain amount of time (i.e., 24 hours), of being placed on "observation status" rather than "admission status" may allow the patient to make alternate arrangements for care and avoid additional charges.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to patient admission status
3 notification; amending s. 395.301, F.S.; providing
4 requirements for licensed facilities for patient
5 notification regarding admission status; providing an
6 effective date.
7
8 Be It Enacted by the Legislature of the State of Florida:
9
10 Section 1. Subsections (9) through (11) of section
11 395.301, Florida Statutes, are renumbered as subsections (10)
12 through (12), respectively, and a new subsection (9) is added to
13 that section to read:
14 395.301 Itemized patient bill; form and content prescribed
15 by the agency; patient admission status notification.—
16 (9)(a) If a licensed facility determines that a patient
17 should be placed on an observation status rather than admission
18 status, the facility shall notify the patient orally and in
19 writing, and include the written notice in the patient's record,
20 of the observation status before the patient is discharged. Such
21 oral and written notice shall include:
22 1. A statement that the patient is not admitted to the
23 facility but is under observation status;
24 2. A statement that observation status may affect the
25 patient's Medicare, Medicaid, or private insurance coverage for:
26 a. Hospital services, including medications and

27 pharmaceutical supplies;
28 b. Home or community-based care or care at a skilled
29 nursing facility, including rehabilitative services, upon the
30 patient's discharge; and
31 c. A recommendation that the patient contact his or her
32 health insurance provider to determine the implications of
33 placement in observation status and his or her right to appeal
34 the determination.
35 (b) The written notice must be signed and dated by the
36 patient receiving the notice or the patient's legal guardian,
37 conservator, or other authorized representative at the time of
38 notification.
39 Section 2. This act shall take effect July 1, 2015.

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

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

1 Committee/Subcommittee hearing bill: Health Care Appropriations
2 Subcommittee
3 Representative Harrison offered the following:
4
5 **Amendment**
6 Remove lines 16-38 and insert:
7 (9) If a licensed facility places a patient on observation
8 rather than inpatient status, observation services shall be
9 documented in the patient's discharge papers. The patient or
10 patient's proxy shall be notified of observation services
11 through discharge papers which may also include brochures,
12 signage, or other forms of communication for this purpose.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 999 Ambulatory Surgical Centers
SPONSOR(S): Health Innovation Subcommittee; Fitzenhagen
TIED BILLS: **IDEN./SIM. BILLS:** SB 1394

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	8 Y, 4 N, As CS	Guzzo	Poche
2) Health Care Appropriations Subcommittee		Clark	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Pursuant to s. 395.002, F.S., an ambulatory surgical center (ASC) is a facility, that is not a part of a hospital, the primary purpose of which is to provide elective surgical care, in which the patient is admitted and discharged within the same working day and is not permitted to stay overnight. Federal law prohibits a patient from staying longer than 24 hours after admission.

The bill changes the allowable length of stay in an ASC from less than one working day to no more than 24 hours, which is the Federal length of stay standard.

The bill creates a new license for a Recovery Care Center (RCC). The new RCC license is modeled after the current licensing procedures for hospitals and ASCs, subjecting RCCs to similar regulatory standards, inspections, and rules.

The bill defines a RCC as a facility the primary purpose of which is to provide recovery care services, to which a patient is admitted and discharged within 72 hours, and which is not part of a hospital. The bill defines recovery care services as:

- Postsurgical and post-diagnostic medical and general nursing care to patients for whom acute hospitalization is not required and an uncomplicated recovery is reasonably expected; and
- Postsurgical rehabilitation services.

Recovery care services do not include intensive care services, coronary care services, or critical care services.

The bill requires all patients to be certified as medically stable and not in need of acute-hospitalization by their attending or referring physician prior to admission in an RCC. A patient may receive recovery care services in an RCC upon:

- Discharge from an ASC after surgery;
- Discharge from a hospital after surgery or other treatment; or
- Receiving an out-patient medical treatment such as chemotherapy.

RCCs must have emergency care and transfer protocols, including transportation arrangements, and referral or admission agreements with at least one hospital.

The bill has an indeterminate, but likely insignificant fiscal impact that can be managed within existing Agency for Health Care Administration resources.

The bill provides an effective date of July 1, 2015.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Ambulatory Surgical Centers (ASCs)

An ASC is a facility, that is not a part of a hospital, the primary purpose of which is to provide elective surgical care, in which the patient is admitted and discharged within the same working day and is not permitted to stay overnight.[1]

In Florida, ambulatory procedures are performed in two settings, hospital-based outpatient facilities and freestanding ASCs. Currently, there are 607 ASCs in Florida, including 402 freestanding ASCs and 205 hospital-based facilities.[2]

In 2013, there were 2,899,326 visits to ASCs in Florida.[3] Hospital outpatient facilities accounted for 46 percent and free standing ASCs accounted for 54 percent of the total number of visits. However, the breakdown of the $31.3 billion in total charges shows that hospital-based facilities accounted for 76 percent of the charges, while ASCs accounted for 24 percent.[4] The average charge at the hospital-based facilities ($17,721) was larger than the average charge at the freestanding ASCs ($4,844).[5] These visits and charges were paid mainly by commercial Insurance and Medicare. Commercial insurance paid for 39 percent of all charges (a total of $12.3 billion), while Medicare paid for 30 percent ($9.5 billion).[6] The next three top payer groups (Medicare Managed Care, Medicaid, and Medicaid Managed Care) accounted for a total of 19 percent ($6.3 billion) of the charge total.[7]

In 2013, the top three procedures accounting for the highest percentage of visits to ASCs were upper gastrointestinal endoscopy, cataract removal, and colonoscopy.[8]

ASC Licensure

ASCs are licensed and regulated by the Agency for Health Care Administration (AHCA) under the same regulatory framework as hospitals.[9]

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[1] Section 395.002(3), F.S. "Ambulatory surgical center" or "mobile surgical facility" means a facility the primary purpose of which is to provide elective surgical care, in which the patient is admitted to and discharged from such facility within the same working day and is not permitted to stay overnight, and which is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy, an office maintained by a physician for the practice of medicine, or an office maintained for the practice of dentistry shall not be construed to be an ambulatory surgical center, provided that any facility or office which is certified or seeks certification as a Medicare ambulatory surgical center shall be licensed as an ambulatory surgical center pursuant to s. 395.003. Any structure or vehicle in which a physician maintains an office and practices surgery, and which can appear to the public to be a mobile office because the structure or vehicle operates at more than one address, shall be construed to be a mobile surgical facility.
[2] Agency for Health Care Administration, *Facilities: All Florida Outpatient Ambulatory Surgical Centers*, available at http://www.floridahealthfinder.gov/CompareCare/ListFacilities.aspx (report generated March 6, 2015).
[3] Agency for Health Care Administration, *Ambulatory Facility Type Visits, 1992-2013*, available at http://floridahealthfinderstore.blob.core.windows.net/documents/researchers/QuickStat/documents/AMBULATORY%20FACILITY%20TYPE%20VISITS%201992-2013.xls (last viewed on March 7, 2015).
[4] Agency for Health Care Administration, *Ambulatory (Outpatient) Surgery Query Results, By Facility Type and Average Charges*, available at http://www.floridahealthfinder.gov/QueryTool/QTResults.aspx (last viewed on March 7, 2015).
[5] Id.
[6] Id., *By Patient, Primary Payer, and Average Charges* (last viewed on March 7, 2015).
[7] Id.
[8] Agency for Health Care Administration, *Ambulatory Surgery and Outpatient Procedures, Visits by Top CPT Codes, 2013*, page 6, available at http://floridahealthfinderstore.blob.core.windows.net/documents/researchers/QuickStat/documents/2013%20Ambulatory%20Quick%20Summary.net.
[9] Sections 395.001-395.1065, F.S., and Part II, Chapter 408, F.S.

Applicants for ASC licensure must submit certain information to AHCA prior to accepting patients for care or treatment, including the:

- Affidavit of compliance with fictitious name;
- Registration of articles of incorporation; and
- ASC's zoning certificate or proof of compliance with zoning requirements.[10]

Upon receipt of an initial application, AHCA is required to conduct a survey to determine compliance with all laws and rules. ASCs are required to provide certain information during the initial inspection, including the:

- Governing body bylaws, rules and regulations;
- Roster of registered nurses and licensed practical nurses with current license numbers;
- Fire plan; and
- Comprehensive Emergency Management Plan.[11]

Rules for ASCs

Pursuant to s. 395.1055, F.S., AHCA is authorized to adopt rules for hospitals and ASCs. Separate standards may be provided for general and specialty hospitals, ASCs, mobile surgical facilities, and statutory rural hospitals, but the rules for all hospitals and ASCs must include minimum standards for ensuring that:

- A sufficient number of qualified types of personnel and occupational disciplines are on duty and available at all times to provide necessary and adequate patient care;
- Infection control, housekeeping, sanitary conditions, and medical record procedures are established and implemented to adequately protect patients;
- A comprehensive emergency management plan is prepared and updated annually;
- Licensed facilities are established, organized, and operated consistent with established standards and rules; and
- Licensed facility beds conform to minimum space, equipment, and furnishing standards

AHCA adopted rule 59A-5, F.A.C., to implement the minimum standards for ASCs.

Staff and Personnel Rules

ASCs are required to have written policies and procedures for surgical services, anesthesia services, nursing services, pharmaceutical services, and laboratory and radiologic services. In providing these services, ACSs are required to have certain professional staff available, including:

- A Registered nurse to serve as operating room circulating nurse;
- An Anesthesiologist or other physician, or a certified registered nurse anesthetist under the on-site medical direction of a licensed physician in the ASC during the anesthesia and post-anesthesia recovery period until all patients are alert or discharged; and
- A Registered professional nurse in the recovery area during the patient's recovery period.[12]

Infection Control Rules

ASCs are required to establish an infection control program, which must include written policies and procedures reflecting the scope of the infection control program. The written policies and procedures

[10] Rule 59A-5.003(4), F.A.C.
[11] Rule 59A-5.003(5), F.A.C.
[12] Rule 59A-5.0085, F.A.C.

must be reviewed at least every two years by the infection control program members. The infection control program must include:

- Surveillance, prevention, and control of infection among patients and personnel;
- A system for identifying, reporting, evaluating and maintaining records of infections;
- Ongoing review and evaluation of aseptic, isolation and sanitation techniques employed by the ASC; and
- Development and coordination of training programs in infection control for all personnel.[13]

Emergency Management Plan Rules

ASCs are required to develop and adopt a written comprehensive emergency management plan for emergency care during an internal or external disaster or emergency. The ASC must review the plan and update it annually.

Accreditation

ASCs may seek voluntary accreditation by the Joint Commission for Health Care Organizations or the Accreditation Association for Ambulatory Health Care. AHCA is required to conduct an annual licensure inspection survey for non-accredited ASCs. AHCA is authorized to accept survey reports of accredited ASCs from accrediting organizations if the standards included in the survey report are determined to document that the ASC is in substantial compliance with state licensure requirements. AHCA is required to conduct annual validation inspections on a minimum of 5 percent of the ASCs which were inspected by an accreditation organization.[14]

AHCA is required to conduct annual life safety inspections of all ASCs to ensure compliance with life safety codes and disaster preparedness requirements. However, the life-safety inspection may be waived if an accreditation inspection was conducted on an ASC by a certified life safety inspector and the ASC was found to be in compliance with the life safety requirements.[15]

In 2014, 373 licensed ASCs in Florida were accredited by a national accrediting organization.[16]

<u>Federal Requirements</u>

Medicare

ASCs are required to have an agreement with the Centers for Medicare and Medicaid Services (CMS) to participate in Medicare. ASCs are also required to comply with specific conditions for coverage. CMS defines "ASC" as any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours[17] following an admission.[18]

CMS may deem an ASC to be in compliance with all of the conditions for coverage if the ASC is accredited by a national accrediting body, or licensed by a state agency, that CMS determines provides

[13] Rule 59A-5.011, F.A.C.
[14] Rule 59A-5.004, F.A.C.
[15] Id.
[16] Agency for Health Care Administration, *Ambulatory Surgical Center Regulatory Overview,* March 2014 (on file with subcommittee staff).
[17] State Operations Manual Appendix L, *Guidance for Surveyors: Ambulatory Surgical Centers* (Rev. 99, 01-31-14) exceeding the 24-hour time frame is expected to be a rare occurrence, and each rare occurrence is expected to be demonstrated to have been something which ordinarily could not have been foreseen. Not meeting this requirement constitutes condition-level noncompliance with §416.25. In addition, review of the cases that exceed the time frame may also reveal noncompliance with CfCs related to surgical services, patient admission and assessment, and quality assurance/performance improvement.
[18] 42 C.F.R. §416.2

reasonable assurance that the conditions are met.[19] All of the CMS conditions for coverage requirements are specifically required in AHCA rule 59A-5, F.A.C., and apply to all ASCs in Florida. The conditions for coverage require ASCs to have a:

- Governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the ASC's total operation;
- Quality assessment and performance improvement program;
- Transfer agreement with one or more acute care general hospitals, which will admit any patient referred who requires continuing care;
- Disaster preparedness plan;
- Organized medical staff;
- Fire control plan;
- Sanitary environment;
- Infection control program; and
- Procedure for patient admission, assessment and discharge.

Recovery Care Centers

Recovery care centers (RCCs) are entities that provide short-term nursing care, support, and pain control for patients that do not require acute hospitalization.[20] RCC patients are typically healthy persons that have had elective surgery. RCCs can be either freestanding or attached to an ASC or hospital. In practice, RCCs typically provide care to patients transferred from ASCs following surgery, which allows ASCs to perform more complex procedures.[21]

RCCs are not eligible for Medicare reimbursement.[22] One 1999 survey noted that RCCs received payment in the following breakdown: 41% from managed care plans, 29% from self-pay, 16% from indemnity plans, and 9% from workers' compensation.[23]

Three states, Arizona, Connecticut, and Illinois, have specific licenses for "recovery care centers."[24] Other states license RCCs as nursing facilities or hospitals.[25] One study found that eighteen states allow RCCs to have stays over 24 hours, usually with a max stay of 72 hours.[26]

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[19] 42 C.F.R. §416.26(1)
[20] MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT FOR POST-SURGICAL RECOVERY CARE CENTERS 3 (2000).
[21] Id. at 4.
[22] *See* MEDICARE PAYMENT ADVISORY COMM'N, *supra* FN 20.
[23] MEDICARE PAYMENT ADVISORY COMM'N, *supra* FN 20, at 6 (citing Federated Ambulatory Surgery Association, Post-Surgical Recovery Care, (2000)).
[24] ARIZ. REV. STAT. ANN. §§ 36-448.51-36-448.55; CONN. AGENCIES REGS. § 19A-495-571; 210 ILL. COMP. STAT. ANN. 3/35.
[25] Sandra Lee Breisch, *Profits in Short Stays*, AM. ACAD. OF ORTHOPAEDIC SURGEONS BULLETIN (June, 1999), *available at* http://www2.aaos.org/bulletin/jun99/asc.htm.
[26] MEDICARE PAYMENT ADVISORY COMM'N, *supra* FN 20, at 4 (citing Federated Ambulatory Surgery Association, Post-Surgical Recovery Care, (2000)).

Comparison of RCC Regulations in Arizona, Connecticut, and Illinois

	Arizona[27]	Connecticut[28]	Illinois[29]
Licensure Required	X	X	X
Written Policies	X	X	X
Maintain Medical Records	X	X	X
Patient's Bill of Rights	X	X	X
Allows Freestanding Facility or Attached	Not Available.	X	X
Length of Stay	Not Available.	Expected 3 days Max 21 days	Expected 48 hours Max 72 hours
Emergency Care Transfer Agreement	Not Available.	With a hospital and an ambulance service.	With a hospital within fifteen minutes travel time.
Prohibited Patients	Patients needing: • Intensive care • Coronary care • Critical care	Patients needing: • Intensive care • Coronary care • Critical care	• Patients with chronic infectious conditions • Children under 3 years of age
Prohibited Services	• Surgical • Radiological • Pediatric • Obstetrical	• Surgical • Radiological • Pre-adolescent pediatric • Hospice • Obstetrical services over 24 week gestation • Intravenous therapy for non-hospital based RCC	• Blood administration (only blood products allowed)
Required Services	• Laboratory • Pharmaceutical • Food	• Pharmaceutical • Dietary • Personal care • Rehabilitation • Therapeutic • Social work	• Laboratory • Pharmaceutical • Food • Radiological
Bed Limitation	Not Available.	Not Available.	20
Required Staff	• Governing authority • Administrator	• Governing body • Administrator	• Consulting committee
Required Medical Personnel	• At least two physicians • Director of nursing	• Medical advisory board • Medical director • Director of nursing	• Medical director • Nursing supervisor
Required Personnel When Patients Are Present	• Director of nursing forty hours per week • One registered nurse • One other nurse	• Two persons for patient care	• One registered nurse • One other nurse

[27] ARIZ. REV. STAT. ANN. §§ 36-448.51-36-448.55; ARIZ. ADMIN. CODE §§ R9-10-501-R9-10-518 (updated in 2013, formerly R9-10-1401-R9-10-1412).
[28] CONN. AGENCIES REGS. § 19A-495-571.
[29] 210 ILL. COMP. STAT. ANN. 3/35; ILL. ADMIN. CODE tit. 77, §§ 210.2500 & 210.2800.

Effect of Proposed Changes

Pursuant to s. 395.002(3), F.S., patients receiving services in an ASC must be discharged on the same working day that they were admitted and they are not permitted to stay overnight. Federal regulations limit the length of stay in an ASC to 24 hours following admission. The bill amends s. 395.002(3), F.S., to permit a patient to stay at an ASC for no longer than 24 hours. The change conforms to the Medicare length of stay requirement.

The bill creates a new license for a Recovery Care Center (RCC). The new RCC license is modeled after the current licensing procedures for hospitals and ASCs in Chapters 395 and 408, F.S. The bill adds RCCs to the list of facilities subject to the provisions of Chapter 395, Part I. An applicant for RCC licensure will have to follow the general licensing procedures of Chapter 408, Part II. Additionally, the applicant will be subject to the license, inspection, safety, facility and other requirements of Chapter 395, Part I.

The bill defines RCC as a facility whose primary purpose is to provide recovery care services, to which the patient is admitted and discharged within 72 hours, and is not part of a hospital. The bill defines recovery care services as:

- Postsurgical and post-diagnostic medical and general nursing care to patients for whom acute-hospitalization is not required and an uncomplicated recovery is reasonably expected; and
- Postsurgical rehabilitation services.

Recovery care services do not include intensive care services, coronary care services, or critical care services.

The bill requires all patients to be certified as medically stable and not in need of acute hospitalization by their attending or referring physician prior to admission in an RCC. A patient may receive recovery care services in an RCC upon:

- Discharge from an ASC after surgery;
- Discharge from a hospital after surgery or other treatment; or
- Receiving an out-patient medical treatment such as chemotherapy.

RCCs must have emergency care and transfer protocols, including transportation arrangements, and referral or admission agreements with at least one hospital. Further, AHCA is authorized to adopt rules to implement admission and discharge procedures.

Section 395.1055, F.S., directs AHCA to adopt rules for hospitals and ASCs that set standards to ensure patient safety, including requirements for:

- Staffing;
- Infection control;
- Housekeeping;
- Medical records;
- Emergency management;
- Inspections;
- Accreditation;
- Organization, including a governing body and organized medical staff;
- Departments and services;
- Quality assessment and improvement;
- Minimum space; and
- Equipment and furnishings.

The bill authorizes AHCA to adopt by rule appropriate standards for RCCs pursuant to s. 395.1055,F.S. In addition, the bill requires AHCA to adopt rules to set standards for dietetic departments, proper use of medications, and pharmacies in RCCs.

The license fee for the RCC license will be set by rule by AHCA and must be at least $1,500.[30]

The bill provides an effective date of July 1, 2015.

B. SECTION DIRECTORY:

Section 1: Amends s. 395.001, F.S., related to legislative intent.
Section 2: Amends s. 395.002, F.S., related to definitions.
Section 3: Amends s. 395.003, F.S., related to licensure; denial, suspension, and revocation.
Section 4: Creates s. 395.0171, F.S., related to recovery care center admissions; emergency and transfer protocols; discharge planning and protocols.
Section 5: Amends s. 395.1055, F.S., related to rules and enforcement.
Section 6: Amends s. 395.10973, F.S., related to powers and duties of the agency.
Section 7: Amends s. 395.301, F.S., related to itemized patient bill; form and content prescribed by the agency.
Section 8: Amends s. 408.802, F.S., related to applicability.
Section 9: Amends s. 408.820, F.S., related to exemptions.
Section 10: Amends s. 394.4787, F.S., related to definitions.
Section 11: Amends s. 409.97, F.S., related to State and local Medicaid partnerships.
Section 12: Amends s. 409.975, F.S., related to managed care plan accountability.
Section 13: Provides an effective date of July 1, 2015.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

Section 408.805, F.S., requires AHCA to set license fees that are reasonably calculated to cover the cost of regulation. The AHCA estimates that five entities may apply for licensure. Applicants for licensure as a RCC will be subject to a Plans and Construction project review fee of $2,000 plus $300 per hour for building plan reviews, an application fee of at least $1,500, and a licensure inspection fee of $400.[31]

2. Expenditures:

The creation of the RCC license will require AHCA to regulate these facilities in accordance with chapters 395 and 408, F.S., and any rules adopted by AHCA. The fees associated with the new license are anticipated to cover the expenses incurred by AHCA in enforcement and regulation of the new license. No additional staff will be required as existing regulatory staff is sufficient to absorb this workload.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

[30] Section 395.004, F.S.
[31] AHCA Agency Bill Analysis, dated March 20, 2015 (on file with Health Care Appropriations Subcommittee Staff).

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Individuals needing surgery may save money by being able to stay longer in an ASC or stay in an RCC rather than having to be transferred to a hospital.

Being able to keep patients longer in an ASC may have a positive fiscal impact on the ASC by being able to perform more complex procedures.

Hospitals may experience a negative fiscal impact if patients receive care in an ASC or RCC.

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

On March 10, 2015, the Health Innovation Subcommittee adopted at strike-all amendment and reported the bill favorably as a committee substitute. The amendment made the following changes to the bill:

- Created a new license for a Recovery Care Center (RCC) modeled after the current licensing procedures for hospitals and ambulatory surgical centers.
- Defined RCC as a facility the primary purpose of which is to provide recovery care services, to which a patient is admitted and discharged within 72 hours, and which is not part of a hospital.
- Defined recovery care services as:
  - Postsurgical and post-diagnostic medical and general nursing care to patients for whom acute-hospitalization is not required and an uncomplicated recovery is reasonably expected; and
  - Postsurgical rehabilitation services.

- Required all patients to be certified as medically stable and not in need of acute hospitalization by their attending or referring physician prior to admission to an RCC.
- Authorized a patient to receive recovery care services in an RCC upon:
  - Discharge from an ambulatory surgical center after surgery;
  - Discharge from a hospital after surgery or other treatment; or
  - Receiving an out-patient medical treatment such as chemotherapy.
- Required RCCs to have emergency care and transfer protocols, including transportation arrangements, and referral or admission agreements with at least one hospital.
- Required RCCs to have procedures for discharge planning and protocols.
- Required AHCA to adopt rules with minimum standards relating to dietetic departments, procedures for proper administration of medications, and pharmacy services.

The analysis is drafted to the committee substitute as passed by the Health Innovation Subcommittee.

1 A bill to be entitled
2 An act relating to recovery care services; amending s.
3 395.001, F.S.; providing legislative intent regarding
4 recovery care centers; amending s. 395.002, F.S.;
5 revising and providing definitions; amending s.
6 395.003, F.S.; including recovery care centers as
7 facilities licensed under chapter 395, F.S.; creating
8 s. 395.0171, F.S.; providing admission criteria for a
9 recovery care center; requiring emergency care,
10 transfer, and discharge protocols; authorizing the
11 Agency for Health Care Administration to adopt rules;
12 amending s. 395.1055, F.S.; authorizing the agency to
13 establish separate standards for the care and
14 treatment of patients in recovery care centers;
15 amending s. 395.10973, F.S.; directing the agency to
16 enforce special-occupancy provisions of the Florida
17 Building Code applicable to recovery care centers;
18 amending s. 395.301, F.S.; providing for format and
19 content of a patient bill from a recovery care center;
20 amending s. 408.802, F.S.; providing applicability of
21 the Health Care Licensing Procedures Act to recovery
22 care centers; amending s. 408.820, F.S.; exempting
23 recovery care centers from specified minimum licensure
24 requirements; amending ss. 394.4787, 409.97, and
25 409.975, F.S.; conforming cross-references; providing
26 an effective date.

27

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

29

30 Section 1. Section 395.001, Florida Statutes, is amended
31 to read:
32 395.001 Legislative intent.—It is the intent of the
33 Legislature to provide for the protection of public health and
34 safety in the establishment, construction, maintenance, and
35 operation of hospitals, ambulatory surgical centers, recovery
36 care centers, and mobile surgical facilities by providing for
37 licensure of same and for the development, establishment, and
38 enforcement of minimum standards with respect thereto.
39 Section 2. Subsections (3), (16), and (23) of section
40 395.002, Florida Statutes, are amended, subsections (25) through
41 (33) are renumbered as subsections (27) through (35),
42 respectively, and new subsections (25) and (26) are added to
43 that section, to read:
44 395.002 Definitions.—As used in this chapter:
45 (3) "Ambulatory surgical center" or "mobile surgical
46 facility" means a facility the primary purpose of which is to
47 provide elective surgical care, in which the patient is admitted
48 to and discharged from such facility within 24 hours ~~the same~~
49 ~~working day and is not permitted to stay overnight,~~ and which is
50 not part of a hospital. However, a facility existing for the
51 primary purpose of performing terminations of pregnancy, an
52 office maintained by a physician for the practice of medicine,

53 or an office maintained for the practice of dentistry shall not
54 be construed to be an ambulatory surgical center, provided that
55 any facility or office which is certified or seeks certification
56 as a Medicare ambulatory surgical center shall be licensed as an
57 ambulatory surgical center pursuant to s. 395.003. Any structure
58 or vehicle in which a physician maintains an office and
59 practices surgery, and which can appear to the public to be a
60 mobile office because the structure or vehicle operates at more
61 than one address, shall be construed to be a mobile surgical
62 facility.
63 (16) "Licensed facility" means a hospital, ambulatory
64 surgical center, recovery care center, or mobile surgical
65 facility licensed in accordance with this chapter.
66 (23) "Premises" means those buildings, beds, and equipment
67 located at the address of the licensed facility and all other
68 buildings, beds, and equipment for the provision of hospital,
69 ambulatory surgical, recovery, or mobile surgical care located
70 in such reasonable proximity to the address of the licensed
71 facility as to appear to the public to be under the dominion and
72 control of the licensee. For any licensee that is a teaching
73 hospital as defined in s. 408.07(45), reasonable proximity
74 includes any buildings, beds, services, programs, and equipment
75 under the dominion and control of the licensee that are located
76 at a site with a main address that is within 1 mile of the main
77 address of the licensed facility; and all such buildings, beds,
78 and equipment may, at the request of a licensee or applicant, be

79 included on the facility license as a single premises.
80 (25) "Recovery care center" means a facility the primary
81 purpose of which is to provide recovery care services, to which
82 a patient is admitted and discharged within 72 hours, and which
83 is not part of a hospital.
84 (26) "Recovery care services" means postsurgical and
85 postdiagnostic medical and general nursing care provided to
86 patients for whom acute care hospitalization is not required and
87 an uncomplicated recovery is reasonably expected. The term
88 includes postsurgical rehabilitation services. The term does not
89 include intensive care services, coronary care services, or
90 critical care services.
91 Section 3. Subsection (1) of section 395.003, Florida
92 Statutes, is amended to read:
93 395.003 Licensure; denial, suspension, and revocation.—
94 (1)(a) The requirements of part II of chapter 408 apply to
95 the provision of services that require licensure pursuant to ss.
96 395.001-395.1065 and part II of chapter 408 and to entities
97 licensed by or applying for such licensure from the Agency for
98 Health Care Administration pursuant to ss. 395.001-395.1065. A
99 license issued by the agency is required in order to operate a
100 hospital, ambulatory surgical center, recovery care center, or
101 mobile surgical facility in this state.
102 (b)1. It is unlawful for a person to use or advertise to
103 the public, in any way or by any medium whatsoever, any facility
104 as a "hospital," "ambulatory surgical center," "recovery care

105 center," or "mobile surgical facility" unless such facility has
106 first secured a license under the provisions of this part.
107 2. This part does not apply to veterinary hospitals or to
108 commercial business establishments using the word "hospital,"
109 "ambulatory surgical center," "recovery care center," or "mobile
110 surgical facility" as a part of a trade name if no treatment of
111 human beings is performed on the premises of such
112 establishments.
113 (c) Until July 1, 2006, additional emergency departments
114 located off the premises of licensed hospitals may not be
115 authorized by the agency.
116 Section 4. Section 395.0171, Florida Statutes, is created
117 to read:
118 395.0171 Recovery care center admissions; emergency and
119 transfer protocols; discharge planning and protocols.—
120 (1) Admissions to a recovery care center shall be
121 restricted to patients who need recovery care services.
122 (2) All patients must be certified by their attending or
123 referring physician or by a physician on staff at the facility
124 as medically stable and not in need of acute care
125 hospitalization before admission.
126 (3) A patient may be admitted for recovery care services
127 upon discharge from a hospital or an ambulatory surgery center.
128 A patient may also be admitted postdiagnosis and posttreatment
129 for recovery care services.
130 (4) A recovery care center must have emergency care and

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

131 transfer protocols, including transportation arrangements, and
132 referral or admission agreements with at least one hospital.
133 (5) A recovery care center must have procedures for
134 discharge planning and discharge protocols.
135 (6) The agency may adopt rules to implement this
136 subsection.
137 Section 5. Subsections (2) and (8) of section 395.1055,
138 Florida Statutes, are amended, and subsection (10) is added to
139 that section, to read:
140 395.1055 Rules and enforcement.—
141 (2) Separate standards may be provided for general and
142 specialty hospitals, ambulatory surgical centers, recovery care
143 centers, mobile surgical facilities, and statutory rural
144 hospitals as defined in s. 395.602.
145 (8) The agency may not adopt any rule governing the
146 design, construction, erection, alteration, modification,
147 repair, or demolition of any public or private hospital,
148 intermediate residential treatment facility, recovery care
149 center, or ambulatory surgical center. It is the intent of the
150 Legislature to preempt that function to the Florida Building
151 Commission and the State Fire Marshal through adoption and
152 maintenance of the Florida Building Code and the Florida Fire
153 Prevention Code. However, the agency shall provide technical
154 assistance to the commission and the State Fire Marshal in
155 updating the construction standards of the Florida Building Code
156 and the Florida Fire Prevention Code which govern hospitals,

157 intermediate residential treatment facilities, recovery care
158 centers, and ambulatory surgical centers.
159 (10) The agency shall adopt rules for recovery care
160 centers which include fair and reasonable minimum standards for
161 ensuring that recovery care centers have:
162 (a) A dietetic department, service, or other similarly
163 titled unit, either on the premises or under contract, which
164 shall be organized, directed, and staffed to ensure the
165 provision of appropriate nutritional care and quality food
166 service.
167 (b) Procedures to ensure the proper administration of
168 medications. Such procedures shall address the prescribing,
169 ordering, preparing, and dispensing of medications and
170 appropriate monitoring of the effects of such medications on the
171 patient.
172 (c) A pharmacy, pharmaceutical department, or
173 pharmaceutical service, or similarly titled unit, on the
174 premises or under contract.
175 Section 6. Subsection (8) of section 395.10973, Florida
176 Statutes, is amended to read:
177 395.10973 Powers and duties of the agency.—It is the
178 function of the agency to:
179 (8) Enforce the special-occupancy provisions of the
180 Florida Building Code which apply to hospitals, intermediate
181 residential treatment facilities, recovery care centers, and
182 ambulatory surgical centers in conducting any inspection

183 authorized by this chapter and part II of chapter 408.
184 Section 7. Subsection (3) of section 395.301, Florida
185 Statutes, is amended to read:
186 395.301 Itemized patient bill; form and content prescribed
187 by the agency.—
188 (3) On each itemized statement submitted pursuant to
189 subsection (1) there shall appear the words "A FOR-PROFIT (or
190 NOT-FOR-PROFIT or PUBLIC) HOSPITAL (or AMBULATORY SURGICAL
191 CENTER or RECOVERY CARE CENTER) LICENSED BY THE STATE OF
192 FLORIDA" or substantially similar words sufficient to identify
193 clearly and plainly the ownership status of the licensed
194 facility. Each itemized statement must prominently display the
195 phone number of the medical facility's patient liaison who is
196 responsible for expediting the resolution of any billing dispute
197 between the patient, or his or her representative, and the
198 billing department.
199 Section 8. Subsection (30) is added to section 408.802,
200 Florida Statutes, to read:
201 408.802 Applicability.—The provisions of this part apply
202 to the provision of services that require licensure as defined
203 in this part and to the following entities licensed, registered,
204 or certified by the agency, as described in chapters 112, 383,
205 390, 394, 395, 400, 429, 440, 483, and 765:
206 (30) Recovery care centers, as provided under part I of
207 chapter 395.
208 Section 9. Subsection (29) is added to section 408.820,

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

209 Florida Statutes, to read:
210 408.820 Exemptions.—Except as prescribed in authorizing
211 statutes, the following exemptions shall apply to specified
212 requirements of this part:
213 (29) Recovery care centers, as provided under part I of
214 chapter 395, are exempt from s. 408.810(7)-(10).
215 Section 10. Subsection (7) of section 394.4787, Florida
216 Statutes, is amended to read:
217 394.4787 Definitions; ss. 394.4786, 394.4787, 394.4788,
218 and 394.4789.—As used in this section and ss. 394.4786,
219 394.4788, and 394.4789:
220 (7) "Specialty psychiatric hospital" means a hospital
221 licensed by the agency pursuant to s. 395.002(30) ~~395.002(28)~~
222 and part II of chapter 408 as a specialty psychiatric hospital.
223 Section 11. Paragraph (a) of subsection (4) of section
224 409.97, Florida Statutes, is amended to read:
225 409.97 State and local Medicaid partnerships.—
226 (4) HOSPITAL RATE DISTRIBUTION.—
227 (a) The agency is authorized to implement a tiered
228 hospital rate system to enhance Medicaid payments to all
229 hospitals when resources for the tiered rates are available from
230 general revenue and such contributions pursuant to subsection
231 (1) as are authorized under the General Appropriations Act.
232 1. Tier 1 hospitals are statutory rural hospitals as
233 defined in s. 395.602, statutory teaching hospitals as defined
234 in s. 408.07(45), and specialty children's hospitals as defined

235 in s. 395.002(30) ~~395.002(28)~~.
236 2. Tier 2 hospitals are community hospitals not included
237 in Tier 1 that provided more than 9 percent of the hospital's
238 total inpatient days to Medicaid patients and charity patients,
239 as defined in s. 409.911, and are located in the jurisdiction of
240 a local funding source pursuant to subsection (1).
241 3. Tier 3 hospitals include all community hospitals.
242 Section 12. Paragraph (b) of subsection (1) of section
243 409.975, Florida Statutes, is amended to read:
244 409.975 Managed care plan accountability.—In addition to
245 the requirements of s. 409.967, plans and providers
246 participating in the managed medical assistance program shall
247 comply with the requirements of this section.
248 (1) PROVIDER NETWORKS.—Managed care plans must develop and
249 maintain provider networks that meet the medical needs of their
250 enrollees in accordance with standards established pursuant to
251 s. 409.967(2)(c). Except as provided in this section, managed
252 care plans may limit the providers in their networks based on
253 credentials, quality indicators, and price.
254 (b) Certain providers are statewide resources and
255 essential providers for all managed care plans in all regions.
256 All managed care plans must include these essential providers in
257 their networks. Statewide essential providers include:
258 1. Faculty plans of Florida medical schools.
259 2. Regional perinatal intensive care centers as defined in
260 s. 383.16(2).

261 3. Hospitals licensed as specialty children's hospitals as
262 defined in s. 395.002(30) ~~395.002(28)~~.
263 4. Accredited and integrated systems serving medically
264 complex children that are comprised of separately licensed, but
265 commonly owned, health care providers delivering at least the
266 following services: medical group home, in-home and outpatient
267 nursing care and therapies, pharmacy services, durable medical
268 equipment, and Prescribed Pediatric Extended Care.
269
270 Managed care plans that have not contracted with all statewide
271 essential providers in all regions as of the first date of
272 recipient enrollment must continue to negotiate in good faith.
273 Payments to physicians on the faculty of nonparticipating
274 Florida medical schools shall be made at the applicable Medicaid
275 rate. Payments for services rendered by regional perinatal
276 intensive care centers shall be made at the applicable Medicaid
277 rate as of the first day of the contract between the agency and
278 the plan. Payments to nonparticipating specialty children's
279 hospitals shall equal the highest rate established by contract
280 between that provider and any other Medicaid managed care plan.
281 Section 13. This act shall take effect July 1, 2015.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1001 Assisted Living Facilities
SPONSOR(S): Ahern
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 382

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	12 Y, 0 N	Guzzo	Poche
2) Health Care Appropriations Subcommittee		Clark	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

HB 1001 strengthens the regulation of Assisted Living Facilities (ALFs) and makes other regulatory changes to improve the quality of ALFs. Specifically, the bill:

- Clarifies who is responsible for assuring that mental health residents in an ALF receive necessary services.
- Requires ALFs to provide information to new residents upon admission that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right.
- Allows licensed register nurses to practice to the full scope of their professional license in ALFs that have a Limited Nursing Services specialty license.
- Creates a provisional Extended Congregate Care (ECC) license for new ALFs and specifies when the Agency for Health Care Administration (AHCA) may deny or revoke a facility's ECC license.
- Requires facilities with one or more, rather than three or more, state supported mental health residents obtain a Limited Mental Health (LMH) license.
- Specifies circumstances under which AHCA must impose an immediate moratorium on a facility.
- Requires AHCA to impose a $500 fine against a facility that does not comply with the background screening requirements of s. 408.809, F.S.
- Allows AHCA to impose a $2,500 fine against a facility that does not show good cause for terminating the residency of an individual.
- Authorizes ALF staff to perform certain additional duties to assist with self-administration of medication and increases the applicable staff training requirements from 4 hours to 6 hours.
- Adds certain responsible parties and agency personnel to the list of people who must report abuse or neglect to the Department of Children and Families' central abuse hotline.
- Requires AHCA to conduct an additional inspection of a facility cited for certain serious violations.
- Requires new facility staff that have not previously completed core training to attend a 2 hour pre-service orientation before interacting with residents.
- Requires the Office of Program Policy Analysis and Government Accountability to conduct a study of inter-surveyor reliability in order to determine the consistency with which regulations are applied to facilities.
- Requires AHCA to add certain content to its website by November 1, 2015, to assist consumers in selecting an ALF.
- Provides an appropriation for two full-time equivalent (FTE) positions with associated salary and rate.

The bill has a significant negative fiscal impact to AHCA. There are no fee revenues to support the appropriation.

The bill provides an effective date of July 1, 2015.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Assisted Living Facility Reform

In April of 2011, the Miami Herald completed a three part investigative series relating to assisted living facilities (ALFs). This series highlighted concerns with the management and administration of ALFs and garnered the attention of not only the public, but many state lawmakers, stakeholders, and facility residents and their families.

Assisted Living Facility Workgroups

In July 2011, Governor Rick Scott directed AHCA to examine the regulation and oversight of ALFs. In response, AHCA created the ALF workgroup. The workgroup's objective was to make recommendations to the Governor and Legislature that would improve the monitoring of safety in ALFs to help ensure the well-being of residents. After a series of meetings, the workgroup produced a final report and recommendations that they felt could strengthen oversight and reassure the public that ALFs are safe. Such recommendations included increasing administrator qualifications, expanding training for administrators and other staff, increasing survey inspection activity, and improving the integration of information among all agencies involved in the regulation of ALFs. The workgroup also noted several other issues that would require more time to evaluate and recommended they be examined by a Phase II workgroup.

Phase II of the workgroup began meeting in June 2012 to resume examining those issues not addressed by Phase I of the workgroup. Phase II of the workgroup will concluded in October, 2012 and produced a final report and recommendations to the Governor and the Legislature on November 26, 2012.

The issue of improving inter-agency communication was included in the workgroup's recommendations. Specifically, the workgroup recommended improving coordination between various federal, state and local agencies with any role in long-term care facilities oversight, especially ALFs. This includes AHCA, the Long Term Care Ombudsman Program, local fire authorities, local health departments, the Department of Children and Families (DCF), the Department of Elder Affairs (DOEA), local law enforcement and the Attorney General's Office.[1]

Assisted Living Facility Negotiated Rulemaking Committee

In June, 2012, DOEA, in consultation with AHCA, DCF, and DOH, began conducting negotiated rulemaking meetings to address ALF regulation. The purpose of the meetings was to draft and amend mutually acceptable proposed rules addressing the safety and quality of services and care provided to residents within ALFs. Most of the issues addressed by the Committee were identified by Phase I of the workgroup as areas of concern that could be reformed via the rulemaking process. The Committee produced a Final Summary Report containing all the proposed rule changes agreed upon by the Committee. These proposed rule changes are currently in the final stages of the standard proposed rule making process required by law.

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[1] Florida Assisted Living Workgroup, Phase II Recommendations, November 26, 2012, available at http://www.ahca.myflorida.com/SCHSCommitteesCouncils/ALWG/index.shtm.

Assisted Living Facilities - General

An ALF is a residential establishment, or part of a residential establishment, that provides housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.[2,3] A personal service is direct physical assistance with, or supervision of, the activities of daily living and the self-administration of medication.[4] Activities of daily living include: ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks.[5]

An ALF is required to provide care and services appropriate to the needs of the residents accepted for admission to the facility.[6] The owner or facility administrator determines whether an individual is appropriate for admission to the facility based on certain criteria.[7] If a resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, as determined by the facility administrator or health care provider, the resident must be discharged in accordance with the Resident Bill of Rights.[8]

As of March 7, 2015, there are 3,042 licensed ALFs in Florida with 88,879 beds.[9] An ALF must have a standard license issued by AHCA, pursuant to part I of ch. 429, F.S., and part II of ch. 408, F.S.

Specialty Licensed Facilities

In addition to a standard license, an ALF may have one or more specialty licenses that allow the ALF to provide additional care. These specialty licenses include: limited nursing services,[10] limited mental health services,[11] and extended congregate care services.[12]

Limited Mental Health License

A mental health resident is "an individual who receives social security disability income due to a mental disorder as determined by the Social Security Administration or receives supplemental security income due to a mental disorder as determined by the Social Security Administration and receives optional state supplementation."[13] A LMH license is required for any facility serving 3 or more mental health residents. [14] To obtain this license, the facility may not have any current uncorrected deficiencies or violations and facility administrator, as well as staff providing direct care to residents must complete 6 hours of training related to LMH duties, which is either provided by or approved by DCF.[15] A LMH license can be obtained during initial licensure, during relicensure, or upon request of the licensee.[16] There are 913 facilities with LMH licenses, providing 14,172 beds.[17]

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[2] S. 429.02(5), F.S.
[3] An ALF does not include an adult family-care home or a non-transient public lodging establishment.
[4] S. 429.02(16), F.S.
[5] S. 429.02(1), F.S.
[6] For specific minimum standards see Rule 58A-5.0182, F.A.C.
[7] S. 429.26, F.S., and Rule 58A-5.0181, F.A.C.
[8] S. 429.28, F.S.
[9] Agency for Health Care Administration, *Facility/Provider Search Results-Assisted Living Facilities*, available at http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx (report generated on March 7, 2015).
[10] S. 429.07(3)(c), F.S.
[11] S. 429.075, F.S.
[12] S. 429.07(3)(b), F.S.
[13] S. 429.02, F.S.
[14] S. 429.075, F.S.
[15] S. 429.075, F.S.
[16] S. 429.075, F.S.
[17] Agency for Health Care Administration, *Assisted Living Facilities with Limited Mental Health*, as of March 2, 2015, available at http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Assisted_Living/docs/alf/Directory_ALF_LMH.pdf (last viewed on March 7, 2015).

Extended Congregate Care License

The ECC specialty license allows an ALF to provide, directly or through contract, services performed by licensed nurses and supportive services to individuals who would otherwise be disqualified from continued residency in an ALF.[18] There are 261 facilities with ECC licenses, providing 16,161 beds.[19]

In order for ECC services to be provided, AHCA must first determine that all requirements in law and rule are met. ECC licensure is regulated pursuant to s. 429.07, F.S., and Rule 58A-5, F.A.C.

The primary purpose of ECC services is to allow residents, as their acuity level rises, to remain in a familiar setting. An ALF licensed to provide ECC services may also admit an individual who exceeds the admission criteria for a facility with a standard license, if the individual is determined appropriate for admission to the ECC facility. A licensed facility must adopt its own requirements within guidelines for continued residency set forth by rule. However, the facility may not serve residents who require 24-hour supervision.

Licensed ECC facilities may provide the following additional services:

- Total help with bathing, dressing, grooming, and toileting;
- Nursing assessments conducted more frequently than monthly;
- Measuring and recording basic vital functions and weight;
- Dietary management, including providing special diets, monitoring nutrition, and observing the resident's food and fluid intake and output;
- Assisting with self-administered medications;
- Supervising residents with dementia and cognitive impairments;
- Health education, counseling, and implementing health-promoting programs;
- Rehabilitative services; and
- Escort services to health-related appointments.[20]

Before being admitted to an ECC licensed facility to receive ECC services, the prospective resident must undergo a medical examination.[21] The ALF must develop a service plan that sets forth how the facility will meet the resident's needs and must maintain a written progress report on each resident who receives ECC services.

ALFs with an ECC license must meet the following staffing requirements:

- Specify a staff member to serve as the ECC supervisor if the administrator does not perform this function;
- The administrator of an ECC licensed facility must have a minimum of 2 years of managerial, nursing, social work, therapeutic recreation, or counseling experience in a residential, long-term care, or acute care setting; and
- A baccalaureate degree may be substituted for one year of the required experience and a nursing home administrator licensed under chapter 468, F.S., shall be considered qualified.[22]

An ECC administrator or supervisor, if different from the administrator, must complete the core training required of a standard licensed ALF administrator (26 hours plus a competency test), and 4 hours of

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[18] S. 429.07(3)(b), F.S.
[19] Agency for Health Care Administration, *Assisted Living Facilities with Extended Congregate Care*, as of March 2, 2015, available at http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Assisted_Living/docs/alf/Directory_ALF_ECC.pdf (last viewed on March 7, 2015).
[20] Rule 58A-5.030(8)(b), F.A.C.
[21] Rule 58A-5.030(6), F.A.C.
[22] Rule 58A-5.030(4), F.A.C.

initial training in ECC care within 3 months of beginning employment. The administrator must complete a minimum of 4 hours of continued education every 2 years.[23]

All staff providing direct ECC care to residents must complete at least 2 hours of initial service training, provided by the administrator, within 6 months of beginning employment.[24]

ALFs with a standard license must pay a biennial license fee of $300 per license, with an additional fee of $50 per resident. The total fee may not exceed $10,000. In addition to the total fee assessed for standard licensed ALFs, facilities providing ECC services must pay an additional fee of $400 per license, with an additional fee of $10 per resident.[25]

Limited Nursing Services License

Limited nursing services are services beyond those provided by standard licensed ALFs. A licensed registered nurse in a facility with a LNS specialty license may only perform certain acts, as specified by rule.[26] Pursuant to Rule 58A-5.031, F.A.C., a licensed registered nurse may provide the following services in an ALF with an LNS license:

- Passive range of motion exercises;
- Ice caps or heat relief;
- Cutting toenails of diabetic residents;
- Ear and Eye irrigations;
- Urine dipstick tests;
- Replacement of urinary catheters;
- Digital stool removal therapies;
- Applying and changing routine dressings that do not require packing or irrigation;
- Care for stage 2 pressure sores;
- Caring for casts, braces and splints;
- Conducting nursing assessments;
- Caring for and monitoring the application of anti-embolism stockings or hosiery;
- Administration and regulation of portable oxygen;
- Applying, caring for and monitoring a transcutaneous electric nerve stimulator; and
- Catheter, colostomy, ileostomy care and maintenance.

A facility holding only a standard or LNS license must meet the admission and continued residency criteria contained in Rule 59A-5.0181, F.A.C.[27] The following admission and continued residency criteria for potential residents must be met:

- Be at least 18 years of age;
- Be free from signs and symptoms of any communicable disease;
- Be able to perform the activities of daily living;
- Be able to transfer, with assistance if necessary;
- Be capable of taking their own medications with assistance from staff if necessary;
- Not be a danger to themselves or others;
- Not require licensed professional mental health treatment on a 24-hour a day basis;
- Not be bedridden;
- Not have any stage 3 or 4 pressure sores;

[23] Rule 58A-5.0191(7), F.A.C.
[24] Id.
[25] S.429.07(4), F.S.
[26] S. 429.02(13), F.S.
[27] Rule 58A-5.031(2), F.A.C.

- Not require nursing services for oral or other suctioning, assistance with tube feeding, monitoring of blood gases, intermittent positive pressure breathing therapy, or treatment of surgical incisions or wounds;
- Not require 24-hour nursing supervision;
- Not require skilled rehabilitative services; and
- Have been determined by the administrator to be appropriate for admission to the facility.[28]

Facilities licensed to provide limited nursing services must employ or contract with a nurse to provide necessary services to facility residents.[29] Licensed LNS facilities must maintain written progress reports on each resident receiving LNS. A registered nurse representing AHCA must visit these facilities at least twice a year to monitor residents and determine compliance.[30] A nursing assessment must be conducted at least monthly on each resident receiving limited nursing services.[31]

Facilities licensed to provide LNS must pay the standard licensure fee of $300 per license, with an additional fee of $50 per resident and the total fee may not exceed $10,000. In addition to the standard fee, in order to obtain the LNS specialty license facilities must pay an additional biennial fee of $250 per license, with an additional fee of $10 per bed.[32] There are 775 facilities with LNS licenses, offering 31,062 slots.[33]

Staff Training

Administrators and Managers

Administrators and other ALF staff must meet minimum training and education requirements established by the DOEA by rule.[34,35] This training and education is intended to assist facilities to appropriately respond to the needs of residents, maintain resident care and facility standards, and meet licensure requirements.[36]

The current ALF core training requirements established by the DOEA consist of a minimum of 26 hours of training and passing a competency test. Administrators and managers must successfully complete the core training requirements within 3 months after becoming a facility administrator or manager. The minimum passing score for the competency test is 75 percent.[37]

Administrators and managers must participate in 12 hours of continuing education in topics related to assisted living every 2 years. A newly hired administrator or manager, who has successfully completed the ALF core training and continuing education requirements, is not required to retake the core training. An administrator or manager, who has successfully completed the core training but has not maintained the continuing education requirements, must retake the ALF core training and retake the competency test.[38]

[28] Rule 58A-5.0181(1), F.A.C.
[29] Rule 58A-5.031(2), F.A.C.
[30] S. 429.07(2)(c), F.S.
[31] Id.
[32] S. 429.07(4)(c), F.S.
[33] Agency for Health Care Administration, *Assisted Living Facilities with Limited Nursing Services*, as of March 2, 2015, available at http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Assisted_Living/docs/alf/Directory_ALF_LNS.pdf (last viewed on March 7, 2015).
[34] Rule 58A-5.0191, F.A.C.
[35] Many of the training requirements in rule may be subject to change due to the recent DOEA negotiated rulemaking process.
[36] S. 429.52(1), F.S.
[37] Administrators who have attended core training prior to July 1, 1997, and managers who attended the core training program prior to April 20, 1998, are not required to take the competency test. Administrators licensed as nursing home administrators in accordance with Part II of Chapter 468, F.S., are exempt from this requirement.
[38] Rule 58A-5.0191, F.A.C.

Staff with Direct Care Responsibilities

Facility administrators or managers are required to provide or arrange for 6 hours of in-service training for facility staff who provide direct care to residents. The training covers a variety of topics as provided by rule.[39] Staff training requirements must generally be met within 30 days after staff begin employment at the facility, however, staff must have at least 1 hour of infection control training before providing direct care to residents. Also, nurses, certified nursing assistants, and home health aides who are on staff with an ALF are exempt from many of the training requirements. In addition to the standard 6 hours of in-service training, staff must also complete 1 hour of elopement training and 1 hour of training on do not resuscitate orders, and may have to complete training on special topics such as self-administration of medication and persons with Alzheimer's disease, if applicable.

ECC Specific Training

The administrator and ECC supervisor, if different from the administrator, must complete 4 hours of initial training in extended congregate care prior to the facility receiving its ECC license or within 3 months after beginning employment in the facility as an administrator or ECC supervisor. They must also complete a minimum of 4 hours of continuing education every 2 years in topics relating to the physical, psychological, or social needs of frail elderly and disabled persons, or persons with Alzheimer's disease or related disorders.[40]

All direct care staff providing care to residents in an ECC program must complete at least 2 hours of in-service training, provided by the facility administrator or ECC supervisor, within 6 months after beginning employment in the facility. The training must address ECC concepts and requirements, including the delivery of personal care and supportive services in an ECC facility.[41]

LMH Specific Training

Administrators, managers, and staff, who have direct contact with mental health residents in a licensed LMH facility must receive a minimum of 6 hours of specialized training in working with individuals with mental health diagnoses and a minimum of 3 hours of continuing education dealing with mental health diagnoses or mental health treatment every 2 years.[42]

Inspections and Surveys

AHCA is required to conduct a survey, investigation, or monitoring visit of an ALF:

- Prior to the issuance of a license.
- Prior to biennial renewal of a license.
- When there is a change of ownership.
- To monitor facilities licensed to provide LNS or ECC services, or facilities cited in the previous year for a class I or class II, or four or more uncorrected class III, violations.[43]
- Upon receipt of an oral or written complaint of practices that threaten the health, safety, or welfare of residents.
- If AHCA has reason to believe a facility is violating a provision of part III of ch. 429, F.S., relating to adult day care centers, or an administrative rule.
- To determine if cited deficiencies have been corrected.
- To determine if a facility is operating without a license.[44]

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[39] See supra, FN 26.
[40] Rule 58A-5.0191(7)(b), F.A.C.
[41] Rule 58A-5.0191(7)(c), F.A.C.
[42] S. 429.075, F.S. and Rule 58A-5.0191(8), F.A.C.
[43] *See below* information under subheading "Violations and Penalties" for a description of each class of violation.
[44] S. 429.34, F.S., and Rule 58A-5.033, F.A.C.

Abbreviated Surveys

An applicant for licensure renewal is eligible for an abbreviated biennial survey by AHCA if the applicant does not have any:

- Class I or class II violations or uncorrected class III violations.
- Confirmed long-term care ombudsman council complaints reported to AHCA by the council.
- Confirmed licensing complaints within the two licensing periods immediately preceding the current renewal date.[45]

An abbreviated survey allows for a quicker and less intrusive survey by narrowing the range of items that AHCA must inspect.[46] AHCA is required to expand an abbreviated survey or conduct a full survey if violations which threaten or potentially threaten the health, safety, or security of residents are identified during an abbreviated survey.[47]

Monitoring Visits

Facilities with LNS or ECC licenses are subject to monitoring visits by AHCA in which the agency inspects the facility for compliance with the requirements of the specialty license type. An LNS licensee is subject to monitoring inspections at least twice a year. At least one registered nurse must be included in the inspection team to monitor residents receiving LNS and to determine if the facility is complying with applicable regulatory requirements.[48] An ECC licensee is subject to quarterly monitoring inspections. At least one registered nurse must be included in the inspection team. AHCA may waive one of the required yearly monitoring visits for an ECC facility that has been licensed for at least 24 months, if the registered nurse who participated in the monitoring inspections determines that the ECC services are being provided appropriately, and there are no serious violations or substantiated complaints about the quality of service or care.[49]

Violations and Penalties

Part II of ch. 408, F.S., provides general licensure standards for all facilities regulated by AHCA. Under s. 408.813, F.S., ALFs may be subject to administrative fines imposed by AHCA for certain types of violations. Violations are categorized into four classes according to the nature of the violation and the gravity of its probable effect on residents.

- Class I violations are those conditions that AHCA determines present an imminent danger to residents or a substantial probability of death or serious physical or emotional harm. Examples include resident death due to medical neglect, risk of resident death due to inability to exit in an emergency, and the suicide of a mental health resident in an ALF licensed for Limited Mental Health. AHCA must issue a fine between $5,000 and $10,000 for each violation.
- Class II violations are those conditions that AHCA determines directly threaten the physical or emotional health, safety, or security of the clients. Examples include having no qualified staff in the facility, the failure to call 911 in a timely manner for resident in a semi-comatose state, and rodents in food storage area. AHCA must issue a fine between $1,000 and $5,000 for each violation.
- Class III violations are those conditions that AHCA determines indirectly or potentially threaten the physical or emotional health, safety, or security of clients. Examples include missing or incomplete resident assessments, erroneous documentation of medication administration, and failure to correct unsatisfactory DOH food service inspection findings in a timely manner. AHCA

[45] Rule 58A-5.033(2), F.A.C.
[46] Rule 58A-5.033(2)(b)
[47] Id.
[48] S. 429.07(3)(c), F.S.
[49] S. 429.07(3)(b), F.S.

must issue a fine between $500 and $1,000 for each violation, but no fine may be imposed if the facility corrects the violation.

- Class IV violations are those conditions that do not have the potential of negatively affecting clients. Examples include failure to file an adverse incident report, incorrect phone numbers posted for advocacy resources, and failure to post current menus. AHCA can only fine a facility (between $100 and $200 for each violation) if the problem is not corrected.[50,51]

Violations for Fiscal Years 2013-14

	Class I Violations	Class II Violations	Class III Violations	Class IV Violations
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Average Fine Amount ALFs With Less than 100 beds	$7,033	$1,862	$602	$300
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

In addition to financial penalties, AHCA can take other actions against a facility. AHCA may deny, revoke, and suspend any license for any of the actions listed in s. 429.14(1)(a)-(k), F.S. AHCA is required to deny or revoke the license of an ALF that has two or more class I violations that are similar to violations identified during a survey, inspection, monitoring visit, or complaint investigation occurring within the previous 2 years.[52] AHCA may also impose an immediate moratorium or emergency suspension on any provider if it determines that any condition presents a threat to the health, safety, or welfare of a client.[53] AHCA is required to publicly post notification of a license suspension or revocation, or denial of a license renewal, at the facility.[54] Finally, Florida's Criminal Code, under ch. 825, F.S., provides criminal penalties for the abuse, neglect, and exploitation of elderly persons[55] and disabled adults.[56]

ALF License Suspensions, Revocations, Denials, Failed to Renew and Closed

	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	Total
[illegible]	1	[illegible]	[illegible]	6	3	[illegible]
Revocations	12	7	17	15	14	65
[illegible]	7	[illegible]	[illegible]	12	[illegible]	[illegible]
Closed/Failed to Renew During Legal Case	40	46	30	28	29	173
Total	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

[50] When fixing the amount of the fine, AHCA must consider the following factors: the gravity of the violation and the extent to which any laws or rules were violated, actions taken to correct the violations, any previous violations, the financial benefit of committing or continuing the violation, and the licensed capacity of the facility. S. 429.19(3), F.S.

[51] S. 429.19(2), F.S.

[52] S. 429.14(4), F.S.

[53] S. 408.814, F.S.

[54] S. 429.14(7), F.S.

[55] "Elderly person" means a person 60 years of age or older who is suffering from the infirmities of aging as manifested by advanced age or organic brain damage, or other physical, mental, or emotional dysfunction, to the extent that the ability of the person to provide adequately for the person's own care or protection is impaired. S. 825.101(5), F.S. It does not constitute a defense to a prosecution for any violation of this chapter that the accused did not know the age of the victim. S. 825.104, F.S.

[56] "Disabled adult" means a person 18 years of age or older who suffers from a condition of physical or mental incapacitation due to a developmental disability, organic brain damage, or mental illness, or who has one or more physical or mental limitations that restrict the person's ability to perform the normal activities of daily living. S. 825.101(4), F.S.

Central Abuse Hotline

The Department of Children and Families is required under s. 415.103, F.S., to establish and maintain a central abuse hotline to receive reports, in writing or through a single statewide toll-free telephone number, of known or suspected abuse, neglect, or exploitation of a vulnerable adult[57] at any hour of the day or night, any day of the week.[58] Persons listed in s. 415.1034, F.S., who know, or have reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited are required to immediately report such knowledge or suspicion to the central abuse hotline.[59]

Personal Property of Residents

Facilities are required under s. 429.27(3), F.S., upon mutual consent with the resident, to provide for the safekeeping of a resident's personal effects not in excess of $500 and funds not in excess of $200 cash. The facility must keep complete and accurate records of all such funds and personal effects received. If a resident is absent from a facility for 24 hours or more, the facility may provide for the safekeeping of the resident's personal effects in excess of $500.

Long-Term Care Ombudsman Program

The Federal Older Americans Act (OAA) requires each state to create a Long-Term Care Ombudsman Program to be eligible to receive funding associated with programs under the OAA.[60] In Florida, the program is a statewide, volunteer-based system of district councils that protect, defend, and advocate on behalf of long-term care facility residents, including residents of nursing homes, ALFs, and adult family-care homes. The ombudsman program is administratively housed in the DOEA and is headed by the State Long-Term Care Ombudsman, who is appointed by the DOEA Secretary.[61] The ombudsman program is required to establish a statewide toll-free telephone number for receiving complaints concerning matters adversely affecting the health, safety, welfare, or rights of residents of ALFs, nursing homes, and adult family care homes. Every resident or representative of a resident must receive, upon admission to a long-term care facility, information regarding the program and the statewide toll-free telephone number for receiving complaints.[62] The names or identities of the complainants or residents involved in a complaint, including any problem identified by an ombudsman council as a result of an investigation, are confidential and exempt from Florida's public records laws, unless the complainant or resident, or the legal representative of the complainant or resident, consents to the disclosure, or the disclosure is required by court order.[63] In addition to investigating and resolving complaints, ombudsmen conduct unannounced visits to assess the quality of care in facilities, referred to as administrative assessments.

Effect of Proposed Changes

Limited Mental Health License

The bill amends s. 394.4574, F.S., to clarify that Medicaid managed care plans are responsible for enrolled state supported mental health residents and that managing entities under contract with the

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[57] "Vulnerable adult" means a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging. S. 415.102(27), F.S.
[58] The central abuse hotline is operated by the DCF to: accept reports for investigation when there is a reasonable cause to suspect that a vulnerable adult has been or is being abused, neglected, or exploited; determine whether the allegations require an immediate, 24-hour, or next-working-day response priority; when appropriate, refer calls that do not allege the abuse, neglect, or exploitation of a vulnerable adult to other organizations that might better resolve the reporter's concerns; immediately identify and locate prior reports of abuse, neglect, or exploitation through the central abuse hotline; Section 415.103(1), F.S.
[59] S. 415.1034, F.S.
[60] 42 U.S.C. 3058, et. seq.. *See also* s. 400.0061(1), F.S.
[61] S. 400.0063, F.S.
[62] S. 400.0078(2), F.S.
[63] S. 400.0077(1)(b), F.S.

DCF are responsible for such residents who are not enrolled with a Medicaid health plan. This section requires a mental health resident's community living support plan be completed and provided to the administrator of the facility within 30 days of admitting a mental health resident and be updated when there is a significant change to the resident's behavioral health status. The resident's case manager must keep a 2-year record of any face-to-face interaction with the resident and make the records available for inspection. Finally, this section charges the case manager responsible for a mental health resident to ensure that there is adequate and consistent monitoring of the community living support plan and to report any concerns about a regulated provider failing to provide services or otherwise acting in a manner with the potential to cause harm to the resident.

The bill amends s. 429.075, F.S., to require facilities with one or more, instead of three or more, mental health residents to obtain a LMH license. It also permits a facility with a LMH license, if it does not have a copy of the resident's community living support plan and cooperative agreement, to provide written evidence that it requested the plan and agreement from the Medicaid managed care plan or the managing entity within 72 hours of the resident's admission.

Long-Term Care Ombudsman Program

Administrative Assessment

The bill amends s. 400.0074, F.S., to require any administrative assessment of an ALF performed by the Long-Term Care Ombudsman to be comprehensive. Further, the bill requires the local Ombudsman to conduct an exit consultation with the long-term care facility administrator to discuss issues and concerns affecting residents and make recommendations for improvement, if necessary.

Resident Grievances

The bill amends s. 400.0078, F.S., to require that ALFs provide information to new residents upon admission to the facility that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. An ALF can also provide this information to the resident's representative.

Extended Congregate Care License

The bill amends s. 429.07, F.S., to make changes to improve the regulation of facilities with ECC and LNS specialty licenses. These changes include:

- Requiring that an ALF be licensed for 2 or more years before being issued an ECC license that is not provisional.
- Clarifying under what circumstances AHCA may deny or revoke a facility's ECC license.
- Creating a provisional ECC license for ALFs that have been licensed for less than 2 years.
- The provisional license lasts for a period of 6 months.
- The facility must inform AHCA when it has admitted one or more residents requiring ECC services.
- After the facility admits one or more ECC residents, AHCA must inspect the facility for compliance with the requirements of the ECC license.
- If the licensee demonstrates compliance with the requirements of an ECC license, AHCA must grant the facility an ECC license.
- If the licensee fails to demonstrate compliance with the requirements of an ECC license or fails to admit an ECC resident within 3 months, the licensee must immediately suspend ECC services and the provisional ECC license expires.
- Authorizing AHCA to extend a provisional ECC license for 1 month in order to compete a follow-up visit.

- Reducing monitoring visits for facilities with ECC licenses from quarterly to twice a year, and for facilities with LNS licenses from twice a year to once a year.
- Clarifying under what circumstances AHCA may waive one of the required monitoring visits for facilities with ECC licenses and also allowing AHCA to waive the required monitoring visit for facilities with an LNS license under the same conditions.

Violations and Penalties

The bill amends s. 429.14, F.S., to:

- Add additional criteria under which AHCA must deny or revoke a facility's license. The criteria include:
  - There are 2 moratoria issued and imposed by final order within a 2-year period.
  - The facility is cited for 2 or more class I violations arising from unrelated circumstances during the same survey or investigation.
  - The facility is cited for 2 or more class I violations within 2 years.
- Require AHCA to impose an immediate moratorium on a facility that fails to provide AHCA with access to the facility or prohibits a regulatory inspection;
- Prohibit a licensee from restricting AHCA staff access to records or prohibiting the confidential interview of facility staff or residents.
- Exempt a facility from the 45-day notice requirement in s. 429.28(k), F.S., if that facility is required to relocate all or some of its residents due to action by AHCA.

The bill amends s. 429.19, F.S., to require AHCA to impose an administrative fine of $500 if a facility is found to be not in compliance with the background screening requirements of s. 408.809, F.S.

Assistance with Self-Administration of Medication

The bill amends s. 429.256, F.S., to allow all facility staff who received the required training to provide several additional services in assisting with self-administration of medication.[64] Specifically, the additional duties are:

- Taking a prefilled insulin syringe from its place of storage and bringing it to a resident;
- Removing the cap of a nebulizer, opening the unit dose of nebulizer solution, and pouring the pre-measured dose of medication into the dispensing cup of the nebulizer;

[64] Staff involved with the management of medications and assisting with the self-administration of medications under s. 429.256, F.S., must complete a minimum of 4 additional hours of training provided by a registered nurse, licensed pharmacist, or department staff. The department shall establish by rule the minimum requirements of this additional training. Section 429.52(5), F.S. Unlicensed persons who will be providing assistance with self-administered medications must meet the training requirements pursuant to s. 429.52(5), F.S., prior to assuming this responsibility. Courses provided in fulfillment of this requirement must meet the following criteria: Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques and provide opportunities for hands-on learning through practice exercises. The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates an ability to: Read and understand a prescription label; Provide assistance with self-administration in accordance with Section 429.256, F.S., and Rule 58A-5.0185, F.A.C., including: Assist with oral dosage forms, topical dosage forms, and topical ophthalmic, otic and nasal dosage forms; Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; Recognize the need to obtain clarification of an "as needed" prescription order; Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; Complete a medication observation record; Retrieve and store medication; and Recognize the general signs of adverse reactions to medications and report such reactions. Unlicensed persons, as defined in Section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 4 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training shall only be provided by a licensed registered nurse, or a licensed pharmacist. Rule 58A-5.0191(5), F.A.C.

- Assisting a resident in using a nebulizer;
- Using a glucometer to perform blood glucose checks;
- Assisting with anti-embolism stockings;
- Assisting with applying and removing an oxygen cannula;
- Assisting with the use of a continuous positive airway pressure device;
- Assisting with the measuring of vital signs; and
- Assisting with the use of colostomy bags.

Personal Property of Residents

The bill amends s. 429.27(3), F.S., to increase the amount of cash that a facility may provide sake-keeping of for a resident from $200 to $500.

Resident Bill of Rights

The bill amends s. 429.28, F.S., to require that the telephone number of Disability Rights Florida (DRF) be included in the posted notice of a resident's rights, obligations, and prohibitions, and that the facility ensure each resident have access to a telephone call DRF. The notice must also specify that complaints made to the ombudsman program, as well as the names and identities of the complainant and any residents involved in the complaint, are confidential and that retaliatory action cannot be taken against a resident for presenting a grievance or exercising a right. This section also creates a fine of $2,500, which is imposed if a facility cannot show good cause in state court for terminating the residency of an individual who has exercised an enumerated right.

The bill requires AHCA to adopt rules for uniform standards and criteria that will be used to determine a facility's compliance with facility standards and residents' rights.

Right of Entry and Inspection

The bill amends s. 429.34, F.S., to require certain state officials, such as Medicaid Fraud investigators and state or local fire marshals, to report any knowledge or reasonable suspicion that a vulnerable adult has been or is being abused, neglected, or exploited to the DCF central abuse hotline.

The bill requires AHCA to inspect each licensed ALF at least once every 24 months to determine compliance with statute and rules. The bill provides that a facility having one or more class I violations, two or more class II violations arising from separate surveys within a 60-day period, or two or more unrelated class II violations cited during one survey be subject to an additional inspection within 6 months.

The bill creates a new, unnumbered section of statute which requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) to conduct a study of inter-surveyor reliability to determine if different surveyors consistently apply licensure standards. The bill requires OPPAGA to report its findings and make recommendations to the Governor, the President of the Senate, and the Speaker of the House by January 1, 2016.

Staffing and Training Requirements

The bill amends s. 429.41, F.S., to clarify that ALF staffing requirements for a continuing care facility or retirement community apply only to residents who receive personal limited nursing services or extended congregate care services. The facility must keep a log of the names and unit numbers of residents receiving such services and make the log available to surveyors upon request.

The bill amends s. 429.52, F.S., to require facilities to provide a 2-hour pre service orientation for all new facility employees who have not previously completed core training. The pre-service orientation must cover topics that help the employee provide responsible care and respond to the needs of the

residents. The employee and the facility's administrator must sign a statement that the new ALF staff member has completed the pre-service orientation. The signed statement must be kept in that staff member's file. The bill clarifies that the pre-service orientation can be provided by the ALF instead of a trainer registered with DOEA.

Consumer Information Resources

The bill creates s. 429.55, F.S., which provides Legislative findings that consumers need additional information in order to select an ALF. To facilitate this, the bill requires AHCA to create a consumer guide website which contains information on each licensed ALF. By November 1, 2015, the website must include:

- The name and address of the facility;
- The name of the owner or operator of the facility;
- The number and type of licensed beds in the facility;
- The types of licenses held by the facility;
- The facility's license expiration date and status;
- The total number of clients that the facility is licensed to serve and the most recent occupancy levels;
- The number of private and semi-private rooms offered;
- The bed-hold policy;
- The religious affiliation, if any, of the ALF;
- The languages spoken by the staff;
- Availability of nurses;
- Forms of payment accepted;
- Identification if the licensee is operating under bankruptcy protection;
- Recreational and other programs available;
- Special care units or programs offered;
- Whether the facility is part of a retirement community that offers other services;
- Links to the State Long-Term Care Ombudsman Program website and the program's statewide toll-free telephone number;
- Links to the internet websites of the providers;
- Other relevant information currently collected by AHCA; and
- Survey and violation information including a list of the facility's violations committed during the previous 60 months, which must be updated monthly and include for each violation:
    - A summary of the violation, with all licensure, revisit, and complaint survey information;
    - Any sanctions imposed by final order; and
    - The date the corrective action was confirmed by AHCA; and
- Links to inspection reports on file with AHCA.

For fiscal year 2015-2016, the bill appropriates $159,308 ($151,322 recurring and $7,986 nonrecurring) and authorizes two FTEs to carry out the regulatory activities provided in the bill.

The bill provides an effective date of July 1, 2015.

B. SECTION DIRECTORY:

Section 1: Amends s. 394.4574, F.S., relating to department responsibilities for a mental health resident who resides in an assisted living facility that holds a limited mental health license.
Section 2: Amends s. 400.0074, F.S., relating to local ombudsman council onsite administrative assessments.
Section 3: Amends s. 400.0078, F.S., relating to citizen access to State Long-Term Care Ombudsman Program services.
Section 4: Amends s. 409.212, F.S., relating to optional supplementation.

Section 5: Amends s. 429.02, F.S., relating to definitions.
Section 6: Amends s. 429.07, F.S., relating to license required; fee.
Section 7: Amends s. 429.075, F.S., relating to limited mental health license.
Section 8: Amends s. 429.14, F.S., relating to administrative penalties.
Section 9: Amends s. 429.178, F.S., relating to special care for persons with Alzheimer's disease or other related disorders.
Section 10: Amends s. 429.19, F.S., relating to violations; imposition of administrative fines; grounds.
Section 11: Amends s. 429.256, F.S., relating to assistance with self-administration of medication.
Section 12: Amends s. 429.27, F.S., relating to property and personal affairs of residents.
Section 13: Amends s. 429.28, F.S., relating to resident bill of rights.
Section 14: Amends s. 429.34, F.S., relating to right of entry and inspection.
Section 15: Amends s. 429.41, F.S., relating to rules establishing standards.
Section 16: Amends s. 429.52, F.S., relating to staff training and educational programs; core educational requirements.
Section 17: Creates s. 429.55, F.S., relating to consumer information website.
Section 18: In an unnamed section of law, requires the Office of Program Policy Analysis and Government Accountability to conduct a study of survey reliability for assisted living facilities and submit a report of its findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2016.
Section 19: For fiscal year 2015-2016, appropriates $151,322 in recurring funds and $7,986 in non-recurring funds from the Health Care Trust Fund to AHCA and authorizes two FTEs for the purposes of carrying out the regulatory activities provided in the act.
Section 20: Provides an effective date of July 1, 2015.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill provides an appropriation for two full-time equivalent positions and associated salary rate and the sums of $7,986 in nonrecurring funds and $151,322 in recurring funds for AHCA to carry out the regulatory activities included within the bill.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Facilities would be required to provide new employees that have not already gone through the ALF core training program with a 2 hour pre-service training session before they work with residents. The cost of this training is not expected to be significant and in many cases is already provided.

Facilities with specialty licenses that meet licensure standards would see fewer monitoring visits from the AHCA. This will positively impact the facilities as they will have less interruption of staff time due to such visits.

Facilities with any state supported mentally ill residents would have to meet limited mental health licensure requirements with one or more mental health residents. Facilities with one or two state supported mentally ill residents that do not meet these requirements may see increased costs to comply. Some facilities with one or two such residents however, may already meet the requirements for a limited mental health license.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill provides AHCA with sufficient rulemaking authority, as necessary, to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to assisted living facilities;
3 amending s. 394.4574, F.S.; providing that Medicaid
4 managed care plans are responsible for enrolled mental
5 health residents; providing that managing entities
6 under contract with the Department of Children and
7 Families are responsible for mental health residents
8 who are not enrolled with a Medicaid managed care
9 plan; requiring that a community living support plan
10 be completed and provided to the administrator of a
11 facility within a specified period after the
12 resident's admission; requiring that the community
13 living support plan be updated when there is a
14 significant change to the mental health resident's
15 behavioral health; requiring a mental health resident
16 case manager to keep certain records of interactions
17 with the resident and to make the records available
18 for inspection; requiring retention of the records for
19 a specified period; requiring the responsible entity
20 to ensure monitoring and implementation of community
21 living support plans and cooperative agreements;
22 amending s. 400.0074, F.S.; requiring a local
23 ombudsman council to conduct comprehensive onsite
24 administrative assessments; requiring a local council
25 to conduct an exit consultation with the facility
26 administrator or administrator designee; amending s.

27 400.0078, F.S.; requiring that a long-term care
28 resident or resident representative be informed of
29 resident immunity from retaliatory action for
30 presenting grievances or exercising resident rights;
31 amending s. 409.212, F.S.; increasing the cap on
32 additional supplementation that a person may receive
33 under certain conditions; amending s. 429.02, F.S.;
34 revising the definition of the term "limited nursing
35 services"; amending s. 429.07, F.S.; requiring that an
36 extended congregate care license be issued to certain
37 facilities licensed as assisted living facilities
38 under certain circumstances and authorizing the
39 issuance of such license if a specified condition is
40 met; providing that the initial extended congregate
41 care license is provisional under certain
42 circumstances; requiring a licensee to notify the
43 agency of acceptance of a resident who qualifies for
44 extended congregate care services; requiring the
45 agency to inspect the facility for compliance with
46 license requirements; requiring the licensee to
47 suspend extended congregate care services under
48 certain circumstances; revising the frequency of
49 monitoring visits to a facility by a registered nurse
50 representing the agency; authorizing the agency to
51 waive a required yearly monitoring visit under certain
52 circumstances; authorizing the agency to deny or

53 revoke a facility's extended congregate care license;
54 authorizing the agency to waive the required yearly
55 monitoring visit for a facility that is licensed to
56 provide limited nursing services under certain
57 circumstances; amending s. 429.075, F.S.; requiring an
58 assisted living facility that serves mental health
59 residents to obtain a limited mental health license;
60 requiring a limited mental health facility to provide
61 written evidence that certain documentation was sent
62 to the department within a specified period; amending
63 s. 429.14, F.S.; requiring the agency to deny or
64 revoke the license of an assisted living facility
65 under certain circumstances; requiring the agency to
66 impose an immediate moratorium on the license of an
67 assisted living facility under certain circumstances;
68 deleting a requirement that the agency provide a list
69 of facilities with denied, suspended, or revoked
70 licenses to the Department of Business and
71 Professional Regulation; exempting a facility from the
72 45-day notice requirement if it is required to
73 relocate residents; amending s. 429.178, F.S.;
74 conforming cross-references; amending s. 429.19, F.S.;
75 requiring the agency to levy a fine for violations
76 that are corrected before an inspection if
77 noncompliance occurred within a specified period of
78 time; amending s. 429.256, F.S.; revising the term

79 "assistance with self-administration of medication" as
80 it relates to the Assisted Living Facilities Act;
81 amending s. 429.27, F.S.; revising the amount of cash
82 for which a facility may provide safekeeping for a
83 resident; amending s. 429.28, F.S.; providing notice
84 requirements regarding confidentiality of resident
85 identity in a complaint made to the State Long-Term
86 Care Ombudsman Program or a local long-term care
87 ombudsman council and immunity from retaliatory action
88 for presenting grievances or exercising resident
89 rights; providing a fine if a facility terminates an
90 individual's residency after the filing of a complaint
91 if good cause is not shown for the termination;
92 requiring the agency to adopt rules; amending s.
93 429.34, F.S.; requiring certain persons to report
94 elder abuse in assisted living facilities; requiring
95 the agency to regularly inspect a licensed assisted
96 living facility; requiring the agency to conduct
97 periodic inspections; amending s. 429.41, F.S.;
98 providing that certain staffing requirements apply
99 only to residents in continuing care facilities who
100 are receiving certain services; amending s. 429.52,
101 F.S.; requiring each newly hired employee of an
102 assisted living facility to attend a preservice
103 orientation; requiring the employee and administrator
104 to sign a statement of completion and keep the

105 statement in the employee's personnel record;
106 requiring additional hours of training for assistance
107 with medication; creating s. 429.55, F.S.; directing
108 the agency to create an assisted living facility
109 consumer information website; providing criteria for
110 webpage content; providing content requirements;
111 authorizing the agency to adopt rules; requiring the
112 Office of Program Policy Analysis and Government
113 Accountability to study the reliability of facility
114 surveys and submit to the Governor and the Legislature
115 its findings and recommendations; providing
116 appropriations and authorizing positions; providing an
117 effective date.
118
119 Be It Enacted by the Legislature of the State of Florida:
120
121 Section 1. Section 394.4574, Florida Statutes, is amended
122 to read:
123 394.4574 ~~Department~~ Responsibilities for coordination of
124 services for a mental health resident who resides in an assisted
125 living facility that holds a limited mental health license.—
126 (1) As used in this section, the term "mental health
127 resident~~,~~" ~~for purposes of this section,~~ means an individual who
128 receives social security disability income due to a mental
129 disorder as determined by the Social Security Administration or
130 receives supplemental security income due to a mental disorder

131 as determined by the Social Security Administration and receives
132 optional state supplementation.
133 (2) <u>Medicaid managed care plans are responsible for</u>
134 <u>Medicaid enrolled mental health residents, and managing entities</u>
135 <u>under contract with the department are responsible for mental</u>
136 <u>health residents who are not enrolled in a Medicaid health plan.</u>
137 <u>A Medicaid managed care plan or a managing entity shall</u> ~~The~~
138 ~~department must~~ ensure that:
139 (a) A mental health resident has been assessed by a
140 psychiatrist, clinical psychologist, clinical social worker, or
141 psychiatric nurse, or an individual who is supervised by one of
142 these professionals, and determined to be appropriate to reside
143 in an assisted living facility. The documentation must be
144 provided to the administrator of the facility within 30 days
145 after the mental health resident has been admitted to the
146 facility. An evaluation completed upon discharge from a state
147 mental hospital meets the requirements of this subsection
148 related to appropriateness for placement as a mental health
149 resident if it was completed within 90 days <u>before</u> ~~prior to~~
150 admission to the facility.
151 (b) A cooperative agreement, as required in s. 429.075, is
152 developed <u>by</u> ~~between~~ the mental health care services provider
153 that serves a mental health resident and the administrator of
154 the assisted living facility with a limited mental health
155 license in which the mental health resident is living. ~~Any~~
156 ~~entity that provides Medicaid prepaid health plan services shall~~

157 ~~ensure the appropriate coordination of health care services with~~
158 ~~an assisted living facility in cases where a Medicaid recipient~~
159 ~~is both a member of the entity's prepaid health plan and a~~
160 ~~resident of the assisted living facility. If the entity is at~~
161 ~~risk for Medicaid targeted case management and behavioral health~~
162 ~~services, the entity shall inform the assisted living facility~~
163 ~~of the procedures to follow should an emergent condition arise.~~
164 (c) The community living support plan, as defined in s.
165 429.02, has been prepared by a mental health resident and <u>his or</u>
166 <u>her</u> ~~a~~ mental health case manager ~~of that resident~~ in
167 consultation with the administrator of the facility or the
168 administrator's designee. The plan must be <u>completed and</u>
169 provided to the administrator of the assisted living facility
170 with a limited mental health license in which the mental health
171 resident lives <u>within 30 days after the resident's admission</u>.
172 The support plan and the agreement may be in one document.
173 (d) The assisted living facility with a limited mental
174 health license is provided with documentation that the
175 individual meets the definition of a mental health resident.
176 (e) The mental health services provider assigns a case
177 manager to each mental health resident <u>for whom the entity is</u>
178 <u>responsible</u> ~~who lives in an assisted living facility with a~~
179 ~~limited mental health license~~. The case manager <u>shall coordinate</u>
180 ~~is responsible for coordinating~~ the development ~~of~~ and
181 implementation of the community living support plan defined in
182 s. 429.02. The plan must be updated at least annually<u>, or when</u>

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183 there is a significant change in the resident's behavioral
184 health status. Each case manager shall keep a record of the date
185 and time of any face-to-face interaction with the resident and
186 make the record available to the responsible entity for
187 inspection. The record must be retained for at least 2 years
188 after the date of the most recent interaction.
189 (f) Consistent monitoring and implementation of community
190 living support plans and cooperative agreements are conducted by
191 the resident's case manager.
192 (g) Concerns are reported to the appropriate regulatory
193 oversight organization if a regulated provider fails to deliver
194 appropriate services or otherwise acts in a manner that has the
195 potential to result in harm to the resident.
196 (3) The Secretary of Children and Families, in
197 consultation with the Agency for Health Care Administration,
198 shall ~~annually~~ require each district administrator to develop,
199 with community input, a detailed annual plan that demonstrates
200 ~~detailed plans that demonstrate~~ how the district will ensure the
201 provision of state-funded mental health and substance abuse
202 treatment services to residents of assisted living facilities
203 that hold a limited mental health license. This plan ~~These plans~~
204 must be consistent with the substance abuse and mental health
205 district plan developed pursuant to s. 394.75 and must address
206 case management services; access to consumer-operated drop-in
207 centers; access to services during evenings, weekends, and
208 holidays; supervision of the clinical needs of the residents;

209 and access to emergency psychiatric care.
210 Section 2. Subsection (1) of section 400.0074, Florida
211 Statutes, is amended, and paragraph (h) is added to subsection
212 (2) of that section, to read:
213 400.0074 Local ombudsman council onsite administrative
214 assessments.—
215 (1) In addition to any specific investigation conducted
216 pursuant to a complaint, the local council shall conduct, at
217 least annually, an onsite administrative assessment of each
218 nursing home, assisted living facility, and adult family-care
219 home within its jurisdiction. This administrative assessment
220 must be comprehensive in nature and must ~~shall~~ focus on factors
221 affecting residents' ~~the~~ rights, health, safety, and welfare ~~of~~
222 ~~the residents~~. Each local council is encouraged to conduct a
223 similar onsite administrative assessment of each additional
224 long-term care facility within its jurisdiction.
225 (2) An onsite administrative assessment conducted by a
226 local council shall be subject to the following conditions:
227 (h) Upon completion of an administrative assessment, the
228 local council shall conduct an exit consultation with the
229 facility administrator or a designee representing the facility
230 to discuss issues and concerns in areas affecting residents'
231 rights, health, safety, and welfare and, if needed, make
232 recommendations for improvement.
233 Section 3. Subsection (2) of section 400.0078, Florida
234 Statutes, is amended to read:

235 400.0078 Citizen access to State Long-Term Care Ombudsman
236 Program services.—
237 (2) ~~Every resident or representative of a resident shall~~
238 ~~receive,~~ Upon admission to a long-term care facility, each
239 resident or representative of a resident must receive
240 information regarding the purpose of the State Long-Term Care
241 Ombudsman Program, the statewide toll-free telephone number for
242 receiving complaints, information that retaliatory action cannot
243 be taken against a resident for presenting grievances or for
244 exercising any other resident right, and other relevant
245 information regarding how to contact the program. Each resident
246 or his or her representative ~~Residents or their representatives~~
247 must be furnished additional copies of this information upon
248 request.
249 Section 4. Paragraph (c) of subsection (4) of section
250 409.212, Florida Statutes, is amended to read:
251 409.212 Optional supplementation.—
252 (4) In addition to the amount of optional supplementation
253 provided by the state, a person may receive additional
254 supplementation from third parties to contribute to his or her
255 cost of care. Additional supplementation may be provided under
256 the following conditions:
257 (c) The additional supplementation shall not exceed four
258 ~~two~~ times the provider rate recognized under the optional state
259 supplementation program.
260 Section 5. Subsection (13) of section 429.02, Florida

261 Statutes, is amended to read:
262 429.02 Definitions.—When used in this part, the term:
263 (13) "Limited nursing services" means acts that may be
264 performed by a person licensed under ~~pursuant to~~ part I of
265 chapter 464 ~~by persons licensed thereunder while carrying out~~
266 ~~their professional duties but limited to those acts which the~~
267 ~~department specifies by rule~~. ~~Acts which may be specified by~~
268 ~~rule as allowable~~ Limited nursing services shall be for persons
269 who meet the admission criteria established by the department
270 for assisted living facilities and shall not be complex enough
271 to require 24-hour nursing supervision and may include such
272 services as the application and care of routine dressings, and
273 care of casts, braces, and splints.
274 Section 6. Paragraphs (b) and (c) of subsection (3) of
275 section 429.07, Florida Statutes, are amended to read:
276 429.07 License required; fee.—
277 (3) In addition to the requirements of s. 408.806, each
278 license granted by the agency must state the type of care for
279 which the license is granted. Licenses shall be issued for one
280 or more of the following categories of care: standard, extended
281 congregate care, limited nursing services, or limited mental
282 health.
283 (b) An extended congregate care license shall be issued to
284 each facility that has been licensed as an assisted living
285 facility for 2 or more years and that provides services
286 ~~facilities providing~~, directly or through contract, ~~services~~

287 beyond those authorized in paragraph (a), including services
288 performed by persons licensed under part I of chapter 464 and
289 supportive services, as defined by rule, to persons who would
290 otherwise be disqualified from continued residence in a facility
291 licensed under this part. An extended congregate care license
292 may be issued to a facility that has a provisional extended
293 congregate care license and meets the requirements for licensure
294 under subparagraph 2. The primary purpose of extended congregate
295 care services is to allow residents the option of remaining in a
296 familiar setting from which they would otherwise be disqualified
297 for continued residency as they become more impaired. A facility
298 licensed to provide extended congregate care services may also
299 admit an individual who exceeds the admission criteria for a
300 facility with a standard license, if he or she is determined
301 appropriate for admission to the extended congregate care
302 facility.
303 1. In order for extended congregate care services to be
304 provided, the agency must first determine that all requirements
305 established in law and rule are met and must specifically
306 designate, on the facility's license, that such services may be
307 provided and whether the designation applies to all or part of
308 the facility. This ~~Such~~ designation may be made at the time of
309 initial licensure or relicensure, or upon request in writing by
310 a licensee under this part and part II of chapter 408. The
311 notification of approval or the denial of the request shall be
312 made in accordance with part II of chapter 408. Each existing

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313 facility that qualifies ~~facilities qualifying~~ to provide
314 extended congregate care services must have maintained a
315 standard license and may not have been subject to administrative
316 sanctions during the previous 2 years, or since initial
317 licensure if the facility has been licensed for less than 2
318 years, for any of the following reasons:
319 a. A class I or class II violation;
320 b. Three or more repeat or recurring class III violations
321 of identical or similar resident care standards from which a
322 pattern of noncompliance is found by the agency;
323 c. Three or more class III violations that were not
324 corrected in accordance with the corrective action plan approved
325 by the agency;
326 d. Violation of resident care standards which results in
327 requiring the facility to employ the services of a consultant
328 pharmacist or consultant dietitian;
329 e. Denial, suspension, or revocation of a license for
330 another facility licensed under this part in which the applicant
331 for an extended congregate care license has at least 25 percent
332 ownership interest; or
333 f. Imposition of a moratorium pursuant to this part or
334 part II of chapter 408 or initiation of injunctive proceedings.
335
336 The agency may deny or revoke a facility's extended congregate
337 care license for not meeting the criteria for an extended
338 congregate care license as provided in this subparagraph.

339 2. If an assisted living facility has been licensed for
340 less than 2 years, the initial extended congregate care license
341 must be provisional and may not exceed 6 months. The licensee
342 shall notify the agency, in writing, when it has admitted at
343 least one extended congregate care resident, after which an
344 unannounced inspection shall be made to determine compliance
345 with the requirements of an extended congregate care license. A
346 licensee with a provisional extended congregate care license
347 that demonstrates compliance with all the requirements of an
348 extended congregate care license during the inspection shall be
349 issued an extended congregate care license. In addition to
350 sanctions authorized under this part, if violations are found
351 during the inspection and the licensee fails to demonstrate
352 compliance with all assisted living facility requirements during
353 a followup inspection, the licensee shall immediately suspend
354 extended congregate care services, and the provisional extended
355 congregate care license expires. The agency may extend the
356 provisional license for not more than 1 month in order to
357 complete a followup visit.
358 3.~~2.~~ A facility that is licensed to provide extended
359 congregate care services shall maintain a written progress
360 report on each person who receives services which describes the
361 type, amount, duration, scope, and outcome of services that are
362 rendered and the general status of the resident's health. A
363 registered nurse, or appropriate designee, representing the
364 agency shall visit the facility at least twice a year ~~quarterly~~

365 to monitor residents who are receiving extended congregate care
366 services and to determine if the facility is in compliance with
367 this part, part II of chapter 408, and relevant rules. One of
368 the visits may be in conjunction with the regular survey. The
369 monitoring visits may be provided through contractual
370 arrangements with appropriate community agencies. A registered
371 nurse shall serve as part of the team that inspects the
372 facility. The agency may waive one of the required yearly
373 monitoring visits for a facility that has:
374 a. Held an extended congregate care license for at least
375 24 months; ~~been licensed for at least 24 months to provide~~
376 ~~extended congregate care services, if, during the inspection,~~
377 ~~the registered nurse determines that extended congregate care~~
378 ~~services are being provided appropriately, and if the facility~~
379 ~~has~~
380 b. No class I or class II violations and no uncorrected
381 class III violations; and~~.~~
382 c. No ombudsman council complaints that resulted in a
383 citation for licensure. ~~The agency must first consult with the~~
384 ~~long-term care ombudsman council for the area in which the~~
385 ~~facility is located to determine if any complaints have been~~
386 ~~made and substantiated about the quality of services or care.~~
387 ~~The agency may not waive one of the required yearly monitoring~~
388 ~~visits if complaints have been made and substantiated.~~
389 4.~~3.~~ A facility that is licensed to provide extended
390 congregate care services must:

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391 a. Demonstrate the capability to meet unanticipated
392 resident service needs.
393 b. Offer a physical environment that promotes a homelike
394 setting, provides for resident privacy, promotes resident
395 independence, and allows sufficient congregate space as defined
396 by rule.
397 c. Have sufficient staff available, taking into account
398 the physical plant and firesafety features of the building, to
399 assist with the evacuation of residents in an emergency.
400 d. Adopt and follow policies and procedures that maximize
401 resident independence, dignity, choice, and decisionmaking to
402 permit residents to age in place, so that moves due to changes
403 in functional status are minimized or avoided.
404 e. Allow residents or, if applicable, a resident's
405 representative, designee, surrogate, guardian, or attorney in
406 fact to make a variety of personal choices, participate in
407 developing service plans, and share responsibility in
408 decisionmaking.
409 f. Implement the concept of managed risk.
410 g. Provide, directly or through contract, the services of
411 a person licensed under part I of chapter 464.
412 h. In addition to the training mandated in s. 429.52,
413 provide specialized training as defined by rule for facility
414 staff.
415 5.~~4.~~ A facility that is licensed to provide extended
416 congregate care services is exempt from the criteria for

417 continued residency set forth in rules adopted under s. 429.41.
418 A licensed facility must adopt its own requirements within
419 guidelines for continued residency set forth by rule. However,
420 the facility may not serve residents who require 24-hour nursing
421 supervision. A licensed facility that provides extended
422 congregate care services must also provide each resident with a
423 written copy of facility policies governing admission and
424 retention.
425 ~~5. The primary purpose of extended congregate care~~
426 ~~services is to allow residents, as they become more impaired,~~
427 ~~the option of remaining in a familiar setting from which they~~
428 ~~would otherwise be disqualified for continued residency. A~~
429 ~~facility licensed to provide extended congregate care services~~
430 ~~may also admit an individual who exceeds the admission criteria~~
431 ~~for a facility with a standard license, if the individual is~~
432 ~~determined appropriate for admission to the extended congregate~~
433 ~~care facility.~~
434 6. Before the admission of an individual to a facility
435 licensed to provide extended congregate care services, the
436 individual must undergo a medical examination as provided in s.
437 429.26(4) and the facility must develop a preliminary service
438 plan for the individual.
439 7. <u>If</u> ~~When~~ a facility can no longer provide or arrange for
440 services in accordance with the resident's service plan and
441 needs and the facility's policy, the facility <u>must</u> ~~shall~~ make
442 arrangements for relocating the person in accordance with s.

443 429.28(1)(k).
444 ~~8. Failure to provide extended congregate care services~~
445 ~~may result in denial of extended congregate care license~~
446 ~~renewal.~~
447 (c) A limited nursing services license shall be issued to
448 a facility that provides services beyond those authorized in
449 paragraph (a) and as specified in this paragraph.
450 1. In order for limited nursing services to be provided in
451 a facility licensed under this part, the agency must first
452 determine that all requirements established in law and rule are
453 met and must specifically designate, on the facility's license,
454 that such services may be provided. This ~~Such~~ designation may be
455 made at the time of initial licensure or licensure renewal
456 ~~relicensure~~, or upon request in writing by a licensee under this
457 part and part II of chapter 408. Notification of approval or
458 denial of such request shall be made in accordance with part II
459 of chapter 408. An existing facility that qualifies ~~facilities~~
460 ~~qualifying~~ to provide limited nursing services must ~~shall~~ have
461 maintained a standard license and may not have been subject to
462 administrative sanctions that affect the health, safety, and
463 welfare of residents for the previous 2 years or since initial
464 licensure if the facility has been licensed for less than 2
465 years.
466 2. A facility ~~Facilities~~ that is ~~are~~ licensed to provide
467 limited nursing services shall maintain a written progress
468 report on each person who receives such nursing services. The~~,~~

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469 ~~which~~ report must describe ~~describes~~ the type, amount, duration,
470 scope, and outcome of services that are rendered and the general
471 status of the resident's health. A registered nurse representing
472 the agency shall visit the facility ~~such facilities~~ at least
473 annually ~~twice a year~~ to monitor residents who are receiving
474 limited nursing services and to determine if the facility is in
475 compliance with applicable provisions of this part, part II of
476 chapter 408, and related rules. The monitoring visits may be
477 provided through contractual arrangements with appropriate
478 community agencies. A registered nurse shall also serve as part
479 of the team that inspects such facility. Visits may be in
480 conjunction with other agency inspections. The agency may waive
481 the required yearly monitoring visit for a facility that has:
482 a. Had a limited nursing services license for at least 24
483 months;
484 b. No class I or class II violations and no uncorrected
485 class III violations; and
486 c. No ombudsman council complaints that resulted in a
487 citation for licensure.
488 3. A person who receives limited nursing services under
489 this part must meet the admission criteria established by the
490 agency for assisted living facilities. When a resident no longer
491 meets the admission criteria for a facility licensed under this
492 part, arrangements for relocating the person shall be made in
493 accordance with s. 429.28(1)(k), unless the facility is licensed
494 to provide extended congregate care services.

495 Section 7. Section 429.075, Florida Statutes, is amended
496 to read:
497 429.075 Limited mental health license.—An assisted living
498 facility that serves one ~~three~~ or more mental health residents
499 must obtain a limited mental health license.
500 (1) To obtain a limited mental health license, a facility
501 must hold a standard license as an assisted living facility,
502 must not have any current uncorrected ~~deficiencies or~~
503 violations, and must ensure that, within 6 months after
504 receiving a limited mental health license, the facility
505 administrator and the staff of the facility who are in direct
506 contact with mental health residents must complete training of
507 no less than 6 hours related to their duties. This ~~Such~~
508 designation may be made at the time of initial licensure or
509 relicensure or upon request in writing by a licensee under this
510 part and part II of chapter 408. Notification of approval or
511 denial of such request shall be made in accordance with this
512 part, part II of chapter 408, and applicable rules. This
513 training must ~~will~~ be provided by or approved by the Department
514 of Children and Families.
515 (2) A facility that is ~~Facilities~~ licensed to provide
516 services to mental health residents must ~~shall~~ provide
517 appropriate supervision and staffing to provide for the health,
518 safety, and welfare of such residents.
519 (3) A facility that has a limited mental health license
520 must:

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521 (a) Have a copy of each mental health resident's community
522 living support plan and the cooperative agreement with the
523 mental health care services provider or provide written evidence
524 that a request for the community living support plan and the
525 cooperative agreement was sent to the Medicaid managed care plan
526 or managing entity under contract with the Department of
527 Children and Families within 72 hours after admission. The
528 support plan and the agreement may be combined.
529 (b) Have documentation ~~that is~~ provided by the department
530 ~~of Children and Families~~ that each mental health resident has
531 been assessed and determined to be able to live in the community
532 in an assisted living facility that has ~~with~~ a limited mental
533 health license or provide written evidence that a request for
534 documentation was sent to the department within 72 hours after
535 admission.
536 (c) Make the community living support plan available for
537 inspection by the resident, the resident's legal guardian or~~,~~
538 ~~the resident's~~ health care surrogate, and other individuals who
539 have a lawful basis for reviewing this document.
540 (d) Assist the mental health resident in carrying out the
541 activities identified in the resident's ~~individual's~~ community
542 living support plan.
543 (4) A facility that has ~~with~~ a limited mental health
544 license may enter into a cooperative agreement with a private
545 mental health provider. For purposes of the limited mental
546 health license, the private mental health provider may act as

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547 the case manager.
548 Section 8. Section 429.14, Florida Statutes, is amended to
549 read:
550 429.14 Administrative penalties.—
551 (1) In addition to the requirements of part II of chapter
552 408, the agency may deny, revoke, and suspend any license issued
553 under this part and impose an administrative fine in the manner
554 provided in chapter 120 against a licensee for a violation of
555 any provision of this part, part II of chapter 408, or
556 applicable rules, or for any of the following actions by a
557 licensee, ~~for the actions of~~ any person subject to level 2
558 background screening under s. 408.809, or ~~for the actions of~~ any
559 facility <u>staff</u> ~~employee~~:
560 (a) An intentional or negligent act seriously affecting
561 the health, safety, or welfare of a resident of the facility.
562 (b) <u>A</u> ~~The~~ determination by the agency that the owner lacks
563 the financial ability to provide continuing adequate care to
564 residents.
565 (c) Misappropriation or conversion of the property of a
566 resident of the facility.
567 (d) Failure to follow the criteria and procedures provided
568 under part I of chapter 394 relating to the transportation,
569 voluntary admission, and involuntary examination of a facility
570 resident.
571 (e) A citation <u>for</u> ~~of~~ any of the following <u>violations</u>
572 ~~deficiencies~~ as specified in s. 429.19:

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573 1. One or more cited class I violations ~~deficiencies~~.
574 2. Three or more cited class II violations ~~deficiencies~~.
575 3. Five or more cited class III violations ~~deficiencies~~
576 that have been cited on a single survey and have not been
577 corrected within the times specified.
578 (f) Failure to comply with the background screening
579 standards of this part, s. 408.809(1), or chapter 435.
580 (g) Violation of a moratorium.
581 (h) Failure of the license applicant, the licensee during
582 relicensure, or a licensee that holds a provisional license to
583 meet the minimum license requirements of this part, or related
584 rules, at the time of license application or renewal.
585 (i) An intentional or negligent life-threatening act in
586 violation of the uniform firesafety standards for assisted
587 living facilities or other firesafety standards which ~~that~~
588 threatens the health, safety, or welfare of a resident of a
589 facility, as communicated to the agency by the local authority
590 having jurisdiction or the State Fire Marshal.
591 (j) Knowingly operating any unlicensed facility or
592 providing without a license any service that must be licensed
593 under this chapter or chapter 400.
594 (k) Any act constituting a ground upon which application
595 for a license may be denied.
596 (2) Upon notification by the local authority having
597 jurisdiction or by the State Fire Marshal, the agency may deny
598 or revoke the license of an assisted living facility that fails

599 to correct cited fire code violations that affect or threaten
600 the health, safety, or welfare of a resident of a facility.
601 (3) The agency may deny a license of an ~~to any~~ applicant
602 or a controlling interest as defined in part II of chapter 408
603 which has or had a 25 percent ~~25-percent~~ or greater financial or
604 ownership interest in any other facility that is licensed under
605 this part, or in any entity licensed by this state or another
606 state to provide health or residential care, if that ~~which~~
607 facility or entity during the 5 years prior to the application
608 for a license closed due to financial inability to operate; had
609 a receiver appointed or a license denied, suspended, or revoked;
610 was subject to a moratorium; or had an injunctive proceeding
611 initiated against it.
612 (4) The agency shall deny or revoke the license of an
613 assisted living facility if:
614 (a) There are two moratoria, issued pursuant to this part
615 or part II of chapter 408, within a 2-year period which are
616 imposed by final order;
617 (b) The facility is cited for two or more class I
618 violations arising from unrelated circumstances during the same
619 survey or investigation; or
620 (c) The facility is cited for two or more class I
621 violations arising from separate surveys or investigations
622 within a 2-year period ~~that has two or more class I violations~~
623 ~~that are similar or identical to violations identified by the~~
624 ~~agency during a survey, inspection, monitoring visit, or~~

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625 ~~complaint investigation occurring within the previous 2 years~~.
626 (5) An action taken by the agency to suspend, deny, or
627 revoke a facility's license under this part or part II of
628 chapter 408, in which the agency claims that the facility owner
629 or an employee of the facility has threatened the health,
630 safety, or welfare of a resident of the facility, shall be heard
631 by the Division of Administrative Hearings of the Department of
632 Management Services within 120 days after receipt of the
633 facility's request for a hearing, unless that time limitation is
634 waived by both parties. The administrative law judge shall ~~must~~
635 render a decision within 30 days after receipt of a proposed
636 recommended order.
637 (6) As provided under s. 408.814, the agency shall impose
638 an immediate moratorium on an assisted living facility that
639 fails to provide the agency with access to the facility or
640 prohibits the agency from conducting a regulatory inspection.
641 The licensee may not restrict agency staff from accessing and
642 copying records at the agency's expense or from conducting
643 confidential interviews with facility staff or any individual
644 who receives services from the facility ~~provide to the Division~~
645 ~~of Hotels and Restaurants of the Department of Business and~~
646 ~~Professional Regulation, on a monthly basis, a list of those~~
647 ~~assisted living facilities that have had their licenses denied,~~
648 ~~suspended, or revoked or that are involved in an appellate~~
649 ~~proceeding pursuant to s. 120.60 related to the denial,~~
650 ~~suspension, or revocation of a license~~.

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651 (7) Agency notification of a license suspension or
652 revocation, or denial of a license renewal, shall be posted and
653 visible to the public at the facility.
654 (8) If a facility is required to relocate some or all of
655 its residents due to agency action, that facility is exempt from
656 the 45-day notice requirement imposed under s. 429.28(1)(k).
657 This subsection does not exempt the facility from any deadlines
658 for corrective action set by the agency.
659 Section 9. Paragraphs (a) and (b) of subsection (2) of
660 section 429.178, Florida Statutes, are amended to read:
661 429.178 Special care for persons with Alzheimer's disease
662 or other related disorders.—
663 (2)(a) An individual who is employed by a facility that
664 provides special care for residents who have ~~with~~ Alzheimer's
665 disease or other related disorders, and who has regular contact
666 with such residents, must complete up to 4 hours of initial
667 dementia-specific training developed or approved by the
668 department. The training must ~~shall~~ be completed within 3 months
669 after beginning employment and satisfy ~~shall satisfy~~ the core
670 training requirements of s. 429.52(3)(g) ~~429.52(2)(g)~~.
671 (b) A direct caregiver who is employed by a facility that
672 provides special care for residents who have ~~with~~ Alzheimer's
673 disease or other related disorders~~,~~ and ~~who~~ provides direct care
674 to such residents~~,~~ must complete the required initial training
675 and 4 additional hours of training developed or approved by the
676 department. The training must ~~shall~~ be completed within 9 months

677 after beginning employment and satisfy ~~shall satisfy~~ the core
678 training requirements of s. 429.52(3)(g) ~~429.52(2)(g)~~.
679 Section 10. Paragraph (e) is added to subsection (2) of
680 section 429.19, Florida Statutes, to read:
681 429.19 Violations; imposition of administrative fines;
682 grounds.—
683 (2) Each violation of this part and adopted rules shall be
684 classified according to the nature of the violation and the
685 gravity of its probable effect on facility residents. The agency
686 shall indicate the classification on the written notice of the
687 violation as follows:
688 (e) Regardless of the class of violation cited, instead of
689 the fine amounts listed in paragraphs (a)-(d), the agency shall
690 impose an administrative fine of $500 if a facility is found not
691 to be in compliance with the background screening requirements
692 as provided in s. 408.809.
693 Section 11. Subsection (3) and paragraph (c) of subsection
694 (4) of section 429.256, Florida Statutes, are amended to read:
695 429.256 Assistance with self-administration of
696 medication.—
697 (3) Assistance with self-administration of medication
698 includes:
699 (a) Taking the medication, in its previously dispensed,
700 properly labeled container, including an insulin syringe that is
701 prefilled with the proper dosage by a pharmacist and an insulin
702 pen that is prefilled by the manufacturer, from where it is

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703 stored, and bringing it to the resident.
704 (b) In the presence of the resident, reading the label,
705 opening the container, removing a prescribed amount of
706 medication from the container, and closing the container.
707 (c) Placing an oral dosage in the resident's hand or
708 placing the dosage in another container and helping the resident
709 by lifting the container to his or her mouth.
710 (d) Applying topical medications.
711 (e) Returning the medication container to proper storage.
712 (f) Keeping a record of when a resident receives
713 assistance with self-administration under this section.
714 (g) Assisting with the use of a nebulizer, including
715 removing the cap of a nebulizer, opening the unit dose of
716 nebulizer solution, and pouring the prescribed premeasured dose
717 of medication into the dispensing cup of the nebulizer.
718 (h) Using a glucometer to perform blood-glucose level
719 checks.
720 (i) Assisting with putting on and taking off antiembolism
721 stockings.
722 (j) Assisting with applying and removing an oxygen cannula
723 but not with titrating the prescribed oxygen settings.
724 (k) Assisting with the use of a continuous positive airway
725 pressure device but not with titrating the prescribed setting of
726 the device.
727 (l) Assisting with measuring vital signs.
728 (m) Assisting with colostomy bags.

729 (4) Assistance with self-administration does not include:
730 ~~(c) Administration of medications through intermittent~~
731 ~~positive pressure breathing machines or a nebulizer.~~
732 Section 12. Subsection (3) of section 429.27, Florida
733 Statutes, is amended to read:
734 429.27 Property and personal affairs of residents.—
735 (3) A facility, upon mutual consent with the resident,
736 shall provide for the safekeeping in the facility of personal
737 effects not in excess of $500 and funds of the resident not in
738 excess of $500 ~~$200~~ cash, and shall keep complete and accurate
739 records of all such funds and personal effects received. If a
740 resident is absent from a facility for 24 hours or more, the
741 facility may provide for the safekeeping of the resident's
742 personal effects in excess of $500.
743 Section 13. Paragraph (a) of subsection (3) and
744 subsections (2), (5), and (6) of section 429.28, Florida
745 Statutes, are amended to read:
746 429.28 Resident bill of rights.—
747 (2) The administrator of a facility shall ensure that a
748 written notice of the rights, obligations, and prohibitions set
749 forth in this part is posted in a prominent place in each
750 facility and read or explained to residents who cannot read. The
751 ~~This~~ notice must ~~shall~~ include the name, address, and telephone
752 numbers of the local ombudsman council, the ~~and~~ central abuse
753 hotline, and, if ~~when~~ applicable, Disability Rights Florida ~~the~~
754 ~~Advocacy Center for Persons with Disabilities, Inc., and the~~

755 ~~Florida local advocacy council~~, where complaints may be lodged.
756 The notice must state that a complaint made to the Office of
757 State Long-Term Care Ombudsman or a local long-term care
758 ombudsman council, the names and identities of the residents
759 involved in the complaint, and the identity of complainants are
760 kept confidential pursuant to s. 400.0077 and that retaliatory
761 action cannot be taken against a resident for presenting
762 grievances or for exercising any other resident right. The
763 facility must ensure a resident's access to a telephone to call
764 the local ombudsman council, central abuse hotline, and
765 Disability Rights Florida ~~Advocacy Center for Persons with~~
766 ~~Disabilities, Inc., and the Florida local advocacy council~~.
767 (3)(a) The agency shall conduct a survey to determine
768 general compliance with facility standards and compliance with
769 residents' rights as a prerequisite to initial licensure or
770 licensure renewal. The agency shall adopt rules for uniform
771 standards and criteria that will be used to determine compliance
772 with facility standards and compliance with residents' rights.
773 (5) A ~~No~~ facility or employee of a facility may not serve
774 notice upon a resident to leave the premises or take any other
775 retaliatory action against any person who:
776 (a) Exercises any right set forth in this section.
777 (b) Appears as a witness in any hearing, inside or outside
778 the facility.
779 (c) Files a civil action alleging a violation of the
780 provisions of this part or notifies a state attorney or the

781 Attorney General of a possible violation of such provisions.
782 (6) A ~~Any~~ facility that ~~which~~ terminates the residency of
783 an individual who participated in activities specified in
784 subsection (5) must ~~shall~~ show good cause in a court of
785 competent jurisdiction. If good cause is not shown, the agency
786 shall impose a fine of $2,500 in addition to any other penalty
787 assessed against the facility.
788 Section 14. Section 429.34, Florida Statutes, is amended
789 to read:
790 429.34 Right of entry and inspection.—
791 (1) In addition to the requirements of s. 408.811, any
792 duly designated officer or employee of the department, the
793 Department of Children and Families, the Medicaid Fraud Control
794 Unit of the Office of the Attorney General, the state or local
795 fire marshal, or a member of the state or local long-term care
796 ombudsman council has ~~shall have~~ the right to enter unannounced
797 upon and into the premises of any facility licensed pursuant to
798 this part in order to determine the state of compliance with ~~the~~
799 ~~provisions of~~ this part, part II of chapter 408, and applicable
800 rules. Data collected by the state or local long-term care
801 ombudsman councils or the state or local advocacy councils may
802 be used by the agency in investigations involving violations of
803 regulatory standards. A person specified in this section who
804 knows or has reasonable cause to suspect that a vulnerable adult
805 has been or is being abused, neglected, or exploited shall
806 immediately report such knowledge or suspicion to the central

807 abuse hotline pursuant to chapter 415.
808 (2) The agency shall inspect each licensed assisted living
809 facility at least once every 24 months to determine compliance
810 with this chapter and related rules. If an assisted living
811 facility is cited for a class I violation or two or more class
812 II violations arising from separate surveys within a 60-day
813 period or due to unrelated circumstances during the same survey,
814 the agency must conduct an additional licensure inspection
815 within 6 months.
816 Section 15. Subsection (2) of section 429.41, Florida
817 Statutes, is amended to read:
818 429.41 Rules establishing standards.—
819 (2) In adopting any rules pursuant to this part, the
820 department, in conjunction with the agency, shall make distinct
821 standards for facilities based upon facility size; the types of
822 care provided; the physical and mental capabilities and needs of
823 residents; the type, frequency, and amount of services and care
824 offered; and the staffing characteristics of the facility. Rules
825 developed pursuant to this section may ~~shall~~ not restrict the
826 use of shared staffing and shared programming in facilities that
827 are part of retirement communities that provide multiple levels
828 of care and otherwise meet the requirements of law and rule. If
829 a continuing care facility licensed under chapter 651 or a
830 retirement community offering multiple levels of care licenses a
831 building or part of a building designated for independent living
832 for assisted living, staffing requirements established in rule

833 apply only to residents who receive personal, limited nursing,
834 or extended congregate care services under this part. Such
835 facilities shall retain a log listing the names and unit number
836 for residents receiving these services. The log must be
837 available to surveyors upon request. Except for uniform
838 firesafety standards, the department shall adopt by rule
839 separate and distinct standards for facilities with 16 or fewer
840 beds and for facilities with 17 or more beds. The standards for
841 facilities with 16 or fewer beds must ~~shall~~ be appropriate for a
842 noninstitutional residential environment; however, ~~provided that~~
843 the structure may not be ~~is no~~ more than two stories in height
844 and all persons who cannot exit the facility unassisted in an
845 emergency must reside on the first floor. The department, in
846 conjunction with the agency, may make other distinctions among
847 types of facilities as necessary to enforce ~~the provisions of~~
848 this part. Where appropriate, the agency shall offer alternate
849 solutions for complying with established standards, based on
850 distinctions made by the department and the agency relative to
851 the physical characteristics of facilities and the types of care
852 offered ~~therein~~.
853 Section 16. Subsections (1) through (11) of section
854 429.52, Florida Statutes, are renumbered as subsections (2)
855 through (12), respectively, present subsections (5) and (9) are
856 amended, and a new subsection (1) is added to that section, to
857 read:
858 429.52 Staff training and educational programs; core

859 educational requirement.—
860 (1) Effective October 1, 2015, each new assisted living
861 facility employee who has not previously completed core training
862 must attend a preservice orientation provided by the facility
863 before interacting with residents. The preservice orientation
864 must be at least 2 hours in duration and cover topics that help
865 the employee provide responsible care and respond to the needs
866 of facility residents. Upon completion, the employee and the
867 administrator of the facility must sign a statement that the
868 employee completed the required preservice orientation. The
869 facility must keep the signed statement in the employee's
870 personnel record.
871 (6)(5) Staff involved with the management of medications
872 and assisting with the self-administration of medications under
873 s. 429.256 must complete a minimum of 6 4 additional hours of
874 training provided by a registered nurse, licensed pharmacist, or
875 department staff. The department shall establish by rule the
876 minimum requirements of this additional training.
877 (10)(9) The training required by this section other than
878 the preservice orientation must shall be conducted by persons
879 registered with the department as having the requisite
880 experience and credentials to conduct the training. A person
881 seeking to register as a trainer must provide the department
882 with proof of completion of the minimum core training education
883 requirements, successful passage of the competency test
884 established under this section, and proof of compliance with the

885 continuing education requirement in subsection (5) ~~(4)~~.
886 Section 17. Section 429.55, Florida Statutes, is created
887 to read:
888 429.55 Consumer information website.—The Legislature finds
889 that consumers need additional information on the quality of
890 care and service in assisted living facilities in order to
891 select the best facility for themselves or their loved ones.
892 Therefore, the Agency for Health Care Administration shall
893 create content that is easily accessible through the home page
894 of the agency's website either directly or indirectly through
895 links to one or more other established websites of the agency's
896 choosing. The website must be searchable by facility name,
897 license type, city, or zip code. By November 1, 2015, the agency
898 shall include all content in its possession on the website and
899 add content when received from facilities. At a minimum, the
900 content must include:
901 (1) Information on each licensed assisted living facility,
902 including, but not limited to:
903 (a) The name and address of the facility.
904 (b) The name of the owner or operator of the facility.
905 (c) The number and type of licensed beds in the facility.
906 (d) The types of licenses held by the facility.
907 (e) The facility's license expiration date and status.
908 (f) The total number of clients that the facility is
909 licensed to serve and the most recently available occupancy
910 levels.

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911 (g) The number of private and semiprivate rooms offered.
912 (h) The bed-hold policy.
913 (i) The religious affiliation, if any, of the assisted
914 living facility.
915 (j) The languages spoken by the staff.
916 (k) Availability of nurses.
917 (l) Forms of payment accepted, including, but not limited
918 to, Medicaid, Medicaid long-term managed care, private
919 insurance, health maintenance organization, United States
920 Department of Veterans Affairs, CHAMPUS program, or workers'
921 compensation coverage.
922 (m) Indication if the licensee is operating under
923 bankruptcy protection.
924 (n) Recreational and other programs available.
925 (o) Special care units or programs offered.
926 (p) Whether the facility is a part of a retirement
927 community that offers other services pursuant to this part or
928 part III of this chapter, part II or part III of chapter 400, or
929 chapter 651.
930 (q) Links to the State Long-Term Care Ombudsman Program
931 website and the program's statewide toll-free telephone number.
932 (r) Links to the websites of the providers.
933 (s) Other relevant information that the agency currently
934 collects.
935 (2) Survey and violation information for the facility,
936 including a list of the facility's violations committed during

937 the previous 60 months, which on July 1, 2015, may include
938 violations committed on or after July 1, 2010. The list shall be
939 updated monthly and include for each violation:
940 (a) A summary of the violation, including all licensure,
941 revisit, and complaint survey information, presented in a manner
942 understandable by the general public.
943 (b) Any sanctions imposed by final order.
944 (c) The date the corrective action was confirmed by the
945 agency.
946 (3) Links to inspection reports that the agency has on
947 file.
948 (4) The agency may adopt rules to administer this section.
949 Section 18. The Legislature finds that consistent
950 regulation of assisted living facilities benefits residents and
951 operators of such facilities. To determine whether surveys are
952 consistent between surveys and surveyors, the Office of Program
953 Policy Analysis and Government Accountability shall conduct a
954 study of intersurveyor reliability for assisted living
955 facilities. By January 1, 2016, the Office of Program Policy
956 Analysis and Government Accountability shall submit a report of
957 its findings to the Governor, the President of the Senate, and
958 the Speaker of the House of Representatives and make any
959 recommendations for improving intersurveyor reliability.
960 Section 19. For fiscal year 2015-2016, the sums of
961 $151,322 in recurring funds and $7,986 in nonrecurring funds
962 from the Health Care Trust Fund are appropriated to the Agency

963 for Health Care Administration, and two full-time equivalent
964 positions with associated salary rate are authorized, for the
965 purpose of carrying out the regulatory activities provided in
966 this act.
967 Section 20. This act shall take effect July 1, 2015.

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

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

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1 Committee/Subcommittee hearing bill: Health Care Appropriations
2 Subcommittee
3 Representative Ahern offered the following:
4
5 **Amendment (with title amendment)**
6 Remove lines 949-966
7
8
9 ---
10 **T I T L E A M E N D M E N T**
11 Remove lines 111-116 and insert:
12 authorizing the agency to adopt rules; providing an

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1305 Home Medical Equipment Providers
SPONSOR(S): Eagle
TIED BILLS: **IDEN./SIM. BILLS:** SB 996

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	12 Y, 0 N	Guzzo	Poche
2) Health Care Appropriations Subcommittee		Clark	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Home medical equipment providers are licensed and regulated by the Agency for Health Care Administration (AHCA) under part VII of ch. 400, F.S. The licensure requirements for home medical equipment providers apply to any person or entity that holds itself out to the public as providing home medical equipment and services or accepts physician orders for home medical equipment and services. Certain individuals and entities are considered exempt from the licensure requirements, including:

- Nursing homes;
- Assisted living facilities;
- Home health agencies;
- Hospices;
- Intermediate care facilities;
- Hospitals;
- Manufacturers and wholesale distributors;
- Pharmacies; and
- Licensed health care practitioners who utilize home medical equipment in the course of their practice but do not sell or rent home medical equipment to their patients.

Electrostimulation medical equipment can be used to treat a number of medical symptoms and conditions. Electrical stimulators can provide direct, alternating, and pulsed waveforms of energy to the human body through electrodes that may be implanted in the skin or used on the surface of the skin. Such devices may be used to exercise muscles, demonstrate a muscular response to stimulation of a nerve, relieve pain, relieve incontinence, and provide test measurements.

The bill amends s. 400.93, F.S., to exempt physicians licensed under chapters 458 and 459, F.S., and chiropractors who sell or rent electrostimulation medical equipment to their patients in the course of their practice from licensure as a home medical equipment provider.

The bill will result in an insignificant loss of revenue to the Agency for Health Care Administration related to licensure fees.

The bill provides an effective date of July 1, 2015.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Home Medical Equipment Providers

Home medical equipment providers are licensed and regulated by the Agency for Health Care Administration (AHCA), under part VII of ch. 400, F.S., and Chapter 59A-25, F.A.C. A home medical equipment license is required for any person or entity that:

- Holds itself out to the public as providing home medical equipment[1] and services;[2]
- Accepts physician orders for home medical equipment and services; or
- Provides home medical equipment that typically requires home medical services.[3]

Section 400.931, F.S., requires any person or entity applying for a home medical equipment provider license to submit certain information to AHCA with the application, including:

- A report of the medical equipment and services that will be provided, and whether the equipment will be provided directly or by contract;
- A list of the persons and entities with whom the applicant contracts;
- Documentation of accreditation, or an application for accreditation, from an accrediting organization recognized by AHCA;
- Proof of liability insurance; and
- An application fee of $300 and an inspection fee of $400[4].

Section 400.934, F.S., requires home medical equipment providers to comply with minimum standards of operation relating to topics such as services, training and personnel, and emergency standards.

A home medical equipment provider must offer and provide home medical equipment and services, as necessary, to consumers who purchase or rent any equipment that requires such services, and must provide at least one category of equipment directly from their own inventory.[5] A home medical equipment provider is required to respond to orders for other equipment from either their own inventory or from the inventory of other contracted companies and must maintain and repair, either directly or through contract, items rented to consumers.[6]

Home medical equipment providers are required to maintain trained personnel to coordinate orders and scheduling of equipment and service deliveries and must ensure that their delivery personnel are

[1] Defined in s. 400.925, F.S., as any product as defined by the federal Food and Drug Administration's Drugs, Devices and Cosmetics Act, any products reimbursed under the Medicare Part B Durable Medical Equipment benefits or any product reimbursed under the Florida Medicaid durable medical equipment program. Home medical equipment includes oxygen and related respiratory equipment; manual, motorized, or customized wheelchairs and related seating and positioning; motorized scooters; personal transfer systems; and specialty beds, for use by a person with a medical need. Home medical equipment does not include prosthetics or orthotics or any splints, braces, or aids custom fabricated by a licensed health care practitioner.
[2] Defined in s. 400.925, F.S., as equipment management and consumer instruction, including selection, delivery, set-up, and maintenance of equipment, and other related services for the use of home medical equipment in the customer's regular or temporary place of residence.
[3] S. 400.93(1) and (2), F.S.
[4] S. 400.933, F.S.; Provides that the home medical equipment provider is exempt from the inspection fee if a survey or inspection has been conducted by an accrediting organization.
[5] S. 400.934(1) and (2), F.S.
[6] S. 400.934(3) and (11), F.S.

appropriately trained.[7] Home medical equipment providers are required to ensure that all personnel have the necessary training and background screening.[8]

A home medical equipment provider must comply with certain emergency standards, including:

- Ensuring that patients are aware of service hours and emergency service procedures;
- Maintaining a safe premises;
- Preparing and maintaining a comprehensive emergency management plan that must be updated annually and provide for continuing home medical equipment services for life-supporting or life-sustaining equipment during an emergency;
- Maintaining a prioritized list of patients who need continued services during an emergency;

Home medical equipment providers are also required to maintain a record for each patient that includes the equipment and services provided, which must contain:

- Any physician's order or certificate of medical necessity;
- Signed and dated delivery slips;
- Notes reflecting all services, maintenance performed, and equipment exchanges;
- The date on which rental equipment was retrieved; and
- Any other appropriate information.[9]

Licensed home medical equipment providers are subject to periodic inspections, including biennial licensure inspections, inspections directed by the federal Centers for Medicare and Medicaid Services, and licensure complaint investigations.[10] Currently there are 779 licensed home medical equipment providers in Florida.[11]

Certain individuals and entities are considered exempt from licensure, including:

- Providers operated by the Department of Health (DOH) or the federal government;
- Nursing homes;
- Assisted living facilities;
- Home health agencies;
- Hospices;
- Intermediate care facilities;
- Homes for special services;
- Transitional living facilities;
- Hospitals;
- Ambulatory surgical centers;
- Manufacturers and wholesale distributors that do not sell directly to the consumer;
- Licensed health care practitioners who utilize home medical equipment in the course of their practice but do not sell or rent home medical equipment to their patient; and
- Pharmacies.[12]

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[7] S. 400.934(4) and (5), F.S.
[8] S. 400.934(16), F.S.
[9] S. 400.94, F.S.
[10] S. 400.932, F.S.
[11] AHCA , Florida Health Finder, *Facility/Provider Search, Home Medical Equipment Providers*, available at http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx (search conducted March 15, 2015).
[12] S. 400.93(5), F.S.

Electrostimulation Medical Equipment

Devices that provide electrical stimulation can be used medically to treat a number of symptoms and conditions. Electrical stimulators can provide direct, alternating, and pulsed waveforms of energy to the human body through electrodes that may be implanted or used on the surface of the skin.[13] Such devices may be used to exercise muscles, demonstrate a muscular response to stimulation of a nerve, relieve pain, relieve incontinence, and provide test measurements.[14]

Functional electrical stimulation (FES), also known as therapeutic electrical stimulation (TES), is used to prevent or reverse muscular atrophy and bone loss by stimulating paralyzed limbs. FES is designed to be used as a part of a self-administered, home-based rehabilitation program for the treatment of upper limb paralysis. An FES system consists of a custom-fitted device and control unit that allows the user to adjust the stimulation intensity and a training mode which can be gradually increased to avoid muscle fatigue.[15]

A second type of electrical stimulation is Transcutaneous Electrical Nerve Stimulation (TENS). A TENS device consists of an electrical signal generator that transmits pulses of electrical current to electrodes on the skin.[16] The TENS unit is programmable and the generators are capable of delivering stimulation in different rates and intensities. Conventional TENS devices have a high stimulation frequency and low intensity. Pulsed burst TENS devices use low-intensity stimulation in high-frequency bursts.

Other types of electrical stimulation include interferential therapy (IFT) and neuromuscular electrical stimulation (NMES). IFT uses two alternating currents applied to the affected area through electrodes to relieve musculoskeletal pain and increase healing in soft tissue injuries and bone fractures. NMES applies electrical currents through the skin to cause muscle contractions and promote the restoration of nerve supply, prevent or slow atrophy, relax muscle spasms, and to promote voluntary control of muscles in patients who have lost muscle function.[17]

Effect of Proposed Changes

The bill amends s. 400.93, F.S., to exempt physicians licensed under Chapters 458 and 459, F.S., and chiropractors who sell or rent electrostimulation medical equipment to their patients in the course of their practice from licensure requirements. The bill permits physicians and chiropractors to sell or rent this type of home medical equipment directly to their patients without incurring a fee for licensure or licensure renewal.

The bill provides an effective date of July 1, 2015.

B. SECTION DIRECTORY:

Section 1: Amends s. 400.93, F.S., relating to licensure required; exemptions; unlawful acts; penalties.
Section 2: Provides an effective date of July 1, 2015.

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[13] United Healthcare Medical Policy, *Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation*, p. 4, (December 1, 2014) https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools%20and%20Resources/Policies%20and%20Protocols/Medical%20Policies/Medical%20Policies/Electrical_Stim_Tx_Pain_Muscle_Rehab.pdf (last viewed March 15, 2015).
[14] Id.
[15] Id.
[16] United Healthcare Medical Policy, *Transcutaneous Electrical Nerve Stimulation (TENS) for the Treatment of Nausea and Vomiting,* p. 2, (November 1, 2014) https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools%20and%20Resources/Policies%20and%20Protocols/Medical%20Policies/Medical%20Policies/TENS_Tx_Nausea_Vomiting.pdf (last viewed March 15, 2015).
[17] Supra at FN 8, pg. 5.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   AHCA may experience a decrease in revenues resulting from a reduction in the number of physicians and chiropractors paying licensure fees to sell or rent electrostimulation medical equipment directly to their patients. The exact amount is uncertain but not significant.

2. Expenditures:

   None. AHCA currently has sufficient fee revenues to cover the licensure of this entity.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Licensed physicians and chiropractors who sell or rent electrostimulation medical equipment to their patients will not have to pay licensure and licensure renewal fees.

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 government.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

No additional rulemaking is necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to home medical equipment providers;
3 amending s. 400.93, F.S.; exempting allopathic,
4 osteopathic, and chiropractic physicians who sell or
5 rent electrostimulation medical equipment from
6 licensure requirements under certain circumstances;
7 providing an effective date.
8
9 Be It Enacted by the Legislature of the State of Florida:
10
11 Section 1. Paragraph (k) is added to subsection (5) of
12 section 400.93, Florida Statutes, to read:
13 400.93 Licensure required; exemptions; unlawful acts;
14 penalties.—
15 (5) The following are exempt from home medical equipment
16 provider licensure, unless they have a separate company,
17 corporation, or division that is in the business of providing
18 home medical equipment and services for sale or rent to
19 consumers at their regular or temporary place of residence
20 pursuant to the provisions of this part:
21 (k) Physicians licensed under chapter 458, chapter 459, or
22 chapter 460 for the sale or rental of electrostimulation medical
23 equipment and electrostimulation medical equipment supplies to
24 their patients in the course of their practice.
25 Section 2. This act shall take effect July 1, 2015.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7045 PCB HIS 15-01 State Veterans' Nursing Homes
SPONSOR(S): Health Innovation Subcommittee, Sprowls
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Innovation Subcommittee	13 Y, 0 N	Guzzo	Poche
1) Health Care Appropriations Subcommittee		Garner	Pridgeon
2) Health & Human Services Committee			

SUMMARY ANALYSIS

The bill creates a site selection process for new state veterans' nursing homes to be administered by the Florida Department of Veterans' Affairs (FDVA).

The State Veterans' Homes Program, administered by FDVA, provides care to eligible veterans in need of either long-term skilled nursing care or assisted living services. Currently, there are six state veterans' nursing homes in Florida. Because of the size and age of the veteran population, Florida is near the top of the list of states with a "Great Need" for veterans' nursing home beds as determined by the U.S. Department of Veterans' Affairs (VA). As a result, Florida will receive priority over other states applying to the VA for grants for the construction of new state veterans' nursing homes.

Currently, no Florida law governs the FDVA's site selection process. FDVA's current process is two-tiered. First, FDVA contracts for a Site Selection Study (Study) to rank each county based on greatest need using certain measureable criteria. Second, FDVA sends applications to the top ten counties identified in the Study. Each county that wishes to be considered in the selection process must complete the application, which includes other measureable criteria, and submit it to FDVA by a specified date. The application is scored by a Site Selection Committee appointed by the Executive Director of FDVA. The county with the highest score is awarded the site, subject to approval by the Governor and the Cabinet.

The bill creates a single step site selection process, in new s. 296.42, F.S. The bill requires FDVA to contract for a study to determine the most appropriate county for construction of a nursing home based on the greatest level of need. The study must be delivered to the Governor, the President of the Senate, and the Speaker of the House of Representatives by November 1, 2015. The bill requires that the study rank each county using the following criteria:

- The distance from the geographic center of the county to the nearest existing state veterans' nursing home;
- The number of veterans aged 65 years and older living in the county;
- The availability of emergency health care in the county;
- The presence of an existing Veterans' Health Administration Medical Center or Outpatient Clinic in the county;
- The number of existing nursing home beds per 1,000 elderly male residents of the county;
- The presence of accredited education institutions with health care programs in the county; and
- The county poverty rate.

FDVA must select the county with the highest ranking as the site for the new home, subject to approval by the Governor and the Cabinet. The bill requires the next highest ranked county to be selected if a higher ranked county cannot participate. The study must be used to determine the site of any new veterans' nursing home authorized before July 1, 2020. The bill requires the Site Selection Study dated February 7, 2014, to be used to select a county for a new veterans' nursing home before November 1, 2015, if authorized.

The bill provides for expiration of s. 296.42, F.S., on July 1, 2020, unless reviewed and rescued from repeal by the Legislature prior to that date.

The House Proposed General Appropriations Act provides a $50,000 nonrecurring appropriation from the Operations and Maintenance Trust Fund for this purpose.

The bill provides an effective date of July 1, 2015.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

State Veterans' Homes Program

The Florida Department of Veterans' Affairs (FDVA) operates the State Veterans' Homes Program (Program) as authorized by Chapters 292 and 296, F.S.[1] The Program provides care to eligible veterans in need of either long-term skilled nursing care or assisted living services. Care is provided to veterans with qualifying war or peacetime service, who are residents of Florida and who require skilled care as certified by a U.S. Department of Veterans' Affairs (USDVA) physician.[2] There are approximately 729,000 veterans aged 65 years and older in the state.[3]

Currently, there are six state veterans' nursing homes in Florida. Five of the six homes have dementia-specific care.[4] The six nursing homes are located in Daytona Beach, Land O' Lakes, Pembroke Pines, Panama City, Port Charlotte, and St. Augustine. The Program has a total of 720 skilled-nursing beds and an average occupancy rate of 97.8% for FY 2013-14.[5] In 2014, St. Lucie County was selected as the site for the seventh nursing home.

Funding

The construction of a new nursing home is subject to approval by the Governor and Cabinet. Funding is based on a 65% / 35% federal - state split of the cost.[6] Florida is near the top of the list of states with a "Great Need" for veterans' nursing home beds as determined by the USDVA.[7] As a result, Florida will receive priority over other states applying to USDVA for grants for the construction of new state veterans' nursing homes. The estimated cost to build a new nursing home can range from $37 million to $50 million, depending on style, land condition, materials used, weather resistance and energy efficiency.[8]

The state pro-rata share for the seventh nursing home in St. Lucie County is approximately $12.5 million based on a VA "cost to build" estimate of $37 million.[9] According to FDVA, the cost figures are estimates as architectural plans are still being completed and are yet to be approved by the USDVA.[10] The state's cost will be paid from the FDVA Operations and Maintenance Trust Fund. Funding for future nursing homes will need to be supported by General Revenue funding.[11]

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[1] S. 292.05(7), F.S. "The Department shall administer this chapter and shall have the authority and responsibility to apply for and administer any federal programs and develop and coordinate such state programs as may be beneficial to the particular interests of the veterans of this state."; part II of ch. 296, F.S., titled "The Veterans' Nursing Home of Florida Act" provides for the establishment of basic standards by FDVA for the operation of veteran's nursing homes for eligible veterans in need of such services."

[2] S. 296.36, F.S.

[3] Florida Department of Veterans' Affairs, *Annual Report: Fiscal Year 2013-14*, page 15, available at http://floridavets.org/about-us/annual-report/ (last visited February 20, 2015).

[4] Id. at page 7.

[5] Id.

[6] 38 CFR §59.80

[7] 38 CFR §59.50(1)(iii); *see also* 38 CFR §§59.40 and .50.

[8] E-mail correspondence, FDVA, February 12, 2015, (on file with Health Innovation Subcommittee staff).

[9] Id.

[10] Id.

[11] Id.

Site Selection Process for Recently Authorized State Veterans' Nursing Homes

State Veterans' Nursing Home Seven (St. Lucie County)

In 2013, the Legislature appropriated funds for FDVA to contract with a private entity to conduct a Site Selection Study (Study).[12] The purpose of the Study was to identify five communities, defined as single-county or multi-county areas, to be given priority for development of a new state veterans' nursing home.

Counties that did not meet certain minimum threshold criteria, including access to emergency care and the availability of health care professionals, were eliminated from consideration before the Study began. Counties with an existing state veterans' nursing home and those located within 25 miles of an existing home were also eliminated from consideration.

The Study used the following criteria to score the counties, rank ordered from greatest to least value assigned:

- Number of elderly veterans in the county;
- Ratio of existing nursing home beds per/1,000 elderly male residents in the county;
- County poverty rate;
- Distance to an existing state veterans' nursing home;
- Presence of an existing veterans' health care facility in the county; and
- Presence of nursing education programs in the county.

The Study identified the following top ten counties with the greatest need for a new state veterans' nursing home, ranked in order of greatest need based on the scoring criteria:

Study Ranking	County
1	Collier
2	Lee
3	Polk
4	Manatee
5	Marion
6	Putnam
7	St. Lucie
8	Hillsborough
9	Palm Beach
10	Sumter

FDVA sent applications to all ten counties listed in the Study. Six of the counties submitted applications: Collier County, Polk County, Manatee County, Marion County, Putnam County, and St. Lucie County. A Site Selection Committee (Committee) was created by the Executive Director of FDVA to evaluate each application.

The Committee established factors for consideration, and assigned a score of 0 to 50 points for each of the following criteria:

- Number of veterans aged 65 or older living within a 75 mile radius of the proposed site;
- Number of nursing home beds and assisted living facility beds located within 10 miles of the proposed site;

[12] Hoy & Stark Architects, *Site Selection Study; Phase I State Veterans' Nursing Homes Statewide*, February 7, 2014, (on file with the Health Innovation Subcommittee staff).

- Suitability of the donated site in terms of its general surroundings and support capabilities;
- Availability of emergency health care, as determined by:
  - Number of hospitals and/or emergency care centers within 25 miles of the proposed site;
  - Number of emergency room holding beds per facility;
  - Presence of in-house physicians on staff in the emergency room 24 hours/day, 7 days/week; and
  - The nursing workforce.
- Availability of health care professionals, as determined by the number of accredited educational institutions located within 50 miles of the proposed site; and
- Availability of infrastructure at the site, including roads, water, sewer, telephone lines, and electricity/natural gas services, all of which must link to the property line of the proposed site at no cost to the state.

The Committee's final rankings were:

Committee Ranking	County	Study Ranking
1	St. Lucie	7
2	Marion	5
3	Collier Site B	1
4	Collier Site A	1
5	Polk Site A	3
6	Polk Site B	3

St. Lucie County was selected as the site for the seventh nursing home, and approved by the Governor and Cabinet in a meeting on September 23, 2014.

State Veterans' Nursing Home Six (St. Johns County)

The same site selection process was used to determine the site of the sixth nursing home. A Study[13] was conducted in 2004 and the home was built in 2010. The extended length of time between site selection and construction of the nursing home was due to a lack of funds caused by the economic recession in the mid-2000s.

The Study identified the following top twelve areas, which included counties and multi-county groups, with the greatest need for a veterans' nursing home:

Study Ranking	County or Area
1	Lake/Marion/Sumter
2	Duval
3	Brevard
4	Escambia/Santa Rosa/Okaloosa
5	Indian River/Martin/St. Lucie
6	Orange/Seminole
7	Collier/Lee
8	Palm Beach
9	Sarasota/Manatee
10	Polk
11	Citrus/Hernando
12	Pinellas

The Committee selected St. Johns County as the site for sixth veterans' nursing home. St. Johns County was not identified in the Study as an area of need.

[13] Health Strategies, Inc., *Nursing Home Site Selection Study,* February 2004, (on file with the Health Innovation Subcommittee staff).

Effect of Proposed Changes

The bill creates a single-step site selection process, in new s. 296.42, F.S. The bill requires FDVA to contract for a study to determine the most appropriate county for construction of a new nursing home based on the greatest level of need. The study must be delivered to the Governor, President of the Senate, and the Speaker of the House of Representatives by November 1, 2015.

The bill requires the study to use the following criteria to rank each county:

- The distance from the geographic center of the county to the nearest existing state veterans' nursing home;
- The number of veterans aged 65 years and older living in the county;
- The availability of emergency health care in the county, as determined by:
  - The number of general hospitals;
  - The number of emergency room holding beds per hospital; and
  - The number of in-house physicians per hospital on staff in the emergency room 24 hours per day.
- The presence of an existing Veterans' Health Administration Medical Center or Outpatient Clinic in the county;
- The number of existing nursing home beds per 1,000 elderly male residents of the county;
- The presence of accredited education institutions with health care programs in the county; and
- The county poverty rate.

The county with the highest ranking must be selected as the site for the new home, subject to approval by the Governor and the Cabinet. The bill requires the next highest ranked county to be selected if a higher ranked county cannot participate. The study must be used to determine the site for any veterans' nursing home authorized before July 1, 2020. For any veterans' nursing home authorized before November 1, 2015, the bill requires the FDVA to use the 2014 Site Selection Study.

Lastly, the bill provides for the expiration of s. 296.42, F.S., on July1, 2020, unless reviewed and saved from repeal by the Legislature prior to that date.

B. SECTION DIRECTORY:

Section 1: Creates s. 296.42, F.S., relating to the site selection process for state veterans' nursing homes.
Section 2: Provides an effective date of July 1, 2015.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill requires the FDVA to contract for a study to rank each county according to greatest need to determine the most appropriate site for a new veterans' nursing home. The Site Selection Study for the determination of the seventh state nursing home location was competitively procured and a

contract was awarded to Hoy + Stark Architects, P.A. for a total cost of $38,692.[14] The House Proposed General Appropriations Act provides a $50,000 nonrecurring appropriation from the Operations and Maintenance Trust Fund for this purpose.

FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

B. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

C. 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:

No additional rule making is necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[14] E-mail correspondence, FDVA, March 19, 2015, (on file with Health Care Appropriations Subcommittee staff).

1 A bill to be entitled
2 An act relating to state veterans' nursing homes;
3 creating s. 296.42, F.S.; directing the Department of
4 Veterans' Affairs to contract for a study to determine
5 the need for additional state veterans' nursing homes
6 and the most appropriate counties in which to locate
7 the homes; directing the department to submit the
8 study to the Governor and Legislature; providing study
9 criteria for ranking each county according to need;
10 requiring the department to use specified studies to
11 select new nursing home sites; providing for
12 expiration; providing an effective date.
13
14 Be It Enacted by the Legislature of the State of Florida:
15
16 Section 1. Section 296.42, Florida Statutes, is created to
17 read:
18 296.42 Site selection process for state veterans' nursing
19 homes.—
20 (1) The department shall contract for a study to determine
21 the need for new state veterans' nursing homes and the most
22 appropriate counties in which to locate the homes based on the
23 greatest level of need. The department shall submit the study to
24 the Governor, the President of the Senate, and the Speaker of
25 the House of Representatives by November 1, 2015.
26 (2) The study shall use the following criteria to rank

27 each county according to need:
28 (a) The distance from the geographic center of the county
29 to the nearest existing state veterans' nursing home.
30 (b) The number of veterans age 65 years or older residing
31 in the county.
32 (c) The presence of an existing federal Veterans' Health
33 Administration medical center or outpatient clinic in the
34 county.
35 (d) Elements of emergency health care in the county, as
36 determined by:
37 1. The number of general hospitals.
38 2. The number of emergency room holding beds per hospital.
39 3. The number of in-house physicians per hospital on staff
40 in the emergency room 24 hours per day.
41 (e) The number of existing community nursing home beds per
42 1,000 males age 65 years or older residing in the county.
43 (f) The presence of an accredited educational institution
44 offering health care programs in the county.
45 (g) The county poverty rate.
46 (3) The department shall use the study ranking to select
47 each new state veterans' nursing home site authorized before
48 July 1, 2020, subject to approval by the Governor and Cabinet.
49 For each new nursing home, the department shall select the
50 highest-ranked county in the study which does not have a
51 veterans' nursing home. If the highest-ranked county cannot
52 serve as the site, the department shall select the next-highest

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

53 ranked county. The department shall use the 2014 Site Selection
54 Study to select a county for any new state veterans' nursing
55 home authorized before November 1, 2015, subject to approval by
56 the Governor and Cabinet.
57 (4) This section expires July 1, 2020.
58 Section 2. This act shall take effect July 1, 2015.