The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Bean, Chair
Senator Sobel, Vice Chair

MEETING DATE: Tuesday, February 3, 2015
TIME: 10:00 a.m.—12:00 noon
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Bean, Chair; Senator Sobel, Vice Chair; Senators Braynon, Flores, Gaetz, Galvano, Garcia, Grimsley, and Joyner

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 322** Stargel	Medicaid Reimbursement for Hospital Providers; Requiring the Agency for Health Care Administration to provide written notice, pursuant to ch. 120, F.S., to providers of hospital reimbursement rates established by the agency; providing that such notice constitutes final agency action; prohibiting the agency from being compelled by an administrative body or court to pay a monetary judgment relating to the establishment of hospital reimbursement rates beyond a specified date, etc. HP 02/03/2015 Temporarily Postponed FP	Temporarily Postponed
2	**SB 190** Bean (Identical H 167)	Hospices; Requiring the Agency for Health Care Administration to assume the need for an additional hospice provider in certain hospice service areas, etc. HP 02/03/2015 Temporarily Postponed AHS AP	Temporarily Postponed
3	**SB 332** Grimsley (Similar H 411)	Nursing Home Facility Pneumococcal Vaccination Requirements; Requiring a resident of a licensed facility to be assessed for eligibility for pneumococcal vaccination or revaccination by a specified date and, if indicated, to be vaccinated or revaccinated by a specified date, etc. HP 02/03/2015 Favorable AHS AP	Favorable Yeas 8 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**SB 382** Sobel (Compare H 293)	Assisted Living Facilities; Providing that Medicaid managed care plans are responsible for mental health residents enrolled in Medicaid; specifying that managing entities under contract with the Department of Children and Families are responsible for mental health residents who are not enrolled in a Medicaid managed care plan; providing notice requirements for informing facility residents that the name and identity of the resident and complainant in any complaint made to the State Long-Term Care Ombudsman Program or a local long-term care ombudsman council is confidential and that retaliatory action may not be taken against a resident for presenting grievances or for exercising any other resident right, etc. HP 02/03/2015 Fav/CS AHS AP	Fav/CS Yeas 8 Nays 0
5	**Presentation on Access to Dental Care** by Marko Vujicic, Ph.D., Managing Vice President, Health Policy Resources Center, American Dental Association.		Presented
	Other Related Meeting Documents		

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 322
INTRODUCER:	Senator Stargel
SUBJECT:	Medicaid Reimbursement for Hospital Providers
DATE:	February 2, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Pre-meeting**
2.			FP	

I. Summary:

SB 322 clarifies reimbursement provisions, provider notification requirements, and the administrative challenge process for Medicaid inpatient and outpatient hospital rates. The bill specifies that the written notice of the hospital reimbursement rates provided by the Agency for Health Care Administration (AHCA or agency) constitutes final agency action for purposes of administrative challenges to the rate. Challenges to the rate are barred if the hospital fails to timely file a petition and include all documentation supporting the challenge in the petition.

The bill also establishes time limitations for rate corrections or adjustments to within the first rate period after either an administrative order or civil judgment is final, but it must occur within five years after the date on which the provider received AHCA's written notice of the reimbursement rate. An administrative body or court may not compel the agency to pay a monetary judgment relating to the hospital reimbursement rates beyond the 5-year timeframe.

These clarifications are deemed remedial in nature and apply retroactively to all proceedings pending or commenced on or after the effective date of this act.

The fiscal impact of the bill is indeterminate; however, should the state not prevail in pending or potential administrative challenges, the state's liability could reach $30 million.

The bill is effective upon becoming a law.

II. Present Situation:

Florida Medicaid

Medicaid is a joint federal and state funded program that provides health care for low income Floridians. The program is administered by the AHCA and financed with federal and state funds.

Over 3.7 million Floridians are currently enrolled in Medicaid[1] and its enrollees make up 20 percent of Florida's population.[2] The state statutory authority for the Medicaid program is contained in ch. 409, F.S.

Medicaid's estimated expenditures for Fiscal Year 2014-2015 are over $23.3 billion.[3] The total budget for the current state fiscal year is over $24.5 billion with $14.6 billion of those funds coming from federal sources.[4]

Nationally, Medicare and Medicaid account for 58 percent of all care provided by hospitals.[5] The Florida Hospital Association reports providing more than $1.4 billion in community benefit to Florida Medicaid and other government programs in 2012.[6]

While hospital participation in Medicaid is voluntary, in order for a hospital receive a federal tax exemption for providing health care to the community, not for profit hospitals are required to care for Medicare and Medicaid beneficiaries.[7]

Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare and Medicaid Services (CMS). The plan outlines current Medicaid eligibility standards, policies, and reimbursement methodologies, including inpatient and outpatient hospital rate charges. Florida's Medicaid state plan and its attachments provide the methodology for the reimbursement of both inpatient and outpatient services.

Hospital Reimbursements for Medicaid

Prior to July 1, 2013, rates for hospital inpatient and outpatient services under the Florida Medicaid program were set on a facility-specific basis based on each facility's reported costs.[8, 9] Outpatient services continue to be facility-specific based on each facility's reported costs. Hospital rates based on reported costs for services provided by the hospital to Medicaid recipients on a fee-for-service basis are an all-inclusive "per diem" rate.

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[1] Agency for Health Care Administration, *Number of Medicaid Eligibles by Age, by Assistance Category as of 12/31/2014 Plus Medikids A, Medikids B, & Medikids C,* http://ahca.myflorida.com/medicaid/about/pdf/age_assistance_category_2014-12-31.pdf (Last visited Jan. 29, 2015).
[2] Agency for Health Care Administration, *Agency for Health Care Administration - An Overview - Presentation to Senate Health and Human Services Appropriations Subcommittee* (January 22, 2015), slide 2, *available at* http://edr.state.fl.us/Content/conferences/medicaid/medsummary.pdf (Last visited Jan. 29, 2015).
[3] Social Services Estimating Conference, *Medicaid Caseloads and Expenditures, June 27, July 22, and August 4, 2014 Executive Summary,* http://edr.state.fl.us/Content/conferences/medicaid/medsummary.pdf (Last visited Jan. 29, 2015).
[4] Agency for Health Care Administration, *see supra* note 2, at slide 3.
[5] American Hospital Association, *Underpayment by Medicare and Medicaid Fact Sheet-2015,* http://www.aha.org/content/15/medicaremedicaidunderpmt.pdf (last visited Jan. 28, 2015).
[6] Florida Hospital Association, *2014 Florida Hospitals' Community Benefit Report,* p. 4, *available at* http://www.fha.org/ (Last visited Jan. 28, 2015).
[7] American Hospital Association, *see supra* note 5.
[8] Agency for Health Care Administration, *Senate Bill 322 Analysis* (January 28, 2015) (on file with Senate Health Policy Committee).
[9] Beginning July 1, 2013, the agency began paying Medicaid inpatient hospital fee-for-service claims under the Diagnosis Related Groups (DRG) method. Under Statewide Medicaid Managed Care, hospitals providing services to Medicaid managed care enrollees are paid by managed care plans typically in accordance with negotiated rates.

The hospital cost report[10] details costs for the entire year and includes any appropriate adjustments as required by the state's adopted *Medicaid Hospital Outpatient or Inpatient Reimbursement Plans* for allowable costs.[11, 12] Both inpatient and outpatient hospital rate reimbursement plans are promulgated as rules under the Florida Administrative Procedures Act and are made available for public comment and inspection.[13]

Hospitals participating in the Medicaid program submitted cost reports to the agency for both inpatient and outpatient services twice a year (July and January) and then just once a year beginning in 2011. These reports are now due no later than five calendar months after the close of the hospital's cost-reporting year.[14,15,16] The AHCA must retain all cost reports for at least 5 years following the date of submission pursuant to the record keeping requirements of 45 CFR 205.60.

Hospitals were notified of their "per diem" rates via letters sent from the AHCA. As amended or updated cost reports were submitted by hospitals, rates were adjusted to reflect the updated reported cost, if applicable. However, hospital rates, once set, are only adjusted under limited circumstances. Those circumstances are:[17]

- The fiscal intermediary[18] or AHCA made an error in the calculation.
- A hospital submits an amended cost report within three years of the initial rate's effective date and the change is material.
- Desk or field audits of the cost reports disclose material changes in the reports. [19,20]
    - For cost reports received on or after October 1, 2003, all desk or onsite audits of these cost reports are final and may not be reopened past three years of the date that the audit adjustments are noticed through a revised per diem rate completed by the agency.
    - Effective October 1, 2013, for cost reports received prior to October 1, 2003, all desk or onsite audits of these cost reports are final and not subject to reopening.

      These limitations do not apply when Medicare audit re-openings result in the issuance of revised Medicaid cost report schedules. Also, a cost report may be reopened for inspection, correction, or referral to a law enforcement agency at any time by the agency

[10] The cost report forms are established by the federal CMS. *See* 42 U.S.C.s. 1396a(6) (2012).
[11] Fla. Admin. Code R. 59G-6.030, *infra,* Note 14, Section I, Paragraph C.
[12] Fla. Admin. Code R. 59G-6.020, *infra* note 15, Section I, Paragraph N.
[13]Fla. Admin. Code R. 59G-6.020, *infra* note 15, Section V, Paragraph B(7).
[14] Fla. Admin. Code R. 59G-6.030, *Florida Title XIX Outpatient Hospital Reimbursement Plan, Version XL,* (Effective July 1, 2013) Section I, Paragraph A (Attachment 4.19-B, Part I) http://ahca.myflorida.com/Medicaid/cost_reim/pdf/Florida_Title_XIX_Hospital_Outpatient_Plan_Version_v24.pdf (Last visited Jan. 30, 2015).
[15] Fla. Admin. Code R. 59G-6.020, *Florida Title XIX Inpatient Hospital Reimbursement Plan, Version XXIV* (Effective July 1, 2013) https://www.flrules.org/gateway/reference.asp?No=Ref-04814 Section I, Paragraph A (Attachment 4.19-A, Part I) (Last visited Jan. 30, 2015).
[16] A hospital filing a certified cost report audited by independent auditors may receive a 30-day extension.
[17] Fla. Admin. Code R. 59G-6.030, *supra* note 14, Section IV, Paragraph G.
[18] The Agency has entered into written agreements with Medicare intermediaries to conduct common hospital cost report audits. These audits are conducted on hospitals located in Florida, Georgia, and Alabama which participate in various federal programs.
[19] Fla. Admin. Code R. 59G-6.020, *supra* note 15, Section I, Paragraph J.
[20] Fla. Admin. Code R. 59G-6.030, *supra* note 14, Section I, Paragraph K.

or its contractor if program payments appear to have been obtained by fraud, similar fault, or abuse.

- The charge structure of a hospital changes.

The *Medicaid Hospital Outpatient Plan* and the *Inpatient Reimbursement Plan* each include a provision for challenging any rate adjustment or denial of a rate adjustment by the AHCA under Rule 28-106 of the Florida Administrative Code and s. 120.57, F.S.

Beginning July 1, 2013, the agency implemented a new prospective payment methodology that uses Diagnosis Related Groups (DRG) for Medicaid inpatient hospital fee-for-service claims. Under this reimbursement methodology, hospital inpatient per diem reimbursement rates are not noticed, except for the state mental health hospitals which will continue to be paid based on a per diem methodology.[21] DRG payments are based on the classification of inpatient stays and then a determination of price based on a combination of the classification and the hospital where the services were performed.[22] Classification of the hospital stay is based on the diagnoses describing the patient's condition, the surgical procedures performed, if any, patient age, and discharge status.[23] These payments are generally fixed based on the DRG assignment, rather than a unique rate per hospital.

Legislation Limiting Hospital Reimbursement Rate Adjustments

In 2011, the Legislature amended s. 409.905(5), F.S., relating to hospital inpatient services with, among other provisions, the following new language:

> Errors in cost reporting or calculation of rates discovered after September 30 must be reconciled in a subsequent rate period. The agency may not make any adjustment to a hospital's reimbursement rate more than 5 years after a hospital is notified of an audited rate established by the agency. The requirement that the agency may not make any adjustment to a hospital's reimbursement rate more than 5 years after a hospital is notified of an audited rate established by the agency is remedial and shall apply to actions by providers involving Medicaid claims for hospital services.[24]

In 2012, the Legislature again amended s. 409.905(5), F.S., and republished the above language changing the September 30 date to October 31 along with a technical, grammatical modification.[25]

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[21] Agency for Health Care Administration, *Hospital Rates*, http://ahca.myflorida.com/Medicaid/cost_reim/hospital_rates.shtml (Last visited Jan. 29, 2015).
[22] Navigant, *DRG Conversion Implementation Plan - Final* (December 21, 2012) http://ahca.myflorida.com/medicaid/cost_reim/pdf/DRG_Payment-Conversion_Implementation_Plan-FL_AHCA-Final.pdf (Last visited Jan. 29, 2015).
[23] Id.
[24] Ch. 2011-135, s. 9, Laws of Fla.
[25] Ch. 2012-33, s. 5, Laws of Fla.

Then in 2013, the Legislature amended s. 409.905(5), F.S., again modifying the provision somewhat and amended subsection (6) relating to hospital outpatient services, with identical new language. Those two subsections now provide:

> Errors in source data or calculations discovered after October 31 must be reconciled in a subsequent rate period. However, the agency may not make any adjustment to a hospital's reimbursement more than 5 years after a hospital is notified of an audited rate established by the agency. The prohibition against adjustments more than 5 years after notification is remedial and applies to actions by providers involving Medicaid claims for hospital services.[26]

Administrative Challenges

Under current law, hospital providers are bringing administrative challenges to fee-for-service, per diem hospital rates regardless of the time passed since the initial rate setting period. Currently, the AHCA is involved in several challenges to hospital rates set under the old, per diem methodology. Some of these challenges involve rates initially set as far back as the 1990's, and even the 1980's.[27] In addition to the costs of litigation, given the passage of time for some of these challenges and the expedited timeframe for administrative hearings, the AHCA may not have all the documentation readily available that is necessary to support and defend the rates challenged.

III. Effect of Proposed Changes:

SB 322 amends s. 409.908, F.S., to clarify provider notification requirements and the administrative challenge process for Medicaid inpatient and outpatient fee-for-service hospital rates by placing clear limits on the time within which hospital reimbursement rates may be challenged, procedural steps for challenging those rates, and time frames for final disposition.

Although the agency has historically provided written notice of the reimbursement rates, the bill requires such notice and specifies the notice is final agency action in order to set the point of entry for an administrative challenge under the Florida Administrative Procedures Act. As a result, the agency may re-notice historical rates in accordance with this bill to start the 21-day clock in order to put an end to the perceived open-ended period for challenging rates.

The bill further provides:

- Any administrative challenge must be filed within 21 days after receipt of the written notice along with all documentation upon which the provider intends to rely, otherwise the hospital reimbursement rate is deemed conclusively accepted by the provider.
- Any correction or adjustment of a hospital reimbursement rate resulting from the challenge must be reconciled in the first rate period after the order or judgment becomes final but within 5 years after the provider received the written notice of the rate.

[26] Ch. 2013-48, s. 3, Laws of Fla.
[27] Agency for Health Care Administration, *see supra* note 8.

- Neither an administrative body nor court may compel the agency to pay a monetary judgment relating to hospital reimbursement rates more than 5 years after the date on which the provider received written notice.
- The periods of time set out in this bill are not tolled by the pendency of any administrative or civil proceeding.
- These clarifications are deemed remedial in nature and apply retroactively to all proceedings pending or commenced upon the act becoming law.

Other sections of related Medicaid and Kidcare statutes, ss. 383.18, 409.8132(4), 409.905(5)(c), and (6)(b), and 409.91211(3)(y), F.S., are reenacted for the purpose of incorporating the amendment made by SB 322.

The bill takes effect upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Specific timelines for filing challenges and addressing corrections or adjustments will establish finality in hospital reimbursements. The bill could affect the ability of privately owned hospitals to seek increased retroactive rate enhancements. Several administrative challenges are currently pending. The results of those petitions is unknown. Private hospitals will have 21 days from re-notice under this bill to file petitions. The fiscal impact of any subsequent challenges is indeterminate at this time according to the AHCA's analysis.[28]

[28] Agency for Health Care Administration, *see supra* note 8.

C. Government Sector Impact:

As with the private sector impact, specific timelines for filing challenges and addressing corrections or adjustments will establish finality in hospital reimbursements. The bill could affect the ability of public hospitals to seek increased retroactive rate enhancements. Several administrative challenges are currently pending. The results of those petitions is unknown. Should the state not prevail in the pending challenges, the state's liability could reach $30 million.[29] Public hospitals will have 21 days from re-notice under this bill to file petitions. The fiscal impact of any subsequent challenges is indeterminate at this time.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends sections 409.908, 383.18, 409.8132, 409.905, and 409.91211 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

[29] Agency for Health Care Administration, *see supra* note 8.

By Senator Stargel

15-01026-15 2015322__

A bill to be entitled

An act relating to Medicaid reimbursement for hospital providers; amending s. 409.908, F.S.; requiring the Agency for Health Care Administration to provide written notice, pursuant to ch. 120, F.S., to providers of hospital reimbursement rates established by the agency; providing that such notice constitutes final agency action; specifying procedures and requirements for a substantially affected provider to challenge the final agency action; providing that the failure to timely file a petition in compliance with the requirements is deemed conclusive acceptance of the reimbursement rates; specifying when a correction or adjustment of a hospital reimbursement rate required by an administrative order or civil judgment may occur; prohibiting the agency from being compelled by an administrative body or court to pay a monetary judgment relating to the establishment of hospital reimbursement rates beyond a specified date; prohibiting specified periods of time from being tolled under certain circumstances; reenacting ss. 383.18, 409.8132(4), 409.905(5)(c) and (6)(b), and 409.91211(3)(y), F.S., to incorporate the amendment made to s. 409.908, F.S., in references thereto; providing that the act is remedial and intended to clarify existing law; providing for retroactive application; providing an effective date.

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

15-01026-15 2015322__

Section 1. Paragraph (e) is added to subsection (1) of section 409.908, Florida Statutes, to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions

provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(1) Reimbursement to hospitals licensed under part I of chapter 395 must be made prospectively or on the basis of negotiation.

(e)1. Pursuant to chapter 120, the agency shall furnish to providers written notice of the hospital reimbursement rates established by the agency. The written notice constitutes final agency action. A substantially affected provider may request an administrative hearing to challenge the final agency action by filing a petition with the agency within 21 days after receipt of the written notice. The petition must include all documentation supporting the challenge upon which the provider intends to rely at the administrative hearing or in any subsequent civil action. The failure to timely file a petition in compliance with this subparagraph is deemed conclusive acceptance of the hospital reimbursement rates established by the agency.

2. A correction or adjustment of a hospital reimbursement rate that is required by an administrative order or civil judgment shall be reconciled in the first rate period after the order or judgment becomes final; however, such reconciliation may not occur more than 5 years after the date on which the provider received written notice under subparagraph 1.

3. The agency may not be compelled by an administrative body or court to pay a monetary judgment relating to the establishment of hospital reimbursement rates by the agency more than 5 years after the date on which the provider received written notice under subparagraph 1.

4. The periods of time specified in this paragraph are not tolled by the pendency of an administrative or civil proceeding.

Section 2. Section 383.18, subsection (4) of s. 409.8132, paragraph (c) of subsection (5) and paragraph (b) of subsection (6) of s. 409.905, and paragraph (y) of subsection (3) of s. 409.91211, Florida Statutes, are reenacted for the purpose of incorporating the amendment made by this act to s. 409.908, Florida Statutes, in references thereto.

Section 3. The amendment made by this act to s. 409.908, Florida Statutes, is remedial in nature, is intended to clarify existing law, and applies retroactively to all proceedings pending or commenced on or after the date on which this act takes effect.

Section 4. This act shall take effect upon becoming a law.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Higher Education, *Chair*
Appropriations Subcommittee on Education
Fiscal Policy
Judiciary
Military and Veterans Affairs, Space, and Domestic Security
Regulated Industries

JOINT COMMITTEE:
Joint Committee on Public Counsel Oversight

SENATOR KELLI STARGEL
15th District

January 27, 2015

The Honorable Aaron Bean
Senate Health Policy Committee, Chair
302 Senate Office Building
404 S. Monroe Street
Tallahassee, FL 32399

Dear Chair Bean:

I am respectfully requesting that SB 322, related to *Medical Reimbursement for Hospital Providers*, be placed on the committee agenda at your earliest convenience.

Thank you for your consideration and please do not hesitate to contact me should you have any questions.

Sincerely,

Kelli Stargel
State Senator, District 15

Cc: Sandra Stovall/ Staff Director
Celia Georgiades/ AA

REPLY TO:
❒ 2033 East Edgewood Drive, Suite 1, Lakeland, Florida 33803
❒ 324 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5015

Senate's Website: *www.flsenate.gov*

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/3/15
Meeting Date

322
Bill Number (if applicable)

Topic Medicaid Reimbursement

Amendment Barcode (if applicable)

Name Bill Bell

Job Title General Counsel

Address 306 E College Ave
Street

Tlh FL 32301
City *State* *Zip*

Phone 222-9800

Email bill@fha.org

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

Representing Fla. Hospital Assn

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/3/2015
Meeting Date

322
Bill Number (if applicable)

Topic Hospital Reimbursement

Amendment Barcode (if applicable)

Name Jan Gorrie

Job Title Lobbyist/attorney

Address 403 E. Park
Street

Phone 813-334-5288

Tallahassee FL 32301
City *State* *Zip*

Email jan@ballardfl.com

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Tampa General Hospital

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/3/15
Meeting Date

SB 322
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Hospitals Reimbursement

Name Tom Wallace

Job Title Bureau Chief, Medicaid Program Finance

Address 2727 Mahan Blvd
Street

Tallahassee FL 32308
City *State* *Zip*

Phone 850-412-3600

Email thomas.wallace@ahca.myflorida.com

Speaking: ☐ For ☐ Against ☒ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Agency for Healthcare Administration

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 190
INTRODUCER:	Senators Bean and Hays
SUBJECT:	Hospices
DATE:	January 28, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall	HP	**Pre-meeting**
2.			AHS	
3.			AP	

I. Summary:

SB 190 requires the Agency for Healthcare Administration (AHCA) to assume a need for an additional hospice provider in any ACHA-designated hospice service area with only one hospice provider that is licensed or has been issued a certificate of need (CON).

II. Present Situation:

Hospice Care

Hospice care is a continuum of palliative and supportive care for the terminally ill patient and his or her family members.[1] Hospice care is provided by a hospice team which includes physicians, nurses, medical social workers, spiritual/pastoral counselors, home health aides, therapists, bereavement counselors, and specially trained volunteers.[2] Hospices can be for-profit or non-profit and provide four levels of care:

- **Routine care** provides the patient with hospice services at home or in a home-like setting. The patient's family provides the primary care with the assistance of the hospice team.
- **Continuous care** provides the patient with skilled nursing services in his or her home during a crisis.
- **Inpatient care** is provided in a healthcare facility for symptoms of a crisis that cannot be managed in the patient's home. Inpatient care is provided on a temporary basis as determined by the patient's physician and the hospice team.
- **Respite care** is provided in a healthcare facility and is primarily to provide the patient's family members and caretakers with a period of relief.[3]

[1] Fla. Admin. Code R. 59C-1.0355.
[2] Florida Hospice and Palliative Care Association, *About Hospice*, available at http://www.floridahospices.org/hospice-palliative-care/about-hospice/, (last visited Jan. 27, 2015).
[3] Id.

Hospices in Florida

Currently, there are 71 licensed hospice providers and three providers that have received a CON but are not yet licensed in the 27 hospice services areas throughout the state. In seven of the 27 hospice service areas there is only one hospice provider that is either licensed or approved to serve that area. Those seven areas include subdistricts 5B, consisting of Pinellas County; 6A, consisting of Hillsborough County; 6C, consisting of Manatee County; 8A, consisting of Charlotte and DeSoto Counties; 8C, consisting of Glades, Hendry, and Lee Counties; 8D, consisting of Sarasota County; and 9A, consisting of Indian River County. In the most recent projections published in October, 2014, the AHCA found a need for new hospice services in subdistricts 5A, consisting of Pasco County, that already has two licensed hospice providers, and 6A, consisting of Hillsborough County.[4]

Certificates of Need (CON)

A CON is a written statement issued by the AHCA evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility, health service, or hospice.[5] The Florida CON program has three levels of review: full, expedited, and exempt.[6] A full CON review is required when establishing a new hospice or establishing an inpatient hospice facility that is part of a licensed hospice program.[7] Adding hospice services in a rural hospital in a number that does not exceed half of the hospital's licensed beds is exempt from the CON process.[8]

Determination of Need

Section 408.043(2), F.S., requires that the need for hospice services be determined based on the need for and availability of hospice services in the community where the proposed hospice services will be located and that the formula on which the CON is based discourage regional monopolies and promote competition. Currently need is determined twice annually for each individual hospice service area[9] based on whether the difference between the projected number of hospice admissions and the actual number of hospice admissions in that service area during a 12-month period is at least 350.[10] Additionally, the AHCA will generally not approve a new hospice in a service area unless all other hospice programs service that area have been operational for at least 2 years prior to the need projection or if there is a hospice program in the service area that has been granted a CON but is not yet licensed.[11]

---

[4] Agency for Health Care Administration, *Florida Need Projections for Hospice Programs*, January 2016, at p. 12, http://ahca.myflorida.com/MCHQ/CON_FA/Publications/docs/FlNeedProjections/Oct2014_HospiceNeedProjections.pdf, (last visited Jan. 15, 2015).
[5] Section 408.032(3), F.S.
[6] Section 408.036, F.S.
[7] Supra note 4, at 2 (Licensed beds designated for inpatient hospice care through contract between an existing health care facility and a licensed hospice program do not require a CON.)
[8] Section 408.036(3)(a), F.S.
[9] Currently there are 27 hospice service areas each of which encompass at least one county. These service areas are established in Fla. Admin. Code R. 59C-1.0355.
[10] Supra. note 4, at 11 (For example, if the AHCA projects 850 hospice admissions and the actual number of admissions was only 450 during the 12-month period, the difference is 400 and the AHCA would determine there is a need for a new hospice provider in that service area.)
[11] Fla. Admin. Code R. 59C-1.0355(4)(b) and (c).

III. Effect of Proposed Changes:

SB 190 requires the AHCA to assume a need for an additional hospice provider in any service area with only one hospice provider that is either currently licensed or has been issued a CON. Currently, based on the most recent need projections, the bill would require the AHCA to assume a need in the following six subdistricts: 5B, consisting of Pinellas County; 6C, consisting of Manatee County; 8A, consisting of Charlotte and DeSoto Counties; 8C, consisting of Glades, Hendry, and Lee Counties; 8D, consisting of Sarasota County; and 9A, consisting of Indian River County.[12]

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

SB 190 may have a positive fiscal impact on hospice patients in affected service areas due to increased competition between hospice providers in those areas.

SB 190 may have a negative fiscal impact on hospice providers currently providing hospice services in the affected service areas due to increased competition.

C. Government Sector Impact:

SB 190 may have a negative fiscal impact on the AHCA due to an increase in the number of inspections of the newly approved hospices the AHCA will be required to perform, however this impact may be offset by licensure fees paid by those hospices.

[12] Note: the AHCA has already found a need for an additional provider in subdistrict 6A, consisting of Hillsborough County.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 408.043 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

548226

LEGISLATIVE ACTION

Senate . House

. .

. .

. .

. .

The Committee on Health Policy (Bean) recommended the following:

Senate Amendment (with title amendment)

Delete lines 21 - 31

and insert:

the agency shall assume that there is a need for one additional hospice provider in that service area to promote competition. When approving any such additional hospice, the agency must give preference to hospice organizations that operate one or more licensed hospices in Florida and whose operating entities are Florida corporations registered to do business in the state. The inpatient hospice care component of a hospice which is a

548226

freestanding facility, or a part of a facility, which is primarily engaged in providing inpatient care and related services and is not licensed as a health care facility shall also be required to obtain a certificate of need. Provision of hospice care by any current provider of health care is a significant change in service and therefore requires a certificate of need for such services.

Section 2. This act shall take effect upon becoming law.

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

And the title is amended as follows:

Between lines 5 and 6

insert:

requiring the agency to give preference to certain hospice providers;

By Senator Bean

4-00307-15 2015190__

A bill to be entitled

An act relating to hospices; amending s. 408.043, F.S.; requiring the Agency for Health Care Administration to assume the need for an additional hospice provider in certain hospice service areas; providing an effective date.

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

Section 1. Subsection (2) of section 408.043, Florida Statutes, is amended to read:

408.043 Special provisions.—

(2) HOSPICES.—When an application is made for a certificate of need to establish or to expand a hospice, the need for such hospice shall be determined on the basis of the need for and availability of hospice services in the community. The formula on which the certificate of need is based shall discourage regional monopolies and promote competition. If an agency-designated hospice service area has only one hospice provider that is licensed or that has been issued a certificate of need, the agency shall assume that there is a need for an additional hospice provider in that service area to promote competition. The inpatient hospice care component of a hospice which is a freestanding facility, or a part of a facility, which is primarily engaged in providing inpatient care and related services and is not licensed as a health care facility shall also be required to obtain a certificate of need. Provision of hospice care by any current provider of health care is a significant change in service and therefore requires a

4-00307-15 2015190__

certificate of need for such services.

Section 2. This act shall take effect July 1, 2015.

Title 42, Chapter IV, Subchapter C, Part 438, Federal Code of Regulations (CFRs)

§438.52 Choice of MCOs, PIHPs, PAHPs, and PCCMs.

(a) *General rule.* Except as specified in paragraphs (b) and (c) of this section, a State that requires Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

(b) *Exception for rural area residents.* (1) Under any of the following programs, and subject to the requirements of paragraph (b)(2) of this section, a State may limit a rural area resident to a single MCO, PIHP, PAHP, or PCCM system:

(i) A program authorized by a plan amendment under section 1932(a) of the Act.

(ii) A waiver under section 1115 of the Act.

(iii) A waiver under section 1915(b) of the Act.

(2) A State that elects the option provided under paragraph (b)(1) of this section, must permit the beneficiary—

(i) To choose from at least two physicians or case managers; and

(ii) To obtain services from any other provider under any of the following circumstances:

(A) The service or type of provider (in terms of training, experience, and specialization) is not available within the MCO, PIHP, PAHP, or PCCM network.

(B) The provider is not part of the network, but is the main source of a service to the beneficiary, provided that—

(*1*) The provider is given the opportunity to become a participating provider under the same requirements for participation in the MCO, PIHP, PAHP, or PCCM network as other network providers of that type.

(*2*) If the provider chooses not to join the network, or does not meet the necessary qualification requirements to join, the enrollee will be transitioned to a participating provider within 60 days (after being given an opportunity to select a provider who participates).

(C) The only plan or provider available to the beneficiary does not, because of moral or religious objections, provide the service the enrollee seeks.

(D) The beneficiary's primary care provider or other provider determines that the beneficiary needs related services that would subject the beneficiary to unnecessary risk if received separately (for example, a cesarean section and a tubal ligation) and not all of the related services are available within the network.

(E) The State determines that other circumstances warrant out-of-network treatment.

(3) As used in this paragraph, "rural area" is any area other than an "urban area" as defined in §412.62(f)(1)(ii) of this chapter.

(c) *Exception for certain health insuring organizations (HIOs).* The State may limit beneficiaries to a single HIO if—

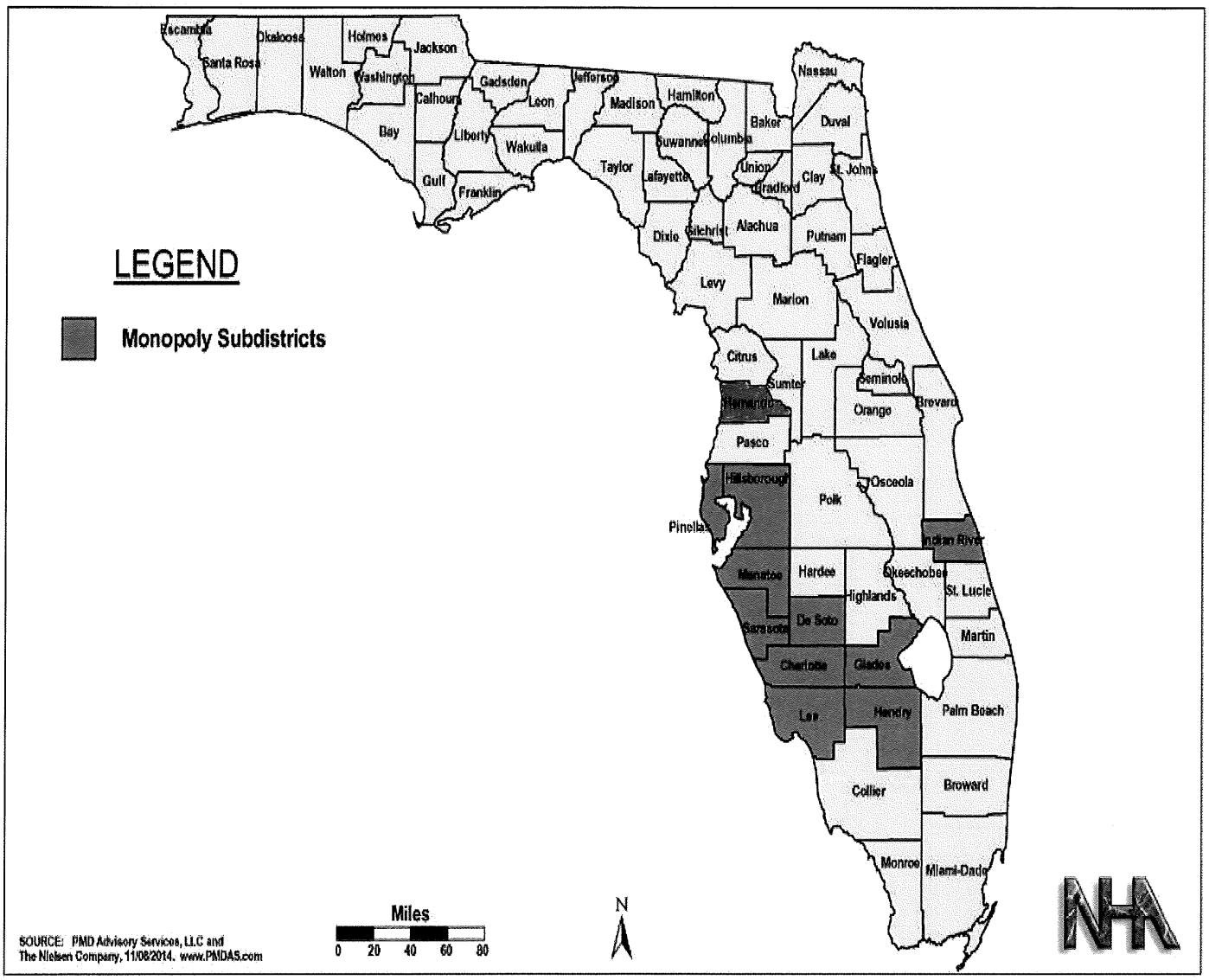
(1) The HIO is one of those described in section 1932(a)(3)(C) of the Act; and

(2) The beneficiary who enrolls in the HIO has a choice of at least two primary care providers within the entity.

(d) *Limitations on changes between primary care providers.* For an enrollee of a single MCO, PIHP, PAHP, or HIO under paragraph (b) or (c) of this section, any limitation the State imposes on his or her freedom to change between primary care providers may be no more restrictive than the limitations on disenrollment under §438.56(c).

[67 FR 41095, June 14, 2002; 67 FR 65505, Oct. 25, 2002]

Hospice Monopoly Service Areas



LTC Model Contract, Exhibits LTC PSN, Exhibit 7, Table 1 at p. 71 of 141

Long-Term Care Plan Benefit	Qualified Service Provider Types	Minimum Provider Qualifications	Minimum Network Adequacy Requirements	
			Urban Counties	Rural Counties
	Agency	400.509, F.S.		
	Health Care Service Pools	Licensed per Chapter 400, Part IX, F. S.		
Hospice	Hospice Organizations	Hospice providers shall be licensed under Chapter 400, Part IV, F. S. and meet Medicaid and Medicare conditions of participation annually.	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Intermittent and Skilled Nursing	Home Health Agency	Licensed per Ch. 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484.	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Medication Administration	RN, LPN	Licensed per Ch. 464, F.S.	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
	Home Health Agency	Licensed per Ch. 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484.		
	Unlicensed Staff Member Trained per 58A-5.0191(5), F.A.C.	Trained per 58A-5.0191(5), F.A.C.; demonstrate ability to accurately read and interpret a prescription label.		
	Nurse Registry	Licensed per 400.506, F.S.		
	Pharmacist	Licensed per Ch. 465, F.S.		
Medication Management	Home Health Agencies	Licensed per Ch. 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484. Individuals providing services shall be an RN or LPN.	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
	Nurse Registries	Licensed per 400.506, F.S. Individuals providing services shall		

Located at: http://ahca.myflorida.com/medicaid/statewide_mc/index.shtml
and then click on "Plans" link.

MMA Model Contract, Attachment II, Exhibit II-B, Table 1 at p. 55 of 84

Long-Term Care Plan Benefit	Qualified Service Provider Types	Minimum Provider Qualifications	Minimum Network Adequacy Requirements	
			Urban Counties	Rural Counties
	Living	licensed under Ch. 205, F. S.		
	General Contractor	Licensed per 459.131, F.S.		
Home Delivered Meals	Food Establishment Older Americans Act	Permit under 500.12, F.S.	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
	Older American's Act (OAA) Provider	As defined in Rule 58A-1, F.A.C.		
	CCE Provider	As defined in Ch. 410 or 430, F.S.		
	Food Service Establishment	Licensed per s. 509.241, F.S.		
Homemaker	Nurse Registry	Licensed per 400.506, F.S.	At least two (2) providers serving each county of the region	At least two (2) providers serving each county of the region
	Home Health Agency	Licensed per Ch. 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484.		
	CCE Provider	As defined in Ch. 410 or 430, F.S.		
	Center for Independent Living	As defined under 413.371, F. S.		
	Homemaker/Companion Agency	Registration in accordance with Ch. 400.509, F.S.		
	Health Care Service Pools	Licensed per Chapter 400, Part IX, F. S.		
Hospice	Hospice Organizations	Hospice providers shall be licensed under Chapter 400, Part IV, F. S. and meet Medicaid and Medicare	At least two (2) providers serving each county of the	At least two (2) providers serving each county of the

Located at: http://ahca.myflorida.com/medicaid/statewide_mc/index.shtml
and then click on "Plans" link.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-3-15
Meeting Date

190
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Hospice

Name Geoff Smith

Job Title Attorney

Address _____
Street

_____
City *State* *Zip*

Phone 850-559-5935

Email geoff@smithlawfh.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Compassionate Care Hospice

Appearing at request of Chair: ☑ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-2-15
Meeting Date

190
Bill Number (if applicable)

Topic S.B. 190

Amendment Barcode (if applicable)

Name Samira K. Beckwith

Job Title President - Hope Hospice

Address 9470 HealthPark Circle
Street

Phone 239.489.9140

City *State* *Zip*

Email Samira.Beckwith@hopehcs.org

Speaking: ☐ For ☒ Against ☐ Information

Waive Speaking: ☐ In Support ☒ Against
(The Chair will read this information into the record.)

Representing Hope Hospice

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-3-15
Meeting Date

190
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Hospice

Name Susan Smith

Job Title Attorney

Address Brevard
Street

City *State* *Zip*

Phone

Email

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Camp. Cove Hospice

Appearing at request of Chair: ☑ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 332
INTRODUCER:	Senator Grimsley
SUBJECT:	Nursing Home Facility Pneumococcal Vaccination Requirements
DATE:	January 28, 2015 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall	HP	**Favorable**
2.			AHS	
3.			AP	

I. Summary:

SB 332 removes the requirement that nursing homes vaccinate eligible new admissions with the pneumococcal polysaccharide vaccination (PPV) and instead allows eligible new admissions to be vaccinated with any pneumococcal vaccination that is recommended by the Centers for Disease Control and Prevention (CDC).

II. Present Situation:

Pneumococcal Disease and Vaccines

Pneumococcal disease is a bacterium know as Streptococcus pneumonia which can cause severe infections of the lungs (pneumonia), bloodstream (bacteremia), and lining of the brain and spinal cord (meningitis).[1] Pneumococcal disease is spread from person to person by direct contact with respiratory secretions, like saliva and mucus. Each year in the United States, pneumococcal disease kills 18,000 adults age 65 and older and thousands more end up in the hospital.[2]

Currently, the CDC recommends two vaccines to prevent pneumococcal disease, PPV and pneumococcal conjugate vaccine (PCV13).[3] PCV13 protects against 13 strains of pneumonia and PPV protects against 23 strains.[4] Both vaccines protect against illness such as meningitis and bacteremia while PCV13 also provides protection against pneumonia.[5] Section 400.141, F.S., specifically requires nursing homes to vaccinate new residents with PPV within 60 days of admission, subject to some exceptions.

---

[1] Centers for Disease Control and Prevention, *Adults: Protect Yourself with Pneumococcal Vaccines*, (Sep. 2014) http://www.cdc.gov/features/adult-pneumococcal/ (last visited Jan. 28, 2015).
[2] Id.
[3] Id.
[4] Id.
[5] Id.

III. Effect of Proposed Changes:

SB 332 amends s. 400.141, F.S., to remove the requirement that nursing homes vaccinate eligible new admissions with the PPV and instead allows eligible new admissions to be vaccinated with any pneumococcal vaccination that is recommended by the CDC.

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Nursing homes and nursing home residents may see a positive fiscal impact due to having additional pneumococcal vaccination options from which to choose.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 400.141 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Grimsley

21-00442-15 2015332__

A bill to be entitled

An act relating to nursing home facility pneumococcal vaccination requirements; amending s. 400.141, F.S.; requiring a resident of a licensed facility to be assessed for eligibility for pneumococcal vaccination or revaccination by a specified date and, if indicated, to be vaccinated or revaccinated by a specified date; deleting obsolete provisions; making technical changes; providing an effective date.

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

Section 1. Paragraph (t) of subsection (1) of section 400.141, Florida Statutes, is amended to read:

400.141 Administration and management of nursing home facilities.—

(1) Every licensed facility shall comply with all applicable standards and rules of the agency and shall:

(t) Assess each resident within 5 business days after admission ~~all residents~~ for eligibility for pneumococcal ~~polysaccharide~~ vaccination or revaccination. If indicated, the resident shall be vaccinated or revaccinated ~~(PPV) and vaccinate residents when indicated~~ within 60 days after admission ~~the effective date of this act~~ in accordance with the recommendations of the United States Centers for Disease Control and Prevention, subject to exemptions for medical contraindications and religious or personal beliefs. ~~Residents admitted after the effective date of this act shall be assessed within 5 working days of admission and, when indicated,~~

21-00442-15 2015332__

~~vaccinated within 60 days in accordance with the recommendations of the United States Centers for Disease Control and Prevention, subject to exemptions for medical contraindications and religious or personal beliefs.~~ Immunization may ~~shall~~ not be provided to a ~~any~~ resident who provides documentation that he or she has been immunized as required by this paragraph. ~~This paragraph does not prohibit~~ A resident may elect to receive ~~from receiving~~ the immunization from his or her personal physician and, if such election is made, the ~~if he or she so chooses. A~~ resident ~~who chooses to receive the immunization from his or her personal physician~~ shall provide proof of the immunization to the facility. The agency may adopt and enforce any rules necessary to comply with or implement this paragraph.

Section 2. This act shall take effect July 1, 2015.

The Florida Senate

Committee Agenda Request

To: Senator Aaron Bean, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: January 21, 2015

I respectfully request that **Senate Bill #332**, relating to Nursing Home Facility Pneumococcal Vaccination Requirements, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Denise Grimsley
Florida Senate, District 21

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-3-2015
Meeting Date

Topic Nursing home- vaccines

Bill Number SB 332 *(if applicable)*

Name Guy Jordan

Amendment Barcode _____ *(if applicable)*

Job Title Government Relations - Pfizer

Address 9628 Deer Valley
Street

Phone 850-322-7168

Tallahassee FL 32312
City *State* *Zip*

E-mail guy.jordan@pfizer.com

Speaking: ☑ For ☐ Against ☐ Information

Representing Pfizer

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/3/14
Meeting Date

332
Bill Number (if applicable)

Topic Pneumonia Vaccine

Amendment Barcode (if applicable)

Name Chris Nuland

Job Title

Address 1000 Riverside Ave #115
Street
Jacksonville, FL 32204
City *State* *Zip*

Phone 904-233-3051

Email nulandlaw@aol.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Public Health Association / Florida Chapter, American College of Physicians

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/3/15
Meeting Date

SB 332
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Immunization in Nursing Homes

Name Larry Gonzalez

Job Title General Counsel

Address 223 S. Gadsden St. *Street*

Phone 850-222-0465

Tallahassee *City* FL *State* 32301 *Zip*

Email lawgonz@earthlink.net

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Society of Health-System Pharmacists

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

WAIVE TIME IN SUPPORT

2-3-2015
Meeting Date

Topic NURSING HOME PNEUMOCCAL VACCINATIONS Bill Number SB 332 *(if applicable)*

Name STEPHEN R. WIRTH Amendment Barcode *(if applicable)*

Job Title EXECUTIVE DIRECTOR FOMA

Address 2007 APALACHEE PARKWAY Phone 878-1277
Street

TALLAHASSEE FL 32301 E-mail
City *State* *Zip*

Speaking: [X] For [ ] Against [ ] Information

Representing FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION

Appearing at request of Chair: [ ] Yes [X] No Lobbyist registered with Legislature: [X] Yes [ ] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	CS/SB 382
INTRODUCER:	Health Policy Committee and Senators Sobel and Gaetz
SUBJECT:	Assisted Living Facilities
DATE:	February 3, 2015 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 382 strengthens the enforcement of current regulations for assisted living facilities (ALF or facility) by revising fines imposed for licensure violations, clarifying existing enforcement tools, and requiring an additional inspection for facilities having significant violations. Among other provisions, the bill:

- Clarifies the criteria under which the Agency for Health Care Administration (AHCA) must revoke or deny a facility's license;
- Adds certain responsible parties and AHCA personnel to the list of people who must report abuse or neglect to the Department of Children and Families' (DCF) central abuse hotline; and,
- Requires the AHCA to implement an ALF rating system by March 1, 2016, and to add certain content to its website by November 1, 2015, to help consumers select an ALF.

II. Present Situation:

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.[1] A personal service is direct physical assistance with, or supervision of, the activities of daily living and the self-

[1] Section 429.02(5), F.S. An ALF does not include an adult family-care home or a non-transient public lodging establishment.

administration of medication.[2] Activities of daily living include ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks.[3]

An ALF is required to provide care and services appropriate to the needs of the residents accepted for admission to the facility.[4] The owner or facility administrator determines whether an individual is appropriate for admission to the facility based on a number of criteria.[5] If, as determined by the facility administrator or health care provider, a resident no longer meets the criteria for continued residency or the facility is unable to meet the resident's needs, the resident must be discharged in accordance with the Resident Bill of Rights.[6]

As of December 1, 2014, there were 3,027 licensed ALFs in Florida having a total of 88,306 beds.[7] An ALF must have a standard license issued by the AHCA under part I of ch. 429, F.S., and part II of ch. 408, F.S. 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 (LNS),[8] limited mental health services (LMH),[9] and extended congregate care services (ECC).[10] There are 826 facilities with LNS specialty licenses, 260 with ECC licenses, and 955 with LMH specialty licenses.[11]

Limited Nursing Services Specialty License

An LNS specialty license enables an ALF to provide, directly or through contract, a select number of nursing services in addition to the personal services that are authorized under the standard license. The nursing services are limited to acts specified in administrative rules, may only be provided as authorized by a health care provider's order, and must be conducted and supervised in accordance with ch. 464, F.S., relating to nursing and the prevailing standard of practice in the nursing community.

Extended Congregate Care Specialty License

An ECC specialty license enables a facility to provide, directly or through contract, services performed by licensed nurses and supportive services[12] to persons who otherwise would be

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[2] Section 429.02(16), F.S.
[3] Section 429.02(1), F.S.
[4] For specific minimum standards see Fla. Admin. Code R 58A-5.0182.
[5] Section 429.26, F.S., and Fla. Admin. Code R 58A-5.0181.
[6] Section 429.28, F.S.
[7] Agency for Health Care Administration, *Assisted Living Facility Directory* (December 1, 2014), http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Assisted_Living/docs/alf/Directory_ALF.pdf (last visited Jan. 26, 2015).
[8] Section 429.07(3)(c), F.S.
[9] Section 429.075, F.S.
[10] Section 429.07(3)(b), F.S.
[11] *See* Agency for Health Care Administration, *Assisted Living Facility*, http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Assisted_Living/alf.shtml (follow the hyperlinks for the ALF directories found under the "Notices/Updates" heading) (last visited Jan. 26, 2015).
[12] Supportive services include social service needs, counseling, emotional support, networking, assistance with securing social and leisure services, shopping service, escort service, companionship, family support, information and referral, assistance in developing and implementing self-directed activities, and volunteer services. Fla. Admin. Code R. 58A-5.030(8)(a).

disqualified from continued residence in an ALF.[13] The primary purpose of ECC services is to allow residents to remain in a familiar setting as they become more impaired with physical or mental limitations. A facility licensed to provide ECC services may also admit an individual who exceeds the admission criteria for a facility having 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, a facility with an ECC license still may not serve residents who require 24-hour nursing supervision.[14]

Limited Mental Health Specialty License

An ALF that serves three or more mental health residents must obtain an LMH specialty license.[15] A mental health resident is an individual who receives social security disability income (SSDI) or supplemental security income (SSI) due to a mental disorder and who receives optional state supplementation (OSS).[16] The department must ensure that a mental health resident is assessed and determined able to live in an ALF with an LMH license.[17]

The administrator of an LMH facility must consult with a mental health resident and the resident's case manager to develop and help execute a community living support plan for the resident detailing the specific needs and services the resident requires.[18] The LMH licensee must also execute a cooperative agreement with the mental health care services provider. The cooperative agreement specifies, among other things, directions for the ALF accessing emergency and after-hours care for the mental health resident.

ALF Staff Training

Administrators and Managers

Administrators and other ALF staff must meet minimum training and education requirements established in rule by the Department of Elder Affairs (DOEA),[19] intended to assist facilities in appropriately responding to the needs of residents, maintaining resident care and facility standards, and meeting licensure requirements.[20]

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[13] An ECC program must provide additional services as required by the resident's service plan including: 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; assisting with self-administered medications or administering medications and treatments pursuant to a health care provider's order; supervising residents with dementia and cognitive impairments; health education, counseling, and implementing health-promoting programs; rehabilitative services; and escort services related to health-related appointments. Section 429.07(3)(b), F.S., and Fla. Admin. Code R. 58A-5.030.
[14] Section 429.07(3)(b), F.S.
[15] Section 429.075, F.S.
[16] Section 429.02(15), F.S. Optional State Supplementation is a cash assistance program. Its purpose is to supplement a person's income to help pay for costs in an assisted living facility, mental health residential treatment facility, or adult family care home, but it is not a Medicaid program. Department of Elder Affairs, *Florida Affordable Assisted Living: Optional State Supplementation (OSS)*, http://elderaffairs.state.fl.us/faal/statesupp.php (last visited Jan. 26, 2015).
[17] Section 394.4574(2)(a), F.S., requires a mental health resident to be assessed by a psychiatrist, clinical psychologist, clinical social worker, psychiatric nurse, or an individual who is supervised by one of these professionals to determine whether it is appropriate for the person to reside in an ALF.
[18] Fla. Admin. Code R. 58A-5.029(2)(c)3.
[19] Fla. Admin. Code R. 58A-5.0191.
[20] Section 429.52(1), F.S.

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.[21]

Administrators and managers must participate in 12 hours of continuing education in topics related to assisted living every 2 years.[22] 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.[23]

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.[24] Staff training requirements must generally be met within 30 days after staff begin employment at the facility; however, staff must have at least one hour of infection control training before providing direct care to residents. 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 complete 1 hour of elopement training and one hour of training on "do not resuscitate" orders. The staff may be required to complete training on special topics such as self-administration of medication and Alzheimer's disease, if applicable.

ECC Specific Training

The administrator and the ECC supervisor, if different from the administrator, must complete four hours of initial training in extended congregate care either prior to the facility receiving its ECC license or within 3 months after beginning employment in the facility as an administrator or ECC supervisor. The administrator and ECC supervisor 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 having Alzheimer's disease or related disorders.[25]

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 statutory and rule requirements and the delivery of personal care and supportive services in an ECC facility.[26]

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[21]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.
[22] Fla. Admin. Code R. 58A-5.0191(1)(c).
[23] Fla. Admin. Code R. 58A-5.0191.
[24] *Id*
[25] Fla. Admin. Code R. 58A-5.0191(7)(a) and (b).
[26] Fla. Admin. Code R. 58A-5.0191(7)(c).

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 having mental health diagnoses and a minimum of three hours of continuing education dealing with mental health diagnoses or mental health treatment every 2 years.[27]

Inspections and Surveys

The 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;
- To monitor facilities cited in the previous year for a class I or class II, or four or more uncorrected class III, violations;[28]
- Upon receipt of an oral or written complaint of practices that threaten the health, safety, or welfare of residents;
- If the 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; or
- To determine if a facility is operating without a license.[29]

Abbreviated Surveys

An applicant for licensure renewal is eligible for an abbreviated biennial survey by the AHCA if the applicant does not have any:
- Class I, class II, or uncorrected class III violations.
- Confirmed complaints from the long-term care ombudsman council which were reported to the AHCA by the council.
- Confirmed licensing complaints within the two licensing periods immediately preceding the current renewal date.[30]

An abbreviated survey allows for a quicker and less intrusive survey by narrowing the range of items the AHCA must inspect.[31] The AHCA must expand an abbreviated survey or conduct a full survey if violations that threaten or potentially threaten the health, safety, or security of residents are identified during an abbreviated survey.[32]

Monitoring Visits

Facilities with LNS or ECC licenses are subject to monitoring visits in which the AHCA inspects the facility for compliance with the requirements of the specialty license. An LNS licensee is

[27] Section 429.075(1), F.S. and Fla. Admin. Code R. 58A-5.0191(8).
[28] *See* "Violations and Penalties" subheading below for a description of the violations.
[29] Section 429.34, F.S.
[30] Fla. Admin. Code R. 58A-5.033(1)(a).
[31] Fla. Admin. Code R. 58A-5.033(1)(b).
[32] Fla. Admin. Code R. 58A-5.033(1)(c).

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 services and to determine if the facility is complying with applicable regulatory requirements.[33] An ECC licensee is subject to quarterly monitoring inspections. At least one registered nurse must be included in the inspection team. The 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.[34]

Violations and Penalties

Part II of ch. 408, F.S., provides general licensure standards for all facilities regulated by the AHCA. Under s. 408.813, F.S., ALFs may be subject to administrative fines imposed by the 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 the 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.
  - The AHCA must fine a facility between $5,000 and $10,000 for each class I violation.
  - During Fiscal Years 2011-2012 and 2012-2013, the AHCA entered 115 final orders for class I violations with an average fine amount of $6,585 for facilities having fewer than 100 beds and $7,454 for facilities having 100 or more beds.[35]
- **Class II violations** are those conditions that the AHCA determines directly threaten the physical or emotional health, safety, or security of the clients.
  - Examples include no qualified staff in the facility, the failure to call 911 in a timely manner for a resident in a semi-comatose state, and rodents in a food storage area.
  - The AHCA must fine a facility between $1,000 and $5,000 for each violation.
  - During Fiscal Years 2011-2012 and 2012-2013, the AHCA entered 749 final orders for class II violations with an average fine amount of $1,542 for facilities having fewer than 100 beds and $1,843 for facilities having 100 or more beds.
- **Class III violations** are those conditions that the 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.
  - The AHCA must fine a facility between $500 and $1,000 for each violation, but no fine may be imposed if the facility corrects the violation.

[33] Section 429.07(3)(c)2., F.S.
[34] Section 429.07(3)(b)2., F.S.
[35] Agency for Health Care Administration, *Senate Bill 248 Analysis* (Nov. 26, 2013) (on file with the Senate Committee on Health Policy).

- During Fiscal Years 2011-2012 and 2012-2013, the AHCA entered 507 final orders for uncorrected class III violations with an average fine amount of $766 for facilities having fewer than 100 beds and $614 for facilities having 100 or more beds.

- **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.
  - The AHCA may fine a facility between $100 and $200 for each violation but only if the problem is not corrected.
  - During Fiscal Years 2011-2012 and 2012-2013, the AHCA entered 18 final orders for uncorrected class IV violations with an average fine amount of $165 for facilities having fewer than 100 beds and $100 for facilities having 100 or more beds.[36,37,38]

In addition to financial penalties, the AHCA can take other actions against a facility. The AHCA may deny, revoke, and suspend any license for any of the actions listed in s. 429.14(1)(a)-(k), F.S. The 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.[39] The AHCA may also impose an immediate moratorium or emergency suspension on any provider if it finds any condition that presents a threat to the health, safety, or welfare of a client.[40] The AHCA is required to publicly post notification of a license suspension, revocation, or denial of a license renewal, at the facility.[41] Finally, ch. 825, F.S., Florida's Criminal Code, provides criminal penalties for the abuse, neglect, and exploitation of elderly persons[42] and disabled adults.[43]

Central Abuse Hotline

The DCF 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[44] at any hour of the day or night,

[36] 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. Section 429.19(3), F.S.
[37] Section 429.19(2), F.S.
[38] Agency for Health Care Administration, *Senate Bill 248 Analysis* (Nov. 26, 2013) (on file with the Senate Committee on Health Policy)
[39] Section 429.14(4), F.S.
[40] Section 408.814, F.S.
[41] Section 429.14(7), F.S.
[42] "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. Section 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. Section 825.104, F.S.
[43] "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. Section 825.101(4), F.S.
[44] "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. Section 415.102(27), F.S.

any day of the week.[45] 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.[46]

Florida's 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.[47] 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.[48] 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.[49] The names and 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.[50] In addition to investigating and resolving complaints, ombudsmen conduct unannounced visits to assess the quality of care in facilities, referred to as administrative assessments.

Consumer Information

Section 400.191, F.S., requires the AHCA to provide information to the public about all licensed nursing homes in the state. The information must be provided in a consumer-friendly electronic format to assist consumers and their families in comparing and evaluating nursing homes. Under s. 400.191(2), F.S., the AHCA must provide an Internet site that includes information such as a list by name and address of all nursing homes in the state, the total number of beds in each facility, and survey and deficiency information. Additional information that the AHCA may provide on the site includes the licensure status history of each facility, the rating history of each facility, and the regulatory history of each facility.

[45] 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; and immediately identify and locate prior reports of abuse, neglect, or exploitation through the central abuse hotline. Section 415.103(1), F.S.
[46] Section 415.1034, F.S.
[47] 42 U.S.C. 3058, et. seq. *See also* s. 400.0061(1), F.S.
[48] Section 400.0063, F.S.
[49] Section 400.0078(2), F.S.
[50] Section 400.0077(1)(b), F.S.

There is no similar requirement in law to provide certain consumer information to the public on the licensed ALFs in the state.

***The Miami Herald* Articles and the Governor's Assisted Living Workgroup**

Beginning on April 30, 2011, *The Miami Herald* published a four-part series, titled "Neglected to Death," which detailed abuses occurring in ALFs and the state regulatory responses to such cases. The newspaper spent a year examining thousands of state inspections, police reports, court cases, autopsy files, emails, and death certificates and conducted dozens of interviews with operators and residents throughout Florida. The series detailed examples of abuses, neglect, and deaths that took place in facilities.[51] The series also examined the state's regulatory and law enforcement agencies' responses to the problems. The newspaper concluded that the state's agencies, and in particular the AHCA, failed to enforce existing laws designed to protect Florida's citizens who reside in ALFs.[52]

Soon after *The Miami Herald* series, Governor Rick Scott vetoed HB 4045,[53] which reduced regulatory requirements on ALFs. The Governor then directed the AHCA to form a task force for the purpose of examining current assisted living regulations and oversight. The task force, referred to as the Assisted Living Workgroup, held meetings and produced two reports, one in August of 2011 and one in October of 2012. In addition to public testimony and presentations, the Assisted Living Workgroup focused on assisted living regulation, consumer information and choice, and long term care services and access. The workgroup made numerous recommendations in its two reports. [54]

III. Effect of Proposed Changes:

Section 1 amends s. 394.4574, F.S., to clarify that Medicaid managed care plans are responsible for state-supported mental health residents enrolled in their plans and that managing entities under contract with the DCF are responsible for mental health residents who are not enrolled with a Medicaid managed care plan. This section requires a mental health resident's community living support plan to 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. Finally, this section charges the entity responsible for a mental health resident with ensuring 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.

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[51] Rob Barry, Michael Sallah and Carol Marbin Miller, *Neglected to Death, Parts 1-3*, THE MIAMI HERALD, April 30, 2011 *available at* http://www.miamiherald.com/2011/04/30/2194842/once-pride-of-florida-now-scenes.html and http://www.miamiherald.com/2011/05/03/2199747/key-medical-logs-doctored-missing.html (see left side of article to access web links to the three-part series) (Last visited on Jan. 27, 2015).

[52] *Id.*

[53] House Bill 4045 (2011) repealed a requirement for the annual dissemination of a list of ALFs that had been sanctioned or fined, a requirement for an ALF to report monthly any liability claims filed against it, a requirement to disseminate the results of the inspection of each ALF, provisions concerning rule promulgation for ALFs by the DOEA, provisions concerning the collection of information regarding the cost of care in ALFs, and the authority for local governments or organizations to contribute to the cost of care of local facility residents.

[54] Agency for Health Care Administration, *Assisted Living Workgroup*, found at http://ahca.myflorida.com/SCHS/ALWG/wgmembers.shtml (last visited Jan. 27, 2015).

Section 2 amends s. 400.0074, F.S., to require the Long-Term Care Ombudsman Program's administrative assessments of facilities be comprehensive in nature. This section also requires ombudsmen to conduct an exit consultation with the facility administrator to discuss issues and concerns from the visit.

Section 3 amends s. 400.0078, F.S., to require an ALF to include a statement that retaliatory action cannot be taken against a resident for presenting grievances when that ALF provides the required information to new residents upon admission to the facility about the purpose of the Long-Term Care Ombudsman Program.

Section 4 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 two or more years before being issued a full ECC license;
- Clarifying under what circumstances the AHCA may deny or revoke a facility's ECC license;
- 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; and
- Clarifying under what circumstances the AHCA may waive one of the required monitoring visits for facilities with ECC licenses and also authorizing the AHCA to waive the required monitoring visit for facilities with an LNS license under the same conditions.

This section of the bill also creates 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 the AHCA when it has admitted one or more residents requiring ECC services, after which the 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, the AHCA must grant the facility a full 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 provisional ECC license expires.

Section 5 amends s. 429.075, F.S., to require facilities having one or more state-supported mental health residents to obtain a LMH license. Current law requires an ALF to obtain an LMH license only if it has three or more state-supported mental health residents.

Section 6 amends s. 429.14, F.S., to clarify the use of administrative penalties, to:

- Allow the AHCA to immediately revoke, rather than only deny,[55] a facility's or a controlling interest's license if that facility or controlling interest has, or had, a 25 percent or greater financial or ownership interest in a second facility that closed due to financial inability to operate or was the subject of other specified administrative sanctions;
- Add additional criteria under which the AHCA must deny or revoke a facility's license; and

[55] Denial of a license occurs when the AHCA refuses to renew the facility's license at the end of the 2-year licensure period.

- Require that the AHCA impose an immediate moratorium on a facility that fails to provide the AHCA with access to the facility, prohibits a regulatory inspection, denies access to records, or prohibits the confidential interview of facility staff or residents.

This section of the bill also clarifies that if a facility is required to relocate its residents due to AHCA action, the facility does not have to give residents 45 days' notice as required under s. 429.28(1)(k), F.S.

Section 7 amends s. 429.178, F.S., to make technical changes and to conform to changes elsewhere in the bill.

Section 8 amends s. 429.19, F.S., relating to the impositions of fines, as follows:

- The dollar amount of fines for facilities having fewer than 100 beds is set at $7,500 for class I violations, $3,000 for class II violations, $750 for class III violations, and $150 for class IV violations. These figures represent the midpoint of the current ranges for fines in current law.
- The dollar amount of fines for facilities having 100 or more beds is set at $11,250 for class I violations, $4,500 for class II violations, $1,125 for class III violations, and $225 for class IV violations. These fines are 1.5 times the amount of the fines for facilities having fewer than 100 beds.
- The bill requires the AHCA to impose a fine on a facility for a class I violation, even if the facility corrects the violation before the AHCA conducts an investigation. Facilities can still challenge such fines through an administrative hearing pursuant to ch. 120, F.S.
- The bill doubles the fines for facilities with repeat class I and class II violations.
- The bill imposes a fine on facilities with repeat class III and class IV violations stemming from the same regulation, regardless of correction. Current law prohibits the AHCA from assessing fines for corrected class III and class IV violations.
- The bill doubles the fines for class III or class IV violations if a facility is cited three or more times for one or more such violations stemming from the same regulation over the course of three licensure inspections.
- The bill substitutes a fine of $500 for failure to comply with background screening requirements. This fine will take the place of any fine assessed based on the class of violation.

Section 9 amends s. 429.256, F.S., to allow unlicensed staff to assist with several additional services that fall under the category of assistance with self-administration of medication. Specifically, unlicensed staff will be allowed to assist with:

- Taking a prefilled insulin syringe to a resident;
- The resident's use of a nebulizer, including removing the cap of a nebulizer, opening the unit dose of nebulizer solution, and pouring the prescribed premeasured dose into the dispensing cup;
- The resident's use of a glucometer to perform blood-glucose level checks;
- Putting on and taking off anti-embolism stockings;
- Applying and removing an oxygen cannula, but not titrating the oxygen levels;
- The resident's use of a continuous positive airway pressure device, but not titrating the device;

- Measuring vital signs; and
- The resident's use of colostomy bags.

Section 10 amends s. 429.28, F.S., to require the posted notice of a resident's rights, obligations, and prohibitions, to specify that complaints made to the ombudsman program, as well as the names and identities of the complainant and any residents involved, are confidential. 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.

Section 11 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 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 licensee must pay a fee to the AHCA to cover the cost of the additional inspection.

Section 12 amends s. 429.41, F.S., to provide that if a continuing care facility or a retirement community licenses part of a building for ALF services, the staffing requirements established in rule apply only to the residents receiving assisted living services.

Section 13 amends s. 429.52, F.S., to require that facilities 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 new employees provide responsible care and respond to the needs of the residents. A new 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 requiring that it be provided by a trainer registered with the DOEA.

The bill also increases the training requirements for staff who assist residents with medication from four to 6 hours.

Section 14 creates an undesignated section of law which finds that consumers need additional information in order to select an ALF. The bill requires the AHCA to implement a rating system for ALFs by March 1, 2016. This section also requires the AHCA to create a consumer guide website with information on ALFs no later than November 1, 2015. At a minimum, the website must include:

- Information on each licensed ALF such as the number and type of licensed beds, the types of licenses held by the facility, and the expiration date of the facility's license;
- A list of the facility's violations, including a summary of the violation, any sanctions imposed, and the date of any corrective action taken by the facility; and
- Links to inspection reports.

Section 15 appropriates $156,943 in recurring funds and $7,546 in nonrecurring funds from the AHCA's Health Care Trust Fund for two full-time equivalent senior attorney positions for the AHCA for the purpose of implementing the bill's regulatory provisions.

Section 16 provides an effective date of July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

CS/SB 382 requires the AHCA to conduct a new survey of an ALF within 6 months after finding a class I violation or two or more class II violations. Facilities that require the additional survey will be charged a fee to cover the cost of the additional survey. According to the AHCA, fees and fines from ALFs under current law do not cover the cost of regulating such facilities statewide.

B. Private Sector Impact:

The bill revises the fine amounts for each of the four classes of violations. Specifically, the bill sets the dollar amount of fines for facilities having fewer than 100 beds at $7,500 for class I violations, $3,000 for class II violations, $750 for class III violations, and $150 for class IV violations. Current law provides for a range of fine amounts. For example a facility cited for a class I violation can be fined between $5,000 and $10,000 under current law. Under the bill, for facilities having 100 or more beds, fines are multiplied by 1.5 to help resolve an inequity in penalties whereby small facilities can pay the same fine amount as much larger facilities. Fixing the fine amounts at the mid-point of each range will provide for more predictable outcomes for facilities that are cited for violations.

Additionally, the bill provides for the following changes to the fine amounts:

- A $2,500 fine if a facility removes a resident without cause, as determined by a state court;
- A doubling of fines for class I or II violations if the facility was previously cited for one or more class I or II violations during the last licensure inspection; and

- An imposition of a fine for class I violations regardless of whether they were corrected prior to being cited by the AHCA.

The AHCA estimates that the new fine structure will initially cost facilities cited for violations a total of approximately $1.3 million per year. However, these increased costs could be reduced by increased compliance with ALF regulations and a corresponding reduction in the number of cited violations.[56] All fines are subject to challenge through an administrative hearing under ch. 120, F.S.

Facilities having significant uncorrected violations will be more likely to see their licenses suspended or revoked under the bill.

Facilities having any state-supported mental health residents will need to meet limited mental health licensure requirements. Facilities that currently have fewer than three state-supported mental health residents and do not meet these requirements may see increased costs to comply.

Facilities with specialty licenses that meet licensure standards will have 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.

The bill requires facilities to provide all new employees who have not already gone through the ALF core training program with a 2-hour pre-service training session before they work with residents. Additionally, the bill increases the training requirements for staff who assist residents with medication from four to 6 hours. The cost of both of these training requirements is not expected to be significant.

C. Government Sector Impact:

The bill will generate approximately $1.1 million of additional net revenues for the AHCA per year when accounting for revenue generated and expenditures incurred as a result of the bill. The bill appropriates $156,943 in recurring funds, $7,546 in nonrecurring funds, and two full-time equivalent positions from the AHCA's Health Care Trust Fund for implementing the bill's regulatory provisions. These costs will likely be offset, and additional revenue will likely be generated, through the increased fines directed to the Health Care Trust Fund. The AHCA estimates, based on the number of violations cited over the past 2 years, that the new fine structure in the bill will generate approximately $1.3 million additional revenue per year. However, this amount could decrease if the new fine amounts result in increased compliance and fewer cited violations.[57]

VI. Technical Deficiencies:

None.

[56] Agency for Health Care Administration, *Senate Bill 248 Analysis* (Nov. 26, 2013) (on file with the Senate Committee on Health Policy).
[57] See Supra note 56

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 394.4574, 400.0074, 400.0078, 429.07, 429.075, 429.14, 429.178, 429.19, 429.256, 429.28, 429.34, 429.41, and 429.52.

This bill creates an undesignated section of Florida law.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on February 3, 2015:
The CS amends SB 382 to remove the requirement that the Office of Program Policy Analysis and Governmental Accountability conduct a study of ALF inter-surveyor reliability and to remove the requirement that the AHCA create a monitored ALF public comment page as well as the appropriations required to create and maintain the comment page.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
02/03/2015	.	
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The Committee on Health Policy (Flores) recommended the following:

Senate Amendment (with title amendment)

Delete lines 285 - 531

and insert:

Section 4. Subsection (2) and paragraph (c) of subsection (3) of section 419.001, Florida Statutes, are amended to read:

419.001 Site selection of community residential homes.—

(2) Homes with ~~of~~ six or fewer residents which otherwise meet the definition of a community residential home are ~~shall be~~ deemed a single-family unit and a noncommercial, residential use


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for the purpose of local laws and ordinances. Homes with ~~of~~ six or fewer residents which otherwise meet the definition of a community residential home must ~~shall~~ be allowed in single-family or multifamily zoning without approval by the local government, provided that such homes may ~~shall~~ not be located within a radius of 1,000 feet of another existing such home with six or fewer residents. Such homes with six or fewer residents may not be located within a radius of 1,200 feet of a community residential home. Such homes with six or fewer residents may ~~shall~~ not be required to comply with the notification provisions of this section; provided that, prior to licensure, the sponsoring agency provides the local government with the most recently published data compiled from the licensing entities that identifies all community residential homes and all such homes with six or fewer residents within the jurisdictional limits of the local government in which the proposed site is to be located in order to show that no other community residential home is within a radius of 1,200 feet of the proposed home with six or fewer residents and that no other such home with six or fewer residents is within a radius of 1,000 feet of the proposed home with six or fewer residents. At the time of home occupancy, the sponsoring agency must notify the local government that the home is licensed by the licensing entity.

(3)

(c) The local government may ~~shall~~ not deny the siting of a community residential home unless the local government establishes that the siting of the home at the site selected:

1. Does not otherwise conform to existing zoning regulations applicable to other multifamily uses in the area.

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2. Does not meet applicable licensing criteria established and determined by the licensing entity, including requirements that the home be located to assure the safe care and supervision of all clients in the home.

3. Would result in such a concentration of community residential homes in the area in proximity to the site selected, or would result in a combination of such homes with other residences in the community, ~~such~~ that the nature and character of the area would be substantially altered. A home that is located within a radius of 1,200 feet of another existing community residential home in a multifamily zone is deemed to ~~shall~~ be an overconcentration of such homes that substantially alters the nature and character of the area. A community residential home may not be located within a radius of 1,200 feet of a home of six or fewer residents which otherwise meets the definition of a community residential home. Distances must be measured between all community residential homes that are less than 1,200 feet apart if they serve residents who are clients of one or more of the agencies and offices described in paragraph (1)(a). A home that is located within a radius of 500 feet of an area of single-family zoning substantially alters the nature and character of the area.

Section 5. Paragraphs (b) and (c) of subsection (3) of section 429.07, Florida Statutes, are amended to read:

429.07 License required; fee.—

(3) In addition to the requirements of s. 408.806, each license granted by the agency must state the type of care for which the license is granted. Licenses shall be issued for one or more of the following categories of care: standard, extended

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congregate care, limited nursing services, or limited mental health.

(b) An extended congregate care license shall be issued to each facility that has been licensed as an assisted living facility for 2 or more years and that provides services ~~facilities providing~~, directly or through contract, ~~services~~ beyond those authorized in paragraph (a), including services performed by persons licensed under part I of chapter 464 and supportive services, as defined by rule, to persons who would otherwise be disqualified from continued residence in a facility licensed under this part. An extended congregate care license may be issued to a facility that has a provisional extended congregate care license and meets the requirements for licensure under subparagraph 2. The primary purpose of extended congregate care services is to allow residents the option of remaining in a familiar setting from which they would otherwise be disqualified for continued residency as they become more impaired. A facility licensed to provide extended congregate care 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 extended congregate care facility.

1. In order for extended congregate care services to be provided, the agency must first determine that all requirements established in law and rule are met and must specifically designate~~,~~ on the facility's license~~,~~ that such services may be provided and whether the designation applies to all or part of the facility. This ~~Such~~ designation may be made at the time of initial licensure or licensure renewal ~~relicensure~~, or upon

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request in writing by a licensee under this part and part II of chapter 408. The notification of approval or the denial of the request must ~~shall~~ be made in accordance with part II of chapter 408. Each existing facility that qualifies ~~facilities qualifying~~ to provide extended congregate care services must have maintained a standard license and may not have been subject to administrative sanctions during the previous 2 years, or since initial licensure if the facility has been licensed for less than 2 years, for any of the following reasons:

a. A class I or class II violation;

b. Three or more repeat or recurring class III violations of identical or similar resident care standards from which a pattern of noncompliance is found by the agency;

c. Three or more class III violations that were not corrected in accordance with the corrective action plan approved by the agency;

d. Violation of resident care standards which results in requiring the facility to employ the services of a consultant pharmacist or consultant dietitian;

e. Denial, suspension, or revocation of a license for another facility licensed under this part in which the applicant for an extended congregate care license has at least 25 percent ownership interest; or

f. Imposition of a moratorium pursuant to this part or part II of chapter 408 or initiation of injunctive proceedings.

The agency may deny or revoke a facility's extended congregate care license if it fails to meet the criteria for an extended congregate care license as provided in this subparagraph.

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2. If an assisted living facility has been licensed for less than 2 years, the initial extended congregate care license must be provisional and may not exceed 6 months. Within the first 3 months after the provisional license is issued, the licensee shall notify the agency, in writing, when it admits at least one extended congregate care resident, after which an unannounced inspection shall be made to determine compliance with requirements of an extended congregate care license. Failure to admit an extended congregate care resident within the first 3 months renders the extended congregate care license void. A licensee that has a provisional extended congregate care license which demonstrates compliance with all of the requirements of an extended congregate care license during the inspection shall be issued an extended congregate care license. In addition to sanctions authorized under this part, if violations are found during the inspection and the licensee fails to demonstrate compliance with all assisted living requirements during a followup inspection, the licensee shall immediately suspend extended congregate care services, and the provisional extended congregate care license expires. The agency may extend the provisional license for not more than 1 month in order to complete a followup visit.

3.~~2.~~ A facility that is licensed to provide extended congregate care services shall maintain a written progress report on each person who receives services which describes the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident’s health. A registered nurse, or appropriate designee, representing the agency shall visit the facility at least twice a year ~~quarterly~~

to monitor residents who are receiving extended congregate care services and to determine if the facility is in compliance with this part, part II of chapter 408, and relevant rules. One of the visits may be in conjunction with the regular survey. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall serve as part of the team that inspects the facility. The agency may waive one of the required yearly monitoring visits for a facility that has:

a. Held an extended congregate care license for at least 24 months; ~~been licensed for at least 24 months to provide extended congregate care services, if, during the inspection, the registered nurse determines that extended congregate care services are being provided appropriately, and if the facility has~~

b. No class I or class II violations and no uncorrected class III violations; and~~.~~

c. No ombudsman council complaints that resulted in a citation for licensure ~~The agency must first consult with the long-term care ombudsman council for the area in which the facility is located to determine if any complaints have been made and substantiated about the quality of services or care~~. ~~The agency may not waive one of the required yearly monitoring visits if complaints have been made and substantiated~~.

4.~~3.~~ A facility that is licensed to provide extended congregate care services must:

a. Demonstrate the capability to meet unanticipated resident service needs.

b. Offer a physical environment that promotes a homelike

setting, provides for resident privacy, promotes resident independence, and allows sufficient congregate space as defined by rule.

c. Have sufficient staff available, taking into account the physical plant and firesafety features of the building, to assist with the evacuation of residents in an emergency.

d. Adopt and follow policies and procedures that maximize resident independence, dignity, choice, and decisionmaking to permit residents to age in place, so that moves due to changes in functional status are minimized or avoided.

e. Allow residents or, if applicable, a resident's representative, designee, surrogate, guardian, or attorney in fact to make a variety of personal choices, participate in developing service plans, and share responsibility in decisionmaking.

f. Implement the concept of managed risk.

g. Provide, directly or through contract, the services of a person licensed under part I of chapter 464.

h. In addition to the training mandated in s. 429.52, provide specialized training as defined by rule for facility staff.

5.~~4.~~ A facility that is licensed to provide extended congregate care services is exempt from the criteria for continued residency set forth in rules adopted under s. 429.41. 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 nursing supervision. A licensed facility that provides extended congregate care services must also provide each resident with a

written copy of facility policies governing admission and retention.

~~5. The primary purpose of extended congregate care services is to allow residents, as they become more impaired, the option of remaining in a familiar setting from which they would otherwise be disqualified for continued residency. A facility licensed to provide extended congregate care 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 extended congregate care facility.~~

6. Before the admission of an individual to a facility licensed to provide extended congregate care services, the individual must undergo a medical examination as provided in s. 429.26(4) and the facility must develop a preliminary service plan for the individual.

7. If ~~When~~ a facility can no longer provide or arrange for services in accordance with the resident's service plan and needs and the facility's policy, the facility must ~~shall~~ make arrangements for relocating the person in accordance with s. 429.28(1)(k).

~~8. Failure to provide extended congregate care services may result in denial of extended congregate care license renewal.~~

(c) A limited nursing services license shall be issued to a facility that provides services beyond those authorized in paragraph (a) and as specified in this paragraph.

1. In order for limited nursing services to be provided in a facility licensed under this part, the agency must first determine that all requirements established in law and rule are

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met and must specifically designate, on the facility's license, that such services may be provided. This ~~Such~~ designation may be made at the time of initial licensure or licensure renewal ~~relicensure~~, or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with part II of chapter 408. An existing facility that qualifies ~~facilities qualifying~~ to provide limited nursing services must ~~shall~~ have maintained a standard license and may not have been subject to administrative sanctions that affect the health, safety, and welfare of residents for the previous 2 years or since initial licensure if the facility has been licensed for less than 2 years.

2. A facility ~~Facilities~~ that is ~~are~~ licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services. The report must describe~~, which report describes~~ the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. A registered nurse representing the agency shall visit the facility ~~such facilities~~ at least annually ~~twice a year~~ to monitor residents who are receiving limited nursing services and to determine if the facility is in compliance with applicable provisions of this part, part II of chapter 408, and related rules. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall also serve as part of the team that inspects such facility. Visits may be in conjunction with other agency inspections. The agency may waive the required yearly monitoring visit for a facility

that has:

a. Had a limited nursing services license for at least 24 months;

b. No class I or class II violations and no uncorrected class III violations; and

c. No ombudsman council complaints that resulted in a citation for licensure.

3. A person who receives limited nursing services under this part must meet the admission criteria established by the agency for assisted living facilities. When a resident no longer meets the admission criteria for a facility licensed under this part, arrangements for relocating the person shall be made in accordance with s. 429.28(1)(k), unless the facility is licensed to provide extended congregate care services.

Section 6. Subsection (2) of s. 393.501, Florida Statutes, is reenacted for the purpose of incorporating the amendment made by this act to s. 419.001, Florida Statutes, in references thereto.

Section 7. Paragraph (a) of subsection (1) of s. 429.22, and subsection (5) of s. 429.26, Florida Statutes, are reenacted for the purpose of incorporating the amendment made by this act to s. 429.07, Florida Statutes, in references thereto.

Section 8. Subsection (2) of s. 409.212, Florida Statutes, is reenacted for the purpose of incorporating the amendment made by this act to s. 429.075, Florida Statutes, in references thereto.

Section 9. Section 429.075, Florida Statutes, is amended to read:

429.075 Limited mental health license.—An assisted living

facility that serves one ~~three~~ or more mental health residents must obtain a limited mental health license.

(1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected ~~deficiencies or~~ violations, and must ensure that, within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. This ~~Such~~ designation may be made at the time of initial licensure or licensure renewal ~~relicensure~~ or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training must ~~will~~ be provided by or approved by the Department of Children and Families.

(2) A facility that is ~~Facilities~~ licensed to provide services to mental health residents shall provide appropriate supervision and staffing to provide for the health, safety, and welfare of such residents. A facility located in an area zoned for residential use in a municipality having a population greater than 200,000 shall also do the following:

(a) Maintain on the premises of the facility 24-hour security services provided by uniformed security personnel, licensed under part III of chapter 493 or by a licensed security officer as defined in s. 493.6101. The security officer must wear a uniform that bears at least one patch or emblem that is visible at all times and clearly displays his or her employing

agency and identity as a licensed security officer.

(b) Notify the municipality within 20 days after accepting a resident who has been discharged from the criminal justice system or who has a history of criminal arrest within the past 5 years.

(c) Maintain surveillance cameras on the premises sufficient to ensure the safety of its residents and the community at large.

(d) Maintain a log of residents who have been discharged from the criminal justice system or who have a history of criminal arrest within the past 5 years. The log must contain the name of the transferring department and the previous address for each such resident. The facility or home shall require residents to sign the log each time they enter or exit the premises. The facility shall send a copy of the log to the chief administrative officer of the municipality in which the facility is located on a quarterly basis and shall keep the log current, maintain it in an accessible area on the premises, and allow its inspection or copying within 45 days of a request by the municipality.

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

And the title is amended as follows:

Delete lines 41 - 79

and insert:

resident right; amending s. 419.001, F.S.; prohibiting the colocation of a home of six or fewer residents which otherwise meets the definition of a community residential home and a community residential home

within a certain distance; requiring the measuring of certain distances between community residential homes; amending s. 429.07, F.S.; revising the requirement that an extended congregate care license be issued to certain facilities that have been licensed as assisted living facilities under certain circumstances and authorizing the issuance of such license if a specified condition is met; providing the purpose of an extended congregate care license; specifying that the initial extended congregate care license of an assisted living facility is provisional under certain circumstances; requiring a licensee to notify the Agency for Health Care Administration if it accepts a resident who qualifies for extended congregate care services; requiring the agency to inspect the facility for compliance with the requirements of an extended congregate care license; requiring the issuance of an extended congregate care license under certain circumstances; requiring the licensee to immediately suspend extended congregate care services under certain circumstances; requiring a registered nurse representing the agency to visit the facility at least twice a year, rather than quarterly, to monitor residents who are receiving extended congregate care services; authorizing the agency to waive one of the required yearly monitoring visits under certain circumstances; authorizing the agency to deny or revoke a facility’s extended congregate care license; requiring a registered nurse representing the agency

to visit the facility at least annually, rather than twice a year, to monitor residents who are receiving limited nursing services; providing that such monitoring visits may be conducted in conjunction with other inspections by the agency; authorizing the agency to waive the required yearly monitoring visit for a facility that is licensed to provide limited nursing services under certain circumstances; reenacting s. 393.501(2), F.S., to incorporate the amendment made to s. 419.001, F.S., in references thereto; reenacting ss. 429.22(1)(a) and 429.26(5), F.S., to incorporate the amendment made to s. 429.07, F.S., in references thereto; reenacting s. 409.212(2), F.S., to incorporate the amendment made to s. 429.075, F.S., in references thereto; amending s. 429.075, F.S.; requiring that an assisted living facility that serves one or more mental health residents, rather than three or more such residents, obtain a limited mental health license; requiring the adoption, use and maintenance of certain security measures and practices by assisted living facilities in municipalities having a population greater than 200,000; amending s.

627072

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/03/2015	.	
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The Committee on Health Policy (Sobel) recommended the following:

Senate Amendment (with title amendment)

Delete lines 998 - 1076

and insert:

Section 14. The Legislature finds that consumers need additional information on the quality of care and service in assisted living facilities in order to select the best facility for themselves or their loved ones. Therefore, the Agency for Health Care Administration shall:

(1) Implement a rating system for assisted living

627072

facilities by March 1, 2016. The agency shall adopt rules to administer this subsection.

(2) By November 1, 2015, create content that is easily accessible through the front page of the agency's website. At a minimum, the content must include:

(a) Information on each licensed assisted living facility, including, but not limited to:

1. The name and address of the facility.

2. The number and type of licensed beds in the facility.

3. The types of licenses held by the facility.

4. The facility's license expiration date and status.

5. Other relevant information that the agency currently collects.

(b) A list of the facility's violations, including, for each violation:

1. A summary of the violation which is presented in a manner understandable by the general public;

2. Any sanctions imposed by final order; and

3. The date the corrective action was confirmed by the agency.

(c) Links to inspection reports that the agency has on file.

Section 15. For the 2015-2016 fiscal year, the sums of $156,943 in recurring funds and $7,546 in nonrecurring funds are appropriated from the Health Care Trust Fund and two full-time equivalent senior attorney positions with associated salary rate of 103,652 are authorized in the Agency for Health Care Administration for the purpose of implementing the regulatory provisions of this act.

627072

Section 16. This act shall take effect July 1, 2015.

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

And the title is amended as follows:

Delete lines 140 - 144

and insert:

conforming a cross-reference; requiring the agency to

By Senator Sobel

33-00555-15 2015382__

A bill to be entitled

An act relating to assisted living facilities; amending s. 394.4574, F.S.; providing that Medicaid managed care plans are responsible for mental health residents enrolled in Medicaid; specifying that managing entities under contract with the Department of Children and Families are responsible for mental health residents who are not enrolled in a Medicaid managed care plan; deleting a provision to conform to changes made by the act; requiring that the community living support plan be completed and provided to the administrator of a facility upon the mental health resident's admission; requiring the community living support plan to be updated when there is a significant change to the mental health resident's behavioral health status; requiring the case manager assigned to a mental health resident for whom the mental health services provider is responsible to keep a record of the date and time of face-to-face interactions with the resident and to make the record available to the entity responsible for inspection; requiring that the record be maintained for a specified time; requiring the responsible entity to ensure that there is adequate and consistent monitoring and enforcement of community living support plans and cooperative agreements and that concerns are reported to the appropriate regulatory oversight organization under certain circumstances; amending s. 400.0074, F.S.; requiring that an administrative assessment conducted

Florida Senate - 2015 **SB 382**

33-00555-15 2015382__

by a local council be comprehensive in nature; requiring a local council to conduct an exit consultation with the facility administrator or administrator designee to discuss issues and concerns in areas affecting residents' rights, health, safety, and welfare and make recommendations for any needed improvements; amending s. 400.0078, F.S.; requiring that a resident of a long-term care facility, or his or her representative, be informed that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right; amending s. 429.07, F.S.; revising the requirement that an extended congregate care license be issued to certain facilities that have been licensed as assisted living facilities under certain circumstances and authorizing the issuance of such license if a specified condition is met; providing the purpose of an extended congregate care license; specifying that the initial extended congregate care license of an assisted living facility is provisional under certain circumstances; requiring a licensee to notify the Agency for Health Care Administration if it accepts a resident who qualifies for extended congregate care services; requiring the agency to inspect the facility for compliance with the requirements of an extended congregate care license; requiring the issuance of an extended congregate care license under certain circumstances; requiring the licensee to immediately suspend extended congregate

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

care services under certain circumstances; requiring a registered nurse representing the agency to visit the facility at least twice a year, rather than quarterly, to monitor residents who are receiving extended congregate care services; authorizing the agency to waive one of the required yearly monitoring visits under certain circumstances; authorizing the agency to deny or revoke a facility's extended congregate care license; requiring a registered nurse representing the agency to visit the facility at least annually, rather than twice a year, to monitor residents who are receiving limited nursing services; providing that such monitoring visits may be conducted in conjunction with other inspections by the agency; authorizing the agency to waive the required yearly monitoring visit for a facility that is licensed to provide limited nursing services under certain circumstances; amending s. 429.075, F.S.; requiring that an assisted living facility that serves one or more mental health residents, rather than three or more such residents, obtain a limited mental health license; amending s. 429.14, F.S.; revising the circumstances under which the agency may deny, revoke, or suspend the license of an assisted living facility and impose an administrative fine; requiring the agency to deny or revoke the license of an assisted living facility under certain circumstances; requiring the agency to impose an immediate moratorium on the license of an assisted living facility under certain circumstances;

prohibiting a licensee from restricting agency staff from accessing and copying certain records or conducting certain interviews; deleting a provision requiring the agency to provide a list of facilities with denied, suspended, or revoked licenses to the Department of Business and Professional Regulation; exempting a facility from the 45-day notice requirement if it is required to relocate some or all of its residents; specifying that the exemption does not exempt a facility from any deadlines for corrective action set by the agency; amending s. 429.178, F.S.; conforming cross-references; amending s. 429.19, F.S.; revising the amounts and uses of administrative fines; requiring the agency to levy a fine for violations that are corrected before an inspection if noncompliance occurred within a specified period of time; deleting factors that the agency is required to consider in determining penalties and fines; amending s. 429.256, F.S.; revising the term "assistance with self-administration of medication" as it relates to the Assisted Living Facilities Act; amending s. 429.28, F.S.; providing notice requirements for informing facility residents that the name and identity of the resident and complainant in any complaint made to the State Long-Term Care Ombudsman Program or a local long-term care ombudsman council is confidential and that retaliatory action may not be taken against a resident for presenting grievances or for exercising any other

resident right; requiring that a facility that terminates an individual's residency after the filing of a complaint be fined if good cause is not shown for the termination; amending s. 429.34, F.S.; requiring certain persons to report elder abuse in assisted living facilities; requiring the agency to regularly inspect each licensed assisted living facility; requiring the agency to conduct more frequent inspections under certain circumstances; requiring the licensee to pay a fee for the cost of additional inspections; requiring the agency to annually adjust the fee; amending s. 429.41, F.S.; providing that certain staffing requirements apply only to residents in continuing care facilities who are receiving relevant services; amending s. 429.52, F.S.; requiring each newly hired employee of an assisted living facility to attend a preservice orientation provided by the assisted living facility; requiring the employee and administrator to sign a statement that the employee completed the required preservice orientation and keep the signed statement in the employee's personnel record; requiring 2 additional hours of training for assistance with medication; conforming a cross-reference; requiring the Office of Program Policy Analysis and Government Accountability to study the reliability of facility surveys and submit to the Governor and the Legislature its findings and recommendations; requiring the agency to implement a rating system for assisted living

facilities by a specified date, adopt rules, and create content for the agency's website by a specified date which provides consumers information regarding assisted living facilities; providing criteria for the content; providing appropriations; providing an effective date.

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

Section 1. Section 394.4574, Florida Statutes, is amended to read:

394.4574 ~~Department~~ Responsibilities for coordination of services for a mental health resident who resides in an assisted living facility that holds a limited mental health license.—

(1) As used in this section, the term "mental health resident" ~~"mental health resident," for purposes of this section,~~ means 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.

(2) Medicaid managed care plans are responsible for Medicaid-enrolled mental health residents, and managing entities under contract with the department are responsible for mental health residents who are not enrolled in a Medicaid health plan. A Medicaid managed care plan or a managing entity, as appropriate, shall ~~The department must~~ ensure that:

(a) A mental health resident has been assessed by a

psychiatrist, clinical psychologist, clinical social worker, or psychiatric nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be provided to the administrator of the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident if it was completed within 90 days before ~~prior to~~ admission to the facility.

(b) A cooperative agreement, as required in s. 429.075, is developed by ~~between~~ the mental health care services provider that serves a mental health resident and the administrator of the assisted living facility with a limited mental health license in which the mental health resident is living. ~~Any entity that provides Medicaid prepaid health plan services shall ensure the appropriate coordination of health care services with an assisted living facility in cases where a Medicaid recipient is both a member of the entity's prepaid health plan and a resident of the assisted living facility. If the entity is at risk for Medicaid targeted case management and behavioral health services, the entity shall inform the assisted living facility of the procedures to follow should an emergent condition arise.~~

(c) The community living support plan, as defined in s. 429.02, has been prepared by a mental health resident and his or her ~~a~~ mental health case manager ~~of that resident~~ in consultation with the administrator of the facility or the administrator's designee. The plan must be completed and

provided to the administrator of the assisted living facility with a limited mental health license in which the mental health resident lives upon the resident's admission. The support plan and the agreement may be in one document.

(d) The assisted living facility with a limited mental health license is provided with documentation that the individual meets the definition of a mental health resident.

(e) The mental health services provider assigns a case manager to each mental health resident for whom the entity is responsible ~~who lives in an assisted living facility with a limited mental health license~~. The case manager shall coordinate ~~is responsible for coordinating~~ the development ~~of~~ and implementation of the community living support plan defined in s. 429.02. The plan must be updated at least annually, or when there is a significant change in the resident's behavioral health status, such as an inpatient admission or a change in medication, level of service, or residence. Each case manager shall keep a record of the date and time of any face-to-face interaction with the resident and make the record available to the responsible entity for inspection. The record must be retained for at least 2 years after the date of the most recent interaction.

(f) Adequate and consistent monitoring and enforcement of community living support plans and cooperative agreements are conducted by the resident's case manager.

(g) Concerns are reported to the appropriate regulatory oversight organization if a regulated provider fails to deliver appropriate services or otherwise acts in a manner that has the potential to result in harm to the resident.

(3) The Secretary of Children and Families, in consultation with the Agency for Health Care Administration, shall ~~annually~~ require each district administrator to develop, with community input, a detailed annual plan that demonstrates ~~detailed plans that demonstrate~~ how the district will ensure the provision of state-funded mental health and substance abuse treatment services to residents of assisted living facilities that hold a limited mental health license. This plan ~~These plans~~ must be consistent with the substance abuse and mental health district plan developed pursuant to s. 394.75 and must address case management services; access to consumer-operated drop-in centers; access to services during evenings, weekends, and holidays; supervision of the clinical needs of the residents; and access to emergency psychiatric care.

Section 2. Subsection (1) of section 400.0074, Florida Statutes, is amended, and paragraph (h) is added to subsection (2) of that section, to read:

400.0074 Local ombudsman council onsite administrative assessments.—

(1) In addition to any specific investigation conducted pursuant to a complaint, the local council shall conduct, at least annually, an onsite administrative assessment of each nursing home, assisted living facility, and adult family-care home within its jurisdiction. This administrative assessment must be comprehensive in nature and must ~~shall~~ focus on factors affecting residents' ~~the~~ rights, health, safety, and welfare ~~of the residents~~. Each local council is encouraged to conduct a similar onsite administrative assessment of each additional long-term care facility within its jurisdiction.

(2) An onsite administrative assessment conducted by a local council shall be subject to the following conditions:

(h) The local council shall conduct an exit consultation with the facility administrator or administrator's designee to discuss issues and concerns in areas affecting residents' rights, health, safety, and welfare and, if needed, make recommendations for improvement.

Section 3. Subsection (2) of section 400.0078, Florida Statutes, is amended to read:

400.0078 Citizen access to State Long-Term Care Ombudsman Program services.—

(2) ~~Every resident or representative of a resident shall receive,~~ Upon admission to a long-term care facility, each resident or representative of a resident must receive information regarding the purpose of the State Long-Term Care Ombudsman Program, the statewide toll-free telephone number for receiving complaints, information that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right, and other relevant information regarding how to contact the program. Each resident or his or her representative ~~Residents or their representatives~~ must be furnished additional copies of this information upon request.

Section 4. Paragraphs (b) and (c) of subsection (3) of section 429.07, Florida Statutes, are amended to read:

429.07 License required; fee.—

(3) In addition to the requirements of s. 408.806, each license granted by the agency must state the type of care for which the license is granted. Licenses shall be issued for one

or more of the following categories of care: standard, extended congregate care, limited nursing services, or limited mental health.

(b) An extended congregate care license shall be issued to each facility that has been licensed as an assisted living facility for 2 or more years and that provides services ~~facilities providing~~, directly or through contract, ~~services~~ beyond those authorized in paragraph (a), including services performed by persons licensed under part I of chapter 464 and supportive services, as defined by rule, to persons who would otherwise be disqualified from continued residence in a facility licensed under this part. An extended congregate care license may be issued to a facility that has a provisional extended congregate care license and meets the requirements for licensure under subparagraph 2. The primary purpose of extended congregate care services is to allow residents the option of remaining in a familiar setting from which they would otherwise be disqualified for continued residency as they become more impaired. A facility licensed to provide extended congregate care 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 extended congregate care facility.

1. In order for extended congregate care services to be provided, the agency must first determine that all requirements established in law and rule are met and must specifically designate~~,~~ on the facility's license~~,~~ that such services may be provided and whether the designation applies to all or part of the facility. This ~~Such~~ designation may be made at the time of

initial licensure or licensure renewal ~~relicensure~~, or upon request in writing by a licensee under this part and part II of chapter 408. The notification of approval or the denial of the request shall be made in accordance with part II of chapter 408. Each existing facility that qualifies ~~facilities qualifying~~ to provide extended congregate care services must have maintained a standard license and may not have been subject to administrative sanctions during the previous 2 years, or since initial licensure if the facility has been licensed for less than 2 years, for any of the following reasons:

a. A class I or class II violation;

b. Three or more repeat or recurring class III violations of identical or similar resident care standards from which a pattern of noncompliance is found by the agency;

c. Three or more class III violations that were not corrected in accordance with the corrective action plan approved by the agency;

d. Violation of resident care standards which results in requiring the facility to employ the services of a consultant pharmacist or consultant dietitian;

e. Denial, suspension, or revocation of a license for another facility licensed under this part in which the applicant for an extended congregate care license has at least 25 percent ownership interest; or

f. Imposition of a moratorium pursuant to this part or part II of chapter 408 or initiation of injunctive proceedings.

The agency may deny or revoke a facility's extended congregate care license if it fails to meet the criteria for an extended

congregate care license as provided in this subparagraph.

2. If an assisted living facility has been licensed for less than 2 years, the initial extended congregate care license must be provisional and may not exceed 6 months. Within the first 3 months after the provisional license is issued, the licensee shall notify the agency, in writing, when it admits at least one extended congregate care resident, after which an unannounced inspection shall be made to determine compliance with requirements of an extended congregate care license. Failure to admit an extended congregate care resident within the first 3 months renders the extended congregate care license void. A licensee that has a provisional extended congregate care license which demonstrates compliance with all of the requirements of an extended congregate care license during the inspection shall be issued an extended congregate care license. In addition to sanctions authorized under this part, if violations are found during the inspection and the licensee fails to demonstrate compliance with all assisted living requirements during a followup inspection, the licensee shall immediately suspend extended congregate care services, and the provisional extended congregate care license expires. The agency may extend the provisional license for not more than 1 month in order to complete a followup visit.

3.~~2.~~ A facility that is licensed to provide extended congregate care services shall maintain a written progress report on each person who receives services which describes the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. A registered nurse, or appropriate designee, representing the

agency shall visit the facility at least twice a year ~~quarterly~~ to monitor residents who are receiving extended congregate care services and to determine if the facility is in compliance with this part, part II of chapter 408, and relevant rules. One of the visits may be in conjunction with the regular survey. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall serve as part of the team that inspects the facility. The agency may waive one of the required yearly monitoring visits for a facility that has:

a. Held an extended congregate care license for at least 24 months; ~~been licensed for at least 24 months to provide extended congregate care services, if, during the inspection, the registered nurse determines that extended congregate care services are being provided appropriately, and if the facility has~~

b. No class I or class II violations and no uncorrected class III violations; and~~.~~

c. No ombudsman council complaints that resulted in a citation for licensure ~~The agency must first consult with the long-term care ombudsman council for the area in which the facility is located to determine if any complaints have been made and substantiated about the quality of services or care. The agency may not waive one of the required yearly monitoring visits if complaints have been made and substantiated.~~

4.~~3.~~ A facility that is licensed to provide extended congregate care services must:

a. Demonstrate the capability to meet unanticipated resident service needs.

b. Offer a physical environment that promotes a homelike setting, provides for resident privacy, promotes resident independence, and allows sufficient congregate space as defined by rule.

c. Have sufficient staff available, taking into account the physical plant and firesafety features of the building, to assist with the evacuation of residents in an emergency.

d. Adopt and follow policies and procedures that maximize resident independence, dignity, choice, and decisionmaking to permit residents to age in place, so that moves due to changes in functional status are minimized or avoided.

e. Allow residents or, if applicable, a resident's representative, designee, surrogate, guardian, or attorney in fact to make a variety of personal choices, participate in developing service plans, and share responsibility in decisionmaking.

f. Implement the concept of managed risk.

g. Provide, directly or through contract, the services of a person licensed under part I of chapter 464.

h. In addition to the training mandated in s. 429.52, provide specialized training as defined by rule for facility staff.

5.~~4.~~ A facility that is licensed to provide extended congregate care services is exempt from the criteria for continued residency set forth in rules adopted under s. 429.41. 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 nursing supervision. A licensed facility that provides extended

congregate care services must also provide each resident with a written copy of facility policies governing admission and retention.

~~5. The primary purpose of extended congregate care services is to allow residents, as they become more impaired, the option of remaining in a familiar setting from which they would otherwise be disqualified for continued residency. A facility licensed to provide extended congregate care 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 extended congregate care facility.~~

6. Before the admission of an individual to a facility licensed to provide extended congregate care services, the individual must undergo a medical examination as provided in s. 429.26(4) and the facility must develop a preliminary service plan for the individual.

7. If ~~When~~ a facility can no longer provide or arrange for services in accordance with the resident's service plan and needs and the facility's policy, the facility must ~~shall~~ make arrangements for relocating the person in accordance with s. 429.28(1)(k).

~~8. Failure to provide extended congregate care services may result in denial of extended congregate care license renewal.~~

(c) A limited nursing services license shall be issued to a facility that provides services beyond those authorized in paragraph (a) and as specified in this paragraph.

1. In order for limited nursing services to be provided in a facility licensed under this part, the agency must first

determine that all requirements established in law and rule are met and must specifically designate, on the facility's license, that such services may be provided. This ~~Such~~ designation may be made at the time of initial licensure or licensure renewal ~~relicensure~~, or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with part II of chapter 408. An existing facility that qualifies ~~facilities qualifying~~ to provide limited nursing services must ~~shall~~ have maintained a standard license and may not have been subject to administrative sanctions that affect the health, safety, and welfare of residents for the previous 2 years or since initial licensure if the facility has been licensed for less than 2 years.

2. A facility ~~Facilities~~ that is ~~are~~ licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services. The~~,~~ ~~which~~ report must describe ~~describes~~ the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. A registered nurse representing the agency shall visit the facility ~~such facilities~~ at least annually ~~twice a year~~ to monitor residents who are receiving limited nursing services and to determine if the facility is in compliance with applicable provisions of this part, part II of chapter 408, and related rules. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall also serve as part of the team that inspects such facility. Visits may be in conjunction with other agency inspections. The agency may waive

the required yearly monitoring visit for a facility that has:

a. Had a limited nursing services license for at least 24 months;

b. No class I or class II violations and no uncorrected class III violations; and

c. No ombudsman council complaints that resulted in a citation for licensure.

3. A person who receives limited nursing services under this part must meet the admission criteria established by the agency for assisted living facilities. When a resident no longer meets the admission criteria for a facility licensed under this part, arrangements for relocating the person shall be made in accordance with s. 429.28(1)(k), unless the facility is licensed to provide extended congregate care services.

Section 5. Section 429.075, Florida Statutes, is amended to read:

429.075 Limited mental health license.—An assisted living facility that serves one ~~three~~ or more mental health residents must obtain a limited mental health license.

(1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected ~~deficiencies or~~ violations, and must ensure that, within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. This ~~Such~~ designation may be made at the time of initial licensure or licensure renewal ~~relicensure~~ or upon request in writing by a

licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training must ~~will~~ be provided by or approved by the Department of Children and Families.

(2) A facility that is ~~Facilities~~ licensed to provide services to mental health residents must ~~shall~~ provide appropriate supervision and staffing to provide for the health, safety, and welfare of such residents.

(3) A facility that has a limited mental health license must:

(a) Have a copy of each mental health resident's community living support plan and the cooperative agreement with the mental health care services provider. The support plan and the agreement may be combined.

(b) Have documentation ~~that is~~ provided by the Department of Children and Families that each mental health resident has been assessed and determined to be able to live in the community in an assisted living facility that has ~~with~~ a limited mental health license.

(c) Make the community living support plan available for inspection by the resident, the resident's legal guardian or~~,~~ ~~the resident's~~ health care surrogate, and other individuals who have a lawful basis for reviewing this document.

(d) Assist the mental health resident in carrying out the activities identified in the individual's community living support plan.

(4) A facility that has ~~with~~ a limited mental health license may enter into a cooperative agreement with a private

mental health provider. For purposes of the limited mental health license, the private mental health provider may act as the case manager.

Section 6. Section 429.14, Florida Statutes, is amended to read:

429.14 Administrative penalties.—

(1) In addition to the requirements of part II of chapter 408, the agency may deny, revoke, and suspend any license issued under this part and impose an administrative fine in the manner provided in chapter 120 against a licensee for a violation of ~~any provision of~~ this part, part II of chapter 408, or applicable rules, or for any of the following actions by a licensee, ~~for the actions of~~ any person subject to level 2 background screening under s. 408.809, or ~~for the actions of~~ any facility staff ~~employee~~:

(a) An intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility.

(b) A ~~The~~ determination by the agency that the owner lacks the financial ability to provide continuing adequate care to residents.

(c) Misappropriation or conversion of the property of a resident of the facility.

(d) Failure to follow the criteria and procedures provided under part I of chapter 394 relating to the transportation, voluntary admission, and involuntary examination of a facility resident.

(e) A citation for ~~of~~ any of the following violations ~~deficiencies~~ as specified in s. 429.19:

1. One or more cited class I violations ~~deficiencies~~.

2. Three or more cited class II violations ~~deficiencies~~.

3. Five or more cited class III violations ~~deficiencies~~ that have been cited on a single survey and have not been corrected within the times specified.

(f) Failure to comply with the background screening standards of this part, s. 408.809(1), or chapter 435.

(g) Violation of a moratorium.

(h) Failure of the license applicant, the licensee during licensure renewal ~~relicensure~~, or a licensee that holds a provisional license to meet the minimum license requirements of this part, or related rules, at the time of license application or renewal.

(i) An intentional or negligent life-threatening act in violation of the uniform firesafety standards for assisted living facilities or other firesafety standards which ~~that~~ threatens the health, safety, or welfare of a resident of a facility, as communicated to the agency by the local authority having jurisdiction or the State Fire Marshal.

(j) Knowingly operating any unlicensed facility or providing without a license any service that must be licensed under this chapter or chapter 400.

(k) Any act constituting a ground upon which application for a license may be denied.

(2) Upon notification by the local authority having jurisdiction or by the State Fire Marshal, the agency may deny or revoke the license of an assisted living facility that fails to correct cited fire code violations that affect or threaten the health, safety, or welfare of a resident of a facility.

(3) The agency may deny or revoke a license of an ~~to any~~

applicant or controlling interest as defined in part II of chapter 408 which has or had a 25 percent ~~25-percent~~ or greater financial or ownership interest in any other facility that is licensed under this part, or in any entity licensed by this state or another state to provide health or residential care, if that ~~which~~ facility or entity during the 5 years before ~~prior to~~ the application for a license closed due to financial inability to operate; had a receiver appointed or a license denied, suspended, or revoked; was subject to a moratorium; or had an injunctive proceeding initiated against it.

(4) The agency shall deny or revoke the license of an assisted living facility if any of the following apply:

(a) There are two moratoria, issued pursuant to this part or part II of chapter 408, within a 2-year period which are imposed by final order.

(b) The facility is cited for two or more class I violations arising from unrelated circumstances during the same survey or investigation.

(c) The facility is cited for two or more class I violations arising from separate surveys or investigations within a 2-year period ~~that has two or more class I violations that are similar or identical to violations identified by the agency during a survey, inspection, monitoring visit, or complaint investigation occurring within the previous 2 years~~.

(5) An action taken by the agency to suspend, deny, or revoke a facility's license under this part or part II of chapter 408, in which the agency claims that the facility owner or an employee of the facility has threatened the health, safety, or welfare of a resident of the facility, shall be heard

by the Division of Administrative Hearings of the Department of Management Services within 120 days after receipt of the facility's request for a hearing, unless that time limitation is waived by both parties. The administrative law judge shall ~~must~~ render a decision within 30 days after receipt of a proposed recommended order.

(6) As provided under s. 408.814, the agency shall impose an immediate moratorium on an assisted living facility that fails to provide the agency access to the facility or prohibits the agency from conducting a regulatory inspection. The licensee may not restrict agency staff in accessing and copying records or in conducting confidential interviews with facility staff or any individual who receives services from the facility ~~provide to the Division of Hotels and Restaurants of the Department of Business and Professional Regulation, on a monthly basis, a list of those assisted living facilities that have had their licenses denied, suspended, or revoked or that are involved in an appellate proceeding pursuant to s. 120.60 related to the denial, suspension, or revocation of a license~~.

(7) Agency notification of a license suspension or revocation, or denial of a license renewal, shall be posted and visible to the public at the facility.

(8) If a facility is required to relocate some or all of its residents due to agency action, that facility is exempt from the 45 days' notice requirement imposed under s. 429.28(1)(k). This subsection does not exempt the facility from any deadline for corrective action set by the agency.

Section 7. Paragraphs (a) and (b) of subsection (2) of section 429.178, Florida Statutes, are amended to read:

429.178 Special care for persons with Alzheimer's disease or other related disorders.—

(2)(a) An individual who is employed by a facility that provides special care for residents who have ~~with~~ Alzheimer's disease or other related disorders, and who has regular contact with such residents, must complete up to 4 hours of initial dementia-specific training developed or approved by the department. The training must ~~shall~~ be completed within 3 months after beginning employment and ~~shall~~ satisfy the core training requirements of s. 429.52(3)(g) ~~s. 429.52(2)(g)~~.

(b) A direct caregiver who is employed by a facility that provides special care for residents who have ~~with~~ Alzheimer's disease or other related disorders, and who provides direct care to such residents, must complete the required initial training and 4 additional hours of training developed or approved by the department. The training must ~~shall~~ be completed within 9 months after beginning employment and ~~shall~~ satisfy the core training requirements of s. 429.52(3)(g) ~~s. 429.52(2)(g)~~.

Section 8. Section 429.19, Florida Statutes, is amended to read:

429.19 Violations; imposition of administrative fines; grounds.—

(1) In addition to the requirements of part II of chapter 408, the agency shall impose an administrative fine in the manner provided in chapter 120 for the violation of any provision of this part, part II of chapter 408, and applicable rules by an assisted living facility, for the actions of any person subject to level 2 background screening under s. 408.809, for the actions of any facility employee, or for an intentional

or negligent act seriously affecting the health, safety, or welfare of a resident of the facility.

(2) Each violation of this part and adopted rules shall be classified according to the nature of the violation and the gravity of its probable effect on facility residents.

(a) The agency shall indicate the classification on the written notice of the violation as follows:

1.~~(a)~~ Class "I" violations are defined in s. 408.813. The agency shall impose an administrative fine of $7,500 for each ~~a~~ cited class I violation in a facility that is licensed for fewer than 100 beds at the time of the ~~in an amount not less than $5,000 and not exceeding $10,000 for each~~ violation. The agency shall impose an administrative fine of $11,250 for each cited class I violation in a facility that is licensed for 100 or more beds at the time of the violation. If the agency has knowledge of a class I violation that occurred within 12 months before an inspection, a fine must be levied for that violation regardless of whether the noncompliance was corrected before the inspection.

2.~~(b)~~ Class "II" violations are defined in s. 408.813. The agency shall impose an administrative fine of $3,000 for each ~~a~~ cited class II violation in a facility that is licensed for fewer than 100 beds at the time of the ~~in an amount not less than $1,000 and not exceeding $5,000 for each~~ violation. The agency shall impose an administrative fine of $4,500 for each cited class II violation in a facility that is licensed for 100 or more beds at the time of the violation.

3.~~(c)~~ Class "III" violations are defined in s. 408.813. The agency shall impose an administrative fine of $750 for each ~~a~~

cited class III violation in a facility that is licensed for fewer than 100 beds at the time of the ~~in an amount not less than $500 and not exceeding $1,000 for each~~ violation. The agency shall impose an administrative fine of $1,125 for each cited class III violation in a facility that is licensed for 100 or more beds at the time of the violation.

4.~~(d)~~ Class "IV" violations are defined in s. 408.813. The agency shall impose an administrative fine of $150 for each ~~a~~ cited class IV violation in a facility that is licensed for fewer than 100 beds at the time of the ~~in an amount not less than $100 and not exceeding $200 for each~~ violation. The agency shall impose an administrative fine of $225 for each cited class IV violation in a facility that is licensed for 100 or more beds at the time of the violation.

(b) Any fine imposed for a class I violation or a class II violation must be doubled if a facility was previously cited for one or more class I or class II violations during the agency's last licensure inspection or any inspection or complaint investigation since the last licensure inspection.

(c) Notwithstanding s. 408.813(2)(c) and (d) and s. 408.832, a fine must be imposed for each class III or class IV violation, regardless of correction, if a facility was previously cited for one or more class III or class IV violations during the agency's last licensure inspection or any inspection or complaint investigation since the last licensure inspection for the same regulatory violation. A fine imposed for a class III or a class IV violation must be doubled if a facility was previously cited for one or more class III or class IV violations during the agency's last two licensure inspections

for the same regulatory violation.

(d) Regardless of the class of violation cited, instead of the fine amounts listed in subparagraphs (a)1.-4., the agency shall impose an administrative fine of $500 if a facility is found not to be in compliance with the background screening requirements as provided in s. 408.809.

~~(3) For purposes of this section, in determining if a penalty is to be imposed and in fixing the amount of the fine, the agency shall consider the following factors:~~

~~(a) The gravity of the violation, including the probability that death or serious physical or emotional harm to a resident will result or has resulted, the severity of the action or potential harm, and the extent to which the provisions of the applicable laws or rules were violated.~~

~~(b) Actions taken by the owner or administrator to correct violations.~~

~~(c) Any previous violations.~~

~~(d) The financial benefit to the facility of committing or continuing the violation.~~

~~(e) The licensed capacity of the facility.~~

(3) ~~(4)~~ Each day of continuing violation after the date established by the agency ~~fixed~~ for correction ~~termination~~ of the violation~~, as ordered by the agency,~~ constitutes an additional, separate, and distinct violation.

(4) ~~(5)~~ An ~~Any~~ action taken to correct a violation shall be documented in writing by the owner or administrator of the facility and verified through followup visits by agency personnel. The agency may impose a fine and, in the case of an owner-operated facility, revoke or deny a facility's license

when a facility administrator fraudulently misrepresents action taken to correct a violation.

(5) ~~(6)~~ A ~~Any~~ facility whose owner fails to apply for a change-of-ownership license in accordance with part II of chapter 408 and operates the facility under the new ownership is subject to a fine of $5,000.

(6) ~~(7)~~ In addition to any administrative fines imposed, the agency may assess a survey fee, equal to the lesser of one half of the facility's biennial license and bed fee or $500, to cover the cost of conducting initial complaint investigations that result in the finding of a violation that was the subject of the complaint or monitoring visits conducted under s. 429.28(3)(c) to verify the correction of the violations.

(7) ~~(8)~~ During an inspection, the agency shall make a reasonable attempt to discuss each violation with the owner or administrator of the facility, before ~~prior to~~ written notification.

(8) ~~(9)~~ The agency shall develop and disseminate an annual list of all facilities sanctioned or fined for violations of state standards, the number and class of violations involved, the penalties imposed, and the current status of cases. The list shall be disseminated, at no charge, to the Department of Elderly Affairs, the Department of Health, the Department of Children and Families, the Agency for Persons with Disabilities, the area agencies on aging, the Florida Statewide Advocacy Council, and the state and local ombudsman councils. The Department of Children and Families shall disseminate the list to service providers under contract to the department who are responsible for referring persons to a facility for residency.

The agency may charge a fee commensurate with the cost of printing and postage to other interested parties requesting a copy of this list. This information may be provided electronically or through the agency's website ~~Internet site~~.

Section 9. Subsection (3) and paragraph (c) of subsection (4) of section 429.256, Florida Statutes, are amended to read:

429.256 Assistance with self-administration of medication.—

(3) Assistance with self-administration of medication includes:

(a) Taking the medication, in its previously dispensed, properly labeled container, including an insulin syringe that is prefilled with the proper dosage by a pharmacist and an insulin pen that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident.

(b) In the presence of the resident, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container.

(c) Placing an oral dosage in the resident's hand or placing the dosage in another container and helping the resident by lifting the container to his or her mouth.

(d) Applying topical medications.

(e) Returning the medication container to proper storage.

(f) Keeping a record of when a resident receives assistance with self-administration under this section.

(g) Assisting with the use of a nebulizer, including removing the cap of a nebulizer, opening the unit dose of nebulizer solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the nebulizer.

(h) Using a glucometer to perform blood-glucose level

checks.

(i) Assisting with putting on and taking off antiembolism stockings.

(j) Assisting with applying and removing an oxygen cannula, but not with titrating the prescribed oxygen settings.

(k) Assisting with the use of a continuous positive airway pressure (CPAP) device, but not with titrating the prescribed setting of the device.

(l) Assisting with measuring vital signs.

(m) Assisting with colostomy bags.

(4) Assistance with self-administration does not include:

~~(c) Administration of medications through intermittent positive pressure breathing machines or a nebulizer.~~

Section 10. Subsections (2), (5), and (6) of section 429.28, Florida Statutes, are amended to read:

429.28 Resident bill of rights.—

(2) The administrator of a facility shall ensure that a written notice of the rights, obligations, and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The ~~This~~ notice must ~~shall~~ include the name, address, and telephone numbers of the local ombudsman council, the ~~and~~ central abuse hotline, and, if ~~when~~ applicable, Disability Rights Florida ~~the Advocacy Center for Persons with Disabilities, Inc., and the Florida local advocacy council~~, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are

kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the local ombudsman council, central abuse hotline, and Disability Rights Florida ~~Advocacy Center for Persons with Disabilities, Inc., and the Florida local advocacy council~~.

(5) A ~~No~~ facility or employee of a facility may not serve notice upon a resident to leave the premises or take any other retaliatory action against any person who:

(a) Exercises any right set forth in this section.

(b) Appears as a witness in any hearing, inside or outside the facility.

(c) Files a civil action alleging a violation of the provisions of this part or notifies a state attorney or the Attorney General of a possible violation of such provisions.

(6) A ~~Any~~ facility that ~~which~~ terminates the residency of an individual who participated in activities specified in subsection (5) must ~~shall~~ show good cause in a court of competent jurisdiction. If good cause is not shown, the agency shall impose a fine of $2,500 in addition to any other penalty assessed against the facility.

Section 11. Section 429.34, Florida Statutes, is amended to read:

429.34 Right of entry and inspection.—

(1) In addition to the requirements of s. 408.811, any duly designated officer or employee of the department, the Department of Children and Families, the Medicaid Fraud Control Unit of the Office of the Attorney General, the state or local fire marshal,

or a member of the state or local long-term care ombudsman council has ~~shall have~~ the right to enter unannounced upon and into the premises of any facility licensed pursuant to this part in order to determine the state of compliance with ~~the provisions of~~ this part, part II of chapter 408, and applicable rules. Data collected by the state or local long-term care ombudsman councils or the state or local advocacy councils may be used by the agency in investigations involving violations of regulatory standards. A person specified in this section who knows or has reasonable cause to suspect that a vulnerable adult has been or is being abused, neglected, or exploited shall immediately report such knowledge or suspicion to the central abuse hotline pursuant to chapter 415.

(2) The agency shall inspect each licensed assisted living facility at least once every 24 months to determine compliance with this chapter and related rules. If an assisted living facility is cited for one or more class I violations or two or more class II violations arising from separate surveys within a 60-day period or due to unrelated circumstances during the same survey, the agency must conduct an additional licensure inspection within 6 months. In addition to any fine imposed on the facility under s. 429.19, the licensee shall pay a fee for the cost of the additional inspection equivalent to the standard assisted living facility license and per-bed fees, without exception for beds designated for recipients of optional state supplementation. The agency shall adjust the fee in accordance with s. 408.805.

Section 12. Subsection (2) of section 429.41, Florida Statutes, is amended to read:

429.41 Rules establishing standards.—

(2) In adopting any rules pursuant to this part, the department, in conjunction with the agency, shall make distinct standards for facilities based upon facility size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and the staffing characteristics of the facility. Rules developed pursuant to this section may ~~shall~~ not restrict the use of shared staffing and shared programming in facilities that are part of retirement communities that provide multiple levels of care and otherwise meet the requirements of law and rule. If a continuing care facility licensed under chapter 651 or a retirement community offering multiple levels of care obtains a license pursuant to this chapter for a building or part of a building designated for independent living, staffing requirements established in rule apply only to residents who receive personal services, limited nursing services, or extended congregate care services under this part. Such facilities shall retain a log listing the names and unit number for residents receiving these services. The log must be available to surveyors upon request. Except for uniform firesafety standards, the department shall adopt by rule separate and distinct standards for facilities with 16 or fewer beds and for facilities with 17 or more beds. The standards for facilities with 16 or fewer beds must ~~shall~~ be appropriate for a noninstitutional residential environment; however, ~~provided that~~ the structure may not be ~~is no~~ more than two stories in height and all persons who cannot exit the facility unassisted in an emergency must reside on the first floor. The department, in conjunction with the agency, may

make other distinctions among types of facilities as necessary to enforce the provisions of this part. Where appropriate, the agency shall offer alternate solutions for complying with established standards, based on distinctions made by the department and the agency relative to the physical characteristics of facilities and the types of care offered ~~therein~~.

Section 13. Present subsections (1) through (11) of section 429.52, Florida Statutes, are redesignated as subsections (2) through (12), respectively, a new subsection (1) is added to that section, and present subsections (5) and (9) of that section are amended, to read:

429.52 Staff training and educational programs; core educational requirement.—

(1) Effective October 1, 2015, each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record.

(6) ~~(5)~~ Staff involved with the management of medications and assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 ~~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.

(10) ~~(9)~~ The training required by this section other than the preservice orientation must ~~shall~~ be conducted by persons registered with the department as having the requisite experience and credentials to conduct the training. A person seeking to register as a trainer must provide the department with proof of completion of the minimum core training education requirements, successful passage of the competency test established under this section, and proof of compliance with the continuing education requirement in subsection (5) ~~(4)~~.

Section 14. The Legislature finds that consistent regulation of assisted living facilities benefits residents and operators of such facilities. To determine whether surveys are consistent between surveys and surveyors, the Office of Program Policy Analysis and Government Accountability (OPPAGA) shall conduct a study of intersurveyor reliability for assisted living facilities. By November 1, 2015, OPPAGA shall report its findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives and make any recommendations for improving intersurveyor reliability.

Section 15. The Legislature finds that consumers need additional information on the quality of care and service in assisted living facilities in order to select the best facility for themselves or their loved ones. Therefore, the Agency for Health Care Administration shall:

(1) Implement a rating system for assisted living facilities by March 1, 2016. The agency shall adopt rules to administer this subsection.

(2) By November 1, 2015, create content that is easily accessible through the front page of the agency's website. At a minimum, the content must include:

(a) Information on each licensed assisted living facility, including, but not limited to:

1. The name and address of the facility.

2. The number and type of licensed beds in the facility.

3. The types of licenses held by the facility.

4. The facility's license expiration date and status.

5. Other relevant information that the agency currently collects.

(b) A list of the facility's violations, including, for each violation:

1. A summary of the violation which is presented in a manner understandable by the general public;

2. Any sanctions imposed by final order; and

3. The date the corrective action was confirmed by the agency.

(c) Links to inspection reports that the agency has on file.

(d) A monitored comment page, maintained by the agency, which allows members of the public to anonymously comment on assisted living facilities that are licensed to operate in this state. This comment page must, at a minimum, allow members of the public to post comments on their experiences with, or observations of, an assisted living facility and to review other people's comments. Comments posted to the agency's comment page may not contain profanity and are intended to provide meaningful feedback about the assisted living facility. The agency shall

review comments for profane content before the comments are posted to the page. A controlling interest, as defined in s. 408.803, Florida Statutes, in an assisted living facility, or an employee or owner of an assisted living facility, is prohibited from posting comments on the page, except that a controlling interest, employee, or owner may respond to comments on the page. The agency shall ensure that such responses are identified as being those of a representative of the facility.

Section 16. For the 2015-2016 fiscal year, the sums of $156,943 in recurring funds and $7,546 in nonrecurring funds are appropriated from the Health Care Trust Fund and two full-time equivalent senior attorney positions with associated salary rate of 103,652 are authorized in the Agency for Health Care Administration for the purpose of implementing the regulatory provisions of this act.

Section 17. For the 2015-2016 fiscal year, for the purpose of implementing and maintaining the public information website enhancements provided under this act:

(1) The sums of $72,435 in recurring funds and $3,773 in nonrecurring funds are appropriated from the Health Care Trust Fund and one full-time equivalent health services and facilities consultant position with associated salary rate of 46,560 is authorized in the Agency for Health Care Administration;

(2) The sums of $30,000 in recurring funds and $15,000 in nonrecurring funds are appropriated from the Health Care Trust Fund to the Agency for Health Care Administration for software purchase, installation, and maintenance services; and

(3) The sums of $2,474 in recurring funds and $82,806 in nonrecurring funds are appropriated from the Health Care Trust

Fund to the Agency for Health Care Administration for contracted services.

Section 18. This act shall take effect July 1, 2015.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Children, Families, and Elder Affairs, *Chair*
Health Policy, *Vice Chair*
Agriculture
Education Pre-K-12
Appropriations Subcommittee on Health and Human Services

SENATOR ELEANOR SOBEL
33rd District

January 26, 2015

Senator Aaron Bean, Chair
Health Policy
302 Senate Office Building
404 South Monroe Street
Tallahassee, Florida 32399

Dear Chair Bean,

This letter is to request that SB 382 relating to Assisted Living Facilities be placed on the agenda of the next scheduled meeting of the Health Policy Committee.

Thank you for your consideration of this request.

Respectfully,

Eleanor Sobel
State Senator, 33rd District

CC: Sandra Stovall, Celia Georgiades

REPLY TO:
❒ The "Old" Library, First Floor, 2600 Hollywood Blvd., Hollywood, Florida 33020 (954) 924-3693 FAX: (954) 924-3695
❒ 410 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5033

Senate's Website: *www.flsenate.gov*

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/3/15
Meeting Date

382
Bill Number (if applicable)

Topic ALE's

Amendment Barcode (if applicable)

Name JACK McRAY

Job Title

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Street

Phone 850-577-5187

TLH FL 32301
City *State* *Zip*

Email jmcray@aarp.org

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing AARP

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

Access to Dental Care in Florida

A Look at the Data

Marko Vujicic, PhD
Chief Economist & Vice President
Health Policy Institute

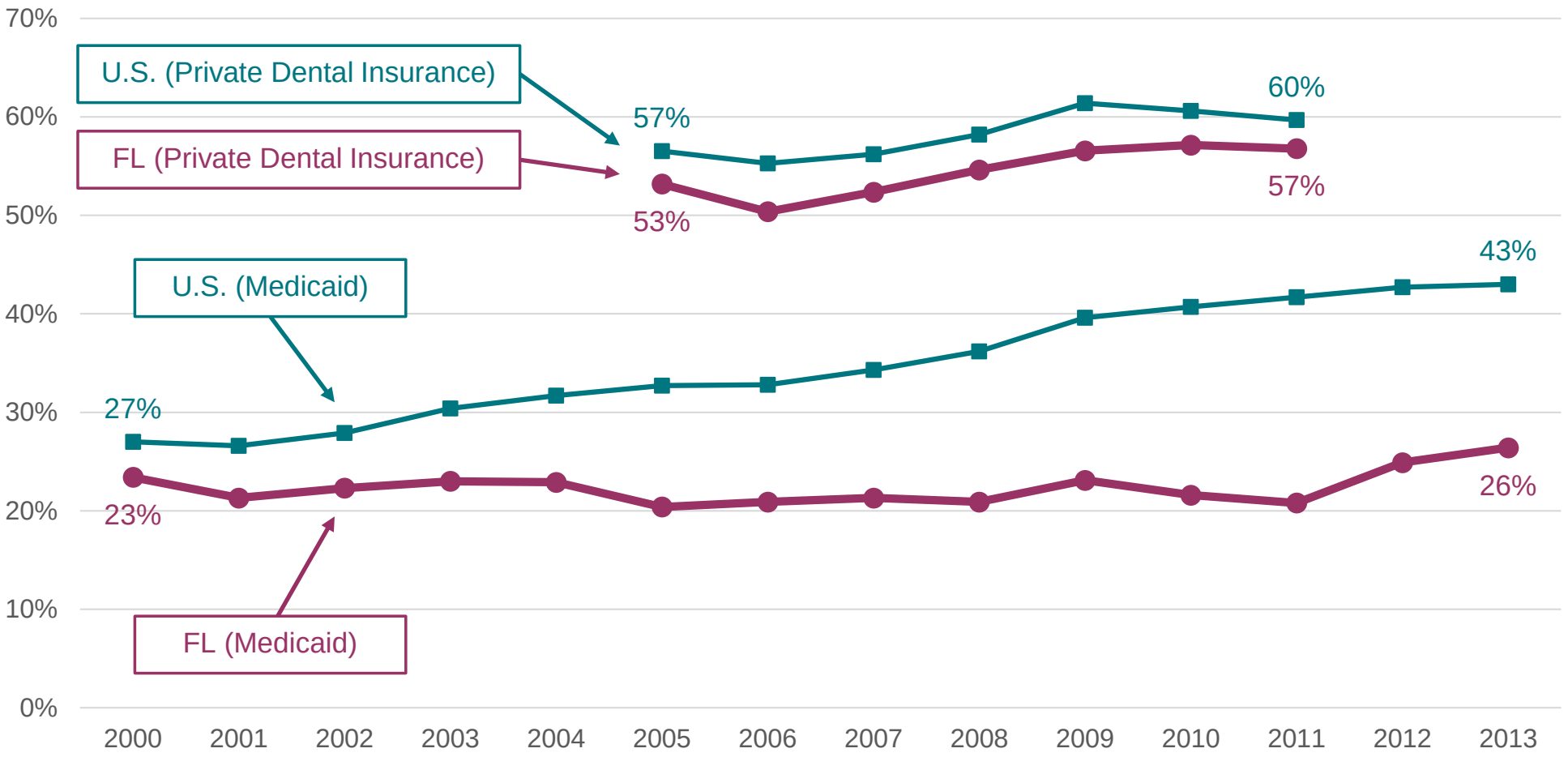
HPI Health Policy Institute
ADA American Dental Association®

The ADA Health Policy Institute

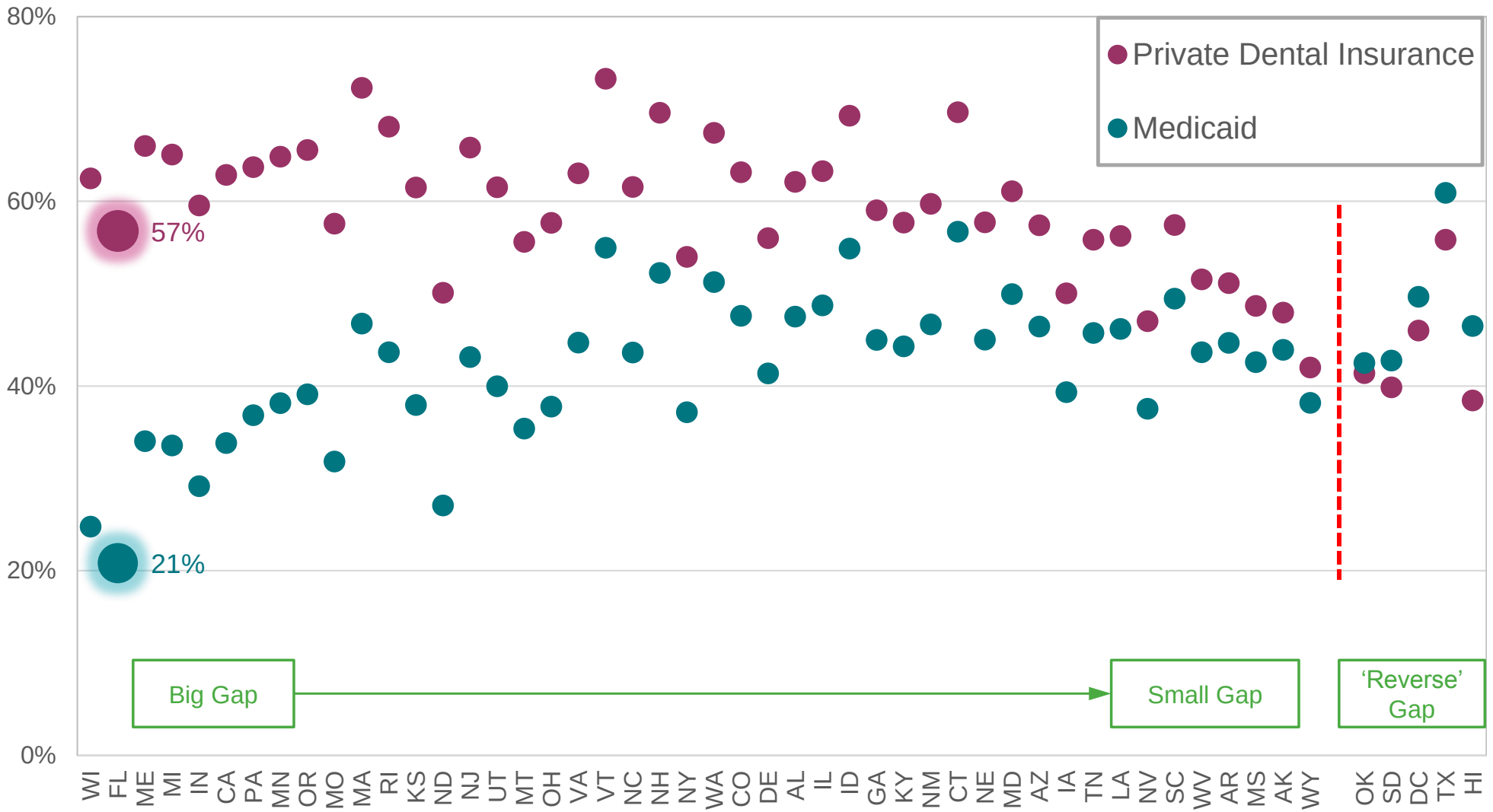
Today

- Data
- What the data mean
- Analysis to guide policy

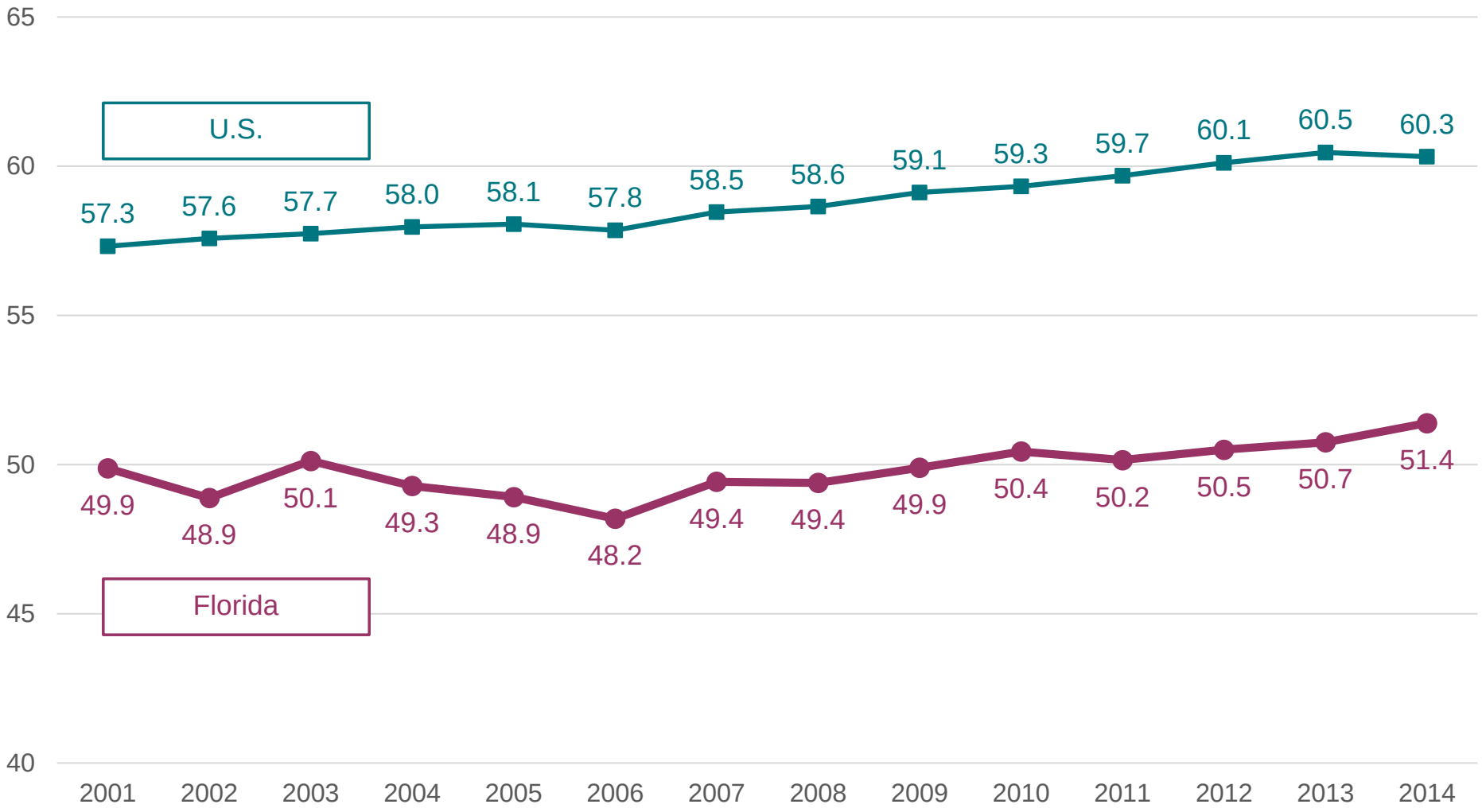
Dental Care Use among Children



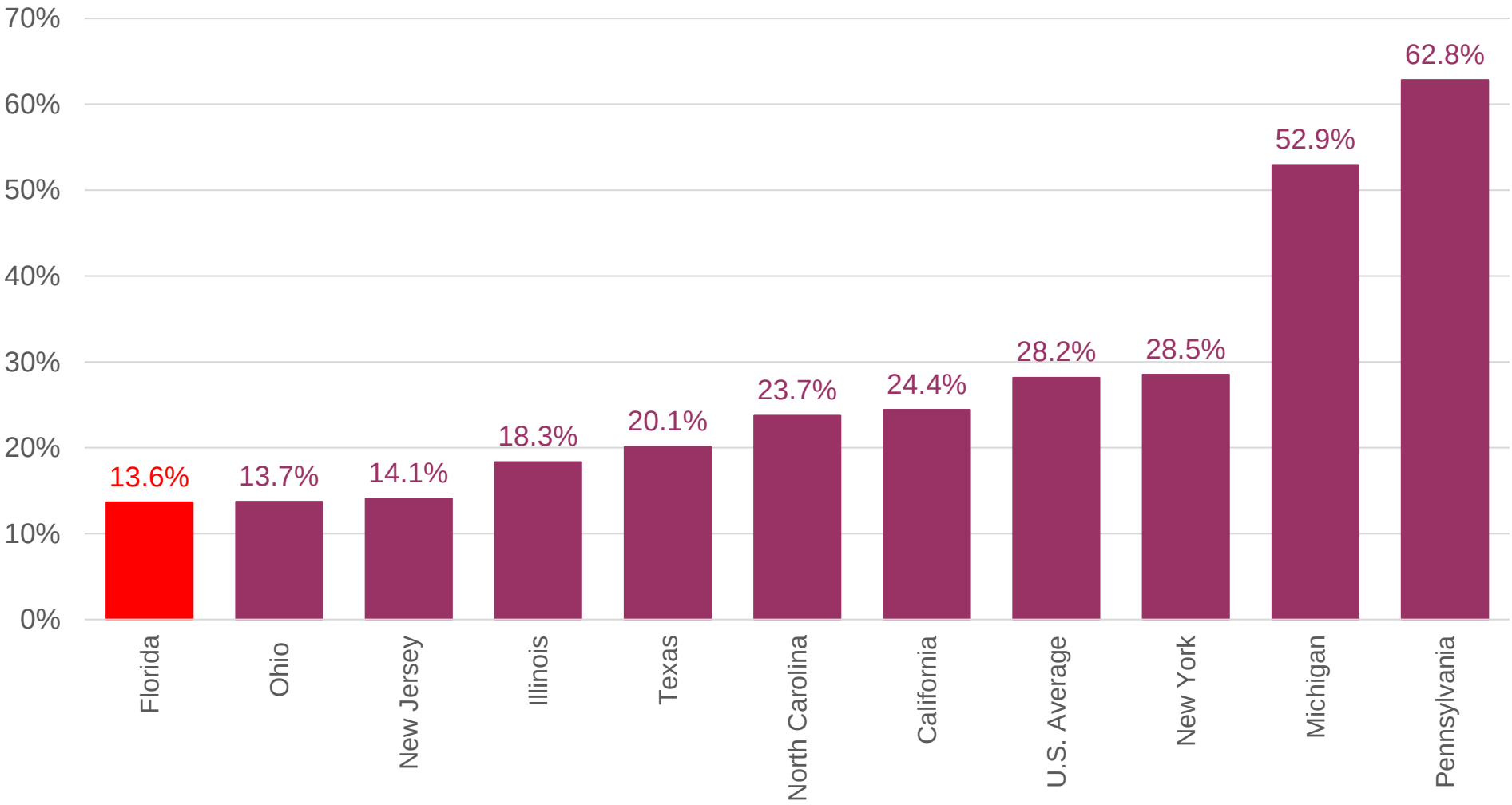
Dental Care Use among Children



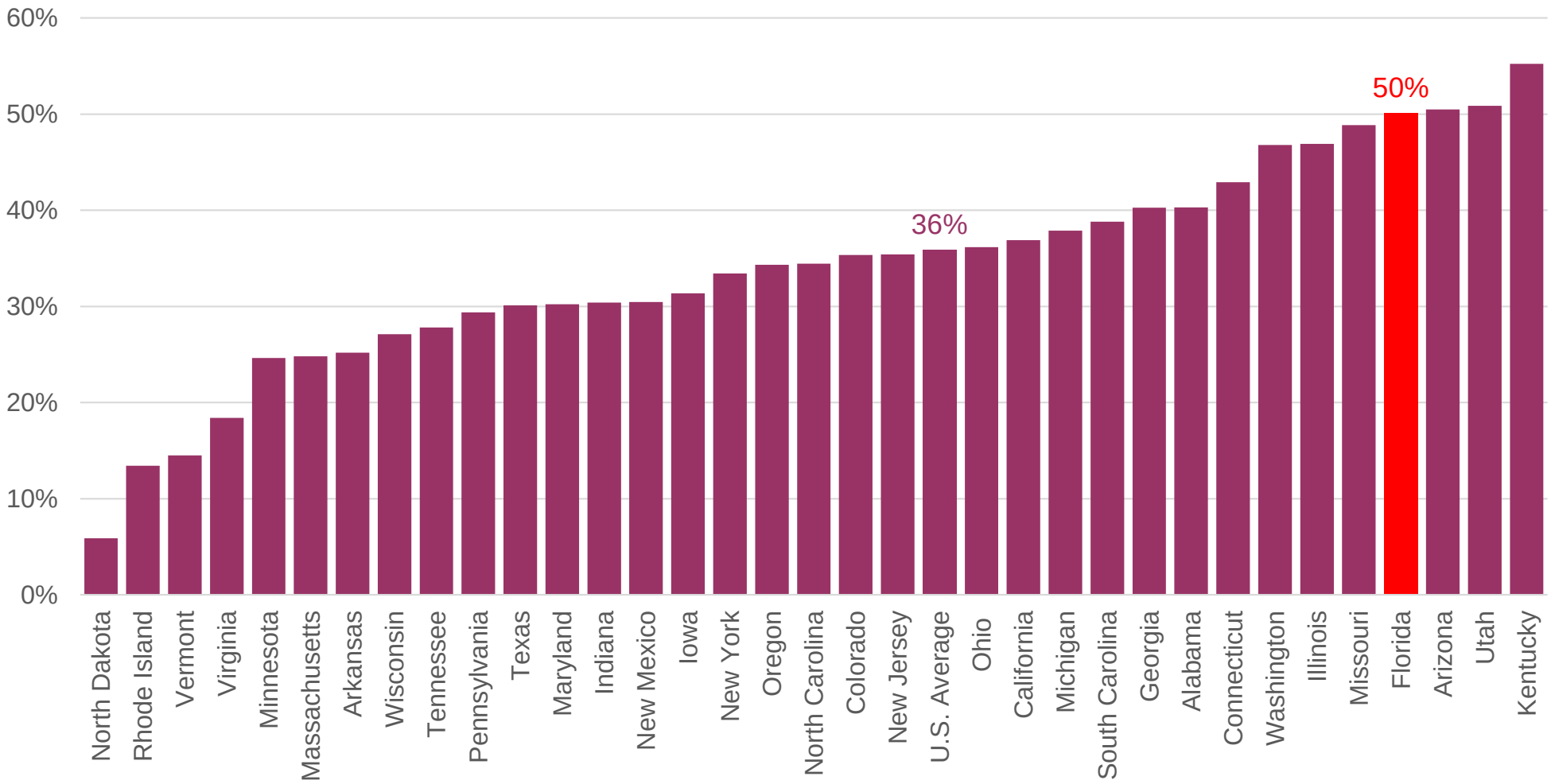
Dentists per 100,000 Population



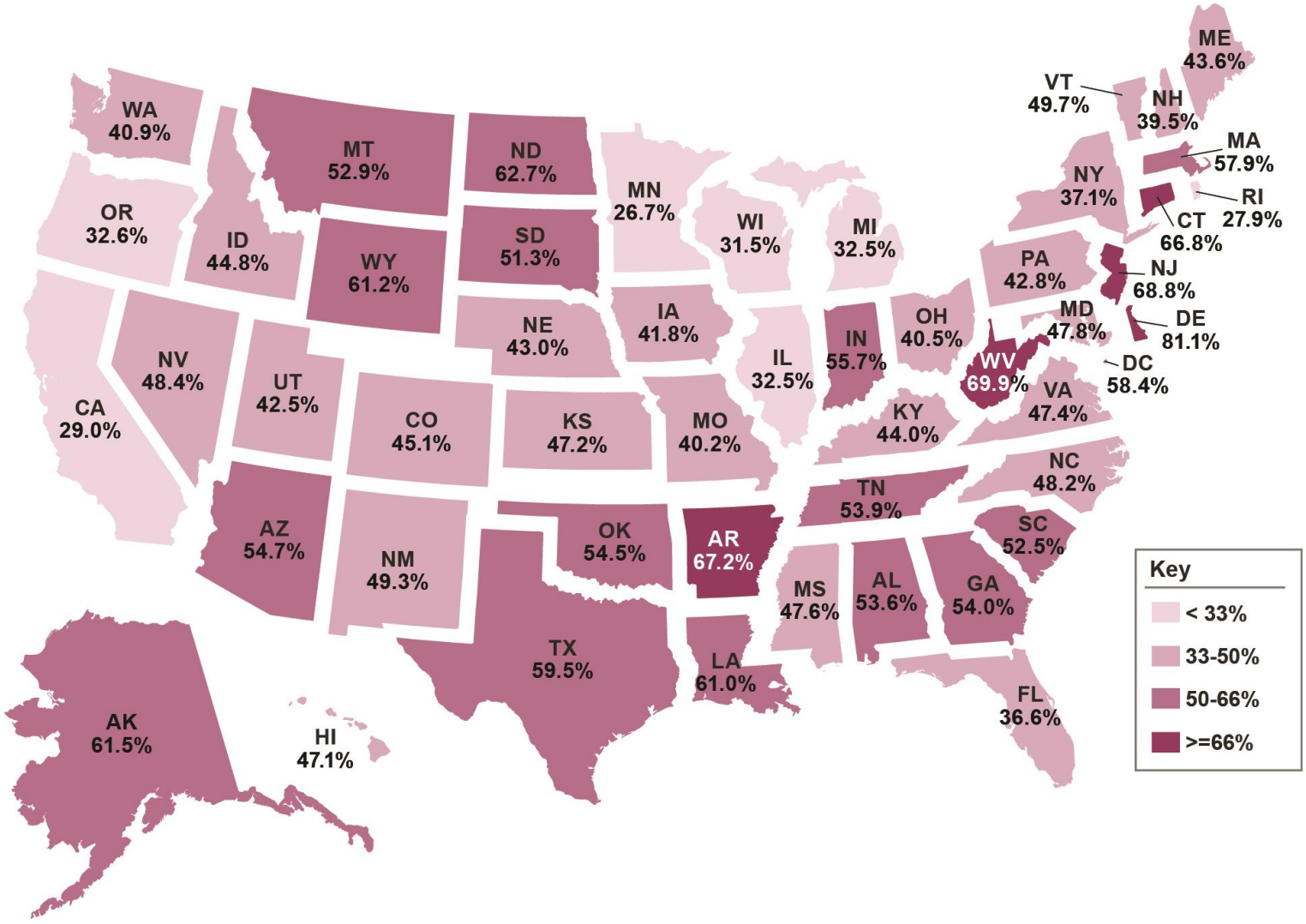
Percent of Dentists Accepting New Medicaid Patients



Percent of Dentists “Not Busy Enough”

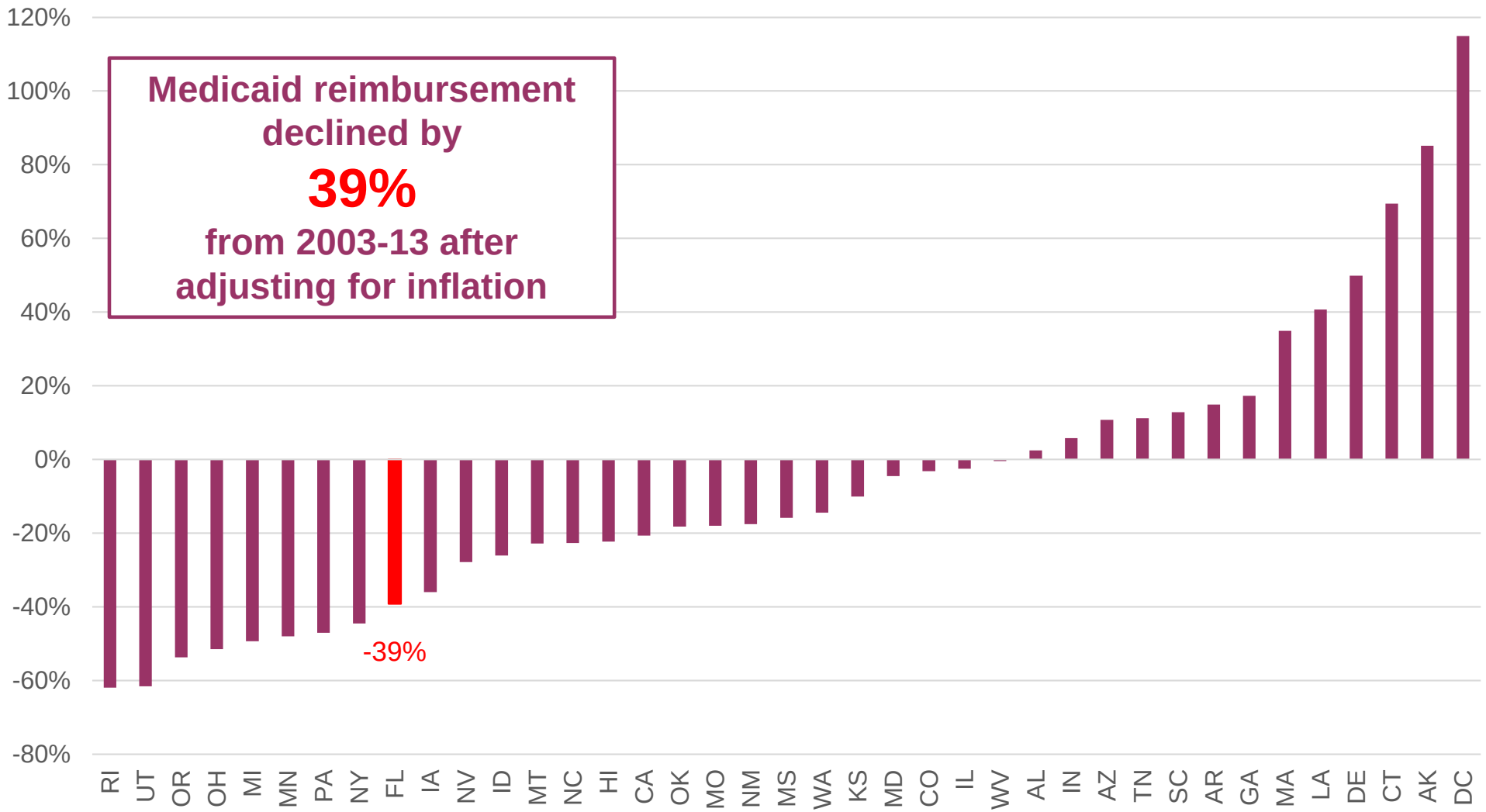


Medicaid Reimbursement



Florida has the 8th lowest reimbursement levels

Medicaid Reimbursement



Key Takeaways

- Dental care use among Medicaid enrolled children in Florida is low and has not increased significantly the past decade
- Evidence strongly suggests there is significant unused capacity within the dental care system in Florida that could be leveraged for underserved populations
- Quick, targeted analysis can significantly improve design and implementation of policy reform

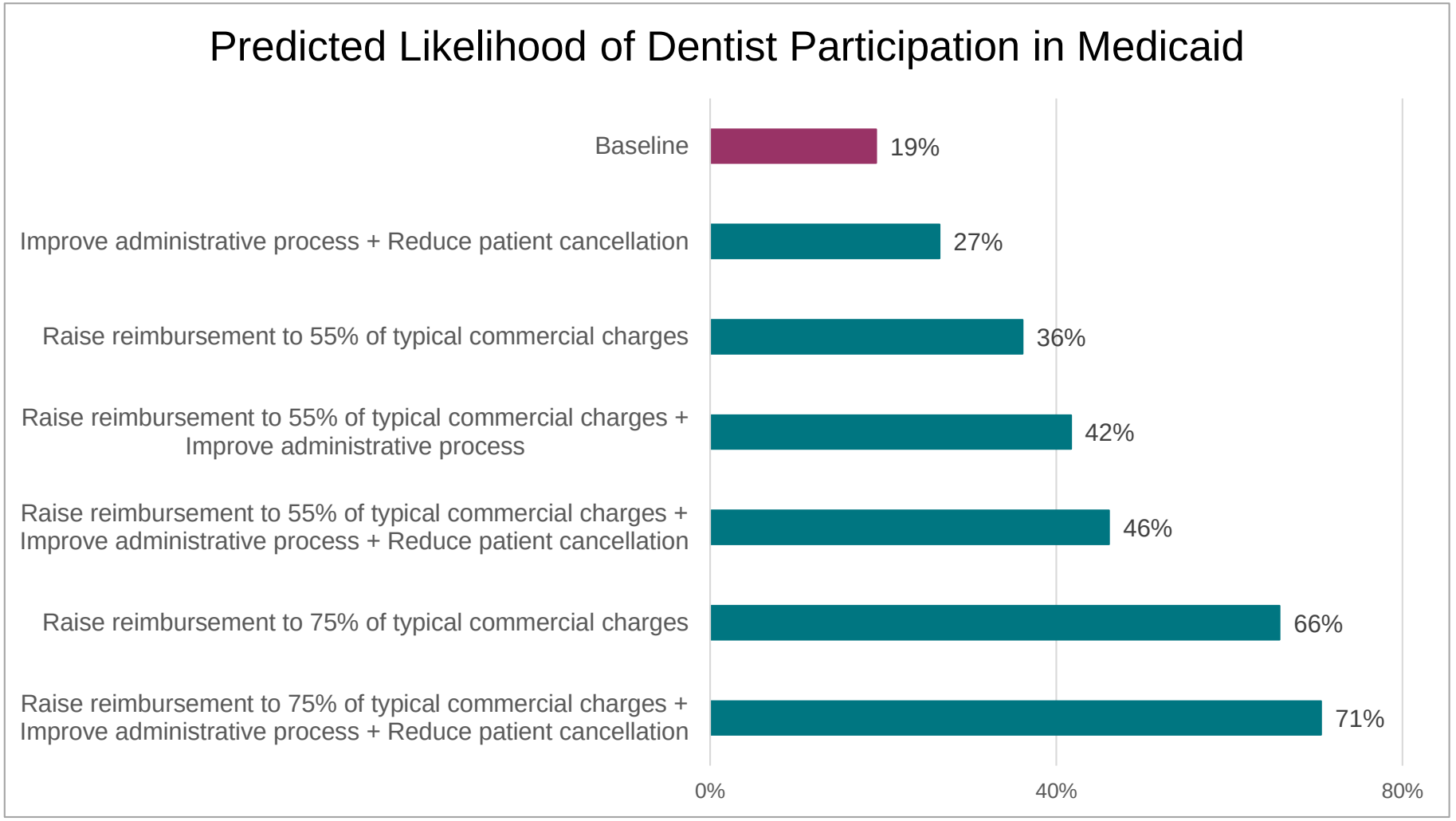
Analysis to Guide Policy Reform

1. Simulating Impact of Alternative Medicaid Reforms on Provider Participation
   a. Innovative methodology to predict how providers will respond to changes to key program aspects
   b. Combined with fiscal analysis, provides powerful cost-benefit data

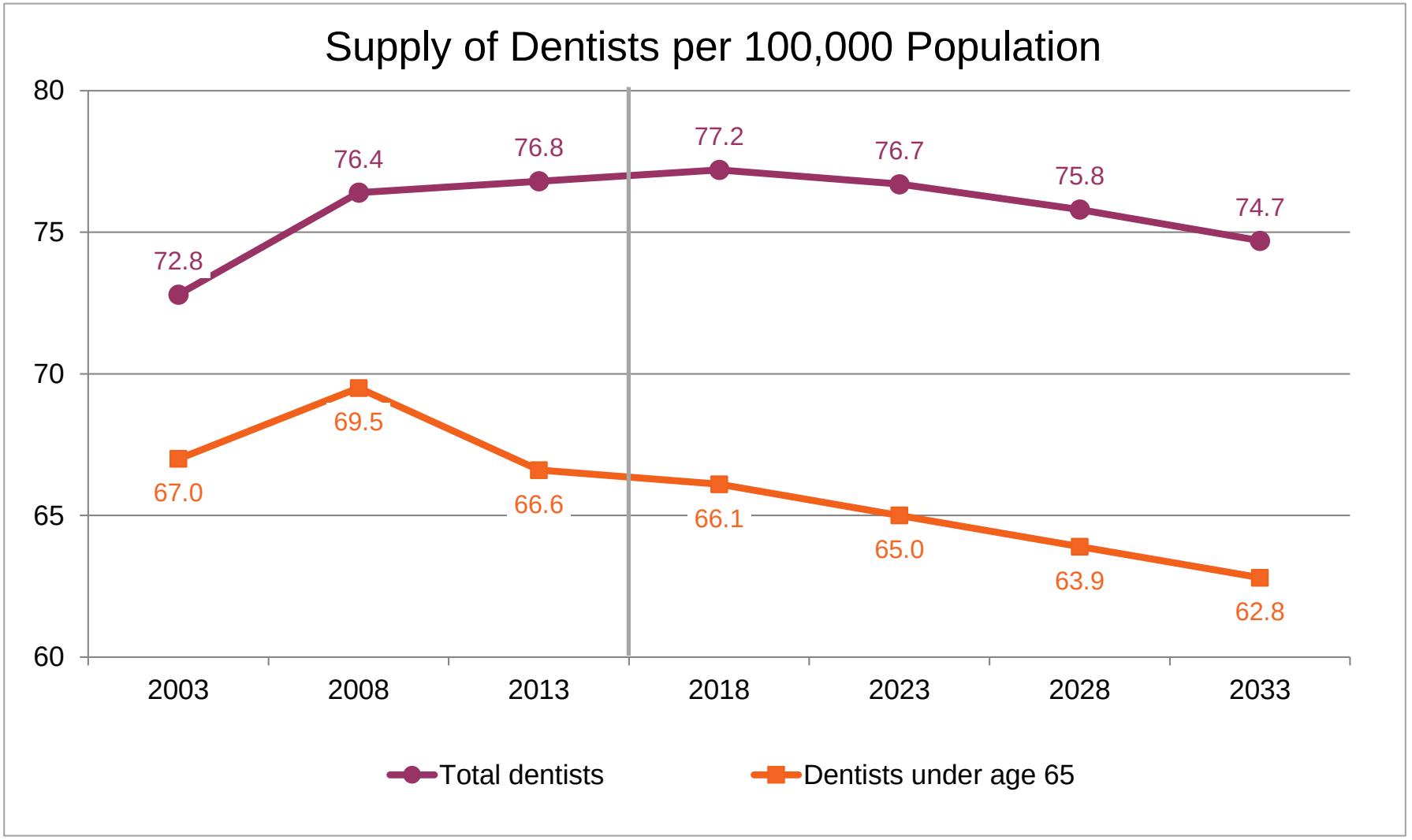
2. Assessing Provider Adequacy
   a. Geo-analytics
      i. Map dental practices and FQHCs
      ii. Overlay Medicaid beneficiary and dental care utilization data
      iii. Identify 'hotspots' where tailored policy interventions are needed
   b. Modeling the Future Supply of Dentists in Florida
      a. Dynamic modeling of inflows to and outflows from dentist workforce

3. Understanding Implications of Alternative Adult Dental Benefit Policies
   a. Modeling costs of alternative coverage and reimbursement levels
   b. Modeling savings due to reduced emergency room visits
   c. Modeling impact on dental care utilization and other outcomes

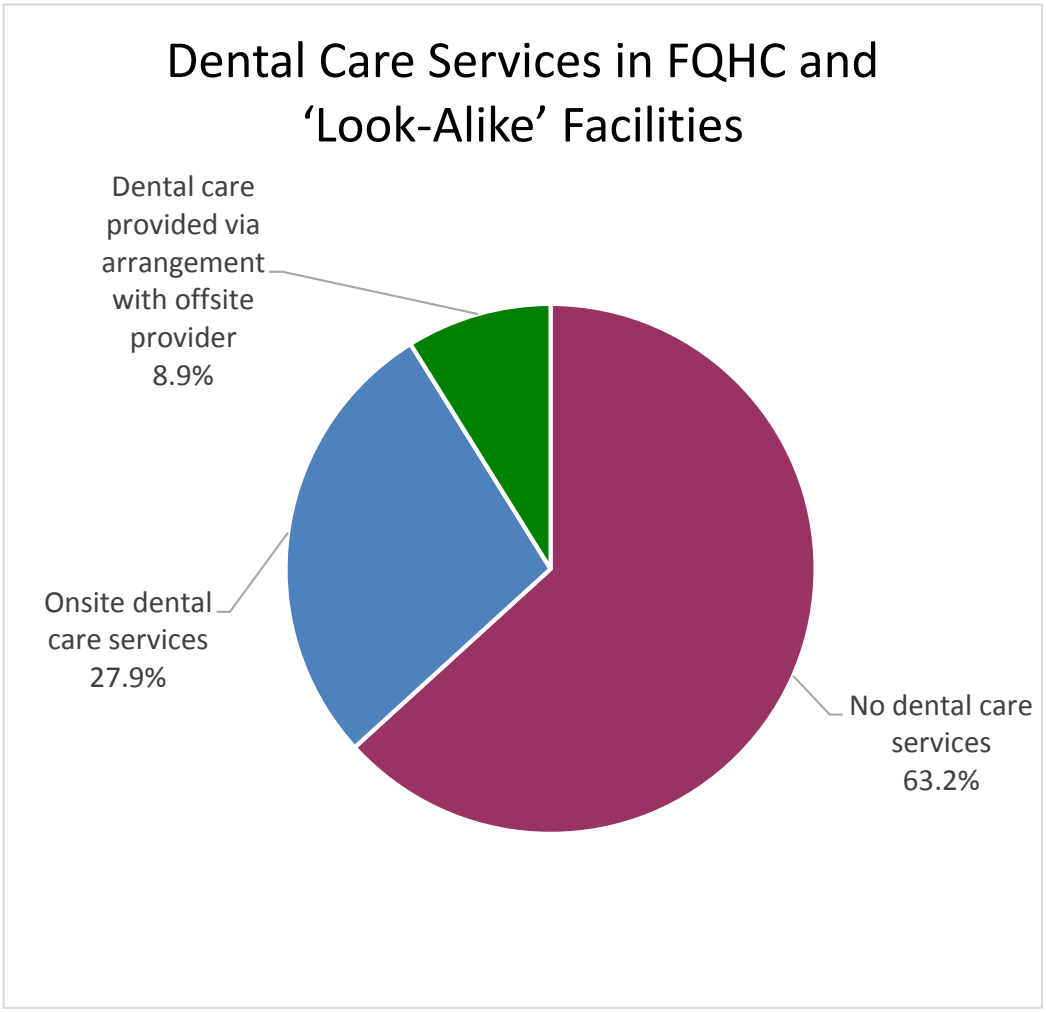
Analysis to Guide Policy Reform (e.g. #1)

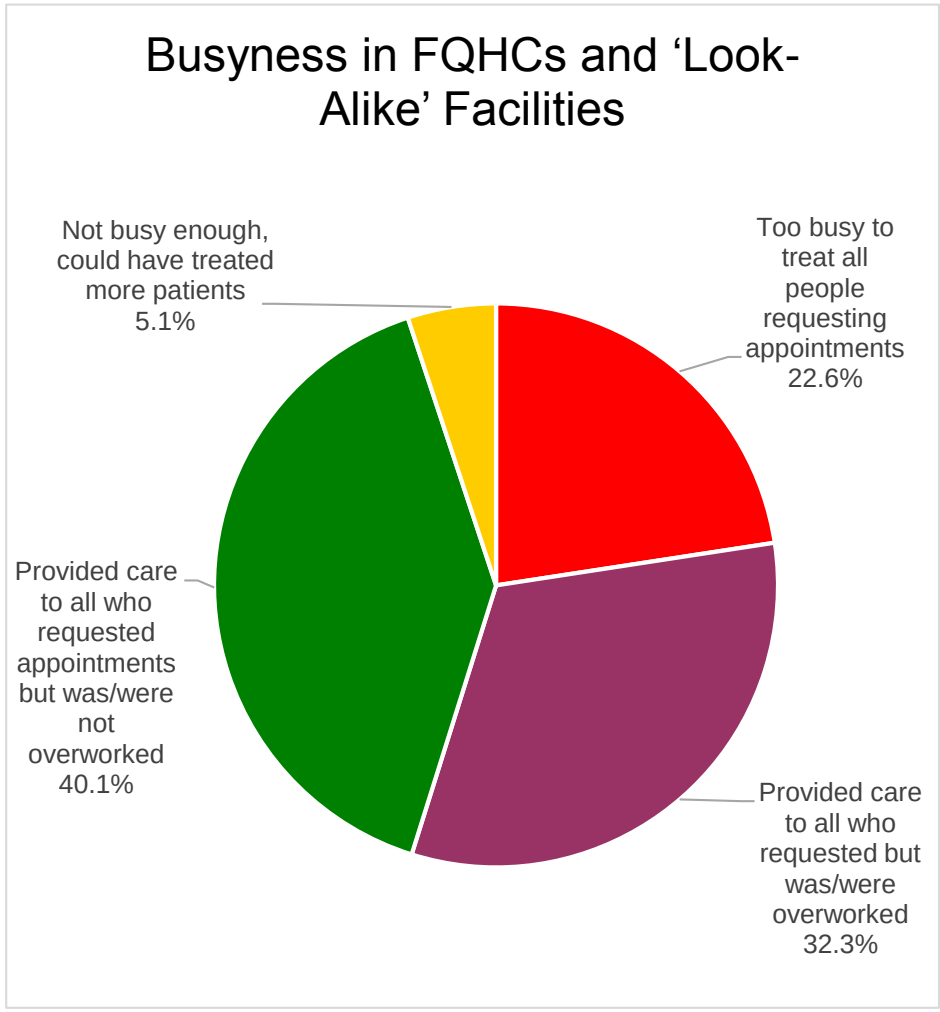


Analysis to Guide Policy Reform (e.g. #2)



Analysis to Guide Policy Reform (e.g. #3)





Thank You!

For more information on the *Health Policy Institute* please visit:

ada.org/hpi

To inquire about state-level custom data analytics please contact:

hpi@ada.org

Data Sources

Slide 4: Health Policy Institute analysis of CMS-416 and Truven MarketScan data. Medicaid data are for 2000-2013. Private dental insurance data are for 2005-2011.

Slide 5: Health Policy Institute analysis of CMS-416 and Truven MarketScan data. Data are for 2011.

Slide 6: Health Policy Institute analysis of the American Dental Association Masterfile and the U.S. Census Bureau population counts. Data are for 2001-2014.

Slide 7: Health Policy Institute analysis Annual Survey of Dental Practice. Data are combined for 2011-2013.

Slide 8: Health Policy Institute Annual Survey of Dental Practice. Data are for 2013.

Slide 9: Nasseh K, Vujicic M, Yarbrough C. A ten-year, state-by-state, analysis of Medicaid fee-for-service reimbursement rates for dental care services. Health Policy Institute Research Brief. American Dental Association. October 2014. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1014_3.ashx. Data are for 2013.

Slide 10: Nasseh K, Vujicic M. Are Medicaid and private dental insurance payment rates for pediatric dental services keeping up with inflation? Health Policy Institute Research Brief. American Dental Association. December 2014. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1214_2.ashx. Data are for 2003 and 2013.

Data Sources

CMS-416 Data (Dental Care Utilization for Medicaid-Enrolled Children):
Utilization of dental services among Medicaid children is based on CMS-416 data for the United States. The CMS-416 is a form that each state Medicaid program fills out and submits to CMS on an annual basis, and it includes children under age 21 (i.e. up to but not including age 21), eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. The percent of Medicaid-enrolled children with a dental visit is calculated as the number of children receiving any dental service divided by the total number of children eligible for EPSDT at any time during a given year. The CMS-416 does not include children covered by the Children's Health Insurance Program (CHIP). The data are downloaded from the Centers for Medicare & Medicaid Services' (CMS) Medicaid website. These data presented today are as of January 27, 2015. HPI checks for updates to the CMS-416 every business day.

Truven MarketScan (Dental Care Utilization for Children with Private Dental Insurance):
The Truven MarketScan database is based on a very large convenience sample of enrollees with employer sponsored health insurance. The data mostly come from large employers. Truven does not indicate the percentage of the market it includes, but in 2011 the MarketScan database included enrollment data for 331,588 Florida residents. Of those, 87,541 were children under 21 years of age as of December 31, 2011, the selection criterion for inclusion in this report. Fifty-seven percent the 87,541 children (49,701) had a dental procedure (defined as having an insurance claim containing any CDT procedure code) during the year.

Data Sources

American Dental Association Masterfile:
The American Dental Association (ADA) Masterfile contains the most up-to-date information on dentists in the United States. The Masterfile is a database of all dentists, practicing and non-practicing, in the United States. It is updated through a variety of methods including reconciliation with state licensure databases, death records, various surveys and censuses of dentists carried out by the ADA. We used the Masterfile's archived datasets to gather historical information on the profile of the dentist population, including dentists' ages and practice locations. This provides us with a "snapshot" for each of our study years. To calculate historical measures of dentists per 100,000 population, we used U.S. Census Bureau population counts.

American Dental Association Health Policy Institute Annual Survey of Dental Practice:
This is an annual survey conducted on a nationally representative random sample of 4,000 to 17,000 dentists in private practice. According to the most recent data available, 92.2% of active dentists in the United States are in private practice. Response rates to the Survey of Dental Practice from 2007 to 2013, our period of focus, varied from 14% to 36%. The most recent year for which data are available is 2013 and the response rate was 18.4%. For Florida, the final adjusted overall response rate for 2013 data was 15.0%. The survey oversampled specialists and selected states to ensure an adequate number of responses for statistical analysis. During data cleaning, outliers were screened and dropped from the analysis where appropriate. A survey question on busyness offered four choices: (a) Too busy to treat all people requesting appointments, (b) Provided care to all who requested appointments but was overworked, (c) Provided care to all who requested appointments but was not overworked, (d) Not busy enough, could have treated more patients. A survey question on acceptance of new patients asked (yes/no) whether dentists' primary practices currently accepted (a) new Medicaid-insured patients or (b) new patients covered by a Children's Health Insurance Program (CHIP). Estimates were weighted, where appropriate, to compensate for oversampling of specialists and oversampling within selected states. In addition, estimates were weighted to compensate for survey nonresponse bias with respect to these dentist characteristics: age group, general practitioner or specialist status, ADA membership status, and county population corresponding to the dentist's location. For estimates from pooled data, years 2011 – 2013, each year's results were given equal weight.

Marko Vujicic, Ph.D.
Chief Economist & Vice President
Health Policy Institute
American Dental Association

Dr. Marko Vujicic is Chief Economist and Vice President, Health Policy Institute at the American Dental Association where he is responsible for overseeing all of the Association's policy research activities. Prior to joining the American Dental Association, he was Senior Economist with The World Bank in Washington D.C. where he directed the global health workforce policy program. He was also a Health Economist with the World Health Organization in Geneva, Switzerland.

Dr. Vujicic is the lead author of the book, *Working in Health*, and has written several book chapters on various health policy issues. He has published extensively in peer-reviewed journals such as *Health Affairs, The New England Journal of Medicine, Health Services Research, Health Policy and Planning, Social Science and Medicine, and Medical Care*. He has worked on broad health care reform issues in Africa, East Asia, the Caribbean and Eastern Europe.

He is a visiting assistant professor at Tufts University in Boston.

Dr. Vujicic obtained his Ph.D. in Economics from the University of British Columbia and a Bachelor's degree in Business from McGill University in Montreal.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/3/15
Meeting Date

Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Dental

Name Marko Vujicic, PhD

Job Title Chief Economist VP, Health Policy Institute

Address 211 E. Chicago Ave
Street

Phone 312-440-7745

Chicago IL 60611
City *State* *Zip*

Email vujicicm@ada.org

Speaking: ☐ For ☐ Against ☒ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FL Dental Assc./American Dental Assc.

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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2/3/15
Meeting Date

Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Dental

Name Dr. Rick Stevenson

Job Title President

Address 118 E. Jefferson St.
Street

Phone 850-224-1089

Tallahassee FL 32301
City *State* *Zip*

Email rstevenson@bot.floridadental.org

Speaking: ☐ For ☐ Against ☒ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FL Dental Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Communications, Energy, and Public Utilities, *Chair*
Agriculture
Appropriations
Appropriations Subcommittee on Health and Human Services
Health Policy
Transportation

JOINT COMMITTEES:
Joint Administrative Procedures Committee
Joint Legislative Budget Commission

SENATOR DENISE GRIMSLEY
Deputy Majority Leader
21st District

January 27, 2015

The Honorable Aaron Bean, Chair
Senate Committee on Health Policy
530 Knott Building
404 S. Monroe Street
Tallahassee, Florida 32399

Dear Mr. Chair,

I am writing to request permission to be excused from the Health Policy Committee meeting to be held on Tuesday, February 3rd, 2015. I am currently the Chair of the Communications, Energy, and Public Utilities Committee and will be attending the Public Service Commission meeting beginning at 9:30 a.m.

Sincerely,

Denise Grimsley
District 21

Cc: Sandra Stovall, Staff Director
Senate Committee on Health Policy

REPLY TO:
- 205 South Commerce Avenue, Suite A, Sebring, Florida 33870 (863) 386-6016
- 212 East Stuart Avenue, Lake Wales, Florida 33853 (863) 679-4847
- 306 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5021

Senate's Website: *www.flsenate.gov*

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

CourtSmart Tag Report

Room: KN 412 **Case:** **Type:**
Caption: Senate Health Policy Committee **Judge:**

Started: 2/3/2015 10:06:15 AM
Ends: 2/3/2015 11:46:03 AM Length: 01:39:49

10:06:18 AM Sen. Bean, Chair
10:07:09 AM Roll Call
10:07:26 AM Quorum Present
10:07:38 AM Chair
10:07:59 AM TAB 5-Presentation on Access to Dental Care: Marko Vujicic, PhD, American Dental Assc.
10:09:36 AM Dental Care Use Among Children
10:11:05 AM Sen. Galvano moves to TP SB 322
10:11:51 AM Dentists per 100,00 Population
10:12:13 AM Percent of Dentists Accepting New Medicaid Patients
10:12:53 AM Percent of Dentists "Not Busy Enough"
10:14:01 AM Medicaid Reimbursement
10:17:52 AM Key Takeaways
10:18:56 AM Analysis to Guide Policy Reform
10:24:13 AM Chair
10:24:21 AM Question by Chair
10:24:43 AM Response by Marko Vujicic
10:25:52 AM Chair
10:26:08 AM Response by Marko Vujicic
10:26:24 AM Chair
10:26:25 AM Response by Marko Vujicic
10:26:49 AM Chair
10:26:51 AM Response by Marko Vujicic
10:27:08 AM Chair
10:27:32 AM Sen. Sobel in Chair
10:28:06 AM Sen. Bean recognized
10:28:10 AM TAB 3-SB 332-Nursing Home Facility Pneumococcal Vaccination Requirements
10:28:17 AM Sen. Galvano
10:29:11 AM Chair, Sen. Sobel
10:29:25 AM Sen. Bean
10:29:57 AM Chair
10:30:00 AM Guy Jordan, Government Relations-Pfizer, Waives in Support
10:30:11 AM Chris Nuland, Florida Public Health Association/Florida Chapter, American College of Physicians, waives in support
10:30:20 AM Stephen R. Winn, Executive Director FOMA, Waives in Support
10:30:23 AM Larry Gonzalez, General Counsel, Representing Florida Society of Health-System Pharmacists, waives in support
10:30:50 AM Chair Opens for Debate on Bill
10:31:29 AM Sen. Bean yields close to Sen. Galvano
10:31:45 AM Roll Call on SB 332
10:32:02 AM SB 332 Reported Favorably
10:32:11 AM TAB 1-SB 322 by Stargel; Medicaid Reimbursement for Hospital Providers
10:32:20 AM Chair, Sen. Bean
10:36:00 AM Chair Opens for Questions for Sen. Stargel
10:36:06 AM Sen. Joyner Recognized
10:36:16 AM Presentation of bill by Sen. Stargel
10:37:11 AM Sen. Joyner Follow-up
10:37:25 AM Sen. Stargel Responds
10:37:27 AM Chair
10:37:47 AM Sen. Joyner Recognized
10:37:59 AM Chair
10:38:35 AM Tom Wallace, AHCA Medicaid Bureau Chief, Program Finance
10:40:02 AM Sen. Joyner Recognized

10:40:19 AM Tom Wallace Responds
10:41:07 AM Follow-up by Sen. Joyner
10:41:14 AM Tom Wallace Responds
10:42:29 AM Chair Opens for Additional Questions
10:42:37 AM Sen. Joyner
10:42:42 AM Tom Wallace Responds
10:43:40 AM Chair
10:44:05 AM Sen. Joyner
10:44:34 AM Sen. Stargel Responds
10:45:26 AM Sen. Joyner
10:46:34 AM Sen. Galvano Responds
10:46:57 AM Sen. Joyner
10:47:11 AM Sen. Gaetz Responds
10:48:56 AM Tom Wallace Responds
10:49:06 AM Sen. Gaetz
10:50:32 AM Chair Opens for Additional Questions
10:50:39 AM Vice Chair Recognized
10:50:47 AM Sen. Stargel Responds
10:51:18 AM Vice Chair
10:51:29 AM Sen. Stargel Responds
10:51:35 AM Chair recognizes Sen. Braynon
10:52:12 AM Tom Wallace Recognized to Respond
10:52:34 AM Sen. Stargel Recognized
10:52:54 AM Sen. Galvano Recognized
10:53:15 AM Sen. Stargel Responds
10:53:26 AM Chair
10:53:39 AM Sen. Flores Recognized
10:54:21 AM Sen. Stargel Responds
10:55:02 AM Chair opens for additional questions
10:55:17 AM Public Testimony
10:55:22 AM Bill Bell, General Counsel, Florida Hospital Association
10:55:33 AM Bill Bell waives in opposition
10:55:45 AM Jan Gorrie, Tampa General Hospital, Recognized
10:59:32 AM Chair Opens for Questions
10:59:39 AM Chair Opens for Debate
10:59:47 AM Sen. Gaetz Recognized
10:59:52 AM Sen. Joyner Recognized
11:03:46 AM Vice Chair Recognized
11:05:13 AM Sen. Flores Recognized
11:07:30 AM Chair Opens for Additional Debate
11:07:34 AM Sen. Gaetz Recognized
11:10:50 AM Chair
11:10:54 AM Sen. Galvano Recognized
11:11:05 AM Sen. Galvano Moves to TP SB 322
11:11:10 AM SB 322 is Temporary Postponed
11:11:17 AM Sen. Stargel Recognized
11:12:17 AM Chair
11:13:01 AM TAB 2-SB 190-Hospices
11:15:09 AM Geoff Smith, Attorney, Compassionate Care Hospice, Recognized
11:19:46 AM Chair
11:19:57 AM Geoff Smith Responds
11:21:07 AM Chair
11:21:10 AM Geoff Smith Responds
11:22:31 AM Chair Opens For Questions
11:22:50 AM Geoff Smith
11:23:20 AM Samira Beckwith, President-Hope Hospice, Recognized
11:27:11 AM Chair
11:27:13 AM Samira Beckwith Responds
11:29:27 AM Chair
11:29:34 AM Chair Opens for Questions
11:29:42 AM Sen. Gaetz Recognized
11:30:34 AM Samira Beckwith Responds

11:32:25 AM Chair
11:33:01 AM Susan Smith, Attorney, Compassionate Care
11:37:47 AM Chair
11:37:59 AM Sen. Garcia Moves to TP SB 190
11:38:14 AM TAB 4-SB 382 by Sobel (CO-INTRODUCERS) Gaetz; (Compare to H 0293) Assisted Living Facilities
11:38:42 AM Vice Chair Recognized
11:40:29 AM Chair
11:40:41 AM AM 113398 Explained by Sen. Flores
11:41:58 AM Sen. Flores Withdraws Amendment
11:42:05 AM Motion to Withdraw Amendment Adopted Without Objection
11:42:18 AM Sen. Sobel Recogonized to Explain Amendment 627072
11:43:16 AM Chair
11:43:21 AM Amendment is Adopted
11:43:37 AM Jack McRay, AARP, waives in support
11:43:56 AM Chairs Opens for Debate
11:44:05 AM Sen. Sobel Recognized
11:44:33 AM Chair
11:44:40 AM Vote on SB382
11:44:46 AM Sen. Garcia Moves to Consider SB 382 as a Committee Substitute
11:45:06 AM Committee Substitute for SB 382 Passed
11:45:40 AM Meeting Adjourned