The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Harrell, Chair
Senator Berman, Vice Chair

MEETING DATE: Tuesday, November 5, 2019
TIME: 10:00 a.m.—12:00 noon
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Harrell, Chair; Senator Berman, Vice Chair; Senators Baxley, Bean, Book, Cruz, Diaz, Hooper, Mayfield, and Rouson

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	Implementation of Prescription Drug Importation Programs - Agency for Health Care Administration and Department of Business and Professional Regulation		Discussed
2	Discussion of Drivers Behind Increases in Prescription Drug Prices		Discussed
3	**SB 66** Cruz (Similar H 77, Compare H 115, S 356, S 474)	Student Loans and Scholarship Obligations of Health Care Practitioners; Establishing that a health care practitioner's failure to repay a student loan or to comply with service scholarship obligations does not constitute grounds for disciplinary action; removing a civil fine; removing the requirement that the Department of Health investigate and prosecute health care practitioners for failing to repay a student loan or to comply with scholarship service obligations, etc. HP 11/05/2019 Fav/CS AED AP	Fav/CS Yeas 9 Nays 0
4	**SB 348** Bean (Identical H 6031)	Florida Kidcare Program; Removing the lifetime maximum cap on covered expenses for a child enrolled in the Florida Healthy Kids program, etc. HP 11/05/2019 Favorable AHS AP	Favorable Yeas 9 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
5	**SB 402** Harrell	Assisted Living Facilities; Clarifying that an assisted living facility licensed to provide extended congregate care services or limited nursing services must maintain a written progress report on each person receiving services from the facility's staff; prohibiting a county or municipality from issuing a business tax receipt, rather than an occupational license, to a facility under certain circumstances; requiring a facility to initiate an investigation of an adverse incident within 24 hours and provide a report of such investigation to the Agency for Health Care Administration within 15 days, etc. HP 11/05/2019 Fav/CS AHS AP	Fav/CS Yeas 9 Nays 0

Other Related Meeting Documents

Committee on Health Policy

CS/HB 19 — Prescription Drug Importation Programs

by Health and Human Services Committee and Rep. Leek and others (CS/CS/SB 1528 by Appropriations Committee; Health Policy Committee; and Senators Bean and Gruters)

The bill establishes two programs to import prescription drugs approved by the federal Food and Drug Administration (FDA) into the state, contingent on federal approval:

- The Canadian Prescription Drug Importation Program (CPDI Program) established by the Agency for Health Care Administration (AHCA) and the International Prescription Drug Importation Program (IPDI Program) established by the Department of Business and Professional Regulation (DBPR) in collaboration with the Department of Health (DOH).
- The CPDI Program focuses on providing savings and options for specific public programs identified in the bill:
  - Recipients in the Medicaid program;
  - Clients of free clinics and county health departments;
  - Inmates in the custody of the Department of Corrections;
  - Clients treated in developmental disability centers; and
  - Patients treated in certain state mental health facilities.
- The bill establishes eligibility criteria for the types of prescription drugs which may be imported and the requirements for entities that may export or import prescription drugs. The eligibility criteria cover:
  - Importation process;
  - Safety standards;
  - Testing requirements;
  - Drug distribution requirements; and
  - Penalties for violations of program requirements.
- Both programs must also adhere to federal product tracing requirements known as *track and trace* as described in Title II of the Drug Quality and Security Act, Drug Supply Chain Security Act, 21 U.S.C. 351 et seq. The bill includes a testing process with random sampling and batch testing of drugs as they enter the state under either program.
- Bond requirements and other financial responsibility requirements provisions were added for the following program contractors with their program noted:
  - Vendors (CPDI Program);
  - Pharmacy permittees (IPDI Program);
  - Wholesale distributor permittees (IPDI);
  - Nonresident prescription drug manufacturer licensees or permittees (IPDI); and
  - International prescription drug wholesale distribution permittees (IPDI).

  The fees for the new licenses and permits that are created under this bill are handled in a separate fee bill as required by the State Constitution. The specific financial requirements for each of these licenses or permits will be set by rule by the AHCA and DBPR.
- Both programs have an immediate suspension provision allowing either the AHCA or the DBPR to immediately suspend the importation of a specific drug or the importation of drugs by a specific importer if either a specific drug or a specific importer is in violation of any provision of the bill or any federal or state law or regulation. The suspension may

be lifted if, after conducting an investigation, the AHCA or DBPR determines that the public is adequately protected from counterfeit or unsafe drugs being imported into the state.

- The bill requires federal approval, followed by state legislative review of an implementation and funding plan, before either program can begin. The IPDI Program requires specific federal approval as there is not any current federal legislation authorizing such a program.
- CS/HB 19 is linked to HB 7073, which authorizes DBPR and DOH to charge fees relating to new permits created in this bill for the IPDI Program.

If approved by the Governor, these provisions take effect July 1, 2019.
Vote: Senate 27-13; House 93-20

HB 19/SB 1528 – PRESCRIPTION DRUG IMPORTATION PROGRAM

Senate Health Policy Committee
November 5, 2019

Walter Copeland
Division Director – Drugs, Devices and Cosmetics

HB 19/SB 1528 Overview

- Established under section 499.0285, Florida Statutes, and entered into Florida Law as Chapter No. 2019-99, this legislation establishes two new programs for the importation of prescription drugs into the state of Florida.

  1. **The International Prescription Drug Importation Program (International Program)**
     - Administered under the Department of Business & Professional Regulation (DBPR) and the Florida Department of Health (DOH)
  2. **The Canadian Prescription Drug Importation Program**
     - Administered under the Agency for Health Care Administration

- Each program requires separate federal approval before being enacted
- The Law requires DBPR and DOH to jointly negotiate a federal arrangement to operate the International Program

International Program – Summary

- Authorizes certain state-permitted importers to import safe and effective prescription drugs from exporters in foreign nations with which the United States has:
  - Current mutual recognition agreements
  - Cooperation agreements
  - Memoranda of understanding
  - Other federal mechanism recognizing their adherence to current good manufacturing practices for pharmaceutical products
- Regulatory and license/permitting requirements under the International Program are more intense than currently required under federal or state law.
- Potential savings to Florida Citizens are substantial

International Program – Implementation, Operation and Oversight

- Divisions within DBPR and DOH responsible for Operation and Oversight of the International Program:
  - DBPR's Division of Drugs, Devices and Cosmetics (DDC)
  - DOH's Division of Medical Quality Assurance (MQA) and Board of Pharmacy (BOP)
- DDC, MQA and BOP Requirements
  - Program proposal for negotiation of federal approval
  - Licensing and permitting, including two new permit types
  - Registration process for participating importers and exporters
  - Information Technology upgrades and requirements
  - Regulatory and enforcement provisions
  - Promulgate rules

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Contact Information

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Managing Prescription Drug Benefits

Senate Health Policy Committee
November 5, 2019

Lauren Rowley
Pharmaceutical Care Management Association (PCMA)

Agenda for Discussion

- Introduction
- The Role of PBMs
- Who Contracts with a Pharmacy Benefit Manager?
- PBM Services & How PBMs Drive Savings & Quality
- Questions

Drug Supply Chain

DRUGMAKERS

Set Drug List Prices

Drugmakers negotiate with PSAOs to distribute their drugs to pharmacies

Drugmakers pay rebates to PBMs per negotiated agreements (on some drugs)

PBMs

Negotiate discounts with drugmakers on behalf of their health plan clients or large employer clients

PSAOs negotiate drug reimbursement on behalf of their pharmacy clients with PBMs

PBMs/health plans pay pharmacy for drugs dispensed

PSAO / WHOLESALER

PSAOs sell/distribute drugs to their pharmacy clients

HEALTH INSURANCE PLANS

Health insurance plans cover enrollees' drug costs

PHARMACY

Patient pays copays for drugs

Pharmacy dispenses drugs to patient

PATIENT

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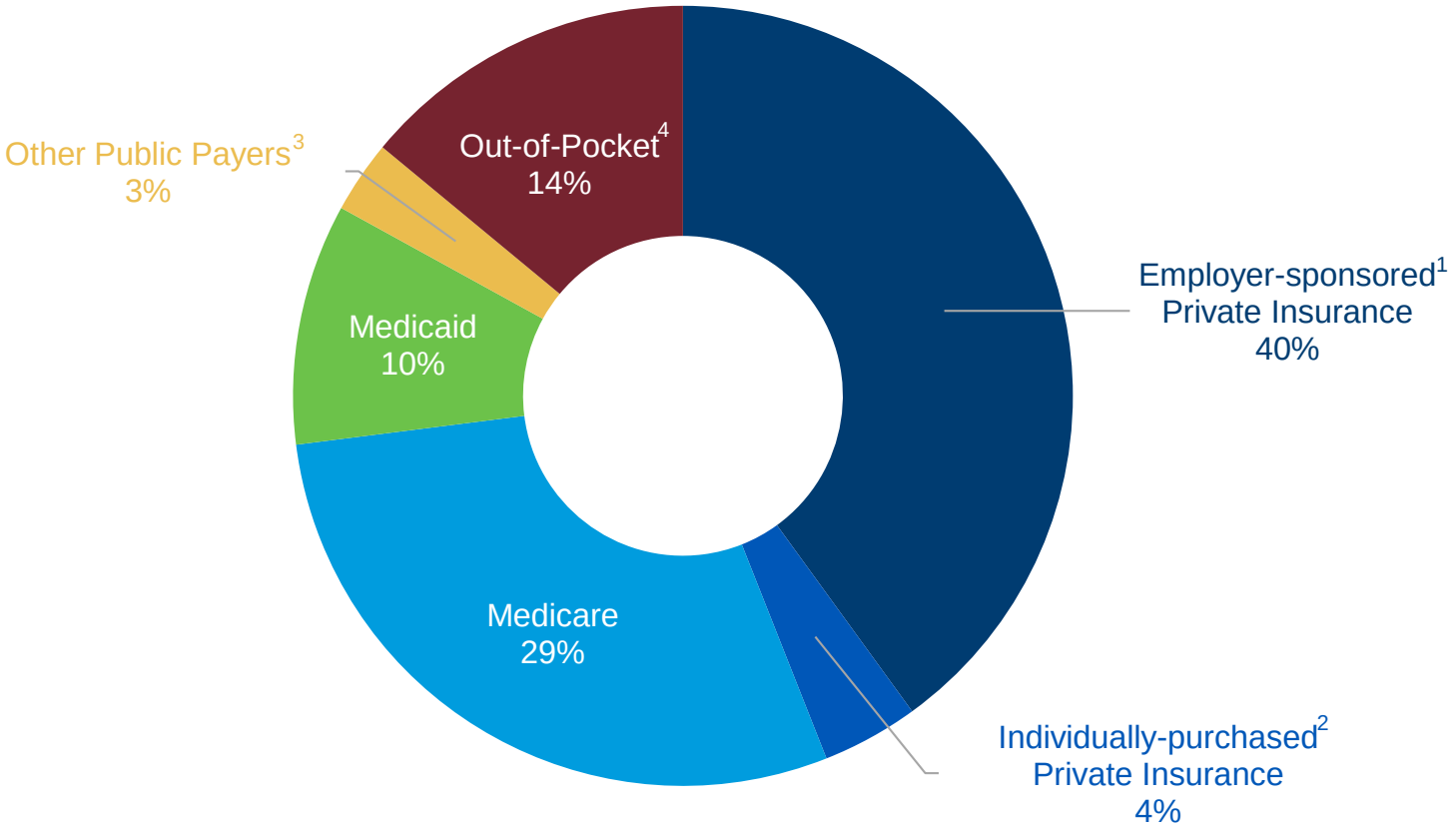
Who Pays for Prescription Drugs?

Source of Payment for Outpatient Prescription Drug Expenditures, 2016



1. Includes workers' compensation and Pembroke Consulting estimates for employer share of private insurance.
2. Includes those with Medicare supplemental coverage and all individually purchased plans, including coverage purchased through the Marketplaces. Figure reflects Drug Channels Institute estimates for prescription drug spending for individually purchased private insurance.
3. Includes Children's Health Insurance Program (Titles XIX and XXI), Department of Defense, Department of Veterans Affairs, Indian Health Service, workers' compensation, general assistance, maternal and child health, and other federal, state, and local programs. Other federal programs include OEO, Federal General and Medical, Federal General and Medical NEC, and High Risk Pools under ASA. Other state and local programs include state and local subsidies and TDI.
4. Consumer out-of-pocket expenditures equal cash-pay prescriptions plus copayments and coinsurance.

Source: Drug Channels Institute analysis of National Health Expenditure Accounts, Office of the Actuary in the Centers for Medicare & Medicaid Services, December 2017. Totals may not sum due to rounding. Data exclude inpatient prescription drug spending within hospitals and nearly all provider-administered outpatient drugs.

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What Role Does a PBM Serve?

- Pharmacy benefit managers (PBMs) negotiate on behalf of plan sponsors and administer the outpatient prescription drug portion of the health care benefit, in a high-quality, cost-effective manner.
- PBMs aggregate the buying clout of millions of enrollees, enabling plan sponsors and individuals to obtain lower costs for prescription drugs.
- PBMs are the only check in the retail Rx drug supply chain against drug makers' power to set and raise prices.

1 Visante, Generating Savings for Plan Sponsors, Feb. 2016, available at: - https://www.pcmanet.org/wp-content/uploads/2016/08/visante-pbm-savings-feb-2016.pdf

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Snapshot of PBM Marketplace

- Competition in PBM Marketplace is strong.
  - 66 PBMs in the U.S.[1]
  - PCMA Represents 18 PBM Members
- PBMs vary in size, geographic footprint, service offerings, expertise and focus.
- Market changes: consolidation, vertical integration, new entrants.
- PBMs' net profit is lowest in supply chain.

1 Pharmacy Benefit Management Institute (PBMI) Data

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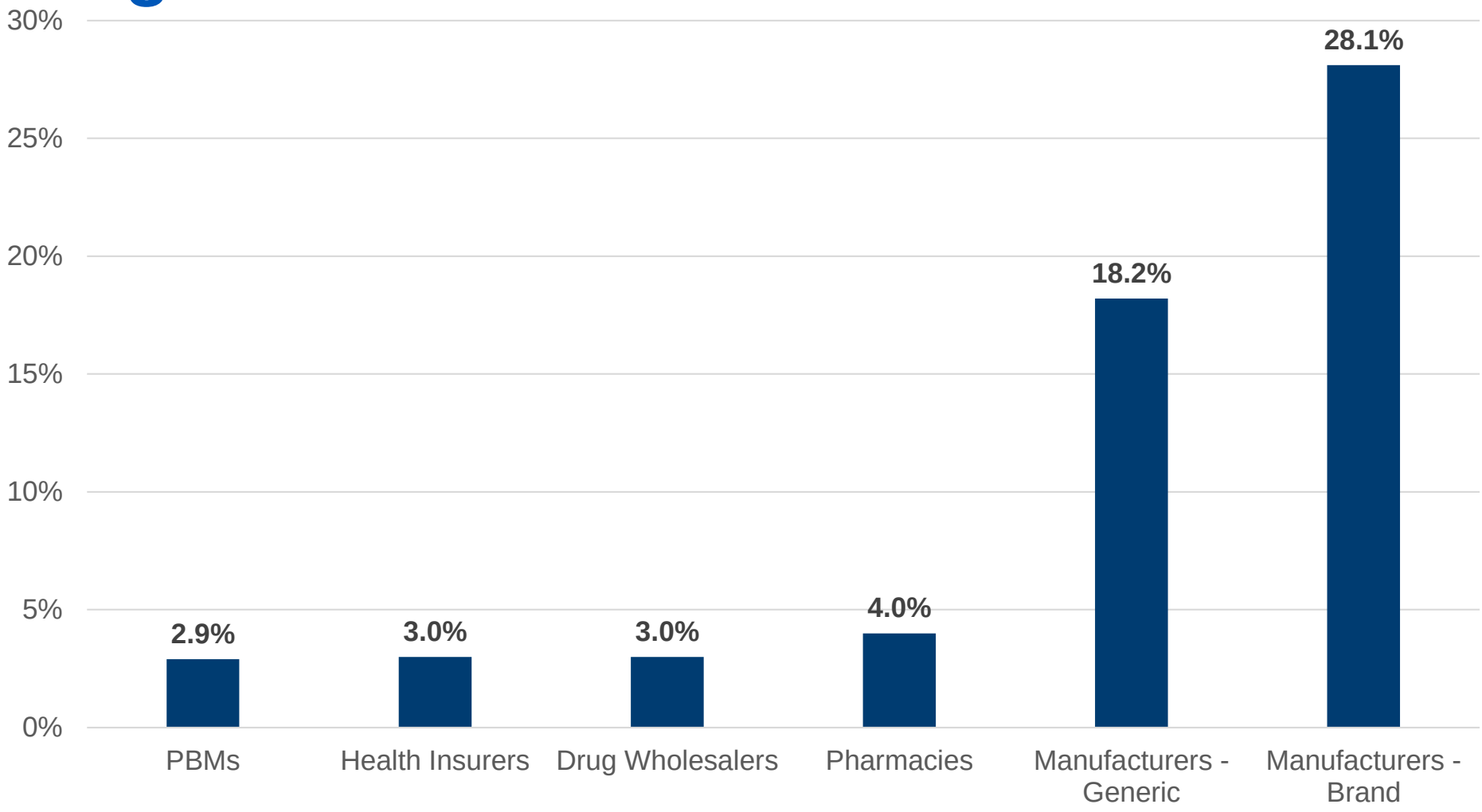
Pharmaceutical Supply Chain Profit Margins



Source: *The Flow of Money Through the Pharmaceutical Distribution System.* Schaeffer Center for Health Policy & Economics, University of Southern California. June 2017

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Who Are PBM Clients?

Private Sector Employers

Public Sector Employers

Commercial Health Plans/
Government Programs

Union Trusts/Taft-Hartley Plans
(ERISA-exempt)

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How Plans Hire PBMs: RFP Process

Plan Issues RFP

- Request for Proposal (RFP) dictates the terms and conditions of the PBM services

PBM Bids

- Multiple PBMs bid in a highly competitive environment
- PBMs offer various design models depending on plan sponsor's specific needs

Plan Decision

- Plan sponsor may utilize benefit consultants for direction
- Decisions often reflect need of a robust pharmacy benefit that delivers cost savings

Plan Design

- PBM provides options based on the plan sponsor's unique needs
- Plan sponsor makes the final decision about the drug benefit plan

PBM – Plan Contracts

- PBMs offer various design models depending on a plan's specific needs:
  - Plans choose how to compensate PBMs: traditional/spread, pass-through/fees, rebate share.
  - Performance guarantees and audit rights protect plans and ensure transparency.
  - On average, more than **90%** of rebates negotiated by PBMs are passed through to plan sponsors.[1]
- The plan sponsor always has the final say when creating a drug benefit plan.
- Things not determined by a PBM: benefit design, cost sharing levels, deductibles, etc.

1 Pew Charitable Trusts, "The Prescription Drug Landscape Explored". 2019

PCMA

Pharmacy Benefit Management Services

Claims Processing

Price, Discount and Rebate Negotiations with Pharmaceutical Manufacturers and Drugstores

Formulary Management

Pharmacy Networks

Mail-service Pharmacy

Specialty Pharmacy

Drug Utilization Review

Disease Management and Adherence Initiatives

PCMA

Why Do Plans Hire PBMs?

- PBMs help save plans 40-50% over unmanaged benefit, increase adherence.[1]
- Reduce medication errors through use of drug utilization review programs.
  - Over next 10 years, PBMs will help prevent 1 billion medication errors.[2]
  - Improve drug therapy and patient adherence, notably in the areas of diabetes and multiple sclerosis.[3]
- Manage programs to address opioid use issues.

1 Visante, Return on Investment on PBM Services, Nov. 2016.
2 Visante estimates based on IMS Health data and DUR programs studies.
3 Visante estimates based on CDC National Diabetes Statistics Report 2014 and studies demonstrating improved adherence by 10+%).

How Do PBMs Drive Savings for Patients?

- Pharmacy Networks
  - PBMs build networks of pharmacies that compete on service, convenience, and quality to attract consumers in a particular health plan. This competition keeps prescription drug costs down.
- Home Delivery of Drugs
  - Health plans and employers offer their members and employees less expensive prescriptions for 90-day supplies of medications when they choose home delivery.
  - Mail-service pharmacies can offer lower prescription drug prices because they have lower overhead costs and are often more efficient than other types of pharmacies.

How Do PBMs Drive Savings for Patients?

- Incentivizing Use of Generic Drugs
  - PBMs help save money by using innovative management tools to increase the use of generic drugs, which are as safe, but less expensive than name brands.
- Drug Price Negotiations and Rebates
  - PBMs help rein in out-of-control prescription drug prices by negotiating price discounts and rebates from pharmacies and drug manufacturers.
- Using these tools, PBMs will save Florida payers over $43 billion across Commercial, Medicare Part D, and Medicaid plans between 2016-2025.[1]

1Visante, "Pharmacy Benefit Managers: Generating Savings for Plan Sponsors and Consumers". 2016

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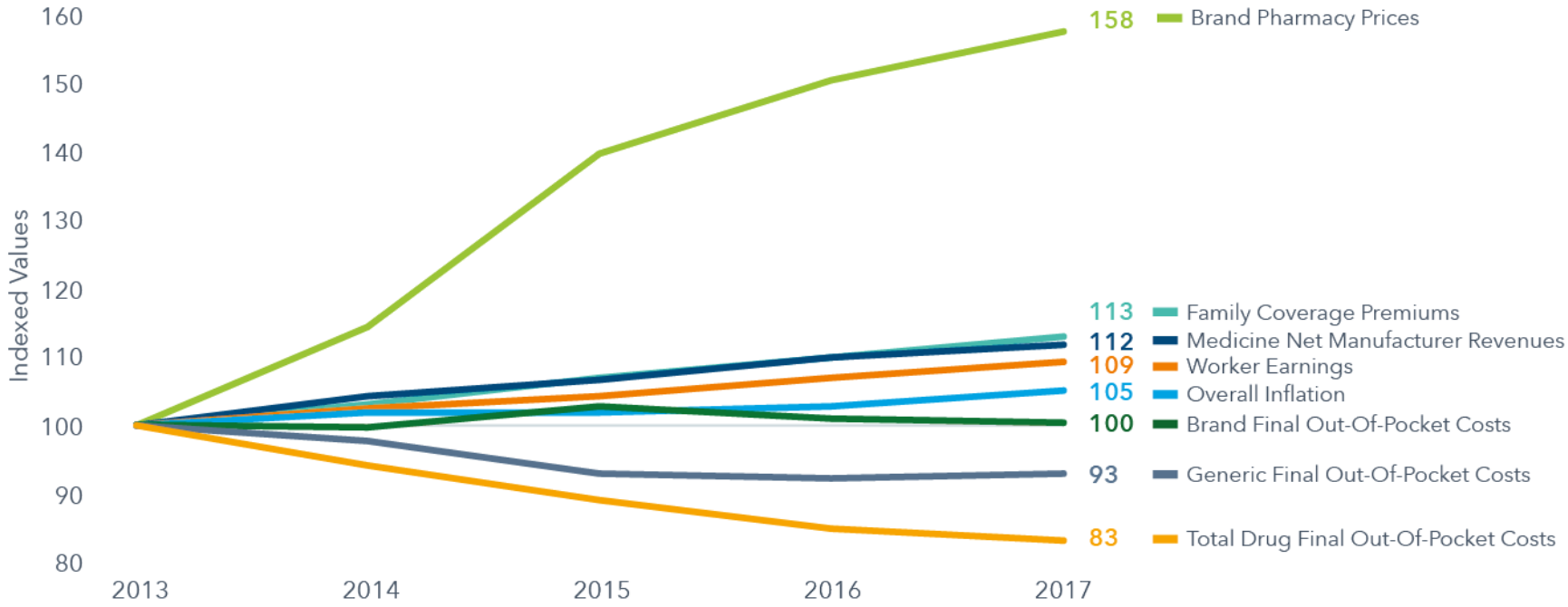
Brand Drug Prices Increased 58% 2013-2017

Changes in Healthcare Costs or Cost Drivers 2013-2017, Indexed (2013 Values + 100)



Source: IQVIA Institute. *Medicine Use and Spending in the U.S.: A Review of 2017 and Outlook to 2022*, April 2018. Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2017; IQVIA Formulary impact Analyzer (FIA). IQVIA Institute, December 2017.

Chart notes: Indices sourced from Kaiser/HRET Employer Survey4 include: family coverage, premiums, workers earnings, overall inflation. Brand, generic and total final out-of-pocket costs and brand pharmacy prices are for commercially insured, Medicare Part D and cash payment types sourced from IQVIA Formulary Impact Analyzer. All charted values are indexed to set their 2013 value equal to 100.

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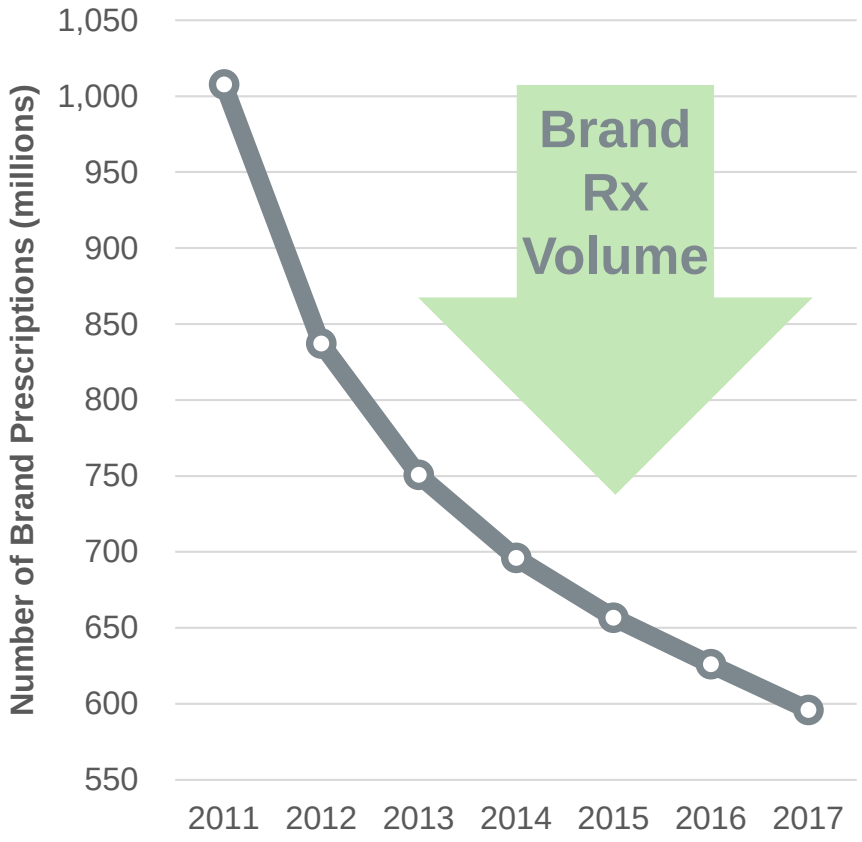
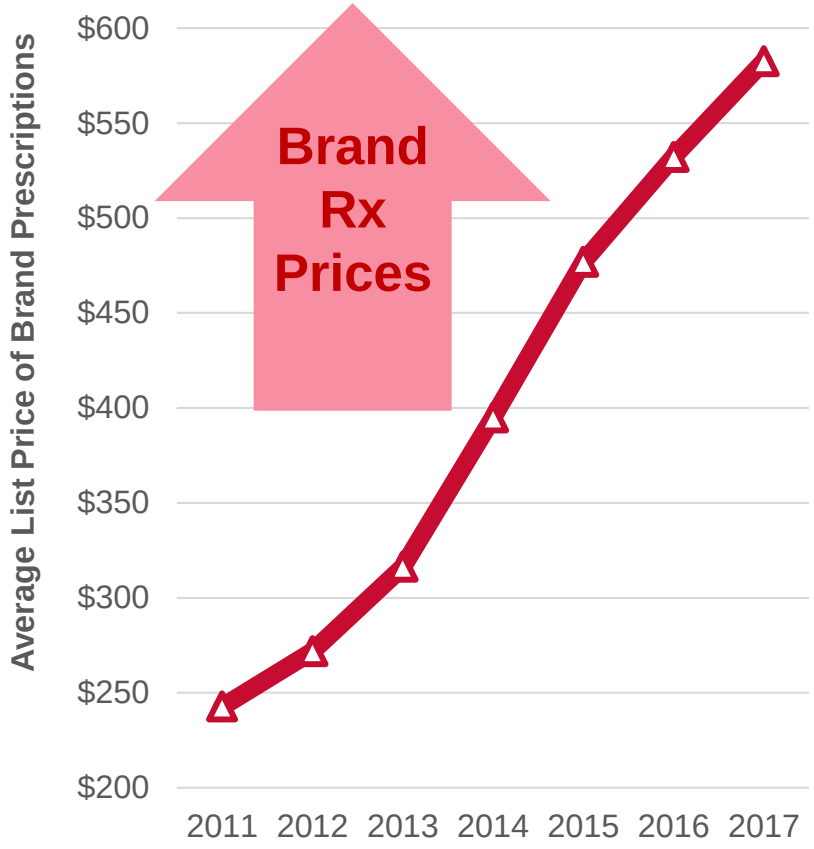
Why Are Manufacturers Increasing Prices? To Counter Shrinking Prescription Volume for Brand Drugs

Brand Prescription Volume Has Plummeted as Generics Have Replaced Brands



Meantime, Brand Drug Prices Have Skyrocketed to Maintain Revenues



Source: Visante analysis data published by the IQVIA Institute, 2018.

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How PBMs Drive Savings and Quality: Manufacturers

- PBMs are able to bring volume to manufacturers and in some cases, obtain price concessions.
- Rebates reduce the net cost of drugs for payers, **but they aren't available on all drugs**—only where there is competition.
  - 90% of drugs dispensed are generics, with little-to-no rebate in commercial programs.
  - In Medicare Part D, 64% of brands were not eligible for rebates.[1]
  - PBM clients get the vast majority of the rebates.[2, 3]
- Rebates help reduce premiums & cost-sharing, and revenue is included in MLR calculation.
- Plans have no alternative tool at this time that is *as* effective at forcing manufacturers to compete, bringing down the net cost of drugs.

[1]Milliman, "Prescription Drug Rebates and Part D Drug Costs." (July 2018); [2]U.S. Government Accountability Office, "Medicare Part D: Use of Pharmacy Benefit Managers and Efforts to Manage Drug Expenditures and Utilization." (July 2019); and [3]Pew Charitable Trusts, "The Prescription Drug Landscape, Explored." (March 2019).

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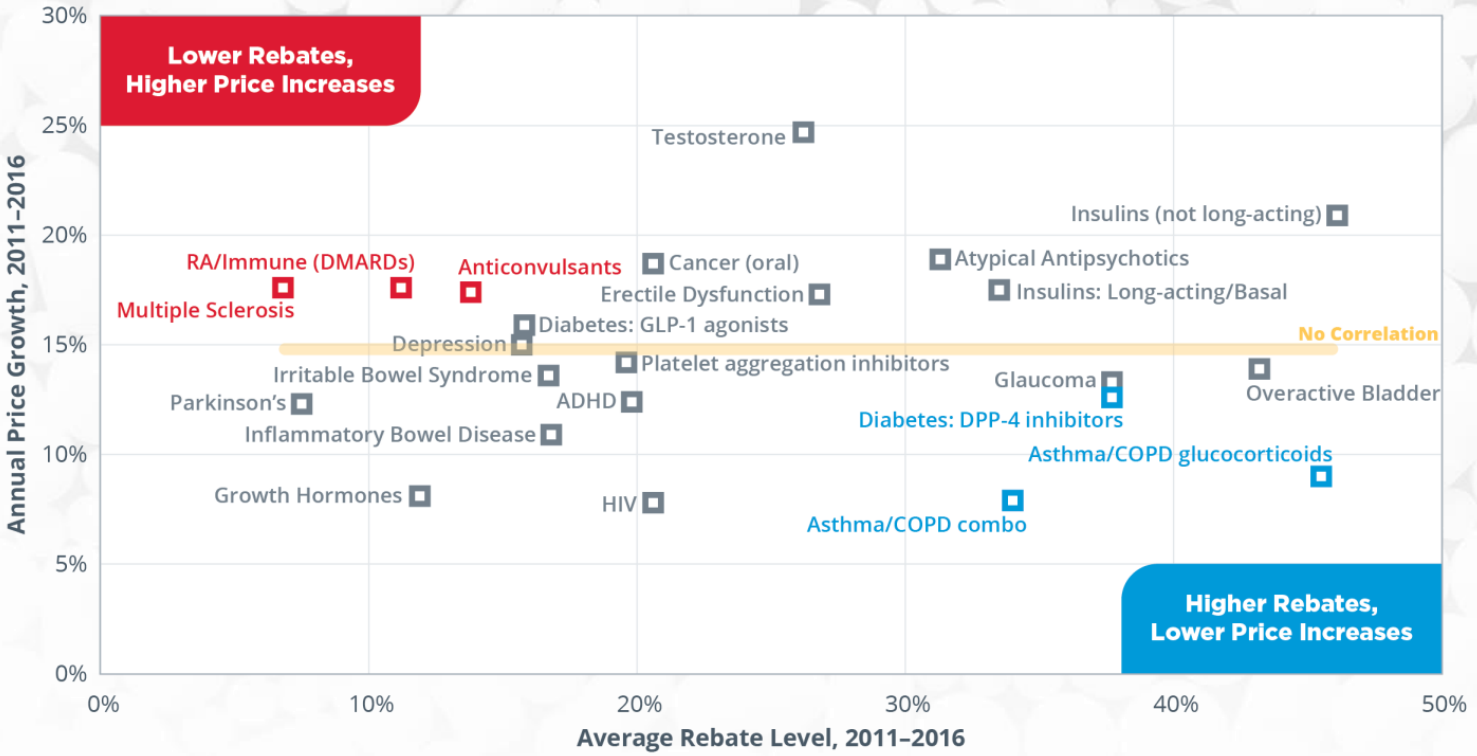
Study Shows No Correlation Between Drug Rebates and Price Increases



Major Findings:

- **No correlation** between drug prices and PBM/payer rebates
- Cases exist of higher-than-average price increases with relatively low rebates
- Cases exist of lower-than-average price increases with relatively high rebates
- Drugmakers are **increasing prices regardless of rebate levels**

Study: Top 200-self-administered, patent-protected, brand-name drugs in 23 major drug categories examined.

Source: Visante, *No Correlation Between Increasing Drug Prices and Manufacturer Rebates in Major Drug Categories*. (April 2017).

PCMA

How PBMs Drive Savings & Quality: Pharmacy Networks

- Plans need a broad variety of pharmacies for adequate networks, and expect pharmacies to compete on both price and quality.
- PBMs:
  - Contract with a variety of pharmacies (typically through PSAOs) to ensure a robust network for health plan enrollees to access.
  - Efficiently process claims, provide real-time reimbursement information and timely payment.
  - Audit pharmacies for fraud, waste and abuse.

Independent Pharmacies & PSAOs

- 80% of independent pharmacies in the U.S. are represented by Pharmacy Services Administrative Organizations (PSAOs).
- PSAOs pool purchasing power of many pharmacies to leverage strength and contracting strategies with payers.
- PSAOs negotiate & enter into contracts with payers on behalf of independent pharmacies, including reimbursement rates, payment term, and audit terms.
- PSAOs also provide inventory and back-office functions to pharmacies.
- The largest PSAOs are owned by the three major drug wholesalers.
- **PBMs have no insight into private contract terms between PSAOs and pharmacies**.
- Independent pharmacies are doing well & national numbers have been flat or trending up since 2010 – 37% of all pharmacies in US are small, independent pharmacies.[1]

1 Quest Analytics of NCPDP Data, Jan. 2019.

PCMA

The Florida Independent Pharmacy Community is Strong

- Since 2010, the number of independent pharmacies in Florida has increased by 32% while chain pharmacies have increased by a mere 2% during the same time period.[1]

Year	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
IND	1,164	1,350	1,524	1,602	1,635	1,738	1,818	1,735	1,695	1,541
CH	3,008	3,046	3,090	3,086	3,108	3,133	3,138	3,076	3,052	3,074

1 Quest Analytics Analysis of NCPDP Data, 2019.

PCMA

Conclusion

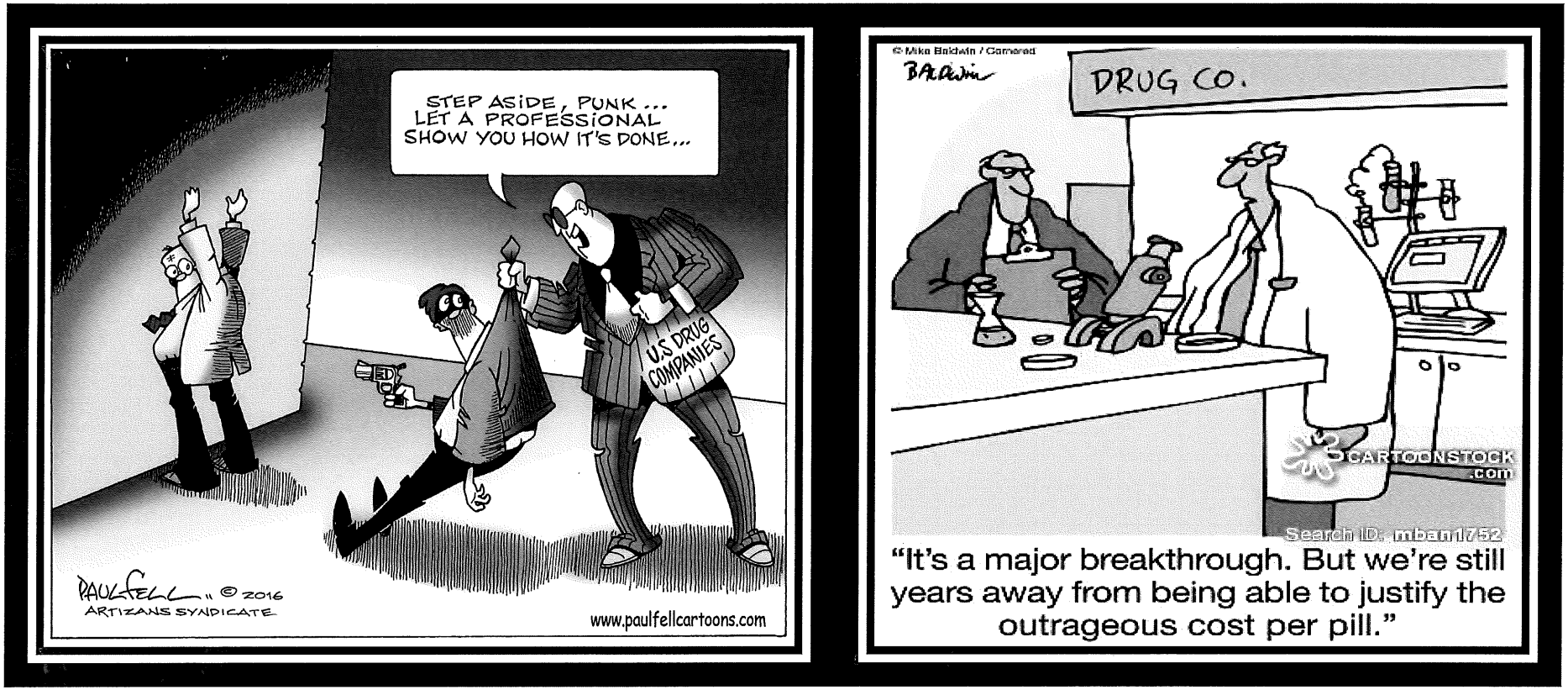
- PBMs have developed as a way to streamline access to prescription drug benefits and help put downward pressure on net cost.
- There are significant cost pressures through high pharmaceutical list prices, for both brands and generics.
- PBMs harness competition in the manufacturer and pharmacy markets when competition exists, aiming for both affordability and quality.
- While no plan is required to use a PBM, most do, because PBMs play a central role in **driving adherence**, **holding down costs**, and **increasing quality.**

Questions?

The Other *Bad Guy* in Our Drug Pricing Problem

Florida Health Policy Committee
November 5, 2019

Madelaine T. Feldman MD, FACR.
Coalition of State Rheumatology Organizations – President
Alliance for Safe Biologic Medicines - Chair
Clinical Instructor/Assis. Prof. of Medicine – Tulane Medical School
MadelaineFeldman@gmail.com


STEP ASIDE, PUNK... LET A PROFESSIONAL SHOW YOU HOW IT'S DONE...
ED
U.S DRUG COMPANIES
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"It's a major breakthrough. But we're still years away from being able to justify the outrageous cost per pill."

A Few Definitions

- **Formulary** – the list of medications that insurance will pay for
- **Tiers** – levels within the formulary – based on cost
- **Preferred Drugs** – drugs that must be "failed first" before other drugs will be paid for – step therapy
- **Specialty Drugs**– "expensive" medications
- **Copay**- fixed amount for a drug or service
- **Co-insurance** - % of price for drug or services

FORMULARY - THE KEY

- **List of drugs** that **insurance will pay for**
- If expensive drug is not on the formulary

NO ONE WILL TAKE IT

Formulary Construction in America

"Perfectly Legal"

and

"Perfectly Wrong"

Who Constructs the Formulary?

- **Pharmacy Benefit Managers** (PBMs)
  - Hired by Health Plans/Employers
    - *manage* prescription drug benefit programs
  - Act as intermediaries
    - Health Plans/Employers, Manufacturers, Pharmacies

Mergers

Vertical Business Relationships Among Insurers, PBMs, and Specialty Pharmacies, 2019

Source: Drug Channels Institute research. AllianceRx Walgreens Prime is jointly owned by Prime Therapeutics and Walgreens Boots Alliance.

This chart appears as Exhibit 77 in *The 2019 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers, Drug Channels Institute.* Available at http://drugch.nl/pharmacy

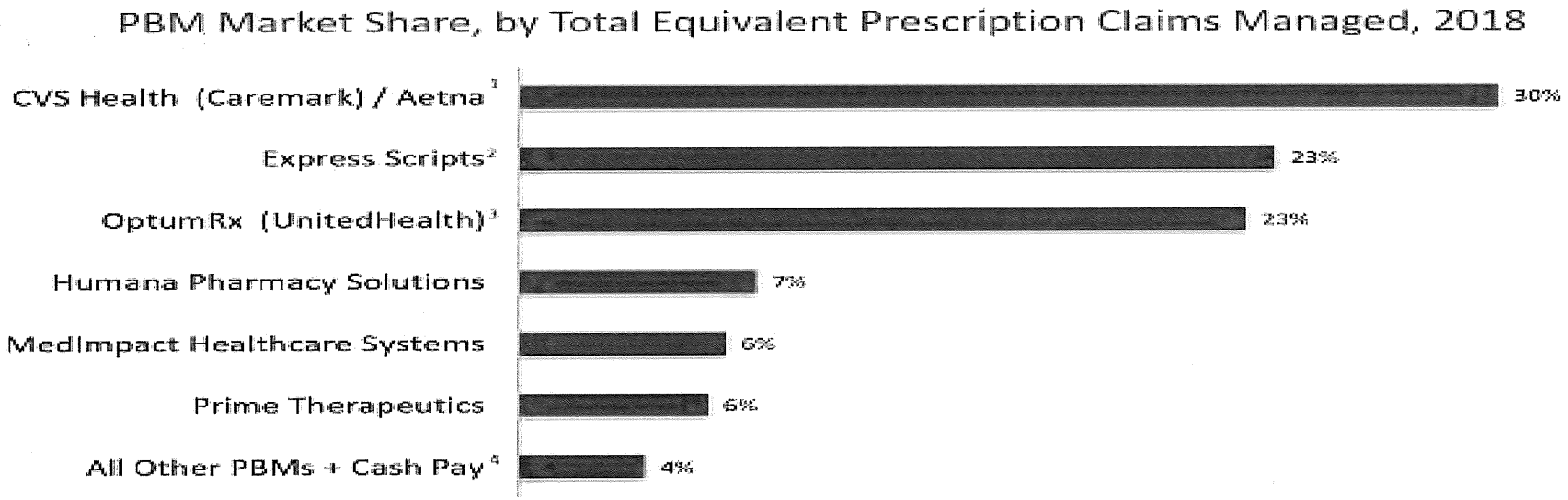
DRUG CHANNELS INSTITUTE

- PBMs claim to *save billions for our health care system* by:
  - Designing formularies based on "negotiated discounts"
    - Secret kickback package - based on list price
  - Utilization Management Tools - Employers want them
    - Keep patients on the most profitable drugs-
    - Many Employers have no idea what they are signing
  - More affordable pharmacy channels
  - Encouraging use of generics & affordable brands
    - Higher priced and brands preferred

CSRO

SOURCES: PCMA. Policy & Issues: PBM Cost-Saving Tools. https://www.pcmanet.org/policy-issues/. Accessed January 10, 2017; Visante. Pharmacy benefit managers (PBMs): Generating savings for plan sponsors and consumers. https://www.pcmanet.org/wpcontent/uploads/2016/08/visante-pbm-savings-feb-2016.pdf. Published February 2016. Accessed January 10, 2017.

Who are the PBMs?



1. Includes pro forma combination of claims processed by Aetna. Excludes double counting of network claims for mail choice claims filled at CVS retail pharmacies.
2. Includes Anthem. During 2019, Anthem claims will be transitioning to IngenioRx.
3. Includes Cigna. By the end of 2020, Cigna claims will transition to Express Scripts.
4. Figure includes some cash pay prescriptions that use a discount card processed by one of the 6 PBMs shown on the chart.

Source: Drug Channels Institute research and estimates. Total equivalent prescription claims includes claims at a PBM's network pharmacies plus prescriptions filled by a PBM's mail and specialty pharmacies. Includes discount card claims. Note that figures may not be comparable with those of previous reports due to changes in publicly reported figures of equivalent prescription claims. Total may not sum due to rounding.

This chart appears as Exhibit 7.1 in *The 2019 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers*, Drug Channels Institute. Available at http://drugch.nl/gbharmacy

DRUG CHANNELS
INSTITUTE

PBMs Reality

Middlemen - Fiduciary Responsibility Only to Shareholders

- Formulary Construction
  - **Based on the most profitable drugs**
- Utilization Management Tools
  - **Keep doctors prescribing the most profitable drugs**

CSRO

SOURCES: ERISA Advisory Council. PBM Compensation and Fee Disclosure https://www.dol.gov/sites/default/files/ebsa/about-ebsa/about-us/erisa-advisory-council/2014ACreport1.pdf. Published November 2014. Eickelberg HC. The prescription drug supply chain black box: How it works and why you should care. American Health Policy Institute. http://www.americanhealthpolicy.org/Content/documents/resources/December%202015_AHPI%20Study_Understanding_the_Pharma_Black_Box.pdf. Published 2015. Accessed January 10, 2017; Compliant, Boss v. CVS Health Corp., No. 2:17-cv-01823 (D.N.J. March 17, 2017), https://www.bloomberglaw.com/public/desktop/document/BOSS_et_al_v_CVS_Health_Corporation_et_al_Docket_No_217cv01823_DN?1496256418.

PBMs Ultimately Determine

What, When, Where
&
How Much

CSRO

Physician's Attitude

Undermines Doctor – Patient Relationship determining

The best treatment - **efficacy, safety and affordability.**

But instead we are faced with:

- **Formulary Restrictions**
  - Step-therapy
  - Non-medical switching
  - Exclusions

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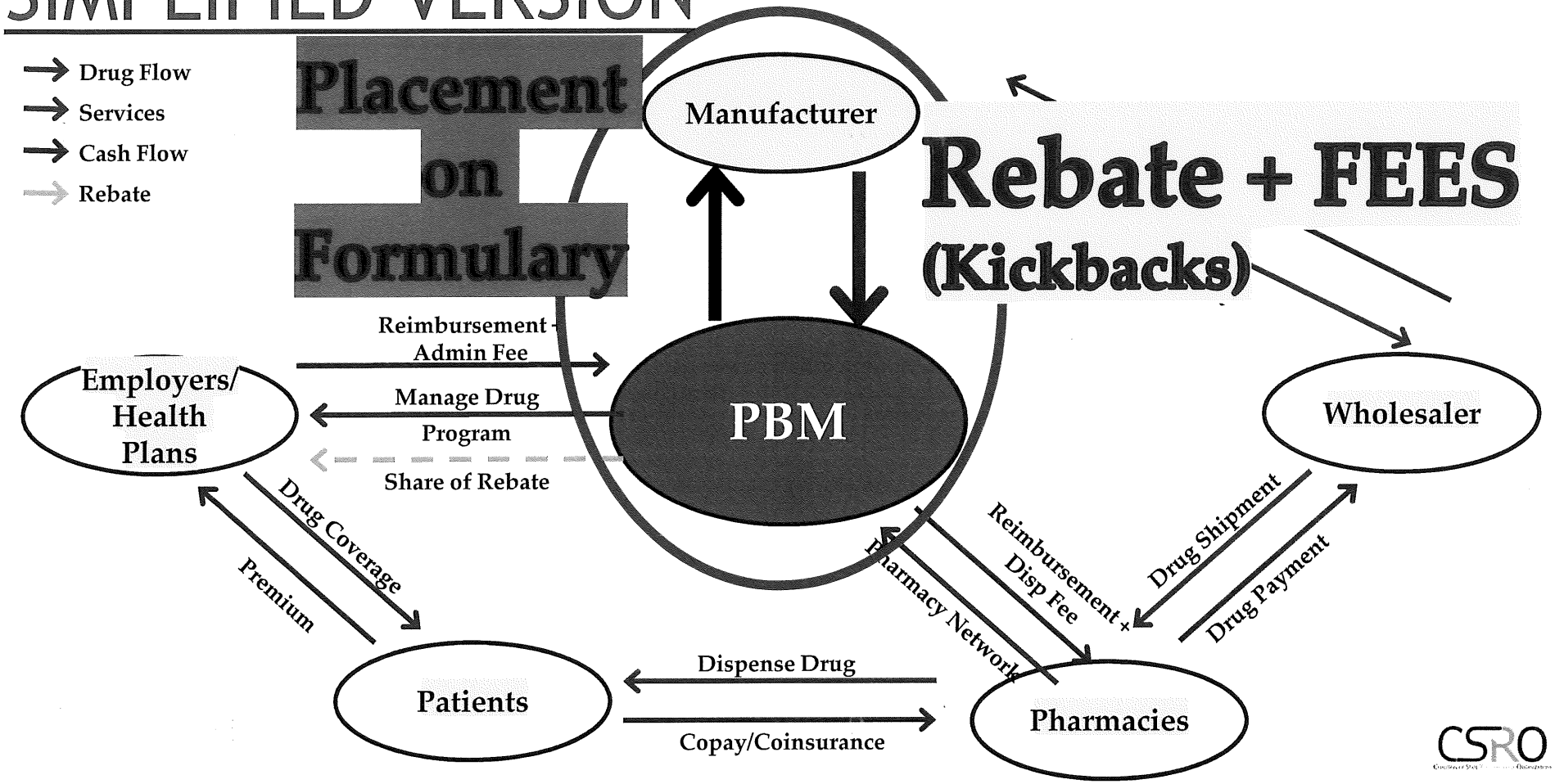
Breaking Down the Drug/Money/Services Flow

CSRO

SIMPLIFIED VERSION



What Determines Preferred Placement?

- **Efficacy?**
- **Safety?**
- **Lowest list price?**

Guess again.....

CSRO

The Rebate Story...

Can't Forget About The Fees !

CSIRO

The Rebate-Price Concession System

- **Rebate (Price Concession)**:
  - A retroactive sum of money paid by a manufacturer to a PBM
    - For each script filled
    - In Exchange For *(Preferred)* Placement On PBM Formulary

How does it work??

SOURCES: ERISA Advisory Council. PBM Compensation and Fee Disclosure https://www.dol.gov/sites/default/files/ebsa/about-ebsa/about-us/erisa-advisory-council/2014ACreport1.pdf. Published November 2014. Eickelberg HC. The prescription drug supply chain black box: How it works and why you should care. American Health Policy Institute. http://www.americanhealthpolicy.org/Content/documents/resources/December%202015_AHPI%20Study_Understanding_the_Pharma_Black_Box.pdf. Published 2015. Accessed January 10, 2017; Compliant, Boss v. CVS Health Corp., No. 2:17-cv-01823 (D.N.J. March 17, 2017), https://www.bloomberglaw.com/public/desktop/document/BOSS_et_al_v_CVS_Health_Corporation_et_al_Docket_No_217cv01823_DN?1496256418.

How Do They Get Away With This?

"Safe Harbor"
From the
Anti-Kickback Statute

How it works...

"Bidding War"

Among Drug Makers

For Preferred Place on Formulary

SOURCES: ERISA Advisory Council. PBM Compensation and Fee Disclosure https://www.dol.gov/sites/default/files/ebsa/about-ebsa/about-us/erisa-advisory-council/2014ACreport1.pdf. Published November 2014. Eickelberg HC. The prescription drug supply chain black box: How it works and why you should care. American Health Policy Institute. http://www.americanhealthpolicy.org/Content/documents/resources/December%202015_AHPI%20Study_Understanding_the_Pharma_Black_Box.pdf. Published 2015. Accessed January 10, 2017; Compliant, Boss v. CVS Health Corp., No. 2:17-cv-01823 (D.N.J. March 17, 2017), https://www.bloomberglaw.com/public/desktop/document/BOSS_et_al_v_CVS_Health_Corporation_et_al_Docket_No_217cv01823_DN?1496256418.

CSRO

Manufacturers Fight For Preferred Placement

- **Benefits Of Preferred Placement**
  - **Step Therapy**-Must step through THEIR drug first
  - **Non Medical Switching** to THEIR drug
  - **Excludes Competitors** to THEIR drug -
    - Performance contracts

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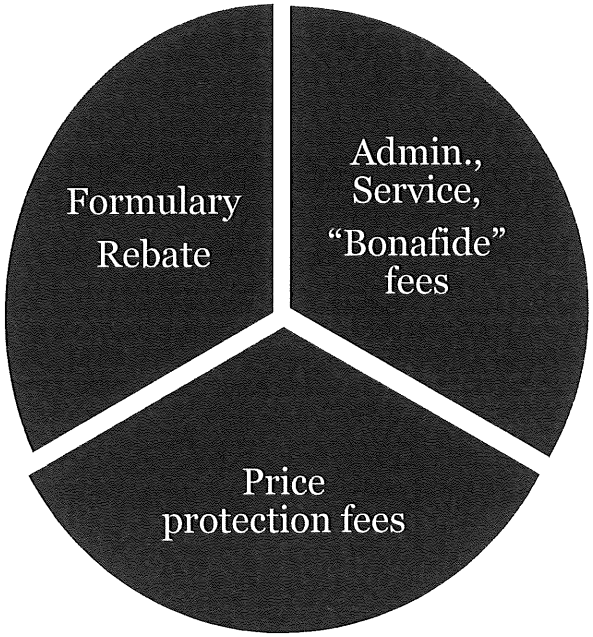
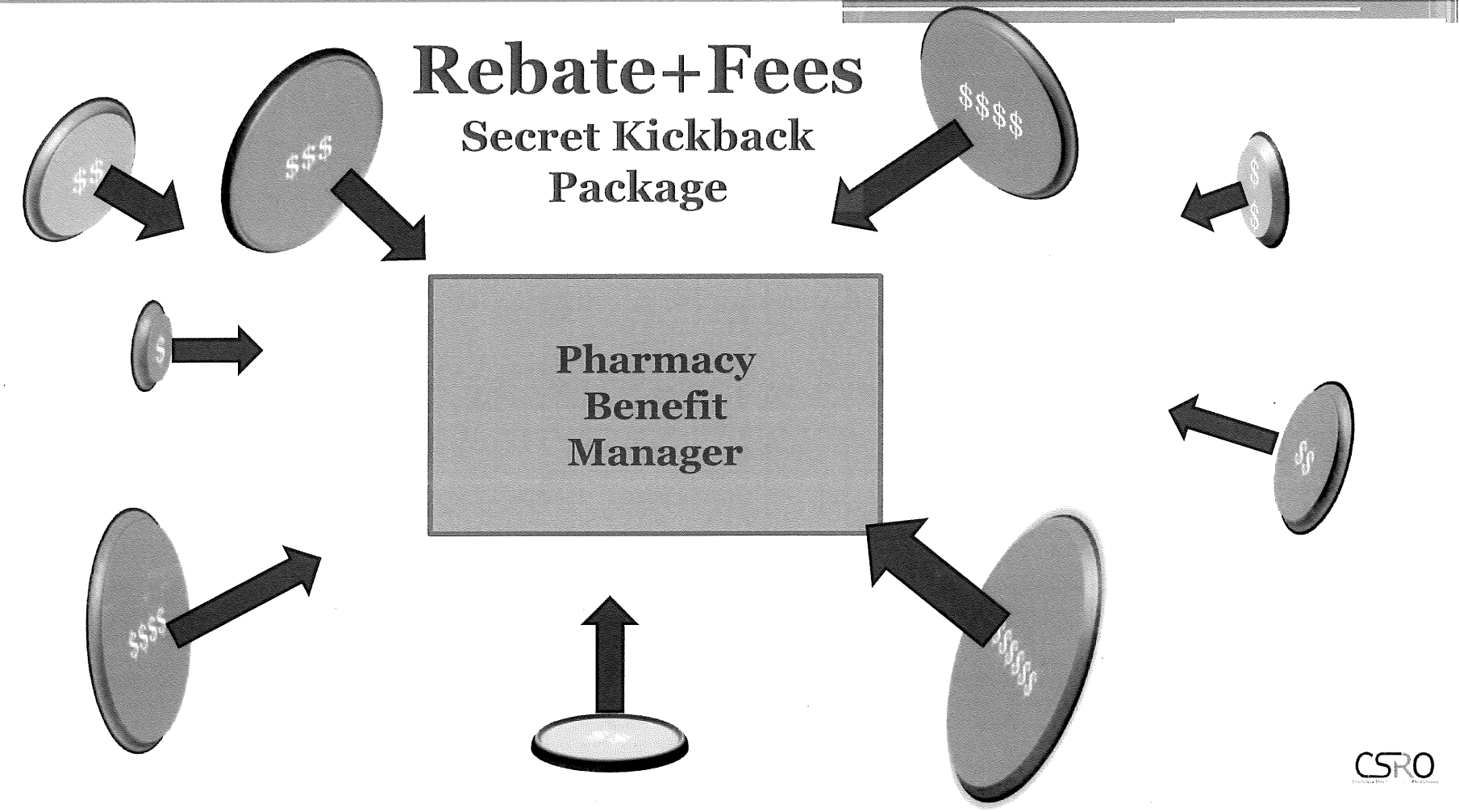
Secret Kickback Package (Price Concession Bid)




Rebate+Fees
Secret Kickback Package
Pharmacy Benefit Manager

The Formula

Formulary Rebate =

List Price x % Discount x # Scripts filled

1. **List price of the drug**
2. **% Discount promised**
3. **# Scripts filled (*Market share*)**

An Increase In Any One Of These Variables

Better Chance At Preferred Placement

CSRO

Which Drug Has The Best Bid?

	Drug A	Drug B	Drug C
List Price	$2,000/mo	$4,000/mo	$5,000/mo
Rebate %	60%	40%	40%
Formulary Rebate	$1,200	$1,600	$2,000

What Does Competition Do ?

Manufacturers Compete for the Preferred Spot...

BUILDING A HOUSE
WINNER= Lowest Bidder

COMPETITION DRIVES PRICES DOWN

COMPETITION DRIVES PRICES UP

SELLING A HOUSE
WINNER= Highest Bidder

OUR DRUG DISTRIBUTION SYSTEM

- PBMs receive rebates/fees based on a % of the list price of the medicine.
- These price concessions can be over 50% of the list price.
- **<u>This creates a perverse incentive for HIGHER PRICED MEDICINES, not lower, because the HIGHER PRICED MEDICINE can provide the larger rebate /fee package.</u>**

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The Higher the LIST PRICE, The Higher the...

- **Patient Cost** - Co-insurance based on list price
- **Administration fees -** Manufacturers pay admin fees that are often based on list price
- **Price protection rebate-** List price increase above a ceiling
  - Triggers additional rebate payments.

******MOST IMPORTANT - Patient Cost**
Patient Co-insurance % Is Based On List Price

CSRO

Invoice Date	Type of Contract	Formulary Rebate	Admin Fee	Price Protection Rebate	Total
Jan-16	Commercial	$1,612.50	$24,963.90	$5,689.26	$32,265.66
Jan-16	Medicare	$450	$2,652.13	$5,184.14	$8,286.57
2/1/16: kaleo increases Evzio list price from $937.50 to $4,687.50					
Apr-16	Commercial	$7,125.00	$129,517.29	$4,951,923.90	$5,088,566.19
May-16	Commercial	$9,937.50	$137,162.51	$2,266,092.01	$2,413,192.02
Dec-16	Commercial	$4,312.50	$56,395.65	$977,873.22	$1,038,581.37
Dec-16	Medicare	$3,375	$12,468.56	$219,218.80	$235,062.36
	Total	**$26,812.50**	**$363,160.04**	**$8,425,981.33**	**$8,815,954.17**

http://www.pharmacybenefitconsultants.com/rx-alerts/time-to-determine-if-your-pbm-is-hiding-rebates/

FROM EXPRESS SCRIPTS CONTRACT (Axios.com)

For sake of clarity, **Rebates do not include**, for example,
Manufacturer Administrative Fees;

- **Inflation payments**;
- **Product discounts or fees related to the procurement** of prescription drug inventories by ESI Specialty Pharmacy or the Mail Service Pharmacy;
- **Fees** received by ESI from pharmaceutical manufacturers for care **management/ services** provided with the dispensing of products;
- Other fee-for-service arrangements whereby pharmaceutical manufacturers generally report the fees paid to ESI or its wholly-owned subsidies for services rendered as **"bona fide service fees"** (collectively, **"Other Pharma Revenue"**)
- Such laws and regulations, as well as ESI's contracts with pharmaceutical manufacturers, generally **prohibit ESI from sharing** any such "bona fide service fees" earned by ESI, whether wholly or in part, **with any ESI client.** https://www.axios.com/drug-pricing-contract-express-scripts-d536e8a9-a8a3-4bc9-8028-05453e617326.html

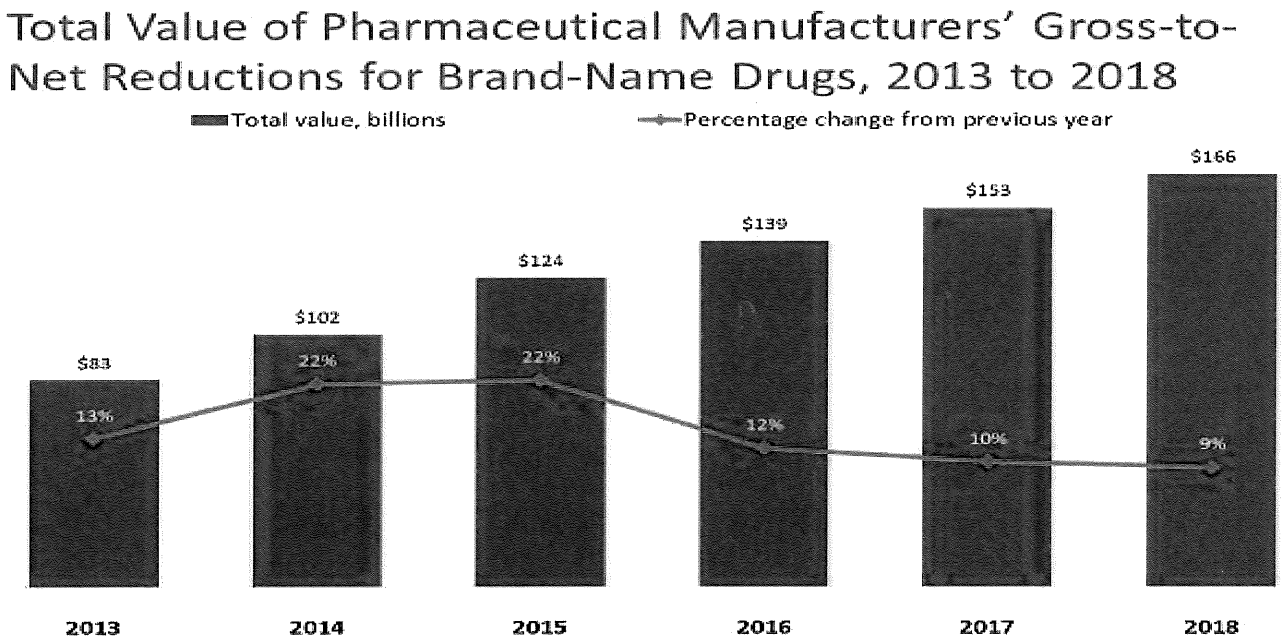
MF

Slide 28

MF1 Madelaine Feldman, 10/3/2018

How Much Money Is Paid In Price Concessions?

(PBMs call rebates/fees "SAVINGS" for US Health system)



Source: Drug Channels Institute analysis of IQVIA Institute data; Drug Channels Institute estimates. Gross-to-Net Reductions include the total value of rebates, off-invoice discounts, copay assistance, price concessions, and such other reductions as distribution fees, product returns, the 340B Drug Pricing Program, and more.

This chart appears as Exhibit 141 in *The 2019 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers, Drug Channels Institute*. Available at http://drugch.nl/pharmacy

DRUG CHANNELS INSTITUTE

CSRO

Where do the "Savings" Go?

- Lower premiums?
- Lower co-pays / coinsurance amounts?
- Lower list prices of medications?

Hmmmmm.....

CSRO

FORTUNE 500 LIST-2017

- #5 -United Health Care (OptumRx)
- #7 -CVS(Caremark) - Bought Aetna for $68,000,000,000
- #25 -Express Scripts - Now owned by Cigna

http://fortune.com/fortune500/

CSRO

- PBMs claim to *save billions for our health care system* by:
  - Designing formularies based on "negotiated discounts"
    - Secret kickback package - based on list price
  - Utilization Management Tools - Employers want them
    - Keep patients on the most profitable drugs-
    - Many Employers have no idea what they are signing
  - More affordable pharmacy channels
  - Encouraging use of generics & affordable brands
    - Higher priced and brands preferred

CSRO
Coalition of State Rx Organizations

SOURCES: PCMA. Policy & Issues: PBM Cost-Saving Tools. https://www.pcmanet.org/policy-issues/. Accessed January 10, 2017; Visante. Pharmacy benefit managers (PBMs): Generating savings for plan sponsors and consumers. https://www.pcmanet.org/wpcontent/uploads/2016/08/visante-pbm-savings-feb-2016.pdf. Published February 2016. Accessed January 10, 2017.

Who Regulates PBMs?

Federal

- Federal Trade Commission - NO
- HHS/CMS-NO
- DOJ - allowed mergers - NO
- **Congress - Senate and House Bills -So FAR NO**

States- Become Very Important

- Legislation, Board of Pharmacy, Insurance commissioners, AG

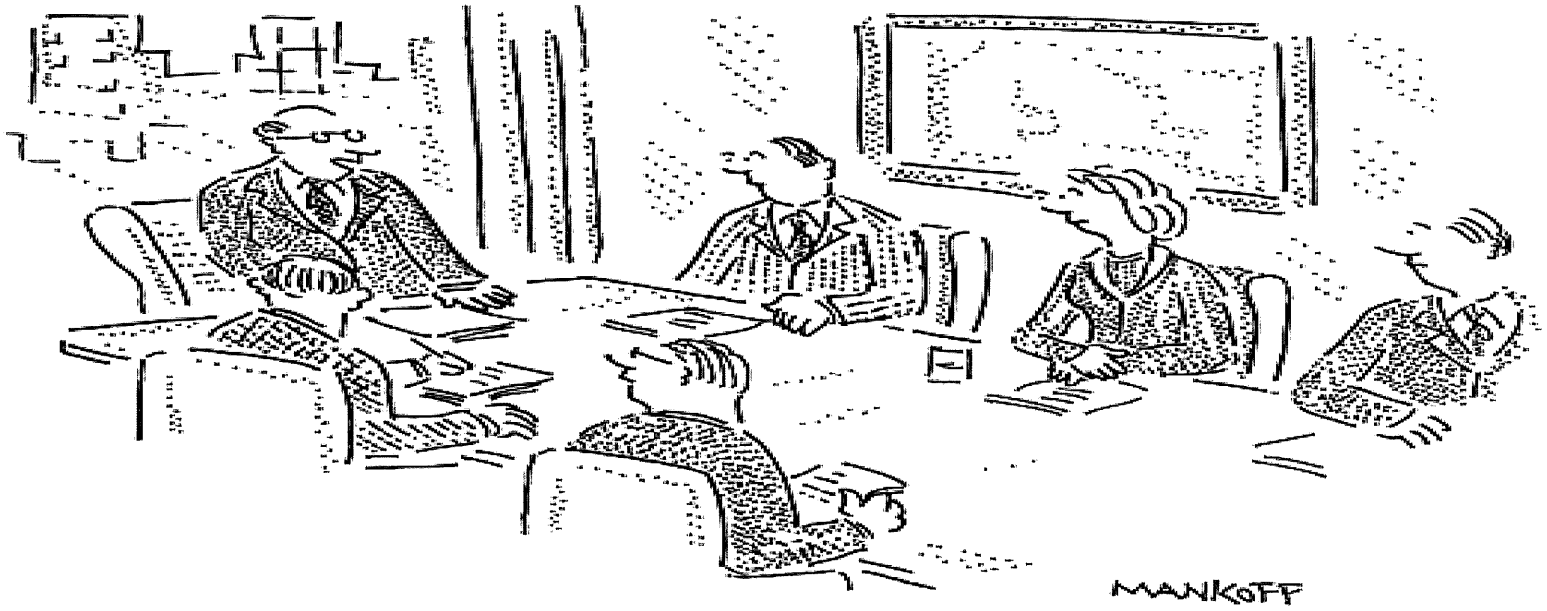
*Removing ERISA's Impediment to State Health Reform Erin C. Fuse Brown, J.D., M.P.H., and Ameet Sarpatwari, J.D., Ph.D. n engl j med 378;1 nejm.org January 4, 2018

CSRO

We Need:

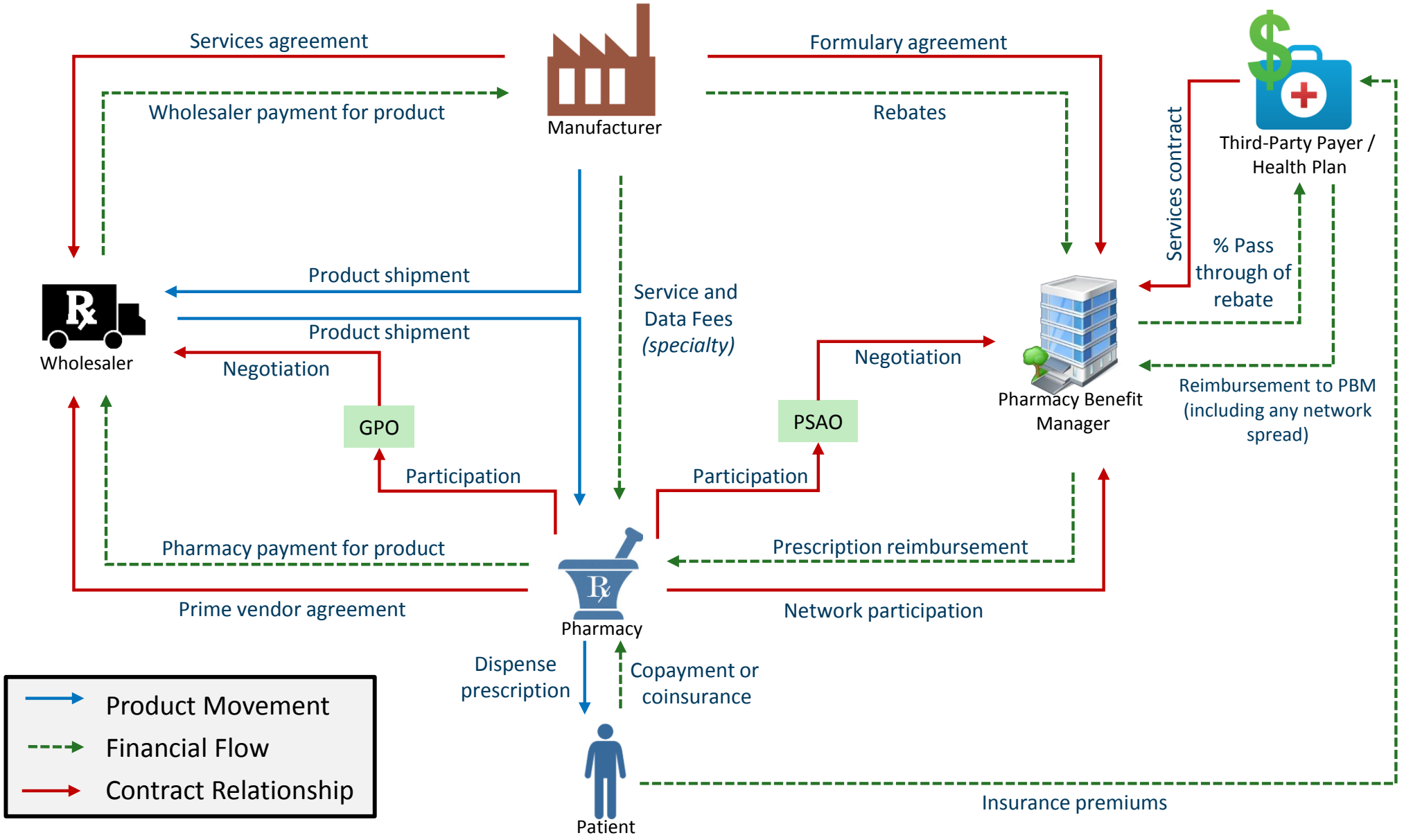
- **Co-insurance for patients based on cost of drug after all concessions****
- **Step Therapy & Non Medical Switching Reform**
- **Uniform Definitions - Transparency**
  - Secret kickback package (Price concessions)
  - Formulary rebates/ admin, service, bonafide fees/
  - Price protection fees
- **Formularies Based on Efficacy, Safety and Lowest List Price**
  - "Race to the bottom" in prices - Not to the top
  - Remove incentive to place higher priced drugs on formulary
  - Allow competition to lower prices - Not raise them

The Transparency Problem



"Let's never forget that the public's desire for transparency has to be balanced by our need for concealment."

U.S. Distribution and Reimbursement System: Patient-Administered, Outpatient Drugs



GPO = Group Purchasing Organization; PSAO = Pharmacy Services Administrative Organization

Source. Fein, Adam J., *The 2018 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers*, Drug Channels Institute, 2018. Chart illustrates flows for Patient-Administered, Outpatient Drugs. Please note that this chart is illustrative. It is not intended to be a complete representation of every type of product movement, financial flow, or contractual relationship in the marketplace.

DRUG CHANNELS INSTITUTE

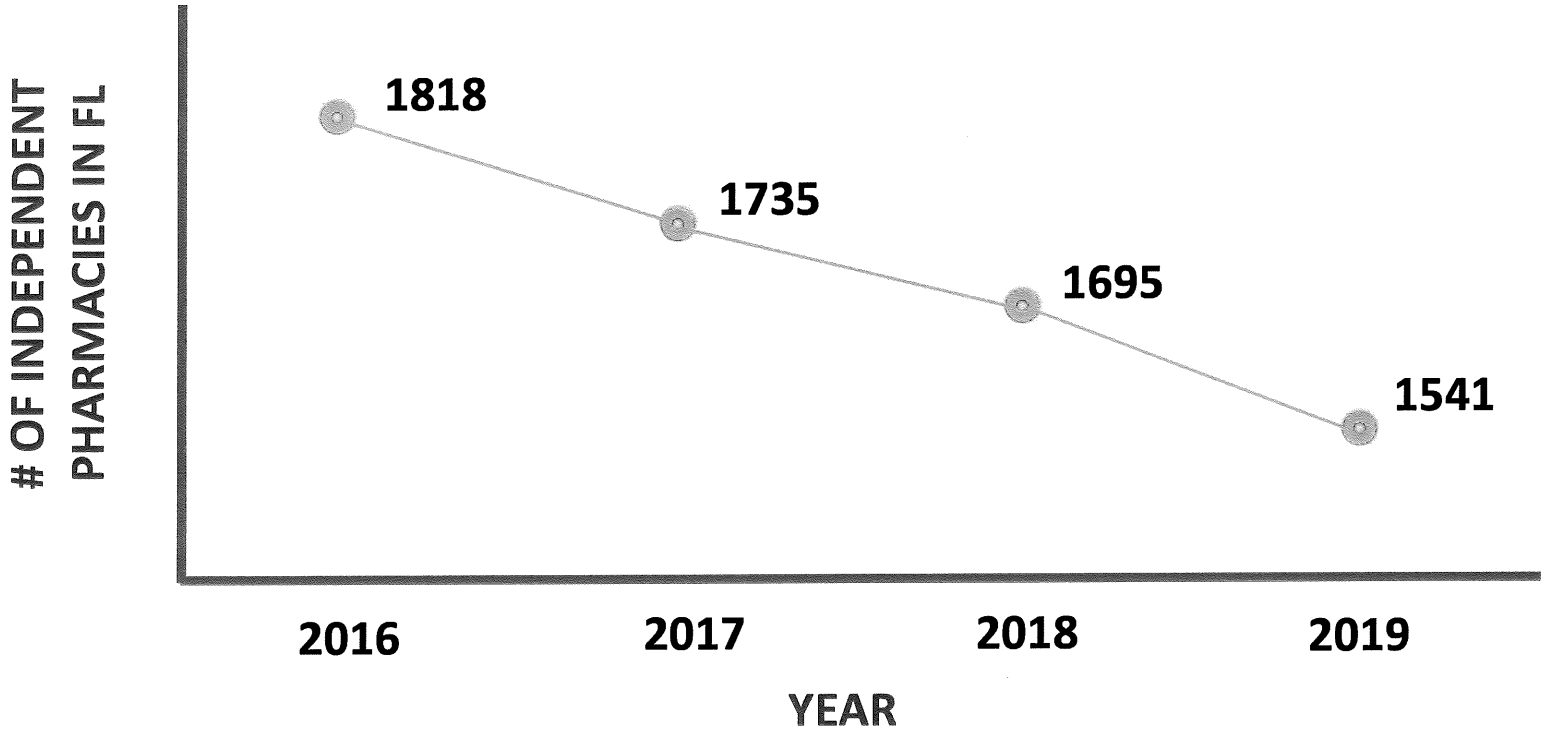
Senate Health Policy Committee

Tuesday, November 5, 2019

Presenter: Kevin Duane
Panama Pharmacy

SPARx

15% Decrease in # of Independent Pharmacies in FL



Source: Quest Analytics analysis of NCPDP Pharmacy Count Data, 2019

Decrease leads to...

Patients lose their local pharmacy

Patients have to drive out of their way to get their prescriptions

Often leads to an overall drop in medication adherence

Problem stems from...

SPARx

- **Contracting Issues**
- **Manipulative Steering**
- **Arbitrary Payments**
- **Debilitating Clawbacks**

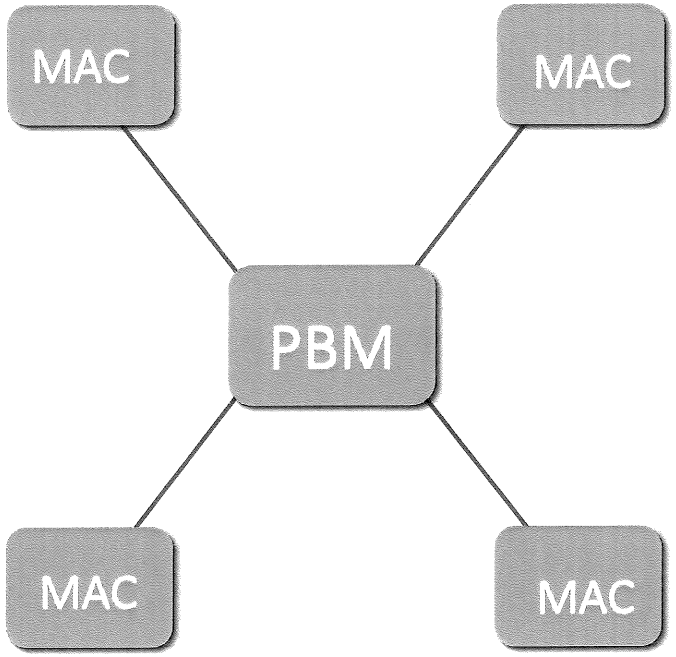
Contracting

PSAOs are presented with take it or leave it contracts	**Plan sends pharmacy direct contract that is take it or leave it** **Non-negotiable contracts as a result of monopolies**	**Closed networks cause patient access issues and eliminate competition**

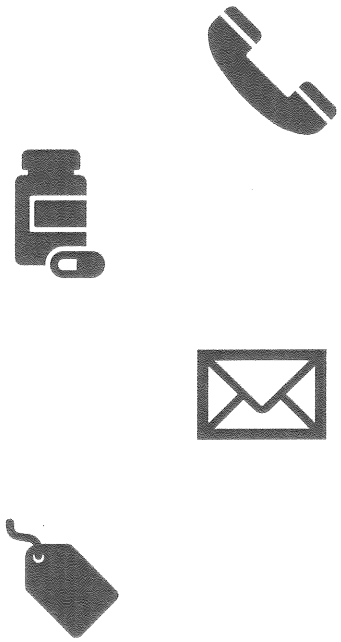
Inefficient contract processes leave neighborhood pharmacies struggling to provide services for their patients

Payments

- **Maximum Allowable Costs (MAC)**
  - **Same PBM uses several MACs**
  - **PBMs uses MAC to adjust profit margin to benefit themselves, not the patient**
  - **Currently subsidizing Medicaid**



Steering



- **PBMs use letters, phone calls, and other incentives to convince patients to use their own pharmacy or mail order pharmacy**
- **Specialty drugs are required to be filled at their pharmacy only**
- **Frequently, this steering leads to patient compliance issues due to non-local access**

Clawbacks

- **Independent pharmacies live in fear of fraudulent audits**
- **Independent pharmacies receive payments that are less than at the time of adjudication**
  - **In network fees**
  - **Out of network fees**
  - **Customer service fees**
- **Clawback money is being used to improve profit margins and not lower health care costs**

Focus On:

Most crucial factor that needs to be addressed is the reduced access for patients.

This can be accomplished through…

- No narrow networks for Medicaid
- No payment below cost of drug
- No steerage for PBM-owned pharmacies, mail order or specialty
- No POST adjudication fees
- No abusive audits with drug cost recoupment (other than fraud)

Contact

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Small Business Pharmacies Aligned for Reform

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 66
INTRODUCER:	Health Policy Committee and Senator Cruz
SUBJECT:	Student Loans and Scholarship Obligations of Health Care Practitioners
DATE:	November 6, 2019 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Brown	HP	**Fav/CS**
2.			AED	
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 66 amends s. 456.071(1)(k), F.S., to provide that the failure to repay a state or federal student loan, or the failure to comply with service scholarship obligations, does not constitute a failure to perform a statutory or legal obligation placed upon a licensed health care practitioner, thereby removing such repayment or scholarship obligation failures as grounds for disciplinary action against a health care practitioner.

The bill repeals s. 456.0721, F.S., which authorizes the Department of Health (DOH) to obtain from the U.S. Department of Health and Human Services (now the U.S. Department of Education) information necessary to investigate and prosecute health care practitioners for failing to repay a student loan or comply with scholarship service obligations.

The bill amends s. 456.074(4), F.S., to delete the requirement for the DOH to notify a practitioner whose student loan is in default, of the DOH's intent to suspend his or her license if the practitioner does not provide proof that new payment terms have been agreed upon by all parties to the loan.

The bill has an effective date of July 1, 2020.

II. Present Situation:

Federal Student Loans Available to Health Care Practitioners

Federal student loan programs were first established in the mid-twentieth century to increase the supply of skilled labor, promote economic and technological development, and provide upward socioeconomic mobility.[1] Federal student loans were first offered in 1958 under the National Defense Education Act to help the United States compete with other countries, especially the Soviet Union with the launch of the satellite *Sputnik*. High school students who showed promise in mathematics, science, engineering, and foreign language, or those who wanted to be teachers, were offered grants, scholarships, and loans.[2] Federal student loans have provided low-cost credit to millions of students, helped increase educational attainment, while holding administrative costs lower than those of the private sector, and generating a profit for the federal government.[3]

The Higher Education Act of 1965

The Higher Education Act of 1965 provided "Educational Opportunity Grants" to colleges recruiting students with considerable financial need. The Guaranteed Student Loan Program (GSLP), also known as the Federal Family Education Loan Program (FFELP), allowed banks and private institutions to provide government subsidized and guaranteed loans to students.[4] The federal government relied on a network of state agencies to administer the program and pursue delinquent borrowers.[5]

By the late 1980s, the government's losses climbed past $1 billion a year, and state agencies started experimenting with aggressive collection tactics. Some states garnished wages. Others put liens on borrowers' cars and houses. Texas and Illinois stopped renewing professional licenses of those with unresolved debts.

The U.S. Department of Education (DOE), currently administers federally guaranteed student loans. The U.S. DOE is the largest provider of student financial aid in the nation. Federal Student Aid is responsible for managing the student financial assistance programs authorized under Title IV of the Higher Education Act of 1965.[6] The Higher Education Act of 1965 was

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[1] Michael Simkovic, *Risk-Based Student Loans*, 70 Wash. & Lee L. Rev. 527 (2013), *available at* https://scholarlycommons.law.wlu.edu/wlulr/vol70/iss1/8 (last visited Sept. 17, 2019).
[2] National Defense Education Act of 1958, Pub. L. 85 – 864, 72 Stat. 1580, 20 U.S.C. 401 et seq., *available at* https://www.govinfo.gov/content/pkg/STATUTE-72/pdf/STATUTE-72-Pg1580.pdf (last visited Sept. 20, 2019).
[3] *Supra* note 1.
[4] Higher Education Act of 1965, Part I – General Higher Education Programs, P.L. 89 – 329, 20 U.S.C. 1001 – 1087uu, *available at* http://legcounsel.house.gov/Comps/HEA65_CMD.pdf (last visited Sept. 27, 2019).
[5] Silver-Greenberg, Jessica, Cowley, Stacy, Kitroeff, Natalie, *When Unpaid Student Loan Bills Mean You Can No Longer Work*, The New York Times Nov. 18, 2017, *available at* https://www.nytimes.com/2017/11/18/business/student-loans-licenses.html?auth=login-email&login=email (last visited Sept. 26, 2019). *See also* National council State Boards of Nursing, *Student Loan Default and State Licensing Board Discipline*, (Mar. 4, 2019), *available at* https://www.ncsbn.org/12849.htm.
[6] Pub. Law No. 89-329, Nov. 8, 1965, 79 Stat. 1219, 20 U.S.C. 1001, *available at* https://legcounsel.house.gov/Comps/Higher%20Education%20Act%20Of%201965.pdf (last visited Sept. 16, 2019). *See also* The Chronical of Higher Education, *What You Need to Know About Reauthorization* (September 19, 2013), *available at* https://www.chronicle.com/article/What-You-Need-to-Know-About/141697 (last visited Sept. 16, 2019).

reauthorized in 1968, 1972, 1976, 1980, 1986, 1992, 1998, and 2008.[7] These programs provide grants, loans, and work-study funds to students attending college or career school.[8]

The 1966, 1972, and 1992 amendments to the Higher Education Act of 1965 added the following to federal student loan programs:

- The National Association of Financial Aid Administrators was created to monitor financial aid throughout the nation;
- The Basic Educational Opportunity Grant, (later called the Pell Grant), was created to help needy students attend college; and
- The Higher Education Amendments create FAFSA, the Direct Lending program, and unsubsidized Stafford loans.[9]

Health Education Assistance Loan Program

The Health Education Assistance Loan (HEAL) Program was originally authorized by sections 701-720 of the Public Health Service Act.[10] The HEAL Program was first administered by the Office of Education in the former Department of Health, Education, and Welfare. On May 21, 1980, the HEAL Program was transferred from the Office of Education to the U.S. Department of Health and Human Services (HHS) until July 1, 2014, when Congress transferred the program to the U.S. Department of Education (DOE) pursuant to Division H, title V, section 525 of the Consolidated Appropriations Act, 2014 (Pub. Law No. 113-76) (Consolidated Appropriations Act, 2014). From federal fiscal year (FFY) 1978 through FFY 1998 the HEAL Program insured loans made by participating lenders to eligible graduate students in schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, public health, pharmacy, and chiropractic, and in programs in health administration and clinical psychology.[11]

Lenders such as banks, savings and loan associations, credit unions, pension funds, State agencies, HEAL schools, and insurance companies made HEAL loans, which were insured by the Federal Government against loss due to borrowers' death, disability, bankruptcy, and default. The purpose of the program was to ensure the availability of funds for loans to eligible students who need to borrow money to pay for their educational costs.[12]

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[7] 20 U.S.C. ch. 28, subchapter IV – Student Assistance, available at: https://uscode.house.gov/view.xhtml;jsessionid=61648FC4573FD86CC2A1E228D0371AB3?req=granuleid%3AUSC-prelim-title20-chapter28&saved=%7CKHRpdGxlOjIwIHNlY3Rpb246MTEzMyBlZGl0aW9uOnByZWxpbSk%3D%7C%7C%7C0%7Cfalse%7Cprelim&edition=prelim (last visited Sept. 16, 2019). *See also* Finaid, *The Smart Student Guide to Financial Aid*, available at: http://www.finaid.org/educators/reauthorization.phtml (last visited Sept. 16, 2019).

[8] Kantrowitz, Mark, Savingforcollege.com, *Reauthorization of the Higher Education Act of 1965*, (December 26, 2018) *available at* https://www.savingforcollege.com/article/reauthorization-of-the-higher-education-act-of-1965 (last visited Sept. 16, 2019).

[9] Gitlen, Jeff, LendEDU, *A Look Into the History of Student Loans*, (Aug. 15, 2016) *available at* https://lendedu.com/blog/history-of-student-loans (last visited Sept. 20, 2019).

[10] *See* 42 U.S.C. 292-292y.

[11] Federal Register Vol. 82, No. 219, Department of Education, *Health Education Assistance Loan (HEAL) Program*, Final Rule, Nov. 15, 2017, 34 CFR Part 681, 82 FR 53374 – 53395, available at: https://www.govinfo.gov/content/pkg/FR-2017-11-15/pdf/2017-24636.pdf (last visited Sept. 12, 2019). See also National Archives , Federal Register, *Health Education Assistance Loan (HEAL) Program*, available at: https://www.federalregister.gov/documents/2017/11/15/2017-24636/health-education-assistance-loan-heal-program (last visited Sept. 12, 2019).

[12] *Id.*

Authorization to fund new HEAL loans to students ended September 30, 1998. Provisions of the HEAL legislation allowing for the refinancing or consolidation of existing HEAL loans expiring September 30, 2004. However, the reporting, notification, and recordkeeping burden associated with refinancing HEAL loans, servicing outstanding loans, and administering and monitoring of the HEAL Program regulations continues.[13] In 2014, the HEAL Program was transferred from the U.S. Department of Health and Human Services (HHS) to the U.S. DOE. To reflect this transfer and to facilitate the servicing of all HEAL loans that are currently held by the U.S. DOE, the Secretary adds the HEAL Program regulations to the U.S. DOE's chapter in the Code of Federal Regulations (CFR).[14]

In 1993, the Student Loan Reform Act amended the Higher Education Act of 1965 to replace the FFELP, under which loans made by private lenders and were guaranteed by the U.S. government, with a Federal Direct Student Loan Program (FDSLP) where the government became direct lender to borrowers.[15]

Higher Education Reconciliation Act of 2005

The 2005 Higher Education Reconciliation Act made many changes to FDSLP student loans, including some of the following:

- Reduced student loan fees from 4% to 1%;
- Allows graduate students to take out PLUS Loans;
- Added a new grant program called Academic Competiveness Gran Program;
- Increased the income protection allowance;
- Adjusted initial eligibility criteria; and
- Changed the definition of independent student.[16]

Student Aid and Fiscal Responsibility Act of 2010

The Health Care and Education Reconciliation Act of 2010, along with the Patient Protection and Affordable Care Act, were signed into law by President Obama. The Student Aid and Fiscal Responsibility Act (Title II) was a rider to the Health Care and Education Reconciliation Act and included a number of federal student loan program reforms, such as:

- Ending the process of the federal government giving subsidies to private banks to give out federally insured loans; instead, loans were to be administered directly by the U. S. DOE,

[13] *Supra* note 13. When the HEAL Program was transferred from HHS to the DOE, to reflect this transfer and to facilitate the servicing of HEAL loans that were held by the DOE, the Secretary added the HEAL Program regulations that were part of HHS's regulations (42 CFR part 60) to Title 34 Subpart B Chapter VI Part 681 of the CFR. Consistent with this regulatory action, HHS removed the HEAL Program regulations from its regulations.

[14] The Federal Register, *Health Education Assistance Loan (HEAL) Program*, Nov. 15, 2017, available at: https://www.federalregister.gov/documents/2017/11/15/2017-24636/health-education-assistance-loan-heal-program (last visited Sept. 20, 2019).

[15] Congress.gov, *H.R.2055 - Student Loan Reform Act of 1993, 103rd Congress* (1993-1994), *available at* https://www.congress.gov/bill/103rd-congress/house-bill/2055 (last visited Sept. 20, 2019).

[16] Analysis of the Higher Education Reconciliation Act of 2005 (S. 1932)(Title VIII of the Deficit Reduction Act of 2005), available at: https://www.nelnet.net/media/newsletters/schoolnews/HERA_BorrowerChanges.pdf (last visited Sept 24, 2019). The Higher Education Reconciliation Act of 2005, which is Title VIII of the Deficit Reduction Act of 2005, was enacted into law February 8, 2006.

- Increasing Pell Grant scholarship awards;
- Allowing newly qualified borrowers starting in 2014, to be able to cap their monthly student loan repayment each month to 10% of their discretionary income, down from 15%;
- Allowing new borrowers after 2014 to be eligible for student loan forgiveness after making timely payments for 20 years, down from 25 years;
- Easing the process for parents to take out federal student loans for their children; and
- Authorizing the spending of several billion dollars to fund schools that served predominantly poor and minority students, as well as increasing community college funding.[17]

The passage of the 2010 federal Health Care and Education Reconciliation Act and the Health Care and Education Reconciliation Act made the FDSLP the sole government-backed student loan program in the United States. All guaranteed student loans that originated with, and were funded by, private lenders, but guaranteed by the government, were eliminated.[18]

Currently, the U.S. DOE awards more than $120 billion a year in grants, work-study funds, and low-interest loans to more than 13 million students.[19] The U.S. DOE's federal student loan program is the William D. Ford FDSLP. Under this program, the U.S. DOE is the lender. There are four types of federal direct loans available:

- Direct Subsidized Loans;[20]
- Direct Unsubsidized Loans;[21]
- Direct PLUS Loans;[22] and
- Direct Consolidation Loans.[23, 24]

As of September 9, 2019, the Federal Reserve reported that there were $1.606 trillion dollars in outstanding federal student loans owned and secured by the U.S. Government.[25] It is the second largest form of consumer debt, just behind mortgages;[26] and more than 10.9 percent of aggregate

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[17] Obamacarefacts.com, *Summary of the Health Care and Education Reconciliation Act of 2010*, (last updated March 2, 2015), *available at*: https://obamacarefacts.com/summary-of-the-health-care-and-education-reconciliation-act-of-2010/ (last visited Sept. 17, 2019).
[18] *Id.*
[19] Federal Student Aid, An Office of the U.S. Department of Education, *Aid and Other Resources from the U.S. Federal Government*, available at: https://studentaid.ed.gov/sa/types (last visited Sept. 17, 2019).
[20] Direct Subsidized Loans are loans made to eligible undergraduate students who demonstrate financial need to help cover the costs of higher education at a college or career school. Federal Student Aid, An Office of the U.S. Department of Education, *What types of federal student loans are available?* available at: https://studentaid.ed.gov/sa/types/loans#types (last visited Sept. 17, 2019).
[21] *Id.* Direct Unsubsidized Loans are loans made to eligible undergraduate, graduate, and professional students, but eligibility is not based on financial need.
[22] *Supra* note 27. Direct PLUS Loans are loans made to graduate or professional students and parents of dependent undergraduate students to help pay for education expenses not covered by other financial aid. Eligibility is not based on financial need, but a credit check is required.
[23] *Supra* note 27. Direct Consolidation Loans allow you to combine all of your eligible federal student loans into a single loan with a single loan servicer.
[24] Federal Student Aid, An Office of the U.S. Department of Education, *Federal Student Loan Programs* (fact sheet), available at: https://studentaid.ed.gov/sa/sites/default/files/federal-loan-programs.pdf (last visited Sept. 17, 2019).
[25] Federal Reserve Bank of St. Lewis, Federal reserve Economic Data, *Student Loans Owned and Securitized, Outstanding*, available at: https://fred.stlouisfed.org/series/SLOAS (last visited Sept. 25, 2019).
[26] LendEDU, Average Student Loan Debt Statistics by School by State 2019, *Student Loan Debt by School By State 2019*, Aug. 8, 2019, available at: https://lendedu.com/student-loan-debt-by-school-by-state-2019/#FL, (last visited Sept. 26, 2019).

student loan debt was delinquent for more than 90 days in the first quarter of 2019. However, delinquency rates for student loans are likely to understate the effective delinquency rates because about half of these loans are currently in deferment, in grace periods, or in forbearance and therefore temporarily not in the repayment cycle. This implies that among loans in the repayment cycle, delinquency rates are roughly twice as high.[27] MAXIMUS Federal Services, Inc., is the loan serving agent for federal student loans in default.[28]

State Student Loans Available to Health Care Practitioners

Florida Health Service Corps

Florida backed health care student loans, and scholarships with service obligation, began in 1992 with the creation of the Florida Health Services Corps (FHSC), to encourage qualified medical professionals to practice in underserved locations where there are shortages of such personnel. The FHSC was developed by the DOH with the FDOE and the State University System. The DOH was to award scholarships to qualified students studying medicine, chiropractic, nursing, or dentistry. The program required a student receiving a scholarship to accept an assignment in a public health care program or work in a specific community located in a medically underserved area upon graduation for one year for each school year of financial assistance, up to a maximum of three years.

The financial penalties for noncompliance with the participation requirements were determined in the same manner as in the NHSC scholarship program.[29] Noncompliance with participation requirements also resulted in ineligibility for professional licensure under chs. 458, 459, 460, 464, 465, and 466, F.S. For a participant unable to complete his or her service obligation for reasons beyond his or her control, such as a disability, the penalty was the actual amount of financial assistance provided to the participant. The financial penalties collected by the DOH were deposited into the FHSC Trust Fund and used to provide additional scholarship and financial assistance. [30, 31]

The FHSC was modeled after the NHSC. It offered loan repayment and scholarships for health professionals in return for service in public health care programs or underserved areas. This program was not funded after 1996 and was repealed in 2012.[32] The Office of Student Financial Assistance (OSFA) within the Florida Department of Education (FDOE) has been the designated

[27] Federal Reserve Bank of New York, Research and Statistics Group, Center for Microeconomic Data, *Quarterly Report on Household Debt and Credit, 2019: Q1* (released May , 2019), available at: https://www.newyorkfed.org/medialibrary/interactives/householdcredit/data/pdf/HHDC_2019Q1.pdf (last visited Sept. 26, 2019).
[28] Federal Student Aid, An office of the U.S. Department of Education, *How to Repay Your Loans, Understanding Delinquency and Default*, available at: https://studentaid.ed.gov/sa/repay-loans/default#default-servicer (last visited Sept. 12, 2019).
[29] The National Health Service Corps (NHSC) Scholarship Program, enacted by Public Law 94- 484 on October 12, 1976, is a program established to bring health care to regions of the country that have critical shortages of health personnel. See The U.S. Department of Health and Human Services, Health Resources & Services Administration, *National Health Services Corps*, available at: https://bhw.hrsa.gov/loans-scholarships/nhsc (last visited Sept. 24, 2019).
[30] Chapter 92-33, s. 111, Laws of Fla.
[31] Section 381.0302, (1992 – 2012), F.S.
[32] Chapter 2012-184, s. 45, Laws of Fla.

guaranty agency for the state of Florida for many years for the Federal Family Education Loans.[33]

In 2002, the Florida Legislature created the Student Loan Program. Section 1009.85, F.S., required the State Board of Education to adopt rules necessary for participation in the guaranteed student loan program, as provided by the Higher Education Act of 1965, as amended. The intent of this legislation was to authorize student loans when Florida, through the FDOE, become an eligible lender under the provisions of the applicable federal laws providing for the guarantee of loans to students and the partial payment of interest on such loans by the United States Government.[34]

In 2002, the Legislature also amended the grounds for disciplinary action against health care practitioners who failed to pay student loans by amending s. 456.072(1)(k), F.S., and created s. 456.074(4), F.S., to enforce it. In amending s. 456.072(1)(k), F.S., and adding s. 456.074(4), F.S., the Legislature made the following specific findings, as of 2002, relating to the state's interest in enacting these regulations:

- The U.S. Department of Health and Human Services reported 9,454 health care practitioners in the nation, and 556 health care practitioners in Florida, had defaulted on educational loan or service scholarship obligations;
- The U.S. Department of Health and Human Services reported that these defaulters cost taxpayers over $694 million, of which $45.6 million was attributable to Florida health care practitioners;
- Needy communities lost the services of essential clinicians when practitioners fail to meet their service obligations;
- Defaulters had received the substantial economic benefit of a health practitioner career education at taxpayer expense;
- It was imperative that defaulters be required to honor their service obligations;
- Because health care practitioners are licensed by the states and not the federal government, it was anticipated that state licensure discipline of the defaulters would motivate the defaulters to honor their commitments and deter others from defaulting on their student loans and service obligations;
- Taxpayers should not have to foot the bill for individuals who had reneged on the repayment obligation of a federal or state loan or scholarship which gave them access to a career as a health care practitioner;
- Defaulters had been, or would be, excluded from participating in Medicare and Medicaid programs and therefore unable to practice in many of the neediest and most underserved areas;
- Defaulters would not be practicing as health care practitioners had the programs not been available to help finance their education; and, while it was not possible to "repossess" the education these programs allowed them to obtain, it was possible to "repossess" the results of that education by suspending their ability to practice through suspension of their licenses; and

[33] The Department of Education, Office of Student Financial Assistance, *FFELP Home*, available at: http://www.floridastudentfinancialaid.org/FFELP/ (last visited Sept. 17, 2019).
[34] Sections 1009.78 – 1009.88, F.S.

- Florida law at that time provided recourse only for failing to repay certain state student loans through s. 381.0302, F.S., and did not address federal educational loan and service scholarship defaulters.[35]

In 2010, with the passage of the federal Health Care and Education Reconciliation Act and its rider, to the Health Care and Education Reconciliation Act, the FDOE, through the OSFA, stopped guaranteeing student loans with first disbursement dates after July 1, 2010. For student loans that had first disbursements dates before July 1, 2010, the OSFA would continue to provide support for the life of the loans as long as the loans remained in the state's portfolio, and remain the designated guaranty agency for Florida.[36]

Health Care Practitioner Regulation

The DOH is charged with the regulation of health practitioners for the preservation of the health, safety, and welfare of the public. The Division of Medical Quality Assurance (MQA), is responsible for the boards and professions within the DOH.[37] The health care practitioners licensed by the DOH include the following:

- Acupuncturist;[38]
- Allopathic physicians and physician assistants;[39]
- Osteopathic physicians and physician assistants;[40]
- Chiropractic physicians, physician assistants, and registered chiropractic assistants;[41]
- Podiatric physicians;[42]
- Naturopathic physicians;[43]
- Optometrists;[44]
- Advanced practice registered nurses, registered nurses, licensed practical nurses and certified nursing assistant;[45]
- Pharmacists;[46]
- Dentists, dental hygienist and dental laboratories;[47]
- Midwives;[48]
- Speech and language pathologists;[49]
- Audiologists;[50]

[35] Chapter 2002-254, Preamble, Laws of Fla.
[36] The Department of Education, Office of Student Financial Assistance (OSFA), The Federal Family Education Loan Program, *FFELP Home*, available at http://www.floridastudentfinancialaid.org/FFELP/ (last visited Oct. 21, 2019).
[37] Section 20.43, F.S.
[38] Chapter 457, F.S.
[39] Chapter 458, F.S.
[40] Chapter 459, F.S.
[41] Chapter 460, F.S.
[42] Chapter 461, F.S.
[43] Chapter 462, F.S.
[44] Chapter 463, F.S.
[45] Chapter 464, F.S.
[46] Chapter 465, F.S.
[47] Chapter 466, F.S.
[48] Chapter 467, F.S.
[49] Part I, Ch. 468, F.S.
[50] *Id.*

- Occupational therapists;[51]
- Respiratory therapists;[52]
- Dieticians and nutritionists;[53]
- Athletic trainers;[54]
- Orthotists, prosthetists, and pedorthists;[55]
- Electrologists;[56]
- Massage therapists;[57]
- Clinical laboratory personnel;[58]
- Medical physicists;[59]
- Opticians;[60]
- Hearing aid specialists;[61]
- Physical therapists;[62]
- Psychologists and school psychologists;[63] and
- Clinical social workers, mental health counselors and marriage and family therapists.[64]

Section 456.072, F.S., enumerates at least 41 specific acts that constitute grounds for disciplinary action against all licensed health care practitioners in Florida. Section 456.072(1)(k), F.S., was amended in 2002[65] to provide the following:

> For purposes of this section, failing to repay a student loan issued or guaranteed by the state or the Federal Government in accordance with the terms of the loan or failing to comply with service scholarship obligations shall be considered a failure to perform a statutory or legal obligation, and the minimum disciplinary action imposed shall be a suspension of the license until new payment terms are agreed upon or the scholarship obligation is resumed, followed by probation for the duration of the student loan or remaining scholarship obligation period, and a fine equal to 10 percent of the defaulted loan amount. Fines collected shall be deposited into the Medical Quality Assurance Trust Fund.

In this way, the failure to make such repayments or comply with such obligations became grounds for disciplinary action in 2002 because failing to perform a statutory or legal obligation was already grounds for disciplinary action.

[51] Part III, Chapter 468, F.S.
[52] Part V, Chapter 468, F.S.
[53] Part X, Chapter 468, F.S.
[54] Part XIII, Chapter 468, F.S.
[55] Part XIV, Chapter 468, F.S.
[56] Chapter 478, F.S.
[57] Chapter 480, F.S.
[58] Part II, ch. 483, F.S.
[59] Part III, ch. 483, F.S.
[60] Part I, ch. 484, F.S.
[61] Part II, ch. 484, F.S.
[62] Chapter 486, F.S.
[63] Chapter 490, F.S.
[64] Chapter 491, F.S.
[65] Chapter 2002-254, s. 2, Laws of Fla.

Section 456.0721, F.S., requires the DOH to obtain from the U. S. Department of Health and Human Services (now the U.S. DOE) information necessary to investigate and prosecute health care practitioners for failing to repay a student loan or comply with scholarship service obligations pursuant to s. 456.072(1)(k), F.S. The DOH is further required to obtain from the U.S. Department of Health and Human Services (now U.S. DOE) a list of default health care practitioners each month, along with the information necessary to investigate a complaint. The DOH may obtain evidence to support the investigation and prosecution from any financial institution or educational institution involved in providing the loan or education to a practitioner.

Section 456.0721, F.S., also requires the DOH to report to the Legislature, as part of its annual report, the number of practitioners in default, along with the results of the DOH's investigations and prosecutions, and the amount of fines collected from the practitioners prosecuted for violating s. 456.072(1)(k), F.S. The DOH Annual Reports to the Legislature from state fiscal year 2005-06, (the first year health care practitioners student loan defaults were reported) through 2017-18, show the following data on health care practitioners student loan defaults.

Health Care Providers Student Loan Defaults for Fiscal Years 2005 through 2018

State Fiscal Year	Reports of Defaults Received	Investigations Complete	Emergency Suspension Orders Issued	Probable Cause Found	No Probable Cause Found	Disciplinary Actions Taken	Amount of Fines Collected
2017-18	850	76	26	21	1	0	$0
2016-17	1	1	1	1	0	0	$0
2015-16	0	1	0	0	0	0	$0
2014-15	1	0	0	0	0	1	$0
2014-13	1	0	1	1	0	0	$0
2013-12	2	2	1	1	0	1	$2,500
2012-11	2	1	0	0	1	0	$0
2011-10	19	0	0	0	0	2	$16,216
2010-09	11	2	2	3	0	2	$7,500
2009-08	13	4	3	4	0	2	$6,000
2008-07	16	1	0	0	0	2	$9,190
2007-06	0	3	1	2	5	4	$29,307
2006-05	13	5	6	4	2	7	$23,886
TOTAL	929	96	41	16	9	21	$94,600

Section 456.074(4), F.S., further requires the DOH, upon receipt of information that a Florida-licensed health care practitioner has defaulted on his or her student loan issued or guaranteed by the state or the federal government, to notify the licensee by certified mail that he or she is subject to immediate suspension of his or her professional license unless, within 45 days after the date of mailing, the licensee provides proof of new payment terms between all parties to the loan. If, after 45 days from the date of mailing the certified notice, the licensee has failed to provide proof of new student loan payment terms, the DOH must issue an emergency order suspending the licensee's license.

Sections 456.0635(2)(e) and (3)(e), F.S., also require each board, or the DOH if there is no board, to refuse to admit a candidate to any examination, refuse to issue a license, certificate, or

registration, and refuse to renew a license, certificate or registration, if the candidate or practitioner is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities (LEIE). Section 1128(b)(14) of the Social Security Act and 42 U.S.C. ss. 1320a-7(b)(14), provide that a default on a health education loan or scholarship obligation is permissive grounds for being placed on the LEIE and make such exclusion last until the default or obligation is resolved. Sections 456.0635(2)(e) and (3)(e), F.S., are not permissible, but mandatory, and require the boards, or the DOH, to refuse to issue, or renew, licenses, certificates, or registrations to a person in default on his or her health education loan or scholarship obligation.

Other States with Licensure Suspension Laws for Student Loan Defaulters

Seven states—Alaska, Hawaii, Iowa, Kentucky, Massachusetts, Tennessee, and Texas—have laws requiring all occupational boards to revoke licenses for defaulting on any type of federal or state education loan. Louisiana will revoke a license only if the professional has defaulted on an education loan issued by the state.[66]

Prior to July 1, 2019, Georgia was included in the above group. During the 2019 Georgia Legislative session, the Georgia passed SB 214, which amended the Official Code of Georgia to prohibit a professional licensing board from suspending a person licensed by that board because:

- He or she was a borrower in default under the Georgia Higher Education Loan Program as determined by the Georgia Higher Education Assistance Corporation; or
- He or she had been certified by any entity of the federal government for nonpayment or default or breach of a repayment or service obligation under any federal educational loan, loan repayment, or service conditional scholarship program.[67]

Five states—Arkansas, California, Mississippi, Minnesota and Florida—revoke the licenses only of health care professionals for defaulting on education loans. In Arkansas and Mississippi, the laws are even narrower, applying only to state health care education loans and scholarship agreements. For example, defaulting physicians in Arkansas may have their license suspended for "a period of years equivalent to the number of years that the recipient is obligated to practice medicine in a rural area" if they default on an Arkansas Rural Medical Practice Student Loan.[68]

Two states—Iowa and South Dakota—revoke all state-issued licenses, including driver's licenses and recreational hunting licenses.[69]

III. Effect of Proposed Changes:

CS/SB 66 amends s. 456.071(1)(k), F.S., to provide that the failure of a licensed health care practitioner to repay a state or federal student loan, or failure to comply with a service scholarship obligation, does not constitute a failure to perform a statutory or legal obligation.

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[66] Wagner, Andrew; National Conference of State Legislatures, *License Suspension for Student Loan Defaulters*, Vol. 26, No. 40, 2018, available at: http://www.ncsl.org/research/labor-and-employment/license-suspension-for-student-loan-defaulters.aspx (last visited Sept. 26, 2019).
[67] Section 43-1-29, *Suspension of license for nonpayment of student loans prohibited*, Official Code of Georgia
[68] *Supra* note 74.
[69] *Supra* note 74.

The bill repeals s. 456.0721, F.S., which authorizes the DOH to obtain from the U.S. Department of Health and Human Services (now the U.S. Department of Education) information necessary to investigate and prosecute health care practitioners for failing to repay a student loan or comply with scholarship service obligations.

The bill amends s. 456.074(4), F.S., to delete the requirement for the DOH to notify a practitioner whose student loan is in default, and of the DOH's intent to suspend his or her license if the practitioner does not provide proof that new payment terms have been agreed upon by all parties to the loan.

The bill takes effect July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Under CS/SB 66, licensed health care practitioners in Florida would no longer be subject to licensure suspension or revocation for failure to repay student loans or failure to comply with service scholarship obligations and would therefore no longer have to stop practicing their health care profession if such discipline were applied.

C. Government Sector Impact:

The bill could reduce the workload of the DOH, MQA, and the boards in prosecuting these cases; and if licenses were not suspended, the practitioners would probably be renewing them and paying licensure fees. The bill could also reduce the DOH revenues from fines for a violation of s. 456.072(1)(k), F.S.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Sections 456.0635(2)(e) and 456.0635(3)(e), F.S., provide that the DOH must refuse to issue or renew a license to a candidate or applicant if the candidate or licensee is currently listed on the United States Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals and Entities (LEIE). Section 1128(b)(14) of the Social Security Act and 42 U.S.C. ss. 1320a-7(b)(14) provide that a default on a health education loan or scholarship obligation is permissive grounds for being placed on the LEIE and that such exclusion lasts until the default or obligation is resolved. If a candidate or applicant is placed on the LEIE for a default on a loan, the DOH would still be required to deny that person's application for initial or renewed licensure.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 456.072 and 456.074.

This bill repeals section 456.0721 of the Florida Statutes.

IX. Additional Information:

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

C**S by Health Policy on November 5, 2019:**
The CS amends s. 456.074(4), F.S., to delete the requirement for the DOH to notify a practitioner whose student loan is in default, and of the DOH's intent to suspend his or her license if the practitioner does not provide the DOH with proof that new payment terms have been agreed upon by all parties to the loan.

B. Amendments:

None.

439576

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
11/05/2019	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Between lines 58 and 59
insert:

Section 3. Subsection (4) of section 456.074, Florida Statutes, is amended to read:

456.074 Certain health care practitioners; immediate suspension of license.—

~~(4) Upon receipt of information that a Florida-licensed health care practitioner has defaulted on a student loan issued or guaranteed by the state or the Federal Government, the~~


439576

~~department shall notify the licensee by certified mail that he or she shall be subject to immediate suspension of license unless, within 45 days after the date of mailing, the licensee provides proof that new payment terms have been agreed upon by all parties to the loan. The department shall issue an emergency order suspending the license of any licensee who, after 45 days following the date of mailing from the department, has failed to provide such proof. Production of such proof shall not prohibit the department from proceeding with disciplinary action against the licensee pursuant to s. 456.073.~~

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

And the title is amended as follows:

Delete line 15

and insert:

report; amending s. 456.074, F.S.; removing the requirement, and related provisions, that the department immediately suspend the licenses of certain health care practitioners for failing to provide proof of new payment terms for defaulted student loans within a specified timeframe; providing an effective date.

By Senator Cruz

18-00091-20 202066__

A bill to be entitled

An act relating to student loans and scholarship obligations of health care practitioners; amending s. 456.072, F.S.; establishing that a health care practitioner's failure to repay a student loan or to comply with service scholarship obligations does not constitute grounds for disciplinary action; removing a civil fine; amending s. 456.0721, F.S.; removing the requirement that the Department of Health investigate and prosecute health care practitioners for failing to repay a student loan or to comply with scholarship service obligations; removing the requirement that the department include specified information related to such investigations and prosecutions in an annual report; providing an effective date.

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

Section 1. Paragraph (k) of subsection (1) of section 456.072, Florida Statutes, is amended to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(k) Failing to perform any statutory or legal obligation placed upon a licensee. For purposes of this section, failing to repay a student loan issued or guaranteed by the state or the Federal Government in accordance with the terms of the loan or failing to comply with service scholarship obligations is not

18-00091-20 202066__

~~shall be~~ considered a failure to perform a statutory or legal obligation~~, and the minimum disciplinary action imposed shall be a suspension of the license until new payment terms are agreed upon or the scholarship obligation is resumed, followed by probation for the duration of the student loan or remaining scholarship obligation period, and a fine equal to 10 percent of the defaulted loan amount. Fines collected shall be deposited into the Medical Quality Assurance Trust Fund~~.

Section 2. Section 456.0721, Florida Statutes, is amended to read:

~~456.0721 Practitioners in default on student loan or scholarship obligations; investigation; report. The Department of Health shall obtain from the United States Department of Health and Human Services information necessary to investigate and prosecute health care practitioners for failing to repay a student loan or comply with scholarship service obligations pursuant to s. 456.072(1)(k). The department shall obtain from the United States Department of Health and Human Services a list of default health care practitioners each month, along with the information necessary to investigate a complaint in accordance with s. 456.073. The department may obtain evidence to support the investigation and prosecution from any financial institution or educational institution involved in providing the loan or education to the practitioner. The department shall report to the Legislature as part of the annual report required by s. 456.026, the number of practitioners in default, along with the results of the department's investigations and prosecutions, and the amount of fines collected from practitioners prosecuted for violating s. 456.072(1)(k).~~

Section 3. This act shall take effect July 1, 2020.

The Florida Senate

Committee Agenda Request

To: Senator Gayle Harrell, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: August 16, 2019

I respectfully request that **Senate Bill #66**, relating to Student Loans and Scholarship Obligations of Health Care Practitioners, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Janet Cruz
Florida Senate, District 18

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)

11/5/2019
Meeting Date

66
Bill Number (if applicable)

Topic Student Loans & Scholarships; HealthCare

Amendment Barcode (if applicable)

Name Rhēb Harbison

Job Title SR Director Government Affairs

Address 301 South Bronough St; Ste. 600
Street
Tallahassee FL 32301
City *State* *Zip*

Phone 850-577-9090

Email rheb.harbison@gray-robinson.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Nurses 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

APPEARANCE RECORD

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

November 5, 2019
Meeting Date

66
Bill Number (if applicable)

Topic Student Loans & Scholarship Obligations Health Care Prac.

Amendment Barcode (if applicable)

Name Janegale Boyd

Job Title Immediate Past President

Address 735 Washington Street
Street

Phone 850-320-4343

Monticello FL 32344
City *State* *Zip*

Email janegaleboyd7@gmail.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Nurses 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

APPEARANCE RECORD

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

11/5	66
Meeting Date	*Bill Number (if applicable)*

Topic Student Loans — *Amendment Barcode (if applicable)*

Name Evan Power

Job Title

Address 120 S Monroe St — Phone (850) 519-1062
Street

Tallahassee — FL — 32301 — Email evan@rembeconsulting.com
City — *State* — *Zip*

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

Representing Florida Chiropractic 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

APPEARANCE RECORD

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

11/5/2019
Meeting Date

66
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Student Loan Default

Name Jorge Chamizo

Job Title Attorney

Address 108 South Monroe St.
Street
Tallahassee, FL 32301
City *State* *Zip*

Phone (850) 681-0024

Email jorge@flapartners.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing FGA Action

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 348
INTRODUCER:	Senator Bean
SUBJECT:	Florida Kidcare Program
DATE:	November 5, 2019
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Kibbey	Brown	HP	**Favorable**
2.			AHS	
3.			AP	

I. Summary:

SB 348 removes the lifetime maximum cap of $1 million on covered expenses for a child enrolled in the Florida Healthy Kids Program.

This bill takes effect upon becoming a law.

II. Present Situation:

The Federal State Children's Health Insurance Program

The State Children's Health Insurance Program (CHIP), enacted as part of the Balanced Budget Act of 1997, created Title XXI of the federal Social Security Act and provides health insurance to uninsured children in low-income families either through a Medicaid delivery system, a separate children's health program, or a combination of both.[1] The CHIP was designed as a federal and state partnership, similar to Medicaid, with the goal of expanding health insurance to children whose families earn too much income to be eligible for Medicaid, but not enough money to purchase private, comprehensive health insurance.

The CHIP is administered by states, according to federal requirements. The program is funded jointly by states and the federal government. On January 22, 2018, Congress passed a six-year extension of CHIP funding through September 30, 2023.[2]

[1] National Conference of State Legislatures, *Children's Health Insurance Program Overview*, (January 10, 2017) *available at* http://www.ncsl.org/research/health/childrens-health-insurance-program-overview.aspx (last visited Oct. 29, 2019).
[2] Kaiser Family Foundation, *Summary of the 2018 CHIP Funding Extension*, (January 24, 2018) *available at* https://www.kff.org/medicaid/fact-sheet/summary-of-the-2018-chip-funding-extension/ (last visited Oct. 29, 2019).

The Florida KidCare Program

The Florida KidCare program is Florida's CHIP program. Florida KidCare was established in 1998 as a combination of Medicaid delivery systems and public and private partnerships, with a wrap-around delivery system serving children with special health care needs.[3] The Florida KidCare program, codified in ss. 409.810-409.821, F.S., is an "umbrella" program. The components described below include Medicaid for children, the Florida Healthy Kids program, MediKids, and the Children's Medical Services Network:[4]

- *MediKids* is a Medicaid "look-alike" program for children ages 1 through 4 who are at or below 200 percent of the federal poverty level (FPL).[5] Families whose income exceeds 200 percent of the FPL can participate in the MediKids full-pay premium option.[6]
- *Healthy Kids* is for children ages 5 through 18. Children in families with income between 133 percent and 200 percent of the FPL ($33,383 and $50,200 for a family of four) are eligible for subsidized coverage through the Healthy Kids program.[7] Children in families whose income exceeds 200 percent of the FPL can participate in the Healthy Kids full-pay option.[8]
- *Children's Medical Services Network* (CMSN) is a program for children from birth through the end of age 18 who have special health care needs.[9] The Department of Health (DOH) operates the program which is open to all children who meet the clinical eligibility criteria that are Medicaid or Title XXI eligible.[10]
- *Medicaid* provides Title XIX coverage to infants from birth to age 1 who are at or below 200 percent of the FPL and children ages 1 through age 18 who are at or below 133 percent of the FPL.[11]

Families who receive Medicaid are not responsible for paying premiums or co-payments. Families with children that qualify for other Florida KidCare program components are responsible for paying monthly premiums and co-payments for certain services. The total monthly family payment for Title XXI enrollees is $15 or $20 for families with incomes between 133 percent and 200 percent of the FPL.[12] The per-child monthly premium rate is $157 for full-pay MediKids coverage and $230 for full-pay Healthy Kids coverage, including dental coverage.[13]

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[3] Chapter 1998-228, Laws of Fla.
[4] Florida KidCare, https://www.floridakidcare.org/ (last visited Oct. 29, 2019).
[5] Section 409.8132(6), F.S.
[6] Agency for Health Care Administration, Florida Kidcare, *Welcome to Medikids*, https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/program_policy/FLKidCare/PDF/FLORIDA_MEDIKIDS_INFORMATION_2019.pdf (last visited Oct. 29, 2019).
[7] Florida Healthy Kids Corporation, *Subsidized Premiums*/Copays, https://www.healthykids.org/cost/subsidized/ (last visited Oct. 29, 2019).
[8] *Id.*
[9] *See* ch. 391, F.S.
[10] *Id.*
[11] Florida Healthy Kids, *Florida Kidcare Health and Dental Insurance 2019 General Annual Income Guidelines*, https://www.healthykids.org/kidcare/eligibility/Florida_KidCare_Income_Guidelines.pdf (last visited Oct. 29, 2019).
[12] *Id.*
[13] *Id.*

As of October 2019, 32,231 children are enrolled in subsidized MediKids; 8,755 children are enrolled in MediKids under the full-pay option; 195,020 children are enrolled in subsidized Healthy Kids; 16,190 children are enrolled in Healthy Kids under the full-pay option; 13,134 children are enrolled in the CMSN; and 1,289,840 children are enrolled in the Medicaid program.[14]

The KidCare program is jointly administered by the Agency for Health Care Administration (AHCA), the Florida Healthy Kids Corporation, the Department of Health, the Department of Children and Family Services, and the Office of Insurance Regulation. The general KidCare program responsibilities of each agency are outlined in the table below:

Entity	Responsibilities
Agency for Health Care Administration[15]	• Administration of the state Medicaid program that serves individuals eligible for Medicaid under Title XIX. • Administration of the MediKids program that serves Title XXI children from age 1 through age 4. • The Title XXI state contact with the federal Centers for Medicare & Medicaid Services. • Distributes federal funds for Title XXI programs. • Manages the contract with the Florida Healthy Kids Corporation. • Develops and maintains the Title XXI Florida KidCare State Plan.
Department of Children and Family Services[16]	• Responsible for processing Medicaid applications and determining children's eligibility for Medicaid.
Department of Health[17]	• Administration of the CMSN that offers a range of services to Title XIX and XXI children from birth through age 18 who have special health care needs. • Chairs the Florida KidCare Coordinating Council. • In consultation with the Florida Healthy Kids Corporation and the Department of Children and Families, establish a toll-free telephone line to assist families with questions about the program.
Florida Healthy Kids Corporation[18]	• Under contract with the AHCA to perform the administrative KidCare functions including: eligibility determination, premium billing and collection, refunds, and customer service. • Administration of the Florida Healthy Kids program for Title XXI children from age 5 through age 18.
Office of Insurance Regulation[19]	• Certifies that health benefits coverage plans seeking to provide services under the KidCare program, aside from services

[14] Florida Healthy Kids, *Florida Kidcare Health and Dental Insurance 2019 General Annual Income Guidelines*, https://www.healthykids.org/data/ (last visited Oct. 30, 2019).
[15] *See* part II of ch. 409, F.S.
[16] Section 409.818(1), F.S.
[17] *See* ch. 391 and s. 409.818(2), F.S.
[18] Section 624.91, F.S.
[19] Section 409.818(4), F.S.

provided under Healthy Kids and CMSN, meet, exceed, or are equivalent to the benchmark benefit plan and that the health insurance plans will be offered at an approved rate.

Florida KidCare Program Administration and Eligibility

The Florida Healthy Kids program component of KidCare is administered by the nonprofit Florida Healthy Kids Corporation (FHKC), established in s. 624.91, F.S. The FHKC contracts with managed care plans throughout the state for the provision of health care coverage.

The Florida KidCare application is a simplified application that serves applicants for both the Title XXI KidCare program and Title XIX Medicaid. Pursuant to federal law, each application is screened for the child's eligibility for Title XIX Medicaid. Children who appear to be eligible for Medicaid are referred to the Department of Children and Family Services for Medicaid eligibility determination, and children who appear to have a special health care need are referred to CMSN within the DOH for evaluation.

If eligible for Medicaid, the child is enrolled immediately into that program. If the child is not eligible for Medicaid, the application is processed for Title XXI, and if the child is eligible under Title XXI, the child is enrolled into the appropriate Florida KidCare program component.

Healthy Kids Lifetime Maximum

Florida Healthy Kids is the only Kidcare program that has a lifetime benefit maximum. Since the inception of Florida's CHIP program in 1998, the state has had the lifetime maximum in place.[20] The FHKC has removed children from the state program upon reaching the $1 million threshold. The FHKC determined that between October 1, 2015 through September 20, 2019, 12 enrollees reached the lifetime limit.[21] As the chart below indicates, at the time the twelve enrollees were terminated from the Healthy Kids program, three became enrolled in Medicaid, eight were enrolled in the CMSN, and one became deceased.[22]

[20] Chapter 1998-288, s. 40, Laws of Fla.
[21] Email from the Florida Healthy Kids Corporation (October 4, 2019) (on file with the Senate Committee on Health Policy).
[22] *Id.*

Age at Healthy Kids Termination	Year	Approximate Time to Reach $1M in Paid Claims	Primary Driver(s)	Medical Claims Paid Amount	Pharmacy Claims Paid Amount	Total Paid Claims by Carriers	Status at Healthy Kids Termination
16	2016	8 months	Lymphoma	$988,050.32	$20,774.47	$1,008,824.79	CMS
10	2016	21 months	Stem Cell Transplant	$809,187.25	$202,918.10	$1,012,105.35	Medicaid
17	2018	7 months	Extensive Burns	$1,003,967.34	$-	$1,003,967.34	Medicaid
9	2018	17 months	Cancer	$1,396,343.49	$68,322.61	$1,464,666.10	CMS
9	2018	39 months	Cancer	$1,158,818.10	$34,354.96	$1,193,173.06	CMS
12	2018	19 months	Auto-Immune Disease	$293,403.55	$807,430.01	$1,100,833.56	CMS
14	2018	31 months	Cystic Fibrosis	$386,605.27	$727,398.50	$1,114,003.77	CMS
17	2018	16 months	Cancer	$976,566.67	$93,525.43	$1,070,092.10	CMS
11	2018	28 months	Car Accident	$997,822.20	$7,483.75	$1,005,305.95	CMS
9	2017	23 months	Hemophilia	$1,857.32	$1,252,669.62	$1,254,526.94	Medicaid
18	2017	85 months	Cystic Fibrosis	$874,158.33	$213,415.30	$1,087,573.63	Deceased
17	2017	30 months	Hemophilia	$6,927.27	$1,329,201.46	$1,336,128.73	CMS

State Plan Requirements

On November 13, 2018, the federal Centers for Medicare & Medicaid Services (federal CMS) within the federal Department of Health and Human Services notified the AHCA that Florida's imposition of the lifetime benefit maximum for Florida Healthy Kids which was not set out in Florida's approved CHIP plan.[23] Because the lifetime maximum affects utilization controls and state disenrollment policies which are required to be set out in each state plan, federal CMS declared that Florida's plan was not in compliance with federal CHIP regulations.[24] If Florida intended to continue imposing the lifetime benefit maximum, the state would need to submit and federal CMS would need to approve a state plan amendment (SPA) setting out an approvable lifetime limit policy.[25]

Because the lifetime maximum was not represented in the state plan and because federal regulations at 42 CFR 457.65(b) prohibit amendments that eliminate or restrict eligibility or benefits from being in effect for longer than a 60-day period before the submission of the SPA, federal CMS has requested the FHKC to reset the account balances for all children currently enrolled in Healthy Kids to $0.[26] The AHCA has agreed to reset all account balances of children

[23] Correspondence from the Centers for Medicare and Medicaid Services (November 13, 2018) (on file with the Senate Committee on Health Policy).
[24] *Id. See also* 42 CFR 457.90 and 42 CFR 457.305(b).
[25] *Id.*
[26] Correspondence from the Centers for Medicare and Medicaid Services (March 6, 2019) (on file with the Senate Committee on Health Policy).

currently enrolled in healthy kids to $0 on January 1, 2020, and will not disenroll a child for reaching the lifetime maximum until the SPA is enacted on that same date.[27] Only services received after January 1, 2020 would count towards the aggregate lifetime limit.

Continuous Eligibility

Federal CMS noted that disenrolling children who hit a lifetime maximum is inconsistent with the state's continuous eligibility policy and federal regulations.[28] Because this is not an approved exception to continuous eligibility as listed in 42 CFR 457.342 and 42 CFR 435.926(d), federal CMS declared it would approve the state plan amendment only if the plan retained children who reach the lifetime maximum in coverage through their annual redetermination date, unless a child meets an approved exception to continuous eligibility such as reaching the age of 19 or ceasing to be a resident of this state.[29]

Sufficient Notice to Parents or Caretakers

Federal regulations in 42 CFR 457.340(e)(1)(iii) require a state to provide sufficient notice to enable the child's parent or caretaker to take appropriate actions to allow coverage to continue without interruption. The FHKC's policies were updated in May 2017 to require the managed care organizations notify FHKC when an enrollee exceeds $700,000 in benefits.[30] The updates include steps that the FHKC will take to remind families of the lifetime limit and inform them of alternative coverage options.[31]

Opportunity to Review Suspension or Termination of Enrollment

Federal regulations at 42 CFR 457.1130(a)(3) require a state to ensure that an applicant or enrollee has an opportunity for review of a suspension or termination of enrollment. Further, 42 CFR 457.1170 requires a state to ensure the opportunity for continuation of enrollment until the review of suspension or termination of enrollment is completed. Florida law does not provide the opportunity for review of the termination of enrollment of an enrollee who reaches the lifetime maximum.[32] Because there is no opportunity for such a review, there is no opportunity for the continuation of enrollment through the completion of the review.[33] The AHCA wrote that it will implement a process to provide impacted enrollees with a notice of adverse benefit determination when the enrollee reaches the lifetime maximum and that it will provide an enrollee the opportunity to dispute and seek review of any claims denials as a result of reaching

[27] Correspondence from the Agency for Health Care Administration (June 7, 2019) (on file with the Senate Committee on Health Policy).
[28] Correspondence from the Centers for Medicare and Medicaid Services (November 13, 2018) (on file with the Senate Committee on Health Policy).
[29] *Id.*
[30] Correspondence from the Agency for Health Care Administration (February 11, 2019) (on file with the Senate Committee on Health Policy).
[31] *Id.*
[32] Correspondence from the Centers for Medicare and Medicaid Services (November 13, 2018) (on file with the Senate Committee on Health Policy).
[33] *Id.*

the limit through the claim-denial process administered by the FHKC's contracted managed care organizations.[34, 35]

Corrective Action Plan

On July 26, 2019, federal CMS approved a corrective action plan that addresses all of the following:[36]

- The submission of an SPA effectuating the lifetime maximum which becomes effective on January 1, 2020.
- The lack of a need for the reenrollment of disenrolled children at that time because none of those children remained eligible for Healthy Kids.
- The resetting of all account balances of children currently enrolled in Healthy Kids to $0 so that only services received after January 1, 2020, will count toward the lifetime maximum.
- A continued collaboration between federal CMS, this state, and the FHKC during the SPA review process to ensure that families are properly notified of the lifetime maximum and to ensure families are not retroactively terminated from coverage.
- Ensuring that an enrollee who reaches the lifetime limit receives a notice of adverse benefit determination.
- Providing for a right to review (appeals) process. Federal CMS will continue to work with the state and the FHKC during the SPA review process to ensure compliance with federal regulations.

III. Effect of Proposed Changes:

Section 1 amends s. 409.815(2), F.S., to delete the lifetime maximum cap of $1 million on covered expenses per child enrolled in the Florida Healthy Kids program. Under the bill, no child will be disenrolled from the Healthy Kids program because he or she has reached the lifetime maximum.

This section of the bill also conforms a cross-reference.

Section 2 provides that the bill shall take effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

[34] Correspondence from the Agency for Health Care Administration (February 11, 2019) (on file with the Senate Committee on Health Policy).
[35] Correspondence from the Agency for Health Care Administration (June 7, 2019) (on file with the Senate Committee on Health Policy).
[36] Correspondence from the Centers for Medicare and Medicaid Services (July 26, 2019) (on file with the Senate Committee on Health Policy).

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

According to an actuarial review by Mercer Government Human Services Consulting on behalf of the FHKC, the costs for the Kidcare program associated with eliminating the lifetime cap on Healthy Kids benefits are estimated in the table below:[37]

Cost Estimates for Eliminating the Lifetime Cap on Healthy Kids Benefits

State Fiscal Year	General Revenue	Federal Match	Total
2019-20*	$45,239	$247,189	$292,428
2020-21	$304,401	$956,854	$1,261,255
2021-22	$379,255	$1,040,052	$1,419,307

*4th quarter of SFY 2019-20

Based on these estimates, the recurring general revenue cost is likely to continue increasing in subsequent years.[38] The AHCA has confirmed these estimates.[39]

The Department of Health and the Department of Children and Families have both reported no fiscal impact under SB 348.

[37] Correspondence from Mercer Government Human Services Consulting (August 16, 2019) (on file with the Senate Committee on Health Policy).
[38] *Id.*
[39] Agency for Health Care Administration, *Senate Bill 348 Agency Analysis* (October 31, 2019) (on file with the Senate Committee on Health Policy).

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following section of the Florida Statutes: 409.815

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 Bean

4-00472A-20 2020348__

A bill to be entitled

An act relating to the Florida Kidcare program; amending s. 409.815, F.S.; removing the lifetime maximum cap on covered expenses for a child enrolled in the Florida Healthy Kids program; conforming a cross-reference; providing an effective date.

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

Section 1. Paragraph (r) and present paragraph (u) of subsection (2) of section 409.815, Florida Statutes, are amended to read:

409.815 Health benefits coverage; limitations.—

(2) BENCHMARK BENEFITS.—In order for health benefits coverage to qualify for premium assistance payments for an eligible child under ss. 409.810-409.821, the health benefits coverage, except for coverage under Medicaid and Medikids, must include the following minimum benefits, as medically necessary.

~~(r) *Lifetime maximum.*—Health benefits coverage obtained under ss. 409.810-409.820 shall pay an enrollee's covered expenses at a lifetime maximum of $1 million per covered child.~~

(t) ~~(u)~~ *Enhancements to minimum requirements.*—

1. This section sets the minimum benefits that must be included in any health benefits coverage, other than Medicaid or Medikids coverage, offered under ss. 409.810-409.821. Health benefits coverage may include additional benefits not included under this subsection, but may not include benefits excluded under paragraph (r) ~~(s)~~.

2. Health benefits coverage may extend any limitations

4-00472A-20 2020348__

beyond the minimum benefits described in this section.

Except for the Children's Medical Services Network, the agency may not increase the premium assistance payment for either additional benefits provided beyond the minimum benefits described in this section or the imposition of less restrictive service limitations.

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

The Florida Senate

Committee Agenda Request

To: Senator Gayle Harrell, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: October 23, 2019

I respectfully request that **Senate Bill # 348**, relating to Florida Kidcare Program, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Aaron Bean

Senator Aaron Bean
Florida Senate, District 4

File signed original with committee office

S-020 (03/2004)

Florida Healthy Kids Enrollees Met $1M Lifetime Maximum
October 1, 2015 through September 20, 2019

Age at Healthy Kids Termination	Year of Termination	Approximate Time to Reach $1M in Paid Claims	Primary Driver(s)	Medical Claims Paid Amount	Pharmacy Claims Paid Amount	Total Paid Claims by Carriers	Status at Healthy Kids Termination
16	2016	8 months	Lymphoma	$ 988,050.32	$ 20,774.47	**$1,008,824.79**	CMS
10	2016	21 months	Stem Cell Transplant	$ 809,187.25	$ 202,918.10	**$1,012,105.35**	Medicaid
17	2018	7 months	Extensive Burns	$ 1,003,967.34	$ -	**$1,003,967.34**	Medicaid
9	2018	17 months	Cancer	$ 1,396,343.49	$ 68,322.61	**$1,464,666.10**	CMS
9	2018	39 months	Cancer	$ 1,158,818.10	$ 34,354.96	**$1,193,173.06**	CMS
12	2018	19 months	Auto-Immune Disease	$ 293,403.55	$ 807,430.01	**$1,100,833.56**	CMS
14	2018	31 months	Cystic Fibrosis	$ 386,605.27	$ 727,398.50	**$1,114,003.77**	CMS
17	2018	16 months	Cancer	$ 976,566.67	$ 93,525.43	**$1,070,092.10**	CMS
11	2018	28 months	Car Accident	$ 997,822.20	$ 7,483.75	**$1,005,305.95**	CMS
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18	2017	85 months	Cystic Fibrosis	$ 874,158.33	$ 213,415.30	**$1,087,573.63**	Deceased
17	2017	30 months	Hemophilia	$ 6,927.27	$ 1,329,201.46	**$1,336,128.73**	CMS

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

NOV 1 3 2018

Beth Kidder
Deputy Secretary for Medicaid
2727 Mahan Drive, MS #20
Tallahassee, FL 32308-5403

Dear Ms. Kidder:

The Centers for Medicare and Medicaid Services (CMS) recently learned that Florida places a $1 million aggregate lifetime limit on benefits for enrollees in the Healthy Kids program, which participates in the federal Children's Health Insurance Program (CHIP). As you are aware, this lifetime limit is not set out in the state's CMS-approved CHIP state plan. CMS and the state held calls to discuss the aggregate lifetime limit on July 16, 2018 and September 21, 2018. As a result, we discovered that, with respect to its lifetime limit policy, the state is not in compliance with federal CHIP regulations related to state plan content, continuous eligibility, termination of enrollment noticing requirements, and eligibility and enrollment review requirements. In order to continue to impose an aggregate lifetime limit, the state must submit, and CMS must approve, a CHIP state plan amendment (SPA) setting out an approvable lifetime limit policy.

CHIP state plans are required to set out utilization controls in the state plan document, as described in 42 CFR 457.490. In addition, 42 CFR 457.305(b) requires the state plan to include a description of the state's disenrollment policies. Florida's state plan sets out neither, with respect to the aggregate lifetime limit.

We note that Florida has elected to provide continuous eligibility to CHIP enrollees in their CHIP state plan. Disenrolling children due to reaching a lifetime limit is inconsistent with the state's continuous eligibility policy and 42 CFR 457.342. Disenrolling children due to reaching a lifetime limit is not an approved exception to continuous eligibility. Should the state choose to continue to implement an aggregate lifetime limit, we would only approve the state plan amendment if the plan retained children who reach the lifetime limit in coverage through their annual redetermination date, unless a child meets an approved exception to continuous eligibility.

Federal regulations at 42 CFR 457.340(e)(1)(iii) require that in the case of a suspension or termination of eligibility, the state must provide sufficient notice to enable the child's parent or other caretaker to take any appropriate actions that may be required to allow coverage to continue without interruption. It is our understanding that the state retroactively terminates children who reach the $1 million aggregate lifetime limit from coverage, which does not

provide enrollees with sufficient notice. For this reason, retroactive termination is not permissible under any circumstances.

Federal regulations related to reviews of eligibility or enrollment matters at 42 CFR 457.1130(a)(3) require that a state must ensure that an applicant or enrollee has an opportunity for review of a suspension or termination of enrollment. It is our understanding that families are given the opportunity to appeal specific health claims but are not given the opportunity to appeal the termination of enrollment. In addition, regulations at 42 CFR 457.1170 require the state to ensure the opportunity for continuation of enrollment pending the completion of review of a suspension or termination of enrollment. Because there is no current opportunity for review, children are not continuing to be enrolled in coverage during the review process.

Florida must complete a Corrective Action Plan (CAP) to address these issues. CMS requests that the CAP contains the following elements:

1) A CHIP SPA articulating an approvable aggregate lifetime limit policy and an actuarial report demonstrating that the addition of an aggregate lifetime limit does not reduce the actuarial value of the coverage as described in 42 CFR 457.440(b);
2) Reenrollment of all children who have been disenrolled due to reaching the lifetime limit in the past five years, if the children are otherwise still eligible for CHIP;
3) Resetting the balances for all children currently enrolled in Healthy Kids to $0, such that only claims for services received on or after the effective date of a state plan amendment that adds the aggregate lifetime limit to the state plan count toward the lifetime limit;
4) Updating the policies for notifying children of their reaching the aggregate lifetime limit;
5) Updating the policies for eligibility and enrollment reviews, such that children who are terminated from coverage due to reaching the lifetime limit are offered an opportunity for review of the termination and continued coverage while the review is ongoing; and
6) A timeline for completion of the CAP.

Please respond within 30 days from the date of this letter with a CAP that describes the actions the state is taking to fully comply with the regulations listed above. States that are not in compliance with Federal regulations are subject to further compliance action, including the withholding of federal payment.

We are available to provide any technical assistance that you need during the next 30 days as you prepare the response. If you have questions or concerns regarding the matters raised in this letter, please contact Amy Lutzky, Director, Division of State Coverage Programs, at (410) 786-0721.

Sincerely,

Anne Marie Costello
Director

cc: Shantrina Roberts, Associate Regional Administrator, CMS Region IV, Atlanta
cc: Rebecca Matthews, Chief Executive Officer, Florida Healthy Kids Corporation

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

MAR 0 6 2019

Shevaun Harris
Assistant Deputy Secretary for Medicaid
2727 Mahan Drive, MS #8
Tallahassee, FL 32308-5403

Dear Ms. Harris:

Thank you for the response to the Centers for Medicare and Medicaid Services' (CMS) request for a Corrective Action Plan (CAP) regarding the $1 million aggregate lifetime limit on benefits for enrollees in the Florida Healthy Kids Program, received February 11, 2019. As discussed during our call on March 5, 2019, CMS requests revisions to the CAP in two key areas. We may have additional feedback on other elements as we review.

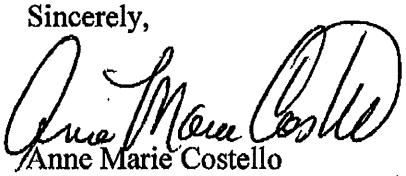
CMS acknowledges Florida Healthy Kids Corporation's (FHKC) hesitation to reset the account balances for all children currently enrolled in Healthy Kids to $0. However, as the state is aware, the aggregate lifetime limit was implemented without explicit approval by CMS through the approval of a state plan amendment (SPA), and as such, the state must submit a Children's Health Insurance Program (CHIP) SPA that articulates an approvable lifetime limit policy in order to continue to implement the $1 million limit. Federal regulations at 42 CFR 457.65(b) specify that amendments that eliminate or restrict eligibility or benefits may not be in effect for longer than a 60-day period prior to submission to CMS. A lifetime limit will restrict eligibility compared to the state's currently approved CHIP state plan. Therefore, the lifetime limit policy cannot be in effect for greater than 60 days prior to the submission of a SPA that includes the limit, and as such, it is not permissible to count claims for services received prior to the effective date of the SPA toward an enrollee's aggregate lifetime limit. Failing to reset the balances would effectively allow the state to have the lifetime limit in place for more than 60 days prior to submission of the SPA. We request that the state include resetting the balances to $0 in their CAP.

Additionally, it appears the state may be retroactively terminating children who reach the $1 million lifetime limit from coverage. According to the policies described in Attachment F of the submitted CAP, children are terminated from coverage effective the last day of the month accumulated paid claims reached $1 million. It appears that FHKC receives a monthly report of the enrollees who have reached the $1 million limit in the prior month. We assume that after FHKC terminates the enrollees after it receives the report. Therefore, it seems that children are retroactively terminated, as FHKC is not made immediately aware of enrollees reaching the $1 million limit. As previously stated in the original request for a CAP, federal regulations at 42

CFR 457.340(e)(1)(iii) require that in the case of a suspension or termination of eligibility, the state must provide sufficient notice to enable the child's parent or other caretaker to take any appropriate actions that may be required to allow coverage to continue without interruption, and retroactive terminations are not permissible under any circumstances. If we are understanding the process correctly, CMS requests that the state revise their policies such that children are only terminated from coverage on a prospective basis. We also request that the state send a copy of the "Healthy Kids Lifetime Maximum Benefits Notice letter" referenced in Attachment F to CMS for review.

As agreed upon during the meeting on March 5, 2019, CMS requests that the state update the CAP as expeditiously as possible. We are available to provide any technical assistance that you need as you prepare the response. If you have questions or concerns regarding the matters raised in this letter, please contact Amy Lutzky, Director, Division of State Coverage Programs, at (410) 786-0721.

Sincerely,



Anne Marie Costello
Director

cc: Shantrina Roberts, Associate Regional Administrator, CMS Region IV, Atlanta
Beth Kidder, Deputy Secretary for Medicaid, Agency for Health Care Administration
Rebecca Matthews, Chief Executive Officer, Florida Healthy Kids Corporation

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

June 7, 2019

Anne Marie Costello, Director
Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, Maryland 21244-1850

Dear Ms. Costello,

The State of Florida is providing updated responses to the Centers for Medicare and Medicaid Services' (CMS) request for a corrective action plan to address the following requirements:

State Plan Amendment (SPA)

1. A Children's Health Insurance Program SPA articulating an approvable aggregate lifetime limit policy and an actuarial report demonstrating that the addition of an aggregate lifetime limit does not reduce the actuarial value of the coverage as described in 42 CFR 457.440(b).

   State Response: The State will revise and submit to CMS an amended state plan amendment that identifies the aggregate lifetime limit policy, with an effective date of January 1, 2020. The $1 million lifetime limit will not be enforced until the effective date of the amended State Plan. As discussed on the call on May 13, 2019, the State agrees that no children will be dis-enrolled due to reaching the lifetime limit until the SPA is in place.

   In response to the request for actuarial value of coverage, the State provided documents to CMS on 02/11/2019 to demonstrate compliance with 42 CFR 457.440(b). Please let us know if you need us to resend the documentation.

Reenrollment of Children

2. Reenrollment of all children who have been dis-enrolled due to reaching the lifetime limit in the past five years, if the children are otherwise still eligible for CHIP.

   State Response: The State determined a total of eleven enrollees reached the lifetime limit since October 1, 2015. Of the eleven enrollees, two are currently enrolled in Medicaid, six are enrolled in Children's Medical Service Network (CMS), two have aged out and one is deceased. For these reasons, it is concluded that the eleven enrollees are either not eligible to reenroll in CHIP or are currently enrolled in CHIP through CMS.

Resetting Balances

3. Resetting the balances for all children currently enrolled in Healthy Kids to $0, such that only claims for services received on or after the effective date of a state plan amendment that adds the aggregate lifetime limit to the state plan count toward the lifetime limit.

   State Response: The current claims balances for enrollees in Healthy Kids will be reset to $0 on January 1, 2020. Only services received after January 1, 2020 would count towards the aggregate lifetime limit.

Notification Policies

4. Updating the policies for notifying children of their reaching the aggregate lifetime limit.

   State Response: The Florida Healthy Kids Corporation's (FHKC) has maintained an internal policy that requires its contracted managed care organizations (MCOs) to notify FHKC when an enrollee exceeds $700,000 in benefits. FHKC updated these polices in May 2017 to require notification to enrollees prior to incurring $1 million in benefits. The policy includes steps FHKC will take to remind families of the lifetime limit and inform them of alternative coverage options. The State provided CMS with a copy of the updated policy on 02/11/2019. Please let us know if you need us to resend the documentation.

Eligibility and Enrollment Review Policies

5. Updating the policies for eligibility and enrollment reviews, such that children who are terminated from coverage due to reaching the lifetime limit are offered an opportunity for review of the termination and continued coverage while the review is ongoing.

   State Response: Florida will provide a process for review through the claim-denial process administered by FHKC's contracted MCOs. Enrollees would receive a notice of adverse benefit determination should the child reach the lifetime limit. The State provided CMS with a copy of the sample notice on 02/11/2019. Please let us know if you need us to resend the documentation.

CAP Completion Timeline

6. A timeline for completion of the CAP.

   State Response: The CHIP state plan amendment will be submitted to CMS within the timeframe necessary to have an effective date of January 1, 2020.

Thank you for your working with us throughout this process. Please contact Cole Giering of my staff by phone at (850) 412-4196 or by email at Cole.Giering@ahca.myflorida.com if you need any additional information.

Sincerely,

Beth Kidder
Deputy Secretary, Medicaid

BK/nmj
Enclosure
cc: Shantrina Roberts, ARA, CMS Region IV

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

February 11, 2019

Anne Marie Costello, Director
Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, Maryland 21244-1850

Dear Ms. Costello:

Enclosed are responses to the Centers for Medicare and Medicaid Services' (CMS) for a corrective action plan to address the following elements:

State Plan Amendment (SPA)

1. A Children's Health Insurance Program SPA articulating an approvable aggregate lifetime limit policy and an actuarial report demonstrating that the addition of an aggregate lifetime limit does not reduce the actuarial value of the coverage as described in 42 CFR 457.440(b).

   State Response:

   The State will revise and submit an amended state plan amendment to incorporate the aggregate lifetime limit policy for approval. The SPA will be submitted within 30 days of CMS' acceptance of Florida's corrective action plan response.

   Since the inception of Florida's CHIP program, the State has had a lifetime limit in place, in accordance with section 409.815(2)(r), Florida Statutes. As this is not a change in how the State has been operating since the on-set of the program, we cannot provide an actuarial report prior to implementation of the program that could be used to demonstrate that the actuarial value has not been reduced. Therefore, per guidance received from CMS on 01/10/2019, the State has included documents that we believe demonstrate that the actuarial value of the benefit has been consistent since the inception of the program and complies with 42 CFR 457.440(b).

   Attachment A: Excerpt of an amendment to the State of Florida Section 1115 Medicaid waiver, dated July 1, 1997. This includes references to the lifetime limit and associated rates based on the benefit schedule.

   Attachment B: Enacting Florida Bill from 1998 demonstrating the limitation, which has not been modified since that time.

   Attachment C: Actuarial review of the rates currently in effect.

Attachment D: Per member per month cost of aligning the CHIP benefits to Medicaid, including the removal of the lifetime limit.

Reenrollment of Children

2. Reenrollment of all children who have been dis-enrolled due to reaching the lifetime limit in the past five years, if the children are otherwise still eligible for CHIP.

   State Response:

   The State determined a total of eleven enrollees reached the lifetime limit in the past five years. Of the eleven enrollees, two are currently enrolled in Medicaid, six are enrolled in Children's Medical Service Network (another component of the Title XXI program), two have aged out and one is deceased. For these reasons, it was concluded that none of the eleven enrollees are eligible to reenroll in the CHIP program.

Resetting Balances

3. Resetting the balances for all children currently enrolled in Healthy Kids to $0, such that only claims for services received on or after the effective date of a state plan amendment that adds the aggregate lifetime limit to the state plan count toward the lifetime limit.

   State Response:

   The Agency's partner, Florida Healthy Kids Corporation has expressed great concern with implementing this request because it would violate state law which mandates that the program include a lifetime limit (see section 409.815 (2)(r) F.S.). See page 2 of 3 of Florida Healthy Kids Corporation response to the Agency on this item of the corrective action plan request to further illustrate their concerns; it is included as **Attachment E**. As such, the State is respectfully requesting a waiver of this specific corrective action measure.

Notification Policies

4. Updating the policies for notifying children of their reaching the aggregate lifetime limit.

   State Response:

   The Florida Healthy Kids Corporation's (FHKC) polices were updated in May 2017 to include provisions which require the managed care organizations to notify FHKC when an enrollee exceeds $700,000 in benefits. The policy also includes steps FHKC will take to remind families of the lifetime limit and inform them of alternative coverage options. The updated policies are included in this response as **Attachment F**.

Eligibility and Enrollment Review Policies

5. Updating the policies for eligibility and enrollment reviews, such that children who are terminated from coverage due to reaching the lifetime limit are offered an opportunity for review of the termination and continued coverage while the review is ongoing.

   State Response:

   Florida will implement a process that provides impacted enrollees with a notice of adverse benefit determination should the enrollee reach the lifetime limit. This would provide the enrollee the opportunity to dispute and review any claims denials as a result of reaching the limit. **Attachment G** is a sample notice that a member would receive.

CAP Completion Timeline

6. A timeline for completion of the CAP.

   State Response:

   The CHIP state plan amendment will be submitted within 30 days of CMS' acceptance of Florida's Corrective Action Plan response. The State anticipates all components of the CAP to be implemented within 6 months of the SPA submission.

Thank you for your consideration of these requests. Please contact Cole Giering of my staff by phone at (850) 412-4196 or by email at Cole.Giering@ahca.myflorida.com if you need any additional information.

Sincerely,

Shevaun Harris
Assistant Deputy Secretary for Medicaid
Policy and Quality

SH/nmj
Enclosure
cc: Shantrina Roberts, ARA, CMS Region IV

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

JUL 2 6 2019

Shevaun Harris
Assistant Deputy Secretary for Medicaid
2727 Mahan Drive, MS #8
Tallahassee, FL 32308-5403

Dear Ms. Harris:

Thank you for the updated response to the Centers for Medicare and Medicaid Services' (CMS) request for a Corrective Action Plan (CAP) regarding the $1 million aggregate lifetime limit on benefits for enrollees in the Florida Healthy Kids Program, received June 11, 2019. CMS approves the CAP as follows:

- **Intended submission of a Children's Health Insurance Program (CHIP) state plan amendment (SPA):** The state intends to submit a CHIP SPA effectuating an aggregate lifetime limit policy effective January 1, 2020. The state has sufficiently demonstrated that this policy will be in compliance with the actuarial value requirements of 42 CFR 457.440(b). The state has agreed that no children will be disenrolled due to reaching $1 million in aggregated claims until this SPA is effective.
- **Reenrollment of children who have been disenrolled due to reaching the lifetime limit:** The state has confirmed that none of the 11 children who have been disenrolled due to reaching the lifetime limit in the past five years are still eligible for CHIP coverage. No further action is needed from the state.
- **Resetting balances:** The state has agreed that only services received after January 1, 2020 (the effective date of the planned SPA) will count towards the aggregate lifetime limit for children currently enrolled in Healthy Kids.
- **Notification policies:** The state has demonstrated that Florida Healthy Kids Corporation (FHKC) is notified by the health plan when an enrollee exceeds $700,000 in aggregated claims. CMS will continue to work with the state and FHKC during the SPA review process to ensure that families are properly notified of the aggregate lifetime limit and to ensure families are not retroactively terminated from coverage.
- **Eligibility and enrollment review policies:** The state will ensure enrollees receive a notice of adverse benefit determination should the child reach the lifetime limit and provide for a right to review (appeals) process. CMS will continue to work with the state and FHKC during the SPA review process to ensure that families are also allowed to appeal the termination in a manner consistent with 42 CFR 457.1130.

We appreciate your cooperation as we have worked through the details of the CAP. We are available to provide any technical assistance that you need as you prepare the SPA. If you have questions or concerns regarding the matters raised in this letter, please contact Amy Lutzky, Director, Division of State Coverage Programs, at (410) 786-0721.

Sincerely,

Anne Marie Costello
Director

cc: Shantrina Roberts, Deputy Director, Division of Medicaid Field Operations South
Beth Kidder, Deputy Secretary for Medicaid, Agency for Health Care Administration
Rebecca Matthews, Chief Executive Officer, Florida Healthy Kids Corporation

2020 AGENCY LEGISLATIVE BILL ANALYSIS

AGENCY: Agency for Health Care Administration

BILL INFORMATION	
BILL NUMBER:	SB 348
BILL TITLE:	Florida Kidcare Program
BILL SPONSOR:	Senator Bean
EFFECTIVE DATE:	The bill takes effect upon becoming a law.

COMMITTEES OF REFERENCE
1) Health Policy
2) Appropriations Subcommittee on Health and Human Services
3) Appropriations
4)
5)

CURRENT COMMITTEE
Health Policy

SIMILAR BILLS	
BILL NUMBER:	N/A
SPONSOR:	

PREVIOUS LEGISLATION	
BILL NUMBER:	N/A
SPONSOR:	
YEAR:	
LAST ACTION:	

IDENTICAL BILLS	
BILL NUMBER:	HB 6031
SPONSOR:	Rep. Pigman

Is this bill part of an agency package?
Y ___ N _X__

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	October 9, 2020
LEAD AGENCY ANALYST:	Angela M. Wiggins / DD Pickle
ADDITIONAL ANALYST(S):	
LEGAL ANALYST:	
FISCAL ANALYST:	

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

Senate Bill (SB) 348 removes a $1 million maximum lifetime limit on covered benefits and services for children enrolled in the Florida Healthy Kids program, which is a component of the Children's Health Insurance Program (CHIP) for children ages 5 through 18.

The bill amends section 409.815(2)(r), Florida Statutes (F.S.) to remove existing provisions establishing a lifetime maximum benefit of $1 million per covered child. Currently, children are disenrolled from the Florida Healthy Kids program upon incurring $1 million in medical expenses. SB 348 will allow children enrolled in the Florida Healthy Kids program to remain in the program and continue to receive comprehensive medical and dental care without disruption. This change will result in operational and fiscal impacts to the Florida Healthy Kids program.

The changes in this bill will have an estimated fiscal impact to the Florida Healthy Kids Program in State Fiscal Year (SFY)19/20 of $292,428 of which $45,239 is General Revenue, based upon the percentage of federal matching funds. The impact to SFY20/21 is $1,261,255, of which $304,401 is General Revenue and in SFY21/22, the impact is $1,419,307 of which $379,255 is General Revenue.

The bill is effective upon becoming a law.

2. SUBSTANTIVE BILL ANALYSIS

1. PRESENT SITUATION:

The Florida KidCare Program

Florida KidCare is the state of Florida's Children's Health Insurance Program for uninsured children who meet income and eligibility requirements. The 1998 Legislature created the Florida KidCare program to provide quality health insurance coverage to children in both the Medicaid program and the Child Health Insurance Program (CHIP), which are also referred to as Title XIX and Title XXI (of the Social Security Act), respectively.

Medicaid is an entitlement program that provides medical and dental care for children under the age of 21 from low-income families, as well as pregnant women, low income elderly, and persons with disabilities. Medicaid is authorized by Title XIX of the Social Security Act. Families that are eligible for Medicaid coverage do not pay a monthly family premium. States are eligible to receive federal matching funds – called Federal Medical Assistance Percentages, or FMAP – for all state expenditures that meet federal program requirements.

The **CHIP** is not an entitlement program and provides medical and dental care for children in families with incomes below 200% of the federal poverty level, but which is too high to qualify for Medicaid. Families participating in the CHIP pay a monthly family premium on a subsidized or full-pay basis, depending on the covered family's income and household size. Title XXI of the Social Security Act authorizes federal matching funds to states to provide medical assistance to uninsured, low-income children. Congress creates a fixed annual federal allotment to fund the CHIP program, and states are eligible to receive FMAP based on that appropriation. In the original CHIP program, Congress created an "enhanced" FMAP that is generally about 15 percentage points higher than the Medicaid rate, averaging 71% nationally. Between fiscal year (FY) 2016 and FY 2019, the Affordable Care Act increased each state's enhanced federal match rate by 23 percentage points, not to exceed a total match rate of 100 percent. A plan to reduce the FMAP over the next two years was created as part of the most recent CHIP reauthorization.

The Florida CHIP includes three components:

- **MediKids**, operated by the Agency, provides services to children ages one through four.
- **Florida Healthy Kids**, operated by the Florida Healthy Kids Corporation, provides services to children ages 5 through 18.
- **Title XXI Children's Medical Services Health Plan**, operated by the Florida Department of Health, provides services to children with special health care needs ages 1 through 18.

While the MediKids and Title XXI CMS Plan programs provide services without a cap on the amount a child can receive, section 409.815(2)(r), F.S., currently establishes a $1 million lifetime limit per covered child enrolled

in Healthy Kids for health benefits coverage. Once a child has incurred $1 million in expenditures, the child is disenrolled from the Healthy Kids program. This limit has been in place since the inception of CHIP. In the last 5 years, 11 children have been disenrolled due to meeting the lifetime limit, and most of them transitioned to another form of coverage (Medicaid, CMS plan, etc.). The Florida Healthy Kids Corporation notifies families when the child has exceeded $700,000 in benefits, reminds the family of the coverage limitation, and informs the family of alternative coverage options. Upon the child reaching the $1 million limit, the Florida Healthy Kids Corporation calls the family and sends a letter to notify the family that the child's coverage will expire at the end of that month.

In November 2018, the Centers for Medicare and Medicaid Services (CMS) notified the Agency that Florida's CHIP state plan was not compliant with federal requirements because it did not explicitly list the lifetime limit. Florida was required to submit a state plan amendment to include language regarding the lifetime limit. To comply with this mandate, the Agency will be submitting a state plan amendment with an effective date of January 1, 2020, to identify the aggregate lifetime limit policy.

2. EFFECT OF THE BILL:

The bill would amend section 409.815, F.S., to remove the lifetime maximum of $1 million per covered child, thereby allowing children in the Florida Healthy Kids program to remain enrolled and reduce the opportunity for disruption in care. This change would result in a fiscal and operational impact to the Florida Healthy Kids program. The Florida Healthy Kids Corporation will have to modify its policies and procedures to remove the process for disenrolling children who have exceeded the aggregate lifetime limit and amend health plan contracts to ensure children are not disenrolled after incurring $1 million of medical expenses. These updates are part of Florida Healthy Kids Corporation's routine business practices and pose an insignificant operational impact. As previously stated, the Agency had planned to submit a state plan amendment to CMS to include the aggregate lifetime limit policy in the CHIP state plan.

Florida Healthy Kids engaged Mercer to perform an analysis to estimate the cost of repealing the lifetime maximum. The results of this analysis are detailed in an August 16, 2019 report to Florida Healthy Kids. The effect of removing the lifetime maximum is $292,428 in SFY19/20, of which $45,239 is General Revenue. This reflects the last four months of the year (April – June 2020). In SFY20/21, the impact is $1,261,255, of which $304,401 is General Revenue. In SFY21-22, the impact is $1,419,307, of which $379,255 is General Revenue.

The bill is effective upon becoming a law.

3. DOES THE BILL DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES? Y ___ N _X__

If yes, explain:	
Is the change consistent with the agency's core mission?	Y ___ N ___
Rule(s) impacted (provide references to F.A.C., etc.):	

4. WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?

Proponents and summary of position:	It is likely that advocates for CHIP and low-income families will be in favor of this change.
Opponents and summary of position:	Unknown

5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL? Y __ N _X___

If yes, provide a description:	
Date Due:	
Bill Section Number(s):	

6. ARE THERE ANY GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSION, ETC.? REQURIED BY THIS BILL? Y ___ N _X__

Board:	
Board Purpose:	
Who Appointments:	
Appointee Term:	
Changes:	
Bill Section Number(s):	

FISCAL ANALYSIS

1. DOES THE BILL HAVE A FISCAL IMPACT TO LOCAL GOVERNMENT? Y ___ N _X__

Revenues:	
Expenditures:	
Does the legislation increase local taxes or fees? If yes, explain.	
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	

2. DOES THE BILL HAVE A FISCAL IMPACT TO STATE GOVERNMENT? Y _X__ N ___

Revenues:	
Expenditures:	The effect of removing the lifetime maximum is $292,428 in SFY19/20, of which $45,239 is General Revenue. In SFY20/21 the impact is $1,261,255, of which $304,401 is General Revenue. In SFY21-22 the impact is $1,419,307, of which $379,255 is General Revenue.

Fiscal Year	Federal Expenditures	State Expenditures	Total	Full Year PMPM Impact
SFY 2019-20 (Partial period of four months April-June 2020) FMAP - 84.53%	$247,189	$45,239	**$292,428**	**$0.12**

****SFY 2020-21** FMAP – FFY 2020: 84.53% FFY 2021: 73.18%	$956,854	$304,401	**$1,261,255**	**$0.48**
SFY 2021-22 FMAP – FFY 2021:73.18% FFY 2022: 73.31%	$1,040,052	$379,255	**$1,419,307**	**$0.51**

Source: * Impact of Repealing Statutory Lifetime Benefit Maximum on Subsidized Population Premiums – Mercer August 16, 2019: Table 1

FISCAL IMPACT:	Year 1 (FY 2019-20)	Year 2 (FY 2020-21)	Year 3 (FY 2021-22)
Non-Recurring Impact:			
Expenditures:			
Total Non-Recurring Expenditures	**$ -**		
Recurring Impact:			
Special Categories/Contracted Services			
100031 G/A-FI Healthy Kids Corp	$ 292,428	$ 1,261,255	$ 1,419,307
Total Special Categories/Contracted Services	**$ 292,428**	**$ 1,261,255**	**$ 1,419,307**
Total Recurring Expenditures	**$ 292,428**	**$ 1,261,255**	**$ 1,419,307**
Total Revenues and Expenditures:			
Sub-Total Recurring Revenues	$ -	$ -	$ -
Total Revenues	**$ -**	**$ -**	**$ -**
Sub-Total Non-Recurring Expenditures	$ -	$ -	$ -
Sub-Total Recurring Expenditures	292,428	1,261,255	1,419,307
Total Expenditures	**$ 292,428**	**$ 1,261,255**	**$ 1,419,307**
Net Impact (Total Revenues minus Total Expenditures)	**$ (292,428)**	**$ (1,261,255)**	**$ (1,419,307)**
Net Impact (By Fund)			
General Revenue Fund (1000)	$ (45,239)	$ (304,401)	$ (379,255)
Medical Care Trust Fund (2474)	(247,189)	(956,854)	(1,040,052)
-	-	-	-
-	-	-	-
Net Impact (By Fund)	**$ (292,428)**	**$ (1,261,255)**	**$ (1,419,307)**

Does the legislation contain a State Government appropriation?	
If yes, was this appropriated last year?	

3. DOES THE BILL HAVE A THE FISCAL IMPACT TO THE PRIVATE SECTOR? Y ___N _X__

Revenues:	
Expenditures:	
Other:	

4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES? Y ___ N _X__

If yes, explain impact.	
Bill Section Number:	

TECHNOLOGY IMPACT

1. DOES THE BILL IMPACT THE AGENCY'S TECHNOLOGY SYSTEMS (I.E. IT SUPPORT, LICENSING SOFTWARE, DATA STORAGE, ETC.)? Y ___ N _X__

If yes, describe the anticipated impact to the agency including any fiscal impact.	

FEDERAL IMPACT

1. DOES THE BILL HAVE A FEDERAL IMPACT (I.E. FEDERAL COMPLIANCE, FEDERAL FUNDING, FEDERAL AGENCY INVOLVEMENT, ETC.)? Y X___ N ___

If yes, describe the anticipated impact including any fiscal impact.	The effect of removing the lifetime maximum limit for children enrolled in the Healthy Kids is $292,428 in SFY19/20, of which $247,189 is federal matching funds. In SFY20/21, the impact is $1,261,255, of which $956,854 is federal matching funds, and in SFY21-22, the impact is $1,419,307 of which $1,040,052 is federal matching funds.

ADDITIONAL COMMENTS

LEGAL – GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments:	

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 402
INTRODUCER:	Health Policy Committee and Senator Harrell
SUBJECT:	Assisted Living Facilities
DATE:	November 6, 2019 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 402 amends various statutes related to the regulation of assisted living facilities (ALF). The bill:

- Adds and amends several defined terms to clarify what is intended by the terms abuse, neglect, and exploitation as well as to increase the ability of an ALF to use assistive devices and physical restraints that the resident is able to operate.
- Amends the definition of the term "adverse incident" to include only events associated with an ALF's intervention and prevents an ALF from being fined for failing to submit a final report until three days after the Agency for Health Care Administration (AHCA) notifies the ALF the final report is due if the incident is determined to, in fact, not be an adverse incident.
- Requires each resident to have a medical examination performed no longer than 60 days prior to or up to 30 days after admission to the ALF and requires the AHCA to adopt a form in rule that may be used by the health care practitioner performing the medical examination.
- Clarifies the requirements for a resident to be admitted to and retained in an ALF.
- Amends the AHCA's rulemaking authority to account for technological advances and to clarify what the AHCA may require when adopting rules for maintenance and sanitary standards.
- Clarifies who may approve an ALF's comprehensive emergency management plan and allows an ALF to submit the plan up to 30 days after receiving a license.
- Consolidates provisions related to firesafety into its own section of law rather than being intermingled with AHCA's rulemaking authority.

- Amends several provisions related to ALF administrator core competency curriculum and examination to clarify that the AHCA must adopt an outline and learning objectives for such curriculum.

The bill's provisions take effect July 1, 2020.

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-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]

There are 3,069 licensed ALFs in Florida having a total of 107,144 beds.[7] An ALF must have a standard license issued by the Agency for Health Care Administration (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 an 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]

ALF Staff Training

Administrators and Managers

Administrators and other ALF staff must meet minimum training and education requirements established in rule by the AHCA,[11] that are intended to assist ALFs in appropriately responding

[1] Section 429.02(5), F.S. An ALF does not include an adult family-care home or a non-transient public lodging establishment.
[2] Section 429.02(17), F.S.
[3] Section 429.02(1), F.S.
[4] *See* Rule 59A-36.007, F.A.C., for specific minimum standards.
[5] Section 429.26, F.S., and Rule 59A-36.006, F.A.C.
[6] Section 429.28, F.S.
[7] Agency for Health Care Administration, Health Care Finder. *See* http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx (last visited October 30, 2019).
[8] Section 429.07(3)(c), F.S.
[9] Section 429.075, F.S.
[10] Section 429.07(3)(b), F.S.
[11] Rule 59A-36.011, F.A.C.

to the needs of residents, maintaining resident care and facility standards, and meeting licensure requirements.[12]

The current ALF core training requirements established by the AHCA 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 three months after becoming an ALF administrator or manager. The minimum passing score for the competency test is 75 percent.[13]

Administrators and managers must participate in 12 hours of continuing education in topics related to assisted living every two years.[14] 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.[15]

Staff with Direct Care Responsibilities

Facility administrators or managers are required to provide or arrange for six hours of in-service training for facility staff who provide direct care to residents.[16] 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 six hours of in-service training, staff must complete one 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.

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 ALFs licensed to provide Limited Nursing Services or Extended Congregate Care services;
- To monitor ALFs cited in the previous year for a class I or class II violation or for four or more uncorrected class III violations;
- Upon receipt of an oral or written complaint of practices that threaten the health, safety, or welfare of residents;

[12] Section 429.52(1), F.S.
[13] 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.
[14] Rule 59A-36.011, F.A.C.
[15] Rule 59A-36.011, F.A.C.
[16] *Id.*

- If the AHCA has reason to believe an ALF 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 an ALF is operating without a license.[17]

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[18] which were reported to the AHCA by the council; or
- Confirmed licensing complaints within the two licensing periods immediately preceding the current renewal date.[19]

III. Effect of Proposed Changes:

CS/SB 402 amends various sections in ch. 429, F.S., related to the regulation of ALFs. In addition to technical and conforming changes:

Section 1 amends s. 429.02, F.S., to add definitions for "abuse,"[20] "exploitation,"[21] and "neglect"[22] all of which have the same meaning as in s. 415.102, F.S. In addition, the bill specifies that the definition of neglect may also include the failure of an ALF to prevent sexual

[17] Section 429.34, F.S.

[18] Florida's Long-Term Care Ombudsman Program was founded in 1975 as a result of the federal Older Americans Act, which grants a special set of residents' rights to individuals who live in long-term care facilities such as nursing homes, assisted living facilities and adult family care homes. Volunteer ombudsmen seek to ensure the health, safety, welfare and rights of these residents throughout Florida. *See* http://ombudsman.myflorida.com/AboutUs.php (last visited on October 30, 2019).

[19] Rule 59A-36.023, F.A.C.

[20] "Abuse" means any willful act or threatened act by a relative, caregiver, or household member which causes or is likely to cause significant impairment to a vulnerable adult's physical, mental, or emotional health. Abuse includes acts and omissions. s. 415.102(1), F.S.

[21] "Exploitation" means a person who stands in a position of trust and confidence with a vulnerable adult and knowingly, by deception or intimidation, obtains or uses, or endeavors to obtain or use, a vulnerable adult's funds, assets, or property with the intent to temporarily or permanently deprive a vulnerable adult of the use, benefit, or possession of the funds, assets, or property for the benefit of someone other than the vulnerable adult; or knows or should know that the vulnerable adult lacks the capacity to consent, and obtains or uses, or endeavors to obtain or use, the vulnerable adult's funds, assets, or property with the intent to temporarily or permanently deprive the vulnerable adult of the use, benefit, or possession of the funds, assets, or property for the benefit of someone other than the vulnerable adult. "Exploitation" may include, but is not limited to breaches of fiduciary relationships, such as the misuse of a power of attorney or the abuse of guardianship duties, resulting in the unauthorized appropriation, sale, or transfer of property; unauthorized taking of personal assets; misappropriation, misuse, or transfer of moneys belonging to a vulnerable adult from a personal or joint account; or intentional or negligent failure to effectively use a vulnerable adult's income and assets for the necessities required for that person's support and maintenance. s. 415.102(9), F.S.

[22] "Neglect" means the failure or omission on the part of the caregiver or vulnerable adult to provide the care, supervision, and services necessary to maintain the physical and mental health of the vulnerable adult, including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services, which a prudent person would consider essential for the well-being of a vulnerable adult. The term "neglect" also means the failure of a caregiver or vulnerable adult to make a reasonable effort to protect a vulnerable adult from abuse, neglect, or exploitation by others. "Neglect" is repeated conduct or a single incident of carelessness which produces or could reasonably be expected to result in serious physical or psychological injury or a substantial risk of death. Section 415.102(16), F.S.

abuse.[23] The bill also defines "assistive device" to mean any device designed or adapted to help a resident perform an action, a task, an activity of daily living, or a transfer; prevent a fall; or recover from a fall. The term does not include a total body lift or a motorized sit-to-stand lift, with the exception of a chair lift or recliner lift that a resident is able to operate independently. Additionally, the bill amends the definition of "physical restraint" to eliminate specific examples of what qualifies as a physical restraint and to specify that a device the resident chooses to use and is able to remove does not qualify as a physical restraint.

Section 2 amends s. 429.07, F.S., to specify that required written progress reports maintained on the services offered by extended congregate care and limited nursing services ALFs must cover only those services offered by the ALF, not those offered by third parties.

Section 3 amends s. 429.11, F.S., to specify that a county or municipality may not issue a business tax receipt, rather than an occupational license, to an ALF without first determining that the ALF is licensed by the AHCA. This is a technical change in terminology.

Section 4 amends s. 429.176, F.S., to specify that when an ALF changes administrators, the owner of the ALF must provide the AHCA with documentation that the new administrator meets educational requirements (in addition to core training requirements that are already required) within 90 days of the change.

Section 5 amends s. 429.23, F.S., to specify that the definition of an "adverse incident" only includes events associated with the ALF's intervention rather than the resident's underlying disease or condition. The bill prevents the AHCA from fining an ALF until three days after providing notice to the ALF for failing to submit a full report if the ALF submitted a preliminary report on an adverse incident and afterwards determined that the event was not an adverse incident. The bill also eliminates the requirement that each ALF file a monthly report with the AHCA that includes any liability claim filed against it.

Section 6 amends s. 429.255, F.S., to make technical changes.

Section 7 amends s. 429.256, F.S., to include transdermal patches in the list of medications that unlicensed ALF staff may assist a resident in self-administering. The bill also clarifies that assistance with the self-administration of medication includes:

- A staff member confirming that the medication is intended for the resident and orally advising the resident of the medication's name and purpose;[24] and
- A staff member assisting with the self-administration of a medication that is prescribed "as needed" if the resident requesting the medication is aware of his or her need for the medication and the purpose for taking the medication.[25]

Section 8 amends s. 429.26, F.S., to require that each resident receive a medical examination by a physician, a physician assistant, or an advanced practice registered nurse within 60 days prior

[23] As defined in s. 415.102, F.S.
[24] Current law requires the staff member read the label on the medication. It is unclear whether the label must be read to the resident, however.
[25] Current law requires the resident to be competent.

to being or within 30 days after the admission to the facility. The practitioner performing the examination must fill out and sign a form that reflects the resident's condition on the date the examination is performed. The bill specifies that the medical examination required for admittance to an ALF is not a guarantee of admission, continued residency, or services to be delivered and that the medical examination is to be used as an informative tool to assist in the determination of the appropriateness of the resident's admission or continued residency. The form used may be the practitioner's own form or a form adopted by the AHCA in rule, both of which must include the following information on the resident:

- Height, weight, and known allergies.
- Significant medical history and diagnoses.
- Physical or sensory limitations, including the need for fall precautions or recommended use of assistive devices.
- Cognitive or behavioral status and a brief description of any behavioral issues known or ascertained by the examining practitioner, including any known history of wandering or elopement.
- Nursing, treatment, or therapy service requirements.
- Whether assistance is needed for ambulating, eating, or transferring.
- Special dietary instructions.
- Whether he or she has any communicable diseases, including necessary precautions.
- Whether he or she is bedridden and the status of any pressure sores that he or she has.
- Whether the resident needs 24-hour nursing supervision or psychiatric care.
- A list of current prescribed medications as known or ascertained by the examining practitioner and whether the resident can self-administer medications, needs assistance, or needs medication administration.

The bill establishes criteria that for a resident's appropriateness for admission or continued residency, including:

- A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party.
- A facility may admit or retain a resident who requires the use of assistive devices.[26]
- A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident.
- A facility may not retain a resident who requires 24-hour nursing supervision, except for a resident who is enrolled in hospice services pursuant to part IV of chapter 400.
- A facility may not admit or retain a resident who is bedridden[27] except that:
    - A bedridden resident may be admitted or retained if he or she is receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is

[26] The term "assistive devices" is defined in section 1 of the bill.

[27] The bill defines "bedridden" as a resident who is confined to a bed because of the inability to: move, turn, or reposition without total physical assistance; transfer to a chair or wheelchair without total physical assistance; or sit safely in a chair or wheelchair without personal assistance or a physical restraint.

provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility.
  - A facility may retain a bedridden resident if the resident is bedridden for no more than seven days or up to 14 days if the facility is licensed to provide extended congregate care.

Additionally, the bill amends the requirement that an ALF must arrange for the necessary care and services to treat a resident who has developed dementia or cognitive impairment to instead require the ALF to notify the resident's designee or representative of the need for such health care services and to assist in making appointments for the resident. If the resident's designee or representative cannot be located or is unresponsive, the ALF retains the requirement to arrange the necessary care for the resident.

Section 9 amends s. 429.28, F.S., to provide the right that a resident at an ALF live free from exploitation; to require that a document stating the reasons for relocation of a resident be provided to the resident or the resident's representative; and to clarify AHCA rulemaking and inspection authority required by the resident's bill of rights.

Section 10 amends s. 429.41, F.S., to:
- Clarify that the AHCA may account for technological advances in the provision of care, safety, and security, including the use of devices, equipment, and other security measures related to wander management, emergency response, staff risk management, and the general safety and security of residents, staff, and the facility in its rules.
- Remove language regarding firesafety standards that are being placed in new section 429.435, F.S. (See section 11 of the bill).
- Clarify that rule requirements for maintenance and sanitary conditions include furnishings for resident bedrooms or sleeping areas, locking devices and linens, but do not include requirements that are duplicative of those in ch. 553, or ss. 381.006, 381.0072, and 633.206, F.S. The bill also requires that the rules clearly delineate the respective responsibilities of the AHCA's licensure and survey staff and the county health departments to ensure that inspections are not duplicative and allows the AHCA to collect fees[28] for food service inspections conducted by the county health department and transfer such fees to the Department of Health.
- Remove the requirement that comprehensive emergency management plans be made available for review by appropriate volunteer organizations and require that an ALF submit its plan to the county emergency management agency within 30 days after being issued a license rather than requiring the plan to be approved prior to the issuance of the license.
- Allow the use of physical restraints (as defined in section 1 of the bill) other than geriatric chairs and Posey restraints[29] in accordance with AHCA rules. Such rules must specify requirements for care planning, staff monitoring, and periodic review by a physician.
- Require the establishment of specific ALF elopement drill requirements, in addition to elopement policies and procedures, and require administrators and direct care staff to review elopement procedures as part of the elopement drill.

[28] The quarterly fee of $300 is established in current law under s. 381.0072, F.S.
[29] Posey restraints are a generic term for a restraint that restricts a patient's free movement while the patient is in bed.

- Allow the AHCA to use an abbreviated survey for an ALF that has had a confirmed ombudsman council complaint or licensure complaint unless such complaint results in a class I, II, or uncorrected class III violation.
- Requires the AHCA to adopt key quality-of-care standards in rule and eliminates the requirement to incorporate input from the state long-term care ombudsman council and representatives of provider groups.

Section 11 creates s. 429.435, F.S., to consolidate requirements relating to uniform fire safety standards for ALFs into the new section. The requirements of this section are transposed from s. 429.41, F.S.

Section 12 amends s. 429.52, F.S., to require the AHCA, in conjunction with ALF providers, to develop core training requirements for administrators consisting of core training learning objectives. The bill also requires the AHCA to adopt a curriculum outline that includes the learning objectives.

The bill requires staff assisting with the self-administration of medication to complete six additional hours of training before providing such assistance and two hours of continuing education annually thereafter. The bill also specifies that topics covered in the preservice orientation for ALF staff are not required to be covered again in staff in-service training and that all required in-service training may be completed in a single course.

Additionally the bill requires the AHCA to establish core trainer registration and removal requirements.

Section 13 establishes an effective date of July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 429.02, 429.07, 429.11, 429.176, 429.23, 429.255, 429.256, 429.26, 429.28, 429.41, and 429.52.

This bill creates section 429.435 of the Florida Statutes.

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 November 5, 2029:
The CS:

- Amends the definition of "neglect" to include the failure to prevent sexual abuse.
- Maintains current law requiring an ALF to submit a preliminary adverse incident report to the AHCA within one business day of the incident occurring.
- Prevents AHCA from fining an ALF for not filing a full adverse incident report until three days after the AHCA provides the ALF with a reminder that the report is due.
- Specifies that the medical examination required for admittance to an ALF is not a guarantee of admission, continued residency, or services to be delivered and that the medical examination is to be used as an informative tool to assist in the determination of the appropriateness of the resident's admission or continued residency.
- Specifies that an ALF must still arrange the necessary care and services to treat a resident with dementia or other similar condition if the ALF cannot locate the resident's representative or he or she is not responsive.

- Specifies ss. 381.006 and 381.0072, F.S., in requiring that ALF rules not conflict with or duplicate provisions in the specified sections. Currently, the bill specifies the entire chapter of law.
- Maintains current law authority for AHCA to adopt rules over elopement policies and procedures.
- Specifies that the six hours of training necessary to provide assistance with medication is in addition to other required training.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
11/05/2019	.	
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The Committee on Health Policy (Harrell) recommended the following:

Senate Amendment

Delete line 119
and insert:
(19) "Neglect" has the same meaning as in s. 415.102. For purposes other than reporting requirements within this part, "neglect" may also include the failure to prevent sexual abuse as defined in s. 415.102.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
11/05/2019	.	
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The Committee on Health Policy (Harrell) recommended the following:

Senate Amendment (with directory and title amendments)

Delete lines 381 - 554
and insert:
(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident~~, by electronic mail, facsimile, or United States mail,~~ a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the

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result ~~status~~ of the facility's investigation of the incident.

(4) Licensed facilities shall provide within 15 days~~, by electronic mail, facsimile, or United States mail,~~ a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.

(5) The agency shall send, by electronic mail, reminders to the facility's administrator and other specified facility contacts 3 business days before the deadline for the submission of the full report. If the facility determines that the event is not an adverse incident, the facility must withdraw the preliminary report. Until 3 business days after the agency provides the reminder, facilities shall not be subject to any administrative or other action for failing to file a full report if the facility determined that the event was not an adverse incident after filing the preliminary report. ~~Each facility shall report monthly to the agency any liability claim filed against it. The report must include the name of the resident, the dates of the incident leading to the claim, if applicable, and the type of injury or violation of rights alleged to have occurred. This report is not discoverable in any civil or administrative action, except in such actions brought by the agency to enforce the provisions of this part.~~

(9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board.

Section 6. Subsection (4) of section 429.255, Florida

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Statutes, is amended to read:

429.255 Use of personnel; emergency care.—

(4) Facility staff may withhold or withdraw cardiopulmonary resuscitation or the use of an automated external defibrillator if presented with an order not to resuscitate executed pursuant to s. 401.45. The agency shall adopt rules providing for the implementation of such orders. Facility staff and facilities may not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator pursuant to such an order and rules adopted by the agency. The absence of an order not to resuscitate executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator as otherwise permitted by law.

Section 7. Subsection (2), paragraph (b) of subsection (3), and paragraphs (e), (f), and (g) of subsection (4) of section 429.256, Florida Statutes, are amended to read:

429.256 Assistance with self-administration of medication.—

(2) Residents who are capable of self-administering their own medications without assistance shall be encouraged and allowed to do so. However, an unlicensed person may, consistent with a dispensed prescription’s label or the package directions of an over-the-counter medication, assist a resident whose condition is medically stable with the self-administration of routine, regularly scheduled medications that are intended to be self-administered. Assistance with self-medication by an unlicensed person may occur only upon a documented request by,

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and the written informed consent of, a resident or the resident's surrogate, guardian, or attorney in fact. For the purposes of this section, self-administered medications include both legend and over-the-counter oral dosage forms, topical dosage forms, transdermal patches, and topical ophthalmic, otic, and nasal dosage forms including solutions, suspensions, sprays, and inhalers.

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

(b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and purpose ~~reading the label~~, opening the container, removing a prescribed amount of medication from the container, and closing the container.

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

(e) The use of irrigations or debriding agents used in the treatment of a skin condition.

(f) Assisting with rectal, urethral, or vaginal preparations.

(g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and ~~at~~ the ~~request of a competent~~ resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication.

Section 8. Section 429.26, Florida Statutes, is amended to read:

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429.26 Appropriateness of placements; examinations of residents.—

(1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must ~~shall~~ be based upon an evaluation ~~assessment~~ of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility:

(a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party.

(b) A facility may admit or retain a resident who requires the use of assistive devices.

(c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and

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unscheduled needs of the resident.

(d)1. Except for a resident who is admitted to hospice as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to:

a. Move, turn, or reposition without total physical assistance;

b. Transfer to a chair or wheelchair without total physical assistance; or

c. Sit safely in a chair or wheelchair without personal assistance or a physical restraint.

2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days.

3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days.

(2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.

(3) ~~(2)~~ A physician, physician assistant, or advanced

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practice registered nurse ~~practitioner~~ who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests ~~interest~~ in the facility.

(4)~~(3)~~ Persons licensed under part I of chapter 464 who are employed by or under contract with a facility shall, on a routine basis or at least monthly, perform a nursing assessment of the residents for whom they are providing nursing services ordered by a physician, except administration of medication, and shall document such assessment, including any substantial changes in a resident's status which may necessitate relocation to a nursing home, hospital, or specialized health care facility. Such records shall be maintained in the facility for inspection by the agency and shall be forwarded to the resident's case manager, if applicable.

(5)~~(4)~~ ~~If possible,~~ Each resident must ~~shall~~ have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse ~~practitioner~~ within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The ~~signed and completed~~ medical examination form, signed by the practitioner, must ~~report shall~~ be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or ~~and~~ continued residency ~~stay~~ in the facility. The medical examination form will only be used to record the health care

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provider's direct observation of the patient at the time of examination and shall include any known medical history. The medical examination form is not a guarantee of admission, continued residency, or services to be delivered and must only be used as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical

====== D I R E C T O R Y C L A U S E A M E N D M E N T ======
And the directory clause is amended as follows:

Delete lines 352 - 356

and insert:

Section 5. Subsections (2) through (5) and (9) of section 429.23, Florida Statutes, are amended to read:

================ T I T L E A M E N D M E N T ================
And the title is amended as follows:

Delete lines 16 - 39

and insert:

F.S.; removing restrictions on the method by which a facility may send a report to the Agency for Health Care Administration; requiring the agency to send a reminder to the facility 3 business days prior to the deadline for submission of the full report; removing a requirement that each facility file reports of liability claims; amending s. 429.255, F.S.; clarifying that the absence of an order not to resuscitate does not preclude a physician from withholding or withdrawing cardiopulmonary

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resuscitation or use of an automated external defibrillator; amending s. 429.256, F.S.; requiring a person assisting with a resident's self-administration of medication to confirm that the medication is intended for that resident and to orally advise the resident of the medication name and purpose; amending s. 429.26, F.S.; including medical examinations within criteria used for admission to an assisted living facility; providing specified criteria for determination of appropriateness for admission and continued residency at an assisted living facility; defining the term "bedridden"; requiring that a resident receive a medical examination within a specified timeframe after admission to a facility; requiring that such examination be recorded on a specified form; providing minimum requirements for such form; providing limitations on the use of such form; revising provisions relating to the

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
11/05/2019	.	
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The Committee on Health Policy (Harrell) recommended the following:

Senate Amendment (with title amendment)

Delete lines 645 - 889

and insert:

the condition. If there is no resident representative or designee, or he or she cannot be located or is unresponsive, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition.

(9) ~~(8)~~ The Department of Children and Families may require

an examination for supplemental security income and optional state supplementation recipients residing in facilities at any time and shall provide the examination whenever a resident's condition requires it. Any facility administrator; personnel of the agency, the department, or the Department of Children and Families; or a representative of the State Long-Term Care Ombudsman Program who believes a resident needs to be evaluated shall notify the resident's case manager, who shall take appropriate action. A report of the examination findings must ~~shall~~ be provided to the resident's case manager and the facility administrator to help the administrator meet his or her responsibilities under subsection (1).

~~(9) A terminally ill resident who no longer meets the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met.~~

(10) Facilities licensed to provide extended congregate care services shall promote aging in place by determining appropriateness of continued residency based on a comprehensive review of the resident's physical and functional status; the ability of the facility, family members, friends, or any other pertinent individuals or agencies to provide the care and services required; and documentation that a written service plan consistent with facility policy has been developed and implemented to ensure that the resident's needs and preferences are addressed.

~~(11) No resident who requires 24-hour nursing supervision,~~

~~except for a resident who is an enrolled hospice patient pursuant to part IV of chapter 400, shall be retained in a facility licensed under this part.~~

Section 9. Paragraphs (a) and (k) of subsection (1) and subsection (3) of section 429.28, Florida Statutes, are amended to read:

429.28 Resident bill of rights.—

(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:

(a) Live in a safe and decent living environment, free from abuse, ~~and~~ neglect, and exploitation.

(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally incapacitated, the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must ~~shall~~ be set forth in writing and provided to the resident or the resident's legal representative. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.

(3)(a) The agency shall conduct a survey to determine

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whether the facility is complying with this section ~~general compliance with facility standards and compliance with residents' rights~~ as a prerequisite to initial licensure or licensure renewal. ~~The agency shall adopt rules for uniform standards and criteria that will be used to determine compliance with facility standards and compliance with residents' rights.~~

(b) In order to determine whether the facility is adequately protecting residents' rights, the licensure renewal ~~biennial~~ survey must ~~shall~~ include private informal conversations with a sample of residents and consultation with the ombudsman council in the district in which the facility is located to discuss residents' experiences within the facility.

Section 10. Section 429.41, Florida Statutes, is amended to read:

429.41 Rules establishing standards.—

(1) It is the intent of the Legislature that rules published and enforced pursuant to this section shall include criteria by which a reasonable and consistent quality of resident care and quality of life may be ensured and the results of such resident care may be demonstrated. Such rules shall also promote ~~ensure~~ a safe and sanitary environment that is residential and noninstitutional in design or nature and may allow for technological advances in the provision of care, safety, and security, including the use of devices, equipment, and other security measures related to wander management, emergency response, staff risk management, and the general safety and security of residents, staff, and the facility. It is further intended that reasonable efforts be made to accommodate the needs and preferences of residents to enhance the quality of

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life in a facility. ~~Uniform firesafety standards for assisted living facilities shall be established by the State Fire Marshal pursuant to s. 633.206. The agency may adopt rules to administer part II of chapter 408. In order to provide safe and sanitary facilities and the highest quality of resident care accommodating the needs and preferences of residents,~~ The agency, in consultation with the Department of Children and Families and the Department of Health, shall adopt rules~~,~~ ~~policies, and procedures~~ to administer this part, which must include reasonable and fair minimum standards in relation to:

(a) The requirements for ~~and~~ maintenance and the sanitary condition of facilities, not in conflict with, or duplicative of, rules adopted pursuant to s. 381.006(16) and s. 381.0072 and standards established under chapter 553 and s. 633.206, relating to a safe and decent living environment, including furnishings for resident bedrooms or sleeping areas, locking devices, linens ~~plumbing, heating, cooling, lighting, ventilation, living space~~, and other housing conditions relating to hazards, which will promote ~~ensure~~ the health, safety, and welfare ~~comfort~~ of residents suitable to the size of the structure. The rules must clearly delineate the respective responsibilities of the agency's licensure and survey staff and the county health departments and ensure that inspections are not duplicative. The agency may collect fees for food service inspections conducted by county health departments and may transfer such fees to the Department of Health.

~~1. Firesafety evacuation capability determination.—An evacuation capability evaluation for initial licensure shall be conducted within 6 months after the date of licensure.~~

~~2. Firesafety requirements.—~~

~~a. The National Fire Protection Association, Life Safety Code, NFPA 101 and 101A, current editions, shall be used in determining the uniform firesafety code adopted by the State Fire Marshal for assisted living facilities, pursuant to s. 633.206.~~

~~b. A local government or a utility may charge fees only in an amount not to exceed the actual expenses incurred by the local government or the utility relating to the installation and maintenance of an automatic fire sprinkler system in a licensed assisted living facility structure.~~

~~c. All licensed facilities must have an annual fire inspection conducted by the local fire marshal or authority having jurisdiction.~~

~~d. An assisted living facility that is issued a building permit or certificate of occupancy before July 1, 2016, may at its option and after notifying the authority having jurisdiction, remain under the provisions of the 1994 and 1995 editions of the National Fire Protection Association, Life Safety Code, NFPA 101, and NFPA 101A. The facility opting to remain under such provisions may make repairs, modernizations, renovations, or additions to, or rehabilitate, the facility in compliance with NFPA 101, 1994 edition, and may utilize the alternative approaches to life safety in compliance with NFPA 101A, 1995 edition. However, a facility for which a building permit or certificate of occupancy is issued before July 1, 2016, that undergoes Level III building alteration or rehabilitation, as defined in the Florida Building Code, or seeks to utilize features not authorized under the 1994 or 1995~~

~~editions of the Life Safety Code must thereafter comply with all aspects of the uniform firesafety standards established under s. 633.206, and the Florida Fire Prevention Code, in effect for assisted living facilities as adopted by the State Fire Marshal.~~

~~3. Resident elopement requirements.—Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills, which shall include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the drills are conducted in a manner consistent with the facility's resident elopement policies and procedures.~~

(b) The preparation and annual update of a comprehensive emergency management plan. Such standards must be included in the rules adopted by the agency after consultation with the Division of Emergency Management. At a minimum, the rules must provide for plan components that address emergency evacuation transportation; adequate sheltering arrangements; postdisaster activities, including provision of emergency power, food, and water; postdisaster transportation; supplies; staffing; emergency equipment; individual identification of residents and transfer of records; communication with families; and responses to family inquiries. The comprehensive emergency management plan is subject to review and approval by the county ~~local~~ emergency management agency. During its review, the county ~~local~~ emergency management agency shall ensure that the following agencies, at a minimum, are given the opportunity to review the plan: the Department of Health, the Agency for Health Care Administration, and the Division of Emergency Management. ~~Also, appropriate~~


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~~volunteer organizations must be given the opportunity to review the plan.~~ The county ~~local~~ emergency management agency shall complete its review within 60 days and either approve the plan or advise the facility of necessary revisions. A facility must submit a comprehensive emergency management plan to the county emergency management agency within 30 days after issuance of a license.

(c) The number, training, and qualifications of all personnel having responsibility for the care of residents. The rules must require adequate staff to provide for the safety of all residents. Facilities licensed for 17 or more residents are required to maintain an alert staff for 24 hours per day.

~~(d) All sanitary conditions within the facility and its surroundings which will ensure the health and comfort of residents. The rules must clearly delineate the responsibilities of the agency's licensure and survey staff, the county health departments, and the local authority having jurisdiction over firesafety and ensure that inspections are not duplicative. The agency may collect fees for food service inspections conducted by the county health departments and transfer such fees to the Department of Health.~~

(d) ~~(e)~~ License application and license renewal, transfer of ownership, proper management of resident funds and personal property, surety bonds, resident contracts, refund policies, financial ability to operate, and facility and staff records.

(e) ~~(f)~~ Inspections, complaint investigations, moratoriums, classification of deficiencies, ~~levying~~ and enforcement of penalties~~, and use of income from fees and fines~~.

(f) ~~(g)~~ The enforcement of the resident bill of rights

specified in s. 429.28.

(g) ~~(h)~~ The care ~~and maintenance~~ of residents provided by the facility, which must include~~, but is not limited to~~:

1. The supervision of residents;

2. The provision of personal services;

3. The provision of, or arrangement for, social and leisure activities;

4. The assistance in making arrangements ~~arrangement~~ for appointments and transportation to appropriate medical, dental, nursing, or mental health services, as needed by residents;

5. The management of medication stored within the facility and as needed by residents;

6. The dietary ~~nutritional~~ needs of residents;

7. Resident records; and

8. Internal risk management and quality assurance.

(h) ~~(i)~~ Facilities holding a limited nursing, extended congregate care, or limited mental health license.

(i) ~~(j)~~ The establishment of specific criteria to define appropriateness of resident admission and continued residency in a facility holding a standard, limited nursing, extended congregate care, and limited mental health license.

(j) ~~(k)~~ The use of physical or chemical restraints. The use of geriatric chairs or Posey restraints is prohibited. Other physical restraints may be used in accordance with agency rules when ordered ~~is limited to half-bed rails as prescribed and documented~~ by the resident's physician and consented to by ~~with the consent of~~ the resident or, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact. Such rules must specify

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requirements for care planning, staff monitoring, and periodic review by a physician. The use of chemical restraints is limited to prescribed dosages of medications authorized by the resident's physician and must be consistent with the resident's diagnosis. Residents who are receiving medications that can serve as chemical restraints must be evaluated by their physician at least annually to assess:

1. The continued need for the medication.

2. The level of the medication in the resident's blood.

3. The need for adjustments in the prescription.

(k) ~~(l)~~ The establishment of specific resident elopement drill requirements, policies, and procedures ~~on resident~~

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

And the title is amended as follows:

Delete line 45

and insert:

circumstances; requiring the facility to arrange for necessary care and services if no resident representative or designee is available or responsive; removing provisions relating to the


255278

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
11/05/2019	.	
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	.	
	.	

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

Senate Amendment

Delete line 1068
and insert:
429.256 must complete a minimum of 6 additional hours of

By Senator Harrell

25-00440A-20 2020402__

A bill to be entitled

An act relating to assisted living facilities; amending s. 429.02, F.S.; defining and redefining terms; amending s. 429.07, F.S.; clarifying that an assisted living facility licensed to provide extended congregate care services or limited nursing services must maintain a written progress report on each person receiving services from the facility's staff; conforming a cross-reference; amending s. 429.11, F.S.; prohibiting a county or municipality from issuing a business tax receipt, rather than an occupational license, to a facility under certain circumstances; amending s. 429.176, F.S.; amending educational requirements for an administrator who is replacing another administrator; amending s. 429.23, F.S.; requiring a facility to initiate an investigation of an adverse incident within 24 hours and provide a report of such investigation to the Agency for Health Care Administration within 15 days; amending s. 429.255, F.S.; clarifying that the absence of an order not to resuscitate does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator; amending s. 429.256, F.S.; requiring a person assisting with a resident's self-administration of medication to confirm that the medication is intended for that resident and to orally advise the resident of the medication name and purpose; amending s. 429.26, F.S.; including medical

25-00440A-20 2020402__

examinations within criteria used for admission to an assisted living facility; providing specified criteria for determination of appropriateness for admission and continued residency at an assisted living facility; defining the term "bedridden"; requiring that a resident receive a medical examination within a specified timeframe after admission to a facility; requiring that such examination be recorded on a specified form; providing minimum requirements for such form; revising provisions relating to the placement of residents by the Department of Children and Families; requiring a facility to notify a resident's representative or designee of the need for health care services and to assist in making appointments for such care and services under certain circumstances; removing provisions relating to the retention of certain residents in a facility; amending s. 429.28, F.S.; revising residents' rights relating to a safe and secure living environment; amending s. 429.41, F.S.; revising legislative intent; removing a provision to conform to changes made by the act; removing a redundant provision authorizing the Agency for Health Care Administration to adopt certain rules; removing provisions relating to firesafety requirements, which are relocated to another section; requiring county emergency management agencies, rather than local emergency management agencies, to review and approve or disapprove of a facility's comprehensive emergency management plan; requiring a

facility to submit a comprehensive emergency management plan to the county emergency management agency within a specified timeframe after its licensure; revising the criteria under which a facility must be fully inspected; revising standards for the care of residents provided by a facility; prohibiting the use of geriatric chairs and Posey restraints in facilities; authorizing other physical restraints to be used under certain conditions and in accordance with certain rules; requiring the agency to establish resident elopement drill requirements; requiring that elopement drills include a review of a facility's procedures to address elopement; revising the criteria under which a facility must be fully inspected; revising provisions requiring the agency to adopt by rule key quality-of-care standards; creating s. 429.435, F.S.; revising uniform firesafety standards for assisted living facilities, which are relocated to this section; amending s. 429.52, F.S.; revising provisions relating to facility staff training and educational requirements; requiring the agency, in conjunction with providers, to establish core training requirements for facility administrators; revising the training and continuing education requirements for facility staff who assist residents with the self-administration of medications; revising provisions relating to the training responsibilities of the agency; requiring the agency to contract with another entity to administer a

certain competency test; requiring the department to adopt a curriculum outline to be used by core trainers; providing an effective date.

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

Section 1. Present subsections (1) through (5), (6) through (10), (11) through (15), and (16) through (27) of section 429.02, Florida Statutes, are redesignated as subsections (2) through (6), (8) through (12), (14) through (18), and (20) through (31), respectively, new subsections (1), (7), (13), and (19) are added, and present subsections (11) and (18) of that section are amended, to read:

429.02 Definitions.—When used in this part, the term:

(1) "Abuse" has the same meaning as in s. 415.102.

(7) "Assistive device" means any device designed or adapted to help a resident perform an action, a task, an activity of daily living, or a transfer; prevent a fall; or recover from a fall. The term does not include a total body lift or a motorized sit-to-stand lift, with the exception of a chair lift or recliner lift that a resident is able to operate independently.

(13) "Exploitation" has the same meaning as in s. 415.102.

(14)~~(11)~~ "Extended congregate care" means acts beyond those authorized in subsection (21) which ~~(17) that~~ may be performed pursuant to part I of chapter 464 by persons licensed thereunder while carrying out their professional duties, and other supportive services that ~~which~~ may be specified by rule. The purpose of such services is to enable residents to age in place in a residential environment despite mental or physical

limitations that might otherwise disqualify them from residency in a facility licensed under this part.

(19) "Neglect" has the same meaning as in s. 415.102.

(22)~~(18)~~ "Physical restraint" means a device that ~~which~~ physically limits, restricts, or deprives an individual of movement or mobility, including~~, but not limited to, a half-bed rail, a full-bed rail, a geriatric chair, and a posey restraint. The term "physical restraint" shall also include~~ any device that is ~~which was~~ not specifically manufactured as a restraint but is ~~which has been~~ altered, arranged, or otherwise used for that ~~this~~ purpose. The term does ~~shall~~ not include any device that the resident chooses to use and is able to remove or avoid independently, or any bandage material used for the purpose of binding a wound or injury.

Section 2. 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, directly or through contract, 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 he or she 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 designation may be made at the time of initial licensure or 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 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 for not meeting 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. The licensee shall notify the agency, in writing, when it has admitted at least one extended congregate care resident, after which an unannounced inspection shall be made to determine compliance with the requirements of an extended congregate care license. A licensee with a provisional extended congregate care license which ~~that~~ demonstrates compliance with all 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 facility 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. A facility that is licensed to provide extended congregate care services shall maintain a written progress report on each person who receives services from the facility's staff 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 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;

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.

4. 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. 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.

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(5) ~~s. 429.26(4)~~ and the facility must develop a preliminary service plan for the individual.

7. If 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 make arrangements for relocating the person in accordance with s. 429.28(1)(k).

(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 designation may be made at the time of initial licensure or licensure renewal, 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 to provide limited nursing services must 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 that is licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services from the facility's staff. The report must describe 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 at least annually 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 3. Subsection (7) of section 429.11, Florida Statutes, is amended to read:

429.11 Initial application for license; provisional license.—

(7) A county or municipality may not issue a business tax receipt ~~an occupational license~~ that is being obtained for the purpose of operating a facility regulated under this part without first ascertaining that the applicant has been licensed to operate such facility at the specified location or locations by the agency. The agency shall furnish to local agencies responsible for issuing business tax receipts ~~occupational licenses~~ sufficient instruction for making such determinations.

Section 4. Section 429.176, Florida Statutes, is amended to read:

429.176 Notice of change of administrator.—If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s.

429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements.

Section 5. Present subsections (6) through (10) of section 429.23, Florida Statutes, are redesignated as subsections (4) through (8), respectively, and subsections (2) and (3) and present subsections (4), (5), and (9) of that section are amended, to read:

429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.—

(2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term~~,~~ "adverse incident" means:

(a) An event over which facility personnel could exercise control which is associated with the facility's intervention, rather than as a result of the resident's underlying disease or condition, and the injury results in:

1. Death;

2. Brain or spinal damage;

3. Permanent disfigurement;

4. Fracture or dislocation of bones or joints;

5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives;

6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or

7. A report made ~~An event that is reported~~ to law

enforcement or its personnel for investigation; or

(b) Resident elopement, if the elopement places the resident at risk of harm or injury.

(3) Licensed facilities shall initiate an investigation within 24 hours ~~provide within 1 business day~~ after the occurrence of an adverse incident~~, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section~~. The facility must complete the investigation and submit a report to the agency within 15 days after the occurrence of the adverse incident. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the result ~~status~~ of the facility's investigation of the incident.

~~(4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.~~

~~(5) Each facility shall report monthly to the agency any liability claim filed against it. The report must include the name of the resident, the dates of the incident leading to the claim, if applicable, and the type of injury or violation of rights alleged to have occurred. This report is not discoverable in any civil or administrative action, except in such actions brought by the agency to enforce the provisions of this part.~~

(7)~~(9)~~ The adverse incident reports ~~and preliminary adverse incident reports~~ required under this section are confidential as provided by law and are not discoverable or admissible in any

civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board.

Section 6. Subsection (4) of section 429.255, Florida Statutes, is amended to read:

429.255 Use of personnel; emergency care.—

(4) Facility staff may withhold or withdraw cardiopulmonary resuscitation or the use of an automated external defibrillator if presented with an order not to resuscitate executed pursuant to s. 401.45. The agency shall adopt rules providing for the implementation of such orders. Facility staff and facilities may not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator pursuant to such an order and rules adopted by the agency. The absence of an order not to resuscitate executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator as otherwise permitted by law.

Section 7. Subsection (2), paragraph (b) of subsection (3), and paragraphs (e), (f), and (g) of subsection (4) of section 429.256, Florida Statutes, are amended to read:

429.256 Assistance with self-administration of medication.—

(2) Residents who are capable of self-administering their own medications without assistance shall be encouraged and allowed to do so. However, an unlicensed person may, consistent with a dispensed prescription's label or the package directions of an over-the-counter medication, assist a resident whose condition is medically stable with the self-administration of

routine, regularly scheduled medications that are intended to be self-administered. Assistance with self-medication by an unlicensed person may occur only upon a documented request by, and the written informed consent of, a resident or the resident's surrogate, guardian, or attorney in fact. For the purposes of this section, self-administered medications include both legend and over-the-counter oral dosage forms, topical dosage forms, transdermal patches, and topical ophthalmic, otic, and nasal dosage forms including solutions, suspensions, sprays, and inhalers.

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

(b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and purpose ~~reading the label~~, opening the container, removing a prescribed amount of medication from the container, and closing the container.

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

(e) The use of irrigations or debriding agents used in the treatment of a skin condition.

(f) Assisting with rectal, urethral, or vaginal preparations.

(g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and ~~at~~ the ~~request of a competent~~ resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the

medication.

Section 8. Section 429.26, Florida Statutes, is amended to read:

429.26 Appropriateness of placements; examinations of residents.—

(1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must ~~shall~~ be based upon an evaluation ~~assessment~~ of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility:

(a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party.

(b) A facility may admit or retain a resident who requires the use of assistive devices.

(c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who

agrees that the physical needs of the resident can be met at the facility. A facility may not retain a resident who requires 24-hour nursing supervision, except for a resident who is enrolled in hospice services pursuant to part IV of chapter 400. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident.

(d)1. Except as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to:

a. Move, turn, or reposition without total physical assistance;

b. Transfer to a chair or wheelchair without total physical assistance; or

c. Sit safely in a chair or wheelchair without personal assistance or a physical restraint.

2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days.

3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days.

(2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed

by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.

(3) ~~(2)~~ A physician, physician assistant, or advanced practice registered nurse ~~practitioner~~ who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests ~~interest~~ in the facility.

(4) ~~(3)~~ Persons licensed under part I of chapter 464 who are employed by or under contract with a facility shall, on a routine basis or at least monthly, perform a nursing assessment of the residents for whom they are providing nursing services ordered by a physician, except administration of medication, and shall document such assessment, including any substantial changes in a resident's status which may necessitate relocation to a nursing home, hospital, or specialized health care facility. Such records shall be maintained in the facility for inspection by the agency and shall be forwarded to the resident's case manager, if applicable.

(5) ~~(4)~~ ~~If possible,~~ Each resident must ~~shall~~ have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse ~~practitioner~~ within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The ~~signed and completed~~ medical examination form, signed by the practitioner, must ~~report shall~~ be submitted to the owner or administrator of the facility, who

shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or ~~and~~ continued stay in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes ~~report shall become~~ a permanent part of the facility's record of the resident ~~at the facility~~ and must ~~shall~~ be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6.

(6) The medical examination form submitted under subsection (5) must include the following information relating to the resident:

(a) Height, weight, and known allergies.

(b) Significant medical history and diagnoses.

(c) Physical or sensory limitations, including the need for fall precautions or recommended use of assistive devices.

(d) Cognitive or behavioral status and a brief description of any behavioral issues known or ascertained by the examining practitioner, including any known history of wandering or elopement.

(e) Nursing, treatment, or therapy service requirements.

(f) Whether assistance is needed for ambulating, eating, or transferring.

(g) Special dietary instructions.

(h) Whether he or she has any communicable diseases, including necessary precautions.

(i) Whether he or she is bedridden and the status of any pressure sores that he or she has.

(j) Whether the resident needs 24-hour nursing supervision or psychiatric care.

(k) A list of current prescribed medications as known or ascertained by the examining practitioner and whether the resident can self-administer medications, needs assistance, or needs medication administration.

~~(5) Except as provided in s. 429.07, if a medical examination has not been completed within 60 days before the admission of the resident to the facility, a licensed physician, licensed physician assistant, or licensed nurse practitioner shall examine the resident and complete a medical examination form provided by the agency within 30 days following the admission to the facility to enable the facility owner or administrator to determine the appropriateness of the admission. The medical examination form shall become a permanent part of the record of the resident at the facility and shall be made available to the agency during inspection by the agency or upon request.~~

(7) ~~(6)~~ Any resident accepted in a facility and placed by ~~the department or~~ the Department of Children and Families must ~~shall~~ have been examined by medical personnel within 30 days before placement in the facility. The examination must ~~shall~~ include an assessment of the appropriateness of placement in a facility. The findings of this examination must ~~shall~~ be recorded on the examination form provided by the agency. The completed form must ~~shall~~ accompany the resident and ~~shall~~ be submitted to the facility owner or administrator. Additionally,

in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual 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 in 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 provided that ~~providing~~ it was completed within 90 days prior to admission to the facility. The ~~applicable~~ Department of Children and Families shall provide to the facility administrator any information about the resident which ~~that~~ would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The ~~applicable~~ Department of Children and Families shall advise and assist the facility administrator when ~~where~~ the special needs of residents who are recipients of optional state supplementation require such assistance.

(8) ~~(7)~~ The facility shall ~~must~~ notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. The notification

must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making appointments for ~~shall arrange, with the appropriate health care provider,~~ the necessary care and services to treat the condition.

(9)~~(8)~~ The Department of Children and Families may require an examination for supplemental security income and optional state supplementation recipients residing in facilities at any time and shall provide the examination whenever a resident's condition requires it. Any facility administrator; personnel of the agency, the department, or the Department of Children and Families; or a representative of the State Long-Term Care Ombudsman Program who believes a resident needs to be evaluated shall notify the resident's case manager, who shall take appropriate action. A report of the examination findings must ~~shall~~ be provided to the resident's case manager and the facility administrator to help the administrator meet his or her responsibilities under subsection (1).

~~(9) A terminally ill resident who no longer meets the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met.~~

(10) Facilities licensed to provide extended congregate care services shall promote aging in place by determining appropriateness of continued residency based on a comprehensive

review of the resident's physical and functional status; the ability of the facility, family members, friends, or any other pertinent individuals or agencies to provide the care and services required; and documentation that a written service plan consistent with facility policy has been developed and implemented to ensure that the resident's needs and preferences are addressed.

~~(11) No resident who requires 24-hour nursing supervision, except for a resident who is an enrolled hospice patient pursuant to part IV of chapter 400, shall be retained in a facility licensed under this part.~~

Section 9. Paragraphs (a) and (k) of subsection (1) and subsection (3) of section 429.28, Florida Statutes, are amended to read:

429.28 Resident bill of rights.—

(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:

(a) Live in a safe and decent living environment, free from abuse, ~~and~~ neglect, and exploitation.

(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally incapacitated, the guardian shall

be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must ~~shall~~ be set forth in writing and provided to the resident or the resident's legal representative. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.

(3)(a) The agency shall conduct a survey to determine whether the facility is complying with this section ~~general compliance with facility standards and compliance with residents' rights~~ as a prerequisite to initial licensure or licensure renewal. ~~The agency shall adopt rules for uniform standards and criteria that will be used to determine compliance with facility standards and compliance with residents' rights.~~

(b) In order to determine whether the facility is adequately protecting residents' rights, the licensure renewal ~~biennial~~ survey must ~~shall~~ include private informal conversations with a sample of residents and consultation with the ombudsman council in the district in which the facility is located to discuss residents' experiences within the facility.

Section 10. Section 429.41, Florida Statutes, is amended to read:

429.41 Rules establishing standards.—

(1) It is the intent of the Legislature that rules published and enforced pursuant to this section shall include criteria by which a reasonable and consistent quality of resident care and quality of life may be ensured and the results of such resident care may be demonstrated. Such rules shall also promote ~~ensure~~ a safe and sanitary environment that is

residential and noninstitutional in design or nature and may allow for technological advances in the provision of care, safety, and security, including the use of devices, equipment, and other security measures related to wander management, emergency response, staff risk management, and the general safety and security of residents, staff, and the facility. It is further intended that reasonable efforts be made to accommodate the needs and preferences of residents to enhance the quality of life in a facility. ~~Uniform firesafety standards for assisted living facilities shall be established by the State Fire Marshal pursuant to s. 633.206. The agency may adopt rules to administer part II of chapter 408. In order to provide safe and sanitary facilities and the highest quality of resident care accommodating the needs and preferences of residents,~~ The agency, in consultation with the Department of Children and Families and the Department of Health, shall adopt rules~~,~~ ~~policies, and procedures~~ to administer this part, which must include reasonable and fair minimum standards in relation to:

(a) The requirements for ~~and~~ maintenance and the sanitary condition of facilities, not in conflict with, or duplicative of, the requirements in chapter 553, chapter 381, or s. 633.206, relating to a safe and decent living environment, including furnishings for resident bedrooms or sleeping areas, locking devices, linens ~~plumbing, heating, cooling, lighting, ventilation, living space~~, and other housing conditions relating to hazards, which will promote ~~ensure~~ the health, safety, and welfare ~~comfort~~ of residents suitable to the size of the structure. The rules must clearly delineate the respective responsibilities of the agency's licensure and survey staff and

the county health departments and ensure that inspections are not duplicative. The agency may collect fees for food service inspections conducted by county health departments and may transfer such fees to the Department of Health.

~~1. Firesafety evacuation capability determination. An evacuation capability evaluation for initial licensure shall be conducted within 6 months after the date of licensure.~~

~~2. Firesafety requirements.—~~

~~a. The National Fire Protection Association, Life Safety Code, NFPA 101 and 101A, current editions, shall be used in determining the uniform firesafety code adopted by the State Fire Marshal for assisted living facilities, pursuant to s. 633.206.~~

~~b. A local government or a utility may charge fees only in an amount not to exceed the actual expenses incurred by the local government or the utility relating to the installation and maintenance of an automatic fire sprinkler system in a licensed assisted living facility structure.~~

~~c. All licensed facilities must have an annual fire inspection conducted by the local fire marshal or authority having jurisdiction.~~

~~d. An assisted living facility that is issued a building permit or certificate of occupancy before July 1, 2016, may at its option and after notifying the authority having jurisdiction, remain under the provisions of the 1994 and 1995 editions of the National Fire Protection Association, Life Safety Code, NFPA 101, and NFPA 101A. The facility opting to remain under such provisions may make repairs, modernizations, renovations, or additions to, or rehabilitate, the facility in~~

~~compliance with NFPA 101, 1994 edition, and may utilize the alternative approaches to life safety in compliance with NFPA 101A, 1995 edition. However, a facility for which a building permit or certificate of occupancy is issued before July 1, 2016, that undergoes Level III building alteration or rehabilitation, as defined in the Florida Building Code, or seeks to utilize features not authorized under the 1994 or 1995 editions of the Life Safety Code must thereafter comply with all aspects of the uniform firesafety standards established under s. 633.206, and the Florida Fire Prevention Code, in effect for assisted living facilities as adopted by the State Fire Marshal.~~

~~3. Resident elopement requirements. Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills, which shall include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the drills are conducted in a manner consistent with the facility's resident elopement policies and procedures.~~

(b) The preparation and annual update of a comprehensive emergency management plan. Such standards must be included in the rules adopted by the agency after consultation with the Division of Emergency Management. At a minimum, the rules must provide for plan components that address emergency evacuation transportation; adequate sheltering arrangements; postdisaster activities, including provision of emergency power, food, and water; postdisaster transportation; supplies; staffing; emergency equipment; individual identification of residents and transfer of records; communication with families; and responses

to family inquiries. The comprehensive emergency management plan is subject to review and approval by the county ~~local~~ emergency management agency. During its review, the county ~~local~~ emergency management agency shall ensure that the following agencies, at a minimum, are given the opportunity to review the plan: the Department of Health, the Agency for Health Care Administration, and the Division of Emergency Management. ~~Also, appropriate volunteer organizations must be given the opportunity to review the plan.~~ The county ~~local~~ emergency management agency shall complete its review within 60 days and either approve the plan or advise the facility of necessary revisions. A facility must submit a comprehensive emergency management plan to the county emergency management agency within 30 days after issuance of a license.

(c) The number, training, and qualifications of all personnel having responsibility for the care of residents. The rules must require adequate staff to provide for the safety of all residents. Facilities licensed for 17 or more residents are required to maintain an alert staff for 24 hours per day.

~~(d) All sanitary conditions within the facility and its surroundings which will ensure the health and comfort of residents. The rules must clearly delineate the responsibilities of the agency's licensure and survey staff, the county health departments, and the local authority having jurisdiction over firesafety and ensure that inspections are not duplicative. The agency may collect fees for food service inspections conducted by the county health departments and transfer such fees to the Department of Health.~~

(d) ~~(c)~~ License application and license renewal, transfer of

ownership, proper management of resident funds and personal property, surety bonds, resident contracts, refund policies, financial ability to operate, and facility and staff records.

(e) ~~(f)~~ Inspections, complaint investigations, moratoriums, classification of deficiencies, ~~levying~~ and enforcement of penalties~~, and use of income from fees and fines~~.

(f) ~~(g)~~ The enforcement of the resident bill of rights specified in s. 429.28.

(g) ~~(h)~~ The care ~~and maintenance~~ of residents provided by the facility, which must include~~, but is not limited to~~:

1. The supervision of residents;

2. The provision of personal services;

3. The provision of, or arrangement for, social and leisure activities;

4. The assistance in making arrangements ~~arrangement~~ for appointments and transportation to appropriate medical, dental, nursing, or mental health services, as needed by residents;

5. The management of medication stored within the facility and as needed by residents;

6. The dietary ~~nutritional~~ needs of residents;

7. Resident records; ~~and~~

8. Internal risk management and quality assurance.

(h) ~~(i)~~ Facilities holding a limited nursing, extended congregate care, or limited mental health license.

(i) ~~(j)~~ The establishment of specific criteria to define appropriateness of resident admission and continued residency in a facility holding a standard, limited nursing, extended congregate care, and limited mental health license.

(j) ~~(k)~~ The use of physical or chemical restraints. The use

of geriatric chairs or Posey restraints is prohibited. Other physical restraints may be used in accordance with agency rules when ordered ~~is limited to half-bed rails as prescribed and documented~~ by the resident's physician and consented to by ~~with the consent of~~ the resident or, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact. Such rules must specify requirements for care planning, staff monitoring, and periodic review by a physician. The use of chemical restraints is limited to prescribed dosages of medications authorized by the resident's physician and must be consistent with the resident's diagnosis. Residents who are receiving medications that can serve as chemical restraints must be evaluated by their physician at least annually to assess:

1. The continued need for the medication.

2. The level of the medication in the resident's blood.

3. The need for adjustments in the prescription.

(k) ~~(l)~~ The establishment of specific resident elopement drill requirements ~~policies and procedures on resident elopement~~. Facilities shall conduct a minimum of two resident elopement drills each year. All administrators and direct care staff shall participate in the drills, which must include a review of the facility's procedures to address resident elopement. Facilities shall document participation in the drills.

(2) In adopting any rules pursuant to this part, 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 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 licenses a building or part of a building designated for independent living for assisted living, staffing requirements established in rule apply only to residents who receive personal, limited nursing, 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 agency 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 be appropriate for a noninstitutional residential environment; however, the structure may not be 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 agency may make other distinctions among types of facilities as necessary to enforce this part. Where appropriate, the agency shall offer alternate solutions for complying with established standards, based on distinctions made by the agency relative to the physical characteristics of facilities and the types of care offered.

(3) Rules adopted by the agency shall encourage the

development of homelike facilities that promote the dignity, individuality, personal strengths, and decisionmaking ability of residents.

(4) The agency may waive rules adopted under this part to demonstrate and evaluate innovative or cost-effective congregate care alternatives that enable individuals to age in place. Such waivers may be granted only in instances where there is reasonable assurance that the health, safety, or welfare of residents will not be endangered. To apply for a waiver, the licensee shall submit to the agency a written description of the concept to be demonstrated, including goals, objectives, and anticipated benefits; the number and types of residents who will be affected, if applicable; a brief description of how the demonstration will be evaluated; and any other information deemed appropriate by the agency. Any facility granted a waiver shall submit a report of findings to the agency within 12 months. At such time, the agency may renew or revoke the waiver or pursue any regulatory or statutory changes necessary to allow other facilities to adopt the same practices. The agency may by rule clarify terms and establish waiver application procedures, criteria for reviewing waiver proposals, and procedures for reporting findings, as necessary to implement this subsection.

(5) The agency may use an abbreviated biennial standard licensure inspection that consists of a review of key quality-of-care standards in lieu of a full inspection in a facility that has a good record of past performance. However, a full inspection must be conducted in a facility that has a history of class I or class II violations; ~~,~~ uncorrected class III violations; or a class I, class II, or uncorrected class III

violation resulting from a complaint referred by the State Long-Term Care Ombudsman Program~~, confirmed ombudsman council complaints, or confirmed licensure complaints~~ within the previous licensure period immediately preceding the inspection or if a potentially serious problem is identified during the abbreviated inspection. The agency shall adopt by rule ~~develop~~ the key quality-of-care standards ~~with input from the State Long-Term Care Ombudsman Council and representatives of provider groups for incorporation into its rules~~.

Section 11. Section 429.435, Florida Statutes, is created to read:

429.435 Uniform firesafety standards.—Uniform firesafety standards for assisted living facilities, which are residential board and care occupancies, shall be established by the State Fire Marshal pursuant to s. 633.206.

(1) EVACUATION CAPABILITY.—A firesafety evacuation capability determination shall be conducted within 6 months after the date of initial licensure of an assisted living facility, if required.

(2) FIRESAFETY REQUIREMENTS.—

(a) The National Fire Protection Association, Life Safety Code, NFPA 101 and 101A, current editions, must be used in determining the uniform firesafety code adopted by the State Fire Marshal for assisted living facilities, pursuant to s. 633.206.

(b) A local government or a utility may charge fees that do not exceed the actual costs incurred by the local government or the utility for the installation and maintenance of an automatic fire sprinkler system in a licensed assisted living facility

structure.

(c) All licensed facilities must have an annual fire inspection conducted by the local fire marshal or authority having jurisdiction.

(d) An assisted living facility that was issued a building permit or certificate of occupancy before July 1, 2016, at its option and after notifying the authority having jurisdiction, may remain under the provisions of the 1994 and 1995 editions of the National Fire Protection Association, Life Safety Code, NFPA 101 and 101A. A facility opting to remain under such provisions may make repairs, modernizations, renovations, or additions to, or rehabilitate, the facility in compliance with NFPA 101, 1994 edition, and may utilize the alternative approaches to life safety in compliance with NFPA 101A, 1995 edition. However, a facility for which a building permit or certificate of occupancy was issued before July 1, 2016, which undergoes Level III building alteration or rehabilitation, as defined in the Florida Building Code, or which seeks to utilize features not authorized under the 1994 or 1995 editions of the Life Safety Code, shall thereafter comply with all aspects of the uniform firesafety standards established under s. 633.206 and the Florida Fire Prevention Code in effect for assisted living facilities as adopted by the State Fire Marshal.

Section 12. Section 429.52, Florida Statutes, is amended to read:

429.52 Staff training and educational requirements ~~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.

(2) Administrators and other assisted living facility staff must meet minimum training and education requirements established by the agency by rule. This training and education is intended to assist facilities to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements.

(3) The agency, in conjunction with providers, shall develop core training requirements for administrators consisting of core training learning objectives, a competency test, and a minimum required score to indicate successful passage ~~completion~~ of the core competency test ~~training and educational requirements~~. The required core competency test ~~training and education~~ must cover at least the following topics:

(a) State law and rules relating to assisted living facilities.

(b) Resident rights and identifying and reporting abuse, neglect, and exploitation.

(c) Special needs of elderly persons, persons with mental illness, and persons with developmental disabilities and how to meet those needs.

(d) Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food.

(e) Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication.

(f) Firesafety requirements, including fire evacuation drill procedures and other emergency procedures.

(g) Care of persons with Alzheimer's disease and related disorders.

(4) A ~~new~~ facility administrator must complete the required core training ~~and education~~, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule.

(5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years.

(6) 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 ~~additional~~ hours of training provided by a registered nurse or~~,~~ a licensed pharmacist before providing assistance~~, or agency staff~~. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this ~~additional~~ training.

(7) ~~Other~~ Facility staff shall participate in in-service training relevant to their job duties as specified by agency rule ~~of the agency~~. Topics covered during the preservice orientation are not required to be repeated during in-service training. A single certificate of completion that covers all required in-service training topics may be issued to a participating staff member if the training is provided in a single training course.

(8) If the agency determines that there are problems in a facility which could be reduced through specific staff training ~~or education~~ beyond that already required under this section, the agency may require~~,~~ and provide, or cause to be provided, the training ~~or education~~ of any personal care staff in the facility.

(9) The agency shall adopt rules related to these training and education requirements, the competency test, necessary procedures, and competency test fees and shall adopt or contract with another entity to develop and administer the competency test. The agency shall adopt a curriculum outline with learning objectives to be used by core trainers~~, which shall be used~~ as the minimum core training content requirements. The agency shall consult with representatives of stakeholder associations and agencies in the development of the curriculum outline.

(10) The core training required by this section ~~other than the preservice orientation~~ must be conducted by persons registered with the agency as having the requisite experience and credentials to conduct the training. A person seeking to register as a core trainer must provide the agency 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).

(11) A person seeking to register as a core trainer also must ~~also~~:

(a) Provide proof of completion of a 4-year degree from an accredited college or university and must have worked in a management position in an assisted living facility for 3 years after being core certified;

(b) Have worked in a management position in an assisted living facility for 5 years after being core certified and have 1 year of teaching experience as an educator or staff trainer for persons who work in assisted living facilities or other long-term care settings;

(c) Have been previously employed as a core trainer for the agency or department; or

(d) Meet other qualification criteria as defined in rule, which the agency is authorized to adopt.

(12) The agency shall adopt rules to establish core trainer registration and removal requirements.

Section 13. This act shall take effect July 1, 2020.

THE FLORIDA SENATE

APPEARANCE RECORD

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

Nov 5, 2019
Meeting Date

SB 402
Bill Number (if applicable)

Topic ALFs

Amendment Barcode (if applicable)

Name Steve Watrel

Job Title Attorney

Address _____ Phone _____
Street

_____ Email _____
City *State* *Zip*

Speaking: ☐ For ☐ Against ☒ Information

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

Representing Florida Seniors

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)

Duplicate

THE FLORIDA SENATE

APPEARANCE RECORD

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

Nov 5 2019
Meeting Date

402
Bill Number (if applicable)

Topic Assisted Living Facilities
Amendment Barcode (if applicable)

Name Jason Hand

Job Title Vice President of Public Policy & Legal Affairs

Address 2292 Wednesday Street
Street

Phone 840.443.0024

Tallahassee FL 32308
City *State* *Zip*

Email jhand@floridaseniorliving.org

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Senior Living 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

APPEARANCE RECORD

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

11/5/19
Meeting Date

402
Bill Number (if applicable)

Topic Assisted Living Facilities

Amendment Barcode (if applicable)

Name Michael Hardy

Job Title GC + Director of Government Affairs

Address 1618 Mahan Center Blvd.
Street

Tallahassee FL 32308
City *State* *Zip*

Phone

Email mike@fala.org

Speaking: ☐ For ☐ Against ☑ Information

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

Representing Florida Assisted Living 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

Senator Manny Diaz, Jr.

District 36

District Office:
Hialeah Gardens City Hall
10001 NW 87 Avenue
Hialeah Gardens, Florida 33016
(305) 364-3073

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November 4, 2019

State Senator Gayle Harrell
Chair, Health Policy
404 S. Monroe Street
530 Knott Building
Tallahassee, FL 32399-1100

Dear Senator Harrell,

Due to a conflict in my schedule, I will not be able to attend the Health Policy Committee Meeting scheduled for Tuesday, November 5, 2019 at 10:00am. Please do not hesitate to contact my office If you require any additional information. Thank you.

Sincerely,

Manny Diaz, Jr.
State Senator
District 36

CC: Staff Director: Allen Brown
Administrative Assistant: Cecilia Georgiades

CourtSmart Tag Report

Room: KN 412 **Case No.:** **Type:**
Caption: Senate Health Policy Committee **Judge:**

Started: 11/5/2019 10:02:21 AM
Ends: 11/5/2019 12:01:23 PM Length: 01:59:03

10:02:20 AM Meeting called to order
10:02:27 AM Chair Harrell's opening comments
10:03:00 AM Roll call
10:03:17 AM Senator Diaz is excused from today's meeting
10:03:35 AM Tab 3 - SB 66, Student Loans and Scholarship Obligations of Health Care Practitioners by Senator Cruz
10:03:48 AM Senator Cruz explains SB 66
10:06:14 AM Chair Harrell AM barcode 439576
10:06:27 AM AM barcode 439576 by Senator Cruz
10:07:01 AM Chair Harrell AM barcode 439576 is accepted as presented
10:07:22 AM Public Testimony
10:07:25 AM Evan Power, FL. Chiropractic Association, waives in support
10:07:35 AM Janegale Boyd, FL. Nurses Association
10:09:34 AM Rheb Harbinson, FL. Nurses Association, waives in support
10:09:49 AM Senator Baxley in debate
10:12:08 AM Senator Rouson in debate
10:12:38 AM Senator Mayfield in debate
10:14:55 AM Senator Cruz to close
10:17:14 AM Roll call - SB 66
10:17:34 AM SB 66 is reported favorably
10:17:42 AM Tab 4 - SB 348, FL. Kidcare Program by Senator Bean
10:17:55 AM Senator Bean explains SB 348
10:19:55 AM Senator Berman in debate
10:20:27 AM Chair Harrell's comments
10:21:04 AM Senator Bean to close
10:21:12 AM Roll call - SB 346
10:21:27 AM SB 348 is reported favorably
10:21:39 AM Chair Harrell passes the chair to Senator Berman
10:21:46 AM Senator Harrell explains SB 402
10:21:54 AM Tab 5 - SB 402, Assisted Living Facilities by Senator Harrell
10:26:58 AM Chair Berman's question
10:27:35 AM Senator Harrell's response
10:28:27 AM AM barcode 406876 by Senator Harrell
10:29:06 AM Senator Harrell waives close
10:29:14 AM AM barcode 406876 is adopted
10:29:21 AM AM barcode 765692 by Senator Harrell
10:31:56 AM Chair Berman's question
10:32:06 AM Senator Harrell's response
10:32:21 AM Chair Berman's follow-up question
10:32:26 AM Senator Harrell's response
10:32:48 AM Senator Harrell waives close
10:32:56 AM AM barcode 765692 is adopted
10:33:02 AM AM barcode 578246 by Senator Harrell
10:34:15 AM Senator Harrell waives close
10:34:22 AM AM barcode 578246 is adopted

10:34:28 AM AM barcode 255278 by Senator Harrell
10:35:10 AM Senator Harrell waives close
10:35:18 AM AM barcode 255278 is adopted
10:35:25 AM Public Testimony
10:35:32 AM Steve Watrel, Florida Seniors
10:40:18 AM Jason Hand, FL. Senior Living Association, waives in support
10:40:26 AM Michael Hardy, FL. Assisted Living Association
10:42:01 AM Senator Baxley's comments in debate

10:46:29 AM Senator Book in debate
10:47:03 AM Senator Rouson in debate
10:48:01 AM Senator Harrell to close
10:51:55 AM Roll call - SB 402
10:52:13 AM SB 402 is reported favorably
10:52:18 AM Senator Berman returns the chair to Senator Harrell
10:52:43 AM Tab 1 - Implementation of Prescription Drug Importation Programs
10:55:00 AM Mary C. Mayhew, AHCA Secretary - Canadian Drug Importation Program
11:02:29 AM Chair Harrell's questions
11:04:53 AM Senator Baxley's questions
11:10:12 AM Senator Berman's questions
11:13:27 AM Chair Harrell's remarks
11:14:13 AM Senator Berman's question
11:16:05 AM Chair Harrell remarks
11:16:43 AM Tab 2 - Discussion of Drivers Behind the Increases in Prescription Drug Prices
11:17:20 AM Senator Baxley's question
11:18:31 AM Lauren Rowley, Vice President for State Affairs Pharmaceutical Care Management Association
11:25:46 AM Senator Baxley's question
11:26:03 AM Madelaine Feldman, M.D., President Coalition of State Rheumatology Organizations
11:33:15 AM Audrey Brown Bridges, President and CEO FL. Association of Health Plans
11:39:05 AM Kevin Duane, Pharmacist SPAR
11:45:55 AM Chair Harrell's remarks
11:46:15 AM Senator Baxley's question
11:48:03 AM Lauren Rowley
11:49:58 AM Senator Berman's question
11:50:55 AM Lauren Rowley
11:52:08 AM Audrey Brown Bridges
11:53:15 AM Dr. Feldman's remarks
11:54:00 AM Lauren Rowley
11:54:36 AM Dr. Feldman's remarks
11:55:12 AM Senator Cruz's question
11:55:36 AM Dr. Feldman's remarks
11:56:06 AM Senator Cruz's follow-up question
11:56:43 AM Dr. Feldman's remarks
11:57:18 AM Senator Mayfield's remarks
11:59:09 AM Audrey Brown Bridges
11:59:47 AM Meeting adjourned
11:59:55 AM Senator Hooper's motion - Vote in the affirmative on SB 66 and and SB 348