HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1503 Health Care
SPONSOR(S): Flores
TIED BILLS: **IDEN./SIM. BILLS:** SB 2138

	REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1)	Health Care Regulation Policy Committee		Holt	Calamas
2)	Health Care Appropriations Committee			
3)	Health & Family Services Policy Council			
4)				
5)				

SUMMARY ANALYSIS

House Bill 1503 amends the Health Care Licensing Procedures Act and the various authorizing statutes of entities regulated by the Agency for Health Care Administration (AHCA) to reduce, streamline, and clarify regulations for those providers.

The bill makes various changes to the regulation of home health agencies. The bill provides a home health agency patient a bill of rights. Home health agency administrators are required to direct the operation of the home health agency and have qualified alternate administrators. The director of nursing must be available during the hours the home health agency is open. The bill specifies the duties of the director of nursing, registered nurse, licensed practical nurse, therapists and therapist's assistants in providing home health care and supervision. Home health aides must be competent to provide care to patients. Skilled services must be performed in compliance with state practice acts and the patient's plan of care. The plan of care is to be reviewed and updated according to specified time frames. The home health agency must provide one type of service directly and may provide other services through arrangements with others if they have a written contract.

The bill amends various licensure provisions, including those related to bankruptcy notifications, licensure renewal notices, billing complaints, accrediting organizations, licensure application document submissions, staffing in geriatric outpatient clinics, property statements, AHCA inspection staff, litigation notices, and health care clinic licensure exemptions.

The bill repeals obsolete or duplicative provisions in licensing and related statutes, including expired reports and regulations and provisions that exist in other sections of law, and resolves conflicts among and between provisions in the Health Care Licensing Procedures Act and various authorizing statutes for individual provider types. The bill makes various revisions to update terminology and conform current law to prior legislative changes.

The bill has a positive fiscal impact on AHCA. The bill will save an estimated $55,700 annually in certified mail costs for license renewal notices and up to $425,273 annually for staffing of AHCA's consumer call center. The bill also redirects revenue from certain traffic fines from AHCA to the Brain and Spinal Cord Trust Fund within the Department of Health. (See Fiscal Comments.)

The bill has an effective date of July 1, 2010, unless expressly provided otherwise.

HOUSE PRINCIPLES

Members are encouraged to evaluate proposed legislation in light of the following guiding principles of the House of Representatives

- Balance the state budget.
- Create a legal and regulatory environment that fosters economic growth and job creation.
- Lower the tax burden on families and businesses.
- Reverse or restrain the growth of government.
- Promote public safety.
- Promote educational accountability, excellence, and choice.
- Foster respect for the family and for innocent human life.
- Protect Florida's natural beauty.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Health Care Licensing Procedures Act

The Agency for Health Care Administration (AHCA) regulates over 41,000 health care providers under various regulatory programs. Regulated providers include:

- Laboratories authorized to perform testing under the Drug-Free Workplace Act (ss. 112.0455, 440.102, F.S.)
- Birth centers (Ch. 383, F.S.).
- Abortion clinics (Ch. 390, F.S.).
- Crisis stabilization units (Pts. I and IV of Ch. 394, F.S.).
- Short-term residential treatment facilities (Pt. I and IV of Ch. 394, F.S.).
- Residential treatment facilities (Pt. IV of Ch. 394, F.S.).
- Residential treatment centers for children and adolescents (Pt. IV of Ch. 394, F.S.).
- Hospitals (Part I of Ch. 395, F.S.).
- Ambulatory surgical centers (Pt. I of Ch. 395, F.S.).
- Mobile surgical facilities (Pt. I of Ch. 395, F.S.).
- Health care risk managers (Pt. I of Ch. 395, F.S.).
- Nursing homes (Pt. II of Ch. 400, F.S.).
- Assisted living facilities (Pt. I of Ch. 429, F.S.).
- Home health agencies (Pt. III of Ch. 400, F.S.).
- Nurse registries (Pt. III of Ch. 400, F.S.).
- Companion services or homemaker services providers (Pt. III of Ch. 400, F.S.).
- Adult day care centers (Pt. III of Ch. 429, F.S.).
- Hospices (Pt. IV of Ch. 400, F.S.).
- Adult family-care homes (Pt. II of Ch. 429, F.S.).
- Homes for special services (Pt. V of Ch. 400, F.S.).
- Transitional living facilities (Pt. V of Ch. 400, F.S.).
- Prescribed pediatric extended care centers (Pt. VI of Ch. 400, F.S.).
- Home medical equipment providers (Pt. VII of Ch. 400, F.S.).
- Intermediate care facilities for persons with developmental disabilities (Pt. VIII of Ch. 400, F.S.).
- Health care services pools (Pt. IX of Ch. 400, F.S.).
- Health care clinics (Pt. X of Ch. 400, F.S.).

- Clinical laboratories (Pt. I of Ch. 483, F.S.).
- Multiphasic health testing centers (Pt. II of Ch. 483, F.S.).
- Organ, tissue, and eye procurement organizations (Pt. V of Ch. 765, F.S.).

Providers are regulated under individual licensing statutes and the Health Care Licensing Procedures Act (Act) in Part II of Chapter 408, Florida Statutes. The Act provides uniform licensing procedures and standards applicable to most AHCA-regulated entities. The Act contains basic licensing standards for 29 provider types in areas such as licensure application requirements, ownership disclosure, staff background screening, inspections, and administrative sanctions, license renewal notices, and bankruptcy and eviction notices.

In addition to the Act, each provider type has an authorizing statute which includes unique provisions for licensure beyond the uniform criteria. Pursuant to s. 408.832, F.S., in the case of conflict between the Act and an individual authorizing statute, the Act prevails. There are several references in authorizing statutes, that conflict with or duplicate provisions in the Act, including references to the classification of deficiencies, penalties for an intentional or negligent act by a provider, provisional licenses, proof of financial ability to operate, inspection requirements and plans of corrections from providers. In 2009, the Legislature passed and the Governor signed into law SB 1986 (Ch. 2009-223 L.O.F), which made changes to part II of Chapter 408 that supersede components of the specific licensing statutes.

The bill repeals obsolete or duplicative provisions in licensing and related statutes, including expired reports and regulations and provisions that exist in other sections of law like the Act. The bill also makes changes to the Act to reduce, streamline, or clarify regulations for all providers regulated by AHCA.

The bill changes individual licensing statutes to reflect updates to the uniform standards in the Act. The bill makes corresponding changes to provider licensing statutes to reflect the changes made to the Act to eliminate conflicts and obsolete language.

The bill amends s. 400.811 related to inspections by AHCA, to clarify that AHCA inspection reports are not subject to challenge under Chapter 120, the Administrative Procedures Act, unless a sanction is imposed.

License Renewal Notices

Section 408.806, F.S., requires AHCA to notify licensees by mail or electronically when it is time to renew their licenses. AHCA mails renewal notices by to over 30,000 providers every two years. While the statute does not specify the manner of mailing notices, AHCA sends them by certified mail to verify receipt by the providers. The cost of certified mail is approximately $55,700 annually. According to AHCA, some certified mail is returned, as providers do not pick it up or the post office is unable to obtain necessary signatures for delivery. AHCA has also encountered situations in which licensees did not timely renew their licenses, and claimed that their lack of receipt of a renewal reminder was a reason for that failure.

The bill clarifies that renewal notices are courtesy reminders only and do not excuse the licensees from the requirement to file timely licensure applications. The revised language gives AHCA clear flexibility to use or not use certified mail to send courtesy renewal reminders.

Classification and Fines for Violations

Section 408.813, F.S., includes criteria for the classification of deficiencies for all providers licensed by AHCA. Some authorizing statutes also contain criteria for the classification of deficiencies, some of which do not match the provisions contained in the Act. The provisions in the Act legally supersede conflicting provisions in the authorizing statutes; however, the dual provisions are confusing, and some conflicts still exist. Additionally, authorizing statutes are inconsistent related to fines for unclassified deficiencies such as failure to maintain insurance or exceeding licensed bed capacity.

The bill modifies the classification of licensure violations related to nursing homes, home health agencies, intermediate care facilities for the developmentally disabled and adult family care homes to refer to the scope and severity in s. 408.813, F.S. Fine amounts for violations are unchanged. The bill adopts federal regulations by allowing a state fine to be imposed for a federal violation for intermediate care facilities for the developmentally disabled. The state fine for Class I, II and II violations are unchanged, but a new Class IV is added consistent with s. 408.813 with a fine not to exceed $500 for intermediate care facilities. The addition of the Class IV violation creates a lower category for minor violations by those facilities. This resolves conflicting or confusing differences between the Act and the authorizing statutes, and resolves inconsistencies between these three authorizing statutes.

In addition, the bill establishes uniform sanction authority for unclassified deficiencies of up to $500 per violation. Examples of unclassified deficiencies include failure to maintain insurance and other administrative requirements, exceeding licensed capacity, or violating a moratorium. Without fine authority, AHCA would be required to initiate revocation action for violations against those providers that do not have general fine authority. These violations may not warrant such a severe sanction.

Notice of Bankruptcy and Eviction

Currently, nursing homes are required to notify AHCA of bankruptcy filing pursuant to s. 400.141(1)(r), F.S. However, nursing homes are not required to notify AHCA of eviction, and there is no statutory requirement for other types of facility providers to notify AHCA if served with an eviction notice or bankruptcy. According to AHCA, recently it has been made aware of several eviction and bankruptcy orders affecting regulated facilities. If notice is not received early in the process, finding alternative resident placement can become difficult and create a hardship for clients.

The bill amends s. 408.806, F.S., to require providers' controlling interests to notify AHCA within 10 days after a court action to initiate bankruptcy foreclosure or eviction proceedings. This applies to any such action to which the controlling interest is a petitioner or defendant. According to AHCA, this allows it to monitor the facility to ensure patient protection and safe transfer, if needed. If the property upon which a licensed provider operates is encumbered by a mortgage or is leased, the bill requires the licensee to notify the mortgage holder or landlord that the property will provide services that require licensure and instruct the mortgage holder or landlord to notify AHCA if action is initiated against the licensee, such as eviction.

Licensure Denial and Revocation

An action by AHCA to deny or revoke a license is subject to challenge under the Administrative Procedures Act (Chapter 120). If a licensee challenges AHCA action, s. 408.815(2), F.S., allows the license to continue to exist and the provider to continue to operate during the pendency of the case. Once a final order is issued on the denial or revocation, if the original licensure expiration date has passed, there is no valid license and the provider must cease operations immediately. According to AHCA, this can be problematic for residents or clients who must immediately be moved to another facility or find another health care provider.

The bill amends s. 408.815, F.S., to authorize AHCA to extend a license expiration date up to 30 days beyond the final order date in the event of a licensure denial or revocation to allow for orderly transfer of residents or patients.

License Display

Section 408.804, F.S., makes it unlawful to provide or offer services that require licensure without having first obtained a license, and makes licenses valid only for the entities to which they are issued. Licensees are required to conspicuously display licenses for clients to see. The Act law does not currently address falsification or ill-usage of license documents.

The bill makes it a second degree misdemeanor to knowingly alter, deface or falsify a license, punishable by up to 60 days in jail and a fine up to $500. The bill makes it an administrative violation for a licensee to display an altered, defaced or falsified license. Such violations are subject to licensure revocation and a fine of up to $1,000 per day.

Hospital Licensure

Currently, Florida law allows AHCA to consider and use hospital accreditation by certain accrediting organizations for various purposes, including accepting accreditation surveys in lieu of AHCA survey, requiring accreditation for designation as certain specialty hospitals, and setting standards for quality improvement programs. Section 395.002, F.S., defines "accrediting organizations" as the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, and the Accreditation Association for Ambulatory Health Care, Inc.

Complaint investigation procedures for hospitals exist in the hospital authorizing chapter as well as in the Act. Section 395.1046, F.S., provides special procedures for hospital complaints regarding emergency access issues. For example, AHCA must: investigate emergency access complaints even if the complaint is withdrawn; prepare an investigative report; and make a probable cause determination. According to AHCA, the federal process for emergency access complaints dictates that these complaints should not be handled any differently from other types of complaints, thereby creating two separate processes for emergency access complaints, one state and one federal.

The bill broadens the definition of "accrediting organizations" for hospitals and ambulatory surgery centers to include any nationally recognized accrediting organization which has standards comparable to AHCA's licensure standards, as determined by AHCA. This gives AHCA and providers greater flexibility to accept new or improving accrediting organizations, and reconsider existing ones based on current statutory and rule-based standards.

The bill repeals s. 395.1046, F.S., which modifies the procedures for investigations hospital emergency access complaints. Under the bill, AHCA would use existing hospital complaint investigation procedures used for all other types of complaints.

Home Health Agency Licensure

Currently, services provided by a home health agency must be covered by an agreement between the home health agency and the patient or the patient's legal representative. The agreement must specify the services being provided, rates or charges for services paid with private funds, and sources of payment.[1] The bill provides that the home health agency must provide a copy of the agreement to the patient or patient's representative.

Patient Rights

In addition, the bill creates new provisions requiring a home health agency to protect and promote the rights of each individual under its care. The home health agency is required to provide the patient a written notice of the patients rights prior to the initiation of treatment. The provisions are:

- The patient has the right to exercise their rights as a patient;
- The patient has the right to have their property treated with respect;
- The patient has the right to voice grievances regarding treatment, care, or lack of respect for personal property;
- The patient must be informed of the right to report complaints via the statewide toll-free telephone number;
- The patient has the right to be informed prior to receiving care and any changes in the plan of care; and

[1] s. 400.487(1), F.S.

- The patient has the right to participate in the planning of care and they must be advised in advance.

The home health agency must investigate any complaint about patient care and failure to respect the patient's property and document both the existence and resolution of the complaint. The patient must be informed of the disciplines (such as registered nurse, home health aide, physical therapist) that will provide the care; notified in advance of the individuals who will provide treatment and care; and the frequency of visits.

Personnel

The bill amends s. 400.476, F.S., to provide additional requirements and limitations of staffing services for home health agencies.

The bill amends the responsibilities of a home health agency administrator. It requires that an alternate administrator meet the same qualifications as an administrator which includes not working for multiple unrelated home health agencies. It prohibits delegation of supervisory and administrative functions to another agency or organization.

The bill requires the director of nursing or a similarly qualified alternate to be available at all times during operating hours; to oversee the assignment of personnel and nursing services, home health aides and certified nursing assistants; and to participate in all activities related to the provision of professional services by the home health agency.

The bill provides that a home health agency's professional staff must comply with applicable state practice acts, accepted professional standards and principles, and the home health agency's policies and procedures. According to AHCA, by referencing the professional practice acts in state law, AHCA surveyors can cite for non-compliance, and follow up to see if a correction is made.[2]

The bill provides that a home health agency may not use a home health aide unless the individual has successfully completed a training and competency evaluation program to ensure they are adequately trained. All aides must be competent and cannot perform tasks for which they received an unsatisfactory evaluation except under direct supervision of a licensed practical nurse.

The bill amends s. 400.487, F.S., to require home health aides and certified nursing assistants to be supervised by a registered nurse. However, supervision may be provided by therapists if therapy services are only provided. The bill requires that a supervisory visit be made to the home of a patient at least once every 60 days while the home health aide or certified nursing is providing care to a patient. If a patient receiving skilled nursing or therapy services a nurse or therapist is required to visit at least once every two weeks, however, the visit does not have to be made while the aide or certified nursing assistant is providing care. The bill requires that home health aides and certified nursing assistants to receive written patient care instructions from their supervisors.

Provision of Services

The bill provides in s. 400.476, F.S., that a home health agency must provide at least one of the types of services directly. The services provided by individuals that are not direct employees and by other organizations under arrangements must have a written contract that specifies the services to be provided, procedures for scheduling visits, submitting notes, evaluating patients, and payment for services.

The bill specifies in s. 400.487, F.S., the services to be provided by a registered nurse, licensed practical nurse, home health aide, certified nursing assistant, therapist and therapist assistant are specified. All personnel serving patients must coordinate their efforts to provide care and show this communication in the patient's record. Verbal orders must be put in writing and plans of care are to be

[2] Agency for Health Care Administration 2010 Bill Analysis & Economic Impact Statement of House Bill 1503 (March 24, 2010).

reviewed every 60 days or more frequently if there is a significant change in the patient's condition. The bill specifies that drugs and treatments can only be provided as ordered by a physician, or advanced registered nurse practitioner or physician's assistant who works under the supervision of a physician. Flu and pneumonia vaccines may be administered to patients in accordance with home health agency policy that is developed in consultation with a physician.

The bill amends the definition of "admission" in s. 400.462, F.S., so that the evaluation of the patient does not have to occur when the patient gets home, but can be done while the patient is still at a hospital or rehabilitation facility. In addition, "home health services" is revised to include the provision of durable medical equipment. The bill provides a new definition for "primary home health agency" designating the agency that is responsible for the services provided as well as the plan of care since many home health agencies contract with other agencies for services.

Nursing Home Licensure

An application for nursing home licensure must include the following:

- A signed affidavit disclosing financial or ownership interest of a nursing home controlling interest in the last five years in any health or residential facility which has closed, filed bankruptcy, has a receiver appointed or an injunction placed against it, or been denied, suspended, or revoked by a regulatory agency. This information is also required in s. 400.111, F.S.
- A plan for quality assurance and risk management. This plan is also reviewed during onsite inspections by AHCA.
- The total number of beds including those certified for Medicaid and Medicaid. This information is also required by s. 408.806(1)(d), F.S.

The bill eliminates routine submission of documents at licensure by amending ss. 400.071, 400.111, 400.1183, 400.141, F.S. to substitute the requirement for nursing homes to routinely submit certain documents at the time of licensure with the ability for AHCA to request them if needed. The bill amends s. 400.0712, F.S., relating to nursing home licensure, removing duplicate language related to an inactive license which now exists in Chapter 408, Part II. The bill removes a requirement of a nursing home to notify AHCA of a change in the management company within 30 days. This provision now exists in Chapter 408, Part II.

Geriatric Outpatient Clinics

Under current law, nursing homes may establish a geriatric outpatient clinic as authorized in s. 400.021, F.S., to provide outpatient health care to persons 60 years of age or older. The clinic can be staffed by a registered nurse or a physician's assistant.

The bill expands the health care professionals that may staff a geriatric outpatient clinic in a nursing home by including licensed practical nurses under the direct supervision of registered nurses or advanced registered nurse practitioners.

Staffing Ratios

Nursing homes must comply with nursing staff-to-resident staffing ratios. Under s. 400.141(1)(o), F.S., if a nursing home fails to comply with minimum staffing requirements for two consecutive days, the facility must cease new admissions until the staffing ratio has been achieved for six consecutive days. Failure to self-impose this moratorium on admissions results in a Class II deficiency cited by AHCA. All other citations for a Class II deficiency represent current, ongoing non-compliance that AHCA determines has compromised a resident's ability to maintain or reach his or her highest practicable physical, mental, and psychosocial well-being. Use of the Class II deficiency for a failure to cease admissions is an inconsistent use of a "Class II" level compared to all other violations. No nursing homes were cited for this violation in 2009.

The bill modifies the penalty for nursing homes that fail to self impose a moratorium for insufficient staffing to a fine of $1,000 instead of a Class II deficiency.

Do Not Resuscitate Orders

Section 400.142, F.S., requires AHCA to develop rules relating to implementation of Do Not Resuscitate Orders for nursing home residents. According to AHCA, draft rules have been developed but are not final. Criteria for Do Not Resuscitate Orders are found in s. 401.45, F.S.

The bill removes the requirement for AHCA to promulgate rules related to the implementation of Do Not Resuscitate Orders for nursing home residents. The statutory requirements for such orders in s. 401.45 are clear and do not require rule implementation.

Inspections and Surveys

AHCA employs staff to inspect nursing homes, referred to as surveyors. Pursuant to s. 400.275, F.S., newly-hired nursing home surveyors must spend two days in a nursing home as part of basic training in a non-regulatory role. Federal regulations prescribe an extensive training process for nursing home inspection staff. Staff must pass the federal Surveyor Minimum Qualifications Test. Federal regulations prohibit an AHCA staff person who formerly worked in a nursing home from inspecting a nursing home within two years of employment with that home; state law requires a five year lapse.

The bill removes the requirement for new AHCA nursing home inspection staff to spend two days in a nursing home as part of basic training and aligns staff requirements with federal regulations. Agency nursing home staff must still be fully qualified under federal requirements for the Surveyor Minimum Qualifications Test.

Litigation Notices

Since 2001, nursing homes have been required by s. 400.147(10), F.S., to report civil notices of intent to litigate (required by s. 400.0233, F.S.) and civil complaints filed with clerks of courts by a resident or representative of a resident. This information has been used to produce the Semi-Annual Report on Nursing Homes required by s. 400.195, F.S. Information is reported in aggregate for all facilities.

The bill eliminates the requirement to report notices of intent to litigate and civil complaints.

Hospice Licensure

In 2009, the Legislature passed and the Governor signed into law SB 1986 (Ch. 2009-223 L.O.F). The new law requires any hospice initial or change of ownership applicant show anticipated provider revenue and expenditures, the basis for financing anticipated cash flow requirements and access to contingency financing, per s. 408.810(8), F.S. Current state law for hospice licensing, s. 400.606(1)(i), F.S., requires that an annual operating budget be submitted, which duplicates the financial information now required in the Act.

The hospice authorizing statutes (ss.400.606-400.609, F.S.) and federal regulations (42 CFR 418.98) require that hospices have inpatient beds for symptom control and pain management and for respite for caregivers. Inpatient beds may be in a hospital, skilled nursing facility or a freestanding inpatient facility operated by a hospice. Section 408.043, F.S., requires that there be a certificate of need for a hospice freestanding facility “primarily engaged in providing inpatient care and related services.” This provision is repeated in the Act (s. 400.606(4), F.S.).

The bill removes the requirement for hospice licensure applicants to submit a projected annual operating budget. Since financial projections are already submitted as part of the proof of financial ability to operate as required in the Act, this removes duplicative requirements.

The bill amends both the Act and the hospice authorizing statute related to certificates of need for inpatient hospice facilities. The bill eliminates the modifier "primarily" to provide that any provision of inpatient hospice care, in any facility not already licensed as a health care facility (like a hospital or nursing home), requires a certificate of need. In effect, the bill provides that no exemptions to this requirement exist.

Home Medical Equipment Licensure

Licensure law, s. 400.931(2), F.S., allows a bond be posted as an alternative to submitted proof of financial ability to operate for a home medical equipment provider. In 2009, the Legislature passed and the Governor signed into law SB 1986 (Ch. 2009-223 L.O.F). The new law, s. 408.8065, F.S., requires that financial statements with evidence of funding to cover start up costs, working capital and contingencies be submitted.

The bill deletes the provisions of s. 400.931, F.S., related to the ability to submit a bond as an alternative to submitting proof of financial ability to operate. Due to the 2009 legislative changes, financial oversight is now addressed in the Act.

Health Care Clinic Licensure

Licensure for health care clinics includes mobile clinics and portable equipment providers. Exemptions from licensure exist for clinics that are wholly owned, directly or indirectly, by a publically traded corporation, among other exemptions.

Licensure law, s. 400.991(4), F.S., allows a bond be posted as an alternative to submitted proof of financial ability to operate for a home medical equipment provider. In 2009, the Legislature passed and the Governor signed into law SB 1986 (Ch. 2009-223 L.O.F). The new law, s. 408.8065, F.S., requires that financial statements with evidence of funding to cover start up costs, working capital and contingencies be submitted in.

The bill provides that portable service providers, such as mobile ultrasound providers, are subject to health care clinic licensure even though they do not deliver care at the clinic's location. The bill also expands an existing exemption from health care clinic licensure for clinics that are wholly owned, directly or indirectly, by a publically traded corporation to include pediatric cardiology or perinatology clinics.

Assisted Living Facility Licensure

Assisted Living Facilities (ALFs) are not currently required to submit resident population data to AHCA. However, there is a requirement to submit disaster/emergency information electronically via AHCA's Emergency Status System (ESS).[3] Submission of ESS data was a result of SB 1986 (Ch. 2009-223 L.O.F), and is being required at the time of licensure renewal. Currently, 42.1 percent (1197) of ALFs are currently enrolled in this system.

Section 429.23, F.S., requires each ALF to submit a monthly report on civil liability claims filed against the facility, and provides that the reports are not discoverable on civil or administrative actions.

Section 429. 35, F.S., requires AHCA to forward the results of biennial licensure surveys to various entities, including a local public library, the local ombudsman council, and the district Adult Services and Mental Health Program Office.

The bill repeals the requirement to monitor extended congregate care facilities, and replaces it with a requirement to monitor based upon citation of serious violations (Class I or Class II) in any ALF. The bill allows AHCA to charge a fee for monitoring visits.

[3] The Emergency Status System is a web-based system for reporting and tracking health care facility status before, during and after an emergency. See

The bill modifies AHCA's consultation duties, and requires AHCA to adopt rules for data submission by ALFs to AHCA related to numbers of residents receiving mental health or nursing services, resident funding sources and staffing. The bill requires facilities to electronically submit resident population data to AHCA on a semi-annual basis.

The bill also eliminates the requirement that ALFs report civil liability claims to AHCA, and allows AHCA to provide biennial survey results to the public electronically or via AHCA website.

Medicaid Long Term Care Waivers

Many of the Medicaid long term care waiver programs offer similar services and cover similar populations. According to AHCA, phasing out the Adult Day Health Care waiver, which is only available in a limited area of the state, will reduce administrative costs and create a system of care that is easier for Medicaid recipients to navigate. Individuals in this waiver will be given the opportunity to choose a comparable waiver program, and funding will be transferred to other waivers as recipients transfer to these other programs. The bill amends s. 409.906, F.S., which phases out the Medicaid Adult Day Health Waiver by December 31, 2010.

Multi-Phasic Health Testing Centers

Multi-phasic health testing centers (centers) are facilities which take human specimens for delivery to clinical laboratories for testing, and which may perform other basic human measurement functions. Centers are licensed and regulated under Part II of Chapter 483, Florida Statutes. Section 483.294, F.S., requires AHCA to inspect centers at least annually. The bill amends the inspection schedule, requiring AHCA to inspect centers biennially.

Brain and Spinal Cord Injury Trust Fund

Under current law, specified traffic fines may be used to provide an enhanced Medicaid rate to nursing homes that serve clients with brain and spinal cord injuries. According to AHCA, funds collected from these fines thus far have not been sufficient to support a Medicaid nursing home supplemental rate for an estimated 100 adult ventilator-dependent patients ($255.80 per day). As of July 2009, the Department of Revenue should have transferred a total of $39,294 to AHCA since May 2008.

The bill redirects the revenue to the Brain and Spinal Cord Injury Trust Fund within the Department of Health, to be used for Medicaid recipients who have sustained a spinal cord injury and who are technologically and respiratory dependent.

Pilot Projects

The Medicaid "Up-or-Out" Quality of Care Contract Management Program in s. 400.148, F.S., was created as a pilot program in 2001 to improve care in poor performing nursing homes and assisted living facilities by assigning trained medical personnel to facilities in select counties similar to Medicare models for managing the medical and supportive-care needs of long-term nursing home residents. The pilot was subject to appropriation; however, an appropriation was not allocated to this program and it was never implemented. According to AHCA, the criteria specified to identify poor performing facilities has been replaced by more comprehensive information for consumers to make informed choices for care.

The bill repeals the Medicaid Up or Out Pilot Quality of Care Contract Management Program.

AHCA Complaint Call Center

Currently s. 408.10, F.S., requires AHCA to operate a consumer call center. Operation of the AHCA call center is currently under contract with a private entity. According to AHCA, a Request for Proposal was advertised to consider new contractors; there was one bidder. The current contract has been extended for a six month period. Current annual budget of the contract is $1,050,482.40. The bill

provides AHCA the authority to provide staffing for this toll-free number through agency staff or other arrangements.

Reports

The semi-annual report on nursing homes in s. 400.195, F.S., was provided from December 2002 through June 2005 as a tool to provide information about litigation in Florida nursing homes. The report included demographic and regulatory information about nursing homes in Florida and aggregate numbers of notices of intent to litigate and civil complaints filed with the clerks of courts against Florida nursing homes. The reporting requirement ended June 2005 by law. The statutory obligation to publish this report has been met and by law expired on June 30, 2005.

The Consumer Directed Care Plus report was created as part of the new program, in s. 409.221(4)(k), F.S. for AHCA, Department of Elder Affairs, and Agency for Persons with Disabilities to provide an annual update of the review of the CDC program and recommendations for improvement. In March 2008, the CDC program was approved to be under the 1915(j) self directed option as a Medicaid state plan amendment instead of an 1115 Research and Demonstrative waiver. The 1915(j) state plan amendment requires annual and three (3) year comprehensive reporting to the federal Centers for Medicare and Medicaid Services (CMS). The report to CMS communicates current status of the CDC program, data on CDC enrollment, demographics, consumer satisfaction and cost effectiveness. This federal report is required by CMS to be available for public review.

The Comprehensive Review for Long Term Care Services program report was required to be submitted to the Legislature by July 1, 2005. However, the language requiring the report still exists in s. 409.912(15)(g), F.S.

The bill repeals these three report requirements.

Statutory Revisions

The bill updates the name of The Joint Commission, formerly known as the Joint Commission of the Accreditation of Healthcare Organizations, the Florida Society for Healthcare Risk Management and Patient Safety, formerly known as the Florida Society of Healthcare Risk Management, The Council on Accreditation, formerly known as the Council on Accreditation for Children and Family Services, and the federal Centers for Medicare and Medicaid Services formerly known as the federal Health Care Financing Administration.

The bill deletes definitions for and references to private review agents and utilization review in s. 395.002, F.S., to conform to repeals made in 2009 (SB 1986, ch. 2009-223 L.O.F.).

The bill makes technical corrections and repeals requested by the Division of Statutory Revision, such as repealing obsolete dates, amending cross-references, and updating the reference to an obsolete rule.

B. SECTION DIRECTORY:

Section 1. Amends s. 1.01, F.S., relating to definitions.
Section 2. Amends s. 112.0455, F.S., relating to drug-free workplace act.
Section 3. Amends s.154.11, F.S., relating to powers of board of trustees.
Section 4. Amends s. 318.21, F.S., relating to disposition of civil penalties by county courts.
Section 5. Repeals s. 383.325, F.S., relating to inspection reports.
Section 6. Amends s. 394.4787, F.S., relating to definitions.
Section 7. Amends s. 394.741, F.S., relating to accreditation requirements for providers of behavioral health care services.
Section 8. Amends s. 395.002, F.S., relating to definitions.
Section 9. Amends s. 395.003, F.S., relating to licensure, denial, suspension, and revocation.
Section 10. Amends s. 395.0193, F.S., relating to licensed facilities, peer review, disciplinary powers, and agency or partnership with physicians.

Section 11. Amends s. 395.1023, F.S., relating to child abuse and neglect cases, and duties.
Section 12. Amends s. 395.1041, F.S., relating to access to emergency services and care.
Section 13. Repeals s. 395.1046, F.S., relating to complaint investigation procedures.
Section 14. Amends s. 395.1055, F.S., relating to rules and enforcement.
Section 15. Amends s. 395.10975, F.S., relating to Health Care Risk Manager Advisory Council.
Section 16. Amends s. 395.2050, F.S., relating to routine inquiry for organ and tissue donation, certification for procurement activities, and death records review.
Section 17. Amends s. 395.3036, F.S., relating to confidentiality of records and meetings of corporations that lease public hospitals or other public health care facilities.
Section 18. Repeals s. 395.3037, F.S., relating to definitions.
Section 19. Amends s. 395.3038, F.S., relating to state-listed primary stroke centers and comprehensive stroke centers, and notification of hospitals.
Section 20. Amends s. 395.602, F.S., relating to rural hospitals.
Section 21. Amends s. 400.021, F.S., relating to definitions.
Section 22. Amends s. 400.0239, F.S., relating to quality of long-term care facility improvement trust fund.
Section 23. Amends s. 400.063, F.S., relating to resident protection.
Section 24. Amends s. 400.071, F.S., relating to application for license.
Section 25. Amends s. 400.0712, F.S., relating to application for inactive license.
Section 26. Amends s. 400.111, F.S., relating to disclosure of controlling interest.
Section 27. Amends s. 400.1183, F.S., relating to resident grievance procedures.
Section 28. Amends s. 400.141, F.S., relating to administration and management of nursing homes facilities.
Section 29. Amends s. 400.142, F.S., relating to emergency medication kits, and orders not to resuscitate.
Section 30. Repeals s. 400.147, F.S., relating to internal risk management and quality assurance program.
Section 31. Repeals s. 400.148, F.S., relating to Medicaid “Up-or-Out” Quality of Care Contract Management Program.
Section 32. Amends s. 400.19, F.S., relating to rights of entry and inspection.
Section 33. Repeals s. 400.195, F.S., relating to agency reporting requirements.
Section 34. Amends s. 400.23, F.S., relating to rules, evaluation and deficiencies, and licensure status.
Section 35. Repeals s. 400.275, F.S., relating to agency duties.
Section 36. Amends s. 400.462, F.S., relating to definitions.
Section 37. Amends s. 400.476, F.S., relating to staffing requirements, notifications, and limitations on staffing services.
Section 38. Amends s. 400.484, F.S., relating to right of inspection, violations and fines.
Section 39. Amends s.400.487, F.S., relating to home health agreements; physician’s, physician assistant’s, and advanced registered nurse practitioner’s treatment orders; patient assessment; establishment and review of plan of care; provision of services; and orders not to resuscitate.
Section 40. Amends s. 400.606, F.S., relating to license, application, renewal, conditional license or permit, and certificate of need.
Section 41. Amends s. 400.607, F.S., relating to denial, suspension, revocation of license; emergency actions; imposition of administrative fine; and grounds.
Section 42. Amends s. 400.925, F.S., relating to definitions.
Section 43. Amends s. 400.931, F.S., relating to application for license and fee.
Section 44. Amends s. 400.932, F.S., relating to administrative penalties.
Section 45. Amends s. 400.933, F.S., relating to licensure inspections and investigations.
Section 46. Amends s. 400.953, F.S., relating to background screening of home medical equipment provider personnel.
Section 47. Amends s. 400.967, F.S., relating to rules and classification of violations.
Section 48. Amends s. 400.969, F.S., relating to violation of part and penalties.
Section 49. Amends s. 400.9905, F.S., relating to definitions.
Section 50. Amends s. 400.991, F.S., relating to license requirements, background screenings, and prohibitions.

Section 51. Amends s. 400.9935, F.S., relating to clinic responsibilities.
Section 52. Amends s. 408.034, F.S., relating to duties and responsibilities of agency and rules.
Section 53. Amends s. 408.036, F.S., relating to projects subject to review and exemptions.
Section 54. Amends s. 408.043, F.S., relating to special provisions.
Section 55. Amends s. 408.05, F.S., relating to Florida Center for Health Information and Policy Analysis.
Section 56. Amends s. 408.061, F.S., relating to data collection, uniform systems of financial reporting, information relating to physician charges, confidential information, and immunity.
Section 57. Amends s. 408.10, F.S., relating to consumer complaints.
Section 58. Repeals s. 408.802, F.S., relating to applicability.
Section 59. Amends s. 408.804, F.S., relating to license required, and display.
Section 60. Amends s. 408.806, F.S., relating to license application process.
Section 61. Amends s. 408.810, F.S., relating to minimum licensure requirements.
Section 62. Amends s. 408.811, F.S., relating to right of inspection, copies, inspection reports, and plan for correction of deficiencies.
Section 63. Amends s. 408.813, F.S., relating to administrative fines, and violations.
Section 64. Amends s. 408.815, F.S., relating to license or application denial, and revocation.
Section 65. Amends s. 409.906, F.S., relating to optional Medicaid services.
Section 66. Repeals s. 409.221, F.S., relating to consumer-directed care program.
Section 67. Repeals s. 409.912, F.S., relating to cost-effective purchasing of health care.
Section 68. Amends s. 429.11, F.S., relating to initial application for license.
Section 69. Repeals s. 429.12, F.S., relating to sale or transfer of ownership of a facility.
Section 70. Amends s. 429.14, F.S., relating to administrative penalities.
Section 71. Amends s. 429.17, F.S., relating to expiration of license, renewal, and conditional license.
Section 72. Repeals s. 429.23, F.S., relating to internal risk management and quality assurance program; adverse incidents and reporting requirements.
Section 73. Amends s. 429.35, F.S., relating to maintenance of records, and reports.
Section 74. Amends s. 429.53, F.S., relating to consultation by the agency.
Section 75. Amends s. 429.65, F.S., relating to definitions.
Section 76. Amends s. 429.71, F.S., relating to classification of violations.
Section 77. Repeals s. 429.911, F.S., relating to denial, suspension, revocation of license; emergency action; administrative fines; investigations and inspections.
Section 78. Amends s. 429.915, F.S., relating to conditional license.
Section 79. Amends s. 430.80, F.S., relating to implementation of a teaching nursing home pilot project.
Section 80. Amends s. 440.13, F.S., relating to medical services and supplies, penalty for violations, and limitations.
Section 81. Amends s. 483.294, F.S., relating to inspection of centers.
Section 82. Amends s. 627.645, F.S., relating to denial of health insurance claims restricted.
Section 83. Amends s. 627.668, F.S., relating to optional coverage for mental and nervous disorders required, and exception.
Section 84. Amends s. 627.669, F.S., relating to optional coverage required for substance abuse impaired persons, and exception.
Section 85. Amends s. 627.736, F.S., relating to required personal injury protection benefits, exclusions, priority, and claims.
Section 86. Amends s. 641.495, F.S., relating to requirements for issuance and maintenance of certificate.
Section 87. Amends s. 651.118, F.S., relating to the Agency for Health Care Administration, certificate of need, sheltered beds, and community beds.
Section 88. Amends s. 766.1015, F.S., relating to civil immunity for members of or consultants to certain boards, committees, or other entities.
Section 89. Provides that the bill takes effect July 1, 2010, unless expressly provided otherwise.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   See Fiscal Comments.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

According to AHCA as of January 26, 2010, 61 percent (940) of the 2,385 licensed home health agencies are also Medicare and/or Medicaid certified. Approximately one-third of these agencies are in the process of becoming certified.[4] Certified agencies are already required to meet the new requirements in this bill. Non-certified home health agencies may be impacted if they are not doing the following:[5]

- Supervisory visits for home health aides and certified nursing assistants
- Reviewing plans of care
- Investigating complaints from patients
- Preparing written contracts for individuals not directly employed and other agencies that are providing services under arrangements
- Having a director of nursing or alternate available during operating hours
- Having a registered nurse provide written instructions on patient care to home health aides and certified nursing assistants

D. FISCAL COMMENTS:

The bill is projected to save an estimated $55,700 annually in certified mail costs for reminder license renewal notices and up to $425,273 annually for staffing of AHCA's consumer call center.[6]

According to AHCA, state savings are derived by providing flexibility for staffing of the consumer call center. AHCA, proposes that the call center be brought in-house beginning FY 2010-2011. The net savings would be $354,273 in the first year and $425,273 annually thereafter.

Bringing operation of the call center in-house will increase the quality of complaint intake, improve efficiency and reduce costs to the state. Staff needed to operate the call center include: two Registered Nurse Specialists, two Health Facility Evaluator I positions, two Regulatory Specialist II positions, and four Regulatory Specialist I positions.

The bill also redirects revenue from certain traffic fines from AHCA to the Brain and Spinal Cord Trust Fund within the Department of Health.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

[4] Agency for Health Care Administration 2010 Bill Analysis & Economic Impact Statement of House Bill 1503 (March 24, 2010).
[5] *Id.*
[6] *Id.*

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES