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 1830
INTRODUCER:	Senator Jones
SUBJECT:	Assisted Living Facilities
DATE:	March 29, 2021
REVISED:	

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

I. Summary:

SB 1830 amends several sections of the Florida statutes related to Medicaid and assisted living facilities (ALF) to require Medicaid managed care plans to pay ALFs a rate that reflects the medical acuity and complexity of each resident, using funds appropriated by the Legislature. The bill also defines the term "medication technician" and allows ALFs to employ medication technicians who have completed six hours of specified training.

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 that are appropriate to the needs of the residents who are 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]

[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* Fla. Admin. Code R. 59A-36.007 (2019), for specific minimum standards.
[5] Section 429.26, F.S., and Fla. Admin. Code R. 59A-36.006 (2019).
[6] Section 429.28, F.S.

There are 3,146 licensed ALFs in Florida having a total of 112,520 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]

Florida Medicaid Program

The Medicaid program is a joint federal-state program that finances health coverage for individuals, including eligible low-income adults, children, pregnant women, elderly adults and persons with disabilities.[11] The Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS) is responsible for administering the federal Medicaid program. Florida Medicaid is the health care safety net for low-income Floridians. Florida's program is administered by the AHCA and financed through state and federal funds.[12]

A Medicaid state plan is an agreement between a state and the federal government describing how the state administers its Medicaid programs. The state plan establishes groups of individuals covered under the Medicaid program, services that are provided, payment methodologies, and other administrative and organizational requirements.

In order to participate in Medicaid, federal law requires states to cover certain population groups (mandatory eligibility groups) and gives states the flexibility to cover other population groups (optional eligibility groups). States set individual eligibility criteria within federal minimum standards. The AHCA may seek an amendment to the state plan as necessary to comply with federal or state laws or to implement program changes. States send state plan amendments to the federal CMS for review and approval.[13]

Medicaid enrollees generally receive benefits through one of two service-delivery systems: fee-for-service (FFS) or managed care. Under FFS, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee. Under managed care, the AHCA contracts with private managed care plans for the coordination and payment of services for Medicaid enrollees. The state pays the managed care plans a capitation payment, or fixed monthly payment, per recipient enrolled in the managed care plan. The managed care plan, in turn, makes payment to providers in the plan's network for services rendered. Managed care plans are "at risk" because their costs may exceed the total capacitated payments. The plans are responsible to pay for all covered services for their enrollees, regardless of whether the costs of those services exceeds the capacitated payments received by the AHCA.

[7] Agency for Health Care Administration, Health Care Finder. *See* http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx (last visited March 26, 2021).
[8] Section 429.07(3)(c), F.S.
[9] Section 429.075, F.S.
[10] Section 429.07(3)(b), F.S.
[11] Medicaid.gov, *Medicaid, available at* https://www.medicaid.gov/medicaid/index.html (last visited Mar. 3, 2021).
[12] Section 20.42, F.S.
[13] Medicaid.gov, *Medicaid State Plan Amendments, available at* https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html (last visited Mar. 3, 2021).

In Florida, the majority of Medicaid recipients receive their services through a managed care plan contracted with the AHCA under the Statewide Medicaid Managed Care (SMMC) program.[14] Florida's SMMC offers a health care package covering both acute and long-term care.[15] The SMMC benefits are authorized by federal authority and are specifically required in ss. 409.973 and 409.98, F.S.

The SMMC program has two components, the Managed Medical Assistance (MMA) program and the Long-term Care (LTC) program. The AHCA contracts with managed care plans to provide services to eligible recipients in the 11 regions across the state. The MMA program, which covers most medical and acute care services for managed care plan enrollees, was fully implemented in August 2014, and was re-procured for a period beginning December 2018 and ending in 2023.[16]

Long-term Care (LTC) Program

The following Medicaid recipients are eligible to participate in the LTC program under SMMC:
- Recipients 65 years of age or older and in need of nursing facility level of care.
- Recipients 18 years of age or older and eligible for Medicaid by reason of a disability, and in need of nursing facility level of care.[17]

Eligibility for placement in nursing facilities is determined by using the Comprehensive Assessment and Review for Long-Term Care Services (CARES) tool which assigns each recipient into one of three levels of need-based care.[18] Recipients in the LTC program can reside either in a Nursing Facility or in a Home and Community-Based Setting (HCBS). An HCBS includes an individual's own home or family home, assisted living facility, or adult family care home.

Section 409.982(5), F.S., requires LTC managed care plans to:
- Pay nursing facilities an amount equal to or greater than the nursing facility-specific payment rates set by the AHCA.
- Pay hospice providers an amount equal to the prospective per diem rate set by the AHCA.

A rate is set for HCBS and for nursing facilities for each region, which under federal law must be "actuarially sound" and approved by the CMS.[19] The rate paid to the plans is a blend of the HCBS and nursing facility rates based on the plan's enrolled population on the first day of the year after applying a transition percentage.[20] The AHCA pays the plan based on where an enrollee resides at the beginning of the year. An enrollee who starts the year in a nursing facility is treated as nursing facility for rate blending for the entire year, even if they transition to an

[14] *Id.*
[15] *Id.*
[16] *Id.*
[17] Section 409.979, (1), F.S.
[18] Section 409.983(4), F.S.
[19] 42 C.F.R. 438.4(b).
[20] Section 409.983(3) and (5), F.S., requires the AHCA to make an incentive adjustment in payment rate in each rate period during the first contract period at a rate of three percentage points per year as compared to the utilization mix at the end of the immediately preceding rate-setting period, until no more than 35 percent of the plan's enrollees are placed in nursing facilities. Plans "win" financially if they beat the target transition percentage and "lose" if they do not meet the target.

HCBS. Conversely, an enrollee who starts the year in an HCBS is treated as HCBS rate for rate blending for the entire year, even if they transition to a nursing facility. This is done to incentivize a transition from more expensive nursing facilities to lesser expensive HBCS (to provide incentives for people to "be at home.")

ALF Staff Training

Administrators and Managers

Administrators and other ALF staff must meet minimum training and education requirements established in rule by the AHCA,[21] that are intended to assist ALFs in appropriately responding to the needs of residents, maintaining resident care and facility standards, and meeting licensure requirements.[22]

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.[23]

Administrators and managers must participate in 12 hours of continuing education in topics related to assisted living every two years.[24] 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.[25]

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.[26] Additionally, staff who will be assisting with the self-administration of medication must take an additional six hours of training prior to providing such assistance.

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

[21] Fla. Admin. Code R. 59A-36.011 (2019).
[22] Section 429.52(1), F.S.
[23] 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.
[24] Fla. Admin. Code R. 59A-36.011 (2019).
[25] Fla. Admin. Code R. 59A-36.011 (2019).
[26] *Id.*

training on special topics such as self-administration of medication and Alzheimer's disease, if applicable.

Assistance with the Self-Administration of Medications

Section 429.256, F.S., establishes requirements for the assistance with the self-administration of medication. Residents who are capable of administering their own medications to do so but an unlicensed person who is 18 years of age or older and has completed the required six hours of training may,[27] 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.

The section specifies that the assistance with self-administration of medication includes:

- Taking the medication, in its previously dispensed, properly labeled container, including an insulin syringe that is prefilled with the proper dosage by a pharmacist and an insulin pen that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident.
- In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change.
- Placing an oral dosage in the resident's hand or placing the dosage in another container and helping the resident by lifting the container to his or her mouth.
- Applying topical medications.
- Returning the medication container to proper storage.
- Keeping a record of when a resident receives assistance with self-administration under this section.
- Assisting with the use of a nebulizer, including removing the cap of a nebulizer, opening the unit dose of nebulizer solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the nebulizer.
- Using a glucometer to perform blood-glucose level checks.
- Assisting with putting on and taking off antiembolism stockings.
- Assisting with applying and removing an oxygen cannula but not with titrating the prescribed oxygen settings.
- Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device.
- Assisting with measuring vital signs.
- Assisting with colostomy bags.

[27] *See* Fla. Admin. Code R. 59A-36.008(3)(a) (2019).

The section also specifies that assistance with self-administration does not include:

- Mixing, compounding, converting, or calculating medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.
- The preparation of syringes for injection or the administration of medications by any injectable route.
- Administration of medications by way of a tube inserted in a cavity of the body.
- Administration of parenteral preparations.
- The use of irrigations or debriding agents used in the treatment of a skin condition.
- Assisting with rectal, urethral, or vaginal preparations.
- 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 the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication.
- Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 409.982, F.S., to require Medicaid managed care plans that participate in the LTC program, and using funds appropriated by the Legislature, to pay ALFs a rate that reflects the medical acuity and complexity of each resident. Such rates under the bill must be based on a three-tiered reimbursement payment system for care. The bill requires managed care plans to ensure that they calculate and make special payments for residents who are diagnosed with serious mental illness and for those who require complex care due to dementia or require more supervision for their own safety. The bill also requires managed care plans to ensure that ALF claims that contain sufficient information for processing are paid within 10 business days after receipt.

Sections 2 and 3 of the bill amend ss. 429.02 and 429.52, F.S., to define "medication technician" to mean an unlicensed staff member who has completed six hours of training approved by the agency and provided by an agency-certified trainer. A medication technician may provide assistance with a resident's self-administration of medications and with his or her use of point-of-care devices.[28] The bill requires medication technicians to complete a minimum of six hours of training, established by AHCA rule. The training must address:

- Infection control;
- Safe handling and use of assistive care devices;
- Communicating with case managers and health care providers;

[28] Point of care (POC) diagnostic devices are used to obtain diagnostic results while with the patient or close to the patient. Used in doctors' offices, hospitals, and in patients' homes, POC diagnostic devices give quick feedback on many sorts of medical tests. POC diagnostic devices are used to test glucose and cholesterol levels, do electrolyte and enzyme analysis, test for drugs of abuse and for infectious diseases, and for pregnancy testing. Blood gases, cardiac markers, and fecal occult blood tests can also be done with POC diagnostic devices. There are several advantages to doing the tests at the point of care, including quick results and faster implementation of therapy, if needed. *See* https://www.labcompare.com/Clinical-Diagnostics/5096-POC-Diagnostic-Devices/ (last visited March 26, 2021).

- Standard of care protocols for the provision of care in licensed ALFs;
- Identification of nursing standards; and
- Methods of assisting residents with the self-administration of medications.

The bill requires the AHCA to authorize approved training for medication technicians to be conducted using online materials and courses approved by the AHCA. An online course must conclude with a trainee taking an end-of-course exam and must provide a certificate with a passing exam score and unique certification number for each trainee.

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:

SB 1830 requires the AHCA to develop a new methodology under which LTC managed care plans will be required to pay ALFs. This requirement is accompanied by the need for the AHCA and its contracted actuaries to develop a new or revised methodology under which an actuarially sound capitation rate for such managed care plans will be developed. Furthermore, if the bill's new payment system for ALFs requires managed care plans to increase ALF reimbursement, those higher costs will be borne by the state Medicaid

program. The AHCA has not provided an estimate for the bill's fiscal impacts. The extent of these potential negative fiscal impacts is indeterminate as of this writing.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.982, 429.02, and 429.52.

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.