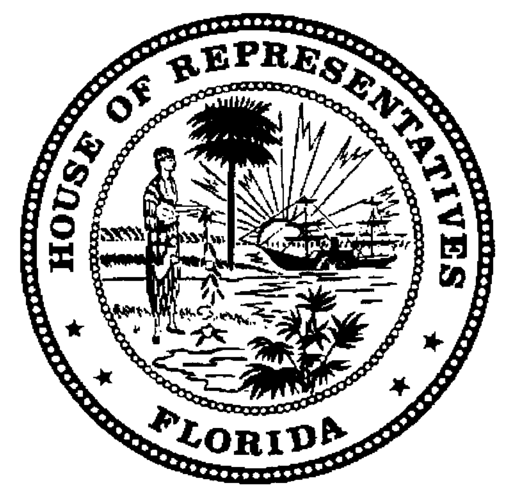

Healthcare Council

Wednesday, April 4, 2007
1:00 PM
Morris Hall

Marco Rubio
Speaker

Aaron Bean
Chair

Council Meeting Notice

HOUSE OF REPRESENTATIVES

Speaker Marco Rubio

Healthcare Council

Start Date and Time: Wednesday, April 04, 2007 01:00 pm

End Date and Time: Wednesday, April 04, 2007 05:00 pm

Location: Morris Hall (17 HOB)
Duration: 4.00 hrs

Consideration of the following bill(s):

HB 97 Medicare Supplement Policies by Hays
HB 385 Nursing Home Facilities by Murzin
HB 397 Caregivers for Adults by Anderson
HB 543 Immunization Services by Zapata
HB 587 Mental Health Facilities by Grimsley
HB 1001 Health Maintenance Contracts by Evers
HB 1269 Infant Mortality by Reed

Consideration of the following bill(s) with proposed council substitute(s):

HB 739 Treatment Programs for Impaired Practitioners by Holder

Consideration of the following proposed council bill(s):

PCB HCC 07-15 -- hospice facilities

It is the intent of the Council to take up proposed council substitute for HB 739 which was voted out of its respective committee and was recommended as a council substitute.

At 3:30 p.m., a presentation by the Agency for Persons with Disabilities on a plan for eliminating the 2007-08 deficit.

Pursuant to rule 7.12, the deadline for amendments to bills on the agenda by non-appointed members shall be 6:00 p.m., Tuesday, April 3, 2007.

By request of the Chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Tuesday, April 3, 2007.

NOTICE FINALIZED on 04/02/2007 16:07 by BAI

HB 97

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 97 Medicare Supplement Policies
SPONSOR(S): Hays
TIED BILLS: **IDEN./SIM. BILLS:** SB 266

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Healthy Seniors	8 Y, 0 N	Walsh	Schoolfield
2) Healthcare Council		Walsh	Gormley
3)			
4)			
5)			

SUMMARY ANALYSIS

House Bill 97 would exclude Medicare Supplement Insurance (Medigap policies) offered by employers or employer groups to employees or former employees from the definition of "Medicare supplement policy." Such policies *issued in Florida* would still be subject to other provisions of the Insurance Code. Medicare supplement policies *issued outside of Florida that cover Florida residents* would be exempt from any regulation by the state of Florida, but would be regulated by applicable federal law and the law of the state where the policy was issued. This change would align Florida statutes with the definition of "Medicare supplement policy" found in federal law and the National Association of Insurance Commissioners (NAIC) model law and regulations.

The act is effective July 1, 2007.

This bill does not appear to have a fiscal impact on state or local governments.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government—Medicare supplement plans issued in Florida and offered by employers or employer groups to employees or former employees would be subject to a lesser number of provisions of the Florida Insurance Code. Such plans issued outside of Florida which cover Florida residents would be exempt from any regulation by this state.

B. EFFECT OF PROPOSED CHANGES:

Background

Medicare Supplement Policies

Part VIII of Chapter 627, F.S., is the "Florida Medicare Supplement Reform Act," which regulates Medicare supplement insurance. A "Medicare supplement policy" is defined in s. 627.672(1), F.S., as a health insurance policy or other health benefit plan offered by a private entity to reimburse the policyholder for expenses incurred but not reimbursable under Medicare.

The policies are also known as Medigap coverage.[1] This coverage is available to persons who have both Medicare Part A (hospital insurance) and Part B (medical insurance), that is, persons age 65 and over. Plans that are marketed as Medigap policies must comply with extensive federal regulations relating to marketing, standardized benefit schedules, and disclosure requirements, among others. Importantly, Medigap policies are guaranteed renewable, which means the insurer must automatically renew or continue coverage as long as the premiums are continuously paid and the insured has not committed fraud.

Premiums for Medigap policies may be set using one of three methods:

- Community-rated (or no-age rated)—Every policyholder pays the same premium regardless of age; premiums may increase because of inflation.
- Issue-age rated—The premium is based on the age of the policyholder at initial purchase, so younger persons pay less; premiums may increase because of inflation.
- Attained-age rated—The premium is based on the policyholder's current (attained) age, so premiums increase each year; premiums may also increase because of inflation.

Out-of-state insurers that issue Medicare supplement policies to Florida residents are required to file a master copy of the policy and any certificate used in the state with the Office of Insurance Regulation (OIR). In-state insurers issuing this type of policy are required to report to the OIR every policy and certificate number and the date of issuance; must file with the OIR rates and rating schedules; and must demonstrate compliance with the loss-ratio standards set forth in s. 627.6745, F.S.

Other Health Insurance Coverage for Persons with Medicare

Medicare supplement policies are not the only kinds of health insurance available to persons with Medicare. Medicare Advantage Plans, Medicare Health Plans, PACE, COBRA coverage, employer and union plans, Tricare, and Veterans' benefits also provide coverage secondary to Medicare.[2]

Retirees of many larger employers receive health insurance coverage that coordinates Medicare in two ways. Some employers are self-insured, and those plans are exempt from state regulation as an

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[1] The discussion of Medigap coverage derives from *2006 Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*, developed jointly by the Centers for Medicare & Medicaid Services (CMS) and the National Association of Insurance Commissioners (NAIC), available online at http://www.medicare.gov/Publications/Pubs/pdf/02110.pdf

[2] These plans are not the subject of the provisions of this bill.

employee benefit by operation of ERISA.[3] Other employers offer retiree health plans, which are exempt from regulation as Medicare supplement policies pursuant to s. 627.673(3), F.S.

Legislative History

Prior to 1988, Florida's definition of Medicare supplement policy contained a specific exemption for such policies provided by employer groups or labor organizations, thus making those Medicare supplement insurance policies exempt from state regulation. The exemption reportedly was removed[4] because a model act recommended by the National Association of Insurance Commissioners (NAIC) contained no such exclusion.

The current NAIC Medicare Supplement Insurance Minimum Standards Model Act now includes an exemption for policies issued by employer groups or labor organizations.[5] The NAIC Model Act, including this definition, has been adopted by 38 other states. The Social Security Act definition of "Medicare supplement policy", 42 U.S.C. s.1395ss, subpart (g)(1), contains an exemption for policies issued by employer groups or labor organizations. In 2000, the Florida Legislature exempted labor organizations from the definition of Medicare supplement policy.[6]

Effect of Proposed Legislation

HB 97 would exclude Medicare Supplement Insurance offered by employers or employer groups to employees or former employees from the definition of "Medicare supplement policy." The bill would conform the Florida definition of Medicare supplement policy to that in federal law, NAIC Model acts, and the laws of 38 other states that have adopted the NAIC Model.

Policies issued in Florida would still be subject to provisions of the Insurance Code other than Part VIII of Chapter 627, F. S. Medicare supplement policies issued outside of Florida which cover Florida residents would be exempt from any regulation by the state of Florida, and OIR would have no authority to assist Florida insured individuals that have problems with or complaints about the insurer. However, the latter policies would be regulated by applicable federal law and the law of the state where the policy was issued.

C. SECTION DIRECTORY:

Section 1: Amends s. 627.672(1), F.S., excluding policies or plans of employers from the definition of Medicare supplement policy.

Section 2: Provides an effective date of July 1, 2007.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

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[3] Employment Retirement Income Security Act of 1974. ERISA is a federal law setting minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in those plans.

[4] Section 1, Chapter 88-338, Laws of Florida.

[5] NAIC 650-1, *Medicare Supplement Insurance Minimum Standards Model Act*, s. 2.B. (National Association of Insurance Commissioners). [The exemption is expressed as part of the applicability and scope of regulation of Medicare supplement policies, not as an exemption as part of a definition of Medicare supplement insurance.]

[6] Chapter 2000-202, Laws of Florida

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

This bill allows employers and employer groups the same exemption afforded labor organizations relating to the provision of health insurance to their employees and retirees on Medicare. Proponents of the bill note that employers could negotiate group coverage on a nationwide basis without being required to have a Florida-specific Medigap standard policy. The premiums would be based on the benefit levels they choose to offer their retirees and the price the employer can afford to pay. As the cost of retiree health insurance escalates, more employers are cutting back on or eliminating this coverage as a retirement benefit. It is expected that the exemption authorized in this bill will provide more affordable options for employers wishing to offer this benefit.

The Office of Insurance Regulation and the Division of Consumer Services in the Department of Financial Services raise concerns that this exemption will result in consumer protections being lost for consumers obtaining policies through an employer group—policies that are similar but not identical to Medicare supplement policies. These policies would not be required to meet form requirements, rate regulation that provides stability of premium costs, or be subject to marketing protections found in current Florida law. They advise that this change could also allow fictitious employer groups to form solely for the purpose of providing insurance benefits to a market that is not currently accessible to the non-Medicare supplement market carriers.[7]

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   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:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

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[7] Reference is made to a product called "Senior Choice" sold here in 2002. It was offered by an insurer under the mistaken assumption that an employer group exemption was in effect at the time. Agents of the company enrolled nursing home residents and other seniors by convincing them that work the senior had performed in the past (e.g., lawn mowing) qualified him or her as an employer or employer group. The policies they were sold were limited health benefit products, which provided substantially less coverage than the Medicare supplement policies they relinquished. The Division of Consumer Services took action in May 2002 to stop the sale of the product in Florida.

D. STATEMENT OF THE SPONSOR:

This legislation will greatly enhance the access to healthcare for Florida's senior citizens.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

At its March 6, 2007, meeting the Committee on Healthy Seniors adopted one amendment to HB 97. That amendment eliminated a difference in drafting styles between the chambers and matched the bill to the Senate bill as originally filed.

The bill was reported favorably with one amendment.

1 A bill to be entitled
2 An act relating to Medicare supplement policies; amending
3 s. 627.672, F.S.; revising an exclusion from a definition
4 of the term "Medicare supplement policy"; providing an
5 effective date.
6
7 Be It Enacted by the Legislature of the State of Florida:
8
9 Section 1. Subsection (1) of section 627.672, Florida
10 Statutes, is amended to read:
11 627.672 Definitions.--For the purposes of ss. 627.671-
12 627.675:
13 (1) A "Medicare supplement policy" is a health insurance
14 policy or other health benefit plan offered by a private entity
15 to individuals who are entitled to have payments for health care
16 costs made under Medicare, Title XVIII of the Social Security
17 Act ("Medicare"), as presently constituted and as may later be
18 amended, which provides reimbursement for expenses incurred for
19 services and items for which payment may be made under Medicare
20 but which expenses are not reimbursable by reason of the
21 applicability of deductibles, coinsurance amounts, or other
22 limitations imposed by Medicare. The term does not include any
23 such policy or plan of one or more employers or labor
24 organizations, or of the trustees of a fund established by one
25 or more employers or labor organizations, or a combination
26 thereof, for employees or former employees, or a combination
27 thereof, of the employers or for employees or former employees,

28 or a combination thereof, or ~~for~~ members or former members, or a
29 combination thereof, of the labor organizations.
30 Section 2. This act shall take effect July 1, 2007.

Bill No. **97**

COUNCIL/COMMITTEE ACTION

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

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1 Council/Committee hearing bill: Healthcare Council
2 Representative(s) Hays offered the following:
3
4 **Amendment (with title amendment)**
5 Remove everything after the enacting clause and insert:
6
7 Be It Enacted by the Legislature of the State of Florida:
8
9 Section 1. Subsection (1) of section 627.672, Florida
10 Statutes, is amended to read:
11 627.672 Definitions.--For the purposes of ss. 627.671-
12 627.675:
13 (1) A "Medicare supplement policy" is a health insurance
14 policy or other health benefit plan offered by a private entity
15 to individuals who are entitled to have payments for health care
16 costs made under Medicare, Title XVIII of the Social Security
17 Act ("Medicare"), as presently constituted and as may later be
18 amended, which provides reimbursement for expenses incurred for
19 services and items for which payment may be made under Medicare
20 but which expenses are not reimbursable by reason of the
21 applicability of deductibles, coinsurance amounts, or other
22 limitations imposed by Medicare. The term does not include any

23 such policy or plan of one or more employers that have at least
24 50 employees at issue or labor organizations, or of the trustees
25 of a fund established by one or more employers or labor
26 organizations, or a combination thereof, for employees or former
27 employees, or a combination thereof, or for members or former
28 members, or a combination thereof, of the labor organizations.
29 Section 2. This act shall take effect July 1, 2007.
30
31
32 ================= T I T L E A M E N D M E N T =================
33 Remove the entire title and insert:
34
35 A bill to be entitled
36 An act relating to Medicare supplement policies; amending
37 s. 627.672, F.S.; redefining the term "Medicare supplement
38 policy" for purposes of part VIII of ch. 627, F.S., to
39 exclude a health insurance policy or other health benefit
40 plan that is offered by one or more employers to employees
41 or former employees; providing an effective date.
42

Amendment No. 1(for drafter's use only)

Bill No. HB 97

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)

ADOPTED AS AMENDED __ (Y/N)

ADOPTED W/O OBJECTION __ (Y/N)

FAILED TO ADOPT __ (Y/N)

WITHDRAWN __ (Y/N)

OTHER ______

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1 Council/Committee hearing bill: Healthcare Council
2 Committee on Healthy Seniors offered the following:
3
4 **Amendment**
5 Remove line(s) 26 and 27 and insert:
6 thereof, for employees or former employees,
7
8

This amendment was adopted in HS on 03/06/07 and is traveling with the bill and requires no further action. However, the new strike all will supercede the traveling amendment which is encompassed in the strike all.

HB 385

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 385 Nursing Home Facilities
SPONSOR(S): Murzin
TIED BILLS: **IDEN./SIM. BILLS:** SB 682

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Health Innovation	8 Y, 0 N	Ciccone	Calamas
2) Healthcare Council		Ciccone	Gormley
3)			
4)			
5)			

SUMMARY ANALYSIS

House Bill 385 revises the frequency of visits to nursing facilities by quality-of-care monitors (QOC) from quarterly to annually. The bill requires that quality of care monitors visit conditionally licensed nursing facilities quarterly and other nursing facilities as deemed appropriate by the Agency for Health Care Administration (the agency). The bill provides that every nursing facility that has a standard license may develop a plan to provide training for certified nursing assistants (CNA).

The bill modifies the definition of adverse incidents as events reported to law enforcement for investigation. The bill deletes the requirement for nursing facilities to submit a one-day adverse incident report as determined by the facility's risk manager to the agency. The bill provides that the most recent survey is considered the annual survey for purposes of future survey scheduling.

The bill specifies that compliance with federal posting standards satisfies state posting standards and specifies that nursing homes are required to post a conditional license only after it has been issued by final order. The bill also modifies the requirements for when a nursing home with a conditional license returns to a standard status. Finally, the bill modifies the definition of class I, class II, class III, and class IV deficiencies to be consistent with partial federal regulations.

There is no fiscal impact associated with this bill.

The bill provides an effective date of July 1, 2007.

BILL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government—The bill reduces the number of QOC visits from quarterly to annually; however quarterly visits would continue to be made to facilities that have conditional licenses (class I or II deficiency, or uncorrected class III deficiency) and the agency would continue to direct QOC visits as deemed appropriate.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

Chapter 400, Part II, F. S., provides that all nursing homes in the state be licensed. The agency is directed to carry out the licensure provisions required in law and currently uses quality-of-care monitors to visit each nursing home quarterly. These quality-of-care monitors are registered nurses with training and experience in nursing facility regulation, long term care practice standards and patient care evaluation. Quality of care monitors assess the overall quality of life in the nursing facility and those facility conditions that are directly related to resident care, including the internal quality improvement and risk management.

Gold Seal Facilities and Training

Section 400.141, F.S., provides that every licensed nursing home facility comply with all applicable standards and rules. Nursing homes that are designated as Gold Seal facilities may develop a plan to provide CNA training as prescribed by federal regulations and state rules. A facility wishing to provide CNA training must not have been cited for substandard quality of care, been terminated from the Medicare/Medicaid program, or had an enforcement action within the previous two years to meet federal requirements. The state is required to withdraw approval of a training program if any of these and/or other specified conditions occur (42 Code of Federal Regulations 483.151). In Florida, CNA training is subject to approval by the Board of Nursing in the Department of Health (DOH) in accordance with section 64B9-15.005, Florida Administrative Code, and appropriate certification by the Department of Education (DOE). There are approximately five Florida nursing homes that are currently certified by the DOE to offer CNA training.

Incident Reporting

Each nursing home must notify the agency in writing within one business day of any adverse incident as defined by statute. The facility must initiate an investigation and provide a complete report to the agency within 15 calendar days after its occurrence. If, after a complete investigation, the facility's risk manager determines that the event does not constitute an adverse incident; the facility must include this information in the report.

Licensure Evaluation and Status

Under s. 400.23(7), F.S., the agency must, at least every 15 months, evaluate each nursing home facility and determine the degree of compliance of the nursing home with licensure requirements in order to assign a licensure status to the nursing home. Based on the most recent inspection report, the agency must assign a licensure status of standard or conditional. A standard licensure status means that a nursing home has no class I or class II deficiencies and has corrected all class III deficiencies within the time established by the agency. A conditional licensure status means that a nursing home, due to the presence of one or more class I or class II deficiencies, or class III deficiencies not corrected within the time established by the agency, is not in substantial compliance with licensure standards at

the time of the survey. If a nursing home has no class I, class II, or class III deficiencies at the time of the follow-up survey, a standard licensure status may be assigned.

Section 400.23(8), F.S., defines class I, class II, class III, and class IV deficiencies as follows:

- A class I deficiency is a deficiency that the agency determines requires immediate corrective action because the nursing home's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in the nursing home.

- A class II deficiency is a deficiency that the agency determines has compromised the resident's ability to maintain or reach his or her highest practicable physical, mental, and psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.

- A class III deficiency is a deficiency that the agency determines will result in no more than minimal physical, mental, or psychosocial discomfort to the resident or has the potential to compromise the resident's ability to maintain or reach his or her highest practical physical, mental, or psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.

- A class IV deficiency is a deficiency that the agency determines has the potential for causing no more than a minor negative impact on the resident.

A conditional license is issued to a nursing home that has been cited for serious deficiencies (class I or II) or failed to correct class III deficiencies. A facility must be in substantial compliance with all regulations before returning to a standard license. Conditional licenses are considered "sanctions" and are subject to the Florida Administrative Procedure Act. These licenses are treated as legal sanctions and a nursing home licensee may challenge the conditional status.

Posting Requirements

State law currently requires each nursing home to post daily the names of staff on duty for the benefit of residents and the public. Federal requirements state that the facility must post the nurse staffing data on a daily basis at the beginning of each shift. The listing must be clear and readable and posted in a prominent place readily accessible to residents and visitors.

Effect of Proposed Legislation

House Bill 385 would reduce the number of QOC visits from quarterly to annually; however, quarterly visits would continue to be made to facilities that have conditional licenses (class I or II deficiency, or uncorrected class III deficiency) and the agency would continue to direct QOC visits as deemed appropriate. Currently only Gold Seal nursing facilities may develop certified nursing assistant (CNA) training. This proposal could increase CNA training by allowing every nursing facility that has a standard license to develop a plan to provide training for CNAs.

The bill modifies the definition of adverse incidents as events reported to law enforcement for investigation, rather than every report to law enforcement. The bill deletes the requirement for nursing facilities to submit a one-day report as determined by the facility's risk manager to the agency. According to the agency, because of combined federal and state nursing regulations regarding reporting requirements, the continued requirement to submit the 15-day report and the agency quality-of-care nurse monitor visits, the elimination of the one-day report would not create a significant gap in monitoring regulatory compliance.[1] The bill also provides that the most recent survey is considered the annual survey for purposes of future survey scheduling. The effect of this proposal would allow the last survey conducted within a six-month survey cycle to be counted as an annual survey in the event that

[1] Agency for Health Care Administration staff analysis, March 2007, on file with committee

the administrative action that originated the six-month cycle is overturned. The effect would be that the next annual investigation would not be scheduled for this facility for up to 15 months.

The bill provides that compliance with federal posting standards satisfies state posting standards and as such aligns federal and state standards. The bill also specifies that nursing homes are required to post a conditional license only after it has been issued by final order. Conditional licenses are considered "sanctions" and are subject to the Florida Administrative Procedures Act and can be challenged by the nursing home (licensee). Since these challenges can last several months or a year, the effect of this proposal could result in a nursing home having been returned to "standard" status before a final order on the conditional license would be finalized and therefore, resulting in most nursing homes never having to post a conditional license.

The bill clarifies that uncorrected class III deficiencies would prevent a nursing facility with a conditional license from getting a standard license. The bill modifies the definition of class I, class II, class III, and class IV deficiencies to be consistent with partial federal regulations.

C. SECTION DIRECTORY:

Section 1. Amends s. 400.118(2)(a), F.S.; relating to nursing home quality assurance.

Section 2. Amends s. 400.141(24), F. S.; relating to nursing home facility administration and management.

Section 3. Renumbers s. 400.147(9) through (15), F.S., as s. 400.147(8) through (14) and amends s. 400.147(5)(e), (7) and (8), F.S.; relating to nursing home internal risk management and quality assurance programs.

Section 4. Amends s. 400.19(3), F.S.; relating to right of agency entry and inspection of nursing home facilities.

Section 5. Amends s. 400.195(1)(d), F.S.; relating to agency reporting requirements; corrects a cross reference.

Section 6. Amends s. 400.23(3)(a), (7)(b)(e) and (8), F.S.; relating to nursing home rules, deficiencies and licensure status.

Section 7. Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

According to the Agency for Health Care Administration, there is no fiscal impact on the agency. The enacting legislation for nursing home and assisted living facility risk management and adverse incident reporting was passed in Senate Bill 1202, during the 2001 Legislative Session. Original staffing for adverse incident reporting was based on an estimate of 3,600 nursing home and assisted living facility adverse incidents per year. The original estimate fell significantly short of actual adverse incidents received each year. During Fiscal Year 2005-2006, 4,672 adverse incidents were processed by the agency—30 percent higher than estimated. The total number of adverse incidents is not affected by this bill. The agency has previously allocated necessary resources to handle this higher than anticipated workload from adverse incident reports and will require all existing resources to manage remaining activities.[2]

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to spend funds or to take any action requiring the expenditure of funds; reduce the authority that municipalities or counties have to raise revenue in the aggregate; or reduce the percentage of a state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Agency for Health Care Administration will require additional rule making authority regarding review and approval of such programs.

C. DRAFTING ISSUES OR OTHER COMMENTS:

On page 13 between lines 347 and 348 insert the following:

The agency may adopt rules as necessary regarding review and approval of such programs.

D. STATEMENT OF THE SPONSOR

No statement submitted.

[2] Agency for Health Care staff analysis, March 2007, on file with the Committee

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

On March 13, 2007, the Health Innovation Committee adopted four amendments to the bill. These amendments do the following:

- Provides that the agency will conduct quarterly visits for a nursing home that is not conditionally licensed and that the quarterly visit request is valid through the current licensure period.
- Authorizes AHCA to develop criteria regarding the approval, suspension and termination of the certified nursing assistant training program by rule.
- Conforms to changes passed in the 2006 Legislative session related to the licensure process for licensed facilities (technical).
- Removes references regarding posting of final survey findings, the affect of deficiencies on the survey process, and the alignment of state and federal deficiency definitions.

The bill was reported favorably with four amendments.

1 A bill to be entitled
2 An act relating to nursing home facilities; amending s.
3 400.118, F.S.; revising provisions relating to frequency
4 of quality-of-care monitoring of specified facilities;
5 amending s. 400.141, F.S.; authorizing facilities with a
6 standard license to provide certified nursing assistant
7 training; amending s. 400.147, F.S.; revising a
8 definition; revising reporting requirements under facility
9 internal risk management and quality assurance programs;
10 amending s. 400.19, F.S.; providing conditions for
11 scheduling surveys when certain deficiencies are
12 overturned; amending s. 400.195, F.S.; correcting a cross-
13 reference; amending s. 400.23, F.S.; revising conditions
14 for documentation of compliance with staffing standards;
15 directing the Agency for Health Care Administration to
16 assign standard licensure status to a facility that has
17 corrected specified deficiencies; revising provisions
18 relating to classification of facility deficiencies;
19 providing a definition; providing an effective date.
20
21 Be It Enacted by the Legislature of the State of Florida:
22
23 Section 1. Paragraph (a) of subsection (2) of section
24 400.118, Florida Statutes, is amended to read:
25 400.118 Quality assurance; early warning system;
26 monitoring; rapid response teams.--
27 (2)(a) The agency shall establish within each district
28 office one or more quality-of-care monitors, based on the number

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

29 of nursing facilities in the district, to monitor all nursing
30 facilities in the district on a regular, unannounced, aperiodic
31 basis, including nights, evenings, weekends, and holidays.
32 Quality-of-care monitors shall visit each nursing facility
33 annually, shall visit each conditionally licensed nursing
34 facility at least quarterly, and shall visit other nursing
35 facilities as directed by the agency. Priority for additional
36 monitoring visits shall be given to nursing facilities with a
37 history of resident care deficiencies. Quality-of-care monitors
38 shall be registered nurses who are trained and experienced in
39 nursing facility regulation, standards of practice in long-term
40 care, and evaluation of patient care. Individuals in these
41 positions shall not be deployed by the agency as a part of the
42 district survey team in the conduct of routine, scheduled
43 surveys, but shall function solely and independently as quality-
44 of-care monitors. Quality-of-care monitors shall assess the
45 overall quality of life in the nursing facility and shall assess
46 specific conditions in the facility directly related to resident
47 care, including the operations of internal quality improvement
48 and risk management programs and adverse incident reports. The
49 quality-of-care monitor shall include in an assessment visit
50 observation of the care and services rendered to residents and
51 formal and informal interviews with residents, family members,
52 facility staff, resident guests, volunteers, other regulatory
53 staff, and representatives of a long-term care ombudsman council
54 or Florida advocacy council.
55 Section 2. Section 400.141, Florida Statutes, is amended
56 to read:

57 400.141 Administration and management of nursing home
58 facilities.--Every licensed facility shall comply with all
59 applicable standards and rules of the agency and shall:
60 (1) Be under the administrative direction and charge of a
61 licensed administrator.
62 (2) Appoint a medical director licensed pursuant to
63 chapter 458 or chapter 459. The agency may establish by rule
64 more specific criteria for the appointment of a medical
65 director.
66 (3) Have available the regular, consultative, and
67 emergency services of physicians licensed by the state.
68 (4) Provide for resident use of a community pharmacy as
69 specified in s. 400.022(1)(q). Any other law to the contrary
70 notwithstanding, a registered pharmacist licensed in Florida,
71 that is under contract with a facility licensed under this
72 chapter or chapter 429, shall repackage a nursing facility
73 resident's bulk prescription medication which has been packaged
74 by another pharmacist licensed in any state in the United States
75 into a unit dose system compatible with the system used by the
76 nursing facility, if the pharmacist is requested to offer such
77 service. In order to be eligible for the repackaging, a resident
78 or the resident's spouse must receive prescription medication
79 benefits provided through a former employer as part of his or
80 her retirement benefits, a qualified pension plan as specified
81 in s. 4972 of the Internal Revenue Code, a federal retirement
82 program as specified under 5 C.F.R. s. 831, or a long-term care
83 policy as defined in s. 627.9404(1). A pharmacist who correctly
84 repackages and relabels the medication and the nursing facility

85 which correctly administers such repackaged medication under the
86 provisions of this subsection shall not be held liable in any
87 civil or administrative action arising from the repackaging. In
88 order to be eligible for the repackaging, a nursing facility
89 resident for whom the medication is to be repackaged shall sign
90 an informed consent form provided by the facility which includes
91 an explanation of the repackaging process and which notifies the
92 resident of the immunities from liability provided herein. A
93 pharmacist who repackages and relabels prescription medications,
94 as authorized under this subsection, may charge a reasonable fee
95 for costs resulting from the implementation of this provision.
96 (5) Provide for the access of the facility residents to
97 dental and other health-related services, recreational services,
98 rehabilitative services, and social work services appropriate to
99 their needs and conditions and not directly furnished by the
100 licensee. When a geriatric outpatient nurse clinic is conducted
101 in accordance with rules adopted by the agency, outpatients
102 attending such clinic shall not be counted as part of the
103 general resident population of the nursing home facility, nor
104 shall the nursing staff of the geriatric outpatient clinic be
105 counted as part of the nursing staff of the facility, until the
106 outpatient clinic load exceeds 15 a day.
107 (6) Be allowed and encouraged by the agency to provide
108 other needed services under certain conditions. If the facility
109 has a standard licensure status, and has had no class I or class
110 II deficiencies during the past 2 years or has been awarded a
111 Gold Seal under the program established in s. 400.235, it may be
112 encouraged by the agency to provide services, including, but not

113 limited to, respite and adult day services, which enable
114 individuals to move in and out of the facility. A facility is
115 not subject to any additional licensure requirements for
116 providing these services. Respite care may be offered to persons
117 in need of short-term or temporary nursing home services.
118 Respite care must be provided in accordance with this part and
119 rules adopted by the agency. However, the agency shall, by rule,
120 adopt modified requirements for resident assessment, resident
121 care plans, resident contracts, physician orders, and other
122 provisions, as appropriate, for short-term or temporary nursing
123 home services. The agency shall allow for shared programming and
124 staff in a facility which meets minimum standards and offers
125 services pursuant to this subsection, but, if the facility is
126 cited for deficiencies in patient care, may require additional
127 staff and programs appropriate to the needs of service
128 recipients. A person who receives respite care may not be
129 counted as a resident of the facility for purposes of the
130 facility's licensed capacity unless that person receives 24-hour
131 respite care. A person receiving either respite care for 24
132 hours or longer or adult day services must be included when
133 calculating minimum staffing for the facility. Any costs and
134 revenues generated by a nursing home facility from
135 nonresidential programs or services shall be excluded from the
136 calculations of Medicaid per diems for nursing home
137 institutional care reimbursement.
138 (7) If the facility has a standard license or is a Gold
139 Seal facility, exceeds the minimum required hours of licensed
140 nursing and certified nursing assistant direct care per resident

141 per day, and is part of a continuing care facility licensed
142 under chapter 651 or a retirement community that offers other
143 services pursuant to part III of this chapter or part I or part
144 III of chapter 429 on a single campus, be allowed to share
145 programming and staff. At the time of inspection and in the
146 semiannual report required pursuant to subsection (15), a
147 continuing care facility or retirement community that uses this
148 option must demonstrate through staffing records that minimum
149 staffing requirements for the facility were met. Licensed nurses
150 and certified nursing assistants who work in the nursing home
151 facility may be used to provide services elsewhere on campus if
152 the facility exceeds the minimum number of direct care hours
153 required per resident per day and the total number of residents
154 receiving direct care services from a licensed nurse or a
155 certified nursing assistant does not cause the facility to
156 violate the staffing ratios required under s. 400.23(3)(a).
157 Compliance with the minimum staffing ratios shall be based on
158 total number of residents receiving direct care services,
159 regardless of where they reside on campus. If the facility
160 receives a conditional license, it may not share staff until the
161 conditional license status ends. This subsection does not
162 restrict the agency's authority under federal or state law to
163 require additional staff if a facility is cited for deficiencies
164 in care which are caused by an insufficient number of certified
165 nursing assistants or licensed nurses. The agency may adopt
166 rules for the documentation necessary to determine compliance
167 with this provision.

168 (8) Maintain the facility premises and equipment and
169 conduct its operations in a safe and sanitary manner.
170 (9) If the licensee furnishes food service, provide a
171 wholesome and nourishing diet sufficient to meet generally
172 accepted standards of proper nutrition for its residents and
173 provide such therapeutic diets as may be prescribed by attending
174 physicians. In making rules to implement this subsection, the
175 agency shall be guided by standards recommended by nationally
176 recognized professional groups and associations with knowledge
177 of dietetics.
178 (10) Keep full records of resident admissions and
179 discharges; medical and general health status, including medical
180 records, personal and social history, and identity and address
181 of next of kin or other persons who may have responsibility for
182 the affairs of the residents; and individual resident care plans
183 including, but not limited to, prescribed services, service
184 frequency and duration, and service goals. The records shall be
185 open to inspection by the agency.
186 (11) Keep such fiscal records of its operations and
187 conditions as may be necessary to provide information pursuant
188 to this part.
189 (12) Furnish copies of personnel records for employees
190 affiliated with such facility, to any other facility licensed by
191 this state requesting this information pursuant to this part.
192 Such information contained in the records may include, but is
193 not limited to, disciplinary matters and any reason for
194 termination. Any facility releasing such records pursuant to
195 this part shall be considered to be acting in good faith and may

196 not be held liable for information contained in such records,
197 absent a showing that the facility maliciously falsified such
198 records.
199 (13) Publicly display a poster provided by the agency
200 containing the names, addresses, and telephone numbers for the
201 state's abuse hotline, the State Long-Term Care Ombudsman, the
202 Agency for Health Care Administration consumer hotline, the
203 Advocacy Center for Persons with Disabilities, the Florida
204 Statewide Advocacy Council, and the Medicaid Fraud Control Unit,
205 with a clear description of the assistance to be expected from
206 each.
207 (14) Submit to the agency the information specified in s.
208 400.071(2)(e) for a management company within 30 days after the
209 effective date of the management agreement.
210 (15) Submit semiannually to the agency, or more frequently
211 if requested by the agency, information regarding facility
212 staff-to-resident ratios, staff turnover, and staff stability,
213 including information regarding certified nursing assistants,
214 licensed nurses, the director of nursing, and the facility
215 administrator. For purposes of this reporting:
216 (a) Staff-to-resident ratios must be reported in the
217 categories specified in s. 400.23(3)(a) and applicable rules.
218 The ratio must be reported as an average for the most recent
219 calendar quarter.
220 (b) Staff turnover must be reported for the most recent
221 12-month period ending on the last workday of the most recent
222 calendar quarter prior to the date the information is submitted.
223 The turnover rate must be computed quarterly, with the annual

224 rate being the cumulative sum of the quarterly rates. The
225 turnover rate is the total number of terminations or separations
226 experienced during the quarter, excluding any employee
227 terminated during a probationary period of 3 months or less,
228 divided by the total number of staff employed at the end of the
229 period for which the rate is computed, and expressed as a
230 percentage.
231 (c) The formula for determining staff stability is the
232 total number of employees that have been employed for more than
233 12 months, divided by the total number of employees employed at
234 the end of the most recent calendar quarter, and expressed as a
235 percentage.
236 (d) A nursing facility that has failed to comply with
237 state minimum-staffing requirements for 2 consecutive days is
238 prohibited from accepting new admissions until the facility has
239 achieved the minimum-staffing requirements for a period of 6
240 consecutive days. For the purposes of this paragraph, any person
241 who was a resident of the facility and was absent from the
242 facility for the purpose of receiving medical care at a separate
243 location or was on a leave of absence is not considered a new
244 admission. Failure to impose such an admissions moratorium
245 constitutes a class II deficiency.
246 (e) A nursing facility which does not have a conditional
247 license may be cited for failure to comply with the standards in
248 s. 400.23(3)(a)1.a. only if it has failed to meet those
249 standards on 2 consecutive days or if it has failed to meet at
250 least 97 percent of those standards on any one day.

251 (f) A facility which has a conditional license must be in
252 compliance with the standards in s. 400.23(3)(a) at all times.
253
254 Nothing in this section shall limit the agency's ability to
255 impose a deficiency or take other actions if a facility does not
256 have enough staff to meet the residents' needs.
257 (16) Report monthly the number of vacant beds in the
258 facility which are available for resident occupancy on the day
259 the information is reported.
260 (17) Notify a licensed physician when a resident exhibits
261 signs of dementia or cognitive impairment or has a change of
262 condition in order to rule out the presence of an underlying
263 physiological condition that may be contributing to such
264 dementia or impairment. The notification must occur within 30
265 days after the acknowledgment of such signs by facility staff.
266 If an underlying condition is determined to exist, the facility
267 shall arrange, with the appropriate health care provider, the
268 necessary care and services to treat the condition.
269 (18) If the facility implements a dining and hospitality
270 attendant program, ensure that the program is developed and
271 implemented under the supervision of the facility director of
272 nursing. A licensed nurse, licensed speech or occupational
273 therapist, or a registered dietitian must conduct training of
274 dining and hospitality attendants. A person employed by a
275 facility as a dining and hospitality attendant must perform
276 tasks under the direct supervision of a licensed nurse.
277 (19) Report to the agency any filing for bankruptcy
278 protection by the facility or its parent corporation,

279 divestiture or spin-off of its assets, or corporate
280 reorganization within 30 days after the completion of such
281 activity.
282 (20) Maintain general and professional liability insurance
283 coverage that is in force at all times. In lieu of general and
284 professional liability insurance coverage, a state-designated
285 teaching nursing home and its affiliated assisted living
286 facilities created under s. 430.80 may demonstrate proof of
287 financial responsibility as provided in s. 430.80(3)(h).
288 (21) Maintain in the medical record for each resident a
289 daily chart of certified nursing assistant services provided to
290 the resident. The certified nursing assistant who is caring for
291 the resident must complete this record by the end of his or her
292 shift. This record must indicate assistance with activities of
293 daily living, assistance with eating, and assistance with
294 drinking, and must record each offering of nutrition and
295 hydration for those residents whose plan of care or assessment
296 indicates a risk for malnutrition or dehydration.
297 (22) Before November 30 of each year, subject to the
298 availability of an adequate supply of the necessary vaccine,
299 provide for immunizations against influenza viruses to all its
300 consenting residents in accordance with the recommendations of
301 the United States Centers for Disease Control and Prevention,
302 subject to exemptions for medical contraindications and
303 religious or personal beliefs. Subject to these exemptions, any
304 consenting person who becomes a resident of the facility after
305 November 30 but before March 31 of the following year must be
306 immunized within 5 working days after becoming a resident.

307 Immunization shall not be provided to any resident who provides
308 documentation that he or she has been immunized as required by
309 this subsection. This subsection does not prohibit a resident
310 from receiving the immunization from his or her personal
311 physician if he or she so chooses. A resident who chooses to
312 receive the immunization from his or her personal physician
313 shall provide proof of immunization to the facility. The agency
314 may adopt and enforce any rules necessary to comply with or
315 implement this subsection.
316 (23) Assess all residents for eligibility for pneumococcal
317 polysaccharide vaccination (PPV) and vaccinate residents when
318 indicated within 60 days after the effective date of this act in
319 accordance with the recommendations of the United States Centers
320 for Disease Control and Prevention, subject to exemptions for
321 medical contraindications and religious or personal beliefs.
322 Residents admitted after the effective date of this act shall be
323 assessed within 5 working days of admission and, when indicated,
324 vaccinated within 60 days in accordance with the recommendations
325 of the United States Centers for Disease Control and Prevention,
326 subject to exemptions for medical contraindications and
327 religious or personal beliefs. Immunization shall not be
328 provided to any resident who provides documentation that he or
329 she has been immunized as required by this subsection. This
330 subsection does not prohibit a resident from receiving the
331 immunization from his or her personal physician if he or she so
332 chooses. A resident who chooses to receive the immunization from
333 his or her personal physician shall provide proof of

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334 immunization to the facility. The agency may adopt and enforce
335 any rules necessary to comply with or implement this subsection.
336 (24) Annually encourage and promote to its employees the
337 benefits associated with immunizations against influenza viruses
338 in accordance with the recommendations of the United States
339 Centers for Disease Control and Prevention. The agency may adopt
340 and enforce any rules necessary to comply with or implement this
341 subsection.
342
343 Every facility with a standard license ~~Facilities that have been~~
344 ~~awarded a Gold Seal under the program established in s. 400.235~~
345 may develop a plan to provide certified nursing assistant
346 training as prescribed by federal regulations and state rules
347 and may apply to the agency for approval of its ~~their~~ program.
348 Section 3. Subsections (9) through (15) of section
349 400.147, Florida Statutes, are renumbered as subsections (8)
350 through (14), respectively, and paragraph (e) of subsection (5),
351 subsection (7), and present subsection (8) of that section are
352 amended to read:
353 400.147 Internal risk management and quality assurance
354 program.--
355 (5) For purposes of reporting to the agency under this
356 section, the term "adverse incident" means:
357 (e) An event that is reported to law enforcement for
358 investigation.
359 (7)(a) The facility shall initiate an investigation ~~and~~
360 ~~shall notify the agency~~ within 1 business day after the risk
361 manager or his or her designee has received a report pursuant to

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362 paragraph (1)(d). ~~The notification must be made in writing and~~
363 ~~be provided electronically, by facsimile device or overnight~~
364 ~~mail delivery. The notification must include information~~
365 ~~regarding the identity of the affected resident, the type of~~
366 ~~adverse incident, the initiation of an investigation by the~~
367 ~~facility, and whether the events causing or resulting in the~~
368 ~~adverse incident represent a potential risk to any other~~
369 ~~resident. The notification is confidential as provided by law~~
370 ~~and is not discoverable or admissible in any civil or~~
371 ~~administrative action, except in disciplinary proceedings by the~~
372 ~~agency or the appropriate regulatory board. The agency may~~
373 ~~investigate, as it deems appropriate, any such incident and~~
374 ~~prescribe measures that must or may be taken in response to the~~
375 ~~incident. The agency shall review each incident and determine~~
376 ~~whether it potentially involved conduct by the health care~~
377 ~~professional who is subject to disciplinary action, in which~~
378 ~~case the provisions of s. 456.073 shall apply.~~
379 (b) ~~(8)(a)~~ Each facility shall complete the investigation
380 and submit an adverse incident report to the agency for each
381 adverse incident within 15 calendar days after its occurrence.
382 If, after a complete investigation, the risk manager determines
383 that the incident was ~~not~~ an adverse incident as defined in
384 subsection (5), the facility shall include this information in
385 the report. The agency shall develop a form for reporting this
386 information.
387 (c) ~~(b)~~ The information reported to the agency pursuant to
388 paragraph (b) that ~~(a) which~~ relates to persons licensed under
389 chapter 458, chapter 459, chapter 461, or chapter 466 shall be

390 reviewed by the agency. The agency shall determine whether any
391 of the incidents potentially involved conduct by a health care
392 professional who is subject to disciplinary action, in which
393 case the provisions of s. 456.073 shall apply.
394 <u>(d)</u>~~(c)~~ The report submitted to the agency must also
395 contain the name of the risk manager of the facility.
396 <u>(e)</u>~~(d)~~ The adverse incident report is confidential as
397 provided by law and is not discoverable or admissible in any
398 civil or administrative action, except in disciplinary
399 proceedings by the agency or the appropriate regulatory board.
400 Section 4. Subsection (3) of section 400.19, Florida
401 Statutes, is amended to read:
402 400.19 Right of entry and inspection.--
403 (3) The agency shall every 15 months conduct at least one
404 unannounced inspection to determine compliance by the licensee
405 with statutes, and with rules promulgated under the provisions
406 of those statutes, governing minimum standards of construction,
407 quality and adequacy of care, and rights of residents. The
408 survey shall be conducted every 6 months for the next 2-year
409 period if the facility has been cited for a class I deficiency,
410 has been cited for two or more class II deficiencies arising
411 from separate surveys or investigations within a 60-day period,
412 or has had three or more substantiated complaints within a 6-
413 month period, each resulting in at least one class I or class II
414 deficiency. In addition to any other fees or fines in this part,
415 the agency shall assess a fine for each facility that is subject
416 to the 6-month survey cycle. The fine for the 2-year period
417 shall be $6,000, one-half to be paid at the completion of each

418 survey. The agency may adjust this fine by the change in the
419 Consumer Price Index, based on the 12 months immediately
420 preceding the increase, to cover the cost of the additional
421 surveys. <u>In the event such deficiencies are overturned as the</u>
422 <u>result of administrative action but additional surveys have</u>
423 <u>already been conducted pursuant to this section, the most recent</u>
424 <u>survey shall be considered an annual survey for purposes of</u>
425 <u>future survey scheduling.</u> The agency shall verify through
426 subsequent inspection that any deficiency identified during the
427 annual inspection is corrected. However, the agency may verify
428 the correction of a class III or class IV deficiency unrelated
429 to resident rights or resident care without reinspecting the
430 facility if adequate written documentation has been received
431 from the facility, which provides assurance that the deficiency
432 has been corrected. The giving or causing to be given of advance
433 notice of such unannounced inspections by an employee of the
434 agency to any unauthorized person shall constitute cause for
435 suspension of not fewer than 5 working days according to the
436 provisions of chapter 110.
437 Section 5. Paragraph (d) of subsection (1) of section
438 400.195, Florida Statutes, is amended to read:
439 400.195 Agency reporting requirements.--
440 (1) For the period beginning June 30, 2001, and ending
441 June 30, 2005, the Agency for Health Care Administration shall
442 provide a report to the Governor, the President of the Senate,
443 and the Speaker of the House of Representatives with respect to
444 nursing homes. The first report shall be submitted no later than
445 December 30, 2002, and subsequent reports shall be submitted

446 every 6 months thereafter. The report shall identify facilities
447 based on their ownership characteristics, size, business
448 structure, for-profit or not-for-profit status, and any other
449 characteristics the agency determines useful in analyzing the
450 varied segments of the nursing home industry and shall report:
451 (d) Information regarding deficiencies cited, including
452 information used to develop the Nursing Home Guide WATCH LIST
453 pursuant to s. 400.191, and applicable rules, a summary of data
454 generated on nursing homes by Centers for Medicare and Medicaid
455 Services Nursing Home Quality Information Project, and
456 information collected pursuant to s. 400.147(8)~~(9)~~, relating to
457 litigation.
458 Section 6. Paragraph (a) of subsection (3), paragraphs (b)
459 and (e) of subsection (7), and subsection (8) of section 400.23,
460 Florida Statutes, are amended to read:
461 400.23 Rules; evaluation and deficiencies; licensure
462 status.--
463 (3)(a)1. The agency shall adopt rules providing minimum
464 staffing requirements for nursing homes. These requirements
465 shall include, for each nursing home facility:
466 a. A minimum certified nursing assistant staffing of 2.6
467 hours of direct care per resident per day beginning January 1,
468 2003, and increasing to 2.7 hours of direct care per resident
469 per day beginning January 1, 2007. Beginning January 1, 2002, no
470 facility shall staff below one certified nursing assistant per
471 20 residents, and a minimum licensed nursing staffing of 1.0
472 hour of direct care per resident per day but never below one
473 licensed nurse per 40 residents.

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474 b. Beginning January 1, 2007, a minimum weekly average
475 certified nursing assistant staffing of 2.9 hours of direct care
476 per resident per day. For the purpose of this sub-subparagraph,
477 a week is defined as Sunday through Saturday.
478 2. Nursing assistants employed under s. 400.211(2) may be
479 included in computing the staffing ratio for certified nursing
480 assistants only if their job responsibilities include only
481 nursing-assistant-related duties.
482 3. Each nursing home must document compliance with
483 staffing standards as required under this paragraph and post
484 daily the names of staff on duty for the benefit of facility
485 residents and the public. Compliance with federal posting
486 requirements shall satisfy the posting requirements of this
487 subparagraph.
488 4. The agency shall recognize the use of licensed nurses
489 for compliance with minimum staffing requirements for certified
490 nursing assistants, provided that the facility otherwise meets
491 the minimum staffing requirements for licensed nurses and that
492 the licensed nurses are performing the duties of a certified
493 nursing assistant. Unless otherwise approved by the agency,
494 licensed nurses counted toward the minimum staffing requirements
495 for certified nursing assistants must exclusively perform the
496 duties of a certified nursing assistant for the entire shift and
497 not also be counted toward the minimum staffing requirements for
498 licensed nurses. If the agency approved a facility's request to
499 use a licensed nurse to perform both licensed nursing and
500 certified nursing assistant duties, the facility must allocate
501 the amount of staff time specifically spent on certified nursing

502 assistant duties for the purpose of documenting compliance with
503 minimum staffing requirements for certified and licensed nursing
504 staff. In no event may the hours of a licensed nurse with dual
505 job responsibilities be counted twice.
506 (7) The agency shall, at least every 15 months, evaluate
507 all nursing home facilities and make a determination as to the
508 degree of compliance by each licensee with the established rules
509 adopted under this part as a basis for assigning a licensure
510 status to that facility. The agency shall base its evaluation on
511 the most recent inspection report, taking into consideration
512 findings from other official reports, surveys, interviews,
513 investigations, and inspections. The agency shall assign a
514 licensure status of standard or conditional to each nursing
515 home.
516 (b) A conditional licensure status means that a facility,
517 due to the presence of one or more class I or class II
518 deficiencies, or class III deficiencies not corrected within the
519 time established by the agency, is not in substantial compliance
520 at the time of the survey with criteria established under this
521 part or with rules adopted by the agency. If the facility has no
522 class I, class II, or uncorrected class III deficiencies at the
523 time of the followup survey, a standard licensure status shall
524 ~~may~~ be assigned.
525 (e) Each licensee shall post its license issued pursuant
526 to final agency action in a prominent place that is in clear and
527 unobstructed public view at or near the place where residents
528 are being admitted to the facility.

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529 (8) The agency shall adopt rules to provide that, when the
530 criteria established under subsection (2) are not met, such
531 deficiencies shall be classified according to the nature and the
532 scope of the deficiency. The scope shall be cited as isolated,
533 patterned, or widespread. An isolated deficiency is a deficiency
534 affecting one or a very limited number of residents, or
535 involving one or a very limited number of staff, or a situation
536 that occurred only occasionally or in a very limited number of
537 locations. A patterned deficiency is a deficiency where more
538 than a very limited number of residents are affected, or more
539 than a very limited number of staff are involved, or the
540 situation has occurred in several locations, or the same
541 resident or residents have been affected by repeated occurrences
542 of the same deficient practice but the effect of the deficient
543 practice is not found to be pervasive throughout the facility. A
544 widespread deficiency is a deficiency in which the problems
545 causing the deficiency are pervasive in the facility or
546 represent systemic failure that has affected or has the
547 potential to affect a large portion of the facility's residents.
548 The agency shall indicate the classification on the face of the
549 notice of deficiencies as follows:
550 (a) A class I deficiency is a deficiency that the agency
551 determines presents a situation in which immediate corrective
552 action is necessary because the facility's noncompliance creates
553 immediate jeopardy to the health or safety of a resident. For
554 purposes of this subsection, "immediate jeopardy" means that the
555 licensee's noncompliance has caused, or is likely to cause,
556 serious injury, harm, impairment, or death to a resident

557 receiving care in a facility. The condition or practice
558 constituting a class I violation shall be abated or eliminated
559 immediately, unless a fixed period of time, as determined by the
560 agency, is required for correction. A class I deficiency is
561 subject to a civil penalty of $10,000 for an isolated
562 deficiency, $12,500 for a patterned deficiency, and $15,000 for
563 a widespread deficiency. The fine amount shall be doubled for
564 each deficiency if the facility was previously cited for one or
565 more class I or class II deficiencies during the last annual
566 inspection or any inspection or complaint investigation since
567 the last annual inspection. A fine must be levied
568 notwithstanding the correction of the deficiency.
569 (b) A class II deficiency is a deficiency that the agency
570 determines has caused actual harm to a resident but did not
571 create immediate jeopardy ~~compromised the resident's ability to~~
572 ~~maintain or reach his or her highest practicable physical,~~
573 ~~mental, and psychosocial well-being, as defined by an accurate~~
574 ~~and comprehensive resident assessment, plan of care, and~~
575 ~~provision of services~~. A class II deficiency is subject to a
576 civil penalty of $2,500 for an isolated deficiency, $5,000 for a
577 patterned deficiency, and $7,500 for a widespread deficiency.
578 The fine amount shall be doubled for each deficiency if the
579 facility was previously cited for one or more class I or class
580 II deficiencies during the last annual inspection or any
581 inspection or complaint investigation since the last annual
582 inspection. A fine shall be levied notwithstanding the
583 correction of the deficiency.

584 (c) A class III deficiency is a deficiency that the agency
585 determines has not caused actual harm to a resident and did not
586 create immediate jeopardy but presents the potential for more
587 than minimal harm ~~will result in no more than minimal physical,~~
588 ~~mental, or psychosocial discomfort to the resident or has the~~
589 ~~potential to compromise the resident's ability to maintain or~~
590 ~~reach his or her highest practical physical, mental, or~~
591 ~~psychosocial well-being, as defined by an accurate and~~
592 ~~comprehensive resident assessment, plan of care, and provision~~
593 ~~of services~~. A class III deficiency is subject to a civil
594 penalty of $1,000 for an isolated deficiency, $2,000 for a
595 patterned deficiency, and $3,000 for a widespread deficiency.
596 The fine amount shall be doubled for each deficiency if the
597 facility was previously cited for one or more class I or class
598 II deficiencies during the last annual inspection or any
599 inspection or complaint investigation since the last annual
600 inspection. A citation for a class III deficiency must specify
601 the time within which the deficiency is required to be
602 corrected. If a class III deficiency is corrected within the
603 time specified, no civil penalty shall be imposed.
604 (d) A class IV deficiency is a deficiency that the agency
605 determines has the potential for causing no more than minimal
606 harm to a ~~minor negative impact on the~~ resident. If the class IV
607 deficiency is isolated, no plan of correction is required.
608 Section 7. This act shall take effect July 1, 2007.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. __1___ (for drafter's use only)

Bill No. **HB 385**

COUNCIL/COMMITTEE ACTION

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

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1 Council/Committee hearing bill: Healthcare Council

2 The Committee on Health Innovation offered the following:

3

4 **Amendment (with directory and title amendments)**

5 Remove line(s) 424 and insert:

6

7 survey shall be considered a licensure survey for purposes of

This amendment was adopted in HI on 03/13/07 and is traveling with the bill and requires no further action.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. __2___ (for drafter's use only)

Bill No. **HB 385**

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)

ADOPTED AS AMENDED __ (Y/N)

ADOPTED W/O OBJECTION __ (Y/N)

FAILED TO ADOPT __ (Y/N)

WITHDRAWN __ (Y/N)

OTHER ______

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1 Council/Committee hearing bill: Healthcare Council

2 The Committee on Health Innovation offered the following:

3

4 **Amendment (with directory and title amendments)**

5 Remove line(s) 506-607

6

7

8 =========== D I R E C T O R Y A M E N D M E N T ==========

9 Remove line(s) 458-460 and insert:

10

11 Section 6. Paragraph (a) of subsection (3), of section

12 400.23, Florida Statutes, is amended to read:

13

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

15 Remove line(s) 15-19 and insert:

16

17 providing an effective date.

This amendment was adopted in HI on 03/13/07 and is traveling with the bill and requires no further action.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. __3___ (for drafter's use only)

Bill No. **HB 385**

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)

ADOPTED AS AMENDED __ (Y/N)

ADOPTED W/O OBJECTION __ (Y/N)

FAILED TO ADOPT __ (Y/N)

WITHDRAWN __ (Y/N)

OTHER ______

---

1 Council/Committee hearing bill: Healthcare Council

2 The Committee on Health Innovation offered the following:

3

4 **Amendment (with directory and title amendments)**

5 On line(s) 347 insert after the period:

6

7 The agency may adopt rules regarding approval, suspension and

8 termination of a facility certified nursing assistant training

9 program.

This amendment was adopted in HI on 03/13/07 and is traveling with the bill and requires no further action.

Amendment No. __4___ (for drafter's use only)

Bill No. **HB 385**

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)

ADOPTED AS AMENDED __ (Y/N)

ADOPTED W/O OBJECTION __ (Y/N)

FAILED TO ADOPT __ (Y/N)

WITHDRAWN __ (Y/N)

OTHER ______

---

1 Council/Committee hearing bill: Healthcare Council

2 The Committee on Health Innovation offered the following:

3

4 **Amendment (with directory and title amendments)**

5 Remove line(s) 35, and insert:

6

7 facilities as directed by the agency. However, upon request, the

8 agency shall conduct quarterly visits for a nursing home that is

9 not conditional. The request shall be valid through the current

10 licensure period and an extension may be requested by the

11 facility at the time of licensure renewal. Priority for

12 additional

This amendment was adopted in HI on 03/13/07 and is traveling with the bill and requires no further action.

HB 397

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 397 Caregivers for Adults
SPONSOR(S): Anderson and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 434

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Healthy Seniors	8 Y, 0 N	Walsh	Schoolfield
2) Healthcare Council		Walsh	Gormley
3) Policy & Budget Council			
4)			
5)			

SUMMARY ANALYSIS

House Bill 397 would allow the Department of Elderly Affairs (DOEA) to establish a pilot program to train economically disadvantaged workers age 55 or older to act as companions and provide personal assistance to frail adults age 60 or older. The agency is directed to use the resources of the Senior Community Service Employment Program (SCSEP), which program is funded by an allocation to the agency from the U.S. Department of Labor to provide training and subsidized jobs to SCSEP participants.

The effective date of this bill is July 1, 2007.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Promote Personal Responsibility—The bill establishes a pilot program to train and employ economically disadvantaged persons age 55 and older to provide care and assistance to frail adults age 60 and older.

B. EFFECT OF PROPOSED CHANGES:

Background

Caregiving

About 10.1 million people over the age of 18 in the U.S.—nearly 4 percent of the population—need another person's assistance to carry out activities such as bathing, feeding, cleaning, or grocery shopping.[1] Within this group, nearly 80 percent of care recipients are 50 and older, and the average age of care recipients 50 and older in the U.S. is 75.[2] Most care recipients (79 percent) who need long-term care live at home or in the community,[3] and those individuals living in nursing homes and other institutional settings could potentially live in the community if appropriate, affordable support was available.[4]

Although family members and friends provide most of the needed assistance for people in home and community-based settings, home care workers, personal assistants, direct support professionals and other direct-care workers are a critical resource for many. Individuals and families rely on these workers to provide them with comfort, companionship, and care in an atmosphere that preserves their dignity and well-being. Such workers are already in short supply in many regions and demand is expected to grow rapidly, due to a combination of consumer demand and changes in public policy.

Federal funds allocated for health care training are typically reserved for the development of various medical professionals (doctors, nurses, etc.). Consequently, there are limited resources available to address the training needs of paraprofessional caregivers who work in community settings.

Senior Community Service Employment Program (SCSEP)

The Senior Community Service Employment Program (SCSEP) is a work-based training program providing subsidized, part-time, community service work-based training for low-income persons age 55 or older who have poor employment prospects. It is administered by and funded through the U. S. Department of Labor (DOL). DOEA and various not for profit organizations are awarded competitive grants to operate SCSEP programs around the state:

- DOEA
- AARP Foundation
- SER Jobs for Progress National, Inc.
- Senior Service America, Inc.
- USDA Forest Service

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[1] McNeil, Jack. 2001. *Americans with disabilities: Household economic studies*. Washington, DC: US Department of Commerce, Economics and Statistics Administration, US Census Bureau.
[2] *Caregiving in the U.S.*, 2004, National Alliance for Caregiving and AARP, available at http://www.aarp.org/research/reference/publicopinions/aresearch-import-853.html.
[3] *Long-term Care Users Range in Age and Most Do Not Live in Nursing Homes: Research Alert*, 2000, Agency for Healthcare Research and Quality, available, in part, at http://www.ahcpr.gov/research/nov00/1100RA19.htm.
[4] *Understanding Medicaid Home and Community Services: A Primer*, 2000, U.S. Department of Health and Human Services. Available at http://aspe.hhs.gov/daltcp/reports/primer.pdf.

- National Caucus & Center on Black Aged, Inc.
- Experience Works

Program participants work an average of 20 hours a week, and are paid the highest of Federal, State or local minimum wage, or the prevailing wage. The goal of the SCSEP program is to transition participants from subsidized training jobs to other employment which is not supported with Federal funds.[5]

Effect of Proposed Legislation

HB 397 would allow DOEA to establish a pilot program to train economically disadvantaged workers age 55 or older to act as companions and provide personal assistance to frail adults age 60 or older. The pilot may begin in Fiscal Year 2007-2008 and cannot exceed three years. The agency is directed to use the resources of the Senior Community Service Employment Program (SCSEP) to the greatest extent allowed by federal law to support the pilot program.

The bill specifies that the purposes of the pilot are to:

- Develop training and employment opportunities for economically disadvantage workers 55 or older.
- Encourage the use of those workers to provide community-based care for frail adults age 60 or older.
- Meet the demand for in-home companion care and assistance service providers to prevent.
- Act as a direct referral service for DOEA.

HB 397 requires that if DOEA establishes the pilot program, it must provide a report to the Speaker of the House and the President of the Senate by January 1, 2010. The report must include the status of the pilot; the number of workers age 55 or older trained to provide community-based care for frail adults age 60 or older; the number of those frail adults served; and recommendations for further legislation, including whether the pilot program should be replicated statewide.

The effective date of the bill is July 1, 2007.

C. SECTION DIRECTORY:

Section 1: Creates an unnumbered section of Florida Statutes allowing DOEA to establish a pilot program to train certain workers to serve frail adults; providing purposes of the pilot; requiring that DOEA report to the Legislature if the pilot program is established.

Section 2: Provides that the act is effective July 1, 2007.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

---

[5] *See, generally, Senior Community Service Employment Program*, available at http://www.doleta.gov/seniors

None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill establishes a pilot program to train and employ economically disadvantaged persons age 55 and older to provide care and assistance to frail adults age 60 and older. It affords opportunities to those with low job prospects to become employed in jobs serving elders in their own homes and communities.

D. FISCAL COMMENTS:

None, but see "Drafting Issues or Other Comments" below.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   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:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

DOEA advises that there are many restrictions on the funding associated with the SCSEP Program. Specifically, the funds are awarded by the Department of Labor based on competitive grants and may be used only for the approved purposes. Accordingly, DOEA would not have the ability to implement the pilot using the "resources of the Senior Community Service Employment Program (SCSEP) to the greatest extent allowed by federal law" until the next grant opportunity, currently scheduled for award in mid-2008.

In addition, President Bush has proposed a 28 percent cut in funding for the SCSEP Program for the 2008 federal fiscal year, putting additional pressure on the award of funds to the state.[6]

D. STATEMENT OF THE SPONSOR:

This bill will provide in-home care services by economically-disadvantaged adults over 55 to Florida's seniors, who are the fastest growing segment of our population. This will make it possible for them to remain in the comfort of their own homes and prevent costly premature institutional placement.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

[6] *Jobs Program for Elderly on Chopping Block*, Sarasota Herald-Tribune, February 25, 2007.

At its March 6, 2007, meeting, the Committee on Healthy Seniors adopted three amendments to HB 397 as filed. The amendments do the following:

- Locate the proposed pilot program in Pasco or Pinellas County or both.
- Appropriate $100,000 from General Revenue to fund the pilot.
- Delete reference to the Senior Community Service Employment Program.

The Committee reported the bill favorably with three amendments.

1 A bill to be entitled
2 An act relating to caregivers for adults; authorizing the
3 Department of Elderly Affairs to create a pilot program to
4 train economically disadvantaged workers of a specified
5 age or older to act as companions and provide certain
6 services to frail adults in the community; specifying
7 additional purposes of the pilot program; requiring an
8 evaluation and report to the Legislature; providing an
9 effective date.
10
11 Be It Enacted by the Legislature of the State of Florida:
12
13 Section 1. (1) Beginning in the 2007-2008 fiscal year and
14 for a period of no longer than 3 years, the Department of
15 Elderly Affairs may establish a pilot program to train
16 economically disadvantaged workers 55 years of age or older to
17 act as companions and provide personal assistance to frail
18 adults 60 years of age or older in the community. The department
19 shall use the resources of the Senior Community Service
20 Employment Program to support the pilot program to the greatest
21 extent allowed by federal law. The purposes of the pilot program
22 are to:
23 (a) Foster the development of training and employment
24 opportunities for economically disadvantaged workers 55 years of
25 age or older;
26 (b) Encourage the use of economically disadvantaged
27 workers 55 years of age or older in providing community-based
28 care for frail adults 60 years of age or older who live in the

29 community;
30 (c) Assist in meeting the growing demand for in-home
31 companion care services and personal care services and
32 preventing costly and premature institutional placements; and
33 (d) Act as a direct referral service for the Department of
34 Elderly Affairs.
35 (2) By January 1, 2010, if the pilot program is
36 established, the Department of Elderly Affairs shall submit a
37 report to the President of the Senate and the Speaker of the
38 House of Representatives which includes the status of the
39 implementation of the program, the number of economically
40 disadvantaged workers 55 years of age or older who have been
41 trained to provide community-based care for frail adults 60
42 years of age or older who live in the community, the number of
43 frail adults 60 years of age or older who have received such
44 services, and recommendations for further legislation, including
45 a recommendation regarding extending the pilot program
46 throughout the state.
47 Section 2. This act shall take effect July 1, 2007.

COUNCIL/COMMITTEE ACTION

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

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1 Council/Committee hearing bill: Healthcare Council
2 Representative(s) Anderson offered the following:
3
4 **Amendment (with title amendment)**
5 Remove everything after the enacting clause and insert:
6
7 Be It Enacted by the Legislature of the State of Florida:
8
9 Section 1. (1) Beginning in the 2007-2008 fiscal year and
10 for a period of no longer than 3 years, the Department of
11 Elderly Affairs may establish a pilot program in Pasco or
12 Pinellas county or both to train persons to act as companions
13 and provide personal assistance to frail adults 60 years of age
14 or older in the community. The purposes of the pilot program
15 are to:
16 (a) Assist in meeting the growing demand for in-home
17 companion care services and personal care services and
18 preventing costly and premature institutional placements; and
19 (b) Act as a direct referral service for the Department of
20 Elderly Affairs.
21 (2) By January 1, 2010, if the pilot program is
22 established, the Department of Elderly Affairs shall submit a

23 report to the President of the Senate and the Speaker of the
24 House of Representatives which includes the status of the
25 implementation of the program, the number of persons who have
26 been trained to provide community-based care for frail adults 60
27 years of age or older who live in the community, the number of
28 frail adults 60 years of age or older who have received such
29 services, and recommendations for further legislation, including
30 a recommendation regarding extending the pilot program
31 throughout the state.
32 Section 2. The sum of $75,000 in non-recurring general
33 revenue funds is appropriated to the Department of Elderly
34 Affairs for the purpose of implementing the provisions of this
35 act.
36 Section 3. This act shall take effect July 1, 2007.
37
38
39 ================ T I T L E A M E N D M E N T ================
40 Remove the entire title and insert:
41 A bill to be entitled
42 An act relating to caregivers for adults; authorizing the
43 Department of Elderly Affairs to create a pilot program in
44 Pasco or Pinellas counties or both to train persons to act
45 as companions and provide certain services to frail adults
46 in the community; specifying additional purposes of the
47 pilot program; requiring an evaluation and report to the
48 Legislature; providing an appropriation; providing an
49 effective date.
50

Amendment No. 1 (for drafter's use only)

Bill No. HB 397

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)

ADOPTED AS AMENDED __ (Y/N)

ADOPTED W/O OBJECTION __ (Y/N)

FAILED TO ADOPT __ (Y/N)

WITHDRAWN __ (Y/N)

OTHER ______

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1 Council/Committee hearing bill: Healthcare Council
2 Committee on Healthy Seniors offered the following:
3
4 **Amendment (with title amendments)**
5 Remove line 15 and insert:
6 Elderly Affairs may establish a pilot program in Pasco or
7 Pinellas county or both to train
8
9 ================ T I T L E A M E N D M E N T =============
10 Remove line 3 and insert:
11 A bill to be entitled
12 Department of Elderly Affairs to create a pilot program in
13 certain counties to
14

This amendment was adopted in HS on 03/06/07 and is traveling with the bill and requires no further action. However, the new strike all will supercede the traveling amendment which is encompassed in the strike all.

Amendment No. 2(for drafter's use only)

Bill No. 397

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)

ADOPTED AS AMENDED __ (Y/N)

ADOPTED W/O OBJECTION __ (Y/N)

FAILED TO ADOPT __ (Y/N)

WITHDRAWN __ (Y/N)

OTHER ______

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1 Council/Committee hearing bill: Healthcare Council

2 Committee on Healthy Seniors offered the following:

3

4 **Amendment (with title amendments)**

5 Remove line 47 and insert:

6 Section 2. There is hereby appropriated from the General

7 Revenue Fund $100,000 to support the pilot program.

8 Section 3. This act shall take effect July 1, 2007.

9

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

11 Remove line 9 and insert:

12 appropriation; providing an effective date.

13

14

15

This amendment was adopted in HS on 03/06/07 and is traveling with the bill and requires no further action. However, the new strike all will supercede the traveling amendment which is encompassed in the strike all.

Amendment No. 3(for drafter's use only)

Bill No. 397

COUNCIL/COMMITTEE ACTION

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

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1 Council/Committee hearing bill: Healthcare Council
2 Committee on Healthy Seniors offered the following:
3
4 **Amendment**
5 Remove line(s) 18 through 21 and insert:
6 adults 60 years of age or older in the community. The purposes
7 of the pilot program
8

This amendment was adopted in HS on 03/06/07 and is traveling with the bill and requires no further action. However, the new strike all will supercede the traveling amendment which is encompassed in the strike all.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 543 Immunization Services
SPONSOR(S): Zapata
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Health Innovation	6 Y, 3 N	Ciccone	Calamas
2) Healthcare Council		Ciccone	Gormley
3) Policy & Budget Council			
4)			
5)			

SUMMARY ANALYSIS

House Bill 543 addresses access to immunization services and provides a comprehensive approach to prevent the spread of certain diseases through increased access to immunization services. The bill provides a mechanism to coordinate immunization programs including vaccine and disease education programs, enhance health care provider use and flexibility, and encourage vaccine production and distribution in Florida.

The bill requires that the Department of Management Services establish a schedule of minimum benefits for health maintenance organization participating in the state group insurance program to include coverage for immunization services. The bill also requires additional insurance option coverage for immunizations on accident or health insurance policies issued, amended, delivered or renewed in Florida. The bill specifies that the additional coverage may be offered for an appropriate additional premium and that this coverage is not subject to the deductible co-payment or coinsurance provisions of the policy.

The bill directs Enterprise Florida, Inc., to conduct an outreach campaign to encourage pharmaceutical companies in Florida to produce vaccines and to encourage pharmaceutical companies outside of Florida to establish facilities in Florida.

The bill directs certain assisted living facilities to implement an immunization program against the influenza virus and pheumococcal bacteria to patients age 65 or older. The bill directs the Department of Health to advise assisted living facilities of their responsibilities related to the immunization program and provides that immunization providers be reimbursed at the Medicare reimbursement rate to administer the immunization and for any applicable reimbursement for the ingredient cost.

The bill authorizes pharmacists to administer immunizations to adults under protocol with a supervising Florida-licensed physician or by written agreement with a county health department. Pharmacists seeking to provide immunizations must meet the following qualifications:

- To maintain at least $200,000 of professional liability insurance;
- To enter into a supervisory protocol with a physician or public health department;
- To have written approval to administer vaccinations from the pharmacy owner; and
- To have received training and immunization certification approved by the Board of Pharmacy in consultation with the Board of Medicine;
- To have 20 hours of continuing education classes approved by the Board of Pharmacy, instruction in safe and effective administration of immunizations, and instruction in potential allergic reactions to immunizations.

The bill directs each district school board and the governing authority of each private school to provide information regarding meningococcal disease to students' parents and leaves the method to provide such information up to the district school board and the governing authority of the private school.

The bill requires that Florida Bright Futures Scholarship awards include immunization coverage for students enrolling in a state university and coverage for yearly recommended student influenza immunizations. The bill also requires that prepaid college plans purchased through the Stanley G. Tate Florida Prepaid College Program include immunization coverage for students enrolling in a state university and one-time coverage for meningococcal immunization at the student's option and for yearly recommended student influenza immunizations.

The cost to implement the bill will be more than $16.3 million in General Revenue annually. (See Fiscal Analysis Section)

The bill provides an effective date of July 1, 2007.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Promote personal responsibility—The bill provides individuals and families with increased access to immunizations services and health insurance immunizations options.

Provide limited government—The bill requires each licensed Assisted Living Facility to implement a program to offer immunizations against influenza and pneumococcal bacteria to all residents age 65 or older in accordance with recommendations of the Advisory Committee on Immunizations Practices and the Centers for Disease Control and Prevention. The bill creates the Commission on the Study of Biotech Competitiveness within the Governor's Office of Tourism, Trade & Economic Development and provides duties and responsibilities.

B. EFFECT OF PROPOSED CHANGES:

House Bill 543 addresses access to immunization services for children and adults and provides a comprehensive approach to preventing the spread of certain diseases through increased access to immunization services. The bill provides a mechanism to coordinate immunization programs and information including vaccine and disease education programs, enhance health care provider flexibility, and encourage vaccine production and distribution in Florida. The intended effect of this bill is to prevent the spread of communicable diseases by improving access to immunization services.

The bill amends s. 400.426, F.S., and requires each licensed Assisted Living Facility to implement a program to offer immunizations against influenza and pneumococcal bacteria to all residents age 65 or older in accordance with recommendations of the Advisory Committee on Immunizations Practices and the Centers for Disease Control and Prevention. This program is to be carried out between October 1 and February 1 or each year, subject to adequate vaccine supplies and subject to the responsible practitioner's clinical judgment. The bill exempts ALFs having ten or fewer residents and requires the Department of Health to provide a notice to each affected ALF.

The bill amends s. 465.003(13), F.S., to revise the definition of the "practice of the profession of pharmacy" to include the administering immunizations to adults by a pharmacist within the framework of an established protocol under a supervisory practitioner who is a Florida-licensed medical or osteopathic physician or by written agreement with a county health department. Each protocol must contain specific procedures to address any unforeseen allergic reaction to an immunization.

A pharmacist may not enter into a protocol unless he or she maintains at least $200,000 of professional liability insurance and not until the pharmacist has completed training in immunizations as required by the Board of Pharmacy. The decision by a supervisory practitioner to enter into such a protocol is a professional decision of the practitioner, and a person may not interfere with a supervisory practitioner's decision as to whether to enter into such a protocol. A pharmacist may not enter into a protocol to administer immunizations while acting as an employee without the written approval of the owner of the pharmacy.

Any pharmacist seeking to immunize patients must be certified to administer immunizations under a certification program approved by the Board of Pharmacy upon consultation with the Board of Medicine. The certification program must, at a minimum, require that a pharmacist attend at least 20 hours of continuing education classes approved by the Board of Pharmacy. The program must have a curriculum of instruction concerning the safe and effective administration of immunizations, including, but not limited to, potential allergic reactions to immunizations.

The bill creates s. 627.64194 Coverage for Immunizations within Part VI of the Florida Insurance Code. This newly created statute would require accident or health insurers to offer optional coverage for immunizations, including those recommended or required for specific international travel. Further, the proposal would allow an insurer to charge an additional premium for immunization coverage and the c overage would not be subject to any deductible co-payment or coinsurance provisions.

Present Situation

Public and Private Schools Immunization Information

Sections 1002.23(7) (e) 2 and 1002.42 (6) (b) 2, F.S., specifies that public and private schools must provide every students' parents with information on the importance of school health and available immunizations and vaccinations, including, but not limited to:

- a recommended immunization schedule, in accordance with the United States Centers for Disease Control and Prevention recommendations; and
- detailed information regarding the causes, symptoms and transmission of meningococcal disease; and the availability, effectiveness, known contraindications and the appropriate age for the administration of any required or recommended vaccine against meningococcal disease, in accordance with the recommendations of the Advisory Committee on Immunizations Practices of the United States Center for Disease Control and Prevention.

Influenza Immunization

Influenza and pneumonia combined represent the fifth leading cause of death in the elderly. Influenza vaccine is the primary method for preventing influenza and its severe complications. Influenza immunization has been shown to be helpful in decreasing hospitalizations and deaths.[1]

There are minimal adverse reactions or side effects associated with influenza vaccination. The most common adverse reactions to inactivated influenza vaccine are related to the body's response to the vaccine components at the site of injection. Common reactions may include inflammation at the injection site including fever, malaise, and muscle aches.[2] Serious immediate allergic reactions to inactivated influenza vaccines may occur within a few minutes to a few hours in individuals who likely have allergies to vaccine components. Immediate allergic reactions can appear mildly as itching and hives. In the severest form, reactions such as difficulty breathing, loss of blood pressure, and even death; however prompt medical treatment is usually effective. These potential side effects should be weighed against its benefits, which include prevention of serious illness, hospitalization, and death.

The influenza vaccine is contraindicated for people with a history of hypersensitivity to eggs or egg products or other components of influenza vaccines. As with all vaccines, it is prudent that recipients remain under observation for the first 15-30 minutes after the vaccine is injected. The purpose of this observation is to detect and treat any rare, serious allergic reactions.

Immunizations in Assisted Living Facilities
Influenza

Assisted living facilities (ALF) are licensed under Part III of Chapter 400, F.S. Currently, there is no requirement that ALF offer immunizations against the influenza virus to their residents.

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[1] See 1999 RAND report prepared for the Centers for Medicare & Medicaid Services, "Interventions that increase Utilization of Medicare-Funded Preventive Services for Persons Age 65 and Older." www.cms.hhs.gov/healthyaging

[2] See "Prevention and control of influenza: Recommendations of the Advisory Committee on Immunization Practices," Morbidity and Mortality Weekly Report 51 (April 12, 2002).

Influenza, commonly called the "flu," is caused by the influenza virus that infects the respiratory tract. The virus is typically spread from person to person when an infected person coughs or sneezes the virus into the air. Transmission rates are greatest for individuals in highly populated areas, such as in schools and residences with crowded living conditions. Influenza can cause severe illness and lead to serious and life-threatening complications in all age groups. Complications such as bacterial pneumonia, dehydration, and conditions such as congestive heart disease and asthma occur most often in vulnerable persons including elderly persons, those living in nursing homes and other long-term care facilities, and persons with chronic conditions.

Flu is a major cause of illness and death in the United States, and leads to over 200,000 hospitalizations and approximately 36,000 deaths each year, according to the Centers for Disease Control and Prevention (CDC).[3]

Vaccines are effective in protecting individuals against illness or serious complications of flu, particularly those individuals who are at high risk for developing serious complications from the disease. The Advisory Committee on Immunization Practices of CDC (ACIP) recommends that, when vaccine is available, persons in high-risk groups including individuals age 65 or older, and people with chronic diseases of the heart, lung, or kidneys, diabetes, immunosuppression, or severe forms of anemia, should be vaccinated against the flu. ACIP also recommends that residents of nursing homes and other chronic-care facilities, children receiving long-term aspirin therapy, and any person who is in close or frequent contact with anyone in the high-risk group, such as health care personnel and volunteers, be vaccinated.[4]

Medicare coverage for flu shots for the elderly began in 1993. Flu shots are available at no cost to individuals enrolled in Medicare Part B from physicians or providers who bill Medicare. If patients receive their flu vaccines from physicians or providers who do not bill Medicare, they may be reimbursed (about $18) by Medicare. Medicare provides coverage for one influenza vaccination per year, but additional vaccinations may be available if reasonable and medically necessary. The Medicaid program covers costs for flu vaccine and administration for Medicaid patients who are residents of nursing homes and long-term care facilities who are not the recipients of Medicare benefits.

An immunization requirement similar to that proposed in the bill is imposed on licensed hospitals pursuant to s. 381.005(2), F.S., as part of the Department of Health's primary and preventative health services mission. Similarly, s. 400.141(22), F.S., directs all licensed nursing home facilities to provide vaccinations against influenza to all consenting residents. Residents may receive the immunization from his or her personal physician and provide proof of immunization to the facility.

Pneumococcal Disease

Pneumococcal pneumonia is a lower respiratory tract infection caused by the bacterium Streptococcus pneumoniae which colonizes in the lungs, but can potentially invade the bloodstream (causing bacteremia) and the tissues and fluids surrounding the brain and spinal cord (resulting in a form of meningitis, an inflammation of the tissues and fluids surrounding the brain and spinal cord). "Pneumonia" is not a single disease, but rather can have over 30 different causes. The five main causes of pneumonia in the U.S. are bacteria, viruses, mycoplasmas, chemical exposure, and exposure to other infectious agents such as fungi (including pneumocystis).

Pneumococcal pneumonia is the most common cause of bacterial pneumonia acquired outside of hospitals, as CDC estimates indicate that S. pneumoniae causes 500,000 cases of pneumonia and is

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[3] See www.aphanet.org/pharmcare/immunofact.

[4] Medicare and Medicaid Programs; conditions of Participation: Long-Term Care Facilities, and Home Health Agencies Final Rule to facilitate the delivery of adult vaccination in participating facilities for influenza and pneumococcal diseases, Federal Register, Vol. 67, No. 191, October 2, 2002.

blamed for 40,000 deaths annually in the United States.[5] This mortality figure is the highest among vaccine-preventable bacterial diseases in the U.S.

Pharmacy Practice

Chapter 465, F.S., governs the practice of the profession of pharmacy. The Board of Pharmacy is authorized to adopt rules for duties conferred upon it under the pharmacy practice act. Section 465.003, F.S., defines the "practice of the profession of pharmacy" to include compounding, dispensing, and consulting concerning contents, therapeutic values, and uses of any medicinal drug; consulting concerning therapeutic values and interactions of patent and proprietary preparations, whether pursuant to prescriptions or in the absence and entirely independent of such prescriptions or orders; and other pharmaceutical services. "Other pharmaceutical services" means the monitoring of the patient's drug therapy and assisting the patient in the management of his or her drug therapy, and includes review of the patient's drug therapy and communication with the patient's prescribing health care provider or the provider's agent regarding the drug therapy. The practice of pharmacy also includes any other act, service, operation, research, or transaction incidental to, or forming a part of, any of the foregoing acts, requiring, involving, or employing the science or art of any branch of the pharmaceutical profession, study, or training, and expressly permits a pharmacist to transmit information from persons authorized to prescribe medicinal drugs to their patients.

As of February 22, 2005, 43 states allow pharmacists to immunize patients.[6] Several of the states permit pharmacists to immunize for virtually any disease for which a vaccine is available.

According to studies published in the *International Journal of Pharmacy Practice and Pharmacotherapy*, pharmacists providing flu vaccinations increased vaccination rates in high risk patients by 74 percent. Standing orders are used in some states to authorize licensed practitioners to administer vaccinations, after assessment for contraindications, according to a physician-approved policy without the need for a physician's order in nursing homes and hospitals.

Immunization Coverage

The state operates the state group health insurance plan as a pre-tax benefit for current and retired employees. Chapter 110, F.S., provides the statutory authority for the implementation of health insurance and prescription drug coverage for officers, employees and their dependents of State of Florida agencies. Employees and retirees may choose between a self-insured indemnity plan, called a preferred provider organization (PPO), and one of several approved health maintenance organizations. Sections 110.123 and 110.12315, F.S., describe the coverage available and specify the minimum complement of benefits each approved provider must offer.

Chapter 216, F.S., contains a procedure for the periodic estimation of revenues and expenses for state employee health insurance. The health insurance estimating conference annually reviews the income and claims experience of the self-insurance fund in an attempt to forecast the utilization demands and the legislative funding requirements for the succeeding coverage period. The plan is administered by the Division of State Group Insurance in the Department of Management Services. The PPO Plan provides universal access to employees in all Florida counties. Provider contracts with health maintenance organizations are negotiated separately. Immunization services are currently established in the schedule of minimum benefits for health maintenance organization coverage.

[5] Pneumococcal Pneumonia, updated December 13, 2004, Department of Health and Human Services National Institute of Allergy and Infectious Diseases, available at www.niaid.nih.gov/factsheets/pneumonia.

[6] See www.aphanet.org/pharmcare/immunofact

Immunization Coverage within Part VI of the Florida Insurance Code

According to the Office of Insurance Regulation, the newly created statute, s. 627.64194, F.S., would require accident or health insurers to offer optional coverage for immunizations, including those recommended or required for specific international travel.[7] The optional coverage would be subject to a co-payment and the coverage would not be subject to any deductible co-payment or coinsurance provisions.

By citing the statute in Part VI of chapter 627, the optional coverage provision is applicable only to individual health or accident policies issued by an insurer and is also made applicable to all types of health or accident policy issued to an individual, including specified disease, hospital indemnity, disability income and long term care policies. The mandatory offer would not apply to an insurer issuing a group health policy, covered under Part VII of chapter 627 or to an HMO issuing a group or individual subscriber contract covered under chapter 641 of the Florida Insurance code.

Florida Bright Futures Scholarship

In 1997, the Florida Legislature created the Florida Bright Futures Scholarship Program. The program is funded by the Florida Lottery and provides academic scholarships based on scholastic achievement during high school. Scholarships are awarded to students pursuing postsecondary education. Florida Bright Futures Scholarship Program includes three levels of awards:[8]

- Florida Academic Scholars Award;
- Florida medallion Scholars Award; and
- Florida Gold Seal Vocational Scholars Award

Levels of awards are based grade point average, required credits, community service, and test scores. The December 2006 Bright Futures Estimating Conference projects 146,554 enrollees.

Florida Prepaid College Program

Section 1009.97, F.S., established the Florida Prepaid College Program (Florida Prepaid) to allow Florida residents to pay the cost of higher education in advance at a fixed level and with a statutory state guarantee. The bill addresses the Florida Prepaid College Plan which currently offers three types of tuition plans:

- 4-Year University Tuition Plan – Covers 120 university undergraduate credit hours;
- 2+2 Tuition Plan – Covers 60 community college credit hours and 60 university undergraduate credit hours;
- 2-Year Community College Tuition Plan – Covers 60 community college credit hours.

Currently, there are approximately 800,000 program enrollees.

Enterprise Florida, Inc.

In 1992, Chapter 288, Part VII, F.S., was created establishing Enterprise Florida, Inc. (EFI) as the principal economic development organization for the state. EFI is a public-private partnership and is responsible for leading Florida's statewide economic development efforts. The organization's mission is to diversify the state's economy and create better paying jobs for its citizens by supporting, attracting and helping to create businesses in innovative, high-growth industries. EFI provides a variety of services to companies and focuses on sectors such as: life sciences, information technology, aviation/aerospace, homeland security and defense and financial and professional services. EFI works

[7] See Office of Insurance regulation Legislative Review 2007, on file with the Committee.
[8] www.MyFloridaEducation.com/brfuture

with regional and local economic development organizations to assist existing and new business with retention, expansion and creation of businesses.

Enterprise Florida, Inc. is governed by a board of directors, consisting of business, economic and government leaders from the State and is chaired by the Governor.

C. SECTION DIRECTORY:

Section 1. Amends s. 110.123 (h) 2.a, F.S., relating to state group insurance programs.

Section 2. Creates s. 288.9416, F.S., relating to vaccine production facilities and outreach campaign for vaccine production.

Section 3. Renumbers s. 381.005 (3) as s. 381.005 (4), and creates a new s. 381.005 (3), F.S., relating to primary and preventive health services.

Section 4. Creates s. 409.908 (23), F.S., relating to reimbursement of Medicaid providers.

Section 5. Amends s. 465.003 (13), F.S., relating to pharmacy definitions.

Section 6. Creates s. 465.189 (1), F.S., relating to administration of vaccines.

Section 7. Creates s. 627.64194, F.S., relating to coverage for immunizations.

Section 8. Creates s. 1003.22 (10) (c), F.S., relating to district school boards and governing authorities of private schools.

Section 9. Amends s. 1009.53 (5), F.S., relating to Florida Bright Futures Scholarship Program.

Section 10. Amends s. 1009.98 92), F.S., relating to Stanley G. Tate Florida Prepaid College Program.

Section 11. Provides an effective date of July 1, 2007.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The administration of immunizations to Medicaid recipients will earn $4,445,088 in federal Medicaid assistance participation.

2. Expenditures:

   *The calculations provided below are based on the assumption that all Bright Futures recipients would choose to have the immunizations and that the cost for all students would be comparable to those at the Florida State University, who received their vaccinations through the Leon County Health Department. The recipient data is from the December 2006 Bright Futures Estimating Conference.

		1st Year	2nd Year	3rd Year
Bright Futures Recipients*	Administering meningococcal vaccine to the freshman class of 46,554 students @ $99 per vaccine	$4,608,846	$4,608,846	$4,608,846
	Administering Hepatitis B series to the freshman class of 46,554 students @ $108 per series[9]	$5,027,832	$5,027,832	$5,027,832
	Administering Influenza to the freshman class of 46,554 students @ $21 per vaccine	$977,934	$977,934	$977,934
	Administering Influenza to 100,000 returning recipients annually @ $21 per vaccine	$2,100,000	$2,100,000	$2,100,000
Enterprise Florida	Research and analysis, marketing materials and marketing outreach	$250,000	$250,000	$250,000
Department of Health	Mailing of annual reminder notices to 1182 Assisted Living Facilities (ALFs) @ $0.46 each	$1,104	$1,104	$1,104
	Subtotal General Revenue	$12,965,716	$12,965,716	$12,965,716
Medicaid	Difference between the current administration fee and the increase up to the VFC allowable maximum rate	$7,810,733	$7,810,733	$7,810,733
	Total General Revenue	$3,365,645	$3,365,645	$3,365,645
	Total Trust Fund	$4,445,088	$4,445,088	$4,445,088

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

[9] The hepatitis B vaccine series consists of three doses spaced out over approximately 6 months. An individual needs to receive the whole series to be protected.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Consumers
Consumers who are at high risk for influenza that may be prevented through immunization may have an increased access to a health care professional who can provide such immunizations, if pharmacists take advantage of the opportunity created in the bill.

Pharmacists
Pharmacists who administer influenza virus immunizations will incur costs for certification and training. According to a representative of the Florida Pharmacy Association, there should be no additional costs to pharmacists for the $200,000 liability insurance mandated in the bill since most pharmacists carry at least $1million in such coverage.

Prepaid College Program
According to the Department of Education, the bill increases the amount all future Prepaid College Plans. Typically these costs are passed on to the consumer. However, the bill also impacts all active outstanding contracts. In June 2006, the 2005-2006 the Prepaid College Program Annual Report states there were 790,670 active outstanding contracts. The increase in cost will have to be absorbed by the Prepaid College Board.

There are currently three different types of tuition plans offered under the Florida Prepaid College Program: the tuition plan, a local fee plan, and a dormitory plan. As drafted, the bill requires all plans to cover the cost of the immunizations. Some students may participate in all three plans.

Health and Accident Policy Insurers
The bill requires the immunization coverage to be offered without being subject to policy co-payments or deductibles, which will increase the cost of the benefit. According to Office of Insurance Regulation, the increased claims costs will be passed through to all policyholders in the form of increased premiums. To the extent that policyholders select this optional coverage, utilization of the benefit to prevent illness and disease represents cost avoidance to both the insurer and the policy holder.

D. FISCAL COMMENTS:

Medicaid
According to Agency for Health Care Administration (AHCA), the Florida Medicaid Program currently does not pay for immunizations administered to adults over the age of 20. The Medicaid Program does reimburse for the administration of childhood immunizations.

Individual's ages 0-18 years are provided immunizations through the Vaccine for Children (VFC) Program. The vaccines are provided at no cost to the provider through the VFC Program for 0-18 year olds. Medicaid also reimburses for the cost of the vaccine and the administration of childhood immunizations for 19-20 year olds. The number of projected enrollees is based on the February 9, 2007 Social Services Estimating Conference results.

Medicaid reimburses the administration fee to providers differently for example: physicians $10, advanced registered nurses and physician assistants $8, and county health departments and federally qualified health centers $5. The Federal Register, published on October 3, 1994, provides a maximum regional charge for vaccine administration by state for VFC eligible recipients. According to the Federal Register, the maximum rate for Florida is $16.06.

The current Medicare reimbursement rate for the administration of influenza and pneumococcal immunizations vary by location: $18.70 in Ft. Lauderdale, $19.59 in Miami, and $17.90 for the remainder of the state. AHCA is concerned that increase in reimbursement rate to the Medicare rate will conflict with the Medicaid reimbursement limitations specified in the Federal Register.

The cost for administering immunizations to adults (20 years or older) is indeterminate. It is impossible ascertain an accurate number of Medicaid eligible adults who would utilize the immunization services. There would be cost associated with the provider reimbursement and the cost for ingredients.

Enterprise Florida Incorporated
According to the Office of Tourism, Trade and Economic Development, the bill will not have a fiscal impact on their agency. However, Enterprise Florida Incorporated has concern that the bill does not reflect costs associated with providing incentives that may be required to encourage pharmaceutical companies, which produce vaccines, to relocate to Florida.

State Group Insurance Program
The Department of Management Services (DMS) manages the state group insurance program that is offered to state employees. Based on a telephone conversation with DMS staff, DMS will incur costs associated with implementing the provisions of the bill. However, they mentioned needing to conduct an actuarial study to determine the increase in the premium amount to provide immunization coverage. DMS estimates that it will cost $ 40,365 (103,500 insured @ $0.39 each) to notify the insured of their right to elect coverage for immunization services.

Board of Pharmacy
According to the Department of Health, they may incur minimal costs associated with the Board of Pharmacy's adoption of any rules to implement training requirements for pharmacists to provide immunizations.

Assisted Living Facilities
Assisted living facilities will incur additional costs to design and implement the program required by the bill.

II. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenues.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

D. STATEMENT OF THE SPONSOR

No statement submitted.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

On March 13, 2007, the Health Innovation Committee adopted one strike-all amendment to the bill. This amendment:

- Creates the Commission on the Study of Biotech Competitiveness within the Governor's Office of Tourism, Trade & Economic Development and provides duties and responsibilities.
- Requires assisted living facilities to offer an immunization program to patients age 65 or older.
- Directs the Department of Health to send annual reminder notices to assisted living facilities regarding immunizations.
- Requires that pneumococcal conjugate vaccine be administered to children less than 2 years of age who are enrolled or are enrolling in child care facilities, family day care or child care homes.
- Authorizes the Department of Health to implement rules regarding pneumococcal conjugate vaccines for children less than 2 years of age.
- Defines "Practice of profession of pharmacy" to include vaccine administration.
- Allow pharmacists to administer vaccines subject to certain criteria such as: pharmacist protocols and requirements regarding supervision, training and immunization certification, continuing education, liability protection, record keeping, and transmission of immunization information to the Department of Health.
- Requires additional insurance option coverage within state accident or health insurance policies and specifies that the additional coverage may be offered for an addition premium not subject to the deductible co-payment or coinsurance provision.
- Removes five sections from the original proposal as follows:
    1. Deletes the requirement that the Department of Management Services establish a schedule of minimum benefits for health maintenance organizations participating in the state group insurance program to include immunization coverage;
    2. Deletes the requirement that Enterprise Florida, Inc. conduct an outreach campaign to encourage pharmaceutical companies to produce vaccines and encourage pharmaceutical companies outside of Florida to establish facilities in Florida;
    3. Deletes the requirement that district school boards and the governing authority of each private school provide information to parents regarding meningococcal disease;
    4. Deletes the requirement that Florida Bright Futures Scholarship awards include immunization coverage for students; and
    5. Deletes the requirement that Stanley G. Tate Florida Prepaid College Program awards include immunization coverage for students.

The bill was reported favorably with one strike-all amendment.

1 A bill to be entitled
2 An act relating to immunization services; amending s.
3 110.123, F.S.; including immunization services in the
4 schedule of minimum benefits for health maintenance
5 organizations participating in the state group insurance
6 program; creating s. 288.9416, F.S.; requiring Enterprise
7 Florida, Inc., to conduct an outreach campaign to
8 encourage pharmaceutical companies to produce vaccines in
9 the state; amending s. 381.005, F.S.; requiring certain
10 assisted living facilities to offer influenza vaccines to
11 certain patients; requiring the Department of Health to
12 send reminder notices to assisted living facilities;
13 amending s. 409.908, F.S.; providing for the reimbursement
14 of Medicaid providers of immunization services; amending
15 s. 465.003, F.S.; redefining the term "practice of the
16 profession of pharmacy" to include the administration of
17 vaccines to adults by a pharmacist; creating s. 465.189,
18 F.S.; authorizing pharmacists to administer vaccines
19 within an established protocol and under a supervisory
20 practitioner who is a licensed physician or by written
21 agreement with a county health department; providing
22 requirements for the protocol; requiring professional
23 liability insurance, training, and certification in
24 vaccination and employer approval before entering into a
25 protocol; requiring a pharmacist to maintain and make
26 available patient records for a certain time period;
27 providing requirements for the certification program;
28 creating s. 627.64194, F.S.; requiring certain health

29 insurance policies to provide an option for immunization
30 services coverage; amending s. 1003.22, F.S.; requiring
31 district school boards and private school governing
32 authorities to provide information relating to
33 meningococcal disease and meningococcal disease vaccine to
34 parents of certain students; requiring the Department of
35 Health to adopt rules specifying which students apply to
36 such information requirement; amending s. 1009.53, F.S.;
37 providing that awards from the Florida Bright Futures
38 Scholarship Program shall include coverage for certain
39 immunizations; amending s. 1009.98, F.S.; requiring all
40 Stanley G. Tate Florida Prepaid College Program plans to
41 include coverage for certain immunizations; providing an
42 effective date.
43
44 Be It Enacted by the Legislature of the State of Florida:
45
46 Section 1. Paragraph (h) of subsection (3) of section
47 110.123, Florida Statutes, is amended to read:
48 110.123 State group insurance program.--
49 (3) STATE GROUP INSURANCE PROGRAM.--
50 (h)1. A person eligible to participate in the state group
51 insurance program may be authorized by rules adopted by the
52 department, in lieu of participating in the state group health
53 insurance plan, to exercise an option to elect membership in a
54 health maintenance organization plan which is under contract
55 with the state in accordance with criteria established by this
56 section and by said rules. The offer of optional membership in a

57 health maintenance organization plan permitted by this paragraph
58 may be limited or conditioned by rule as may be necessary to
59 meet the requirements of state and federal laws.
60 2. The department shall contract with health maintenance
61 organizations seeking to participate in the state group
62 insurance program through a request for proposal or other
63 procurement process, as developed by the Department of
64 Management Services and determined to be appropriate.
65 a. The department shall establish a schedule of minimum
66 benefits for health maintenance organization coverage, and that
67 schedule shall include: physician services; inpatient and
68 outpatient hospital services; emergency medical services,
69 including out-of-area emergency coverage; diagnostic laboratory
70 and diagnostic and therapeutic radiologic services; mental
71 health, alcohol, and chemical dependency treatment services
72 meeting the minimum requirements of state and federal law;
73 skilled nursing facilities and services; prescription drugs;
74 age-based and gender-based wellness benefits; immunization
75 services; and other benefits as may be required by the
76 department. Additional services may be provided subject to the
77 contract between the department and the HMO. As used in this
78 paragraph, the term "age-based and gender-based wellness
79 benefits" includes aerobic exercise, education in alcohol and
80 substance abuse prevention, blood cholesterol screening, health
81 risk appraisals, blood pressure screening and education,
82 nutrition education, program planning, safety belt education,
83 smoking cessation, stress management, weight management, and
84 women's health education.

85 b. The department may establish uniform deductibles,
86 copayments, coverage tiers, or coinsurance schedules for all
87 participating HMO plans.
88 c. The department may require detailed information from
89 each health maintenance organization participating in the
90 procurement process, including information pertaining to
91 organizational status, experience in providing prepaid health
92 benefits, accessibility of services, financial stability of the
93 plan, quality of management services, accreditation status,
94 quality of medical services, network access and adequacy,
95 performance measurement, ability to meet the department's
96 reporting requirements, and the actuarial basis of the proposed
97 rates and other data determined by the director to be necessary
98 for the evaluation and selection of health maintenance
99 organization plans and negotiation of appropriate rates for
100 these plans. Upon receipt of proposals by health maintenance
101 organization plans and the evaluation of those proposals, the
102 department may enter into negotiations with all of the plans or
103 a subset of the plans, as the department determines appropriate.
104 Nothing shall preclude the department from negotiating regional
105 or statewide contracts with health maintenance organization
106 plans when this is cost-effective and when the department
107 determines that the plan offers high value to enrollees.
108 d. The department may limit the number of HMOs that it
109 contracts with in each service area based on the nature of the
110 bids the department receives, the number of state employees in
111 the service area, or any unique geographical characteristics of

112 the service area. The department shall establish by rule service
113 areas throughout the state.
114 e. All persons participating in the state group insurance
115 program may be required to contribute towards a total state
116 group health premium that may vary depending upon the plan and
117 coverage tier selected by the enrollee and the level of state
118 contribution authorized by the Legislature.
119 3. The department is authorized to negotiate and to
120 contract with specialty psychiatric hospitals for mental health
121 benefits, on a regional basis, for alcohol, drug abuse, and
122 mental and nervous disorders. The department may establish,
123 subject to the approval of the Legislature pursuant to
124 subsection (5), any such regional plan upon completion of an
125 actuarial study to determine any impact on plan benefits and
126 premiums.
127 4. In addition to contracting pursuant to subparagraph 2.,
128 the department may enter into contract with any HMO to
129 participate in the state group insurance program which:
130 a. Serves greater than 5,000 recipients on a prepaid basis
131 under the Medicaid program;
132 b. Does not currently meet the 25-percent non-
133 Medicare/non-Medicaid enrollment composition requirement
134 established by the Department of Health excluding participants
135 enrolled in the state group insurance program;
136 c. Meets the minimum benefit package and copayments and
137 deductibles contained in sub-subparagraphs 2.a. and b.;
138 d. Is willing to participate in the state group insurance
139 program at a cost of premiums that is not greater than 95

140 percent of the cost of HMO premiums accepted by the department
141 in each service area; and
142 e. Meets the minimum surplus requirements of s. 641.225.
143
144 The department is authorized to contract with HMOs that meet the
145 requirements of sub-subparagraphs a.-d. prior to the open
146 enrollment period for state employees. The department is not
147 required to renew the contract with the HMOs as set forth in
148 this paragraph more than twice. Thereafter, the HMOs shall be
149 eligible to participate in the state group insurance program
150 only through the request for proposal or invitation to negotiate
151 process described in subparagraph 2.
152 5. All enrollees in a state group health insurance plan, a
153 TRICARE supplemental insurance plan, or any health maintenance
154 organization plan have the option of changing to any other
155 health plan that is offered by the state within any open
156 enrollment period designated by the department. Open enrollment
157 shall be held at least once each calendar year.
158 6. When a contract between a treating provider and the
159 state-contracted health maintenance organization is terminated
160 for any reason other than for cause, each party shall allow any
161 enrollee for whom treatment was active to continue coverage and
162 care when medically necessary, through completion of treatment
163 of a condition for which the enrollee was receiving care at the
164 time of the termination, until the enrollee selects another
165 treating provider, or until the next open enrollment period
166 offered, whichever is longer, but no longer than 6 months after
167 termination of the contract. Each party to the terminated

168 contract shall allow an enrollee who has initiated a course of
169 prenatal care, regardless of the trimester in which care was
170 initiated, to continue care and coverage until completion of
171 postpartum care. This does not prevent a provider from refusing
172 to continue to provide care to an enrollee who is abusive,
173 noncompliant, or in arrears in payments for services provided.
174 For care continued under this subparagraph, the program and the
175 provider shall continue to be bound by the terms of the
176 terminated contract. Changes made within 30 days before
177 termination of a contract are effective only if agreed to by
178 both parties.
179 7. Any HMO participating in the state group insurance
180 program shall submit health care utilization and cost data to
181 the department, in such form and in such manner as the
182 department shall require, as a condition of participating in the
183 program. The department shall enter into negotiations with its
184 contracting HMOs to determine the nature and scope of the data
185 submission and the final requirements, format, penalties
186 associated with noncompliance, and timetables for submission.
187 These determinations shall be adopted by rule.
188 8. The department may establish and direct, with respect
189 to collective bargaining issues, a comprehensive package of
190 insurance benefits that may include supplemental health and life
191 coverage, dental care, long-term care, vision care, and other
192 benefits it determines necessary to enable state employees to
193 select from among benefit options that best suit their
194 individual and family needs.

195 a. Based upon a desired benefit package, the department
196 shall issue a request for proposal or invitation to negotiate
197 for health insurance providers interested in participating in
198 the state group insurance program, and the department shall
199 issue a request for proposal or invitation to negotiate for
200 insurance providers interested in participating in the non-
201 health-related components of the state group insurance program.
202 Upon receipt of all proposals, the department may enter into
203 contract negotiations with insurance providers submitting bids
204 or negotiate a specially designed benefit package. Insurance
205 providers offering or providing supplemental coverage as of May
206 30, 1991, which qualify for pretax benefit treatment pursuant to
207 s. 125 of the Internal Revenue Code of 1986, with 5,500 or more
208 state employees currently enrolled may be included by the
209 department in the supplemental insurance benefit plan
210 established by the department without participating in a request
211 for proposal, submitting bids, negotiating contracts, or
212 negotiating a specially designed benefit package. These
213 contracts shall provide state employees with the most cost-
214 effective and comprehensive coverage available; however, no
215 state or agency funds shall be contributed toward the cost of
216 any part of the premium of such supplemental benefit plans. With
217 respect to dental coverage, the division shall include in any
218 solicitation or contract for any state group dental program made
219 after July 1, 2001, a comprehensive indemnity dental plan option
220 which offers enrollees a completely unrestricted choice of
221 dentists. If a dental plan is endorsed, or in some manner
222 recognized as the preferred product, such plan shall include a

223 comprehensive indemnity dental plan option which provides
224 enrollees with a completely unrestricted choice of dentists.
225 b. Pursuant to the applicable provisions of s. 110.161,
226 and s. 125 of the Internal Revenue Code of 1986, the department
227 shall enroll in the pretax benefit program those state employees
228 who voluntarily elect coverage in any of the supplemental
229 insurance benefit plans as provided by sub-subparagraph a.
230 c. Nothing herein contained shall be construed to prohibit
231 insurance providers from continuing to provide or offer
232 supplemental benefit coverage to state employees as provided
233 under existing agency plans.
234 Section 2. Section 288.9416, Florida Statutes, is created
235 to read:
236 288.9416 Vaccine production facilities; outreach campaign
237 for vaccine production.--Enterprise Florida, Inc., as the
238 principal economic development organization for the state under
239 s. 288.9015, shall conduct an outreach campaign to encourage
240 pharmaceutical companies located in this state to produce
241 vaccines for the prevention of communicable diseases and to
242 encourage pharmaceutical companies located outside of this state
243 to establish facilities in this state to produce vaccines for
244 the prevention of communicable diseases.
245 Section 3. Subsection (3) of section 381.005, Florida
246 Statutes, is renumbered as section (4), and a new subsection (3)
247 is added to that section, to read:
248 381.005 Primary and preventive health services.--
249 (3) Between October 1 of each year, or earlier if the
250 vaccination is available, and February 1 of the following year,

251 subject to the availability of an adequate supply of the
252 necessary vaccine, each assisted living facility licensed
253 pursuant to chapter 400 that has 11 or more licensed beds shall
254 implement a program to offer immunizations against the influenza
255 virus and pneumococcal bacteria to all patients age 65 or older,
256 in accordance with the recommendations of the Advisory Committee
257 on Immunization Practices of the United States Centers for
258 Disease Control and Prevention and subject to the clinical
259 judgment of the responsible practitioner. By September 1 of each
260 year, the department or its designee shall send to each assisted
261 living facility under this section a reminder notice of the
262 responsibilities of each assisted living facility under this
263 section.
264 Section 4. Subsection (23) is added to section 409.908,
265 Florida Statutes, to read:
266 409.908 Reimbursement of Medicaid providers.--Subject to
267 specific appropriations, the agency shall reimburse Medicaid
268 providers, in accordance with state and federal law, according
269 to methodologies set forth in the rules of the agency and in
270 policy manuals and handbooks incorporated by reference therein.
271 These methodologies may include fee schedules, reimbursement
272 methods based on cost reporting, negotiated fees, competitive
273 bidding pursuant to s. 287.057, and other mechanisms the agency
274 considers efficient and effective for purchasing services or
275 goods on behalf of recipients. If a provider is reimbursed based
276 on cost reporting and submits a cost report late and that cost
277 report would have been used to set a lower reimbursement rate
278 for a rate semester, then the provider's rate for that semester

279 shall be retroactively calculated using the new cost report, and
280 full payment at the recalculated rate shall be effected
281 retroactively. Medicare-granted extensions for filing cost
282 reports, if applicable, shall also apply to Medicaid cost
283 reports. Payment for Medicaid compensable services made on
284 behalf of Medicaid eligible persons is subject to the
285 availability of moneys and any limitations or directions
286 provided for in the General Appropriations Act or chapter 216.
287 Further, nothing in this section shall be construed to prevent
288 or limit the agency from adjusting fees, reimbursement rates,
289 lengths of stay, number of visits, or number of services, or
290 making any other adjustments necessary to comply with the
291 availability of moneys and any limitations or directions
292 provided for in the General Appropriations Act, provided the
293 adjustment is consistent with legislative intent.
294 (23) A provider of immunization services shall be
295 reimbursed at the Medicare reimbursement rate for the
296 administration of immunizations in addition to any applicable
297 reimbursement for the ingredient cost of the immunizations.
298 Section 5. Subsection (13) of section 465.003, Florida
299 Statutes, is amended to read:
300 465.003 Definitions.--As used in this chapter, the term:
301 (13) "Practice of the profession of pharmacy" includes
302 compounding, dispensing, and consulting concerning contents,
303 therapeutic values, and uses of any medicinal drug; consulting
304 concerning therapeutic values and interactions of patent or
305 proprietary preparations, whether pursuant to prescriptions or
306 in the absence and entirely independent of such prescriptions or

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

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307 orders; and other pharmaceutical services. For purposes of this
308 subsection, "other pharmaceutical services" means the monitoring
309 of the patient's drug therapy and assisting the patient in the
310 management of his or her drug therapy, and includes review of
311 the patient's drug therapy and communication with the patient's
312 prescribing health care provider as licensed under chapter 458,
313 chapter 459, chapter 461, or chapter 466, or similar statutory
314 provision in another jurisdiction, or such provider's agent or
315 such other persons as specifically authorized by the patient,
316 regarding the drug therapy. However, nothing in this subsection
317 may be interpreted to permit an alteration of a prescriber's
318 directions, the diagnosis or treatment of any disease, the
319 initiation of any drug therapy, the practice of medicine, or the
320 practice of osteopathic medicine, unless otherwise permitted by
321 law. "Practice of the profession of pharmacy" also includes any
322 other act, service, operation, research, or transaction
323 incidental to, or forming a part of, any of the foregoing acts,
324 requiring, involving, or employing the science or art of any
325 branch of the pharmaceutical profession, study, or training, and
326 shall expressly permit a pharmacist to transmit information from
327 persons authorized to prescribe medicinal drugs to their
328 patients. "Practice of the profession of pharmacy" also includes
329 the administration to adults of vaccines under s. 468.189.
330 Section 6. Section 465.189, Florida Statutes, is created
331 to read:
332 465.189 Administration of vaccines.--
333 (1) Pharmacists may administer vaccines to adults within
334 the framework of an established protocol under a supervisory

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

335 practitioner who is a physician licensed under chapter 458 or
336 chapter 459 or by written agreement with a county health
337 department. Each protocol shall contain specific procedures for
338 addressing any unforeseen allergic reaction to a vaccine.
339 (2) A pharmacist may not enter into a protocol unless he
340 or she maintains at least $200,000 of professional liability
341 insurance and not until the pharmacist has completed training in
342 vaccines as provided in this section.
343 (3) A pharmacist administering a vaccine shall maintain
344 and make available patient records using the same standards for
345 confidentiality and maintenance of such records as those that
346 are imposed on health care practitioners under s. 456.057. These
347 records shall be maintained for a minimum of 5 years.
348 (4) The decision by a supervisory practitioner to enter
349 into a protocol under this section is a professional decision of
350 the practitioner, and a person may not interfere with a
351 supervisory practitioner's decision as to whether to enter into
352 such a protocol. A pharmacist may not enter into a protocol that
353 is to be performed while acting as an employee without the
354 written approval of the owner of the pharmacy.
355 (5) Any pharmacist seeking to vaccinate patients under
356 this section shall be certified to administer vaccines pursuant
357 to a certification program approved by the Board of Pharmacy.
358 The certification program shall, at a minimum, require that a
359 pharmacist attend at least 20 hours of continuing education
360 classes approved by the board. The program shall have a
361 curriculum of instruction concerning the safe and effective
362 administration of vaccines, including, but not limited to,

363 potential allergic reactions to vaccines.
364 (6) The pharmacist shall submit to the Board of Pharmacy a
365 copy of the protocol or written agreement to administer a
366 vaccine.
367 Section 7. Section 627.64194, Florida Statutes, is created
368 to read:
369 627.64194 Coverage for immunizations.--An accident or
370 health insurance policy issued, amended, delivered, or renewed
371 in this state shall provide an option for the insured to elect
372 coverage for immunization services.
373 (1) The immunizations covered under this section shall
374 include: diphtheria; hepatitis B; measles; mumps; pertussis;
375 polio; rubella; tetanus; hemophilus influenza B (HIB);
376 pneumococcal; meningococcal; and any other immunization that the
377 Advisory Committee on Immunization Practices of the United
378 States Centers for Disease Control and Prevention or the
379 Department of Health determines to be recommended or required by
380 law, or that the Centers for Disease Control and Prevention
381 recommends or requires for specific international travel that
382 the policyholder is conducting.
383 (2) The coverage may be offered for an appropriate
384 additional premium.
385 (3) The coverage shall be offered without being subject to
386 the deductible copayment or coinsurance provisions of the
387 policy.
388 Section 8. Paragraph (c) is added to subsection (10) of
389 section 1003.22, Florida Statutes, to read:

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390 1003.22 School-entry health examinations; immunization
391 against communicable diseases; exemptions; duties of Department
392 of Health.--
393 (10) Each district school board and the governing
394 authority of each private school shall:
395 (c) Provide detailed information concerning the causes,
396 symptoms, and transmission of meningococcal disease; the risks
397 associated with meningococcal disease; and the availability,
398 effectiveness, and known contraindications of any required or
399 recommended vaccine against meningococcal disease to every
400 student's parent, in accordance with the recommended ages of
401 students determined by the Department of Health to be
402 appropriate for the administration of such vaccine. The
403 department shall adopt rules that specify the age or grade level
404 of students for whom such information shall be provided,
405 consistent with the recommendations of the Advisory Committee on
406 Immunization Practices of the United States Centers for Disease
407 Control and Prevention concerning the appropriate age for the
408 administration of the vaccine, and shall make available
409 information concerning the causes symptoms, and transmission of
410 meningococcal disease; the risks associated with meningococcal
411 disease; and the availability, effectiveness, and known
412 contraindications of any required or recommended vaccine to
413 school districts and the governing authorities of each private
414 school. Each district school board and the governing authority
415 of each private school shall determine the means and methods for
416 the provision of such information to students' parents.

417 Section 9. Subsection (5) of section 1009.53, Florida
418 Statutes, is amended to read:
419 1009.53 Florida Bright Futures Scholarship Program.--
420 (5) The department shall issue awards from the scholarship
421 program annually. Annual awards may be for up to 45 semester
422 credit hours or the equivalent. Awards shall include coverage
423 for the student to receive immunizations required by the Florida
424 State University System for enrollment, and shall include one-
425 time coverage for the recommended meningococcal immunization at
426 the option of the student. Awards shall include coverage for
427 yearly recommended influenza immunizations. Before the
428 registration period each semester, the department shall transmit
429 payment for each award to the president or director of the
430 postsecondary education institution, or his or her
431 representative, except that the department may withhold payment
432 if the receiving institution fails to report or to make refunds
433 to the department as required in this section.
434 (a) Within 30 days after the end of regular registration
435 each semester, the educational institution shall certify to the
436 department the eligibility status of each student who receives
437 an award. After the end of the drop and add period, an
438 institution is not required to reevaluate or revise a student's
439 eligibility status, but must make a refund to the department if
440 a student who receives an award disbursement terminates
441 enrollment for any reason during an academic term and a refund
442 is permitted by the institution's refund policy.
443 (b) An institution that receives funds from the program
444 shall certify to the department the amount of funds disbursed to

445 each student and shall remit to the department any undisbursed
446 advances within 60 days after the end of regular registration.
447 (c) Each institution that receives moneys through this
448 program shall prepare an annual report that includes an annual
449 financial audit, conducted by an independent certified public
450 accountant or the Auditor General. The report shall include an
451 audit of the institution's administration of the program and a
452 complete accounting of the moneys for the program. This report
453 must be submitted to the department annually by March 1. The
454 department may conduct its own annual audit of an institution's
455 administration of the program. The department may request a
456 refund of any moneys overpaid to the institution for the
457 program. The department may suspend or revoke an institution's
458 eligibility to receive future moneys for the program if the
459 department finds that an institution has not complied with this
460 section. The institution must remit within 60 days any refund
461 requested in accordance with this subsection.
462 Section 10. Subsection (2) of section 1009.98, Florida
463 Statutes, is amended to read:
464 1009.98 Stanley G. Tate Florida Prepaid College Program.--
465 (2) PREPAID COLLEGE PLANS.--At a minimum, the board shall
466 make advance payment contracts available for two independent
467 plans to be known as the community college plan and the
468 university plan. The board may also make advance payment
469 contracts available for a dormitory residence plan. All plans
470 shall include coverage for the student to receive immunizations
471 required by the Florida State University System for enrollment
472 and shall include one-time coverage for the recommended

473 meningococcal immunization at the option of the student. Awards
474 shall include coverage for yearly recommended influenza
475 immunizations. The board may restrict the number of participants
476 in the community college plan, university plan, and dormitory
477 residence plan, respectively. However, any person denied
478 participation solely on the basis of such restriction shall be
479 granted priority for participation during the succeeding year.
480 (a)1. Through the community college plan, the advance
481 payment contract shall provide prepaid registration fees for a
482 specified number of undergraduate semester credit hours not to
483 exceed the average number of hours required for the conference
484 of an associate degree. Qualified beneficiaries shall bear the
485 cost of any laboratory fees associated with enrollment in
486 specific courses. Each qualified beneficiary shall be classified
487 as a resident for tuition purposes, pursuant to s. 1009.21,
488 regardless of his or her actual legal residence.
489 2. Effective July 1, 1998, the board may provide advance
490 payment contracts for additional fees delineated in s. 1009.23,
491 not to exceed the average number of hours required for the
492 conference of an associate degree, in conjunction with advance
493 payment contracts for registration fees. Community college plan
494 contracts purchased prior to July 1, 1998, shall be limited to
495 the payment of registration fees as defined in s. 1009.97.
496 (b)1. Through the university plan, the advance payment
497 contract shall provide prepaid registration fees for a specified
498 number of undergraduate semester credit hours not to exceed the
499 average number of hours required for the conference of a
500 baccalaureate degree. Qualified beneficiaries shall bear the

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501 cost of any laboratory fees associated with enrollment in
502 specific courses. Each qualified beneficiary shall be classified
503 as a resident for tuition purposes pursuant to s. 1009.21,
504 regardless of his or her actual legal residence.
505 2. Effective July 1, 1998, the board may provide advance
506 payment contracts for additional fees delineated in s.
507 1009.24(8)-(11), for a specified number of undergraduate
508 semester credit hours not to exceed the average number of hours
509 required for the conference of a baccalaureate degree, in
510 conjunction with advance payment contracts for registration
511 fees. Such contracts shall provide prepaid coverage for the sum
512 of such fees, to a maximum of 45 percent of the cost of
513 registration fees. University plan contracts purchased prior to
514 July 1, 1998, shall be limited to the payment of registration
515 fees as defined in s. 1009.97.
516 (c) The cost of participation in contracts authorized
517 under paragraph (a) or paragraph (b) shall be based primarily on
518 the current and projected registration fees within the Florida
519 Community College System or the State University System,
520 respectively, and the number of years expected to elapse between
521 the purchase of the plan on behalf of a qualified beneficiary
522 and the exercise of the benefits provided in the plan by such
523 beneficiary.
524 (d) Through the dormitory residence plan, the advance
525 payment contract may provide prepaid housing fees for a maximum
526 of 10 semesters of full-time undergraduate enrollment in a state
527 university. Dormitory residence plans shall be purchased in
528 increments of 2 semesters. The cost of participation in the

529 dormitory residence plan shall be based primarily on the average
530 current and projected housing fees within the State University
531 System and the number of years expected to elapse between the
532 purchase of the plan on behalf of a qualified beneficiary and
533 the exercise of the benefits provided in the plan by such
534 beneficiary. Qualified beneficiaries shall have the highest
535 priority in the assignment of housing within university
536 residence halls. Qualified beneficiaries shall bear the cost of
537 any additional elective charges such as laundry service or long-
538 distance telephone service. Each state university may specify
539 the residence halls or other university-held residences eligible
540 for inclusion in the plan. In addition, any state university may
541 request immediate termination of a dormitory residence contract
542 based on a violation or multiple violations of rules of the
543 residence hall or other university-held residences. In the event
544 that sufficient housing is not available for all qualified
545 beneficiaries, the board shall refund the purchaser or qualified
546 beneficiary an amount equal to the fees charged for dormitory
547 residence during that semester. If a qualified beneficiary fails
548 to be admitted to a state university or chooses to attend a
549 community college that operates one or more dormitories or
550 residency opportunities, or has one or more dormitories or
551 residency opportunities operated by the community college
552 direct-support organization, the qualified beneficiary may
553 transfer or cause to have transferred to the community college,
554 or community college direct-support organization, the fees
555 associated with dormitory residence. Dormitory fees transferred
556 to the community college or community college direct-support

557 organization may not exceed the maximum fees charged for state
558 university dormitory residence for the purposes of this section,
559 or the fees charged for community college or community college
560 direct-support organization dormitories or residency
561 opportunities, whichever is less.
562 Section 11. This act shall take effect July 1, 2007.

COUNCIL/COMMITTEE ACTION

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

1 Council/Committee hearing bill: Healthcare Council
2 The Committee on Health Innovation offered the following:
3
4 **Amendment (with title amendment)**
5 Remove everything after the enacting clause and insert:
6
7 Section 1. Section 288.9416, Florida Statutes, is created
8 to read:
9 288.9416 Commission for the Study of Biotech
10 Competitiveness: creation; organization.--
11 (1) The Legislature finds that an estimated twenty
12 diseases can be cured through immunizations, and that
13 immunizations provided early in a child's life and as scheduled
14 during adolescence and adulthood, provide a strong foundation of
15 disease prevention and overall health. The Legislature further
16 finds that every dollar spent on immunization, saves an average
17 $10 in future disease-related health care costs. The Legislature
18 recognizes that immunization education and disease awareness
19 programs lead to improved vaccine usage and better health
20 outcomes. The Legislature further acknowledges that rapid
21 immunization distribution is an important factor to manage the

22 containment of disease under normal circumstances, and is of
23 vital importance during mass outbreaks of diseases or natural
24 disasters. The Legislature recognizes that the threat of a
25 bioterrorism, pandemic influenza or other disaster of widespread
26 proportion exists in our world today, and that access to
27 vaccines and health care services are essential combatants
28 against these threats.
29 (2) The Legislature recognizes that immunization
30 manufacturing and distribution is enhanced by siting vaccine
31 manufacturing corporations in Florida. Additionally, the
32 Legislature acknowledges that the state's efforts through
33 existing biotech research funded through the various research
34 programs in Florida including the James and Esther King
35 Biomedical Research Program, the William G. "Bill" Bankhead,
36 Jr., David Coley Cancer Research Program, the Johnnie B. Byrd
37 Senior Alzheimer's Center and Research Institute, the Scripps
38 Florida Funding Corporation and the High Impact Performance
39 Incentive Grants which are targeted toward developing and
40 expanding the biotech industry in Florida, result in the
41 expansion of the state's biotech research capacity and create
42 biotech manufacturing and distribution jobs in Florida. The
43 Legislature finds that the current and future collaboration
44 among Florida's university researchers and private and public
45 research efforts creates a robust opportunity to encourage
46 biotech research, manufacturing and distribution of vaccines. In
47 order to further this goal, the Commission on the Study of
48 Biotech Competitiveness is created.
49 (3) It is the intent of the Legislature that Florida
50 strives to become the nation's leader in immunizations, and
51 commit itself to encouraging companies to locate to Florida to

52 help achieve this goal. Moreover, it is the intent of the
53 Legislature to expand the state's economy by attracting biotech
54 manufacturing companies to Florida.
55 (4) There is created within the Governor's Office of
56 Tourism, Trade, and Economic Development (OTTED) the Commission
57 on the Study of Biotech Competitiveness. The staff shall provide
58 support for the study using internal staff or through a
59 contracted consultant.
60 (a) The commission shall consist of seventeen (17) members
61 appointed as follows:
62 1. The Governor shall appoint 7 members: one member from
63 the Governor's Office of Tourism, Trade and Economic
64 Development, the Secretary or Surgeon General of the Department
65 of Health or her designee; one member from the Department of
66 Education with expertise in workforce education, one member from
67 the Agency for Workforce Innovation with expertise in workforce
68 readiness, one member from the Florida Research Consortium with
69 training and experience in technology transfer, one member
70 representing the Medical Device Manufacturing Association, and
71 one member from Enterprise Florida, Inc.
72 2. The Speaker of the House of Representatives shall
73 appoint 5 members: one member representing the Scripps Research
74 Institute, one member representing BioFlorida, one member
75 representing the State Water Management Districts, one member
76 representing a local economic development authority, and one
77 member representing the Florida Board of Governors.
78 3. The Senate President shall appoint 5 members: one
79 member representing the Torrey Pines Research Institute, one
80 member representing the Burnham Research Institute, one member
81 representing an established biotech company which has sited a

82 manufacturing or distribution facility outside of Florida in the
83 last twelve months, one member who is a site selection
84 consultant who has worked with biotech companies in the sighting
85 of manufacturing and distribution facilities in states outside
86 of Florida, and one member representing the Florida Public
87 Health Foundation, Inc.
88 (b) In making these appointments the Governor, the
89 President of the Senate, and the Speaker of the House of
90 Representatives shall select members who reflect the diversity
91 of the state's population. One member shall be designated by the
92 Governor as chair of the commission.
93 (c) The appointments shall be for a 3-year term and an
94 appointment may not serve more than two consecutive terms.
95 (5) Members of the commission shall meet at least annually
96 and shall serve without compensation, but may receive
97 reimbursement as provided in s. 112.061 for travel and other
98 necessary expenses incurred in the performance of their official
99 duties.
100 (6) The commission shall study economic policies necessary
101 to ensure that Florida is competitive with other states to
102 attract and retain a biotech manufacturing and distribution
103 workforce. The study shall include but not be limited to the
104 following review and analysis:
105 (a) Florida's corporate taxation system and its impact to
106 attract biotech manufacturing and distribution facilities to the
107 state. This review shall include but not be limited to
108 implementing a single sales factor formula to apportion the
109 corporate income of biotech businesses for tax purposes;
110 (b) Florida's water policies and their impact on water
111 needs of the biotech manufacturing process;

112 (c) Florida's education and workforce training programs
113 and citizens' preparedness for employment in the biotech
114 manufacturing and distribution fields;
115 (d) Florida's Medicaid, state employee health plan and
116 private health insurance policies and regulations and the extent
117 to which they provide support for products generated by biotech
118 companies; and
119 (e) Other state initiatives that have had success in
120 attracting and retaining biotech manufacturing and distribution
121 facilities and shall evaluate Florida's readiness to compete
122 with other states.
123 (7) The study shall provide recommendations concerning
124 maximizing federal revenues to the state.
125 (8) The study shall provide recommendations concerning how
126 Florida's existing policies and programs can be modified to
127 ensure Florida's competitiveness when evaluated by companies
128 making sighting decisions related to biotech manufacturing and
129 distribution facilities.
130 (9) The commission shall report the findings of the study
131 to the Governor, the President of the Senate and the Speaker of
132 the House of Representatives by January 1, 2009.
133 Section 2. Subsection (3) of section 381.005, Florida
134 Statutes, is renumbered as section (4), and a new subsection (3)
135 is added to that section, to read:
136 381.005 Primary and preventive health services.--
137 (3) Between October 1 of each year, or earlier if the
138 vaccination is available, and February 1 of the following year,
139 subject to the availability of an adequate supply of the
140 necessary vaccine, each assisted living facility licensed
141 pursuant to chapter 400 that has 11 or more licensed beds shall

142 implement a program to offer immunizations against the influenza
143 virus and pneumococcal bacteria to all patients age 65 or older,
144 in accordance with the recommendations of the Advisory Committee
145 on Immunization Practices of the United States Centers for
146 Disease Control and Prevention and subject to the clinical
147 judgment of the responsible practitioner. By September 1 of each
148 year, the department or its designee shall send to each assisted
149 living facility under this section a reminder notice of the
150 responsibilities of each assisted living facility under this
151 section.
152 Section 3. Subsection (13) of section 465.003, Florida
153 Statutes, is amended to read:
154 465.003 Definitions.--As used in this chapter, the term:
155 (13) "Practice of the profession of pharmacy" includes
156 compounding, dispensing, and consulting concerning contents,
157 therapeutic values, and uses of any medicinal drug; consulting
158 concerning therapeutic values and interactions of patent or
159 proprietary preparations, whether pursuant to prescriptions or
160 in the absence and entirely independent of such prescriptions or
161 orders; and other pharmaceutical services. For purposes of this
162 subsection, "other pharmaceutical services" means the monitoring
163 of the patient's drug therapy and assisting the patient in the
164 management of his or her drug therapy, and includes review of
165 the patient's drug therapy and communication with the patient's
166 prescribing health care provider as licensed under chapter 458,
167 chapter 459, chapter 461, or chapter 466, or similar statutory
168 provision in another jurisdiction, or such provider's agent or
169 such other persons as specifically authorized by the patient,
170 regarding the drug therapy. However, nothing in this subsection
171 may be interpreted to permit an alteration of a prescriber's

172 directions, the diagnosis or treatment of any disease, the
173 initiation of any drug therapy, the practice of medicine, or the
174 practice of osteopathic medicine, unless otherwise permitted by
175 law. "Practice of the profession of pharmacy" also includes any
176 other act, service, operation, research, or transaction
177 incidental to, or forming a part of, any of the foregoing acts,
178 requiring, involving, or employing the science or art of any
179 branch of the pharmaceutical profession, study, or training, and
180 shall expressly permit a pharmacist to transmit information from
181 persons authorized to prescribe medicinal drugs to their
182 patients. "Practice of the profession of pharmacy" also includes
183 the administration to adults of influenza virus immunizations
184 under s. 465.189.
185 Section 4. Section 465.189, Florida Statutes, is created
186 to read:
187 465.189 Administration of influenza virus immunizations.--
188 (1) Pharmacists may administer influenza virus
189 immunizations to adults within the framework of an established
190 protocol under a supervisory practitioner who is a physician
191 licensed under chapter 458 or chapter 459 or by written
192 agreement with a county health department. Each protocol shall
193 contain specific procedures for addressing any unforeseen
194 allergic reaction to influenza virus immunizations.
195 (2) A pharmacist may not enter into a protocol unless he
196 or she maintains at least $200,000 of professional liability
197 insurance and not until the pharmacist has completed training in
198 influenza virus immunizations as provided in this section.
199 (3) A pharmacist administering influenza virus
200 immunizations shall maintain and make available patient records
201 using the same standards for confidentiality and maintenance of

202 such records as those that are imposed on health care
203 practitioners under s. 456.057. These records shall be
204 maintained for a minimum of 5 years.
205 (4) The decision by a supervisory practitioner to enter
206 into a protocol under this section is a professional decision of
207 the practitioner, and a person may not interfere with a
208 supervisory practitioner's decision as to whether to enter into
209 such a protocol. A pharmacist may not enter into a protocol that
210 is to be performed while acting as an employee without the
211 written approval of the owner of the pharmacy. Pharmacists shall
212 forward immunization records to the Department of Health for
213 inclusion in the state registry of immunization information.
214 (5) Any pharmacist seeking to administer influenza virus
215 immunizations to patients under this section shall be certified
216 to administer influenza virus immunizations pursuant to a
217 certification program approved by the Board of Pharmacy. The
218 certification program shall, at a minimum, require that a
219 pharmacist attend at least 20 hours of continuing education
220 classes approved by the board. The program shall have a
221 curriculum of instruction concerning the safe and effective
222 administration of influenza virus immunizations, including, but
223 not limited to, potential allergic reactions to influenza virus
224 immunizations.
225 (6) The pharmacist shall submit to the Board of Pharmacy a
226 copy of the protocol or written agreement to administer
227 influenza virus immunizations.
228 (7) The State Surgeon General may develop a list of
229 additional immunizations that may be administered by
230 pharmacists.
231 Section 5. This act shall take effect July 1, 2007.

This amendment was adopted in HI on 3/13/07 and is traveling with the bill and requires no further action.

232
233 ================ T I T L E A M E N D M E N T ================
234 Remove the entire title and insert:
235 A bill to be entitled
236 An act relating to immunization services; creating s.
237 288.9416, F.S.; creating the Commission for the Study of
238 Biotech Competitiveness; providing for appointment of
239 members; requiring a study; providing for staff support by
240 the Governor's Office of Tourism, Trade, and Economic
241 Development; requiring a report to the Governor and the
242 Legislature; amending s. 381.005, F.S., requiring certain
243 assisted living facilities to offer influenza vaccines to
244 certain patients; requiring the Department of Health to
245 send reminder notices to assisted living facilities;
246 amending s. 465.003, F.S.; revising a definition; creating
247 s. 465.189, F.S.; authorizing pharmacists to administer
248 influenza virus immunizations to adults; providing
249 requirements with respect thereto; providing an effective
250 date.

This amendment was adopted in HI on 3/13/07 and is traveling with the bill and requires no further action.

HB 587

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 587 Mental Health Facilities
SPONSOR(S): Grimsley
TIED BILLS: **IDEN./SIM. BILLS:** SB 430

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Health Innovation	7 Y, 0 N	Ciccone	Calamas
2) Healthcare Council		Ciccone	Gormley
3) Policy & Budget Council			
4)			
5)			

SUMMARY ANALYSIS

House Bill 587 entitles private facilities that examine and treat patients pursuant to Florida's Baker Act to reimbursement by the Department of Children and Family Services (DCF) for the provision of those services. The bill establishes data reporting requirements for licensed crisis stabilization units (CSU) and licensed mental health residential treatment facilities.

In addition, the bill requires the Agency for Health Care Administration (AHCA) to make certain mental health care provider data available to consumers and to publish the collected data in an annual report.

There is a $117,510,624 fiscal impact on state government and $39,020,120 fiscal impact on county governments associated with this bill, the bulk of which is for reimbursement of mental health services. DCF will incur costs related to contract management activities, and AHCA will incur costs to implement the rulemaking and data collection required by the bill.

This bill requires a 2/3 vote of the membership of each house of the Legislature. See Applicability of Municipality/County Mandates Provision.

The bill provides an effective date of July 1, 2007.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government—This bill entitles private facilities to be reimbursed by DCF for the facilities' examination and treatment of mental health patients pursuant to Florida's Baker Act. The bill establishes data reporting requirements for licensed crisis stabilization units and licensed mental health residential treatment facilities. In addition, the bill requires AHCA to make certain mental health care provider data available to consumers and to publish the collected data in an annual report.

B. EFFECT OF PROPOSED CHANGES:

Background

Florida's Baker Act[1] requires that people who, because of mental illness, appear to a law enforcement officer to be a danger to themselves or others, be taken to the nearest receiving facility for emergency evaluation and/or treatment. Individuals may also present themselves voluntarily for evaluation or treatment. Many of those who are taken for or seek mental health treatment under the Baker Act are indigent or uninsured.

Persons in crisis may be transported to a community hospital, many of which are designated as Baker Act receiving facilities and operate psychiatric beds, where they remain until space is available in a state contracted crisis stabilization unit (CSU). Others may voluntarily seek crisis intervention at a designated community hospital, and certain federal statutes require that they will be initially admitted for stabilization, rather than immediately transported to another facility. For these reasons, community hospitals have provided a considerable amount of uncompensated care for people who have no insurance or personal funds to pay for treatment. Because the number of licensed psychiatric hospital beds in Florida has decreased substantially over the past ten years, those hospitals which continue to maintain these beds bear an ever higher financial burden for uncompensated care.

In Fiscal Year 2006-2007, DCF received a fixed annual appropriation for Baker Act services of $78,627,156.[2] These funds are primarily contracted to licensed CSU operated by private not for profit community mental health providers. The department contracts with these entities for crisis services for low income individuals needing mental health care.

The number of psychiatric beds needed to meet statewide need, based on Florida's adult population, is 1,377. Current DCF- and Medicaid-funded beds total 1,115, resulting in an unmet need for 262 additional beds.[3]

DCF is already authorized to pay for Baker Act services in hospitals. However, the average payment to a CSU is $291 per day, inclusive of physician charges, while hospitals have an average Florida Medicaid cost based rate of $1,390 per day, exclusive of physician charges.[4] Thus, with a fixed appropriation, fewer people can be served in hospitals than in CSU.

Effect of Proposed Legislation

HB 587 amends s. 394.461, F.S., to entitle private facilities receiving and treating voluntary and involuntary patients under the Baker Act to reimbursement by DCF for provision of those services. It requires licensed facilities to report financial and health service data to DCF pursuant to s. 408.061,

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[1] Section 394.451, F.S., *et seq.*; also known as the Florida Mental Health Act.
[2] Specific Appropriations 384 and 393, 2006 General Appropriations Act.
[3] Source: DCF Division of Mental Health.
[4] *Ibid.*

F.S. The bill includes CSU and mental health residential facilities among those entities required to report health care and financial data to AHCA.

HB 587 specifies the data which must be submitted by a provider licensed under s. 394.875, F.S., to include:

- Admission data
- Patient referral source
- Discharge data
- Average patient length of stay by payer class
- Total patient days & total patient admissions by payer class
- The primary & secondary diagnosis of each patient
- The number of licensed beds in the facility
- The number of contracted beds in a public facility (defined in s. 394.455(25), F.S.)
- Total revenues by payer class, defined to include, without limitation, Medicare, Medicare HMO, Medicaid, Medicaid HMO, private-pay insurance, private health care maintenance organization, private preferred provider organization, services contracted by the Department of Children and Family Services, self-pay, charity, and other government programs
- Operating expenses

It mandates quarterly electronic data submission to AHCA, with certification of its truth and accuracy. ACHA is required to publish an annual report of collected data.

The bill reenacts the Financial Information and Disclosure requirements of the Patients Bill of Rights to incorporate the amendment to s. 408.05, F.S., made by this act.

The effective date of the act is July 1, 2007.

C. SECTION DIRECTORY:

Section 1. Amends s. 394.461, F.S.; entitles certain private facilities to reimbursement by DCF; requires the facilities to report certain information to DCF.

Section 2. Amends s. 408.05(3)(k), F.S.; requiring CSU and mental health residential facilities to report certain data to AHCA.

Section 3. Amends s. 408.061(1) F.S.; specifying data reporting requirements.

Section 4. Reenacts s. 381.026(4)(c), F.S., incorporating the amendment to s. 408.05, F.S., made by this act.

Section 5. Provides an effective date of July 1, 2007.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT: The following fiscal information is derived from information provided by the affected agencies detailed in "Fiscal Comments" in Part II.D. below.

		Amount Year 1 (FY 2007-2008)	Amount Year 2 (FY 2008-2009)
1.	Non-recurring or First-Year Start-Up Effects:	$0	$0
2.	Recurring or Annualized Continuation Effects:		
Services		$117,060,360	$117,060,360
OPS		$ 352,500	$ 320,000
Expense		$ 97,764	$ 71,790
3.	Long-Run Effects Other Than Normal Growth:		
4.	Appropriations Consequences	**$ 117,510,624**	**$ 117,452,151**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS: Pursuant to s. 394.76(3)(b), F.S., counties are required to provide **$39,020,120** in local match annually.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR: Private sector hospitals would receive most all of the $156,080,480 that would be needed to implement this bill.

D. FISCAL COMMENTS:

Fiscal Impact on DCF related to Reimbursement for Provision of Mental Health Services

The impact on services estimated above was calculated by DCF using the following information and assumptions. There are 2,268 adult and 299 children's psychiatric beds in hospitals that are designated private Baker Act receiving facilities. There are 640 adult and 100 children's psychiatric beds in hospitals that are designated public Baker Act receiving facilities. Public receiving facilities are hospitals (and crisis stabilization units) that receive *some* fixed funding (usually for a small portion of a hospital's bed capacity) from DCF through the current Baker Act appropriation. Private receiving facilities do not receive this funding and are not obligated to accept people referred by the department.

There are 2,567 Baker Act private receiving facility beds in hospitals in Florida. The average occupancy rate for these facilities is 65 percent. The uninsured rate in Florida, *i.e.*, people without Medicaid, Medicare, or other third party payer, is 19.1 percent of the population, with approximately 9 in 10 of these uninsured individuals having incomes under 250 percent of the Federal Poverty Level (FPL), or 17.2 percent of the population. Medicaid pays an average of $1,390 per day for a hospital bed. Additionally, physician charges estimated at about $100 per day might be expected for medical coverage, for a total of $1,490 per patient day. If the department were liable for psychiatric hospital days in private hospital based receiving facilities for uninsured people under 250 percent FPL, the potential cost would be as follows:

There are 2,268 private receiving facility beds in hospitals for adults and 299 for children, totaling 2,567 private facility beds. 2,567 x 365 = 936,955 patient days at 100 percent occupancy x 65 percent average occupancy = 609,021 patient days x 17.2 percent uninsured rate < 250 percent FPL = 104,752 low income uninsured bed days x $1,490 per day = $156,080,480 impact for current private receiving facilities only. This would require $117,060,360 in state funds and $39,020,120 local (county) match.

Fiscal Impact related to DCF Contract Management Capacity

DCF estimates that its district offices would require six OPS positions, each managing 15 contracts, at $45,000 annually to manage contracts with the approximately 92 hospitals with licensed psychiatric beds. (The facilities would be reimbursed for the mental health services provided by contract with DCF.)

Fiscal Year 2007-2008

6 X $33,750 =	$202,500 OPS (9 months)
6 X $16,294 =	$ 97,764 Expense (includes computer)

Fiscal Year 2008-2009

6 X $45,000 =	$270,000 OPS (12 months)
6 X $11,965 =	$ 71,790 Expense (recurring)

Fiscal Impact related to AHCA Rulemaking and Data Collection and Analysis

Fiscal impact on AHCA encompasses technical and material support for the initial development, rule development and implementation, ongoing data collection, data processing, data analysis and reporting of the new data set.

AHCA estimates that it would collect patient level data from approximately 200 mental health facilities licensed under s. 394.875, F.S., each quarter. This requires the collection and reporting of a new data set by facilities not previously engaged in electronic data report submissions to AHCA, specifically to the Florida Center.

The total expenditures for implementation of the provisions of this bill will be paid from contracted services and funded 100 percent from the General Revenue Fund.

Fiscal Year 2007-2008: $150,000
Fiscal Year 2008-2009: $ 50,000

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill requires counties in the aggregate to expend $39,020,120 in matching funds. The bill does not state that the law fulfills an important state interest. Assuming it is amended to make this finding, the bill must pass by a 2/3 vote of the membership in each house of the Legislature.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Lines 47-49: The amendment to s. 394.461, F.S., requires that data required pursuant to s. 408.061, F.S., be reported to DCF. However, s. 408.061, F.S., relates to data collection and the uniform system of financial reporting required of providers by AHCA.

D. STATEMENT OF THE SPONSOR

The fiscal issues raised by committee staff is being addressed in the strike-all amendment.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

On March 20, 2007, the Health Innovation Committee adopted a strike-all amendment. The amendment:

- Removed the fiscal impact in the original bill.
- Provided specific reporting requirements of public receiving and treatment facilities by the Department of Children and Families and coordinated data collection with the Agency for Health Care Administration.

The bill was reported favorably with one amendment.

1 A bill to be entitled
2 An act relating to mental health facilities; amending s.
3 394.461, F.S.; authorizing reimbursement of certain
4 private mental health receiving and treatment facilities
5 by the Department of Children and Family Services;
6 requiring licensed mental health receiving and treatment
7 facilities designated by the department to report
8 financial and health service data to the department;
9 amending s. 408.05, F.S.; requiring the Agency for Health
10 Care Administration to make certain health care data
11 collected from specified mental health care providers
12 available to consumers; amending s. 408.061, F.S.;
13 requiring that certain data be collected by specified
14 mental health care providers and submitted to the agency
15 each quarter; defining the term "payer class"; requiring
16 the agency to publish an annual report from the data
17 collected; reenacting s. 381.026(4)(c), F.S., relating to
18 the patient's bill of rights and responsibilities, to
19 incorporate the amendments made to s. 408.05, F.S., in a
20 reference thereto; providing an effective date.
21
22 Be It Enacted by the Legislature of the State of Florida:
23
24 Section 1. Subsections (3) and (4) of section 394.461,
25 Florida Statutes, are amended to read:
26 394.461 Designation of receiving and treatment
27 facilities.--The department is authorized to designate and
28 monitor receiving facilities and treatment facilities and may

29 suspend or withdraw such designation for failure to comply with
30 this part and rules adopted under this part. Unless designated
31 by the department, facilities are not permitted to hold or treat
32 involuntary patients under this part.
33 (3) PRIVATE FACILITIES.--Private facilities designated as
34 receiving and treatment facilities by the department may provide
35 examination and treatment of involuntary patients, as well as
36 voluntary patients, are entitled to reimbursement from the
37 department, and are subject to all the provisions of this part.
38 (4) RULES.--The department shall adopt rules relating to:
39 (a) Procedures and criteria for receiving and evaluating
40 facility applications for designation, which may include onsite
41 facility inspection and evaluation of an applicant's licensing
42 status and performance history, as well as consideration of
43 local service needs.
44 (b) Minimum standards consistent with this part which ~~that~~
45 a facility must meet and maintain in order to be designated as a
46 receiving or treatment facility and procedures for monitoring
47 continued adherence to such standards. Licensed facilities must
48 report financial and health service data to the department
49 pursuant to s. 408.061.
50 (c) Procedures for receiving complaints against a
51 designated facility and for initiating inspections and
52 investigations of facilities alleged to have violated ~~the~~
53 ~~provisions of~~ this part or rules adopted under this part.
54 (d) Procedures and criteria for the suspension or
55 withdrawal of designation.

56 Section 2. Paragraph (k) of subsection (3) of section
57 408.05, Florida Statutes, is amended to read:
58 408.05 Florida Center for Health Information and Policy
59 Analysis.--
60 (3) COMPREHENSIVE HEALTH INFORMATION SYSTEM.--In order to
61 produce comparable and uniform health information and statistics
62 for the development of policy recommendations, the agency shall
63 perform the following functions:
64 (k) Develop, in conjunction with the State Consumer Health
65 Information and Policy Advisory Council, and implement a long-
66 range plan for making available health care quality measures and
67 financial data that will allow consumers to compare health care
68 services. The health care quality measures and financial data
69 the agency must make available shall include, but is not limited
70 to, pharmaceuticals, physicians, health care facilities,
71 including health care facilities licensed under s. 394.875, and
72 health plans and managed care entities. The agency shall submit
73 the initial plan to the Governor, the President of the Senate,
74 and the Speaker of the House of Representatives by January 1,
75 2006, and shall update the plan and report on the status of its
76 implementation annually thereafter. The agency shall also make
77 the plan and status report available to the public on its
78 Internet website. As part of the plan, the agency shall identify
79 the process and timeframes for implementation, any barriers to
80 implementation, and recommendations of changes in the law that
81 may be enacted by the Legislature to eliminate the barriers. As
82 preliminary elements of the plan, the agency shall:

83 1. Make available patient-safety indicators, inpatient
84 quality indicators, and performance outcome and patient charge
85 data collected from health care facilities pursuant to s.
86 408.061(1)(a) and (2). The terms "patient-safety indicators" and
87 "inpatient quality indicators" shall be as defined by the
88 Centers for Medicare and Medicaid Services, the National Quality
89 Forum, the Joint Commission on Accreditation of Healthcare
90 Organizations, the Agency for Healthcare Research and Quality,
91 the Centers for Disease Control and Prevention, or a similar
92 national entity that establishes standards to measure the
93 performance of health care providers, or by other states. The
94 agency shall determine which conditions, procedures, health care
95 quality measures, and patient charge data to disclose based upon
96 input from the council. When determining which conditions and
97 procedures are to be disclosed, the council and the agency shall
98 consider variation in costs, variation in outcomes, and
99 magnitude of variations and other relevant information. When
100 determining which health care quality measures to disclose, the
101 agency:
102 a. Shall consider such factors as volume of cases; average
103 patient charges; average length of stay; complication rates;
104 mortality rates; and infection rates, among others, which shall
105 be adjusted for case mix and severity, if applicable.
106 b. May consider such additional measures that are adopted
107 by the Centers for Medicare and Medicaid Studies, National
108 Quality Forum, the Joint Commission on Accreditation of
109 Healthcare Organizations, the Agency for Healthcare Research and
110 Quality, Centers for Disease Control and Prevention, or a

CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

111 similar national entity that establishes standards to measure
112 the performance of health care providers, or by other states.
113
114 When determining which patient charge data to disclose, the
115 agency shall consider such measures as average charge, average
116 net revenue per adjusted patient day, average cost per adjusted
117 patient day, and average cost per admission, among others.
118 2. Make available performance measures, benefit design,
119 and premium cost data from health plans licensed pursuant to
120 chapter 627 or chapter 641. The agency shall determine which
121 health care quality measures and member and subscriber cost data
122 to disclose, based upon input from the council. When determining
123 which data to disclose, the agency shall consider information
124 that may be required by either individual or group purchasers to
125 assess the value of the product, which may include membership
126 satisfaction, quality of care, current enrollment or membership,
127 coverage areas, accreditation status, premium costs, plan costs,
128 premium increases, range of benefits, copayments and
129 deductibles, accuracy and speed of claims payment, credentials
130 of physicians, number of providers, names of network providers,
131 and hospitals in the network. Health plans shall make available
132 to the agency any such data or information that is not currently
133 reported to the agency or the office.
134 3. Determine the method and format for public disclosure
135 of data reported pursuant to this paragraph. The agency shall
136 make its determination based upon input from the State Consumer
137 Health Information and Policy Advisory Council. At a minimum,
138 the data shall be made available on the agency's Internet

139 website in a manner that allows consumers to conduct an
140 interactive search that allows them to view and compare the
141 information for specific providers. The website must include
142 such additional information as is determined necessary to ensure
143 that the website enhances informed decisionmaking among
144 consumers and health care purchasers, which shall include, at a
145 minimum, appropriate guidance on how to use the data and an
146 explanation of why the data may vary from provider to provider.
147 The data specified in subparagraph 1. shall be released no later
148 than January 1, 2006, for the reporting of infection rates, and
149 no later than October 1, 2005, for mortality rates and
150 complication rates. The data specified in subparagraph 2. shall
151 be released no later than October 1, 2006.
152 Section 3. Present paragraph (e) of subsection (1) of
153 section 408.061, Florida Statutes, is redesignated as paragraph
154 (f), and a new paragraph (e) is added to that subsection, to
155 read:
156 408.061 Data collection; uniform systems of financial
157 reporting; information relating to physician charges;
158 confidential information; immunity.--
159 (1) The agency shall require the submission by health care
160 facilities, health care providers, and health insurers of data
161 necessary to carry out the agency's duties. Specifications for
162 data to be collected under this section shall be developed by
163 the agency with the assistance of technical advisory panels
164 including representatives of affected entities, consumers,
165 purchasers, and such other interested parties as may be
166 determined by the agency.

167 (e)1. Data to be submitted by a health care provider
168 licensed under s. 394.875 must include, but need not be limited
169 to, admission data and the source of patient referral; discharge
170 data; the patient's status at discharge; the average patient
171 length of stay by payer class; total patient days and total
172 patient admissions by payer class; the primary and secondary
173 diagnoses of each patient; the number of licensed beds in the
174 facility; the number of contracted beds in a public facility as
175 defined in s. 394.455(25); total revenues by payer class; and
176 operating expenses.
177 2. For the purpose of this paragraph, the term "payer
178 class" includes, but is not limited to, Medicare, Medicare HMO,
179 Medicaid, Medicaid HMO, private-pay insurance, private health
180 care maintenance organization, private preferred provider
181 organization, services contracted by the Department of Children
182 and Family Services, self-pay, charity, and other government
183 programs.
184 3. The data collected by a health care provider licensed
185 under s. 394.875 must be submitted to the agency quarterly. The
186 chief executive officer or an authorized representative or
187 employee of the licensed facility must certify that the
188 information submitted is true and accurate. Data elements shall
189 be reported electronically. The agency shall publish an annual
190 report detailing the information submitted by health care
191 providers.
192 Section 4. For the purpose of incorporating the amendment
193 made by this act to section 408.05, Florida Statutes, in a

194 reference thereto, paragraph (c) of subsection (4) of section
195 381.026, Florida Statutes, is reenacted to read:
196 381.026 Florida Patient's Bill of Rights and
197 Responsibilities.--
198 (4) RIGHTS OF PATIENTS.--Each health care facility or
199 provider shall observe the following standards:
200 (c) Financial information and disclosure.--
201 1. A patient has the right to be given, upon request, by
202 the responsible provider, his or her designee, or a
203 representative of the health care facility full information and
204 necessary counseling on the availability of known financial
205 resources for the patient's health care.
206 2. A health care provider or a health care facility shall,
207 upon request, disclose to each patient who is eligible for
208 Medicare, in advance of treatment, whether the health care
209 provider or the health care facility in which the patient is
210 receiving medical services accepts assignment under Medicare
211 reimbursement as payment in full for medical services and
212 treatment rendered in the health care provider's office or
213 health care facility.
214 3. A health care provider or a health care facility shall,
215 upon request, furnish a person, prior to provision of medical
216 services, a reasonable estimate of charges for such services.
217 Such reasonable estimate shall not preclude the health care
218 provider or health care facility from exceeding the estimate or
219 making additional charges based on changes in the patient's
220 condition or treatment needs.

221 4. Each licensed facility not operated by the state shall
222 make available to the public on its Internet website or by other
223 electronic means a description of and a link to the performance
224 outcome and financial data that is published by the agency
225 pursuant to s. 408.05(3)(k). The facility shall place a notice
226 in the reception area that such information is available
227 electronically and the website address. The licensed facility
228 may indicate that the pricing information is based on a
229 compilation of charges for the average patient and that each
230 patient's bill may vary from the average depending upon the
231 severity of illness and individual resources consumed. The
232 licensed facility may also indicate that the price of service is
233 negotiable for eligible patients based upon the patient's
234 ability to pay.
235 5. A patient has the right to receive a copy of an
236 itemized bill upon request. A patient has a right to be given an
237 explanation of charges upon request.
238 Section 5. This act shall take effect July 1, 2007.

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)

ADOPTED AS AMENDED __ (Y/N)

ADOPTED W/O OBJECTION __ (Y/N)

FAILED TO ADOPT __ (Y/N)

WITHDRAWN __ (Y/N)

OTHER ______

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1 Council/Committee hearing bill: Healthcare Council
2 The Committee on Health Innovation offered the following:
3
4 **Amendment (with title amendment)**
5 Remove everything after the enacting clause and insert:
6 Section 1. Subsection (4) of section 394.461, Florida
7 Statutes, is renumbered as subsection (5), and a new subsection
8 (4) is added to that section, to read:
9 394.461 Designation of receiving and treatment
10 facilities.--The department is authorized to designate and
11 monitor receiving facilities and treatment facilities and may
12 suspend or withdraw such designation for failure to comply with
13 this part and rules adopted under this part. Unless designated
14 by the department, facilities are not permitted to hold or treat
15 involuntary patients under this part.
16 (4)(a) A facility designated as a public receiving or
17 treatment facility under this section shall report to the
18 department on an annual basis the following data, unless these
19 data are currently being submitted to the Agency for Health Care
20 Administration:
21 1. Number of licensed beds.

This amendment was adopted in HI on 03/20/07 and is traveling with the bill and requires no further action

22 2. Number of contract days.

23 3. Number of admissions by payer class and diagnoses.

24 4. Number of bed days by payer class.

25 5. Average length of stay by payer class.

26 6. Total revenues by payer class.

27 (b) For the purposes of this subsection, "payer class"
28 means Medicare, Medicare HMO, Medicaid, Medicaid HMO, private-
29 pay health insurance, private-pay health maintenance
30 organization, private preferred provider organization, the
31 Department of Children and Family Services, other government
32 programs, self-pay patients, and charity care.

33 (c) The data required under this subsection shall be
34 submitted to the department no later than 90 days following the
35 end of the facility's fiscal year. A facility designated as a
36 public receiving or treatment facility shall submit its initial
37 report for the 6-month period ending June 30, 2008.

38 (d) The department shall issue an annual report based on
39 the data required pursuant to this subsection. The report shall
40 include individual facilities' data, as well as statewide
41 totals. The report shall be submitted to the Governor, the
42 President of the Florida Senate, and the Speaker of the Florida
43 House of Representatives.

44 Section 2. This act shall take effect July 1, 2007.

45

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

47 Remove the entire title and insert:

48 A bill to be entitled

49 An act relating to mental health facilities; amending s.
50 394.461, F.S.; requiring mental health receiving and
51 treatment facilities designated by the Department of

52 Children and Family Services to report certain financial
53 and health service data to the department; providing a
54 definition; providing reporting deadlines; providing a
55 report by the department; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1001 Health Maintenance Contracts
SPONSOR(S): Evers
TIED BILLS: **IDEN./SIM. BILLS:** SB 590

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Healthy Seniors	7 Y, 0 N	Walsh	Schoolfield
2) Healthcare Council		Walsh	Gormley
3)			
4)			
5)			

SUMMARY ANALYSIS

House Bill 1001 expands the right of a subscriber covered under a health maintenance organization (HMO) contract who is a resident of a continuing care facility or a retirement facility, to be referred to that facility's skilled nursing unit or assisted living facility upon the subscriber's request and with the agreement of the facility. The bill requires that the HMO provide a written disclosure of these rights to new subscribers who live in these facilities, including the right to use a specified grievance process if their request to be referred is not honored.

The act is effective July 1, 2007.

This bill does not appear to have a fiscal impact on state or local governments.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Safeguard Individual Liberty --- The bill preserves the arrangements of those seniors who are HMO subscribers to receive their lifetime care in the facilities of their chosen continuing care or retirement facility, by allowing them to request that medically necessary rehabilitative care be delivered in their home communities.

B. EFFECT OF PROPOSED CHANGES:

Background

Health Maintenance Organizations (HMO)

The Office of Insurance Regulation (OIR) regulates HMO under Part I of Chapter 641, F.S., while the Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMO under Part III of Chapter 641, F.S. Before receiving a certificate of authority from OIR, an HMO must receive a Health Care Provider Certificate from AHCA. Any entity that is issued a certificate of authority and that is otherwise in compliance with the licensure provisions under Part I may enter into contracts in Florida to provide an agreed-upon set of comprehensive health care services to subscribers.

Generally, health maintenance contracts, certificates, or member handbooks are required to clearly state all of the services to which a subscriber is entitled under the contract and must include a clear and understandable statement of any limitations on the services or kinds of services to be provided.[1] Every HMO is required to have a grievance procedure available to its subscribers, as required by s. 641.511, F.S. If the HMO's internal review process does not resolve the grievance, the subscriber may submit a grievance to the Subscriber Assistance Program administered by AHCA, as provided in s. 408.7056, F.S.

Continuing Care Retirement Communities (CCRC) and Retirement Facilities

A Continuing Care Retirement Community (CCRC) allows seniors flexible accommodations that are designed to meet their health and housing needs as these needs change over time. This type of facility offers three levels of care on one campus: independent living, assisted living facilities, and skilled nursing facilities.

Contract residents of a CCRC have a commitment for lifetime care. They make a substantial investment to prepay for their potential care and are guaranteed living space suitable for their needs for the rest of their lives. CCRC are licensed and regulated by OIR under Chapter 651, F.S. In addition, their skilled nursing and assisted living components are subject to regulation by AHCA.[2] There are a total of 69 licensed CCRC in Florida. These communities are home to approximately 24,000 Florida seniors.

Retirement facilities consisting of residential apartments and a nursing home or assisted living facility or both also provide their residents flexibility in accommodations over time; however, they operate without the prepaid contracts of the CCRC model.

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[1] Section 641.31 (4), F.S.

[2] *See*, ss. 400.141, 400.235, 429.04, and 651.118, F.S.

Referral of HMO Subscribers for Nursing Care at CCRC or Retirement Facility

Section 641.31(25), F.S., provides that if a person covered under an HMO contract ("subscriber") is a resident of a continuing care facility or of a retirement facility consisting of a nursing home and residential apartments, the HMO primary care physician **must** refer the subscriber to that facility's skilled nursing care unit if the primary care physician finds it is in the best interest of the subscriber to do so; and if the facility agrees to be reimbursed at the HMO contract rate negotiated with similar providers. In addition, the facility must meet all guidelines established by the HMO related to quality of care, utilization, referral authorization, risk assumption, use of the HMOs network, and other criteria applicable to providers under contract.

It has been reported that HMO physicians have not always referred their subscribers to the skilled nursing facilities associated with their home CCRC or retirement facility campuses for rehabilitation after hospitalization. This can result in the subscriber being physically isolated from his or her spouse, friends, and other caregivers at a time when such support is most important. Placements away from their home campuses also thwart the careful retirement planning these individuals engaged in and serve to discourage others from such planning.

Effect of Proposed Bill

HB 1001 expands the right of a subscriber covered under an HMO contract who is a resident of a CCRC or a retirement facility to be referred to that facility's skilled nursing unit or assisted living facility upon the subscriber's request and with the agreement of the facility.[3] The bill specifies the physicians who may make the referral.

The bill requires that the HMO provide a written disclosure of these rights to new subscribers living in CCRC or retirement facilities, including the right to use the grievance process in s. 641.511, F. S., if their request to be referred is not honored.

HB 1001 is effective July 1, 2007.

C. SECTION DIRECTORY:

Section 1: Amends s. 641.31(25), F. S.; provides additional criteria for referral; specifies physicians who can make referral; requires disclosure; specifies grievance process.

Section 2: Provides effective date of July 1, 2007.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

[3] The bill does not change the requirement that the subscriber's HMO primary care physician find such placement to be in the subscriber's best interest.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

If a subscriber elects to be referred to the nursing home or assisted living facility of his or her own facility, that facility must accept the contract rate negotiated by the HMO with similar providers for the same services, as well as being subject to all requirements of the HMO related to quality of care, utilization, referral authorization, and risk assumption.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   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:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Lines 24-26: The bill includes a list of physicians who may make the required finding of subscriber best interest. However, the definition of "Health Maintenance Organization" at s. 641.19(12)(e), F.S., provides that a primary physician is any physician licensed under Chapters 458, 459, 460, or 461, F.S. It is suggested that the bill be amended to remove the list as it is unnecessary.

D. STATEMENT OF THE SPONSOR:

No statement submitted.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

At its March 13, 2007, meeting, the Committee on Healthy Seniors adopted one amendment to HB 1001 as filed. The amendment conforms the House bill to its Senate companion and requires that the subscriber's primary care physician make a finding that the requested care is medically necessary, rather than in the subscriber's best interest. The amendment also removes the unnecessary list of physician The Committee reported the bill favorably with one amendment.

1 A bill to be entitled
2 An act relating to health maintenance contracts; amending
3 s. 641.31, F.S.; requiring a health maintenance
4 organization to provide in writing a disclosure of rights
5 to new subscribers who reside at a continuing care
6 facility or retirement facility; providing that if a
7 subscriber's request to be referred to the skilled nursing
8 unit or assisted living facility that is part of the
9 subscriber's place of residence is not honored, the
10 subscriber may use a specified grievance process;
11 providing an effective date.
12
13 Be It Enacted by the Legislature of the State of Florida:
14
15 Section 1. Subsection (25) of section 641.31, Florida
16 Statutes, is amended to read:
17 641.31 Health maintenance contracts.--
18 (25) If a subscriber is a resident of a continuing care
19 facility certified under chapter 651 or a retirement facility
20 consisting of a nursing home <u>or assisted living facility</u> and
21 residential apartments, the subscriber's primary care physician
22 must refer the subscriber to that facility's skilled nursing
23 unit <u>or assisted living facility if requested by the subscriber</u>
24 <u>and agreed to by the facility</u> if the primary care physician<u>, or</u>
25 <u>any other physician licensed under chapter 458, chapter 459,</u>
26 <u>chapter 460, or chapter 461,</u> finds that it is in the best
27 interest of the patient to do so; if the facility agrees to be
28 reimbursed at the health maintenance organization's contract

29 rate negotiated with similar providers for the same services and
30 supplies; and if the facility meets all guidelines established
31 by the health maintenance organization related to quality of
32 care, utilization, referral authorization, risk assumption, use
33 of the health maintenance organization's network, and other
34 criteria applicable to providers under contract for the same
35 services and supplies. If a health maintenance organization
36 enrolls a new subscriber who already resides in a continuing
37 care facility or a retirement facility as described in this
38 subsection, the health maintenance organization must provide in
39 writing a disclosure of the subscriber's rights under this
40 subsection. If a subscriber's request to be referred to the
41 skilled nursing unit or assisted living facility that is part of
42 the subscriber's place of residence is not honored, the
43 subscriber may use the grievance process provided in s. 641.511.
44 Section 2. This act shall take effect July 1, 2007.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 1 (for drafter's use only)

Bill No. **1001**

COUNCIL/COMMITTEE ACTION

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

1 Council/Committee hearing bill: Healthcare Council
2 Committee on Healthy Seniors offered the following:
3
4 **Amendment**
5 Remove line(s) 24-27 and insert:
6 <u>and agreed to by the facility;</u> if the primary care physician
7 finds that <u>such care is medically necessary;</u> ~~it is in the best~~
8 ~~interest of the patient to do so;~~ if the facility agrees to be
9

This amendment was adopted in HS on 03/13/07 and is traveling with the bill and requires no further action

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1269 Infant Mortality
SPONSOR(S): Reed
TIED BILLS: **IDEN./SIM. BILLS:** SB 2120

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Healthcare Council		Guy	Gormley
2) Policy & Budget Council			
3)			
4)			
5)			

SUMMARY ANALYSIS

House Bill 1269 creates the black infant health practice initiative ("initiative") and outlines objectives of the initiative to include determining factors that contribute to racial disparity in infant mortality and developing interventions to address that disparity.

The bill authorizes the Department of Health to distribute 10 grants to local healthy start coalitions for participation in the initiative. Each participating coalition must serve a county that has a nonwhite infant mortality rate at least twice that of the white infant mortality rate. The bill requires participating coalitions to use specific infant mortality data collection and review methodology as developed by a public university or college with expertise in public health.

The bill requires the department to annually evaluate the initiative. Participating coalitions are required to produce annual reports that include their findings and recommendations.

The bill clarifies that the participating coalitions, their professional staff, and review team members are immune from civil liability pursuant to section 766.101, F.S.

The bill appropriates $1 million from the General Revenue Fund and authorizes 1 FTE to implement provisions of the bill.

The bill provides an effective date of July 1, 2007.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Empower families – the bill provides for increased efforts to identify causes of elevated rates of infant mortality in minority populations.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

Infant Mortality in Florida and Around the Nation
Infant mortality data serves as an indicator for the overall health of a community and the infrastructure of its public and private health systems.[1] Infant mortality is defined as the death of a child before the age of 1. The leading causes of infant death include congenital abnormalities, pre-term/low birth weight, Sudden Infant Death Syndrome (SIDS), problems related to complications of pregnancy, and respiratory distress syndrome.[2] Although the national rate has declined steadily for the previous 50 years, in 2004 (the most recent data available), the national infant mortality was 6.8 deaths per 1,000 live births. In 2005 in Florida, the infant mortality rate was 7.2 deaths per 1,000 live births. The United States ranked 28th in the world in infant mortality in 1998.[3]

Significant racial disparities exist in infant mortality. Nationally, infant mortality among African-Americans occurred at a rate twice the national average.[4] SIDS deaths among American Indians and Alaska Natives is 2.3 times the rate for non-Hispanic white mothers.[5] Florida also has a rate of twice the average for infant mortality among African-Americans.[6] In Florida, in 2005, the infant mortality rate for nonwhites per 1,000 births was 12.5, while the rate for white births was 5.3.[7] Many factors contribute to this disparity, including higher incidents of low birthweight, little to no prenatal care and geographic racial segregation. Infants with very low birthweight account for approximately two-thirds of the black-white gap in infant mortality.[8]

Healthy Start Programs
Healthy Start is a statewide initiative designed to decrease the risk of pregnancy complications and poor birth outcomes for all pregnant women, and decrease the risk of death or impairment in health, intellect or functional ability for all infants.[9] The primary tasks of Healthy Start are: identify those women who are at high risk; provide professional assessment of their needs; and provide referrals and services.[10] The federal government funds several Healthy Start Projects and a Healthy Start grants program. Florida's Healthy Start Coalitions ("coalitions") provide services to pregnant women and children up to 3 years of age. There are 32 coalitions, organized as non-profit agencies that serve all 67 counties.

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[1] 2006 Florida Healthy Start Annual Report.
[2] Ibid.
[3] Centers for Disease Control and Prevention. http://www.cdc.gov/omh/AMH/factsheets/infant.htm (last viewed on April 2, 2007).
[4] According to the Centers for Disease Control and Prevention, the rate was 14.1 deaths per 1,000 live births in 2000, the year for which the most recent data was available. The national average in 2000 was 6.9 deaths per 1,000 live births. http://www.cdc.gov/omh/AMH/factsheets/infant.htm (last viewed April 2, 2007.
[5] Ibid.
[6] 2006 Florida Healthy Start Annual Report.
[7] 2005 Florida Vital Statistics Annual Report. http://www.flpublichealth.com/VSBOOK/VSBOOK.aspx# (last viewed on April 2, 2007).
[8] MMWR Weekly, April 19, 2002. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5115a4.htm (last viewed on April 2, 2007).
[9] 2006 Healthy Start Annual Report.
[10] Ibid.

The coalitions are authorized in section 383.216, Florida Statutes, and are overseen by the Department of Health ("department"). Each coalition may receive up to $150,000 in grant from the department provided the coalition has demonstrated a local match of 25 percent.[11]

The coalitions are also required to provide the department with annual data on the number of mothers and children at risk in each service area and services provided by the coalition. In 2005, the Healthy Start screening process identified 120,652 pregnant women and infants at-risk for poor outcomes. The program provided 1,654,997 services to 112,190 pregnant women and 965,848 services to 70,025 infants, which includes families identified prior to 2005.[12]

Fetal and Infant Mortality Review (FIMR)
Fetal and Infant Mortality Review (FIMR) is a process by which a multi-disciplinary community team is brought together to examine individual cases of infant and fetal deaths in an effort to identify critical community strengths and weaknesses as well as unique health and social issues associated with poor outcomes.[13] The process began in the early 1990s as collaboration between the American College of Obstetricians and Gynecologists and the Federal Maternal and Child Health Bureau. The FIMR process is used across the country by city and county health departments, local hospitals, regional perinatal centers and community based maternal and child health coalitions.[14] According to the department, in Florida, 12 coalitions are partially funded to provide FIMR services for 29 counties. Case selection is done randomly and does not specifically target African-American deaths: the proportion of these deaths reviewed is equivalent to the proportion of African-American births in a particular county or coalition.

Perinatal Periods of Risk (PPOR)
While FIMR teams analyze individual cases of infant and fetal deaths, the Perinatal Periods of Risk (PPOR) methodology uses all available infant and fetal death data in a given year in a particular community. The PPOR uses four "cells" to produce fetal-infant mortality data. The cells are: maternal health and prematurity; maternal care; newborn care; and infant care.[15] The PPOR methodology was developed by the World Health Organization for use in many communities, both in the United States and internationally. Many of the larger communities in Florida use the PPOR analysis to identify the influencing factors related to fetal and infant deaths.[16] Data collected from this process is used by the coalitions and public health officials to develop local responses to curb infant mortality. According to the department, the seven largest coalitions have participated in a statewide PPOR collaborative applying this analytic framework to their community data.

Medical Review Committees
Section 766.101, F.S., provides for immunity from liability for medical review committees. Included in this section are reviews of mortality records for a number of entities, and their employees, including healthy start coalitions.

<u>Effect of Proposed Changes</u>

The bill creates the black infant health practice initiative ("initiative") and requires the initiative to be administered through collaboration among the department, federal and state healthy start coalitions, and public universities and colleges that have expertise in public health. The bill outlines objectives of the initiative to include:

- Determine factors associated with racial disparity in infant mortality using FIMR and PPOR reviews;

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[11] Section 383.216(7), F.S.
[12] 2006 Healthy Start Annual Report.
[13] Sudden, Unexplained Infant Death Initiative (DUDID): Fetal and Infant Mortality Information. http://www.cdc.gov/SIDS/mortality.htm (last viewed on April 2, 2007).
[14] Florida Association of Healthy Start Coalitions. http://www.healthystartflorida.com/work/mortality.asp (last viewed on April 2, 2007).
[15] Perinatal Periods of Risk, An assessment Approach to Understanding Fetal and Infant Deaths in Florida, 1995-1998. Florida Department of Health, 2001.
[16] 2006 Healthy Start Annual Report.

- Develop interventions that address the identified factors for use to improve service delivery and community resources;
- Participate in the implementation of those interventions; and
- Assess the progress of those interventions.

The bill authorizes coalitions (defined in the bill as federal or local healthy start coalitions or consortiums) to participate in the initiative and requires the department to develop a grant program for use by the coalitions to implement objectives of the initiative. Grants shall be awarded to 10 coalitions (five serving rural counties and five serving urban counties) and specifies infant mortality statistics that must be present in a county for a participating coalition to receive a grant. The department is required to fund each coalition that participates, subject to appropriations. Participating coalitions must develop an interdisciplinary team to oversee the process and use PPOR when appropriate to examine infant deaths. Participating coalitions must use a modified FIMR to examine infant deaths by:

- Creating a case review FIMR team that includes physicians and other health care practitioners and experts in infant mortality;
- Utilizing professional staff to present individual case reviews to the FIMR team on a quarterly basis; and
- Developing abstracts of sample infant mortalities that also identify factors associated with racial disparity.

The bill requires the department to release a request for proposals for the grant program in a manner that will allow each coalition to begin reviewing cases no later than January 1, 2008.

The bill requires public universities or colleges that have public health expertise to assist the coalitions in developing the review methodology and providing technical assistant to the coalitions. The bill requires each coalition to utilize the same review methodology.

The bill also requires the department to conduct an annual evaluation of the initiative. The evaluation must include, for each coalition, the number of case reviews, grant balances and recommendations to improving the overall initiative. Each participating coalition is required to produce an annual report to the Governor and Legislature detailing findings and recommendations.

The bill clarifies that the participating coalitions, their professional staff, and review team members are immune from civil liability pursuant to section 766.101, F.S.

C. SECTION DIRECTORY:

Section 1. Creates an unnumbered section of Florida Statutes to create the black infant health practice initiative.

Section 2. Provides for an appropriation of $1 million from the General Revenue Fund and 1 FTE to implement provisions of the bill.

Section 3. Provides for an effective date of July 1, 2007.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

The bill appropriates $1 million from the General Revenue Fund and 1 FTE to implement provisions of the bill. The initiative will require financial support for infrastructure, staffing, and academic and community providers. Ten contracts will be awarded to coalitions to implement this initiative.

Estimated Expenditures	(25% lapse)	(Annualized/Recurr.)
Salaries		
1.0 FTE Government Operations Consultant II PG23 = 52,737 + 29% fringe .75 for first year Salary reflects midrange for pay grade	$51,023	$70,072 (with 3% COL)
Expense (with maximum travel)	$23,427	$20,001
Operating Capital Outlay	$1,300	
Human Resources Services	$401	$ 401
Contractual Services		
10 Black Infant Mortality Reviews Contracts:		
5 Urban County Coalition grants	$585,479	$609,383
5 Rural County Coalition grants	$288,370	$300,143
Contract with university for methodology	$50,000	
Total Estimated Expenditures	$1,000,000.00	$1,000,000.00

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not appear to affect municipal or county government.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill contains rule-making authority for the department to implement provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill requires, on lines 132 and 158, the use of a request for proposal process to distribute grants to 10 coalitions to implement provisions of the bill. According to the department, a request for proposals is not the appropriate procurement mechanism for providing research grants.

D. STATEMENT OF THE SPONSOR

No statement submitted.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to infant mortality; providing legislative
3 intent relating to the black infant health practice
4 initiative; providing definitions; providing objectives;
5 providing for administration of the initiative; requiring
6 a local community to develop a team to serve as a part of
7 a statewide practice collaborative; requiring healthy
8 start coalitions to conduct case reviews; requiring
9 certain public universities or colleges to provide
10 technical assistance, to assist in determining certain
11 criteria, and to present findings and make
12 recommendations; requiring the Department of Health to
13 distribute funding to the coalitions; providing duties of
14 each participating coalition; requiring the department to
15 award grants; requiring the department to conduct an
16 annual evaluation of the initiative; requiring each
17 coalition to submit a report to the Governor, the
18 Legislature, and the department; providing immunity from
19 liability to participating coalitions; requiring the
20 department to adopt rules; providing a timeframe for
21 reviewing cases; providing an appropriation; providing an
22 effective date.
23
24 WHEREAS, the Legislature recognizes that pregnancy, birth,
25 and infant health outcomes are internationally recognized as
26 measures of health for a community, as these outcomes are
27 indicators of population sustenance, growth, and quality of
28 life, and

29 WHEREAS, the Legislature also recognizes that infant
30 mortality disproportionately affects African-American infants,
31 as the resident infant mortality rate in 2005 for nonwhites is
32 12.5 per 1,000 live births, which is more than double the infant
33 mortality rate for whites, which is 5.3 per 1,000 live births,
34 and
35 WHEREAS, the Legislature recognizes that a continued effort
36 to identify the causes of racial disparities in infant mortality
37 benefits all citizens of Florida, NOW, THEREFORE,
38
39 Be It Enacted by the Legislature of the State of Florida:
40
41 Section 1. Black infant health practice initiative.--
42 (1) LEGISLATIVE INTENT.--It is the intent of the
43 Legislature to create a black infant health practice initiative.
44 The initiative shall include reviews of infant mortality in
45 select counties in this state in order to identify factors in
46 the health and social services systems contributing to higher
47 mortality rates among African-American infants. It is also the
48 intent of the Legislature that the initiative produce
49 recommendations on how to address the factors identified by the
50 reviews as contributing to these higher infant mortality rates.
51 (2) DEFINITIONS.--As used in this section, the term:
52 (a) "Coalition" means a federal or local healthy start
53 coalition or consortium.
54 (b) "Department" means the Department of Health.
55 (c) "FIMR" means a fetal and infant mortality review
56 committee.

57 (d) "Infant mortality" means the death of a live-born
58 infant within 364 days after the infant's birth.
59 (e) "Infant mortality rate" means the number of infant
60 deaths per 1,000 annual live births.
61 (3) OBJECTIVES.--The objectives of the initiative include:
62 (a) Determining the significant social, economic,
63 cultural, safety, and health system factors that are associated
64 with racial disparities in infant mortality rates through a
65 practice collaborative approach using perinatal periods of risk
66 and modified fetal infant mortality reviews.
67 (b) Developing a series of interventions and policies that
68 address these factors to improve the service systems and
69 community resources.
70 (c) Participating in the implementation of community-based
71 interventions and policies that address racial disparities in
72 infant mortality rates.
73 (d) Assessing the progress of interventions.
74 (4) ADMINISTRATION.--The black infant health practice
75 initiative shall be administered through a collaboration among
76 the department, federal and state healthy start coalitions, and
77 public universities or colleges having expertise in public
78 health. A local community shall develop an interdisciplinary
79 team to serve as part of a statewide practice collaborative.
80 Both perinatal periods of risk and fetal infant mortality
81 reviews may be used. A case review shall be conducted by each
82 participating healthy start coalition using professional in-
83 house staff or through contracts with an outside professional.
84 Public universities or colleges having expertise in public

85 health shall provide technical assistance in developing a
86 standard research methodology based on the fetal and infant
87 mortality review method. Public universities or colleges having
88 expertise in public health shall assist each participating
89 coalition in determining the selection of comparison groups,
90 identifying data collection and housing issues, and presenting
91 findings and recommendations. A single methodology for the
92 reviews conducted through the initiative shall be used by each
93 participating coalition. The department shall distribute funding
94 to each coalition that participates in the initiative through
95 annual grants that are subject to specific appropriations by the
96 Legislature.
97 (5) FUNCTIONS OF THE INITIATIVE.--Each participating
98 coalition shall:
99 (a) Develop an interdisciplinary team to oversee the
100 process in its local community.
101 (b) Use perinatal periods of risk methodology when
102 appropriate to examine infant deaths in its community.
103 (c) Use a modified FIMR approach to examine infant deaths
104 in its community by:
105 1. Creating a case review FIMR team that may include
106 obstetricians, neonatologists, perinatalogists, pathologists,
107 registered nurses, social workers, hospital and clinic
108 administrators, social service agencies, researchers, citizens
109 and consumers, and other experts considered necessary to conduct
110 a standardized review of infant mortality.
111 2. Hiring or contracting with professional staff that may
112 include licensed nurses and social workers to abstract and

113 present individual case reviews that omit identifying
114 information regarding infant deaths compared to live births to
115 the case review team.
116 3. Developing abstracts of sample infant mortalities and
117 comparative live births that omit identifying information and
118 that identify social, economic, cultural, safety, and health
119 system factors that are associated with racial disparities in
120 infant mortality rates. The number of abstracted cases that must
121 be conducted by each participating coalition shall be determined
122 by a standard research methodology developed in conjunction with
123 a public university or college having expertise in public
124 health.
125 4. Presenting abstracts that omit identifying information
126 to its case review team at least quarterly for their review and
127 discussion.
128 (d) Develop findings and recommendations for interventions
129 and policy changes to reduce racial disparities in infant
130 mortality.
131 (6) GRANT AWARDS.--The department shall award annual
132 grants through a request-for-proposal process that is subject to
133 specific appropriations by the Legislature. The department shall
134 award five grants to coalitions representing urban counties and
135 five grants to coalitions representing rural counties. Priority
136 of grant awards shall be given to those coalitions representing
137 counties having a nonwhite infant mortality rate at least two
138 times greater than the white infant mortality rate and at least
139 40 nonwhite infant deaths annually between 2003 and 2005 for
140 urban counties and five nonwhite infant deaths annually between

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

141 2003 and 2005 for rural counties.
142 (7) EVALUATIONS AND REPORTS.--The department shall conduct
143 an annual evaluation of the implementation of the initiative
144 describing which areas are participating in the initiative, the
145 number of reviews conducted by each participating coalition,
146 grant balances, and recommendations for modifying the
147 initiative. A participating coalition shall produce a report on
148 its collective findings and recommendations by January 1, 2010,
149 to the Governor, the President of the Senate, the Speaker of the
150 House of Representatives, and the Secretary of Health.
151 (8) IMMUNITY.--Each participating coalition, its case
152 review team members, and professional staff are immune from
153 liability pursuant to s. 766.101, Florida Statutes.
154 (9) RULEMAKING.--The department shall adopt rules,
155 pursuant to ss. 120.536(1) and 120.54, Florida Statutes,
156 necessary to implement this section.
157 (10) IMPLEMENTATION TIMELINE.--The department shall
158 release a request for proposals in a manner that will allow each
159 participating coalition to begin reviewing cases no later than
160 January 1, 2008.
161 Section 2. The sum of $1 million is appropriated from the
162 General Revenue Fund to the Department of Health for the 2007-
163 2008 fiscal year to implement the black infant health practice
164 initiative and to fund one full-time equivalent position to
165 carry out the provisions of this act.
166 Section 3. This act shall take effect July 1, 2007.

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

Amendment No. 1 (for drafter's use only)

Bill No. **1269**

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)

ADOPTED AS AMENDED __ (Y/N)

ADOPTED W/O OBJECTION __ (Y/N)

FAILED TO ADOPT __ (Y/N)

WITHDRAWN __ (Y/N)

OTHER ______

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1 Council/Committee hearing bill: Healthcare Council

2 Representative(s) Reed offered the following:

3

4 **Amendment**

5 Remove line(s) 161-165 and insert:

6 Section 2. The sum of $1 million in nonrecurring general

7 revenue funds is appropriated to the Department of Health for

8 the 2007-2008 fiscal year to implement the provisions of this

9 act.

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Amendment No. 2 (for drafter's use only)

Bill No. **1269**

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)

ADOPTED AS AMENDED __ (Y/N)

ADOPTED W/O OBJECTION __ (Y/N)

FAILED TO ADOPT __ (Y/N)

WITHDRAWN __ (Y/N)

OTHER ______

---

1 Council/Committee hearing bill: Healthcare Council
2 Representative(s) Reed offered the following:
3
4 **Amendment**
5 Remove line(s) 131-141 and insert:
6 (6) GRANT AWARDS.--The department shall award annual
7 grants, subject to specific appropriations by the Legislature.
8 The department shall award at least one grant to coalitions
9 representing urban counties and at least one grant to coalitions
10 representing rural counties. Priority of grant awards shall be
11 given to those coalitions representing counties having an
12 average nonwhite infant mortality rate at least 1.75 times
13 greater than the white infant mortality rate between 2003 and
14 2005 and an average of at least 40 nonwhite infant deaths
15 between 2003 and 2005 for urban counties or an average of at
16 least five nonwhite infant deaths between 2003 and 2005 for
17 rural counties.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 3 (for drafter's use only)

Bill No. **1269**

COUNCIL/COMMITTEE ACTION

ADOPTED ___ (Y/N)

ADOPTED AS AMENDED ___ (Y/N)

ADOPTED W/O OBJECTION ___ (Y/N)

FAILED TO ADOPT ___ (Y/N)

WITHDRAWN ___ (Y/N)

OTHER ______

---

1 Council/Committee hearing bill: Healthcare Council

2 Representative(s) Reed offered the following:

3

4 **Amendment**

5 Remove line(s) 158 and insert:

6 administer grants in a manner that will allow each

000000

HB 1269 amendment #3.doc

PCS/HB 739

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 739 — Treatment Programs for Impaired Practitioners
SPONSOR(S): Holder
TIED BILLS: — **IDEN./SIM. BILLS:** SB 2096

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Health Quality	9 Y, 0 N	Guy	Lowell
2) Healthcare Council		Guy	Gormley
3) Policy & Budget Council			
4)			
5)			

SUMMARY ANALYSIS

House Bill 739 revises provisions relating to the impaired practitioner program within the Department of Health. The bill requires the Department of Health to contract with impaired practitioner program consultants to provide services to students enrolled in schools that provide training for professions licensed under Chapter 456, F.S.

The bill grants sovereign immunity to an impaired practitioner consultant, its officers, employees, and agents for actions taken within the scope of a contract with the Department of Health.

The bill appears to have a significant fiscal impact on the state by adding students who are enrolled in allied health schools to the list of individuals eligible for treatment services offered by impaired practitioner programs. The fiscal impact to defend potential litigation is indeterminate. The Department of Health would be liable for a maximum of $200,000 per incident unless the Legislature approves a claims bill for additional compensation.

The bill provides for an effective date of July 1, 2007.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government – this bill will grant sovereign immunity to contractor consultants for actions taken within the scope of a contract with the Department of Health.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

Impaired Practitioner Programs
Healthcare professions are established within individual practice acts and are further regulated by Chapter 456, Florida Statutes, within the Department of Health ("department") in the Division of Medical Quality Assurance ("division"). Section 456.076, F.S., authorizes the department to contract with impaired practitioner consultants for services relating to intervention, evaluation, referral, and monitoring of impaired practitioners who have voluntarily agreed to treatment through an impaired practitioner program.[1] Impaired practitioner programs are available to licensed healthcare providers under Chapter 456, F.S., or other licensed professionals regulated by the division.

Consultants do not provide medical treatment, nor do they have the authority to render decisions relating to licensure of a particular practitioner. However, the consultant is required to make recommendations to the department regarding a practitioner patient's ability to practice.[2] Consultants are required by department rules to refer practitioner patients to department-approved treatment programs and providers. They have specified case management duties with regards to practitioner patient progress in a treatment program. Further, the consultant acts as the records custodian for all treatment information on the practitioner patients they are contracted to monitor. A typical contract between a consultant and an impaired practitioner under treatment is 5 years.

Currently, the department contracts with two groups for impaired practitioner consulting services: the Intervention Project for Nurses ("IPN") for nurses licensed under Chapter 464, F.S., and the Professionals Resource Network ("PRN") for other health care professionals, including allopathic and osteopathic physicians licensed under Chapters 458 and 459, F.S., respectively. According to the department, there are approximately 2,700 participants enrolled in the programs: 1,500 in the IPN and 1,200 in the PRN.

Sovereign Immunity
Sovereign immunity is the legal doctrine which provides that a government may not be sued for a claim without its consent. However, the federal government and most states have waived their immunity from suit in varying degrees in certain cases. Article X, section 13 of the Florida Constitution establishes that laws may be enacted in the statutes for suits to be brought against the state for its liabilities. Accordingly, s. 768.28(1), F.S., provides that the state "waives sovereign immunity for liability for torts, but only to the extent specified in this act."

Specifically, s. 768.28(5), F.S., provides that the state has limited its financial liability for a tort action by any one person to $100,000 or to $200,000 for additional claims and judgments arising from the same incident or occurrence. If a judgment is rendered by a court in excess of those amounts, the plaintiff may pursue a claim bill in the Legislature for the amount in excess of the statutory limit.

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[1] Rules 64B31-10.10.001 and 64B31-10.002, F.A.C.
[2] Section 456.076(5)(a), F.S.

Section 768.28(9)(a) F.S., further provides that the exclusive remedy for injury or damage suffered as a result of an act, event, or omission of an officer, employee, or agent of the state is an action against the governmental entity, the head of such entity in his or her official capacity, or the constitutional officer of which the officer, employee, or agent is an employee, unless the act or omission was committed in bad faith, with malicious purpose, or in a manner exhibiting wanton and willful disregard of human rights, safety, or property. In addition, an officer, employee, or agent of the state or any of its subdivisions may not be held personally liable or named as a defendant for an injury or damage if the act occurred in the scope of his or her employment unless the officer, employee, or agent acted in bad faith, with malicious purpose, or in a manner that exhibited a wanton and willful disregard of human rights, safety, or property. "Officer, employee or agent" is defined in s. 768.28(9), F.S., to include any health care provider providing services pursuant to s. 766.1115, F.S.,[3] any member of the Florida Health Services Corps, as defined in s. 381.0302, F.S., who provides uncompensated care to medically indigent persons referred by the department, and any public defender or his or her employee or agent, including among others, an assistant public defender and an investigator.

Among other things, the Bureau of State Liability Claims ("bureau") within the Department of Financial Services was established to provide general liability claims investigations and coverage through the State Risk Management Trust Fund as established in s. 284.30, F.S. The bureau provides protection against general liability claims and suits filed pursuant to Section 768.28, Florida Statutes.[4]

Effect of Proposed Changes

The bill requires all impaired practitioner program consultants to be a practitioner or recovered practitioner licensed under chapters 458, 459, or Part I of 464, or an entity that employs a medical director who is a practitioner or recovered practitioner licensed as an allopathic or osteopathic physician or nurse under chapters 458, 459 or part I of 464, F.S., respectively.

The bill requires the department to contract with impaired practitioner program consultants to provide services to students enrolled in schools that provide training for professions licensed under Chapter 456, F.S.

The bill grants sovereign immunity for actions taken by an impaired practitioner consultant, its officers, employees, and agents, within the scope of a contract with the department. The bill directs the Department of Legal Affairs to defend the consultant, its officers, employees or agents from any legal action brought as a result of contracted program activities.

C. SECTION DIRECTORY:

Section 1. Amends s. 456.076, F.S., requiring impaired practitioner programs for students and extending sovereign immunity for impaired practitioner program consultants, their officers, employees and agents, for actions performed under contract with the department.

Section 2. Provides an effective date of July 1, 2007.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

---

[3] Otherwise known as the "Access to Health Care Act."

[4] http://www.fldfs.com/Risk/SLC/index.htm

Currently, impaired practitioner consultants are not agents of the department, but a vendor/consultant. If a cause of action (litigation) is brought against a vendor it is currently the responsibility of the vendor/consultant to pay for all costs associated with defending any claim, suit, or proceeding.

The bill will require the Department of Legal Affairs to defend claims against a vendor by making them agents of the department. The potential fiscal impact is indeterminate. The department would be liable for a maximum of $200,000 per incident unless the Legislature approves a claims bill for the incident. The department has stated that the Medical Quality Assurance (MQA) Trust Fund would have to reimburse the Department of Legal Affairs for all costs associated with defending any claim, suit, or proceeding against an impaired practitioner consultant. The MQA Trust Fund is funded by fees collected from all licensed practitioners under chapter 456, F.S.

The bill expands eligibility for treatment services provided by impaired practitioner programs to students enrolled in a school that lead to licensure in an allied health profession. Currently, students are not required to pay fees that are collected by the MQA Trust Fund until they are licensed.

The department has estimated that expanding treatment services to students will increase enrollment in the IPN or PRN program by 5% or 135 participants per year. The current annual contracted cost is approximately $980 per participant annually. This amount only pays for the services of the vendor/consultant. The contracted cost is paid out of the Medical Quality Assurance Trust Fund. According to the department, contracts between the department and impaired practitioner consultants in FY 2006-2007 were $2,644,311.

Additionally, the department estimates that approximately $25,000 will be spent per year for the first two years in marketing efforts to students and additional programmatic startup costs. The start-up costs of the programs may include consultant expenses, staff training, meeting and travel expenses, additional equipment, and printing and postage costs. Costs are allocated in the following manner: 25% to OPS; 75% to Contracted Services.

Estimated Expenditures	1st Year	2nd Year (Annualized/Recurr.)
Salaries	-	-
Other Personal Services	$ 39,325	$ 39,325
Contracted Services	$ 117,975	$ 117,975
Operating Capital Outlay		
Total Estimated Expenditures	$ 157,300	$ 157,300

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Approved treatment providers may experience an increase in demand for services with the addition of medical profession students in impaired practitioner programs.

Students who are found impaired are eligible to enter into a contract to receive services provided by the IPN or PRN program. Based on impairment contracts for licensed practitioners, a student may be required to enter into a contract for up to 5-years. While in the impairment program the students would be required to pay for all treatment services such as initial evaluations, urinalysis testing and ongoing psychotherapy. Initial evaluations can range from $300-$500 and up to $1000 if chronic pain evaluation is required. The average cost is $42 per urinalysis, the number per month varies depending upon the recovery process. The cost of four group therapy meetings per month can range from $50-$150 per month. If the impairment is found to be physical, then the cost may be nominal. All participants are required to have a primary care physician, but no visits are required. Both impairment programs (IPN and PRN) offer a financial hardship option to eligible participants. All treatment services are paid directly to the provider or third party administrator and not through the IPN or PRN program.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not appear to affect municipal or county government.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

No additional rule-making authority is required as a result of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

It appears that the bill may be overbroad with respect to the extension of sovereign immunity to impaired practitioner consultants' officers, employees, and agents. Extension of sovereign immunity to this degree places the state at risk for the actions of individuals that the state does not necessarily have control over (such as agents of the consultant).

The bill requires the Department of Legal Affairs to defend any legal actions brought against an impaired practitioner consultant, or its officers, employees or agents, as a result of actions taken while acting under a contract with the department. This may conflict with current law which allows the Department of Financial Services to "assign or reassign the claim to counsel."[5]

D. STATEMENT OF THE SPONSOR

No statement submitted.

[5] Section 284.385, F.S.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

On March 20, 2007, the Health Quality Committee adopted one amendment to the bill. The amendment clarifies that the department is authorized, rather than required, to contract with a consultant for impaired practitioner services for students enrolled in schools for licensure under Chapter 456, F.S. The amendment provides immunity to the school from civil action for the referral of a student to a consultant. The amendment narrows the scope of sovereign immunity to the consultant, its officers, and employees and specifies contractual conditions under which sovereign immunity is granted. The amendment clarifies that the Department of Financial Services, not the Department of Legal Affairs, will defend any claims against the consultant, its officers and employees while acting under the scope of a contract with the department.

The bill was reported favorably with a Recommended Council Substitute.

Bill No. 0739

COUNCIL/COMMITTEE ACTION

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

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1 Council/Committee hearing bill: Healthcare Council
2 Committee on Health Quality offered the following:
3
4 **Amendment (with title amendment)**
5 Remove everything after the enacting clause and insert:
6 Section 1. Subsections (1) and (2) of section 456.076,
7 Florida Statutes, are amended and subsection (7) is added to
8 that section, to read:
9 456.076 Treatment programs for impaired practitioners.--
10 (1) For professions that do not have impaired practitioner
11 programs provided for in their practice acts, the department
12 shall, by rule, designate approved impaired practitioner
13 programs under this section. The department may adopt rules
14 setting forth appropriate criteria for approval of treatment
15 providers. The rules may specify the manner in which the
16 consultant, retained as set forth in subsection (2), works with
17 the department in intervention, requirements for evaluating and
18 treating a professional, and requirements for ~~the~~ continued care
19 and monitoring ~~of a professional~~ by the consultant ~~by an~~
20 ~~approved treatment provider~~.

21 (2) The department shall retain one or more impaired
22 practitioner consultants. TheA consultant shall be either a
23 licensee under the jurisdiction of the Division of Medical
24 Quality Assurance within the department who~~, and at least one~~
25 ~~consultant~~ must be a practitioner or recovered practitioner
26 licensed under chapter 458, chapter 459, or part I of chapter
27 464 or an entity that employs a medical director who must be a
28 practitioner or recovered practitioner licensed under chapter
29 458, chapter 459, or part I or chapter 464. The consultant shall
30 assist the probable cause panel and department in carrying out
31 the responsibilities of this section. This shall include working
32 with department investigators to determine whether a
33 practitioner is, in fact, impaired. The department may contract
34 with the consultant, for appropriate compensation, for services
35 to be provided, if requested by the school, for students
36 enrolled in schools for licensees listed in s. 456.073(12)(a)
37 who are alleged to be impaired as a result of the misuse or
38 abuse of alcohol or drugs, or both, or due to a mental or
39 physical condition. No medical school accredited by the Liaison
40 Committee on Medical Education or Commission on Osteopathic
41 College Accreditation, or other school, that provides for the
42 education of students in health care professions listed in
43 456.073(12)(a), that is governed by accreditation standards that
44 require notice and the provision of due process procedures to
45 students, shall be held liable in any civil action for referring
46 a student to the consultant retained by the department or for
47 taking actions in reliance of the recommendations, reports or
48 conclusions provided by such consultant, without intentional
49 fraud in carrying out the provisions of this section.

50 (7)(a) An impaired practitioner consultant retained
51 pursuant to subsection (2), and its officers and employees,
52 shall be considered agents of the department for purposes of s.
53 768.28, while acting within the scope of its duties under the
54 contract with the department, if the contract complies with the
55 requirements of this section. The contract must provide:
56 1. That the impaired practitioner consultant establish a
57 quality assurance program to monitor services delivered under
58 the contract.
59 2. Quarterly evaluations of the impaired practitioner
60 consultant's quality assurance program, treatment, and
61 monitoring records.
62 3. That the impaired practitioner consultant's quality
63 assurance program is subject to review and approval by the
64 department.
65 4. That the impaired practitioner consultant operate under
66 policies and procedures approved by the department.
67 5. That the impaired practitioner consultant provide to the
68 department for approval a policy and procedure manual that
69 comports to all statutes, rules and contract provisions approved
70 by the department.
71 6. That the department be entitled to review the records
72 relating to the impaired practitioner consultant's performance
73 under the contract for the purpose of management audits,
74 financial audits, or program evaluation.
75 7. That all performance measures and standards be subject
76 to verification and approval by the department.
77 8. That the department may terminate the contract with the
78 impaired practitioner consultant for non compliance with the
79 contract.

80 (b) In accordance with s. 284.385, the Department of
81 Financial Services shall defend any claim, suit, action or
82 proceeding against the consultant or its officers and employees
83 brought as a result of any act or omission of action of any of
84 its officers or employees for an act or omission arising out of
85 and in the scope of the consultant's duties under its contract
86 with the department.

87 (c) If the impaired practitioner consultant retained
88 pursuant to this section is retained by any other state agency,
89 and if the contract between the state agency and the consultant
90 complies with the requirements of this section, then the
91 consultant, and its officers and employees shall be considered
92 agents of the State of Florida for the purposes of this section,
93 while acting within the scope of and pursuant to guidelines
94 established in the contract between the state agency and the
95 consultant.

96 Section 2. This act shall take effect July 1, 2007.

97

98

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

100 Remove the entire title and insert:

101 A bill to be entitled

102 An act relating to treatment programs for impaired
103 practitioners; amending s. 456.076, F.S.; revising
104 requirements for program consultants; authorizing the
105 Department of Health to contract with consultants to
106 provide treatment services for all health professions and
107 occupations students alleged to be impaired; providing for
108 absence of liability in civil actions of certain schools
109 for referring students to such consultants or taking

110 certain actions without intentional fraud; providing
111 limited sovereign immunity for certain program consultants
112 under specific contractual conditions; requiring the
113 Department of Financial Services to defend actions against
114 program consultants; providing an effective date.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 1a (for drafter's use only)

Bill No. **0739**

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)

ADOPTED AS AMENDED __ (Y/N)

ADOPTED W/O OBJECTION __ (Y/N)

FAILED TO ADOPT __ (Y/N)

WITHDRAWN __ (Y/N)

OTHER ______

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1 Council/Committee hearing bill: Healthcare Council

2 Representative(s) Holder offered the following:

3

4 **Amendment 1 to h0739-hcc strike-all amendment**

5 Remove line(s) 47-48 and insert:

6 disciplinary actions that adversely affect the status of a

7 student when the disciplinary actions are instituted in

8 reasonable reliance on the recommendations, reports, or

9 conclusions provided by such consultant, provided that the

10 school, referring the student or in taking disciplinary action,

11 adheres to the due process procedures adopted by the applicable

12 accreditation entities and provided that the school committed no

13 intentional

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Bill No. **0739**

COUNCIL/COMMITTEE ACTION

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

---

1 Council/Committee hearing bill: Healthcare Council
2 Representative(s) Holder offered the following:
3
4 **Amendment 2 to h0739-hcc strike-all amendment**
5 Remove line(s) 51-91 and insert:
6 pursuant to subsection (2), and its officers, employees, and
7 those acting at the direction of the consultant for the limited
8 purpose of an emergency intervention of a licensee or student as
9 described in subsection (2), when the consultant is unable to
10 perform such intervention, shall be considered agents of the
11 department for purposes of s. 768.28, while acting within the
12 scope of its duties under the contract with the department, if
13 the contract complies with the requirements of this section. The
14 contract must provide:
15 1. That the impaired practitioner consultant establish a
16 quality assurance program to monitor services delivered under
17 the contract.
18 2. Quarterly evaluations of the impaired practitioner
19 consultant's quality assurance program, treatment, and
20 monitoring records.

21 3. That the impaired practitioner consultant's quality
22 assurance program is subject to review and approval by the
23 department.
24 4. That the impaired practitioner consultant operate under
25 policies and procedures approved by the department.
26 5. That the impaired practitioner consultant provide to
27 the department for approval a policy and procedure manual that
28 comports to all statutes, rules and contract provisions approved
29 by the department.
30 6. That the department be entitled to review the records
31 relating to the impaired practitioner consultant's performance
32 under the contract for the purpose of management audits,
33 financial audits, or program evaluation.
34 7. That all performance measures and standards be subject
35 to verification and approval by the department.
36 8. That the department may terminate the contract with the
37 impaired practitioner consultant for non compliance with the
38 contract.
39 (b) In accordance with s. 284.385, the Department of
40 Financial Services shall defend any claim, suit, action, or
41 proceeding against the consultant or its officers, employees,
42 and those acting at the direction of the consultant for the
43 limited purpose of an emergency intervention of a licensee or
44 student as described in subsection (2), when the consultant is
45 unable to perform such intervention, brought as a result of any
46 act or omission of action of any of its officers, employees, and
47 those acting at the direction of the consultant for the limited
48 purpose of an emergency intervention of a licensee or student as
49 described in subsection (2), when the consultant is unable to
50 perform such intervention, for an act or omission arising out of

51 and in the scope of the consultant's duties under its contract
52 with the department.
53 (c) If the impaired practitioner consultant retained
54 pursuant to this section is retained by any other state agency,
55 and if the contract between the state agency and the consultant
56 complies with the requirements of this section, then the
57 consultant, and its officers, employees, and those acting at the
58 direction of the consultant for the limited purpose of an
59 emergency intervention of a licensee or student as described in
60 subsection (2), when the consultant is unable to perform such
61 intervention, shall be considered

Bill No. **739**

COUNCIL/COMMITTEE ACTION

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

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1 Council/Committee hearing bill: Healthcare Council
2 Representative(s) Bean offered the following:
3
4 **Amendment 3 to h0739-hcc strike-all amendment (with title**
5 **amendments)**
6 Remove line(s) 36 and insert:
7 enrolled in schools in preparation for licensure as physicians
8 under chapter 458 or chapter 459
9
10 ================ T I T L E A M E N D M E N T =============
11 Remove line(s) 106-107 and insert:
12 provide treatment services for allopathic and osteopathic
13 physician students alleged to be impaired; providing for

Bill No. 739

COUNCIL/COMMITTEE ACTION

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

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1 Council/Committee hearing bill: Healthcare Council
2 Representative(s) Bean offered the following:
3
4 **Amendment 4 to h0739-hcc strike-all amendment**
5 Remove line(s) 42-43 and insert:
6 education of students enrolled in preparation for licensure
7 under chapter 458 or chapter 459, which is governed by
8 accreditation standards that

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 5a (for drafter's use only)

Bill No. **739**

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)

ADOPTED AS AMENDED __ (Y/N)

ADOPTED W/O OBJECTION __ (Y/N)

FAILED TO ADOPT __ (Y/N)

WITHDRAWN __ (Y/N)

OTHER ______

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1 Council/Committee hearing bill: Healthcare Council

2 Representative(s) Bean offered the following:

3

4 **Amendment 5 to h0739-hcc strike-all amendment**

5 Remove line(s) 59 and insert:

6 2. For quarterly evaluations of the impaired practitioner

PCB HCC 07-15

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCC 07-15 Hospice Facilities
SPONSOR(S): Healthcare Council and Rep. Garcia
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.: Healthcare Council		Ciccone SC	Gormley
1)			
2)			
3)			
4)			
5)			

SUMMARY ANALYSIS

PCB HCC 07-15 provides that the Agency for Health Care Administration may conduct an informal construction plan review of a facility upon the request of a prospective licensee of an inpatient hospice facility to assist the facility in complying with Florida Building Code requirements. The bill provides that the agency may charge a fee commensurate with the cost of providing consultation, and that no part of the fee is refundable.

The fiscal impact of the bill appears to be insignificant (see Section II.D. Fiscal Comments).

The bill provides an effective date of July 1, 2007.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government – The bill provides that the Agency for Health Care Administration may conduct an informal construction plan review of a hospice facility upon the request of a prospective licensee to assist the facility in complying with Florida Building Code requirements. The bill provides that the agency may charge a fee commensurate with the cost of providing consultation, and that no part of the fee is refundable. Providing facilities with an opportunity to have construction plans reviewed prior to the facility being built should reduce costly post-construction repairs, delayed facility licensure, and services to citizens.

B. EFFECT OF PROPOSED CHANGES:

Background

Hospice Care for Terminally ill Patients

Hospice care is an alternative approach to the traditional medical model for end-of-life care. Hospice programs specialize in providing basic medical care, palliation and pain management, and social, psychological, and spiritual support to terminally-ill[1] individuals and their families. In Fiscal Year 2004-2005, Florida hospice programs provided care to more than 98,000 individuals with terminal illnesses.[2] Nationally, the number of individuals receiving hospice care has increased 300 percent in the last decade, from 340,000 hospice patients in 1994 to 1,060,000 patients in 2004.[3]

Building Code and Construction Review:

Part IV of Chapter 553, F.S., sets forth the requirements for the Florida Building Code. The intent of the law is to create a "mechanism for the uniform adoption, updating, amendment, interpretation, and enforcement of a single, unified state building code." The Florida Building Code consists of a single set of documents that contain or incorporate by reference all laws and rules which pertain to and govern the design, construction, erection, alteration, modification, repair, and demolition of public and private buildings, structures, and facilities and enforcement of such laws and rules.[4]

During the 2005 Legislative Session, the Legislature added hospice residential and inpatient facilities and units to the provisions and requirements that the Florida Building Code must contain. The expressed intent of the legislation[5] specified that hospice residential facilities and inpatient facilities or units should be considered another type of "health care facility" and as such, should be included in the code.

Currently, the agency has no authority to review a hospice facility's construction and renovation plans prior to the facility being constructed, to determine compliance with those building requirements in the Florida Building Code. Once the facility has been constructed, the agency is required to conduct a facility inspection prior to issuing the facility a license.

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[1] To be eligible for hospice services in Florida, patients must receive a referral from their attending or primary physician for hospice care based on a diagnosis of a terminal illness with a life expectancy of one year or less, per s. 400.601(10), F.S.

[2] *Florida's Certificate of Need Process Ensures Qualified Hospice Programs; Performance Reporting Is Important to Assess Hospice Quality,* Report 06-29, March 2006, Office of Program Policy Analysis and Government Accountability.

[3] 3 *NHPCO's 2004 Facts and Figures*, accessed March 23, 2006, National Hospice and Palliative Care Organization, available at: http://www.nhpco.org/files/public/Facts_Figures_for2004data.pdf.

[4] See Sec. 553.73(1), F.S.

[5] HB 189, Ch. 2005-191, LOF

Effect of Proposed Changes:

PCB HCC 07-15 provides authority for the Agency for Health Care Administration, at the request of the inpatient hospice provider, to provide an informal review of an inpatient hospice facility prior to construction in order to assist the facility in complying with agency rules and construction standards of the Florida Building Code which govern hospice facilities. The agency may charge the provider for this consultation service at a fee commensurate to cost of this service. By reviewing the construction documents before construction is undertaken, code deficiencies can be identified and corrected without the cost of renovating the built facility and without the operational cost associated with lost income due to licensing delays.

C. SECTION DIRECTORY:

Section 1. Amends s. 400.6051, F.S., relating to hospice construction and renovation; relating to requirements.

Section 2. Provides an effective date of July 1, 2007.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None. Refer to Fiscal Comment Section.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The private sector should experience a positive economic impact as a result of a facility requesting the Agency for Health Care Administration's pre-construction compliance review rather than an after construction compliance review.

D. FISCAL COMMENTS:

The Agency for Health Care Administration anticipates no fiscal impact.[6] The agency anticipates that few hospice facilities will use this option and related costs will not be material. Existing staff will absorb any increase in the workload.

[6] Agency for Health Care Administration staff analysis, on file with the Council.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Counties and municipalities are unaffected by this legislation.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

D. STATEMENT OF THE SPONSOR

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to hospice facilities; amending s.
3 400.6051, F.S.; providing for construction plan review by
4 the Agency for Health Care Administration; authorizing the
5 agency to charge a construction plan review fee;
6 specifying that the fee is nonrefundable; providing an
7 effective date.
8
9 Be It Enacted by the Legislature of the State of Florida:
10
11 Section 1. Section 400.6051, Florida Statutes, is amended
12 to read:
13 400.6051 Construction and renovation; requirements.--
14 (1) The requirements for the construction and the
15 renovation of a hospice residential or inpatient facility or unit
16 must comply with the provisions of chapter 553 which pertain to
17 building construction standards, including plumbing, electrical
18 code, glass, manufactured buildings, accessibility for persons
19 with disabilities, and the state minimum building codes. The
20 Agency for Health Care Administration shall provide technical
21 assistance to the Florida Building Commission in updating the
22 construction standards of the Florida Building Code which govern
23 hospice facilities.
24 (2) Upon request by the prospective licensee of an
25 inpatient hospice facility, the agency may provide an informal
26 review of a facility prior to construction in order to assist the
27 facility in complying with agency rules and this part.

28 (3) The agency may charge a fee commensurate with the cost
29 of providing consultation under this section. No part of the fee
30 is refundable.
31 Section 2. This act shall take effect July 1, 2007.

Presentation by the Agency for Persons with Disabilities on a plan for eliminating the 2007-08 deficit

Barney Ray

Plan for Eliminating Projected Deficit and Improving Management of Waivers

apd

agency for persons with disabilities

State of Florida

- Charlie Crist, Governor
- Barney Ray, APD Chief of Staff

House Healthcare Council

Wednesday, April 4, 2007

Presentation Topics

- Current State of the Agency
  - Appropriations & Projected Expenditures
  - Governor's Recommended Budget
- Variables that effect Cost
- Actions Effecting FY 07/08
- Actions Effecting FY 08/09

Appropriations versus Projected Expenditures

Fiscal Year 2006-07

- Total HCBS/DD Waiver Appropriation: $776,837,838
- AHCA Expenditure Projection: ($881,630,169)
- Projected Deficit based on AHCA methodology: ($104,792,331) Total

  ($ 46,905,017) GR

Fiscal Year 2007-08

Economic & Demographic Research (EDR) Expenditure Projection

- Total HCBS/DD Waiver Appropriation: $776,837,838
- EDR Expenditure Projection (as of 03/2007): ($929,708,917)
- Projected Deficit based on EDR's methodology: ($152,871,079) Total

  ($ 65,872,148) GR

APD Expenditure Projection

- Total HCBS/DD Waiver Appropriation: $776,837,838
- APD Expenditure Projection (as of 3/2007): ($924,174,378)
- Projected Deficit based on APD's methodology: ($147,336,540) Total

  ($ 63,487,315) GR

Governor's Recommended Budget

Issue Detail of Gov.'s Amended Recommended Legislative Budget Request			
Description	**GR**	**Trust funds**	**Total**
Funding for Utilization Growth	$16,000,000	$22,797,284	$38,797,284
Additional Funding for Deficit Correction	$33,389,052	$44,097,725	$77,486,777
Transfer from FSL and Room and Board	$10,000,000	$12,678,951	$22,678,951
Realignment of FMAP	$20,433,868	($1,701,823)	$18,732,045
PROPOSED TOTAL TO ADDRESS DEFICIT	**$79,822,920**	**$77,872,137**	**$157,695,057**

Going Forward
Recommendations for Managing Costs

- **The Three Key Variables:**
  - **Variable I. Caseload**
    - Just aligning enrollment by itself will not keep program costs within appropriation if utilization for enrollees continues to increase at current rates. No utilization cap.
    - Once enrolled, you remain enrolled.
  - **Variable II. Price Level**
    - Price Level is <u>not</u> an attributing factor to the Agency's deficit.
    - We could reduce projected deficit by reducing service rates.
  - **Variable III. Utilization**
    - Utilization increases are the main driver of over-spending.
    - No cap or limit on utilization other than medical necessity.

Costs of HCBS\DD Waiver Services Provided in FY 2005/06

Cost Rank	Service	Total Paid*	% Total
1	Residential Habilitation - (Day)	$268,156,522	38.2%
2	Adult Day Training - Facility Based	$70,251,125	10.0%
3	Personal Care Assistance	$70,055,692	10.0%
4	In - Home Supports (Live-In Staff) Day	$44,403,209	6.3%
5	Support Coordination	$39,559,803	5.6%
6	Supported Living Coaching	$29,730,114	4.2%
7	Transportation (Trip)	$26,574,753	3.8%
8	Non-Residential Support Services	$25,750,678	3.7%
9	Companion	$18,852,468	2.7%
10	Consumable Medical Supplies	$12,431,848	1.8%
11	In - Home Supports (Awake Staff) Qtr. Hr	$11,519,622	1.6%
12	Respite Care - Quarter Hour	$7,812,596	1.1%
13	Supported Employment	$7,725,635	1.1%

Utilization Growth Summary

Service	Utilization Trend	What Explains Utilization Growth?		
		More Units/ Client	Higher Levels of Service	Increased Share of Waiver Clients
Residential Habilitation - (Day)	Increase	No	Yes	Yes
Adult Day Training - Facility Based	Flat			
Personal Care Assistance	Increase	Yes	No	Yes
In - Home Supports (Live-In Staff) Day	Increase	No	Yes	Yes
Support Coordination	Flat			
Supported Living Coaching	Increase	Yes	No	Yes
Transportation (Trip)	Increase	No	Yes	Yes
Non-Residential Support Services	Increase	Yes	Yes	Yes
Companion	Increase	Yes	No	Yes
Consumable Medical Supplies	Increase	Yes	No	Yes
In - Home Supports (Awake Staff) Qtr. Hour	Decline			
Respite Care - Quarter Hour	Increase	Yes	No	Yes
Supported Employment	Increase	Yes	Yes	Yes

Going Forward
Recommendations for Managing Costs

ACTIONS TAKEN TO DATE:

- All enrollment activity has ceased (Jan 07).
- Options for Consideration were developed by APD that identified revised service limitations to impact waiver spending.
- APD reassigned workload to provide dedicated staff resources to develop and implement this plan.
- A Systems Review Workgroup was established of representative stakeholders tasked with the responsibility of evaluating and planning short and long-term recommendations to establish a more effective and cost efficient waiver service delivery system.
- Members of the workgroup included representatives from the Family Care Council (parents), self-advocates, provider associations, support coordination associations, APD Area staff, and the DD Council.
- The work group meetings began Feb. 2007. The meetings have been frequent and intensive to be sensitive to time constraints.
- The group reviewed the APD Options for Consideration, information from other states, other options for short and long term system change.

Work Group Recommendations

- APD adopted the following work group recommendations to achieve system efficiencies and has extended these recommendations into the current plan.
- APD work group activities continue to identify further cost savings and system improvements.
- Work necessary to implement short and long term plan activities has already begun.

Recommendations for Managing Cost & Current Challenges

Short-term Management Efficiencies for FY 07/08

ACTION 1.
Stabilize the system by suspending the cost plan amendment process to eliminate requested changes in services except for health and safety issues, or requests for a reduction in services and cost.
TIME TO IMPLEMENT
This issue is currently under legal review and has also been referred to AHCA. The time-frame will be determined once legal review is complete.
IMPACT ON CONSUMER
Ability to request additional or different services will be allowed only if there is a change in the individual's "condition" (for example, living arrangement), for a health and safety reason, or if the request is for a reduction in services and costs.
IMPACT ON PROGRAM BUDGET
This is a management efficiency and will minimize the expenditures liability.

Recommendations for Managing Cost & Current Challenges

Short-term Management Efficiencies for FY 07/08

ACTION 2.

Initiate Annual Cost Plan continuation by Area Office for cost plans with no changes. Annual cost plan renewals, where there is no change in cost or services, would be approved at the area office level. (Continuation of services to simplify the system.) Requested changes, "High Cost" and Intensive Behavioral Services will continue to be reviewed by Prior Service Authorization.

TIME TO IMPLEMENT

Start Date: March 2007
Full Implementation: July 2007

IMPACT ON CONSUMER

No negative impact. Reduces the number of times a plan is submitted for prior authorization review.

IMPACT ON PROGRAM BUDGET

This is a management efficiency and will increase workload of APD area staff.

Recommendations for Managing Cost & Current Challenges

Short-term Management Efficiencies for FY 07/08

ACTION 3
Align Cost Plan begin and end dates with APD Fiscal Year to enhance the Agency's ability to predict approved service allocations annually, and more readily detect utilization trends.
TIME TO IMPLEMENT
Start Date: March 2007 Full Implementation: July 2007
IMPACT ON CONSUMER
No direct impact. APD, in conjunction with waiver support coordinators, will have to educate consumers and families on this process.
IMPACT ON PROGRAM BUDGET
This is a management efficiency and will increase workload of APD area staff.

Recommendations for Managing Cost & Current Challenges

Short-term Management Efficiencies for FY 07/08

ACTION 4.
Work with AHCA to remove remaining barriers for supported employment services and explore methods to offer incentives for movement out of Adult Day Training facilities
TIME TO IMPLEMENT
Start Date: March 2007 Full Implementation: July 2007
IMPACT ON CONSUMER
Increases opportunities for employment, a driver of outcomes for people. Decreases the number of people receiving services in an Adult Day Training facility.
IMPACT ON PROGRAM BUDGET
This is a management efficiency.

Recommendations for Managing Cost & Current Challenges

Short-term Management Efficiencies for FY 07/08

ACTION 5.
Work with AHCA's Medicaid Program Integrity to establish trend models that can be used to indicate possible fraud.
TIME TO IMPLEMENT
Start Date: March 2007 Full Implementation: July 2007
IMPACT ON CONSUMER
No direct impact. Decreases individual's exposure to fraudulent service providers.
IMPACT ON PROGRAM BUDGET
This is a management efficiency.

Recommendations for Managing Cost & Current Challenges

Short-term Management Efficiencies for FY 07/08

ACTION 6.

Initiate activities necessary to change spending limits on identified services:

Description	Total	GR (43.09%)	OMTF (56.91%)
Limit Non-Residential Support Services	$2,225,504	$958,970	$1,266,534
Limit Supported Living Coaching	$1,667,258	$718,421	$948,837
Limit Support Coordination for children under 18	$8,312,829	$3,581,998	$4,730,831
Eliminate Homemaker services for individuals receiving In-Home Support Services	$193,533	$83,393	$110,140
Limit Companion Services to no more than 35 hours per week	$58,728	$25,306	$33,422
Eliminate Homemaker services for individuals receiving Personal Care Assistance	$1,616,071	$696,365	$919,706
Eliminate the rate modifier for Personal Care Assistance	$1,548,421	$667,215	$881,206
Limit Homemaker services to no more than 4 hours per week	$768,659	$331,215	$437,444
Eliminate the Chore and Homemaker services for children	$210,225	$90,586	$119,639
Limit Chore Services to no more than 192 qtr hrs per year	$89,587	$38,603	$50,984
Eliminate Psychological Assessment as a waiver service	$4,500	$1,939	$2,561
Total	**$16,695,315**	**$7,194,011**	**$9,501,304**

Recommendations for Managing Cost & Current Challenges

Short-term Management Efficiencies for FY 07/08

ACTION 6. continued
TIME TO IMPLEMENT
Start Date: March 2007 Date to Savings: July 2007
IMPACT ON CONSUMER
Impacts nearly 12,504 individuals.
IMPACT ON PROGRAM BUDGET
These initiatives will generate approximately $7M General Revenue and $16M total savings. The Agency will not be able to fund the current projected FY 07/08 deficit by implementing these program changes alone. The Agency would still need additional appropriation for FY 07/08.

Recommendations for Managing Cost & Current Challenges

Long-term Management Efficiencies for FY 08/09

Two actions provide the strongest Waiver management & were universally accepted by Systems Review Workgroup (SWG).

1. Implementation of a Valid needs assessment tool and process – better cost projects and plans for Waiver consumers.
2. Development of service packages for appropriate supports, more flexibility of medically necessary service levels, and cost limit for each service plan – improve reliable estimates.

   Measurable primary cost drivers are use to identify appropriate service packages.

- **Total Estimated Long-Term Savings: $77,178,076**

Summary of Projected Savings

Description	Total	GR (43.09%)	OMTF (56.91%)
Estimated Long-Term Savings for FY 08/09	$77,178,076	$33,256,033	$43,922,043
Estimated Short-Term Savings	$16,695,315	$7,194,011	$9,501,304
Total	**$93,873,391**	**$40,450,044**	**$53,423,347**

Recommendations for Managing Cost & Current Challenges

Long-term Actions for FY 08/09

ACTION 7.
Develop data and procedures for Area office review of cost plans with significant utilization changes. Initiate Area review of plans identified. Work with consumer, family and waiver support coordinator to identify more efficient plans.
TIME TO IMPLEMENT
Start Date: March 2007 Full Implementation: July 2007
IMPACT ON CONSUMER
No direct impact. APD, in conjunction with waiver support coordinators, will have to educate consumers and families on this process. There may be a reduction in services for some individuals.
IMPACT ON PROGRAM BUDGET
Targeted at $5.2M This is a management efficiency and will increase workload of Area staff.

Recommendations for Managing Cost & Current Challenges

Long-term Actions for FY 08/09

ACTION 8.

Collapse rates in residential habilitation facilities to reduce the number of rates available, reflect support needs, and gain cost efficiencies. (There are approximately 720 rate options for this service. Revisions reduce utilization "creep".)

Verify resulting rate structure through use of a qualified consultant or AHCA Actuary contract.

TIME TO IMPLEMENT

Start Date: March 2007
Full Implementation: August 2007

IMPACT ON CONSUMER

Some individuals will have an adjustment in the support hours available in the residential setting. The adjustment should not have a significant impact.

IMPACT ON PROGRAM BUDGET

Expected savings of approximately $7M in savings.

Needs verification by AHCA Actuary.

Recommendations for Managing Cost & Current Challenges

Long-term Actions for FY 08/09

ACTION 9.

Establish a uniform published rate structure for residential facilities providing intensive behavior level of services. (Rate are currently negotiated and vary across the state.) New rates will be promulgated into the current Home and Community-based Developmental Disabilities Waiver Provider Rate Table

Begin promulgation no later than 7/1/07.

TIME TO IMPLEMENT

Start Date: April 2007
Full Implementation: July 2007

IMPACT ON CONSUMER

Some individuals will have an adjustment in the support hours available in the residential setting. The adjustment should not have a significant impact.

IMPACT ON PROGRAM BUDGET

Targeted at $4.7M

Needs verification by AHCA Actuary.

Recommendations for Managing Cost & Current Challenges

Long-term Actions for FY 08/09

ACTION 10.
Eliminate Companion Services. Expand the description of In-Home Support Services to include limited companion service responsibilities. Requires a revision to the HCBS DD Wavier and rule change. Current spending is $21,000,000 for this services.
TIME TO IMPLEMENT
Start Date: April 2007 Full Implementation: January 2008
IMPACT ON CONSUMER
Approximately 4791 individuals currently receive this service. Some individuals will lose this support. Others may shift this support into requested increases in In-home Support service hours. Tracking of the request for increases in In-home supports will be initiated.
IMPACT ON PROGRAM BUDGET
Targeted at $14M. The Agency is working to better verify this target.

Recommendations for Managing Cost & Current Challenges

Long-term Actions for FY 08/09

ACTION 11.

Establish cost models – a series of predetermined service packages with an identified allocation limit – based on primary cost driver. Drivers are defined as age, living setting, medical/physical issues, behavioral factors, adaptive ability (self-care/daily living skills).

A change in a service plan would only be approved based on a change in a primary driver, or a request for 1 time limited services such as purchase of a new wheelchair.

TIME TO IMPLEMENT

Start Date: March 2007
Full Implementation: January 2008

IMPACT ON CONSUMER

Service packages will be built from existing data that indicates service usage and need. Individuals will continue to have choice of services within the service package, but cannot exceed the approved allocation for the package.

IMPACT ON PROGRAM BUDGET

This action stabilizes utilization growth and cost savings are expected to be approximately $46M

Recommendations for Managing Cost & Current Challenges

Long-term Actions for FY 08/09

ACTION 12.
Develop an implementation plan for phase-in of the service package model.
TIME TO IMPLEMENT
Start Date: April 2007 Full Implementation: January 2008
IMPACT ON CONSUMER
APD will assure communication with, and education of service recipients and families on the revised system.
IMPACT ON PROGRAM BUDGET
This action uses available resources and communication linkages to inform stakeholders of the system revisions.

Recommendations for Managing Cost & Current Challenges

Long-term Actions for FY 08/09

ACTION 13.

Use an assessment to enhance primary driver information. APD will use currently owned and available assessments to expedite implementation of the system change. The Individual Cost Guidelines (ICG) is currently administered to all participants. The Florida Status Tracking Survey (FSTS), a stronger assessment of medical and behavioral concerns, will be paired with the ICG for a more complete assessment package.

Correlate assessment information with the service packages to determine the relationship with services and level of need, or level of support needs for adaptive areas.

TIME TO IMPLEMENT

Start Date: April 2007
Full Implementation: November 2007

IMPACT ON CONSUMER

All individuals have been assessed using the Individual Cost Guidelines. An additional assessment using the Florida Status Tracking Survey will be performed.

IMPACT ON PROGRAM BUDGET

Strengthens predictability of service packages and utilization containment measures.

Recommendations for Managing Cost & Current Challenges

Long-term Actions for FY 08/09

ACTION 14 & 15.
Administer the assessments and apply corresponding service package cost information with individuals on the wait list to project future funding needs. Correlate assessment information with the service packages to determine the relationship with services and level of need, or level of support needs for adaptive areas. Establish both assessments as web based applications to facilitate data collection and monitoring of the service package system. Resources for building the web component will have to be explored.
TIME TO IMPLEMENT
Start Date: To be Determined Full Implementation: To be Determined
IMPACT ON CONSUMER
Individuals on the waitlist will be assessed using the identified tools.
IMPACT ON PROGRAM BUDGET
This action will increase workload for APD IT staff or resources for contracting support.

Recommendations for Managing Cost & Current Challenges

Long-term Actions for FY 08/09

ACTION 16.

Simplify the contracted Prior Service Authorization (PSA) process. Initial medical necessity review will verify that the identified service package meets individual needs. Subsequent annual cost plans will be reviewed at the Area office level as a continuation of prior approved services.

A full PSA review of the service package will be required every 3 years, or if a new plan is developed due to a change in primary cost driver.

TIME TO IMPLEMENT

Start Date: January 2008
Full Implementation: To be Determined

IMPACT ON CONSUMER

Establishes continuity of services by using the least intrusive method of service review while still adhering to medical necessity requirements.

PSA reviews will continue to be required annually for all Intensive Behavioral Residential Habilitation services, one time add on services such as Environmental Adaptation (available 1 X every 5 yrs.) and "high cost" plans, considered outliers to the revised system.

IMPACT ON PROGRAM BUDGET

This is a management efficiency and will increase workload of APD area staff.

Recommendations for Managing Cost & Current Challenges

Long-term Actions for FY 08/09

ACTION 17.
Prior Service Authorization contracts will be reviewed for cost reduction and/or revision of responsibilities, such as administering assessments.
TIME TO IMPLEMENT
Start Date: January 2008 Full Implementation: To be Determined
IMPACT ON CONSUMER
No Impact
IMPACT ON PROGRAM BUDGET
Evaluation to maximize funding available.

Recommendations for Managing Cost & Current Challenges

Long-term Actions for FY 08/09

ACTION 18.

Alter role of Waiver Support Coordination to strengthen:

1. Education of individuals and families on the negative impact of utilization and importance of achieving cost efficiencies.
2. Monitoring service provision to assure services are provided as authorized and billed appropriately,
3. Building natural and community supports for services outside of an individual's service package.

TIME TO IMPLEMENT

Start Date: November 2007
Full Implementation: To be Determined

IMPACT ON CONSUMER

The consumer and family will be assisted to understand the revised system and limitations established in funding.

IMPACT ON PROGRAM BUDGET

The action will be continually evaluated to strengthen the system.

Conclusion

- These actions have gone through a preliminary review by APD and AHCA.

- APD will continue to work with the Office of the General Counsel (APD and AHCA), AHCA Medicaid Office, Centers for Medicare/Medicaid Services (CMS) prior to implementation, which may require modification.

- APD has proposed organizational changes to improve agency operations to include a Chief of Staff and an Office of Strategic Planning.
  - **Establish Long – Range Plan for the Agency**
  - **Establish, monitor, and report on performance measures**

Conclusion

- APD has enlisted assistance from AHCA's actuarial staff to provide expenditure analysis to better determine cost savings of long-term actions.
- The actual budgetary impacts will not be realized or accurately estimated until evaluation and implementation is complete.
- With the adoption of Governor's recommended budget and efficiencies implemented, APD could begin enrolling from the wait list the latter part of FY 08/09.

agency for persons with disabilities

State of Florida

QUESTIONS

House Healthcare Council

Wednesday, April 4, 2007

Agency for Persons with Disabilities
Plan for Eliminating Projected 2007-2008 Deficit and Managing Costs in the Developmental Disabilities Waiver
March 12, 2007
Updated March 30, 2007

Waiver Expenditures

Every dollar spent in the Home and Community Based Services Waiver is paid to providers of approved services for children and adults enrolled in this waiver.

The three variables that control the total cost for these services are:
1. **Enrollment** (increase or decrease to total number enrolled)
2. **Unit Price** (for each unit of service)
3. **Utilization** (Measure of increase or decrease in total units and/or intensity of services by individuals enrolled)

Waiver Wait List

The Agency for Persons with Disabilities (APD) maintains one wait list for waiver services for either the Developmental Disabilities (DD) waiver or Family and Support Living (FSL) waiver. The DD waiver has no cap on total expenditures per consumer annually and has 33 available services. The FSL waiver is capped at $14,792 per consumer annually and has 11 available services.

As of April 2007, the wait list for waiver services was 20,266. Of this total 6,006 are currently enrolled and receiving services under the FSL waiver but are waiting enrollment to the DD waiver. Available funding in fiscal year 2005-2006 allowed new enrollment totaling 6,560 in the two waivers. A total of 4,074 children or adults were extended offers but did not accept and remain on the waitlist.

Projected Costs for DD Waiver in Fiscal Year 2007-2008

APD is working with the Legislative Office of Economic and Demographic Research (EDR) and the State of Florida Agency for Health Care Administration (AHCA) to explore and implement new projection methodologies for improving the accuracy of expenditure forecasts. APD's new approach is to use two or three different methodologies and chart their accuracy over time to determine if one is better than the others. This effort will continue during the implementation of the APD plan.

Based upon an EDR projection of DD waiver expenditures as of March 2007 for Fiscal Year 2007-2008, APD projects the following deficit if no new funding is provided for this waiver:

Total Continuation Budget with Technical Changes	**$776,837,838**
Total Projected Cost for Fiscal Yr 2007-2008 Services	**$929,700,000**
Total Projected Deficit	**$152,871,079**

Systems Review Workgroup

In February 2007, the Interim Director directed that staff responsibilities be reassigned to provide for dedicated resources to investigating, developing and implementing a plan to manage costs in the Home and Community Based Services Developmental Disabilities (HCBS/DD) Waiver. In addition, representatives of parents, consumers, support coordinators, service providers, advocacy groups, APD local administrators and the Agency for Health Care Administration (AHCA) were invited to participate in a Systems Review Workgroup (SRW) lead by APD Central Office staff. The SRW was tasked with discovering and developing recommendations for reducing costs to fit within appropriations and provide for better manage of the waiver.

Interim Director shared his three core goals with the SRW in reviewing and developing recommendations:

1. **Serve more people**
2. **Remain within appropriations**
3. **Maintain quality services which includes consumer choice**

The SRW invited and received presentations of Projected Cost Model pilot projects from the Florida Association of Rehabilitation Facilities, a provider group from APD Area 1 (SB 1826), and the Area 13 pilot project (HB 1597 combines Area 1 and 13 pilots). APD provided the SRW with a variety of paid claims and cost plan information to assist in identifying trends and answering questions.

The SRW also reviewed APD options developed to eliminate duplication of services and promote cost efficiencies. Many of these were widely accepted by the SRW. This workgroup will continue to meet to review and advise the agency on this plan and any new ideas that are brought to APD's attention.

Summary of the Plan

- **Short-term (Effective July 1, 2007)**

The resulting recommendations were adopted by APD and staff have already begun actions necessary to accomplish the tasks identified, including drafting rule revision language to implement the short-term actions. The short-term actions listed within the plan will provide cost savings of $16 million in Fiscal Year 2007-2008 and provide better management controls.

Total estimated short-term savings: $16,695,315.00

- **Long-term (Effective after July 1, 2007, but before June 30, 2008)**

The work needed to implement long-term actions will begin immediately. Each action is listed within includes target dates for completion. Cost savings from these actions will have better cost savings estimates as further work is completed, but reliable estimates are not available at this time.

Two of the actions in particular provide the strongest management of the waiver and were universally accepted by the SWG.
1. Implementation of a valid needs assessment tool and process will provide better cost projections and plans for individuals served on the waiver.
2. Development of service packages which provide for appropriate supports for individuals, more flexibility of selection of medically necessary service levels and a cost limit for each service plan which improves reliable estimates. Measurable primary cost drivers such as age, medical/physical issues, behavior factors, where one lives, and adaptive ability are use to identify appropriate service packages for each individual.

Individuals will still receive the appropriate level of service support and have flexibility in selecting the service and unit level needed without going through prior service authorization for each incremental change in units of service as long as the cost limit for their service is not exceeded. If a primary driver changes such as residential placement, a new service package would be requested.

Total estimated long-term savings: $77,178,076.00

Total estimated combined savings: $93,873,391.00

The Future

1. APD will continue to work with members of the DD community to develop future cost savings and develop innovative ideas in order to remain within appropriations in fiscal year 2007-2008.

2. APD will aggressively continue its efforts to comply with Executive Order 07-01 in reviewing how services are delivered and implement changes to the system.

3. APD will provide regular reports to all parties including the legislature as is required for progress in this effort.

Agency for Persons with Disabilities
Deficit Reduction and Cost Management Plan
March 12, 2007

Action Item #	Action	Time Frame	Impact on Consumer	Impact on Program Budget	Impact on Provider
	Short-term Management Efficiencies				
1.	Stabilize the system by suspending the cost plan amendment process to eliminate requested changes in services except for health and safety issues, or requests for a reduction in services and cost.	To be determined.	Ability to request additional or different services will be allowed only if there is a change in the individual's "condition" (for example, living arrangement), for a health and safety reason, or if the request is for a reduction in services and costs.	Currently under legal review. Management efficiency.	No impact.
2.	Initiate Annual Cost Plan continuation by Area Office for cost plans with no changes. Annual cost plan renewals, where there is no change in cost or services, would be approved at the area office level. (Continuation of services to simplify the system.) Requested changes, "High Cost" and Intensive Behavioral Services will continue to be reviewed by Prior Service Authorization.	3/12/07 7/1/07	No negative impact. Reduces the number of times a plan is submitted for prior authorization review.	Management efficiency. Increased workload for Area staff.	No impact.

Action Item #	Action	Time Frame	Impact on Consumer	Impact on Program Budget	Impact on Provider
3.	Align Cost Plan begin and end dates with APD Fiscal Year to enhance the Agency's ability to predict approved service allocations annually, and more readily detect utilization trends.	3/12/07 7/1/07	No direct impact. APD, in conjunction with waiver support coordinators, will have to educate consumers and families on this process.	Management efficiency. Increased workload for Area staff.	Waiver support coordinators will have to alter current cost plans to align with the fiscal year dates.
4.	Work with AHCA to remove remaining barriers for supported employment services and explore methods to offer incentives for movement out of Adult Day Training facilities.	3/12/07 7/1/07	Increases opportunities for employment, a driver of outcomes for people. Decreases the number of people receiving services in an Adult Day Training facility.	Management efficiency.	Reduction in enrollment for Day Training facilities, or a modification of the services provided.
5.	Work with Medicaid Program Integrity to establish trend models that can be used to indicate possible fraud.	3/12/07 7/1/07	No direct impact. Decreases individual's exposure to fraudulent service providers.	Management efficiency.	Identifies and/or deters fraudulent practices.
6.	Initiate activities necessary to change spending limits on identified services to achieve $16,695,315.00 savings.	3/12/07 7/1/07	See Below.	$16,695,315.00	See Below.

Action Item #	Action	Time Frame	Impact on Consumer	Impact on Program Budget	Impact on Provider
A.	Limit Non-Residential Support Services (NRSS) to individuals 18 or 22 years and older, and no longer provide to school aged children. Revise qualifications to require a degree and experience and tighten the service description to focus on pre-work activities, including volunteering. Estimated annual savings if set at age 22.	7/1/07	Impacts on 638 individuals. Services are available through other means. Children under the age of 22 have access to transition services through the public school system. Parents of school age children may also carry out community inclusion activities.	$2,225,504	Some providers will not be able to provide this service once qualifications change. Some providers will have a reduction in work volume. Cost Plans will have to be updated by the waiver support coordinator to reflect the change.
B.	Limit supported living coaching to no more than 20 hours per month for individuals who also receive In-Home Support Services-Live In. Establish a monthly rate for supported living services.	7/1/07	Impacts on 436 adults. Anticipated to have a minimal impact. Some duties of Supported Living Coaches are duplicated by In-Home Support Services at a more cost-effective rate. (For example, assisting with grocery shopping.) In-Home Live-in services offer up to 24-hour support and can assume routine responsibilities now performed by the Supported Living Coach.	$1,667,258	Some providers will experience a reduction in work volume. Cost Plans will have to be updated by the waiver support coordinator to reflect the change.

Action Item #	Action	Time Frame	Impact on Consumer	Impact on Program Budget	Impact on Provider
C.	Require that Support Coordination be at the "Limited" level of service and rate for children under the age of 18 who live in the family home. (Reduces the amount of contact time that is required in full support coordination. Sets the rate at half that earned for full support coordination.)	7/1/07	Impacts on 9,970 children living in the family home. Children living in their family home are eligible for an array of services other than the DD Waiver. These include, but are not limited to, services from the Public School system, Children's Medical Services and Medicaid State Plan. Case management functions are also included in some of these services. Limited Support Coordination, working in conjunction with the parents of the child, may provide adequate support to this consumer group. Procedures will be established to handle emergency transition needs.	$8,312,829.	Some providers will experience a reduction in work volume. Cost Plans will have to be updated by the waiver support coordinator to reflect the change. A monthly rate will be established to assist the provider in meeting fluctuations in support needs.

Action Item #	Action	Time Frame	Impact on Consumer	Impact on Program Budget	Impact on Provider
D.	Eliminate the provision of Homemaker services for individuals who receive In- Home Support Services.	7/1/07	Impacts 88 individuals. Anticipated to have minimal impact. The service description for In-Home supports includes housekeeping responsibilities. The change eliminates duplication, but allows the provision of the support through another service.	$193,533	Some providers will experience a reduction in work volume. Cost Plans will have to be updated by the waiver support coordinator to reflect the change.
E.	Limit companion services to no more than 35 hours per week as part of a meaningful day activity.	7/1/07	Impacts on 14 individuals who receive this service more than 5 hrs. a day. Anticipated minimal impact. Includes companion services into the meaningful day options for a participant. The current limit for companion services is 10 hrs./day which is excessive when aligned with other service options.	$58,728	Some providers will experience a reduction in work volume. Cost Plans will have to be updated by the waiver support coordinator to reflect the change.
F.	Eliminate the provision of Homemaker services for individuals who receive Personal Care Assistance.	7/1/07	Impacts on 565 individuals. Anticipated to have minimal impact. The service description for Personal Care Assistance includes housekeeping responsibilities. Eliminates duplication.	$1,616,071	Some providers will experience a reduction in work volume. Cost Plans will have to be updated by the waiver support coordinator to reflect the change.

Action Item #	Action	Time Frame	Impact on Consumer	Impact on Program Budget	Impact on Provider
G.	Eliminate the rate modifier for Personal Care Assistance.	7/1/07	Impacts on 301 individuals. Personal Care Assistance has a 3 tiered rate structure based on intensity of an individual's need. The rate structure currently allows for adequate payment for more involved or intense services.	$1,548,421	Rates will be reduced by the amount of the modifier for providers receiving this rate. Cost Plans will have to be updated by the waiver support coordinator to reflect the change.
H.	Limit Homemaker services to no more than 4 hours per week.	7/1/07	Impacts on 344 individuals. Impact should be minimal. The current service limits for Homemaker services at 10 hrs. a day exceeds limits for most community living environments. The reduction in hours is compatible with community standards.	$768,659	Some providers will experience a reduction in work volume. Cost Plans will have to be updated by the waiver support coordinator to reflect the change.
I.	Eliminate the provision of Chore and Homemaker services for children under the age of 18.	7/1/07	Impacts on 85 children. Children living in their family home may have these activities provided as part of a normal family routine and responsibility. Children living in foster or group homes are not eligible for Chore and Homemaker services.	$210,225.	Some providers will experience a reduction in work volume. Cost Plans will have to be updated by the waiver support coordinator to reflect the change.

Action Item #	Action	Time Frame	Impact on Consumer	Impact on Program Budget	Impact on Provider
J.	Limit Chore services to no more than 192 qt. hours per year.	7/1/07	Impacts on 48 individuals. Impact should be minimal as limits were set at an annual level. Chore services, currently available up to 4 hrs a day, provide "heavy" housecleaning, yard and "light" home maintenance and repairs. The reduction in hours is compatible with community standards, and the change in billing practice allows the individual flexible options for service use during the year.	$89,587	Some providers will experience a reduction in work volume. Cost Plans will have to be updated by the waiver support coordinator to reflect the change.
K.	Eliminate Psychological Assessment as a waiver service.	7/1/07	15 individuals received this service last year. Individuals on the waiver have already been determined eligible for services and have no need for a psychological assessment (IQ testing.) No anticipated impact.	$4,500	Providers will loose revenue and the ability to perform this waiver service. Cost Plans will have to be updated by the waiver support coordinator to reflect the change.

	Long-Term Activities to Control Utilization				
Action Item #	**Action**	**Time Frame**	**Impact on Consumer**	**Impact on Program Budget**	**Impact on Provider**
7.	Develop data and procedures for Area office review of cost plans with significant utilization changes. Initiate Area review of plans identified. Work with consumer, family and waiver support coordinator to identify more efficient plans.	3/12/07 1/1/08	There may be a reduction in services for some individuals.	Targeted at: $5,230,436.00 Management efficiency. Increased workload for Area staff.	Some providers will experience a reduction in enrollment and revenue.
8.	Collapse rates in residential habilitation facilities to reduce the number of rates available, reflect support needs, and gain cost efficiencies. (There are approximately 720 rate options for this service. Revisions reduce utilization "creep".) Verify resulting rate structure through use of a qualified consultant or AHCA Actuary contract.	3/12/07 8/1/07	Some individuals will have an adjustment in the support hours available in the residential setting. The adjustment should not have a significant impact.	Currently under evaluation. $7,008,586.00 in savings. Needs verification by AHCA Actuary.	Some providers may experience a rate reduction. Others will have no impact, or a slight rate increase.

Action Item #	Action	Time Frame	Impact on Consumer	Impact on Program Budget	Impact on Provider
9.	Establish a uniform published rate structure for residential facilities providing intensive behavior level of services. (Rates are currently negotiated and vary across the state.) New rates will be promulgated into the current Home and Community-based Developmental Disabilities Waiver Provider Rate Table. Begin promulgation no later than 7/1/07.	4/1/07 7/1/07	Some individuals will have an adjustment in the support hours available in the residential setting. The adjustment should not have a significant impact.	Targeted at $4,730,335.00 Needs verification by AHCA Actuary.	Some providers may experience a rate reduction. Others will have no impact, or a slight rate increase.
10.	Eliminate Companion Services. Expand the description of In-Home Support Services to include limited companion service responsibilities. Requires a revision to the HCBS DD Waiver and rule change. Current spending is $21,000,000 for this service.	4/1/07 1/1/08	Approximately 4791 individuals currently receive this service. Some individuals will loose this support. Others may shift this support into requested increases in In-home Support service hours. Tracking of the request for increases in In-home supports will be initiated.	Targeted at $14,000,000.00 The Agency is working to better verify this target.	Some providers will experience a loss of business or revenue.

Action Item #	Action	Time Frame	Impact on Consumer	Impact on Program Budget	Impact on Provider
11.	Establish cost models – a series of predetermined service packages with an identified allocation limit - based on primary cost drivers. Drivers are defined as a) age, b) living setting, c) medical/physical issues, d) behavioral factors, e) adaptive ability (self-care/daily living skills). A change in a service plan would only be approved based on a change in a primary driver, or a request for 1 time limited services such as purchase of a new wheelchair.	3/12/07 1/1/08	Service packages will be built from existing data that indicates service usage and need. Individuals will continue to have choice of services within the service package, but cannot exceed the approved allocation for the package.	Stabilizes utilization growth. $46,208,719.00	May reduce work volume for some providers. Individuals will continue to choose service providers.
12.	Develop an implementation plan for phase-in of the service package model.	4/1/07 1/1/08	APD will assure communication with, and education of service recipients and families on the revised system.	Use all available resources and communication linkages to inform stakeholders of the system revision.	APD will assure communication and education of service providers on the revised system.

Action Item #	Action	Time Frame	Impact on Consumer	Impact on Program Budget	Impact on Provider
13.	Use an assessment to enhance primary driver information. APD will use currently owned and available assessments to expedite implementation of the system change. The Individual Cost Guidelines (ICG) is currently administered to all participants. The Florida Status Tracking Survey (FSTS), a stronger assessment of medical and behavioral concerns, will be paired with the ICG for a more complete assessment package. Correlate assessment information with the service packages to determine the relationship with services and level of need, or level of support needs, for adaptive areas.	4/1/07 11/1/07	All individuals have been assessed using the Individual Cost Guidelines. An additional assessment using the Florida Status Tracking Survey will be performed.	Strengthens predictability of service packages and utilization containment measures.	Waiver support coordinators will have to be trained in the use of the Florida Status Tracking Survey and administer the assessment.
14.	Administer the assessments and apply corresponding service package cost information with individuals on the wait list to project future funding needs. Establishes cost and needs information related to individuals on the waitlist that is not currently available.	By 1/1/08	Individuals on the waitlist will be assessed using the identified tools.	Will assist the Agency to project enrollment cost.	Area APD staff would administer the assessments and apply cost projections.

Action Item #	Action	Time Frame	Impact on Consumer	Impact on Program Budget	Impact on Provider
15.	Establish both assessments as web based applications to facilitate data collection and monitoring of the service package system. Resources for building the web component will have to be explored.	TBD	No impact.	Increased workload for APD IT staff, or resources for contracting the function.	Increased information will be available to project service needs and cost for building capacity or adjusting current service delivery methods.
16.	Simplify the contracted Prior Service Authorization (PSA) process. Initial medical necessity review will verify that the identified service package meets individual needs. Subsequent annual cost plans will be reviewed at the Area office level as a continuation of prior approved services. A full PSA review of the service package will be required every 3 years, or if a new plan is developed due to a change in primary cost driver.	By 1/1/08	Establishes continuity of services by using the least intrusive method of service review while still adhering to medical necessity requirements. PSA reviews will continue to be required annually for all Intensive Behavioral Residential Habilitation services, one time add on services such as Environmental Adaptation (available 1 X every 5 yrs.) and "high cost" plans, considered outliers to the revised system.	Increased workload for Area APD staff.	Establishes some predictability of service usage.
17.	Prior Service Authorization contracts will be reviewed for cost reduction and/or revision of responsibilities, such as administering assessments.	By 1/1/08	No impact.	Evaluation to maximize funding available.	No impact.

Action Item #	Action	Time Frame	Impact on Consumer	Impact on Program Budget	Impact on Provider
18.	Alter role of Waiver Support Coordination to strengthen: 1) education of individuals and families on the negative impact of utilization and importance of achieving cost efficiencies. 2) monitoring service provision to assure services are provided as authorized and billed appropriately, 3) building natural and community supports for services outside of an individual's service package.	By 11/1/07	The consumer and family will be assisted to understand the revised system and limitations established in funding.	Continue to evaluate role of waiver support coordinator to strengthen system.	Coordinators will experience a change in their role and functioning as a waiver provider.