Health Innovation Subcommittee

Tuesday, February 11, 2014
3:30 PM - 5:30 PM
306 HOB

Will Weatherford
Speaker

Jason T. Brodeur
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health Innovation Subcommittee

Start Date and Time:	Tuesday, February 11, 2014 03:30 pm
End Date and Time:	Tuesday, February 11, 2014 05:30 pm
Location:	306 HOB
Duration:	2.00 hrs

Consideration of the following bill(s):

HB 7 Florida Kidcare Program by Diaz, J.
HB 27 Cost-effective Purchasing of Health Care by Diaz, J.
HB 463 Background Screening by Reed
HB 573 Assisted Living Facilities by Ahern

Pursuant to rule 7.12, the deadline for amendments to bills on the agenda by non-appointed members is 6:00 p.m., Monday, February 10, 2014.

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., Monday, February 10, 2014.

NOTICE FINALIZED on 02/04/2014 16:18 by Iseminger.Bobbye

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7 Florida Kidcare Program
SPONSOR(S): Diaz and others
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Poche	Shaw
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The Florida Kidcare Program (Kidcare) was created by the Florida Legislature in 1998 in response to the federal enactment of the State Children's Health Insurance Program in 1997, later known more simply as the Children's Health Insurance Program (CHIP). CHIP provides subsidized health insurance coverage to uninsured children who do not qualify for Medicaid but who meet other eligibility requirements. The state statutory authority for Kidcare is found in part II of ch. 409, F.S.

Kidcare consists of Medicaid, MediKids, the Children's Medical Services Network, and Florida Healthy Kids. Kidcare coverage is funded by state and federal funds through Title XIX (Medicaid) and Title XXI (CHIP) of the federal Social Security Act. Families also contribute to the cost of the coverage under the Title XXI-funded components of Kidcare based on their household size, income, and other eligibility factors. For families with incomes above the income limits for premium assistance or who do not otherwise qualify for assistance, Kidcare also offers an option under the Healthy Kids component and the Medikids component for the family to obtain coverage for their children by paying the full premium.

Federal law restricted the eligibility of documented immigrants, including children and pregnant women, for social service benefits and programs such as Medicaid and CHIP. Documented immigrants were ineligible to apply for and received these benefits for 5 years, beginning with the date of their arrival in the United States. In 2009, the Children's Health Insurance Program Reauthorization Act permitted states to remove the 5 year waiting period and allow certain children immediate eligibility for Medicaid and CHIP coverage.

HB 7 removes the 5 year waiting period for lawfully present children in Florida, making those children immediately eligible for health care coverage through Kidcare and for payment of optional medical assistance and related services under Medicaid. The bill clearly states that eligibility for the Program is not being extended to undocumented immigrants.

The bill has a significant fiscal impact of $69,213,107, of which $27,526,573 is the General Revenue impact.

The bill provides an effective date of July 1, 2014.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Florida Kidcare Program

The Florida Kidcare Program (Kidcare or Program) was created by the Florida Legislature in 1998 in response to the federal enactment of the State Children's Health Insurance Program in 1997, later known more simply as the Children's Health Insurance Program (CHIP). The federal authority for the CHIP is located in Title XXI of the Social Security Act. Initially authorized for 10 years and then recently re-authorized through 2019 with federal funding through 2015[1], the CHIP provides subsidized health insurance coverage to uninsured children who do not qualify for Medicaid but who meet other eligibility requirements. The state statutory authority for the Program is found in part II of ch. 409, F.S.

Kidcare encompasses four programs:

- Medicaid for children;
- The Medikids program;
- The Children's Medical Services Network; and
- The Florida Healthy Kids program.

Kidcare coverage is funded by state and federal funds through Title XIX (Medicaid) and Title XXI (CHIP) of the federal Social Security Act. Families also contribute to the cost of the coverage under the Title XXI-funded components of Kidcare based on their household size, income, and other eligibility factors. For families with incomes above the income limits for premium assistance or who do not otherwise qualify for assistance, Kidcare also offers an option under the Healthy Kids component and the Medikids component for the family to obtain coverage for their children by paying the full premium. Eligibility for the Program components that are funded by Title XXI is determined in part by age and household income as follows:

- Medicaid for Children: Title XXI funding is available from birth until age 1 for family incomes between 185 percent and 200 percent of the Federal Poverty Level (FPL).
- Medikids: Title XXI funding is available from age 1 until age 5 for family incomes between 133 percent and 200 percent of the FPL.
- Healthy Kids: Title XXI funding is available from age 5 until age 6 for family incomes between 133 percent and 200 percent of the FPL. For age 6 until age 19, Title XXI funding is available for family incomes between 100 percent and 200 percent of the FPL.
- Children's Medical Services Network: Title XXI and Title XIX funds are available from birth until age 19 for family incomes up to 200 percent of the FPL for children with special health care needs. The Department of Health assesses whether children meet the program's clinical requirements.

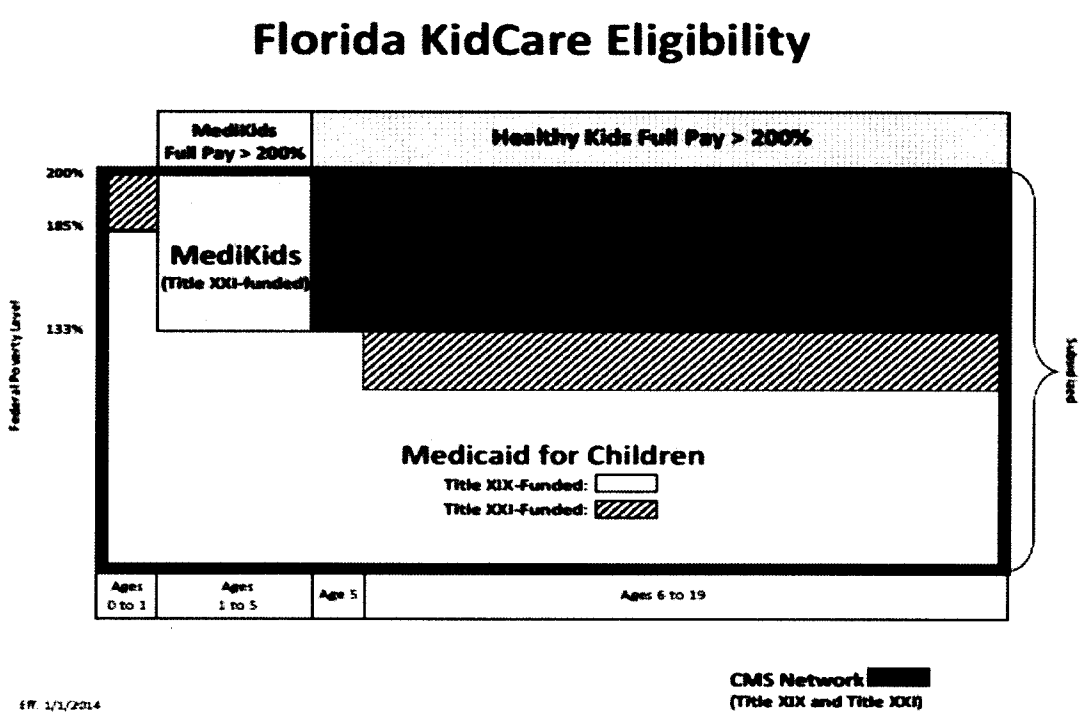
Kidcare is administered jointly by the Agency for Health Care Administration (AHCA), the Department of Children and Families (DCF), the Department of Health (DOH), and the Florida Healthy Kids Corporation (FHKC). Each entity has specific duties and responsibilities under Kidcare as detailed in part II of ch. 409, F.S. The DCF determines eligibility for Medicaid, and the FHKC processes all Kidcare applications and determines eligibility for the CHIP, which includes a Medicaid screening and referral process to the DCF, as appropriate.

[1] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, s. 10203.

To enroll in Kidcare, families utilize a form that is both a Medicaid and CHIP application. Families may apply using the paper application or an online application. Both formats are available in English, Spanish, and Creole. Income eligibility is determined through electronic data matches with available databases or, in cases where income cannot be verified electronically, through submission of current pay stubs, tax returns, or W-2 forms. Children are then determined to be eligible for the appropriate Program component based on the applicable income standards or they are determined to be ineligible for the Program based on applicable income standards.

Currently, FHKC receives all KidCare applications and screens for Medicaid eligibility. Families can apply for Medicaid for children or the Title XXI programs using the KidCare application. Families may also apply for Medicaid using the DCF form, Request for Assistance. The DCF Request for Assistance form cannot be used to apply for the Title XXI programs. Families can apply for both programs online. KidCare applications for children potentially eligible for Medicaid are electronically sent to the DCF for a complete Medicaid eligibility determination. If the child is not eligible for Medicaid, FHKC is notified to continue the Title XXI eligibility determination. FHKC determines eligibility for all of the Title XXI programs.

The following chart summarizes eligibility and funding for Kidcare.[2]



The 2013-2014 General Appropriations Act appropriated $474,825,007 for the Title XXI (CHIP) Program.[3] As of January 2014, a total of 2,118,228 children are enrolled in Kidcare.[4] The following chart details the enrollment totals for each component of the Kidcare:[5]

[2] Florida KidCare, Florida KidCare Eligibility, available at www.floridahealth.gov/AlternateSites/KidCare/images/data/2014KidCareFlag.pdf (last viewed on February 8, 2014).
[3] Ch. 2013-40, ss. 174-179.
[4] Agency for Health Care Administration, Florida KidCare Enrollment Report- January 2014 (Revised) (on file with Health Innovation subcommittee staff).
[5] MediKids and Medicaid enrollment numbers reflect retrospective data as reported by the Agency for Health Care Administration, Program Analysis. Healthy Kids enrollment is reported by Florida Healthy Kids Corporation and CMS Network enrollment is reported by the Department of Health.

PROGRAM	ENROLLMENT
Medicaid- Title XIX	1,824,176
Healthy Kids- Title XXI	233,307
CMS Network- Title XXI	21,247
MediKids- Title XXI	25,997
(full pay enrollees)	(4,405)
Funded Medicaid[6]	9,096
TOTAL	**2,118,228**

The Social Services Estimating Conference convened on October 2 and October 25, 2013 to adopt a caseload and expenditure forecast for the Program through June 2018. Caseload projections under the new forecast for Healthy Kids are slightly lower than the estimates adopted in June 2013 for FY 2013-14.[7] For fiscal year 2013-14, the program is projected to end the year with a General Revenue surplus of $0.94 million.[8] For fiscal year 2014-15, there is a projected General Revenue surplus of $8.45 million relative to the continuation budget.[9]

Eligibility of Alien Children for Medicaid and CHIP

The Immigration and Nationality Act (INA)[10] was created in 1952 to consolidate statutes governing immigration law. The INA defines the term "alien" as "any person not a citizen or national of the United States."[11] Generally, under the INA, an alien is not eligible for any State or local public benefit, including health benefits, unless the alien is:

- A qualified alien,
- A nonimmigrant alien under the INA, or
- An alien who is paroled into the United States under the INA.[12]

The INA permits a state to provide an alien, who is not lawfully present in the United States, eligibility for any state or local public benefit for which the alien would otherwise be ineligible, but only through the enactment of a state law which affirmatively provides for such eligibility.[13]

The enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 ("Reconciliation Act)[14] placed limitations on federal funding for health coverage of immigrant families. The law imposed a 5-year waiting period on certain groups of qualified aliens, including most children and pregnant women who were otherwise eligible for Medicaid.[15] Medicaid coverage for individuals subject to the 5-year waiting period and for those who do not meet the definition of qualified alien was limited to treatment of an emergency medical condition. The 5-year waiting period also applies to children and pregnant women under the CHIP.

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[6] Includes newly eligible and Medicaid children who would have previously been referred to CHIP.
[7] The Florida Legislature, Office of Economic and Demographic Research, Social Services Estimating Conference-Florida KidCare Program-Executive Summary, October 25, 2013, available at http://edr.state.fl.us/Content/conferences/kidcare/kidcareexec.pdf (last viewed on February 8, 2014).
[8] Id.
[9] Id.
[10] Pub. L. No. 82-414
[11] Id. at s. 101(3)
[12] 8 U.S.C. §1621(a)(1)-(3)
[13] 8 U.S.C. §1621(d)
[14] Pub. L. No. 104-193
[15] Id. at s. 403(a)

Children's Health Insurance Program Reauthorization Act of 2009

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)[16] permits states to cover certain children and pregnant women who are "lawfully residing in the United States" in both Medicaid and the CHIP, notwithstanding certain provisions in the Reconciliation Act. States may elect to cover these groups under Medicaid only or under both Medicaid and the CHIP. The law does not permit states to cover these new groups only in the CHIP, without also extending the option to Medicaid.

On July 1, 2010, the Centers for Medicare and Medicaid Services sent a letter to state health officials regarding Medicaid and CHIP coverage for lawfully residing children and pregnant women. The letter states that children and pregnant women who fall into one of the following categories will be considered lawfully present. These individuals are eligible for Medicaid and CHIP coverage, if the state elects the new option under CHIPRA, and the child or pregnant woman meets the state residency requirements and other Medicaid or CHIP eligibility requirements.

- A qualified alien as defined in section 431 of Reconciliation Act (8 U.S.C. §1641).
- An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission.
- An alien who has been paroled into the U.S. pursuant to section 212(d)(5) of the INA (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings.
- An alien who belongs to one of the following classes:
    - Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
    - Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;
    - Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
    - Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;
    - Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
    - Aliens currently in deferred action status; or
    - Aliens whose visa petition has been approved and who have a pending application for adjustment of status.
- A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. §1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. §1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days.
- An alien who has been granted withholding of removal under the Convention Against Torture.
- A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. §1101(a)(27)(J)).
- An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. §1806(e).
- An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

[16] Pub. L. No. 111-3

Effect of Proposed Changes

The bill adds the definition of "lawfully residing child" to the Florida Kidcare Act.[17] To meet the definition, a child must be lawfully present in the United States and meet state residency requirements for CHIP or Medicaid, and may be eligible for assistance under CHIPRA.

The bill makes a lawfully residing child immediately eligible for health benefits coverage under Kidcare, and eligible for payment of optional Medicaid assistance and related services, thereby removing the 5 year waiting period imposed under the Reconciliation Act and exercising the state's option to do so as provided under CHIPRA.

The bill clearly states that Kidcare eligibility is not being extended to an undocumented immigrant by the changes to s. 409.814, F.S. The bill also clearly states that Kidcare eligibility for optional Medicaid payments or other services is not being extended to an undocumented immigrant by the changes to s. 409.904, F.S.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.811, F.S., relating to definitions relating to Florida Kidcare Act.
Section 2: Amends s. 409.814, F.S., relating to eligibility.
Section 3: Amends s. 409.904, F.S., relating to optional payments for eligible persons.
Section 4: Provides an effective date of July 1, 2014.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The Agency for Health Care Administration provides the following fiscal impact analysis of the bill on both CHIP and Medicaid programs (emphasis added):[18]

   Title XXI (CHIP)

   As federal funds are available for these expenditures, the state would incur its share of this additional cost. For SFY 2014-15, the state will pay 28.63% of the qualified expenditures and the federal government under Title XXI covers the remaining 71.37%. This analysis assumes that funding will continue for the Title XXI KidCare eligible children. **2,652** additional children will be covered a month for the first 12 months and this number will be recurring.

Total Additional Costs	$5,580,328
Less: Federal Funds under Title XXI (67.04%)	$3,741,169
Less: Grants & Donation Trust Fund (6.07%)	$338,392
State Funds required (26.89%) General Revenue	**$1,500,766**

[17] SS. 409.810, F.S., through 409.821, F.S.
[18] Agency for Health Care Administration, 2014 Agency Legislative Bill Analysis- HB 7, January 21, 2014, pages 5-6 (on file with Health Innovation subcommittee).

Funds derived from the Grants and Donation Trust Fund derived from family payment of premiums is proportionately applied to reduce state and federal share.

Title XIX (Medicaid)

As federal funds are available for these expenditures, the state would incur its share of this additional cost. For SFY 2014-15, the state will pay 40.90% of the qualified expenditures and the federal government under covers the remaining 59.10%. This analysis assumes that funding will continue for Title XIX Medicaid eligible children at the Title XIX FMAP. **22,903** additional children will be covered a month for the first 12 months and this number will be recurring.

Total Additional Cost with no Family Premiums	$63,632,779
Less: Federal Funds under Title XIX (59.10%)	$37,606,972
Less: Grants & Donation Trust Fund	$0
State Funds required (40.90%) General Revenue	**$26,025,807**

The total fiscal impact on the Agency for both Title XXI and Title XIX in SFY 2014-15 for the provisions in this bill will be $69,213,107 with $27,526,573 being the General Revenue impact.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Health care providers may see an increase in patients who receive health insurance coverage through the Program sooner than under current law. Children who are lawfully present in the state will be eligibility for health insurance coverage, potentially increasing the frequency of access to medical care.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The DOH, the DCF, and the AHCA have appropriate rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to the Florida Kidcare program; amending s. 409.811, F.S.; defining the term "lawfully residing child"; amending s. 409.814, F.S.; revising eligibility for the program; excluding undocumented immigrants from eligibility; amending s. 409.904, F.S.; providing eligibility for optional payments for medical assistance and related services for certain lawfully residing children; excluding undocumented immigrants from eligibility for optional Medicaid payments or related services; providing an effective date.

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

Section 1. Subsections (17) through (26) of section 409.811, Florida Statutes, are renumbered as subsections (18) through (27), respectively, and a new subsection (17) is added to that section to read:

409.811 Definitions relating to Florida Kidcare Act.—As used in ss. 409.810-409.821, the term:

(17) "Lawfully residing child" means a child who is lawfully present in the United States as defined in 8 C.F.R. s. 103.12(a), meets Medicaid or CHIP residency requirements, and may be eligible for medical assistance with federal financial participation as provided under s. 214 of the Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, and related federal rules and regulations.

Section 2. Paragraph (c) of subsection (4) of section 409.814, Florida Statutes, is amended to read:

409.814 Eligibility.—A child who has not reached 19 years of age whose family income is equal to or below 200 percent of the federal poverty level is eligible for the Florida Kidcare program as provided in this section. If an enrolled individual is determined to be ineligible for coverage, he or she must be immediately disenrolled from the respective Florida Kidcare program component.

(4) The following children are not eligible to receive Title XXI-funded premium assistance for health benefits coverage under the Florida Kidcare program, except under Medicaid if the child would have been eligible for Medicaid under s. 409.903 or s. 409.904 as of June 1, 1997:

(c) A child who is an alien~~,~~ but who does not meet the definition of a lawfully residing child under s. 409.811(17) ~~qualified alien, in the United States~~. This paragraph does not extend Kidcare program eligibility to an undocumented immigrant.

Section 3. Subsections (8) and (9) of section 409.904, Florida Statutes, are renumbered as subsections (9) and (10), respectively, and a new subsection (8) is added to that section to read:

409.904 Optional payments for eligible persons.—The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the

availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(8) A child younger than 19 years of age who would be eligible for Medicaid under s. 409.903, except that the child is a lawfully residing child as defined in s. 409.811(17). This subsection does not extend eligibility for optional Medicaid payments or related services to an undocumented immigrant.

Section 4. This act shall take effect July 1, 2014.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 27 Cost-effective Purchasing of Health Care
SPONSOR(S): Diaz
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		McElroy CM	Shaw
2) Health & Human Services Committee			

SUMMARY ANALYSIS

Medicaid covers dental services for children, and, on a more limited basis, for adults. Currently, dental services are delivered to Medicaid recipients on a prepaid or fee-for-service basis through prepaid dental health plans (PDHPs), in counties not participating in the 5-county Medicaid reform pilot program.

In 2011, Florida established the Statewide Medicaid Managed Care (SMMC) program. The SMMC program requires the Agency for Health Care Administration (AHCA) to create an integrated managed care program for Medicaid enrollees to provide all the mandatory and optional Medicaid benefits for primary and acute care, including dental. On February 6, 2014, AHCA executed contracts with the managed care plans selected to provide care under the SMMC. AHCA will begin implementing the SMMC program in selected regions on May 1, 2014, with the last regions being implemented on August 1, 2014. The SMMC program must be fully implemented in all regions by October, 2014.

When the Legislature established the SMMC program, it also created a method to transition Medicaid recipients from PDHPs and fee-for-service into the SMMC program. The Legislature gave AHCA authority to maintain contracts with PDHPs until the SMMC program is scheduled to be fully implemented. Section 409.912(41)(b), F.S., which authorized AHCA to use PDHPs for dental services in Miami-Dade County, expired on July 1, 2013. Section 409.912(41)(a), F.S., which authorizes PSHPs in counties not participating in reform, is scheduled to sunset October 1, 2014.

The bill amends s. 409.912(41)(a), F.S., to continue the PDHP program and to postpone its scheduled expiration until October 1, 2017. The bill reenacts s. 409.912(41)(b), F.S., and authorizes AHCA to provide a Medicaid prepaid dental program in Miami-Dade on a permanent basis.

The bill creates a conflict with the SMMC program. Dental services cannot be excluded from the SMMC program without federal authority. The federal waiver authority to provide dental services through PDHPs expired on January 31, 2014. AHCA can seek new federal authorization but new authorization cannot be obtained prior to the effective date of the bill. Irrespective of this lack of authority, excluding dental services from the SMMC program is currently a logistic impossibility due to federal requirements and IT system limitations. The bill's provisions cannot be accomplished prior to full implementation of the SMMC program.

The bill requires AHCA to provide an annual report to the Governor and Legislature which compares the utilization, benefit and cost data from Medicaid dental contractors as well as compliance reports and access to care to the state's overall Medicaid dental population.

The bill authorizes AHCA to seek any necessary state plan amendments or waiver authority in order to implement this legislation.

The bill has a significant fiscal impact on state government.

The bill provides an effective date of July 1, 2014.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Medicaid

Medicaid is a joint federal- and state-funded program that provides health care for low-income Floridians, administered by AHCA under ch. 409, F.S. Federal law establishes the mandatory services to be covered in order to receive federal matching funds. Benefit requirements can vary by eligibility category. For example, more benefits are required for children than for the adult population. Florida's mandatory and optional benefits are prescribed in state law under ss. 409.905, and 409.906 F.S., respectively.

Dental services are an optional Medicaid benefit. Florida provides full dental services for children and only dentures and medically necessary, emergency dental procedures to alleviate pain or infection for adults.[1]

The delivery of Medicaid services through managed care is not expressly authorized by federal law. If a state wants to use a managed care delivery system, it must seek a waiver of certain requirements of Title XIX of the Social Security Act (Medicaid). Section 1915(b) of the Social Security Act provides authority for Secretary of Health and Human Services to waive requirements of the Act to the extent she "finds it to be cost-effective and efficient and not inconsistent with the purposes of this title."

Florida has received waiver authority for Medicaid recipients receive dental benefits through a managed care delivery system.

Prepaid Dental Health Plans

A prepaid dental health plan (PDHP) is:

> A managed care plan that is licensed or certified as a risk-bearing entity, or qualified pursuant to s. 409.912(4)(d), F.S., in the state and is paid a prospective per-member, per-month payment by the agency.[2]

In 2001, proviso language in the General Appropriations Act (GAA) authorized AHCA to initiate a PDHP pilot program in Miami-Dade County.[3] Similar statutory authority was provided in 2003.[4] AHCA implemented the program in Miami-Dade County in July 2004 for Medicaid children under age 21.[5] In the 2010-2011 GAA, the Legislature directed AHCA to provide enrollees with a choice of at least two

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[1] S. 409.906(1), (6), F.S.
[2] S. 409.962, F.S., See Agency for Health Care Administration, Model Statewide Prepaid Dental Health Plan (SPDHP) Contract, Attachment II-Core Contract Provisions, p. 17, http://ahca.myflorida.com/medicaid/pdhp/docs/120120_Attachment_II_Core.pdf (last visited February 6, 2014). PDHPs are classified as prepaid ambulatory health plans by 42 CFR Part 438.
[3] *See* Specific Proviso 135A, General Appropriations Act 2001-2002 (Conference Report on CS/SB 2C).
[4] Chapter 2003-405, s. 18.
[5] Agency for Health Care Administration, *Statewide Prepaid Dental Program,* *http://www.fdhc.state.fl.us/medicaid/pdhp/index.shtml#Home* (last visited: February 6, 2014).

licensed plans in Miami-Dade County and increased the number to three in the 2011-2012 and 2012-2013 GAAs.[6] Currently, two PDHPs serve Medicaid recipients in Miami-Dade County.[7]

In 2003, the Legislature expanded the PDHP initiative beyond Miami-Dade County by authorizing AHCA to contract with PDHPs without specifying the county or the population.[8] The 2010-2011 GAA proviso specifically authorized AHCA to contract with PDHPs on either a regional or statewide basis.[9] This authority was not limited to children, and the contracts were not to exceed 2 years. The authority excluded Miami-Dade County from this contracting process but did permit AHCA the option of including the Medicaid reform pilot counties in the procurement.[10] AHCA elected not to include those counties. (Children enrolled in managed care plans in the reform counties receive their dental benefits through comprehensive managed care plans; not through PDHPs.)[11]

The statewide proviso language was repeated in the 2011-2012 GAA,[12] and similar language was enacted in s. 409.912(41)(a), F.S. However, these provisions made PDHP contracting mandatory, not discretionary, outside the reform counties (and Miami-Dade County). However, s. 409.912(41)(b), F.S., limited the use of PHDPs by requiring that AHCA may not limit dental services to PDHPs and must allow dental services to be provided on a fee-for-service basis as well.

AHCA issued a competitive procurement for the statewide PDHP program in 2011 and awarded contracts to two PDHPs to provide dental services to Medicaid recipients in all Florida counties with the exceptions noted above. During 2012, the Agency implemented the statewide PDHP program in Medicaid Area 9 on January 1; Areas 5, 6, and 7 on October 1; and Areas 1, 2, 3, 4, 8, and 11 (Monroe County only) on December 1, 2012. The original procurement period was December 1, 2011 through September 30, 2013. The ITN for this procurement allows for renewal, but the renewal cannot exceed three years. The first renewal to the program extended the contracts through September 30, 2014. Section 287.057(13), F.S. limits state contract renewals to no more than three years. Consequently, current contracts with the PDHPs could not be extended beyond September 30, 2016 without having to re-procure.

Statewide Medicaid Managed Care

In 2011, Florida established the Statewide Medicaid Managed Care (SMMC) program as Part IV of Chapter 409, F.S. The SMMC requires AHCA to create an integrated managed care program for Medicaid enrollees to provide all the mandatory and optional Medicaid benefits for primary and acute care, including dental. Dental services will be provided by comprehensive managed care organizations (provider service networks and health maintenance organizations) instead of being delivered as a separate benefit under a separate managed care contract, and the fee-for-service option will be eliminated.[13] Each Medicaid recipient will have one managed care organization to coordinate all health

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[6] See, Specific Proviso, line 204, General Appropriations Act for Fiscal Year 2010-2011 (Conference Report on HB 5001); Specific Proviso, line 192, General Appropriations Act for Fiscal Year 2011-2012 (Conference Report on SB 5000); Specific Proviso, line 186, General Appropriations Act for Fiscal Year 2021-2013 (Conference Report on HB 5001). Note, however, "an appropriations bill must not change or amend existing law on subjects other than appropriations". Brown v. Firestone, 382 So.2d 654 (Fla., 1980).

[7] AHCA, *supra,* note 5.

[8] S. 409.912(42), F.S. (2003).

[9] *See* Specific Proviso 204, General Appropriations Act 2010-2011 (Conference Report on HB 5001).

[10] In 2005, the Legislature enacted laws to reform the delivery and payment of services through the Medicaid program and directed AHCA to seek a federal waiver for a Medicaid managed care pilot program over five years. The program began in Broward and Duval counties in 2006 and later expanded to Baker, Clay and Nassau counties in 2007, as authorized in statute. The five-year waiver was set to expire June 30, 2011, but has been renewed through June 30, 2014.

[11] Agency for Health Care Administration, Capitated Health Plan Contract, Scope of Services, Attachment I, http://ahca.myflorida.com/mchq/Managed_Health_Care/MHMO/docs/contract/1215_Contract/2012-2015/Sept1-Versions/2012-15_HP-ContractAtt-I-CAP-CLEAN-SEPT2012.pdf (last visited: February 6, 2014).

[12] *See* Chapter 2011-69; Specific Proviso for Line Item 192, General Appropriations Act 2011-2012, (Conference Report on SB 2000).

[13] S. 409.973, F.S.

care services, rather than various entities as in the current Medicaid program. This comprehensive coordinated system of care was successfully implemented in the 5-county Medicaid reform pilot program. Such coordinated care is particularly important in the area of oral health, which is connected to overall health outcomes.[14]

The SMMC program will be the primary method of delivery for Medicaid services. The program's enacting laws repeal many sections of current Medicaid law effective upon the implementation of the SMMC program. Pursuant to this change in policy, the PDHP laws will sunset as well. Section 409.912(41)(b), F.S., expired on July 1, 2013, and s. 409.912(41)(a), F.S., will sunset October 1, 2014. The sunset of these subsections eliminates a conflict with the SMMC program. Even if they were not repealed, they would be preempted by the SMMC program: s. 409.961, F.S., requires any conflict between the SMMC program law and pre-reform laws to be resolved in favor of the SMMC laws.

The SMMC program has two components: the Long-term Care Managed Care Program and the Managed Medical Assistance (MMA) Program. The MMA program provides primary and acute medical assistance and related services. On December 28, 2012, AHCA released an Invitation to Negotiate (ITN) to competitively procure managed care plans on a statewide basis for the MMA program.[15] AHCA subsequently selected managed care plans that it will contract with for the MMA program via the competitive procurement and issued recommended contract awards on September 23, 2013. On February 6, 2014, AHCA executed contracts with the managed care plans selected to provide care under the MMA component of the SMMC program.

Under the MMA contracts, all managed care plans are required to provide comprehensive Medicaid services, including all Medicaid covered dental services, to their enrollees. A majority of MMA managed care plans will also provide full dental services, not currently covered under Medicaid, to adult enrollees at no additional cost to the state. Full adult dental services have never before been offered by Florida Medicaid. These additional services are valued at over $100 million over the 5-year duration of the MMA contracts.[16]

AHCA will begin implementing the SMMC program in selected regions on May 1, 2014 with the last regions being implemented on August 1, 2014. The SMMC must be fully implemented in all regions by October, 2014, as directed in s. 409.971, F.S.

On October 1, 2014, the statutory authority for the Agency to contract with PDHPs to provide dental services to eligible Medicaid recipients is scheduled to sunset with the implementation of the SMMC program. Medicaid recipients who are enrolled in the SMMC program will receive their dental services through the fully integrated managed care plans.

Federal Waiver Authority

To use the PDHP model to deliver dental services to Medicaid recipients, AHCA had to obtain section 1915(b) waiver authority. This waiver authority expired on January 31, 2014. AHCA did not seek renewal of the waiver, and the deadline for seeking renewal under federal law has passed. Instead, the federal government has agreed to give a series of temporary extensions to the 1915(b) waiver as

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[14] U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000. http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBJT/ (last viewed February 9, 2014);

[15] AHCA Invitation to Negotiate, *Statewide Medicaid Managed Care*, *Addendum 2* Solicitations Number: AHCA ITN 017-12/13; dated February 26, 2013. http://myflorida.com/apps/vbs/vbs_www.ad.view_ad?advertisement_key_num=105774 (February 6, 2014); AHCA Invitation to Negotiate, *Statewide Medicaid Managed Care*, Solicitation Number: AHCA ITN 017-12/13; dated December 28, 2012 http://myflorida.com/apps/vbs/vbs_www.ad.view_ad?advertisement_key_num=105774 (last visited February 6, 2014).

[16] AHCA 2014 Agency Legislative Bill Analysis for HB 27, dated November 13, 2014 (currently on file with the Florida House of Representatives Health Innovation Subcommittee).

AHCA implements the SMMC program, allowing dental services to be gradually folded into the SMMC program and then letting the section 1915(b) waiver expire.[17]

To implement the SMMC program, AHCA applied for and obtained section 1115 waiver authority. Section 1115 of the Social Security Act allows states to use innovative service delivery systems that improve care, increase efficiency, and reduce costs. Federal authority for including dental services in the SMMC program is in the approved section 1115 waiver.[18]

Currently, Florida only has federal authority to provide dental services to Medicaid recipients as an integrated component of the SMMC program.

PDHP Performance

AHCA measures the performance of PDHPs based on standards established by the National Committee for Quality Assurance called the Healthcare Effectiveness Data and Information Set (HEDIS). Annual pediatric dental visits in Miami-Dade, statewide, and in the reform pilot counties are reflected below.

HEDIS Annual Dental Visit Scores for Reform Plans and PDHP[19]

Calendar Year	Reform Pilot Plans	Dentaquest[20] Statewide	Dentaquest Miami-Dade	MCNA Statewide	MCNA Miami-Dade
2012	40.4%	47.3%	41.4%	39.3%	36.8%

Under the terms and conditions of the 1115 waiver, AHCA must work with MMA plans on an oral health quality improvement initiative. AHCA developed the framework for initiative and included it in the contracts with the MMA plans.

Effect of the Proposed Changes

Section 409.912(41)(a), F.S., requires that AHCA contract with PDHPs, and sunsets October 1, 2014.[21] The bill postpones the repeal to October 1, 2017. In addition, the bill eliminates the requirement that AHCA continue to allow fee-for-service dental as an option, making PDHPs the exclusive delivery method for those services.

Section 409.912(41)(b), F.S., created separate authority for AHCA to create a Medicaid prepaid dental health program in Miami-Dade. The statute expired on July 1, 2013. The bill reenacts the subsection and authorizes AHCA to provide a Medicaid prepaid dental program in Miami-Dade on a permanent basis. This action would allow AHCA to continue to provide a separate Medicaid prepaid dental plan in Miami-Dade County.

The bill's provisions cannot be accomplished prior to full implementation of the SMMC program. Federal authorization is required for AHCA to operate the PDHP program. To reestablish authority to have a stand-alone dental managed care program, AHCA would have to either apply for a new 1915(b) waiver, or seek an amendment to the approved section 1115 waiver. To remove dental services from the SMMC program, AHCA would have to apply for an amendment of the approved section 1115 waiver. The federal government has no time limits for reviewing a request for a section 1115 waiver;

[17] Id.
[18] Id.
[19] Information from AHCA and on file with the Health Innovation Subcomittee.
[20] Dentaquest has contracted with several MMA plans to provide dental coverage in the SMMC for both children and adults.
[21] Section 409.912 (41)(a), F.S.

therefore, it is unknowable how long the process would take. In the interim, AHCA is required to proceed, as required by ch. 409, with the full implementation of the SMMC program.

Dental services cannot immediately be excluded from the SMMC program, even if AHCA currently had federal authority to do so. AHCA will begin implementing the SMMC on a staggered regional basis beginning on May 1, 2014, with the final regions implemented on August 1, 2014.[22] AHCA will open its choice counseling lines roughly 75 days in advance of the implementation in each region, with the first choice counseling lines will open in mid-February 2014.[23] The service packages and the provider networks for the plans must be programmed into the choice counseling system in well in advance of the implementation. This includes loading dental service packages and dental networks into the system and loading capitation rates that include dental services into the system, as current law requires that these services be in the SMMC program.[24] It is a logistical impossibility for AHCA to make the system changes necessary to exclude dental services from the SMMC prior to mid-February 2014.[25] Thus, dental services cannot be excluded prior to full implementation of the SMMC.

The bill's provisions conflict with the SMMC statutory requirements. On December 28, 2012, AHCA released an Invitation to Negotiate (ITN) to competitively procure managed care plans on a statewide basis.[26] Dental services were included in the ITN as one of the enumerated services to be provided under the SMMC. On February 6, 2014, AHCA executed contracts with the managed care plans selected to provide care, including dental services, under the SMMC. The bill's provisions however require the exclusion of dental services from the SMMC.

Legal challenges could result to due to the change in the term of the contracts. The contracts were negotiated, rates were set, and provider networks were established based on the requirement that dental services be included. The contacted rates and networks would not be valid under the bill; therefore, AHCA may have to reopen rate negotiations prior to implementing the SMMC program.[27] Rates cannot be re-negotiated by AHCA and still allow AHCA to meet the statutory implementation deadline.

The bill's provisions require the continued use of PDHPs. The existing statewide PDHPs were procured through a competitive process. The original procurement period was December 1, 2011 through September 30, 2013.[28] The ITN for this procurement allowed for renewal, but the renewal cannot exceed beyond September 30, 2016 because s. 287.057(13), F.S. limits state contract renewals to no more than three years. The first renewal to the program extended the contracts for one year through September 30, 2014. Consequently, current contracts with the PDHPs would have to be competitively re-procured to continue to program beyond September 30, 2016.

The bill requires AHCA to provide an annual report to the Governor and Legislature which compares the utilization, benefit and cost data from Medicaid dental contractors as well as compliance reports and access to care to the state's overall Medicaid dental population.

The bill authorizes AHCA to seek any state plan amendments or waiver authority necessary to reestablish federal authority to have a stand-alone dental managed care program.

B. SECTION DIRECTORY:

Section 1. Amends s. 409.912, F.S., relating to cost effective purchasing of health care.

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[22] AHCA, *supra,* note 16.
[23] Id.
[24] Id.
[25] Id.
[26] AHCA, *supra,* note 15.
[27] AHCA, *supra,* note 16.
[28] Id.

Section 2. Provides an effective date of July 1, 2014.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   AHCA would need to add two pay grade 24 FTEs to function as contract managers for the two PDHPs. AHCA would also need increased funding for travel expenses to perform additional plan monitoring that is required. Expenditures for these activities would begin in SFY 2014-2015 based on the July 1, 2014, effective date of the bill and have recurring costs of $131,489.00 annually.[29]

   There are indeterminate, but likely significant, costs related to re-negotiation of the MMA contracts, re-procurement of the SMMC program, re-procurement of the PDHPs, legal challenges and system changes required to implement the exclusion of dental services from the SMMC.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

For the majority of adult Medicaid enrollees, current dental benefits are extremely limited. Under MMA, AHCA negotiated expanded dental benefits with the managed care organizations at no cost to AHCA. AHCA estimates the value of these additional benefits at $100 million over 5 years, at no additional cost to taxpayers.[30] However, if the pediatric enrollees are carved out of the MMA contracts, AHCA believes that the managed care organizations will lose leverage with the dental providers and existing dental provider networks resulting in the loss of the expanded benefit for the adults.[31] In all likelihood, adult Medicaid enrollees will lose access to expanded dental benefits, dental providers may lose the opportunity for increased patients and revenue, and taxpayers will not have the benefit of a no-cost $100 million negotiated contract term.

D. FISCAL COMMENTS:

If the SMMC implementation is delayed to re-negotiate rates or obtain amended waivers, AHCA expects that the state will also lose anticipated savings from the MMA contracts. Based on the projected 5 percent aggregate savings per year contemplated in s. 409.966(3)(d), F.S., and the estimated contract value of $70 billion over 5 years, the minimum impact for a 1 year delay is $736 million in lost savings.[32]

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[29] Id.
[30] AHCA, *supra.*
[31] AHCA, *supra,* note 16.
[32] Id.

The bill's provisions may also result in duplicative demand for payment for dental service benefits. The bill requires PDHP to continue to provide dental services. The current contracts for these services were set to expire with the implementation of the SMMC. However, dental services cannot be excluded prior to the full implementation of the SMMC due to the expiration of the 1915(b) waiver. AHCA can seek a new waiver or request an amendment to the 1115 waiver but it will be several months, possibly much longer, before either is provided. Thus, dental services are required under the PDHP pursuant to bill's provisions and under the MMA pursuant to the SMMC. Until the new waiver or amendment is provided or the MMA contracts are renegotiated, the potential exists that the state may be responsible for double payment of the dental service benefits. Since the federal government will not reimburse a state for duplicative payment for benefits, AHCA only remedy may be to delay the implementation of the SMMC program.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

   Requiring AHCA to contract with licensed prepaid dental health plans for Medicaid dental services after October 1, 2014, could result in a legal challenge that the bill's provisions create an unconstitutional impairment of contracts.

   On December 28, 2012, AHCA released an Invitation to Negotiate (ITN) to competitively procure managed care plans on a statewide basis.[33] Dental services were included in the ITN as one of the enumerated services to be provided under the SMMC. On February 6, 2014, AHCA executed contracts with the managed care plans selected to provide care, including dental services, under the SMMC.

   The United States Constitution and the Florida Constitution prohibit the state from passing any law impairing the obligation of contracts.[34] The courts will subject state actions that impact state-held contracts to an elevated form of scrutiny when the Legislature passes laws that impact such contracts. *Cf. Chiles v. United Faculty of Fla.,* 615 So.2d 671 (Fla. 1993). "[T]he first inquiry must be whether the state law has, in fact, operated as a substantial impairment of a contractual relationship. The severity of the impairment measures the height of the hurdle the state legislation must clear."[35]

   The estimated annualized value of the MMA contracts is approximately $70 billion over 5 years. The change in the value of these MMA contracts due to the value of removing the dental benefit may be deemed substantial if AHCA must re-negotiate these contracts or re-procure due to severing dental benefits from the benefits to be provided.

   If a law does impair contracts, the courts will assess whether the law is deemed reasonable and necessary to serve an important public purpose.[36] The court will also consider three factors when balancing the impairment of contracts with the important public purpose:

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[33] AHCA, *supra,* note 15.
[34] U.S. Const. art. I, § 10; art. I, s. 10, Fla. Const.
[35] *Pomponio v. Claridge of Pompano Condominium, Inc.,* 378 So. 2d 774 (Fla. 1980). *See also General Motors Corp. v. Romein,* 503 U.S. 181 (1992).
[36] *Park Benzinger & Co. v. Southern Wine & Spirits, Inc.,* 391 So. 2d 681 (Fla. 1980); *Yellow Cab C., v. Dade County,* 412 So. 2d 395 (Fla. 3rd DCA 1982). *See also Exxon Corp. v. Eagerton,* 462 U.S. 176 (1983).

- Whether the law was enacted to deal with a broad economic or social problem;
- Whether the law operates in an area that was already subject to state regulation at the time the contract was entered into; and,
- Whether the effect on the contractual relationship is temporary; not severe, permanent, immediate, and retroactive.[37]

A law that is deemed to be an impairment of contract will be deemed to be invalid as it applies to any contracts entered into prior to the effective date of the act.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Section 409.961, F.S., provides that "it is the intent of the Legislature that if any conflict exists between the provisions contained in this part [SMMC program] and in other parts of this chapter the provisions in this part [SMMC program] control." The bill's provisions exclude dental services from otherwise integrated services in the SMMC program. However, s. 409.973(1)(e), F.S, still expressly provides that dental services must be included in the SMMC program. The bill expressly exempts its provisions from the conflict resolution language in s. 409.961, F.S., thereby creating ambiguity as to which provision controls.

There is a potential that non-winning vendors of the SMMC procurement might initiate litigation. Non-winning vendors who had not included comparable dental benefits might challenge the change in terms and argue a different approach would have been taken if they had known that dental would be carved out later. Similarly, some vendors that chose not to compete due to an inadequate dental network might challenge a re-negotiation.

AHCA notes that creating a carve-out for any single service would set a bad precedent for the future of the new, reformed Medicaid program, and expects other service providers to seek carve-outs from the Legislature if HB 27 is enacted. [38] A unified, coordinated system of care is a primary characteristic of Medicaid reform, in part because it solves the problem of complexity with which Florida's Medicaid program has been plagued for decades. In 2010, the Florida House of Representatives contracted with a consultant to analyze Florida's Medicaid program and identify problems and possible solutions. One of the consultant's conclusions was that Florida Medicaid's fragmented, complex system makes it difficult to improve value for patients and taxpayers.[39]

Since only pediatric dental services are currently provided by the PDHPs, AHCA's analysis assumes that only pediatric dental services would be provided by the PDHPs; however, the bill refers to "dental services" which would include both adult and pediatric. Consequently, it is unclear whether all dental, or only pediatric dental services, would be provided by the PDHPs.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[37] *Pomponio v. Cladridge of Pompanio Condo., Inc.,* 378 So. 2d 774 (Fla. 1980).
[38] AHCA, *supra,* note 16.
[39] Medicaid Managed Care Study, Pacific Health Policy Group, p. 73, March 2010

A bill to be entitled

An act relating to cost-effective purchasing of health care; amending s. 409.912, F.S.; extending the authorization period for the Agency for Health Care Administration to enter into contracts on a prepaid or fixed-sum basis with appropriately licensed prepaid dental health plans to provide dental services; limiting agency authorization for the provision of prepaid dental health programs to Miami-Dade County; requiring an annual report to the Governor and Legislature; authorizing the agency to seek federal waivers or amendments to the state plan; providing an effective date.

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

Section 1. Subsection (41) of section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion

shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as

Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers are not entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(41)(a) Notwithstanding s. 409.961, the agency shall contract on a prepaid or fixed-sum basis with appropriately licensed prepaid dental health plans to provide dental services. This paragraph expires October 1, 2017 ~~2014~~.

(b) Notwithstanding paragraph (a) ~~and for the 2012-2013 fiscal year only~~, the agency is authorized to provide a Medicaid prepaid dental health program in Miami-Dade County. ~~For all other counties, the agency may not limit dental services to prepaid plans and must allow qualified dental providers to provide dental services under Medicaid on a fee-for-service reimbursement methodology. The agency may seek any necessary revisions or amendments to the state plan or federal waivers in order to implement this paragraph. The agency shall terminate existing contracts as needed to implement this paragraph. This paragraph expires July 1, 2013.~~

(c) The agency shall provide an annual report by January 15 to the Governor, the President of the Senate, and the Speaker of the House of Representatives that compares the combined reported annual benefits utilization and encounter data from all contractors, along with the agency's findings with respect to projected and budgeted annual program costs, the extent to which each contracting entity is complying with all contract terms and conditions, the effect that each entity's operation is having on access to care for Medicaid recipients in the contractor's service area, and the statistical trends associated with indicators of good oral health among all recipients served in comparison with the state's population as a whole.

(d) The agency may seek any necessary revisions or amendments to the state plan or federal waivers in order to implement this subsection.

Section 2. This act shall take effect July 1, 2014.

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health Innovation Subcommittee

Representative Diaz, J. offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Section 409.91205, Florida Statutes, is created to read:

409.91205 Statewide prepaid dental program.—

(1) The Legislature finds and declares that the design and delivery of children's Medicaid dental services should be directed by the principle that the health of children should be an overriding concern. The Legislature also finds that the delivery of dental services as compared to other health care services is considerably different and, considering the historical shortcomings of access to dental care in Florida, special attention must be given to children's dental care

accessibility and provider network sustainability. Therefore, it is the intent of the Legislature that a Medicaid prepaid dental program be established, on a statewide basis in all counties, separate and apart from the Medicaid managed medical assistance program described in sections 409.961-409.985. Further, the Legislature finds that it is of paramount interest to the Medicaid program that continuous and high-quality dental care be provided to Medicaid recipients, and thus the agency shall ensure a seamless transition of the responsibility for the provision of dental services to children from the managed medical assistance program to the statewide prepaid dental program.

(2) Notwithstanding sections 409.961-409.985, the agency shall implement the statewide prepaid dental program by contracting on a prepaid or fixed-sum basis with at least two appropriately licensed prepaid dental health plans to provide dental services to children statewide that demonstrate extensive experience in administering dental benefits for children enrolled in Medicaid and that have experience in constructing and maintaining statewide dental and specialty dental provider networks for Medicaid programs.

(a) The agency shall apply for and implement state plan amendments or waivers of applicable federal laws and regulations necessary to implement the statewide prepaid dental program.

(b) In order to ensure continuous and high-quality dental care is provided to Medicaid recipients upon receiving the

necessary federal approval for the statewide prepaid dental program, the agency shall extend the existing contracts with licensed prepaid dental health plans as described in s. 409.912(41). The agency shall amend the existing contracts to include all counties.

(c) Enrollment in the statewide prepaid dental program shall not begin until the necessary state plan amendments or waivers of applicable federal laws and regulations are obtained and implemented; however, enrollment shall begin no later than September 1, 2015.

(d). A child who is eligible to receive Medicaid benefits between the effective date of this act and the implementation of the statewide prepaid dental plans shall receive dental services as provided in sections 409.961-409.985 until the child is eligible to enroll in the statewide prepaid dental program.

(e) Prior to enrollment in the statewide prepaid dental program, the agency shall provide any required notice to recipients regarding the transition. The agency may assess the costs incurred in providing the notice to the plans participating in the statewide prepaid dental program.

(f) The prepaid dental plans participating in statewide prepaid dental program shall be required by contract to submit encounter data as described in s. 409.967 (2)(d).

(g) The agency shall require a medical loss ratio of 85 percent for prepaid dental plans participating in statewide prepaid dental program. The calculation shall use uniform

financial data collected from all plans and shall be computed for each plan on a statewide basis. The method for calculating the medical loss ratio shall require that expenditures be classified in a manner consistent with 45 C.F.R. part 158.

(3) The agency shall provide a report by January 15 of each year of operation of the statewide prepaid dental program to the Governor, the President of the Senate, and the Speaker of the House of Representatives which compares the combined annual benefits utilization and encounter data reported by all participating prepaid dental plans, along with the agency's findings with respect to projected and budgeted annual program costs, the extent to which each plan is complying with all contract terms and conditions, the effect that each plan's operation is having on access to care for Medicaid recipients in the plan's service area, and the statistical trends associated with indicators of good oral health among all recipients served in comparison with the state's population as a whole.

Section 2. Paragraph (e) of subsection (1) of section 409.973, Florida Statutes, is amended to read:

409.973 Benefits.—

(1) MINIMUM BENEFITS.—Managed care plans shall cover, at a minimum, the following services:

(e) Adult dental services as described in s. 409.906(1).

Section 3. This act shall take effect upon becoming a law.

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

Remove everything before the enacting clause and insert:

An act relating to the statewide prepaid dental program; creating s. 409.91205, F.S.; providing legislative findings; creating the Medicaid statewide prepaid dental program; directing the Agency for Health Care Administration to contract with prepaid dental health plans meeting specified criteria; directing the agency to apply for and implement state plan amendments or waivers of applicable federal laws and regulations necessary to implement the statewide prepaid dental program; directing the agency to extend certain contracts with prepaid dental plans; providing that enrollment in the statewide prepaid dental program shall not be begin until the necessary state plan amendments or waivers of applicable federal laws and regulations are obtained and implemented; providing that a child who becomes eligible to receive Medicaid benefits between the effective date of this act and the implementation of the statewide prepaid dental plans shall receive dental services through the Medicaid managed medical assistance program; directing the agency to provide any required notice to recipients regarding the transition from Medicaid managed medical assistance program to the statewide prepaid dental program; providing the agency may assess the costs incurred in providing the notice to the plans participating in the statewide

prepaid dental program; requiring prepaid dental plans participating in statewide prepaid dental program to submit encounter data; providing that the agency shall require a medical loss ratio for prepaid dental plans participating in statewide prepaid dental program; requiring the agency to submit an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives; specifies the contents of the report; amending s. 409.973, F.S.; removing the requirement that managed care plans participating in the Medicaid managed assistance program provide pediatric dental services; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 463 Background Screening
SPONSOR(S): Reed
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Guzzo	Shaw
2) Judiciary Committee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

In 2012, the Legislature created the Care Provider Background Screening Clearinghouse (Clearinghouse) to create a single program of screening individuals for criminal background checks prior to employment in certain health related service positions. The Clearinghouse is created under the Agency for Health Care Administration (AHCA), and was implemented by AHCA on January 1, 2013. There are six state agencies designated to participate in the Clearinghouse, including, AHCA, the Department of Health (DOH), the Department of Children and Families, the Department of Elder Affairs, the Agency for Persons with Disabilities, and Vocational Rehabilitation (DVR) within the Department of Education. The bill makes several changes to the provisions of the Clearinghouse, to clarify what is required of participating agencies and applicants.

Specifically, the bill:

- Clarifies that employers must perform the registration and initiation of all criminal history background checks made through the Clearinghouse;
- Requires vendors who submit fingerprints on behalf of employers to include specific identifying information of the person screened;
- Makes the requirement to submit a photo at the time of screening only to the Clearinghouse;
- Allows the Department of Highway Safety and Motor Vehicles to share driver's license photographs with DOH, and AHCA's Background Screening Unit through an interagency agreement; and
- Specifies demographic information that must be submitted with a request for a criminal background check to verify proper identity as required for a federal check.

The bill also:

- Eliminates the three-year waiting period to apply for an exemption from disqualification for a criminal offense for individuals who have completed all monetary sanctions for a felony disqualifying offense, as long as all sanctions are paid or completed before eligibility for an exemption;
- Updates the disqualifying offenses in chapter 435, F.S., to include criminal offenses involving theft that are similar to existing disqualifying offenses; and
- Revises applicability of background screening requirements for certain service providers who must register with DVR.

The bill does not appear to have a significant fiscal impact on state or local government.

The bill provides an effective date of July 1, 2014.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Florida has one of the largest vulnerable populations in the country with over 25% of the state's population over the age of 65, and many more children and disabled adults. These vulnerable populations require special care because they are at an increased risk of abuse.

In 1995, the Legislature created standard procedures for criminal history background screening of prospective employees, owners, operators, contractors, and volunteers. Chapter 435, F.S., outlines the screening requirements. In 2010, the Legislature substantially rewrote the requirements and procedures for background screening.[1] Major changes made by the 2010 legislation include:

- No person who is required to be screened may begin work until the screening has been completed.
- All Level 1[2] screenings were increased to Level 2[3] screenings.
- By July 1, 2012, all fingerprints submitted to the Florida Department of Law Enforcement (FDLE) must be submitted electronically.
- Certain personnel that were not being screened were required to begin Level 2 screening.
- The addition of serious crimes that disqualify an individual from employment working with vulnerable populations.
- Authorization for agencies to request the retention of fingerprints by FDLE.
- That an exemption for a disqualifying felony may not be granted until at least three years after the completion of all sentencing sanctions for that felony.
- That all exemptions from disqualification may be granted only by the agency head.

In 2012, the Legislature passed CS/CS/CS/HB 943, which created the Care Provider Background Screening Clearinghouse (Clearinghouse) to create a single "program" of screening individuals and allow for the results of criminal history checks of persons acting as covered care providers to be shared among the specified agencies. Designated agencies include the Agency for Health Care Administration (AHCA), the Department of Health, the Department of Children and Families, the Department of Elder Affairs, the Agency for Persons with Disabilities, and Vocational Rehabilitation within the Department of Education. Once a person's screening record is in the Clearinghouse, that person will avoid the need for any future state screens and related fees. Final implementation of the Clearinghouse by the designated state agencies was required by October 1, 2013. The Clearinghouse was initially implemented by AHCA on January 1, 2013.

Current Background Screening Law

Florida licensure laws require providers licensed by AHCA to conduct Level 2 criminal background screening for:[4]

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[1] Chapter 2010-114, L.O.F.

[2] Section 435.03, F.S. Level 1 screenings are name-based demographic screenings that must include, but are not limited to, employment history checks and statewide criminal correspondence checks through FDLE. Level 1 screenings may also include local criminal records checks through local law enforcement agencies. A person undergoing a Level 1 screening must not have been found guilty of any of the listed offenses.

[3] Section 435.04, F.S. A Level 2 screening consists of a fingerprint-based search of FDLE and the Federal Bureau of Investigation databases for state and national criminal arrest records. Any person undergoing a Level 2 screening must not have been found guilty of any of the listed offenses.

[4] Section 408.809, F.S.

- The licensee;
- Administrators and financial officers;
- Staff of health care providers who offer residential and home care services that provide personal care services or have access to client property, funds or living areas; and
- Any person who is a controlling interest if there is reason to suspect they have committed a disqualifying criminal offense.

Current background screening standards in ch. 435, F.S., and s. 408.809, F.S., include various disqualifying offenses pertaining, but not limited to, domestic violence, patient brokering, criminal use of personal identification information, fraudulent use of credit cards, forgery, and possession/sale of illegal drugs.

There are some criminal offenses, not presently listed as disqualifying offenses, that are substantially similar to current disqualifying offenses. For example, s. 408.809(4)(k), F.S., states that fraudulent use of credit cards, if the offense was a felony, as described in s. 817.61, F.S., is a disqualifying offense. Under current background screening standards, obtaining goods by use of a false or expired credit, if the offense was a felony, as described in s. 817.841, F.S., is not considered a disqualifying offense.

The Department of Highway Safety and Motor Vehicles (DHSMV) has the authority to maintain a record of driver license photographs together with other data required for identification and retrieval.[5] The DHSMV also has the authority to share those photographs, through interagency agreements, with specific state agencies.[6]

Collecting photographs at the time of screening is an important part of implementing the Clearinghouse. The requirement to submit a photograph was added to law during the 2012 Legislative Session. However, instead of being in the Clearinghouse statute of s. 435.12, F.S., the requirement currently exists in the general Level 2 screening standards of s. 435.04(1)(e), F.S.

Designated agencies have the authority to grant exemptions from disqualification.[7] The exemptions enable people who have been convicted of a disqualifying criminal offense to present information as to why they should not be excluded from working with vulnerable individuals. The information includes specifics of the offense, how long ago the offense occurred, work history, and rehabilitation. Current law states that an applicant who applies for an exemption for a felony offense must have had three years elapse since completion of any sentence or have been lawfully released from confinement, supervision, or sanction for the disqualifying felony.[8] The three-year waiting period would include even the smallest sanction, such as an unpaid balance of a fine. The requirement is similar for disqualifying misdemeanors, except that there is no specific time frame mandated post completion of being lawfully released from confinement, supervision, or sanction.

The term "sanction" does not currently have a formal definition in chapter 435, F.S. Numerous state agencies are bound by chapter 435, F.S., and the interpretation of the term "sanction" varies widely among the agencies.[9]

Employers of individuals subject to screening by a specified agency are required to register with the Clearinghouse and maintain the employment status of all employees with the Clearinghouse for screenings conducted after the date the state agency begins participation in the Clearinghouse. Initial

[5] Section 322.142(4), F.S.
[6] Section 322.142(4), F.S., provides that DHSMV may provide reproductions of the file or digital record to the Department of Business and Professional Regulation, the Department of State, the Department of Revenue, the Department of Children and Families, the Department of Financial Services, or to district medical examiners.
[7] Section 435.07, F.S.
[8] *Id.*
[9] HB 1021 (2013) Bill Analysis and Economic Impact Statement, Agency for Health Care Administration, at page 4, March 13, 2013 (on file with the Health Innovation Subcommittee).

employment status and any change in status must be reported by the employer within 10 business days.[10] Currently, it is not a requirement that screenings be initiated through the Clearinghouse.

Effect of Proposed Changes

The bill amends s. 322.142, F.S., to authorize DHSMV to make available to DOH and AHCA a record of driver license photographs for the purpose of verifying photographs in the Clearinghouse.

The bill amends ss. 408.809 and 435.04, F.S., to provide additional disqualifying offenses. The criminal offenses added include obtaining goods by use of false or expired credit cards or other credit device, if the offense was a felony (s. 817.481, F.S.), fraudulently obtaining goods or services from a health care provider (s. 817.50, F.S.), racketeering (s. 895.03, F.S.), violating the Florida Money Laundering Act (s. 896.101, F.S.), and criminal offenses that involve attempts, solicitation, and conspiracy to commit an offense (s. 777.04, F.S.) that is one of the listed disqualifying offenses.

The bill amends s. 413.208, F.S., to revise the applicability of background screening requirements for certain Division of Vocational Rehabilitation providers, to apply only to registrations entered into or renewed after the Clearinghouse becomes operational and retains background screening results pursuant to s. 435.12, F.S.

The bill relocates language from s. 435.04(1)(e)2, F.S., to s. 435.12(2)(d), F.S. As a result, the submission of a photograph will be a requirement of the Clearinghouse, and not a requirement for all screenings conducted pursuant to chapter 435, F.S. This change will allow the agency to enter into an agreement with the DHSMV, to verify photographs of individuals that have been background screened through the Clearinghouse by comparing the submitted photograph to the driver's license photograph.

The bill amends s. 435.04(1)(e), F.S., to require vendors who submit fingerprints on behalf of employers to submit specific identifying information for the person screened, including the applicant's:

- Full first name, middle initial, and last name;
- Social security number;
- Date of birth;
- Mailing address;
- Sex; and
- Race.

The bill modifies requirements relating to exemptions from disqualification. Some applicants who are otherwise qualified for an exemption are unaware of outstanding monetary sanctions related to their disqualifying offense until being notified by the agency. In some cases, the applicant's criminal case may have been closed for over a decade but the applicant may still have an outstanding monetary sanction related to the disqualifying offense. Once the outstanding monetary sanction has been paid, the applicant would not be eligible to be granted an exemption from disqualification for period of three years post completion of the sanction.

The bill amends s. 435.07, F.S., to delete the term "sanction", and replace it with "nonmonetary condition imposed by the court" to eliminate differing interpretations of the term sanction. Court ordered nonmonetary sanctions could include various types of community service and rehabilitation courses, such as anger management, theft prevention courses, and drug rehabilitation. Monetary sanctions that are court ordered could include any fee, fine, fund, lien, civil judgment, application, and costs of prosecution, trust or restitution. The bill would eliminate the three-year waiting period for individuals that have completed all monetary sanctions for a felony disqualifying offense. The three-year waiting period would still apply for any felony disqualifying offense where, confinement, supervision, or nonmonetary condition is involved. As a result, well qualified and rehabilitated

[10] Section 435.12(2), F.S.

employees will have an opportunity to gain lawful employment in the healthcare facilities licensed by AHCA.[11]

Finally, the bill requires screenings to be initiated and registered by the employer through the Clearinghouse prior to referring an employee or potential employee for electronic fingerprint submission. The bill requires the registration to include the same information as required by s. 435.04, F.S., as amended. In addition, the bill requires an individual taxpayer identification number to be included for registration of individuals that cannot legally obtain a social security number. AHCA will be able to obtain information on the initiating facility and allow screening tracking updates to be sent to the initiating facility as the information becomes available.[12] Providers will be able to obtain screening results much faster than screenings not initiated through the Clearinghouse.[13]

B. SECTION DIRECTORY:

Section 1: Amends s. 322.142, F.S., relating to color photographic or digital imaged licenses.
Section 2: Amends s. 408.809, F.S., relating to background screening; prohibited offenses.
Section 3: Amends s. 413.208, F.S., relating to service providers; quality assurance; fitness for responsibilities; background screening.
Section 4: Repeals s. 7 of chapter 2012-73, Laws of Florida, relating to background screening requirements for registrants of the Division of Vocational Rehabilitation.
Section 5: Amends s. 435.04, F.S., relating to level 2 screening standards.
Section 6: Amends s. 435.07, F.S., relating to exemptions from disqualification.
Section 7: Amends s. 435.12, F.S., relating to the Care Provider Background Screening Clearinghouse.
Section 8: Provides an effective date of July 1, 2014.

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.

[11] *See supra* at FN 9.
[12] *Id.*
[13] *Id.*

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

No additional rule-making is necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to background screening; amending s. 322.142, F.S.; authorizing the Department of Highway Safety and Motor Vehicles to share reproductions of driver license images with the Department of Health and the Agency for Health Care Administration for specified purposes; amending s. 408.809, F.S.; adding additional qualifying offenses to background screening requirements; amending s. 413.208, F.S., and repealing s. 7, chapter 2012-73, Laws of Florida; revising the applicability of background screening requirements for certain service providers who must register with the Division of Vocational Rehabilitation of the Department of Education; amending s. 435.04, F.S.; revising information required for vendors submitting employee fingerprints; adding additional qualifying offenses to background screening requirements; amending s. 435.07, F.S.; revising criteria for an exemption from disqualification for an employee under certain conditions; amending s. 435.12, F.S.; requiring simultaneous submission of a photographic image and electronic fingerprints to the Care Provider Background Screening Clearinghouse; requiring an employer to follow certain criminal history checks procedures and include specified information regarding referral and registration of an employee for

electronic fingerprinting with the clearinghouse; providing an effective date.

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

Section 1. Subsection (4) of section 322.142, Florida Statutes, is amended to read:

322.142 Color photographic or digital imaged licenses.—

(4) The department may maintain a film negative or print file. The department shall maintain a record of the digital image and signature of the licensees, together with other data required by the department for identification and retrieval. Reproductions from the file or digital record are exempt from the provisions of s. 119.07(1) and may ~~shall~~ be made and issued only:

(a) For departmental administrative purposes;

(b) For the issuance of duplicate licenses;

(c) In response to law enforcement agency requests;

(d) To the Department of Business and Professional Regulation and the Department of Health pursuant to an interagency agreement for the purpose of accessing digital images for reproduction of licenses issued by the Department of Business and Professional Regulation or the Department of Health;

(e) To the Department of State pursuant to an interagency agreement to facilitate determinations of eligibility of voter

registration applicants and registered voters in accordance with ss. 98.045 and 98.075;

(f) To the Department of Revenue pursuant to an interagency agreement for use in establishing paternity and establishing, modifying, or enforcing support obligations in Title IV-D cases;

(g) To the Department of Children and Families pursuant to an interagency agreement to conduct protective investigations under part III of chapter 39 and chapter 415;

(h) To the Department of Children and Families pursuant to an interagency agreement specifying the number of employees in each of that department's regions to be granted access to the records for use as verification of identity to expedite the determination of eligibility for public assistance and for use in public assistance fraud investigations;

(i) To the Agency for Health Care Administration pursuant to an interagency agreement for the purpose of verifying photographs in the Care Provider Background Screening Clearinghouse authorized in s. 435.12;

(j) ~~(i)~~ To the Department of Financial Services pursuant to an interagency agreement to facilitate the location of owners of unclaimed property, the validation of unclaimed property claims, and the identification of fraudulent or false claims;

(k) ~~(j)~~ To district medical examiners pursuant to an interagency agreement for the purpose of identifying a deceased individual, determining cause of death, and notifying next of

kin of any investigations, including autopsies and other laboratory examinations, authorized in s. 406.11; or

(l) ~~(k)~~ To the following persons for the purpose of identifying a person as part of the official work of a court:

1. A justice or judge of this state;

2. An employee of the state courts system who works in a position that is designated in writing for access by the Chief Justice of the Supreme Court or a chief judge of a district or circuit court, or by his or her designee; or

3. A government employee who performs functions on behalf of the state courts system in a position that is designated in writing for access by the Chief Justice or a chief judge, or by his or her designee.

Section 2. Paragraphs (f) and (g) and (h) through (q) of subsection (4) of section 408.809, Florida Statutes, are redesignated as paragraphs (g) and (h) and (k) through (t), respectively, and new paragraphs (f), (i), (j), (u), and (v) are added to that subsection to read:

408.809 Background screening; prohibited offenses.—

(4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an arrest awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for

any of the following offenses or any similar offense of another jurisdiction:

(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.

(j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.

(u) Section 895.03, relating to racketeering and collection of unlawful debts.

(v) Section 896.101, relating to the Florida Money Laundering Act.

Section 3. Subsection (5) is added to section 413.208, Florida Statutes, to read:

413.208 Service providers; quality assurance; fitness for responsibilities; background screening.—

(5) The background screening requirements of this section apply only to registrations entered into or renewed with the division after the Care Provider Background Screening Clearinghouse becomes operational and retains the background screening results in the clearinghouse pursuant to s. 435.12.

Section 4. Section 7 of chapter 2012-73, Laws of Florida, is repealed.

Section 5. Paragraphs (d) through (yy) of subsection (2) of section 435.04, Florida Statutes, are redesignated as

paragraphs (e) through (zz), respectively, paragraph (e) of subsection (1) is amended, and a new paragraph (d) is added to subsection (2) of that section, to read:

435.04 Level 2 screening standards.—

(1)

(e) Vendors who submit fingerprints on behalf of employers must:

1. Meet the requirements of s. 943.053; and

2. Have the ability to communicate electronically with the state agency accepting screening results from the Department of Law Enforcement and provide the applicant's full first name, middle initial, and last name, social security number, date of birth, mailing address, sex, and race ~~a photograph of the applicant taken at the time the fingerprints are submitted~~.

(2) The security background investigations under this section must ensure that no persons subject to the provisions of this section have been arrested for and are awaiting final disposition of, have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, or have been adjudicated delinquent and the record has not been sealed or expunged for, any offense prohibited under any of the following provisions of state law or similar law of another jurisdiction:

(d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

Section 6. Subsections (1) and (2) of section 435.07,

Florida Statutes, are amended to read:

435.07 Exemptions from disqualification.—Unless otherwise provided by law, the provisions of this section apply to exemptions from disqualification for disqualifying offenses revealed pursuant to background screenings required under this chapter, regardless of whether those disqualifying offenses are listed in this chapter or other laws.

(1)(a) The head of the appropriate agency may grant to any employee otherwise disqualified from employment an exemption from disqualification for:

1.~~(a)~~ Felonies for which at least 3 years have elapsed since the applicant for the exemption has completed or been lawfully released from confinement, supervision, or nonmonetary condition imposed by the court ~~sanction~~ for the disqualifying felony;

2.~~(b)~~ Misdemeanors prohibited under any of the statutes cited in this chapter or under similar statutes of other jurisdictions for which the applicant for the exemption has completed or been lawfully released from confinement, supervision, or nonmonetary condition imposed by the court ~~sanction~~;

3.~~(c)~~ Offenses that were felonies when committed but that are now misdemeanors and for which the applicant for the exemption has completed or been lawfully released from confinement, supervision, or nonmonetary condition imposed by the court ~~sanction~~; or

4. ~~(d)~~ Findings of delinquency. For offenses that would be felonies if committed by an adult and the record has not been sealed or expunged, the exemption may not be granted until at least 3 years have elapsed since the applicant for the exemption has completed or been lawfully released from confinement, supervision, or nonmonetary condition imposed by the court ~~sanction~~ for the disqualifying offense.

(b) A person applying for an exemption who was ordered to pay any amount for any fee, fine, fund, lien, civil judgment, application, costs of prosecution, trust, or restitution as part of the judgment and sentence for any disqualifying felony or misdemeanor must have paid the court-ordered amount in full before being eligible for the exemption.

For the purposes of this subsection, the term "felonies" means both felonies prohibited under any of the statutes cited in this chapter or under similar statutes of other jurisdictions.

(2) Persons employed, or applicants for employment, by treatment providers who treat adolescents 13 years of age and older who are disqualified from employment solely because of crimes under s. 817.563, s. 893.13, or s. 893.147 may be exempted from disqualification from employment pursuant to this chapter without application of the waiting period in subparagraph (1)(a)1 ~~paragraph (1)(a)~~.

Section 7. Paragraph (a) of subsection (2) of section 435.12, Florida Statutes, is amended, and paragraph (d) is added

to that subsection, to read:

435.12 Care Provider Background Screening Clearinghouse.—

(2)(a) To ensure that the information in the clearinghouse is current, the fingerprints of an employee required to be screened by a specified agency and included in the clearinghouse must be:

1. Retained by the Department of Law Enforcement pursuant to s. 943.05(2)(g) and (h) and (3), and the Department of Law Enforcement must report the results of searching those fingerprints against state incoming arrest fingerprint submissions to the Agency for Health Care Administration for inclusion in the clearinghouse.

2. Resubmitted for a Federal Bureau of Investigation national criminal history check every 5 years until such time as the fingerprints are retained by the Federal Bureau of Investigation.

3. Subject to retention on a 5-year renewal basis with fees collected at the time of initial submission or resubmission of fingerprints.

4. Submitted with a photograph of the person taken at the time the fingerprints are submitted.

(d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic fingerprint submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle

initial, and last name, social security number, date of birth, mailing address, sex, and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number.

Section 8. This act shall take effect July 1, 2014.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 573 Assisted Living Facilities
SPONSOR(S): Ahern
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 248

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Guzzo	Shaw
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The bill strengthens the regulation of Assisted Living Facilities (ALFs) and makes other regulatory changes to improve the quality of ALFs.

Specifically, the bill:

- Clarifies who is responsible for assuring that mental health residents in an ALF receive necessary services.
- Requires ALFs to provided information to new residents upon admission that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right.
- Creates a provisional Extended Congregate Care (ECC) license for new ALFs and specifies when the Agency for Health Care Administration (AHCA) may deny or revoke a facility's ECC license.
- Requires facilities with one or more, rather than three or more, state supported mental health residents obtain a Limited Mental Health (LMH) license.
- Allows AHCA to revoke the license of a facility with a controlling interest that has or had a 25 percent or greater financial or ownership interest in a second facility which closed due to financial inability to operate or was the subject of other specified administrative sanctions.
- Specifies circumstances under which AHCA must impose an immediate moratorium on a facility.
- Sets fines for all classes of violations to a fixed amount at the midpoint of the current range and multiplies these new fine amounts for facilities licensed for 100 or more beds by 1.5 times.
- Allows AHCA to impose a fine for a class I violation even if it is corrected before AHCA inspects a facility.
- Doubles fines for repeated serious violations.
- Requires that fines be imposed for repeat minor violations regardless of correction.
- Doubles the fines for minor violations if a facility is cited for the same minor violation three or more times over the course of three licensure inspections.
- Allows AHCA to impose a $2,500 fine against a facility that does not show good cause for terminating the residency of an individual.
- Authorizes ALF staff to perform certain additional duties to assist with self-administration of medication and increases the applicable staff training requirements from 4 hours to 6 hours.
- Adds certain responsible parties and agency personnel to the list of people who must report abuse or neglect to the Department of Children and Families' central abuse hotline.
- Requires AHCA to conduct an additional inspection of a facility cited for certain serious violations.
- Requires new facility staff, who have not previously completed core training, to attend a 2 hour pre-service orientation before interacting with residents.
- Requires the Office of Program Policy Analysis and Government Accountability to conduct a study of inter-surveyor reliability in order to determine the consistency with which regulations are applied to facilities.
- Requires AHCA to implement an ALF rating system by March 1, 2015.
- Requires AHCA to add certain content to its website by November 1, 2014, to assist consumers in selecting an ALF.

The bill has a positive fiscal impact due to increased fines; however, AHCA will require additional staff resources to implement the provisions of the legislation. The additional fine revenue is expected to exceed the cost of the additional resources.

The bill provides an effective date of July 1, 2014.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Assisted Living Facility Reform

In April of 2011, the Miami Herald completed a three part investigative series relating to assisted living facilities (ALFs). This series highlighted concerns with the management and administration of ALFs and garnered the attention of not only the public, but many state lawmakers, stakeholders, and facility residents and their families.

Assisted Living Facility Workgroups

In July 2011, Governor Rick Scott directed AHCA to examine the regulation and oversight of ALFs. In response, AHCA created the ALF workgroup. The workgroup's objective was to make recommendations to the Governor and Legislature that would improve the monitoring of safety in ALFs to help ensure the well-being of residents. After a series of meetings, the workgroup produced a final report and recommendations that they felt could strengthen oversight and reassure the public that ALFs are safe. Such recommendations included increasing administrator qualifications, expanding training for administrators and other staff, increasing survey inspection activity, and improving the integration of information among all agencies involved in the regulation of ALFs. The workgroup also noted several other issues that would require more time to evaluate and recommended they be examined by a Phase II workgroup.

Phase II of the workgroup began meeting in June 2012 to resume examining those issues not addressed by Phase I of the workgroup. Phase II of the workgroup will concluded in October, 2012 and produced a final report and recommendations to the Governor and the Legislature on November 26, 2012.

The issue of improving inter-agency communication was included in the workgroup's recommendations. Specifically, the workgroup recommended improving coordination between various federal, state and local agencies with any role in long-term care facilities oversight, especially ALFs. This includes AHCA, the Long Term Care Ombudsman Program, local fire authorities, local health departments, the Department of Children and Families (DCF), the Department of Elder Affairs (DOEA), local law enforcement and the Attorney General's Office.[1]

Assisted Living Facility Negotiated Rulemaking Committee

In June, 2012, DOEA, in consultation with AHCA, DCF, and DOH, began conducting negotiated rulemaking meetings to address ALF regulation. The purpose of the meetings was to draft and amend mutually acceptable proposed rules addressing the safety and quality of services and care provided to residents within ALFs. Most of the issues addressed by the Committee were identified by Phase I of the workgroup as areas of concern that could be reformed via the rulemaking process. The Committee produced a Final Summary Report containing all the proposed rule changes agreed upon by the Committee. These proposed rule changes are currently in the final stages of the standard proposed rule making process required by law.

[1] Florida Assisted Living Workgroup, Phase II Recommendations, November 26, 2012, available at http://www.ahca.myflorida.com/SCHSCommitteesCouncils/ALWG/index.shtm.

Assisted Living Facilities - General

An ALF is a residential establishment, or part of a residential establishment, that provides housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.[2,3] A personal service is direct physical assistance with, or supervision of, the activities of daily living and the self-administration of medication.[4] Activities of daily living include: ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks.[5]

An ALF is required to provide care and services appropriate to the needs of the residents accepted for admission to the facility.[6] The owner or facility administrator determines whether an individual is appropriate for admission to the facility based on certain criteria.[7] If a resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, as determined by the facility administrator or health care provider, the resident must be discharged in accordance with the Resident Bill of Rights.[8]

As of February 3, 2014, there were 3,035 licensed ALFs in Florida with 86,707 beds.[9] An ALF must have a standard license issued by AHCA, pursuant to part I of ch. 429, F.S., and part II of ch. 408, F.S.

Specialty Licensed Facilities

In addition to a standard license, an ALF may have one or more specialty licenses that allow the ALF to provide additional care. These specialty licenses include: limited nursing services,[10] limited mental health services,[11] and extended congregate care services.[12]

Limited Mental Health License

A mental health resident is "an individual who receives social security disability income due to a mental disorder as determined by the Social Security Administration or receives supplemental security income due to a mental disorder as determined by the Social Security Administration and receives optional state supplementation."[13] A LMH license is required for any facility serving 3 or more mental health residents. [14] To obtain this license, the facility may not have any current uncorrected deficiencies or violations and facility administrator, as well as staff providing direct care to residents must complete 6 hours of training related to LMH duties, which is either provided by or approved by DCF.[15] A LMH license can be obtained during initial licensure, during relicensure, or upon request of the licensee.[16] There are 1,022 facilities with LMH licenses.[17]

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[2] Section 429.02(5), F.S.
[3] An ALF does not include an adult family-care home or a non-transient public lodging establishment.
[4] Section 429.02(16), F.S.
[5] Section 429.02(1), F.S.
[6] For specific minimum standards see Rule 58A-5.0182, F.A.C.
[7] S. 429.26, F.S., and Rule 58A-5.0181, F.A.C.
[8] S. 429.28, F.S.
[9] Agency for Health Care Administration, *Assisted Living Directory* (February 3, 2014), available at http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Assisted_Living/docs/alf/Directory_ALF.pdf (last visited February 7, 2014).
[10] S. 429.07(3)(c), F.S.
[11] S. 429.075, F.S.
[12] Section 429.07(3)(b), F.S.
[13] S. 429.02, F.S.
[14] S. 429.075, F.S.
[15] S. 429.075, F.S.
[16] S. 429.075, F.S.
[17] *See* Agency for Health Care Administration, *Assisted Living Facility*, available at http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Assisted_Living/alf.shtml (last visited February 7, 2014).

Extended Congregate Care License

The ECC specialty license allows an ALF to provide, directly or through contract, services performed by licensed nurses and supportive services to individuals who would otherwise be disqualified from continued residency in an ALF.[18] There are 277 facilities with ECC licenses.[19]

In order for ECC services to be provided, AHCA must first determine that all requirements in law and rule are met. ECC licensure is regulated pursuant to s. 429.07, F.S., and Rule 58A-5, F.A.C.

The primary purpose of ECC services is to allow residents, as their acuity level rises, to remain in a familiar setting. An ALF licensed to provide ECC services may also admit an individual who exceeds the admission criteria for a facility with a standard license, if the individual is determined appropriate for admission to the ECC facility. A licensed facility must adopt its own requirements within guidelines for continued residency set forth by rule. However, the facility may not serve residents who require 24-hour supervision.

Licensed ECC facilities may provide the following additional services:[20]

- Total help with bathing, dressing, grooming, and toileting;
- Nursing assessments conducted more frequently than monthly;
- Measuring and recording basic vital functions and weight;
- Dietary management, including providing special diets, monitoring nutrition, and observing the resident's food and fluid intake and output;
- Assisting with self-administered medications;
- Supervising residents with dementia and cognitive impairments;
- Health education, counseling, and implementing health-promoting programs;
- Rehabilitative services; and
- Escort services to health-related appointments.

Before being admitted to an ECC licensed facility to receive ECC services, the prospective resident must undergo a medical examination.[21] The ALF must develop a service plan that sets forth how the facility will meet the resident's needs and must maintain a written progress report on each resident who receives ECC services.

ALFs with an ECC license must meet the following staffing requirements:[22]

- Specify a staff member to serve as the ECC supervisor if the administrator does not perform this function;
- The administrator of an ECC licensed facility must have a minimum of 2 years of managerial, nursing, social work, therapeutic recreation, or counseling experience in a residential, long-term care, or acute care setting; and
- A baccalaureate degree may be substituted for one year of the required experience and a nursing home administrator licensed under chapter 468, F.S., shall be considered qualified.

An ECC administrator or supervisor, if different from the administrator, must complete the core training required of a standard licensed ALF administrator (26 hours plus a competency test), and 4 hours of initial training in ECC care within 3 months of beginning employment. The administrator must complete a minimum of 4 hours of continued education every 2 years. [23]

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[18] S. 429.07(3)(b), F.S.
[19] *See supra* at FN 17.
[20] Rule 58A-5.030(8)(b), F.A.C.
[21] Rule 58A-5.030(6), F.A.C.
[22] Rule 58A-5.030(4), F.A.C.
[23] Rule 58A-5.0191(7), F.A.C.

All staff providing direct ECC care to residents must complete at least 2 hours of initial service training, provided by the administrator, within 6 months of beginning employment.[24]

ALFs with a standard license must pay a biennial license fee of $300 per license, with an additional fee of $50 per resident. The total fee may not exceed $10,000. In addition to the total fee assessed for standard licensed ALFs, facilities providing ECC services must pay an additional fee of $400 per license, with an additional fee of $10 per resident.[25]

Limited Nursing Services License

Limited nursing services are services beyond those provided by standard licensed ALFs. A facility with a LNS specialty license may provide the following services:[26]

- Passive range of motion exercises;
- Ice caps or heat relief;
- Cutting toenails of diabetic residents;
- Ear and Eye irrigations;
- Urine dipstick tests;
- Replacement of urinary catheters;
- Digital stool removal therapies;
- Applying and changing routine dressings that do not require packing or irrigation;
- Care for stage 2 pressure sores;
- Caring for casts, braces and splints;
- Conducting nursing assessments;
- Caring for and monitoring the application of anti-embolism stockings or hosiery;
- Administration and regulation of portable oxygen;
- Applying, caring for and monitoring a transcutaneous electric nerve stimulator; and
- Catheter, colostomy, ileostomy care and maintenance.

A facility holding only a standard or LNS license must meet the admission and continued residency criteria contained in Rule 59A-5.0181, F.A.C.[27] The following admission and continued residency criteria for potential residents must be met:[28]

- Be at least 18 years of age;
- Be free from signs and symptoms of any communicable disease;
- Be able to perform the activities of daily living;
- Be able to transfer, with assistance if necessary;
- Be capable of taking their own medications with assistance from staff if necessary;
- Not be a danger to themselves or others;
- Not require licensed professional mental health treatment on a 24-hour a day basis;
- Not be bedridden;
- Not have any stage 3 or 4 pressure sores;
- Not require nursing services for oral or other suctioning, assistance with tube feeding, monitoring of blood gases, intermittent positive pressure breathing therapy, or treatment of surgical incisions or wounds;
- Not require 24-hour nursing supervision;
- Not require skilled rehabilitative services; and

[24] *Id.*
[25] S.429.07(4), F.S.
[26] Rule 58A-5.031(1), F.A.C.
[27] Rule 58A-5.031(2), F.A.C.
[28] Rule 58A-5.0181(1), F.A.C.

- Have been determined by the administrator to be appropriate for admission to the facility.

Facilities licensed to provide limited nursing services must employ or contract with a nurse to provide necessary services to facility residents.[29] Licensed LNS facilities must maintain written progress reports on each resident receiving LNS. A registered nurse representing AHCA must visit these facilities at least twice a year to monitor residents and determine compliance.[30] A nursing assessment must be conducted at least monthly on each resident receiving limited nursing services.[31]

Facilities licensed to provide LNS must pay the standard licensure fee of $300 per license, with an additional fee of $50 per resident and the total fee may not exceed $10,000. In addition to the standard fee, in order to obtain the LNS specialty license facilities must pay an additional biennial fee of $250 per license, with an additional fee of $10 per bed.[32] There are 999 facilities with LNS licenses.[33]

Staff Training

Administrators and Managers

Administrators and other ALF staff must meet minimum training and education requirements established by the DOEA by rule.[34,35] This training and education is intended to assist facilities to appropriately respond to the needs of residents, maintain resident care and facility standards, and meet licensure requirements.[36]

The current ALF core training requirements established by the DOEA consist of a minimum of 26 hours of training and passing a competency test. Administrators and managers must successfully complete the core training requirements within 3 months after becoming a facility administrator or manager. The minimum passing score for the competency test is 75 percent.[37]

Administrators and managers must participate in 12 hours of continuing education in topics related to assisted living every 2 years. A newly hired administrator or manager, who has successfully completed the ALF core training and continuing education requirements, is not required to retake the core training. An administrator or manager, who has successfully completed the core training but has not maintained the continuing education requirements, must retake the ALF core training and retake the competency test.[38]

Staff with Direct Care Responsibilities

Facility administrators or managers are required to provide or arrange for 6 hours of in-service training for facility staff who provide direct care to residents. The training covers a variety of topics as provided by rule.[39] Staff training requirements must generally be met within 30 days after staff begin employment at the facility, however, staff must have at least 1 hour of infection control training before providing direct care to residents. Also, nurses, certified nursing assistants, and home health aides who are on staff with an ALF are exempt from many of the training requirements. In addition to the standard 6 hours of in-service training, staff must also complete 1 hour of elopement training and 1 hour of training

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[29] Rule 58A-5.031(2), F.A.C.
[30] S. 429.07(2)(c), F.S.
[31] *Id.*
[32] S. 429.07(4)(c), F.S.
[33] *See supra* at FN 17.
[34] Rule 58A-5.0191, F.A.C.
[35] Many of the training requirements in rule may be subject to change due to the recent DOEA negotiated rulemaking process.
[36] Section 429.52(1), F.S.
[37] Administrators who have attended core training prior to July 1, 1997, and managers who attended the core training program prior to April 20, 1998, are not required to take the competency test. Administrators licensed as nursing home administrators in accordance with Part II of Chapter 468, F.S., are exempt from this requirement.
[38] Rule 58A-5.0191, F.A.C.
[39] See note 26.

on do not resuscitate orders, and may have to complete training on special topics such as self-administration of medication and persons with Alzheimer's disease, if applicable.

ECC Specific Training

The administrator and ECC supervisor, if different from the administrator, must complete 4 hours of initial training in extended congregate care prior to the facility receiving its ECC license or within 3 months after beginning employment in the facility as an administrator or ECC supervisor. They must also complete a minimum of 4 hours of continuing education every 2 years in topics relating to the physical, psychological, or social needs of frail elderly and disabled persons, or persons with Alzheimer's disease or related disorders.[40]

All direct care staff providing care to residents in an ECC program must complete at least 2 hours of in-service training, provided by the facility administrator or ECC supervisor, within 6 months after beginning employment in the facility. The training must address ECC concepts and requirements, including the delivery of personal care and supportive services in an ECC facility.[41]

LMH Specific Training

Administrators, managers, and staff, who have direct contact with mental health residents in a licensed LMH facility must receive a minimum of 6 hours of specialized training in working with individuals with mental health diagnoses and a minimum of 3 hours of continuing education dealing with mental health diagnoses or mental health treatment every 2 years.[42]

Inspections and Surveys

AHCA is required to conduct a survey, investigation, or monitoring visit of an ALF:

- Prior to the issuance of a license.
- Prior to biennial renewal of a license.
- When there is a change of ownership.
- To monitor facilities licensed to provide LNS or ECC services, or facilities cited in the previous year for a class I or class II, or four or more uncorrected class III, violations.[43]
- Upon receipt of an oral or written complaint of practices that threaten the health, safety, or welfare of residents.
- If AHCA has reason to believe a facility is violating a provision of part III of ch. 429, F.S., relating to adult day care centers, or an administrative rule.
- To determine if cited deficiencies have been corrected.
- To determine if a facility is operating without a license.[44]

Abbreviated Surveys

An applicant for licensure renewal is eligible for an abbreviated biennial survey by AHCA if the applicant does not have any:

- Class I or class II violations or uncorrected class III violations.
- Confirmed long-term care ombudsman council complaints reported to AHCA by the council.
- Confirmed licensing complaints within the two licensing periods immediately preceding the current renewal date.[45]

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[40] Rule 58A-5.0191(7)(b), F.A.C.
[41] Rule 58A-5.0191(7)(c), F.A.C.
[42] S. 429.075, F.S. and Rule 58A-5.0191(8), F.A.C.
[43] *See below* information under subheading "Violations and Penalties" for a description of each class of violation.
[44] *See* s. 429.34, F.S., and Rule 58A-5.033, F.A.C.
[45] Rule 58A-5.033(2), F.A.C.

An abbreviated survey allows for a quicker and less intrusive survey by narrowing the range of items that AHCA must inspect.[46] AHCA is required to expand an abbreviated survey or conduct a full survey if violations which threaten or potentially threaten the health, safety, or security of residents are identified during an abbreviated survey.[47]

Monitoring Visits

Facilities with LNS or ECC licenses are subject to monitoring visits by AHCA in which the agency inspects the facility for compliance with the requirements of the specialty license type. An LNS licensee is subject to monitoring inspections at least twice a year. At least one registered nurse must be included in the inspection team to monitor residents receiving LNS and to determine if the facility is complying with applicable regulatory requirements.[48] An ECC licensee is subject to quarterly monitoring inspections. At least one registered nurse must be included in the inspection team. AHCA may waive one of the required yearly monitoring visits for an ECC facility that has been licensed for at least 24 months, if the registered nurse who participated in the monitoring inspections determines that the ECC services are being provided appropriately, and there are no serious violations or substantiated complaints about the quality of service or care.[49]

Violations and Penalties

Part II of ch. 408, F.S., provides general licensure standards for all facilities regulated by AHCA. Under s. 408.813, F.S., ALFs may be subject to administrative fines imposed by AHCA for certain types of violations. Violations are categorized into four classes according to the nature of the violation and the gravity of its probable effect on residents.

- Class I violations are those conditions that AHCA determines present an imminent danger to residents or a substantial probability of death or serious physical or emotional harm. Examples include resident death due to medical neglect, risk of resident death due to inability to exit in an emergency, and the suicide of a mental health resident in an ALF licensed for Limited Mental Health. AHCA must issue a fine between $5,000 and $10,000 for each violation.
- Class II violations are those conditions that AHCA determines directly threaten the physical or emotional health, safety, or security of the clients. Examples include having no qualified staff in the facility, the failure to call 911 in a timely manner for resident in a semi-comatose state, and rodents in food storage area. AHCA must issue a fine a between $1,000 and $5,000 for each violation.
- Class III violations are those conditions that AHCA determines indirectly or potentially threaten the physical or emotional health, safety, or security of clients. Examples include missing or incomplete resident assessments, erroneous documentation of medication administration, and failure to correct unsatisfactory DOH food service inspection findings in a timely manner. AHCA must issue a fine between $500 and $1,000 for each violation, but no fine may be imposed if the facility corrects the violation.
- Class IV violations are those conditions that do not have the potential of negatively affecting clients. Examples include failure to file an adverse incident report, incorrect phone numbers posted for advocacy resources, and failure to post current menus. AHCA can only fine a facility (between $100 and $200 for each violation) if the problem is not corrected. [50,51]

[46] Rule 58A-5.033(2)(b)
[47] *Id.*
[48] S. 429.07(3)(c), F.S.
[49] S. 429.07(3)(b), F.S.
[50] When fixing the amount of the fine, AHCA must consider the following factors: the gravity of the violation and the extent to which any laws or rules were violated, actions taken to correct the violations, any previous violations, the financial benefit of committing or continuing the violation, and the licensed capacity of the facility. Section 429.19(3), F.S.
[51] Section 429.19(2), F.S.

Violations for Fiscal Years 2011-13

	Class I Violations	Class II Violations	Class III Violations	Class IV Violations
Total Violations	115	749	507	18
Average Fine Amount ALFs With Less than 100 beds	$6,585	$1,542	$766	$165
Average Fine Amount ALFs With More Than 100 Beds	$7,454	$1,843	$614	$100

In addition to financial penalties, AHCA can take other actions against a facility. AHCA may deny, revoke, and suspend any license for any of the actions listed in s. 429.14(1)(a)-(k), F.S. AHCA is required to deny or revoke the license of an ALF that has two or more class I violations that are similar to violations identified during a survey, inspection, monitoring visit, or complaint investigation occurring within the previous 2 years.[52] AHCA may also impose an immediate moratorium or emergency suspension on any provider if it determines that any condition presents a threat to the health, safety, or welfare of a client.[53] AHCA is required to publicly post notification of a license suspension or revocation, or denial of a license renewal, at the facility.[54] Finally, Florida's Criminal Code, under ch. 825, F.S., provides criminal penalties for the abuse, neglect, and exploitation of elderly persons[55] and disabled adults.[56]

ALF License Suspensions, Revocations, Denials, Failed to Renew and Closed

	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13	Total
Suspensions	2	1	2	5	6	16
Revocations	4	12	7	17	15	55
Denials	11	7	5	9	12	44
Closed/Failed to Renew During Legal Case	37	40	46	38	28	189
Total	54	60	60	69	61	304

Central Abuse Hotline

The Department of Children and Families is required under s. 415.103, F.S., to establish and maintain a central abuse hotline to receive reports, in writing or through a single statewide toll-free telephone number, of known or suspected abuse, neglect, or exploitation of a vulnerable adult[57] at any hour of the day or night, any day of the week.[58] Persons listed in s. 415.1034, F.S., who know, or have reasonable

[52] Section 429.14(4), F.S.
[53] Section 408.814, F.S.
[54] Section 429.14(7), F.S.
[55] "Elderly person" means a person 60 years of age or older who is suffering from the infirmities of aging as manifested by advanced age or organic brain damage, or other physical, mental, or emotional dysfunction, to the extent that the ability of the person to provide adequately for the person's own care or protection is impaired. Section 825.101(5), F.S. It does not constitute a defense to a prosecution for any violation of this chapter that the accused did not know the age of the victim. Section 825.104, F.S.
[56] "Disabled adult" means a person 18 years of age or older who suffers from a condition of physical or mental incapacitation due to a developmental disability, organic brain damage, or mental illness, or who has one or more physical or mental limitations that restrict the person's ability to perform the normal activities of daily living. Section 825.101(4), F.S.
[57] "Vulnerable adult" means a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging. Section 415.102(27), F.S.
[58] The central abuse hotline is operated by the DCF to: accept reports for investigation when there is a reasonable cause to suspect that a vulnerable adult has been or is being abused, neglected, or exploited; determine whether the allegations require an immediate, 24-hour, or next-working-day response priority; when appropriate, refer calls that do not allege the abuse, neglect, or exploitation of a

cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited are required to immediately report such knowledge or suspicion to the central abuse hotline.[59]

Long-Term Care Ombudsman Program

The Federal Older Americans Act (OAA) requires each state to create a Long-Term Care Ombudsman Program to be eligible to receive funding associated with programs under the OAA.[60] In Florida, the program is a statewide, volunteer-based system of district councils that protect, defend, and advocate on behalf of long-term care facility residents, including residents of nursing homes, ALFs, and adult family-care homes. The ombudsman program is administratively housed in the DOEA and is headed by the State Long-Term Care Ombudsman, who is appointed by the DOEA Secretary.[61] The ombudsman program is required to establish a statewide toll-free telephone number for receiving complaints concerning matters adversely affecting the health, safety, welfare, or rights of residents of ALFs, nursing homes, and adult family care homes. Every resident or representative of a resident must receive, upon admission to a long-term care facility, information regarding the program and the statewide toll-free telephone number for receiving complaints.[62] The names or identities of the complainants or residents involved in a complaint, including any problem identified by an ombudsman council as a result of an investigation, are confidential and exempt from Florida's public records laws, unless the complainant or resident, or the legal representative of the complainant or resident, consents to the disclosure, or the disclosure is required by court order.[63] In addition to investigating and resolving complaints, ombudsmen conduct unannounced visits to assess the quality of care in facilities, referred to as administrative assessments.

Effect of Proposed Changes

The bill amends s. 394.4574, F.S., to clarify that Medicaid prepaid behavioral health plans are responsible for enrolled state supported mental health residents and that managing entities under contract with the DCF are responsible for such residents who are not enrolled with a Medicaid prepaid behavioral health plan. This section requires a mental health resident's community living support plan be completed and provided to the administrator of the facility when the facility admits a mental health resident and be updated when there is a significant change to the resident's behavioral health status. The resident's case manager must keep a 2-year record of any face-to-face interaction with the resident. Finally, this section charges the entity responsible for a mental health resident to ensure that there is adequate and consistent monitoring of the community living support plan and to report any concerns about a regulated provider failing to provide services or otherwise acting in a manner with the potential to cause harm to the resident.

The bill amends s. 400.0074, F.S., to require the administrative assessment performed by the Long-Term Care Ombudsman to be comprehensive. Further, the bill requires the local Ombudsman to conduct an exit consultation with the long-term care facility administrator.

The bill amends s. 400.0078, F.S., to require that ALFs provide information to new residents upon admission to the facility that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right.

The bill amends s. 429.07, F.S., to make changes to improve the regulation of facilities with ECC and LNS specialty licenses. These changes include:

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vulnerable adult to other organizations that might better resolve the reporter's concerns; immediately identify and locate prior reports of abuse, neglect, or exploitation through the central abuse hotline; Section 415.103(1), F.S.

[59] Section 415.1034, F.S.

[60] 42 U.S.C. 3058, et. seq.. *See also* s. 400.0061(1), F.S.

[61] Section 400.0063, F.S.

[62] Section 400.0078(2), F.S.

[63] Section 400.0077(1)(b), F.S.

- Requiring that an ALF be licensed for 2 or more years before being issued an ECC license that is not provisional.
- Clarifying under what circumstances AHCA may deny or revoke a facility's ECC license.
- Creating a provisional ECC license for ALFs that have been licensed for less than 2 years.
- The provisional license lasts for a period of 6 months.
- The facility must inform AHCA when it has admitted one or more residents requiring ECC services.
- After the facility admits one or more ECC residents, AHCA must inspect the facility for compliance with the requirements of the ECC license.
- If the licensee demonstrates compliance with the requirements of an ECC license, AHCA must grant the facility an ECC license.
- If the licensee fails to demonstrate compliance with the requirements of an ECC license or fails to admit an ECC resident within 3 months, the licensee must immediately suspend ECC services and the provisional ECC license expires.
- Authorizing AHCA to extend a provisional ECC license for 1 month in order to compete a follow-up visit.
- Reducing monitoring visits for facilities with ECC licenses from quarterly to twice a year, and for facilities with LNS licenses from twice a year to once a year.
- Clarifying under what circumstances AHCA may waive one of the required monitoring visits for facilities with ECC licenses and also allowing AHCA to waive the required monitoring visit for facilities with an LNS license under the same conditions.

The bill amends s. 429.075, F.S., to require facilities with one or more, instead of three or more, mental health residents to obtain a LMH license.

The bill amends s. 429.14, F.S., to:

- Allow AHCA to revoke, rather than just deny, a license for a facility with a controlling interest that has, or had, a 25 percent or greater financial or ownership interest in a second facility that closed due to financial inability to operate or was the subject of other specified administrative sanctions.
- Add additional criteria under which AHCA must deny or revoke a facility's license. The criteria include:
    - There are 2 moratoria issued within a 2-year period.
    - The facility is cited for 2 or more class I violations arising from unrelated circumstances during the same investigation.
    - The facility is cited for 2 or more class I violations within 2 years.
- Require AHCA to impose an immediate moratorium on a facility that fails to provide AHCA with access to the facility, prohibits a regulatory inspection, denies access to records, or prohibits the confidential interview of facility staff or residents.
- Exempt a facility from the 45-day notice requirement in s. 429.28(k), F.S., if that facility is required to relocate all or some of its residents due to action by AHCA.

The bill amends s. 429.19, F.S., relating to the impositions of fines in order to reduce the discretion of AHCA and to make such penalties more predictable. Specifically, the bill would:

- Amend the dollar amount for fines at $7,500 for class I violations, $3,000 for class II violations, $750 for class III violations, and $150 for class IV violations for facilities licensed for few than 100 beds at the time of the violation. This is the midpoint of the current ranges for fines in current law.
- Multiply fine amounts by 1.5 times for facilities licensed for 100 or more beds, so that the fine is $11,250 for class I violations, $4,500 for class II violations, $1,125 for class IV violations, and $225 for class IV violations.

- Allow AHCA to impose a fine on a facility for a class I violation, even if the facility corrects the violation before the AHCA conducts an investigation. Facilities can still challenge such fines through an administrative hearing pursuant to ch.120, F.S.
- Double the fines for facilities with repeat class I and class II violations.
- Allow AHCA to impose a fine on facilities with repeat class III and class IV violations, regardless of correction. Current law prohibiting AHCA from assessing fines for corrected class III and IV violations continues for the first survey finding such violations.
- Allow AHCA to double the fines for class III or class IV violations if a facility is cited for two or more such violations, stemming from the same regulation, during AHCA's last two licensure inspections.
- Fine a facility $500 for failure to comply with background screening requirements. This fine will take the place of fines based on the class of the violation.

The bill amends s. 429.256, F.S., to allow all facility staff who have received the required training to provide several additional services in assisting with self-administration of medication.[64] Specifically, the additional duties are:

- Taking a prefilled insulin syringe from its place of storage and bringing it to a resident;
- Removing the cap of a nebulizer, opening the unit dose of nebulizer solution, and pouring the pre-measured dose of medication into the dispensing cup of the nebulizer;
- Assisting a resident in using a nebulizer;
- Using a glucometer to perform blood glucose checks;
- Assisting with anti-embolism stockings;
- Assisting with applying and removing an oxygen cannula;
- Assisting with the use of a continuous positive airway pressure device;
- Assisting with the measuring of vital signs; and
- Assisting with the use of colostomy bags.

The bill also increases the training requirements for staff who assist residents with medication from 4 to 6 hours.

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

[64] Staff involved with the management of medications and assisting with the self-administration of medications under s. 429.256, F.S., must complete a minimum of 4 additional hours of training provided by a registered nurse, licensed pharmacist, or department staff. The department shall establish by rule the minimum requirements of this additional training. Section 429.52(5), F.S. Unlicensed persons who will be providing assistance with self-administered medications must meet the training requirements pursuant to s. 429.52(5), F.S., prior to assuming this responsibility. Courses provided in fulfillment of this requirement must meet the following criteria: Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques and provide opportunities for hands-on learning through practice exercises. The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates an ability to: Read and understand a prescription label; Provide assistance with self-administration in accordance with Section 429.256, F.S., and Rule 58A-5.0185, F.A.C., including: Assist with oral dosage forms, topical dosage forms, and topical ophthalmic, otic and nasal dosage forms; Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; Recognize the need to obtain clarification of an "as needed" prescription order; Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; Complete a medication observation record; Retrieve and store medication; and Recognize the general signs of adverse reactions to medications and report such reactions. Unlicensed persons, as defined in Section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 4 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training shall only be provided by a licensed registered nurse, or a licensed pharmacist. Rule 58A-5.0191(5), F.A.C.

fine of $2,500, which is imposed if a facility cannot show good cause in state court for terminating the residency of an individual who has exercised an enumerated right.

The bill amends s. 429.34, F.S., to require certain state officials, such as Medicaid Fraud investigators and state or local fire marshals, to report any knowledge or reasonable suspicion that a vulnerable adult has been or is being abused, neglected, or exploited to the DCF central abuse hotline.

The bill provides that a facility having one or more class I violations, two or more class II violations arising from separate surveys within a 60-day period, or two or more unrelated class II violations cited during one survey be subject to an additional inspection within 6 months. The licensee must pay a fee to AHCA to cover the cost of the additional inspection.

The bill amends s. 429.41, F.S., to clarify that ALF staffing requirements for a continuing care facility or retirement community apply only to residents who receive personal limited nursing services or extended congregate care services.

The bill amends s. 429.52, F.S., to require facilities to provide a 2-hour pre service orientation for all new facility employees who have not previously completed core training. The pre-service orientation must cover topics that help the employee provide responsible care and respond to the needs of the residents. The employee and the facility's administrator must sign a statement that the new ALF staff member has completed the pre-service orientation. The signed statement must be kept in that staff member's file. The bill clarifies that the pre-service orientation can be provided by the ALF instead of requiring that it be provided by a trainer registered with DOEA.

The bill creates a new, unnumbered section of statute which requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) to conduct a study of inter-surveyor reliability to determine if different surveyors consistently apply licensure standards. The bill requires OPPAGA to report its findings and make recommendations to the Governor, the President of the Senate, and the Speaker of the House by November 1, 2014.

The bill creates a new, unnumbered section of statute which provides Legislative findings that consumers need additional information in order to select an ALF. To facilitate this, the bill requires AHCA to implement a rating system for ALFs by March 1, 2015. This section also requires AHCA to create a consumer guide website, which contains information on each licensed ALF, including, but not limited to:

- The name and address of the facility;
- The number and type of licensed beds in the facility;
- The types of licenses held by the facility;
- The facility's license expiration date and status;
- Affiliations with any other organization who owns or manages more than one ALF in Florida;
- The total number of clients that the facility is licensed to serve and the most recent occupancy levels;
- The number of private and semi-private rooms offered;
- The bed-hold policy;
- The religious affiliation, if any, of the ALF;
- The languages spoken by the staff;
- Availability of nurses;
- Forms of payment accepted;
- Identification if the licensee is operating under bankruptcy protection;
- Recreational and other programs available;
- Special care units or programs offered;
- Availability of mental health services;
- Whether the facility is part of a retirement community that offers other services;

- Links to the State Long-Term Care Ombudsman Program website and the program's statewide toll-free telephone number;
- Links to the internet websites of the providers or their affiliates;
- Other relevant information currently collected by AHCA; and
- Survey and violation information including a list of the facility's violations committed during the previous 60 months, which must be updated monthly.

B. SECTION DIRECTORY:

Section 1: Amends s. 394.4574, F.S., relating to responsibilities for coordination of services for a mental health resident who resides in an assisted living facility that holds a limited mental health license.

Section 2: Amends s. 400.0074, F.S., relating to local ombudsman council onsite administrative assessments.

Section 3: Amends s. 400.0078, F.S., relating to citizen access to State Long-Term Care Ombudsman Program services.

Section 4: Amends s. 429.07, F.S., relating to license required; fee.

Section 5: Amends s. 429.075, F.S., relating to limited mental health licenses.

Section 6: Amends s. 429.14, F.S., relating to administrative penalties.

Section 7: Amends s. 429.178, F.S., relating to special care for persons with Alzheimer's disease or other related disorders.

Section 8: Amends s. 429.19, F.S., relating to violations; imposition of administrative fines; grounds.

Section 9: Amends s. 429.256, F.S., relating to assistance with self-administration of medication.

Section 10: Amends s. 429.28, F.S., relating to resident bill of rights.

Section 11: Amends s. 429.34, F.S., relating to right of entry and inspection.

Section 12: Amends s. 429.41, F.S., relating to rules establishing standards.

Section 13: Amends s. 429.52, F.S., relating to staff training and educational programs; and core educational requirements.

Section 14: In an unnamed section of law, requiring Office of Program Policy Analysis and Government Accountability to conduct a study of survey reliability for assisted living facilities and submit a report of its findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives by November 1, 2014.

Section 15: In an unnamed section of law, requiring the Agency for Health Care Administration to implement a rating system for assisted living facilities and to include certain information on their website about each licensed facility to assist consumers in selecting the best facility for themselves or their loved ones.

Section 16: Provides an effective date of July 1, 2014

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The bill amends the administrative penalties and fines for all classes of violations. AHCA estimates there will be minimal fiscal increase from the fines on facilities with less than 100 beds. Facilities that exceed 100 beds will have their fine amounts increased over the current maximum fees for certain violations. Over a six year period, beginning in Fiscal Year 2006-07, in excess of $5.4 million in fines and penalties have been imposed on ALFs, with over $1.6 million imposed in FY

2011-12. Fine revenues of $354,883 for the first year and $245,098 for each recurring year are expected and will provide sufficient revenues to pay for the expenses of the proposed legislation.[65]

2. Expenditures:

AHCA estimates an increase in the number of legal cases that will be generated as a result of the increased administrative penalties and fines. AHCA anticipates that an additional 143 legal cases will be created and will need two full-time equivalent Senior Attorney positions to process the additional cases. The total fiscal impact is $159,308 for Year 1 and $151,322 for each recurring year. AHCA estimates that the additional fines collected will exceed the cost of the two full-time equivalent positions.[66]

Additionally, AHCA has indicated that they will need one full-time equivalent Health Services and Facilities Consultant position to implement the assisted living facility rating system and create AHCA's ALF webpage. The fiscal impact is $65,295 for year one and $61,302 for each recurring year. AHCA would also require contracted services for the development and maintenance of the consumer information webpage. The total impact for implementation of an ALF rating system and consumer information webpage is $130,280 for year one and $32,474 for each recurring year.[67]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill revises fines used to sanction facilities with violations, but such fines can still be challenged and settled through ch. 120, F.S. Facilities with fewer than 100 beds with class I violations will now be assessed a fine of $7,500 (current law allows the fine to be between $5,000 and $10,000). Some facilities will see a reduction in their fine, while other will see an increase. The range for fines for class II, III, and IV violations are replaced with an amount equal to the midpoint of the range. Fines for facilities with 100 beds or more will see higher fines.

Facilities would also be assessed a fine for class I violations even if they are corrected when the AHCA visits the facility. Facilities violating the background screening requirements would be levied a fine of $500. Currently, facilities are cited for a class II or III violation for not screening the background of facility staff so the fine amount can vary. All fines are subject to challenge through an administrative hearing under ch. 120, F.S.

Facilities would be required to provide new employees that have not already gone through the ALF core training program with a 2 hour pre-service training session before they work with residents. The cost of this training is not expected to be significant and in many cases is already provided.

Facilities with specialty licenses that meet licensure standards would see fewer monitoring visits from the AHCA. This will positively impact the facilities as they will have less interruption of staff time due to such visits.

[65] Agency for Health Care Administration Legislative Bill Analysis for HB 573, November 26, 2013.
[66] *Id.*
[67] *Id.*

Facilities with any state supported mentally ill residents would have to meet limited mental health licensure requirements with one or more mental health residents. Facilities with one or two state supported mentally ill residents that do not meet these requirements may see increased costs to comply. Some facilities with one or two such residents however, may already meet the requirements for a limited mental health license.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

No additional rule-making authority is necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

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

reported to the appropriate regulatory oversight organization under certain circumstances; amending s. 400.0074, F.S.; requiring that an administrative assessment conducted by a local council be comprehensive in nature and focus on factors affecting the rights, health, safety, and welfare of nursing home residents; requiring a local council to conduct an exit consultation with the facility administrator or administrator designee to discuss issues and concerns in areas affecting the rights, health, safety, and welfare of residents and make recommendations for improvement; amending s. 400.0078, F.S.; requiring that a resident or a representative of a resident of a long-term care facility be informed that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right; amending s. 429.07, F.S.; requiring that an extended congregate care license be issued to certain facilities that have been licensed as assisted living facilities under certain circumstances and authorizing the issuance of such license if a specified condition is met; providing the purpose of an extended congregate care license; providing that the initial extended congregate care license of an assisted living facility is provisional under certain circumstances; requiring a licensee to

notify the Agency for Health Care Administration if it accepts a resident who qualifies for extended congregate care services; requiring the agency to inspect the facility for compliance with the requirements of an extended congregate care license; requiring the issuance of an extended congregate care license under certain circumstances; requiring the licensee to immediately suspend extended congregate care services under certain circumstances; requiring a registered nurse representing the agency to visit the facility at least twice a year, rather than quarterly, to monitor residents who are receiving extended congregate care services; authorizing the agency to waive one of the required yearly monitoring visits under certain circumstances; authorizing the agency to deny or revoke a facility's extended congregate care license; requiring a registered nurse representing the agency to visit the facility at least annually, rather than twice a year, to monitor residents who are receiving limited nursing services; providing that such monitoring visits may be conducted in conjunction with other agency inspections; authorizing the agency to waive the required yearly monitoring visit for a facility that is licensed to provide limited nursing services under certain circumstances; amending s. 429.075, F.S.; requiring an assisted living facility

that serves one or more mental health residents to obtain a limited mental health license; amending s. 429.14, F.S.; revising the circumstances under which the agency may deny, revoke, or suspend the license of an assisted living facility and impose an administrative fine; requiring the agency to deny or revoke the license of an assisted living facility under certain circumstances; requiring the agency to impose an immediate moratorium on the license of an assisted living facility under certain circumstances; deleting a provision requiring the agency to provide a list of facilities with denied, suspended, or revoked licenses to the Department of Business and Professional Regulation; exempting a facility from the 45-day notice requirement if it is required to relocate some or all of its residents; amending s. 429.178, F.S.; conforming cross-references; amending s. 429.19, F.S.; revising the amounts and uses of administrative fines; requiring the agency to levy a fine for violations that are corrected before an inspection if noncompliance occurred within a specified period of time; deleting factors that the agency is required to consider in determining penalties and fines; amending s. 429.256, F.S.; revising the term "assistance with self-administration of medication" as it relates to the Assisted Living

Facilities Act; amending s. 429.28, F.S.; providing notice requirements to inform facility residents that the identity of the resident and complainant in any complaint made to the State Long-Term Care Ombudsman Program or a local long-term care ombudsman council is confidential and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right; requiring that a facility that terminates an individual's residency after the filing of a complaint be fined if good cause is not shown for the termination; amending s. 429.34, F.S.; requiring certain persons to report elder abuse in assisted living facilities; requiring the agency to regularly inspect every licensed assisted living facility; requiring the agency to conduct more frequent inspections under certain circumstances; requiring the licensee to pay a fee for the cost of additional inspections; requiring the agency to annually adjust the fee; amending s. 429.41, F.S.; providing that certain staffing requirements apply only to residents in continuing care facilities who are receiving the relevant service; amending s. 429.52, F.S.; requiring each newly hired employee of an assisted living facility to attend a preservice orientation provided by the assisted living facility; requiring the employee and administrator to sign a

statement that the employee completed the required pre-service orientation and keep the signed statement in the employee's personnel record; requiring additional hours of training for assistance with medication; conforming a cross-reference; creating s. 429.55, F.S.; requiring the Office of Program Policy Analysis and Government Accountability to study the reliability of facility surveys and submit to the Governor and the Legislature its findings and recommendations; requiring the agency to implement a rating system of assisted living facilities by a specified date, adopt rules, and create content for the agency's website that makes available to consumers information regarding assisted living facilities; providing criteria for the content; providing an effective date.

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

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

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

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

receives social security disability income due to a mental disorder as determined by the Social Security Administration or receives supplemental security income due to a mental disorder as determined by the Social Security Administration and receives optional state supplementation.

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

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

(b) A cooperative agreement, as required in s. 429.075, is developed by ~~between~~ the mental health care services provider that serves a mental health resident and the administrator of

the assisted living facility with a limited mental health license in which the mental health resident is living. ~~Any entity that provides Medicaid prepaid health plan services shall ensure the appropriate coordination of health care services with an assisted living facility in cases where a Medicaid recipient is both a member of the entity's prepaid health plan and a resident of the assisted living facility. If the entity is at risk for Medicaid targeted case management and behavioral health services, the entity shall inform the assisted living facility of the procedures to follow should an emergent condition arise.~~

(c) The community living support plan, as defined in s. 429.02, has been prepared by a mental health resident and his or her ~~a~~ mental health case manager ~~of that resident~~ in consultation with the administrator of the facility or the administrator's designee. The plan must be completed and provided to the administrator of the assisted living facility with a limited mental health license in which the mental health resident lives upon the resident's admission. The support plan and the agreement may be in one document.

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

(e) The mental health services provider assigns a case manager to each mental health resident for whom the entity is responsible ~~who lives in an assisted living facility with a limited mental health license~~. The case manager shall coordinate

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

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

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

(3) The Secretary of Children and Families ~~Family Services~~, in consultation with the Agency for Health Care Administration, shall ~~annually~~ require each district administrator to develop, with community input, a detailed annual plan that demonstrates ~~detailed plans that demonstrate~~ how the district will ensure the provision of state-funded mental health and substance abuse treatment services to residents of assisted living facilities that hold a limited

mental health license. This plan ~~These plans~~ must be consistent with the substance abuse and mental health district plan developed pursuant to s. 394.75 and must address case management services; access to consumer-operated drop-in centers; access to services during evenings, weekends, and holidays; supervision of the clinical needs of the residents; and access to emergency psychiatric care.

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

400.0074 Local ombudsman council onsite administrative assessments.—

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

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

(h) The local council shall conduct an exit consultation with the facility administrator or administrator designee to

discuss issues and concerns in areas affecting residents' rights, health, safety, and welfare and, if needed, make recommendations for improvement.

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

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

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

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

429.07 License required; fee.—

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

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

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

1. In order for extended congregate care services to be provided, the agency must first determine that all requirements established in law and rule are met and must specifically designate, on the facility's license, that such services may be

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

a. A class I or class II violation;

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

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

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

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

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

The agency may deny or revoke a facility's extended congregate care license for not meeting the criteria for an extended congregate care license as provided in this subparagraph.

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

may extend the provisional license for not more than 1 month in order to complete a followup visit.

3.~~2.~~ A facility that is licensed to provide extended congregate care services shall maintain a written progress report on each person who receives services which describes the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. A registered nurse, or appropriate designee, representing the agency shall visit the facility at least twice a year ~~quarterly~~ to monitor residents who are receiving extended congregate care services and to determine if the facility is in compliance with this part, part II of chapter 408, and relevant rules. One of the visits may be in conjunction with the regular survey. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall serve as part of the team that inspects the facility. The agency may waive one of the required yearly monitoring visits for a facility that has:

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

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

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

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

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

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

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

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

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

decisionmaking.

f. Implement the concept of managed risk.

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

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

5.~~4.~~ A facility that is licensed to provide extended congregate care services is exempt from the criteria for continued residency set forth in rules adopted under s. 429.41. A licensed facility must adopt its own requirements within guidelines for continued residency set forth by rule. However, the facility may not serve residents who require 24-hour nursing supervision. A licensed facility that provides extended congregate care services must also provide each resident with a written copy of facility policies governing admission and retention.

~~5. The primary purpose of extended congregate care services is to allow residents, as they become more impaired, the option of remaining in a familiar setting from which they would otherwise be disqualified for continued residency. A facility licensed to provide extended congregate care services may also admit an individual who exceeds the admission criteria for a facility with a standard license, if the individual is determined appropriate for admission to the extended congregate care facility.~~

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

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

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

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

1. In order for limited nursing services to be provided in a facility licensed under this part, the agency must first determine that all requirements established in law and rule are met and must specifically designate, on the facility's license, that such services may be provided. This ~~Such~~ designation may be made at the time of initial licensure or licensure renewal ~~relicensure~~, or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with part II of chapter 408. An existing facility that qualifies ~~facilities~~

~~qualifying~~ to provide limited nursing services must ~~shall~~ have maintained a standard license and may not have been subject to administrative sanctions that affect the health, safety, and welfare of residents for the previous 2 years or since initial licensure if the facility has been licensed for less than 2 years.

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

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

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

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

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

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

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

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

part, part II of chapter 408, and applicable rules. This training must ~~will~~ be provided by or approved by the Department of Children and Families ~~Family Services~~.

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

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

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

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

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

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

(4) A facility that has ~~with~~ a limited mental health

license may enter into a cooperative agreement with a private mental health provider. For purposes of the limited mental health license, the private mental health provider may act as the case manager.

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

429.14 Administrative penalties.—

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

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

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

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

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

resident.

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

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

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

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

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

(g) Violation of a moratorium.

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

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

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

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

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

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

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

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

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

(c) The facility is cited for two or more class I violations arising from separate surveys or investigations

within a 2-year period ~~that has two or more class I violations that are similar or identical to violations identified by the agency during a survey, inspection, monitoring visit, or complaint investigation occurring within the previous 2 years~~.

(5) An action taken by the agency to suspend, deny, or revoke a facility's license under this part or part II of chapter 408, in which the agency claims that the facility owner or an employee of the facility has threatened the health, safety, or welfare of a resident of the facility, must be heard by the Division of Administrative Hearings of the Department of Management Services within 120 days after receipt of the facility's request for a hearing, unless that time limitation is waived by both parties. The administrative law judge shall ~~must~~ render a decision within 30 days after receipt of a proposed recommended order.

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

~~are involved in an appellate proceeding pursuant to s. 120.60 related to the denial, suspension, or revocation of a license~~.

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

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

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

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

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

(b) A direct caregiver who is employed by a facility that provides special care for residents who have ~~with~~ Alzheimer's disease or other related disorders~~,~~ and ~~who~~ provides direct care to such residents~~,~~ must complete the required initial training

and 4 additional hours of training developed or approved by the department. The training must ~~shall~~ be completed within 9 months after beginning employment and satisfy ~~shall satisfy~~ the core training requirements of s. 429.52(3)(g) ~~429.52(2)(g)~~.

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

429.19 Violations; imposition of administrative fines; grounds.—

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

(2) Each violation of this part and adopted rules must ~~shall~~ be classified according to the nature of the violation and the gravity of its probable effect on facility residents. The agency shall indicate the classification on the written notice of the violation as follows:

(a) Class "I" violations are defined in s. 408.813. The agency shall impose an administrative fine of $7,500 for each ~~a~~ cited class I violation in a facility that is licensed for fewer than 100 beds at the time of the violation ~~in an amount not less~~

~~than $5,000 and not exceeding $10,000 for each violation~~. The agency shall impose an administrative fine of $11,250 for each cited class I violation in a facility that is licensed for 100 or more beds at the time of the violation. If the agency has knowledge of a class I violation which occurred within 12 months before an inspection, a fine must be levied for that violation, regardless of whether the noncompliance is corrected before the inspection.

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

(c) Class "III" violations are defined in s. 408.813. The agency shall impose an administrative fine of $750 for each ~~a~~ cited class III violation in a facility that is licensed for fewer than 100 beds at the time of the violation ~~in an amount not less than $500 and not exceeding $1,000 for each violation~~. The agency shall impose an administrative fine of $1,125 for each cited class III violation in a facility that is licensed for 100 or more beds at the time of the violation.

(d) Class "IV" violations are defined in s. 408.813. The agency shall impose an administrative fine of $150 for each ~~a~~

cited class IV violation in a facility that is licensed for fewer than 100 beds at the time of the violation ~~in an amount not less than $100 and not exceeding $200 for each violation~~. The agency shall impose an administrative fine of $225 for each cited class IV violation in a facility that is licensed for 100 or more beds at the time of the violation.

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

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

(g) Regardless of the class of violation cited, instead of the fine amounts listed in paragraphs (a)-(d), the agency shall impose an administrative fine of $500 if a facility is found not to be in compliance with the background screening requirements

as provided in s. 408.809.

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

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

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

~~(c) Any previous violations.~~

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

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

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

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

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

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

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

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

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

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

429.256 Assistance with self-administration of medication.—

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

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

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

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

(d) Applying topical medications.

(e) Returning the medication container to proper storage.

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

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

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

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

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

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

(l) Assisting with measuring vital signs.

(m) Assisting with colostomy bags.

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

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

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

429.28 Resident bill of rights.—

(2) The administrator of a facility shall ensure that a written notice of the rights, obligations, and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The ~~This~~ notice must ~~shall~~ include the name, address, and telephone

numbers of the local ombudsman council, the ~~and~~ central abuse hotline, and, if ~~when~~ applicable, Disability Rights Florida ~~the Advocacy Center for Persons with Disabilities, Inc., and the Florida local advocacy council~~, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the local ombudsman council, central abuse hotline, and Disability Rights Florida ~~Advocacy Center for Persons with Disabilities, Inc., and the Florida local advocacy council~~.

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

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

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

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

(6) A ~~Any~~ facility that ~~which~~ terminates the residency of an individual who participated in activities specified in

subsection (5) must ~~shall~~ show good cause in a court of competent jurisdiction. If good cause is not shown, the agency shall impose a fine of $2,500 in addition to any other penalty assessed against the facility.

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

429.34 Right of entry and inspection.—

(1) In addition to the requirements of s. 408.811, any duly designated officer or employee of the department, the Department of Children and Families ~~Family Services~~, the Medicaid Fraud Control Unit of the Office of the Attorney General, the state or local fire marshal, or a member of the state or local long-term care ombudsman council has ~~shall have~~ the right to enter unannounced upon and into the premises of any facility licensed pursuant to this part in order to determine the state of compliance with ~~the provisions of~~ this part, part II of chapter 408, and applicable rules. Data collected by the state or local long-term care ombudsman councils or the state or local advocacy councils may be used by the agency in investigations involving violations of regulatory standards. A person specified in this section who knows or has reasonable cause to suspect that a vulnerable adult has been or is being abused, neglected, or exploited shall immediately report such knowledge or suspicion to the central abuse hotline pursuant to chapter 415.

(2) The agency shall inspect each licensed assisted living

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

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

429.41 Rules establishing standards.—

(2) In adopting any rules pursuant to this part, the department, in conjunction with the agency, shall make distinct standards for facilities based upon facility size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and the staffing characteristics of the facility. Rules developed pursuant to this section may ~~shall~~ not restrict the use of shared staffing and shared programming in facilities that are part of retirement communities that provide multiple levels of care and otherwise meet the requirements of law and rule. If

a continuing care facility licensed under chapter 651 or a retirement community offering multiple levels of care licenses a building or part of a building designated for independent living for assisted living, staffing requirements established in rule apply only to residents who receive personal, limited nursing, or extended congregate care services under this part. Such facilities shall retain a log listing the names and unit number for residents receiving these services. The log must be available to surveyors upon request. Except for uniform firesafety standards, the department shall adopt by rule separate and distinct standards for facilities with 16 or fewer beds and for facilities with 17 or more beds. The standards for facilities with 16 or fewer beds must ~~shall~~ be appropriate for a noninstitutional residential environment~~;~~ however, ~~provided that~~ the structure may not be ~~is no~~ more than two stories in height and all persons who cannot exit the facility unassisted in an emergency must reside on the first floor. The department, in conjunction with the agency, may make other distinctions among types of facilities as necessary to enforce the provisions of this part. Where appropriate, the agency shall offer alternate solutions for complying with established standards, based on distinctions made by the department and the agency relative to the physical characteristics of facilities and the types of care offered ~~therein~~.

Section 13. Subsections (1) through (11) of section 429.52, Florida Statutes, are renumbered as subsections (2)

through (12), respectively, a new subsection (1) is added to that section, and present subsections (5) and (9) of that section are amended, to read:

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

(1) Effective October 1, 2014, each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required pre-service orientation. The facility must keep the signed statement in the employee's personnel record.

(6) ~~(5)~~ Staff involved with the management of medications and assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 ~~4~~ additional hours of training provided by a registered nurse, licensed pharmacist, or department staff. The department shall establish by rule the minimum requirements of this additional training.

(10) ~~(9)~~ The training required by this section other than the preservice orientation must ~~shall~~ be conducted by persons registered with the department as having the requisite experience and credentials to conduct the training. A person

seeking to register as a trainer must provide the department with proof of completion of the minimum core training education requirements, successful passage of the competency test established under this section, and proof of compliance with the continuing education requirement in subsection (5) ~~(4)~~.

Section 14. The Legislature finds that consistent regulation of assisted living facilities benefits residents and operators of such facilities. To determine whether surveys are consistent between surveys and surveyors, the Office of Program Policy Analysis and Government Accountability shall conduct a study of intersurveyor reliability for assisted living facilities. By November 1, 2014, the Office of Program Policy Analysis and Government Accountability shall submit a report of its findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives and make any recommendations for improving intersurveyor reliability.

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

(1) Implement a rating system for assisted living facilities by March 1, 2015. The agency shall adopt rules to administer this subsection.

(2) By November 1, 2014, create content that is easily accessible through the front page of the agency's Internet

website either directly or indirectly through a link to another established website or websites of the agency's choosing. The website must be searchable by facility name, city, or zip code. At a minimum, the content must include:

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

1. The name and address of the facility.

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

3. The types of licenses held by the facility.

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

5. Proprietary or nonproprietary status of the licensee.

6. Any affiliation with a company or other organization owning or managing more than one assisted living facility in this state.

7. The total number of clients that the facility is licensed to serve and the most recently available occupancy levels.

8. The number of private and semiprivate rooms offered.

9. The bed-hold policy.

10. The religious affiliation, if any, of the assisted living facility.

11. The languages spoken by the staff.

12. Availability of nurses.

13. Forms of payment accepted, including, but not limited to, Medicaid, Medicaid long-term managed care, private insurance, health maintenance organization, Veterans

Administration, CHAMPUS program, or workers' compensation coverage.

14. Indication if the licensee is operating under bankruptcy protection.

15. Recreational and other programs available.

16. Special care units or programs offered.

17. Whether the facility provides mental health services, as defined in s. 394.67, Florida Statutes, to residents with mental illness and the number of mental health residents.

18. Whether the facility is a part of a retirement community that offers other services pursuant to part II or part III of chapter 400, part I or part III of chapter 429, or chapter 651, Florida Statutes.

19. Links to the State Long-Term Care Ombudsman Program website and the program's statewide toll-free telephone number.

20. Links to the Internet websites of the providers or their affiliates.

21. Other relevant information that the agency currently collects.

(b) Survey and violation information for the facility, including a list of the facility's violations committed during the previous 60 months, which upon the effective date of this act may include violations committed on or after July 1, 2009. The list shall be updated monthly and include for each violation:

1. A summary of the violation, including all licensure,

revisit, and complaint survey information, presented in a manner understandable by the general public.

2. Any sanctions imposed by final order.

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

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

Section 16. This act shall take effect July 1, 2014.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 573 (2014)

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health Innovation Subcommittee

Representative Ahern offered the following:

Amendment (with title amendment)

Remove line 200 and insert:

resident lives within 30 days after the resident's admission. The support plan

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

Remove line 12 and insert:

administrator of a facility within 30 days after the

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 573 (2014)

Amendment No. 2

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health Innovation Subcommittee

Representative Ahern offered the following:

Amendment (with title amendment)

Remove line 220 and insert:

(f) Adequate and consistent monitoring and implementation of

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

Remove line 25 and insert:

monitoring and implementation of community living support

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 573 (2014)

Amendment No. 3

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health Innovation Subcommittee

Representative Ahern offered the following:

Amendment

Remove lines 719-750 and insert:

(c) Class "III" violations are defined in s. 408.813. The agency shall impose an administrative fine of $500 for each ~~a~~ cited class III violation in a facility that is licensed for 6 or fewer beds at the time of the violation ~~in an amount not less than $500 and not exceeding $1,000 for each violation~~. The agency shall impose an administrative fine of $750 for each cited class III violation in a facility that is licensed for 7 to 24 beds at the time of the violation. The agency shall impose an administrative fine of $1,000 for each cited class III violation in a facility that is licensed for 25 to 99 beds at the time of the violation. The agency shall impose an

administrative fine of $1,125 for each cited class III violation in a facility that is licensed for 100 or more beds at the time of the violation.

(d) Class "IV" violations are defined in s. 408.813. The agency shall impose an administrative fine of $100 for each ~~a~~ cited class IV violation in a facility that is licensed for 6 or fewer beds at the time of the violation ~~in an amount not less than $100 and not exceeding $200 for each violation~~. The agency shall impose an administrative fine of $150 for each cited class IV violation in a facility that is licensed for 7 to 24 beds at the time of the violation. The agency shall impose an administrative fine of $200 for each cited class IV violation in a facility that is licensed for 25 to 99 beds at the time of the violation. The agency shall impose an administrative fine of $225 for each cited class IV violation in a facility that is licensed for 100 or more beds at the time of the violation.

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

(f) Notwithstanding s. 408.813(2)(c) and (d) and s. 408.832, a fine may be imposed for each class III or class IV violation, regardless of correction, if a facility was previously cited for one or more class III or class IV

violations during the agency's last licensure inspection for a comparable violation.

Amendment No. 4

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health Innovation Subcommittee

Representative Ahern offered the following:

Amendment (with title amendment)

Between lines 850 and 851, insert:

Section 10. Subsection (3) of section 429.27, Florida Statutes, is amended to read:

429.27 Property and personal affairs of residents.—

(3) A facility, upon mutual consent with the resident, shall provide for the safekeeping in the facility of personal effects not in excess of $500 and funds of the resident not in excess of $500 ~~$200~~ cash, and shall keep complete and accurate records of all such funds and personal effects received. If a resident is absent from a facility for 24 hours or more, the facility may provide for the safekeeping of the resident's personal effects in excess of $500.

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

Remove line 105 and insert:

Facilities Act; amending s. 429.27, F.S., revising the dollar amount of cash that a facility may provide sakekeeping for a resident from $200 to $500; amending s. 429.28, F.S.; providing