The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Policy and Steering Committee on Ways and Means

BILL:	CS/CS/CS/SB 2138
INTRODUCER:	Policy and Steering Committee on Ways and Means, Children, Families, and Elder Affairs Committee and Health Regulation Committee and Senator Gardiner
SUBJECT:	Health Care
DATE:	April 15, 2010 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Stovall	Wilson	HR	**Fav/CS**
2.	Walsh	Walsh	CF	**Fav/CS**
3.	Hansen	Coburn	WPSC	**Fav/CS**
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

Committee Substitute for Committee Substitute for Senate Bill 2138 repeals obsolete and duplicative provisions related to certain facilities regulated by the Agency for Health Care Administration (AHCA or agency) and streamlines reporting by nursing homes, assisted living facilities, and state agencies.

The bill enhances the regulation of home health agencies by imposing specific responsibilities on specified staff, requiring the primary home health agency to be responsible for monitoring services furnished to patients, whether provided directly or through contracts, and requiring a notice of patient's rights; and providing for supervisory visits for services provided to patients and clients of a home health agency.

The bill transfers administrative responsibility for the "Community Health Centers Access Program Act" from the Department of Health to the agency; requires the development of a federally qualified health center based statewide assessment and strategic plan every 5 years; and requires the agency to contract with an entity to be responsible for program support to the federally qualified health centers.

The bill appropriates $150,000 and one FTE to the AHCA and deletes $75,000 in General Revenue from the Department of Health.

This bill amends the following sections of the Florida Statutes: 400.0239, 400.476, 400.487, and 409.991255.

The bill repeals the following sections of the Florida Statutes: 112.0455(10)(e), 383.325, 395.1046, 395.3037, 400.147(10), 400.148, 400.195, 408.802(11), 409.912(15)(e),(f), and (g), 429.12(2), 429.23(5), and 429.911(2)(a).

II. Present Situation:

Health Care Licensing

The AHCA regulates over 41,000 health care providers under several regulatory programs based upon individual licensing statutes and the general licensing provisions in part II of ch. 408, F.S. The health care providers include:

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

- Health care services pools, as provided under part IX of ch. 400, F.S.;
- Health care clinics, as provided under part X of ch. 400, F.S.;
- Clinical laboratories, as provided under part I of ch. 483, F.S.;
- Multiphasic health testing centers, as provided under part II of ch. 483, F.S.; and
- Organ, tissue, and eye procurement organizations, as provided under part V of ch. 765, F.S.

The general licensing provisions contain standards for: licensure application requirements, ownership disclosure, staff background screening, inspections, and administrative sanctions. Each provider type has an authorizing statute (as listed above) that includes unique provisions for licensure beyond the general licensing provisions. If a conflict exists between the general licensing provisions and the authorizing statute, s. 408.832, F.S., provides that the general licensing provisions prevail.

There are several references in the authorizing statutes that conflict with or duplicate regulations in the general licensing provisions, including references to the classification of deficiencies, penalties for an intentional or negligent act by a provider, provisional licenses, proof of financial ability to operate, inspection requirements, and plans of corrections from providers.

Home Health Agencies

Home health agencies are organizations that are licensed by the AHCA to provide home health services and staffing services. Home health services are health and medical services and medical supplies furnished to an individual in the individual's home or place of residence. The services include:

- Nursing care;
- Physical, occupational, respiratory, or speech therapy;
- Home health aide services (assistance with daily living such as bathing, dressing, eating, personal hygiene, and ambulation);
- Dietetics and nutrition practice and nutrition counseling; and
- Medical supplies, restricted to drugs and biologicals prescribed by a physician.[1]

A home health agency may also provide homemaker and companion services without additional licensing or registration. These services do not involve hands-on personal care to a client and typically include housekeeping, meal planning and preparation, shopping assistance, routine household activities, and accompanying the client on outings.

State law does not specify duties and responsibilities for administrators of home health agencies and specifies only limited duties and responsibilities for the director of nursing. A director of nursing is required for each home health agency that provides skilled nursing care unless the home health agency is not Medicare or Medicaid certified and does not provide skilled care or provides only physical, occupational, or speech therapy.[2]

Home health aides are not required under state law to be certified or licensed, although they are required to be trained or pass a competency test.[3] State law does not require supervision over

[1] Section 400.462(14), Florida Statutes.
[2] s. 400.476(2)(c), F.S.
[3] s. 400.462(15), F.S. See also Rule 59A-8.0095, F.A.C.

home health aide services unless the patient requests it and pays for it. Similarly, state law does not adequately address responsibilities for home health agencies that contract with individuals or other agencies to provide services.

The AHCA indicates that the number of complaints received for home health agencies has increased from 401 in 2008 to 501 in 2009, and that 41 percent of the allegations were related to patient care and services.[4]

CARES Program

The AHCA is required to submit a report to the Legislature annually regarding the operations of the Comprehensive Assessment and Review for Long-Term Care Services (CARES) program.[5] The CARES program, which is housed in the Department of Elderly Affairs (DOEA), is Florida's federally mandated pre-admission screening program for nursing facility applicants seeking Medicaid funding for their care. The purpose of the CARES program is to ensure that Medicaid payment for nursing facility care is made only for individuals whose conditions require such care and to ensure that long-term care services are provided in the setting most appropriate to the needs of the person and in the most economical manner possible. In addition to pre-admission screening, the CARES program provides assessments for individuals in need of home and community-based services.

The annual report describes:

- The rate of diversion to community alternative programs,
- The CARES program staffing needs to achieve additional diversions,
- Reasons that diversions did not occur when the individuals desired the less restrictive setting and could have been served in that setting,
- Barriers to appropriate placement, and
- Statutory changes needed to ensure services are provided in the least restrictive setting.

The DOEA is required to track individuals over time who are assessed under the CARES program and diverted from nursing home placement. The DOEA is to report annually: demographic information on those individuals who have been diverted, a summary of community services provided to individuals for one year after diversion, a summary of inpatient hospital admissions for these individuals who have been diverted, and a summary of the length of time between diversion and subsequent entry into a nursing home or death.

Federally Qualified Health Center Access Program

Section 409.9125 establishes the Federally qualified Health Center Access Program under the Department of Health. The purpose of the program is to provide assistance to federally qualified health centers so they can expand comprehensive primary and preventive health care and urgent care services that reduce the morbidity, mortality, and cost of care among the uninsured population of the state. In addition, the program is required to provide for distribution of financial assistance to federally qualified health centers that apply and domonstrate a need for such assistance in order to sustain or expand the delivery of primary and preventive health care

[4] See the AHCA 2010 Bill Analysis and Economic Impact Statement for SB 2138 on file with the Senate Committee on Health Regulation.
[5] s. 409.912(15)(e), F.S.

services. The law establishes standards for the receipt of this assistance, and requires that a review panel be established to review all applications for assistance. Finally, the law requires the department to contract with the Florida Association of Community Health Centers to administer the program.

III. Effect of Proposed Changes:

Sections 1, 2, 3, 4, 6, 7, 8, 11, 14, and 16. Repeal the following obsolete or duplicative sections of the Florida Statutes:

- s. 112.0455(10)(e), F.S., to remove an obsolete provision concerning drug testing within the Drug-Free Workplace Act. The Division of Statutory Revision requested clarification of this provision;
- s. 383.325, F.S., related to public access to governmental inspection reports for birth centers since this is required in the general licensing provisions in part II of ch. 408, F.S.;
- s. 395.1046, F.S., related to the AHCA's investigation procedures for complaints against a hospital for violations of the access to emergency services and care provisions under s. 395.1041, F.S. Complaint procedures exist in the general licensing provisions in part II of ch. 408, F.S. The federal process for emergency access complaints dictates that access to emergency services and care complaints be handled similarly to routine complaints;
- s. 395.3037, F.S., related to definitions of Department and Agency as they pertain to stroke centers. These terms are already defined in s. 395.002, F.S., which provides definitions for all of ch. 395, F.S.;
- s. 400.147(10), F.S., related to the requirement for a licensed nursing home to report to the AHCA monthly any notice of claims against the facility for violation of a resident's rights or negligence. The information has been required to be submitted since 2001 for inclusion in AHCA's Semi-Annual Report on Nursing Homes. This Report on Nursing Homes is repealed in section 8 of this committee substitute, which repeals s. 400.195, F.S.
- s. 400.148, F.S., related to the obsolete Medicaid "Up-or-Out" Quality of Care Contract Management Program;
- s. 400.195, F.S., related to an obsolete requirement for the AHCA to report on lawsuits against and deficiencies in nursing homes. The statutory reporting requirement was for the period June 30, 2001 through June 30, 2005;
- s. 408.802(11), F.S., related to the general licensure provisions, to delete reference to private review agents. The regulation of private review agents was repealed by the Legislature in 2009;
- s. 429.12(2), F.S., related to change of ownership for assisted living facilities since this is addressed under the general licensing provisions in part II of ch. 408, F.S.; and
- s. 429.911(2)(a), F.S., related to adult day care center licensure, to remove a duplicative provision that now exists in the general licensing provisions in part II of ch. 408, F.S.[6]

Section 5. Amends s. 400.0239, F.S., to eliminate reference to the Medicaid "Up-or-Out" Quality of Care Contract Management Program that is repealed in section 7 of this committee substitute.

[6] Section 408.815(1)(b), F.S.

Section 9. Amends s. 400.476, F.S., to require an alternate administrator for a home health agency to meet the requirements of an administrator.

Additional responsibilities are assigned to the administrator of a home health agency to manage the operations, staff, and patient care. Administrative and supervisory functions may not be delegated to another agency or organization, and the primary home health agency shall monitor and control all services that are not furnished directly, including services provided through contracts.

The director of nursing, or a similarly qualified alternate, must be available at all times during operating hours and participate in all activities relevant to the professional services furnished by the home health agency.

A home health agency may only use a home health aide who has completed a training and competency evaluation program, or a competency evaluation program, which meets the minimum standards established by the AHCA. A home health aide may perform a task for which he or she is evaluated as "unsatisfactory" only under the direct supervision of a licensed nurse until he or she satisfactorily passes a subsequent evaluation.

Specific provisions concerning personnel are added to this section of law, including:
- A requirement for the home health agency and its staff to comply with applicable state practice acts and the home health agency's policies and procedures;
- Provisions governing contracted personnel and the required elements in a written contract between the parties;
- A requirement for the home health agency to provide at least one of the types of services through employees. Additional services are authorized to be provided by another agency or organization or an individual pursuant to a written contract that contains the elements required in this section of law;
- Responsibilities of the primary home health agency when contracted personnel services are used; and
- A clinical record or minutes of case conferences to ensure that effective interchange, reporting, and coordination of patient care occurs.

Section 10. Amends s. 400.487, F.S., to require a home health agency to provide a copy of the agreement for services to the patient or the patient's legal representative and to establish provisions related to patient rights. The home health agency is required to provide the patient with a written notice of the patient's rights prior to furnishing care to the patient or during the initial evaluation visit and must maintain documentation of compliance with this requirement. The broad categories of rights include the exercise of rights and respect for property and person and the right to be informed and to participate in planning care and treatment.

The home health agency must furnish skilled nursing services, directly or under contract, by or under the supervision of a registered nurse. Therapy services must be provided by licensed persons under the applicable practice acts within the scope of their license. A qualified therapist is required to assist the physician in evaluating the level of function, help develop or revise the plan of care, prepare clinical and progress notes, advise and consult with the family and other

home health agency personnel, and participate in in-service programs. Speech therapy services may be furnished only by or under supervision of a qualified speech pathologist or audiologist.

The physician or health professional who provided the treatment orders and the home health agency personnel must review the plan of care as often as the severity of the patient's condition requires or when certain events occur, but at least once every 60 days.

Drugs and treatments ordered by a physician or other authorized health professional may be administered only by professional staff, except influenza and pneumococcal polysaccharide vaccines, which may be administered according to the policy of the home health agency developed in consultation with a physician and after an assessment for contraindications. Verbal orders must be reduced to writing and signed and dated with the date the registered nurse or qualified therapist received it. A verbal order may be accepted only by personnel who are authorized to do so by applicable laws, rules, and internal policies of the home health agency.

A registered nurse is required to conduct the initial evaluation of the patient and perform other enumerated responsibilities. Specific responsibilities and services that may be provided are also designated for licensed practical nurses, home health aides, and certified nursing assistants. A registered nurse must assign a home health aide or certified nursing assistant to a specific patient, unless the home health agency providing the home health aide services is not certified by CMS and does not provide skilled care. The home health aide or certified nursing assistant must be provided with written patient care instructions.

A registered nurse must perform the supervisory visit for a patient who receives skilled nursing care. If a patient is receiving physical, occupational, or speech-language therapy without skilled nursing care, the appropriate therapist may provide the supervision for these services. The registered nurse or the appropriate therapist must make an onsite visit to the patient's home at least once every 2 weeks; however the visit is not required to occur while the aide is providing care. If a patient is not receiving skilled nursing services or therapy, a registered nurse must make a supervisory visit to the patient's home at least once every 60 days while the aide is providing patient care, unless the home health agency providing the home health aide services is not certified by CMS and does not provide skilled care, either directly or through contracts. A home health agency must arrange for additional supervisory visits by a registered nurse according to the patient's direction, approval, and agreement to pay the charge for the visits.

Section 12. Repeals s. 409.912(15)(e),(f), and (g), F.S., related to the CARES program. Paragraphs (e) and (f) require the submission of annual reports by the AHCA concerning the operations of the CARES program and the DOEA on the longitudinal study of individuals who are diverted from nursing home placement. Paragraph (g) includes an obsolete reporting requirement that expired in 2005.

Section 13. Amends s. 409.9125, F.S., to transfer administrative responsibility for the "Community Health Centers Access Program Act" from the Department of Health to the agency; to require the development of a Federally qualified health center based statewide assessment and strategic plan every 5 years; and to require the agency to contract with an entity to be responsible for program support to the federally qualified health centers. The contracted entity is responsible for program support and asumes all costs related to the administration of the program.

Section 15. Repeals s. 429.23(5), F.S., the requirement for an assisted living facility to report monthly to the AHCA any liability claim filed against it.

Section 17. Appropriates $150,000 and 1 FTE to the AHCA and reduces recurring General Revenue funding to the Department of Health by $75,000 and 1 FTE.

Section 18. Provides an effective date of July 1, 2010.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of the bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

This committee substitute for the committee substitute streamlines regulations for some provider types regulated by the AHCA. The additional requirements for home health agencies will impact primarily those that are not certified by the CMS and not otherwise engaging in these practices, since most of these new requirements are similar to federal requirements for certified home health agencies.

C. Government Sector Impact:

The committee substitute for the committee substitute reduces reporting requirements for the AHCA and the DOEA and eliminates obsolete language in the statutes.

For the FY 2010-11 fiscal year, the bill: appropriates $75,000 in General Revenue, $75,000 from the Medical Care Trust Fund, 52,554 in rate, and 1 FTE to the AHCA; and reduces appropriations by $75,000 in recurring General Revenue, 52,554 in rate, and 1 FTE for the Department of Health.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

CS by Health Regulation on March 18, 2010:
The changes in this committee substitute include eliminating the following items from the bill:

- The definition of "Joint Commission" and updating references throughout the statutes to the current name;
- The redirection of funding to serve Medicaid recipients with complex spinal cord injuries into the DOH trust fund;
- Correction of various cross-references and other technical corrections;
- Repeal or the striking of obsolete language concerning utilization review activities, off-site emergency departments, hospital service capability, and a condition for qualification as a rural hospital,
- Expanded staffing in a geriatric outpatient clinic in a nursing home;
- Repeal of certain provisions within the authorizing statutes that were addressed within the general licensing provisions;
- Revisions to the regulation of nursing homes as follows:
  - Substituting submission of certain information for licensure on a per request basis rather than a mandatory requirement for all applicants,
  - Repeal of the requirement to report grievances received by the facility upon licensure renewal,
  - Disclosure of information pertaining to the closure of other licensed facilities,
  - Repeal of the authority to request an inactive license for a portion of the facility's beds,
  - Substituting a $1,000 fine for failure to comply with the required moratorium when minimum staff ratios are not met,
  - The repeal of the requirement for the AHCA to adopt rules related to cardiopulmonary resuscitation,
  - The authority for AHCA to determine correction of certain deficiencies based on written documentation, and
  - Reinstating the requirement for newly hired nursing home surveyors to observe a facility as a part of basic training;
- New definitions related to the regulation of home health agencies;
- The requirement for the physician or health professional to put their verbal order in writing and to sign it;

- Clarification of grounds for administrative action against a hospice and home medical equipment provider;
- Repeal of the option for an applicant for a home medical equipment license or health care clinic license to submit a surety bond;
- Authorization for the AHCA to refuse to accept a conditional accreditation in lieu of an inspection by the AHCA;
- Authorization for a home health equipment provider to submit the background screening affidavit biennially rather than annually;
- A new basis for administrative action against an intermediate care facility for developmentally disabled persons for failing to comply with federal certification provisions;
- The requirement for a portable service provider to obtain a health care clinic license;
- Explicit authority for the AHCA to staff the toll-free telephone for handling consumer complaints;
- Criminal and administrative penalties for activities with an altered, defaced, or false license certificate;
- Provisions related to the courtesy nature of a license renewal notice;
- An additional licensure requirement concerning mortgaged or rented property;
- The provision that an inspection report is not subject to challenge under ch. 120, F.S.;
- Administrative fining authority for unclassified violations;
- Authority to extend a license expiration date;
- Phase-out of the Medicaid adult day health care waiver program;
- Repeal of the review, assessment, and reporting requirements concerning the Consumer-directed care program;
- Authorization for the AHCA to report electronically or through its website information about the license status of certain assisted living facilities or inspection results;
- Modification to the scope of consulting services for assisted living facilities;
- Expansion of the number of persons who may own or rent an adult family-care home;
- Repeal of all but one of the enforcement provisions in the authorizing statute for adult day care centers; and
- The change to biennial inspections for licensed multiphasic health testing centers.

The effective date for all provisions in the amendment is July 1, 2010.

CS by Children, Families, and Elder Affairs on March 26, 2010:
The Committee Substitute for Committee Substitute for Senate Bill 2138 amends the CS to specify that a registered nurse must assign a home health aide or certified nursing assistant to a specific patient, unless the home health agency providing the home health aide services is not certified by CMS and does not provide skilled care; and to correct an inadvertent deletion in the CS by deleting s. 429.911(2)(a), F.S. (rather than subparagraph b), a provision which is duplicated in AHCA's general licensing provisions at s. 408.815(1)(b), F.S.

CS by Ways and Means on April 15, 2010:
The Committee Substitute for Committee Substitute for Committee Substitute for Senate Bill 2138 amends the CS/CS to:

- transfer administrative responsibility for the "Community Health Centers Access Program Act" from the Department of Health to the agency;
- require the development of a Federally qualified health center based statewide assessment and strategic plan every 5 years; and
- require the agency to contract with an entity to be responsible for program support to the federally qualified health centers.

The bill appropriates $150,000 and one FTE to the AHCA, and deletes $75,000 in recurring General Revenue and 1 FTE from the Department of Health.

B. Amendments:

None.