HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 621 Nursing Homes and Related Health Care Facilities
SPONSOR(S): Frishe
TIED BILLS: **IDEN./SIM. BILLS:** SB 482

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health & Human Services Quality Subcommittee	12 Y, 3 N	Guzzo	Calamas
2) Health Care Appropriations Subcommittee	13 Y, 1 N	Hicks	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Nursing homes and related health care facilities are regulated by the Agency for Health Care Administration (AHCA) under the Health Care Licensing Procedures Act (Act) in part II of chapter 408, F.S., and chapter 400, F.S. The bill streamlines regulations relating to nursing homes and related health care facilities through repeal of obsolete or duplicative provisions and reform of regulations. The bill makes the following changes to current law:

- Clarifies that nursing home residents are excluded from the landlord tenant laws of s. 83.42, F.S.
- Removes language requiring the director of nursing to sign the resident care plan.
- Repeals s. 400.145, F.S., to remove the requirement for nursing home facilities to furnish copies of resident records to the spouse, guardian, surrogate, or attorney of a resident upon receipt of a written request and amends s. 400.191, F.S., to retain language from s. 400.145, F.S., defining the amount a facility may charge for copying resident's records.
- Requires the licensee to maintain clinical records on each resident in accordance with accepted professional standards.
- Repeals s. 400.148, F.S., which created the Medicaid "Up-or-Out" Pilot project to improve the quality of care for Medicaid recipients in nursing homes and assisted living facilities with poor performance records.
- Removes the requirement for nursing home licensure applicants to submit a signed affidavit disclosing financial interest of controlling interest and allows applicants to submit controlling interest information if requested by AHCA.
- Removes duplicative language requiring nursing home applicants to submit data relating to the total number of beds, copies of any civil verdict or judgment involving the applicant rendered within 10 years preceding the application, and a plan for quality assurance and risk management.
- Removes duplicative language that allows AHCA to issue an inactive license to a nursing home for all or a portion of its beds.
- Removes language requiring a facility to be awarded a Gold Seal and have no Class I or Class II deficiencies during the past two years in order to provide other needed services.
- Adds language that outlines detailed requirements for facilities offering respite care.
- Reduces the Class II deficiency fine amount from $7,500 to $1,000 for facilities that fail to meet the minimum staffing requirements for two consecutive days.
- Adds language outlining minimum staffing requirements for facilities that provide care for persons under 21 years of age who are medically fragile or require skilled care.
- Removes the requirement for facilities to report grievance data to AHCA at the time of re-licensure and adds language allowing AHCA to review the grievance data during inspections.
- Removes the requirement for facilities to report adverse incidents to AHCA within one day of receiving an adverse incident report. The bill retains the requirement for facilities to submit a report to AHCA within 15 calendar days after an incident is determined to be an adverse incident.
- Removes the requirement for AHCA to adopt rules relating to the implementation of Do Not Resuscitate Orders for nursing home residents. These requirements are already contained in s. 401.45, F.S.
- Amends the definition of remuneration as it relates to home health agencies to allow providers to give away certain novelty items with an individual value of up to $15.

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, 2012.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Nursing Homes

Licensure

Nursing homes are regulated by the Agency for Health Care Administration (AHCA) under the Health Care Licensing Procedures Act (Act) in part II of chapter 408, F.S. The Act contains uniform licensing standards for 29 provider types, including nursing homes, in areas such as licensure application requirements, ownership disclosure, staff background screening, inspections, administrative sanctions, license renewal notices, and bankruptcy and eviction notices.

In addition to the Act, nursing homes must comply with the requirements contained in the individual authorizing statutes of part II of chapter 400, F.S., which includes unique provisions for licensure beyond the uniform criteria. Pursuant to s. 408.832, F.S., in the case of conflict between the Act and an individual authorizing statute, the Act prevails. There are several references in authorizing statutes that conflict with or duplicate provisions in the Act. Chapter 2009-223, L.O.F., made changes to part II of chapter 408, F.S., which supersede components of the specific licensing statutes.

An application for nursing home licensure must include the following:

- A signed affidavit disclosing financial or ownership interest of a nursing home controlling interest in the last five years in any health or residential facility which has closed, filed bankruptcy, has a receiver appointed or an injunction placed against it, or been denied, suspended, or revoked by a regulatory agency.[1]
- A plan for quality assurance and risk management.[2]
- The total number of beds including those certified for Medicare and Medicaid. This information is also required by s. 408.806(1)(d), F.S.
- Copies of any civil verdicts or judgments involving the applicant rendered within the last 10 years.

The bill amends s. 400.071(1)(b), F.S., to remove the requirement for prospective licensees to routinely submit a signed affidavit disclosing financial or ownership interest at the time of licensure and provides AHCA the authority to request the documents if needed.

The bill amends s. 400.071(5), F.S., to remove the requirement for prospective licensees to submit with their applications a plan for quality assurance and for conducting risk management. The plans for quality assurance and risk management are reviewed by AHCA as part of its licensure inspection process.[3]

The bill amends s. 400.071(1)(c), F.S., to remove to duplicative language requiring prospective licensees to submit the total number of beds including those certified for Medicare and Medicaid at the time of licensure. This information is also required under s. 408.806(1)(d), F.S.

The bill amends s. 400.071(1)(e), F.S., to remove the requirement for applicants to submit with their applications copies of civil verdicts or judgments involving the applicant rendered within the last 10 years and provides AHCA the authority to request the documents if needed.

[1] SS. 400.071(1)(b), and 400.111, F.S.
[2] S. 400.071(5), F.S.
[3] S. 400.147(11), F.S.

The bill also amends s. 400.0712, F.S., relating to inactive licensure of nursing homes, to remove duplicative language. Inactive licenses may be issued by AHCA to nursing homes for all or a portion of its beds, pursuant to part II of chapter 400, F.S., and s. 400.0712(1), F.S.

Resident Transfer and Discharge

The landlord tenant laws under part II of chapter 83, F.S., apply generally to the rental of a dwelling unit.[4] Nursing home facilities are governed by the specific transfer and discharge requirements contained in s. 400.0255, F.S, which apply to transfers and discharges that are initiated by the nursing home facility. Facilities are required to provide at least 30 days advance notice of a proposed transfer or discharge to the resident.[5] The notice must be in writing and must contain all information required by state and federal law, rules, or regulations applicable to Medicaid or Medicare cases.[6] Residents are entitled to a fair hearing to challenge a facility's proposed transfer or discharge.[7] The Department of Children and Family Services' Office of Appeals Hearings is tasked with conducting the hearings. A hearing decision must be rendered within 90 days after receipt of request for the hearing.[8]

The bill adds language to clarify that nursing home residents are excluded from the landlord tenant laws found under part II of chapter 83, F.S. The transfer and discharge procedures under s. 400.0255, F.S., govern all transfers and discharges for residents of all facilities licensed under part II of chapter 400, F.S.

Administration and Management

Section 400.021(16), F.S., defines "resident care plan" as a written plan developed, maintained, and reviewed not less than quarterly by a registered nurse, which includes a comprehensive assessment of the needs of an individual resident. The resident care plan is required to be signed by the director of nursing or another registered nurse employed by the facility.

Section 400.145, F.S., requires nursing homes to furnish copies of resident records to the spouse, guardian, surrogate, proxy, or attorney of a resident upon receipt of a written request. The frequency of obtaining records and the fee the facility may charge are also defined in this section. Section 400.191, F.S., addresses the availability, distribution, and posting of reports and records. Resident rights are also provided under federal law pursuant to the federal Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, the resident or the residents' legal representative has the right to access all records, including clinical records, within 24 hours of a written or oral request.[9] After receipt of his or her records, the resident may purchase photocopies of the records at a cost not to exceed the community standard for photocopies.[10]

Section 400.141(1)(j), F.S., requires licensees to maintain full patient records. AHCA Rule 59A-4.118, F.A.C., establishes certain requirements regarding the credentials of nursing home records personnel. Specifically, the rule requires nursing homes to employ or contract with a person who is eligible for certification as a registered record administrator or an accredited record technician by the American Health Information Management Association or is a graduate of a school of medical record science that is accredited jointly by the Council on Medical Education of the American Medical Association and the American Health Information Management Association. AHCA Rule 59A-4.118, F.A.C., was promulgated in 1994 and the credentialing organizations referred to in the rule presently do not exist as listed. There is also no authorizing statute that requires nursing homes to contract with a medical records consultant.

[4] S. 83.41, F.S.
[5] S. 400.0255(7), F.S.
[6] S. 400.0255(8), F.S.
[7] S. 400.0255(10)(a), F.S.
[8] S. 400.0255(15), F.S.
[9] 42 C.F.R. 483.10(b)(2)
[10] I*d*.

Section 400.141(1)(v), F.S., requires facilities to assess all residents for eligibility for pneumococcal polysaccharide vaccination (PPV) and vaccinate residents when indicated within 60 days after the effective date of this act. PPV is an infection that is caused by a bacterium and can result in infections of the middle ear, sinus infections, lung infections (pneumonia), blood stream infections, and meningitis.[11]

The bill removes the requirement that the director of nursing or other administrative nurse sign the resident care plan.

The bill repeals s. 400.145, F.S., relating to copies of medical records. The bill amends s. 400.191, F.S., to retain the language from s. 400.145, F.S., defining the amount a facility may charge for copying resident's records. A resident's right to access clinical records is sufficiently addressed in the HIPAA.

The bill amends s. 400.141(1)(j), F.S., to include federal language regarding maintenance of medical records consistent with federal medical records regulations contained in Title 42, Code of Federal Regulations. Specifically, the federal regulations require nursing homes to maintain medical records in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized.[12] The addition of these federal standards will require the repeal of AHCA Rule 59A-4.118, F.A.C., related to the credentials of medical records personnel. Industry estimates indicate an annual savings of $335,000 to providers as a result of removing the requirement for facilities to secure the consultative services of Medical Records Practitioners.[13]

The bill removes obsolete language requiring facilities to vaccinate residents for PPV within 60 days after the effective date of the act which made this law. The bill retains language that requires new residents to be assessed for PPV within five working days after admission and if needed, vaccinated within 60 days.

Nursing homes are required to maintain records of all grievances, and to report to the agency, upon licensure renewal, various data regarding those grievances.[14] The bill retains the requirement for nursing homes to maintain all grievance records, but removes the requirement that nursing homes report the grievance information at the time of relicensure. The bill requires nursing homes to maintain a report, subject to inspection by AHCA, of the total number of grievances handled.

Inspections and Deficiencies

Under s. 408.813, F.S., which provides the general licensure standards for all facilities regulated by AHCA, nursing homes may be subject to administrative fines imposed by the AHCA for certain types of violations. Each violation is classified according to the nature of the violation and the gravity of its probable effect on facility residents:

- Class "I" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients, which AHCA determines present an imminent danger to the clients of the provider or a substantial probability that death or serious physical or emotional harm would occur. The condition or practice constituting a Class I violation must be abated or eliminated within 24 hours, unless a fixed period, as determined by AHCA, is required for correction. AHCA must impose an administrative fine for a cited Class I violation, notwithstanding the correction of the violation.
- Class "II" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which AHCA determines directly threaten the physical or emotional health, safety, or security of the clients, other than Class I violations. AHCA must impose an administrative fine, notwithstanding the correction of the violation.

[11] *See* Vaccines & Immunizations, Pneumococcal Disease Q&A, Department of Health and Human Services, Centers for Disease Control and Prevention, available at http://www.cdc.gov/vaccines/vpd-vac/pneumo/dis-faqs.htm (last viewed January 9, 2012).
[12] 42 C.F.R. 483.75
[13] AHCA, *Staff Analysis and Economic Impact, House Bill Number 621* (January 10, 2012).
[14] S. 400.1183(2), F.S.

- Class “III” violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which AHCA determines indirectly or potentially threaten the physical or emotional health, safety, or security of clients, other than Class I or Class II violations. AHCA must impose an administrative fine and a citation for a Class III violation, which must specify the time within which the violation is required to be corrected. If a Class III violation is corrected within the time specified, a fine may not be imposed.
- Class “IV” violations are those conditions or occurrences related to the operation and maintenance of a provider or to required reports, forms, or documents that do not have the potential of negatively affecting clients. These violations are of a type that the AHCA determines do not threaten the health, safety, or security of clients. AHCA must impose an administrative fine and a citation for a Class IV violation, which must specify the time within which the violation is required to be corrected. If a Class IV violation is corrected within the time specified, a fine may not be imposed.

Section 400.19(3), F.S., requires AHCA to conduct at least one unannounced inspection every 15 months of nursing home facilities to determine compliance relating to quality and adequacy of care. If a deficiency is cited, AHCA must conduct a subsequent inspection to determine if the deficiency identified during inspection has been corrected. If the cited deficiency is a Class III or Class IV deficiency, AHCA may verify the correction without re-inspecting the facility if adequate written documentation has been received from the facility ensuring that the deficiency has been corrected. However, the Class III or IV deficiency must be unrelated to resident rights or resident care.[15]

The bill amends s. 400.19, F.S., to remove the requirement that Class III or Class IV deficiencies must be unrelated to resident rights or resident care in order for AHCA to be able to verify that the deficiency has been corrected without re-inspecting the facility. As a result, this section of law will be more consistent with federal nursing home regulations, which allow facilities to submit documentation of corrected deficiencies if the existing deficiencies do not jeopardize the health and safety of patients nor limit the facility’s capacity to render adequate care.[16]

Staffing Requirements

Nursing homes must comply with staff-to-resident ratios requirements. Under s. 400.141(1)(o), F.S., nursing homes are required to semiannually submit to AHCA information regarding facility staff-to-resident ratios, staff turnover, and staff stability, including information regarding certified nursing assistants, licensed nurses, the director of nursing, and the facility administrator. The ratio must be reported as an average of the most recent calendar quarter. Staff turnover must be reported for the most recent 12-month period. The formula for determining staff stability is the total number of employees that have been employed for more than 12 months, divided by the total number of employees employed at the end of the most recent calendar quarter, and expressed as a percentage.

If a nursing home fails to comply with minimum staffing requirements for two consecutive days, the facility must cease new admissions until the staffing ratio has been achieved for six consecutive days. Failure to self-impose this moratorium on admissions results in a Class II deficiency cited by AHCA. All other citations for a Class II deficiency represent current ongoing non-compliance that AHCA determines has compromised a resident’s ability to maintain or reach his or her highest practicable physical, mental, and psychosocial well-being. Use of the Class II deficiency for a failure to cease admissions is an inconsistent use of a “Class II” deficiency in comparison to all other violations. No nursing homes were cited for this violation in 2011.[17]

The bill removes the requirements under s. 400.141(1)(o), F.S., for reporting staff-to-resident ratio information semiannually to AHCA.

[15] S. 400.19(3), F.S.
[16] 42 C.F.R. 488.28.
[17] AHCA, *Staff Analysis and Economic Impact, House Bill Number 621* (December 20, 2011).

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

Pediatric Staffing Requirements

Section 400.23(5), F.S., requires AHCA, in collaboration with the Division of Children's Medical Services within the Department of Health (DOH), to adopt rules for minimum standards of care for persons under 21 years of age who reside in nursing home facilities. In 1997, Rule 59A-4.1295, F.A.C., was adopted to provide these additional standards of care for pediatric nursing homes which consist of the following:

- For residents who require **skilled care**, each nursing home must provide an average of 3.5 hours of nursing care per patient per day. A maximum of 1.5 hours may be provided by a certified nursing assistant (CNA), and no less than 1 hour of care must be provided by a licensed nurse.
- For residents who are **fragile,** each nursing home must provide an average of 5 hours of direct care per patient per day. A maximum of 1.5 hours of care may be provided by a CNA, and no less than 1.7 hours of care must be provided by a licensed nurse.

Section 400.23(3)(a), F.S., establishes general nursing home staffing standards. Until 2001, s. 400.23(3)(a) did not require a minimum number of licensed nurses or certified nursing assistants. When Rule 59A-4.1295, F.A.C., was adopted in 1997, it was in compliance with s. 400.23(3)(a), F.S., because there were no minimum staffing standards required in the statute at that time. However, the minimum staffing requirements in s. 400.23(3)(a), F.S., have changed since the rule language above was adopted.

In 2001, s. 400.23(3)(a), F.S., was amended to include a minimum staffing standard, which is still in effect today. Currently, s. 400.23(3)(a), F.S., establishes general nursing home staffing standards and requires at least 3.6 hours of licensed nursing and CNA direct care per resident per day. Minimums of 2.5 hours of direct care by a CNA and 1 hour of direct care by a licensed nurse are required. The minimum staffing requirements for pediatric nursing homes in Rule 59A-4.1295, F.A.C., are inconsistent with those required for general nursing homes in s. 400.23(3)(a), F.S. The rule limits CNA care to no more than 1.5 hours per day for both fragile and skilled patients, while the statute allows a minimum of 2.5 hours of CNA care per day.

The bill requires AHCA and the Children's Medical Services Network to adopt rules for minimum staffing requirements for nursing homes that serve individuals less than 21 years of age. Further, the bill provides that these rules are to apply in lieu of the standards contained in s. 400.23(3)(a), F.S. The staffing requirements are as follows:

- For individuals under age 21 who require **skilled** care, each nursing home facility must provide a minimum combined average of licensed nurses, respiratory therapists, and certified nursing assistants of 3.9 hours of direct care per resident per day.
- For individuals under age 21 who are **fragile**, each nursing home must include a minimum combined average of licensed nurses, respiratory therapists, and certified nursing assistances of 5.0 hours of direct care per resident per day.

Current General 400.23(3)(a)	Current Pediatric Skilled 59A-4.1295(8)(a)	HB 621 Pediatric Skilled	Current Pediatric Medically Fragile 59A-4.1295(8)(b)	HB 621 Pediatric Medically Fragile
Nurse – 1 hr.	Nurse – 1 hr. minimum	3.9 hrs.	Nurse – 1.7 hrs. minimum	5 hrs.
CNAs – 2.5 hrs. minimum	CNAs – 1.5 hrs. maximum	Can be all CNAs	CNAs – 1.5 hrs. maximum	Can be all CNAs

Do Not Resuscitate Orders

Section 400.142, F.S., requires AHCA to develop rules relating to implementation of do not resuscitate orders (DNRs) for nursing home residents. Criteria for DNRs are found in s. 401.45, F.S., which allows for emergency pre-hospital treatment to be provided by any licensee and provides that resuscitation may be withheld from a patient by an emergency medical technician (EMT) or paramedic if evidence of a DNR is presented.[18] Section 401.45, F.S., also provides rule-making authority to DOH to implement this section and requires DOH, in consultation with the Department of Elderly Affairs and AHCA, to develop a standardized DNR identification system with devices that signify, when carried or worn, that the patient has been issued an order not to administer cardiopulmonary resuscitation by a physician.[19]

DOH developed Rule 64J-2.018, F.A.C., which became effective October, 1 2008, while AHCA has yet to promulgate any rules relating to the implementation of DNRs. Rule 64J-2.018, F.A.C., provides the following:[20]

- An EMT or paramedic must withhold or withdraw cardiopulmonary resuscitation if presented with an original or completed copy of DH Form 1896 (Florida DNR Form).
- The DNR Order form must be printed on yellow paper and have the words “DO NOT RESUSCITATE ORDER” printed in black.
- A patient identification device is a miniature version of DH Form 1896 and is a voluntary device intended to provide convenient and portable DNR order form.
- The DNR order form and patient identification device must be signed by the patient’s physician.
- An EMT or paramedic must verify the identity of the patient in possession of the DNR order form or patient identification device by means of the patient’s driver license or a witness in the presence of the patient.
- During transport, the EMT must ensure that a copy of the DNR order form or the patient identification device accompanies the live patient.
- A DNR may be revoked at any time by the patient.

The bill removes the requirement for AHCA to promulgate rules related to the implementation of DNRs for nursing home residents. This requirement appears to be duplicative of DOH rulemaking authority in s. 401.45(5), F.S.

Internal Risk Management and Quality Assurance Program

Sections 400.147(10) and 400.0233, F.S., require nursing homes to report civil notices of intent to litigate and civil complaints filed with clerks of courts by a resident or representative of a resident. This information has been used to produce the Semi-Annual Report on Nursing Homes required by s. 400.195, F.S. However, s. 400.195, F.S., was repealed in 2010.

[18] S. 401.45, F.S.
[19] Id.
[20] Florida Department of Health Rule 64J-2.018, F.A.C.

Section 400.147(7), F.S., requires nursing homes to initiate an investigation and notify AHCA within one business day after the risk manager has received an incident report. The notification must be made in writing and be provided electronically, by facsimile device or overnight mail delivery.

The bill eliminates the requirement to report notices of intent to litigate and civil complaints. The bill also eliminates the requirement that nursing homes notify AHCA in writing when they initiate an investigation. However, providers must still initiate their own evaluation within one day. A full report is also still required to be sent to AHCA within 15 calendar days if the incident is determined to be an adverse incident.

Respite Care

Section 400.141(1)(f), F.S., allows nursing homes to provide respite care for people needing short-term or temporary nursing home services. Only nursing homes with standard licensure status with no Class I or Class II deficiencies in the past two years or having Gold Seal status may provide respite services. AHCA is authorized to promulgate rules for the provision of respite services.

The bill amends s. 400.141, F.S., to expand the ability of nursing homes to provide respite services not exceeding 60 days per year and individual stays may not exceed 14 days. The bill allows all licensed nursing homes to provide respite services without limitations based on prior deficiencies. The bill provides additional criteria for the provision of respite services. For each patient, the nursing home must:

- Have an abbreviated plan of care for each respite patient, covering nutrition, medication, physician orders, nursing assessments and dietary preferences;
- Have a contract that covers the services to be provided;
- Ensure patient release to the proper person; and
- Assume the duties of the patient's primary caregiver.

The bill provides that respite patients are exempt from discharge planning requirements, allowed to use his or her personal medication with a physician's order, and covered by the resident rights as delineated in s. 400.022, F.S., except those related to transfer, choice of physician, bed reservation policies, and discharge challenges. The bill requires prospective respite patients to provide certain medical information to the nursing home and entitles the patient to retain his or her personal physician.

"Up-or-Out" Program

The Medicaid "Up-or-Out" Quality of Care Contract Management Program authorized in s. 400.148, F.S., was created as a pilot program in 2001. The purpose of the program was to improve care in poor performing nursing homes and assisted living facilities by assigning trained medical personnel to facilities in select counties similar to Medicare models for managing the medical and supportive-care needs of long-term nursing home residents. The pilot was subject to appropriation; however, an appropriation was not allocated. Therefore, the program was never implemented.

Since the enactment of s. 400.148, F.S., new resources have become available to provide information relating to facility performance and to help consumers make informed choices for care. The nursing home guide is an available resource to assist consumers in finding quality care by allowing them to compare facilities' performance ratings.[21] Consumers can also view a facility's "statement of deficiencies" online, which displays violations of regulations found during an inspection or investigation.[22]

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

[21] Florida's *Nursing Home Guide* available at http://www.floridahealthfinder.gov/index.html (last viewed January 9, 2012).
[22] Agency for Health Care Administration, *Public Records Search, Statement of Deficiencies and Final Orders* available at http://apps.ahca.myflorida.com/dm_web/(S(m0lde3n51dftvokbz23ycn5p))/default.aspx (last viewed January 9, 2012).

Home Health Agencies

Section 400.174(6), F.S., requires AHCA to deny, revoke, or suspend the license of a home health agency and impose a fine of $5,000 against a home health agency that:

- Gives remuneration for staffing services;
- Gives remuneration to an individual who is involved in the facilities discharge planning process;
- Gives cash, or its equivalent, to a Medicare or Medicaid beneficiary;
- Gives remuneration to a physician, member of the physician's staff, or an immediate family member of the physician without a medical director contract being in effect;

Section 400.462(27), F.S., defines "remuneration", as it relates to home health agencies, as any payment or other benefit made directly or indirectly, overtly or covertly, in cash or in kind. The bill amends the definition of remuneration to help clarify what is meant by remuneration as used in s. 400.174(6), F.S. The new language clarifies that the term remuneration does not apply to novelty items that have an individual value of up to $15, provided the item is intended solely for presentation or is customarily given away for promotional, recognition, or advertising purposes. According to AHCA, this language should result in fewer complaints from home health agencies relating to other home health agencies that give items of minimal cost to advertise or promote their business.[23]

B. SECTION DIRECTORY:

Section 1: Amends s. 83.42, F.S., relating to nursing home resident transfer.
Section 2: Amends s. 400.021, F.S., relating to nursing home resident care plans.
Section 3: Amends s. 400.0234, F.S. relating to availability of facility records for investigation of resident's rights violations and defenses.
Section 4: Amends s. 400.0239, F.S., relating to the quality of long-term care facility improvement trust fund.
Section 5: Amends s. 400.0255, F.S., relating to requirements for resident transfers and discharges.
Section 6: Amends s. 400.063, F.S., relating to resident protection.
Section 7: Amends s. 400.071, F.S., relating to application for licensure.
Section 8: Amends s. 400.0712, F.S., relating to inactive licensure.
Section 9: Amends s. 400.111, F.S., relating to disclosure of controlling interests.
Section 10: Amends s. 400.1183, F.S., relating to resident grievance procedures.
Section 11: Amends s. 400.141, F.S., relating to the administration and management of nursing home facilities.
Section 12: Amends s. 400.142, F.S., relating to emergency medication kits and orders not to resuscitate.
Section 13: Repeals s. 400.145, F.S., relating to records of care and treatment of residents; copies to be furnished.
Section 14: Amends s. 400.147, F.S., relating to the internal risk management and quality assurance program.
Section 15: Repeals s. 400.148, F.S., relating to Medicaid "Up-or-Out" quality of care contract management program.
Section 16: Amends s. 400.19, F.S., relating to the right of entry and inspection.
Section 17: Amends s. 400.191, F.S., relating to the availability, distribution, and posting of reports and records.
Section 18: Amends s. 400.23, F.S., relating to rules, evaluation and deficiencies and licensure status.
Section 19: Amends s. 400.462, F.S, relating to home health agency remuneration.
Section 20: Amends s. 429.294, F.S., relating to the availability of facility records for investigation of resident's rights, violations and penalties.
Section 21: Amends s. 430.80, F.S., relating to the implementation of a teaching nursing home pilot project.

[23] AHCA, *Staff Analysis and Economic Impact, House Bill Number 621* (December 20, 2011).

Section 22: Amends s. 430.81, F.S., relating to the implementation of a teaching agency for home and community based care.

Section 23: Amends s. 651.118, F.S., relating to the Agency for Health Care Administration; certificates of need; sheltered beds; and community beds.

Section 24: Provides an effective date of July 1, 2012.

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:

The bill is expected to result in estimated savings to providers of $335,000 annually. The savings are the result of the elimination of rules regarding securing the services of a qualified Medical Records Practitioner on a consultation basis who is eligible for certification as a Registered Record Administrator or Accredited Records Technician. This savings is based upon an estimate that approximately 335 nursing homes spend $1,000 annually to hire a consultant to meet this requirement.[24]

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 bill provides appropriate rulemaking authority to the Agency for Health Care Administration to implement the provisions of the proposed legislation.

[24] *AHCA, Staff Analysis and Economic Impact, House Bill Number 621 (January 10, 2012).*

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES