The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH REGULATION
Senator Garcia, Chair
Senator Sobel, Vice Chair

MEETING DATE: Tuesday, January 31, 2012
TIME: 15 minutes after adjournment—6:00 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Garcia, Chair; Senator Sobel, Vice Chair; Senators Diaz de la Portilla, Fasano, Gaetz, Jones, and Norman

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 1856** Flores (Compare H 655, CS/H 657, Link CS/S 616)	Public Records and Public Meetings/Peer Review Panels; Amending provisions relating to the James and Esther King Biomedical Research Program; providing an exemption from public records and public meetings requirements for peer review panels meeting to review certain grant proposals; amending provisions relating to the William G. “Bill” Bankhead, Jr., and David Coley Cancer Research Program; providing an exemption from public records and public meetings requirements for peer review panels meeting to review certain grant proposals, etc. HR 01/25/2012 Not Considered HR 01/31/2012 Fav/CS GO	Fav/CS Yeas 7 Nays 0
2	**CS/SB 820** Environmental Preservation and Conservation / Dean (Similar CS/H 999, Compare H 79, H 115, S 114, S 178, S 558, CS/S 704)	Onsite Sewage Treatment and Disposal Systems; Providing for any permit issued and approved by the Department of Health for the installation, modification, or repair of an onsite sewage treatment and disposal system to transfer with the title of the property; providing circumstances in which an onsite sewage treatment and disposal system is not considered abandoned; providing for the validity of an onsite sewage treatment and disposal system permit if rules change before final approval of the constructed system; providing that a system modification, replacement, or upgrade is not required unless a bedroom is added to a single-family home; requiring the Department of Environmental Protection to notify those counties or municipalities of the use of, and access to, certain state and federal program funds and to provide certain guidance and technical assistance upon request, etc. EP 01/09/2012 Fav/CS HR 01/31/2012 Fav/CS BC	Fav/CS Yeas 7 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
3	**SB 1600** Storms (Similar H 659)	Telebehavioral Health Care Services; Requiring that the Agency for Health Care Administration implement telebehavioral health care services by licensed mental health professionals as authorized by the Centers for Medicare and Medicaid Services for all community-based behavioral health care services, except for those services that require physical contact; requiring that telebehavioral health care services be delivered by certain persons from a location in this state; requiring that the agency seek authorization from the Centers for Medicare and Medicaid Services to allow the delivery of telebehavioral health care services by any person currently authorized by rule to deliver such services, etc. HR 01/31/2012 Fav/CS BC	Fav/CS Yeas 6 Nays 1
4	**SB 1826** Gardiner (Identical H 1371)	Developmental Disabilities; Requiring that health care providers provide pregnant women with current information about the conditions that are tested for in a prenatal test, the accuracy of such tests, and resources for obtaining support services for such conditions, including information and support services regarding Down syndrome and other prenatally diagnosed conditions; establishing a prenatal advocacy council within the Department of Health; requiring that each school provide information regarding the John M. McKay Scholarship Program upon the enrollment of a dependent child of a member of the United States Armed Forces; requiring each regional autism center in this state to provide coordination and dissemination of local and regional information regarding available resources for services for children who have developmental disabilities, not just autism or autistic-like disabilities, etc. HR 01/31/2012 Fav/CS BC	Fav/CS Yeas 7 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
5	**SB 1316** Gaetz (Compare CS/H 653, CS/CS/H 943, H 1091, CS/CS/S 208, S 1884)	Health Care; Revising the fine that may be imposed against a home health agency for failing to timely submit certain information to the Agency for Health Care Administration; authorizing the agency to review and analyze information from sources other than Medicaid-enrolled providers for purposes of determining fraud, abuse, overpayment, or neglect; authorizing the agency and the Medicaid Fraud Control Unit to review certain records; requiring the agency to submit a report to the Legislature on adverse incident reports from assisted living facilities; revising the federal offenses for which the Department of Health must issue an emergency order suspending the license of certain health care professionals; requiring the agency to prepare a report for public comment and submission to the Legislature following the expansion of services to new populations or of new services, etc. HR 01/31/2012 Temporarily Postponed BC	Temporarily Postponed
6	**CS/SB 1516** Children, Families, and Elder Affairs / Negron (Compare H 991, S 460)	Agency for Persons with Disabilities; Clarifying provisions relating to eligibility requirements based on citizenship and state residency; requiring the agency to promote partnerships and collaborative efforts to enhance the availability of nonwaiver services; revising provisions relating to eligibility under the Medicaid waiver redesign; providing criteria for calculating a client's initial iBudget; providing that facilities that are accredited by certain organizations must be inspected and reviewed by the agency every 2 years; providing limitations on the amount of cost sharing which may be required of parents for home and community-based services provided to their minor children, etc. CF 01/25/2012 Fav/CS HR 01/31/2012 Temporarily Postponed BC	Temporarily Postponed
	Comments from the Secretary of the Agency for Health Care Administration concerning Assisted Living Facilities		Discussed

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
7	**SB 1884** Garcia (Similar H 1419, Compare H 621, H 787, CS/CS/H 943, S 320, S 482, S 1292, S 1316)	Health Regulation by the Agency for Health Care Administration; Amending provisions relating to exclusions from part II of ch. 83, F.S., the Florida Residential Landlord and Tenant Act; providing criteria for the provision of respite services by nursing homes; deleting a requirement that the rules for minimum standards of care for persons under 21 years of age include a certain methodology; requiring each applicant for initial licensure, change of ownership, or license renewal to operate a licensed home medical equipment provider at a location outside the state to submit documentation of accreditation, or an application for accreditation, from an accrediting organization that is recognized by the Agency for Health Care Administration; designating the Florida Hospital/Sanford-Burnham Translational Research Institute as a State of Florida Resource for research in diabetes diagnosis, prevention, and treatment, etc. HR 01/31/2012 Fav/CS BI	Fav/CS Yeas 6 Nays 0

A proposed committee substitute for the following bill (SB 2074) is available:

	SB 2074 Health Regulation (Compare CS/S 2050)	Assisted Living Facilities; Revising the duties of the case manager for, and the community living support plan of, a mental health resident of an assisted living facility; requiring the revocation of a facility license for certain violations that result in the death of a resident; requiring the licensure of facility administrators; revising training requirements for staff who provide care for persons with Alzheimer's disease and related disorders; providing that facility that terminates an individual's residency will be fined if good cause is not shown in court; directing the Agency for Health Care Administration to establish an online, user-friendly facility rating system that may be accessed by the public, etc. HR 01/31/2012 Fav/CS BC	Fav/CS Yeas 7 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
8	**SB 1198** Bogdanoff (Compare H 915, S 904)	Prescribing of Controlled Substances; Providing that the management of pain in certain patients requires consultation with or referral to a psychiatrist, rather than a physiatrist; providing that a prescription is deemed compliant with the standards of practice and is valid for dispensing when a pharmacy receives it; providing that the standards of practice regarding the prescribing of controlled substances do not apply to certain board-certified psychiatrists and rheumatologists; requiring that a pain-management clinic register with the Department of Health unless the clinic is wholly owned and operated by certain health care professionals, including a board-certified psychiatrist or rheumatologist, etc. HR 01/31/2012 Fav/CS CJ BC	Fav/CS Yeas 7 Nays 0

Other Related Meeting Materials

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 Health Regulation Committee

BILL: CS/SB 1856

INTRODUCER: Health Regulation Committee and Senator Flores

SUBJECT: Public Meetings and Public Records

DATE: February 1, 2012 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	O'Callaghan	Stovall	HR	**Fav/CS**
2.			GO	
3.				
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:

The committee substitute (CS) exempts from Florida's public records and public meetings laws information related to a peer review panel's review of applications for biomedical research grants under the James and Esther King Biomedical Research Program (King Program) and the William G. "Bill" Bankhead, Jr., and David Coley Cancer Research Program (Bankhead-Coley Program).

The CS authorizes the disclosure of the exempted information under certain circumstances.

The CS provides for the repeal of the public records and public meetings exemption and provides a statement of public necessity for the exemption.

Because this CS creates a new public records exemption, it requires a two-thirds vote of each house of the Legislature for passage.

This CS is linked to SB 616 and will take effect on the same date that SB 616 or similar legislation becomes a law.

This CS creates two undesignated sections of law.

II. Present Situation:

The James and Esther King Biomedical Research Program

The purpose of the King Program[1] is to provide an annual and perpetual source of funding to support research initiatives that address the health care problems of Floridians in the areas of tobacco-related cancer, cardiovascular disease, stroke, and pulmonary disease.[2] The long-term goals of the program are to:

- Improve the health of Floridians by researching better prevention, diagnoses, treatments, and cures for cancer, cardiovascular disease, stroke, and pulmonary disease;
- Expand the foundation of biomedical knowledge relating to the prevention, diagnosis, treatment, and cure of diseases related to tobacco use;
- Improve the quality of the state's academic health centers by bringing the advances of biomedical research into the training of physicians and other health care providers;
- Increase the state's per capita funding for research by undertaking new initiatives in public health and biomedical research that will attract additional funding from outside of Florida; and
- Stimulate economic activity in the state in areas related to biomedical research, such as the research and production of pharmaceuticals, biotechnology, and medical devices.

The King Program offers competitive grants to researchers throughout Florida. Grant applications from any university or established research institute[3] in Florida will be considered for biomedical research funding. All qualified investigators in the state, regardless of institutional affiliation, have equal access and opportunity to compete for the research funding.

The State Surgeon General, after consultation with the council, is authorized to award grants and fellowships on the basis of scientific merit[4] within the following three categories:

- Investigator-initiated research grants;
- Institutional research grants; and
- Predoctoral and postdoctoral research fellowships.[5]

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[1] The Florida Legislature created the Florida Biomedical Research Program in 1999 within the department (ch. 99-167, L.O.F.). The Florida Biomedical Research Program was renamed the James and Esther King Biomedical Research Program during Special Session B of the 2003 Legislature (ch. 2003-414, L.O.F.).

[2] Section 215.5602, F.S.

[3] An "established research institute" is any Florida non-profit or foreign non-profit corporation covered under ch. 617, F.S., with a physical location in Florida, whose stated purpose and power is scientific, biomedical or biotechnological research or development and is legally registered with the Florida Department of State, Division of Corporations. This includes the federal government and non-profit medical and surgical hospitals, including veterans' administration hospitals. *See* James & Esther King Biomedical Research Program, *Call for Grant Applications: Biomedical, Biotechnological, and Social Scientific Research and Development, Fiscal Year 2009-2010*, page 7, available at: http://forms.floridabiomed.com/jek_call/King%20Call%2009-10.pdf (Last visited on January 23, 2012).

[4] *See* the "Grant Application Review and Processing" section of Senate Interim Report 2010-219, page 7, for more information about assessing scientific merit. The report is available at: http://archive.flsenate.gov/data/Publications/2010/Senate/reports/interim_reports/pdf/2010-219hr.pdf (Last visited on January 23, 2012).

[5] Section 215.5602(5)(b), F.S.

The King Program was to expire on January 1, 2011, pursuant to s. 215.5602, F.S. However, the Legislature continued the program in 2010 by enacting HB 5311.[6]

The William G. "Bill" Bankhead, Jr., and David Coley Cancer Research Program

The 2006 Legislature created the Bankhead-Coley Program within the Department of Health (the department).[7] The purpose of the program is to advance progress toward cures for cancer through grants awarded for cancer research.

Applications for funding cancer research from any university or established research institute in the state will be considered under the Bankhead-Coley Program. All qualified investigators in the state, regardless of institutional affiliation, have equal access and opportunity to compete for the research funding. The State Surgeon General, after consultation with the council, is authorized to award grants and fellowships on the basis of scientific merit[8] within the following three categories:

- Investigator-initiated research grants;
- Institutional research grants; and
- Collaborative research grants, including those that advance the finding of cures through basic or applied research.

As with the King Program, the Bankhead-Coley Program was to expire on January 1, 2011, pursuant to s. 215.5602, F.S. However, the Legislature also continued this program in 2010 when it enacted HB 5311.[9]

Biomedical Research Advisory Council[10] and Peer Review Panel[11]

The purpose of the council is to advise the State Surgeon General as to the direction and scope of the King Program. The council is also required to consult with the State Surgeon General concerning grant awards for cancer research through the Bankhead-Coley Program.[12] Currently there are 11 members on the council, authorized to serve no more than two consecutive, 3-year terms.

In order to ensure that proposals for research funding within the King Program and the Bankhead-Coley Program are appropriate and evaluated fairly on the basis of scientific merit, a peer review panel of independent, scientifically qualified individuals is appointed to review the scientific content of each proposal to establish a "scientific"[13] priority score.[14] To eliminate

[6] Chapter 2010-161, L.O.F.
[7] Section 381.922, F.S., (ch. 2006-182, L.O.F.).
[8] *Supra* fn. 5.
[9] Chapter 2010-161, L.O.F.
[10] Section 215.5602(3), F.S.
[11] Section 215.5602(6) and (7), and s. 381.922(3)(b), F.S.
[12] Section 381.922(3)(a), F.S. However, s. 215.5602(11), F.S., contains an inconsistency with respect to the responsibility of the Council concerning awarding grants for cancer research.
[13] The King Program requires a *scientific* priority score in s. 215.5602(6), F.S. The Bankhead-Coley Program requires a priority score in s. 381.922(3)(b), F.S.

conflicts of interest, peer reviewers come from outside the state of Florida. Reviewers are experts in their fields from universities, government agencies, and private industry who are matched according to application topic and area of expertise. The priority scores must be considered by the council in determining which proposals will be recommended for funding to the State Surgeon General.

Meetings of the council and the peer review panel are subject to ch. 119, F.S., relating to public records; s. 286.011, F.S., relating to public meetings; and s. 24, Art. I of the State Constitution relating to access to public meetings and records.

Public Records

Article I, s. 24 of the State Constitution, provides that:

> (a) Every person has the right to inspect or copy any public record made or received in connection with the official business of any public body, officer, or employee of the state, or persons acting on their behalf, except with respect to records exempted pursuant to this section or specifically made confidential by this Constitution. This section specifically includes the legislative, executive, and judicial branches of government and each agency or department created thereunder; counties, municipalities, and districts; and each constitutional officer, board, commission, or entity created pursuant to law or this Constitution.

In addition to the State Constitution, the Public Records Act,[15] which pre-dates the current State Constitution, specifies conditions under which public access must be provided to records of the executive branch and other agencies. Section 119.07(1)(a), F.S., states:

> Every person who has custody of a public record shall permit the record to be inspected and copied by any person desiring to do so, at any reasonable time, under reasonable conditions, and under supervision by the custodian of the public records.

Unless specifically exempted, all agency[16] records are available for public inspection. The term "public record" is broadly defined to mean:

> . . .all documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of the physical form, characteristics, or means of transmission, made or received pursuant to law or ordinance or in connection with the transaction of official business by any agency.[17]

[14] A Bridge Grant application is ranked solely by the priority score or percentile assigned to its qualifying federal proposal in an eligible federal review process.
[15] Chapter 119, F.S.
[16] The word "agency" is defined in s. 119.011(2), F.S., to mean ". . . any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law including, for the purposes of this chapter, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency."
[17] s. 119.011(12), F.S.

The Florida Supreme Court has interpreted this definition to encompass all materials made or received by an agency in connection with official business, which are used to perpetuate, communicate, or formalize knowledge.[18] All such materials, regardless of whether they are in final form, are open for public inspection unless made exempt.[19]

There is a difference between records that the Legislature has made exempt from public inspection and those that are *confidential* and exempt. If the Legislature makes a record confidential and exempt, such information may not be released by an agency to anyone other than to the persons or entities designated in the statute.[20] If a record is simply made exempt from disclosure requirements, an agency is not prohibited from disclosing the record in all circumstances.[21]

The Open Government Sunset Review Act (the Act)[22] provides for the systematic review, through a 5-year cycle ending October 2 of the 5th year following enactment, of an exemption from the Public Records Act. The Act states that an exemption may be created, revised, or maintained only if it serves an identifiable public purpose and if the exemption is no broader than is necessary to meet the public purpose it serves. An identifiable public purpose is served if the exemption meets one of three specified criteria and if the Legislature finds that the purpose is sufficiently compelling to override the strong public policy of open government and cannot be accomplished without the exemption. The three statutory criteria are that the exemption:

- Allows the state or its political subdivisions to effectively and efficiently administer a governmental program, which administration would be significantly impaired without the exemption;
- Protects information of a sensitive personal nature concerning individuals, the release of which would be defamatory or cause unwarranted damage to the good name or reputation of such individuals, or would jeopardize their safety; or
- Protects information of a confidential nature concerning entities, including, but not limited to, a formula, pattern, device, combination of devices, or compilation of information that is used to protect or further a business advantage over those who do not know or use it, the disclosure of which would injure the affected entity in the marketplace.[23]

The Act also requires the Legislature to consider the following:

- What specific records or meetings are affected by the exemption?
- Whom does the exemption uniquely affect, as opposed to the general public?
- What is the identifiable public purpose or goal of the exemption?
- Can the information contained in the records or discussed in the meeting be readily obtained by alternative means? If so, how?
- Is the record or meeting protected by another exemption?
- Are there multiple exemptions for the same type of record or meeting that it would be appropriate to merge?

[18] *Shevin v. Byron, Harless, Schaffer, Reid and Associates, Inc.*, 379 So.2d 633, 640 (Fla. 1980).
[19] *Wait v. Florida Power & Light Company*, 372 So.2d 420 (Fla. 1979).
[20] Attorney General Opinion 85-62.
[21] *Williams v. City of Minneola*, 575 So.2d 683, 687 (Fla. 5th DCA), review denied, 589 So.2d 289 (Fla. 1991).
[22] s. 119.15, F.S.
[23] s. 119.15(6)(b), F.S.

Linked Bill

SB 616 is linked to this CS and revises several provisions relating to the King Program and the Bankhead-Coley Program.

III. Effect of Proposed Changes:

The CS exempts from Florida's public records and public meetings laws information related to a peer review panel's review of applications for biomedical research grants under the King Program and the Bankhead-Coley Program.

Specifically, the CS:

- Exempts that portion of a meeting of a peer review panel in which applications for biomedical research grants under the King Program and the Bankhead-Coley Program are discussed.
- Makes confidential and exempt any records generated by the peer review panel relating to the review of applications for biomedical research grants, except final recommendations.
- Makes confidential and exempt research grant applications provided to the peer review panel.

Information made confidential and exempt from Florida's public records laws by the CS may be disclosed with the express written consent of the individual to whom the information pertains or the individual's legally authorized representative, or by court order upon showing good cause.

The CS makes the exemption subject to the Open Government Sunset Review Act, which requires the repeal of the exemption on October 2, 2017, unless the Legislature reviews the exemption and saves it from repeal through reenactment.

The CS also provides a statement of public necessity for the exemption. The statement provides that research grant applications contain information of a confidential nature, including ideas and processes, which could injure the affected researcher if such information was disclosed. In addition, the statement provides that maintaining confidentiality is a hallmark of scientific peer review, as practiced by the national Science Foundation and the National Institutes of Health, when awarding grants and allows for candid exchanges between reviewers critiquing proposals. Furthermore, closing access to meetings of the scientific peer review panels in which biomedical research applications are discussed and protecting the records generated during such meetings ensures that decisions are based upon merit without bias or undue influence.

The CS will take effect on the same date that the linked bill or similar legislation takes effect, if such a bill is adopted during the same legislative session or extension thereof and becomes law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this CS 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:

This CS exempts portions of meetings of a peer review panel in which applications for biomedical research grants under the King Program and the Bankhead-Coley Program are discussed from Florida's public meetings laws. The CS makes confidential and exempt from Florida's public records laws any records generated by the peer review panel relating to the review of such applications, except final recommendations. The CS also makes confidential and exempt from public records laws research grant applications provided to the peer review panel.

The CS authorizes the disclosure of the confidential and exempt public records if the person to whom the confidential and exempt information pertains, or his or her legal representative, provides express written consent to the disclosure or if a court orders the disclosure upon a showing of good cause.

C. Trust Funds Restrictions:

The provisions of this CS 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:

Information discussed by a peer review panel, related records, and applications for biomedical research grants will be made confidential and exempt from public record.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

Lines 65-67 of the CS should say, " Further, the Legislature finds that records generated by the peer review panels related to the review of applications for biomedical research grants…" to be consistent with the exemption provided for in lines 27-31 of the CS.

Line 62 of the CS uses the term "scientific peer review panels." The remainder of the CS uses the term "peer review panels" and omits the term "scientific." The term "scientific" should be deleted in line 62 or added to the other references to "peer review panels" for consistency.

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 January 31, 2012:
Creates a public records exemption relating to peer review panels, which is linked to the substantive bill CS/SB 616, concerning biomedical research.
Specifically, the CS:

- Exempts the portion of a meeting of a peer review panel in which applications for biomedical research grants are discussed.
- Exempts any records generated by the peer review panel relating to the review of such applications, except records of the panel's final recommendations.
- Exempts research grant applications provided to the panel.
- Provides for the disclosure of the exempted information under certain circumstances.
- Provides a sunset review of the public records exemption.
- Expands the public necessity statement.
- Revises the effective date of the bill, to make the effective date contingent on the passing of CS/SB 616 or similar legislation.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
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The Committee on Health Regulation (Garcia) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Exemptions from public records and public meetings requirements; peer review panels.—

(1) That portion of a meeting of a peer review panel in which applications for biomedical research grants under s. 215.5602, Florida Statutes, or s. 381.922, Florida Statutes, are discussed is exempt from s. 286.011, Florida Statutes, and s. 24(b), Art. I of the State Constitution.

(2) Any records generated by the peer review panel relating

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to review of applications for biomedical research grants, except final recommendations, are confidential and exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Art. I of the State Constitution.

(3) Research grant applications provided to the peer review panel are confidential and exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Art. I of the State Constitution.

(4) Information which is held confidential and exempt under this section may be disclosed with the express written consent of the individual to whom the information pertains or the individual's legally authorized representative, or by court order upon showing good cause.

(5) Subsections (1), (2), and (3) are subject to the Open Government Sunset Review Act in accordance with s. 119.15, Florida Statutes, and shall stand repealed on October 2, 2017, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. The Legislature finds that it is a public necessity that meetings of peer review panels under the James and Esther King Biomedical Research Program and the William G. "Bill" Bankhead, Jr., and David Coley Cancer Research Program, in which applications for the biomedical research grants are discussed, certain records generated by the peer review panel related to the review of applications for biomedical research grants, and research grant applications provided to such peer review panels be held confidential and exempt from disclosure. The research grant applications contain information of a confidential nature, including ideas and processes, the disclosure of which could injure the affected researcher.

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Maintaining confidentiality is a hallmark of scientific peer review when awarding grants, is practiced by the National Science Foundation and the National Institutes of Health, and allows for candid exchanges between reviewers critiquing proposals. The Legislature further finds that closing access to meetings of scientific peer review panels in which biomedical research applications are discussed serves a public good by ensuring that decisions are based upon merit without bias or undue influence. Further, the Legislature finds that records generated during meetings of the peer review panels related to the review of applications for biomedical research grants must be protected for the same reasons that justify the closing of such meetings.

Section 3. This act shall take effect on the same date that SB 616 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes law.

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

And the title is amended as follows:

Delete everything before the enacting clause

and insert:

A bill to be entitled

An act relating to public meetings and public records; providing an exemption from public meeting requirements for certain meetings of a peer review panel under the James and Esther King Biomedical Research Program and the William G. "Bill" Bankhead, Jr., and David Coley Cancer Research Program;

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providing an exemption from public records requirements for certain records related to biomedical research grant applications; providing an exemption from public records requirements for research grant applications provided to, and reviewed by, the peer review panel; providing exceptions to the exemption; providing for legislative review and repeal of the exemptions; providing a statement of public necessity; providing a contingent effective date.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Judiciary, *Chair*
Budget
Budget - Subcommittee on Education Pre-K - 12 Appropriations
Commerce and Tourism
Communications, Energy, and Public Utilities
Governmental Oversight and Accountability
Reapportionment
Rules

SENATOR ANITERE FLORES
Majority Whip
38th District

January 18, 2012

The Honorable Rene Garcia
Chair of Committee on Health Regulation
310 Senate Office Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Chairman Garcia:

I respectfully request that you place SB 1856, regarding public records and public meetings, on the next Health Regulation Committee agenda. SB 1856 is a link bill to SB 616 which passed unanimously in the committee for Health Regulation.

I look forward to presenting this bill before your committee.

Please do not hesitate to contact me should you have any questions. Thank you for your consideration.

Sincerely,

Anitere Flores

Anitere Flores

CC: Ms. Sandra Stovall, Staff Director, Committee on Health Regulation, 530 Knott Building

ENTERED

REPLY TO:
❒ 10691 North Kendall Drive, Suite 309, Miami, Florida 33176 (305) 270-6550
❒ 316 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5130

Senate's Website: *www.flsenate.gov*

MIKE HARIDOPOLOS
President of the Senate

MICHAEL S. "MIKE" BENNETT
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1-31-12
Meeting Date

Topic Public Records

Bill Number 1856 *(if applicable)*

Name MIKE FISCHER

Amendment Barcode *(if applicable)*

Job Title

Address PO Box 1197
Street

Phone 222-6344

TLH FL 32302
City *State* *Zip*

E-mail

Speaking: ☑ For ☐ Against ☐ Information

Representing AMERICAN CANCER SOCIETY

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/31/12
Meeting Date

Topic Public Records/Biomedical Research Bill Number 1856 *(if applicable)*

Name Jo Morris Amendment Barcode *(if applicable)*

Job Title Government Analyst

Address 4052 Bald Cypress Way Bin A-100 Phone 850-245-4006
Street

Tallahassee FL 32399 E-mail
City *State* *Zip*

Speaking: ☑ For ☐ Against ☐ Information

Representing Florida Department of Health

Appearing at request of Chair: ☐ Yes ☑ No Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

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 Health Regulation Committee

BILL: CS/CS/SB 820

INTRODUCER: Health Regulation Committee, Environmental Preservation and Conservation Committee, and Senator Dean

SUBJECT: Onsite Sewage Treatment and Disposal Systems

DATE: February 1, 2012 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Uchino	Yeatman	EP	**Fav/CS**
2.	O'Callaghan	Stovall	HR	**Fav/CS**
3.			BC	
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:

The bill repeals the state-wide onsite sewage treatment and disposal system (septic system) evaluation program, including program requirements, and the Department of Health's (DOH) rulemaking authority to implement the program.

The bill requires a county or municipality with a first magnitude spring to develop and adopt by local ordinance a septic system evaluation and assessment program, unless the county or municipality opts out. All other counties and municipalities may opt in. Existing septic system inspection programs are grandfathered-in unless they contain a mandatory inspection at the point of sale in a real estate transaction.

If an evaluation program is adopted by a county or municipality by ordinance, the bill requires:

- A pump out and evaluation of a septic system to be performed every 5 years, unless an exception applies;
- Only authorized persons to perform the pump out and evaluation;
- Notice to be given to septic system owners at least 60 days before the septic system is due for an evaluation;

- Penalties for qualified contractors and septic system owners who do not comply with the requirements of the evaluation program;
- Certain evaluation and assessment procedures to be followed during the inspection of a septic system;
- The DOH to allow county health departments and qualified contractors access to the environmental health database to track relevant information and assimilate data from assessment and evaluation reports of the overall condition of onsite sewage treatment and disposal systems. The database is required to include certain information and allow for notification of homeowners when evaluations are due;
- A county or municipality to notify the Secretary of Environmental Protection upon the adoption of the ordinance establishing the program; and
- The Department of Environmental Protection (DEP), within existing resources, to notify a county or municipality of potential funding under the Clean Water Act or Clean Water State Revolving Fund and assist such counties or municipalities to model and establish low-interest loan programs.

The bill provides that a local ordinance may authorize the assessment of reasonable fees to cover the costs of administering the evaluation program.

The bill repeals the grant program for low-income residents to repair and replace septic systems.

The bill also:

- Defines "bedroom";
- Provides that a permit issued by the DOH for the installation, modification, or repair of a septic system transfers with title to the property. A title is not encumbered when the title is transferred if new permit requirements are in place at the time of transfer;
- Provides for the reconnection of properly functioning septic systems, and clarifies that such systems are not considered "abandoned";
- Clarifies that if there is a rule change within 5 years after approval for construction, the rules in place at the time of initial approval apply at the time of final approval under certain circumstances;
- Clarifies that a modification, replacement, or upgrade of a septic system is not required for a remodeling addition to a single-family home if a bedroom is not added;
- Reduces the annual operating permit fee for waterless, incinerating, or organic waste composting toilets to $15-30 from $50-150;
- Repeals various obsolete provisions; and
- Fixes several cross-references and other technical errors.

The bill substantially amends ss. 381.0065 and 381.0066 of the Florida Statutes.

The bill repeals section 381.00656 of the Florida Statutes.

The bill creates section 381.00651 of the Florida Statutes.

II. Present Situation:

The Department of Health's Regulation of Septic Tanks

The DOH oversees an environmental health program as part of fulfilling the state's public health mission. The purpose of this program is to detect and prevent disease caused by natural and manmade factors in the environment. One component of the program is administration of septic systems.[1]

An "onsite sewage treatment and disposal system" is a system that contains a standard subsurface, filled, or mound drainfield system; an aerobic treatment unit; a graywater system tank; a laundry wastewater system tank; a septic tank; a grease interceptor; a pump tank; a solid or effluent pump; a waterless, incinerating, or organic waste-composting toilet; or a sanitary pit privy that is installed or proposed to be installed beyond the building sewer on land of the owner or on other land to which the owner has the legal right to install a system. The term includes any item placed within, or intended to be used as a part of or in conjunction with, the system. The term does not include package sewage treatment facilities and other treatment works regulated under ch. 403, F.S.[2]

The DOH estimates there are approximately 2.67 million septic tanks in use statewide.[3] The DOH's Bureau of Onsite Sewage (bureau) develops statewide rules and provides training and standardization for county health department employees responsible for permitting the installation and repair of septic systems within the state. The bureau also licenses septic system contractors, approves continuing education courses and courses provided for septic system contractors, funds a hands-on training center, and mediates septic system contracting complaints. The bureau manages a state-funded research program, prepares research grants, and reviews and approves innovative products and septic system designs.[4]

In 2008, the Legislature directed the DOH to submit a report to the Executive Office of the Governor, the President of the Senate, and the Speaker of the House of Representatives by no later than October 1, 2008, which identifies the range of costs to implement a mandatory statewide 5-year septic tank inspection program to be phased in over 10 years pursuant to the DOH's procedure for voluntary inspection, including use of fees to offset costs.[5] This resulted in the "Report on Range of Costs to Implement a Mandatory Statewide 5-Year Septic Tank Inspection Program" (report).[6] According to the report, three Florida counties, Charlotte, Escambia and Santa Rosa, have implemented mandatory septic tank inspections at a cost of $83.93 to $215 per inspection.

[1] *See* s. 381.006, F.S.
[2] Section 381.0065(2)(j), F.S.
[3] Florida Dep't of Health, Bureau of Onsite Sewage, *Home*, http://www.myfloridaeh.com/ostds/index.html (last visited January 29, 2012).
[4] Florida Dep't of Health, Bureau of Onsite Sewage, *OSTDS Description*, http://www.myfloridaeh.com/ostds/OSTDSdescription.html (last visited January 29, 2012).
[5] *See* ch. 2008-152, Laws of Fla.
[6] Florida Dep't of Health, Bureau of Onsite Sewage, *Report on Range of Costs to Implement a Mandatory Statewide 5-Year Septic Tank Inspection Program*, October 1, 2008, available at http://www.doh.state.fl.us/environment/ostds/pdfiles/forms/MSIP.pdf (last visited January 29, 2012).

The report stated that 99 percent of septic tanks in Florida are not under any management or maintenance requirements. Also, the report found that while these systems were designed and installed in accordance with the regulations at the time of construction and installation, many are aging and may be under-designed by today's standards. The DOH's statistics indicate that approximately 2 million septic systems are 20 years or older, which is the average lifespan of a septic system in Florida.[7] Because repairs of septic systems were not regulated or permitted by the DOH until March 1992, some septic systems may have been unlawfully repaired, modified or replaced. Furthermore, 1.3 million septic systems were installed prior to 1983. Pre-1983 septic systems were required to have a 6-inch separation from the bottom of the drainfield to the estimated seasonal high water table. The standard since 1983 for drainfield separation is 24 inches and is based on the 1982 Water Quality Assurance Act and on research findings compiled by the DOH that indicate for septic tank effluent, the presence of at least 24 inches of unsaturated fine sandy soil is needed to provide a relatively high degree of treatment for pathogens and most other septic system effluent constituents.[8] Therefore, Florida's pre-1983 septic systems and any illegally repaired, modified or installed septic systems may not provide the same level of protection expected from systems permitted and installed under current construction standards.[9]

Flow and Septic System Design Determinations

For residences, domestic sewage flows are calculated using the number of bedrooms and the building area as criteria for consideration, including existing structures and any proposed additions.[10] Depending on the estimated sewage flow, the septic system may or may not be approved by the DOH. For example, a current three bedroom, 1,300 square foot home is able to add building area to have a total of 2,250 square feet of building area with no change in their approved system, provided no additional bedrooms are added.[11]

Minimum required treatment capacities for septic systems serving any structure, building or group of buildings are based on estimated daily sewage flows as determined below.[12]

TABLE OF AEROBIC SYSTEMS PLANT SIZING RESIDENTIAL

Number of Bedrooms	Building Area (ft^2)	Minimum Required Treatment Capacity (gallons per day)
1 or 2	Up to 1200	400
3	1201-2250	500
4	2251-3300	600

[7] Florida Dep't of Health, Bureau of Onsite Sewage, *Onsite Sewage Treatment and Disposal Systems in Florida (2010)*, available at http://www.doh.state.fl.us/Environment/ostds/statistics/newInstallations.pdf (last visited January 29, 2012). *See also* Florida Dep't of Health, Bureau of Onsite Sewage, *What's New?*, available at http://www.doh.state.fl.us/environment/ostds/New.htm (last visited on January 29, 2012).
[8] Florida Dep't of Heath, Bureau of Onsite Sewage, *Bureau of Onsite Sewage Programs Introduction*, available at http://www.doh.state.fl.us/Environment/learning/hses-intro-transcript.htm (last visited January 29, 2012).
[9] *Id.*
[10] Rule 64E-6.001, F.A.C.
[11] *Id.*
[12] Table adapted from Rule 64E-6.012, F.A.C.

Minimum design flows for septic systems serving any structure, building or group of buildings are based on the estimated daily sewage flow. For residences, the flows are based on the number of bedrooms and square footage of building area. For a single- or multiple-family dwelling unit, the estimated sewage flows are: for 1 bedroom with 750 square feet or less building area, 100 gallons; for two bedrooms with 751-1,200 square feet, 200 gallons; for three bedrooms with 1,201-2,250 square feet, 300 gallons; and for four bedrooms with 2,251-3,300 square feet, 400 gallons. For each additional bedroom or each additional 750 square feet of building area or fraction thereof in a dwelling unit, system sizing is to be increased by 100 gallons.[13]

Current Status of Evaluation Program

In 2010, SB 550 was signed into law, which became ch. 2010-205, Laws of Florida. This law provides for additional legislative intent on the importance of properly managing septic tanks and creates a septic system evaluation program. The DOH was to implement the evaluation program beginning January 1, 2011, with full implementation by January 1, 2016.[14] The evaluation program:

- Requires all septic tanks to be evaluated for functionality at least once every 5 years;
- Directs the DOH to provide proper notice to septic owners that their evaluations are due;
- Ensures proper separations from the wettest-season water table; and
- Specifies the professional qualifications necessary to carry out an evaluation.

The law also establishes a grant program under s. 381.00656, F.S., for owners of septic systems earning less than or equal to 133 percent of the federal poverty level. The grant program is to provide funding for inspections, pump-outs, repairs, or replacements. The DOH is authorized under the law to adopt rules to establish the application and award process for grants.

Finally, ch. 2010-205, Laws of Florida, amends s. 381.0066, F.S., establishing a minimum and maximum evaluation fee that the DOH may collect. No more than $5 of each evaluation fee may be used to fund the grant program. The State Surgeon General, in consultation with the Revenue Estimating Conference, must determine a revenue neutral evaluation fee.

Several bills were introduced during the 2011 Regular Session aimed at either eliminating the inspection program or scaling it back. Although none passed, language was inserted into a budget implementing bill that prohibited the DOH from expending funds to implement the inspection program until it submitted a plan to the Legislative Budget Commission (LBC).[15] If approved, the DOH would then be able to expend funds to begin implementation. Currently, the DOH has not submitted a plan to the LBC for approval.

Springs in Florida

Florida has more than 700 recognized springs. It also has 33 historical first magnitude springs in 19 counties that discharge more than 64 million gallons of water per day.[16] First magnitude

[13] Rule 64E-6.008, F.A.C.
[14] However, implementation was delayed until July 1, 2011, by the Legislature's enactment of SB 2-A (2010). *See also* ch. 2010-283, L.O.F.
[15] *See* ch. 2011-047, s. 13, Laws of Fla.
[16] Florida Geological Survey, Bulletin No. 66, *Springs of Florida*, available at

springs are those that discharge 100 cubic feet of water per second or greater. Spring discharges, primarily from the Floridan Aquifer, are used to determine ground water quality and the degree of human impact on the spring's recharge area. Rainfall, surface conditions, soil type, mineralogy, the composition and porous nature of the aquifer system, flow, and length of time in the aquifer all contribute to ground water chemistry. Springs are historically low nitrogen systems. The DEP recently submitted numeric nutrient standards to the Legislature for ratification that include a nitrate-nitrite (variants of nitrogen) limit of 0.35 milligrams per liter for springs. For comparison, the U.S. Environmental Protection Agency's drinking water standard for nitrite is 1.0 milligrams per liter; for nitrate, 10 milligrams per liter.[17]

Local Government Powers and Legislative Preemption

The Florida Constitution grants counties or municipalities broad home rule authority. Specifically, non-charter county governments may exercise those powers of self-government that are provided by general or special law.[18] Those counties operating under a county charter have all powers of self-government not inconsistent with general law, or special law approved by the vote of the electors.[19] Likewise, municipalities have those governmental, corporate, and proprietary powers that enable them to conduct municipal government, perform their functions and provide services, and exercise any power for municipal purposes, except as otherwise provided by law.[20] Section 125.01, F.S., enumerates the powers and duties of all county governments, unless preempted on a particular subject by general or special law.

Under its broad home rule powers, a municipality or a charter county may legislate concurrently with the Legislature on any subject which has not been expressly preempted to the State.[21] Express preemption of a municipality's power to legislate requires a specific statement; preemption cannot be made by implication or by inference.[22] A county or municipality cannot forbid what legislature has expressly licensed, authorized or required, nor may it authorize what legislature has expressly forbidden.[23] The Legislature can preempt a county's broad authority to enact ordinances and may do so either expressly or by implication.[24]

III. Effect of Proposed Changes:

Section 1 amends s. 381.0065, F.S.

The bill repeals the state-wide septic system evaluation program, including program requirements, and the DOH's rulemaking authority to implement the program. It repeals

http://www.dep.state.fl.us/geology/geologictopics/springs/bulletin66.htm (last visited Dec. 19, 2011).
[17] U.S. Environmental Protection Agency, *National Primary Drinking Water Regulations*, available at http://water.epa.gov/drink/contaminants/upload/mcl-2.pdf (last visited January 29, 2012).
[18] FLA. CONST. art. VIII, s. 1(f).
[19] FLA. CONST. art. VIII, s. 1(g).
[20] FLA. CONST. art. VIII, s. 2(b); *see also* s. 166.021, F.S.
[21] *See, e.g., City of Hollywood v. Mulligan*, 934 So. 2d 1238 (Fla. 2006); *Phantom of Clearwater, Inc. v. Pinellas County*, 894 So. 2d 1011 (Fla. 2d DCA 2005).
[22] *Id.*
[23] *Rinzler v. Carson*, 262 So. 2d 661 (Fla. 1972); *Phantom of Clearwater, Inc. v. Pinellas County*, 894 So. 2d 1011 (Fla. 2d DCA 2005).
[24] *Phantom of Clearwater, Inc. v. Pinellas County*, 894 So. 2d 1011 (Fla. 2d DCA 2005).

legislative intent regarding the DOH's administration of a state-wide septic system evaluation program and an obsolete reporting requirement regarding the land application of septage.

The bill defines "bedroom" as a room that can be used for sleeping that, for site-built dwellings, has a minimum 70 square feet of conditioned space; or for manufactured homes, constructed to HUD standards having a minimum of 50 square feet of floor area. The room must be located along an exterior wall, have a closet and a door or an entrance where a door could be reasonably installed. It also must have an emergency means of escape and rescue opening to the outside. A room may not be considered a bedroom if it is used to access another room, unless the room that is accessed is a bathroom or closet. The term does not include a hallway, bathroom, kitchen, living room, family room, dining room, den, breakfast nook, pantry, laundry room, sunroom, recreation room, media/video room, or exercise room. It also fixes two cross-references. One is related to research fees collected to fund hands-on training centers for septic systems. The other relates to determining the mean annual flood line.

The bill provides that a permit issued and approved by the DOH for the installation, modification, or repair of a septic system transfers with the title to the property. A title is not encumbered when transferred by new permit requirements that differ from the original permit requirements in effect when the septic system was permitted, modified or repaired. It also prohibits a government entity from requiring a septic system inspection at the point of sale in a real estate transaction.

The bill specifies a septic system serving a foreclosed property is not considered abandoned. It also specifies a septic system is not considered "abandoned" if it was properly functioning when disconnected from a structure made unusable or destroyed following a disaster, and the septic system was not adversely affected by the disaster. The septic system may be reconnected to a rebuilt structure if:

- Reconnection of the septic system is to the same type of structure that existed prior to the disaster;
- Has the same number of bedrooms or less than the structure that existed prior to the disaster;
- Is within 110 percent of the size of the structure that existed prior to the disaster;
- The septic system is not a sanitary nuisance; and
- The septic system has not been altered without prior authorization.

The bill provides that if a rule change occurs within 5 years after approval for construction, the rules applicable and in effect at the time of approval for construction apply at the time of the final approval of the septic system, but only if fundamental site conditions have not changed between the time of construction approval and final approval.

The bill provides that a modification, replacement, or upgrade of a septic system is not required for a remodeling addition to a single-family home if a bedroom is not added.

Section 2 creates s. 381.00651, F.S.

A county or municipality containing a first magnitude spring within its boundary must develop and adopt by ordinance a local septic system evaluation and assessment program meeting the requirements of this section within all or part of its geographic area by January 1, 2013, unless it

opts out. All other counties and municipalities may opt in but otherwise are not required to take any affirmative action. Evaluation programs adopted before July 1, 2011, and that do not contain a mandatory septic system inspection at the point of sale in a real estate transaction are not affected by this bill. Existing evaluation programs that require point of sale inspections are preempted by the bill regardless of when the program was adopted.

A county or municipality may opt out by majority plus one vote of the local elected body before January 1, 2013, by adopting a separate resolution. The resolution must be filed with the Secretary of State. Absent an interlocal agreement or county charter provision to the contrary, a municipality may elect to opt out of the requirements of this section notwithstanding the decision of the county in which it is located. A county or municipality may subsequently adopt an ordinance imposing a septic system evaluation and assessment program if the program meets the requirements of this section. The bill preempts counties' and municipalities' authority to adopt more stringent requirements for a septic system evaluation program than those contained in the bill.

Local ordinances must provide for the following:

- An evaluation of a septic system, including drainfield, every 5 years to assess the fundamental operational condition of the system and to identify system failures. The ordinance may not mandate an evaluation at the point of sale in a real estate transaction or a soil examination. The location of the system shall be identified;
- May not require a septic system inspection at the point of sale in a real estate transaction;
- May not require a soil examination;
- Each evaluation must be performed by:
  - A septic tank contractor or master septic tank contractor registered under part III of ch. 489, F.S.,
  - A professional engineer having wastewater treatment system experience and licensed pursuant to ch. 471, F.S.,
  - An environmental health professional certified under ch 381, F.S., in the area of septic system evaluation, or
  - An authorized employee working under the supervision of any of the above four listed individuals. Soil samples may only be conducted by certified individuals.

Evaluation forms must be written or electronically signed by a qualified contractor.

The local ordinance may not require a repair, modification or replacement of a septic system as a result of an evaluation unless the evaluation identifies a failure. The term "system failure" is defined as:

- A condition existing within a septic system that results in the discharge of untreated or partially treated wastewater onto the ground surface or into surface water; or
- Results in a sanitary nuisance caused by the failure of building plumbing to discharge properly.

A system is not a failure if an obstruction in a sanitary line or an effluent screen or filter prevents effluent from flowing into a drainfield. The bill specifies that a drainfield not achieving the minimum separation distance from the bottom of the drainfield to the wettest season water table contained in current law is not a system failure.

The local ordinance may not require more than the least costly remedial measure to resolve the system failure. The homeowner may choose the remedial measure to fix the system. There may be instances in which a pump out is sufficient to resolve a system failure. Remedial measures to resolve a system failure must meet, to the extent possible, the requirements in effect at the time the repair is made, subject to the exceptions specified in s. 381.0065(4)(g), F.S. This allows certain older septic systems to be repaired instead of replaced if they cannot be repaired to operate to current code. An ordinance may not require an engineer-designed performance-based system as an alternative septic system to remediate a failure of a conventional septic system.

The bill specifies that the following systems are exempt from inclusion in a septic system evaluation program:

- A septic system that is required to obtain an operating permit or that is inspected by the department on an annual basis pursuant to ch. 513, F.S., related to mobile home and recreational vehicle parks;. and
- A septic system serving a residential dwelling unit on a lot with a ratio of one bedroom per acre or greater. For example, if a person has a four-bedroom house served by a septic system on a four-acre or larger lot, that septic system is exempt.

An ordinance may also exempt or grant an extension of time for a septic system serving a structure that will soon be connected to a sewer system if the connection is available, imminent and written arrangements have been made for payment of connection fees or assessments by the septic system owner.

The bill requires the owner of a septic system subject to an evaluation program to have it pumped out and evaluated at least once every 5 years. A pump out is not required if the owner can provide documentation to show a pump out has been performed or there has been a permitted new installation, repair or modification of the septic system within the previous 5 years. The documentation must show both the capacity and that the condition of the tank is structurally sound and watertight.

If a tank, in the opinion of the qualified contractor, is in danger of being damaged by leaving the tank empty after inspection, the tank must be refilled before concluding the inspection. Replacing broken or damaged lids or manholes does not require a repair permit.

In addition to a pump out, the evaluation procedures require an assessment of the apparent structural condition and watertightness of the tank and an estimation of its size. A visual inspection of a tank is required when the tank is empty to detect cracks, leaks or other defects. The baffles or tees must be checked to ensure that they are intact and secure.[25] The evaluation must note the presence and condition of:

- Outlet devices;

[25] The septic tank baffle or tee is a device on the inlet or outlet of a septic tank which prevents sewage back-flow into the inlet or outlet pipe. The device may be made of concrete, steel, plastic, or other materials, but in all cases the septic tank tee or baffle forms a barrier between the septic tank and the inlet or outlet pipes to or from the septic tank. InspectAPedia, *Encyclopedia of Building & Environmental Inspection, Testing, Diagnosis, Repair*, available at http://www.inspectapedia.com/septic/tanktees.htm (last visited January 29, 2012).

- Effluent filters;
- Compartment walls;
- Any structural defect in the tank; and
- The condition and fit of the tank lid, including manholes.

The bill also requires a drainfield evaluation and requires certain assessments to be performed when a system contains pumps, siphons or alarms. The drainfield evaluation must include a determination of the approximate size and location of the drainfield. The evaluation must contain a statement noting whether there is any visible effluent on the ground or discharging to a ditch or water body and identifying the location of any downspout or other source of water near the drainfield.

If the septic system contains pumps, siphons or alarms, the following information may be provided:

- An assessment of dosing tank integrity, including the approximate volume and the type of material used in construction;
- Whether the pump is elevated off of the bottom of the chamber and its operational status;
- Whether the septic system has a check valve and purge hole; and
- Whether there is a high-water alarm, including whether the type of alarm is audio, visual or both, the location of the alarm, its operational condition and whether the electrical connections appears satisfactory.

The bill provides that if a homeowner does not request information about the system's pumps, siphons, or alarms, the qualified contractor and its employee are not liable for any damages directly relating from a failure of the system's pumps, siphons, or alarms. The evaluation report completed by the contractor must include a statement on the front cover that provides notice of the exclusion of such liability.

The reporting procedures provided for in the bill require:

- The qualified contractor to document all the evaluation procedures used;
- The qualified contractor to provide a copy of a written, signed evaluation report to the property owner and the county health department within 30 days after the evaluation;
- The name and license number of the company providing the report;
- The local county health department to retain a copy of the evaluation report for a minimum of 5 years and until a subsequent report is filed;
- The front cover of the report to identify any system failure and include a clear and conspicuous notice to the owner that the owner has a right to have any remediation performed by a contractor other than the contractor performing the evaluation;
- The report to identify tank defects, improper fit or other defects in the tank, manhole or lid, and any other missing component of the septic system;
- Noting if any sewage or effluent is present on the ground or discharging to a ditch or surface water body;
- Stating if any downspout, stormwater or other source of water is directed onto or towards the septic system;
- Identification of any maintenance need or condition that has the potential to interfere with or restrict any future repair or modification to the existing septic system; and

- Conclude with an overall assessment of the fundamental operational condition of the septic system.

The county health department will be responsible for administering the program on behalf of a county or municipality. A county or municipality may develop a reasonable fee schedule in consultation with a county health department. The fee must only be used to pay for the costs of administering the program and must be revenue neutral. The fee schedule must be included in the adopted ordinance for a septic system evaluation program. The fee shall be assessed to the septic system owner, collected by the qualified contractor and remitted to the county health department.

The county health department in a jurisdiction where a septic system evaluation program is adopted must:

- Provide a notice to a septic system owner at least 60 days before the septic system is due for an evaluation;
- In consultation with the DOH, provide for uniform disciplinary procedures and penalties for qualified contractors who do not comply with the requirements of the adopted ordinance; and
- Be the sole entity to assess penalties against a septic tank owner who fails to comply with the requirements of an adopted ordinance.

The bill requires the DOH to allow county health departments and qualified contractors to access the environmental health database to track relevant information and assimilate data from assessment and evaluation reports of the overall condition of onsite sewage treatment and disposal systems. The database must be used by qualified contractors to report service evaluations and by county health departments to notify septic system owners that their evaluations are due.

The bill requires a county or municipality that adopts a septic system evaluation and assessment program to notify the Secretary of Environmental Protection, the DOH and the requisite county health department. Once the DEP receives notice a county or municipality has adopted an evaluation program, it must, within existing resources, notify the county or municipality of the potential availability of Clean Water Act or Clean Water State Revolving Fund funds. If a county or municipality requests, the DEP must, within existing resources, provide guidance in the application process to access the abovementioned funding sources and provide advice and technical assistance on how to establish a low-interest revolving loan program or how to model a revolving loan program after the low-interest loan program of the Clean Water State Revolving Fund. The DEP is not required to provide any money to fund such programs. The bill specifically prohibits the DOH from adopting any rule that alters the provisions contained in the bill.

The bill specifies that it does not derogate or limit county and municipal home rule authority to act outside the scope of the evaluation program created in this bill. The bill clarifies it does not repeal or affect any other law relating to the subject matter of this section. It does not prohibit a county or municipality that has adopted an evaluation program pursuant to this section from:

- Enforcing existing ordinances or adopting new ordinances if such ordinances do not repeal, suspend or alter the requirements or limitations of this section; or
- Exercising its independent and existing authority to use and meet the requirements of s. 381.00655, F.S. (relating to connection to central sewer systems).

Section 3 repeals s. 381.00656, F.S., related to a low-income grant program to assist residents with costs associated from a septic system evaluation program and any necessary repairs or replacements.

Section 4 amends s. 381.0066, F.S., related to septic system fees. The bill deletes the existing fees for the 5-year evaluation report. The bill also reduces the annual operating permit fee for waterless, incinerating or organic waste composting toilets from not less than $50 to not less than $15 and from not more than $150 to not more than $30.

The bill repeals an obsolete provision related to setting a revenue neutral fee schedule for a state-wide septic system inspection program.

Section 5 provides an effective date of July 1, 2012.

Other Potential Implications:
The bill prohibits local ordinances from requiring repairs, modifications or system replacements unless a septic system is found to be failing. Septic system problems that do not rise to the level of a system failure cannot be required to be remedied under an ordinance. The septic system owner will have the option to repair or modify a septic system found to have problems. A county or municipality is preempted from requiring more stringent repair guidelines in its ordinance.

The bill prohibits counties and municipalities from acting outside the requirements and limitations of the bill to address public health and safety or provide for pollution abatement measures for water quality improvements. This prohibition may directly conflict with existing laws to address these issues. In addition, a local county or municipality may be required to take future action to comply with a future determination that an area within its jurisdiction is contributing to violations of water quality standards but may be prohibited from doing so by the provisions in this bill.

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:

The bill allows a county or municipality to assess a reasonable fee to cover the costs of administering the evaluation program. The fee will likely vary from jurisdiction to jurisdiction.

The bill reduces the fees for annual operating permits for waterless, incinerating, or organic waste composting toilets from not less than $50 to not less than $15 and from not more than $150 to not more than $30.

B. Private Sector Impact:

Owners of septic systems subject to the evaluation program will have to pay for septic system evaluations, including pump outs, every 5 years. The owners will also be responsible for the cost of required repairs, modifications or replacements of the septic system if it is found to be "failing." Although owners are responsible under current law for repairing failing septic systems, they may be unaware of the failing condition or unwilling or unable to pay for repairs or replacements.

A survey of septic contractors has not been completed to determine costs for inspections; however, anecdotal evidence has demonstrated a cost between $75 and $200, depending on the area of the state.

Current costs for pump outs range as low as $75 to over $300 depending on the size of the tank and local disposal options. Evaluation costs would be set by private contractors. Septic system owners would pay for any necessary remediation, including permit fees. Repair costs will vary from minor repairs to full system replacements and will only be available on a case-by-case basis. Whether or not demand for septic system contractor service increases is dependent on how many counties or municipalities implement inspection programs. Therefore, the impact of supply and demand on pricing trends cannot be determined at this time.

Therefore, adding in all potential costs not including repairs or replacements required under current law or the local administrative fee, a septic system owner can expect to pay between $150 and $500 every 5 years. It should be noted that in June 2010, the DOH and the Revenue Estimating Conference settled on a $50 fee per inspection report to cover programmatic costs of implementing a state-wide program.

The DOH estimates a cost savings to the public of $2,500 to $7,500 per system through preventive maintenance, thus eliminating the need for costly repairs associated with neglected, failing or improperly functioning systems.

C. Government Sector Impact:

The cost to counties or municipalities adopting evaluation programs is indeterminate as it depends on how large an area is covered by the evaluation program and how many septic systems are included.[26] Counties or municipalities with first magnitude springs will be required to expend funds to implement the provisions of this bill unless they opt out.

The DOH may incur costs associated with reprogramming the environmental health database to support the information reported by contractors and to be used by county health departments to notify owners when system evaluations are due. The DOH is in the process of determining whether there is a fiscal impact associated with reprogramming the database.

The DEP is required to take certain actions if and when it is notified of an ordinance that implements a local septic system evaluation program but only within existing resources.

VI. Technical Deficiencies:

The bill references "system" and "conventional system" to be understood in context as an "onsite sewage treatment and disposal system;" however, these terms are not defined in the bill. The bill may need to be amended to define a "system" or a "conventional system" as an "onsite sewage treatment and disposal system" if a shortened variant is warranted. Otherwise those instances that refer to "system" or "conventional system" should be changed to "onsite sewage treatment and disposal system" to be consistent with the existing definition.

The bill explicitly provides that it does not affect certain home rule authority. The provisions may be construed to conflict with the preemptions contained in this bill for both existing and potentially future septic system evaluation programs. For example, lines 671-672 provide that the bill does not "repeal or affect" laws related to septic systems; however, the bill explicitly preempts, in lines 217-219, existing septic system evaluation ordinances that require a point of sale inspection in a real estate transaction. These potential inconsistencies should be clarified.

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 January 31, 2012:

- Specifies that if a rule change occurs within 5 years after approval for construction, the rules applicable and in effect at the time of approval for construction apply at the time of the final approval of the septic system.
- Exempts contractors from liability from damages relating to a failure of a sewage system's pumps, siphons, or alarms, if a homeowner does not request specific

[26] There are 19 counties with first magnitude springs: Alachua, Bay, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Jackson, Jefferson, Lafayette, Lake, Leon, Levy, Madison, Marion, Suwannee, Volusia and Wakulla.

information about such devices during an evaluation. The exclusion from liability must be stated on the front cover of the evaluation report.
- Deletes the requirement that county health departments develop their own databases to track evaluations and evaluation programs and instead allows the county health departments and qualified contractors to access the Department of Health's environmental health database to track such information.

CS by Environmental Preservation and Conservation on January 9, 2012:
- Fixes cross-references;
- Prohibits a government entity from mandating point of sale inspections for septic systems in a real estate transaction;
- Clarifies the types and sizes of rebuilt structures that can be reconnected to an existing septic system after a disaster;
- Eliminates the requirement that exempted geographic areas from a septic system evaluation program not lead to additional or continued degradation of a first magnitude spring;
- Requires a majority plus one vote of a local governing body for counties or municipalities containing a first magnitude spring to opt out;
- Specifies existing evaluation programs are grandfathered in if they were in existence prior to July 1, 2011;
- Preempts any existing septic system evaluation program if it includes a point of sale inspection requirement;
- Removes impacts "groundwater" from the "system failure" definition;
- Removes the requirement that qualified contractors note the state of surface vegetation;
- Specifies a drainfield that does not achieve the required minimum separation distance between the bottom of the drainfield and the wettest season water table is not considered a system failure;
- Prohibits ordinances from requiring engineer-designed performance-based systems to remediate system failures for conventional septic systems;
- Allows development of a "reasonable" administrative fee for programmatic costs;
- Clarifies that only the county health department may assess penalties against a septic system owner;
- Expands the use of database and tracking system for recording information related to service evaluations;
- Prohibits the DOH from adopting rules that alter the provisions of the CS;
- Clarifies home rule authority as it relates to a local septic system evaluation program;
- Specifies the CS does not repeal or affect any existing law relating to septic systems;
- Limits a county or municipality from continuing to enforce existing ordinances or adopting new ones to address public health or safety if such ordinances affect the programmatic requirements contained in this CS;
- Limits a county or municipality from adopting pollution abatement measures for water quality improvements if such measures affect the programmatic requirements contained in this CS; and

- Allows a county or municipality to exercise its independent and existing authority to use and meet the requirements of s. 381.00655, F.S., related to connection to central sewer systems.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
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	.	

The Committee on Health Regulation (Jones) recommended the following:

Senate Amendment

Delete lines 239 - 685
and insert:
rule occurs within 5 years after the approval of the system for construction but before the final approval of the system, the rules applicable and in effect at the time of construction approval apply at the time of final approval if fundamental site conditions have not changed between the time of construction approval and final approval.

(z) A modification, replacement, or upgrade of an onsite sewage treatment and disposal system is not required for a

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remodeling addition to a single-family home if a bedroom is not added.

~~(5) EVALUATION AND ASSESSMENT.~~

~~(a) Beginning July 1, 2011, the department shall administer an onsite sewage treatment and disposal system evaluation program for the purpose of assessing the fundamental operational condition of systems and identifying any failures within the systems. The department shall adopt rules implementing the program standards, procedures, and requirements, including, but not limited to, a schedule for a 5-year evaluation cycle, requirements for the pump-out of a system or repair of a failing system, enforcement procedures for failure of a system owner to obtain an evaluation of the system, and failure of a contractor to timely submit evaluation results to the department and the system owner. The department shall ensure statewide implementation of the evaluation and assessment program by January 1, 2016.~~

~~(b) Owners of an onsite sewage treatment and disposal system, excluding a system that is required to obtain an operating permit, shall have the system evaluated at least once every 5 years to assess the fundamental operational condition of the system, and identify any failure within the system.~~

~~(c) All evaluation procedures must be documented and nothing in this subsection limits the amount of detail an evaluator may provide at his or her professional discretion. The evaluation must include a tank and drainfield evaluation, a written assessment of the condition of the system, and, if necessary, a disclosure statement pursuant to the department's procedure.~~

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~~(d)1. Systems being evaluated that were installed prior to January 1, 1983, shall meet a minimum 6-inch separation from the bottom of the drainfield to the wettest season water table elevation as defined by department rule. All drainfield repairs, replacements or modifications to systems installed prior to January 1, 1983, shall meet a minimum 12-inch separation from the bottom of the drainfield to the wettest season water table elevation as defined by department rule.~~

~~2. Systems being evaluated that were installed on or after January 1, 1983, shall meet a minimum 12-inch separation from the bottom of the drainfield to the wettest season water table elevation as defined by department rule. All drainfield repairs, replacements or modification to systems developed on or after January 1, 1983, shall meet a minimum 24-inch separation from the bottom of the drainfield to the wettest season water table elevation.~~

~~(c) If documentation of a tank pump-out or a permitted new installation, repair, or modification of the system within the previous 5 years is provided, and states the capacity of the tank and indicates that the condition of the tank is not a sanitary or public health nuisance pursuant to department rule, a pump-out of the system is not required.~~

~~(f) Owners are responsible for paying the cost of any required pump-out, repair, or replacement pursuant to department rule, and may not request partial evaluation or the omission of portions of the evaluation.~~

~~(g) Each evaluation or pump-out required under this subsection must be performed by a septic tank contractor or master septic tank contractor registered under part III of~~

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~~chapter 489, a professional engineer with wastewater treatment system experience licensed pursuant to chapter 471, or an environmental health professional certified under chapter 381 in the area of onsite sewage treatment and disposal system evaluation.~~

~~(h) The evaluation report fee collected pursuant to s. 381.0066(2)(b) shall be remitted to the department by the evaluator at the time the report is submitted.~~

~~(i) Prior to any evaluation deadline, the department must provide a minimum of 60 days' notice to owners that their systems must be evaluated by that deadline. The department may include a copy of any homeowner educational materials developed pursuant to this section which provides information on the proper maintenance of onsite sewage treatment and disposal systems.~~

(5)~~(6)~~ ENFORCEMENT; RIGHT OF ENTRY; CITATIONS.—

(a) Department personnel who have reason to believe noncompliance exists, may at any reasonable time, enter the premises permitted under ss. 381.0065-381.0066, or the business premises of any septic tank contractor or master septic tank contractor registered under part III of chapter 489, or any premises that the department has reason to believe is being operated or maintained not in compliance, to determine compliance with the provisions of this section, part I of chapter 386, or part III of chapter 489 or rules or standards adopted under ss. 381.0065-381.0067, part I of chapter 386, or part III of chapter 489. As used in this paragraph, the term "premises" does not include a residence or private building. To gain entry to a residence or private building, the department

must obtain permission from the owner or occupant or secure an inspection warrant from a court of competent jurisdiction.

(b)1. The department may issue citations that may contain an order of correction or an order to pay a fine, or both, for violations of ss. 381.0065-381.0067, part I of chapter 386, or part III of chapter 489 or the rules adopted by the department, when a violation of these sections or rules is enforceable by an administrative or civil remedy, or when a violation of these sections or rules is a misdemeanor of the second degree. A citation issued under ss. 381.0065-381.0067, part I of chapter 386, or part III of chapter 489 constitutes a notice of proposed agency action.

2. A citation must be in writing and must describe the particular nature of the violation, including specific reference to the provisions of law or rule allegedly violated.

3. The fines imposed by a citation issued by the department may not exceed $500 for each violation. Each day the violation exists constitutes a separate violation for which a citation may be issued.

4. The department shall inform the recipient, by written notice pursuant to ss. 120.569 and 120.57, of the right to an administrative hearing to contest the citation within 21 days after the date the citation is received. The citation must contain a conspicuous statement that if the recipient fails to pay the fine within the time allowed, or fails to appear to contest the citation after having requested a hearing, the recipient has waived the recipient's right to contest the citation and must pay an amount up to the maximum fine.

5. The department may reduce or waive the fine imposed by

the citation. In determining whether to reduce or waive the fine, the department must consider the gravity of the violation, the person's attempts at correcting the violation, and the person's history of previous violations including violations for which enforcement actions were taken under ss. 381.0065-381.0067, part I of chapter 386, part III of chapter 489, or other provisions of law or rule.

6. Any person who willfully refuses to sign and accept a citation issued by the department commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

7. The department, pursuant to ss. 381.0065-381.0067, part I of chapter 386, or part III of chapter 489, shall deposit any fines it collects in the county health department trust fund for use in providing services specified in those sections.

8. This section provides an alternative means of enforcing ss. 381.0065-381.0067, part I of chapter 386, and part III of chapter 489. This section does not prohibit the department from enforcing ss. 381.0065-381.0067, part I of chapter 386, or part III of chapter 489, or its rules, by any other means. However, the department must elect to use only a single method of enforcement for each violation.

(6) ~~(7)~~ LAND APPLICATION OF SEPTAGE PROHIBITED.—Effective January 1, 2016, the land application of septage from onsite sewage treatment and disposal systems is prohibited. ~~By February 1, 2011, the department, in consultation with the Department of Environmental Protection, shall provide a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives, recommending alternative methods to~~

~~establish enhanced treatment levels for the land application of septage from onsite sewage and disposal systems. The report shall include, but is not limited to, a schedule for the reduction in land application, appropriate treatment levels, alternative methods for treatment and disposal, enhanced application site permitting requirements including any requirements for nutrient management plans, and the range of costs to local governments, affected businesses, and individuals for alternative treatment and disposal methods. The report shall also include any recommendations for legislation or rule authority needed to reduce land application of septage.~~

Section 2. Section 381.00651, Florida Statutes, is created to read:

381.00651 Periodic evaluation and assessment of onsite sewage treatment and disposal systems.—

(1) For the purposes of this section, the term "first magnitude spring" means a spring that has a median water discharge of greater than or equal to 100 cubic feet per second for the period of record, as determined by the Department of Environmental Protection.

(2) A county or municipality that contains a first magnitude spring shall, by no later than January 1, 2013, develop and adopt by local ordinance an onsite sewage treatment and disposal system evaluation and assessment program that meets the requirements of this section. The ordinance may apply within all or part of its geographic area. Those counties or municipalities containing a first magnitude spring which have already adopted an onsite sewage treatment and disposal system evaluation and assessment program and which meet the

grandfathering requirements contained in this section, or have chosen to opt out of this section in the manner provided herein, are exempt from the requirement to adopt an ordinance implementing an evaluation and assessment program. The governing body of a local government that chooses to opt out of this section, by a majority plus one vote of the members of the governing board, shall do so by adopting a resolution that indicates an intent on the part of such local government not to adopt an onsite sewage treatment and disposal system evaluation and assessment program. Such resolution shall be addressed and transmitted to the Secretary of State. Absent an interlocal agreement or county charter provision to the contrary, a municipality may elect to opt out of the requirements of this section, by a majority plus one vote of the members of the governing board, notwithstanding a contrary decision of the governing body of a county. Any local government that has properly opted out of this section but subsequently chooses to adopt an evaluation and assessment program may do so only pursuant to the requirements of this section and may not deviate from such requirements.

(3) Any county or municipality that does not contain a first magnitude spring may at any time develop and adopt by local ordinance an onsite sewage treatment and disposal system evaluation and assessment program, provided such program meets and does not deviate from the requirements of this section.

(4) Notwithstanding any other provision in this section, a county or municipality that has adopted a program before July 1, 2011, may continue to enforce its current program without having to meet the requirements of this section, provided such program

does not require an evaluation at the point of sale in a real estate transaction.

(5) Any county or municipality may repeal an ordinance adopted pursuant to this section only if the county or municipality notifies the Secretary of State by letter of the repeal. No county or municipality may adopt an onsite sewage treatment and disposal system evaluation and assessment program except pursuant to this section.

(6) The requirements for an onsite sewage treatment and disposal system evaluation and assessment program are as follows:

(a) *Evaluations.*—An evaluation of each onsite sewage treatment and disposal system within all or part of the county's or municipality's jurisdiction must take place once every 5 years to assess the fundamental operational condition of the system and to identify system failures. The ordinance may not mandate an evaluation at the point of sale in a real estate transaction and may not require a soil examination. The location of the system shall be identified. A tank and drainfield evaluation and a written assessment of the overall condition of the system pursuant to the assessment procedure prescribed in subsection (7) are required.

(b) *Qualified contractors.*—Each evaluation required under this subsection must be performed by a qualified contractor, who may be a septic tank contractor or master septic tank contractor registered under part III of chapter 489, a professional engineer having wastewater treatment system experience and licensed under chapter 471, or an environmental health professional certified under this chapter in the area of onsite

sewage treatment and disposal system evaluation. Evaluations and pump-outs may also be performed by an authorized employee working under the supervision of an individual listed in this paragraph; however, all evaluation forms must be signed by a qualified contractor in writing or by electronic signature.

(c) *Repair of systems.*—The local ordinance may not require a repair, modification, or replacement of a system as a result of an evaluation unless the evaluation identifies a system failure. For purposes of this subsection, the term "system failure" means a condition existing within an onsite sewage treatment and disposal system which results in the discharge of untreated or partially treated wastewater onto the ground surface or into surface water or that results in the failure of building plumbing to discharge properly and presents a sanitary nuisance. A system is not in failure if the system does not have a minimum separation distance between the drainfield and the wettest season water table or if an obstruction in a sanitary line or an effluent screen or filter prevents effluent from flowing into a drainfield. If a system failure is identified and several allowable remedial measures are available to resolve the failure, the system owner may choose the least costly allowable remedial measure to fix the system. There may be instances in which a pump-out is sufficient to resolve a system failure. Allowable remedial measures to resolve a system failure are limited to what is necessary to resolve the failure and must meet, to the maximum extent practicable, the requirements of the repair code in effect when the repair is made, subject to the exceptions specified in s. 381.0065(4)(g). An engineer-designed performance-based treatment system to reduce nutrients may not

be required as an alternative remediation measure to resolve the failure of a conventional system.

(d) *Exemptions.*—

1. The local ordinance shall exempt from the evaluation requirements any system that is required to obtain an operating permit pursuant to state law or that is inspected by the department pursuant to the annual permit inspection requirements of chapter 513.

2. The local ordinance may provide for an exemption or an extension of time to obtain an evaluation and assessment if connection to a sewer system is available, connection to the sewer system is imminent, and written arrangements for payment of any utility assessments or connection fees have been made by the system owner.

3. An onsite sewage treatment and disposal system serving a residential dwelling unit on a lot with a ratio of one bedroom per acre or greater is exempt from the requirements of this section and may not be included in any onsite sewage treatment and disposal system inspection program.

(7) The following procedures shall be used for conducting evaluations:

(a) *Tank evaluation.*—The tank evaluation shall assess the apparent structural condition and watertightness of the tank and shall estimate the size of the tank. The evaluation must include a pump-out. However, an ordinance may not require a pump-out if there is documentation indicating that a tank pump-out or a permitted new installation, repair, or modification of the system has occurred within the previous 5 years, identifying the capacity of the tank, and indicating that the condition of the

tank is structurally sound and watertight. Visual inspection of the tank must be made when the tank is empty to detect cracks, leaks, or other defects. Baffles or tees must be checked to ensure that they are intact and secure. The evaluation shall note the presence and condition of outlet devices, effluent filters, and compartment walls; any structural defect in the tank; the condition and fit of the tank lid, including manholes; whether surface water can infiltrate the tank; and whether the tank was pumped out. If the tank, in the opinion of the qualified contractor, is in danger of being damaged by leaving the tank empty after inspection, the tank shall be refilled before concluding the inspection. Broken or damaged lids or manholes shall be replaced without obtaining a repair permit.

(b) *Drainfield evaluation.*—The drainfield evaluation must include a determination of the approximate size and location of the drainfield. The evaluation shall state whether there is any sewage or effluent visible on the ground or discharging to a ditch or other water body and the location of any downspout or other source of water near or in the vicinity of the drainfield.

(c) *Special circumstances.*—If the system contains pumps, siphons, or alarms, the following information may be provided at the request of the homeowner:

1. An assessment of dosing tank integrity, including the approximate volume and the type of material used in the tank's construction;

2. Whether the pump is elevated off the bottom of the chamber and its operational status;

3. Whether the system has a check valve and purge hole; and

4. Whether the system has a high-water alarm, and if so

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whether the alarm is audio or visual or both, the location and operational condition of the alarm, and whether the electrical connections to the alarm appear satisfactory.

If the homeowner does not request this information, the qualified contractor and its employee are not liable for any damages directly relating from a failure of the system's pumps, siphons, or alarms. This exclusion of liability must be stated on the front cover of the report required under paragraph (d).

(d) *Assessment procedure.*—All evaluation procedures used by a qualified contractor shall be documented in the environmental health database of the Department of Health. The qualified contractor shall provide a copy of a written, signed evaluation report to the property owner upon completion of the evaluation and to the county health department within 30 days after the evaluation. The report shall contain the name and license number of the company providing the report. A copy of the evaluation report shall be retained by the local county health department for a minimum of 5 years and until a subsequent inspection report is filed. The front cover of the report must identify any system failure and include a clear and conspicuous notice to the owner that the owner has a right to have any remediation of the failure performed by a qualified contractor other than the contractor performing the evaluation. The report must further identify any crack, leak, improper fit, or other defect in the tank, manhole, or lid, and any other damaged or missing component; any sewage or effluent visible on the ground or discharging to a ditch or other surface water body; any downspout, stormwater, or other source of water directed onto or

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toward the system; and any other maintenance need or condition of the system at the time of the evaluation which, in the opinion of the qualified contractor, would possibly interfere with or restrict any future repair or modification to the existing system. The report shall conclude with an overall assessment of the fundamental operational condition of the system.

(8) The county health department shall administer any evaluation program on behalf of a county, or a municipality within the county, that has adopted an evaluation program pursuant to this section. In order to administer the evaluation program, the county or municipality, in consultation with the county health department, may develop a reasonable fee schedule to be used solely to pay for the costs of administering the evaluation program. Such a fee schedule shall be identified in the ordinance that adopts the evaluation program. When arriving at a reasonable fee schedule, the estimated annual revenues to be derived from fees may not exceed reasonable estimated annual costs of the program. Fees shall be assessed to the system owner during an inspection and separately identified on the invoice of the qualified contractor. Fees shall be remitted by the qualified contractor to the county health department. The county health department's administrative responsibilities include the following:

(a) Providing a notice to the system owner at least 60 days before the system is due for an evaluation. The notice may include information on the proper maintenance of onsite sewage treatment and disposal systems.

(b) In consultation with the Department of Health,


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providing uniform disciplinary procedures and penalties for qualified contractors who do not comply with the requirements of the adopted ordinance, including, but not limited to, failure to provide the evaluation report as required in this subsection to the system owner and the county health department. Only the county health department may assess penalties against system owners for failure to comply with the adopted ordinance, consistent with existing requirements of law.

(9)(a) A county or municipality that adopts an onsite sewage treatment and disposal system evaluation and assessment program pursuant to this section shall notify the Secretary of Environmental Protection, the Department of Health, and the applicable county health department upon the adoption of its ordinance establishing the program.

(b) Upon receipt of the notice under paragraph (a), the Department of Environmental Protection shall, within existing resources, notify the county or municipality of the potential use of, and access to, program funds under the Clean Water State Revolving Fund or s. 319 of the Clean Water Act, provide guidance in the application process to receive such moneys, and provide advice and technical assistance to the county or municipality on how to establish a low-interest revolving loan program or how to model a revolving loan program after the low-interest loan program of the Clean Water State Revolving Fund. This paragraph does not obligate the Department of Environmental Protection to provide any county or municipality with money to fund such programs.

(c) The Department of Health may not adopt any rule that alters the provisions of this section.


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(d) The Department of Health must allow county health departments and qualified contractors access to the environmental health database to track relevant information and assimilate data from assessment and evaluation reports of the overall condition of onsite sewage treatment and disposal systems. The environmental health database must be used by contractors to report each service and evaluation event and by a county health department to notify owners of onsite sewage treatment and disposal systems when evaluations are due. Data and information must be recorded and updated as service and evaluations are conducted and reported.

(10) This section does not:

(a) Limit county and municipal home rule authority to act outside the scope of the evaluation and assessment program set forth in this section;

(b) Repeal or affect any other law relating to the subject matter of onsite sewage treatment and disposal systems; or

(c) Prohibit a county or municipality from:

1. Enforcing existing ordinances or adopting new ordinances relating to onsite sewage treatment facilities to address public health and safety if such ordinances do not repeal, suspend, or alter the requirements or limitations of this section.

2. Adopting local environmental and pollution abatement ordinances for water quality improvement as provided for by law if such ordinances do not repeal, suspend, or alter the requirements or limitations of this section.

3. Exercising its independent and existing authority to meet the requirements of s. 381.0065.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Environmental Preservation and Conservation, *Chair*
Criminal Justice, *Vice Chair*
Budget - Subcommittee on Transportation, Tourism, and Economic Development Appropriations
Governmental Oversight and Accountability
Reapportionment
Regulated Industries

SENATOR CHARLES S. DEAN, SR.
3rd District

December 11, 2012

The Honorable Rene Garcia
310 Senate Office Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Mr. Chairman:

I respectfully request you place Senate Bill 820, relating to Onsite Sewage Treatment and Disposal Sytems, on your Health Regulation Committee agenda at your earliest convenience.

If you have any concerns, please do not hesitate to contact me personally.

Sincerely,

Charles S. Dean
State Senator District 3

cc: Sandra Stovall, Staff Director

ENTERED

REPLY TO:
❒ 405 Tompkins Street, Inverness, Florida 34450 (352) 860-5175
❒ Post Office Box 2558, Ocala, Florida 34478-2558 (352) 873-6513
❒ 302 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5017

Senate's Website: *www.flsenate.gov*

MIKE HARIDOPOLOS
President of the Senate

MICHAEL S. "MIKE" BENNETT
President Pro Tempore

TRI-COUNTY ASSOCIATION H.E.L.P., Inc.

Health
Environmental
Legislative
Policies

MEMORANDUM TO: Senate Health Regulation Committee: Senator Rene Garcia, Chair; Senator Eleanor Sobel, Vice Chair; Senator Miguel Diaz de la Portilla; Senator Mike Fasano; Senator Don Gaetz; Senator Dennis L. Jones; Senator Jim Norman
SUBJECT: Senate Bill CS/SB 820

Dear Committee Members,
TRI-County Association H.E.L.P., Inc. represents homeowners and businesses in Lake, Orange, and Seminole County. Our Board members and Advisors have been involved in this issue for more than six years and have conducted intense research. We have continuously attended all TRAP and RRAC meetings, Wekiva Basin Commission meetings and congressional EPA meetings so that we can understand and communicate the facts and address the concerns about septic systems.

As you deliberate the merits of Senate Bill CS/SB 820, we appreciate your consideration of the following information and conclusions:

(1) septic systems are the least significant contributor to pollution issues.
(2) properly installed and maintained septic systems are in fact very efficient at removing nutrients and bacteria
(3) the maximum benefit to the environment and public health will be delivered if a simple and affordable inspection and maintenance process is put in place for communities to adopt and homeowners to follow.

CS/SB 820 puts simple inspection process and maintenance program in place that can address effectively any public health or environmental threats presented by failing septic systems. It provides the means for the relatively few systems that actually are failing to be repaired according to existing state statutes and codes. These statutes and codes have been put in place to provide maximum environmental and public health protection. Homeowners across Florida have relied on these statutes and codes as their assurance that their health, the health of the environment, and the investment in their property is protected. Further, the majority of existing systems have already been installed or repaired according to existing code. That said, the most cost-effective and appropriate time to address the issue of water table separation is when a system is no longer functioning, as defined in CS/SB820.

CS/SB 820 also provides for a means to protect all of Florida's springs and watersheds, not just the First Magnitude Springs. Communities know where the environmental "hot spots" are. It's in their own best interests and in the best interests of the citizens who require safe drinking water to deal effectively and efficiently with those "hot spots." They are also in the best position to accommodate the financial conditions of their residents, many of whom are facing extreme financial hardship. However, we do not have to favor one goal over another. TRI-County Association believes CS/SB 820 creates a situation where we, as a state, can deal realistically and sympathetically with local economic challenges without sacrificing clean water goals.

Senate Bill 550 introduced a scenario of huge cost to the state and the implementation proposals introduced staggering cost to our residents. It did not, however, introduce a reasonable cost/benefit justification. CS/SB820 removes those huge costs, and it provides exactly the cost/benefit justification that is needed in any worthwhile effort. It is the stuff of best practice solutions, good policy, and good legislation. After these many years of intense research and attention to the detail of this bill and its House companion, HB999, we believe your yes vote is amply justified and validated by the science, the scope, and the nature of the problems this committee and our state's residents are trying to solve.

Thank you,
Andrea Samson, President
TRI-County Association H.E.L.P., Inc.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1-31-2012
Meeting Date

Topic _____ Bill Number 820 + amendment *(if applicable)*

Name John Rothell Amendment Barcode _____ *(if applicable)*

Job Title Dir. of Pol. Operations

Address 200 S. Monroe St. Phone 224-1400

Street

Tallahassee FL 32301 E-mail johnr@floridarealtors.org

City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information

Representing FL Realtors

Appearing at request of Chair: ☐ Yes ☐ No Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/31/12
Meeting Date

Topic onsite sewer treatment & disposal systems

Bill Number 820 *(if applicable)*

Name Keyna Cory

Amendment Barcode _____ *(if applicable)*

Job Title Senior Lobbyist

Address 110 E. College Ave
Street
Tallahassee FL 32301
City *State* *Zip*

Phone 8506811065

E-mail keynacory@pacensultants.com

Speaking: ☒ For ☐ Against ☐ Information

Representing AIF

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

Spoke

1/31/2012
Meeting Date

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Topic Septic System / On Site Sewage Disposal

Bill Number SB 820 *(if applicable)*

Name Dan Peterson

Amendment Barcode *(if applicable)*

Job Title Executive Director

Address ~~5202~~ 2878 S. Osceola Ave
Street

Phone 407-758-2491

Orlando FL 32806
City *State* *Zip*

E-mail danpeterson@proprights.com

Speaking: ☒ For ☐ Against ☐ Information

Representing Coalition for Property Rights

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

31 Jan 2012
Meeting Date

Topic ONSITE SEWAGE

Bill Number 820 *(if applicable)*

Name Roxanne GROOVER

Amendment Barcode *(if applicable)*

Job Title EXECUTIVE DIRECTOR

Address 5115 STATE ROAD 557
Street

LAKE ALFRED FL 33850
City *State* *Zip*

Phone 8639565540

E-mail rgroover@fowaonsite.com

Speaking: ☑ For ☐ Against ☐ Information

Representing FLORIDA ONSITE WASTEWATER ASSOCIATION

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

Spoke

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1-31-12
Meeting Date

Topic GSTDs

Bill Number 820
(if applicable)

Name David Cullen

Amendment Barcode
(if applicable)

Job Title

Address 1674 University Pkwy #246
Street

Sarasota FL 34243
City *State* *Zip*

Phone 941.323.2404

E-mail cullenassoc@aol.com

Speaking: ☐ For ☑ Against ☐ Information

Representing Sierra Club Florida

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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S-001 (10/20/11)

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 Health Regulation Committee

BILL: CS/SB 1600

INTRODUCER: Health Regulation Committee and Senator Storms

SUBJECT: Telebehavioral Health Care Services

DATE: February 1, 2012 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Wilson	Stovall	HR	**Fav/CS**
2.			BC	
3.				
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:

The bill directs the Agency for Health Care Administration (AHCA) to implement telebehavioral health care services, as an optional Medicaid-covered service, for all community-based behavioral health services, except for those services that require physical contact, such as physical exams. These services must be delivered by a person who is: licensed in Florida, under contract with a Medicaid provider that is enrolled in Florida's Medicaid program, and authorized to provide Medicaid community mental health services. The bill also directs the AHCA to seek federal authorization to allow the delivery of telebehavioral health care services by any person currently authorized by rule to deliver such services.

This bill substantially amends section 409.906 of the Florida Statutes.

II. Present Situation:

Medicaid

Medicaid is the medical assistance program that provides access to health care for low-income families and individuals. Medicaid also assists aged and disabled people with the costs of nursing facility care and other medical expenses. The Agency for Health Care Administration (AHCA) is responsible for administering the Medicaid program. Medicaid serves approximately 3.19 million people in Florida. Estimated Medicaid expenditures for FY 2011-2012 are approximately $20.3 billion.

Medicaid reimburses health care providers that have a provider agreement with the AHCA only for goods and services that are covered by the Medicaid program and only for individuals who are eligible for medical assistance from Medicaid. Section 409.905, F.S., identifies those services for which the Medicaid program is required to make payments. Section 409.906, F.S., identifies the services for which Florida has, at its option, decided to make payments under the Medicaid program.

Subsection 409.906(8), F.S., authorizes Medicaid to cover community behavioral health services provided to a recipient by a mental health or substance abuse provider under contract with the AHCA or the Department of Children and Family Services. Community behavioral health services include mental health and substance abuse services. The services include: assessments; treatment planning; medical and psychiatric services; individual, group and family therapies; community support and rehabilitative services; therapeutic behavioral on-site services for children and adolescents; as well as therapeutic foster care and group care services.[1]

Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare and Medicaid Services (CMS). Florida's Medicaid State Plan is a comprehensive written statement describing the scope and nature of the Medicaid program. The plan outlines current Medicaid eligibility standards, policies, and reimbursement methodologies to ensure the state program receives matching federal funds under Title XIX of the Social Security Act.

Telemedicine

The AHCA sought and has received approval from the CMS for a state plan amendment for telemedicine. Attachment 3.1-B (page 11) of the state plan[2] contains a description of telemedicine services under the Florida Medicaid program. Telemedicine services are subject to the specifications, conditions, and limitations set by the State. Telemedicine is defined as the practice of health care delivery by a practitioner who is located at a site other than the site where the patient is located for the purposes of evaluation, diagnosis, or recommendation of treatment.

Providers rendering telemedicine must involve the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time, interactive communication between the recipient and the practitioner to provide and support care when distance separates participants who are in different geographical locations. Telephone conversations, chart review, electronic mail messages, or facsimile transmissions are not considered telemedicine. All equipment required to provide telemedicine services is the responsibility of the providers.

[1] *Florida Medicaid Summary of Services, Fiscal Year 2011-2012*, page 51, Agency for Health Care Administration. Found at: <http://ahca.myflorida.com/Medicaid/flmedicaid.shtml> (Last visited on January 30, 2012).
[2] Found at: <http://ahca.myflorida.com/Medicaid/stateplanpdf/attachment_3-1-B.pdf> (Last visited on January 30, 2012).

The following providers are eligible to provide telemedicine services under Medicaid if they are licensed under the applicable Florida licensing statute:

- Physicians,
- Dentists,
- Psychiatric nurses,
- Registered nurses,
- Advanced registered nurse practitioners,
- Physician assistants,
- Clinical social workers,
- Mental health counselors,
- Marriage and family therapists,
- Masters level certified addictions professionals, and
- Psychologists.

Medicaid Telebehavioral Health Care Services

The Florida Medicaid program does not currently cover telebehavioral health care services. However, the AHCA expects to soon promulgate new Medicaid policy and contract amendments under the telemedicine provisions of the state plan that will allow reimbursement for telemedicine delivered by licensed mental health practitioners and psychiatrists. The fees, restrictions, and limitations will mirror the respective service delivered face-to-face to eliminate the possibility of any financial impact on Medicaid.

Currently, the AHCA is promulgating revisions for the *Medicaid Community Behavioral Health Services Coverage and Limitations Handbook* to add telemedicine as an approved service delivery method for several services. In addition, the AHCA is drafting a model amendment for Medicaid managed care plan contracts that will allow plans to cover telemedicine for Medicaid behavioral health services. These services will include telemedicine for behavioral health therapy and for psychiatric medication management. When the handbook and contract amendment are completed, Medicaid will be able to reimburse for *certain* telebehavioral health care services.

III. Effect of Proposed Changes:

The bill amends the list of optional Medicaid services to include telebehavioral health care services by licensed mental health professionals for *all* community-based behavioral health care services, except for those services that require physical contact, such as physical exams. The telebehavioral health care services must be delivered by a person who is: licensed in Florida, under contract with a Medicaid provider that is enrolled in Florida's Medicaid program, and authorized to provide Medicaid community mental health services. The bill requires the AHCA to seek authorization from the CMS to allow the delivery of such services by any person currently authorized by rule to deliver the services.

In implementing telemedicine for Medicaid behavioral health care services, the AHCA has anticipated limiting the coverage to psychiatric medication management and individual behavioral health therapy only. This decision was based on concerns the AHCA had about opening the door to more fraud and abuse by using this service modality to bill for services that

may occur with groups of recipients.[3] This bill would potentially allow licensed mental health practitioners to deliver most of the Medicaid community behavioral health services, including those that are allowed for groups of recipients, such as psychosocial rehabilitation services, day treatment, and group therapy, through telemedicine.

The effective date of the bill is July 1, 2012.

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:

Providers who wish to deliver telebehavioral health care services will have to invest in the necessary equipment.

Providers who deliver telebehavioral health care services may see their costs for reimbursing practitioners' travel (which is not reimbursable under Medicaid) reduced.

C. Government Sector Impact:

The fees, restrictions, and limitations for telebehavioral health care services will mirror the respective service delivered face-to-face to eliminate the possibility of any financial impact on Medicaid.

The potential for, and extent of, fraud and abuse that could occur by including certain services under telemedicine are unknown and the fiscal impact cannot be estimated.

[3] *See* Agency for Health Care Administration 2012 Bill Analysis and Economic Impact Statement for HB 659/SB 1600 – on file with the Senate Health Regulation Committee.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Using telemedicine for services provided in group settings could dilute the benefits of group and peer interactions for recipients. The social dynamics for these services constitute an important component of the treatment.[4]

Using telemedicine for services provided in group settings makes it more difficult to control for the confidentiality of participants. For a group that is addressed face-to-face, the practitioner can control what occurs in the room. Telemedicine delivered to a group does not easily allow for a way to prevent others from viewing or recording information about their peers.[5]

Recipients who participate in psychosocial rehabilitation and day treatment tend to be more vulnerable and less stable. Practitioners using telemedicine will likely experience a loss of clinical details about their recipient's physical status that is reflective of the recipient's mental health. These details include: gait, tremors, affect, dress, cleanliness (self-care), coordination, and evidence of self-injury.[6]

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 January 31, 2012:
The CS requires telebehavioral health care services to be delivered by a person who is: licensed in Florida, under contract with a Medicaid provider that is enrolled in Florida's Medicaid program, and authorized to provide Medicaid community mental health services. The service would no longer have to be provided from a location in Florida.

B. Amendments:

None.

[4] *Id.*
[5] *Id.*
[6] *Id.*

395126

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
	.	
	.	
	.	

The Committee on Health Regulation (Fasano) recommended the following:

Senate Amendment (with title amendment)

Delete lines 90 - 92
and insert:
exams. Telebehavioral health care services must be delivered by a person who is licensed in this state, under contract with a Medicaid provider that is enrolled in this state, and authorized to provide services under this subsection. The agency shall also seek authorization

========== T I T L E A M E N D M E N T ==========
And the title is amended as follows:

Florida Senate - 2012 COMMITTEE AMENDMENT
Bill No. SB 1600

395126

Delete line 11
and insert:
a licensed person who is under contract with a Medicaid provider that is enrolled in this state and authorized to provide telebehavioral health care services;

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Children, Families, and Elder Affairs, *Chair*
Budget - Subcommittee on Criminal and Civil Justice Appropriations
Community Affairs
Military Affairs, Space, and Domestic Security
Reapportionment
Transportation

SENATOR RONDA STORMS
10th District

January 17, 2012

Senator Rene Garcia, Chairman
Senate Committee on Health Regulation
310 Senate Office Building
404 S. Monroe Street
Tallahassee, FL 32399-1100

Dear Chairman Garcia:

Senate Bill 1600, relating to *Telebehavioral Health Care Services,* has been referred to your committee for its first committee of reference.

I would greatly appreciate you placing SB 1600 on the Health Regulation committee's agenda at your earliest convenience. Please do not hesitate to contact me should you have any questions.

Thank you for your consideration of this request.

Sincerely,

Senator Ronda Storms
Florida State Senate
10th District

Cc: Ms. Sandra R. Stovall, Staff Director
530 Knott Building

ENTERED

REPLY TO:
❒ Lithia Oaks Business Center, 421 Lithia Pinecrest Road, Brandon, Florida 33511 (813) 651-2189 FAX: (813) 651-2188
❒ 413 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5072
Internet Address: storms.ronda.web@flsenate.gov

Senate's Website: *www.flsenate.gov*

spoke

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/31/2012
Meeting Date

Topic Telebehavioral Health

Bill Number SB 1600 *(if applicable)*

Name Karen Koch (Cook)

Amendment Barcode *(if applicable)*

Job Title VP

Address 316 E. Park Avenue
Street
Tallahassee FL 32301
City *State* *Zip*

Phone 850-224-6048

E-mail Karen@fccmh.org

Speaking: ☒ For ☐ Against ☐ Information

Representing FL. Council for Behavioral Health care

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/20/11)

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 Health Regulation Committee

BILL: SB 1826

INTRODUCER: Senator Gardiner

SUBJECT: Developmental Disabilities

DATE: January 27, 2012 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Davlantes	Stovall	HR	**Pre-meeting**
2.			BC	
3.				
4.				
5.				
6.				

I. Summary:

This bill requires a healthcare provider who diagnoses a medical condition in a fetus based on a screening test to provide the pregnant mother with current information about the conditions that were tested for, the accuracy of such tests, and resources for support services for the diagnosed disorder. The bill also creates a prenatal advisory council within the Department of Health (the department) to establish a clearinghouse of information relating to support services for pregnant mothers of fetuses with prenatally-diagnosed conditions. The Office of Vital Statistics is required to refer women at risk for preterm birth or other high-risk conditions to appropriate health, education, social services, and other support services in accordance with s. 383.141, F.S.

The bill also amends provisions concerning the John M. McKay Scholarship Program to widen eligibility criteria and increase awareness of the program among military personnel. Regional autism centers must provide information on local resources for children who have all types of developmental disabilities and support state agencies in the development of training for early child care providers and educators with respect to all developmental disabilities.

This bill creates s. 383.141, Florida Statutes, and amends ss. 383.14, 1002.39, and 1004.55, Florida Statutes.

II. Present Situation:

Prenatal Screening in Medicine[1]

Prenatal testing is divided into two types, screening tests and diagnostic tests. Screening tests are safe, minimally-invasive studies performed in large, low-risk populations to detect conditions in which timely intervention can alter outcomes. Screening tests frequently produce false-positive results, so any positive finding must be confirmed with a diagnostic test.

Prenatal screening uses a combination of maternal blood tests and ultrasound to evaluate a fetus for various conditions. Diseases which may be detected on prenatal screening include Down syndrome (trisomy 21) and other trisomies; neural tube defects such as spina bifida; abdominal wall defects; kidney, skin, heart, lung, or limb malformations; ovarian tumors; abnormalities in the mother's uterus or placenta; and Tay-Sachs disease.

Diagnostic tests are more accurate, invasive, and prone to complications than screening tests. They are administered to women who have received a positive screening test result or who have risk factors or a family history for certain diseases. Such tests may involve analyzing amniotic fluid or drawing fetal blood. Diagnoses which may be made by such testing include Tay-Sachs disease, sickle-cell anemia, hemophilia, muscular dystrophy, cystic fibrosis, fetal hemolysis, Prader-Willi syndrome, thalassemia, and phenylketonuria (PKU).

More than 800 prenatal tests are available evaluate a wide range of diseases. Genetic counseling is an essential part of the testing process to keep families informed about the diagnosis, severity, and prognosis of any discovered disorder as well as available options for treatment.

Prenatal Screening in Statute

The Florida Healthy Start Program[2] provides for universal risk screening of all Florida's pregnant women and newborn infants to identify those at risk of poor birth, health, and developmental outcomes. Healthy Start also includes targeted support services to address identified risks, including information and referral, comprehensive assessment of service needs in light of family and community resources, ongoing care coordination and support to assure access to needed services, psychosocial, nutritional, and smoking cessation counseling, and childbirth, breastfeeding, and parenting support and education.[3]

Healthy Start prenatal screening focuses on improving mothers' medical or socioeconomic risk factors to create a healthier pregnancy. Factors considered in pregnant women include level of education, presence of other special needs children, marital status, mental health screening, financial hardship, drug and tobacco use, feelings about the pregnancy, and any medical problems. Healthy Start does not place any emphasis on support for those babies who have been

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[1] Medscape Reference, *Prenatal Diagnosis and Fetal Therapy*, available at: http://emedicine.medscape.com/article/936318-overview#aw2aab6b3 (last visited on January 27, 2012).
[2] Provisions for this program are located in s. 383.14, F.S., and related rules.
[3] Department of Health, *Florida's Healthy Start*, available at: http://www.doh.state.fl.us/Family/mch/hs/hs.html (last visited on January 27, 2012).

given a medical diagnosis via medical prenatal screening or genetic testing.[4] Physicians are required to administer such screening on the patient's initial pregnancy visit and report the results to the Office of Vital Statistics for further care coordination.[5]

Department screening for medical diseases occurs after the birth of the child. Specific diseases which are screened for and procedures for reporting are specified in rule. Newborns who receive a positive result on any of the disease screens are referred to appropriate healthcare professionals and support and counseling services.[6]

The department is also required to educate the public about the prevention and management of metabolic, hereditary, and congenital disorders associated with environmental risk factors; and promote the availability of genetic studies and counseling in order that the parents, siblings, and affected newborns may benefit from available knowledge of the condition.[7] Healthy Start provides information and support concerning environmental risk factors during pregnancy, and Children's Medical Services coordinates counseling for any disorders identified during post-natal screening, but currently no programs focus on prenatally-diagnosed medical conditions.[8]

Informed Consent

Before performing any medical testing or treatments, a patient must give voluntary, informed consent to the practitioner performing the procedure. The nature of the procedure, risks, benefits, potential results, and other available options must be explained to the patient in terms that he or she can understand. The patient must also be deemed mentally competent, meaning that he or she can understand the options and their implications and be able to make his or her own decisions. If a patient is not deemed mentally competent, the person appointed to make decisions for the patient must give informed consent.

Consent is often implied for routine tests such as blood draws or X-rays but must always be explicitly given for more invasive procedures such as surgery.[9,10]

Genetics and Newborn Screening Advisory Council

The Genetics and Newborn Screening Advisory Council (the council) was created within the department in 1980[11] to recommend the conditions that should be tested through newborn screening or genetic testing, the appropriate modalities to use, and how to make current testing services more coordinated and efficient. The council consists of:

- Two consumer members;
- Three pediatricians, including at least one pediatric hematologist;

[4] Department of Health, Healthy Start Program, *Prenatal Risk Screening Form*, available at: http://www.doh.state.fl.us/Family/mch/hs/english_prenatal_screen.pdf (last visited on January 27, 2012).
[5] Section 383.14(1)(a), F.S.
[6] Rule 64C-7, F.A.C.
[7] Section 383.14(3)(c) and (f), F.S.
[8] Telephone conversations with Healthy Start, Children's Medical Services, and department legislative staff.
[9] EMedicine Health, *Informed Consent*, available at: http://www.emedicinehealth.com/informed_consent/article_em.htm (last visited on January 27, 2012).
[10] Standards of practice for informed consent are also found in Rule 64B8-9.007, F.A.C.
[11] Phone conversation with Florida Newborn Screening Program staff.

- One representative from each of the four medical schools in the state;
- The State Surgeon General or his or her designee;
- One representative from Children's Medical Services;
- One representative from the Florida Hospital Association;
- One individual with experience in newborn screening programs;
- One individual representing audiologists; and
- One representative from the Agency for Persons with Disabilities.

Ad hoc or temporary technical advisory groups may be formed to assist the council with specific topics. Council members serve without pay but may be reimbursed for travel expenses.[12]

Statutory Creation of Advisory Bodies, Commissions, or Boards

The statutory creation of any collegial body to serve as an adjunct to an executive agency is subject to certain provisions in s. 20.052, F.S. Such a body may only be created when it is found to be necessary and beneficial to the furtherance of a public purpose, and it must be terminated by the Legislature when it no longer fulfills such a purpose. The Legislature and the public must be kept informed of the numbers, purposes, memberships, activities, and expenses of any collegial or advisory bodies.

A committee or task force is defined in statute to mean "an advisory body created without specific statutory enactment for a time not to exceed 1 year or created by specific statutory enactment for a time not to exceed 3 years and appointed to study a problem and recommend a solution or policy alternative with respect to that problem. Its existence terminates upon the completion of its assignment."[13]

Private citizen members of any advisory body (with exceptions for members of commissions or boards of trustees) may only be appointed by the Governor, the head of the executive agency to which the advisory body is adjunct, the executive director of the agency, or a Cabinet officer. Private citizen members of a commission or a board of trustees may only be appointed by the Governor, must be confirmed by the Senate, and are subject to the dual-office-holding prohibition of s. 5(a), Art. II of the State Constitution.

Members of agency advisory bodies serve for 4-year staggered terms and are ineligible for any compensation other than travel expenses, unless expressly provided otherwise in the State Constitution. Unless an exemption is specified by law, all meetings are public, and records of minutes and votes must be maintained.[14]

John M. McKay Scholarship for Students with Disabilities Program

The John M. McKay Scholarship for Students with Disabilities Program is established to provide the option to attend a public school other than the one to which assigned or to provide a

[12] Section 383.14(5)
[13] Section 20.03(8), F.S.
[14] Section 20.052, F.S.

scholarship to a private school of choice for certain students with disabilities.[15] To receive such a scholarship for enrollment in a private school, a student must have been accepted to a school which is eligible to participate in the program and have:

- Received specialized instructional services as part of a public pre-kindergarten program during the previous school year and has a current individual educational plan developed by the local school board fulfilling certain criteria;
- Attended a Florida public school or the Florida School for the Deaf and Blind during the previous school year; or
- Was enrolled in a public school during any of the 5 years prior to the 2010-2011 fiscal year, has a current individual educational plan developed by the local school board fulfilling certain criteria, and receives a first-time John M. McKay scholarship for the 2011-2012 school year.

A dependent child of a member of the military who transfers to a school in this state from another jurisdiction due to a parent's permanent change of station orders is exempt from these requirements.[16]

The scholarship will remain in force until the student returns to a public school, graduates from high school, or reaches the age of 22, whichever comes first. If a student enters a Department of Juvenile Justice detention center for more than 21 days, this is considered as a return to public school.[17]

Regional Autism Centers

Seven regional autism centers exist in Florida to provide nonresidential resource and training services to people with autism, pervasive developmental disorders not otherwise specified, autistic-like disabilities, dual sensory impairments (both permanent visual and hearing impairments[18]), or who have a sensory impairment with other handicapping conditions. The centers are located in Tallahassee, Gainesville, Jacksonville, Tampa, Miami, Orlando, and Boca Raton and operate independently of one another to coordinate services for residents in their regions. Centers coordinate services within and between state and local agencies and school districts but may not duplicate services provided by those agencies or school districts.

Each center provides:

- Staff with expertise in autism, autistic-like behaviors, and sensory impairments;
- Individual and direct family assistance in the home, community, and school;
- Technical assistance and consultation services for a client of the center, the client's family, and the school district;
- Professional training programs for personnel who work with the populations served by the centers;

[15] Students with disabilities eligible for this scholarship include K-12 students with documented intellectual disabilities, speech or language impairments, visual or hearing impairments, orthopedic impairments, other health impairments, emotional or behavioral disabilities, learning disabilities, traumatic brain injuries, developmental delay, or autism spectrum disorders. See s. 1002.39, F.S.
[16] Section 1002.39(1) and (2), F.S.
[17] Section 1002.39(4), F.S.
[18] Section 427.703(4), F.S.

- Public education programs to increase awareness of the public about autism, autistic-related disabilities of communication and behavior, dual sensory impairments, and sensory impairments with other handicapping conditions;
- Coordination and dissemination of information regarding available resources for children with the developmental disabilities served by regional autism centers;
- Support to state agencies in the development of training for early child care providers and educators with respect to the developmental disabilities served by regional autism centers.[19]

III. Effect of Proposed Changes:

Section 1 creates s. 383.141, F.S. This section provides legislative intent that pregnant women who choose to undergo prenatal screening should have access to timely and informative counseling about the conditions being tested for, the accuracy of such tests, and resources for obtaining support services for such conditions. Definitions for various terms are provided.

The bill requires a healthcare provider who diagnoses a medical condition in a fetus based on a prenatal test to provide the pregnant mother with current information about the conditions that were tested for, the accuracy of such tests, and resources for support services for the diagnosed disorder. Such services include information hotlines specific to Down syndrome or other prenatally-diagnosed conditions, support groups for parents and families, information clearinghouses, and developmental evaluation and intervention services under s. 391.303, F.S.

The bill also creates a prenatal advisory council within the department to establish a clearinghouse of information relating to support services for pregnant mothers of fetuses with prenatally-diagnosed conditions. The council will consist nine members who are health care providers or caregivers who perform health care services for persons who have developmental disabilities, including Down syndrome and autism. Three members each are appointed by the Governor, the President of the Senate, and the Speaker of the House of Representatives. The council will meet quarterly and will serve without compensation, although reimbursement for travel expenses is permitted. The department will provide administrative support to the council.

Section 2 amends s. 383.14, F.S., to require that the Office of Vital Statistics refer women at risk for preterm birth or other high-risk conditions to appropriate health, education, social services, and other support services in accordance with s. 383.141, F.S., created in this bill.

Section 3 amends s. 1002.39, F.S., concerning the John M. McKay Scholarship Program. Students who were enrolled in public school during any of the 5 years prior to the 2010-2011 fiscal year, have current individualized educational plans developed by the district school board following certain conditions, and receive a John M. McKay scholarship for the 2011-2012 school year— regardless of whether it was a first-time scholarship—will be able to enroll in an eligible private school. Dependent children of military personnel who transfer to a school in Florida from another jurisdiction pursuant to a parent's permanent change of station orders must be provided information on the John M. McKay Scholarship Program by the school.

[19] Section 1004.55, F.S.

Section 4 amends s. 1004.55, F.S., to require regional autism centers to provide information on local resources for children who have all types of developmental disabilities, not simply those described in subsection (1) of this section. Section 1004.55, F.S., pertains to services for persons of all ages and of all levels of intellectual functioning who have autism, pervasive developmental disorders that are not otherwise specified, autistic-like disabilities, dual sensory impairments, or sensory impairments with other handicapping conditions. Regional autism centers must also support state agencies in the development of training for early child care providers and educators with respect to all developmental disabilities.

Section 5 provides an effective date of July 1, 2012.

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 this 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:

Pregnant mothers of children prenatally-diagnosed with medical conditions will be better informed about the nature of the disease, treatment options, and support services. Additional children may qualify for the John M. McKay Scholarship Program, and military personnel who were reassigned to Florida will have greater awareness of the program. Families of children with all types of developmental disabilities will receive better support from regional autism centers.

C. Government Sector Impact:

Additional children may apply for the John M. McKay Scholarship Program due to increased eligibility criteria and increased awareness. Workload and costs for the department will increase related to administrative support of the prenatal advocacy council. Regional autism centers will experience an increase in workload and a negative

fiscal impact related to compiling resources and creating educational programs related to additional types of developmental disabilities.

VI. Technical Deficiencies:

The term “prenatally diagnosed condition” is broader than testing for developmental disabilities, which appears to be the focus of this bill. Other provisions in the bill could be amended for consistency.

VII. Related Issues:

Section 1004.55(1), F.S., states that regional autism centers may coordinate services within and between state and local agencies and school districts but may not duplicate services provided by those agencies or districts. The bill’s expansion of the types of developmental disabilities for which regional autism centers must provide support could go against this provision.

VIII. Additional Information:

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

None.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
	.	
	.	
	.	

The Committee on Health Regulation (Gaetz) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 383.141, Florida Statutes, is created to read:

383.141 Prenatally diagnosed conditions; patient to be provided information; definitions; clearinghouse of information; advisory council.—

(1) The Legislature finds that pregnant women who choose to undergo prenatal testing for developmental disabilities should have access to timely and informative counseling about the

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conditions being tested for, the accuracy of such tests, and resources for obtaining support services for such conditions. It is especially essential for a pregnant woman whose unborn child has been diagnosed with a developmental disability through prenatal testing to be adequately informed of the accuracy of such testing, implications of the diagnosis, possible treatment options, and available support networks, as the results of such testing and the counseling that follows may lead to the unnecessary abortion of unborn humans.

(2) As used in this section, the term:

(a) “Down syndrome” means a chromosomal disorder caused by an error in cell division which results in the presence of an extra whole or partial copy of chromosome 21.

(b) "Developmental disability" includes Down syndrome and other developmental disabilities defined by s. 393.063(9).

(c) “Health care provider” means a physician licensed or registered under ch. 458 or 459.

(d) “Prenatally diagnosed condition” means an adverse fetal health condition identified by prenatal testing.

(e) “Prenatal test” or "prenatal testing" means a diagnostic procedure or screening procedure performed on a pregnant woman or her unborn offspring to obtain information about her offspring’s health or development.

(3) When a developmental disability is diagnosed based on the results of a prenatal test, the health care provider who ordered the prenatal test, or his or her designee, shall provide the patient with current information about the nature of the developmental disability, the accuracy of the prenatal test, and resources for obtaining relevant support services, including

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hotlines, resource centers, and information clearinghouses related to Down syndrome or other prenatally diagnosed developmental disabilities; support programs for parents and families; and developmental evaluation and intervention services under s. 391.303.

(4) The Department of Health shall establish a clearinghouse of information related to developmental disabilities concerning providers of supportive services, information hotlines specific to Down syndrome and other prenatally diagnosed developmental disabilities, resource centers, educational programs, other support programs for parents and families, and developmental evaluation and intervention services under s. 391.303. Such information shall be made available to health care providers for use in counseling pregnant women whose unborn children have been prenatally diagnosed with developmental disabilities.

(a) There is established an advisory council within the Department of Health which consists of health care providers and caregivers who perform health care services for persons who have developmental disabilities, including Down syndrome and autism. This group shall consist of nine members:

1. Three members appointed by the Governor;

2. Three members appointed by the President of the Senate; and

3. Three members appointed by the Speaker of the House of Representatives.

(b) The advisory council shall provide technical assistance to the Department of Health in the establishment of the information clearinghouse and give the department the benefit of

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the council members' knowledge and experience relating to the needs of patients and families of patients with developmental disabilities and available support services.

(c) Members of the council shall elect a chairperson and a vice chairperson. The elected chairperson and vice chairperson shall serve in these roles until their terms of appointment on the council expire.

(d) The advisory council shall meet quarterly to review this clearinghouse of information, and may meet more often at the call of the chairperson or as determined by a majority of members.

(e) The council members shall serve four-year terms, except that, to provide for staggered terms, one initial appointee each from the Governor, the President of the Senate, and the Speaker of the House of Representatives shall serve a two-year term, one appointee each from these officials shall serve a three-year term, and the remaining initial appointees shall serve four-year terms. All subsequent appointments shall be for four-year terms. A vacancy shall be filled for the remainder of the unexpired term in the same manner as the original appointment.

(f) Members of the council shall serve without compensation but are entitled to reimbursement for per diem and travel expenses as provided in s. 112.061.

(f) The Department of Health shall provide administrative support for the advisory council.

Section 2. Paragraph (a) of subsection (2) of section 1002.39, Florida Statutes, is amended, and section (14) is added to that section to read:

1002.39 The John M. McKay Scholarships for Students with

Disabilities Program.—There is established a program that is separate and distinct from the Opportunity Scholarship Program and is named the John M. McKay Scholarships for Students with Disabilities Program.

(2) JOHN M. MCKAY SCHOLARSHIP ELIGIBILITY.—The parent of a student with a disability may request and receive from the state a John M. McKay Scholarship for the child to enroll in and attend a private school in accordance with this section if:

(a) The student has:

1. Received specialized instructional services under the Voluntary Prekindergarten Education Program pursuant to s. 1002.66 during the previous school year and the student has a current individual educational plan developed by the local school board in accordance with rules of the State Board of Education for the John M. McKay Scholarships for Students with Disabilities Program or a 504 accommodation plan has been issued under s. 504 of the Rehabilitation Act of 1973;

2. Spent the prior school year in attendance at a Florida public school or the Florida School for the Deaf and the Blind. For purposes of this subparagraph, prior school year in attendance means that the student was enrolled and reported by:

a. A school district for funding during the preceding October and February Florida Education Finance Program surveys in kindergarten through grade 12, which includes time spent in a Department of Juvenile Justice commitment program if funded under the Florida Education Finance Program;

b. The Florida School for the Deaf and the Blind during the preceding October and February student membership surveys in kindergarten through grade 12; or

c. A school district for funding during the preceding October and February Florida Education Finance Program surveys, was at least 4 years of age when so enrolled and reported, and was eligible for services under s. 1003.21(1)(e); or

3. Been enrolled and reported by a school district for funding, during the October and February Florida Education Finance Program surveys, in any of the 5 years prior to the 2010-2011 fiscal year; has a current individualized educational plan developed by the district school board in accordance with rules of the State Board of Education for the John M. McKay Scholarship Program no later than June 30, 2011; and receives a ~~first-time~~ John M. McKay scholarship for the 2011-2012 school year. Upon request of the parent, the local school district shall complete a matrix of services as required in subparagraph (5)(b)1. for a student requesting a current individualized educational plan in accordance with the provisions of this subparagraph.

However, a dependent child of a member of the United States Armed Forces who transfers to a school in this state from out of state or from a foreign country due to a parent's permanent change of station orders is exempt from this paragraph but must meet all other eligibility requirements to participate in the program. Upon the enrollment of the dependent child of a member of the United States Armed Forces, the school shall provide information regarding this program.

(14) THE JOHN M. MCKAY SCHOLARSHIPS FOR STUDENTS WITH DISABILITIES PILOT PROGRAM.—

(a) The John M. McKay Scholarships for Students with

Disabilities Pilot Program is established for 2 years in the Charlotte, DeSoto, Manatee, and Sarasota school districts to provide the option to receive a scholarship for instruction at private schools for students who:

1. Have a disability;

2. Are 22 years of age;

3. Are receiving instruction from an instructor in a private school to meet the high school graduation requirements in s. 1003.428;

4. Do not have a standard high school diploma or a special high school diploma; and

5. Receive supported employment services, which is employment that is located or provided in an integrated work setting, with earnings paid on a commensurate wage basis, and for which continued support is needed for job maintenance.

As used in this subsection, the term "student with a disability" includes a student who is documented as having an intellectual disability; a speech impairment; a language impairment; a hearing impairment, including deafness; a visual impairment, including blindness; a dual sensory impairment; an orthopedic impairment; another health impairment; an emotional or behavioral disability; a specific learning disability, including, but not limited to, dyslexia, dyscalculia, or developmental aphasia; a traumatic brain injury; a developmental delay; or autism spectrum disorder.

(b) For purposes of continuity of educational choice, a student participating in the John M. McKay Scholarship Pilot Program may continue to participate in the program until the

student graduates from high school, or reaches the age of 23, whichever occurs first.

(c) The supported employment services may be provided at more than one site.

(d) The provider of supported employment services must be a nonprofit corporation under s. 501(c)(3) of the Internal Revenue Code which serves Charlotte, DeSoto, Manatee, or Sarasota school districts and must contract with a private school in this state which meets the requirements in paragraph (e).

(e) A private school that participates in the program may be sectarian or nonsectarian and must meet the following requirements:

1. Be academically accountable for meeting the educational needs of the student by annually providing to the provider of supported employment services a written explanation of the student's progress.

2. Comply with the anti-discrimination provisions of 42 U.S.C. s. 2000d.

3. Meet state and local health and safety laws and codes.

4. Provide to the provider of supported employment services all documentation required for a student's participation, including the private school's and student's fee schedules, at least 30 days before any quarterly scholarship payment is made for the student. A student is not eligible to receive a quarterly scholarship payment if the private school fails to meet this deadline.

The inability of a private school to meet the requirements of this paragraph constitutes a basis for the ineligibility of the

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private school to participate in the scholarship program.

(f)1. If the student chooses to participate in the program and is accepted by the provider of supported employment services, the student must notify the Department of Education of his or her acceptance into the program 60 days before the first scholarship payment and before participating in the program in order to be eligible for the scholarship.

2. Upon receipt of a scholarship warrant, the student or parent to whom the warrant is made must restrictively endorse the warrant to the provider of supported employment services for deposit into the account of the provider. The student or parent may not designate any entity or individual associated with the participating provider of supported employment services as the student's or parent's attorney in fact to endorse a scholarship warrant. A participant who fails to comply with this paragraph forfeits the scholarship.

(g) Funds for the scholarship shall be provided through the Florida Education Finance Program to the school district for students who reside in the Charlotte, DeSoto, Manatee, or Sarasota school districts. During the 2-year pilot program, the maximum scholarship granted for an eligible student with a disability shall be equivalent to the base student allocation in the Florida Education Finance Program, multiplied by the high school cost factor, and multiplied by the district cost differential for the district in which the student resides.

(h) Upon notification by the Department of Education that it has received the required documentation, the Chief Financial Officer shall make scholarship payments in four equal amounts no later than September 1, November 1, February 1, and April 1 of

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each academic year in which the scholarship is in force. The initial payment shall be made after the Department of Education verifies that the student was accepted into the program, and subsequent payments shall be made upon verification of continued participation in the program. Payment must be by individual warrant made payable to the student or parent and mailed by the Department of Education to the provider of supported employment services, and the student or parent shall restrictively endorse the warrant to the provider of supported employment services for deposit into the account of that provider.

(i) Subsequent to each scholarship payment, the Department of Education shall request from the Department of Financial Services a sample of endorsed warrants to review and confirm compliance with endorsement requirements.

Section 3. Paragraphs (f) and (g) of subsection (4) of section 1004.55, Florida Statutes, are amended to read:

1004.55 Regional autism centers; public record exemptions.—

(4) Each center shall provide:

(f) Coordination and dissemination of local and regional information regarding available resources for services for children who have ~~with the~~ developmental disabilities as defined in s. 393.063(9) and s.393.063(13)~~described in subsection (1)~~.

(g) Support to state agencies in the development of training for early child care providers and educators with respect to ~~the~~ developmental disabilities as defined in s. 393.063(9) and s.393.063(13)~~described in subsection (1)~~.

Section 4. This act shall take effect July 1, 2012.

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

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And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to developmental disabilities; creating s. 383.141, F.S.; providing legislative findings; providing definitions; requiring that health care providers provide pregnant women with current information about the nature of the developmental disabilities tested for in certain prenatal tests, the accuracy of such tests, and resources for obtaining support services for Down syndrome and other prenatally diagnosed developmental disabilities; providing duties for the Department of Health concerning establishment of an information clearinghouse; creating an advocacy council within the Department of Health to provide technical assistance in forming the clearinghouse; providing membership for the council; providing duties of the council; providing terms for members of the council; providing for election of a chairperson and vice chairperson; providing meeting times for the council; requiring the members to serve without compensation but be reimbursed for per diem and travel expenses; requiring the Department of Health to provide administrative support; amending s. 1002.39, F.S.; expanding eligibility requirements; requiring that each school provide information regarding the John M. McKay Scholarship Program upon the enrollment of certain

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dependent children members of the United States Armed Forces; creating a 2-year pilot program to provide for scholarships to certain students who have disabilities to attend certain private schools under contract with providers of supported employment services; providing eligibility requirements for students; providing a definition for a student who has a disability; providing for the term of the scholarship; authorizing supported employment services to be provided at multiple sites; providing eligibility requirements for providers of supported employment services and private schools; providing that a private school that fails to meet the eligibility requirements is ineligible to participate in the program; requiring that a student who chooses to participate in the program notify the Department of Education of the student's acceptance into the program; providing for the restrictive endorsement of a warrant by a participating scholarship student or parent; prohibiting a power of attorney for endorsing a scholarship warrant; providing requirements for scholarship funding and payment; requiring that the Department of Education request from the Department of Financial Services a sample of endorsed warrants to review and confirm compliance with endorsement requirements; amending s. 1004.55, F.S.; requiring each regional autism center in this state to provide coordination and dissemination of local and regional information regarding available resources for services for

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children who have developmental disabilities; revising the requirements for regional autism centers with respect to supporting state agencies in development training; providing an effective date.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Communications, Energy, and Public Utilities, *Chair*
Budget - Subcommittee on Finance and Tax
Judiciary
Reapportionment
Rules

SENATOR ANDY GARDINER
Majority Leader
9th District

January 17, 2012

The Honorable Rene Garcia, Chair
Committee on Health Regulation
530 Knott Building
404 South Monroe Street
Tallahassee, Florida 32399

Dear Chair Garcia,

Senate Bill 1826 Developmental Disabilities has been referred to your committee. This legislation requires health care providers to provide pregnant women with current information regarding prenatal screenings. I respectfully request that Senate Bill 1826 be heard before your committee.

If you have any questions regarding this request, please do not hesitate to contact my office. Thank you for your time and consideration of this legislation.

Sincerely,

Andy Gardiner
State Senate, District 09

Cc: Sandra Stovall, Staff Director
Celia Georgiades, Committee Administrative Assistant

AG: svc

ENTERED

REPLY TO:
❒ 1013 East Michigan Street, Orlando, Florida 32806 (407) 428-5800
❒ 330 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5047

Senate's Website: *www.flsenate.gov*

MIKE HARIDOPOLOS
President of the Senate

MICHAEL S. "MIKE" BENNETT
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/31/2012
Meeting Date

Topic Services for people with developmental disabilities

Bill Number 1826 *(if applicable)*

Name Bill Muir

Amendment Barcode _____ *(if applicable)*

Job Title _____

Address 1800 S. Ocean Blvd
Street

Boca Raton FI 33432
City *State* *Zip*

Phone _____

E-mail wpmjbm@aol.com

Speaking: ☐ For ☐ Against ☑ Information

Representing self

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

COMMITTEE APPEARANCE RECORD

(Submit to Committee Chair or Administrative Assistant)

1/31/'12
Date

S.B. 1826
Bill Number

Name MARY-LYNN CULLEN

Phone 941-928-0278

Address 1674 University PKwy
Street

E-mail aichildren@aol.com

Sarasota FL 34243
City *State* *Zip*

Job Title Legislative Liaison

Speaking: ☑ For ☐ Against ☐ Information

Appearing at request of Chair ☐

Subject Developmental Disabilities

Representing Advocacy Institute for Children

Lobbyist registered with Legislature: ☑ Yes ☐ No

Pursuant to s. 11.061, *Florida Statutes*, state, state university, or community college employees are required to file the first copy of this form with the Committee, unless appearance has been requested by the Chair as a witness or for informational purposes.

If designated employee: Time: from _____ ___ .m. to _____ ___ .m.

S-001 (08/2005)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/31/2012
Meeting Date

Topic Services for people with developmental disabilities

Bill Number 1826 *(if applicable)*

Name Julie Delmonego

Amendment Barcode *(if applicable)*

Job Title Parent

Address 2117 Queenswood DR
Street

Phone

TLH FL 32303
City *State* *Zip*

E-mail rnjdelmonego@comcast.net

Speaking: ☐ For ☐ Against ☑ Information

Representing self

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

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 Health Regulation Committee

BILL:	SB 1316
INTRODUCER:	Senator Gaetz
SUBJECT:	Health Care
DATE:	January 27, 2012 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Wilson	Stovall	HR	**Pre-meeting**
2.			BC	
3.				
4.				
5.				
6.				

I. Summary:

This bill deals generally with accountability of health care providers. It modifies existing statutory provisions relating to health care fraud, particularly in the Florida Medicaid program. Modifications include the following:

- Reducing the penalty for home health agencies that fail to timely file certain reports;
- Adding specified offenses for which persons rendering care under the Medicaid consumer-directed care program must be screened and rescreened;
- Requiring Medicaid providers to retain all medical and Medicaid-related records for 6 years rather than the current 5-year retention period;
- Requiring Medicaid providers to report a change in any principal of the provider to the Agency for Health Care Administration (AHCA) in writing no later than 30 days after the change occurs;
- Defining the term "administrative fines" for purposes of liability of parties for payment of such fines in the event of a change of ownership;
- Authorizing the AHCA to conduct onsite inspections of the service location of a provider applying for a provider agreement, before entering into a provider agreement with that provider, to determine the provider's ability to provide services in compliance with the Medicaid program and professional regulations;
- Removing certain exceptions to background screening requirements for Medicaid providers;
- Including participants in a Medicaid managed care provider network in the definition of "Medicaid provider" for purposes of oversight of the integrity of the Medicaid program;
- Authorizing the AHCA to review and analyze information from sources other than enrolled Medicaid providers in conducting investigations of potential fraud, abuse, overpayment or recipient neglect;

- Expanding the list of offenses for which the AHCA must terminate the participation of a Medicaid provider in the Medicaid program;
- Requiring the AHCA to impose the sanction of termination for cause against a provider that voluntarily relinquishes its Medicaid provider number under certain circumstances;
- Requiring the AHCA, when it is making a determination that an overpayment has occurred, to base its determination solely upon information available to it before issuance of the audit report and upon contemporaneous records;
- Removing a requirement that the AHCA pay interest at the rate of 10 percent a year on provider payments that have been withheld under suspicion of fraud or abuse, if it is determined that there was no fraud or abuse;
- Requiring overpayments and fines to be paid within 30 days after a final order;
- Clarifying the scope of the immunity from civil liability for persons who provide the state with information about fraud or suspected fraudulent acts by a Medicaid provider; and
- Modifying the grounds under which a professional board or the Department of Health (DOH) must refuse to admit a candidate to an examination and refuse to issue or renew a license, certificate, or registration of a health care practitioner.

The bill reinstates certain statutory provisions that previously were repealed. The reinstated provisions include:

- The submission by the AHCA of an annual report on adverse incidents reported by assisted living facilities;
- Medical examinations and mental health evaluations of residents of assisted living facilities who appear to need care beyond that which the facility is licensed to provide.

The bill includes the following new provisions:

- Restrictions on the techniques used by Medicaid managed care plans to manage the use of prescribed drugs by enrollees;
- A requirement for the AHCA to report on the impact of the implementation of an expansion of managed care to new populations or the provision of new items and services.

This bill substantially amends the following sections of the Florida Statutes: 400.474, 409.221, 409.907, 409.913, 409.920, 409.967, 429.23, 429.26, 456.036, 456.0635, and 456.074. The bill also creates one undesignated section of law.

II. Present Situation:

Health Care Fraud

In 2009, the Legislature passed CS/CS/CS/SB 1986, a comprehensive bill designed to address systemic health care fraud in Florida. That bill increased the Medicaid program's authority to address fraud, particularly as it relates to home health services; increased health care facility and health care practitioner licensing standards to keep fraudulent actors from obtaining a health care license in Florida; and created disincentives to commit Medicaid fraud by increasing the administrative penalties for committing Medicaid fraud, posting sanctioned and terminated

Medicaid providers on the AHCA website, and creating additional criminal felonies for committing health care fraud; among other anti-fraud provisions.[1]

With over 2 years of experience with the implementation of CS/CS/CS/SB 1986, some changes have been identified that would enhance Florida's efforts to prevent health care fraud and abuse and to effectively counter fraud and abuse that does occur. This bill addresses some of the practical effects of CS/CS/CS/SB 1986: provisions that appear to be too onerous, gaps in enforcement authority, and consumer protections that were repealed that maybe should have been retained.

Home Health Agency Regulation

Home health agencies are licensed and regulated by the AHCA under the authority of part III of ch. 400, F.S. Section 400.474, F.S., authorizes the AHCA to deny, revoke, or suspend the license of a home health agency and requires the AHCA to impose a $5,000 fine against a home health agency that commits certain acts. One of these acts is the failure of the home health agency to submit a report, within 15 days after the end of each calendar quarter, that includes the following information:

- The number of insulin dependent diabetic patients receiving insulin-injection services from the home health agency;
- The number of patients receiving both home health services from the home health agency and hospice services;
- The number of patients receiving home health services from that home health agency; and
- The names and license numbers of nurses whose primary job responsibility is to provide home health services to patients and who received remuneration from the home health agency in excess of $25,000 during the calendar quarter.

These data items help identify possible fraud, such as billing for a high number of injection visits for insulin-dependent patients who could self-inject insulin, fraudulent billing for patients who did not receive the visits, possible duplicate payment for patients receiving both hospice and home health services, and nurses earning well above the average salary that could indicate false billing. The results of each quarter's reporting are shared with the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services' Medicare Program Integrity Miami Satellite Division, the AHCA's Medicaid Program Integrity Office, and the Medicare Fraud Investigations Manager at SafeGuard Services, LLC.

Medicaid

Medicaid is the medical assistance program that provides access to health care for low-income families and individuals. Medicaid also assists aged and disabled people with the costs of nursing facility care and other medical expenses. The AHCA is responsible for Medicaid. Medicaid serves approximately 3.19 million people in Florida. Estimated Medicaid expenditures for fiscal year 2011-2012 are approximately $20.3 billion. The statutory authority for the Medicaid program is contained in part III of ch. 409, F.S.

[1] *See* ch. 2009-223, Laws of Florida.

Medicaid reimburses health care providers that have a provider agreement with the AHCA only for goods and services that are covered by the Medicaid program and only for individuals who are eligible for medical assistance from Medicaid. Section 409.907, F.S., establishes requirements for Medicaid provider agreements, which include, among other things, background screening requirements, notification requirements for change of ownership of a Medicaid provider, records retention requirements, authority for AHCA site-visits of provider service locations, and surety bond requirements.

Under s. 409.912(37), F.S., the AHCA is required to implement a Medicaid prescribed-drug spending-control program that includes a preferred drug list (PDL), which is a listing of cost-effective therapeutic options recommended by the Medicaid Pharmaceutical and Therapeutics Committee established pursuant to s. 409.91195, F.S. The PDL is used to inform clinicians of effective products that provide favorable net costs to Medicaid. The PDL educates clinicians about cost effective choices in prescribing for Medicaid recipients, but clinicians always retain the option of selecting the drug product they feel is most appropriate for their patient by calling the Therapeutic Consultation Program. If the prescriber cannot readily obtain authorization the pharmacist may dispense a 72-hour supply. The pharmacist may also use his or her professional judgment if other situations arise that would necessitate a 72-hour emergency supply.[2]

Section 409.913, F.S., outlines provisions relating to the AHCA's responsibilities for oversight of the integrity of the Medicaid program, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate.

Sections 409.920, 409.9201, 409.9203, and 409.9205, F.S., contain provisions relating specifically to Medicaid fraud. One of these is a provision that provides immunity from civil liability for a person who provides the State with information about fraud or suspected fraud by a Medicaid provider, including a managed care organization.[3]

Part IV of ch. 409, F.S., requires all Medicaid recipients to enroll in a managed care plan unless they are specifically exempted. The statewide Medicaid managed care program includes the long-term care managed care program and the managed medical assistance program. The law directs the AHCA to begin implementation of the long-term care managed care program by July 1, 2012, with full implementation in all regions of the State by October 1, 2013. By January 1, 2013, the AHCA must begin implementation of the managed medical assistance program, with full implementation in all regions of the State by October 1, 2014.

Section 409.967, F.S., establishes requirements for the accountability of managed care plans in the new statewide Medicaid managed care program, including requirements regarding coverage of prescription drugs. The AHCA is required to establish standards relating to access to care, which include the following statements regarding prescription drugs:

- The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards.

[2] Medicaid Pharmaceutical and Therapeutics Committee, Agency for Health Care Administration. Found at: <http://ahca.myflorida.com/medicaid/Prescribed_Drug/pharm_thera/index.shtml> (Last visited on January 26, 2012).
[3] *See* s. 409.920(8), F.S.

- Each managed care plan must publish any prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers.
- The plan must update the list within 24 hours after making a change.
- Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers.

These requirements will apply to all plans by October 1, 2014. Currently, operating Medicaid managed care plans may develop their own utilization and clinical protocols to manage drug costs, so long as they are ultimately no more restrictive than the Medicaid fee-for-service drug benefit. The contracts between the managed care plans and the AHCA specify requirements concerning access to the drug benefit.

Background Screening

Chapter 435, F.S., establishes standards for background screening for employment. Section 435.03, F.S., sets standards for Level 1 background screening. Level 1 background screening includes, but is not limited to, employment history checks and statewide criminal correspondence checks through the Department of Law Enforcement, and a check of the Dru Sjodin National Sex Offender Public Website, and may include local criminal records checks through local law enforcement agencies.

Level 2 background screening includes, but is not limited to, fingerprinting for statewide criminal history records checks through the Department of Law Enforcement and national criminal history records checks through the Federal Bureau of Investigation. They may also include local criminal records checks through local law enforcement agencies. Section 435.04(2), F.S., lists the offenses that will disqualify an applicant from employment.

Section 409.809, F.S., establishes background screening requirements and procedures for entities licensed by the AHCA. The AHCA must conduct Level 2 background screening for specified individuals. Each person subject to this section is subject to Level 2 background screening every 5 years. This section of law also specifies additional disqualifying offenses beyond those included in s. 435.04(2), F.S.

Florida Consumer-Directed Care Act

The Florida Consumer-Directed Care Act[4] requires the AHCA to establish the consumer-directed care program for persons with disabilities who need long-term care services and who are enrolled in one of the Medicaid home and community-based waiver programs. These types of waiver programs offer services that allow frail elders and people with disabilities to receive long-term-care services in their homes or in the community to keep them from needing care in a nursing facility or intermediate care facility for the developmentally disabled. The purpose of the consumer-directed care program is to allow enrolled persons to choose the providers of services and to direct the delivery of services, to best meet their long-term care needs.

[4] *See* s. 409.221, F.S.

All persons who render care in the program are required to undergo Level 2 background screening pursuant to ch. 435, F.S. The Florida Consumer-Directed Care Act does not currently require re-screening and authorizes persons who have been subject to background screening and who have not been unemployed for more than 90 days following such screening to not be required to be rescreened. They must attest to not having been convicted of a disqualifying offense since completing screening.

Health Care Practitioner Licensure Authority of the Department of Health

The DOH is responsible for the licensure of most health care practitioners in the state. Chapter 456, F.S., provides general provisions for the regulation of health care professions in addition to the regulatory authority in specific practice acts for each profession or occupation. Section 456.001, F.S., defines "health care practitioner" as any person licensed under:

- Chapter 457 (acupuncture),
- Chapter 458 (medical practice),
- Chapter 459 (osteopathic medicine),
- Chapter 460 (chiropractic medicine),
- Chapter 461 (podiatric medicine),
- Chapter 462 (naturopathy),
- Chapter 463 (optometry),
- Chapter 464 (nursing),
- Chapter 465 (pharmacy),
- Chapter 466 (dentistry),
- Chapter 467 (midwifery),
- Part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468 (speech-language pathology and audiology; nursing home administration; occupational therapy; respiratory therapy; dietetics and nutrition practice; athletic trainers; and orthotics, prosthetics, and pedorthics),
- Chapter 478 (electrolysis),
- Chapter 480 (massage practice),
- Part III or part IV of chapter 483 (clinical laboratory personnel and medical physicists),
- Chapter 484 (dispensing of optical devices and hearing aids),
- Chapter 486 (physical therapy practice),
- Chapter 490 (psychological services), and
- Chapter 491 (clinical, counseling, and psychotherapy services)

Current law[5] prohibits the DOH and the medical boards within the DOH from allowing any person to sit for an examination who has been:

- Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under ch. 409, F.S.,[6] ch. 817, F.S.,[7] ch. 893, F.S.,[8] 21 U.S.C. ss. 801-970,[9] or

[5] *See* s. 456.0635, F.S.
[6] Ch. 409, F.S., "Social and Economic Assistance," is in Title XXX, "Social Welfare," and includes the Florida Medicaid and Kidcare programs, among other programs.
[7] ch. 817, F.S., "Fraudulent Practices," is in Title XLVI, "Crimes."
[8] ch. 893, F.S., "Drug Abuse Prevention and Control," is in Title XLVI, "Crimes."

42 U.S.C. ss. 1395-1396,[10] unless the sentence and any subsequent period of probation for such conviction or pleas ended more than 15 years prior to the date of the application;

- Terminated for cause from the Florida Medicaid program, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5 years; or
- Terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from any other state Medicaid program or the federal Medicare program, unless the applicant has been in good standing with a state Medicaid program or the federal Medicare program for the most recent 5 years and the termination occurred at least 20 years prior to the date of application.

The DOH and the medical boards must refuse to issue or renew a license, certificate, or registration if an applicant or person affiliated with that applicant has violated any of the provisions listed above. The DOH applies the denial of licensure renewals to offenses occurring after July 1, 2009, when the new provisions requiring denial of renewals went into effect. Neither the boards nor the DOH currently deny initial licensure or licensure renewal based upon termination for cause from the Medicare program, because no such termination exists in federal law. Federal law references mandatory and permissive exclusions.

Any individual who is seeking licensure must apply for licensure and meet the current requirements regardless of whether the applicant previously held a Florida license. If an applicant is required to have passed a licensure examination within a certain number of years prior to licensure, then an applicant whose test scores have "expired" would be required to re-test and pass the licensure examination. Between July 1, 2009, and November 22, 2011, 91 licensees have been denied renewal under s. 456.0635, F.S.

Regulation of Assisted Living Facilities

Assisted living facilities are regulated under part I of ch. 429, F.S. Section 429.23, F.S., requires assisted living facilities to submit to the AHCA, within 1 day after the occurrence of an adverse incident, a preliminary report concerning the incident. The assisted living facility is also required to provide a more detailed report to the AHCA within 15 days after the incident. The AHCA collects and stores the data received from the adverse incident reports. The information is currently confidential and is not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the AHCA or appropriate regulatory board. However, the AHCA does fill public record's requests for statistical information, but detailed information on an adverse incident is not provided.

Section 429.26, F.S., establishes requirements relating to the appropriateness of placements of individuals in assisted living facilities and examinations of residents in an assisted living facility. The AHCA requires that residents be examined only at admission, every 3 years, and after a "significant change." A significant change is defined in Rule 58A-35.0131(33), F.A.C.,[11] to mean a sudden or major shift in behavior or mood, or deterioration in health status such as

[9] 21 U.S.C. ss. 801-970 create the Controlled Substances Act, which regulates the registration of manufacturers, distributors, and dispensers of controlled substances at the federal level.
[10] 42 U.S.C. ss. 1395-1396 create the federal Medicare, Medicaid, and Children's Health Insurance programs.
[11] Found at: <https://www.flrules.org/gateway/RuleNo.asp?title=ASSISTED%20LIVING%20FACILITIES&ID=58A-5.0131> (Last visited on January 26, 2012).

unplanned weight change, stroke, heart condition, or stage 2, 3, or 4 pressure sores. The facility administrator is responsible for determining the appropriateness of placement. If the AHCA determines a resident is not appropriate based on observations and facility documentation, a facility is cited for the violation and required to take appropriate action to discharge the resident to a facility that can meet the resident's needs.

III. Effect of Proposed Changes:

Section 1 amends s. 400.474, F.S., to reduce the fine that the AHCA currently must impose on a home health agency that fails to submit, within 15 days after the end of each calendar quarter, the report that includes certain fraud detection information. The bill changes the penalty to a mandatory $50 per day fine, with no maximum, instead of the current permissive denial, revocation, or suspension of the home health agency's license and a mandatory fine of $5,000. Thus, the amount of the fine will be substantially less for those agencies that are only a few days late submitting the report. However, reports more than 100 days late will exceed the existing fine of $5,000.

Section 2 amends s. 409.221, F.S., to require persons who render care under the Medicaid consumer-directed care program to undergo Level 2 background screening pursuant to the provisions of s. 408.809, F.S., in addition to the provisions of ch. 435, F.S. The effect is to require persons rendering care under the consumer-directed care program to be screened for additional disqualifying offenses and to be re-screened every 5 years.

Section 3 amends s. 409.907, F.S., relating to Medicaid provider agreements, to require Medicaid providers to retain all medical and Medicaid-related records for 6 years, rather than the current statutory retention period of 5 years, consistent with Health Insurance Portability and Accountability Act (HIPAA) of 1996 administrative simplification rules.[12]

The bill requires a Medicaid provider to report in writing any change of any principal of the provider to the AHCA no later than 30 days after the change occurs. The bill specifies who is included in the term "principal."

The bill amends the statutory provisions relating to the liability of Medicaid providers in a change of ownership for outstanding overpayments, administrative fines, and any other moneys owed to the AHCA. The bill defines "administrative fines" to include any amount identified in any notice of a monetary penalty or fine that has been issued by the AHCA or any other regulatory or licensing agency which governs the provider.

The requirement for the AHCA to conduct random onsite inspections of Medicaid providers' service locations within 60 days after receipt of a fully complete new provider's application and prior to making the first payment to the provider for Medicaid services is amended to authorize, rather than require, the AHCA to perform onsite inspections. The inspection would be conducted prior to the AHCA entering into a Medicaid provider agreement with the provider and would be used to determine the applicant's ability to provide services in compliance with the Medicaid

[12] *See* 45 CFR 164.316(b)(2). Found at: <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=be9877c2440a17a8ebe3b02b0948a06a&rgn=div8&view=text&node=45:1.0.1.3.79.3.27.8&idno=45> (Last visited on January 26, 2012).

program and professional regulations. The law currently only requires the AHCA to determine the applicant's ability to provide the services for which they will seek Medicaid payment. The bill also removes an exception to the current onsite-inspection requirement for a provider or program that is licensed by the AHCA, that provides services under waiver programs for home and community-based services, or that is licensed as a medical foster home by the Department of Children and Family Services, since the selection of providers for onsite inspections is no longer a random selection, but is left up to the discretion of the AHCA under the bill.

The bill amends the requirements for a criminal history record check of each Medicaid provider, or each principal of the provider, to remove an exemption from such checks for hospitals, nursing homes, hospices, and assisted living facilities. The bill specifies that for hospitals and nursing homes the principals of the provider are those who meet the definition of a controlling interest in s. 408.803, F.S.

The bill removes the provision that proof of compliance with Level 2 background screening under ch. 435, F.S., conducted within 12 months before the date the Medicaid provider application is submitted to the AHCA satisfies the requirements for a criminal history background check. This conforms to screening provisions in ch. 435, F.S., and ch. 408, F.S.

Section 4 amends s. 409.913, F.S., which relates to oversight of the integrity of the Medicaid program. The bill defines "Medicaid provider" or "provider" to include not only persons or entities that have a Medicaid provider agreement in effect with the AHCA and that are in good standing with the AHCA, but also, for purposes of oversight of the integrity of the Medicaid program, participants in a Medicaid managed care provider network.

The bill authorizes the AHCA, as part of its fraud and abuse detection efforts, to review and analyze information from sources other than enrolled Medicaid providers. Medicaid providers are required to retain medical, professional, financial, and business records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid for 6 years, rather than the current statutory retention period of 5 years.

The bill amends subsection (13) of s. 409.913, F.S., to remove a requirement that the AHCA *immediately* terminate participation of a Medicaid provider that has been convicted of certain offenses. In order to immediately terminate a provider, the AHCA must show an immediate harm to the public health, which is not always possible. The AHCA still must terminate a Medicaid provider from participation in the Medicaid program, unless the AHCA determines that the provider did not participate or acquiesce in the offense, and may seek civil remedies or impose administrative sanctions if a provider *has been convicted* of any of the following offenses.

- A criminal offense under federal law or the law of any state relating to the practice of the provider's profession.
- An offense listed in s. 409.907(10), F.S., relating to factors the AHCA may consider when reviewing an application for a Medicaid provider agreement, which includes:
  - Making a false representation or omission of any material fact in making an application for a provider agreement;
  - Exclusion, suspension, termination, or involuntary withdrawal from participation in any Medicaid program or other governmental or private health care or health insurance program;

  - Being convicted of a criminal offense relating to the delivery of any goods or services under Medicaid or Medicare or any other public or private health care or health insurance program including the performance of management or administrative services relating to the delivery of goods or services under any such program;
  - Being convicted of a criminal offense under federal or state law related to the neglect or abuse of a patient in connection with the delivery of any health care goods or services;
  - Being convicted of a criminal offense under federal or state law related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance;
  - Being convicted of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;
  - Being convicted of a criminal offense under federal or state law punishable by imprisonment of 1 year or more which involves moral turpitude;
  - Being convicted in connection with the interference or obstruction of any investigation into any criminal offense listed above;
  - Violation of federal or state laws, rules, or regulations governing any Medicaid program, the Medicare program, or any other publicly funded federal or state health care or health insurance program, if they have been sanctioned accordingly;
  - Violation of the standards or conditions relating to professional licensure or certification or the quality of services provided; or
  - Failure to pay fines and overpayments under the Medicaid program.
- An offense listed in s. 408.809(4), F.S., relating to background screening of licensees, which includes the following offenses or any similar offense of another jurisdiction:
  - Any authorizing statutes, if the offense was a felony;
  - Chapter 408, F.S., if the offense was a felony;
  - Section 409.920, F.S., relating to Medicaid provider fraud;
  - Section 409.9201, F.S., relating to Medicaid fraud;
  - Section 741.28, F.S., relating to domestic violence;
  - Section 817.034, F.S., relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems;
  - Section 817.234, F.S., relating to false and fraudulent insurance claims;
  - Section 817.505, F.S., relating to patient brokering;
  - Section 817.568, F.S., relating to criminal use of personal identification information;
  - Section 817.60, F.S., relating to obtaining a credit card through fraudulent means;
  - Section 817.61, F.S., relating to fraudulent use of credit cards, if the offense was a felony;
  - Section 831.01, F.S., relating to forgery;
  - Section 831.02, F.S., relating to uttering forged instruments;
  - Section 831.07, F.S., relating to forging bank bills, checks, drafts, or promissory notes;
  - Section 831.09, F.S., relating to uttering forged bank bills, checks, drafts, or promissory notes;
  - Section 831.30, F.S., relating to fraud in obtaining medicinal drugs; or
  - Section 831.31, F.S., relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.
- An offense listed in s. 435.04(2), F.S., relating to employee background screening, which includes the following offenses or any similar offense of another jurisdiction:
  - Section 393.135, F.S., relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct;

- Section 394.4593, F.S., relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct;
- Section 415.111, F.S., relating to adult abuse, neglect, or exploitation of aged persons or disabled adults;
- Section 782.04, F.S., relating to murder;
- Section 782.07, F.S., relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child;
- Section 782.071, F.S., relating to vehicular homicide;
- Section 782.09, F.S., relating to killing of an unborn quick child by injury to the mother;
- Chapter 784, F.S., relating to assault, battery, and culpable negligence, if the offense was a felony;
- Section 784.011, F.S., relating to assault, if the victim of the offense was a minor;
- Section 784.03, F.S., relating to battery, if the victim of the offense was a minor;
- Section 787.01, F.S., relating to kidnapping;
- Section 787.02, F.S., relating to false imprisonment;
- Section 787.025, F.S., relating to luring or enticing a child;
- Section 787.04(2), F.S., relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings;
- Section 787.04(3), F.S., relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person;
- Section 790.115(1), F.S., relating to exhibiting firearms or weapons within 1,000 feet of a school;
- Section 790.115(2)(b), F.S., relating to possessing an electric weapon or device, destructive device, or other weapon on school property;
- Section 794.011, F.S., relating to sexual battery;
- Former s. 794.041, F.S., relating to prohibited acts of persons in familial or custodial authority;
- Section 794.05, F.S., relating to unlawful sexual activity with certain minors;
- Chapter 796, F.S., relating to prostitution;
- Section 798.02, F.S., relating to lewd and lascivious behavior;
- Chapter 800, F.S., relating to lewdness and indecent exposure;
- Section 806.01, F.S., relating to arson;
- Section 810.02, F.S., relating to burglary;
- Section 810.14, F.S., relating to voyeurism, if the offense is a felony;
- Section 810.145, F.S., relating to video voyeurism, if the offense is a felony;
- Chapter 812, F.S., relating to theft, robbery, and related crimes, if the offense is a felony;
- Section 817.563, F.S., relating to fraudulent sale of controlled substances, only if the offense was a felony;
- Section 825.102, F.S., relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult;
- Section 825.1025, F.S., relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult;
- Section 825.103, F.S., relating to exploitation of an elderly person or disabled adult, if the offense was a felony;
- Section 826.04, F.S., relating to incest;
- Section 827.03, F.S., relating to child abuse, aggravated child abuse, or neglect of a child;

- Section 827.04, F.S., relating to contributing to the delinquency or dependency of a child;
- Former s. 827.05, F.S., relating to negligent treatment of children;
- Section 827.071, F.S., relating to sexual performance by a child;
- Section 843.01, F.S., relating to resisting arrest with violence;
- Section 843.025, F.S., relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication;
- Section 843.12, F.S., relating to aiding in an escape;
- Section 843.13, F.S., relating to aiding in the escape of juvenile inmates in correctional institutions;
- Chapter 847, F.S., relating to obscene literature;
- Section 874.05(1), F.S., relating to encouraging or recruiting another to join a criminal gang;
- Chapter 893, F.S., relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor;
- Section 916.1075, F.S., relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct;
- Section 944.35(3), F.S., relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm;
- Section 944.40, F.S., relating to escape;
- Section 944.46, F.S., relating to harboring, concealing, or aiding an escaped prisoner;
- Section 944.47, F.S., relating to introduction of contraband into a correctional facility;
- Section 985.701, F.S., relating to sexual misconduct in juvenile justice programs; or
- Section 985.711, F.S., relating to contraband introduced into detention facilities.

The bill amends subsection (15) of s. 409.913, F.S., relating to noncriminal actions of Medicaid providers for which the AHCA may impose sanctions, to include the act of *authorizing* certain services that are inappropriate, unnecessary, excessive, or harmful to the recipient or are of inferior quality, or *authorizing* certain requests and reports that contain materially false or incorrect information. The bill also adds that the AHCA may sanction a provider if the provider is charged by information or indictment with any offense referenced in subsection (13). (See above for a listing of the offenses.) The AHCA may impose sanctions under this subsection if the provider or certain persons affiliated with the provider participated or acquiesced in the proscribed activity.

Subsection (16) of s. 409.913, F.S., relating to sanctions the AHCA may impose for the acts listed in subsection (15), is amended to state that, if a Medicaid provider voluntarily relinquishes its Medicaid provider number after receiving notice of an audit or investigation for which the sanction of suspension or termination will be imposed, the AHCA must impose the sanction of termination for cause against the provider. Currently, if a Medicaid provider receives notification that they are going to be suspended or terminated, they are able to voluntarily terminate their contract. By doing this, a provider has the ability to avoid sanctions of suspension or termination, which would affect the ability of the provider to reenter the program in the future. Existing language in this subsection gives the Secretary of AHCA the authority to make a determination that imposition of a sanction is not in the best interest of the Medicaid program, in which case a sanction may not be imposed.

The bill amends subsection (21) of s. 409.913, F.S., to specify that when the AHCA is making a determination that an overpayment has occurred, the determination must be based solely upon information available to it before it issues the audit report and, in the case of documentation obtained to substantiate claims for Medicaid reimbursement, based solely upon contemporaneous records. Subsection (22) is amended to specify that testimony or evidence that is not based upon contemporaneous records or that was not furnished to the AHCA within 21 days after the issuance of the audit report is inadmissible in an administrative hearing on a Medicaid overpayment or an administrative sanction. Also, all documentation to be offered as evidence in an administrative hearing on an administrative sanction (in addition to Medicaid overpayments) must be exchanged by all parties at least 14 days before the administrative hearing or excluded from consideration.

Subsection (25) of s. 409.913, F.S., is amended to remove the requirement that the AHCA pay, interest at the rate of 10 percent a year on Medicaid payments that have been withheld from a provider based on suspected fraud or criminal activity, if it is determined that there was no fraud or that a crime did not occur. Also, payment arrangements for overpayments and fines owed to the AHCA must be made within 30 days after the date of the final order and are not subject to further appeal.

The bill amends subsection (28) of s. 409.913, F.S., to make Leon County the venue for all Medicaid program integrity cases, not just overpayment cases. However, the AHCA has discretion concerning venue. Subsection (29) is amended to authorize the AHCA and the Medicaid Fraud Control Unit of the Department of Legal Affairs to review a *person's*, in addition to a provider's, Medicaid-related and non-Medicaid-related records in order to determine the total output of a provider's practice to reconcile quantities of goods or services billed to Medicaid with quantities of goods or services used in the provider's total practice.

Subsection (30) of s. 409.913, F.S., is amended to require the AHCA to terminate a provider's participation in the Medicaid program if the provider fails to reimburse a fine within 30 days after the date of the final order imposing the fine. The time within which a provider must reimburse an overpayment is reduced from 35 to 30 days after the date of the final order. Subsection (31) is amended to include fines, as well as overpayments, that are due upon the issuance of a final order at the conclusion of a requested administrative hearing.

Section 5 amends s. 409.920, F.S., relating to Medicaid provider fraud, to clarify that the existing immunity from civil liability extended to persons who provide information about fraud or suspected fraudulent acts is for civil liability for libel, slander, or any other relevant tort. The bill defines "fraudulent acts" for purposes of the immunity from civil liability to include actual or suspected fraud, abuse, or overpayment, including any fraud-related matters that a provider or health plan is required to report to the AHCA or a law enforcement agency. The immunity from civil liability extends to reports conveyed to the AHCA in any manner and includes all discussions subsequent to the report and subsequent inquiries from the AHCA, unless the person reporting acted with knowledge that the information was false or with reckless disregard for the truth or falsity of the information.

Section 6 amends s. 409.967, F.S., relating to Medicaid managed care plan accountability, to establish requirements for managed care plans relating to coverage of prescribed drugs, which do

not currently exist for the Medicaid fee-for-service drug program or Medicaid managed care plans. With regard to standards for managed care plan networks, the bill states that exclusive use of mail-order pharmacies *is not sufficient* to meet network access standards. Current law states that exclusive use of mail-order pharmacies *may not be sufficient*. The effect is that managed care plans will be required to use some pharmacies that are not mail-order pharmacies.

The bill establishes the following requirements for managed care plans that use a prescribed drug formulary or preferred drug list. The plan must:

- Provide coverage for drugs in categories and classes for all disease states and provide a broad range of therapeutic options for all therapeutic categories;
- Include coverage for each new drug approved by the federal Food and Drug Administration until the plan's Pharmaceutical and Therapeutics Committee reviews the drug for inclusion on its formulary;
- Provide a response within 24 hours after receipt of all necessary information for a request for prior authorization or override of other medical management tools; and
- Report all denials to the AHCA on a quarterly basis. For each nonformulary drug, the plan must report the total number of requests and the total number of denials.

The bill requires a managed care plan to continue to permit an enrollee who was receiving a prescription drug that was on the plan's formulary and subsequently removed or changed to continue to receive that drug if requested by the enrollee and the prescriber for as long as the enrollee is a member of the plan.

The bill establishes requirements for the use of step-therapy or fail-first protocols by managed care plans. Plans that impose step-therapy or a fail-first protocol must:

- Provide the prescriber with access to a clear and convenient process to expeditiously request an override of a restriction;
- Expeditiously grant an override of a restriction if the prescriber can demonstrate to the plan that the preferred treatment required under the step-therapy or fail-first protocol:
  - Has been ineffective in the treatment of the enrollee's disease or medical condition;
  - Is reasonably expected to be ineffective based on the known relevant physical or mental characteristics and medical history of the enrollee and known characteristics of the drug regimen; or
  - Will cause or will likely cause an adverse reaction or other physical harm to the enrollee.
- Limit the maximum duration of a step-therapy or fail-first protocol requirement so that it is no longer than the customary period for the prescribed drug if the treatment is demonstrated by the prescriber to be clinically ineffective. (The bill authorizes a plan, under specified circumstances, to extend the step-therapy or fail-first protocol.) Once the prescriber deems the treatment to be clinically ineffective, the plan must dispense and cover the originally prescribed drug.

The bill establishes prior authorization requirements relating to prescribed drugs.

- Each managed care plan must ensure that the prior authorization process is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers. (This is an existing statutory requirement that is being relocated.)

- If a drug is subject to prior authorization, the managed care plan must provide payment to the pharmacist for dispensing the drug without seeking prior authorization if the pharmacist confirms that:
  - The prescription is a refill or renewal of the same drug for the same beneficiary written by the same prescriber; or
  - If the drug is generally prescribed for an indication that is treated on an ongoing basis by continuous medication or as-needed, the enrollee for whom the drug is prescribed has filled a prescription for the same drug within the preceding 30 to 90 days.
- If a prescribed drug requires prior authorization, the managed care plan must reimburse the pharmacist for dispensing a 72-hour supply to the enrollee and process the prior authorization request and send a response to the requesting pharmacist within 24 hours after receiving the pharmacist's request for prior authorization.

Section 7 amends s. 429.23, F.S., relating to adverse incident reporting requirements for assisted living facilities, to reestablish a requirement for the AHCA to annually submit a report on adverse incident reports by assisted living facilities. The requirement for an annual report was repealed July 1, 2009 (s. 63 of ch. 2009-223, L.O.F.). The AHCA will once again be required to submit an annual report to the Legislature containing certain information, by county, about reported adverse incidents in assisted living facilities.

Section 8 amends s. 429.26, F.S., relating to appropriateness of placement of residents of assisted living facilities, to reestablish a requirement for physical examination or mental health evaluation of residents who appear to need care beyond that which the assisted living facility is licensed to provide. The requirement for such examinations or evaluations was repealed July 1, 2009 (s. 64 of ch. 2009-223, L.O.F.).

If personnel of the AHCA question whether a resident needs care beyond that which the facility is licensed to provide, the AHCA may require the resident to be physically examined by a licensed physician, licensed physician assistant, or certified nurse practitioner. To the extent possible, the examination must be performed by a health care provider who is preferred by the resident. The cost of the examination must be paid for by the resident with personal funds, except for certain low-income residents. The requirement for the AHCA to have such an examination conducted does not preclude the AHCA from imposing sanctions against an assisted living facility for violating its duty to determine the continuing appropriateness of placement of its residents.

Following the physical examination and based on a completed medical form submitted to the AHCA by the examining health care provider, a medical team designated by the AHCA must determine if the resident is appropriately residing in the facility. The AHCA may consult with the examining provider if necessary. A determination by the medical team that the resident's placement is not appropriate is final and binding upon the facility and the resident. A resident who is determined to be inappropriately residing in a facility must be given 30 days' written notice to relocate, unless the resident's continued residence in the facility presents an imminent danger to the health, safety, or welfare of the resident or a substantial probability exists that death or serious physical harm to the resident would result if the resident is allowed to remain in the facility.

If a mental health resident appears to have needs in addition to those identified in the community living support plan, the AHCA may require an evaluation by a mental health professional, as determined by the Department of Children and Family Services.

A facility may not be required to retain a resident who requires more services or care than the facility is able to provide in accordance with its policies and criteria for admission and continued residency.

Section 9 amends s. 456.0635, F.S., effective July 1, 2012, relating to disqualification for licensure, certification, or registration of health care practitioners for Medicaid fraud. The catch line is changed from "Medicaid fraud; disqualification for license, certificate, or registration," to "Health care fraud; disqualification for license, certificate, or registration." Other references in the statute to the general subject of "Medicaid fraud" are changed to "health care fraud." References to "candidate" vs. "candidate or applicant" are also standardized.

The bill separates the disqualifications for initial licensure, certification, or registration from those relating to licensure renewal into two different statutory subsections.

The bill requires a board or the DOH to refuse to admit a candidate to any examination and to refuse to issue a license to any applicant who has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under ch. 409, F.S., ch. 817, F.S., ch. 893, F.S., *or similar felony offenses committed in another state or jurisdiction*. The bill deletes the provision in current law that nullifies the prohibition if the sentence and probation period ended more than 15 years prior to the date of application, and replaces it with the following provisions:

- For felonies of the first or second degree, the prohibition expires when the sentence and probation period have ended more than 15 years before the date of application.
- For felonies of the third degree, the prohibition expires when the sentence and probation period have ended more than 10 years before the date of application, except for felonies of the third degree under s. 893.13(6)(a), F.S.[13]
- For felonies of the third degree under s. 893.13(6)(a), F.S., the prohibition expires when the sentence and probation period have ended more than 5 years before the date of application.

An applicant or candidate who has been convicted of or pled guilty or nolo contendere to any state felony listed above is eligible for initial licensure without any prohibition if he or she successfully completes a pretrial intervention or drug diversion program for that felony.

The bill moves into a new paragraph the requirement for a board or the DOH to refuse to admit a candidate to any examination and to refuse to issue a license to any applicant who has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a

[13] Section 893.13(6)(a), F.S., makes it unlawful for any person to be in actual or constructive possession of a controlled substance unless such controlled substance was lawfully obtained from a practitioner or pursuant to a valid prescription or order of a practitioner while acting in the course of his or her professional practice, or to be in actual or constructive possession of a controlled substance except as otherwise authorized by ch. 893, F.S.

felony under 21 U.S.C. ss. 801-970[14] or 42 U.S.C. ss. 1395-1396,[15] unless the sentence and any probation period for such conviction or plea ended more than 15 years before the date of the application.

The bill deletes reference to "terminated for cause" from the federal Medicare program as grounds for which a board or the DOH is required to deny a license and creates a new standard to exclude applicants currently listed on the U.S. Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

The bill specifies that the prohibitions above relating to examination, licensure, certification, or registration do not apply to applicants for initial licensure or certification who were enrolled in a DOH- or board-recognized educational or training program on or before July 1, 2009, and who applied for licensure after July 1, 2012.

The bill creates a new statutory subsection relating to license *renewal* that requires a board or the DOH to deny renewal to applicants who, after July 1, 2009, have been convicted of or pled guilty or nolo contendere to the same felony offenses listed under the subsection on initial licensure. The same 5, 10, and 15-year prohibition periods apply concerning eligibility for relicensure after a felony as for initial licensure after a felony. Applicants who have been convicted of or pled guilty or nolo contendere to specified state felonies are eligible for license renewal without any prohibition period if they are currently enrolled in or have successfully completed a pretrial intervention or drug diversion program for that felony.

The bill also includes the same provisions for denying licensure renewal as those described above for initial examination, licensure, certification, and registration, relative to exclusion from the Medicare program and termination from Medicaid programs in Florida or in other states.

Section 10 amends s. 456.036, F.S., effective July 1, 2012, to authorize any person who has been denied renewal of licensure, certification, or registration under s. 456.0635(3), F.S., to regain licensure, certification, or registration by undergoing the procedure for initial licensure as defined by a board or the department. However, a person who was denied renewal between July 1, 2009 and June 30, 2012, is not required to retake any examinations which would otherwise be necessary for initial licensure.

Section 11 amends s. 456.074, F.S., relating to the immediate suspension of the license of certain health care practitioners who plead guilty to, are convicted or found guilty of, or who enter a plea of nolo contendere to, regardless of adjudication, certain offenses. The bill removes the limiting clause "relating to the Medicaid program" as it modifies a list of federal misdemeanor or felony offenses. The effect would be that the listed health care practitioners would be subject to immediate suspension of their license for the misdemeanor or felony offenses, whether or not the offense related to the Medicaid program.

[14] 21 U.S.C. ss. 801-970 relates to drug abuse prevention and control. It regulates the registration of manufacturers, distributors, and dispensers of controlled substances; provides for offenses and penalties; and regulates the import and export of controlled substances.
[15] 42 U.S.C. ss. 1395-1396 contain provisions relating to Medicare, Medicaid, and the Children's Health Insurance Program.

Section 12 creates a new undesignated section of law to require the AHCA to prepare a report within 18 months after the implementation of an expansion of managed care to new populations or the provision of new items and services. The AHCA must post a draft of the report on its website and provide an opportunity for public comment. The final report must be submitted to the Legislature, along with a description of the process for public input. The report must include an assessment of:

- The impact of managed care on patient access to care, including any new barriers to the use of services or prescription drugs created by the use of medical management or cost-containment tools.
- The impact of managed care expansion on the utilization of services, quality of care, and patient outcomes.
- The use of prior authorization and other utilization management tools, including whether these tools pose an undue administrative burden for health care providers or create barriers to needed care.

Section 13 provides that the bill will take effect upon becoming a law, except that sections 9 and 10 take effect on July 1, 2012.

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:

The change in the fine imposed on home health agencies will result in a reduction in the amount of the fines assessed, but the fiscal impact is indeterminate.

A resident in an assisted living facility may incur the cost of a medical examination if the AHCA questions whether a resident needs care beyond that which the facility is licensed to provide.

C. Government Sector Impact:

Department of Health
The DOH will experience recurring and non-recurring increases in workload to implement the provisions of this bill, but current resources and budget authority are adequate to absorb the costs of these increases.

Agency for Health Care Administration
The AHCA indicates that the bill has no fiscal impact on the agency.

VI. Technical Deficiencies:

The word "authorized" should be included after the word "ordered" on lines 585, 593, and 620.

On line 788, the underlined language should be "or pay a fine" since fines are not reimbursed to the AHCA.

On line 899, the word "insurer" should be "plan."

On line 900, the word "expeditiously" does not establish a clear time period within which the override must be granted.

Lines 912 -923 should be reworded to make clear what "customary period" means and what "original customary period" means.

On line 944, the word "beneficiary" should be changed to "enrollee."

VII. Related Issues:

It is not clear whether the intent of lines 537 through 541 is to terminate a Medicaid provider's participation in the Medicaid program only if the provider has been convicted of criminal offenses in the enumerated sections of statute or whether noncriminal actions in those sections of statute would also be grounds for termination from the Medicaid program.

On lines 866 and 867, the bill uses the phrase "a broad range of therapeutic options for all therapeutic categories." It is not clear how the word "broad" should be interpreted. For some therapeutic categories this might mean that the plan would have to cover all therapeutic options, or all drugs available for that therapeutic category.

According to the AHCA, the requirement in Section 12 for the AHCA to prepare a report within 18 months after implementation of an expansion of managed care is a duplication of federal requirements for the Section 1915(b) Long Term Care Managed Care Waiver and Section 1115

Research and Demonstration Waiver. The AHCA suggests that Section 12 is not necessary and should either be removed or revised to accurately reflect the federal requirements for waivers.[16]

VIII. Additional Information:

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

None.

B. Amendments:

None.

[16] *See* Agency for Health Care Administration 2012 Bill Analysis and Economic Impact Statement for SB 1316 – on file with the Senate Health Regulation Committee.

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LEGISLATIVE ACTION

Senate . House

. . . . . .

The Committee on Health Regulation (Gaetz) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Subsection (6) of section 400.474, Florida Statutes, is amended, present subsection (7) of that section is renumbered as subsection (8), and a new subsection (7) is added to that section, to read:

400.474 Administrative penalties.—

(6) The agency may deny, revoke, or suspend the license of a home health agency and shall impose a fine of $5,000 against a home health agency that:

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(a) Gives remuneration for staffing services to:

1. Another home health agency with which it has formal or informal patient-referral transactions or arrangements; or

2. A health services pool with which it has formal or informal patient-referral transactions or arrangements,

unless the home health agency has activated its comprehensive emergency management plan in accordance with s. 400.492. This paragraph does not apply to a Medicare-certified home health agency that provides fair market value remuneration for staffing services to a non-Medicare-certified home health agency that is part of a continuing care facility licensed under chapter 651 for providing services to its own residents if each resident receiving home health services pursuant to this arrangement attests in writing that he or she made a decision without influence from staff of the facility to select, from a list of Medicare-certified home health agencies provided by the facility, that Medicare-certified home health agency to provide the services.

(b) Provides services to residents in an assisted living facility for which the home health agency does not receive fair market value remuneration.

(c) Provides staffing to an assisted living facility for which the home health agency does not receive fair market value remuneration.

(d) Fails to provide the agency, upon request, with copies of all contracts with assisted living facilities which were executed within 5 years before the request.

(e) Gives remuneration to a case manager, discharge

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planner, facility-based staff member, or third-party vendor who is involved in the discharge planning process of a facility licensed under chapter 395, chapter 429, or this chapter from whom the home health agency receives referrals.

~~(f) Fails to submit to the agency, within 15 days after the end of each calendar quarter, a written report that includes the following data based on data as it existed on the last day of the quarter:~~

~~1. The number of insulin-dependent diabetic patients receiving insulin-injection services from the home health agency;~~

~~2. The number of patients receiving both home health services from the home health agency and hospice services;~~

~~3. The number of patients receiving home health services from that home health agency; and~~

~~4. The names and license numbers of nurses whose primary job responsibility is to provide home health services to patients and who received remuneration from the home health agency in excess of $25,000 during the calendar quarter.~~

(f) ~~(g)~~ Gives cash, or its equivalent, to a Medicare or Medicaid beneficiary.

(g) ~~(h)~~ Has more than one medical director contract in effect at one time or more than one medical director contract and one contract with a physician-specialist whose services are mandated for the home health agency in order to qualify to participate in a federal or state health care program at one time.

(h) ~~(i)~~ Gives remuneration to a physician without a medical director contract being in effect. The contract must:

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1. Be in writing and signed by both parties;

2. Provide for remuneration that is at fair market value for an hourly rate, which must be supported by invoices submitted by the medical director describing the work performed, the dates on which that work was performed, and the duration of that work; and

3. Be for a term of at least 1 year.

The hourly rate specified in the contract may not be increased during the term of the contract. The home health agency may not execute a subsequent contract with that physician which has an increased hourly rate and covers any portion of the term that was in the original contract.

(i) ~~(j)~~ Gives remuneration to:

1. A physician, and the home health agency is in violation of paragraph (g) ~~(h)~~ or paragraph (h) ~~(i)~~;

2. A member of the physician's office staff; or

3. An immediate family member of the physician,

if the home health agency has received a patient referral in the preceding 12 months from that physician or physician's office staff.

(j) ~~(k)~~ Fails to provide to the agency, upon request, copies of all contracts with a medical director which were executed within 5 years before the request.

(k) ~~(l)~~ Demonstrates a pattern of billing the Medicaid program for services to Medicaid recipients which are medically unnecessary as determined by a final order. A pattern may be demonstrated by a showing of at least two such medically

unnecessary services within one Medicaid program integrity audit period.

Paragraphs (e) and (i) do not apply to or preclude ~~Nothing in paragraph (c) or paragraph (j) shall be interpreted as applying to or precluding~~ any discount, compensation, waiver of payment, or payment practice permitted by 42 U.S.C. s. 1320a-7(b) or regulations adopted thereunder, including 42 C.F.R. s. 1001.952 or s. 1395nn or regulations adopted thereunder.

(7) The agency shall impose a fine of $50 per day against a home health agency that fails to submit to the agency, within 15 days after the end of each calendar quarter, a written report that includes the following data based on data as it existed on the last day of the quarter:

(a) The number of patients receiving both home health services from the home health agency and hospice services;

(b) The number of patients receiving home health services from the home health agency;

(c) The number of insulin-dependent diabetic patients receiving insulin-injection services from the home health agency; and

(d) The names and license numbers of nurses whose primary job responsibility is to provide home health services to patients and who received remuneration from the home health agency in excess of $25,000 during the calendar quarter.

Section 2. Paragraph (l) of subsection (4) of section 400.9905, Florida Statutes, is amended, and paragraph (m) is added to that subsection, to read:

400.9905 Definitions.—

(4) "Clinic" means an entity at which health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider. For purposes of this part, the term does not include and the licensure requirements of this part do not apply to:

(l) Orthotic, ~~or~~ prosthetic, pediatric cardiology, or perinatology clinical facilities or anesthesia clinical facilities that are not otherwise exempt under paragraph (a) or paragraph (k) and that are a publicly traded corporation or ~~that~~ are wholly owned, directly or indirectly, by a publicly traded corporation. As used in this paragraph, a publicly traded corporation is a corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange.

(m) Entities that are owned or controlled, directly or indirectly, by a publicly traded entity that has $100 million or more, in the aggregate, in total annual revenues derived from providing health care services by licensed health care practitioners who are employed or contracted by an entity described in this paragraph.

Section 3. Paragraph (i) of subsection (4) of section 409.221, Florida Statutes, is amended to read:

409.221 Consumer-directed care program.—

(4) CONSUMER-DIRECTED CARE.—

(i) *Background screening requirements.*—All persons who render care under this section must undergo level 2 background screening pursuant to chapter 435 and s. 408.809. The agency shall, as allowable, reimburse consumer-employed caregivers for

the cost of conducting such ~~background~~ screening ~~as required by this section~~. For purposes of this section, a person who has undergone screening, who is qualified for employment under this section and applicable rule, and who has not been unemployed for more than 90 days following such screening is not required to be rescreened. Such person must attest under penalty of perjury to not having been convicted of a disqualifying offense since completing such screening.

Section 4. Paragraph (c) of subsection (3) of section 409.907, Florida Statutes, is amended, paragraph (k) is added to that subsection, and subsections (6), (7), and (8) of that section are amended, to read:

409.907 Medicaid provider agreements.—The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

(3) The provider agreement developed by the agency, in addition to the requirements specified in subsections (1) and (2), shall require the provider to:

(c) Retain all medical and Medicaid-related records for 6 ~~a period of 5~~ years to satisfy all necessary inquiries by the agency.

(k) Report a change in any principal of the provider,

including any officer, director, agent, managing employee, or affiliated person, or any partner or shareholder who has an ownership interest equal to 5 percent or more in the provider, to the agency in writing no later than 30 days after the change occurs.

(6) A Medicaid provider agreement may be revoked, at the option of the agency, due to ~~as the result of~~ a change of ownership of any facility, association, partnership, or other entity named as the provider in the provider agreement.

(a) In the event of a change of ownership, the transferor remains liable for all outstanding overpayments, administrative fines, and any other moneys owed to the agency before the effective date of the change of ownership. ~~In addition to the continuing liability of the transferor,~~ The transferee is also liable to the agency for all outstanding overpayments identified by the agency on or before the effective date of the change of ownership. ~~For purposes of this subsection, the term "outstanding overpayment" includes any amount identified in a preliminary audit report issued to the transferor by the agency on or before the effective date of the change of ownership.~~ In the event of a change of ownership for a skilled nursing facility or intermediate care facility, the Medicaid provider agreement shall be assigned to the transferee if the transferee meets all other Medicaid provider qualifications. In the event of a change of ownership involving a skilled nursing facility licensed under part II of chapter 400, liability for all outstanding overpayments, administrative fines, and any moneys owed to the agency before the effective date of the change of ownership shall be determined in accordance with s. 400.179.

(b) At least 60 days before the anticipated date of the change of ownership, the transferor must ~~shall~~ notify the agency of the intended change of ownership and the transferee must ~~shall~~ submit to the agency a Medicaid provider enrollment application. If a change of ownership occurs without compliance with the notice requirements of this subsection, the transferor and transferee are ~~shall be~~ jointly and severally liable for all overpayments, administrative fines, and other moneys due to the agency, regardless of whether the agency identified the overpayments, administrative fines, or other moneys before or after the effective date of the change of ownership. The agency may not approve a transferee's Medicaid provider enrollment application if the transferee or transferor has not paid or agreed in writing to a payment plan for all outstanding overpayments, administrative fines, and other moneys due to the agency. This subsection does not preclude the agency from seeking any other legal or equitable remedies available to the agency for the recovery of moneys owed to the Medicaid program. In the event of a change of ownership involving a skilled nursing facility licensed under part II of chapter 400, liability for all outstanding overpayments, administrative fines, and any moneys owed to the agency before the effective date of the change of ownership shall be determined in accordance with s. 400.179 if the Medicaid provider enrollment application for change of ownership is submitted before the change of ownership.

(c) As used in this subsection, the term:

1. "Administrative fines" includes any amount identified in a notice of a monetary penalty or fine which has been issued by

the agency or other regulatory or licensing agency that governs the provider.

2. "Outstanding overpayment" includes any amount identified in a preliminary audit report issued to the transferor by the agency on or before the effective date of a change of ownership.

(7) ~~The agency may require,~~ As a condition of participating in the Medicaid program and before entering into the provider agreement, the agency may require ~~that~~ the provider to submit information, in an initial and any required renewal applications, concerning the professional, business, and personal background of the provider and permit an onsite inspection of the provider's service location by agency staff or other personnel designated by the agency to perform this function. Before entering into a provider agreement, the agency may ~~shall~~ perform an ~~a random~~ onsite inspection~~, within 60 days after receipt of a fully complete new provider's application,~~ of the provider's service location ~~prior to making its first payment to the provider for Medicaid services~~ to determine the applicant's ability to provide ~~the~~ services in compliance with the Medicaid program and professional regulations ~~that the applicant is proposing to provide for Medicaid reimbursement~~. ~~The agency is not required to perform an onsite inspection of a provider or program that is licensed by the agency, that provides services under waiver programs for home and community-based services, or that is licensed as a medical foster home by the Department of Children and Family Services.~~ As a continuing condition of participation in the Medicaid program, a provider must ~~shall~~ immediately notify the agency of any current or pending bankruptcy filing. Before entering into the provider


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agreement, or as a condition of continuing participation in the Medicaid program, the agency may also require that Medicaid providers reimbursed on a fee-for-services basis or fee schedule basis that ~~which~~ is not cost-based, post a surety bond not to exceed $50,000 or the total amount billed by the provider to the program during the current or most recent calendar year, whichever is greater. For new providers, the amount of the surety bond shall be determined by the agency based on the provider's estimate of its first year's billing. If the provider's billing during the first year exceeds the bond amount, the agency may require the provider to acquire an additional bond equal to the actual billing level of the provider. A provider's bond need ~~shall~~ not exceed $50,000 if a physician or group of physicians licensed under chapter 458, chapter 459, or chapter 460 has a 50 percent or greater ownership interest in the provider or if the provider is an assisted living facility licensed under chapter 429. The bonds permitted by this section are in addition to the bonds referenced in s. 400.179(2)(d). If the provider is a corporation, partnership, association, or other entity, the agency may require the provider to submit information concerning the background of that entity and of any principal of the entity, including any partner or shareholder having an ownership interest in the entity equal to 5 percent or greater, and any treating provider who participates in or intends to participate in Medicaid through the entity. The information must include:

(a) Proof of holding a valid license or operating certificate, as applicable, if required by the state or local jurisdiction in which the provider is located or if required by


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the Federal Government.

(b) Information concerning any prior violation, fine, suspension, termination, or other administrative action taken under the Medicaid laws, rules, or regulations of this state or of any other state or the Federal Government; any prior violation of the laws, rules, or regulations relating to the Medicare program; any prior violation of the rules or regulations of any other public or private insurer; and any prior violation of the laws, rules, or regulations of any regulatory body of this or any other state.

(c) Full and accurate disclosure of any financial or ownership interest that the provider, or any principal, partner, or major shareholder thereof, may hold in any other Medicaid provider or health care related entity or any other entity that is licensed by the state to provide health or residential care and treatment to persons.

(d) If a group provider, identification of all members of the group and attestation that all members of the group are enrolled in or have applied to enroll in the Medicaid program.

(8) ~~(a)~~ Each provider, or each principal of the provider if the provider is a corporation, partnership, association, or other entity, seeking to participate in the Medicaid program must submit a complete set of his or her fingerprints to the agency for the purpose of conducting a criminal history record check. Principals of the provider include any officer, director, billing agent, managing employee, or affiliated person, or any partner or shareholder who has an ownership interest equal to 5 percent or more in the provider. However, for a hospital licensed under chapter 395 or a nursing home licensed under

chapter 400, principals of the provider are those who meet the definition of a controlling interest under s. 408.803. A director of a not-for-profit corporation or organization is not a principal for purposes of a background investigation as required by this section if the director: serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration from the not-for-profit corporation or organization for his or her service on the board of directors, has no financial interest in the not-for-profit corporation or organization, and has no family members with a financial interest in the not-for-profit corporation or organization; and if the director submits an affidavit, under penalty of perjury, to this effect to the agency and the not-for-profit corporation or organization submits an affidavit, under penalty of perjury, to this effect to the agency as part of the corporation's or organization's Medicaid provider agreement application.

(a) Notwithstanding the above, the agency may require a background check for any person reasonably suspected by the agency to have been convicted of a crime. This subsection does not apply to:

~~1. A hospital licensed under chapter 395;~~

~~2. A nursing home licensed under chapter 400;~~

~~3. A hospice licensed under chapter 400;~~

~~4. An assisted living facility licensed under chapter 429;~~

1.~~5.~~ A unit of local government, except that requirements of this subsection apply to nongovernmental providers and entities contracting with the local government to provide

Medicaid services. The actual cost of the state and national criminal history record checks must be borne by the nongovernmental provider or entity; or

2.~~6.~~ Any business that derives more than 50 percent of its revenue from the sale of goods to the final consumer, and the business or its controlling parent is required to file a form 10-K or other similar statement with the Securities and Exchange Commission or has a net worth of $50 million or more.

(b) Background screening shall be conducted in accordance with chapter 435 and s. 408.809. The cost of the state and national criminal record check shall be borne by the provider.

~~(c) Proof of compliance with the requirements of level 2 screening under chapter 435 conducted within 12 months before the date the Medicaid provider application is submitted to the agency fulfills the requirements of this subsection.~~

Section 5. Present paragraphs (e) and (f) of subsection (1) of section 409.913, Florida Statutes, are redesignated as paragraphs (f) and (g), respectively, a new paragraph (e) is added to that subsection, and subsections (2), (9), (13), (15), (16), (21), (22), (25), (28), (29), (30), and (31) of that section are amended, to read:

409.913 Oversight of the integrity of the Medicaid program.—The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. Beginning January 1, 2003, and each year thereafter, the agency and the Medicaid Fraud Control Unit of

the Department of Legal Affairs shall submit a joint report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report must describe the number of cases opened and investigated each year; the sources of the cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must include policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud. All policy recommendations in the report must include a detailed

fiscal analysis, including, but not limited to, implementation costs, estimated savings to the Medicaid program, and the return on investment. The agency must submit the policy recommendations and fiscal analyses in the report to the appropriate estimating conference, pursuant to s. 216.137, by February 15 of each year. The agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs each must include detailed unit-specific performance standards, benchmarks, and metrics in the report, including projected cost savings to the state Medicaid program during the following fiscal year.

(1) For the purposes of this section, the term:

(e) "Medicaid provider" or "provider" has the same meaning as provided in s. 409.901 and, for purposes of oversight of the integrity of the Medicaid program, also includes a participant in a Medicaid managed care provider network.

(2) The agency shall conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and ~~shall~~ report the findings of any overpayments in audit reports as appropriate. At least 5 percent of all audits must ~~shall~~ be conducted on a random basis. As part of its ongoing fraud detection activities, the agency shall identify and monitor, by contract or otherwise, patterns of overutilization of Medicaid services based on state averages. The agency shall track Medicaid provider prescription and billing patterns and evaluate them against Medicaid medical necessity criteria and coverage and limitation guidelines adopted by rule. Medical necessity determination requires that service be consistent with

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symptoms or confirmed diagnosis of illness or injury under treatment and not in excess of the patient's needs. The agency shall conduct reviews of provider exceptions to peer group norms and ~~shall~~, using statistical methodologies, provider profiling, and analysis of billing patterns, detect and investigate abnormal or unusual increases in billing or payment of claims for Medicaid services and medically unnecessary provision of services. The agency may review and analyze information from sources other than enrolled Medicaid providers in conducting its activities under this subsection.

(9) A Medicaid provider shall retain medical, professional, financial, and business records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid for 6 ~~a period of 5~~ years after the date of furnishing such services or goods. The agency may investigate, review, or analyze such records, which must be made available during normal business hours. However, 24-hour notice must be provided if patient treatment would be disrupted. The provider is responsible for furnishing to the agency, and keeping the agency informed of the location of, the provider's Medicaid-related records. The authority of the agency to obtain Medicaid-related records from a provider is neither curtailed nor limited during a period of litigation between the agency and the provider.

(13) The agency shall ~~immediately~~ terminate participation of a Medicaid provider in the Medicaid program and may seek civil remedies or impose other administrative sanctions against a Medicaid provider, if the provider or any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership

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interest in the provider equal to 5 percent or greater, has been convicted of a criminal offense under federal law or the law of any state relating to the practice of the provider's profession, or an offense listed under s. 409.907(10), s. 408.809(4), or s. 435.04(2) ~~has been:~~

~~(a) Convicted of a criminal offense related to the delivery of any health care goods or services, including the performance of management or administrative functions relating to the delivery of health care goods or services;~~

~~(b) Convicted of a criminal offense under federal law or the law of any state relating to the practice of the provider's profession; or~~

~~(c) Found by a court of competent jurisdiction to have neglected or physically abused a patient in connection with the delivery of health care goods or services~~. If the agency determines that the ~~a~~ provider did not participate or acquiesce in the ~~an~~ offense ~~specified in paragraph (a), paragraph (b), or paragraph (c)~~, termination will not be imposed. If the agency effects a termination under this subsection, the agency shall issue an immediate final order pursuant to s. 120.569(2)(n).

(15) The agency shall seek a remedy provided by law, including, but not limited to, any remedy provided in subsections (13) and (16) and s. 812.035, if:

(a) The provider's license has not been renewed, or has been revoked, suspended, or terminated, for cause, by the licensing agency of any state;

(b) The provider has failed to make available or has refused access to Medicaid-related records to an auditor, investigator, or other authorized employee or agent of the

agency, the Attorney General, a state attorney, or the Federal Government;

(c) The provider has not furnished or has failed to make available such Medicaid-related records as the agency has found necessary to determine whether Medicaid payments are or were due and the amounts thereof;

(d) The provider has failed to maintain medical records made at the time of service, or prior to service if prior authorization is required, demonstrating the necessity and appropriateness of the goods or services rendered;

(e) The provider is not in compliance with provisions of Medicaid provider publications that have been adopted by reference as rules in the Florida Administrative Code; with provisions of state or federal laws, rules, or regulations; with provisions of the provider agreement between the agency and the provider; or with certifications found on claim forms or on transmittal forms for electronically submitted claims that are submitted by the provider or authorized representative, as such provisions apply to the Medicaid program;

(f) The provider or person who ordered, authorized, or prescribed the care, services, or supplies has furnished, ~~or~~ ordered, or authorized the furnishing of~~,~~ goods or services to a recipient which are inappropriate, unnecessary, excessive, or harmful to the recipient or are of inferior quality;

(g) The provider has demonstrated a pattern of failure to provide goods or services that are medically necessary;

(h) The provider or an authorized representative of the provider, or a person who ordered, authorized, or prescribed the goods or services, has submitted or caused to be submitted false

or a pattern of erroneous Medicaid claims;

(i) The provider or an authorized representative of the provider, or a person who has ordered, authorized, or prescribed the goods or services, has submitted or caused to be submitted a Medicaid provider enrollment application, a request for prior authorization for Medicaid services, a drug exception request, or a Medicaid cost report that contains materially false or incorrect information;

(j) The provider or an authorized representative of the provider has collected from or billed a recipient or a recipient's responsible party improperly for amounts that should not have been so collected or billed by reason of the provider's billing the Medicaid program for the same service;

(k) The provider or an authorized representative of the provider has included in a cost report costs that are not allowable under a Florida Title XIX reimbursement plan~~,~~ after the provider or authorized representative had been advised in an audit exit conference or audit report that the costs were not allowable;

(l) The provider is charged by information or indictment with fraudulent billing practices or any offense referenced in subsection (13). The sanction applied for this reason is limited to suspension of the provider's participation in the Medicaid program for the duration of the indictment unless the provider is found guilty pursuant to the information or indictment;

(m) The provider or a person who has ordered, authorized, or prescribed the goods or services is found liable for negligent practice resulting in death or injury to the provider's patient;

(n) The provider fails to demonstrate that it had available during a specific audit or review period sufficient quantities of goods, or sufficient time in the case of services, to support the provider's billings to the Medicaid program;

(o) The provider has failed to comply with the notice and reporting requirements of s. 409.907;

(p) The agency has received reliable information of patient abuse or neglect or of any act prohibited by s. 409.920; or

(q) The provider has failed to comply with an agreed-upon repayment schedule.

A provider is subject to sanctions for violations of this subsection as the result of actions or inactions of the provider, or actions or inactions of any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, in which the provider participated or acquiesced.

(16) The agency shall impose any of the following sanctions or disincentives on a provider or a person for any of the acts described in subsection (15):

(a) Suspension for a specific period of time of not more than 1 year. Suspension precludes ~~shall preclude~~ participation in the Medicaid program, which includes any action that results in a claim for payment to the Medicaid program as a result of furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services.

(b) Termination for a specific period of time of from more than 1 year to 20 years. Termination precludes ~~shall preclude~~

participation in the Medicaid program, which includes any action that results in a claim for payment to the Medicaid program as a result of furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services.

(c) Imposition of a fine of up to $5,000 for each violation. Each day that an ongoing violation continues, such as refusing to furnish Medicaid-related records or refusing access to records, is considered, for the purposes of this section, to be a separate violation. Each instance of improper billing of a Medicaid recipient; each instance of including an unallowable cost on a hospital or nursing home Medicaid cost report after the provider or authorized representative has been advised in an audit exit conference or previous audit report of the cost unallowability; each instance of furnishing a Medicaid recipient goods or professional services that are inappropriate or of inferior quality as determined by competent peer judgment; each instance of knowingly submitting a materially false or erroneous Medicaid provider enrollment application, request for prior authorization for Medicaid services, drug exception request, or cost report; each instance of inappropriate prescribing of drugs for a Medicaid recipient as determined by competent peer judgment; and each false or erroneous Medicaid claim leading to an overpayment to a provider is considered, for the purposes of this section, to be a separate violation.

(d) Immediate suspension, if the agency has received information of patient abuse or neglect or of any act prohibited by s. 409.920. Upon suspension, the agency must issue an immediate final order under s. 120.569(2)(n).

(e) A fine, not to exceed $10,000, for a violation of

paragraph (15)(i).

(f) Imposition of liens against provider assets, including, but not limited to, financial assets and real property, not to exceed the amount of fines or recoveries sought, upon entry of an order determining that such moneys are due or recoverable.

(g) Prepayment reviews of claims for a specified period of time.

(h) Comprehensive followup reviews of providers every 6 months to ensure that they are billing Medicaid correctly.

(i) Corrective-action plans that ~~would~~ remain in effect ~~for providers~~ for up to 3 years and that are ~~would be~~ monitored by the agency every 6 months while in effect.

(j) Other remedies as permitted by law to effect the recovery of a fine or overpayment.

If a provider voluntarily relinquishes its Medicaid provider number after receiving written notice that the agency is conducting, or has conducted, an audit or investigation and the sanction of suspension or termination will be imposed for noncompliance discovered as a result of the audit or investigation, the agency shall impose the sanction of termination for cause against the provider. The Secretary of Health Care Administration may make a determination that imposition of a sanction or disincentive is not in the best interest of the Medicaid program, in which case a sanction or disincentive may ~~shall~~ not be imposed.

(21) When making a determination that an overpayment has occurred, the agency shall prepare and issue an audit report to the provider showing the calculation of overpayments. The

agency's determination shall be based solely upon information available to it before issuance of the audit report and, in the case of documentation obtained to substantiate claims for Medicaid reimbursement, based solely upon contemporaneous records.

(22) The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment. A provider may not present or elicit testimony, ~~either~~ on direct examination or cross-examination in any court or administrative proceeding, regarding the purchase or acquisition by any means of drugs, goods, or supplies; sales or divestment by any means of drugs, goods, or supplies; or inventory of drugs, goods, or supplies, unless such acquisition, sales, divestment, or inventory is documented by written invoices, written inventory records, or other competent written documentary evidence maintained in the normal course of the provider's business. Testimony or evidence that is not based upon contemporaneous records or that was not furnished to the agency within 21 days after the issuance of the audit report is inadmissible in an administrative hearing on a Medicaid overpayment or an administrative sanction. Notwithstanding the applicable rules of discovery, all documentation to ~~that will~~ be offered as evidence at an administrative hearing on a Medicaid overpayment or an administrative sanction must be exchanged by all parties at least 14 days before the administrative hearing or ~~must be~~ excluded from consideration.

(25)(a) The agency shall withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a

withholding of payments involve fraud, willful misrepresentation, or abuse under the Medicaid program, or a crime committed while rendering goods or services to Medicaid recipients. If it is determined that fraud, willful misrepresentation, abuse, or a crime did not occur, the payments withheld must be paid to the provider within 14 days after such determination ~~with interest at the rate of 10 percent a year~~. ~~Any money withheld in accordance with this paragraph shall be placed in a suspended account, readily accessible to the agency, so that any payment ultimately due the provider shall be made within 14 days.~~

(b) The agency shall deny payment, or require repayment, if the goods or services were furnished, supervised, or caused to be furnished by a person who has been suspended or terminated from the Medicaid program or Medicare program by the Federal Government or any state.

(c) Overpayments owed to the agency bear interest at the rate of 10 percent per year from the date of determination of the overpayment by the agency, and payment arrangements regarding overpayments and fines must be made within 30 days after the date of the final order and are not subject to further appeal ~~at the conclusion of legal proceedings~~. ~~A provider who does not enter into or adhere to an agreed-upon repayment schedule may be terminated by the agency for nonpayment or partial payment.~~

(d) The agency, upon entry of a final agency order, a judgment or order of a court of competent jurisdiction, or a stipulation or settlement, may collect the moneys owed by all means allowable by law, including, but not limited to, notifying

any fiscal intermediary of Medicare benefits that the state has a superior right of payment. Upon receipt of such written notification, the Medicare fiscal intermediary shall remit to the state the sum claimed.

(e) The agency may institute amnesty programs to allow Medicaid providers the opportunity to voluntarily repay overpayments. The agency may adopt rules to administer such programs.

(28) Venue for all Medicaid program integrity ~~overpayment~~ cases lies ~~shall lie~~ in Leon County, at the discretion of the agency.

(29) Notwithstanding other provisions of law, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs may review a person's or provider's Medicaid-related and non-Medicaid-related records in order to determine the total output of a provider's practice to reconcile quantities of goods or services billed to Medicaid with quantities of goods or services used in the provider's total practice.

(30) The agency shall terminate a provider's participation in the Medicaid program if the provider fails to reimburse an overpayment or pay a fine that has been determined by final order, not subject to further appeal, within 30 ~~35~~ days after the date of the final order, unless the provider and the agency have entered into a repayment agreement.

(31) If a provider requests an administrative hearing pursuant to chapter 120, such hearing must be conducted within 90 days following assignment of an administrative law judge, absent exceptionally good cause shown as determined by the administrative law judge or hearing officer. Upon issuance of a

final order, the outstanding balance of the amount determined to constitute the overpayment and fines is ~~shall become~~ due. If a provider fails to make payments in full, fails to enter into a satisfactory repayment plan, or fails to comply with the terms of a repayment plan or settlement agreement, the agency shall withhold ~~medical assistance~~ reimbursement payments for Medicaid services until the amount due is paid in full.

Section 6. Subsection (8) of section 409.920, Florida Statutes, is amended to read:

409.920 Medicaid provider fraud.—

(8) A person who provides the state, any state agency, any of the state's political subdivisions, or any agency of the state's political subdivisions with information about fraud or suspected fraudulent acts ~~fraud~~ by a Medicaid provider, including a managed care organization, is immune from civil liability for libel, slander, or any other relevant tort for providing any ~~the~~ information about fraud or suspected fraudulent acts, unless the person acted with knowledge that the information was false or with reckless disregard for the truth or falsity of the information. For purposes of this subsection, the term "fraudulent acts" includes actual or suspected fraud, abuse, or overpayment, including any fraud-related matters that a provider or health plan is required to report to the agency or a law enforcement agency. The immunity from civil liability extends to reports of fraudulent acts conveyed to the agency in any manner, including any forum and with any audience as directed by the agency, and includes all discussions subsequent to the report and subsequent inquiries from the agency, unless the person acted with knowledge that the information was false

or with reckless disregard for the truth or falsity of the information.

Section 7. Paragraph (c) of subsection (2) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(c) *Access.*—

1. Providers.—The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. The exclusive use of mail-order pharmacies is ~~may~~ not ~~be~~ sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. A plan may contract with a new hospital facility before the date the hospital becomes operational if the hospital has commenced construction, will be licensed and operational by January 1, 2013, and a final order has issued in any civil or administrative challenge. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance

indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider.

2. Prescribed drugs.—

a. If establishing a prescribed drug formulary or preferred drug list, a managed care plan must:

(I) Provide coverage for drugs in categories and classes for all disease states and provide a broad range of therapeutic options for all therapeutic categories;

(II) Include coverage for each drug newly approved by the federal Food and Drug Administration until the plan's Pharmaceutical and Therapeutics Committee reviews such drug for inclusion on the formulary;

(III) Provide a response within 24 hours after receipt of all necessary information for a request for prior authorization or override of other medical management tools; and

(IV) Report all denials to the agency on a quarterly basis. For each nonformulary drug, the plan must report the total number of requests and the total number of denials.

b. Each managed care plan shall ~~must~~ publish any prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after making a change. ~~Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible~~

~~to health care providers, including posting appropriate contact information on its website and providing timely responses to providers.~~

c. The managed care plan must continue to permit an enrollee who was receiving a prescription drug that was on the plan's formulary and subsequently removed or changed to continue to receive that drug if requested by the enrollee and prescriber for as long as the enrollee is a member of the plan.

d. A managed care plan that imposes a step-therapy or a fail-first protocol must do so in accordance with the following:

(I) If prescribed drugs for the treatment of a medical condition are restricted for use by the plan through a step-therapy or fail-first protocol, the plan must provide the prescriber with access to a clear and convenient process to expeditiously request an override of such restriction from the plan.

(II) An override of the restriction must be expeditiously granted by the plan if the prescriber can demonstrate to the plan that the preferred treatment required under the step-therapy or fail-first protocol:

(A) Has been ineffective in the treatment of the enrollee's disease or medical condition;

(B) Is reasonably expected to be ineffective based on the known relevant physical or mental characteristics and medical history of the enrollee and known characteristics of the drug regimen; or

(C) Will cause or will likely cause an adverse reaction or other physical harm to the enrollee.

(III) The maximum duration of a step-therapy or fail-first

protocol requirement may not be longer than the customary period for the prescribed drug if such treatment is demonstrated by the prescriber to be clinically ineffective. If the plan can demonstrate, through sound clinical evidence, that the originally prescribed drug is likely to require more than the customary period for such drug to provide any relief or amelioration to the enrollee, the step-therapy or fail-first protocol may be extended, but no longer than the original customary period for the drug, after which time the prescriber may deem such treatment as clinically ineffective for the enrollee. Once the prescriber deems the treatment to be clinically ineffective, the plan must dispense and cover the originally prescribed drug recommended by the prescriber.

e. For enrollees ~~Medicaid recipients~~ diagnosed with hemophilia who have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those products and hemophilia overlay services through the agency's hemophilia disease management program.

3. Prior authorization.—

a. Each managed care plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers.

b. If a drug, determined to be medically necessary and prescribed for an enrollee by a physician using sound clinical judgment, is subject to prior authorization, the managed care plan must provide payment to the pharmacist for dispensing such drug without seeking prior authorization if the pharmacist

confirms that:

(I) The prescription is a refill or renewal of the same drug for the same enrollee written by the same prescriber; or

(II) If the drug is generally prescribed for an indication that is treated on an ongoing basis by continuous medication or as-needed, the enrollee for whom the drug is prescribed has filled a prescription for the same drug within the preceding 30 to 90 days.

c. If a prescribed drug requires prior authorization, the managed care plan shall reimburse the pharmacist for dispensing a 72-hour supply to the enrollee and process the prior authorization request and send a response to the requesting pharmacist within 24 hours after receiving the pharmacist's request for prior authorization.

d.~~3.~~ Managed care plans, and their fiscal agents or intermediaries, must accept prior authorization requests for any service electronically.

Section 8. Subsection (11) is added to section 429.23, Florida Statutes, to read:

429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.—

(11) The agency shall annually submit a report to the Legislature on adverse incident reports by assisted living facilities. The report must include the following information arranged by county:

(a) A total number of adverse incidents;

(b) A listing, by category, of the type of adverse incidents occurring within each category and the type of staff involved;

(c) A listing, by category, of the types of injuries, if any, and the number of injuries occurring within each category;

(d) Types of liability claims filed based on an adverse incident report or reportable injury; and

(e) Disciplinary action taken against staff, categorized by the type of staff involved.

Section 9. Present subsections (9), (10), and (11) of section 429.26, Florida Statutes, are renumbered as subsections (12), (13), and (14), respectively, and new subsections (9), (10), and (11) are added to that section, to read:

429.26 Appropriateness of placements; examinations of residents.—

(9) If, at any time after admission to a facility, agency personnel question whether a resident needs care beyond that which the facility is licensed to provide, the agency may require the resident to be physically examined by a licensed physician, licensed physician assistant, or certified nurse practitioner. To the extent possible, the examination must be performed by the resident's preferred physician, physician assistant, or nurse practitioner and paid for by the resident with personal funds, except as provided in s. 429.18(2). This subsection does not preclude the agency from imposing sanctions for violations of subsection (1).

(a) Following examination, the examining physician, physician assistant, or nurse practitioner shall complete and sign a medical form provided by the agency. The completed medical form must be submitted to the agency within 30 days after the date the facility owner or administrator was notified by the agency that a physical examination is required.

(b) A medical review team designated by the agency shall determine whether the resident is appropriately residing in the facility based on the completed medical form and, if necessary, consultation with the physician, physician assistant, or nurse practitioner who performed the examination. Members of the medical review team making the determination may not include the agency personnel who initially questioned the appropriateness of the resident's placement. The medical review team shall base its decision on a comprehensive review of the resident's physical and functional status. A determination that the resident's placement is not appropriate is final and binding upon the facility and the resident.

(c) A resident who is determined by the medical review team to be inappropriately residing in a facility shall be given 30 days' written notice to relocate by the owner or administrator, unless the resident's continued residence in the facility presents an imminent danger to the health, safety, or welfare of the resident or a substantial probability exists that death or serious physical harm to the resident would result if the resident is allowed to remain in the facility.

(10) If a mental health resident appears to have needs in addition to those identified in the community living support plan, the agency may require an evaluation by a mental health professional, as determined by the Department of Children and Family Services.

(11) A facility may not be required to retain a resident who requires more services or care than the facility is able to provide in accordance with its policies and criteria for admission and continued residency.

Section 10. Effective July 1, 2012, section 456.0635, Florida Statutes, is amended to read:

456.0635 Health care ~~Medicaid~~ fraud; disqualification for license, certificate, or registration.—

(1) Health care ~~Medicaid~~ fraud in the practice of a health care profession is prohibited.

(2) Each board under ~~within~~ the jurisdiction of the department, or the department if there is no board, shall refuse to admit a candidate to an ~~any~~ examination and refuse to issue ~~or renew~~ a license, certificate, or registration to an ~~any~~ applicant if the candidate or applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant~~, has been~~:

(a) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, or chapter 893, or a similar felony offense committed in another state or jurisdiction, unless the candidate or applicant has successfully completed a drug court program for that felony and provides proof that the plea has been withdrawn or the charges have been dismissed. Any such conviction or plea shall exclude the applicant or candidate from licensure, examination, certification, or registration ~~21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396,~~ unless the sentence and any subsequent period of probation for such conviction or plea ~~pleas~~ ended: ~~more than 15 years prior to the date of the application;~~

1. For felonies of the first or second degree, more than 15 years before the date of application.

2. For felonies of the third degree, more than 10 years

before the date of application, except for felonies of the third degree under s. 893.13(6)(a).

3. For felonies of the third degree under s. 893.13(6)(a), more than 5 years before the date of application.

(b) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396, unless the sentence and any subsequent period of probation for such conviction or plea ended more than 15 years before the date of the application.

(c) ~~(b)~~ Has been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the candidate or applicant has been in good standing with the Florida Medicaid program for the most recent 5 years.~~;~~

(d) ~~(c)~~ Has been terminated for cause, pursuant to the appeals procedures established by the state ~~or Federal Government~~, from any other state Medicaid program ~~or the federal Medicare program~~, unless the candidate or applicant has been in good standing with that ~~a~~ state Medicaid program ~~or the federal Medicare program~~ for the most recent 5 years and the termination occurred at least 20 years before ~~prior to~~ the date of the application.

(e) Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

This subsection does not apply to candidates or applicants for initial licensure or certification who were enrolled in an educational or training program on or before July 1, 2009, which


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was recognized by a board or, if there is no board, recognized by the department, and who applied for licensure after July 1, 2012.

(3) The department shall refuse to renew a license, certificate, or registration of any applicant if the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant:

(a) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, or chapter 893, or a similar felony offense committed in another state or jurisdiction, unless the applicant is currently enrolled in a drug court program that allows the withdrawal of the plea for that felony upon successful completion of that program. Any such conviction or plea excludes the applicant or candidate from licensure, examination, certification, or registration unless the sentence and any subsequent period of probation for such conviction or plea ended:

1. For felonies of the first or second degree, more than 15 years before the date of application.

2. For felonies of the third degree, more than 10 years before the date of application, except for felonies of the third degree under s. 893.13(6)(a).

3. For felonies of the third degree under s. 893.13(6)(a), more than 5 years before the date of application.

(b) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 since July 1, 2009, unless the sentence and any subsequent period of probation


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for such conviction or plea ended more than 15 years before the date of the application.

(c) Has been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5 years.

(d) Has been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program, unless the applicant has been in good standing with that state Medicaid program for the most recent 5 years and the termination occurred at least 20 years before the date of the application.

(e) Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

(4) ~~(3)~~ Licensed health care practitioners shall report allegations of health care ~~Medicaid~~ fraud to the department, regardless of the practice setting in which the alleged health care ~~Medicaid~~ fraud occurred.

(5) ~~(4)~~ The acceptance by a licensing authority of a licensee's ~~candidate's~~ relinquishment of a license which is offered in response to or anticipation of the filing of administrative charges alleging health care ~~Medicaid~~ fraud or similar charges constitutes the permanent revocation of the license.

Section 11. Effective July 1, 2012, present subsections (14) and (15) of section 456.036, Florida Statutes, are renumbered as subsections (15) and (16), respectively, and a new subsection (14) is added to that section, to read:

456.036 Licenses; active and inactive status; delinquency.—

(14) A person who has been denied license renewal, certification, or registration under s. 456.0635(3) may regain licensure, certification, or registration only by meeting the qualifications and completing the application process for initial licensure as defined by the board, or the department if there is no board. However, a person who was denied renewal of licensure, certification, or registration under s. 24 of chapter 2009-223, Laws of Florida, between July 1, 2009, and June 30, 2012, is not required to retake and pass examinations applicable for initial licensure, certification, or registration.

Section 12. Subsection (1) of section 456.074, Florida Statutes, is amended to read:

456.074 Certain health care practitioners; immediate suspension of license.—

(1) The department shall issue an emergency order suspending the license of any person licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 464, chapter 465, chapter 466, or chapter 484 who pleads guilty to, is convicted or found guilty of, or who enters a plea of nolo contendere to, regardless of adjudication~~, to~~:

(a) A felony under chapter 409, chapter 817, or chapter 893 or under 21 U.S.C. ss. 801-970 or ~~under~~ 42 U.S.C. ss. 1395-1396; or

(b) A misdemeanor or felony under 18 U.S.C. s. 669, ss. 285-287, s. 371, s. 1001, s. 1035, s. 1341, s. 1343, s. 1347, s. 1349, or s. 1518 or 42 U.S.C. ss. 1320a-7b~~, relating to the Medicaid program~~.

Section 13. Paragraph (a) of subsection (54) of section

499.003, Florida Statutes, is amended to read:

499.003 Definitions of terms used in this part.—As used in this part, the term:

(54) "Wholesale distribution" means distribution of prescription drugs to persons other than a consumer or patient, but does not include:

(a) Any of the following activities, which is not a violation of s. 499.005(21) if such activity is conducted in accordance with s. 499.01(2)(g):

1. The purchase or other acquisition by a hospital or other health care entity that is a member of a group purchasing organization of a prescription drug for its own use from the group purchasing organization or from other hospitals or health care entities that are members of that organization.

2. The sale, purchase, or trade of a prescription drug or an offer to sell, purchase, or trade a prescription drug by a charitable organization described in s. 501(c)(3) of the Internal Revenue Code of 1986, as amended and revised, to a nonprofit affiliate of the organization to the extent otherwise permitted by law.

3. The sale, purchase, or trade of a prescription drug or an offer to sell, purchase, or trade a prescription drug among hospitals or other health care entities that are under common control. For purposes of this subparagraph, "common control" means the power to direct or cause the direction of the management and policies of a person or an organization, whether by ownership of stock, by voting rights, by contract, or otherwise.

4. The sale, purchase, trade, or other transfer of a

prescription drug from or for any federal, state, or local government agency or any entity eligible to purchase prescription drugs at public health services prices pursuant to Pub. L. No. 102-585, s. 602 to a contract provider or its subcontractor for eligible patients of the agency or entity under the following conditions:

a. The agency or entity must obtain written authorization for the sale, purchase, trade, or other transfer of a prescription drug under this subparagraph from the State Surgeon General or his or her designee.

b. The contract provider or subcontractor must be authorized by law to administer or dispense prescription drugs.

c. In the case of a subcontractor, the agency or entity must be a party to and execute the subcontract.

~~d. A contract provider or subcontractor must maintain separate and apart from other prescription drug inventory any prescription drugs of the agency or entity in its possession.~~

d.~~e.~~ The contract provider and subcontractor must maintain and produce immediately for inspection all records of movement or transfer of all the prescription drugs belonging to the agency or entity, including, but not limited to, the records of receipt and disposition of prescription drugs. Each contractor and subcontractor dispensing or administering these drugs must maintain and produce records documenting the dispensing or administration. Records that are required to be maintained include, but are not limited to, a perpetual inventory itemizing drugs received and drugs dispensed by prescription number or administered by patient identifier, which must be submitted to the agency or entity quarterly.

e.~~f.~~ The contract provider or subcontractor may administer or dispense the prescription drugs only to the eligible patients of the agency or entity or must return the prescription drugs for or to the agency or entity. The contract provider or subcontractor must require proof from each person seeking to fill a prescription or obtain treatment that the person is an eligible patient of the agency or entity and must, at a minimum, maintain a copy of this proof as part of the records of the contractor or subcontractor required under sub-subparagraph e.

f.~~g.~~ In addition to the departmental inspection authority set forth in s. 499.051, the establishment of the contract provider and subcontractor and all records pertaining to prescription drugs subject to this subparagraph shall be subject to inspection by the agency or entity. All records relating to prescription drugs of a manufacturer under this subparagraph shall be subject to audit by the manufacturer of those drugs, without identifying individual patient information.

Section 14. The Agency for Health Care Administration shall prepare a report within 18 months after the implementation of an expansion of managed care to new populations or the provision of new items and services. The agency shall post a draft of the report on its website and provide an opportunity for public comment. The final report shall be submitted to the Legislature, along with a description of the process for public input. The report must include an assessment of:

(1) The impact of managed care on patient access to care, including an evaluation of any new barriers to the use of services and prescription drugs, created by the use of medical management or cost-containment tools.

(2) The impact of the increased managed care expansion on the utilization of services, quality of care, and patient outcomes.

(3) The use of prior authorization and other utilization management tools, including an assessment of whether these tools pose an undue administrative burden for health care providers or create barriers to needed care.

Section 15. Except as otherwise expressly provided in this act, this act shall take effect upon becoming a law.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to health care; amending s. 400.474, F.S.; revising the fine that may be imposed against a home health agency for failing to timely submit certain information to the Agency for Health Care Administration; amending s. 400.9905, F.S.; revising the definition of the term "clinic" as it relates to the Health Care Clinic Act; amending s. 409.221, F.S.; revising the background screening requirements for persons rendering care in the consumer-directed care program administered by the Agency for Health Care Administration; amending s. 409.907, F.S.; extending the records-retention period for certain Medicaid provider records; revising the provider agreement to require Medicaid providers to report changes in any

principal of the provider to the agency; defining the term "administrative fines" for purposes of revoking a Medicaid provider agreement due to changes of ownership; authorizing, rather than requiring, an onsite inspection of a Medicaid provider's service location before entering into a provider agreement; specifying the principals of a hospital or nursing home provider for the purposes of submitting fingerprints for background screening; removing certain providers from being subject to agency background checks; amending s. 409.913, F.S.; defining the term "Medicaid provider" or "provider" for purposes of oversight of the integrity of the Medicaid program; authorizing the agency to review and analyze information from sources other than Medicaid-enrolled providers for purposes of determining fraud, abuse, overpayment, or neglect; extending the records-retention period for certain Medicaid provider records; revising the grounds for terminating a provider from the Medicaid program; requiring the agency to base its overpayment audit reports on certain information; deleting a requirement that the agency pay interest on certain withheld Medicaid payments; requiring payment arrangements for overpayments and fines to be made within a certain time; specifying that the venue for all Medicaid program integrity cases lies in Leon County; authorizing the agency and the Medicaid Fraud Control Unit to review certain records; amending s. 409.920,

F.S.; clarifying the applicability of immunity from civil liability extended to persons who provide information about fraud or suspected fraudulent acts by a Medicaid provider; amending s. 409.967, F.S.; specifying required components of a Medicaid managed care plan relating to the provisions of medications; amending s. 429.23, F.S.; requiring the agency to submit a report to the Legislature on adverse incident reports from assisted living facilities; amending s. 429.26, F.S.; authorizing the agency to require a resident of an assisted living facility to undergo a physical examination if the agency questions the appropriateness of the resident's placement in that facility; authorizing release of the results of the examination to a medical review team to be used along with additional information to determine whether the resident's placement in the assisted living facility is appropriate; providing for resident notification and relocation if the resident's continued placement in the facility is not appropriate; authorizing the agency to require the evaluation of a mental health resident by a mental health professional; authorizing an assisted living facility to discharge a resident who requires more services or care than the facility is able to provide; amending s. 456.0635, F.S.; revising the grounds under which the Department of Health or corresponding board is required to refuse to admit a candidate to an examination and refuse to issue or renew a license, certificate, or registration

of a health care practitioner; providing an exception; amending s. 456.036, F.S.; providing that all persons who were denied renewal of licensure, certification, or registration under s. 456.0635(3), F.S., may regain licensure, certification, or registration only by completing the application process for initial licensure; providing an exception; amending s. 456.074, F.S.; revising the federal offenses for which the Department of Health must issue an emergency order suspending the license of certain health care professionals; amending s. 499.003, F.S.; removing a requirement that a contract provider or subcontractor maintain prescription drugs of the agency or entity in its possession separate and apart from other prescription drugs; requiring the Agency for Health Care Administration to prepare a report for public comment and submission to the Legislature following the expansion of services to new populations or of new services; providing effective dates.

SENATOR DON GAETZ
4th District

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Reapportionment, Chair
Banking and Insurance
Budget
Budget - Subcommittee on Transportation, Tourism, and Economic Development Appropriations
Budget - Subcommittee on Health and Human Services Appropriations
Health Regulation
Rules
Rules - Subcommittee on Ethics and Elections

JOINT COMMITTEE:
Legislative Budget Commission

January 12, 2012

The Honorable Rene Garcia, Chair
Health Regulation Committee
310 Senate Office Building
404 South Monroe Street
Tallahassee, Fl 32399-1100

Dear Senator Garcia,

I respectfully request that you place Senate Bill 1316, relating to Healthcare Provider Accountability, on your Healthcare Regulation committee agenda as soon as conveniently possible.

Please do not hesitate to contact me if you have any questions.

Sincerely,

Senator Don Gaetz
District 4

CC: Sandra Stovall, Staff Director

ENTERED
1-13-12

REPLY TO:
❒ 4300 Legendary Drive, Suite 230, Destin, Florida 32541 (850) 897-5747
❒ 420 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5009

Senate's Website: *www.flsenate.gov*

MIKE HARIDOPOLOS
President of the Senate

MICHAEL S. "MIKE" BENNETT
President Pro Tempore

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 Health Regulation Committee

BILL: CS/SB 1516

INTRODUCER: Children, Families, and Elder Affairs Committee, Senator Negron, and others

SUBJECT: Agency for Persons with Disabilities

DATE: January 28, 2012 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Daniell	Farmer	CF	**Fav/CS**
2.	Wilson	Stovall	HR	**Pre-meeting**
3.			BC	
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:

This bill makes significant changes to Florida law relating to the Agency for Persons with Disabilities (APD or agency). Specifically, the bill:

- Provides that it is the intent of the Legislature to prioritize state funds for those services needed to ensure the health and safety of individuals with disabilities, and that other services should be supported through natural supports and community resources, with the Medicaid waivers being the payor of last resort for home and community-based programs;
- Defines "adult day services," "nonwaiver resources," and "waiver"; amends the definition of "adult day training," "personal care services," and "support coordinator"; and deletes the definition of "domicile";
- Requires an individual to be a U.S. citizen or qualified noncitizen in order to receive services;
- Makes the authorization of certain services contingent on available funding;
- Provides that tier eligibility under the four-tiered waiver system may not be made until a waiver slot and funding become available, and that assignment to a higher tier must be based on crisis criteria;
- Prohibits the APD from authorizing a waiver service if that service can be covered by the Medicaid state plan;

- Removes the $150,000 per-client cap for total annual tier one expenditures per year;
- Changes the definitions of tier two and tier three to include clients whose need for services meets the criteria of the tier above but which can be met within the expenditure of either tier two or tier three;
- Authorizes the APD to collect fees, in addition to premiums or other cost sharing methods, from the parents of children being served by a waiver;
- Establishes a framework to evaluate waiver support coordinators;
- Provides flexibility to a client in determining the type, amount, frequency, duration, and scope of services if the agency determines such services meet the individual's health and safety needs;
- Provides a methodology for the determination of a client's iBudget allocation;
- Provides for an abbreviated inspection and review process if a facility has certain accreditation;
- Authorizes the APD to execute a petition for involuntary admission to residential services;
- Authorizes the APD to issue a final order at the conclusion of a Medicaid hearing conducted by the Department of Children and Family Services (DCF or department);
- Provides that the welfare of clients includes the establishment, maintenance, and operation of sheltered workshops that include client wages;
- Prohibits the premium, fee, or other cost sharing paid by a parent on behalf of a child under the age of 18 from exceeding the cost of waiver services to the client;
- Provides that a client may not be denied waiver services due to nonpayment by a parent, however, adoptive and foster parents are exempt from payment of any premiums, fees, or other cost-sharing; and
- Makes technical and conforming changes.

This bill substantially amends the following sections of the Florida Statutes: 393.062, 393.063, 393.065, 393.066, 393.0661, 393.0662, 393.067, 393.068, 393.11, 393.125, 393.23, 409.906, and 514.072.

II. Present Situation:

Agency for Persons with Disabilities

In October 2004, the Developmental Disabilities Program separated from the DCF and became the APD.[1] The agency was tasked with serving the needs of Floridians with developmental disabilities.[2] The primary purpose of the APD is to work in partnership with local communities to ensure the safety, well-being, and self-sufficiency of the people served by the agency, and provide assistance in identifying needs and funding to purchase supports and services.[3]

[1] Agency for Persons with Disabilities, *About Us.* Found at: <http://apdcares.org/about/> (Last visited on January 27, 2012).
[2] *Id.*
[3] Office of Program Policy Analysis & Government Accountability, The Florida Legislature, *Agency for Persons with Disabilities.* Found at: <http://www.oppaga.state.fl.us/profiles/5060/> (Last visited on January 27, 2012).

The agency provides services to individuals with developmental disabilities[4] in home and community-based settings, private intermediate care facilities, or state-run developmental services institutions. Individuals who need minimal or limited support may live in their own home, a family home, or a group home, all of which are considered "home and community-based settings." During fiscal year 2009-2010, the APD served over 53,000 individuals in the community.[5]

One of the primary goals of the APD is to improve the quality of life of persons with disabilities by helping them live and work in the community, rather than being placed in an institution. Toward that end, the APD administers the Home and Community-based Services waivers (HCBS waivers) system. This system offers 28 supports and services to assist individuals with developmental disabilities live in their community.[6] The system has four tiers, described below:

- Tier one is limited to individuals with intensive medical or adaptive needs and for whom services are essential to avoid institutionalization, or who possess exceptional behavioral problems. Tier one has a $150,000 per-client annual expenditure cap, unless the individual can show a documented medical necessity requiring intensive behavioral residential habilitation services, intensive behavioral residential habilitation services with medical needs, or special medical home care. Tier one is limited to persons with service needs that can't be met in any of the other tiers.
- Tier two is for individuals who have high-cost residential facility and residential habilitation service needs or supported living needs that are greater than six hours per day. Tier two has a $53,625 per-client annual expenditure cap.
- Tier three has a $34,125 per-client annual expenditure cap and is for individuals who require lower residential placements, independent or supported living situations, and persons who live in their family home.
- Tier four has a $14,422 per-client annual expenditure cap and is for individuals who were formerly enrolled in the Family and Supported Living Waiver. This tier funds 12 services.[7]

For Fiscal Year 2011-2012, the APD was appropriated $1,009,499,581 by the Florida Legislature to operate the agency.[8] Out of that, $810 million – or approximately 80 percent – is budgeted for clients on the Medicaid HCBS waivers.[9] In October 2011, 29,641 individuals were served by the HCBS waivers.[10]

Historically, the agency has had problems keeping waiver spending in line with its appropriation. In Fiscal Year 2005-2006, the APD was required to provide quarterly reports to the Executive Office of the Governor, the chair of the Senate Ways and Means Committee, and the chair of the

[4] Section 393.063(9), F.S., defines the term "developmental disability" as a disorder or syndrome that is attributable to retardation, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome; that manifests before the age of 18; and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely.
[5] Office of Program Policy Analysis & Government Accountability, *supra* note 3.
[6] Agency for Persons with Disabilities, *HCBS Waiver Services*. Found at: <http://apd.myflorida.com/brochures/supports-and-services-brochure.pdf> (Last visited on January 28, 2012).
[7] Office of Program Policy Analysis & Government Accountability, *supra* note 3.
[8] *Id*.
[9] Agency for Persons with Disabilities, *2012 Bill Analysis, SB 1516* (January 20, 2012) (on file with the Senate Committee on Children, Families, and Elder Affairs).
[10] *Id*.

House Fiscal Council regarding the financial status of the HCBS waivers.[11] In a presentation on its Fiscal Year 2009-2010 Legislative Budget Request, the agency reported "significant progress" in managing the waivers.[12] However, in March 2009, the agency requested $26 million to cover the remaining HCBS waivers deficit, and by February 2010, the APD's budget recommendation included a request for $100 million to eliminate the projected deficit in the HCBS waivers.[13] The deficit reached nearly $169 million during the 2011 Regular Session,[14] and the agency is facing the same challenges in Fiscal Year 2011-2012, as the agency is projecting $930 million in community-based expenditures which is to be covered with an $810 million legislative appropriation.[15]

A number of strategies have been employed to achieve the goal of containing costs, including: a standardized rate structure; ongoing utilization reviews; a prior authorization process for services; pre-payment billing review; support coordination; and capping costs through use of a tiered rate structure based on an assessment of needs.[16]

In 2010, the Legislature directed the APD to pursue development and implementation of a comprehensive redesign of the HCBS waivers delivery system to combat deficit spending. Individual Budgeting, known as iBudget Florida, involves giving each waiver service recipient an annual budget that is based on the legislative appropriation and factors that include an individual's abilities, disability, needs, and living situation.[17] The iBudget system will replace the tier structure. The state received federal approval to implement the iBudget system in March 2011, and implementation has begun in North Florida.[18]

Medicaid

Medicaid is the medical assistance program that provides access to health care for low-income families and individuals. Medicaid also assists aged and disabled people with the costs of nursing facility care and other medical expenses. Medicaid reimburses health care providers that have a provider agreement with the Agency for Health Care Administration only for goods and services that are covered by the Medicaid program and only for individuals who are eligible for medical assistance from Medicaid.

The Agency for Health Care Administration is responsible for Medicaid. Medicaid serves approximately 3.19 million people in Florida. Estimated Medicaid expenditures for FY 2011-2012 are approximately $20.3 billion. The statutory authority for the Medicaid program is contained in part III of ch. 409, F.S.

[11] Chapter 2005-70 and Chapter 2005-71, L.O.F. This requirement is now codified in s. 393.0661(9), F.S.
[12] Budget Committee, The Florida Senate, *Bill Analysis and Fiscal Impact Statement SB 2148*, (April 1, 2011). Found at: <http://www.flsenate.gov/Session/Bill/2011/2148/Analyses/YX4Y4hiD5jfSJG5bH97TJYAiHoA=%7C7/Public/Bills/2100-2199/2148/Analysis/2011s2148.bc.PDF> (Last visited on January 27, 2012).
[13] *Id*.
[14] *Id*.
[15] Agency for Persons with Disabilities, *supra* note 9.
[16] *Id*.
[17] *Id*.
[18] *Id*.

Medicaid HCBS waiver programs are authorized under s. 1915(c) of the Social Security Act and governed by Title 42, Code of Federal Regulations (C.F.R.), Parts 440 and 441. Section 409.906, F.S., and Chapter 59G, Florida Administrative Code (F.A.C.), authorize the Florida Medicaid developmental disabilities waivers. There are five Medicaid HCBS waivers; the Developmental Disabilities waivers Tiers 1-4 and the Individual Budgeting waiver. The Developmental Disabilities Waivers Tiers One, Two, Three, and Four are Medicaid programs that provide home and community-based supports and services to eligible persons with developmental disabilities living at home or in a home-like setting. The waivers are funded by the federal Centers for Medicare and Medicaid Services and matching state dollars.

III. Effect of Proposed Changes:

This bill makes significant changes to Florida law relating to the APD. According to the agency, the changes proposed in this bill will:

> [A]ssist the agency in improving accountability, predicting cost and allocating [scarce] resources. . . The bill continues the evolvement of the basic waiver program structure, and emphasizes a more robust utilization of natural supports and community resources to augment waiver resources. The bill's strategic approach is to make the Medicaid waivers only one of the many strategies employed to address the needs of individuals with disabilities and the waiver as the funding of last resort.[19]

Section 1 amends s. 393.062, F.S., to state that priority *should*, rather than *shall*, be given to the development and implementation of community-based services that will enable individuals to achieve their greatest potential for independent and productive living in noninstitutional settings. The bill provides that it is the intent of the Legislature to prioritize state funds for those services needed to ensure the health and safety of individuals with disabilities, and that other services be supported through natural supports and community resources. To accomplish this goal, the bill provides that the Medicaid waiver will be the payor of last resort for home and community-based programs.

Section 2 amends s. 393.063, F.S., to define:

- "Adult day services" as services that are provided in a nonresidential setting, separate from the home or facility in which the client resides, unless the client resides in a planned residential community as defined in s. 419.001(1), F.S.; that are intended to support the participation of clients in daily, meaningful, and valued routines of the community; and that may provide social activities.
- "Nonwaiver resources" as supports or services obtainable through private insurance, the Medicaid state plan, nonprofit organizations, charitable donations from private businesses, other government programs, family, natural supports, community resources, and any other source other than a waiver.
- "Waiver" as a federally approved Medicaid waiver program, including, but not limited to, the Developmental Disabilities Home and Community-Based Services Waivers Tiers 1-4, the Developmental Disabilities Individual Budget Waiver, and the Consumer-Directed Care Plus

[19] *Id*.

Program, authorized pursuant to s. 409.906, F.S., and administered by the agency to provide home and community-based services to clients.

The bill also amends the definitions of "adult day training," "developmental disability," "personal care services," and "support coordinator." The definition of "developmental disability" is amended to include Down syndrome. The bill deletes the definition of "domicile."

Section 3 amends s. 393.065, F.S., to limit eligibility for APD services to U.S. citizens and qualified noncitizens who meet the criteria provided in s. 414.095(3), F.S.,[20] and who have established domicile in Florida or are otherwise determined to be legal residents of this state.

Section 4 amends s. 393.066, F.S., to clearly delineate the agency's goal of providing community services in the most cost-effective manner, to the extent resources are specified in the General Appropriations Act, to avoid institutionalization. The bill narrows the scope of the purpose of APD services, removes a requirement that all elements of community-based services must be made available, and removes a requirement that eligibility for services must be consistent across the state.

The bill revises the list of services allowed by adding adult day services, residential habilitation services, and support coordination. The bill removes from the list of services parent training, recreation, and social services. The bill requires the APD to identify and engage in efforts to develop, increase, or enhance the availability of nonwaiver resources to individuals and to promote collaborative efforts with families and organizations. Subsection 393.066(5), F.S., relating to the development of day habilitation services is deleted.[21]

Section 5 amends s. 393.0661, F.S., to specify that a final determination of tier eligibility may not be made until a waiver slot and funding becomes available. A client who is eligible for a higher tier may only move based on crisis criteria as adopted by rule. The bill authorizes the agency to move a client to a lower tier if the client's service needs change and can be met by services provided in a lower tier. Also, the bill provides that the APD may not authorize services that are duplicated by, or above the coverage limits of, the Medicaid state plan.

The bill amends the current tier structure. First, the bill removes the $150,000 per-client expenditure cap in tier one. The bill amends tier two to provide that it also includes clients whose need for services meets the criteria for tier one but which can be met within the expenditure limit of tier two. Tier three is also amended to provide that the tier includes clients whose need for services meets the criteria for tier two but which can be met within the expenditure limit of tier three.

The bill removes language concerning adjusting a client's cost plan that is supported by certain waivers to conform with other sections of the bill.

[20] Section 414.095(3), F.S., defines which noncitizens are eligible for cash assistance through the Temporary Assistance for Needy Families (TANF) program.
[21] According to the APD, deleting the language in subsection (5) of s. 393.066, F.S., is technical and conforming in nature. Agency for Persons with Disabilities, *supra* note 9.

The bill authorizes the APD to collect fees, in addition to premiums or other cost sharing, from the parents of children younger than 18 years of age being served by the agency through a waiver. Refer to section 12 of the bill for limits on the fees.

The bill makes a support coordinator responsible for assisting the client in meeting his or her service needs through nonwaiver resources, as well as through the client's budget allocation or cost plan under the waiver. The bill requires the APD to review waiver support coordination performance to ensure that the support coordinator meets or exceeds the criteria established by the agency. Criteria for evaluating support coordinator performance include:

- The protection of the health and safety of clients.
- Assisting clients to obtain employment and pursue other meaningful activities.
- Assisting clients to access services that allow them to live in their community.
- The use of family resources.
- The use of private resources.
- The use of community resources.
- The use of charitable resources.
- The use of volunteer resources.
- The use of services from other governmental entities.
- The overall outcome in securing nonwaiver resources.
- The cost-effective use of waiver resources.
- Coordinating all available resources to ensure that clients' outcomes are met.

The agency is authorized to exempt a waiver support coordinator from annual quality assurance reviews if the coordinator consistently has superior performance, and the agency may sanction poor performance.

Section 6 amends s. 393.0662, F.S., relating to the iBudget. The bill provides that a client shall have the flexibility to determine the type, amount, frequency, duration, and scope of the services on his or her cost plan if the agency determines that such services meet his or her health and safety needs, meet the requirements contained in the Coverage and Limitations Handbook, and comply with the other requirements of s. 393.0662, F.S.

Further, the bill provides that during the 2011-2012 and 2012-2013 fiscal years, the APD shall determine a client's iBudget by comparing the client's algorithm allocation to the client's existing annual cost plan and the amount for the client's extraordinary needs. A client's allocation is the amount determined by the algorithm, adjusted to the APD's appropriation, and any necessary set-asides, such as funding for extraordinary needs. A client's extraordinary needs shall be the annualized sum of any of the following services authorized on the client's cost plan in the amount, duration, frequency, intensity, and scope determined by the agency to be necessary for the client's health and safety:

- Behavior assessment, behavior analysis services, and behavior assistant services.
- Consumable medical supplies.
- Durable medical equipment.
- In-home support services.
- Nursing services.
- Occupational therapy assessment and occupational therapy.

- Personal care assistance.
- Physical therapy assessment and physical therapy.
- Residential habilitation.
- Respiratory therapy assessment and respiratory therapy.
- Special medical home care.
- Support coordination.
- Supported employment.
- Supported living coaching.

The bill does not reference a client's "significant needs" when determining a client's iBudget allocation, although current law provides that the APD may approve an increase in the amount of money allocated based on a client having significant needs (see lines 905-965 of the bill). However, according to the APD, both a client's significant needs and extraordinary needs will be considered when calculating a client's iBudget allocation.[22]

The way the APD determines a client's initial iBudget allocation is if the client's algorithm allocation is:

- Greater than the client's cost plan, the client's iBudget is equal to the cost plan.
- Less than the client's cost plan but greater than the amount for the client's extraordinary needs, the client's iBudget is equal to the algorithm allocation.
- Less than the amount for the client's extraordinary needs, the client's iBudget is equal to the amount for the client's extraordinary needs.

The bill provides that a client's initial iBudget amount may not be less than 50 percent of that client's existing annualized cost plan. Increases to the client's initial iBudget amount may only be granted if his or her situation meets the crisis criteria.

Section 7 amends s. 393.067, F.S., to authorize the APD to inspect and review facilities or programs that have certain accreditation once every two years, rather than annually. Notwithstanding accreditation, the APD may continue to monitor the facility or program with respect to:

- Ensuring that services for which the agency is paying are being provided;
- Investigating complaints, identifying problems that would affect the safety or viability of the facility or program, and monitoring the facility or program's compliance with any resulting negotiated terms and conditions;
- Ensuring compliance with federal and state laws, federal regulations, or state rules if such monitoring does not duplicate the accrediting organization's review; and
- Ensuring Medicaid compliance with federal certification and precertification review requirements.

Section 8 amends s. 393.068, F.S., to make technical and conforming changes.

[22] E-mail from Chris Coker, Legislative Affairs Director, Agency for Persons with Disabilities, to Senate professional staff of the Committee on Children, Families, and Elder Affairs (January 24, 2012) (on file with the Senate Committee on Children, Families, and Elder Affairs).

Section 9 amends s. 393.11, F.S., to authorize the APD to execute a petition for involuntary admission to residential services. In cases of involuntary admission, the individual ("defendant" as changed by this bill) has a right to notice and a hearing. At the hearing, if the defendant's attorney or any other interested party believes that the person's presence at the hearing is not in the person's best interest, or good cause is otherwise shown, the court may order that the defendant be excluded from the hearing.

Section 10 amends s. 393.125, F.S., to provide that at the conclusion of the hearing related to Medicaid programs, the DCF shall submit its recommended order to the APD and the agency shall issue the final order. This is current practice.

Section 11 amends s. 393.23, F.S., to provide that the welfare of clients includes the establishment, maintenance, and operation of sheltered workshops that include client wages.

Section 12 amends s. 409.906, F.S., to provide that premiums, fees, or other cost sharing for home and community-based services may not exceed the cost of the services to the client, and for parents who have more than one child, the parent may not be required to pay more than the amount required for the child with the highest expenditures. The bill provides that a client may not be denied services due to nonpayment by a parent. Adoptive and foster parents are exempt from payment of any premiums, fees, or other cost sharing. The bill authorizes the Agency for Health Care Administration, the APD, and the DCF to adopt rules to administer this paragraph.

Section 13 amends s. 514.072, F.S., to correct a cross-reference, delete obsolete language, and make conforming changes.

Section 14 provides an effective date of July 1, 2012.

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 bill spells out the APD methodology for determining a client's iBudget allocation. The way the APD determines a client's initial iBudget allocation is if the client's algorithm allocation is:

- Greater than the client's cost plan, the client's iBudget is equal to the cost plan.
- Less than the client's cost plan but greater than the amount for the client's extraordinary needs, the client's iBudget is equal to the algorithm allocation.
- Less than the amount for the client's extraordinary needs, the client's iBudget is equal to the amount for the client's extraordinary needs.

It appears that in certain situations, a client's iBudget allocation may be less than what he or she is receiving with their current cost plan.

C. Government Sector Impact:

According to the APD and the Agency for Health Care Administration, this bill is not expected to have a fiscal impact on either agency.

The bill amends s. 393.125, F.S., specifying that at the conclusion of a Medicaid hearing, the DCF shall submit a recommended order to the APD, and the agency shall issue the final order. According to the DCF, its Office of Appeals Hearings currently issues recommended orders in Medicaid waiver benefits cases. Accordingly, the bill does not appear to have a fiscal impact on the DCF.[23]

VI. Technical Deficiencies:

On lines 202-203, the definition of "down syndrome" is changed. Down syndrome occurs when some or all of a person's cells have an extra full or partial copy of chromosome 21.[24] The words "full or partial" should be inserted after the word "extra."

Section 5 of the bill (starting on line 522) removes intent language that APD develop and implement a comprehensive redesign of the home and community-based services delivery system. Reference to the "redesign" is also deleted on line 533. These references are being deleted because the system redesign has already occurred. Accordingly, the Legislature may wish to amend the bill to remove "comprehensive redesign" from the catch-line of the statute on line 525.

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[23] Department of Children and Families, *Staff Analysis and Economic Impact, SB 1516* (January 10, 2012) (on file with the Senate Committee on Children, Families, and Elder Affairs).
[24] *Down Syndrome Fact Sheet*, National Down Syndrome Society. Found at: <http://www.ndss.org/index.php?option=com_content&view=article&id=54:down-syndrome-fact-sheet&catid=35:about-down-syndrome&Itemid=74> (Last visited on January 28, 2012).

On line 821, the bill refers to "Medicaid" waiver programs. The word "Medicaid" is removed in the rest of the bill when referring to waivers or waiver programs.

On lines 977 and 980, the bill refers to a cost plan. The term is not defined in statute. The Legislature may wish to include a definition of "cost plan" in s. 393.063, F.S. The cost plan is the document used by the waiver support coordinator that lists all waiver services requested by the recipient on the support plan and the anticipated cost of each waiver service.[25]

On lines 1170-1172, the bill authorizes the APD to execute a petition for involuntary admission to residential services. In current law only a petitioning commission can execute the petition and the "name, age, and present address of the commissioners and their relationship to the person" must be listed in the petition (see lines 1177-1179). The bill does not require similar identifying information to be provided if the agency is the one executing the petition. According to the APD, the agency and any agency witnesses are easily identified and contacted.[26] However, it may still be beneficial to provide a requirement for the agency to list some contact information in the petition.

VII. Related Issues:

Under the bill, the APD would be the agency that issues final orders in Medicaid fair hearings. This creates a conflict with existing state law and federal law and rules that require the Agency for Health Care Administration to be the single state Medicaid agency designated to administer or supervise the administration of the State Medicaid Plan, including providing for Medicaid Fair Hearings. The DCF conducts fair hearings pursuant to an agreement with the Agency for Health Care Administration.[27]

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 the Children, Families, and Elder Affairs Committee on January 25, 2012
The committee substitute:

- Adds the phrase "unless the client resides in a planned residential community as defined in s. 419.001(1)" to both the newly created definition of "adult day services" and to the current definition of "adult day training";
- Removes the prohibition of a client or support coordinator from applying for additional waiver funding unless the client is determined to be in crisis;

[25] Agency for Health Care Administration, Florida Medicaid, *Developmental Disabilities Waiver Services Coverage and Limitations Handbook*, page 2-9, May 2010. Found at: http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL_10_100501_DD_Waiver_ver1.0.pdf (Last visited on January 27, 2012).
[26] E-mail from Chris Coker, Legislative Affairs Director, Agency for Persons with Disabilities, to Senate professional staff of the Committee on Children, Families, and Elder Affairs (January 24, 2012) (on file with the Senate Committee on Children, Families, and Elder Affairs).
[27] Agency for Health Care Administration, *2012 Bill Analysis and Economic Impact Statement for SB 1516*, (on file with the Senate Committee on Health Regulation).

- Revises the list of available community services allowed as long as the APD has the resources specified in the General Appropriations Act; and
- Reinstates current law relating to the rate structure for reimbursing a provider of services rendered to a persons with developmental disabilities pursuant to a waiver.

B. Amendments:

None.

SENATOR JOE NEGRON
28th District

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Budget - Subcommittee on Health and Human Services Appropriations, *Chair*
Budget, *Vice Chair*
Banking and Insurance
Communications, Energy, and Public Utilities
Higher Education
Reapportionment
Rules

SELECT COMMITTEE:
Protecting Florida's Children, *Chair*

JOINT COMMITTEE:
Legislative Budget Commission

January 26, 2012

The Honorable Rene Garcia, Chair
Committee on Health Regulation
530 Knott Building
404 S Monroe Street
Tallahassee, FL 32399-1100

Re: Senate Bill 1516

Dear Chairman Garcia:

I would like to request Senate Bill 1516 relating to the Agency for Persons with Disabilities be placed on the agenda for the next scheduled committee meeting.

Thank you, in advance, for your consideration of this request.

Sincerely yours,

Joe Negron
State Senator
District 28

JN/hd
c: Sandra R. Stovall, Staff Director ✓

ENTERED

REPLY TO:
❒ 3500 SW Corporate Parkway, Suite 204, Palm City, Florida 34990 (772) 219-1665
❒ 306 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5088

Senate's Website: *www.flsenate.gov*

MIKE HARIDOPOLOS
President of the Senate

MICHAEL S. "MIKE" BENNETT
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Jan 31, 2012
Meeting Date

Topic APD

Bill Number CS/SB 1516 *(if applicable)*

Name Dixie Sansom

Amendment Barcode *(if applicable)*

Job Title Lobbyist

Address PO Box 98
Street

Phone 321-543-7190

Cocoa, FL 32923-0098
City *State* *Zip*

E-mail dixiesansom@aol.com

Speaking: ☐ For ☐ Against ☒ Information

Representing The Arc of Florida

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1-31-2012
Meeting Date

Topic APD MED WAIVER REDESIGN

Bill Number SB 1516 *(if applicable)*

Name CASEY + DOREEN STEWART

Amendment Barcode _____ *(if applicable)*

Job Title —

Address 11510 N.W. 23 ST.
Street
PEMBROKE PINES, FL 33026
City *State* *Zip*

Phone 954) 632-7319

E-mail DOREEN99@BELLSOUTH.NET

Speaking: ☐ For ☑ Against ☐ Information

Representing CASEY STEWART AND OTHER PEOPLE WITH DEVELOPMENTAL DISABILITIES.

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/31/12
Meeting Date

Topic APD

Bill Number CS/SB 1576 *(if applicable)*

Name JOHN L. DERENZO JR.

Amendment Barcode _____ *(if applicable)*

Job Title ADJ. PROFESSOR

Address 3090 POLK AVE.
Street

Phone 352-684-4760

SPRING HILL, FL. 34609
City *State* *Zip*

E-mail jldjprof@gmail.com

Speaking: ☐ For ☐ Against ☒ Information

Representing THE ARC NATURE COAST

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/31/12
Meeting Date

Topic APD

Bill Number CS/SB 1516 *(if applicable)*

Name Mark Barry

Amendment Barcode *(if applicable)*

Job Title Exec. Dirct.

Address 1391 Coronado Dr
Street
Spring Hill FL 34609
City *State* *Zip*

Phone 352 650 1745

E-mail mbarry@thearc-nathrecoast.org

Speaking: ☐ For ☐ Against ☒ Information

Representing The Arc Nature Coast

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

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 Health Regulation Committee

BILL: CS/SB 1884

INTRODUCER: Health Regulation Committee and Senator Garcia

SUBJECT: Health Regulation by the Agency for Health Care Administration

DATE: February 2, 2012 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Stovall	Stovall	HR	**Fav/CS**
2.			BI	
3.				
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:

The bill streamlines regulations for providers regulated by the Agency for Health Care Administration (AHCA) by repealing obsolete or duplicative provisions in licensing laws and reforming regulations related to inspections, electronic publication of documents and reports, timeframes for reporting licensure changes, and financial information and bonds.

Additionally, the bill makes the following substantive changes:

- Expands the authorized staffing of a geriatric outpatient clinic in a nursing home to include a licensed practical nurse under the direct supervision of a registered nurse, advanced registered nurse practitioner, or physician;
- Eliminates the requirement for a resident care plan to be signed by certain persons;
- Authorizes home health agencies and nurse registries to provide small token items of minimum value (up to $15 individually) to referring entities without penalty;
- Authorizes an administrator of a nurse registry to manage up to five nurse registries in certain circumstances;
- Expands the definition of a portable equipment provider within the requirements for a health care clinic license to include a portable *health service* or equipment provider;
- Provides additional exemptions for licensure and regulation as a health care clinic;

- Enhances the general licensing provisions of part II of ch. 408, F.S., to:
  - Provide that the license renewal notice that the AHCA sends is a *courtesy* notice;
  - Authorize the AHCA to impose an administrative fine, not to exceed $500 per violation, for violations that do not qualify within the classification scheme of class I – class IV violations; an
  - Prohibit activities related to altering, defacing, or falsifying a license certificate;
- Authorizes the AHCA to impose an administrative fine for class IV violations that are uncorrected or repeated by a licensed intermediate care facility for developmentally disabled persons;
- Effective May 1, 2012, limits the applicability of the subscriber assistance program to health plans that meet the grandfathered provisions under the federal Patient Protection and Affordable Care Act;
- Authorizes the AHCA to post prior-authorization and step-edit criteria related to certain drugs on the AHCA's website within 21 days after approval;
- Revises the membership of the Medicaid Pharmaceutical and Therapeutics Committee and requires a minimum amount of time for each presenter at the committee meetings;
- Effective upon the act becoming a law, declares that each essential provider and each hospital that are necessary for a managed care plan to demonstrate an adequate network for enrollment in the statewide Medicaid Managed Care Program are part of that plan's network, and provides for a payment rate for those providers;
- Authorizes advanced registered nurse practitioners to license and operate a clinical laboratory in certain situations;
- Prohibits a licensed clinical laboratory from placing a specimen collector in any physician's office unless they are co-owned, and establishes a private cause of action to an aggrieved person;
- Authorizes a virtual inventory for certain prescription drugs that were purchased under the 340B program;
- Effective May 1, 2012, requires certain individual, group, blanket, and franchise health insurance policies to comply with the NAIC's Uniform Health Carrier External Review Model Act in accordance with rules adopted by the Office of Insurance Regulation and certain provisions of the ERISA relating to internal grievances;
- Designates the Florida Hospital/Burnham Translational Research Institute as a state resource for research in diabetes diagnosis, prevention, and treatment; and
- Directs the Division of Statutory Revision to assist the substantive committees of the Senate and House of Representatives with drafting legislation to correct the names of accrediting organizations in the Florida Statutes.

This bill substantially amends the following sections of the Florida Statutes: 83.42, 112.0455, 318.21, 395.002, 395.003, 395.0161, 395.0193, 395.1023, 395.1041, 395.1055, 395.3025, 395.3036, 395.602, 400.021, 400.275, 400.474, 400.484, 400.506, 400.509, 400.601, 400.606, 400.915, 400.931, 400.967, 400.9905, 400.991, 408.033, 408.034, 408.036, 408.037, 408.043, 408.061, 408.07, 408.10, 408.7056, 408.804, 408.806, 408.8065, 408.809, 408.810, 408.813, 409.91195, 409.912, 409.975, 429.294, 429.915, 430.80, 430.81, 483.035, 483.051, 483.245, 483.294, 499.003, 627.602, and 651.118.

The bill repeals the following sections of the Florida Statutes: 383.325, 395.1046, 395.3037, 408.802(11), 429.11, and 440.102(9)(d).

The bill creates the following sections of the Florida Statutes: 385.2031, 627.6513, and, 641.312, and three undesignated sections of law.

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 and program, 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 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.

The AHCA mails license renewal notices by certified mail to over 30,000 providers every 2 years. Reminder notices are sent by certified mail to verify receipt by the providers. Many other regulatory agencies send postcards or some other form of license reminder notices that are less expensive and more easily delivered.

Section 408.10(2), F.S., provides authority to review billing complaints across all programs and gives the impression that the AHCA can take issue with all billing practices. However, without a specific regulatory standard in the licensing standards of a provider, the AHCA cannot cite violations. Several licensing regulations include billing standards for providers such as nursing homes and assisted living facilities. When a complaint is received for one of the providers where the AHCA has authority over billing matters, a review for regulatory compliance would still occur. Violations found are made public as part of routine inspection reports which are posted online.

For calendar year 2011, the AHCA received 436 complaints that alleged billing-related issues. Of those, 126 were for providers that have billing standards in their licensure statutes. The remaining 310 were related to billing issues where no regulatory authority existed for billing matters. In these cases, the AHCA does not have authority to require a health care provider to act in a particular manner. There is no regulatory standard for "unreasonable and unfair" billing practices as used in s. 408.10(2), F.S.[1]

Nursing Homes

Nursing homes provide long-term and sub-acute care to persons in need of 24-hour nursing services or significant supportive services. Nursing home residents are generally frail, physically and psychosocially compromised, heavily dependent upon others for basic care and sustenance, and, in some cases, Agency for Health Care Administration 2012 Bill Analysis for SB 1884, on file with the Senate Health Regulation Committee near the end of their lives. Such residents who live in an environment where they are totally dependent on others are especially vulnerable to abuse, neglect, and exploitation.

[1] Agency for Health Care Administration *2012 Bill Analysis for SB 1884*, on file with the Senate Health Regulation Committee.

Nursing homes are subject to regulation under part II of ch. 400, F.S., the general licensing provisions of part II, of ch. 408, F.S., and the minimum standards for nursing homes found in Rule chapter 59A-4, F.A.C. In addition, nursing homes that receive funding from Medicare or Medicaid are subject to federal standards and conditions of participation as certified Medicare or Medicaid providers.

Rule 59A-4.1295(8), F.A.C., sets forth the minimum staffing requirements for residents less than 21 years of age, who require skilled care. For those residents there must be one registered nurse onsite 24 hours a day where the children reside, and the facility must provide an average of 3.5 hours of nursing care per patient day. This number includes registered nurses (RN), licensed practical nurses (LPN), respiratory therapists (RT), respiratory care practitioners and certified nursing assistants (CNA). In determining the nursing hours, there may be no more than 1.5 hours per patient day of CNA care and no less than 1.7 hours per patient day of LPN care. For fragile residents less than 21 years of age, one RN is required onsite 24 hours per day with an average of 5.0 hours of nursing care required per patient day. This also includes RNs, LPNs, and respiratory therapists, respiratory care practitioners and CNAs. If more than 42 children are in the facility, there can be no fewer than two RNs on duty onsite for 24 hours per day. Section 400.23, F.S., requires at least 3.9 hours of licensed nursing and CNA direct care per resident per day.

The minimum staffing requirements in s. 400.23, F.S., have changed since the rule language was last amended. During rule development, the Joint Administrative Procedures Committee (JAPC) informed the AHCA that according to rule 120.52(8)(c), F.A.C., a rule which "enlarges, modifies or contravenes the specific provisions of law implemented" is an "invalid exercise of delegated legislative authority." According to the JAPC, the rule's staffing requirements must comport with the current version of s. 400.23, F.S. The AHCA proposed amending language in rule to be consistent with these legal requirements of minimum staffing. The AHCA attempted to repeal portions of the current rule. Opponents to this action challenged the rule.[2]

Home Health Agencies and Nurse Registries

Home health agencies and nurse registries are regulated under part III of ch. 400, F.S., the general licensing provisions of part II, of ch. 408, F.S., and applicable rules found in Rule chapters 59A-8 and 59A-18, F.A.C.

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, also referred to as personal services (assistance with daily living activities, such as bathing, dressing, eating, personal hygiene, ambulation, and assisting with the administration of medication if trained to do so);
- Dietetics and nutrition practice and nutrition counseling; and

[2] *Id.*

- Medical supplies, restricted to drugs and biologicals prescribed by a physician.[3]

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.

Section 400.474, F.S., authorizes the AHCA to deny, revoke, or suspend the license of a home health agency and requires the AHCA to impose a $5,000 fine against a home health agency that commits certain acts. One of these acts is the failure of the home health agency to submit a report, within 15 days after the end of each calendar quarter that includes the following information:

- The number of insulin-dependent diabetic patients receiving insulin-injection services from the home health agency;
- The number of patients receiving both home health services from the home health agency and hospice services;
- The number of patients receiving home health services from that home health agency; and
- The names and license numbers of nurses whose primary job responsibility is to provide home health services to patients and who received remuneration from the home health agency in excess of $25,000 during the calendar quarter.

These data items help identify possible fraud, such as billing for a high number of injection visits for insulin-dependent patients who could self-inject insulin, fraudulent billing for patients who did not receive the visits, possible duplicate payments for patients receiving both hospice and home health services, and nurses earning well above the average salary that could indicate false billing. The results of each quarter's reporting are shared with the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services' Medicare Program Integrity Miami Satellite Division, the AHCA's Medicaid Program Integrity Office, and the Medicare Fraud Investigations Manager at SafeGuard Services, LLC.

A nurse registry procures, offers, promises, or attempts to secure health care-related contracts for registered nurses, licensed practical nurses, certified nursing assistants, home health aides, companions, or homemakers. Such personnel are compensated by fees as independent contractors. The contracts for services might include providing services to patients as well as providing private duty or staffing services to health care facilities or other business entities.[4]

Homemaker and Companion Services

Section 400.509, F.S., requires the registration of organizations that provide homemaker and companion or sitter services to disabled adults and elderly persons. Homemakers provide housekeeping, errands, shopping, and meal preparation. Companions or sitters keep people company and take them to recreational activities, shopping, or appointments. There are no

[3] Section 400.462(14), F.S.
[4] Section 400.462(21), F.S.

requirements of homemakers and companions other than background screening. Homemakers and companions or sitters may not provide any hands-on personal care according to state law.[5]

The AHCA currently has registered 2,203 homemaker and companion services organizations. Of that total, 503 are contractors of the Agency for Persons with Disabilities and provide companion services through the Developmental Disabilities Medicaid Waiver. The Agency for Persons with Disabilities requires training and experience as well as background screening.[6]

The 1999 Florida Legislature exempted from home health agency and nurse registry licensing, the companion and sitter organizations that were registered by the AHCA on January 1, 1999, and authorized them to provide personal services to developmentally disabled persons to any past, present and future clients who need personal care services[7] Currently there are seven organizations exempt under this law.[8]

Laboratory Licensure

Clinical laboratory providers seeking to perform non-waived tests must by licensed by the AHCA and hold a valid federal CLIA certificate before any testing may be done.[9] Non-waived testing is not currently defined.

Clinical laboratory hospital providers are required to report any alternate testing locations within the hospital at the time of licensure renewal. All alternate locations are under the direction of the clinical laboratory director and documented in hospital laboratory records.

Clinical laboratories are prohibited from offering rebates, commissions, bonuses, split-fee arrangements, and kickbacks.[10] What constitutes a rebate, commission, bonus, split-fee arrangement or kickback is not defined in statute. The AHCA defined the term "kickback" under Rule 59A-7.020(14), F.A.C. The AHCA was petitioned for a declaratory statement related to the placing of specimen collections in physician offices when there was no lease agreement and whether or not laboratories could provide free specimen cups that also provided an on-site clinical laboratory test. The AHCA issued a declaratory statement in 2008, declaring that the placement of specimen collectors as described in the petition in a physician office was a violation of this regulation, as was the provision of free specimen cups that offered physicians an instant test reading on-site.[11] There is currently pending litigation related to the AHCA's interpretation of what constitutes a kickback as defined under this administrative rule. Clarification in other areas was provided in a letter to providers dated August 5, 2011.[12]

[5] Section 400.462(7) and, (16), F.S.
[6] *Supra*, fn 1.
[7] Section 400.464(5)(b)4., F.S.
[8] *Supra*, fn 1.
[9] *See* part III of ch. 483, F.S.
[10] Section 483.245, F.S.
[11] The Declaratory Statement and Final Order is available at: <http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Laboratory_Licensure/docs/FinalOrderDominion2008.pdf.> (Last visited on January 29, 2012).
[12] This letter is available at: <http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Laboratory_Licensure/kickback.shtml> (Last visited on January 29, 2012).

Aggrieved parties are currently able to bring action in civil cases.

Advanced Registered Nurse Practitioners are not listed as practitioners with the ability to diagnose and treat their own patients using clinical laboratory tests even though they are authorized under practitioner regulations to operate their own practices.

Specialty-licensed Children's Hospitals / High Risk Pregnancies

There are three specialty-licensed children's hospitals in the state. All Children's Hospital in Tampa has 97 licensed neonatal intensive care unit (NICU) beds,[13] Miami Children's Hospital has 51 Level II and Level III NICU beds,[14] and Nemours Pediatric Partners at AtlantiCare in Jacksonville has 22 NICU beds.[15]

Risk factors for a high-risk pregnancy can include:
- Young or old maternal age;
- Being overweight or underweight;
- Having had problems with previous pregnancies; and
- Pre-existing health conditions, such as high blood pressure, diabetes, or HIV.[16]

Medicaid Pharmaceutical and Therapeutics Committee

The Medicaid Pharmaceutical and Therapeutics Committee (P&T) is established in s. 409.91195, F.S. The purpose of the P&T is to develop a Medicaid preferred drug list (PDL). The committee is composed of 11 members who are appointed by the Governor. Four members must be allopathic physicians licensed under ch. 458, F.S., one member must be an osteopathic physician licensed under ch. 459, F.S., five members must be pharmacists licensed under ch. 465, F.S., and one member must be a consumer representative.

The P&T is required to ensure that interested parties, including pharmaceutical manufacturers agreeing to provide a supplemental rebate, have an opportunity to present public testimony concerning information or evidence supporting inclusion of a product on the PDL before the P&T makes any recommendation for inclusion on or exclusion.

Currently, the AHCA limits public presentations at committee meetings to 10 speakers for 2 minutes each. Overall, the public testimony portion consumes about 30 minutes of the 4-hour meeting slot. Unlimited testimony could be accommodated by written submission in lieu of public testimony or by altering the amount of time available for public testimony based upon historic participation and allocating the amount of time to each speaker dependent upon the number of individuals wishing to speak.[17]

[13] See <http://www.allkids.org/body.cfm?id=14> (Last visited on January 28, 2012).
[14] See <http://www.mch.com/page/EN/256/Medical-Services/Neonatology.aspx> (Last visited on January 28, 2012).
[15] See <http://www.nemours.org/filebox/healthpro/patientreferral/npppomonanicu.pdf> (Last visited on January 28, 2012).
[16] National Institutes of Health <http://www.nichd.nih.gov/health/topics/high_risk_pregnancy.cfm> (Last visited on January 28, 2012).
[17] *Supra*, fn 1.

Statewide Medicaid Managed Care

Medicaid is the medical assistance program that provides access to health care for low-income families and individuals. Medicaid also assists aged and disabled people with the costs of nursing facility care and other medical expenses. The AHCA is responsible for Medicaid. Medicaid serves approximately 3.19 million people in Florida. Estimated Medicaid expenditures for fiscal year 2011-2012 are approximately $20.3 billion. The statutory authority for the Medicaid program is contained in part III of ch. 409, F.S.

Part IV of ch. 409, F.S., requires all Medicaid recipients to enroll in a managed care plan unless they are specifically exempted. The statewide Medicaid managed care program includes the long-term care managed care program and the managed medical assistance program. The law directs the AHCA to begin implementation of the long-term care managed care program by July 1, 2012, with full implementation in all regions of the State by October 1, 2013. By January 1, 2013, the AHCA must begin implementation of the managed medical assistance program, with full implementation in all regions of the State by October 1, 2014.

Plans will compete for Medicaid contracts via an invitation-to-negotiate process based on specified qualifications, such as price, provider network adequacy, accreditation, community partnerships, additional benefit offerings, and performance history.[18] A limited number of plans will be selected for each of the 11 regions. Among other things, the AHCA must consider evidence that an eligible plan has written agreements or signed contracts, or has made substantial progress in establishing relationships with providers before the plan submits a response. The agency must evaluate and give special weight to evidence of signed contracts with essential providers.[19]

The AHCA, at a minimum, shall determine which providers in the following categories are essential Medicaid providers: federally qualified health centers, statutory teaching hospitals, trauma centers, and hospitals that are located at least 25 miles from any other hospital with similar services.[20]

Managed care plans that have not contracted with applicable essential providers must negotiate in good faith for one year or until an agreement is reached, whichever is first. Payment for services rendered by a nonparticipating essential provider shall be made at the applicable Medicaid rate as of the first day of the contract between the AHCA and the plan. After 1 year, managed care plans that are unable to contract with essential providers shall notify the AHCA and propose an alternative arrangement for securing the essential services. If the alternative arrangement is approved by the AHCA, payments to nonparticipating essential providers after the date of the AHCA's approval shall equal 90 percent of the applicable Medicaid rate. If the alternative arrangement is not approved by the AHCA, the payment rate to a nonparticipating provider shall equal 110 percent of the applicable Medicaid rate.

In addition, certain providers are statewide resources and essential providers for all managed care plans in all regions. All managed care plans must include these essential providers in their

[18] Section 409.966, F.S.
[19] Section 409.974, F.S.
[20] Section 409.975, F.S.

networks. Managed care plans that have not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment must continue to negotiate in good faith. The statewide essential providers and applicable payment rates for the nonparticipating statewide essential providers set forth in statute are:[21]

- For facility plans of Florida medical schools, payment shall be made at the applicable Medicaid rate;
- For regional perinatal intensive care centers, payment shall be made at the applicable Medicaid rate as of the first day of the contract between the AHCA and the plan; and
- For specialty children's hospitals, payment shall equal the highest rate established by contract between that provider and any other Medicaid managed care plan.
- Certain accredited and integrated systems serving medically complex children are identified as statewide essential providers; however no payment rate is specified in statute.

Health Maintenance Organization (HMO) Subscriber Grievance Resolution

Parts I and III of ch. 641, F.S., govern HMOs in Florida. Section 641.185, F.S., relating to HMO subscriber protections, establishes standards to be followed by the Financial Services Commission, the Office of Insurance Regulation (OIR), the Department of Financial Services, and the AHCA in exercising their powers and duties, in exercising administrative discretion, in administrative interpretations of the law, in enforcing its provisions, and in adopting rule. Two of these standards relate to subscriber grievances and provide the following:

- An HMO subscriber should receive timely and, if necessary, urgent review of grievances and appeals *within* the HMO pursuant to:
  - s. 641.228, F.S., relating to the Florida HMO Consumer Assistance Plan that is established to protect subscribers against the failure of an HMO to perform its contractual obligations due to its insolvency;
  - s. 641.31(5), F.S., relating to HMO subscriber contracts, which must provide information about resolution of subscriber grievances, including subscribers' rights and responsibilities under the grievance process;
  - s. 641.47, F.S., which defines the term "grievance"; and
  - s. 641.511, F.S.; which establishes internal HMO subscriber grievance reporting and resolution requirements.
- An HMO should receive timely and, if necessary, urgent review by an independent state external review organization for unresolved grievances and appeals pursuant to s. 408.7056, F.S., the Subscriber Assistance Program.

Under s. 641.511, F.S., the Employee Retirement Income Security Act of 1974 (ERISA), as implemented by 29 C.F.R. s. 2560.503-1, is adopted and incorporated by reference as applicable to all HMOs that administer small and large group health plans that are subject to 29 C.F.R. s. 2560.503-1. The claims procedures of the regulations of the ERISA, are the minimum standards for grievance processes for claims for benefits for applicable small and large group health plans.

[21] *Id.*

Subscriber Assistance Program

Under s. 408.7056, F.S., the AHCA administers the Subscriber Assistance Program to provide assistance to subscribers of managed care entities who have grievances that have not been resolved by the internal grievance process of the managed care entity. Managed care entities covered by the program include HMOs or a prepaid health clinics certified under ch. 641, F.S., Medicaid prepaid health plans authorized under s. 409.912, F.S, or exclusive provider organizations certified under s. 627.6472, F.S.

The subscriber must first complete the entire grievance process of the managed care entity before filing a grievance with the program, unless the grievance is of an urgent nature. If the subscriber's grievance meets the required criteria, the program's staff schedules it for a hearing before an independent panel. After the hearing, the panel makes a recommendation based on the finding of fact either to the AHCA or the OIR. The recommendation may include specific actions the managed care entity must take to comply with state laws or rules regulating managed care entities. The AHCA or the OIR may issue a proposed order under ch. 120, F.S., that requires the managed care entity to take a specific action. The proposed order is subject to a summary hearing in accordance with s. 120.574, F.S., unless all of the parties agree otherwise.

Uniform Health Carrier External Review Act[22]

In April 2010 the National Association of Insurance Commissioners (NAIC) adopted the Uniform Health Carrier External Review Model Act (the Act). The purpose of the Act is to provide uniform standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination by a health carrier. Adverse determination is defined to mean "a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated."

III. Effect of Proposed Changes:

Section 1 amends s. 83.42, F.S., relating to the Florida Residential Landlord and Tenant Act, to clarify that state law on evictions under this act does not apply to nursing home transfers and discharges. Instead, transfers and discharges related to residents of a nursing home are governed by s. 400.0255, F.S.

Section 2 repeals s. 112.0455(10)(e) and (12)(d), 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. Also, this bill repeals a monthly reporting requirement for a laboratory to notify the AHCA of statistical information regarding drug testing.

[22] National Association of Insurance Commissioners, *Uniform Health Carrier External Review Model Act*, April 2010. Found at: <http://www.naic.org/documents/committees_b_uniform_health_carrier_ext_rev_model_act.pdf> (Last visited on January 28, 2012).

Section 3 amends s. 318.21, F.S., to direct 50 percent of certain traffic fines to be deposited into the Brain and Spinal Cord Injury Trust Fund of the DOH to benefit Medicaid recipients who have a brain and spinal cord injury and are medically complex and technologically and respiratory dependent. These funds could be used for Medicaid recipients who are in settings other than nursing homes.

Section 4 repeals 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.

Section 5 creates s. 385.2031, F.S., to designate the Florida Hospital/Sanford-Burnham Translational Research Institute for Metabolism and Diabetes as a resource in this state for research in the prevention and treatment of diabetes.

Section 6 amends s. 395.002, F.S., to redefine the term "accrediting organizations" as it relates to hospitals and other licensed facilities to delete the list of four organizations that are identified in statute. The term is redefined to mean national accrediting organizations that are approved by the Centers for Medicare and Medicaid Services (CMS) and whose standards incorporate comparable licensure regulations required by the state.

Section 7 amends s. 395.003, F.S., to remove obsolete language concerning emergency departments located off-site from licensed hospitals.

The bill also authorizes a specialty-licensed children's hospital that has at least 50 licensed neonatal intensive care unit beds to provide obstetrical services, which are restricted to the diagnosis, care, and treatment of certain pregnant women. The pregnant women may be of any age but must have at least one maternal or fetal characteristic or condition that would characterize the pregnancy or delivery as high-risk, or have received medical advice or a diagnosis indicating their fetus will require at least one perinatal intervention. The services may include labor and delivery. The AHCA is authorized to adopt rules that establish standards and guidelines for admission to these programs.

Section 8 amends s. 395.0161, F.S., to allow for payment of the per-bed licensure inspection fee and lifesafety inspection fee at the time of the hospital's licensure renewal.

Section 9 amends s. 395.0193, F.S., related to peer review of physicians within hospitals and licensed facilities, to correct references to the Division of Medical Quality Assurance of the DOH.

Section 10 amends s. 395.1023, F.S., related to reporting actual or suspected cases of child abuse, abandonment, or neglect by hospitals and licensed facilities, to clarify that references to the Department mean the Department of Children and Family Services (DCF).

Section 11 amends s. 395.1041, F.S., to remove obsolete language pertaining to services within a hospital's service capability for purposes of access to emergency services and care in an emergency department. The Division of Statutory Revision requested clarification of this provision.

Section 12 repeals 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.

Section 13 amends s. 395.1055, F.S., to require that the AHCA's rulemaking concerning licensed facility beds conform to standards specified by the AHCA, the Florida Building Code, and the Florida Fire Prevention Code.

Section 14 amends s. 395.3025, F.S., relating to patient and personnel records, to correctly reflect that the DOH, rather than the AHCA, is authorized under s. 456.071, F.S., to subpoena records for purposes of disciplinary proceedings against health care professionals by the DOH or the appropriate regulatory board. The DOH will pay the fee established in statute for records provided to patients.

Section 15 amends s. 395.3036, F.S., to correct a cross-reference concerning the confidentiality of records and meetings of corporations that lease public health care facilities. The Division of Statutory Revision requested clarification of this provision.

Section 16 repeals s. 395.3037, F.S., relating 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.

Section 17 amends s. 395.602, F.S., to eliminate one of the conditions that qualifies a hospital as a rural hospital. This condition is a hospital in a constitutional charter county with a population of over 1 million persons that has imposed a local option health service tax, in an area that was directly impacted by a catastrophic event on August 24, 1992, for which the Governor of Florida declared a state of emergency, has 120 beds or less and serves an agricultural community with an emergency room utilization of no less than 20,000 visits, and a Medicaid inpatient utilization rate greater than 15 percent. No hospitals meet this condition.

Section 18 amends s. 400.021, F.S., to authorize a licensed practical nurse who is under the direct supervision of a registered nurse, an advanced registered nurse practitioner, a physician assistant, or a physician to staff a geriatric outpatient clinic.

The bill also removes the requirement that a resident care plan for a nursing home resident be signed by the director of nursing or alternate and the resident or the resident's designee or legal representative. The prohibition on a facility using an agency or temporary registered nurse to complete the resident care plan is removed.

Section 19 amends s. 400.275, F.S., to strike the requirement that a newly hired nursing home surveyor must be assigned full-time to a licensed nursing home for at least 2 days to observe facility operations as a part of basic training. Also, the bill relaxes the number of years that must elapse before an individual who was an employee of a nursing home may participate on a survey team of that nursing home from 5 years to 2 years.

Section 20 amends s. 400.474, F.S., to reduce the fine that the AHCA currently must impose on a home health agency that fails to submit, within 15 days after the end of each calendar quarter, the report that includes certain fraud detection information. The bill changes the penalty to a mandatory $200 per day fine for each day the report is late, with a maximum fine not to exceed $5,000 per quarter. This is in lieu of the current permissive denial, revocation, or suspension of the home health agency's license and a mandatory fine of $5,000.

Section 21 amends s. 400.484, F.S., relating to violations in part II of ch. 400, F.S., relating to home health agencies and related providers. The term "deficiency" is changed to "violation," and instead of repeating a description of each class of violation, the bill refers to the general licensing provisions in part II of ch. 408, F.S.

Section 22 amends s. 400.506, F.S., to authorize an administrator of a nurse registry to manage up to five registries if all five have identical controlling interests and are located within one AHCA-geographic service area or an immediately contiguous county. The administrator must designate in writing a qualified alternate administrator to serve at each licensed entity when the administrator is not present.

Section 23 amends s. 400.509, F.S., to exempt from registration as a companion service or homemaker service an organization that contracts with the Agency for Persons with Disabilities to provide companion services only for persons with a developmental disability.

Section 24 amends s. 400.601, F.S., to revise the definition of a hospice to include a limited liability company as an entity that might obtain licensure.

Section 25 amends s. 400.606, F.S., to eliminate the requirement for an applicant for a hospice license to submit the projected annual operating cost of the hospice. Under the general licensing provisions, in part II of ch. 408, F.S., an applicant for licensure must submit information pertaining to the applicant's financial ability to operate. The term "primarily" is removed to clarify that a certificate of need is required to provide inpatient services in any facility that is not already licensed as a health care facility, such as a hospital skilled nursing facility.

Section 26 amends s. 400.915, F.S., to correct an obsolete cross-reference to an administrative rule concerning the construction or renovation of a prescribed pediatric extended care center. This correction was requested by the Joint Administrative Procedures Committee.

Section 27 amends s. 400.931, F.S., to require an applicant that is located outside of the state to submit documentation of accreditation, or a copy of an application for accreditation, when applying for a home medical equipment provider license. The applicant must provide proof of accreditation that is not conditional or provisional within 120 days after the AHCA's receipt of the application for licensure or the application shall be withdrawn from further consideration. Further, the accreditation must be maintained by the home medical equipment provider in order to maintain licensure. The bill also repeals the option for an applicant for a home medical equipment provider license to submit a $50,000 surety bond in lieu of proof of financial ability to operate.

Section 28 amends s. 400.967, F.S., related to violations by intermediate care facilities for developmentally disabled persons, to cross-reference the definitions of the classes of violations in the general licensing provisions in part II of ch. 408, F.S., thereby eliminating redundant definitions for deficiencies in this section. In addition, the bill requires the AHCA to impose an administrative fine not to exceed $500 for each occurrence and each day that an uncorrected or repeated class IV violation exists.

Section 29 amends s. 400.9905, F.S., to revise the definitions related to the Health Care Clinic Act. This includes an entity that contracts with or employs a person to provide portable *health services or* equipment to multiple locations, which bills third-party payors for those services, and that otherwise, meets the definition of a clinic, even though they do not deliver care at the clinic's location.

The bill also exempts the following entities from the definition and regulation as a health care clinic:

- A pediatric cardiology or perinatology clinic facility or anesthesia clinical facility that is not otherwise exempt under another paragraph, that is a publicly traded corporation or that is wholly owned by a publicly traded corporation;
- An entity that is owned or controlled, directly or indirectly, by a publicly traded entity with $100 million or more in total annual revenues derived from providing health care services by licensed health care practitioners who are employed with or contracted by the entity;
- An entity that is owned by a corporation that has $250 million or more in total annual sales of health care services provided by licensed health care practitioners if at least one of the owners of the entity is a health care practitioner who is licensed in this state, is responsible for supervising the business activities, and is legally responsible for the entity's compliance with state law; and
- An entity that employs 50 or more health care practitioners who are licensed under the allopathic or osteopathic practice act, if the billing for medical services is under a single corporate tax identification number. The bill requires the application for exemption to contain information that identifies the entity that owns the practice, a complete list and contact information of all the officers and directors, identifying information for each health care practitioner who is licensed in Florid and employed by the entity, the entity's corporate tax identification number, a listing of the health care services to be provided by the entity; and a certified statement prepared by an independent certified public accountant which states that neither the entity or the entity's clinics have received payment for health care services under personal injury protection (PIP) insurance for the preceding year. The AHCA is authorized to deny or revoke an exemption from licensure if the entity has received payment under a PIP policy.

Section 30 amends s. 400.991, F.S., to repeal the option for an applicant for a health care clinic license to submit a $500,000 surety bond in lieu of proof of financial ability to operate. Another cross-reference is added to reflect an existing provision concerning proof of financial ability to operate for an applicant for a health care clinic license.

Section 31 amends s. 408.033, F.S., to authorize annual health care assessments that must be paid by licensed health care facilities to be paid concurrently with applicable licensure fees.

Section 32 amends s. 408.034, F.S., to correct a reference to the AHCA's authority to issue licenses to intermediate care facilities for developmentally disabled persons under part VIII of ch. 400, F.S., without the facility first obtaining a certificate of need as required by s. 408.036(1)(a), F.S.

Section 33 amends s. 408.036, F.S., to eliminate a cross-reference to an exception to the certificate-of-need requirements for a hospice. No exceptions are currently provided in s. 408.043, F.S.

Section 34 amends s. 408.037, F.S., to authorize an application for a certificate of need to include the audited financial statements of the applicant's parent corporation if the applicant does not have audited financial statements.

Section 35 amends s. 408.043, F.S., to remove the term "primarily" to clarify that a certificate of need is required to establish or expand an inpatient hospice facility unless the facility is licensed as a health care facility, such as a hospital or skilled nursing facility.

Section 35 amends s. 408.061, F.S., to remove an inappropriate reference to an administrative rule that describes data reporting.

Section 37 amends s. 408.07, F.S., to conform the definition of a rural hospital to the provisions related to licensure of rural hospitals in s. 395.602, F.S., as amended in this bill.

Section 38 amends s. 408.10, F.S., to eliminate the requirement for the AHCA to investigate consumer complaints related to health care facilities' billing practices and publish related reports.

Section 39, effective May 1, 2012, amends s. 408.7056, F.S., to limit the applicability of the subscriber assistance program to health plans that meet the requirements of 45 C.F.R. 147.140, which addresses grandfathered health plans under the federal Patient Protection and Affordable Care Act. The bill also retains the ability for prepaid clinics and the Florida Healthy Kids health plan to utilize the Subscriber Assistance Program to resolve subscriber disputes regarding managed care plan grievances.

Section 40 repeals 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.

Section 41 amends s. 408.804, F.S., related to the general licensing provisions. The act of, or causing another to alter, deface, or falsify a license certificate is a misdemeanor of the second degree. A licensee or provider who displays an altered, defaced, or falsified license certificate is subject to an administrative fine of $1,000 for each day of illegal display, and a license or application for a license is subject to revocation or denial.

Section 42 amends s. 408.806, F.S., related to general licensing provisions, to require the AHCA to send a courtesy notice to the licensee 90 days before renewal. However, if the licensee does not receive the notice, it does not excuse the licensee's responsibility to timely submit the

renewal application and fee. Submission of the renewal application, application fee, and any applicable late fees is required to renew the license.

Section 43 amends s. 408.8065, F.S., to modify the description of the financial statements that a home health agency, home medical equipment provide, or health care clinic must submit for initial licensure to "projected" financial statements instead of "pro forma" financial statements.

Section 44 amends s. 408.809, F.S., to provide, in law, a schedule for background rescreening for persons who are required to be screened by July 31, 2015. The schedule is based on the recency of the individual's last screening. Authority for the AHCA to adopt rules to establish the reschedule is repealed. The bill also adds the Department of Elderly Affairs to the list of agencies that require background screening to ensure that all persons working for health care providers licensed by the AHCA are eligible for employment using the same screening criteria.

Section 45 amends s. 408.810, F.S., related to general licensing provisions, to include the requirement for a controlling interest to notify the AHCA within 10 days after a court action to initiate bankruptcy, foreclosure, or eviction proceedings concerning the provider in which the controlling interest is a petitioner or defendant.

Section 46 amends s. 408.813, F.S., related to general licensing provisions, to authorize the AHCA to impose an administrative fine, not to exceed $500 per violation, for violations that do not qualify within the classification scheme of class I – class IV violations. Unclassified violations might include: violating any term or condition of a license; violating any provision of the general licensing provisions, authorizing statutes, or applicable rules; exceeding licensed capacity without authorization; providing services beyond the scope of the license; or violating a moratorium.

Section 47 amends s. 409.912, F.S., to authorize the AHCA to post prior-authorization and step-edit criteria, protocols, and updates to the list of drugs that are subject to prior authorization on the AHCA's website within 21 days after the prior authorization, criteria, protocols, or updates are approved by the AHCA.

Section 48 amends s, 409.91195, F.S., to identify specific professional academies, societies, associations or other groups that will nominate members to the Medicaid Pharmaceutical and Therapeutics Committee (P&T). The bill requires nine professional organizations and one advocacy group to nominate professionals for appointment by the Governor's Office. The bill requires the committee to allow an unlimited number of speakers to present for three minutes each at the P&T meetings and authorizes members to ask questions of the persons providing public testimony. If the AHCA does not follow a recommendation by the P&T committee, the AHCA must notify the committee members in writing of its action at the next committee meeting following the reversal of its recommendation.

Section 49 effective upon becoming a law, the bill declares that each essential provider and each hospital that are necessary in order for a managed care plan to demonstrate an adequate network under the new statewide Medicaid managed care program are part of that managed care plan's network for purposes of the provider's or hospital's application for enrollment or expansion in

the Medicaid program. A managed care plan's payment to an essential provider must be made in accordance with s. 409.975, F.S.

Section 50 repeals s. 429.11(6), F.S., to remove duplicative language pertaining to the issuance of a provisional license for ALFs. Provisional licenses are provided for in the general licensing provisions under part II of ch. 408, F.S.

Section 51 amends s. 429.294, F.S., to remove a cross-reference to a section of law and substitute a different statute. However, the new statutory subsection does not currently exist and is not created in this bill.

Section 52 amends s. 429.71, F.S., to remove duplicative language concerning the classification of adult family care home violations that are also in the general licensing provisions under part II of ch. 408, F.S, and substitutes the term "violations" for "deficiencies."

Section 53 amends s. 429.915, F.S., to remove the requirement for a plan of correction as a part of issuing a conditional license for an adult day care facility since this is authorized in the general licensing provisions in part II of ch. 408, F.S.

Sections 54 and 55 amend ss. 430.80 and 430.81, F.S., to change a statutory cross-reference. However, since s. 400.141, F.S., is not amended in the committee substitute, existing language is correct.

Section 56 repeals s. 440.102(9)(d), F.S., to remove a monthly reporting requirement for a laboratory to notify the AHCA of statistical information regarding drug testing under workers' compensation provisions.

Section 57 amends s. 483.035, F.S., to authorize an advanced registered nurse practitioner to license and operate a clinical laboratory exclusively in connection with the diagnosis and treatment of his or her own patients.

Section 58 amends s. 483.051, F.S., to provide that the AHCA will license nonwaived clinical laboratories and to provide for the requirements for licensure, including submitting a copy of the application for or proof of a federal Clinical Laboratory Improvement Amendment (CLIA) certificate. The term "nonwaived clinical laboratories" is defined to mean any laboratories that perform any test that the CMS has determined does not qualify for a certificate of waiver. The bill repeals the requirement for alternate site testing locations to be registered when the clinical laboratory applies to renew its license.

Section 59 amends s. 483.245, F.S., relating to prohibiting rebates, to prohibit a licensed clinical laboratory from placing, directly or indirectly, through an independent staffing company or lease arrangement, or otherwise, a specimen collector or other personnel in any physician's office, unless the clinical lab and the physician's office are owned and operated by the same entity. The bill establishes a private action for any person aggrieved by a violation of this section. The person may bring a civil action for a declaratory judgment, injunctive relief, and actual damages.

Section 60 amends s. 483.294, F.S., to conform the inspection frequency (biennially) for licensed multiphasic health testing centers with the general licensing provisions in part II of ch. 408, F.S.

Section 61 amends s. 499.003, F.S., to delete the requirement that contractors and subcontractor that receive prescription drugs from an entity that purchased the drugs under the 340B program (federal Public Health Services Act) maintain these drugs separate from any other prescription drugs in their possession.

Section 62, effective May 1, 2012, amends s. 627.602, F.S., relating to individual health insurance policies, to require such policies to comply with:

- Rules developed by the OIR to administer the provisions of the NAIC's Uniform Health Carrier External Review Model Act, dated April 2010; and
- The provisions of the ERISA, as implemented by 29 C.F.R. s. 2560.503-1, relating to internal grievances.

Health insurance policies that are subject to the Florida Subscriber Assistance Program are exempt from this requirement.

Section 63, effective May 1, 2012, creates s. 627.6513, F.S., to apply the following provisions to all group health insurance policies issued under part VII of ch. 627, F.S. (group, blanket, and franchise health insurance policies):

- Rules developed by the OIR to administer the provisions of the NAIC's Uniform Health Carrier External Review Model Act, dated April 2010; and
- The provisions of the ERISA, as implemented by 29 C.F.R. s. 2560.503-1, relating to internal grievances.

Group health insurance policies that are subject to the Florida Subscriber Assistance Program are exempt from this requirement.

Section 64, effective May 1, 2012, creates s. 641.312, F.S., to require the OIR to adopt rules to administer the provisions of the NAIC's Uniform Health Carrier External Review Model Act, dated April 2010. This provision does not apply to an HMO contract that is subject to the Florida Subscriber Assistance Program.

Section 65 amends s. 651.118, F.S., to change a cross-reference to s. 400.141, F.S. However, s. 400.141, F.S., is not amended in this committee substitute and the existing language is correct.

Section 66 creates an undesignated section of law directing the Division of Statutory Revision to provide the relevant substantive committees of the Senate and House of Representatives with assistance, if requested, in drafting legislation to correct the names of accrediting organizations in the Florida Statutes. This is to occur prior to the 2013 Regular Session of the Legislature.

Section 67 provides that except as otherwise expressly provided in the act, and except for this section which takes effect upon the act becoming a law, the law takes effect July 1, 2012.

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 this 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:

Entities regulated by the AHCA may be favorably impacted due to the elimination of certain reporting and administrative requirements. Nursing homes and family caregivers may benefit from the authority for nursing homes to provide short-term respite services.

C. Government Sector Impact:

The bill does not have a fiscal impact on the AHCA.[23]

VI. Technical Deficiencies:

Sections 51, 54, 55, and 65 amend ss. 429.294, 430.80, 430.81, and 651.118, F.S., to change a cross-reference to s. 400.141, F.S. However, s. 400.141, F.S., is not amended in this committee substitute, so the current language is correct. These sections should be removed from the bill.

VII. Related Issues:

None.

[23] *Supra*, fn 1.

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 January 31, 2011:

- Deletes several sections from the bill that were amending certain provisions relating to nursing homes, including ss. 400.0234, 400.0255, 400.063, 400.071, 400.0712, 400.111, 400.1183, 400.141, 400.142, 400.145, 400.147, 400.19, 400.23, 400.462, and 400.464, F.S.;
- Requires the AHCA to adopt rules to clarify clinical details for implementation of the provision allowing certain specialty-licensed children's hospitals to provide obstetrical services;
- Removes additional duplicative language regarding the issuance of a provisional license for ALFs and the classification of adult family care home violations;
- Provides a cross-reference to allowable fees for copying and providing resident records;
- Adds the Department of Elderly Affairs to the list of agencies to ensure that all persons working for health care providers licensed by the AHCA are eligible for employment using the same screening criteria;
- Retains the ability for prepaid clinics and the Florida Healthy Kids health plan to utilize the Subscriber Assistance Program;
- Deletes provisions relating to nursing homes and a provision that would allow companion and sitter organizations that have a developmental services provider certificate to provide personal services to persons with developmental disabilities, without additional licensure;
- Places a provision that was in an undesignated section of law into a specific statute; and
- Provides additional exemptions from licensure as a health care clinic.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
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The Committee on Health Regulation (Garcia) recommended the following:

Senate Amendment (with title amendment)

Between lines 506 and 507
insert:
The agency shall adopt rules that establish standards and guidelines for admission to any program that qualifies under this subsection.

========== T I T L E A M E N D M E N T ==========
And the title is amended as follows:
Delete line 40
and insert:

300932

and treatment of certain pregnant women; authorizing the Agency for Health Care Administration to adopt rules; amending s.

207662

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
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The Committee on Health Regulation (Garcia) recommended the following:

Senate Amendment (with title amendment)

Delete lines 805 - 1518
and insert:
Section 19. Subsection (1) of section 400.275, Florida Statutes, is amended to read:
400.275 Agency duties.—
(1) ~~The agency shall ensure that each newly hired nursing home surveyor, as a part of basic training, is assigned full-time to a licensed nursing home for at least 2 days within a 7-day period to observe facility operations outside of the survey process before the surveyor begins survey responsibilities. Such~~

207662

~~observations may not be the sole basis of a deficiency citation against the facility.~~ The agency may not assign an individual to be a member of a survey team for purposes of a survey, evaluation, or consultation visit at a nursing home facility in which the surveyor was an employee within the preceding 2 ~~5~~ years.

========== T I T L E A M E N D M E N T ==========
And the title is amended as follows:
Delete lines 79 - 142
and insert:
care plan"; amending s. 400.275, F.S.; revising agency duties with regard to training nursing home surveyor teams; revising requirements for team members;

520050

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
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The Committee on Health Regulation (Garcia) recommended the following:

Senate Amendment

Between lines 2148 and 2149
insert:

(n) Entities that are owned by a corporation that has $250 million or more in total annual sales of health care services provided by licensed health care practitioners if one or more of the owners of the entity is a health care practitioner who is licensed in this state, is responsible for supervising the business activities of the entity, and is legally responsible for the entity's compliance with state law for purposes of this section.

520050

(o) Entities that employ 50 or more health care practitioners who are licensed under chapter 458 or chapter 459 if the billing for medical services is under a single corporate tax identification number. The application for exemption under this paragraph must contain information that includes the name, residence address, business address, and telephone number of the entity that owns the practice; a complete list of the names and contact information of all the officers and directors of the entity; the name, residence address, business address, and medical license number of each health care practitioner who is licensed to practice in this state and employed by the entity; the corporate tax identification number of the entity seeking an exemption; a listing of health care services to be provided by the entity at the health care clinics owned or operated by the entity; and a certified statement prepared by an independent certified public accountant which states that the entity and the health care clinics owned or operated by the entity have not received payment for health care services under insurance coverage for personal injury protection for the preceding year. If the agency determines that an entity that is exempt under this paragraph has received payments for medical services for insurance coverage for personal injury protection, the agency may deny or revoke the exemption from licensure under this paragraph.

166208

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
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The Committee on Health Regulation (Garcia) recommended the following:

Senate Amendment

Delete line 2350
and insert:
(15) This section applies only to prepaid health clinics certified under chapter 641, Florida Healthy Kids health plans and to health plans that meet

638326

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
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The Committee on Health Regulation (Garcia) recommended the following:

Senate Amendment

Delete lines 2463 - 2475
and insert:
fingerprinted. Proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Agency, the Department of Health, the Agency for Persons with Disabilities, the Department of Children and Family Services, the Department of Elderly Affairs, or the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a

638326

continuing care retirement community under chapter 651 satisfies the requirements of this section if the screening standards and disqualifying offenses are equivalent to those specified in section 453.04 and this section, and the person subject to screening has not been unemployed for more than 90 days and such proof is accompanied, under penalty of perjury, by an affidavit of compliance with the provisions of chapter 435 and this section using forms provided by the Agency.

482684

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
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The Committee on Health Regulation (Garcia) recommended the following:

Senate Amendment (with title amendment)

Delete lines 3049 - 3060
and insert:
Section 64. Subsection (6) of section 429.11 is repealed.
Section 65. Subsection (1) of section 429.294, Florida Statutes is amended to read:
429.294 Availability of facility records for investigation of resident's rights violations and defenses; penalty.—
(1) Failure to provide complete copies of a resident's records, including, but not limited to, all medical records and the resident's chart, within the control or possession of the

facility within 10 days, in accordance with the provisions of s. 400.141(3)~~400.145~~, shall constitute evidence of failure of that party to comply with good faith discovery requirements and shall waive the good faith certificate and presuit notice requirements under this part by the requesting party.

Section 66. Subsections (1) and (5) of section 429.71, Florida Statutes, are amended to read:

429.71 Classification of violations ~~deficiencies~~; administrative fines.—

(1) In addition to the requirements of part II of chapter 408 and in addition to any other liability or penalty provided by law, the agency may impose an administrative fine on a provider according to the following classification:

(a) Class I violations are defined in s. 408.813 ~~those conditions or practices related to the operation and maintenance of an adult family-care home or to the care of residents which the agency determines present an imminent danger to the residents or guests of the facility or a substantial probability that death or serious physical or emotional harm would result therefrom. The condition or practice that constitutes a class I violation must be abated or eliminated within 24 hours, unless a fixed period, as determined by the agency, is required for correction~~. A class I violation ~~deficiency~~ is subject to an administrative fine in an amount not less than $500 and not exceeding $1,000 for each violation. ~~A fine may be levied notwithstanding the correction of the deficiency.~~

(b) Class II violations are defined in s. 408.813 ~~those conditions or practices related to the operation and maintenance of an adult family-care home or to the care of residents which~~

~~the agency determines directly threaten the physical or emotional health, safety, or security of the residents, other than class I violations~~. A class II violation is subject to an administrative fine in an amount not less than $250 and not exceeding $500 for each violation. ~~A citation for a class II violation must specify the time within which the violation is required to be corrected. If a class II violation is corrected within the time specified, no civil penalty shall be imposed, unless it is a repeated offense.~~

(c) Class III violations are defined in s. 408.813 ~~those conditions or practices related to the operation and maintenance of an adult family-care home or to the care of residents which the agency determines indirectly or potentially threaten the physical or emotional health, safety, or security of residents, other than class I or class II violations~~. A class III violation is subject to an administrative fine in an amount not less than $100 and not exceeding $250 for each violation. ~~A citation for a class III violation shall specify the time within which the violation is required to be corrected.~~ If a class III violation is corrected within the time specified, no civil penalty shall be imposed, unless it is a repeated violation ~~offense~~.

(d) Class IV violations are defined in s. 408.813 ~~those conditions or occurrences related to the operation and maintenance of an adult family-care home, or related to the required reports, forms, or documents, which do not have the potential of negatively affecting the residents~~. ~~A provider that does not correct~~ A class IV violation ~~within the time limit specified by the agency~~ is subject to an administrative fine in an amount not less than $50 and not exceeding $100 for each

482684

violation. Any class IV violation that is corrected during the time the agency survey is conducted will be identified as an agency finding and not as a violation, unless it is a repeat violation.

~~(5) As an alternative to or in conjunction with an administrative action against a provider, the agency may request a plan of corrective action that demonstrates a good faith effort to remedy each violation by a specific date, subject to the approval of the agency.~~

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

And the title is amended as follows:

Delete lines 258 - 259

and insert:

committee; repealing subsection (6) of s 429.11, Florida Statutes, relating to provisional licenses for assisted living facilities; amending s. 429.294, F.S., revising a cross-reference; amending s. 429.915, F.S.; revising

515912

LEGISLATIVE ACTION

Senate . House

. . . . . .

The Committee on Health Regulation (Garcia) recommended the following:

Senate Amendment (with title amendment)

Delete lines 3223 - 3226.

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

And the title is amended as follows:

Delete lines 283 - 285

and insert:

and operated by the same entity; amending s. 483.294

511952

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
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The Committee on Health Regulation (Garcia) recommended the following:

Senate Amendment (with title amendment)

Delete lines 3345 - 3348.

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

And the title is amended as follows:

Delete lines 307 - 310

and insert:

a cross-reference;

784986

LEGISLATIVE ACTION

Senate	.	House
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The Committee on Health Regulation (Garcia) recommended the following:

Senate Amendment

Delete lines 3349 - 3359

and insert:

Section 79. Effective upon this act becoming law paragraph (3) is added to subsection (1) of section 409.975. Before the selection of managed care plans as specified in s. 409.966, each essential provider and each hospital that are necessary in order for managed care plan to demonstrate an adequate network, as determined by the agency, are a part of that managed care plan's network for purposes of the provider's or hospital's application for enrollment or expansion in the Medicaid program. A managed

784986

care plan's payment under this section to an essential provider must be made in accordance with this section.

314786

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
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The Committee on Health Regulation (Garcia) recommended the following:

Senate Amendment (with directory and title amendments)

Delete lines 3349 - 3359
and insert:
409.975 Managed care plan accountability.—In addition to the requirements of s. 409.967, plans and providers participating in the managed medical assistance program shall comply with the requirements of this section.
(1) PROVIDER NETWORKS.—Managed care plans must develop and maintain provider networks that meet the medical needs of their enrollees in accordance with standards established pursuant to s. 409.967(2)(b). Except as provided in this section, managed

314786

care plans may limit the providers in their networks based on credentials, quality indicators, and price.

(e) Before the selection of managed care plans as specified in s. 409.966, each essential provider and each hospital that are necessary in order for a managed care plan to demonstrate an adequate network, as determined by the agency, are a part of that managed care plan's network for purposes of the provider's or hospital's application for enrollment or expansion in the Medicaid program. A managed care plan's payment under this section to an essential provider must be made in accordance with this section.

====== D I R E C T O R Y C L A U S E A M E N D M E N T ======

And the directory clause is amended as follows:

Between lines 3348 and 3349

insert:

Section 79. Effective upon this act becoming law, paragraph (e) is added to subsection (1) of section 409.975, Florida Statutes, to read:

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

And the title is amended as follows:

Between lines 310 and 311

insert:

amending s. 409.975, F.S.;

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/31/12
Meeting Date

Topic CLINIC LICENSURE

Bill Number SB 1884 *(if applicable)*

Name JAMES EATON

Amendment Barcode 520050 *(if applicable)*

Job Title

Address P.O. BOX 1713 *Street*

Phone 850 224 6789

TALLAHASSEE *City* FL *State* 32302 *Zip*

E-mail jimeaton53@aol.com

Speaking: ☑ For ☐ Against ☐ Information

Representing 21ST CENTURY ONCOLOGY, MILLENIUM PHYSICIANS GROUP

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

spoke

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/31/12
Meeting Date

Topic SECTION 79 - MANAGED CARE PLANS

Bill Number SB 1884 *(if applicable)*

Name PAUL BELCHER

Amendment Barcode *(if applicable)*

Job Title SR. V. P.

Address 306 E. COLLEGE AVE *Street*

TALLAHASSEE, FLA. 32309 *City State Zip*

Phone 850-222-9800

E-mail PAUL@FHA.ORG

Speaking: ☐ For ☑ Against ☐ Information

Representing FLORIDA HOSPITAL ASSOCIATION

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Spoke ✓

1/31/2012
Meeting Date

Topic Section 79

Bill Number SB 1884 *(if applicable)*

Name Mark Delegal

Amendment Barcode *(if applicable)*

Job Title Counsel

Address 215 S. Monroe St. #200
Street
Tallahassee FL 32301
City *State* *Zip*

Phone 850-222-3533

E-mail mdelegal@penningtonlaw.com

Speaking: ☐ For ☑ Against ☐ Information

Representing Safety Net Hospital Alliance

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

Spoke

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/31/12
Meeting Date

Topic MEDICAID

Bill Number SB 1884 *(if applicable)*

Name MICHAEL GOOD, M.D.

Amendment Barcode *(if applicable)*

Job Title DEAN, UF COLLEGE OF MEDICINE

Address P.O. BOX 100215 *Street*

Phone 352-273-7500

GAINESVILLE *City* FL *State* 32610 *Zip*

E-mail Mgood@ufl.edu

Speaking: ☐ For ☒ Against ☐ Information

Representing COUNCIL OF FLORIDA MEDICAL SCHOOL DEANS

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

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 Health Regulation Committee

BILL: CS/SB 2074

INTRODUCER: Health Regulation Committee

SUBJECT: Assisted Living Facilities

DATE: February 2, 2012 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	O'Callaghan	Stovall	HR	**Fav/CS**
2.			BC	
3.				
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:

The bill increases regulation pertaining to assisted living facilities (ALFs) in order to improve the safety of persons living in ALFs.

This bill revises part I of ch. 429, F.S., relating to ALFs, to:

- Require an ALF to obtain a limited mental health license if any mental health resident resides in the facility.
- Revise the eligibility requirements for licensure of a facility seeking to be a limited mental health licensee.
- Require ALFs to provide notice to residents of the confidential nature of complaints to the Office of State Long-Term Care Ombudsman (Ombudsman Office).
- Require state and local agency employees to report abuse, neglect, and exploitation of residents to the Department of Children and Families (DCF) central abuse hotline.
- Increase certain facility licensure fees for ALFs with a history of certain violations for a certain period of time.
- Increase certain administrative and criminal penalties and reduce the Agency for Health Care Administration's (AHCA) discretion to impose certain penalties.
- Require all ALF staff to complete at least 2 hours of pre-service orientation.

- Designate the AHCA as the central agency for receiving and tracking complaints against ALFs.
- Require agencies, if funding is available, to develop or modify electronic systems to ensure the transfer of information between agencies pertaining to ALFs.
- Create a task force to look at streamlining agency regulatory oversight of ALFs.
- Revise the AHCA's inspection authority and requirements, such as requiring the AHCA to monitor a certain number of ALF elopement drills.
- Require the AHCA to have lead surveyors in each field office, who specialize in assessing ALFs, to train other surveyors of ALFs and facilitate consistent inspections.
- Create a task force to review the AHCA inspection forms to ensure ALFs are being assessed appropriately for resident needs and safety.
- Authorize the Department of Elderly Affairs (DOEA) to require additional staffing in ALFs, depending on the number of residents receiving special care and the type of special care being provided.
- Require ALFs to semiannually report to the AHCA information relating to occupancy rates and residents' acuity and demographics in order for the AHCA to track the information.
- Require the AHCA to develop a user-friendly rating system of ALFs.

This bill renames part I, ch. 468 of the Florida Statutes, as "Nursing Home and Assisted Living Facility Administration." In addition, the board created under that part is renamed as the "Board of Nursing Home and Assisted Living Facility Administrators" (Board). The Board's responsibilities are expanded to include:

- Issuing licenses to ALF administrators who hold a certificate from a third-party credentialing entity;
- Approving one or more third-party credentialing entities to issue certificates to applicants for licensure as ALF administrators if the applicants meet delineated eligibility requirements;
- Disciplining ALF administrators for certain violations;
- Developing training curricula for ALF staff;
- Approving and certifying training and testing centers;
- Certifying and disciplining core training providers; and
- If funding is available, developing and maintaining a database of core training providers and attendees of core training.

The bill also requires an ALF to operate under the management of a licensed administrator.

Additional provisions affecting other chapters of law require:

- Community living support plans to be updated more frequently.
- Case managers to record interaction with residents.
- Consistent and adequate monitoring of community living support plans and cooperative agreements by the DOEA.

This bill substantially amends the following sections of the Florida Statutes: 394.4574, 400.0078, 415.1034, 429.02, 429.07, 429.075, 429.14, 429.176, 429.178, 429.19, 429.23, 429.256, 429.28, 429.34, 429.41, 429.49, 429.52, 429.54, 468.1635, 468.1645, 468.1655, 468.1665, 468.1685, 468.1695, 468.1705, 468.1725, 468.1735, 468.1745, 468.1755, 468.1756, .

This bill creates the following sections of the Florida Statutes: 429.515, 429.521, 429.522, 429.523, 429.55, and 429.56.

This bill also creates four undesignated sections of the Florida Statutes.

II. Present Situation:

Assisted Living Facilities

An ALF is a residential establishment, or part of a residential establishment, that provides housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.[1, 2] A personal service is direct physical assistance with, or supervision of, the activities of daily living and the self-administration of medication.[3] Activities of daily living include: ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks.[4]

Assisted living facilities are licensed by the AHCA, pursuant to part I of ch. 429, F.S., relating to ALFs, and part II of ch. 408, F.S., relating to the general licensing provisions for health care facilities. Assisted living facilities are also subject to regulation under Chapter 58A-5, Florida Administrative Code (F.A.C.). These rules are adopted by the DOEA in consultation with the AHCA, the DCF, and the Department of Health (DOH).[5] An ALF must also comply with the Uniform Fire Safety Standards for ALFs contained in Chapter 69A-40, F.A.C., and standards enforced by the DOH concerning food hygiene; physical plant sanitation; biomedical waste; and well, pool, or septic systems.[6]

As of December 1, 2011, there were 2,985 licensed ALFs in Florida.[7] In addition to a standard license, an ALF may have specialty licenses that authorize the ALF to provide limited nursing services (LNS),[8] limited mental health (LMH) services,[9] and extended congregate care (ECC)

[1] Section 429.02(5), F.S.
[2] An ALF does not include an adult family-care home or a non-transient public lodging establishment. An adult family-care home is regulated under ss. 429.60–429.87, F.S., and is defined as a full-time, family-type living arrangement, in a private home where the person who owns or rents the home provides room, board, and personal care, on a 24-hour basis, for no more than five disabled adults or frail elders who are not relatives. A non-transient establishment (a.k.a. boarding house) is regulated under part I of ch. 509, F.S., and is defined as any public lodging establishment that is rented or leased to guests by an operator whose intention is that the dwelling unit occupied will be the sole residence of the guest.
[3] Section 429.02(16), F.S.
[4] Section 429.02(1), F.S.
[5] Section 429.41(1), F.S.
[6] *See* chs. 64E-12, 64E-11, and 64E-16, F.A.C.
[7] Agency for Health Care Administration, *Assisted Living Directory*, available at: http://ahca.myflorida.com/MCHQ/Long_Term_Care/Assisted_living/pdf/Directory_ALF.pdf (Last visited on January 16, 2012).
[8] Section 429.07(3)(c), F.S.
[9] An ALF that serves three or more mental health residents must obtain a limited mental health specialty license. A mental health resident is an individual who receives social security disability income (SSDI) due to a mental disorder or supplemental security income (SSI) due to a mental disorder, and receives optional state supplementation (OSS). *See* ss. 429.075 and 429.02(15), F.S.

services.[10] Out of the 2,985 licensed ALFs, 1,083 have LNS licenses, 1,108 have LMH licenses, and 267 have ECC licenses.[11]

An ALF is required to provide care and services appropriate to the needs of the residents accepted for admission to the facility. Generally, the care and services include at a minimum:[12]

- Supervising the resident in order to monitor the resident's diet; being aware of the general health, safety, and physical and emotional well-being of the resident; and recording significant changes, illnesses, incidents, and other changes which resulted in the provision of additional services;
- Contacting appropriate persons upon a significant change in the resident or if the resident is discharged or moves out;
- Providing and coordinating social and leisure activities in keeping with each resident's needs, abilities, and interests;
- Arranging for health care by assisting in making appointments, reminding residents about scheduled appointments, and providing or arranging for transportation as needed; and
- Providing to the resident a copy of, and adhering to, the Resident Bill of Rights.

The owner or facility administrator determines whether an individual is appropriate for admission to the facility based on an assessment of the strengths, needs, and preferences of the individual; the health assessment; the preliminary service plan; the facility's residency criteria; services offered or arranged for by the facility to meet resident needs; and the ability of the facility to meet the uniform fire-safety standards.[13] A resident who requires 24-hour nursing supervision[14] may not reside in an ALF, unless the resident is enrolled as a hospice patient.[15]

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.[16]

Limited Nursing Services Specialty License
An LNS specialty license enables an ALF to provide, directly or through contract, a select number of nursing services in addition to the personal services that are authorized under the standard license.

[10] Section 429.07(3)(b), F.S.
[11] Agency for Health Care Administration, *Directories*, available at: http://ahca.myflorida.com/MCHQ/Long_Term_Care/Assisted_living/alf.shtml (Last visited on January 16, 2012).
[12] Rule 58A-5.0182, F.A.C.
[13] Section 429.26, F.S., and Rule 58A-5.030, F.A.C.
[14] "Twenty-four-hour nursing supervision" means services that are ordered by a physician for a resident whose condition requires the supervision of a physician and continued monitoring of vital signs and physical status. Such services must be: medically complex enough to require constant supervision, assessment, planning, or intervention by a nurse; required to be performed by or under the direct supervision of licensed nursing personnel or other professional personnel for safe and effective performance; required on a daily basis; and consistent with the nature and severity of the resident's condition or disease state or stage. Definition found at s. 429.02(26), F.S.
[15] Continued residency of a hospice patient is conditioned upon a mutual agreement between the resident and the facility, additional care being rendered through a licensed hospice, and the resident being under the care of a physician who agrees that the physical needs of the resident are being met. Section 429.26, F.S.
[16] Section 429.28, F.S.

The nursing services authorized to be provided with this license are limited to acts specified in administrative rules, may only be provided as authorized by a health care provider's order, and must be conducted and supervised in accordance with ch. 464, F.S., relating to nursing, and the prevailing standard of practice in the nursing community. A nursing assessment, that describes the type, amount, duration, scope, and outcomes or services that are rendered and the general status of the resident's health, is required to be conducted at least monthly on each resident who receives a limited nursing service.[17]

Extended Congregate Care Specialty License

An ECC specialty license enables an ALF to provide, directly or through contract, services performed by licensed nurses and supportive services[18] to persons who otherwise would be disqualified from continued residence in an ALF.[19]

The primary purpose of ECC services is to allow residents, as they become more impaired with physical or mental limitations, 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 nursing supervision.[20]

Facilities holding an ECC license must:

- Ensure that the administrator of the facility and the ECC supervisor, if separate from the administrator, has 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 or agency serving elderly or disabled persons. A baccalaureate degree may be substituted for 1 year of the required experience and a nursing home administrator is considered to be qualified for the position.
- Provide enough qualified staff to meet the needs of ECC residents considering the amount and type of services established in each resident's service plan.
- Immediately provide additional or more qualified staff, when the AHCA determines that service plans are not being followed or that residents' needs are not being met because of the lack of sufficient or adequately trained staff.
- Ensure and document that staff receive required ECC training.

[17] Section 429.26, F.S., and Rule 58A-5.031(3)(c), F.A.C.
[18] Supportive services include social service needs, counseling, emotional support, networking, assistance with securing social and leisure services, shopping service, escort service, companionship, family support, information and referral, assistance in developing and implementing self-directed activities, and volunteer services. *See* Rule 58A-5.030(8)(a), F.A.C.
[19] An ECC program may provide additional services, such as: total help with bathing, dressing, grooming, and toileting; nursing assessments conducted more frequently than monthly; measuring and recoding basic vital functions and weight; dietary management; assisting with self-administered medications or administering medications and treatments pursuant to a health care provider's order; supervising residents with dementia and cognitive impairments; health education, counseling, and implementing health-promoting programs; rehabilitative services; and escort services related to health-related appointments. Section 429.07(3)(b), F.S., and Rule 58A-5.030, F.A.C.
[20] Section 429.07(3)(b), F.S.

Limited Mental Health Specialty License

An ALF that serves three or more mental health residents must obtain an LMH specialty license.[21] A mental health resident is an individual who receives social security disability income (SSDI) due to a mental disorder or supplemental security income (SSI) due to a mental disorder, and receives optional state supplementation (OSS).[22,23] The DCF is responsible for ensuring that a mental health resident is assessed and determined able to live in the community in an ALF with an LMH license.[24]

An ALF licensed to provide LMH services must assist the mental health resident in carrying out the activities in the resident's community living support plan. The mental health resident's community living support plan, which is updated annually, includes:[25]

- The specific needs of the resident which must be met for the resident to live in the ALF and community;
- The clinical mental health services to be provided by the mental health care provider to help meet the resident's needs, and the frequency and duration of such services;
- Any other services and activities to be provided by or arranged for by the mental health care provider or mental health case manager to meet the resident's needs, and the frequency and duration of such services and activities;
- Obligations of the ALF to facilitate and assist the resident in attending appointments and arranging transportation to appointments for the services and activities identified in the plan;
- A description of other services to be provided or arranged by the ALF; and
- A list of factors pertinent to the care, safety, and welfare of the mental health resident and a description of the signs and symptoms particular to the resident that indicates the immediate need for professional mental health services.

The LMH licensee must execute a cooperative agreement between the ALF and the mental health care services provider. The cooperative agreement specifies, among other things, directions for the ALF accessing emergency and after-hours care for the mental health resident.

Additionally, according to Rule 58A-5.029, F.A.C., facilities holding an LMH license must:

- Provide an opportunity for private face-to-face contact between the mental health resident and the resident's mental health case manager or other treatment personnel of the resident's mental health care provider.
- Observe resident behavior and functioning in the facility, and record and communicate observations to the resident's mental health case manager or mental health care provider regarding any significant behavioral or situational changes which may signify the need for a

[21] Section 429.075, F.S.
[22] Section 429.02(15), F.S.
[23] Optional State Supplementation is a cash assistance program. Its purpose is to supplement a person's income to help pay for costs in an assisted living facility, mental health residential treatment facility, or adult family care home, but it is not a Medicaid program. Department of Elder Affairs, *Florida Affordable Assisted Living: Optional State Supplementation (OSS)*, available at: http://elderaffairs.state.fl.us/faal/operator/statesupp.html (Last visited on January 17, 2012).
[24] Section 394.4574, F.S., requires a mental health resident to be assessed by a psychiatrist, clinical psychologist, clinical social worker, psychiatric nurse, or an individual who is supervised by one of these professionals to determine whether it is appropriate for the person to reside in an ALF.
[25] Rule 58A-5.029(2)(c)3., F.A.C.

change in the resident's professional mental health services, supports and services described in the community living support plan, or that the resident is no longer appropriate for residency in the facility.
- Ensure that designated staff have completed the required LMH training.
- Maintain facility, staff, and resident records in accordance with the requirements of the law.

ALF Staffing Requirements
Every ALF must be under the supervision of an administrator, who is responsible for the operation and maintenance of the facility, including the management of all staff and the provision of adequate care to all residents.

Rule 58A-5.019(4), F.A.C., provides the minimum staffing requirements for ALFs. An ALF may be required by the AHCA to immediately increase staff above the minimum staffing levels if the AHCA determines that adequate supervision and care are not being provided to residents, resident care standards are not being met, or that the facility is failing to meet the terms of residents' contracts. When additional staff is required above the minimum, the AHCA requires the submission of a corrective action plan indicating how the increased staffing is to be achieved and resident service needs will be met.[26]

Resident Elopement
All facilities must assess residents at risk for elopement or must identify those residents having any history of elopement in order for staff to be alerted to their needs for support and supervision. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at-risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number.[27]

The facility is required to develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must include:
- An immediate staff search of the facility and premises;
- The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities;
- The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to an immediate search of the facility and premises; and
- The continued care of all residents within the facility in the event of an elopement.[28]

Use of Restraints
Florida law limits the use of restraints on residents of ALFs. The use of physical restraints[29] is limited to half-bed rails as prescribed and documented by the resident's physician with the

[26] Rule 58A-5.019(4), F.A.C.
[27] Rule 58A-5.0182(8), F.A.C.
[28] *Id.*
[29] "Physical restraint" means a device which physically limits, restricts, or deprives an individual of movement or mobility, including, but not limited to, a half-bed rail, a full-bed rail, a geriatric chair, and a posey restraint. The term "physical restraint" shall also include any device which was not specifically manufactured as a restraint but which has been altered, arranged, or otherwise used for this purpose. The term shall not include bandage material used for the purpose of binding a wound or injury. Section 429.02(17), F.S.

consent of the resident or, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact. The physician is to review the order for physical restraints biannually.[30] The use of chemical restraints[31] is limited to prescribed dosages of medications authorized by the resident's physician and must be consistent with the resident's diagnosis. Residents who are receiving medications that can serve as chemical restraints must be evaluated by their physician at least annually to assess the continued need for the medication, the level of the medication in the resident's blood, and the need for adjustments in the prescription.

ALF Staff Training
Administrators and other ALF staff[32] must meet minimum training and education requirements established by the DOEA by rule.[33] This training and education is intended to assist facilities appropriately respond to the needs of residents, maintain resident care and facility standards, and meet licensure requirements.[34]

The ALF core training requirements established by the DOEA consist of a minimum of 26 hours of training and a competency test. Administrators and managers are required to successfully complete the ALF core training requirements within 3 months from the date of becoming a facility administrator or manager. Successful completion of the core training requirements includes passing the competency test.[35] The minimum passing score for the competency test is 75 percent.[36]

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, is considered a new administrator or manager for the purposes of the core training requirements. He or she must retake the ALF core training and retake and pass the competency test.[37]

Facility administrators or managers are required to provide or arrange for the following in-service training to facility staff:

[30] Rule 58A-5.0182(6)(h), F.S.
[31] "Chemical restraint" means a pharmacologic drug that physically limits, restricts, or deprives an individual of movement or mobility, and is used for discipline or convenience and not required for the treatment of medical symptoms. Section 429.02(6), F.S.
[32] An ALF administrator must be at least 21 years of age and have a high school diploma or general equivalency diploma (G.E.D.) An administrator must be in compliance with level 2 background screening standards and complete a core training requirement. Section 429.174, F.S., and Rule 58A-5.019, F.A.C. In addition, all staff, who are employed by or contracted with the ALF to provide personal services to residents, must receive a level 2 background screening. Section 408.809(1)(e), F.S. and s. 429.174, F.S.
[33] Rule 58A-5.0191, F.A.C.
[34] Section 429.52(1), F.S.
[35] Rule 58A-5.0191, F.A.C.
[36] 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.
[37] Rule 58A-5.0191, F.A.C.

- Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides must receive a minimum of 1-hour in-service training in infection control, including universal precautions, and facility sanitation procedures before providing personal care to residents.[38]
- Staff who provide direct care to residents must receive a minimum of 1-hour in-service training within 30 days of employment that covers the reporting of major incidents, reporting of adverse incidents, and facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.
- Staff who provide direct care to residents, who have not taken the core training program, must receive a minimum of 1-hour in-service training within 30 days of employment that covers resident rights in an ALF and recognizing and reporting resident abuse, neglect, and exploitation.
- Staff who provide direct care to residents, other than nurses, CNAs, or home health aides must receive 3 hours of in-service training within 30 days of employment that covers resident behavior and needs and providing assistance with the activities of daily living.
- Staff who prepare or serve food and who have not taken the ALF core training, must receive a minimum of 1-hour in-service training within 30 days of employment in safe food handling practices.

All facility staff are required to receive in-service training regarding the facility's resident elopement response policies and procedures within 30 days of employment, must be provided with a copy of the facility's resident elopement response policies and procedures, and must demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.[39]

Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills, which must include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the drills are conducted in a manner consistent with the facility's resident elopement policies and procedures.[40]

Assistance with Self-Administered Medications
Unlicensed persons who are to provide assistance with self-administered medications must complete a minimum of 4 additional hours of training provided by a registered nurse, licensed pharmacist, or department staff and receive a training certificate.[41] Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in ALFs; 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

[38] Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to blood borne pathogens, may be used to meet this requirement. Rule 58A-5.0191(2)(a), F.A.C.
[39] Rule 58A-5.0191, F.A.C.
[40] Section 429.41(1)(a)3., F.S.
[41] Section 429.52(5), F.S.

keeping; and medication storage and disposal. Training must include demonstrations of proper techniques and provide opportunities for hands-on learning through practice exercises.[42]

Those unlicensed persons, 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 ALF.[43]

ECC Specific
The administrator and ECC supervisor, if different from the administrator, must complete core training and 4 hours of initial training in extended congregate care prior to the facility's receiving its ECC license or within 3 months of beginning employment in the facility as an administrator or ECC supervisor.[44] The administrator and the ECC supervisor, if different from the administrator, must 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.[45]

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 of beginning employment in the facility. The training must address ECC concepts and requirements, including statutory and rule requirements, and delivery of personal care and supportive services in an ECC facility.[46]

LMH Specific
The administrator, managers, and staff, who have direct contact with mental health residents in a licensed LMH facility, must receive the following training:[47]

- A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses.
- A minimum of 3 hours of continuing education, which may be provided by the ALF administrator or through distance learning, biennially thereafter in subjects dealing with mental health diagnoses or mental health treatment.

Special Care for Persons with Alzheimer's Disease
Facilities which advertise that they provide special care for persons with Alzheimer's disease and related disorders must ensure that facility staff, who have regular contact with or provide direct care to residents with Alzheimer's disease and related disorders, obtain 4 hours of initial training, entitled "Alzheimer's Disease and Related Disorders Level I Training," within 3 months of employment.[48]

[42] Rule 58A-5.0191(5)(a), F.A.C.
[43] Rule 58A-5.0191(5)(c), F.A.C.
[44] ECC supervisors who attended the ALF core training prior to April 20, 1998, are not required to take the ALF core training competency test. Rule 58A-5.0191(7), F.A.C.
[45] Rule 58A-5.0191(7)(b), F.A.C.
[46] Rule 58A-5.0191(7)(c), F.A.C.
[47] Section 429.075, F.S. and Rule 58A-5.0191(8), F.A.C.
[48] Those that have completed the core training program between April 20, 1998, and July 1, 2003, are deemed to have satisfied this requirement. Those qualified to provide such training are not required to complete this requirement or the

Facility staff, who provide direct care to residents with Alzheimer's disease and related disorders, must obtain an additional 4 hours of training, entitled "Alzheimer's Disease and Related Disorders Level II Training," within 9 months of employment.

Direct care staff is required to participate in 4 hours of continuing education annually.[49] Facility staff who, have only incidental contact[50] with residents with Alzheimer's disease and related disorders, must receive general written information provided by the facility on interacting with such residents within 3 months of employment.[51]

Do Not Resuscitate Orders

Facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least 1 hour of training in the facility's policies and procedures regarding Do Not Resuscitate Orders within 30 days after employment.[52]

Trainers

Training for administrators must be performed by trainers registered with the DOEA. The trainer must provide the DOEA with proof that he or she has completed the minimum core training education requirements, successfully passed the competency test, and complied with continuing education requirements (12 contact hours of continuing education in topics related to assisted living every 2 years), and meet one of the following requirements:

- Provide proof of completion of a 4-year degree from an accredited college or university and have worked in a management position in an ALF for 3 years after being core certified;
- Have worked in a management position in an ALF for 5 years after being core certified and have 1 year of teaching experience as an educator or staff trainer for persons who work in ALFs or other long-term care settings;
- Have been previously employed as a core trainer for the DOEA;
- Have a minimum of 5 years of employment with the AHCA, or formerly the Department of Health and Rehabilitative Services, as a surveyor of ALFs;
- Have a minimum of 5 years of employment in a professional position in the AHCA Assisted Living Unit;
- Have a minimum of 5 years employment as an educator or staff trainer for persons working in an ALF or other long-term care settings;
- Have a minimum of 5 years of employment as an ALF core trainer, which was not directly associated with the DOEA; or
- Have a minimum of a 4-year degree from an accredited college or university in the areas of healthcare, gerontology, social work, education or human services, and a minimum of 4 years experience as an educator or staff trainer for persons working in an ALF or other long-term care settings after core certification.[53]

requirement for Alzheimer's Disease and Related Disorders Level II Training. *See* Rule 58A-5.0191, F.A.C.

[49] Section 429.178, F.S.

[50] "Incidental contact" means all staff who neither provide direct care nor are in regular contact with such residents. Rule 58A-5.0191(9)(f), F.A.C.

[51] Section 429.178, F.S.

[52] Rule 58A-5.0191(11), F.A.C.

[53] Section 429.52(9)-(10), F.S. and Rule 58T-1.203, F.A.C.

Inspections and Surveys

The AHCA is required to conduct a survey, investigation, or appraisal 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.[54]
- Upon receipt of an oral or written complaint of practices that threaten the health, safety, or welfare of residents.
- If the 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.[55]
- An applicant for licensure renewal is eligible for an abbreviated biennial survey by the 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 the AHCA by the council.
- Confirmed licensing complaints within the two licensing periods immediately preceding the current renewal date.[56]

The AHCA must 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.[57]

An LNS licensee is subject to monitoring inspections by the AHCA or its agents 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.[58]

An ECC licensee is subject to quarterly monitoring inspections by the AHCA or its agents. At least one registered nurse must be included in the inspection team. The 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.[59]

There is no additional monitoring requirement of LMH licensees.

[54] *See below* information under subheading "Violations and Penalties" for a description of each class of violation.

[55] *See* s. 429.34, F.S., and Rule 58A-5.033, F.A.C.

[56] Rule 58A-5.033(2), F.A.C.

[57] *Id.*

[58] Section 429.07(3)(c), F.S.

[59] Section 429.07(3)(b), F.S.

Violations and Penalties

Part II of ch. 408, F.S., provides the general licensure standards for all facilities regulated by the AHCA. Under s. 408.813, F.S., ALFs may be subject to administrative fines imposed by the 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 facility residents.[60]

The AHCA must provide written notice of a violation and must impose an administrative fine[61] for a cited class I violation in an amount not less than $5,000 and not exceeding $10,000 for each violation; impose an administrative fine for a cited class II violation in an amount not less than $1,000 and not exceeding $5,000 for each violation; impose an administrative fine for a cited class III violation in an amount not less than $500 and not exceeding $1,000 for each violation; and impose an administrative fine for a cited class IV violation in an amount not less than $100 and not exceeding $200 for each violation.[62]

The AHCA may deny, revoke, and suspend any license and impose an administrative fine against a licensee for a violation of any provision of part I of ch. 429, F.S., part II of ch. 408, F.S., or applicable rules; for the actions of any person subject to level 2 background screening under s. 408.809, F.S.; for the actions of any facility employee; or for any of the following actions by a licensee:

- An intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility.
- A determination by the AHCA that the owner lacks the financial ability to provide continuing adequate care to residents.
- Misappropriation or conversion of the property of a resident of the facility.
- Failure to follow the criteria and procedures provided under part I of ch. 394, F.S., relating to the transportation, voluntary admission, and involuntary examination of a facility resident.
- A citation for one or more cited class I deficiencies, three or more cited class II deficiencies, or five or more cited class III deficiencies that have been cited on a single survey and have not been corrected within the times specified.
- Failure to comply with background screening standards.
- Violation of a moratorium.

[60] Class "I" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients, which the 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 result therefrom. Class "II" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the AHCA determines directly threaten the physical or emotional health, safety, or security of the clients, other than class I violations. Class "III" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the AHCA determines indirectly or potentially threaten the physical or emotional health, safety, or security of clients, other than class I or class II violations. 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.

[61] When determining if a penalty is to be imposed and in fixing the amount of the fine, the 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.

[62] Section 429.19(2), F.S.

- Failure of the license applicant, the licensee during re-licensure, or a licensee that holds a provisional license to meet the minimum license requirements at the time of license application or renewal.
- An intentional or negligent life-threatening act in violation of the uniform fire-safety standards for ALFs or other fire-safety standards that threatens the health, safety, or welfare of a resident of a facility, as communicated to the AHCA by the local authority having jurisdiction or the State Fire Marshal.
- Knowingly operating any unlicensed facility or providing without a license any service that must be licensed.
- Any act constituting a ground upon which application for a license may be denied.[63]

The AHCA is required to deny or revoke the license of an ALF that has two or more class I violations that are similar or identical to violations identified by the AHCA during a survey, inspection, monitoring visit, or complaint investigation occurring within the previous 2 years.[64]

The AHCA may also impose an immediate moratorium[65] or emergency suspension on any provider if the AHCA determines that any condition related to the provider or licensee presents a threat to the health, safety, or welfare of a client.[66] The AHCA is required to publicly post notification of a license suspension or revocation, or denial of a license renewal, at the facility.[67]

Florida's Criminal Code, under ch. 825, F.S., provides criminal penalties for the abuse, neglect, and exploitation of elderly persons[68] and disabled adults.[69]

Licensure Fees

The biennial licensure fees for the ALF standard license and specialty licenses are found in s. 429.07(4), F.S. This section refers to the general health care licensure provisions in part II of ch. 408, F.S. Section 408.805, F.S., provides for licensure fees to be adjusted annually by not more than the change in the Consumer Price Index (CPI) based on the 12 months immediately preceding the increase.[70]

[63] Section 429.14, F.S.

[64] Section 429.14(4), F.S.

[65] "Moratorium" means a prohibition on the acceptance of new clients. Section 408.803(10), F.S.

[66] Section 408.814, F.S.

[67] Section 429.14(7), F.S.

[68] "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.

[69] "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.

[70] The current CPI adjusted fees are: $371 for a standard license, $62 for a standard license per-bed fee, $523 for an ECC license, $10 for an ECC per-bed fee, $250 for an LNS license, and $10 for an LNS per-bed fee. Agency for Health Care Administration, Bureau of Long Term Care, Form Letter to ALF Providers, available at: http://ahca.myflorida.com/MCHQ/LONG_TERM_CARE/Assisted_living/alf/ALF_fee_increase.pdf (Last visited on January 16, 2012).

Income from fees and fines collected by the AHCA must be used by the AHCA for the following purposes:

- Up to 50 percent of the trust funds accrued each fiscal year may be used to offset the expenses of receivership,[71] if the court determines that the income and assets of the facility are insufficient to provide for adequate management and operation.
- An amount of $5,000 of the trust funds accrued each year must be allocated to pay for inspection-related physical and mental health examinations requested by the AHCA for residents who are either recipients of SSI or have monthly incomes not in excess of the maximum combined federal and state cash subsidies available to SSI recipients, but such funds are only to be used where the resident is ineligible for Medicaid.
- Any trust funds accrued each year and not used for the purposes of receivership or inspection-related physical and mental health examinations must be used to offset the costs of the licensure program, verifying information submitted, defraying the costs of processing the names of ALF applicants, and conducting inspections and monitoring visits.[72]

Adult Protective Services

The DCF 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[73] at any hour of the day or night, any day of the week.[74]

The following persons, who know, or have reasonable 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:

- A physician, osteopathic physician, medical examiner, chiropractic physician, nurse, paramedic, emergency medical technician, or hospital personnel engaged in the admission, examination, care, or treatment of vulnerable adults;
- A health professional or mental health professional;
- A practitioner who relies solely on spiritual means for healing;
- Nursing home staff; ALF staff; adult day care center staff; adult family-care home staff; social worker; or other professional adult care, residential, or institutional staff;
- A state, county, or municipal criminal justice employee or law enforcement officer;
- An employee of the Department of Business and Professional Regulation conducting inspections of public lodging establishments;
- A Florida advocacy council member or long-term care ombudsman council member; or

[71] *See* s. 429.22, F.S., for instances as to when a court may appoint a receiver for an ALF.
[72] Section 429.18, F.S.
[73] "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.
[74] The central abuse hotline must be operated in such a manner as to enable 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 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.

- An officer, trustee, or employee of a bank, savings and loan, or credit union.[75]

If at any time during a protective investigation the DCF has reasonable cause to believe that an employee of a facility that provides day or residential care or treatment for vulnerable adults is the alleged perpetrator of abuse, neglect, or exploitation of a vulnerable adult, the DCF must notify the AHCA, Division of Health Quality Assurance, in writing. If at any time during a protective investigation the DCF has reasonable cause to believe that professional licensure violations have occurred, the DCF must notify the Division of Medical Quality Assurance within the DOH in writing. The DCF must provide a copy of its investigation to the AHCA when the DCF has reason to believe that a vulnerable adult resident of a facility licensed by the AHCA or to the DOH when the investigation determines that a health professional licensed or certified under the DOH may have abused, neglected, or exploited a vulnerable adult.[76]

The DCF must also provide written notification to the state attorney having jurisdiction in the county in which the abuse, neglect, or exploitation occurred if evidence indicates that further criminal investigation is warranted. At the conclusion of a protective investigation at a facility, the DCF must notify, in writing, either the Florida local advocacy council or long-term care ombudsman council of the results of the investigation.[77]

To ensure coordination, communication, and cooperation with the investigation of abuse, neglect, or exploitation of vulnerable adults, the DCF is required to develop and maintain inter-program agreements or operational procedures among appropriate departmental programs and the State Long-Term Care Ombudsman Council, the Florida Statewide Advocacy Council, and other agencies that provide services to vulnerable adults. These agreements or procedures must cover such subjects as the appropriate roles and responsibilities of the DCF in identifying and responding to reports of abuse, neglect, or exploitation of vulnerable adults; the provision of services; and related coordinated activities. In addition, the DCF must cooperate with and seek cooperation from all appropriate public and private agencies, including health agencies, educational agencies, social service agencies, courts, organizations, or programs providing or concerned with human services related to the prevention, identification, or treatment of abuse, neglect, or exploitation of vulnerable adults.[78]

Florida's 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.[79] 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 Office is administratively housed in the DOEA and is headed by the State Long-Term Care Ombudsman, who is appointed

[75] Section 415.1034, F.S.
[76] Section 415.1055, F.S.
[77] *Id.*
[78] Section 415.106(2), F.S.
[79] 42 U.S.C. 3058. *See also* s. 400.0061(1), F.S.

by and serves at the pleasure of the Secretary of Elderly Affairs.[80] The program is supported with both federal and state funding.[81]

Florida's Long-Term Care Ombudsman Program (State Program) is made up of nearly 400 volunteers, who are organized into councils in 17 districts[82] around the state. During fiscal year 2009-2010 (October 1, 2009 to September 30, 2010), ombudsmen:

- Completed 4,015 administrative assessments statewide, visiting 100 percent of the licensed long-term care facilities in Florida;
- Completed 9,098 complaint investigations;[83]
- Donated 20,221 hours of volunteer service to the residents; and
- Provided 5,829 free in-service trainings in nursing homes, ALFs, and adult family care homes throughout the state to encourage facility staff members to adopt best practices to improve the residents' quality of life.[84]

The Ombudsman Office 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 nursing homes, ALFs 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 purpose of the State Program, the statewide toll-free telephone number for receiving complaints, and other relevant information regarding how to contact the State Program. Residents or their representatives must be furnished additional copies of this information upon request.[85]

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 in writing; the complainant or resident consents orally and the consent is documented contemporaneously in writing by the ombudsman council requesting such consent; or the disclosure is required by court order.[86]

[80] Section 400.0063, F.S.
[81] According to *Florida's Long-Term Care Ombudsman Program 2009-2010 Annual Report*, in fiscal year 2009-2010, the program received a total of $3,242,586 in funding; the state contribution totaled $1,452,977. *Florida's Long-Term Care Ombudsman Program 2009-2010 Annual Report*, available at: http://ombudsman.myflorida.com/publications/ar/2009-2010%20Annual%20Report.pdf (Last visited on January 17, 2012).
[82] A list of the district offices is available at: http://ombudsman.myflorida.com/DistrictsList.php (Last visited on January 17, 2012).
[83] Section 400.0073, F.S., requires a local council to investigate any complaint of a resident, a representative of a resident, or any other credible source based on the action or inaction of an administrator, employee, or representative of a long-term care facility, which might be contrary to law; unreasonable, unfair, oppressive, or unnecessarily discriminatory, even though in accordance with law; based on a mistake of fact; based on improper or irrelevant grounds; unaccompanied by an adequate statement of reasons; performed in an inefficient manner; or otherwise adversely affecting the health, safety, welfare, or rights of a resident.
[84] *Florida's Long-Term Care Ombudsman Program 2009-2010 Annual Report*, available at: http://ombudsman.myflorida.com/publications/ar/2009-2010%20Annual%20Report.pdf (Last visited on January 17, 2012).
[85] Section 400.0078, F.S.
[86] Section 400.0077(1)(b), F.S.

The Miami Herald Investigative Series on Assisted Living Facilities

Beginning on April 30, 2011, the Miami Herald published a three-part series, titled "Neglected to Death," which exposed several examples of abuses occurring in ALFs and the state regulatory responses to such cases. According to the publication, the Miami Herald spent a year examining thousands of state inspections, police reports, court cases, autopsy files, e-mails, and death certificates and conducting dozens of interviews with operators and residents throughout Florida.

The three-part investigative series gives several examples of abuses or neglect that took place at facilities in Florida, including:[87]

- The administrator of an ALF in Caryville punished his disabled residents by refusing to give them food and drugs, threatened the residents with a stick, doped the residents with powerful tranquilizers, beat residents who broke the facilities rules, forced residents to live without air conditioning even when temperatures reached 100 degrees Fahrenheit, and fell asleep on the job while a 71-year-old woman with mental illness wandered outside the facility and drowned in a nearby pond.
- In an ALF in Kendall, a 74-year-old woman was bound for more than 6 hours, the restraints pulled so tightly that they ripped into her skin and killed her.
- In an ALF in Hialeah, a 71-year-old man with mental illness died from burns after he was left in a bathtub filled with scalding water.
- In an ALF in Clearwater, a 75-year-old Alzheimer's patient was torn apart by an alligator after he wandered from his ALF for the fourth time.
- In an ALF in Haines City, a 74-year-old suffering from diabetes and depression died after going 13 days without crucial antibiotics and several days without food or water.
- An ALF in Miami-Dade County had a door alarm and video cameras in disrepair, an unlocked back gate on the premises, and an attendant who had fallen asleep, which enabled an 85-year-old to wander from the facility and drown in a pond.
- The administrator of an ALF in Dunedin drove a male resident with a criminal history to a pharmacy to fill a prescription for powerful narcotics but failed to collect the drugs from the resident. The resident fed the drugs to a 20-year-old female resident with mental illness, raped her, and caused her to die of an overdose.
- In an ALF in Tampa, a 55-year-old man died after his caretakers failed to give him food, water, or medicine.
- An ALF in Orlando failed to give an 82-year-old woman critical heart medication for 4 days, failed to read her medical chart, and gave her the wrong drugs on the day she died.
- An ALF in West Melbourne shut off the facility's exit alarm when it was triggered without doing a head count or calling 911 as a 74-year-old man slipped out the door and drowned in a nearby pond.
- An ALF in Deerfield Beach did not provide protections to a 98-year-old woman who fell 11 times and died of resulting injuries, including a fractured neck.
- A caretaker in an ALF in Miami-Dade County strapped down a 74-year-old woman for at least 6 hours so tightly that she lost circulation in her legs and as a result a blood clot formed which killed her.

[87] The Miami Herald, *Neglected to Death, Parts 1-3*, available at: http://www.miamiherald.com/2011/04/30/2194842/once-pride-of-florida-now-scenes.html and http://www.miamiherald.com/2011/05/03/2199747/key-medical-logs-doctored-missing.html (Last visited on January 17, 2012) (see left side of article to access weblinks to the three-part series).

The investigative series decried the state's regulatory and law enforcement agencies responses to the alleged egregious acts claiming:[88]

- Nearly once a month residents die from abuse and neglect, with some caretakers altering and forging records to conceal evidence, but law enforcement agencies almost never make arrests.
- Facilities are routinely caught using illegal restraints, including powerful tranquilizers, locked closets, and ropes, but the state rarely punishes them.
- State regulators could have shut down 70 facilities in the past 2 years for a host of severe violations, but only seven facilities were closed.
- Although the number of ALFs has increased substantially over the last 5 years, the state has dropped critical inspections by 33 percent.
- Although the state has the authority to fine ALFs that break the law, the penalties are routinely decreased, delayed, or dropped altogether.
- The state's lack of enforcement has prompted other government agencies to cut off funding and in some cases the agencies refuse to send clients to live in certain ALFs.
- In at least one case, an investigation was never performed by the AHCA, although a woman drowned after wandering off the premises.
- It took the AHCA inspectors an average of 37 days to complete a complaint investigation in 2009, which was 10 days longer than 5 years earlier.
- At least five times, other state agencies were forced to take the lead in shutting down homes when the AHCA did not act.

Governor Rick Scott's ALF Task Force

In response to the Miami Herald Investigative Series on ALFs, Governor Rick Scott announced in his veto message of HB 4045 (2011),[89] which pertains to ALFs, that he was going to form an ALF task force for the purpose of examining current assisted living regulations and oversight.[90] Governor Scott directed the task force to develop recommendations to improve the state's ability to monitor quality and safety in ALFs and ensure the well-being of their residents.[91]

The task force, which is now referred to as the Assisted Living Workgroup, held meetings on August 8, 2011, in Tallahassee; September 23, 2011, in Tampa; and November 7 and 8, 2011 in

[88] *Id.*
[89] HB 4045 (2011) repealed a requirement for the annual dissemination of a list of ALFs that had been sanction or fined, a requirement for an ALF to report monthly any liability claims filed against it, a requirement to disseminate the results of the inspection of each ALF, provisions concerning rule promulgation for ALFs by the DOEA, provisions concerning the collection of information regarding the cost of care in ALFs, and the authority for local governments or organizations to contribute to the cost of care of local facility residents.
[90] The task force, which is now referred to as the "Assisted Living Workgroup," consists of 14 members. These members represent the following entities: Florida Association of Homes and Services for the Aging; Eastside Care, Inc.; Palm Breeze Assisted Living Facility; Long Term Care Ombudsman; Florida House of Representatives; Lenderman and Associates; The Florida Bar, Elder Law Section; Florida State University, the Pepper Center; the Villa at Carpenters; Florida Council for Community Mental Health; Florida Assisted Living Association; Villa Serena I-V, Florida Senate; and Florida Health Care Association. Agency for Health Care Administration, *Assisted Living Workgroup Members*, available at: http://ahca.myflorida.com/SCHS/ALWG2011/wgmembers.shtml (Last visited on January 16, 2012).
[91] Governor Rick Scott's veto message for HB 4045 (2011) is available at: http://www.flgov.com/wp-content/uploads/2011/06/hb4045.pdf (Last visited on January 17, 2012).

Miami. In addition to public testimony and presentations, the Assisted Living Workgroup discussion focused on assisted living regulation, consumer information and choice, and long term care services and access.[92]

The Assisted Living Workgroup made several recommendations in a final report released in December 2011, stating that it believed the recommendations would strengthen oversight and reassure the public that ALFs are safe places for their residents. The general recommendations of the workgroup are to:

- Increase administrator qualifications.
- Expand and improve training for administrators and other staff.
- Increase survey and inspection activity with a focus on facilities with poor track records.
- Create a systematic appeal process for residents who want to contest a notice of eviction.
- Increase reporting of resident data by facilities.
- Enhance enforcement capacity by state agencies.
- Create of a permanent policy review and oversight council with members representing all stakeholder groups.
- Require all facilities with at least one resident receiving mental health care to be licensed as an LMH facility.
- Provide greater integration of information from all agencies involved in ALF regulation in order to identify potential problems sooner.[93]

The Assisted Living Workgroup also decided that there are additional matters that should be reviewed more in-depth prior to making recommendations and therefore, recommended that a phase II workgroup be appointed by the Governor to review these additional matters at a later date.[94]

Interim Report 2012-128

Professional staff of the Senate Health Regulation Committee recommended in Interim Report 2012-128, Review Regulatory Oversight of Assisted Living Facilities in Florida,[95] a myriad of options for the Legislature to consider to improve the regulatory oversight of ALFs. To better protect residents from abuse, neglect, or otherwise harmful conditions in ALFs in Florida, the report recommends that the Legislature enact legislation to:

- Require ALFs to report occupancy rates and demographic and resident acuity information.
- Require the AHCA to conduct abbreviated inspections and develop targeted and efficient inspection plans.
- Require the AHCA to use lead surveyors to ensure consistent inspections.
- Create a workgroup to assess the AHCA's inspection forms.
- Better fund the AHCA to conduct inspections, whether through fee or fine increases.

[92] Agency For Health Care Administration, Assisted Living Workgroup, *Final Report And Recommendations*, available at: http://ahca.myflorida.com/SCHS/ALWG2011/alwg2011.shtml (Last visited on January 16, 2012).
[93] *Id.*
[94] *Id.*
[95] Florida Senate, Interim Report 2012-128, is available at: http://www.flsenate.gov/PublishedContent/Session/2012/InterimReports/2012-128hr.pdf (Last visited on January 17, 2012).

- Require additional monitoring of LMH facilities, akin to the additional monitoring currently conducted on LNS and ECC facilities.
- Require better oversight of core training providers.
- Expand Florida's core training curriculum and require additional administrator qualifications.
- Require staff to demonstrate, by a short examination, receipt and comprehension of staff training.
- Increase staffing ratios for facilities with specialty licenses.
- Increasing elopement training requirements and require AHCA attendance of elopement drills.
- Require additional administrator qualifications and additional training for all staff of LMH facilities.
- Require a facility with any mental health resident, instead of three mental health residents, to obtain an LMH license.
- Reduce the AHCA's discretion to assess administrative penalties and increase administrative penalties.
- Establish a workgroup to review agency regulatory oversight of ALFs and make recommendations, if any, to streamline the regulatory oversight of ALFs.
- Designate the AHCA as the lead agency to coordinate all complaints related to ALFs.
- Require each agency to establish a direct line of communication to the AHCA to communicate complaints and require the AHCA to maintain a database to track such complaints.
- Require staff of regulatory state or local agencies to immediately report abuse, neglect, or exploitation of a vulnerable adult to the DCF's central abuse hotline.
- Require the AHCA to develop and implement a user-friendly rating system of ALFs for consumers to use.
- Require ALFs to notify residents that any complaint made to an ombudsman, and the identification of the person making the complaint, is confidential.

III. Effect of Proposed Changes:

Section 1 amends s. 394.4574, F.S., to require community living support plans to be updated as needed, not only annually. Case managers are required to maintain a record of the date and time of face-to-face interaction with mental health residents, in order for the DCF to inspect such records for compliance with contractual or other requirements. The records must be retained for 2 years after the date of the last interaction.

This section also requires the DCF to ensure adequate and consistent monitoring and enforcement of community living support plans and cooperative agreements.

Section 2 amends s. 400.0078, F.S., to require a long-term care facility to provide notice to each resident or representative of a resident, upon admission, that the subject matter of a complaint made to the State Long-Term Care Ombudsman Program and the complainant's name and identity are confidential.

Section 3 amends s. 415.1034, F.S., to require an employee or agent of a state or local agency who has regulatory responsibilities over, or who provides services to, persons residing in a state-

licensed facility to report abuse, neglect, or exploitation of vulnerable adults to the DCF central abuse hotline.

Section 4 amends s. 429.02, F.S., to define the term "board" to mean the Board of Nursing Home and Assisted Living Facility Administrators and the term "mental health professional" to mean a person licensed under chapters 458, 459, 464, 490, or 491, related to the practice of medicine, allopathic medicine, nursing, psychological services, and clinical counseling and psychotherapy services, respectively, who provides mental health services, or an individual who has a 4-year baccalaureate degree with a concentration in mental health and at least 5 years of experience providing services that improve an individual's mental health or that treat mental illness.

Section 5 amends s. 429.07, F.S., to conform a cross-reference and increase the standard licensure fee from $300 to $500, increase the bed fee from $50 to $55, and increase the total fee cap from $10,000 to $20,000, for an ALF that has one or more class I or class II violations imposed by final order within the 2 years before licensure renewal. The bill clarifies that the increased fee amounts are in addition to the fee amount as adjusted under the consumer price index in accordance with s. 408.805, F.S. The increased fees are to be imposed for one licensure cycle, unless the facility has a class I or class II violation during the next biennial inspection.

Section 6 amends s. 429.075, F.S., to require an ALF with any mental health residents, rather than three mental health residents, to obtain an LMH license. The eligibility requirements for obtaining an LMH specialty license are strengthened. A successful applicant may not have been administratively sanctioned during the previous 2 years, or since initial licensure, for:

- Two or more class I or class II violations;
- 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 AHCA;
- Three or more class III violations that were not corrected in accordance with an AHCA-approved corrective action plan;
- A violation of resident care standards, which required the ALF to employ certain consultant services;
- Denial, suspension, or revocation of a license for another licensed facility under which the license applicant has at least a 25 percent ownership interest; or
- Imposition of a moratorium or initiation of injunctive proceedings.

This section clarifies that for an ALF to obtain an LMH license, it must ensure that employees meet the LMH training requirements, in addition to any other training or education requirements.

This section also provides that after July 1, 2013, an administrator of a facility that has an LMH license must, in addition to any other educational requirements, have completed at least 6 semester credit hours of college-level coursework relating to mental health.

This section requires a mental health professional to serve as part of the AHCA inspection team that inspects LMH licensees. An LMH licensee must be monitored by a mental health professional quarterly. However, one of the monitoring visits may be in conjunction with a regular survey. A mental health professional may conduct an inspection on his or her own and may report to the AHCA his or her findings. If an ALF has been licensed for at least 2 years and

has had a good performance record, one of the quarterly monitors may be waived by the AHCA, but not before the AHCA has first consulted with the ombudsman council to determine if any complaint has been made and the outcome of such complaint. The AHCA is prohibited from waiving one of the required monitoring visits if an ombudsman referral was made to the AHCA that resulted in a citation of a licensure violation.

Section 7 amends s. 429.14, F.S., to require the AHCA to deny or revoke the license of an ALF that has two or more class I or class II violations that are similar or identical to violations identified by the AHCA within the previous 2 years or if the ALF committed a class I violation or any intentional or negligent act that, based on a court findings, caused the death of a resident.

Section 8 amends s. 429.176, F.S., to provide a cross-reference to part I of ch. 468, F.S., under which the eligibility requirements for an applicant for licensure as an ALF administrator may be found.

This section requires an administrator of an LMH licensee to have completed at least 6 semester credit hours of college-level coursework relating to mental health, in addition to any other education requirements.

A licensed administrator must, to prevent a license from entering into inactive status, take at least 18 hours of continuing education and pass a competency test with a minimum score of 80 every 2 years.

This section provides that a manager of an ALF must meet the core training requirements within 30 days of being employed as, or becoming, a facility manager.

Section 9 amends s. 429.178, F.S., to clarify that all staff members, including administrators, employed by an ALF providing special care to residents with Alzheimer's disease or other related disorders and who provide regular or direct care to such residents, must complete up to 4 hours of initial dementia-specific training within 3 months after beginning employment. This section also reduces the amount of time, from 9 months to 6 months, that a direct caregiver working at such a facility and providing direct care to such residents must complete an additional 4 hours of training.

This section also removes the provision that any of the training related to Alzheimer's disease or related disorders required under this section satisfies the core training requirements for administrators, which relate to Alzheimer's disease or related disorders.

Section 10 amends s. 429.19, F.S., to provide a cross-reference and establish certain penalties for violations. This section requires the AHCA to impose an administrative fine for each class I violation, even if the violation was corrected before the citation has been issued. For a violation that results in the death of a resident, the AHCA must impose the maximum penalty for the class of violation committed. If a second or subsequent violation that is in the same class as a prior violation cited as a result of or since the last inspection is cited, the AHCA must double the fine that was previously assessed against the ALF when assessing a fine for the second or subsequent violation. The AHCA is also required to impose a fine for each class III violation when a facility

has been cited for ten or more of such violations, regardless of whether the violations are corrected.

Section 11 amends s. 429.23, F.S., to require, instead of authorize, a licensed ALF to establish a risk management and quality assurance program.

Section 12 amends s. 429.256, F.S., to conform a cross-reference to other changes made in the bill.

Section 13 amends s. 429.28, F.S., relating to resident bill of rights, to require an ALF to post notice in a prominent place in each facility that the subject matter of a complaint made to the Ombudsman Office or a local long-term care ombudsman council and the names and identities of the residents involved in the complaint and complainants are confidential.

This section also requires, instead of permits, the AHCA to conduct periodic followup inspections to monitor the compliance of facilities having a history of class I violations that threaten the health, safety, or security of residents.

This section requires the AHCA to impose a fine of $2,500, in addition to any other penalty, if the ALF cannot show in a court of law good cause for the termination of a resident when that act is challenged as retaliatory.

Section 14 amends s. 429.34, F.S., to designate the AHCA as the central agency for receiving and tracking complaints to ensure that allegations regarding facilities are timely responded to and that licensure enforcement action is initiated if warranted. State agencies regulating, or providing services to residents of ALFs, must report any substantiated allegations complaints, or allegations or complaints that are likely to have occurred, to the AHCA as soon as reasonably possible.

This section requires the AHCA to have lead surveyors in each field office who specialize in assessing ALFs and requires such surveyors to provide initial and ongoing training to surveyors inspecting and monitoring ALFs to ensure consistent monitoring and inspections of ALFs. In addition, the AHCA must have one statewide lead surveyor who specializes in ALF inspections to coordinate communication between lead surveyors and ensure statewide consistency in applying facility inspection laws and rules.

Section 15 amends s. 429.41, F.S., to require the AHCA to randomly select 10 percent of the ALFs to have an AHCA employee attend and observe a resident elopement drill at each of the selected facilities. The observed elopement drill is to coincide with an inspection or survey conducted by the AHCA. If the AHCA employee observes an elopement drill that does not meet standards established by rule, the AHCA must notify the ALF of the deficiencies within 15 calendar days after the drill and the ALF must submit a corrective action plan to the AHCA within 30 calendar days after receiving such notice.

This section authorizes the DOEA to require additional staffing for facilities that have specialty licenses, but the additional staffing must correlate with the number of residents receiving special care and the type of special care required.

This section requires, rather than authorizes, the AHCA to conduct an abbreviated biennial standard licensure inspection in a facility that has a good record of past performance in order to allocate AHCA resources efficiently.

Section 16 amends s. 429.49, F.S., to increase the criminal penalty from a misdemeanor of the second degree to a misdemeanor of the first degree for any person who fraudulently alters, defaces, or falsifies any medical or other record of an ALF, or causes or procures any such offense to be committed.

Section 17 creates s. 429.515, F.S., to require all employees hired by an ALF after October 1, 2012, to attend a pre-service orientation, which must be at least 2 hours in duration and cover the following topics:

- Care of persons who have Alzheimer's disease or other related disorders.
- De-escalation techniques.
- Aggression control.
- Elopement prevention.
- Behavior management.

Upon completion of the pre-service orientation, the employee must sign an affidavit, under penalty of perjury, stating that the employee completed the orientation. The affidavit must be maintained in the employee's work file.

Section 18 amends s. 429.52, F.S., to require ALF staff members who provide regular or direct care to residents to complete a board-approved training curriculum within 30 days after employment, in addition to pre-service orientation. This requirement does not pertain to administrators. The individual participating in the training, or the participant's employer, is required to pay any cost or fee associated with the training. After completing such training, the staff member must complete an interactive online tutorial to demonstrate an understanding of the training received. Upon completing the tutorial, the staff member will receive a certificate of completion, which must be maintained in the employee's work file.

The staff members who provide regular or direct care to residents must participate in a minimum of 8 hours of continuing education every 2 years. The continuing education may be offered through online courses and the person taking the courses, or such person's employer, is responsible for paying any fee associated with the courses.

Section 19 creates s. 429.521, F.S., to require administrators and staff members who provide regular or direct care to residents of an ECC licensee to complete a minimum of 6 hours of board-approved ECC training within 30 days after beginning employment.

This section also requires administrators employed by an LNS licensee to complete a minimum of 4 hours of board-approved courses that train and educate administrators on the special needs and care of those requiring LNS services. Staff of an LNS licensee, who provide regular and direct care to residents receiving limited nursing services, are required to complete a minimum of 2 hours of such courses. The training must be completed within 30 days after employment.

Staff, including administrators, who prepare or serve food must receive a minimum of 1 hour of in-service training in safe food handling practices within 30 days after beginning employment, which is consistent with current law.

This section clarifies that administrators, as well as staff members, must receive at least 1 hour of in-service training on the ALF's resident elopement response policies and procedures within 30 days after beginning employment. A copy of the ALF's resident elopement policies and procedures must be provided to staff *and* the administrator. Staff *and* administrator, must demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.

This section requires administrators of an LMH licensee and staff members who provide regular or direct care to mental health residents to complete a minimum of 8 hours of board-approved mental health training within 30 days after beginning employment. Within 30 days after completing the LMH training, a staff member must complete an online interactive tutorial to demonstrate an understanding of the training received and pay for any fee associated with the tutorial. An administrator must pass an examination related to the training with a minimum score of 80 and must pay for any fee associated with the examination. A staff member who does not complete the tutorial, or an administrator who fails the examination may not provide regular or direct care to residents until the staff member completes the tutorial or the administrator passes the examination. If the administrator does not pass the examination within 6 months after completing the mental health training, the administrator may not be an administrator of an LMH licensee until the administrator passes the examination.

This section requires administrators, as well as staff members, involved with the management of medications and the assistance with self-administration of medications to complete a minimum of 4 additional hours of training provided by a registered nurse, licensed pharmacist, or DOEA staff member, which is consistent with current law. The Board must establish, by rule, the minimum requirements of this training, including continuing education requirements.

This section authorizes the Board to, by rule, require other facility staff members to participate in training relevant to their job duties.

Section 20 creates s. 429.522, F.S., to require any individual seeking to provide core training in Florida on or after January 1, 2013, to be certified by the Board. The applicant for certification as a core training provider must provide the Board with proof of completion of core training, passage of the ALF administrator licensure examination, and compliance with continuing education requirements. In addition, an applicant for certification must:

- Provide proof of completion of a 4-year baccalaureate degree from an accredited college or university and have worked in a management position in an ALF for 3 years after obtaining certification in core training courses;
- Have worked in a management position in an ALF for 5 years after obtaining certification in the core training courses and have 1 year of teaching experience as an educator or staff trainer for persons who work in an ALF or another long-term care setting;
- Have been previously employed as a trainer of core training courses for the DOEA;
- Have at least 5 years of employment with the AHCA as a surveyor of ALFs;

- Have at least 5 years of employment in a professional position in the AHCA's assisted living unit;
- Have at least 5 years of employment as an educator or staff trainer for persons working in an ALF or another long-term care setting;
- Have at least 5 years of employment as a trainer of core of ALF courses not directly associated with the DOEA;
- Have a 4-year baccalaureate degree from an accredited college or university in the areas of health care, gerontology, social work, education, or human services and at least 4 years of experience as an educator or staff trainer for persons working in an ALF or another long-term care setting after receiving certification in core courses; or
- Meet other qualification criteria as defined by rule of the Board.

The Board is required to oversee core training providers and establish, by rule, requirements for trainer certification and de-certification or other disciplinary actions.

This section requires the Board, if funding is available, to develop by January 1, 2013, an electronic database, which must list all persons holding a certificate as a core training provider and any history of violations. The Board must maintain the database and make the database accessible to the public. Core trainers must also submit to the Board a list of individuals who have completed training within 24 hours after the training has been completed in order for such information to be included in the database.

Section 21 creates s. 429.523, F.S., to authorize training and testing required under part I, ch. 429, F.S., to be provided by board-approved training and testing centers. The Board, when reviewing an applicant, must consider whether the center will provide sufficient space for training, the location of the center and whether another center already provides training or testing services in the approximate area, the fee to be charged by the center for providing such services, whether the center has sufficient and qualified staff to provide such services, and any other consideration the Board deems necessary to approve a center.

The Board is required to provide a certificate of approval to an approved center and the center must keep the certificate on file as long as it provides training or examination services.

The Board is authorized to inspect training and testing centers to determine whether the centers meet law and rule requirements. The Board may de-certify a center that does not continue to meet such requirements.

The trainer employed by the center must keep a record of attendees and report such information to the Board.

Section 22 amends s. 429.54, F.S., to require the AHCA, the DOEA, the DCF, and the APD, if funds are available, to develop or modify electronic systems of communication among state-supported automated systems to ensure that relevant information pertaining to the regulation of ALFs and ALF staff is timely and effectively communicated among agencies in order to facilitate the protection of residents.

This section also requires ALFs to submit semiannually, electronic reports to the AHCA, which must include:

- The number of beds in the facility;
- The number of beds being occupied;
- The number of residents who are younger than 65 years of age, are 65 to 74 years of age, are 75 to 84 years of age, and are 85 years of age or older;
- The number of residents who are mental health residents, who are receiving extended congregate care, who are receiving limited nursing services, and who are receiving hospice care;
- If there is a facility waiting list, the number of individuals on the waiting list and the type of services or care that they require, if known;
- The number of residents receiving OSS; and
- The number of residents who are Medicaid recipients and the type of waiver used to fund each such resident's care.

The report must be submitted in accordance with a reporting cycle established by AHCA rule.

The AHCA is required to maintain the reported information in electronic format and must use the reported information to track trends in ALF resident populations and needs.

The ALF reporting requirement is scheduled to expire on July 1, 2017, which will allow the Legislature to review whether the reporting requirement is overly burdensome to ALFs and whether the reported information is beneficial to the AHCA and the Legislature to track trends relating to ALF residents.

Section 23 creates s. 429.56, F.S., to require the AHCA, in consultation with the DOEA, the DCF, and the Ombudsman Office, to develop and adopt by rule a user-friendly ALF rating system. The rating system must be publicly available on the Internet and must be based on resident satisfaction, the number and class of deficiencies for which the facility has been cited, AHCA inspection reports, inspection reports of any other regulatory agency, assessments conducted by the ombudsman program, and other criteria as determined by the AHCA. The Internet home page for the rating system must include a link that allows consumers to complete a voluntary survey that provides feedback on whether the rating system is helpful and suggestions for improvement.

This section also gives the AHCA rulemaking authority to implement the rating system.

Section 24 requests the Division of Statutory Revision to rename part II of ch. 468, F.S., as "Nursing Home and Assisted Living Facility Administration," instead of "Nursing Home Administration."

Section 25 amends s. 468.1635, F.S., to include in the purpose of the chapter that it is the purpose to ensure that every assisted living facility administrator meets minimum requirements for safe practice.

Section 26 amends s. 468.1645, F.S., to require ALFs to operate under the management of an ALF administrator, effective July 1, 2013.

Section 27 amends s. 468.1655, F.S., to add the definitions of the terms "assisted living facility," "assisted living facility administrator," "assisted living facility administrator certification," and "practice of assisted living facility administration." The definition of the term "board" is amended to rename the Board of Nursing Home Administrators the "Board of Nursing Home and Assisted Living Facility Administrators."

Section 28 amends s. 468.1665, F.S., to create the Board, which is to consist of eleven members, three of which are licensed ALF administrators. One of the layperson members of the Board must be a resident of an ALF.

This section prohibits a person from being appointed to the Board if a conflict of interest exists, except a nursing home or ALF administrator who is appointed may retain a financial interest in the institution or facility that he or she administers at the time of appointment.

Section 29 amends s. 468.1685, F.S., to provide that it is the function and duty of the Board to develop, impose, and enforce specific standards to be met by individuals in order to be licensed as an ALF administrator.

This section requires the Board to approve one or more third-party credentialing entities for the purpose of developing and administering ALF administrator certification programs. A third-party credentialing entity must be a nonprofit organization that has met nationally recognized standards for developing and administering professional certification programs. In order to obtain board-approval, a third-party credentialing entity must:

- Establish professional requirements and standards that applicants must achieve in order to obtain an ALF administrator certification and to maintain such certification. At a minimum, these requirements and standards must include completion of the requirements for ALF administrators required in this part and in rules adopted by the board, including all education and continuing education requirements;
- Develop and apply core competencies and examination instruments according to nationally recognized certification and psychometric standards, and agree to assist the board with developing the training and testing materials;
- Maintain a professional code of ethics and a disciplinary process that applies to all persons holding certification as ALF administrator;
- Maintain an internet based database, accessible to the public, of all persons holding an ALF administrator certification, including any history of ethical violations; and
- Require continuing education and, at least, biennial certification renewal for persons holding an ALF administrator certification.

The Board must, in consultation with the AHCA, DOEA, and DCF, develop a core training curriculum, to be completed by an applicant for administrator licensure, which must consist of at least 40 hours of training, be offered in English and Spanish, be reviewed at least annually by the Board, and be updated as needed to reflect changes in the law, rules, and best practices. The curriculum must, at a minimum, cover state law and rules relating to ALFs; resident rights and the identification and reporting of abuse, neglect, and exploitation; special needs of elderly

persons, persons who have mental illness, and persons who have developmental disabilities and how to meet those needs; nutrition and food service; medication management, recordkeeping, and proper techniques for assisting residents who self-administer medication; firesafety requirements; care of persons who have Alzheimer's disease and related disorders; elopement prevention; aggression and behavior management, de-escalation techniques, and proper protocols and procedures relating to the Baker Act; do-not-resuscitate orders; infection control; admission and continued residency; phases of care and interacting with residents; best practices in the industry; and business operations, including, but not limited to, human resources, financial management, and supervision of staff.

The Board must develop an ALF administrator licensure examination in consultation with the AHCA, the DOEA, and the DCF. The examination must be offered in English and Spanish and must be updated as needed, but no less than annually. A minimum score of 80 percent is required to demonstrate successful completion of the training requirements.

The Board must, in consultation with the AHCA, the DOEA, and the DCF, develop a continuing education curriculum for ALF administrators. The Board must require additional credit hours for administrators who are employed by ECC, LNS, or LMH licensees. The Board must also develop a short test for administrators to take upon completing each continuing education course. The Board must review the continuing education curriculum and test at least annually, and update the curriculum and examinations as needed to reflect changes in the law, rules, and best practices. Continuing education must include topics similar to those of the core training and may include additional subject matter that enhances the knowledge, skills, and abilities of administrators and staff members, as adopted by rule.

The Board must also develop a LMH curriculum and examination in consultation with a panel of limited mental health professionals, which must be completed by an ALF administrator within 30 days after being employed by a LMH licensee. The examination must be available online, must be offered in English and Spanish, and must be updated as needed, but at least annually.

The Board must develop, in consultation with stakeholders, a standardized staff training curriculum for staff members of an ALF, other than an administrator, who provide regular or direct care to residents. Only staff members hired on or after July 1, 2012, are subject to this training requirement. The curriculum must include at least 20 hours of in-service training, with at least 1 hour of training per topic, covering, at a minimum, reporting major incidents; reporting adverse incidents; facility emergency procedures; resident rights in an ALF; recognizing and reporting resident abuse, neglect, and exploitation; resident behavior and needs; providing assistance with the activities of daily living; infection control; and aggression and behavior management and de-escalation techniques. The Board is to develop an online interactive tutorial, which staff is to complete after taking the required 20 hours of in-service training. The tutorial must be offered in English and Spanish and must be updated as needed, but at least annually. The Board is to issue a certificate of completion after the tutorial has been completed.

The Board must develop, in consultation with a panel of at least three mental health professionals, a limited mental health curriculum and an interactive online tutorial, which must be completed by facility staff members who provide regular or direct care to ALF mental health residents. The tutorial must be based on LMH training. The Board must offer the tutorial in

English and Spanish and update the tutorial as needed, but at least annually. The Board shall provide a certificate to each staff member who completes the tutorial.

The Board is to require and provide, or cause to be provided, the training or education of staff members of a facility beyond that which is required under part I of ch. 429, F.S., if the Board or the AHCA determines that there are problems in a facility which could be reduced through specific staff training or education.

The Board is also authorized to certify assisted living training providers who meet the required qualifications for certification and approve testing and training centers.

Section 30 amends s. 468.1695, F.S., to establish the criteria for ALF administrator licensure by certification. An applicant must apply to the DOH, remit a fee set by the Board not to exceed $500, and provide proof of a current and valid ALF administrator certification.

This section requires a board-approved third-party credentialing entity to certify an individual who:

- Is at least 21 years old;
- Holds a 4-year baccalaureate degree that includes some coursework in health care, gerontology, or geriatrics; a 4-year baccalaureate degree with at least 2 years of experience in direct patient care in an ALF or nursing home; or a 2-year associate degree that includes coursework in health care, gerontology, or geriatrics and at least 2 years of experience in direct patient care in an ALF or nursing home;
- Has completed at least 40 hours of core training;
- Has passed an examination that documents core competencies in the training required for ALF administrators prior to licensure with a minimum score of 80 percent;
- Has completed background screening; and
- Otherwise meets any other requirements under part I of ch. 468, F.S., or part I of ch. 429, F.S.

This section also exempts existing ALF administrators and nursing home administrators, who have been continuously employed as an ALF administrator or nursing home administrator for at least the 2 years before July 1, 2012, from the education requirements for licensure and the licensure examination. However, an applicant must provide the Board with proof of compliance with continuing education requirements, the administrator must not have been an administrator of a nursing home or facility that was cited for a class I or class II violation within the prior 2 years, and the administrator is still required to complete core training. This section also authorizes the Board, by rule, to exempt other licensed professionals from some or all of the core training requirements.

This section provides that a licensed ALF administrator applying for licensure renewal must submit an application, remit any applicable fees, and demonstrate that he or she has maintained his or her ALF administrator certification that substantiates the individual has completed all continuing education and other requirements to obtain licensure renewal.

Section 31 amends s. 468.1705, F.S., to make a technical conforming correction.

Section 32 amends s. 468.1725, F.S., to provide that a nursing home or ALF administrator may apply for inactive licensure status or a license may become inactive if an administrator does not complete continuing education courses on time or the administrator does not pay licensure renewal fees on time. A license may only be reactivated by the Board if renewal fees or delinquent fees and a reactivation fee are paid. The Board is given rulemaking authority relating to the inactive status and the reactivation of licenses and any related fees.

Section 33 amends s. 468.1735, F.S., to authorize the Board to develop rules relating to, and to issue, ALF administrator provisional licenses. Provisional licenses may be issued only to fill a position of an ALF administrator which unexpectedly becomes vacant and may only be issued for a single period not to exceed 6 months. The provisional license is to be issued to the person who is designated as the responsible person next in command in the event of the administrator's departure. The Board is prohibited from issuing a provisional license if the applicant is under investigation for, or has committed certain acts. The Board is authorized to set an application fee for a provisional license not to exceed $500.

Section 34 amends s. 468.1745, F.S., to provide that it is a misdemeanor of the second degree if a person commits any of the following:

- Practices ALF administration with a revoked, suspended, inactive, or delinquent license.
- Uses the name or title "assisted living facility administrator" if the person has not been licensed as such.
- Presents as his or her own the license of another.
- Gives false or forged evidence to the Board or a member thereof for the purpose of obtaining a license.
- Uses or attempts to use an administrator's license that has been suspended or revoked.
- Knowingly employing unlicensed persons in the practice of ALF administration.
- Knowingly conceals information relative to violations of part I, ch. 468, F.S.

Section 35 amends s. 468.1755, F.S., to provide the Board with disciplinary authority over ALF administrators, authorizing the Board to deny licensure or license renewal or suspend or revoke the license of an administrator who is under investigation for, or who has committed any of the following:

- Attempting to procure a license to practice ALF administration by bribery, fraudulent misrepresentation, or through an error of the AHCA or the Board.
- Having a license to practice ALF administration revoked, suspended, or otherwise acted against, including the denial of licensure by the licensing authority of another state, territory, or country.
- Being convicted or found guilty of, or entered a plea of nolo contendre, regardless of adjudication, to a crime in any jurisdiction which relates to the practice of ALF administration.
- Making or filing a report or record that the licensee knows to be false, intentionally failing to file a report or record required by state or federal law, willfully impeding or obstructing such filing, or inducing another person to impede or obstruct such filing. Such reports or records include only those which are signed in the capacity of a licensed ALF administrator.
- Advertising goods or services in a manner that is fraudulent, false, deceptive, or misleading in form or content.

- Committing fraud or deceit or exhibiting negligence, incompetence, or misconduct in the practice of ALF administration.
- Violating a lawful order of the Board or AHCA previously entered in a disciplinary hearing or failing to comply with a lawfully issued subpoena of the Board or AHCA.
- Repeatedly acting in a manner that is inconsistent with the health, safety, or welfare of the residents of the facility in which he or she is the administrator.
- Being unable to practice ALF administration with reasonable skill and safety to residents by reason of illness, drunkenness, use of drugs, narcotics, chemicals, or any other material or substance or as a result of any mental or physical condition.
- Paying, giving, causing to be paid or given, or offering to pay or to give to any person a commission or other valuable consideration for the solicitation or procurement, directly or indirectly, of ALF usage.
- Willfully permitting unauthorized disclosure of information relating to a resident or his or her records.
- Discriminating with respect to residents, employees, or staff members on account of race, religion, sex, or national origin.
- Violating any provision of part I of ch. 429, F.S., part II of ch. 408, F.S., or rules adopted pursuant to part I of ch. 429, F.S.

The Board is required to revoke the license of an administrator who knowingly participates in intentional misconduct, or engages in conduct that constitutes gross negligence, and contributes to the death of a resident.

Section 36 amends s. 468.1756, F.S., to make a technical change to conform a cross-reference to changes made in the bill.

Section 37 creates an undesignated section of law to require the AHCA to create a task force consisting of at least one representative from the AHCA, the DOEA, the DCF, the DOH, and the Ombudsman Office, for the purpose of determining whether agencies have overlapping regulatory responsibilities over ALFs. The task force is required to meet at least 3 times and must submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives, by January 1, 2013. The report must include the task force's findings and recommendations pertaining to streamlining agency oversight of ALFs and improving the effectiveness of regulatory functions.

The task force is scheduled to be terminated as of March 1, 2013.

Section 38 creates an undesignated section of law to require the AHCA, by January 1, 2013, to submit copies of all of its inspection forms used to inspect ALFs to the Ombudsman Office. The Ombudsman Office is required to create and act as the chair of a task force of up to 11 members, consisting of an ombudsman, one representative of a nonprofit ALF, one representative of a for-profit ALF, at least one ALF resident or family member of a resident, other stakeholders, and one representative from each of the following:

- The AHCA.
- The DOEA.
- The DCF.

- The DOH.

The task force is required to provide recommendations, if any, to modify the inspection forms to ensure the inspections adequately assess whether the ALFs are in compliance with the law, meet the needs of residents, and ensure resident safety. The task force must provide its recommendations, and explanations of any recommendations, to the AHCA within 90 days after receiving the inspection forms.

The task force is scheduled to terminate on July 1, 2013.

Section 39 creates an undesignated section of law to ensure that licensure fees, which are currently adjusted to the consumer price index, are not reset by any changes made to such fees in the bill.

Section 40 provides an effective date of July 1, 2012.

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 this 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:

The bill increases the standard ALF license fee from $300 to $500, when an ALF has one or more class I or class II violations imposed by final order by AHCA within the two years prior to licensure renewal. Additionally, the per-bed fee is increased from $50 to $55, and the total licensure fee is capped at $20,000, instead of the current $10,000 fee cap. These fees are in addition to the licensure and per resident fees already adjusted to the consumer price index pursuant to s. 408.805, F.S., and are imposed for one licensure cycle.

The bill establishes ALF administrator licensure fees up to $500 for initial licensure. The bill also requires participants, or their employers, to pay for any training fees or fees required to take a tutorial or examination.

The bill provides that an administrator must pay a fee when applying for inactive status of his or her license and that an administrator with a license in inactive status must pay a reactivation fee in addition to any delinquency fee.

The bill authorizes the Board to establish an application fee not to exceed to $500 for a provisional license for an ALF administrator.

B. Private Sector Impact:

ALFs that are cited for certain types of violations would be subject to increased fines and fees. An ALF that commits a retaliatory act against a resident without showing good cause in court would be subject to a fine of $2,500.

Those who are required to complete certain training requirements under the bill are responsible for the cost of such training, or the training costs may be incurred by the employer of such person.

C. Government Sector Impact:

The AHCA and DOH, including the Board under the DOH, would incur an indeterminate amount of costs associated with the additional rulemaking and oversight responsibilities provided for in the bill. The AHCA's costs should be somewhat offset by the increased fine and fee amounts provided for in the bill.

A fiscal analysis on this CS has not yet been conducted by the AHCA or DOH.

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 January 31, 2012:

- Authorizes the Board to approve one or more third-party credentialing entities to award certificates to applicants for ALF administrator licensure if they meet specified eligibility criteria.
- Specifies that the third-party credentialing entity must be a nonprofit organization and must have met nationally recognized standards for developing and administering professional certification programs.

- Authorizes the Board to issue administrator licenses to those who hold such a certificate, apply for licensure, and remit the applicable licensure fees.
- Revises the effective date of the provision requiring new ALF staff to take pre-service orientation, to allow ALFs sufficient time to develop the pre-service orientation.
- Revises the effective date of the provision requiring an ALF administrator of a limited mental health licensee to meet a specified education requirement, to give the administrator time to enroll and complete the requirement.
- Specifies that increased licensure and bed fees are only increased if class I and class II violations have been imposed by the AHCA by final order.

B. Amendments:

None.

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 Health Regulation Committee

BILL: PCS/SB 2074 (368338)

INTRODUCER: Health Regulation Committee

SUBJECT: Assisted Living Facilities

DATE: January 30, 2012 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	O'Callaghan	Stovall	HR	**Pre-meeting**
2.				
3.				
4.				
5.				
6.				

I. Summary:

The bill increases regulation pertaining to assisted living facilities (ALFs) in order to improve the safety of persons living in ALFs.

This bill revises part I of ch. 429, F.S., relating to ALFs, to:

- Require an ALF to obtain a limited mental health license if any mental health resident resides in the facility.
- Revise the eligibility requirements for licensure of a facility seeking to be a limited mental health licensee.
- Require ALFs to provide notice to residents of the confidential nature of complaints to the Office of State Long-Term Care Ombudsman (Ombudsman Office).
- Require state and local agency employees to report abuse, neglect, and exploitation of residents to the Department of Children and Families (DCF) central abuse hotline.
- Increase certain facility licensure fees for ALFs with a history of certain violations.
- Increase certain administrative and criminal penalties and reduce the Agency for Health Care Administration's (AHCA) discretion to impose certain penalties.
- Require all ALF staff to complete at least 2 hours of pre-service orientation.
- Designate the AHCA as the central agency for receiving and tracking complaints against ALFs.
- Require agencies, if funding is available, to develop or modify electronic systems to ensure the transfer of information between agencies pertaining to ALFs.
- Create a task force to look at streamlining agency regulatory oversight of ALFs.
- Revise the AHCA's inspection authority and requirements, such as requiring the AHCA to monitor a certain number of ALF elopement drills.

- Require the AHCA to have lead surveyors in each field office, who specialize in assessing ALFs, to train other surveyors of ALFs and facilitate consistent inspections.
- Create a task force to review the AHCA inspection forms to ensure ALFs are being assessed appropriately for resident needs and safety.
- Authorize the Department of Elderly Affairs (DOEA) to require additional staffing in ALFs, depending on the number of residents receiving special care and the type of special care being provided.
- Require ALFs to semiannually report to the AHCA information relating to occupancy rates and residents' acuity and demographics in order for the AHCA to track the information.
- Require the AHCA to develop a user-friendly rating system of ALFs.

This bill renames part I, ch. 468 of the Florida Statutes, as "Nursing Home and Assisted Living Facility Administration." In addition, the board created under that part is renamed as the "Board of Nursing Home and Assisted Living Facility Administrators." The board's responsibilities are expanded to include:

- Issuing licenses to ALF administrators who meet delineated eligibility requirements, including age, education, training, and examination requirements;
- Disciplining ALF administrators for certain violations;
- Developing training curricula for ALF staff;
- Approving and certifying training and testing centers;
- Certifying and disciplining core training providers; and
- If funding is available, developing and maintaining a database of core training providers and attendees of core training.

The bill also requires an ALF to operate under the management of a licensed administrator.

Additional provisions affecting other chapters of law require:

- Community living support plans to be updated more frequently.
- Case managers to record interaction with residents.
- Consistent and adequate monitoring of community living support plans and cooperative agreements by the DOEA.

This bill substantially amends the following sections of the Florida Statutes: 394.4574, 400.0078, 415.1034, 429.02, 429.07, 429.075, 429.14, 429.176, 429.178, 429.19, 429.23, 429.256, 429.28, 429.34, 429.41, 429.49, 429.52, 429.54, 468.1635, 468.1645, 468.1655, 468.1665, 468.1685, 468.1695, 468.1705, 468.1725, 468.1735, 468.1745, 468.1755, 468.1756, .

This bill creates the following sections of the Florida Statutes: 429.515, 429.521, 429.522, 429.523, 429.55, and 429.56.

This bill also creates four undesignated sections of the Florida Statutes.

II. Present Situation:

Assisted Living Facilities

An ALF is a residential establishment, or part of a residential establishment, that provides housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.[1, 2] A personal service is direct physical assistance with, or supervision of, the activities of daily living and the self-administration of medication.[3] Activities of daily living include: ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks.[4]

Assisted living facilities are licensed by the AHCA, pursuant to part I of ch. 429, F.S., relating to ALFs, and part II of ch. 408, F.S., relating to the general licensing provisions for health care facilities. Assisted living facilities are also subject to regulation under Chapter 58A-5, Florida Administrative Code (F.A.C.). These rules are adopted by the DOEA in consultation with the AHCA, the DCF, and the Department of Health (DOH).[5] An ALF must also comply with the Uniform Fire Safety Standards for ALFs contained in Chapter 69A-40, F.A.C., and standards enforced by the DOH concerning food hygiene; physical plant sanitation; biomedical waste; and well, pool, or septic systems.[6]

As of December 1, 2011, there were 2,985 licensed ALFs in Florida.[7] In addition to a standard license, an ALF may have specialty licenses that authorize the ALF to provide limited nursing services (LNS),[8] limited mental health (LMH) services,[9] and extended congregate care (ECC) services.[10] Out of the 2,985 licensed ALFs, 1,083 have LNS licenses, 1,108 have LMH licenses, and 267 have ECC licenses.[11]

[1] Section 429.02(5), F.S.
[2] An ALF does not include an adult family-care home or a non-transient public lodging establishment. An adult family-care home is regulated under ss. 429.60–429.87, F.S., and is defined as a full-time, family-type living arrangement, in a private home where the person who owns or rents the home provides room, board, and personal care, on a 24-hour basis, for no more than five disabled adults or frail elders who are not relatives. A non-transient establishment (a.k.a. boarding house) is regulated under part I of ch. 509, F.S., and is defined as any public lodging establishment that is rented or leased to guests by an operator whose intention is that the dwelling unit occupied will be the sole residence of the guest.
[3] Section 429.02(16), F.S.
[4] Section 429.02(1), F.S.
[5] Section 429.41(1), F.S.
[6] *See* chs. 64E-12, 64E-11, and 64E-16, F.A.C.
[7] Agency for Health Care Administration, *Assisted Living Directory*, available at: http://ahca.myflorida.com/MCHQ/Long_Term_Care/Assisted_living/pdf/Directory_ALF.pdf (Last visited on January 16, 2012).
[8] Section 429.07(3)(c), F.S.
[9] An ALF that serves three or more mental health residents must obtain a limited mental health specialty license. A mental health resident is an individual who receives social security disability income (SSDI) due to a mental disorder or supplemental security income (SSI) due to a mental disorder, and receives optional state supplementation (OSS). *See* ss. 429.075 and 429.02(15), F.S.
[10] Section 429.07(3)(b), F.S.
[11] Agency for Health Care Administration, *Directories*, available at: http://ahca.myflorida.com/MCHQ/Long_Term_Care/Assisted_living/alf.shtml (Last visited on January 16, 2012).

An ALF is required to provide care and services appropriate to the needs of the residents accepted for admission to the facility. Generally, the care and services include at a minimum:[12]

- Supervising the resident in order to monitor the resident's diet; being aware of the general health, safety, and physical and emotional well-being of the resident; and recording significant changes, illnesses, incidents, and other changes which resulted in the provision of additional services;
- Contacting appropriate persons upon a significant change in the resident or if the resident is discharged or moves out;
- Providing and coordinating social and leisure activities in keeping with each resident's needs, abilities, and interests;
- Arranging for health care by assisting in making appointments, reminding residents about scheduled appointments, and providing or arranging for transportation as needed; and
- Providing to the resident a copy of, and adhering to, the Resident Bill of Rights.

The owner or facility administrator determines whether an individual is appropriate for admission to the facility based on an assessment of the strengths, needs, and preferences of the individual; the health assessment; the preliminary service plan; the facility's residency criteria; services offered or arranged for by the facility to meet resident needs; and the ability of the facility to meet the uniform fire-safety standards.[13] A resident who requires 24-hour nursing supervision[14] may not reside in an ALF, unless the resident is enrolled as a hospice patient.[15]

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.[16]

Limited Nursing Services Specialty License
An LNS specialty license enables an ALF to provide, directly or through contract, a select number of nursing services in addition to the personal services that are authorized under the standard license.

The nursing services authorized to be provided with this license are limited to acts specified in administrative rules, may only be provided as authorized by a health care provider's order, and must be conducted and supervised in accordance with ch. 464, F.S., relating to nursing, and the prevailing standard of practice in the nursing community. A nursing assessment, that describes the type, amount, duration, scope, and outcomes or services that are rendered and the general

[12] Rule 58A-5.0182, F.A.C.
[13] Section 429.26, F.S., and Rule 58A-5.030, F.A.C.
[14] "Twenty-four-hour nursing supervision" means services that are ordered by a physician for a resident whose condition requires the supervision of a physician and continued monitoring of vital signs and physical status. Such services must be: medically complex enough to require constant supervision, assessment, planning, or intervention by a nurse; required to be performed by or under the direct supervision of licensed nursing personnel or other professional personnel for safe and effective performance; required on a daily basis; and consistent with the nature and severity of the resident's condition or disease state or stage. Definition found at s. 429.02(26), F.S.
[15] Continued residency of a hospice patient is conditioned upon a mutual agreement between the resident and the facility, additional care being rendered through a licensed hospice, and the resident being under the care of a physician who agrees that the physical needs of the resident are being met. Section 429.26, F.S.
[16] Section 429.28, F.S.

status of the resident's health, is required to be conducted at least monthly on each resident who receives a limited nursing service.[17]

Extended Congregate Care Specialty License

An ECC specialty license enables an ALF to provide, directly or through contract, services performed by licensed nurses and supportive services[18] to persons who otherwise would be disqualified from continued residence in an ALF.[19]

The primary purpose of ECC services is to allow residents, as they become more impaired with physical or mental limitations, 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 nursing supervision.[20]

Facilities holding an ECC license must:

- Ensure that the administrator of the facility and the ECC supervisor, if separate from the administrator, has 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 or agency serving elderly or disabled persons. A baccalaureate degree may be substituted for 1 year of the required experience and a nursing home administrator is considered to be qualified for the position.
- Provide enough qualified staff to meet the needs of ECC residents considering the amount and type of services established in each resident's service plan.
- Immediately provide additional or more qualified staff, when the AHCA determines that service plans are not being followed or that residents' needs are not being met because of the lack of sufficient or adequately trained staff.
- Ensure and document that staff receive required ECC training.

Limited Mental Health Specialty License

An ALF that serves three or more mental health residents must obtain an LMH specialty license.[21] A mental health resident is an individual who receives social security disability income (SSDI) due to a mental disorder or supplemental security income (SSI) due to a mental disorder, and receives optional state supplementation (OSS).[22,23] The DCF is responsible for ensuring that

[17] Section 429.26, F.S., and Rule 58A-5.031(3)(c), F.A.C.
[18] Supportive services include social service needs, counseling, emotional support, networking, assistance with securing social and leisure services, shopping service, escort service, companionship, family support, information and referral, assistance in developing and implementing self-directed activities, and volunteer services. *See* Rule 58A-5.030(8)(a), F.A.C.
[19] An ECC program may provide additional services, such as: total help with bathing, dressing, grooming, and toileting; nursing assessments conducted more frequently than monthly; measuring and recoding basic vital functions and weight; dietary management; assisting with self-administered medications or administering medications and treatments pursuant to a health care provider's order; supervising residents with dementia and cognitive impairments; health education, counseling, and implementing health-promoting programs; rehabilitative services; and escort services related to health-related appointments. Section 429.07(3)(b), F.S., and Rule 58A-5.030, F.A.C.
[20] Section 429.07(3)(b), F.S.
[21] Section 429.075, F.S.
[22] Section 429.02(15), F.S.

a mental health resident is assessed and determined able to live in the community in an ALF with an LMH license.[24]

An ALF licensed to provide LMH services must assist the mental health resident in carrying out the activities in the resident's community living support plan. The mental health resident's community living support plan, which is updated annually, includes:[25]

- The specific needs of the resident which must be met for the resident to live in the ALF and community;
- The clinical mental health services to be provided by the mental health care provider to help meet the resident's needs, and the frequency and duration of such services;
- Any other services and activities to be provided by or arranged for by the mental health care provider or mental health case manager to meet the resident's needs, and the frequency and duration of such services and activities;
- Obligations of the ALF to facilitate and assist the resident in attending appointments and arranging transportation to appointments for the services and activities identified in the plan;
- A description of other services to be provided or arranged by the ALF; and
- A list of factors pertinent to the care, safety, and welfare of the mental health resident and a description of the signs and symptoms particular to the resident that indicates the immediate need for professional mental health services.

The LMH licensee must execute a cooperative agreement between the ALF and the mental health care services provider. The cooperative agreement specifies, among other things, directions for the ALF accessing emergency and after-hours care for the mental health resident.

Additionally, according to Rule 58A-5.029, F.A.C., facilities holding an LMH license must:

- Provide an opportunity for private face-to-face contact between the mental health resident and the resident's mental health case manager or other treatment personnel of the resident's mental health care provider.
- Observe resident behavior and functioning in the facility, and record and communicate observations to the resident's mental health case manager or mental health care provider regarding any significant behavioral or situational changes which may signify the need for a change in the resident's professional mental health services, supports and services described in the community living support plan, or that the resident is no longer appropriate for residency in the facility.
- Ensure that designated staff have completed the required LMH training.
- Maintain facility, staff, and resident records in accordance with the requirements of the law.

[23] Optional State Supplementation is a cash assistance program. Its purpose is to supplement a person's income to help pay for costs in an assisted living facility, mental health residential treatment facility, or adult family care home, but it is not a Medicaid program. Department of Elder Affairs, *Florida Affordable Assisted Living: Optional State Supplementation (OSS)*, available at: http://elderaffairs.state.fl.us/faal/operator/statesupp.html (Last visited on January 17, 2012).
[24] Section 394.4574, F.S., requires a mental health resident to be assessed by a psychiatrist, clinical psychologist, clinical social worker, psychiatric nurse, or an individual who is supervised by one of these professionals to determine whether it is appropriate for the person to reside in an ALF.
[25] Rule 58A-5.029(2)(c)3., F.A.C.

ALF Staffing Requirements

Every ALF must be under the supervision of an administrator, who is responsible for the operation and maintenance of the facility, including the management of all staff and the provision of adequate care to all residents.

Rule 58A-5.019(4), F.A.C., provides the minimum staffing requirements for ALFs. An ALF may be required by the AHCA to immediately increase staff above the minimum staffing levels if the AHCA determines that adequate supervision and care are not being provided to residents, resident care standards are not being met, or that the facility is failing to meet the terms of residents' contracts. When additional staff is required above the minimum, the AHCA requires the submission of a corrective action plan indicating how the increased staffing is to be achieved and resident service needs will be met.[26]

Resident Elopement

All facilities must assess residents at risk for elopement or must identify those residents having any history of elopement in order for staff to be alerted to their needs for support and supervision. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at-risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number.[27]

The facility is required to develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must include:

- An immediate staff search of the facility and premises;
- The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities;
- The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to an immediate search of the facility and premises; and
- The continued care of all residents within the facility in the event of an elopement.[28]

Use of Restraints

Florida law limits the use of restraints on residents of ALFs. The use of physical restraints[29] is limited to half-bed rails as prescribed and documented by the resident's physician with the consent of the resident or, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact. The physician is to review the order for physical restraints biannually.[30] The use of chemical restraints[31] is limited to prescribed dosages of

[26] Rule 58A-5.019(4), F.A.C.
[27] Rule 58A-5.0182(8), F.A.C.
[28] *Id.*
[29] "Physical restraint" means a device which physically limits, restricts, or deprives an individual of movement or mobility, including, but not limited to, a half-bed rail, a full-bed rail, a geriatric chair, and a posey restraint. The term "physical restraint" shall also include any device which was not specifically manufactured as a restraint but which has been altered, arranged, or otherwise used for this purpose. The term shall not include bandage material used for the purpose of binding a wound or injury. Section 429.02(17), F.S.
[30] Rule 58A-5.0182(6)(h), F.S.
[31] "Chemical restraint" means a pharmacologic drug that physically limits, restricts, or deprives an individual of movement or mobility, and is used for discipline or convenience and not required for the treatment of medical symptoms. Section 429.02(6), F.S.

medications authorized by the resident's physician and must be consistent with the resident's diagnosis. Residents who are receiving medications that can serve as chemical restraints must be evaluated by their physician at least annually to assess the continued need for the medication, the level of the medication in the resident's blood, and the need for adjustments in the prescription.

ALF Staff Training

Administrators and other ALF staff[32] must meet minimum training and education requirements established by the DOEA by rule.[33] This training and education is intended to assist facilities appropriately respond to the needs of residents, maintain resident care and facility standards, and meet licensure requirements.[34]

The ALF core training requirements established by the DOEA consist of a minimum of 26 hours of training and a competency test. Administrators and managers are required to successfully complete the ALF core training requirements within 3 months from the date of becoming a facility administrator or manager. Successful completion of the core training requirements includes passing the competency test.[35] The minimum passing score for the competency test is 75 percent.[36]

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, is considered a new administrator or manager for the purposes of the core training requirements. He or she must retake the ALF core training and retake and pass the competency test.[37]

Facility administrators or managers are required to provide or arrange for the following in-service training to facility staff:

- Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides must receive a minimum of 1-hour in-service training in infection control, including universal precautions, and facility sanitation procedures before providing personal care to residents.[38]
- Staff who provide direct care to residents must receive a minimum of 1-hour in-service training within 30 days of employment that covers the reporting of major incidents, reporting

[32] An ALF administrator must be at least 21 years of age and have a high school diploma or general equivalency diploma (G.E.D.) An administrator must be in compliance with level 2 background screening standards and complete a core training requirement. Section 429.174, F.S., and Rule 58A-5.019, F.A.C. In addition, all staff, who are employed by or contracted with the ALF to provide personal services to residents, must receive a level 2 background screening. Section 408.809(1)(e), F.S. and s. 429.174, F.S.
[33] Rule 58A-5.0191, F.A.C.
[34] Section 429.52(1), F.S.
[35] Rule 58A-5.0191, F.A.C.
[36] 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.
[37] Rule 58A-5.0191, F.A.C.
[38] Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to blood borne pathogens, may be used to meet this requirement. Rule 58A-5.0191(2)(a), F.A.C.

of adverse incidents, and facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.

- Staff who provide direct care to residents, who have not taken the core training program, must receive a minimum of 1-hour in-service training within 30 days of employment that covers resident rights in an ALF and recognizing and reporting resident abuse, neglect, and exploitation.
- Staff who provide direct care to residents, other than nurses, CNAs, or home health aides must receive 3 hours of in-service training within 30 days of employment that covers resident behavior and needs and providing assistance with the activities of daily living.
- Staff who prepare or serve food and who have not taken the ALF core training, must receive a minimum of 1-hour in-service training within 30 days of employment in safe food handling practices.

All facility staff are required to receive in-service training regarding the facility's resident elopement response policies and procedures within 30 days of employment, must be provided with a copy of the facility's resident elopement response policies and procedures, and must demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.[39]

Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills, which must include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the drills are conducted in a manner consistent with the facility's resident elopement policies and procedures.[40]

Assistance with Self-Administered Medications

Unlicensed persons who are to provide assistance with self-administered medications must complete a minimum of 4 additional hours of training provided by a registered nurse, licensed pharmacist, or department staff and receive a training certificate.[41] Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in ALFs; 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 must include demonstrations of proper techniques and provide opportunities for hands-on learning through practice exercises.[42]

Those unlicensed persons, 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 ALF.[43]

[39] Rule 58A-5.0191, F.A.C.
[40] Section 429.41(1)(a)3., F.S.
[41] Section 429.52(5), F.S.
[42] Rule 58A-5.0191(5)(a), F.A.C.
[43] Rule 58A-5.0191(5)(c), F.A.C.

ECC Specific

The administrator and ECC supervisor, if different from the administrator, must complete core training and 4 hours of initial training in extended congregate care prior to the facility's receiving its ECC license or within 3 months of beginning employment in the facility as an administrator or ECC supervisor.[44] The administrator and the ECC supervisor, if different from the administrator, must 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.[45]

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 of beginning employment in the facility. The training must address ECC concepts and requirements, including statutory and rule requirements, and delivery of personal care and supportive services in an ECC facility.[46]

LMH Specific

The administrator, managers, and staff, who have direct contact with mental health residents in a licensed LMH facility, must receive the following training:[47]

- A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses.
- A minimum of 3 hours of continuing education, which may be provided by the ALF administrator or through distance learning, biennially thereafter in subjects dealing with mental health diagnoses or mental health treatment.

Special Care for Persons with Alzheimer's Disease

Facilities which advertise that they provide special care for persons with Alzheimer's disease and related disorders must ensure that facility staff, who have regular contact with or provide direct care to residents with Alzheimer's disease and related disorders, obtain 4 hours of initial training, entitled "Alzheimer's Disease and Related Disorders Level I Training," within 3 months of employment.[48]

Facility staff, who provide direct care to residents with Alzheimer's disease and related disorders, must obtain an additional 4 hours of training, entitled "Alzheimer's Disease and Related Disorders Level II Training," within 9 months of employment.

Direct care staff is required to participate in 4 hours of continuing education annually.[49] Facility staff who, have only incidental contact[50] with residents with Alzheimer's disease and related

[44] ECC supervisors who attended the ALF core training prior to April 20, 1998, are not required to take the ALF core training competency test. Rule 58A-5.0191(7), F.A.C.
[45] Rule 58A-5.0191(7)(b), F.A.C.
[46] Rule 58A-5.0191(7)(c), F.A.C.
[47] Section 429.075, F.S. and Rule 58A-5.0191(8), F.A.C.
[48] Those that have completed the core training program between April 20, 1998, and July 1, 2003, are deemed to have satisfied this requirement. Those qualified to provide such training are not required to complete this requirement or the requirement for Alzheimer's Disease and Related Disorders Level II Training. *See* Rule 58A-5.0191, F.A.C.
[49] Section 429.178, F.S.

disorders, must receive general written information provided by the facility on interacting with such residents within 3 months of employment.[51]

Do Not Resuscitate Orders
Facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least 1 hour of training in the facility's policies and procedures regarding Do Not Resuscitate Orders within 30 days after employment.[52]

Trainers
Training for administrators must be performed by trainers registered with the DOEA. The trainer must provide the DOEA with proof that he or she has completed the minimum core training education requirements, successfully passed the competency test, and complied with continuing education requirements (12 contact hours of continuing education in topics related to assisted living every 2 years), and meet one of the following requirements:

- Provide proof of completion of a 4-year degree from an accredited college or university and have worked in a management position in an ALF for 3 years after being core certified;
- Have worked in a management position in an ALF for 5 years after being core certified and have 1 year of teaching experience as an educator or staff trainer for persons who work in ALFs or other long-term care settings;
- Have been previously employed as a core trainer for the DOEA;
- Have a minimum of 5 years of employment with the AHCA, or formerly the Department of Health and Rehabilitative Services, as a surveyor of ALFs;
- Have a minimum of 5 years of employment in a professional position in the AHCA Assisted Living Unit;
- Have a minimum of 5 years employment as an educator or staff trainer for persons working in an ALF or other long-term care settings;
- Have a minimum of 5 years of employment as an ALF core trainer, which was not directly associated with the DOEA; or
- Have a minimum of a 4-year degree from an accredited college or university in the areas of healthcare, gerontology, social work, education or human services, and a minimum of 4 years experience as an educator or staff trainer for persons working in an ALF or other long-term care settings after core certification.[53]

Inspections and Surveys
The AHCA is required to conduct a survey, investigation, or appraisal 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.[54]

[50] "Incidental contact" means all staff who neither provide direct care nor are in regular contact with such residents. Rule 58A-5.0191(9)(f), F.A.C.
[51] Section 429.178, F.S.
[52] Rule 58A-5.0191(11), F.A.C.
[53] Section 429.52(9)-(10), F.S. and Rule 58T-1.203, F.A.C.
[54] *See below* information under subheading "Violations and Penalties" for a description of each class of violation.

- Upon receipt of an oral or written complaint of practices that threaten the health, safety, or welfare of residents.
- If the 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.[55]
-
- An applicant for licensure renewal is eligible for an abbreviated biennial survey by the 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 the AHCA by the council.
- Confirmed licensing complaints within the two licensing periods immediately preceding the current renewal date.[56]

The AHCA must 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.[57]

An LNS licensee is subject to monitoring inspections by the AHCA or its agents 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.[58]

An ECC licensee is subject to quarterly monitoring inspections by the AHCA or its agents. At least one registered nurse must be included in the inspection team. The 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.[59]

There is no additional monitoring requirement of LMH licensees.

Violations and Penalties
Part II of ch. 408, F.S., provides the general licensure standards for all facilities regulated by the AHCA. Under s. 408.813, F.S., ALFs may be subject to administrative fines imposed by the 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 facility residents.[60]

[55] *See* s. 429.34, F.S., and Rule 58A-5.033, F.A.C.
[56] Rule 58A-5.033(2), F.A.C.
[57] *Id.*
[58] Section 429.07(3)(c), F.S.
[59] Section 429.07(3)(b), F.S.
[60] Class "I" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients, which the 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 result therefrom. Class "II" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the AHCA determines

The AHCA must provide written notice of a violation and must impose an administrative fine[61] for a cited class I violation in an amount not less than $5,000 and not exceeding $10,000 for each violation; impose an administrative fine for a cited class II violation in an amount not less than $1,000 and not exceeding $5,000 for each violation; impose an administrative fine for a cited class III violation in an amount not less than $500 and not exceeding $1,000 for each violation; and impose an administrative fine for a cited class IV violation in an amount not less than $100 and not exceeding $200 for each violation.[62]

The AHCA may deny, revoke, and suspend any license and impose an administrative fine against a licensee for a violation of any provision of part I of ch. 429, F.S., part II of ch. 408, F.S., or applicable rules; for the actions of any person subject to level 2 background screening under s. 408.809, F.S.; for the actions of any facility employee; or for any of the following actions by a licensee:

- An intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility.
- A determination by the AHCA that the owner lacks the financial ability to provide continuing adequate care to residents.
- Misappropriation or conversion of the property of a resident of the facility.
- Failure to follow the criteria and procedures provided under part I of ch. 394, F.S., relating to the transportation, voluntary admission, and involuntary examination of a facility resident.
- A citation for one or more cited class I deficiencies, three or more cited class II deficiencies, or five or more cited class III deficiencies that have been cited on a single survey and have not been corrected within the times specified.
- Failure to comply with background screening standards.
- Violation of a moratorium.
- Failure of the license applicant, the licensee during re-licensure, or a licensee that holds a provisional license to meet the minimum license requirements at the time of license application or renewal.
- An intentional or negligent life-threatening act in violation of the uniform fire-safety standards for ALFs or other fire-safety standards that threatens the health, safety, or welfare of a resident of a facility, as communicated to the AHCA by the local authority having jurisdiction or the State Fire Marshal.
- Knowingly operating any unlicensed facility or providing without a license any service that must be licensed.

directly threaten the physical or emotional health, safety, or security of the clients, other than class I violations. Class "III" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the AHCA determines indirectly or potentially threaten the physical or emotional health, safety, or security of clients, other than class I or class II violations. 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.

[61] When determining if a penalty is to be imposed and in fixing the amount of the fine, the 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.

[62] Section 429.19(2), F.S.

- Any act constituting a ground upon which application for a license may be denied.[63]

The AHCA is required to deny or revoke the license of an ALF that has two or more class I violations that are similar or identical to violations identified by the AHCA during a survey, inspection, monitoring visit, or complaint investigation occurring within the previous 2 years.[64]

The AHCA may also impose an immediate moratorium[65] or emergency suspension on any provider if the AHCA determines that any condition related to the provider or licensee presents a threat to the health, safety, or welfare of a client.[66] The AHCA is required to publicly post notification of a license suspension or revocation, or denial of a license renewal, at the facility.[67]

Florida's Criminal Code, under ch. 825, F.S., provides criminal penalties for the abuse, neglect, and exploitation of elderly persons[68] and disabled adults.[69]

Licensure Fees

The biennial licensure fees for the ALF standard license and specialty licenses are found in s. 429.07(4), F.S. This section refers to the general health care licensure provisions in part II of ch. 408, F.S. Section 408.805, F.S., provides for licensure fees to be adjusted annually by not more than the change in the Consumer Price Index (CPI) based on the 12 months immediately preceding the increase.[70]

Income from fees and fines collected by the AHCA must be used by the AHCA for the following purposes:

- Up to 50 percent of the trust funds accrued each fiscal year may be used to offset the expenses of receivership,[71] if the court determines that the income and assets of the facility are insufficient to provide for adequate management and operation.
- An amount of $5,000 of the trust funds accrued each year must be allocated to pay for inspection-related physical and mental health examinations requested by the AHCA for residents who are either recipients of SSI or have monthly incomes not in excess of the

[63] Section 429.14, F.S.

[64] Section 429.14(4), F.S.

[65] "Moratorium" means a prohibition on the acceptance of new clients. Section 408.803(10), F.S.

[66] Section 408.814, F.S.

[67] Section 429.14(7), F.S.

[68] "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.

[69] "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.

[70] The current CPI adjusted fees are: $371 for a standard license, $62 for a standard license per-bed fee, $523 for an ECC license, $10 for an ECC per-bed fee, $250 for an LNS license, and $10 for an LNS per-bed fee. Agency for Health Care Administration, Bureau of Long Term Care, Form Letter to ALF Providers, available at: http://ahca.myflorida.com/MCHQ/LONG_TERM_CARE/Assisted_living/alf/ALF_fee_increase.pdf (Last visited on January 16, 2012).

[71] *See* s. 429.22, F.S., for instances as to when a court may appoint a receiver for an ALF.

maximum combined federal and state cash subsidies available to SSI recipients, but such funds are only to be used where the resident is ineligible for Medicaid.

- Any trust funds accrued each year and not used for the purposes of receivership or inspection-related physical and mental health examinations must be used to offset the costs of the licensure program, verifying information submitted, defraying the costs of processing the names of ALF applicants, and conducting inspections and monitoring visits.[72]

Adult Protective Services

The DCF 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[73] at any hour of the day or night, any day of the week.[74]

The following persons, who know, or have reasonable 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:

- A physician, osteopathic physician, medical examiner, chiropractic physician, nurse, paramedic, emergency medical technician, or hospital personnel engaged in the admission, examination, care, or treatment of vulnerable adults;
- A health professional or mental health professional;
- A practitioner who relies solely on spiritual means for healing;
- Nursing home staff; ALF staff; adult day care center staff; adult family-care home staff; social worker; or other professional adult care, residential, or institutional staff;
- A state, county, or municipal criminal justice employee or law enforcement officer;
- An employee of the Department of Business and Professional Regulation conducting inspections of public lodging establishments;
- A Florida advocacy council member or long-term care ombudsman council member; or
- An officer, trustee, or employee of a bank, savings and loan, or credit union.[75]

If at any time during a protective investigation the DCF has reasonable cause to believe that an employee of a facility that provides day or residential care or treatment for vulnerable adults is the alleged perpetrator of abuse, neglect, or exploitation of a vulnerable adult, the DCF must notify the AHCA, Division of Health Quality Assurance, in writing. If at any time during a protective investigation the DCF has reasonable cause to believe that professional licensure violations have occurred, the DCF must notify the Division of Medical Quality Assurance within

[72] Section 429.18, F.S.
[73] "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.
[74] The central abuse hotline must be operated in such a manner as to enable 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 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.
[75] Section 415.1034, F.S.

the DOH in writing. The DCF must provide a copy of its investigation to the AHCA when the DCF has reason to believe that a vulnerable adult resident of a facility licensed by the AHCA or to the DOH when the investigation determines that a health professional licensed or certified under the DOH may have abused, neglected, or exploited a vulnerable adult.[76]

The DCF must also provide written notification to the state attorney having jurisdiction in the county in which the abuse, neglect, or exploitation occurred if evidence indicates that further criminal investigation is warranted. At the conclusion of a protective investigation at a facility, the DCF must notify, in writing, either the Florida local advocacy council or long-term care ombudsman council of the results of the investigation.[77]

To ensure coordination, communication, and cooperation with the investigation of abuse, neglect, or exploitation of vulnerable adults, the DCF is required to develop and maintain inter-program agreements or operational procedures among appropriate departmental programs and the State Long-Term Care Ombudsman Council, the Florida Statewide Advocacy Council, and other agencies that provide services to vulnerable adults. These agreements or procedures must cover such subjects as the appropriate roles and responsibilities of the DCF in identifying and responding to reports of abuse, neglect, or exploitation of vulnerable adults; the provision of services; and related coordinated activities. In addition, the DCF must cooperate with and seek cooperation from all appropriate public and private agencies, including health agencies, educational agencies, social service agencies, courts, organizations, or programs providing or concerned with human services related to the prevention, identification, or treatment of abuse, neglect, or exploitation of vulnerable adults.[78]

Florida's 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.[79] 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 Office is administratively housed in the DOEA and is headed by the State Long-Term Care Ombudsman, who is appointed by and serves at the pleasure of the Secretary of Elderly Affairs.[80] The program is supported with both federal and state funding.[81]

Florida's Long-Term Care Ombudsman Program (State Program) is made up of nearly 400 volunteers, who are organized into councils in 17 districts[82] around the state. During fiscal year 2009-2010 (October 1, 2009 to September 30, 2010), ombudsmen:

[76] Section 415.1055, F.S.
[77] *Id.*
[78] Section 415.106(2), F.S.
[79] 42 U.S.C. 3058. *See also* s. 400.0061(1), F.S.
[80] Section 400.0063, F.S.
[81] According to *Florida's Long-Term Care Ombudsman Program 2009-2010 Annual Report*, in fiscal year 2009-2010, the program received a total of $3,242,586 in funding; the state contribution totaled $1,452,977. *Florida's Long-Term Care Ombudsman Program 2009-2010 Annual Report*, available at: http://ombudsman.myflorida.com/publications/ar/2009-2010%20Annual%20Report.pdf (Last visited on January 17, 2012).
[82] A list of the district offices is available at: http://ombudsman.myflorida.com/DistrictsList.php (Last visited on January 17,

- Completed 4,015 administrative assessments statewide, visiting 100 percent of the licensed long-term care facilities in Florida;
- Completed 9,098 complaint investigations;[83]
- Donated 20,221 hours of volunteer service to the residents; and
- Provided 5,829 free in-service trainings in nursing homes, ALFs, and adult family care homes throughout the state to encourage facility staff members to adopt best practices to improve the residents' quality of life.[84]

The Ombudsman Office 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 nursing homes, ALFs 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 purpose of the State Program, the statewide toll-free telephone number for receiving complaints, and other relevant information regarding how to contact the State Program. Residents or their representatives must be furnished additional copies of this information upon request.[85]

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 in writing; the complainant or resident consents orally and the consent is documented contemporaneously in writing by the ombudsman council requesting such consent; or the disclosure is required by court order.[86]

The Miami Herald Investigative Series on Assisted Living Facilities

Beginning on April 30, 2011, the Miami Herald published a three-part series, titled "Neglected to Death," which exposed several examples of abuses occurring in ALFs and the state regulatory responses to such cases. According to the publication, the Miami Herald spent a year examining thousands of state inspections, police reports, court cases, autopsy files, e-mails, and death certificates and conducting dozens of interviews with operators and residents throughout Florida.

The three-part investigative series gives several examples of abuses or neglect that took place at facilities in Florida, including:[87]

2012).

[83] Section 400.0073, F.S., requires a local council to investigate any complaint of a resident, a representative of a resident, or any other credible source based on the action or inaction of an administrator, employee, or representative of a long-term care facility, which might be contrary to law; unreasonable, unfair, oppressive, or unnecessarily discriminatory, even though in accordance with law; based on a mistake of fact; based on improper or irrelevant grounds; unaccompanied by an adequate statement of reasons; performed in an inefficient manner; or otherwise adversely affecting the health, safety, welfare, or rights of a resident.

[84] *Florida's Long-Term Care Ombudsman Program 2009-2010 Annual Report*, available at: http://ombudsman.myflorida.com/publications/ar/2009-2010%20Annual%20Report.pdf (Last visited on January 17, 2012).

[85] Section 400.0078, F.S.

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

[87] The Miami Herald, *Neglected to Death, Parts 1-3*, available at: http://www.miamiherald.com/2011/04/30/2194842/once-pride-of-florida-now-scenes.html and http://www.miamiherald.com/2011/05/03/2199747/key-medical-logs-doctored-

- The administrator of an ALF in Caryville punished his disabled residents by refusing to give them food and drugs, threatened the residents with a stick, doped the residents with powerful tranquilizers, beat residents who broke the facilities rules, forced residents to live without air conditioning even when temperatures reached 100 degrees Fahrenheit, and fell asleep on the job while a 71-year-old woman with mental illness wandered outside the facility and drowned in a nearby pond.
- In an ALF in Kendall, a 74-year-old woman was bound for more than 6 hours, the restraints pulled so tightly that they ripped into her skin and killed her.
- In an ALF in Hialeah, a 71-year-old man with mental illness died from burns after he was left in a bathtub filled with scalding water.
- In an ALF in Clearwater, a 75-year-old Alzheimer's patient was torn apart by an alligator after he wandered from his ALF for the fourth time.
- In an ALF in Haines City, a 74-year-old suffering from diabetes and depression died after going 13 days without crucial antibiotics and several days without food or water.
- An ALF in Miami-Dade County had a door alarm and video cameras in disrepair, an unlocked back gate on the premises, and an attendant who had fallen asleep, which enabled an 85-year-old to wander from the facility and drown in a pond.
- The administrator of an ALF in Dunedin drove a male resident with a criminal history to a pharmacy to fill a prescription for powerful narcotics but failed to collect the drugs from the resident. The resident fed the drugs to a 20-year-old female resident with mental illness, raped her, and caused her to die of an overdose.
- In an ALF in Tampa, a 55-year-old man died after his caretakers failed to give him food, water, or medicine.
- An ALF in Orlando failed to give an 82-year-old woman critical heart medication for 4 days, failed to read her medical chart, and gave her the wrong drugs on the day she died.
- An ALF in West Melbourne shut off the facility's exit alarm when it was triggered without doing a head count or calling 911 as a 74-year-old man slipped out the door and drowned in a nearby pond.
- An ALF in Deerfield Beach did not provide protections to a 98-year-old woman who fell 11 times and died of resulting injuries, including a fractured neck.
- A caretaker in an ALF in Miami-Dade County strapped down a 74-year-old woman for at least 6 hours so tightly that she lost circulation in her legs and as a result a blood clot formed which killed her.

The investigative series decried the state's regulatory and law enforcement agencies responses to the alleged egregious acts claiming:[88]

- Nearly once a month residents die from abuse and neglect, with some caretakers altering and forging records to conceal evidence, but law enforcement agencies almost never make arrests.
- Facilities are routinely caught using illegal restraints, including powerful tranquilizers, locked closets, and ropes, but the state rarely punishes them.
- State regulators could have shut down 70 facilities in the past 2 years for a host of severe violations, but only seven facilities were closed.

missing.html (Last visited on January 17, 2012) (see left side of article to access weblinks to the three-part series).

[88] *Id.*

- Although the number of ALFs has increased substantially over the last 5 years, the state has dropped critical inspections by 33 percent.
- Although the state has the authority to fine ALFs that break the law, the penalties are routinely decreased, delayed, or dropped altogether.
- The state's lack of enforcement has prompted other government agencies to cut off funding and in some cases the agencies refuse to send clients to live in certain ALFs.
- In at least one case, an investigation was never performed by the AHCA, although a woman drowned after wandering off the premises.
- It took the AHCA inspectors an average of 37 days to complete a complaint investigation in 2009, which was 10 days longer than 5 years earlier.
- At least five times, other state agencies were forced to take the lead in shutting down homes when the AHCA did not act.

Governor Rick Scott's ALF Task Force

In response to the Miami Herald Investigative Series on ALFs, Governor Rick Scott announced in his veto message of HB 4045 (2011),[89] which pertains to ALFs, that he was going to form an ALF task force for the purpose of examining current assisted living regulations and oversight.[90] Governor Scott directed the task force to develop recommendations to improve the state's ability to monitor quality and safety in ALFs and ensure the well-being of their residents.[91]

The task force, which is now referred to as the Assisted Living Workgroup, held meetings on August 8, 2011, in Tallahassee; September 23, 2011, in Tampa; and November 7 and 8, 2011 in Miami. In addition to public testimony and presentations, the Assisted Living Workgroup discussion focused on assisted living regulation, consumer information and choice, and long term care services and access.[92]

The Assisted Living Workgroup made several recommendations in a final report released in December 2011, stating that it believed the recommendations would strengthen oversight and reassure the public that ALFs are safe places for their residents. The general recommendations of the workgroup are to:

- Increase administrator qualifications.

[89] HB 4045 (2011) repealed a requirement for the annual dissemination of a list of ALFs that had been sanction or fined, a requirement for an ALF to report monthly any liability claims filed against it, a requirement to disseminate the results of the inspection of each ALF, provisions concerning rule promulgation for ALFs by the DOEA, provisions concerning the collection of information regarding the cost of care in ALFs, and the authority for local governments or organizations to contribute to the cost of care of local facility residents.

[90] The task force, which is now referred to as the "Assisted Living Workgroup," consists of 14 members. These members represent the following entities: Florida Association of Homes and Services for the Aging; Eastside Care, Inc.; Palm Breeze Assisted Living Facility; Long Term Care Ombudsman; Florida House of Representatives; Lenderman and Associates; The Florida Bar, Elder Law Section; Florida State University, the Pepper Center; the Villa at Carpenters; Florida Council for Community Mental Health; Florida Assisted Living Association; Villa Serena I-V, Florida Senate; and Florida Health Care Association. Agency for Health Care Administration, *Assisted Living Workgroup Members*, available at: http://ahca.myflorida.com/SCHS/ALWG2011/wgmembers.shtml (Last visited on January 16, 2012).

[91] Governor Rick Scott's veto message for HB 4045 (2011) is available at: http://www.flgov.com/wp-content/uploads/2011/06/hb4045.pdf (Last visited on January 17, 2012).

[92] Agency For Health Care Administration, Assisted Living Workgroup, *Final Report And Recommendations*, available at: http://ahca.myflorida.com/SCHS/ALWG2011/alwg2011.shtml (Last visited on January 16, 2012).

- Expand and improve training for administrators and other staff.
- Increase survey and inspection activity with a focus on facilities with poor track records.
- Create a systematic appeal process for residents who want to contest a notice of eviction.
- Increase reporting of resident data by facilities.
- Enhance enforcement capacity by state agencies.
- Create of a permanent policy review and oversight council with members representing all stakeholder groups.
- Require all facilities with at least one resident receiving mental health care to be licensed as an LMH facility.
- Provide greater integration of information from all agencies involved in ALF regulation in order to identify potential problems sooner.[93]

The Assisted Living Workgroup also decided that there are additional matters that should be reviewed more in-depth prior to making recommendations and therefore, recommended that a phase II workgroup be appointed by the Governor to review these additional matters at a later date.[94]

Interim Report 2012-128

Professional staff of the Senate Health Regulation Committee recommended in Interim Report 2012-128, Review Regulatory Oversight of Assisted Living Facilities in Florida,[95] a myriad of options for the Legislature to consider to improve the regulatory oversight of ALFs. To better protect residents from abuse, neglect, or otherwise harmful conditions in ALFs in Florida, the report recommends that the Legislature enact legislation to:

- Require ALFs to report occupancy rates and demographic and resident acuity information.
- Require the AHCA to conduct abbreviated inspections and develop targeted and efficient inspection plans.
- Require the AHCA to use lead surveyors to ensure consistent inspections.
- Create a workgroup to assess the AHCA's inspection forms.
- Better fund the AHCA to conduct inspections, whether through fee or fine increases.
- Require additional monitoring of LMH facilities, akin to the additional monitoring currently conducted on LNS and ECC facilities.
- Require better oversight of core training providers.
- Expand Florida's core training curriculum and require additional administrator qualifications.
- Require staff to demonstrate, by a short examination, receipt and comprehension of staff training.
- Increase staffing ratios for facilities with specialty licenses.
- Increasing elopement training requirements and require AHCA attendance of elopement drills.
- Require additional administrator qualifications and additional training for all staff of LMH facilities.

[93] *Id.*

[94] *Id.*

[95] Florida Senate, Interim Report 2012-128, is available at: http://www.flsenate.gov/PublishedContent/Session/2012/InterimReports/2012-128hr.pdf (Last visited on January 17, 2012).

- Require a facility with any mental health resident, instead of three mental health residents, to obtain an LMH license.
- Reduce the AHCA's discretion to assess administrative penalties and increase administrative penalties.
- Establish a workgroup to review agency regulatory oversight of ALFs and make recommendations, if any, to streamline the regulatory oversight of ALFs.
- Designate the AHCA as the lead agency to coordinate all complaints related to ALFs.
- Require each agency to establish a direct line of communication to the AHCA to communicate complaints and require the AHCA to maintain a database to track such complaints.
- Require staff of regulatory state or local agencies to immediately report abuse, neglect, or exploitation of a vulnerable adult to the DCF's central abuse hotline.
- Require the AHCA to develop and implement a user-friendly rating system of ALFs for consumers to use.
- Require ALFs to notify residents that any complaint made to an ombudsman, and the identification of the person making the complaint, is confidential.

III. Effect of Proposed Changes:

Section 1 amends s. 394.4574, F.S., to require community living support plans to be updated as needed, not only annually. Case managers are required to maintain a record of the date and time of face-to-face interaction with mental health residents, in order for the DCF to inspect such records for compliance with contractual or other requirements. The records must be retained for 2 years after the date of the last interaction.

This section also requires the DCF to ensure adequate and consistent monitoring and enforcement of community living support plans and cooperative agreements.

Section 2 amends s. 400.0078, F.S., to require a long-term care facility to provide notice to each resident or representative of a resident, upon admission, that the subject matter of a complaint made to the State Long-Term Care Ombudsman Program and the complainant's name and identity are confidential.

Section 3 amends s. 415.1034, F.S., to require an employee or agent of a state or local agency who has regulatory responsibilities over, or who provides services to, persons residing in a state-licensed facility to report abuse, neglect, or exploitation of vulnerable adults to the DCF central abuse hotline.

Section 4 amends s. 429.02, F.S., to define the term "board" to mean the Board of Nursing Home and Assisted Living Facility Administrators and the term "mental health professional" to mean a person licensed under chapters 458, 459, 464, 490, or 491, related to the practice of medicine, allopathic medicine, nursing, psychological services, and clinical counseling and psychotherapy services, respectively, who provides mental health services, or an individual who has a 4-year baccalaureate degree with a concentration in mental health and at least 5 years of experience providing services that improve an individual's mental health or that treat mental illness.

Section 5 amends s. 429.07, F.S., to conform a cross-reference and increase the standard licensure fee from $300 to $500, increase the per resident fee from $50 to $55, and increase the total fee cap from $10,000 to $20,000, for an ALF that has one or more class I or class II violations within the 2 years before licensure renewal. The bill clarifies that the increased fee amounts are in addition to the fee amount as adjusted under the consumer price index in accordance with s. 408.805, F.S. The increased fees are to be imposed for one licensure cycle, unless the facility has a class I or class II violation during the next biennial inspection.

Section 6 amends s. 429.075, F.S., to require an ALF with any mental health residents, rather than three mental health residents, to obtain an LMH license. The eligibility requirements for obtaining an LMH specialty license are strengthened. A successful applicant may not have been administratively sanctioned during the previous 2 years, or since initial licensure, for:

- Two or more class I or class II violations;
- 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 AHCA;
- Three or more class III violations that were not corrected in accordance with an AHCA-approved corrective action plan;
- A violation of resident care standards, which required the ALF to employ certain consultant services;
- Denial, suspension, or revocation of a license for another licensed facility under which the license applicant has at least a 25 percent ownership interest; or
- Imposition of a moratorium or initiation of injunctive proceedings.

This section clarifies that for an ALF to obtain an LMH license, it must ensure that employees meet the LMH training requirements, in addition to any other training or education requirements.

This section also provides that after July 1, 2012, an administrator of a facility that has an LMH license must, in addition to any other educational requirements, have completed at least 6 semester credit hours of college-level coursework relating to mental health.

This section requires a mental health professional to serve as part of the AHCA inspection team that inspects LMH licensees. An LMH licensee must be monitored by a mental health professional quarterly. However, one of the monitoring visits may be in conjunction with a regular survey. A mental health professional may conduct an inspection on his or her own and may report to the AHCA his or her findings. If an ALF has been licensed for at least 2 years and has had a good performance record, one of the quarterly monitors may be waived by the AHCA, but not before the AHCA has first consulted with the ombudsman council to determine if any complaint has been made and the outcome of such complaint. The AHCA is prohibited from waiving one of the required monitoring visits if an ombudsman referral was made to the AHCA that resulted in a citation of a licensure violation.

Section 7 amends s. 429.14, F.S., to require the AHCA to deny or revoke the license of an ALF that has two or more class I or class II violations that are similar or identical to violations identified by the AHCA within the previous 2 years or if the ALF committed a class I violation or any intentional or negligent act that, based on a court findings, caused the death of a resident.

Section 8 amends s. 429.176, F.S., to provide a cross-reference to part I of ch. 468, F.S., under which the eligibility requirements for an applicant for licensure as an ALF administrator may be found.

This section requires an administrator of an LMH licensee to have completed at least 6 semester credit hours of college-level coursework relating to mental health, in addition to any other education requirements.

A licensed administrator must, to prevent a license from entering into inactive status, take at least 18 hours of continuing education and pass a competency test with a minimum score of 80 every 2 years.

This section provides that a manager of an ALF must meet the core training requirements within 30 days of being employed as, or becoming, a facility manager.

Section 9 amends s. 429.178, F.S., to clarify that all staff members, including administrators, employed by an ALF providing special care to residents with Alzheimer's disease or other related disorders and who provide regular or direct care to such residents, must complete up to 4 hours of initial dementia-specific training within 3 months after beginning employment. This section also reduces the amount of time, from 9 months to 6 months, that a direct caregiver working at such a facility and providing direct care to such residents must complete an additional 4 hours of training.

This section also removes the provision that any of the training related to Alzheimer's disease or related disorders required under this section satisfies the core training requirements for administrators, which relate to Alzheimer's disease or related disorders.

Section 10 amends s. 429.19, F.S., to provide a cross-reference and establish certain penalties for violations. This section requires the AHCA to impose an administrative fine for each class I violation, even if the violation was corrected before the citation has been issued. For a violation that results in the death of a resident, the AHCA must impose the maximum penalty for the class of violation committed. If a second or subsequent violation that is in the same class as a prior violation cited as a result of or since the last inspection is cited, the AHCA must double the fine that was previously assessed against the ALF when assessing a fine for the second or subsequent violation. The AHCA is also required to impose a fine for each class III violation when a facility has been cited for ten or more of such violations, regardless of whether the violations are corrected.

Section 11 amends s. 429.23, F.S., to require, instead of authorize, a licensed ALF to establish a risk management and quality assurance program.

Section 12 amends s. 429.256, F.S., to conform a cross-reference to other changes made in the bill.

Section 13 amends s. 429.28, F.S., relating to resident bill of rights, to require an ALF to post notice in a prominent place in each facility that the subject matter of a complaint made to the

Ombudsman Office or a local long-term care ombudsman council and the names and identities of the residents involved in the complaint and complainants are confidential.

This section also requires, instead of permits, the AHCA to conduct periodic followup inspections to monitor the compliance of facilities having a history of class I violations that threaten the health, safety, or security of residents.

This section requires the AHCA to impose a fine of $2,500, in addition to any other penalty, if the ALF cannot show in a court of law good cause for the termination of a resident when that act is challenged as retaliatory.

Section 14 amends s. 429.34, F.S., to designate the AHCA as the central agency for receiving and tracking complaints to ensure that allegations regarding facilities are timely responded to and that licensure enforcement action is initiated if warranted. State agencies regulating, or providing services to residents of ALFs, must report any substantiated allegations complaints, or allegations or complaints that are likely to have occurred, to the AHCA as soon as reasonably possible.

This section requires the AHCA to have lead surveyors in each field office who specialize in assessing ALFs and requires such surveyors to provide initial and ongoing training to surveyors inspecting and monitoring ALFs to ensure consistent monitoring and inspections of ALFs. In addition, the AHCA must have one statewide lead surveyor who specializes in ALF inspections to coordinate communication between lead surveyors and ensure statewide consistency in applying facility inspection laws and rules.

Section 15 amends s. 429.41, F.S., to require the AHCA to randomly select 10 percent of the ALFs to have an AHCA employee attend and observe a resident elopement drill at each of the selected facilities. The observed elopement drill is to coincide with an inspection or survey conducted by the AHCA. If the AHCA employee observes an elopement drill that does not meet standards established by rule, the AHCA must notify the ALF of the deficiencies within 15 calendar days after the drill and the ALF must submit a corrective action plan to the AHCA within 30 calendar days after receiving such notice.

This section authorizes the DOEA to require additional staffing for facilities that have specialty licenses, but the additional staffing must correlate with the number of residents receiving special care and the type of special care required.

This section requires, rather than authorizes, the AHCA to conduct an abbreviated biennial standard licensure inspection in a facility that has a good record of past performance in order to allocate AHCA resources efficiently.

Section 16 amends s. 429.49, F.S., to increase the criminal penalty from a misdemeanor of the second degree to a misdemeanor of the first degree for any person who fraudulently alters, defaces, or falsifies any medical or other record of an ALF, or causes or procures any such offense to be committed.

Section 17 creates s. 429.515, F.S., to require all employees hired by an ALF after July 1, 2012, to attend a pre-service orientation, which must be at least 2 hours in duration and cover the following topics:

- Care of persons who have Alzheimer's disease or other related disorders.
- De-escalation techniques.
- Aggression control.
- Elopement prevention.
- Behavior management.

Upon completion of the pre-service orientation, the employee must sign an affidavit, under penalty of perjury, stating that the employee completed the orientation. The affidavit must be maintained in the employee's work file.

Section 18 amends s. 429.52, F.S., to require ALF staff members who provide regular or direct care to residents to complete a board-approved training curriculum within 30 days after employment, in addition to pre-service orientation. This requirement does not pertain to administrators. The individual participating in the training, or the participant's employer, is required to pay any cost or fee associated with the training. After completing such training, the staff member must complete an interactive online tutorial to demonstrate an understanding of the training received. Upon completing the tutorial, the staff member will receive a certificate of completion, which must be maintained in the employee's work file.

The staff members who provide regular or direct care to residents must participate in a minimum of 8 hours of continuing education every 2 years. The continuing education may be offered through online courses and the person taking the courses, or such person's employer, is responsible for paying any fee associated with the courses.

Section 19 creates s. 429.521, F.S., to require administrators and staff members who provide regular or direct care to residents of an ECC licensee to complete a minimum of 6 hours of board-approved ECC training within 30 days after beginning employment.

This section also requires administrators employed by an LNS licensee to complete a minimum of 4 hours of board-approved courses that train and educate administrators on the special needs and care of those requiring LNS services. Staff of an LNS licensee, who provide regular and direct care to residents receiving limited nursing services, are required to complete a minimum of 2 hours of such courses. The training must be completed within 30 days after employment.

Staff, including administrators, who prepare or serve food must receive a minimum of 1 hour of in-service training in safe food handling practices within 30 days after beginning employment, which is consistent with current law.

This section clarifies that administrators, as well as staff members, must receive at least 1 hour of in-service training on the ALF's resident elopement response policies and procedures within 30 days after beginning employment. A copy of the ALF's resident elopement policies and procedures must be provided to staff *and* the administrator. Staff *and* administrator, must demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.

This section requires administrators of an LMH licensee and staff members who provide regular or direct care to mental health residents to complete a minimum of 8 hours of board-approved mental health training within 30 days after beginning employment. Within 30 days after completing the LMH training, a staff member must complete an online interactive tutorial to demonstrate an understanding of the training received and pay for any fee associated with the tutorial. An administrator must pass an examination related to the training with a minimum score of 80 and must pay for any fee associated with the examination. A staff member who does not complete the tutorial, or an administrator who fails the examination may not provide regular or direct care to residents until the staff member completes the tutorial or the administrator passes the examination. If the administrator does not pass the examination within 6 months after completing the mental health training, the administrator may not be an administrator of an LMH licensee until the administrator passes the examination.

This section requires administrators, as well as staff members, involved with the management of medications and the assistance with self-administration of medications to complete a minimum of 4 additional hours of training provided by a registered nurse, licensed pharmacist, or DOEA staff member, which is consistent with current law. The Board must establish, by rule, the minimum requirements of this training, including continuing education requirements.

This section authorizes the Board to, by rule, require other facility staff members to participate in training relevant to their job duties.

Section 20 creates s. 429.522, F.S., to require any individual seeking to provide core training in Florida on or after January 1, 2013, to be certified by the Board. The applicant for certification as a core training provider must provide the Board with proof of completion of core training, passage of the ALF administrator licensure examination, and compliance with continuing education requirements. In addition, an applicant for certification must:

- Provide proof of completion of a 4-year baccalaureate degree from an accredited college or university and have worked in a management position in an ALF for 3 years after obtaining certification in core training courses;
- Have worked in a management position in an ALF for 5 years after obtaining certification in the core training courses and have 1 year of teaching experience as an educator or staff trainer for persons who work in an ALF or another long-term care setting;
- Have been previously employed as a trainer of core training courses for the DOEA;
- Have at least 5 years of employment with the AHCA as a surveyor of ALFs;
- Have at least 5 years of employment in a professional position in the AHCA's assisted living unit;
- Have at least 5 years of employment as an educator or staff trainer for persons working in an ALF or another long-term care setting;
- Have at least 5 years of employment as a trainer of core of ALF courses not directly associated with the DOEA;
- Have a 4-year baccalaureate degree from an accredited college or university in the areas of health care, gerontology, social work, education, or human services and at least 4 years of experience as an educator or staff trainer for persons working in an ALF or another long-term care setting after receiving certification in core courses; or

- Meet other qualification criteria as defined by rule of the Board.

The Board is required to oversee core training providers and establish, by rule, requirements for trainer certification and de-certification or other disciplinary actions.

This section requires the Board, if funding is available, to develop by January 1, 2013, an electronic database, which must list all persons holding a certificate as a core training provider and any history of violations. The Board must maintain the database and make the database accessible to the public. Core trainers must also submit to the Board a list of individuals who have completed training within 24 hours after the training has been completed in order for such information to be included in the database.

Section 21 creates s. 429.523, F.S., to authorize training and testing required under part I, ch. 429, F.S., to be provided by board-approved training and testing centers. The Board, when reviewing an applicant, must consider whether the center will provide sufficient space for training, the location of the center and whether another center already provides training or testing services in the approximate area, the fee to be charged by the center for providing such services, whether the center has sufficient and qualified staff to provide such services, and any other consideration the Board deems necessary to approve a center.

The Board is required to provide a certificate of approval to an approved center and the center must keep the certificate on file as long as it provides training or examination services.

The Board is authorized to inspect training and testing centers to determine whether the centers meet law and rule requirements. The Board may de-certify a center that does not continue to meet such requirements.

The trainer employed by the center must keep a record of attendees and report such information to the Board.

Section 22 amends s. 429.54, F.S., to require the AHCA, the DOEA, the DCF, and the APD, if funds are available, to develop or modify electronic systems of communication among state-supported automated systems to ensure that relevant information pertaining to the regulation of ALFs and ALF staff is timely and effectively communicated among agencies in order to facilitate the protection of residents.

This section also requires ALFs to submit semiannually, electronic reports to the AHCA, which must include:

- The number of beds in the facility;
- The number of beds being occupied;
- The number of residents who are younger than 65 years of age, are 65 to 74 years of age, are 75 to 84 years of age, and are 85 years of age or older;
- The number of residents who are mental health residents, who are receiving extended congregate care, who are receiving limited nursing services, and who are receiving hospice care;
- If there is a facility waiting list, the number of individuals on the waiting list and the type of services or care that they require, if known;

- The number of residents receiving OSS; and
- The number of residents who are Medicaid recipients and the type of waiver used to fund each such resident's care.

The report must be submitted in accordance with a reporting cycle established by AHCA rule.

The AHCA is required to maintain the reported information in electronic format and must use the reported information to track trends in ALF resident populations and needs.

The ALF reporting requirement is scheduled to expire on July 1, 2017, which will allow the Legislature to review whether the reporting requirement is overly burdensome to ALFs and whether the reported information is beneficial to the AHCA and the Legislature to track trends relating to ALF residents.

Section 23 creates s. 429.56, F.S., to require the AHCA, in consultation with the DOEA, the DCF, and the Ombudsman Office, to develop and adopt by rule a user-friendly ALF rating system. The rating system must be publicly available on the Internet and must be based on resident satisfaction, the number and class of deficiencies for which the facility has been cited, AHCA inspection reports, inspection reports of any other regulatory agency, assessments conducted by the ombudsman program, and other criteria as determined by the AHCA. The Internet home page for the rating system must include a link that allows consumers to complete a voluntary survey that provides feedback on whether the rating system is helpful and suggestions for improvement.

This section also gives the AHCA rulemaking authority to implement the rating system.

Section 24 requests the Division of Statutory Revision to rename part II of ch. 468, F.S., as "Nursing Home and Assisted Living Facility Administration," instead of "Nursing Home Administration."

Section 25 amends s. 468.1635, F.S., to include in the purpose of the chapter that it is the purpose to ensure that every assisted living facility administrator meets minimum requirements for safe practice.

Section 26 amends s. 468.1645, F.S., to require ALFs to operate under the management of an ALF administrator, effective July 1, 2013.

Section 27 amends s. 468.1655, F.S., to add the definitions of the terms "assisted living facility," "assisted living facility administrator," and "practice of assisted living facility administration." The definition of the term "board" is amended to rename the Board of Nursing Home Administrators the "Board of Nursing Home and Assisted Living Facility Administrators."

Section 28 amends s. 468.1665, F.S., to create the Board, which is to consist of eleven members, three of which are licensed ALF administrators. One of the layperson members of the Board must be a resident of an ALF.

This section prohibits a person from being appointed to the Board if a conflict of interest exists, except a nursing home or ALF administrator who is appointed may retain a financial interest in the institution or facility that he or she administers at the time of appointment.

Section 29 amends s. 468.1685, F.S., to provide that it is the function and duty of the Board to develop, impose, and enforce specific standards to be met by individuals in order to be licensed as an ALF administrator.

The Board must develop a core training curriculum, to be completed by an applicant for administrator licensure, which must consist of at least 40 hours of training, be offered in English and Spanish, be reviewed at least annually by the Board, and be updated as needed to reflect changes in the law, rules, and best practices. The curriculum must, at a minimum, cover state law and rules relating to ALFs; resident rights and the identification and reporting of abuse, neglect, and exploitation; special needs of elderly persons, persons who have mental illness, and persons who have developmental disabilities and how to meet those needs; nutrition and food service; medication management, recordkeeping, and proper techniques for assisting residents who self-administer medication; firesafety requirements; care of persons who have Alzheimer's disease and related disorders; elopement prevention; aggression and behavior management, de-escalation techniques, and proper protocols and procedures relating to the Baker Act; do-not-resuscitate orders; infection control; admission and continued residency; phases of care and interacting with residents; best practices in the industry; and business operations, including, but not limited to, human resources, financial management, and supervision of staff.

The Board must develop an ALF administrator licensure examination in consultation with the AHCA, the DOEA, and the DCF. The examination must be offered in English and Spanish and must be updated as needed, but no less than annually.

The Board must also develop a LMH curriculum and examination in consultation with a panel of limited mental health professionals, which must be completed by an ALF administrator within 30 days after being employed by a LMH licensee. The examination must be available online, must be offered in English and Spanish, and must be updated as needed, but at least annually.

The Board must develop a continuing education curriculum, in consultation with the AHCA, the DOEA, and the DCF for ALF administrators. The Board must require additional credit hours for administrators who are employed by ECC, LNS, or LMH licensees. The Board must also develop a short test for administrators to take upon completing each continuing education course. The Board must review the continuing education curriculum and test at least annually, and update the curriculum and examinations as needed to reflect changes in the law, rules, and best practices. Continuing education must include topics similar to those of the core training and in-service training and may include additional subject matter that enhances the knowledge, skills, and abilities of administrators and staff members, as adopted by rule.

The Board must develop, in consultation with stakeholders, a standardized staff training curriculum for staff members of an ALF, other than an administrator, who provide regular or direct care to residents. Only staff members hired on or after July 1, 2012, are subject to this training requirement. The Board may exempt from this training requirement nurses, certified nursing assistants, and home health aides who can demonstrate that they have already completed

such training or substantially similar training. The curriculum must include at least 20 hours of in-service training, with at least 1 hour of training per topic, covering, at a minimum, reporting major incidents; reporting adverse incidents; facility emergency procedures; resident rights in an ALF; recognizing and reporting resident abuse, neglect, and exploitation; resident behavior and needs; providing assistance with the activities of daily living; infection control; and aggression and behavior management and de-escalation techniques. The Board is to develop an online interactive tutorial, which staff is to complete after taking the required 20 hours of in-service training. The tutorial must be offered in English and Spanish and must be updated as needed, but at least annually. The Board is to issue a certificate of completion after the tutorial has been completed.

The Board must develop an interactive online tutorial, in consultation with the AHCA, the DOEA, the DCF, and stakeholders, which must be completed by facility staff members who provide regular or direct care to ALF mental health residents. The tutorial must be based on LMH training. The Board must offer the tutorial in English and Spanish and update the tutorial as needed, but at least annually. The Board shall provide a certificate to each staff member who completes the tutorial.

The Board is to require and provide, or cause to be provided, the training or education of staff members of a facility beyond that which is required under part I of ch. 429, F.S., if the Board or the AHCA determines that there are problems in a facility which could be reduced through specific staff training or education.

The Board is also authorized to approve testing and training centers and certify assisted living training providers who meet the required qualifications for certification.

Section 30 amends s. 468.1695, F.S., to establish the criteria for ALF administrator licensure by examination. An applicant must apply to the DOH to take the licensure examination and such examination must cover the subject matter covered during the applicant's core training.

The licensure exam fee is set by the Board and is not to exceed $250.

The applicant is eligible to take the licensure examination if he or she:

- Is at least 21 years old;
- Holds a 4-year baccalaureate degree that includes some coursework in health care, gerontology, or geriatrics; a 4-year baccalaureate degree with at least 2 years of experience in direct patient care in an ALF or nursing home; or a 2-year associate degree that includes coursework in health care, gerontology, or geriatrics and at least 2 years of experience in direct patient care in an ALF or nursing home;
- Has completed at least 40 hours of core training;
- Has completed background screening; and
- Otherwise meets any other requirements under this part I of ch. 468, F.S., or part I of ch. 429, F.S.

This section also exempts existing ALF administrators and nursing home administrators, who have been continuously employed as an ALF administrator or nursing home administrator for at least the 2 years before July 1, 2012, from the education requirements for licensure and the

licensure examination. However, an applicant must provide the Board with proof of compliance with continuing education requirements, the administrator must not have been an administrator of a nursing home or facility that was cited for a class I or class II violation within the prior 2 years, and the administrator is still required to complete core training. This section also provides for the exemption of other licensed professionals as determined by the Board, by rule.

This section provides that an applicant for administrator licensure, who fails the licensure examination, must wait 10 days to retake the licensure examination and may take the examination up to three times. If the applicant fails the examination three times, then he or she must retake the initial core and supplemental training before retaking the examination.

Section 31 amends s. 468.1705, F.S., to make a technical conforming correction.

Section 32 amends s. 468.1725, F.S., to provide that a nursing home or ALF administrator may apply for inactive licensure status or a license may become inactive if an administrator does not complete continuing education courses on time or the administrator does not pay licensure renewal fees on time. A license may only be reactivated by the Board if renewal fees or delinquent fees and a reactivation fee are paid. The Board is given rulemaking authority relating to the inactive status and the reactivation of licenses and any related fees.

Section 33 amends s. 468.1735, F.S., to authorize the Board to develop rules relating to, and to issue, ALF administrator provisional licenses. Provisional licenses may be issued only to fill a position of an ALF administrator which unexpectedly becomes vacant and may only be issued for a single period not to exceed 6 months. The provisional license is to be issued to the person who is designated as the responsible person next in command in the event of the administrator's departure. The Board is prohibited from issuing a provisional license if the applicant is under investigation for, or has committed certain acts. The Board is authorized to set an application fee for a provisional license not to exceed $500.

Section 34 amends s. 468.1745, F.S., to provide that it is a misdemeanor of the second degree if a person commits any of the following:

- Practices ALF administration with a revoked, suspended, inactive, or delinquent license.
- Uses the name or title "assisted living facility administrator" if the person has not been licensed as such.
- Presents as his or her own the license of another.
- Gives false or forged evidence to the Board or a member thereof for the purpose of obtaining a license.
- Uses or attempts to use an administrator's license that has been suspended or revoked.
- Knowingly employing unlicensed persons in the practice of ALF administration.
- Knowingly conceals information relative to violations of part I, ch. 468, F.S.

Section 35 amends s. 468.1755, F.S., to provide the Board with disciplinary authority over ALF administrators, authorizing the Board to deny licensure or license renewal or suspend or revoke the license of an administrator who is under investigation for, or who has committed any of the following:

- Attempting to procure a license to practice ALF administration by bribery, fraudulent misrepresentation, or through an error of the AHCA or the Board.
- Having a license to practice ALF administration revoked, suspended, or otherwise acted against, including the denial of licensure by the licensing authority of another state, territory, or country.
- Being convicted or found guilty of, or entered a plea of nolo contendre, regardless of adjudication, to a crime in any jurisdiction which relates to the practice of ALF administration.
- Making or filing a report or record that the licensee knows to be false, intentionally failing to file a report or record required by state or federal law, willfully impeding or obstructing such filing, or inducing another person to impede or obstruct such filing. Such reports or records include only those which are signed in the capacity of a licensed ALF administrator.
- Advertising goods or services in a manner that is fraudulent, false, deceptive, or misleading in form or content.
- Committing fraud or deceit or exhibiting negligence, incompetence, or misconduct in the practice of ALF administration.
- Violating a lawful order of the Board or AHCA previously entered in a disciplinary hearing or failing to comply with a lawfully issued subpoena of the Board or AHCA.
- Repeatedly acting in a manner that is inconsistent with the health, safety, or welfare of the residents of the facility in which he or she is the administrator.
- Being unable to practice ALF administration with reasonable skill and safety to residents by reason of illness, drunkenness, use of drugs, narcotics, chemicals, or any other material or substance or as a result of any mental or physical condition.
- Paying, giving, causing to be paid or given, or offering to pay or to give to any person a commission or other valuable consideration for the solicitation or procurement, directly or indirectly, of ALF usage.
- Willfully permitting unauthorized disclosure of information relating to a resident or his or her records.
- Discriminating with respect to residents, employees, or staff members on account of race, religion, sex, or national origin.
- Violating any provision of part I of ch. 429, F.S., part II of ch. 408, F.S., or rules adopted pursuant to part I of ch. 429, F.S.

The Board is required to revoke the license of an administrator who knowingly participates in intentional misconduct, or engages in conduct that constitutes gross negligence, and contributes to the death of a resident.

Section 36 amends s. 468.1756, F.S., to make a technical change to conform a cross-reference to changes made in the bill.

Section 37 creates an undesignated section of law to require the AHCA to create a task force consisting of at least one representative from the AHCA, the DOEA, the DCF, the DOH, and the Ombudsman Office, for the purpose of determining whether agencies have overlapping regulatory responsibilities over ALFs. The task force is required to meet at least 3 times and must submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives, by January 1, 2013. The report must include the task force's findings and

recommendations pertaining to streamlining agency oversight of ALFs and improving the effectiveness of regulatory functions.

The task force is scheduled to be terminated as of March 1, 2013.

Section 38 creates an undesignated section of law to require the AHCA, by January 1, 2013, to submit copies of all of its inspection forms used to inspect ALFs to the Ombudsman Office. The Ombudsman Office is required to create and act as the chair of a task force of up to 11 members, consisting of an ombudsman, one representative of a nonprofit ALF, one representative of a for-profit ALF, at least one ALF resident or family member of a resident, other stakeholders, and one representative from each of the following:

- The AHCA.
- The DOEA.
- The DCF.
- The DOH.

The task force is required to provide recommendations, if any, to modify the inspection forms to ensure the inspections adequately assess whether the ALFs are in compliance with the law, meet the needs of residents, and ensure resident safety. The task force must provide its recommendations, and explanations of any recommendations, to the AHCA within 90 days after receiving the inspection forms.

The task force is scheduled to terminate on July 1, 2013.

Section 39 creates an undesignated section of law to ensure that licensure fees, which are currently adjusted to the consumer price index, are not reset by any changes made to such fees in the bill.

Section 40 provides an effective date of July 1, 2012.

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 this 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:

The bill increases the standard ALF license fee from $300 to $500, when an ALF is cited for one or more class I or class II violations within the two years prior to licensure renewal. Additionally, the per-bed fee is increased from $50 to $55, and the total licensure fee is capped at $20,000, instead of the current $10,000 fee cap. These fees are in addition to the licensure and per resident fees already adjusted to the consumer price index pursuant to s. 408.805, F.S.

The bill establishes ALF administrator licensure fees of $250 for initial licensure and $250 for each licensure renewal period. The bill also requires participants to pay for any training fees or fees required to take a tutorial or examination.

The bill provides that an administrator must pay a fee when applying for inactive status of his or her license and that an administrator with a license in inactive status must pay a reactivation fee in addition to any delinquency fee.

The bill authorizes the Board to establish an application fee not to exceed to $500 for a provisional license for an ALF administrator.

B. Private Sector Impact:

ALFs that are cited for certain types of violations would be subject to increased fines and fees. An ALF that commits a retaliatory act against a resident without showing good cause in court would be subject to a fine of $2,500.

Those who are required to complete certain training requirements under the bill are responsible for the cost of such training, or the training costs may be incurred by the employer of such person.

C. Government Sector Impact:

The AHCA and DOH, including the Board under the DOH, would incur an indeterminate amount of costs associated with the additional rulemaking and oversight responsibilities provided for in the bill. The AHCA's costs should be somewhat offset by the increased fine and fee amounts provided for in the bill.

A fiscal analysis has been requested, but was not available for this analysis.

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.)

None.

B. Amendments:

None.

588-02542B-12

Proposed Committee Substitute by the Committee on Health Regulation

A bill to be entitled

An act relating to assisted living facilities; amending s. 394.4574, F.S.; revising the duties of the case manager for, and the community living support plan of, a mental health resident of an assisted living facility; amending s. 400.0078, F.S.; requiring residents of long-term care facilities to be informed about the confidentiality of the subject matter and identity of the complainant of a complaint received by the State Long-Term Care Ombudsman Program; amending s. 415.1034, F.S.; adding certain employees or agents of a state or local agency to the list of persons who must report the known or suspected abuse of a vulnerable adult to the abuse hotline; amending s. 429.02, F.S.; providing definitions for "board" and "mental health professional"; amending s. 429.07, F.S.; conforming a cross-reference; increasing the biennial license fee required for a facility that has certain violations within the 2 years preceding license renewal; amending s. 429.075, F.S.; revising the criteria preventing a licensed facility from receiving a limited mental health license; providing training requirements for administrators and staff members of facilities that hold a limited mental health license; requiring that a mental health professional be part of the team inspecting a facility that holds a limited mental health license; requiring

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quarterly monitoring of the facility; providing for an exception from quarterly monitoring; amending s. 429.14, F.S.; requiring the revocation of a facility license for certain violations that result in the death of a resident; amending s. 429.176, F.S.; requiring the licensure of facility administrators; providing administrator education and examination requirements; providing training requirements for facility managers during the temporary absence of an administrator; amending s. 429.178, F.S.; revising training requirements for staff who provide care for persons with Alzheimer's disease and related disorders; amending s. 429.19, F.S.; conforming provisions to changes made by the act; authorizing the Agency for Health Care Administration to impose an increased fine for certain violations that result in the death of a resident; amending s. 429.23, F.S.; requiring a facility to establish a risk management and quality assurance program; amending s. 429.256, F.S.; conforming a cross-reference; amending s. 429.28, F.S.; requiring residents of facilities to be informed about the confidentiality of the subject matter and identity of the resident and complainant of a complaint made to the State Long-Term Care Ombudsman Program; requiring the agency to conduct followup inspections of facilities that have a history of certain violations; providing that a facility that terminates an individual's residency will be fined if good cause is not shown in court; amending s. 429.34,

F.S.; providing that the agency is designated as the central agency for receiving and tracking facility complaints; requiring the agency to have lead surveyors who specialize in assessing facilities; amending s. 429.41, F.S.; requiring the agency to observe the elopement drills of a randomly selected group of facilities; authorizing the agency to require additional staffing for facilities that hold a specialty license; requiring the agency to conduct an abbreviated biennial licensure inspection; amending s. 429.49, F.S.; increasing the criminal penalty for altering facility records; creating s. 429.515, F.S.; requiring new facility employees to attend a preservice orientation; providing requirements for such orientation; amending s. 429.52, F.S.; revising training and continuing education requirements for facility staff other than administrators; providing for the use of interactive online tutorials; creating s. 429.521, F.S.; providing specialty training requirements for certain staff of facilities that hold an extended congregate care, limited nursing, and limited mental health license; providing for examinations; authorizing the Board of Assisted Living Facility Administration to adopt rules; creating s. 429.522, F.S.; requiring training providers to be certified by the board and provide trainer oversight; providing trainer requirements; requiring the board to maintain an electronic database of certified providers and persons who complete training if funding is

available; creating s. 429.523, F.S.; providing for board approval of training and testing centers; providing approval criteria; amending s. 429.54, F.S.; requiring specified state agencies to have an electronic system of communication pertaining to the regulation of facilities; requiring facilities to submit certain facility and resident information electronically to the agency twice yearly; providing for the maintenance and use of such information; providing for expiration of this requirement; creating s. 429.55, F.S.; directing the agency to establish an online, user-friendly facility rating system that may be accessed by the public; providing a directive to the Division of Statutory Revision; amending s. 498.1635, F.S.; revising the purpose of part II of ch. 669, F.S., to include assisted living administrators; amending s. 468.1645, F.S.; requiring assisted living facilities to be operated under the management of a licensed administrator; amending s. 468.1655, F.S.; revising definitions to conform to changes made by the act; amending s. 468.1665, F.S.; revising the membership of the Board of Nursing Home and Assisted Living Facility Administrators; amending s. 468.1685, F.S.; revising the duties of the board to include the development of assisted living facility administrator training and examination, administrator continuing education curriculum, a limited mental health curriculum and examination, a staff training curriculum, an interactive online tutorial for

facility staff, a continuing education curriculum for facility staff, and other training requirements as necessary; requiring the board to certify assisted living training providers and approve testing and training centers; amending s. 468.1695, F.S.; providing requirements for assisted living facility administrator examination; amending s. 468.1705, F.S., relating to licensure by endorsement to conform to changes made by the act; amending s. 468.1725, F.S.; revising provisions relating to the inactive status of an administrator's license; amending s. 468.1735, F.S., relating to provisional licensing; conforming provisions to changes made by the act; amending s. 468.1745, F.S.; providing requirements for who must be licensed as an assisted living facility administrator; amending s. 468.1755, F.S.; conforming provisions to changes made by the act; providing grounds for disciplinary action for assisted living facility administrators; amending s. 468.1756, F.S.; conforming provisions to changes made by the act; requiring the agency to create a task force to determine whether state agencies have overlapping regulatory jurisdiction over facilities and to submit findings and recommendations to the Governor and Legislature by a certain date; providing for termination; requiring the Office of the State Long-Term Care Ombudsman to create a task force to review the agency's facility inspection forms and to submit its recommendations to the agency by a certain date; providing for

termination; providing an effective date.

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

Section 1. Paragraph (e) of subsection (2) of section 394.4574, Florida Statutes, is amended, and paragraph (f) is added to that subsection, to read:

394.4574 Department responsibilities for a mental health resident who resides in an assisted living facility that holds a limited mental health license.—

(2) The department must ensure that:

(e) The mental health services provider assigns a case manager to each mental health resident who lives in an assisted living facility with a limited mental health license. The case manager 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 as needed, but at least annually, to ensure that the ongoing needs of the resident are addressed. Each case manager shall keep a record of the date and time of any face-to-face interaction with the mental health resident and make the record available to the department for inspection. The record must be retained for 2 years after the date of the last interaction.

(f) There is adequate and consistent monitoring and enforcement of community living support plans and cooperative agreements by the department.

Section 2. 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, the confidentiality of the subject matter of a complaint and the complainant's name and identity, and other relevant information regarding how to contact the program. Residents or their representatives must be furnished additional copies of this information upon request.

Section 3. Paragraph (a) of subsection (1) of section 415.1034, Florida Statutes, is amended to read:

415.1034 Mandatory reporting of abuse, neglect, or exploitation of vulnerable adults; mandatory reports of death.—

(1) MANDATORY REPORTING.—

(a) Any person, including, but not limited to~~, any~~:

1. A physician, osteopathic physician, medical examiner, chiropractic physician, nurse, paramedic, emergency medical technician, or hospital personnel engaged in the admission, examination, care, or treatment of vulnerable adults;

2. A health professional or mental health professional other than one listed in subparagraph 1.;

3. A practitioner who relies solely on spiritual means for healing;

4. Nursing home staff; assisted living facility staff; adult day care center staff; adult family-care home staff; social worker; or other professional adult care, residential, or institutional staff;

5. A state, county, or municipal criminal justice employee or law enforcement officer;

6. An employee of the Department of Business and Professional Regulation conducting inspections of public lodging establishments under s. 509.032;

7. A Florida advocacy council member or long-term care ombudsman council member; ~~or~~

8. A bank, savings and loan, or credit union officer, trustee, or employee; or

9. An employee or agent of a state or local agency who has regulatory responsibilities over, or who provides services to, persons residing in a state-licensed facility,

who knows, or has reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited must ~~shall~~ immediately report such knowledge or suspicion to the central abuse hotline.

Section 4. Subsections (5) and (11) of section 429.02, Florida Statutes, are amended, present subsections (6) through (14) of that section are redesignated as subsections (7) through (15), respectively, present subsections (15) through (26) of that section are redesignated as subsections (17) through (28), respectively, and new subsections (6) and (16) are added to that section, to read:

429.02 Definitions.—When used in this part, the term:

(5) "Assisted living facility" or "facility" means any building or buildings, section or distinct part of a building, private home, boarding home, home for the aged, or other residential facility, whether operated for profit or not, which

undertakes through its ownership or management to provide 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.

(6) "Board" means the Board of Nursing Home and Assisted Living Facility Administrators established under s. 468.1665.

(12)~~(11)~~ "Extended congregate care" means acts beyond those authorized in subsection (18) which ~~(16) that~~ may be performed pursuant to part I of chapter 464 by persons licensed thereunder while carrying out their professional duties, and other supportive services which may be specified by rule. The purpose of such services is to enable residents to age in place in a residential environment despite mental or physical limitations that might otherwise disqualify them from residency in a facility licensed under this part.

(16) "Mental health professional" means an individual licensed under chapter 458, chapter 459, chapter 464, chapter 490, or chapter 491 who provides mental health services as defined in s. 394.67, or an individual who has a 4-year baccalaureate degree with a concentration in mental health from an accredited college or university and at least 5 years of experience providing services that improve an individual's mental health or that treat mental illness.

Section 5. Section 429.07, Florida Statutes, is amended to read:

429.07 Facility license required; fee.—

(1) The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to this part and part II of chapter 408 and to entities licensed by or

applying for such licensure from the agency pursuant to this part. A license issued by the agency is required in order to operate an assisted living facility in this state.

(2) Separate licenses are ~~shall be~~ required for facilities maintained in separate premises, even though operated under the same management. A separate license is ~~shall~~ not ~~be~~ required for separate buildings on the same grounds.

(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.

(a) A standard license shall be issued to facilities providing one or more of the personal services identified in s. 429.02. Such facilities may also employ or contract with a person licensed under part I of chapter 464 to administer medications and perform other tasks as specified in s. 429.255.

(b) An extended congregate care license shall be issued to 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.

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. 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. Existing 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 had ~~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.

2. A facility that is licensed to provide extended

congregate care services must ~~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 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 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 no class I or class II violations and no uncorrected class III violations. 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.

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 in order 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 and the specialized training provided in s. 429.521, provide specialized training as defined by rule for facility staff.

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. 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 part II of chapter 408. Existing facilities qualifying to provide limited nursing services 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. Facilities that are licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services, which report 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 such facilities at least 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.

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.

(4) In accordance with s. 408.805, an applicant or licensee shall pay a fee for each license application submitted under this part, part II of chapter 408, and applicable rules. The amount of the fee shall be established by rule.

(a) The biennial license fee required of a facility is $300 per license, plus ~~with~~ an additional fee of $50 per resident based on the total licensed resident capacity of the facility, except that an ~~no~~ additional fee may not ~~will~~ be assessed for beds designated for recipients of optional state supplementation payments provided under ~~for in~~ s. 409.212. The total fee may not exceed $10,000. However, the biennial license fee for a licensed facility that has one or more class I or class II violations within the 2 years before licensure renewal is $500 per license plus a fee of $55 per resident. The increased fee amounts are in addition to any adjusted fee amounts imposed pursuant to s. 408.805. The total fee for such facilities may not exceed $20,000. The increased fees shall be imposed for one licensure cycle, unless the facility has a class I or class II violation during the next biennial inspection.

(b) In addition to the total fee assessed under paragraph (a), the agency shall require facilities that are licensed to provide extended congregate care services under this part to pay an additional fee per licensed facility. The amount of the biennial fee shall be $400 per license, with an additional fee

of $10 per resident based on the total licensed resident capacity of the facility.

(c) In addition to the total fee assessed under paragraph (a), the agency shall require facilities that are licensed to provide limited nursing services under this part to pay an additional fee per licensed facility. The amount of the biennial fee shall be $250 per license, with an additional fee of $10 per resident based on the total licensed resident capacity of the facility.

(5) Counties or municipalities applying for licenses under this part are exempt from the payment of license fees.

Section 6. Section 429.075, Florida Statutes, is amended to read:

429.075 Limited mental health license.—An assisted living facility that serves ~~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 and~~,~~ must 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) Two or more class I or class II violations;

(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 facility's corrective action plan approved by the agency;

(d) A violation of resident care standards which resulted in requiring the facility to employ the consultant services of a licensed pharmacist or a registered or licensed dietitian under s. 429.42;

(e) Denial, suspension, or revocation of a license for another facility licensed under this part in which the license applicant had at least a 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 ~~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~~. ~~Such designation~~

(2) Licensure to provide services to mental health residents 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 agency approval or denial of such request must ~~shall~~ be made in accordance with this part, part II of chapter 408, and applicable rules. ~~This training will be provided by or approved by the Department of Children and Family Services.~~

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

(a) In addition to the general training or educational requirements under this part or part II of chapter 468, as

applicable, each administrator and staff member who provides regular or direct care to the residents of a facility licensed to provide services to mental health residents must meet the specialized limited mental health training requirements set forth in s. 429.521.

(b) Effective July 1, 2012, an administrator of a facility that has a limited mental health license, in addition to the education requirements under part II of chapter 468, must have also completed at least 6 semester credit hours of college-level coursework relating to mental health.

(4) ~~(3)~~ A facility that holds ~~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 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 with a limited mental health license.

(c) Make the community living support plan available for inspection by the resident, the resident's legal guardian, 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.

(5) ~~(4)~~ A facility that holds ~~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.

(6) A mental health professional shall serve as part of the team that inspects a facility that holds a limited mental health license, and may conduct the inspection without other agency representatives. A mental health professional representing the agency shall visit the facility at least quarterly to monitor residents who are receiving limited mental health services and to determine if the facility is in compliance with this part, part II of chapter 408, and relevant rules, and may send a report to the agency reporting his or her findings. One of those visits may be in conjunction with the agency's regular survey. The monitoring visits may be provided through a contractual arrangement with an appropriate community agency. The agency may waive one of the quarterly monitoring visits of a facility that has had a mental health license for at least 2 years if, during an inspection, the mental health professional determines that mental health services are being provided appropriately and the facility has had no class I or class II violation and no uncorrected class III violation in the past 2 years. Before waiving a monitoring visit, the agency must first consult with a representative of the local long-term care ombudsman council for the area in which the facility is located to determine if any complaint has been made and the outcome of the complaint. The agency may not waive one of the required monitoring visits if an ombudsman referral was made to the agency which resulted in a citation for a licensure violation.

Section 7. Subsection (4) of section 429.14, Florida Statutes, is amended to read:

429.14 Administrative penalties.—

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

(a) Has two or more class I or class II 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; or~~.~~

(b) Committed a class I violation that caused the death of a resident or an intentional or negligent act that, based on a court's findings, caused the death of a resident.

Section 8. Section 429.176, Florida Statutes, is amended to read:

429.176 ~~Notice of change of~~ Administrator license; educational requirements; change of administrator; managers.—

(1) To be an administrator of an assisted living facility, an applicant must meet the requirements under part I of chapter 468.

(2) A licensed administrator must complete a minimum of 18 hours of continuing education every 2 years and pass a short examination that corresponds to each continuing education course with a minimum score of 80 in order to demonstrate receipt and comprehension of the training. The examination may be offered online and any fees associated with the online service must be borne by the participant. The license of a facility whose administrator had not maintained these continuing education requirements shall enter inactive status.

(3) The administrator of a facility that holds a limited

mental health license must have met the educational requirements of s. 429.521(3).

(4) If, during the period for which a standard license is issued, the facility owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation that the administrator is licensed or has been granted a provisional license ~~within 90 days that the new administrator has completed the applicable core educational requirements under s. 429.52~~.

(5) A manager of a facility who assumes responsibility for the operation of the facility during the temporary absence of an administrator must meet the core training requirements under s. 468.1685(9)(a) within 30 days after being employed as, or becoming, a facility manager.

Section 9. 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) Staff members, including administrators, ~~An individual~~ who are ~~is~~ employed by a facility that provides special care for residents with Alzheimer's disease or other related disorders, and who provide ~~has~~ regular or direct care to ~~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 shall satisfy the core training requirements of s. 429.52(2)(g)~~.

(b) A direct caregiver who is employed by a facility that provides special care for residents 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 6 months ~~9 months~~ after beginning employment ~~and shall satisfy the core training requirements of s. 429.52(2)(g)~~.

Section 10. Subsections (1) and (2) of section 429.19, Florida Statutes, are amended to read:

429.19 Violations; imposition of administrative fines; grounds.—

(1) In addition to the requirements of part II of chapter 408 and s. 429.28(6), the agency shall impose an administrative fine in the manner provided under ~~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 shall be classified according to the nature of the violation and the gravity of its probable effect on facility residents as provided in s. 408.813.

(a) The agency shall indicate the classification on the written notice of the violation as follows:

1.~~(a)~~ For class "I" violations~~,~~ ~~are defined in s. 408.813.~~ the agency shall impose an administrative fine ~~for a cited class I violation~~ in an amount not less than $5,000 and not exceeding $10,000 for each violation.

2.~~(b)~~ For class "II" violations~~,~~ ~~are defined in s. 408.813.~~ the agency shall impose an administrative fine ~~for a cited class II violation~~ in an amount not less than $1,000 and not exceeding $5,000 for each violation.

3.~~(c)~~ For class "III" violations~~,~~ ~~are defined in s. 408.813.~~ the agency shall impose an administrative fine ~~for a cited class III violation~~ in an amount not less than $500 and not exceeding $1,000 for each violation even if the violation is corrected before the citation is issued.

4.~~(d)~~ For class "IV" violations~~,~~ ~~are defined in s. 408.813.~~ the agency shall impose an administrative fine ~~for a cited class IV violation~~ in an amount not less than $100 and not exceeding $200 for each violation.

(b) The agency shall impose the maximum penalty for the class of violation which results in the death of a resident. If the facility is cited for a second or subsequent violation that is in the same class as a prior violation that the facility has been cited for at, or since, the last inspection, the agency shall double the fine for the second or subsequent violation even if the fine exceeds the maximum amount authorized. Notwithstanding s. 408.813(c), if a facility is cited for ten or more class III violations during an inspection or survey, the agency shall impose a fine for each violation.

Section 11. Subsection (1) of section 429.23, Florida Statutes, is amended to read:

429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.—

(1) As part of its administrative functions, an assisted living ~~Every~~ facility licensed under this part shall ~~may, as~~

~~part of its administrative functions, voluntarily~~ establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences.

Section 12. Paragraph (b) of subsection (1) of section 429.256, Florida Statutes, is amended to read:

429.256 Assistance with self-administration of medication.—

(1) For the purposes of this section, the term:

(b) "Unlicensed person" means an individual not currently licensed to practice nursing or medicine who is employed by or under contract to an assisted living facility and who has received training with respect to assisting with the self-administration of medication in an assisted living facility, as provided under s. 429.521, before ~~429.52 prior to~~ providing such assistance as described in this section.

Section 13. Subsection (2), paragraph (d) of subsection (3), and subsection (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 and central abuse hotline and, if ~~when~~ applicable, the Advocacy Center for Persons with Disabilities, Inc., and the Florida local advocacy council,

where complaints may be lodged. The notice must state that the subject matter of a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council and the names and identities of the residents involved in the complaint and the complainants are confidential pursuant to s. 400.0077. The facility must ensure a resident's access to a telephone to call the local ombudsman council, central abuse hotline, Advocacy Center for Persons with Disabilities, Inc., and the Florida local advocacy council.

(3)

(d) The agency shall conduct periodic followup inspections to monitor the compliance of facilities having a history of class I violations that threaten the health, safety, or security of residents, and may conduct periodic followup inspections as necessary to monitor the compliance of facilities having ~~with~~ a history of ~~any class I,~~ class II~~,~~ or class III violations that threaten the health, safety, or security of residents.

(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 14. 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, a ~~any duly~~ designated officer or employee of the department, the Department of Children and 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 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.

(2) The agency is designated the central agency for receiving and tracking complaints to ensure that allegations regarding facilities are timely responded to and that licensure enforcement action is initiated if warranted. Any other state agency regulating, or providing services to residents of, assisted living facilities must report any allegations or complaints that have been substantiated or are likely to have occurred to the agency as soon as reasonably possible.

(3) The agency shall have lead surveyors in each field office who specialize in assessing assisted living facilities. The lead surveyors shall provide initial and ongoing training to surveyors who will be inspecting and monitoring facilities. The lead surveyors shall ensure that consistent inspection and monitoring assessments are conducted.

(4) The agency shall have one statewide lead surveyor who specializes in assisted living facility inspections. The lead surveyor shall coordinate communication between lead surveyors of assisted living facilities throughout the state and ensure statewide consistency in applying facility inspection laws and

rules.

Section 15. Paragraph (l) of subsection (1) and subsections (2) and (5) of section 429.41, Florida Statutes, are amended to read:

429.41 Rules establishing standards.—

(1) It is the intent of the Legislature that rules published and enforced pursuant to this section shall include criteria by which a reasonable and consistent quality of resident care and quality of life may be ensured and the results of such resident care may be demonstrated. Such rules shall also ensure a safe and sanitary environment that is residential and noninstitutional in design or nature. It is further intended that reasonable efforts be made to accommodate the needs and preferences of residents to enhance the quality of life in a facility. The agency, in consultation with the department, may adopt rules to administer the requirements of part II of chapter 408. In order to provide safe and sanitary facilities and the highest quality of resident care accommodating the needs and preferences of residents, the department, in consultation with the agency, the Department of Children and Family Services, and the Department of Health, shall adopt rules, policies, and procedures to administer this part, which must include reasonable and fair minimum standards in relation to:

(l) The establishment of specific policies and procedures on resident elopement. Facilities shall conduct a minimum of two resident elopement drills each year. All administrators and direct care staff shall participate in the drills. Facilities shall document the drills. Each calendar year, the agency shall observe the elopement drills of 10 percent of the licensed

facilities in the state. The facilities must be randomly selected by the agency and the elopement drills must coincide with an inspection or survey conducted by the agency. If an agency employee observes an elopement drill that does not meet standards established by rule, the agency shall provide notice of the deficiencies to the facility within 15 calendar days after the drill. The facility shall submit a corrective action plan to the agency within 30 calendar days after receiving such notice.

(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. The department may require additional staffing for facilities that have specialty licenses, but the additional staffing must correlate with the number of residents receiving special care and the type of special care required. 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 if~~, provided that~~ the structure is no more than two stories in height and all persons

who cannot exit the facility unassisted in an emergency 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. If ~~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~~.

(5) In order to allocate resources efficiently, the agency shall conduct ~~may use~~ an abbreviated biennial standard licensure inspection that consists of a review of key quality-of-care standards in lieu of a full inspection in a facility that has a good record of past performance. However, a full inspection must be conducted in a facility that has a history of class I or class II violations, uncorrected class III violations, confirmed ombudsman council complaints, or confirmed licensure complaints, within the previous licensure period immediately preceding the inspection or if a potentially serious problem is identified during the abbreviated inspection. The agency, in consultation with the department, shall develop the key quality-of-care standards with input from the State Long-Term Care Ombudsman Council and representatives of provider groups for incorporation into its rules.

Section 16. Subsection (1) of section 429.49, Florida Statutes, is amended to read:

429.49 Resident records; penalties for alteration.—

(1) Any person who fraudulently alters, defaces, or falsifies any medical or other record of an assisted living

facility, or causes or procures any such offense to be committed, commits a misdemeanor of the first ~~second~~ degree, punishable as provided in s. 775.082 or s. 775.083.

Section 17. Section 429.515, Florida Statutes, is created to read:

429.515 Preservice orientation.—

(1) Effective July 1, 2012, a new employee, including an administrator, of an assisted living facility must attend a preservice orientation provided by the facility which covers topics that will enable the employee to relate and respond to the residents of that facility. The orientation must be at least 2 hours in duration, be available in English and Spanish, and, at a minimum, cover the following topics:

(a) Care of persons who have Alzheimer's disease or other related disorders.

(b) Deescalation techniques.

(c) Aggression control.

(d) Elopement prevention.

(e) Behavior management.

(2) Upon completion of the preservice orientation, the employee must sign an affidavit, under penalty of perjury, stating that the employee completed the orientation. The administrator of the facility must maintain the signed affidavit in the employee's work file.

Section 18. Section 429.52, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 429.52, F.S., for present text.)

429.52 Staff member training; tutorial; continuing

education.—

(1) Staff members, other than administrators, providing regular or direct care to residents must complete a staff training curriculum developed by the board. The training must be completed within 30 days after employment and is in addition to the preservice orientation required under s. 429.515. Any cost or fee associated with the training shall be borne by the participant or the participant's employer.

(2) Staff members, other than administrators, providing regular or direct care to residents must complete an interactive online tutorial developed by the board that demonstrates an understanding of the training received under subsection (1). The board shall provide a certificate to each staff member who completes the tutorial. The certificate must be maintained in the employee's work file.

(3) Staff members, other than administrators, providing regular or direct care to residents must participate in a minimum of 8 hours of continuing education every 2 years as developed by the board. The continuing education may be offered through online courses and any fee associated with the online service shall be borne by the participant or the participant's employer.

Section 19. Section 429.521, Florida Statutes, is created to read:

429.521 Specialty training and education; examinations.—

(1) Administrators and staff members who provide regular or direct care to residents of a facility that holds an extended congregate care license must complete a minimum of 6 hours of board-approved extended congregate care training within 30 days

after beginning employment.

(2) If a facility holds a limited nursing services license:

(a) The administrator must complete a minimum of 4 hours of board-approved courses that train and educate administrators on the special needs and care of those requiring limited nursing services.

(b) Staff members providing regular and direct care to residents receiving limited nursing services must complete a minimum of 2 hours of courses that train and educate staff on the special needs and care of those requiring limited nursing services. The training must be completed within 30 days after employment.

(3) Staff members who provide regular or direct care to mental health residents and administrators who are employed by a facility that holds a limited mental health license must complete a minimum of 8 hours of board-approved mental health training within 30 days after beginning employment. Within 30 days after completing such training, a staff member must complete an online interactive tutorial related to the training and receive a certificate of completion in order to demonstrate an understanding of the training received. An administrator must pass an examination related to the administrator's training with a minimum score of 80. The participant or the participant's employer shall pay any fee associated with taking the tutorial or examination.

(a) A staff member who does not complete the tutorial or an administrator who fails the examination may not provide regular or direct care to mental health residents until he or she successfully completes the tutorial or passes the examination.

(b) An administrator who does not pass the examination within 6 months after completing the mental health training may not be an administrator of a facility that holds a limited mental health license until the administrator achieves a passing score.

(4) Staff, including administrators, who prepare or serve food must receive a minimum of 1 hour of inservice training in safe food handling practices within 30 days after beginning employment.

(5) Staff members, including administrators, must receive at least 1 hour of inservice training on the facility's resident elopement response policies and procedures within 30 days after beginning employment.

(a) A copy of the facility's resident elopement response policies and procedures must be provided to staff members and the administrator.

(b) Staff members and the administrator must demonstrate understanding and competency in the implementation of the elopement response policies and procedures.

(6) Staff members, including the administrator, involved with the management of medications and the assistance with self-administration of medications under s. 429.256 must complete a minimum of 4 additional hours of training provided by a registered nurse, licensed pharmacist, or department staff member. The board shall establish by rule the minimum requirements of this training, including continuing education requirements.

(7) Other facility staff members shall participate in training relevant to their job duties as specified by board

rule.

Section 20. Section 429.522, Florida Statutes, is created to read:

429.522 Assisted living training providers; certification.—

(1) Effective January 1, 2013, an individual seeking to provide assisted living training in this state must be certified by the board. The applicant must provide the board with proof of completion of the minimum core training requirements, successful passage of the assisted living facility administrator licensure examination, and proof of compliance with any continuing education requirements.

(2) A person seeking to be certified as a trainer must also:

(a) Provide proof of completion of a 4-year baccalaureate degree from an accredited college or university and have worked in a management position in an assisted living facility for 3 years after obtaining certification in core training courses;

(b) Have worked in a management position in an assisted living facility for 5 years after obtaining certification in the core training courses and have 1 year of teaching experience as an educator or staff trainer for persons who work in an assisted living facility or another long-term care setting;

(c) Have been previously employed as a trainer of core training courses for the department;

(d) Have at least 5 years of employment with the agency as a surveyor of assisted living facilities;

(e) Have at least 5 years of employment in a professional position in the agency's assisted living unit;

(f) Have at least 5 years of employment as an educator or

staff trainer for persons working in an assisted living facility or another long-term care setting;

(g) Have at least 5 years of employment as a trainer of core assisted living facility courses not directly associated with the department;

(h) Have a 4-year baccalaureate degree from an accredited college or university in the areas of health care, gerontology, social work, education, or human services and at least 4 years of experience as an educator or staff trainer for persons working in an assisted living facility or another long-term care setting after receiving certification in core courses; or

(i) Meet other qualification criteria as defined by rule of the board.

(3) The board shall provide oversight of the assisted living training providers. The board shall adopt rules to establish requirements for trainer certification, disciplinary action that may be taken against a trainer, and a trainer decertification process.

(4) If funding is available, by January 1, 2013, the board shall develop and maintain an electronic database, accessible to the public, which lists all persons holding certification as an assisted living trainer, including any history of violations. Assisted living trainers shall keep a record of individuals who complete training and shall submit the record to the board within 24 hours after the completion of a course in order for the board to include the information in the database.

Section 21. Section 429.523, Florida Statutes, is created to read:

429.523 Training and testing centers.—In addition to

certified assisted living trainers under s. 429.522, training and testing centers approved by the board may conduct assisted living training or examinations under this part.

(1) The board shall consider the following when reviewing a center applicant:

(a) Whether the center will provide sufficient space for training.

(b) The location of the center and whether another center already provides assisted living training or testing in the approximate area.

(c) The fee to be charged by the center for providing such services.

(d) Whether the center has sufficient staff who meet the qualifications for assisted living training providers under s. 429.522.

(e) Any other consideration that the board deems necessary to approve a center.

(2) The board shall provide a certificate of approval to an applicant that meets with the board's approval. The training and testing center shall keep the certificate on file as long as it provides assisted living training or examination services.

(3) The board or the agency may inspect a center to determine whether the training or testing center meets law and rule requirements and may decertify a training and testing center that does not continue to meet such requirements.

(4) An assisted living trainer employed by the training or testing center must perform the recordkeeping and reporting required under s. 429.522(4).

Section 22. Section 429.54, Florida Statutes, is amended to

read:

429.54 Collection of information; local subsidy; interagency communication; facility reporting.—

(1) To enable the department to collect the information requested by the Legislature regarding the actual cost of providing room, board, and personal care in assisted living facilities, the department may ~~is authorized to~~ conduct field visits and audits of facilities as ~~may be~~ necessary. The owners of randomly sampled facilities shall submit such reports, audits, and accountings of cost as the department may require by rule; however, ~~provided that~~ such reports, audits, and accountings may not be more than ~~shall be~~ the minimum necessary to implement the provisions of this subsection ~~section~~. Any facility selected to participate in the study shall cooperate with the department by providing cost of operation information to interviewers.

(2) Local governments or organizations may contribute to the cost of care of local facility residents by further subsidizing the rate of state-authorized payment to such facilities. Implementation of local subsidy shall require departmental approval and may ~~shall~~ not result in reductions in the state supplement.

(3) Subject to the availability of funds, the agency, the Department of Elderly Affairs, the Department of Children and Family Services, and the Agency for Persons with Disabilities shall develop or modify electronic systems of communication among state-supported automated systems to ensure that relevant information pertaining to the regulation of assisted living facilities and facility staff is timely and effectively

communicated among agencies in order to facilitate the protection of residents.

(4) All assisted living facilities shall submit twice a year electronic reports to the agency.

(a) The reports must include the following information and must be submitted in accordance with a reporting cycle established by the agency by rule:

1. The number of beds in the facility;

2. The number of beds being occupied;

3. The number of residents who are younger than 65 years of age, from 65 to 74 years of age, from 75 to 84 years of age, and 85 years of age or older;

4. The number of residents who are mental health residents, who are receiving extended congregate care, who are receiving limited nursing services, and who are receiving hospice care;

5. If there is a facility waiting list, the number of individuals on the waiting list and the type of services or care that they require, if known;

6. The number of residents receiving optional state supplementation; and

7. The number of residents who are Medicaid recipients and the type of waiver used to fund each such resident's care.

(b) The agency must maintain electronically the information it receives and, at a minimum, use such information to track trends in resident populations and needs.

(c) This subsection expires July 1, 2017.

Section 23. Section 429.55, Florida Statutes, is created to read:

429.55 Assisted living facility rating system.—

(1) The agency, in consultation with the department, the Department of Children and Family Services, and the Office of State Long-Term Care Ombudsman, shall develop and adopt by rule a user-friendly assisted living facility rating system.

(2) The rating system must be publicly available on the Internet in order to assist consumers in evaluating assisted living facilities and the services provided by such facilities.

(3) The rating system must be based on resident satisfaction, the number and class of deficiencies for which the facility has been cited, agency inspection reports, the inspection reports of any other regulatory agency, assessments conducted by the ombudsman program pursuant to part of chapter 400, and other criteria as determined by the agency.

(4) The Internet home page for the rating system must include a link that allows consumers to complete a voluntary survey that provides feedback on whether the rating system is helpful and suggestions for improvement.

(5) The agency may adopt rules as necessary to administer this section.

Section 24. The Division of Statutory Revision is requested to rename part II of chapter 468, Florida Statutes, consisting of ss. 468.1635-468.1756, Florida Statutes, as "Nursing Home and Assisted Living Facility Administration."

Section 25. Section 468.1635, Florida Statutes, is amended to read:

468.1635 Purpose.—The sole legislative purpose for enacting this part ~~chapter~~ is to ensure that every nursing home administrator and assisted living facility administrator practicing in this state meets minimum requirements for safe

practice. It is ~~the~~ legislative intent that nursing home administrators and assisted living facility administrators who fall below minimum competency or who otherwise present a danger to the public ~~shall~~ be prohibited from practicing in this state.

Section 26. Section 468.1645, Florida Statutes, is amended to read:

468.1645 Administrator license required.—

(1) A ~~No~~ nursing home ~~in the state~~ may not operate in this state unless it is under the management of a nursing home administrator, and, effective July 1, 2013, an assisted living facility may not operate in this state unless it is under the management of an assisted living facility administrator, who holds a currently valid license, provisional license, or temporary license.

(2) Nothing in this part or in the rules adopted hereunder ~~shall~~ require an administrator of any facility or institution operated by and for persons who rely exclusively upon treatment by spiritual means through prayer, in accordance with the creed or tenets of any organized church or religious denomination, to be licensed as a nursing home or assisted living facility administrator if the administrator is employed only to administer in such facilities or institutions for the care and treatment of the sick.

Section 27. Section 468.1655, Florida Statutes, is reordered and amended to read:

468.1655 Definitions.—As used in this part:

(1) "Assisted living facility" means a facility licensed under part I of chapter 429.

(2) "Assisted living facility administrator" means a person

who is licensed to engage in the practice of assisted living facility administration in this state under the authority of this part.

(3) ~~(1)~~ "Board" means the Board of Nursing Home and Assisted Living Facility Administrators.

(4) ~~(2)~~ "Department" means the Department of Health.

(6) ~~(3)~~ "Nursing home administrator" means a person who is licensed to engage in the practice of nursing home administration in this state under the authority of this part.

(7) "Practice of assisted living facility administration" means any service requiring assisted living facility administration education, training, or experience and the application of such to the planning, organizing, staffing, directing, and controlling of the total management of an assisted living facility. A person is practicing or offering to practice assisted living facility administration if such person:

(a) Practices any of the above services.

(b) Holds himself or herself out as able to perform, or does perform, any form of assisted living facility administration by written or verbal claim, sign, advertisement, letterhead, or card; or in any other way represents himself or herself to be, or implies that he or she is, an assisted living facility administrator.

(8) ~~(4)~~ "Practice of nursing home administration" means any service requiring nursing home administration education, training, or experience and the application of such to the planning, organizing, staffing, directing, and controlling of the total management of a nursing home. A person is practicing or offering ~~shall be construed to practice or to offer~~ to

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practice nursing home administration if such person ~~who~~:

(a) Practices any of the above services.

(b) Holds himself or herself out as able to perform, or does perform, any form of nursing home administration by written or verbal claim, sign, advertisement, letterhead, or card; or in any other way represents himself or herself to be, or implies that he or she is, a nursing home administrator.

(5) "Nursing home" means an institution or facility licensed as such under part II of chapter 400.

Section 28. Section 468.1665, Florida Statutes, is amended to read:

468.1665 Board of Nursing Home and Assisted Living Facility Administrators; membership; appointment; terms.—

(1) The Board of Nursing Home and Assisted Living Facility Administrators is created within the department and shall consist of eleven ~~seven~~ members, to be appointed by the Governor and confirmed by the Senate to a term of 4 years or for a term to complete an unexpired vacancy.

(2) Three members of the board must be licensed nursing home administrators. Three members of the board must be licensed assisted living facility administrators. Two members of the board must be health care practitioners. Three ~~The remaining two~~ members of the board must be laypersons who are not, and have never been, nursing home or assisted living facility administrators or members of any health care profession or occupation, and at least one of these laypersons must be a resident of an assisted living facility. At least one member of the board must be 60 years of age or older.

(3) A person may not be appointed as a member of the board

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if a conflict of interest exists, except that a nursing home administrator or an assisted living facility administrator who is appointed to the board may retain a financial interest in the institution or facility he or she administers at the time of appointment ~~Only board members who are nursing home administrators may have a direct financial interest in any nursing home~~.

(4) All provisions of chapter 456 relating to activities of regulatory boards shall apply.

Section 29. Section 468.1685, Florida Statutes, is amended to read:

468.1685 Powers and duties of board and department.—It is the function and duty of the board, together with the department, to:

(1) Adopt rules ~~pursuant to ss. 120.536(1) and 120.54~~ to implement the provisions of this part conferring duties upon the board.

(2) Develop, impose, and enforce specific standards within the scope of the general qualifications established by this part which must be met by individuals in order to receive licenses as nursing home or assisted living facility administrators. These standards shall be designed to ensure that nursing home and assisted living facility administrators are individuals of good character and otherwise suitable and, by training or experience in the field of health care facility ~~institutional~~ administration, qualified to serve as nursing home or assisted living facility administrators.

(3) Develop by appropriate techniques, including examinations and investigations, a method for determining

whether an individual meets such standards.

(4) Issue licenses to qualified individuals meeting the standards of the board and revoke or suspend licenses previously issued by the board if ~~when~~ the individual holding such license is determined to have failed to ~~conform~~ substantially conform to the requirements of such standards.

(5) Establish by rule and carry out procedures~~, by rule,~~ designed to ensure that licensed nursing home or assisted living facility administrators ~~will~~ comply with the standards adopted by the board.

(6) Receive, investigate, and take appropriate action with respect to any charge or complaint filed with the department ~~to the effect~~ that a licensed nursing home or assisted living facility administrator has failed to comply with the requirements or standards adopted by the board.

(7) Conduct a continuing study and investigation of nursing homes and assisted living facilities and the administrators of nursing homes and assisted living facilities in order to improve the standards imposed for the licensing of such administrators and the procedures and methods for enforcing such standards with respect to licensed administrators ~~of nursing homes who have been licensed as such~~.

(8) Set up procedures by rule for advising and acting together with the department ~~Department of Health~~ and other boards of other health professions in matters affecting procedures and methods for effectively enforcing the purpose of this part and the administration of chapters 400 and 429.

(9) In consultation with the Agency for Health Care Administration, the Department of Elderly Affairs, and the

Department of Children and Family Services, develop the following which must be completed by an applicant for licensure as an assisted living facility administrator:

(a) Assisted living facility administrator core training that includes at least 40 hours of training, is offered in English and Spanish, is reviewed at least annually by the board, and updated as needed to reflect changes in the law, rules, and best practices. The curriculum, at a minimum, must cover the following topics:

1. State law and rules relating to assisted living facilities.

2. Resident rights and the identification and reporting of abuse, neglect, and exploitation.

3. The special needs of elderly persons, persons who have mental illness, and persons who have developmental disabilities and how to meet those needs.

4. Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food.

5. Medication management, recordkeeping, and proper techniques for assisting residents who self-administer medication.

6. Firesafety requirements, including procedures for fire evacuation drills and other emergency procedures.

7. The care of persons who have Alzheimer’s disease and related disorders.

8. Elopement prevention.

9. Aggression and behavior management, de-escalation techniques, and proper protocols and procedures relating to the Baker Act as provided in part I of chapter 394.

10. Do-not-resuscitate orders.

11. Infection control.

12. Admission and continued residency.

13. Phases of care and interacting with residents.

14. Best practices in the industry.

15. Business operations, including, but not limited to, human resources, financial management, and supervision of staff.

(b) An assisted living facility administrator licensure examination that tests the applicant's knowledge and training of the core training topics listed in paragraph (a). The examination must be offered in English and Spanish, reviewed at least annually by the board, and updated as needed to reflect changes in the law, rules, and best practices. A minimum score of 80 is required to demonstrate successful completion of the training requirements.

(10) In consultation with the Agency for Health Care Administration, the Department of Elderly Affairs, and the Department of Children and Family Services, develop a continuing education curriculum, for licensed assisted living facility administrators. Administrators who are employed by extended congregate care, limited nursing services, or limited mental health licensees must complete additional credit hours as determined by the board. The board shall also develop a short examination that corresponds with each continuing education course and must be offered in English and Spanish. The board must review the continuing education curriculum and each examination at least annually, and update the curriculum and examinations as needed to reflect changes in the law, rules, and best practices. Continuing education must include topics similar

to those of the core training in paragraph (9), and may include additional subject matter that enhances the knowledge, skills, and abilities of assisted living facility administrators, as adopted by rule.

(11) In consultation with a panel of at least three mental health professionals, develop a limited mental health curriculum and examination, which must be completed by an assisted living facility administrator within 30 days after being employed by a limited mental health licensee. The examination must be offered in English and Spanish and must be available online. The board shall review the examination at least annually and update as needed.

(12) In consultation with stakeholders, develop the standardized staff training curriculum required under s. 429.52 for assisted living facility staff members, other than an administrator, who provide regular or direct care to residents. The curriculum must be reviewed at least annually by the board, and updated as needed to reflect changes in the law, rules, and best practices. The curriculum must include at least 20 hours of inservice training, with at least 1 hour of training per topic, covering at least the following topics:

(a) Reporting major incidents.

(b) Reporting adverse incidents.

(c) Facility emergency procedures, including chain-of-command and staff member roles relating to emergency evacuation.

(d) Resident rights in an assisted living facility.

(e) Recognizing and reporting resident abuse, neglect, and exploitation.

(f) Resident behavior and needs.

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(g) Providing assistance with the activities of daily living.

(h) Infection control.

(i) Aggression and behavior management and deescalation techniques.

(13) In consultation with the Agency for Health Care Administration, the Department of Elderly Affairs, the Department of Children and Family Services, and stakeholders, develop the interactive online tutorial required under s. 429.52 which must be completed by assisted living facility staff members who provide regular or direct care to assisted living facility residents. The tutorial must be based on the training required under subsection (12). The board must offer the tutorial in English and Spanish and update the tutorial as needed, but at least annually.

(14) In consultation with the Agency for Health Care Administration, the Department of Elderly Affairs, and the Department of Children and Family Services, develop the continuing education curriculum required under s. 429.52 for staff members of an assisted living facility who provide regular or direct care to assisted living facility residents. The board shall require additional credit hours for assisted living facility staff who are employed by extended congregate care, limited nursing services, or limited mental health licensees. The board must review the continuing education curriculum at least annually and update the curriculum as needed. Continuing education must include topics similar to those listed in subsection (12), and may include additional subject matter that enhances the knowledge, skills, and abilities of assisted living

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facility staff, as adopted by rule.

(15) In consultation with a panel of at least three mental health professionals, develop the limited mental health curriculum and online interactive tutorial required under s. 429.521(3) which must be completed by assisted living facility staff, other than the administrator, who provide regular and direct care to mental health residents. The board must ensure that the tutorial is offered in English and Spanish, and must be updated as needed, but at least annually.

(16) Require and provide, or cause to be provided, the training or education of staff members of an assisted living facility beyond that which is required under this part if the board or department determines that there are problems in a facility which could be reduced through specific staff training or education.

(17) Certify assisted living training providers who meet the qualifications under s. 429.522.

(18) Approve testing and training centers pursuant to s. 429.523.

Section 30. Subsection (2) of section 468.1695, Florida Statutes, is amended and subsections (5) through (9) are added to that section, to read:

468.1695 Licensure by examination.—

(2) The department shall examine each applicant for a nursing home administrator license who the board certifies has completed the application form and remitted an examination fee set by the board not to exceed $250 and who:

(a)1. Holds a baccalaureate degree from an accredited college or university and majored in health care administration

or has credit for at least 60 semester hours in subjects, as prescribed by rule of the board, which prepare the applicant for total management of a nursing home; and

2. Has fulfilled the requirements of a college-affiliated or university-affiliated internship in nursing home administration or of a 1,000-hour nursing home administrator-in-training program prescribed by the board; or

(b)1. Holds a baccalaureate degree from an accredited college or university; and

2.a. Has fulfilled the requirements of a 2,000-hour nursing home administrator-in-training program prescribed by the board; or

b. Has 1 year of management experience allowing for the application of executive duties and skills, including the staffing, budgeting, and directing of resident care, dietary, and bookkeeping departments within a skilled nursing facility, hospital, hospice, assisted living facility with a minimum of 60 licensed beds, or geriatric residential treatment program and, if such experience is not in a skilled nursing facility, has fulfilled the requirements of a 1,000-hour nursing home administrator-in-training program prescribed by the board.

(5) Any person desiring to be licensed as an assisted living facility administrator must apply to the department to take the licensure examination. The examination shall be given at least two times a year and consists of, but is not limited to, questions on the following subjects:

(a) State law and rules relating to assisted living facilities.

(b) Resident rights and the identification and reporting of

abuse, neglect, and exploitation.

(c) The special needs of elderly persons, persons who have mental illness, and persons who have developmental disabilities and how to meet those needs.

(d) Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food.

(e) Medication management, recordkeeping, and proper techniques for assisting residents who self-administer medication.

(f) Firesafety requirements, including procedures for fire evacuation drills and other emergency procedures.

(g) The care of persons who have Alzheimer's disease and related disorders.

(h) Elopement prevention.

(i) Aggression and behavior management, de-escalation techniques, and proper protocols and procedures relating to the Baker Act as provided in part I of chapter 394.

(j) Do-not-resuscitate orders.

(k) Infection control.

(l) Admission and continued residency.

(m) Phases of care and interacting with residents.

(n) Best practices in the industry.

(o) Business operations, including, but not limited to, human resources, financial management, and supervision of staff.

(6) The department shall examine each applicant for an assisted living facility administrator license who the board certifies has completed the application form and remitted an examination fee set by the board not to exceed $250 and who:

(a) Is at least 21 years old;

(b) Holds a 4-year baccalaureate degree from an accredited college or university that includes some coursework in health care, gerontology, or geriatrics; a 4-year baccalaureate degree from an accredited college or university and at least 2 years of experience in direct care in an assisted living facility or nursing home; or a 2-year associate degree that includes coursework in health care, gerontology, or geriatrics and at least 2 years of experience in direct care in an assisted living facility or nursing home;

(c) Has completed a least 40 hours of core training;

(d) Has passed the licensure examination in subsection (5) with a minimum score of 80;

(e) Has completed background screening pursuant to s. 429.174; and

(f) Otherwise meets the requirements of this part and part I of chapter 429.

(7) An assisted living facility administrator who is continuously employed as a facility administrator, or a nursing home administrator who is continuously employed as a nursing home administrator, for at least the 2 years before July 1, 2012, is eligible for licensure as an assisted living facility administrator without meeting the educational requirements of this section or taking the licensure examination if:

(a) The core training under this part has been completed.

(b) All continuing education requirements have been completed.

(c) The applicant was not the administrator of a facility or nursing home that was cited for a class I or class II violation within the 2 years before July 1, 2012.

(8) Other licensed professionals may be exempted from some or all of the training requirements of this section to be eligible for licensure as an assisted living facility administrator, as determined by the board by rule.

(9) If an applicant for assisted living facility administration licensure fails the licensure examination, the applicant must wait at least 10 days before retaking it. If an applicant fails the licensure examination three times, the applicant must retake the initial core training before retaking the examination.

Section 31. Subsection (1) of section 468.1705, Florida Statutes, is amended to read:

468.1705 Licensure by endorsement; temporary license.—

(1) The department shall issue a nursing home administrator license by endorsement to an ~~any~~ applicant who, upon applying to the department and remitting a fee set by the board not to exceed $500, demonstrates to the board that he or she:

(a) Meets one of the following requirements:

1. Holds a valid active license to practice nursing home administration in another state of the United States if~~,~~ ~~provided that~~ the current requirements for licensure in that state are substantially equivalent to, or more stringent than, current requirements in this state; or

2. Meets the qualifications for licensure in s. 468.1695; and

(b)1. Has successfully completed a national examination which is substantially equivalent to, or more stringent than, the examination given by the department;

2. Has passed an examination on the laws and rules of this

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state governing the administration of nursing homes; and

3. Has worked as a fully licensed nursing home administrator for 2 years within the 5-year period immediately preceding the application by endorsement.

Section 32. Section 468.1725, Florida Statutes, is amended to read:

468.1725 Inactive status.—An administrator's license may become inactive if an administrator applies for inactive licensure status, does not pay licensure renewal fees on time, or does not complete continuing education courses within the requisite time.

(1) If a license becomes inactive because:

(a) The administrator applied for and was granted inactive licensure status, he or she must pay a reactivation fee in order to reactive the license.

(b) The administrator failed to timely pay licensure renewal fees, the he or she must pay the biennial renewal fee, a delinquency fee, and a reactivation fee.

(c) The administrator did not timely complete continuing education requirements.

~~(1)~~ Unless otherwise prescribed in law, the board shall prescribe by rule continuing education requirements as a condition of reactivating a license. The continuing education requirements for reactivating a license may not exceed 20 classroom hours for each year the license was inactive, in addition to completing ~~completion of~~ the number of hours required for renewal on the date the license became inactive. The board may not reactivate the license until he or she completes the continuing education requirements and pays a

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delinquency and reactivation fee

(2) The board shall adopt rules relating to application procedures for inactive status, for the renewal of inactive licenses, and for the reactivation of licenses. The board shall prescribe by rule an application fee for inactive status, ~~a renewal fee for inactive status,~~ a delinquency fee, and a fee for the reactivation of a license. ~~None of~~ These fees may not exceed the biennial renewal fee established by the board for an active license.

~~(3) The department may not reactivate a license unless the inactive or delinquent licensee has paid any applicable biennial renewal or delinquency fee, or both, and a reactivation fee.~~

Section 33. Section 468.1735, Florida Statutes, is amended to read:

468.1735 Provisional license.—The board may establish by rule requirements for issuance of a provisional license. A provisional license shall be issued only to fill a position of nursing home administrator that unexpectedly becomes vacant due to illness, sudden death of the administrator, or abandonment of position and shall be issued for one single period as provided by rule not to exceed 6 months. The department shall not issue a provisional license to any applicant who is under investigation in this state or another jurisdiction for an offense which would constitute a violation of s. 468.1745, ~~or~~ s. 468.1755, or s. 429.55(4)(a), as applicable. Upon completion of the investigation relating to a nursing home administrator, the provisions of s. 468.1755 shall apply. The provisional license may be issued to a person who does not meet all of the licensing requirements established by this part, but the board shall by

rule establish minimal requirements to ensure protection of the public health, safety, and welfare. The provisional license shall be issued to the person who is designated as the responsible person next in command in the event of the administrator's departure. The board may set an application fee not to exceed $500 for a provisional license.

Section 34. Section 468.1745, Florida Statutes, is amended to read:

468.1745 Prohibitions; penalties.—

(1) A ~~No~~ person may not ~~shall~~:

(a) Practice nursing home administration unless the person holds an active license to practice nursing home administration.

(b) Use the name or title "nursing home administrator" if ~~when~~ the person has not been licensed pursuant to this part ~~act~~.

(c) Present as his or her own the license of another.

(d) Give false or forged evidence to the board or a member thereof for the purpose of obtaining a license.

(e) Use or attempt to use a nursing home administrator's license that ~~which~~ has been suspended or revoked.

(f) Knowingly employ unlicensed persons in the practice of nursing home administration.

(g) Knowingly conceal information relative to violations of this part.

(2) A person may not:

(a) Practice assisted living facility administration unless the person holds an active license to practice assisted living facility administration.

(b) Use the name or title "assisted living facility administrator" if the person has not been licensed pursuant to

this part.

(c) Present as his or her own the license of another.

(d) Give false or forged evidence to the board or a member thereof for the purpose of obtaining a license.

(e) Use or attempt to use an assisted living facility administrator's license that has been suspended or revoked.

(f) Knowingly employ unlicensed persons in the practice of assisted living facility administration.

(g) Knowingly conceal information relative to violations of this part.

(3) ~~(2)~~ Any person who violates the provisions of this section is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 35. Section 468.1755, Florida Statutes, is amended to read:

468.1755 Disciplinary proceedings.—

(1) The following acts constitute grounds for denial of a nursing home administrator license or disciplinary action, as specified in s. 456.072(2):

(a) Violation of any provision of s. 456.072(1) or s. 468.1745(1).

(b) Attempting to procure a license to practice nursing home administration by bribery, by fraudulent misrepresentation, or through an error of the department or the board.

(c) Having a license to practice nursing home administration revoked, suspended, or otherwise acted against, including the denial of licensure, by the licensing authority of another state, territory, or country.

(d) Being convicted or found guilty, regardless of

adjudication, of a crime in any jurisdiction which relates to the practice of nursing home administration or the ability to practice nursing home administration. Any plea of nolo contendere shall be considered a conviction for purposes of this part.

(e) Making or filing a report or record which the licensee knows to be false, intentionally failing to file a report or record required by state or federal law, willfully impeding or obstructing such filing, or inducing another person to impede or obstruct such filing. Such reports or records shall include only those which are signed in the capacity of a licensed nursing home administrator.

(f) Authorizing the discharge or transfer of a resident for a reason other than those provided in ss. 400.022 and 400.0255.

(g) Advertising goods or services in a manner which is fraudulent, false, deceptive, or misleading in form or content.

(h) Fraud or deceit, negligence, incompetence, or misconduct in the practice of nursing home administration.

(i) Violation of a lawful order of the board or department previously entered in a disciplinary hearing or failing to comply with a lawfully issued subpoena of the board or department.

(j) Practicing with a revoked, suspended, inactive, or delinquent license.

(k) Repeatedly acting in a manner inconsistent with the health, safety, or welfare of the patients of the facility in which he or she is the administrator.

(l) Being unable to practice nursing home administration with reasonable skill and safety to patients by reason of

illness, drunkenness, use of drugs, narcotics, chemicals, or any other material or substance or as a result of any mental or physical condition. In enforcing this paragraph, upon a finding of the State Surgeon General or his or her designee that probable cause exists to believe that the licensee is unable to serve as a nursing home administrator due to the reasons stated in this paragraph, the department shall have the authority to issue an order to compel the licensee to submit to a mental or physical examination by a physician designated by the department. If the licensee refuses to comply with such order, the department's order directing such examination may be enforced by filing a petition for enforcement in the circuit court where the licensee resides or serves as a nursing home administrator. The licensee against whom the petition is filed shall not be named or identified by initials in any public court records or documents, and the proceedings shall be closed to the public. The department shall be entitled to the summary procedure provided in s. 51.011. A licensee affected under this paragraph shall have the opportunity, at reasonable intervals, to demonstrate that he or she can resume the competent practice of nursing home administration with reasonable skill and safety to patients.

(m) Willfully or repeatedly violating any of the provisions of the law, code, or rules of the licensing or supervising authority or agency of the state or political subdivision thereof having jurisdiction of the operation and licensing of nursing homes.

(n) Paying, giving, causing to be paid or given, or offering to pay or to give to any person a commission or other

valuable consideration for the solicitation or procurement, either directly or indirectly, of nursing home usage.

(o) Willfully permitting unauthorized disclosure of information relating to a patient or his or her records.

(p) Discriminating with respect to patients, employees, or staff on account of race, religion, color, sex, or national origin.

(q) Failing to implement an ongoing quality assurance program directed by an interdisciplinary team that meets at least every other month.

(r) Violating any provision of this chapter or chapter 456, or any rules adopted pursuant thereto.

(2) The board may enter an order denying nursing home administrator licensure or imposing any of the penalties in s. 456.072(2) against any applicant for licensure or licensee who is found guilty of violating any provision of subsection (1) of this section or who is found guilty of violating any provision of s. 456.072(1).

(3) The board may enter an order denying licensure or license renewal and may suspend or revoke the license of an assisted living facility administrator who is under investigation for, or who has committed, in this state or another jurisdiction, any of the following:

(a) Attempting to procure a license to practice assisted living facility administration by bribery, fraudulent misrepresentation, or through an error of the agency or the board.

(b) Having an license to practice assisted living facility administration revoked, suspended, or otherwise acted against,

including the denial of licensure by the licensing authority of another state, territory, or country.

(c) Being convicted or found guilty of, or entered a plea of nolo contendre, regardless of adjudication, to a crime in any jurisdiction which relates to the practice of assisted living facility administration.

(d) Making or filing a report or record that the licensee knows to be false, intentionally failing to file a report or record required by state or federal law, willfully impeding or obstructing such filing, or inducing another person to impede or obstruct such filing. Such reports or records include only those that are signed in the capacity of a licensed assisted living facility administrator.

(e) Advertising goods or services in a manner that is fraudulent, false, deceptive, or misleading in form or content.

(f) Committing fraud or deceit or exhibiting negligence, incompetence, or misconduct in the practice of assisted living facility administration.

(g) Violating a lawful order of the board or agency previously entered in a disciplinary hearing or failing to comply with a lawfully issued subpoena of the board or agency.

(h) Repeatedly acting in a manner that is inconsistent with the health, safety, or welfare of the residents of the assisted living facility in which he or she is the administrator.

(i) Being unable to practice assisted living facility administration with reasonable skill and safety to residents by reason of illness, drunkenness, use of drugs, narcotics, chemicals, or any other material or substance or as a result of any mental or physical condition. To enforce this subparagraph,

upon a finding of the Secretary of Health Care Administration or his or her designee that probable cause exists to believe that the licensee is unable to serve as an assisted living facility administrator due to the reasons stated in this subparagraph, the agency may issue an order to compel the licensee to submit to a mental or physical examination by a physician designated by the agency. If the licensee refuses to comply with such order, the order may be enforced by filing a petition for enforcement in the circuit court where the licensee resides or serves as a facility administrator. The licensee against whom the petition is filed may not be named or identified by initials in any public court records or documents and the proceedings shall be closed to the public. The agency is entitled to the summary procedure pursuant to s. 51.011. At reasonable intervals, the licensee affected must be provided an opportunity to demonstrate that he or she can resume the competent practice of assisted living facility administration with reasonable skill and safety to residents.

(j) Paying, giving, causing to be paid or given, or offering to pay or to give to any person a commission or other valuable consideration for the solicitation or procurement, directly or indirectly, of assisted living facility usage.

(k) Willfully permitting unauthorized disclosure of information relating to a resident or his or her records.

(l) Discriminating with respect to residents, employees, or staff members on account of race, religion, sex, or national origin.

(m) Violating any provision of this part, part II of chapter 408, or rules adopted pursuant to this part.

(4) The board shall revoke the license of an assisted living facility administrator who knowingly participates in intentional misconduct, or engages in conduct that constitutes gross negligence, and contributes to the death of a resident.

(5) ~~(3)~~ The department shall reissue the license of a disciplined licensee upon certification by the board that the disciplined licensee has complied with all of the terms and conditions set forth in the final order.

Section 36. Section 468.1756, Florida Statutes, is amended to read:

468.1756 Statute of limitations.—An administrative complaint may only be filed pursuant to s. 456.073 for an act listed in s. 468.1755 ~~(1)(c)-(q)~~ within 4 years after ~~from~~ the time of the incident giving rise to the complaint, or within 4 years after ~~from~~ the time the incident is discovered or should have been discovered.

Section 37. Assisted living facility streamlining task force.—

(1) The Agency for Health Care Administration shall create a task force consisting of at least one representative from the agency, the Department of Elderly Affairs, the Department of Children and Family Services, the Department of Health, and the Office of State Long-Term Care Ombudsman.

(2) The purpose of the task force is to determine whether agencies currently have overlapping regulatory responsibilities over assisted living facilities and whether increased efficiency and effectiveness may be realized by transferring, consolidating, eliminating, or modifying such oversight between agencies.

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588-02542B-12

(3) The task force shall meet at least three times and submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2013, which includes the task force's findings and recommendations pertaining to streamlining agency oversight and improving the effectiveness of regulatory functions.

(4) The task force is terminated effective March 1, 2013.

Section 38. By January 1, 2013, the Agency for Health Care Administration shall submit copies of all of its inspection forms used to inspect assisted living facilities to the Office of State Long-Term Care Ombudsman. The office shall create and act as the chair of a task force of up to 11 members, consisting of an ombudsman, one representative of a nonprofit assisted living facility, one representative of a for-profit assisted living facility, at least one resident or family member of a resident, other stakeholders, and one representative of the agency, the Department of Elderly Affairs, the Department of Children and Family Services, and the Department of Health, to review the inspection forms. The task force shall provide recommendations, if any, to modify the forms in order to ensure that inspections adequately assess whether the assisted living facilities are in compliance with the law, meet the needs of residents, and ensure resident safety. The task force must provide its recommendations, including explanations of its recommendations, to the agency within 90 days after receiving the inspection forms. The task force is terminated July 1, 2013.

Section 39. This act shall take effect July 1, 2012.

408414

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
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	.	
	.	

The Committee on Health Regulation (Garcia) recommended the following:

Senate Amendment

Delete lines 450 - 452
and insert:
facility that has one or more class I or class II violations imposed by final order within the 2 years before licensure renewal is $500 per license plus a fee of $55 per bed. The increased fee amounts are in

904592

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
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The Committee on Health Regulation (Garcia) recommended the following:

Senate Amendment

Delete line 526
and insert:
(b) Effective July 1, 2013, an administrator of a facility

593352

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
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	.	

The Committee on Health Regulation (Garcia) recommended the following:

Senate Amendment

Delete line 875
and insert:
(1) Effective October 1, 2012, a new employee, including an

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
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The Committee on Health Regulation (Garcia) recommended the following:

Senate Amendment (with title amendment)

Between lines 1190 and 1191
insert:

(3) "Assisted living facility administrator certification" means a professional credential awarded by a board-approved third-party credentialing entity to individuals who demonstrate core competency in the practice of assisted living facility administration and who meet the education, background screening, and other criteria specified by the board for licensure as an assisted living facility administrator.

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Delete lines 1273 - 1545
and insert:

(3) Develop by appropriate techniques, including examinations and investigations, a method for determining whether an individual meets such standards.

(a) The board shall approve one or more third-party credentialing entities for the purpose of developing and administering assisted living facility administrator certification programs. A third-party credentialing entity must be a nonprofit organization that has met nationally recognized standards for developing and administering professional certification programs. In order to obtain approval, a third-party credentialing entity must also:

1. Establish professional requirements and standards that applicants must achieve in order to obtain an assisted living facility administrator certification and to maintain such certification. At a minimum, these requirements and standards must include completion of the requirements for assisted living facility administrators required in this part and in rules adopted by the board, including all education and continuing education requirements;

2. Develop and apply core competencies and examination instruments according to nationally recognized certification and psychometric standards, and agree to assist the board with developing the training and testing materials under subsections (9), (10), and (11);

3. Maintain a professional code of ethics and a


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disciplinary process that applies to all persons holding certification as an assisted living facility administrator;

4. Maintain an internet based database, accessible to the public, of all persons holding an assisted living facility administrator certification, including any history of ethical violations; and

5. Require continuing education and, at least, biennial certification renewal for persons holding an assisted living facility administrator certification.

(4) Issue licenses to qualified individuals meeting the standards of the board and revoke or suspend licenses previously issued by the board if ~~when~~ the individual holding such license is determined to have failed to ~~conform~~ substantially conform to the requirements of such standards.

(5) Establish by rule and carry out procedures~~, by rule,~~ designed to ensure that licensed nursing home or assisted living facility administrators ~~will~~ comply with the standards adopted by the board.

(6) Receive, investigate, and take appropriate action with respect to any charge or complaint filed with the department ~~to the effect~~ that a licensed nursing home or assisted living facility administrator has failed to comply with the requirements or standards adopted by the board.

(7) Conduct a continuing study and investigation of nursing homes and assisted living facilities and the administrators of nursing homes and assisted living facilities in order to improve the standards imposed for the licensing of such administrators and the procedures and methods for enforcing such standards with respect to licensed administrators ~~of nursing homes who have~~


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~~been licensed as such~~.

(8) Set up procedures by rule for advising and acting together with the department ~~Department of Health~~ and other boards of other health professions in matters affecting procedures and methods for effectively enforcing the purpose of this part and the administration of chapters 400 and 429.

(9) In consultation with the Agency for Health Care Administration, the Department of Elderly Affairs, and the Department of Children and Family Services, develop the following which must be completed by an applicant for licensure as an assisted living facility administrator:

(a) Assisted living facility administrator core training that includes at least 40 hours of training, is offered in English and Spanish, is reviewed at least annually by the board or its agent, and updated as needed to reflect changes in the law, rules, and best practices. The curriculum, at a minimum, must cover the following topics:

1. State law and rules relating to assisted living facilities.

2. Resident rights and the identification and reporting of abuse, neglect, and exploitation.

3. The special needs of elderly persons, persons who have mental illness, and persons who have developmental disabilities and how to meet those needs.

4. Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food.

5. Medication management, recordkeeping, and proper techniques for assisting residents who self-administer medication.

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6. Firesafety requirements, including procedures for fire evacuation drills and other emergency procedures.

7. The care of persons who have Alzheimer's disease and related disorders.

8. Elopement prevention.

9. Aggression and behavior management, de-escalation techniques, and proper protocols and procedures relating to the Baker Act as provided in part I of chapter 394.

10. Do-not-resuscitate orders.

11. Infection control.

12. Admission and continued residency.

13. Phases of care and interacting with residents.

14. Best practices in the industry.

15. Business operations, including, but not limited to, human resources, financial management, and supervision of staff.

(b) An assisted living facility administrator examination that tests the applicant's knowledge and training of the core training topics listed in paragraph (a). The examination must be offered in English and Spanish, reviewed at least annually by the board or its agent, and updated as needed to reflect changes in the law, rules, and best practices. A minimum score of 80 is required to demonstrate successful completion of the training requirements.

(10) In consultation with the Agency for Health Care Administration, the Department of Elderly Affairs, and the Department of Children and Family Services, develop a continuing education curriculum, for licensed assisted living facility administrators. Administrators who are employed by extended congregate care, limited nursing services, or limited mental

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health licensees must complete additional credit hours as determined by the board. The board or its agent shall also develop a short examination that corresponds with each continuing education course and must be offered in English and Spanish. The board or its agent must review the continuing education curriculum and each examination at least annually, and update the curriculum and examinations as needed to reflect changes in the law, rules, and best practices. Continuing education must include topics similar to those of the core training in paragraph (9), and may include additional subject matter that enhances the knowledge, skills, and abilities of assisted living facility administrators, as adopted by rule.

(11) In consultation with a panel of at least three mental health professionals, develop a limited mental health curriculum and examination, which must be completed by an assisted living facility administrator within 30 days after being employed by a limited mental health licensee. The examination must be offered in English and Spanish and must be available online. The board or its agent shall review the examination at least annually and update as needed.

(12) In consultation with stakeholders, develop the standardized staff training curriculum required under s. 429.52 for assisted living facility staff members, other than an administrator, who provide regular or direct care to residents. The curriculum must be reviewed at least annually by the board or its agent, and updated as needed to reflect changes in the law, rules, and best practices. The curriculum must include at least 20 hours of inservice training, with at least 1 hour of training per topic, covering at least the following topics:

(a) Reporting major incidents.

(b) Reporting adverse incidents.

(c) Facility emergency procedures, including chain-of-command and staff member roles relating to emergency evacuation.

(d) Resident rights in an assisted living facility.

(e) Recognizing and reporting resident abuse, neglect, and exploitation.

(f) Resident behavior and needs.

(g) Providing assistance with the activities of daily living.

(h) Infection control.

(i) Aggression and behavior management and deescalation techniques.

(13) In consultation with the Agency for Health Care Administration, the Department of Elderly Affairs, the Department of Children and Family Services, and stakeholders, develop the interactive online tutorial required under s. 429.52 which must be completed by assisted living facility staff members who provide regular or direct care to assisted living facility residents. The tutorial must be based on the training required under subsection (12). The board must offer the tutorial in English and Spanish and update the tutorial as needed, but at least annually.

(14) In consultation with the Agency for Health Care Administration, the Department of Elderly Affairs, and the Department of Children and Family Services, develop the continuing education curriculum required under s. 429.52 for staff members of an assisted living facility who provide regular or direct care to assisted living facility residents. The board

shall require additional credit hours for assisted living facility staff who are employed by extended congregate care, limited nursing services, or limited mental health licensees. The board or its agent must review the continuing education curriculum at least annually and update the curriculum as needed. Continuing education must include topics similar to those listed in subsection (12), and may include additional subject matter that enhances the knowledge, skills, and abilities of assisted living facility staff, as adopted by rule.

(15) In consultation with a panel of at least three mental health professionals, develop the limited mental health curriculum and online interactive tutorial required under s. 429.521(3) which must be completed by assisted living facility staff, other than the administrator, who provide regular and direct care to mental health residents. The board or its agents must ensure that the tutorial is offered in English and Spanish, and must be updated as needed, but at least annually.

(16) Require and provide, or cause to be provided, the training or education of staff members of an assisted living facility beyond that which is required under this part if the board or department determines that there are problems in a facility which could be reduced through specific staff training or education.

(17) Certify assisted living training providers who meet the qualifications under s. 429.522.

(18) Approve testing and training centers pursuant to s. 429.523.

Section 30. Subsection (2) of section 468.1695, Florida Statutes, is amended and subsections (5) through (9) are added

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to that section, to read:

468.1695 Licensure by examination; licensure by certification.—

(2) The department shall examine each applicant for a nursing home administrator license who the board certifies has completed the application form and remitted an examination fee set by the board not to exceed $250 and who:

(a)1. Holds a baccalaureate degree from an accredited college or university and majored in health care administration or has credit for at least 60 semester hours in subjects, as prescribed by rule of the board, which prepare the applicant for total management of a nursing home; and

2. Has fulfilled the requirements of a college-affiliated or university-affiliated internship in nursing home administration or of a 1,000-hour nursing home administrator-in-training program prescribed by the board; or

(b)1. Holds a baccalaureate degree from an accredited college or university; and

2.a. Has fulfilled the requirements of a 2,000-hour nursing home administrator-in-training program prescribed by the board; or

b. Has 1 year of management experience allowing for the application of executive duties and skills, including the staffing, budgeting, and directing of resident care, dietary, and bookkeeping departments within a skilled nursing facility, hospital, hospice, assisted living facility with a minimum of 60 licensed beds, or geriatric residential treatment program and, if such experience is not in a skilled nursing facility, has fulfilled the requirements of a 1,000-hour nursing home

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administrator-in-training program prescribed by the board.

(5) Any person desiring to be licensed as an assisted living facility administrator must apply to the department, remit a fee set by the board not to exceed $500, and provide proof of a current and valid assisted living facility administrator certification.

(6) An assisted living facility administrator certification must be issued by a board-approved third-party credentialing entity that certifies the individual:

(a) Is at least 21 years old;

(b) Holds a 4-year baccalaureate degree from an accredited college or university that includes some coursework in health care, gerontology, or geriatrics; a 4-year baccalaureate degree from an accredited college or university and at least 2 years of experience in direct care in an assisted living facility or nursing home; or a 2-year associate degree that includes coursework in health care, gerontology, or geriatrics and at least 2 years of experience in direct care in an assisted living facility or nursing home;

(c) Has completed a least 40 hours of core training;

(d) Has passed an examination that documents core competencies in the training required for assisted living facility administrators prior to licensure with a minimum score of 80;

(e) Has completed background screening pursuant to s. 429.174 and s. 456.0365; and

(f) Otherwise meets the requirements of this part and part I of chapter 429.

(7) An assisted living facility administrator who is

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continuously employed as a facility administrator, or a nursing home administrator who is continuously employed as a nursing home administrator, for at least the 2 years before July 1, 2012, is eligible for certification as an assisted living facility administrator without meeting the educational requirements of this section or taking the licensure examination if:

(a) The core training under this part has been completed.

(b) All continuing education requirements have been completed.

(c) The applicant was not the administrator of a facility or nursing home that was cited for a class I or class II violation within the 2 years before July 1, 2012.

(8) Other licensed professionals may be exempted from some or all of the training requirements of this section to be eligible for assisted living facility administrator certification, as determined by the board by rule.

(9)A licensed assisted living facility administrator applying for relicensure must submit an application, remit applicable fees, and demonstrate that he or she has maintained his or her assisted living facility administrator certification which substantiates the individual has completed all continuing education and other requirements under this part to obtain licensure renewal.

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

And the title is amended as follows:

Delete lines 109 - 121

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and insert:

F.S.; revising duties of the board to include approving third-party credentialing entities for the purpose of an assisted living facility administrator certification program; establishing requirements and standards for certification; providing for the development of assisted living facility administrator trainings and testing and staff trainings and interactive tutorials; authorizing additional training for certain facilities; and certifying trainers and testing and training centers; amending s. 468.1695; providing for licensure of assisted living facility administrators through certification; establishing a maximum fee; amending s. 468.1705, F.S.,

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/31/12
Meeting Date

Topic ALFs

Bill Number 2074 *(if applicable)*

Name JACK McRAY

Amendment Barcode *(if applicable)*

Job Title

Address 200 W. COLLEGE ST. #304 *Street*

Phone 850-577-5187

TLH *City* FL *State* 32301 *Zip*

E-mail jmcray@aarp.org

Speaking: ☑ For ☐ Against ☐ Information

Representing AARP

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

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THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/31/12
Meeting Date

Topic Assisted Living

Bill Number SB 2074 *(if applicable)*

Name Brian Bobare

Amendment Barcode *(if applicable)*

Job Title Chief Operating Officer

Address 1001 Carpenter's Way
Street
Lakeland, FL 33809
City *State* *Zip*

Phone

E-mail

Speaking: ☐ For ☐ Against ☑ Information

Representing Estates of Carpenter & Leading Age Florida

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Spoke

1/31/12
Meeting Date

Topic Assisted Living

Bill Number 2074 *(if applicable)*

Name Kevin Smaage

Amendment Barcode *(if applicable)*

Job Title Director of Health Services

Address 130 W. Armstrong Ave
Street

Phone 386-734-6401

DeLand FL 32720
City *State* *Zip*

E-mail

Speaking: ☐ For ☐ Against ☑ Information

Representing Leading Age Florida

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

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 Health Regulation Committee

BILL: CS/SB 1198

INTRODUCER: Health Regulation Committee and Senator Bogandoff

SUBJECT: Prescribing of Controlled Substances

DATE: February 2, 2012 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Davlantes	Stovall	HR	**Fav/CS**
2.			CJ	
3.			BC	
4.				
5.				
6.				

I. Summary:

This bill redefines "addiction medicine specialist," "board-certified pain management physician," and "chronic nonmalignant pain." Only physicians who prescribe Schedule II, Schedule III, or Schedule IV controlled substances for the treatment of chronic nonmalignant pain are required to register as controlled substance prescribing practitioners. Patients who are prescribed controlled substances who are especially at risk for substance abuse must be co-managed by the prescribing physician and either an addictionologist or a psychiatrist, rather than a physiatrist. The bill states that when a pharmacy subject to s. 456.44, F.S., receives a prescription, the prescription is deemed compliant with the standards of practice under this section and, therefore, valid for dispensing.

Additional physicians are exempted from following the standards of practice for prescribing controlled substances found in ch. 456, F.S. Additional clinics are exempted from registration as pain-management clinics under chs. 458 or 459, F.S.

A pharmacy, prescriber, or dispenser is allowed to have access to information in the prescription drug monitoring program's database which relates to a potential patient in a manner established by the department as needed for the purpose of reviewing the patient's controlled substance prescription history. Pharmacists or health care practitioners who are administering controlled substances to patients who are receiving hospice care or to patients or residents receiving care at certain licensed health care facilities are exempted from provisions of the prescription drug monitoring program.

This bill substantially amends ss. 456.44, 458.3265, 459.0137, 465.0276, and 893.055, F.S.

II. Present Situation:

Physician Specialties

Physiatrists, or rehabilitation physicians, are medical doctors who specialize in nerve, muscle, and bone injuries and illnesses which affect the way patients move. Physiatrists focus on treating the whole patient, not just symptoms, and aim to restore maximum function after strokes, limb amputations, and other conditions. Physiatrists also treat patients with chronic pain and do not perform surgery.[1] To practice as a physiatrist, a physician must complete at least 3 years of residency training in physical medicine and rehabilitation.[2]

Rheumatologists are physicians who focus on diseases of the joints, muscles, and bones.[3] Rheumatologists mainly diagnose and manage the progress of immune-mediated or degenerative diseases, as opposed to physiatrists, who emphasize rehabilitation of patients following injuries. Common conditions treated by rheumatologists include osteoarthritis, rheumatoid arthritis, and lupus. Rheumatologists must complete 3 years of residency training in either pediatrics or internal medicine as well as a 2- to 3-year fellowship in rheumatology.[4]

Psychiatrists are physicians who specialize in the prevention, diagnosis, and treatment of mental, addictive, and emotional disorders. Psychiatrists are trained in the medical, psychological, and social components of mental, emotional, and behavioral disorders and utilize a broad range of treatment modalities to treat such disorders, including medication, psychotherapy, and support services for helping patients and their families cope with stress and crises.[5] Disorders managed by psychiatrists include autism, schizophrenia, and attention-deficit hyperactive disorder (ADHD). Residency training programs for psychiatry are 4 years in length.[6]

Addiction medicine physicians have expertise in the recognition and treatment of patients with addictive disorders, including both physical and psychological addiction. They are certified by the American Board of Addiction Medicine and must have completed at least 1 year of fellowship training in addiction medicine or 1,920 hours of practical experience in the field.[7] Addiction medicine physicians usually have a background in psychiatry, but some fellowship

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[1] American Academy of Physical Medicine and Rehabilitation, *What is a Physiatrist?*, available at: http://www.aapmr.org/patients/aboutpmr/pages/physiatrist.aspx (last visited on January 27, 2012).
[2] American Medical Association, *FREIDA Online Program Information*, available at: https://freida.ama-assn.org/Freida/user/programSearchDispatch.do (last visited on January 27, 2012).
[3] American College of Rheumatology, *What is a Rheumatologist?*, available at: http://www.rheumatology.org/practice/clinical/patients/rheumatologist.asp (last visited on January 27, 2012).
[4] *Supra* fn. 2.
[5] Michigan Psychiatric Society, *What is a Psychiatrist?*, available at: http://www.mpsonline.org/psychiatry/Pages/WhatisaPsychiatrist.aspx (last visited on January 27, 2012).
[6] *Supra* fn. 2.
[7] American Board of Addiction Medicine, *Booklet for the 2012 Certification Examination and the 2012 Recertification Examination*, available at: http://www.abam.net/wp-content/uploads/2011/08/ABAM-Exam-Book-2012Final2.pdf (last visited on January 27, 2012).

programs are open to all physician specialties.[8] Certification of specifically osteopathic addiction medicine specialists is also available as through the board of family medicine.[9]

Controlled Substances

"Controlled substance" means any substance named or described in Schedules I-V of s. 839.03, F.S.[10] Drug schedules are specified by the United States Department of Justice Drug Enforcement Administration (DEA) in 21 C.F.R. ss. 1308.11-15 and in s. 893.03, F.S.

Schedule I controlled substances currently have no accepted medical use in treatment in the United States and therefore may not be prescribed, administered, or dispensed for medical use. These substances have a high potential for abuse and include heroin, lysergic acid diethylamide (LSD), and marijuana. Schedule II controlled substances have a high potential for abuse which may lead to severe psychological or physical dependence, including morphine and its derivatives, amphetamines, cocaine, and pentobarbital. Schedule III controlled substances have lower abuse potential than Schedule II substances but may still cause psychological or physical dependence. Schedule III substances include products containing less than 15 milligrams (mg) of hydrocodone (such as Vicodin) or less than 90 mg of codeine per dose (such as Tylenol #3), ketamine, and anabolic steroids. Schedule IV substances have a low potential for abuse and include propoxyphene (Darvocet), alprazolam (Xanax), and lorazepam (Ativan). Schedule V controlled substances have an extremely low potential for abuse and primarily consist of preparations containing limited quantities of certain narcotics, such as cough syrup.[11]

Any health care professional wishing to prescribe controlled substances must apply for a prescribing number from the DEA. Prescribing numbers are linked to state licenses and may be suspended or revoked upon any disciplinary action taken against a licensee. The DEA will grant prescribing numbers to a wide range of health care professionals, including physicians, nurse practitioners, physician assistants, optometrists, dentists, and veterinarians, but such professionals may only prescribe controlled substances which have been authorized to them under state law. Prescribing numbers must be renewed every 3 years.[12]

Controlled Substance Prescribing

As of January 1, 2012, every physician, podiatrist, or dentist who prescribes controlled substances in the state for the treatment of chronic nonmalignant pain[13] must register as a

[8] American Society of Addiction Medicine, *Addiction Medicine Fellowships*, available at: http://www.asam.org/membership/resident-and-student-center/addiction-medicine-fellowships (last visited on January 27, 2012).
[9] American Osteopathic Board of Family Physicians, *Welcome*, available at: http://www.aobfp.org/home.html (last visited on January 27, 2012).
[10] Section 893.02(4), F.S.
[11] DEA, Office of Diversion Control, *Controlled Substance Schedules*, available at: http://www.deadiversion.usdoj.gov/schedules/#define (last visited on January 25, 2012).
[12] DEA, *Questions and Answers*, available at: http://www.deadiversion.usdoj.gov/drugreg/faq.htm (last visited on January 26, 2012).
[13] As defined in s. 456.44, F.S., chronic nonmalignant pain means pain unrelated to cancer or rheumatoid arthritis which persists beyond the usual course of disease or injury which caused the pain or for more than 90 days after surgery.

controlled substance prescribing practitioner and comply with certain practice standards specified in statute and rule.[14]

Before prescribing any controlled substances for the treatment of chronic nonmalignant pain, a practitioner must document certain characteristics about the nature of the pain, success of past treatments, any underlying health problems, and history of alcohol and substance abuse. The practitioner must develop a written plan for assessing the patient's risk for aberrant drug-related behavior and monitor such behavior throughout the course of controlled substance treatment. Each practitioner must also enter into a controlled substance agreement with their patients; such agreements must include the risks and benefits of controlled substance use, including the risk for addiction or dependence; the number and frequency of permitted prescriptions and refills; a statement of reasons for discontinuation of therapy, including violation of the agreement; and the requirement that patients' chronic nonmalignant pain only be treated by one practitioner at a time unless otherwise authorized and documented. This agreement must be signed by the patient or his or her legal representative and by the prescribing practitioner.

Patients treated with controlled substances must been seen by their prescribing practitioners at least once every 3 months to monitor progress and compliance, and detailed medical records relating to such treatment must be maintained. Patients at special risk for drug abuse or diversion may require co-monitoring by an addiction medicine physician or a psychiatrist. Anyone with signs or symptoms of substance abuse must be immediately referred to a pain management physician, an addiction medicine specialist, or an addiction medicine facility.[15]

Anesthesiologists, physiatrists, neurologists, and surgeons are exempt from all these provisions. Physicians who hold certain credentials relating to pain medicine are also exempt.

Pain Management Clinics

A pain management clinic is any facility that advertises pain management services or where a majority of patients are prescribed opioids, benzodiazepines, barbiturates, or carisoprodol for the treatment of chronic nonmalignant pain. Until January 1, 2016, all pain management clinics must register as such with the Department of Health (the department) and meet certain provisions concerning staffing, sanitation, recordkeeping, and quality assurance.[16] Clinics are exempt from these provisions if they are:

- Licensed under ch. 395, F.S., as a hospital, ambulatory surgical center, or mobile surgical facility;
- Staffed primarily by surgeons;

[14] Section 456.44(3), F.S., and Rules 64B8-9.013 and 64B15-14.005, F.A.C.
[15] According to s. 456.44(1), F.S., an addiction medicine specialist is a board-certified physiatrist with a subspecialty certification in addiction medicine or who is eligible for such subspecialty certification in addiction medicine, an addiction medicine physician certified or eligible for certification by the American Society of Addiction Medicine, or an osteopathic physician who holds a certificate of added qualification in addiction medicine through the American Osteopathic Association. A board-certified pain management physician is a physician who possesses board certification in pain medicine by the American Board of Pain Medicine, board certification by the American Board of Interventional Pain Physicians, or board certification or sub-certification in pain management by a specialty board recognized by the American Association of Physician Specialists or an osteopathic physician who holds a certificate in pain management by the American Osteopathic Association. A mental health addiction facility means a facility licensed under ch. 394 or ch. 397, F.S.
[16] *See* ss. 458.3265 and 459.0137, F.S.

- Owned by a publicly held corporation whose shares are traded on a national exchange or on the over-the-counter market and whose total assets at the end of the corporation's most recent fiscal quarter exceeded $50 million;
- Affiliated with an accredited medical school at which training is provided for medical student, residents, or fellows;
- Not involved in prescribing controlled substances for the treatment of pain;
- Owned by a corporate entity exempt from federal taxation under 26 U.S.C. s. 501(c)(3); or
- Wholly owned and operated by anesthesiologists, physiatrists, or neurologists, or physicians holding certain credentials in pain medicine.

All clinics must be owned by at least one licensed physician or be licensed as a health care clinic under part X or ch. 400, F.S., to be eligible for registration. Physicians connected with a pain management clinic must be free of past disciplinary action against their medical licenses and DEA numbers in any jurisdiction as well as any convictions or pleas for illicit drug felonies within the past 10 years.

Pain management clinics are inspected annually by the department unless they hold current certification from a department-approved national accrediting agency. The department may suspend or revoke clinic registration or impose administrative fines of up to $5000 per violation for any offenses against state pain management clinic provisions or related federal laws and rules.

If the registration for a pain management clinic is revoked for any reason, the clinic must cease to operate immediately, remove all signs or symbols identifying the facility as a pain management clinic, and dispose of any medication on the premises. No owner or operator of the clinic may own or operate another pain clinic for 5 years after revocation of registration.[17]

Board Certification Organizations

The gold standard for certification of a physician in a medical subspecialty is certification by the American Board of Medical Specialties (ABMS). ABMS member boards certify physicians in more than 150 different specialties and subspecialties. Major national healthcare organizations such as The Joint Commission, the National Committee for Quality Assurance, hospitals, and insurance companies use ABMS board certification as an essential tool to assess physician specialty credentials, and numerous studies have demonstrated that physicians who are board-certified by an ABMS member board deliver higher-quality care and have better patient outcomes than those certified by other organizations.[18] ABMS board certification is available to both allopathic and osteopathic physicians. Another gold standard of certification for osteopathic physicians is receiving a certificate of added qualification through the American Osteopathic Association (AOA).

[17] Section 458.3265, F.S. Similar language is found in s. 459.0137, F.S. Related rules are found in Rules 64B8-9 and 64B15-14, F.A.C.
[18] ABMS, *The Highest Standard*, available at: http://www.certificationmatters.org/about-board-certified-doctors/the-highest-standard.aspx (last visited on February 2, 2012).

III. Effect of Proposed Changes:

Section 1 amends s. 456.44, F.S., to define an addiction medicine specialist as a board-certified psychiatrist, not a board-certified physiatrist. The definition of "board-certified pain management physician" is amended to include a physician certified in pain management by the ABMS, and the definition of "chronic nonmalignant pain" is amended to exclude pain related to sickle-cell anemia.

Instead of requiring certain physicians to register as controlled substance prescribing practitioners if any controlled substances are prescribed for the treatment of chronic nonmalignant pain, registration is required only if controlled substances in schedules II-IV are prescribed. The bill also requires that patients prescribed controlled substances who are especially at risk for substance abuse be co-managed by the prescribing physician and an addictionologist or a psychiatrist, rather than a physiatrist. The bill states that when a pharmacy subject to this section receives a prescription, the prescription is deemed compliant with the standards of practice under this section and, therefore, valid for dispensing.

The following physicians are exempted from following the standards of practice for prescribing controlled substances in this bill:

- Board-eligible, in addition to board-certified, physicians in certain specialties and holding certain certifications. The certain specialties are expanded to include psychiatrists and rheumatologists, and the certain certifications are expanded to include pain medicine certification by a board approved by the American Board of Pain Medicine;
- Physicians who are certified in hospice and palliative medicine by the ABMS or who hold a certificate of added qualification in hospice and palliative medicine through the AOA;
- Physicians treating patients in accordance with an approved clinical trial; and
- Physicians who prescribe medically-necessary controlled substances for patients during inpatient stays or while providing emergency services and care in hospitals licensed under ch. 395, F.S.

Section 2 amends s. 458.3265, F.S., to amend the definition of "chronic nonmalignant pain" to exclude pain related to sickle-cell anemia. The following clinics are exempted from registration as pain-management clinics:

- Clinics wholly owned by one or more board-eligible or board-certified anesthesiologists, physiatrists, psychiatrists, rheumatologists, or neurologists. The requirement that the clinics must also be operated by one or more of these physicians is removed;
- Clinics wholly owned by one or more board-eligible medical specialists in areas already listed in statute. The requirement that the clinics must also be operated by one or more of these physicians is removed, and the American Board of Pain Medicine is added as an approved board for certification of pain medicine specialists;
- Clinics organized as physician-owned group practices as defined in 42 C.F.R. 411.352; and
- Clinics which, before June 1, 2011, were wholly owned by physicians who are not board-eligible or board-certified but who successfully completed residency programs in anesthesiology, physiatry, psychiatry, rheumatology, or neurology and who have 7 years of documented, full-time practice in pain medicine in this state. "Full-time" is defined as practicing an average of 20 hours per week each year in pain medicine.

Section 3 amends s. 459.0137, F.S., to amend the definition of "chronic nonmalignant pain" to exclude pain related to sickle-cell anemia. The following clinics are exempted from registration as pain-management clinics:

- Clinics wholly owned by one or more board-eligible or board-certified anesthesiologists, physiatrists, psychiatrists, rheumatologists, or neurologists. The requirement that the clinics must also be operated by one or more of these physicians is removed; and
- Clinics wholly owned by one or more board-eligible medical specialists who hold certain qualifications relating to pain medicine. The requirement that the clinics must also be operated by one or more of these physicians is removed, and the American Association of Physician Specialties is added as an approved board for certification of pain medicine specialists.

Section 4 amends s. 465.0276, F.S., to revise the language that authorizes physicians to dispense Schedule II or III controlled substances as part of clinical research conducted under protocols approved by the United States Food and Drug Administration (FDA).

Section 5 amends s. 893.055, F.S., to allow a pharmacy, prescriber, or dispenser to have access to information in the prescription drug monitoring program's database which relates to a potential patient in a manner established by the department as needed for the purpose of reviewing the patient's controlled substance prescription history. Pharmacists or health care practitioners who are administering controlled substances to patients who are receiving hospice care or to patients or residents receiving care at certain licensed health care facilities are exempted from reporting pursuant to the prescription drug monitoring program.

Section 6 provides an effective date of July 1, 2012.

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:

Psychiatrists, rheumatologists, and practitioners who work under their supervision will be exempt from certain controlled substance prescribing and pain management clinic registration provisions.

C. Government Sector Impact:

The department may experience a decrease in workload related to applications for pain management clinic certifications from physician offices newly exempt from statutory requirements, although this will be offset by a corresponding decrease in fees related to these services. The department will also lose some oversight over the controlled substance prescribing activity of these physicians.

VI. Technical Deficiencies:

Lines 61-69 define an addiction medicine specialist as including a medicine physician who has been certified by the American Society of Addiction Medicine. However, the American Board of Addiction Medicine, rather than the American Society of Addiction Medicine, is responsible for certifying physicians in this field. This language is in existing law. Furthermore, "medicine physician" in line 65 is a technically incorrect term and should be changed to "physician."

"Addictionologist" in line 173 is not a term defined in statute. Perhaps this should be changed to "addiction medicine specialist." This term is in existing law.

"Hospitalists or other physicians" in lines 243-244 is redundant. Hospitalists are physicians. This phrase could be reduced to "physicians" for clarity.

Line 293 states that physicians who are board-certified in pain medicine by a board approved by the American Board of Pain Medicine may be exempt from registering their clinics as pain-management clinics under ch. 458, F.S. However, the American Board of Pain Medicine is itself a certifying board; it does not approve other boards for certification.

"Physiatry" as mentioned in line 302 is not the name of any residency program. Physiatrists complete their residency training in Physical Medicine and Rehabilitation.

The definitions of "chronic nonmalignant pain" in chs. 456, 458, and 459, F.S., are amended to read "pain unrelated to cancer, rheumatoid arthritis, or sickle cell anemia which persists beyond the usual course of disease or beyond the injury that is the cause of the pain or which persists more than 90 days after surgery." The second "beyond" in that definition should be deleted for clarity.

The AMBS certifies physicians in pain medicine, not in pain management as is often mentioned in the bill.

VII. Related Issues:

This bill is entitled "an act relating to the prescribing of controlled substances." However, statutes related to controlled substance prescribing, controlled substance dispensing, the prescription drug monitoring program, and registration and regulation of pain management clinics are amended in this bill.

The bill allows certain board-certified or board-eligible physicians to be exempted from registering their offices as pain-management clinics under chs. 458 or 459, F.S. Board certification in a medical specialty is an industry-recognized standard for expertise in that specialty. To become board-certified, physicians must complete residency and sometimes fellowship training in specialty areas, pass a rigorous examination, hold a valid medical license in a state, and meet certain practice requirements. It is unclear how many of these criteria a physician must fulfill to be considered "board-eligible" by statute.

Language in sections 1, 2, and 3 of the bill references board-certified physicians, although the specifications for which boards must certify them are inconsistent or sometimes absent. For example, lines 224-227 exempt board-certified anesthesiologists, physiatrists, psychiatrists, and rheumatologists from provisions of ch. 456, F.S., but there is no mention of what board must certify such individuals. This language is in current statute, but similar problems exist in lines 284-290, 299-306, and 341-346.

Furthermore, criteria for exempting physicians from registering their clinics as pain-management clinics are inconsistent between allopathic and osteopathic physicians. Clinics organized as physician-group practices, owned by physicians board-eligible or board-certified in pain medicine by a board approved by the American Board of Pain Medicine, or owned by certain anesthesiologists, physiatrists, rheumatologists, or neurologists prior to June 1, 2011, are exempt from registration as pain-management clinics under ch. 458, F.S. However, such clinics are not eligible for exemption from registration under ch. 459, F.S. Clinics owned by physicians board-eligible or board-certified in pain medicine by a board approved by the American Association of Physician Specialties are eligible for exemption, although these are not eligible for exemption under ch. 458, F.S.

Lines 219-222 state that when a pharmacy subject to s. 456.44, F.S., receives a prescription, the prescription is deemed compliant with the standards of practice under this section and, therefore, valid for dispensing. However, prescribing practitioners, not pharmacists or prescriptions, are subject to the provisions of s. 456.44, F.S. Clearer language to convey the intention of this amendment might be, "when a pharmacy receives a prescription written by a practitioner subject to this section, the prescription is deemed valid for dispensing." However, this language does not absolve pharmacists from the requirement to be vigilant against patients obtaining or attempting to obtain controlled substances through fraudulent means.[19]

Lines 243-247 exempt physicians who prescribe medically necessary controlled substances while providing emergency services and care in a hospital licensed under ch. 395, F.S., from standards of practice for controlled substance prescribing in ch. 456, F.S. Like hospital emergency

[19] Section 465.015(3), F.S.

departments, urgent care clinics also provide episodic care to patients, and physicians working there are unlikely to see their patients more than once. However, physicians in urgent care clinics are not exempted from the standards of practice for controlled substance prescribing.

Lines 387-394 state that pharmacists may dispense controlled substances as part of an approved clinical trial conducted under protocols approved by the FDA. The FDA is charged with approving new drugs for sale in the United States and sometimes approves clinical trial protocols related to testing of new drugs. However, the FDA is not part of approving clinical trials which concern drugs which have already been FDA-approved; such trials are instead approved by an institutional review board. If this provision in the bill is intended to allow controlled substances to be prescribed in Florida as part of any clinical trial, not just trials which are part of the process of gaining FDA approval, then this aim has not been accomplished.

Lines 415-420 state that a pharmacy, prescriber, or dispenser may have access to information in the prescription drug monitoring program's database which relates to a patient *or a potential patient* of that pharmacy, prescriber, or dispenser in a manner established by the department as needed for the purpose of reviewing the patient's controlled substance prescription history. However, this language might be so broad as to violate privacy laws. Anyone might at some point be a potential patient of a pharmacy, including those who are not currently prescribed pain medications, but their privacy should be respected until they seek medical care or try to fill a prescription for controlled substances.

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 January 31, 2012:
The CS makes the following changes from the original bill:

- Requires physicians who prescribe Schedules II-IV controlled substances for the treatment of chronic nonmalignant pain to register as controlled substance prescribing practitioners under ch. 456, F.S.
- Adds physicians certified in pain management by the American Board of Medical Specialties to the definition of "board-certified pain management physician" in ch. 456, F.S.
- Adds sickle-cell anemia to diseases exempted from the definition of "chronic nonmalignant pain" in chs. 456, 458, and 459, F.S.
- Exempts the following physicians from the standards of practice for prescribing controlled substances in ch. 456, F.S.:
  - Board-eligible, in addition to board-certified, physicians in certain specialties and holding certain certifications. The certain specialties are expanded to include psychiatrists and rheumatologists, and the certain certifications are expanded to include pain medicine certification by a board approved by the American Board of Pain Medicine;
  - Physicians who are certified in hospice and palliative medicine by the American Board of Medical Specialties or who hold a certificate of added qualification in hospice and palliative medicine through the American Osteopathic Association;

  - Physicians treating patients in accordance with an approved clinical trial; and
  - Physicians who prescribe medically-necessary controlled substances for patients during inpatient stays or while providing emergency services and care in hospitals licensed under ch. 395, F.S.
- Exempts the following clinics from registration as pain-management clinics under ch. 458, F.S.:
  - Clinics wholly owned (no longer requires that they also be operated) by one or more board-eligible or board-certified anesthesiologists, physiatrists, psychiatrists, rheumatologists, or neurologists;
  - Clinics wholly owned (no longer requires that they also be operated) by one or more board-eligible medical specialists in areas already listed in statute. The American Board of Pain Medicine is added as an approved board for certification of pain medicine specialists;
  - Clinics organized as physician-owned group practices as defined in 42 C.F.R. 411.352; and
  - Clinics which, before June 1, 2011, were wholly owned by physicians who are not board-eligible or board-certified but who successfully completed residency programs in anesthesiology, physiatry, psychiatry, rheumatology, or neurology and who have 7 years of documented, full-time practice in pain medicine in this state. "Full-time" is defined as practicing an average of 20 hours per week each year in pain medicine.
- Exempts the following clinics from registration as pain-management clinics under ch. 459, F.S.:
  - Clinics wholly owned (no longer requires that they also be operated) by one or more board-eligible or board-certified anesthesiologists, physiatrists, psychiatrists, rheumatologists, or neurologists; and
  - Clinics wholly owned (no longer requires that they also be operated) by one or more board-eligible medical specialists who hold certain qualifications relating to pain medicine. The American Association of Physician Specialties is added as an approved board for certification of pain medicine specialists.
- Allows pharmacists to dispense Schedule II or Schedule III controlled substances as part of clinical research conducted under protocols approved by the FDA.
- Allows a pharmacy, prescriber, or dispenser to have access to information in the prescription drug monitoring program's database which relates to a potential patient. Pharmacists or health care practitioners who are administering controlled substances to patients who are receiving hospice care or to patients or residents receiving care at certain licensed health care facilities are exempted from provisions of the prescription drug monitoring program.

B. Amendments:

None.

924852

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
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The Committee on Health Regulation (Diaz de la Portilla) recommended the following:

Senate Amendment (with title amendment)

Delete lines 24 - 36
and insert:
Section 1. Paragraphs (a) and (c) of subsection (1) and subsection (3) of section 456.44, Florida Statutes, are amended to read:
456.44 Controlled substance prescribing.—
(1) DEFINITIONS.—
(a) "Addiction medicine specialist" means a board-certified psychiatrist who holds ~~physiatrist with~~ a subspecialty certification in addiction medicine or who is eligible for such

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subspecialty certification in addiction medicine, a ~~an addiction medicine~~ physician who is certified or eligible for certification by the American Society of Addiction Medicine, or an osteopathic physician who holds a certificate of added qualification in Addiction Medicine through the American Osteopathic Association.
(c) "Board-certified pain management physician" means a physician who possesses board certification in pain medicine by the American Board of Pain Medicine, board certification by the American Board of Interventional Pain Physicians, or board certification or subcertification in pain management by a specialty board recognized by the American Association of Physician Specialists or the American Board of Medical Specialties or an osteopathic physician who holds a certificate in Pain Management by the American Osteopathic Association.

========== T I T L E A M E N D M E N T ==========
And the title is amended as follows:
Delete line 6
and insert:
a physiatrist; redefining the term "board-certified pain management physician" to include a physician who possesses board certification or subcertification in pain management by a specialty board recognized by the American Board of Medical Specialties; providing that the management of pain

126352

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
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The Committee on Health Regulation (Diaz de la Portilla) recommended the following:

Senate Amendment (with directory and title amendments)

Between lines 36 and 37
insert:
(2) REGISTRATION.—Effective January 1, 2012, a physician licensed under chapter 458, chapter 459, chapter 461, or chapter 466 who prescribes any controlled substance listed in Schedule II, Schedule III, or Schedule IV of ~~as defined in~~ s. 893.03, for the treatment of chronic nonmalignant pain, must:
(a) Designate himself or herself as a controlled substance prescribing practitioner on the physician's practitioner profile.

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(b) Comply with the requirements of this section and applicable board rules.

====== D I R E C T O R Y C L A U S E A M E N D M E N T ======
And the directory clause is amended as follows:
Delete lines 24 - 25
and insert:
Section 1. Paragraph (a) of subsection (1) and subsections (2) and (3) of section 456.44, Florida Statutes, are amended to read:

================ T I T L E A M E N D M E N T ================
And the title is amended as follows:
Delete line 6
and insert:
a physiatrist; providing requirements that a physician who prescribes certain specific controlled substances for the treatment of chronic nonmalignant pain must fulfill; providing that the management of pain

685832

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
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The Committee on Health Regulation (Diaz de la Portilla) recommended the following:

Senate Amendment (with directory and title amendments)

Between lines 36 and 37
insert:

(d) "Chronic nonmalignant pain" means pain unrelated to cancer, ~~or~~ rheumatoid arthritis, or sickle cell anemia which persists beyond the usual course of disease or beyond the injury that is the cause of the pain or which persists more than 90 days after surgery.

====== D I R E C T O R Y C L A U S E A M E N D M E N T ======

685832

And the directory clause is amended as follows:

Delete lines 24 - 25
and insert:

Section 1. Paragraphs (a) and (d) of subsection (1) and subsection (3) of section 456.44, Florida Statutes, are amended to read:

================ T I T L E A M E N D M E N T ================
And the title is amended as follows:

Delete line 6
and insert:

a physiatrist; revising the definition of the term "chronic nonmalignant pain"; providing that the management of pain

837556

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
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The Committee on Health Regulation (Diaz de la Portilla) recommended the following:

Senate Amendment (with title amendment)

Delete lines 163 - 175
and insert:
This subsection does not apply to a board-eligible or board-certified anesthesiologist, physiatrist, psychiatrist, rheumatologist, or neurologist, or to a board-certified physician who has surgical privileges at a hospital or ambulatory surgery center and primarily provides surgical services. This subsection does not apply to a board-eligible or board-certified medical specialist who has also completed a fellowship in pain medicine approved by the Accreditation

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Council for Graduate Medical Education or the American Osteopathic Association, or who is board eligible or board certified in pain medicine by a board approved by the American Board of Pain Medicine, the American Board of Medical Specialties, or the American Osteopathic Association and performs interventional pain procedures of the type routinely billed using surgical codes.

========== T I T L E A M E N D M E N T ==========
And the title is amended as follows:
Delete lines 11 - 14
and insert:
when a pharmacy receives it; providing that the standards of practice regarding the prescribing of controlled substances do not apply to certain board-eligible or board-certified health care practitioners, including psychiatrists and rheumatologists; amending

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
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The Committee on Health Regulation (Diaz de la Portilla) recommended the following:

Senate Amendment (with title amendment)

Delete lines 163 - 263
and insert:
This subsection does not apply to a board-certified anesthesiologist, physiatrist, psychiatrist, rheumatologist, or neurologist, or to a board-certified physician who has surgical privileges at a hospital or ambulatory surgery center and primarily provides surgical services. This subsection does not apply to a board-certified medical specialist who has also completed a fellowship in pain medicine approved by the Accreditation Council for Graduate Medical Education or the

390072

American Osteopathic Association, or who is board certified in pain medicine by a board approved by the American Board of Medical Specialties or the American Osteopathic Association and performs interventional pain procedures of the type routinely billed using surgical codes. This subsection does not apply to a physician who is treating a patient in accordance with an approved clinical trial.

Section 2. Paragraph (a) of subsection (1) of section 458.3265, Florida Statutes, is amended to read:

458.3265 Pain-management clinics.—

(1) REGISTRATION.—

(a)1. As used in this section, the term:

a. "Chronic nonmalignant pain" means pain unrelated to cancer or rheumatoid arthritis which persists beyond the usual course of disease or beyond the injury that is the cause of the pain or which persists more than 90 days after surgery.

b. "Pain-management clinic" or "clinic" means any publicly or privately owned facility:

(I) That advertises in any medium for any type of pain-management services; or

(II) Where in any month a majority of patients are prescribed opioids, benzodiazepines, barbiturates, or carisoprodol for the treatment of chronic nonmalignant pain.

2. Each pain-management clinic must register with the department unless:

a. The ~~That~~ clinic is licensed as a facility pursuant to chapter 395;

b. The majority of the physicians who provide services in the clinic ~~primarily~~ provide primarily surgical services;

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c. The clinic is owned by a publicly held corporation whose shares are traded on a national exchange or on the over-the-counter market and whose total assets at the end of the corporation's most recent fiscal quarter exceeded $50 million;

d. The clinic is affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows;

e. The clinic does not prescribe controlled substances for the treatment of pain;

f. The clinic is owned by a corporate entity exempt from federal taxation under 26 U.S.C. s. 501(c)(3);

g. The clinic is wholly owned and operated by one or more board-certified anesthesiologists, physiatrists, psychiatrists, rheumatologists, or neurologists; or

h. The clinic is wholly owned and operated by one or more board-certified medical specialists who have also completed fellowships in pain medicine approved by the Accreditation Council for Graduate Medical Education, or who are also board-certified in pain medicine by a board approved by the American Board of Medical Specialties and perform interventional pain procedures of the type routinely billed using surgical codes.

Section 3. Paragraph (a) of subsection (1) of section 459.0137, Florida Statutes, is amended to read:

459.0137 Pain-management clinics.—

(1) REGISTRATION.—

(a)1. As used in this section, the term:

a. "Chronic nonmalignant pain" means pain unrelated to cancer or rheumatoid arthritis which persists beyond the usual course of disease or beyond the injury that is the cause of the

390072

pain or which persists more than 90 days after surgery.

b. "Pain-management clinic" or "clinic" means any publicly or privately owned facility:

(I) That advertises in any medium for any type of pain-management services; or

(II) Where in any month a majority of patients are prescribed opioids, benzodiazepines, barbiturates, or carisoprodol for the treatment of chronic nonmalignant pain.

2. Each pain-management clinic must register with the department unless:

a. The ~~That~~ clinic is licensed as a facility pursuant to chapter 395;

b. The majority of the physicians who provide services in the clinic ~~primarily~~ provide primarily surgical services;

c. The clinic is owned by a publicly held corporation whose shares are traded on a national exchange or on the over-the-counter market and whose total assets at the end of the corporation's most recent fiscal quarter exceeded $50 million;

d. The clinic is affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows;

e. The clinic does not prescribe controlled substances for the treatment of pain;

f. The clinic is owned by a corporate entity exempt from federal taxation under 26 U.S.C. s. 501(c)(3);

g. The clinic is wholly owned and operated by one or more board-certified anesthesiologists, physiatrists, psychiatrists, rheumatologists, or neurologists; or

h. The clinic is wholly owned and operated by one or more

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board-certified medical specialists who have also completed fellowships in pain medicine approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, or who are also board-certified in pain medicine by a board approved by the American Board of Medical Specialties or the American Osteopathic Association and perform interventional pain procedures of the type routinely billed using surgical codes.

Section 4. Paragraph (b) of subsection (1) of section 465.0276, Florida Statutes, is amended to read:

465.0276 Dispensing practitioner.—

(1)

(b) A practitioner registered under this section may not dispense a controlled substance listed in Schedule II or Schedule III as provided in s. 893.03. This paragraph does not apply to:

1. The dispensing of complimentary packages of medicinal drugs which are labeled as a drug sample or complimentary drug as defined in s. 499.028 to the practitioner's own patients in the regular course of her or his practice without the payment of a fee or remuneration of any kind, whether direct or indirect, as provided in subsection (5).

2. The dispensing of controlled substances in the health care system of the Department of Corrections.

3. The dispensing of a controlled substance listed in Schedule II or Schedule III in connection with the performance of a surgical procedure. The amount dispensed pursuant to the subparagraph may not exceed a 14-day supply. This exception does not allow for the dispensing of a controlled substance listed in

390072

Schedule II or Schedule III more than 14 days after the performance of the surgical procedure. For purposes of this subparagraph, the term "surgical procedure" means any procedure in any setting which involves, or reasonably should involve:

a. Perioperative medication and sedation that allows the patient to tolerate unpleasant procedures while maintaining adequate cardiorespiratory function and the ability to respond purposefully to verbal or tactile stimulation and makes intra- and postoperative monitoring necessary; or

b. The use of general anesthesia or major conduction anesthesia and preoperative sedation.

4. The dispensing of a controlled substance listed in Schedule II or Schedule III pursuant to an approved clinical trial. For purposes of this subparagraph, the term "approved clinical trial" means a clinical research study or clinical investigation that, in whole or in part, is state or federally funded or is conducted under protocols approved by ~~an investigational new drug application that is reviewed by~~ the United States Food and Drug Administration.

5. The dispensing of methadone in a facility licensed under s. 397.427 where medication-assisted treatment for opiate addiction is provided.

6. The dispensing of a controlled substance listed in Schedule II or Schedule III to a patient of a facility licensed under part IV of chapter 400.

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

And the title is amended as follows:

Delete lines 11 - 19

390072

and insert:
when a pharmacy receives it; providing that the standards of practice regarding the prescribing of controlled substances do not apply to certain physicians; amending ss. 458.3265 and 459.0137, F.S.; requiring that a pain-management clinic register with the Department of Health unless the clinic is wholly owned and operated by certain health care professionals, including a board-certified psychiatrist or rheumatologist; amending s. 465.0276, F.S.; redefining the term "approved clinical trial" as it relates to the Florida Pharmacy Act;

393116

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
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The Committee on Health Regulation (Diaz de la Portilla) recommended the following:

Senate Amendment (with title amendment)

Delete line 175
and insert:
billed using surgical codes. This subsection does not apply to hospitalists or other physicians who prescribe medically necessary controlled substances for a patient during an inpatient stay or while providing emergency services and care in a hospital licensed under chapter 395.

========== T I T L E A M E N D M E N T ==========
And the title is amended as follows:

393116

Delete line 14
and insert:
certified psychiatrists or rheumatologists or to hospitalists or other physicians who prescribe medically necessary controlled substances for a patient during an inpatient stay or while providing emergency services and care in a hospital licensed under ch. 395, F.S.; amending

362074

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
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The Committee on Health Regulation (Diaz de la Portilla) recommended the following:

Senate Amendment (with title amendment)

Delete line 175
and insert:

billed using surgical codes. This subsection does not apply to a physician certified by the American Board of Medical Specialties in hospice and palliative medicine or to an osteopathic physician who holds a certificate of added qualification in hospice and palliative medicine through the American Osteopathic Association.

362074

========== T I T L E A M E N D M E N T ==========
And the title is amended as follows:

Delete line 14
and insert:

certified psychiatrists, rheumatologists, and other specified physicians; amending

829118

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
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The Committee on Health Regulation (Diaz de la Portilla) recommended the following:

Senate Amendment (with title amendment)

Delete lines 178 - 218
and insert:
458.3265 Pain-management clinics.—
(1) REGISTRATION.—
(a)1. As used in this section, the term:
a. "Chronic nonmalignant pain" means pain unrelated to cancer or rheumatoid arthritis which persists beyond the usual course of disease or beyond the injury that is the cause of the pain or which persists more than 90 days after surgery.
b. "Pain-management clinic" or "clinic" means any publicly

829118

or privately owned facility:

(I) That advertises in any medium for any type of pain-management services; or

(II) Where in any month a majority of patients are prescribed opioids, benzodiazepines, barbiturates, or carisoprodol for the treatment of chronic nonmalignant pain.

2. Each pain-management clinic must register with the department unless:

a. The ~~That~~ clinic is licensed as a facility pursuant to chapter 395;

b. The majority of the physicians who provide services in the clinic ~~primarily~~ provide primarily surgical services;

c. The clinic is owned by a publicly held corporation whose shares are traded on a national exchange or on the over-the-counter market and whose total assets at the end of the corporation's most recent fiscal quarter exceeded $50 million;

d. The clinic is affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows;

e. The clinic does not prescribe controlled substances for the treatment of pain;

f. The clinic is owned by a corporate entity exempt from federal taxation under 26 U.S.C. s. 501(c)(3);

g. The clinic is wholly owned ~~and operated~~ by one or more board-eligible or board-certified anesthesiologists, physiatrists, psychiatrists, rheumatologists, or neurologists; ~~or~~

h. The clinic is wholly owned ~~and operated~~ by one or more board-eligible or board-certified medical specialists who have

829118

also completed fellowships in pain medicine approved by the Accreditation Council for Graduate Medical Education, or who are also board-eligible or board-certified in pain medicine by a board approved by the American Board of Pain Medicine or the American Board of Medical Specialties and perform interventional pain procedures of the type routinely billed using surgical codes; ~~.~~

i. The clinic is organized as a physician-owned group practice as defined in 42 C.F.R. 411.352; or

j. Before June 1, 2011, the clinic was wholly owned by physicians who are not board eligible or board certified but who successfully completed a residency program in anesthesiology, physiatry, psychiatry, rheumatology, or neurology and who have 7 years of documented, full-time practice in pain medicine in this state. For purposes of this paragraph, the term "full time" is defined as practicing an average of 20 hours per week each year in pain medicine.

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

And the title is amended as follows:

Delete lines 15 - 19

and insert:

s. 458.3265, F.S.; requiring that a pain-management clinic register with the Department of Health unless the clinic is wholly owned by certain board-eligible or board-certified physicians or medical specialists, organized as a physician-owned group practice, or wholly owned by physicians who are not board eligible or board certified but who completed specified

829118

residency programs and have a specified number of years of full-time practice in pain medicine; amending s. 459.0137, F.S.; requiring that a pain-management clinic register with the Department of Health unless the clinic is wholly owned and operated by certain physicians, including a board-certified psychiatrist or rheumatologist;

557472

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
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The Committee on Health Regulation (Diaz de la Portilla) recommended the following:

Senate Amendment (with title amendment)

Delete lines 181 - 184
and insert:

a. "Chronic nonmalignant pain" means pain unrelated to cancer, ~~or~~ rheumatoid arthritis, or sickle cell anemia which persists beyond the usual course of disease or beyond the injury that is the cause of the pain or which persists more than 90 days after surgery.

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

557472

And the title is amended as follows:

Delete line 15
and insert:

ss. 458.3265 and 459.0137, F.S.; revising the definition of the term "chronic nonmalignant pain"; requiring that a

574482

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
01/31/2012	.	
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The Committee on Health Regulation (Diaz de la Portilla) recommended the following:

Senate Amendment

Delete line 217
and insert:
Board of Medical Specialties or the American Association of Physician Specialties and perform interventional pain

Delete line 261
and insert:
Specialties, the American Association of Physician Specialties, or the American Osteopathic Association and perform

401216

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
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The Committee on Health Regulation (Diaz de la Portilla) recommended the following:

Senate Amendment (with title amendment)

Delete lines 224 - 227
and insert:
a. "Chronic nonmalignant pain" means pain unrelated to cancer, ~~or~~ rheumatoid arthritis, or sickle cell anemia which persists beyond the usual course of disease or beyond the injury that is the cause of the pain or which persists more than 90 days after surgery.

========== T I T L E A M E N D M E N T ==========
And the title is amended as follows:

401216

Delete line 15
and insert:

ss. 458.3265 and 459.0137, F.S.; revising the definition of the term "chronic nonmalignant pain"; requiring that a

430950

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
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The Committee on Health Regulation (Diaz de la Portilla) recommended the following:

Senate Amendment (with title amendment)

Delete lines 252 - 263
and insert:
g. The clinic is wholly owned ~~and operated~~ by one or more board-eligible or board-certified anesthesiologists, physiatrists, psychiatrists, rheumatologists, or neurologists; or
h. The clinic is wholly owned ~~and operated~~ by one or more board-eligible or board-certified medical specialists who have also completed fellowships in pain medicine approved by the Accreditation Council for Graduate Medical Education or the

430950

American Osteopathic Association, or who are also board-eligible or board-certified in pain medicine by a board approved by the American Board of Medical Specialties, the American Association of Physician Specialties, or the American Osteopathic Association and perform interventional pain procedures of the type routinely billed using surgical codes.

========== T I T L E A M E N D M E N T ==========
And the title is amended as follows:
Delete lines 15 - 19
and insert:
s. 458.3265, F.S.; requiring that a pain-management clinic register with the Department of Health unless the clinic is wholly owned and operated by certain health care professionals, including a board-certified psychiatrist or rheumatologist; amending s. 459.0137, F.S.; requiring that a pain-management clinic register with the Department of Health unless the clinic is wholly owned by certain health care practitioners;

244070

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
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The Committee on Health Regulation (Diaz de la Portilla) recommended the following:

Senate Amendment (with title amendment)

Between lines 263 and 264
insert:
Section 4. Paragraph (b) of subsection (5) of section 893.055, Florida Statutes, is amended to read:
893.055 Prescription drug monitoring program.—
(5) When the following acts of dispensing or administering occur, the following are exempt from reporting under this section for that specific act of dispensing or administration:
(b) A pharmacist or health care practitioner when administering a controlled substance to a patient who is

244070

receiving hospice care or to a patient or resident receiving care as a patient at a hospital, nursing home, ambulatory surgical center, hospice, or intermediate care facility for the developmentally disabled which is licensed in this state.

========== T I T L E A M E N D M E N T ==========
And the title is amended as follows:
Delete line 19
and insert:
board-certified psychiatrist or rheumatologist; amending s. 893.055, F.S.; providing that a pharmacist or health care practitioner is exempt from reporting a dispensed controlled substance to the Department of Health when administering the controlled substance to a patient who is receiving hospice care or to a patient or resident receiving care at certain medical facilities licensed in this state;

794354

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/31/2012	.	
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The Committee on Health Regulation (Diaz de la Portilla) recommended the following:

Senate Amendment (with title amendment)

Between lines 263 and 264
insert:
Section 4. Paragraph (b) of subsection (7) of section 893.055, Florida Statutes, is amended to read:
893.055 Prescription drug monitoring program.—
(7)
(b) A pharmacy, prescriber, or dispenser shall have access to information in the prescription drug monitoring program's database which relates to a patient, or a potential patient, of that pharmacy, prescriber, or dispenser in a manner established

794354

by the department as needed for the purpose of reviewing the patient's controlled substance prescription history. Other access to the program's database shall be limited to the program's manager and to the designated program and support staff, who may act only at the direction of the program manager or, in the absence of the program manager, as authorized. Access by the program manager or such designated staff is for prescription drug program management only or for management of the program's database and its system in support of the requirements of this section and in furtherance of the prescription drug monitoring program. Confidential and exempt information in the database shall be released only as provided in paragraph (c) and s. 893.0551. The program manager, designated program and support staff who act at the direction of or in the absence of the program manager, and any individual who has similar access regarding the management of the database from the prescription drug monitoring program shall submit fingerprints to the department for background screening. The department shall follow the procedure established by the Department of Law Enforcement to request a statewide criminal history record check and to request that the Department of Law Enforcement forward the fingerprints to the Federal Bureau of Investigation for a national criminal history record check.

========== T I T L E A M E N D M E N T ==========
And the title is amended as follows:
Delete line 19
and insert:
board-certified psychiatrist or rheumatologist;

794354

amending s. 893.055, F.S.; requiring that a pharmacy, prescriber, or dispenser have access to information in the prescription drug monitoring program's database which relates to a patient, or a potential patient, of that pharmacy, prescriber, or dispenser for the purpose of reviewing the patient's controlled substance prescription history;

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR ELLYN SETNOR BOGDANOFF
25th District

COMMITTEES:
Budget - Subcommittee on Finance and Tax, *Chair*
Budget
Budget - Subcommittee on Transportation, Tourism, and Economic Development
Appropriations
Communications, Energy, and Public Utilities
Education Pre-K - 12
Governmental Oversight and Accountability
Regulated Industries

JOINT COMMITTEE:
Administrative Procedures, *Alternating Chair*

January 26, 2011

Senator Rene Garcia, Chair
Senate Committee on Health Regulation
530 Knott Building
404 S. Monroe Street
Tallahassee, FL 32399

Re: SB 1198, Relating to Prescribing of Controlled Substances

Chair Garcia:

I am writing to request that you place **SB 1198, Relating to Prescribing of Controlled Substances** on the agenda of your Committee on Health Regulation at your earliest convenience.

Feel free to contact me with any questions or concerns about this legislation.

Sincerely,

Senator Ellyn Setnor Bogdanoff
Florida Senate –District 25

cc: Sandra R. Stovall, Staff Director

REPLY TO:
❒ 312 Clematis Street, Suite 403, West Palm Beach, FL 33401 (561) 650-6833
❒ 1845 Cordova Road, Suite 202, Fort Lauderdale, Florida 33316 (954) 467-4205
❒ 212 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5100

Senate's Website: *www.flsenate.gov*

MIKE HARIDOPOLOS
President of the Senate

MICHAEL S. "MIKE" BENNETT
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1-31-12
Meeting Date

Topic _____ Bill Number SB 1195 *(if applicable)*

Name Tim Cerio Amendment Barcode _____ *(if applicable)*

Job Title _____

Address ~~32~~ 301 S. Bronough Ave, Suite 600 Phone 577-9090
Street

Tall FL 32311 E-mail tcerio@gray-robinson.com
City *State* *Zip*

Speaking: [X] For [ ] Against [ ] Information

Representing Florida Academy of Pain Medicine

Appearing at request of Chair: [ ] Yes [X] No Lobbyist registered with Legislature: [✓] Yes [ ] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/31/12
Meeting Date

Topic _____ Bill Number 1198 and *(if applicable)*

Name Stephen Ecenia Amendment Barcode 393116 *(if applicable)*

Job Title _____

Address 119 S. Monroe St. Suite 202 *Street* Phone (850) 681-6788

Tallahassee *City* FL *State* 32312 *Zip* E-mail steve@reuphlaw.com

Speaking: ☑ For ☐ Against ☐ Information

Representing HCA

Appearing at request of Chair: ☐ Yes ☐ No Lobbyist registered with Legislature: ☐ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/31/12
Meeting Date

Topic Support of Bill

Bill Number 1198 *(if applicable)*

Name Toni Large

Amendment Barcode *(if applicable)*

Job Title

Address 519 E. Park Ave.
Street

Phone 556-1461

Tallahassee, FL 32308
City *State* *Zip*

E-mail toni@sulaw.net

Speaking: ☐ For ☐ Against ☐ Information

Representing Florida Society of Rheumatology

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

CourtSmart Tag Report

Room: KN 412 **Case:** **Type:**
Caption: Senate Health Regulation **Judge:**

Started: 1/31/2012 4:03:57 PM
Ends: 1/31/2012 5:55:30 PM Length: 01:51:34

4:03:58 PM Opening Remarks
4:04:05 PM Roll Call
4:04:31 PM Senator Gaetz temporarily postpones SB 1516
4:04:55 PM SB 1316 temporarily postponed.
4:05:26 PM Tab 2 - SB 820 Senator Dean
4:05:42 PM Senator Dean explains amendment
4:07:39 PM Senator Gaetz with questions
4:07:57 PM Senator Dean to answer
4:08:04 PM Senator Gaetz w/question
4:08:48 PM Senator Dean to answer
4:08:55 PM Senator Jones w/question
4:09:04 PM Senator Dean to answer
4:09:16 PM Senator Sobel
4:09:29 PM John Rothell, Florida Realtors
4:09:54 PM Senator Dean explains bill as amended
4:11:23 PM Senator Sobel
4:11:29 PM Keyna Cory, AIF
4:11:54 PM Dan Peterson, Coalition for Property Rights
4:13:53 PM Roxanne Groover, Florida Onsite Wastewater Association
4:14:01 PM David Cullen, Sierra Club Florida
4:16:31 PM Senator Sobel w/comments
4:17:26 PM Senator Jones w/comments
4:17:51 PM Senator Sobel
4:17:59 PM Senator Dean closes on bill
4:18:20 PM Roll call on SB 820
4:18:55 PM Senator Sobel
4:19:01 PM Tab 9 - SB 1198 Senator Bogdanoff
4:20:15 PM Senator Gaetz w/comments
4:21:30 PM Senator Fasano w/comments
4:22:16 PM Senator Jones w/questions
4:22:32 PM Senator Bogdanoff
4:22:41 PM Senator Sobel
4:23:01 PM Senator Bogdanoff
4:23:12 PM Senator Sobel
4:23:17 PM Explains amendments
4:24:36 PM Senator Fasano
4:24:45 PM Elizabeth Davlantes
4:25:15 PM Senator Bogdanoff explains amendments
4:25:51 PM Senator Fasano w/question
4:26:20 PM Senator Bogdanoff to respond
4:26:52 PM Senator Sobel
4:27:01 PM Senator Bogdanoff
4:27:09 PM Senator Fasano
4:27:36 PM Senator Bogdanoff to respond
4:28:03 PM Stephen Ecenia, HCA
4:29:14 PM Senator Bogdanoff explains amendment
4:29:31 PM Senator Sobel
4:29:50 PM Senator Bogdanoff
4:32:08 PM Senator Fasano
4:32:38 PM Senator Bogdanoff
4:33:26 PM Senator Fasano
4:34:01 PM Senator Sobel

4:34:15 PM Tim Cerio, Florida Academy of Pain Medicine
4:34:29 PM Toni Large, Florida Society of Rheumatology
4:34:58 PM Roll call on bill
4:35:10 PM Tab 4 - Senator Gardiner SB 1826
4:35:44 PM Explains strike all
4:37:16 PM Senator Sobel
4:37:25 PM Senator Gardiner
4:37:59 PM Mary Lynn Cullen, Advocacy Institute for Children
4:38:17 PM Bill Muir, parent
4:40:56 PM Senator Sobel
4:41:03 PM Julie Delmonego, parent
4:44:03 PM Senator Sobel
4:44:18 PM Senator Gardiner
4:45:15 PM Senator Sobel
4:45:45 PM Roll Call
4:45:58 PM Secretary Dudek with comments on Assisted Living Facilities
4:55:32 PM Senator Gaetz w/questions
4:57:46 PM Secretary Dudek to answer
4:59:31 PM Senator Gaetz w/comments
5:00:28 PM Secretary Dudek
5:00:41 PM Senator Sobel
5:01:34 PM Secretary Dudek
5:02:28 PM Senator Sobel
5:02:59 PM Secretary Dudek
5:03:17 PM Senator Sobel w/comments
5:03:37 PM Secretary Dudek
5:03:57 PM Senator Garcia w/comments
5:04:40 PM Tab 3 - SB 1600 Senator Storms presented by Tim Parsons
5:06:32 PM Senator Jones w/questions
5:06:46 PM Tim Parsons to answer
5:06:56 PM Senator Sobel w/question
5:07:07 PM Tim Parsons to answer
5:07:14 PM Senator Garcia
5:07:22 PM Tim Parsons explains amendment
5:07:58 PM Senator Sobel w/comments
5:08:20 PM Senator Gaetz w/questions
5:09:17 PM Tim Parsons to answer
5:09:41 PM Karen Koch, Florida Council fo Behavioral Healthcare
5:10:39 PM Senator Gaetz w/question
5:11:39 PM Karen Koch to answer
5:12:00 PM Senator Gaetz
5:12:55 PM Secretary Dudek to answer
5:13:28 PM Senator Garcia
5:13:49 PM Senator Sobel w/question
5:14:15 PM Secretary Dudek to respond
5:14:31 PM Senator Garcia
5:15:02 PM Roll Call
5:15:09 PM Tab 1 Senator Flores' SB 1856 presented by Patricia Flor
5:16:41 PM Senator Garcia
5:16:52 PM Mike Fischer, American Cancer Society
5:17:21 PM Senator Garcia
5:17:28 PM Tab 8 - SB 2074 ALF by HR
5:18:09 PM Mandy O'Callaghan to present proposed committee substitute
5:20:47 PM Explains amendments
5:22:53 PM On bill as amended
5:23:02 PM Senator Garcia
5:23:09 PM Jack McRay AARP
5:23:37 PM Brian Bobare, Estates of Carpenter & Leading Age Florida (left)
5:23:56 PM Kevin Smaage, Leading Age Florida
5:27:03 PM Senator Gaetz w/comment
5:28:08 PM Senator Garcia w/comments
5:28:55 PM Roll Call

5:29:30 PM Senator Sobel
5:30:01 PM Tab 7 - SB 1884 Senator Garcia
5:32:38 PM Senator Garcia explains bill and amendments
5:35:37 PM Senator Sobel
5:36:28 PM Senator Garcia
5:36:55 PM James Eaton, 21st Century Oncology
5:37:36 PM Paul Belcher, Florida Hospital Association
5:39:23 PM Senator Sobel
5:39:56 PM Senator Garcia w/questions
5:40:03 PM Paul Belcher to answer
5:40:24 PM Senator Garcia
5:41:03 PM Paul Belcher
5:41:24 PM Senator Garcia
5:41:32 PM Paul Belcher
5:41:50 PM Senator Gaetz w/questions
5:43:32 PM Paul Belcher to answer
5:43:47 PM Mark Delegal, Safety Net Hospital Alliance of Florida
5:46:48 PM Senator Gaetz
5:47:06 PM Mark Delegal to answer
5:47:21 PM Senator Sobel
5:47:46 PM Senator Garcia to answer
5:48:09 PM Mark Delegal
5:50:01 PM Senator Jones -Motion to vote time certain 5:55 pm
5:50:18 PM Senator Sobel
5:50:25 PM Michael Good, M.D., Council of Florida Medical School Deans
5:52:12 PM Senator Gaetz w/questions
5:53:17 PM Dr. Good
5:53:34 PM Senator Gaetz
5:53:52 PM Dr. Good
5:54:39 PM Senator Sobel
5:54:55 PM Senator Garcia -Meeting adjourned