

SB 422 by Benacquisto (CO-INTRODUCERS) Hays, Bradley, Simpson, Bullard, Soto, Gibson, Detert, Ring, Clemens, Negron, Evers, Margolis, Abruzzo, Stargel, Thompson, Flores, Sobel, Hukill, Altman, Smith, Diaz de la Portilla, Braynon; (Identical to H 0301) Cancer Treatment

106542	A	S	WD	HP, Bean	Delete L.114:	03/07 09:58 AM

SB 646 by CF; (Compare to H 0187) Assisted Living Facilities

256146	PCS	S	RCS	HP		03/07 11:14 AM
652094	PCS:A	S	RCS	HP, Sobel	Delete L.712:	03/07 11:14 AM
287394	PCS:A	S	RCS	HP, Sobel	Delete L.909 - 915:	03/07 11:14 AM

SB 1258 by Grimsley; (Compare to H 1319) Comprehensive Health Information System

CS/SB 258 by RI, Bradley (CO-INTRODUCERS) Dean, Hays, Negron; (Compare to H 0141) Florida Clean Indoor Air Act

731142	A	S	FAV	HP, Braynon	Delete L.44 - 45:	03/08 11:03 AM

SB 536 by Detert; (Similar to CS/H 0413) Physical Therapy

340402	A	S	RCS	HP, Sobel	Delete L.32 - 35:	03/07 10:52 AM

SB 844 by Grimsley; (Similar to H 0939) Medicaid Fraud

861804	A	S	RCS	HP, Grimsley	Delete L.201 - 655:	03/07 10:56 AM
852784	AA	S	RCS	HP, Garcia	Delete L.321 - 327:	03/07 10:56 AM
437058	AA	S	RCS	HP, Garcia	Delete L.339 - 360:	03/07 10:56 AM

SB 612 by Galvano; (Identical to H 0805) Health Care Practitioners

124818	A	S	RCS	HP, Grimsley	Delete L.18 - 34:	03/07 10:57 AM

SB 966 by Bean; (Identical to H 1071) Health Care

SB 604 by Bean; (Identical to H 0639) Practitioners

The Florida Senate
COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Bean, Chair
Senator Sobel, Vice Chair

MEETING DATE: Thursday, March 7, 2013**TIME:** 8:00 —10:00 a.m.**PLACE:** Pat Thomas Committee Room, 412 Knott Building**MEMBERS:** Senator Bean, Chair; Senator Sobel, Vice Chair; Senators Brandes, Braynon, Flores, Galvano, Garcia, Grimsley, and Joyner

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	SB 422 Benacquisto (Identical H 301)	Cancer Treatment; Citing this act as the "Cancer Treatment Fairness Act"; requiring that an individual or group insurance policy or contract or a health maintenance contract that provides coverage for cancer treatment medications provide coverage for orally administered cancer treatment medications on a basis no less favorable than that required by the policy or contract for intravenously administered or injected cancer treatment medications; prohibiting insurers, health maintenance organizations, and certain other entities from engaging in specified actions to avoid compliance with this act, etc. HP 03/07/2013 Favorable BI AP	Favorable Yeas 7 Nays 2
A proposed committee substitute for the following bill (SB 646) is expected to be considered:			
2	SB 646 Children, Families, and Elder Affairs (Compare H 187, H 1015, H 1313, H 1319, S 1212)	Assisted Living Facilities; Providing that Medicaid prepaid behavioral health plans are responsible for enrolled mental health residents; authorizing the Agency for Health Care Administration to deny, revoke, or suspend a license of an assisted living facility for a negligent act of any facility staff which seriously affects the health, safety, or welfare of a resident; requiring the agency to regularly inspect every licensed assisted living facility; requiring the agency to propose a rating system of assisted living facilities for consumers and create content for the agency's website that makes available to consumers information regarding assisted living facilities, etc. HP 03/07/2013 Fav/CS JU	Fav/CS Yeas 9 Nays 0

COMMITTEE MEETING EXPANDED AGENDA

Health Policy

Thursday, March 7, 2013, 8:00 —10:00 a.m.

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
3	SB 1258 Grimsley (Compare H 1319)	Comprehensive Health Information System; Renaming the Florida Center for Health Information and Policy Analysis as the Florida Health Information Transparency Initiative; revising the functions that the Agency for Health Care Information must perform in order to collect and disseminate health information and statistics; requiring the agency to implement the transparency initiative in a manner that recognizes state-collected data as an asset and rewards taxpayer investment in information collection and management; abolishing the State Consumer Health Information and Policy Advisory Council, etc. HP 03/07/2013 Favorable AHS AP	Favorable Yeas 9 Nays 0
4	CS/SB 258 Regulated Industries / Bradley (Compare H 141, H 439)	Florida Clean Indoor Air Act; Authorizing municipalities and counties to restrict smoking on certain properties; providing limitations on such restrictions; authorizing a law enforcement officer to issue a citation under certain circumstances, etc. RI 02/21/2013 Fav/CS HP 03/07/2013 Fav/1 Amendment CA	Fav/1 Amendment (731142) Yeas 6 Nays 3
5	SB 536 Detert (Similar CS/H 413)	Physical Therapy; Authorizing physical therapists to implement physical therapy treatment plans of a specified duration which are provided by advanced registered nurse practitioners, etc. HP 03/07/2013 Fav/CS BI RC	Fav/CS Yeas 9 Nays 0
6	SB 844 Grimsley (Similar H 939)	Medicaid Fraud; Adding an additional provision relating to a change in principal that must be included in a Medicaid provider agreement with the Agency for Health Care Administration; requiring the agency to enter into an interagency agreement with the Division of Insurance Fraud regarding anti-fraud plans by managed care plans; revising provisions specifying grounds for terminating a provider from the program, for seeking certain remedies for violations, and for imposing certain sanctions, etc. HP 03/07/2013 Fav/CS BI AHS AP	Fav/CS Yeas 9 Nays 0

COMMITTEE MEETING EXPANDED AGENDA

Health Policy

Thursday, March 7, 2013, 8:00 —10:00 a.m.

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
7	SB 612 Galvano (Identical H 805)	Health Care Practitioners; Requiring that certain health care practitioners make specified disclosures when presenting themselves as "Doctor" or "Dr."; providing criminal penalties for violations if there is an intent to mislead, etc. HP 03/07/2013 Fav/CS CJ ACJ AP	Fav/CS Yeas 8 Nays 1
8	SB 966 Bean (Identical H 1071)	Health Care; Conforming provisions to a redefinition of the term "accrediting organizations" in s. 395.002, F.S., relating to hospital licensing and regulation; designating the Florida Hospital Sanford-Burnham Translational Research Institute for Metabolism and Diabetes as a resource for diabetes research in this state, etc HP 03/07/2013 Temporarily Postponed AP	Temporarily Postponed
9	SB 604 Bean (Identical H 639)	Practitioners; Reorganizing provisions relating to license fees for certain practitioners; providing that the Department of Financial Services shall defend certain claims, suits, actions, or proceedings for injunctive, affirmative, or declaratory relief involving emergency interventions on behalf of impaired practitioners; allowing impaired practitioner consultants access to certain confidential information in the prescription drug monitoring program's database when necessary to evaluate or monitor a practitioner as part of a treatment program for impaired practitioners, etc. HP 03/07/2013 Favorable JU RC	Favorable Yeas 9 Nays 0

Other Related Meeting Documents

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 Committee on Health Policy

BILL: SB 422

INTRODUCER: Senator Benacquisto and others

SUBJECT: Cancer Treatment

DATE: March 4, 2013

REVISED: _____

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. Lloyd	Stovall	HP	Favorable
2. _____	_____	BI	_____
3. _____	_____	AP	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

I. Summary:

SB 422 creates the “Cancer Treatment Fairness Act.” The bill requires individual and group health insurance or health maintenance policies that provide coverage for cancer treatment medications to provide coverage for oral medications in a manner no less favorable than those provided intravenously or as injectables.

The bill also prohibits insurers and health maintenance organizations (HMOs) from increasing or varying the cost sharing for intravenous or injectable medications in order to comply with the changes in this legislation. Insurers and HMOs are also prohibited from providing any incentive, recommending a service, or changing the classification of any medication in order to meet the requirements of this bill.

The bill includes a directive to the Division of Law Revision and Information to replace references in the bill to the effective date to the actual date the bill becomes effective. The bill provides a specific effective date of July 1, 2013.

This bill creates two new sections of law, sections 627.42391 and 641.313, Florida Statutes.

II. Present Situation:

Cancer is the general name for a group of more than 100 unique diseases, but they share a common thread in that all cancers start because abnormal cells grow out of control.¹ Half of all

¹ American Cancer Society, *What is Cancer?*, <http://www.cancer.org/cancer/cancerbasics/what-is-cancer> (last visited Feb. 6, 2013).

men and one-third of all women in the United States will develop some form of cancer during their lifetime.² The National Cancer Institute estimates that approximately 13.7 million Americans with a history of cancer were alive on January 1, 2012, and about 1,660,290 new cancer cases are expected in 2013.³ In Florida, the number of new cases in 2013 is expected to be 118,320.⁴

After diagnosis, a cancer treatment plan is developed based on a number of factors, including the type of cancer, the stage of the disease, the patient's age and overall health.⁵ Treatment options include surgery, radiation therapy or anticancer drug therapy; some plans may also include stem cell transplantation.⁶ Anticancer drug therapy is further broken down into three types: cytotoxic agents (chemotherapy), biologic agents and hormonal agents.⁷ These agents can include oral and intravenous or injectable products.⁸

Chemotherapy is a specific type of cancer treatment that uses drugs to kill cancer cells. It works by stopping or slowing the growth of cancer cells.⁹ Historically, intravenous therapies have been the most common method for administering anticancer drug therapies.¹⁰

A 2010 Texas Department of Insurance report found that 28 percent of the oral anticancer medications approved by the Food and Drug Administration had intravenous/injected substitutes and 23 percent had generic equivalents.¹¹ However, treatment delivery systems are changing and pills are quickly becoming a more prevalent option.¹² At least 25 percent of the drugs in the oncology development phase are oral medications.¹³ Not all oral medications have an injectable or IV equivalent.

Intravenous medications are usually administered in a physician's office or outpatient hospital setting, but an oral medication is typically dispensed as a prescription and most often provided

² American Cancer Society, *How Common is Cancer?*, <http://www.cancer.org/cancer/cancerbasics/what-is-cancer>, (last visited Feb. 6, 2013).

³ American Cancer Society, *Cancer Facts & Figures*, 2013, (1), <http://www.cancer.org/acs/groups/content/@epidemiologysurveillance/documents/document/acspc-036845.pdf> (last visited Feb. 6, 2013).

⁴ American Cancer Society, *Cancer Facts & Figures*, *supra* note 3 at 5.

⁵ National Cancer Institute at the National Institutes of Health, *What You Need to Know About Cancer: Treatment*, <http://www.cancer.gov/cancertopics/wyntk/cancer/page8>, (last visited Feb.8, 2013).

⁶ *Ibid.*

⁷ Milliman, NY, Kathryn Fitch et al., *Parity for Oral and Intravenous/Injected Cancer Drug*, 3, (Jan. 25, 2010), <http://publications.milliman.com/research/health-rr/pdfs/parity-oral-intravenous-injected.pdf> (last visited Feb. 6, 2013).

⁸ *Ibid.*

⁹ Washington State Department of Health, *Oral Chemotherapy Drug Coverage Mandated Benefit Sunrise Review*, 7 (Publication Number 631-014) (December 2010), <http://www.doh.wa.gov/portals/1/Documents/Pubs/631014.pdf> (last visited Feb.6, 2013).

¹⁰ National Cancer Institute at the National Institutes of Health, *Oral Chemotherapy: Potentials and Misconceptions*, <http://www.nccn.com/understanding-cancer/233-oral-chemotherapy.html>, (last visited Feb.15, 2013).

¹¹ Texas Department of Insurance, *Patient Cost Disparity between Orally and Intravenously Administered Chemotherapies*, Report on Senate Bill 1143, Section 3, (12), 81st Legislature, Regular Session, 2009, August 2010.

¹² Michelle Andrews, *Some States Mandate Better Coverage of Oral Cancer Drugs*, Kaiser Health News, May 14, 2012, <http://www.kaiserhealthnews.org/features/insuring-your-health/2012/cancer-drugs-by-pill-instead-of-iv-michelle-andrews-051512.aspx>, (last visited on Feb.6, 2013).

¹³ *Ibid.*

through a pharmacy.¹⁴ The intravenous or injectable medication is usually covered as a medical benefit as an office or hospital outpatient service.¹⁵

In contrast, coverage for an oral cancer drug generally falls under a plan's prescription benefit.¹⁶ The patient's out of pocket cost for an office visit or outpatient hospital visit compared to the co-payment, co-insurance or deductible for a prescription can differ by thousands of dollars, depending most frequently on the cost of the drug.¹⁷ And, unlike the medical portion of many health plans, the prescription drug benefit may not include a maximum out of pocket limit.¹⁸ In addition, when the prescription costs reach a certain level, patient compliance drops and prescriptions remain unfilled.¹⁹ Beginning in January 2014, federal law prescribes out of pocket limits for many health insurance plans under the federal Patient Protection and Affordable Care Act (PPACA).²⁰

As of January 2013, 21 states plus the District of Columbia had passed oral oncology parity laws.²¹ Parity laws generally require that insurance coverage for orally administered chemotherapy medication be provided on a basis no less favorable than coverage for intravenous or injected medications.²²

The National Comprehensive Cancer Network (NCCN) notes that oral chemotherapy is a more attractive option for those patients for whom cancer is a chronic disease.²³ Moreover, oral medications can be less costly to administer since they are taken at home and not in a physician's office or hospital setting.²⁴ While a physician or the physician's nursing staff may not be present for the dosing of the oral medication, there can still be a significant investment made in education and support of the patient to ensure appropriate use of the medication.²⁵

The NCCN website includes a list of misconceptions about the use of oral chemotherapy drugs.²⁶ The NCCN notes that oral chemotherapy is not for everyone and patients should be aware that oral chemotherapy is not simple to administer nor does it automatically have fewer side effects than intravenous treatment.²⁷

Patient advocacy groups for oral chemotherapy parity argue that oral medications reduce the amount of time that family members and caregivers miss work for appointments as well as

¹⁴ Milliman, *supra* note 7 at 7.

¹⁵ Ibid.

¹⁶ Milliman, *supra* note 7 at 1.

¹⁷ Milliman, *supra* note 7 at 12.

¹⁸ Milliman, *supra* note 7 at 4.

¹⁹ Andrews, *supra* note 12.

²⁰ See *infra* note 30.

²¹ Alliance for Access to Cancer Care, *Fact Sheet* (February 2013); On file in the Senate Health Policy Committee.

²² Milliman, *supra* note 7 at 12.

²³ National Comprehensive Cancer Network, *Oral Chemotherapy: Potentials and Misconceptions*, <http://www.nccn.com/understanding-cancer/233-oral-chemotherapy.html> (last visited: Feb. 7, 2013).

²⁴ Texas Department of Insurance, *Patient Cost Disparity between Orally and Intravenously Administered Chemotherapies*, Report on Senate Bill 1143, Section 3, (11-12), 81st Legislature, Regular Session, 2009, Aug. 2010.

²⁵ Ibid.

²⁶ National Comprehensive Cancer Network, *Oral Chemotherapy: Potentials and Misconceptions*, <http://www.nccn.com/understanding-cancer/233-oral-chemotherapy.html> (last visited: Feb. 7, 2013).

²⁷ Ibid.

provide the patient with a sense of empowerment.^{28,29} More than a quarter of employees are acting as caregivers to family members who are experiencing an illness, including cancer.³⁰

Patient Protection and Affordable Care Act

In March 2010, the Congress passed and the President signed the Patient Protection and Affordable Care Act (PPACA).³¹ Under PPACA, qualified health plans (QHP) would be available from the state or federal Exchange beginning January 1, 2014. PPACA required the Secretary of Health and Human Services to establish for those QHP's a minimum package of essential health benefits (EHB).³² The EHB package must cover benefits across ten general categories from preventive services, maternity care, hospital services to prescription drugs.³³

Section 1311(d)(3)(B) of PPACA allows a state to require QHPs to cover additional benefits above those required under the EHB; however, the law also directs the state or the issuer to offset the costs of those supplemental benefits to the enrollee.³⁴ Under the proposed rule released on November 26, 2012, a distinction in the proposed rule's preamble is made between changes in benefits versus changes in cost sharing. The proposed rule limits the offset requirement only to "care, treatment and services," thereby excluding a state's obligations to defray costs relating to changes relating to provider types, cost-sharing or reimbursement.³⁵

In addition to these provisions, certain plans under PPACA received "grandfather status." A grandfathered health plan is a plan that existed on March 23, 2010, the date that PPACA was enacted, and that at least one person had been continuously covered for one year.³⁶ Some consumer protection elements do not apply to grandfathered plans that were part of PPACA but others are applicable, regardless of the type of plan.³⁷

Providing the essential health benefits are also not required of grandfathered health plans.³⁸ A grandfathered plan can lose its status if significant changes to benefits or cost sharing changes are made to the plan since attaining its grandfathered status.³⁹ Grandfathered plans are required

²⁸ Patients Equal Access Coalition, *White Paper: Cost Effectiveness of Oral Chemotherapy*, <http://www.readbag.com/myeloma-pdfs-advocacy-peac-cost-effectiveness-oral-chemo> (last visited Feb. 15, 2013).

²⁹ Texas Department of Insurance, *supra* note 24 at 12.

³⁰ National Business Group on Health and National Comprehensive Cancer Network, *An Employer's Guide to Cancer Treatment and Prevention*, 1, (2011).

³¹ Pub. Law No. 111-148, H.R. 3590, 111th Cong. (Mar. 23, 2010).

³² *Ibid.*

³³ Center for Consumer Information and Insurance Oversight, *Essential Health Benefits Coverage Bulletin*, (1), Dec. 16, 2011, available at: http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf (last visited: Feb. 18, 2012).

³⁴ 77 Fed. Reg. 70,644, 70,647, (Nov. 26, 2012), available at: <http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28362.pdf> (last visited Feb. 18, 2013).

³⁵ *Ibid.*

³⁶ Healthcare.gov, *Grandfathered Health Plans*, <http://www.healthcare.gov/law/features/rights/grandfathered-plans/index.html> (last visited Feb.11, 2013).

³⁷ Healthcare.gov., <http://www.healthcare.gov/news/factsheets/2012/11/ehb11202012a.html>, (last visited Feb. 11, 2013).

³⁸ Sarah Barr, *FAQ: Grandfathered Health Plans* (Dec. 2012), <http://www.kaiserhealthnews.org/stories/2012/december/17/grandfathered-plans-faq.aspx> (last visited Feb. 12, 2013).

³⁹ Healthcare.gov, *Keeping the Health Plan You Have: The Affordable Care Act and "Grandfathered Health Plans"* (June 14, 2010), <http://www.healthcare.gov/news/factsheets/2010/06/keeping-the-health-plan-you-have-grandfathered.html> (last visited Feb. 12, 2013).

to disclose their status to their enrollees every time plan materials are distributed and to identify the consumer protections that are not available as a grandfathered plan.⁴⁰ Even though exempt from the EHB, a grandfathered plan could still be required to meet a new requirement under state law if otherwise required under state requirements.⁴¹

The PPACA's provisions include annual limitations on cost sharing in section 1302(c)(1) and an annual limitation on deductibles in section 1302(c)(2) of the Affordable Care Act effective January 1, 2014. The type of plan an individual is enrolled in and the level of benefits selected or "medal plan," will determine the amount of out of pocket costs that an individual may incur; however, out of pocket costs must still remain within certain guidelines.

The federal law further prohibits the imposition of annual and lifetime benefit limits, except for certain grandfathered plans, effective January 1, 2014. These protections went into effect for children earlier, September 23, 2010, and apply to grandfathered group health insurance plans. These restrictions would impact any out of pocket costs applied to prescription drug coverage whether delivered as an oral or an injectable medication.

Florida Mandates

A "mandate" is usually defined as required health coverage for specific type of treatments, benefits, providers or categories of dependants.⁴² In Florida, health insurance coverage mandates are spread throughout the insurance statutes depending on the coverage type and insurance product. In addition, some types of health insurance coverage are exempt from state mandates, such as self-funded plans.⁴³ As a result, specific mandates may not be applicable to all insured persons as not all benefits are applicable to all insurance coverage types.⁴⁴ Florida has at least 52 different "mandates" falling across the small group, individual or large group health insurance market, including health maintenance organizations (HMOs).⁴⁵

Under current state law, s. 627.4239, F.S., coverage for the use of drugs in the treatment of cancer is mandated under any individual or group policy that covers cancer if that drug is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature.⁴⁶ Coverage is also required for the administration of the medically necessary services to administer those drugs.⁴⁷ Current state law does not specifically address coverage under

⁴⁰ Ibid.

⁴¹ 75 Fed. Reg. 34, 538, 34,540 (June 17, 2010)

⁴² National Conference of State Legislatures, *Mandated Health Insurance Benefits and State Laws*, <http://www.ncsl.org/issues-research/health/mandated-health-insurance-benefits-and-state-laws.aspx> (last visited Feb. 20, 2013).

⁴³ Florida Department of Financial Services, *Insurance Library*, available at: http://www.myfloridacfo.com/consumers/insuranceLibrary/Insurance/L_and_H/Health_Care/Self-Funded_Medical_Plans/Self-Funded_-_Regulation.htm (last visited Feb. 20, 2013).

⁴⁴ Florida Department of Financial Services, *Insurance Library*, available at: http://www.myfloridacfo.com/consumers/insuranceLibrary/Insurance/L_and_H/Health_General/MandatedHealthInsAndHMOBenefits.pdf (last visited Feb. 20, 2013).

⁴⁵ Ibid.

⁴⁶ See s. 627.4239(2)(a), F.S.

⁴⁷ See s. 627.4236(2)(b), F.S..

HMOs or parity for any co-insurance, deductible or copayment that may be related to how cancer treatment medicine is delivered.

Required Study by Advocates

Section 624.215, F.S., requires every person or organization seeking consideration of a legislative proposal that would mandate specific health coverage to submit to the Agency for Health Care Administration and the appropriate legislative committee a report reviewing the social and financial impacts of the proposed coverage. The statute lists twelve components for assessment, if available:

- To what extent is the treatment or service generally used by a significant portion of the population?
- To what extent is the insurance coverage generally available?
- If the insurance coverage is not generally available, to what extent does the lack of coverage result in persons avoiding necessary health care treatment?
- If the coverage is not generally available, to what extent does the lack of coverage result in unreasonable financial hardship?
- The level of public demand for the treatment or service.
- The level of public demand for insurance coverage of the treatment or service.
- The level of interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts.
- To what extent will the coverage increase or decrease the cost of the treatment or service?
- To what extent will the coverage increase the appropriate uses of the treatment or service?
- To what extent will the coverage increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders?
- The impact of this coverage on the total cost of health care.

The International Myeloma Foundation (Foundation) delivered a report to the Senate Health Policy Committee on February 21, 2013, assessing SB 422 and HB 301 against the criteria of s. 624.215, F.S., while specifically not admitting, that the bill's directives mandate any specific health coverage.⁴⁸

According to the Foundation, insurance coverage of oral cancer medications is not the precise issue. The issue is the out of pocket cost differential to patients between intravenous or injectables and oral treatments as most insurance plans already cover the medication.⁴⁹ The report states that there is a direct correlation between the levels of out of pocket costs and the number of prescriptions left abandoned. For example, claims with patient cost sharing over \$500 had more than four times the likelihood of abandonment as opposed to those that cost less than \$100.⁵⁰ In addition, one in five persons uses all or most of their savings to pay for cancer treatment.⁵¹

⁴⁸ International Myeloma Foundation, Health Insurance Mandate Report, *Parity for Oral and Intravenous Cancer Medications*, 1, (February 2013) (on file with the Senate Committee on Health Policy).

⁴⁹ International Myeloma Foundation, *supra* note 48 at 2.

⁵⁰ International Myeloma Foundation, *supra* note 48 at 3.

⁵¹ International Myeloma Foundation, *supra* note 48 at 3.

The report indicates that for some cancers, oral treatment is the only standard treatment.⁵² More treatments are being approved as over 40 oral medications have been approved for 54 different types of cancer.⁵³ The report argues that oral medications are less costly to administer at home, may have fewer side effects, provide patient empowerment and are more convenient for the patient and the patient's caregivers.⁵⁴

With reduced copayments, the report points out that fewer prescriptions would be abandoned or unfilled leading to greater medication compliance.⁵⁵ The Foundation argues that by keeping these out of pocket costs affordable and making prescription drug compliance easier that the overall costs of cancer will decrease.⁵⁶

As to the potential for increased costs, the report notes that minor increases in administrative expenses may be incurred by insurance companies, but that administrative expenses saved from fewer office visits may offset those costs.⁵⁷ Citing the Milliman study, the Foundation report re-states an estimate of not more than \$0.50 per member per month for the cost of implementing cancer treatment parity. The Foundation report also notes that in a survey of nine other states plus the District of Columbia with a similar parity provision, the legislation's impact on premiums was zero to negligible.⁵⁸

III. Effect of Proposed Changes:

Section 1 of the bill names the act the "Cancer Treatment Fairness Act."

Sections 2 and 3 of the bill create new sections of law, ss. 627.42391 and 641.313, F.S., to address cancer treatment parity for orally administered medications under individual and group insurance and HMO insurance policies, respectively. Under these sections, the bill adds definitions for "cancer treatment medication" and "cost sharing."

In addition, the bill provides that for any individual, group, or HMO policy that is delivered, issued, renewed or amended in Florida that includes major medical or other comprehensive coverage that also provides cancer treatment, such policy must also provide coverage for orally prescribed cancer medications. The bill provides that cost sharing provisions for those orally prescribed medication may not be less favorable than any cost sharing required for intravenous or injected cost sharing medications. Insurers are prohibited from taking certain actions to thwart the intent of this bill, specifically:

- Varying the terms of their policies as they exist on the effective date of this act in order to comply with this requirement. In effect, insurers may not increase cost sharing on

⁵² International Myeloma Foundation, *supra* note 48 at 1.

⁵³ International Myeloma Foundation, *supra* note 48 at 1.

⁵⁴ *Ibid.*

⁵⁵ International Myeloma Foundation, *supra* note 48 at 5.

⁵⁶ *Ibid.*

⁵⁷ International Myeloma Foundation, *supra* note 48 at 6.

⁵⁸ *Ibid.*

intravenous medications or injections rather than reduce cost sharing on orally prescribed cancer treatments to meet this requirement.

- Offering an incentive that would encourage any person to accept less than the minimum protections offered under this act.
- Penalizing a health care practitioner through a reduction in compensation for recommending or providing services to a person covered under this section of law.
- Incentivizing a health care provider to not comply with this act.
- Changing the classification of any intravenous or injected cancer treatment medication.
- Increasing the cost sharing for any intravenous or injectable medications to comply with this act.

Section 4 provides a directive to the Division of Law and Information to replace any instances of “the effective date of this act” with the final effective date once this act becomes law.

Section 5 specifies the effective date of the act is July 1, 2013.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

SB 422 may impact the cost of health insurance coverage provided in the private sector. A 2010 report by Milliman estimated that for most commercial benefit plans, the cost for oral cancer treatment parity would be under \$0.50 per member per month.⁵⁹ The actual cost would vary based on the benefit plan and the level of cost sharing incurred by the employee or patient.⁶⁰

⁵⁹ Milliman, *supra* note 7 at 1.

⁶⁰ *Ibid.*

The statutorily mandated study submitted by the International Myeloma Foundation cites both the Milliman report for cost estimates as well as other state survey data that shows nominal cost impacts.

C. Government Sector Impact:

The bill's provisions may impact the cost of health insurance coverage provided to employees across all groups in the government sector.

A 2010 report by Milliman estimated that for most commercial benefit plans, the cost for oral cancer treatment parity would be under \$0.50 per member per month.⁶¹ The actual cost would vary based on the benefit plan and the level of cost sharing incurred by the employee or patient.⁶²

The statutorily mandated study submitted by the International Myeloma Foundation cites both the Milliman report for cost estimates as well as other state survey data that shows nominal cost impacts.

VI. Technical Deficiencies:

The Office of Insurance Regulation (OIR) identified a potential conflict with current law at section 627.4239, F.S.,⁶³ which governs coverage of drugs for the treatment of cancer. This law currently requires insurers to cover these drugs as well as the administration of those drugs by a licensed health care practitioner in the small group, large group and individual markets. It is unclear how a health plan could comply with the "no less favorable" provisions of this bill given the current requirements that costs also be covered for the administration of the same drug by a licensed health care practitioner.

Additionally, the OIR recommends that the current section of law be amended to accommodate this change rather than create a new section of law.

VII. Related Issues:

The bill includes a directive to add an effective date once the act takes effect; however, the bill already includes an effective date in Section 5. It is unclear why Section 4 is necessary when an effective date has been provided and no conflicting effective dates are included in the bill.

VIII. Additional Information:

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

None.

⁶¹ Ibid.

⁶² Ibid.

⁶³ Florida Office of Insurance Regulation, *Senate Bill 422 Bill Analysis and Fiscal Impact* (January 23, 2013) (on file with the Senate Committee on Health Policy).

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.



106542

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
03/07/2013	.	
	.	
	.	
	.	

The Committee on Health Policy (Bean) recommended the following:

Senate Amendment

Delete line 114
and insert:
Section 5. This act shall take effect January 1, 2014.

By Senator Benacquisto

30-00169A-13

2013422__

A bill to be entitled
An act relating to cancer treatment; providing a short
title; creating ss. 627.42391 and 641.313, F.S.;
providing definitions; requiring that an individual or
group insurance policy or contract or a health
maintenance contract that provides coverage for cancer
treatment medications provide coverage for orally
administered cancer treatment medications on a basis
no less favorable than that required by the policy or
contract for intravenously administered or injected
cancer treatment medications; prohibiting insurers,
health maintenance organizations, and certain other
entities from engaging in specified actions to avoid
compliance with this act; providing a directive to the
Division of Law Revision and Information; providing an
effective date.

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

Section 1. This act may be cited as the "Cancer Treatment
Fairness Act."

Section 2. Section 627.42391, Florida Statutes, is created
to read:

627.42391 Insurance policies; cancer treatment parity;
orally administered cancer treatment medications.—

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

(a) "Cancer treatment medication" means medication
prescribed by a treating physician who determines that the
medication is medically necessary to kill or slow the growth of

30-00169A-13

2013422__

30 cancerous cells in a manner consistent with nationally accepted
31 standards of practice.

32 (b) "Cost sharing" includes copayments, coinsurance, dollar
33 limits, and deductibles imposed on the covered person.

34 (2) An individual or group insurance policy delivered,
35 issued for delivery, renewed, amended, or continued in this
36 state that provides medical, major medical, or similar
37 comprehensive coverage and includes coverage for cancer
38 treatment medications must also cover prescribed, orally
39 administered cancer treatment medications and may not apply
40 cost-sharing requirements for orally administered cancer
41 treatment medications that are less favorable to the covered
42 person than cost-sharing requirements for intravenous or
43 injected cancer treatment medications covered under the policy
44 or contract.

45 (3) An insurer providing a policy or contract described in
46 subsection (2) and any participating entity through which the
47 insurer offers health services may not:

48 (a) Vary the terms of the policy in effect on the effective
49 date of this act to avoid compliance with this section.

50 (b) Provide any incentive, including, but not limited to, a
51 monetary incentive, or impose treatment limitations to encourage
52 a covered person to accept less than the minimum protections
53 available under this section.

54 (c) Penalize a health care practitioner or reduce or limit
55 the compensation of a health care practitioner for recommending
56 or providing services or care to a covered person as required
57 under this section.

58 (d) Provide any incentive, including, but not limited to, a

30-00169A-13

2013422__

monetary incentive, to induce a health care practitioner to provide care or services that do not comply with this section.

(e) Change the classification of any intravenous or injected cancer treatment medication or increase the amount of cost sharing applicable to any intravenous or injected cancer treatment medication in effect on the effective date of this act in order to achieve compliance with this section.

Section 3. Section 641.313, Florida Statutes, is created to read:

641.313 Health maintenance contracts; cancer treatment parity; orally administered cancer treatment medications.-

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

(a) "Cancer treatment medication" means medication prescribed by a treating physician who determines that the medication is medically necessary to kill or slow the growth of cancerous cells in a manner consistent with nationally accepted standards of practice.

(b) "Cost sharing" includes copayments, coinsurance, dollar limits, and deductibles imposed on the covered person.

(2) A health maintenance contract delivered, issued for delivery, renewed, amended, or continued in this state that provides medical, major medical, or similar comprehensive coverage and includes coverage for cancer treatment medications must also cover prescribed, orally administered cancer treatment medications and may not apply cost-sharing requirements for orally administered cancer treatment medications that are less favorable to the covered person than cost-sharing requirements for intravenous or injected cancer treatment medications covered under the contract.

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2013422__

88 (3) A health maintenance organization providing a contract
89 described in subsection (2) and any participating entity through
90 which the health maintenance organization offers health services
91 may not:

92 (a) Vary the terms of the policy in effect on the effective
93 date of this act to avoid compliance with this section.

94 (b) Provide any incentive, including, but not limited to, a
95 monetary incentive, or impose treatment limitations to encourage
96 a covered person to accept less than the minimum protections
97 available under this section.

98 (c) Penalize a health care practitioner or reduce or limit
99 the compensation of a health care practitioner for recommending
100 or providing services or care to a covered person as required
101 under this section.

102 (d) Provide any incentive, including, but not limited to, a
103 monetary incentive, to induce a health care practitioner to
104 provide care or services that do not comply with this section.

105 (e) Change the classification of any intravenous or
106 injected cancer treatment medication or increase the amount of
107 cost sharing applicable to any intravenous or injected cancer
108 treatment medication in effect on the effective date of this act
109 in order to achieve compliance with this section.

110 Section 4. The Division of Law Revision and Information is
111 directed to replace the phrase "the effective date of this act"
112 wherever it occurs in this act with the date this act takes
113 effect.

114 Section 5. This act shall take effect July 1, 2013.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:

Appropriations, *Vice Chair*
Appropriations Subcommittee on Education
Appropriations Subcommittee on Health
and Human Services
Banking and Insurance
Education
Ethics and Elections
Gaming
Governmental Oversight and Accountability
Rules

SENATOR LIZBETH BENACQUISTO

Majority Leader
30th District

January 28, 2013

The Honorable Aaron Bean
Senate Health Policy, Chair
302 Senate Office Building
418 South Monroe Street
Tallahassee, FL 32399

RE: SB 422 – Relating to Cancer Treatment

Dear Mr. Chairman:

Please allow this letter to serve as my respectful request to agenda SB 422, Cancer Treatment Fairness Act, for a public hearing at your earliest convenience.

Your kind consideration of this request is greatly appreciated. Please feel free to contact my office for any additional information.

Sincerely,



Lizbeth Benacquisto
Senate District 30

Cc: Sandra Stovall

 ENTERED

REPLY TO:

- ☐ 1926 Victoria Ave, 2nd Floor, Fort Myers, Florida 33901 (239) 338-2570
- ☐ 330 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5030

Senate's Website: www.flsenate.gov

DON GAETZ
President of the Senate

GARRETT RICHTER
President Pro Tempore



✓

THE FLORIDA SENATE
APPEARANCE RECORD

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

Meeting Date _____

Topic SB 422 Cancer Fair Treatment Act Bill Number SB 422
Name Aileen Pruitt Amendment Barcode _____
(if applicable) (if applicable)

Job Title _____

Address 10750 Heil Rd. Phone (772) 486-2265
Street
Ft. Pierce, FL 34945 E-mail ampruitt@yahoo.com
City State Zip

Speaking: ☒ For ☐ Against ☐ Information

Representing myself

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)

3/7/13

Meeting Date

Topic Cancer Treatment Fairness Act

Bill Number SB422
(if applicable)

Name Karen Warmack

Amendment Barcode _____
(if applicable)

Job Title _____

Address 9975 Woodland Hills
Street

Phone _____

Tallahassee FL 32309
City State Zip

E-mail _____

Speaking: ☒ For ☐ Against ☐ Information

Representing patient perspective

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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3-7-13

Meeting Date

Topic Cancer Treatment Fairness Act

Bill Number SB0422
(if applicable)

Name WAYNE Taylor, MD

Amendment Barcode _____
(if applicable)

Job Title Leukemia survivor + Physician

Address 19126 Branch Rd
Street
Hudson FL 34667
City State Zip

Phone 727-992-7000

E-mail <twayne43@hotmail.com>

Speaking: ☒ For ☐ Against ☐ Information

Representing Leukemia + Lymphoma 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.

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THE FLORIDA SENATE
APPEARANCE RECORD

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3/7/13

Meeting Date

Topic The Cancer Treatment Fairness Act

Bill Number SB422
(if applicable)

Name Luke Webb

Amendment Barcode _____
(if applicable)

Job Title _____

Address 4500 Prairie Ave
Street

Phone _____

Miami Beach FL 33140
City State Zip

E-mail _____

Speaking: ☒ For ☐ Against ☐ Information

Representing Alliance for Access to Cancer Care

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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THE FLORIDA SENATE
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3 - 7 - 13

Meeting Date

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

Topic Cancer Treatment Fairness Act

Bill Number 422
(if applicable)

Name Katie Rose Robison

Amendment Barcode _____
(if applicable)

Job Title PR

Address 2011 Delta Blvd.
Street

Phone 850 - 224 - 0174

Tallahassee FL 32308
City State Zip

E-mail katier@moorecomm
group.com

Speaking: ☒ For ☐ Against ☐ Information

Representing _____

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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THE FLORIDA SENATE
APPEARANCE RECORD



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3-7-13

Meeting Date

Topic Cancer Treatment Fairness Act

Bill Number 422
(if applicable)

Name Emily Bell

Amendment Barcode _____
(if applicable)

Job Title PR

Address 2011 Delta Blvd

Phone 850-224-0174

Street

Tallahassee

FL 32303

City

State

Zip

E-mail emilyb@moorecommgroup.com

Speaking: ☐ For ☐ Against ☐ Information

Representing _____

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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APPEARANCE RECORD

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

3/7/13

Meeting Date

Topic Cancer Treatment Fairness Act

Bill Number 422
(if applicable)

Name Cheryl Amundsen

Amendment Barcode _____
(if applicable)

Job Title disabled

Address 3300 Thomas Butler Rd
Street
Tallahassee FL 32308
City State Zip

Phone 817-205-7505

E-mail camundsen99@cfl.fl.gov
com

Speaking: ☒ For ☐ Against ☐ Information

Representing _____

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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W

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APPEARANCE RECORD

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5/7/13

Meeting Date

Topic Cancer Treatment Fairness Act

Bill Number 422
(if applicable)

Name Katie Spillman

Amendment Barcode _____
(if applicable)

Job Title PR

Address 2011 Delta Blvd
Street

Phone 850-224-0174

Tallahassee FL 32308
City State Zip

E-mail katie.s@moorecommgroup.com

Speaking: ☒ For ☐ Against ☐ Information

Representing _____

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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APPEARANCE RECORD

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3/7/2013

Meeting Date

Topic CANCER FAIRNESS ACT

Bill Number SB 422
(if applicable)

Name MARSHA GOLDFINE

Amendment Barcode _____
(if applicable)

Job Title PUBLIC POLICY CHAIR SWF KOMEN

Address 6107 FAIRWAY CT A
Street

Phone 239-596-2641

NAPLES FL 34110
City State Zip

E-mail MARSHA.GOLDFINE@COMCAST.NET

Speaking: ☒ For ☐ Against ☐ Information

Representing SUSAN G KOMEN FOR THE CURE

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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APPEARANCE RECORD



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

3-7-13

Meeting Date

Topic Cancer Treatment Fairness Act

Bill Number SB 422
(if applicable)

Name Dr. Melvin Goldfine

Amendment Barcode _____
(if applicable)

Job Title Dentist (retired)

Address 6107 Fairway Ct.
Street
Naples, Florida 34110
City State Zip

Phone (239) 596-2641

E-mail melgoldfine@gmail.com

Speaking: ☒ For ☐ Against ☐ Information

Representing Susan G Komen for the Cure

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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APPEARANCE RECORD

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3/7/13

Meeting Date

Topic Cancer Fairness Act

Bill Number SB422
(if applicable)

Name Molly Teter

Amendment Barcode _____
(if applicable)

Job Title Interior Designer

Address 4500 Prairie Ave
Street

Phone 7868592092

Miami Beach FL 33140
City State Zip

E-mail mteter27@yahoo.com

Speaking: ☒ For ☐ Against ☐ Information

Representing Oral Parity

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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APPEARANCE RECORD

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3 - 7 - 13

Meeting Date

Topic SB 422 CANCER FAIRNESS ACT

Bill Number SB 422

(if applicable)

Name ANA VALLADARES

Amendment Barcode

(if applicable)

Job Title DESIGNER

Address 16731 HARBOR CT

Phone 754-234-2634

Street

WESTON

FLORIDA

33326

City

State

Zip

E-mail ANAVALLADARES@YAHOO.COM

Speaking: ☒ For ☐ Against ☐ Information

Representing LEUKEMIA & LYMPHOMA SOCIETY - SOUTH FLORIDA

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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3-7-13

Meeting Date

Topic SB 422 Cancer Fairness Act

Bill Number SB422
(if applicable)

Name BARRY BIRDWELL

Amendment Barcode _____
(if applicable)

Job Title ENGINEER

Address 120 Sandy Shoes
Street
Melbourne Beach F 32951
City State Zip

Phone 321 794-8481
E-mail barry@thebirdwells.com

Speaking: ☒ For ☐ Against ☐ Information

Representing Leukemia + Lymphoma 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.

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THE FLORIDA SENATE
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3-7-13
Meeting Date

Topic ACCESS TO CANCER TREATMENT Bill Number 50422
(if applicable)

Name JERI FRANCOEUR Amendment Barcode _____
(if applicable)

Job Title ~~SUSAN G. KOMEN PUBLIC POLICY~~

Address 1 SHARON TERR Phone 386-295-1554
Street

ORMOND BEACH FL 32174 E-mail jfrancoeur@gmail.com
City State Zip

Speaking: ☒ For ☐ Against ☐ Information

Representing SUSAN G. KOMEN

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

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3/7/13

Meeting Date

Topic Cancer Fairness Act

Bill Number SB 422
(if applicable)

Name Vanessa Vicente

Amendment Barcode _____
(if applicable)

Job Title Community Outreach mgr -

Leukemia +
Lymphoma Society

Address 907 NE 199th St., #207

Phone 305-332-7190

Miami, FL 33179
City State Zip

E-mail vanessa.vicente@
lls.org

Speaking: ☒ For ☐ Against ☐ Information

Representing oral parity

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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3-7-13

Meeting Date

Topic Cancer Fairness Act

Bill Number SB 422
(if applicable)

Name Maria Avenancio

Amendment Barcode _____
(if applicable)

Job Title Patient Services Manager

Address 2013 Coulson Alley
Street
Orlando FL 32814
City State Zip

Phone 407-579-6975

E-mail Maria.Avenancio@
LLS.org

Speaking: ☒ For ☐ Against ☐ Information

Representing Leukemia + Lymphoma Society

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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THE FLORIDA SENATE
APPEARANCE RECORD

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3-7-13

Meeting Date

Topic Cancer Fairness Treatment Act

Bill Number SB0422

(if applicable)

Name Leon E (Ed) Herndon

Amendment Barcode _____

(if applicable)

Job Title Advocate (Advocacy Chair Tampa)

Address 12507 Phodine Rd.

Street

Phone 813-310-0079

Riverview

City

FL

State

33529

Zip

E-mail herndonlee@aol.com

Speaking: ☒ For ☐ Against ☐ Information

Representing Leukemia & Lymphoma Society of Tampa

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

3/7/13
Meeting Date

Topic Cancer Treatment Fairness Act

Bill Number 422
(if applicable)

Name Lorraine A Schaumburg MSW

Amendment Barcode _____
(if applicable)

Job Title Social Worker

Address 2482 SE Avalon Rd.

Phone 772-263-8216

PSL, FL - 34952
City State Zip

E-mail kschaum@bellsouth.net

Speaking: ☒ For ☐ Against ☐ Information

Representing Susan B Komen Foundation

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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THE FLORIDA SENATE
APPEARANCE RECORD



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3/7/13

Meeting Date

Topic Cancer Treatment Fairness Act

Bill Number 422
(if applicable)

Name Patricia Foley

Amendment Barcode _____
(if applicable)

Job Title Volunteer

Address 3061 SW circle St

Phone 772-341-8753

Street

Port St Lucie FL 34953

City

State

Zip

E-mail PJFoley31@gmail.com

Speaking: ☒ For ☐ Against ☐ Information

Representing Susan G. Komen Foundation

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)

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APPEARANCE RECORD

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3/7/13
Meeting Date

Topic Cancer Treatment Fairness Act

Bill Number 422
(if applicable)

Name Ashley Pruitt

Amendment Barcode _____
(if applicable)

Job Title Mission Coordinator

Address 1604 Oriedo Grove Cir.
Street
Oriedo FL 32765
City State Zip

Phone 772-812-4798

E-mail apruitt@akomencentral
florida.org

Speaking: ☒ For ☐ Against ☐ Information

Representing Susan G. Komen for the Cure

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 (10/2011)

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APPEARANCE RECORD

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3/7/13

Meeting Date

Topic Cancer Treatment Fairness Act

Bill Number SB 422
(if applicable)

Name Kirsten Pitroff

Amendment Barcode _____
(if applicable)

Job Title Event Intern

Address 34133 Fortunado Street
Sorrento FL 32776
City State Zip

Phone 407-790-2581

E-mail Kpitroff77@gmail.com

Speaking: ☒ For ☐ Against ☐ Information

Representing Susan G. Komen

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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THE FLORIDA SENATE
APPEARANCE RECORD



3-7-13

Meeting Date

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

Topic Cancer Treatment Fairness Act

Bill Number SB 422
(if applicable)

Name Brittany Becker

Amendment Barcode _____
(if applicable)

Job Title mission intern

Address 421 N. woodland blvd unit 5879

Phone 631-438-2065

Deland FL 32723
City State Zip

E-mail bjbecker@stetson.edu

Speaking: ☒ For ☐ Against ☐ Information

Representing Susan G. Komen

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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THE FLORIDA SENATE

APPEARANCE RECORD

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

9.7.13

Meeting Date

Topic Cancer Treatment Fairness Act

Bill Number 422
(if applicable)

Name Stefanie Steele

Amendment Barcode _____
(if applicable)

Job Title Director

Address 301 E South St #4019
Street

Phone 386-334-8738

Orlando FL 32801
City State Zip

E-mail _____

Speaking: ☒ For ☐ Against ☐ Information

Representing Susan G. Komen

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)

3-7-13

Meeting Date

Topic Cancer Treatment Fairness Act
Name Sean McQuade
Job Title _____

Bill Number SB 422
(if applicable)
Amendment Barcode _____
(if applicable)

Address 2012 Schuller Way
Street
Casselberry FL 32707
City State Zip

Phone 407-949-4654
E-mail SMcquadel7@gmail.com

Speaking: ☒ For ☐ Against ☐ Information

Representing Libby's Legacy

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

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

Meeting Date _____

Topic Cancer Fair Treatment Act

Bill Number 422
(if applicable)

Name Ken Pruitt

Amendment Barcode _____
(if applicable)

Job Title _____

Address 10750 HEIL AL

Phone _____

Street

A. Pierce FL

34945

City

State

Zip

E-mail _____

Speaking: ☐ For ☐ Against ☐ Information

Representing Susan Komen Foundation

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

3-7-2013

Meeting Date

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

Topic CANCER TREATMENT

Bill Number SB 422
(if applicable)

Name STEPHEN R. WINN

Amendment Barcode _____
(if applicable)

Job Title EXECUTIVE DIRECTOR

Address 2007 APALACHE PARKWAY

Phone 878-7463

Street

TALLAHASSEE

FL

32301

City

State

Zip

E-mail _____

Speaking: ☒ For ☐ Against ☐ Information

WAIVE IN SUPPORT

Representing FLORIDA OSTEOPATHIC MEDICAL 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

to amendment

3/7/13
Meeting Date

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

Topic SB422 - Cancer Treatment Fairness Bill Number SB 422
(if applicable)

Name Lisa Nelson Amendment Barcode 106542
(if applicable)

Job Title Senior Director Leukemia & Lymphoma Society

Address 10 C St NE Phone 361 873 1498
Street
City Washington State DC Zip 20016 E-mail lisa.nelson@lls.org

Speaking: ☐ For ☒ Against ☐ Information

Representing Leukemia & Lymphoma

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

3/7/13

Meeting Date

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

Topic Cancer Treatment Fairness Act

Bill Number SB 422
(if applicable)

Name Lisa Nelson

Amendment Barcode _____
(if applicable)

Job Title Senior Director State Government Affairs

Address 10 G St NE
Street

Phone (301) 873 1498

Washington DC 20016
City State Zip

E-mail lisa.nelson@lfs.org

Speaking: ☒ For ☐ Against ☐ Information

Representing Leukemia & Lymphoma 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.

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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)

3/7/13

Meeting Date

Topic Cancer Treatment Fairness Act

Bill Number SB422
(if applicable)

Name Dr. Scott Tetreault

Amendment Barcode _____
(if applicable)

Job Title Oncologist

Address 1815 Tuscan Hill Dr.
Street

Phone _____

Tallahassee FL 32312
City State Zip

E-mail Stetreault@flcancer.com

Speaking: ☒ For ☐ Against ☐ Information

Representing physician perspective

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)

3/7/13

Meeting Date

Topic ~~Public Hearing~~ ~~Senate Hearing~~ Cancer Treatment Fairness Bill Number SB 422
(if applicable)

Name Matt Sherer Amendment Barcode _____
(if applicable)

Job Title Oncology Administrator

Address 1775 One Healing Place Phone 706 905 9382
Street

Tallahassee FL 32308 E-mail matt.sherer@fmh.org
City State Zip

Speaking: ☒ For ☐ Against ☐ Information

Representing Tallahassee Memorial Hospital

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)

3/7/13

Meeting Date

Topic Cancer Treatment Fairness Act

Bill Number SB 422
(if applicable)

Name Dr Jeannine Silberman

Amendment Barcode _____
(if applicable)

Job Title Medical Oncologist

Address 1775 One Healing Place

Phone 850-431-5061

Street

Tallahassee

FL

32308

City

State

Zip

E-mail jeannine.silberman@tmh.org

Speaking: ☒ For ☐ Against ☐ Information

Representing Tallahassee Memorial Healthcare

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



3/7/13

Meeting Date

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

Topic Cancer Treatment Fairness Act

Bill Number SB422
(if applicable)

Name Tracey Thompson

Amendment Barcode _____
(if applicable)

Job Title Unit Executive Director

Address 2619 Centennial Blvd

Phone 850 329 4559

Street

Tallahassee FL 32308

City

State

Zip

E-mail tracey.thompson@
Cancer.org

Speaking: ☒ For ☐ Against ☐ Information

Representing American Cancer Society

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

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

3/7/2013

Meeting Date

Topic Cancer Treatment Fairness Act

Bill Number SB 422

(if applicable)

Name Heather Wildermuth

Amendment Barcode

(if applicable)

Job Title Director of Government Relations

Address 2619 Centennial Blvd, Suite 101

Street

Phone 251-2111

Tallahassee

FL

State

32308

Zip

E-mail heather.wildermuth@
cancer.org

City

Speaking: ☒ For

☐ Against

☐ Information

Representing American Cancer

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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THE FLORIDA SENATE
APPEARANCE RECORD

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

3/7/13

Meeting Date

Topic Cancer Treatment

Bill Number SB 422
(if applicable)

Name Courtney Cox

Amendment Barcode _____
(if applicable)

Job Title _____

Address 11355 Turkey Roast Rd.
Street

Phone 850-559-0708

Tallahassee FL 32317
City State Zip

E-mail cec09h@my.fsu.edu

Speaking: ☒ For ☐ Against ☐ Information

Representing Florida Breast Cancer Foundation

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)

3-7-13
Meeting Date

Topic Access to Cancer Treatment Fairness Act Bill Number SB 422
(if applicable)

Name Lauren A. Francoeur Amendment Barcode _____
(if applicable)

Job Title _____

Address 1 Sharon Terrace Phone 386 290 1989
Street
Grand Beach FL 32174
City State Zip
E-mail armyranger911@gmail.com

Speaking: ☒ For ☐ Against ☐ Information

Representing FORCE

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 (10/2011)

THE FLORIDA SENATE
APPEARANCE RECORD

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

3-7-13

Meeting Date

Topic ACCESS TO CANCER TREATMENT
FAIRNESS ACT

Bill Number SB 422
(if applicable)

Name JEFF FRANCOEUR

Amendment Barcode _____
(if applicable)

Job Title _____

Address 1 SHARON TERR
Street
ORLANDO BEACH
City State Zip

Phone 386-295-1554

E-mail jhfrancoeur@gmail.com

Speaking: ☒ For ☐ Against ☐ Information

Representing COMMUNITY ONCOLOGY ALLIANCE

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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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)

3-7-13

Meeting Date

Topic Cancer Treatment

Bill Number 422
(if applicable)

Name Michelle Jacquis

Amendment Barcode _____
(if applicable)

Job Title Dir. of Legislative Advocacy

Address PO BOX 102609

Phone 251-2288

Tallah, FL 32302
City State Zip

E-mail mjacquis@flmedical.org

Speaking: ☒ For ☐ Against ☐ Information

Representing FL Medical Assoc.

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

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

3/7/13

Meeting Date

Topic Support SB 422

Bill Number SB 422
(if applicable)

Name Chris Hansen

Amendment Barcode _____
(if applicable)

Job Title Gray Robinson

Address _____
Street
Tallahassee FL 32301
City State Zip

Phone 850/577-9090

E-mail Chansen@gray-robinson

Speaking: ☐ For ☐ Against ☐ Information

Representing Bayer HealthCare

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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THE FLORIDA SENATE
APPEARANCE RECORD

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3/7/13

Meeting Date

Topic Cancer Parity

Bill Number SB 422
(if applicable)

Name Kristina Wiggins

Amendment Barcode _____
(if applicable)

Job Title Associate - PS group

Address _____
Street

Phone (850) 251-8694

City _____ State _____ Zip _____

E-mail _____

Speaking: ☒ For ☐ Against ☐ Information

Representing Susan B Kohmen

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

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

3/7/13

Meeting Date

Topic Cancer Treatment Fairness Act

Bill Number SB 422
(if applicable)

Name Rebecca Mahony

Amendment Barcode _____
(if applicable)

Job Title Account Executive

Address 102 Greenleaf Ln.
Street
Cumterville FL 32327
City State Zip

Phone 352-422-4427
E-mail wordhand9@yahoo.com

Speaking: ☒ For ☐ Against ☐ Information

Representing Alliance for Access to Cancer Care

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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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)

3/7/2013

Meeting Date

Topic CANCER TREATMENT FAIRNESS ACT

Bill Number SB 422
(if applicable)

Name STEVE MORGAN

Amendment Barcode _____
(if applicable)

Job Title _____

Address 1280 KISSIMMEE ST,
Street

Phone _____

TALLAHASSEE FL _____
City State Zip

E-mail WMORGAN@FLHOUSE.COM

Speaking: ☒ For ☐ Against ☐ Information

Representing ALLIANCE FOR ACCESS TO CANCER 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
APPEARANCE RECORD



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

3/8/2013

Meeting Date

Topic CANCER TREATMENT FAIRNESS ACT

Bill Number _____
(if applicable)

Name STEPHEN VARNELL

Amendment Barcode _____
(if applicable)

Job Title CONCERNED CITIZEN

Address 411 CHAPEL DR

Phone 817-565-9208

TALLY FL 32304
City State Zip

E-mail SKV12@my.fsu.edu

Speaking: ☒ For ☐ Against ☐ Information

Representing _____

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

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

Meeting Date _____

Topic SB 422 - CANCER CARE TREATMENT ACT

Bill Number SB 422
(if applicable)

Name ATRICK Q VINZAN

Amendment Barcode _____
(if applicable)

Job Title ATTORNEY

Address 200 ELWA PLACE
Street
WEST PALM BEACH FL 33405
City State Zip

Phone 561-252-2218

E-mail _____

Speaking: ☒ For ☐ Against ☐ Information

Representing LEUKEMIA + LYMPHOMA SOCIETY

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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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)

3/07/13
Meeting Date

Topic Cancer treatment fairness Act

Bill Number 422

Name Jalisa Pierre-Louis

Amendment Barcode 287394
(if applicable)

Job Title Pharmacy Intern

Address 1417 Pullen Rd #504

Phone 954-803-1879

Tallahassee FL 32303
City State Zip

E-mail Jalisa.p@aol.com

Speaking: ☒ For ☐ Against ☐ Information

Representing The American Cancer Society ; FAMU Relay for Life

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

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

3/7/13
Meeting Date

Topic Cancer Treatment Fairness Act Bill Number SB 422
(if applicable)

Name Richard O'cell Estes Amendment Barcode _____
(if applicable)

Job Title A/C

Address 1949 Sellars Pond Dr Phone _____
Street
Tallahassee FL 32305
City State Zip

Speaking: ☒ For ☐ Against ☐ Information

Representing Alliance for Access to Cancer 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
APPEARANCE RECORD

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

3/7/13

Meeting Date

Topic Cancer Parity Bill Number 422
Name Merritt Martin Amendment Barcode _____ (if applicable)
Job Title State Legislative Affairs - Moffitt Cancer Center (if applicable)
Address 502 S. Willow Ave #2 Phone 813-240-3454
Street
City Tampa State FL Zip _____
E-mail merritt.martin@gmail.com
Speaking: ☒ For ☐ Against ☐ Information
Representing Moffitt Cancer Center
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

3/7/13

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

Meeting Date

Topic _____

Bill Number 422
(if applicable)

Name John Langdon MD

Amendment Barcode _____
(if applicable)

Job Title _____

Address 412 POINCIANA
Street
WINTER PARK
City State Zip

Phone _____

E-mail FloridaChiropractic.com@gmail.com

Speaking: ☒ For ☐ Against ☐ Information

Representing FL Chapter American College of Physicians

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)

2/7/12

Meeting Date

Topic Cancer Treatment Fairness Act

Bill Number 422
(if applicable)

Name Jordan Jacobs

Amendment Barcode _____
(if applicable)

Job Title Director

Address 2011 DeHa Blvd
Street

Phone 850-879-2250

Tallahassee FL 32301
City State Zip

E-mail jordanj@moorelawgarden.com

Speaking: ☒ For ☐ Against ☐ Information

Representing _____

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)

3/7/13

Meeting Date

Topic Cancer Treatment Fairness Act

Bill Number 422
(if applicable)

Name Ashley Candler

Amendment Barcode _____
(if applicable)

Job Title student FSU

Address 2011 Delta Blvd

Phone 219-851-3003

Street

Tallahassee

FL

State

32303

Zip

E-mail ancb2@my.fsu.edu

Speaking: ☒ For ☐ Against ☐ Information

Representing _____

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)

3/7/13

Meeting Date

Topic Cancer Treatment Fairness

act

Bill Number 422

(if applicable)

Name Becca Freitong

Amendment Barcode _____

(if applicable)

Job Title Student FSU

Address 2011 Delta Blvd

Street

Phone 904-11

Tallahassee FL

City

State

Zip

E-mail _____

Speaking: ☒ For ☐ Against ☐ Information

Representing _____

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



3/7/13

Meeting Date

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

Topic Cancer Treatment Fairness Act

Bill Number 422
(if applicable)

Name Melissa Miranda

Amendment Barcode _____
(if applicable)

Job Title Student FSU

Address 2011 Delta Blvd
Street

Phone 407-967-9551

Tallahassee FL 32303
City State Zip

E-mail mam12n@mg.fsu.edu

Speaking: ☒ For ☐ Against ☐ Information

Representing _____

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

3/8/13

Meeting Date

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

Topic SB 422

Bill Number 422
(if applicable)

Name Logan McFaddin

Amendment Barcode _____
(if applicable)

Job Title Legislative Affairs Director

Address LL-26 Capitol
Street

Phone 413-2390

Tally FL 32399
City State Zip

E-mail logan.mcfaddin@myfloridaleg.com

Speaking: ☒ For ☐ Against ☐ Information

Representing Dept. of Financial Services

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)

3-7-13
Meeting Date

Topic SUPPORT OF SB 422

Bill Number SB 422
(if applicable)

Name JIM AKIN

Amendment Barcode _____
(if applicable)

Job Title EXECUTIVE DIRECTOR

Address 1931 DELWOOD DRIVE
Street

Phone 850-224-2400

TALLAHASSEE FL 32303
City State Zip

E-mail JIM@NASWFL.ORG

Speaking: ☒ For ☐ Against ☐ Information

Representing NATIONAL ASSOCIATION OF SOCIAL WORKERS - 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.

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S-001 (10/20/11)

THE FLORIDA SENATE
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3/7/13

Meeting Date

Topic _____

Bill Number 422
(if applicable)

Name Chris Nuland

Amendment Barcode _____
(if applicable)

Job Title _____

Address 1000 Riverside Ave #115

Phone 904-355-1555

Jacksonville, FL 32204
City State Zip

E-mail nulandlaweol.com

Speaking: ☒ For ☐ Against ☐ Information

Representing Florida Chapter, American Coll

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
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3-7-2013

Meeting Date

Topic Cancer Treatment

Bill Number 0422
(if applicable)

Name Layne Smith

Amendment Barcode NA
(if applicable)

Job Title Director, State Government Relations

Address 4500 San Pablo Road
Street
Jacksonville FL 32224
City State Zip

Phone 904-953-7334

E-mail smith.layne@mayo.edu

Speaking: ☒ For ☐ Against ☐ Information

Representing Mayo Clinic

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)

3/7/12

Meeting Date

Topic Cancer Treatment

Bill Number 402
(if applicable)

Name Corinne mixon

Amendment Barcode _____
(if applicable)

Job Title Lobbyist

Address 119 E. Park Ave
Street

Phone 222-2591

Tallahassee FL 32307
City State Zip

E-mail _____

Speaking: ☒ For ☐ Against ☐ Information

Representing Florida Academy of physician Assistants

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)



652094

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/07/2013	.	
	.	
	.	
	.	

The Committee on Health Policy (Sobel) recommended the following:

Senate Amendment

Delete line 712
and insert:
(f) Notwithstanding s. 408.813(2)(c) and (d) and s.
408.832, a fine must



287394

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/07/2013	.	
	.	
	.	
	.	

The Committee on Health Policy (Sobel) recommended the following:

Senate Amendment

Delete lines 909 - 915
and insert:

(b) A list of the facility's violations including, for each violation:

1. A summary of the violation that is presented in a manner understandable by the general public;

2. Any sanctions imposed by final order; and

3. A summary of any corrective action taken by the facility.

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



287394

13 file.



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Proposed Committee Substitute by the Committee on Health Policy

A bill to be entitled

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



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circumstances; amending s. 400.0074, F.S.; providing that an administrative assessment conducted by a local council be comprehensive in nature and focus on factors affecting the rights, health, safety, and welfare of the residents of a nursing home; requiring a local council to conduct an exit consultation with the facility administrator or administrator designee to discuss issues and concerns in areas affecting rights, health, safety, and welfare of residents and make recommendations for improvement; amending s. 400.0078, F.S.; requiring that residents of long-term care facilities be informed that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right; amending s. 429.07, F.S.; providing that an extended congregate care license is issued to certain facilities that have been licensed as assisted living facilities under certain circumstances; providing the purpose of an extended congregate care license; providing that the initial extended congregate care license of an assisted living facility is provisional under certain circumstances; requiring the licensee to notify the Agency for Health Care Administration whenever it accepts a resident who qualifies for extended congregate care services; requiring the agency to inspect the facility for compliance with the requirements of an extended congregate care license; authorizing the agency to waive one of the required yearly monitoring visits under certain circumstances;



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authorizing the agency to deny or revoke a facility's extended congregate care license for certain reasons or on certain grounds; requiring a registered nurse representing the agency to visit the facility at least annually, rather than twice a year, to monitor residents who are receiving limited nursing services; providing that the agency's monitoring visits may be in conjunction with other agency inspections; authorizing the agency to waive one of the required yearly monitoring visits for certain facilities; amending s. 429.075, F.S.; requiring an assisted living facility that serves one or more mental health residents to obtain a limited mental health license; amending s. 429.14, F.S.; revising the actions in which the agency may deny, revoke, or suspend the license of an assisted living facility and impose an administrative fine; revising the criteria upon which the agency must deny or revoke the license of an assisted living facility; requiring the agency to impose an immediate moratorium on the license of an assisted living facility under certain circumstances; deleting a provision requiring the agency to provide a list of facilities with denied, suspended, or revoked licenses to the Department of Business and Professional Regulation; exempting a facility from the 45-day notice requirement if it is required to relocate some or all of its residents; amending s. 429.178, F.S.; conforming cross-references; amending s. 429.19, F.S.; revising the amounts and uses of



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administrative fines; requiring the agency to levy a fine for violations that are corrected before an inspection if noncompliance occurred within a specified period of time; deleting factors that the agency is required to consider to determine penalties and fines; amending s. 429.28, F.S.; requiring that residents of facilities be informed that the identity of the resident and complainant in a complaint made to the State Long-Term Care Ombudsman Program are confidential and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right; providing that a facility that terminates an individual's residency is fined if good cause is not shown in court; amending s. 429.34, F.S.; requiring certain persons to report elder abuse in assisted living facilities; requiring the agency to regularly inspect every licensed assisted living facility; requiring the agency to conduct more frequent inspections under certain circumstances; requiring the licensee to pay a fee for the cost of additional inspections; requiring the agency to adjust the fee; amending s. 429.52, F.S.; requiring each newly hired employee of an assisted living facility to attend a preservice orientation provided by the assisted living facility; requiring the employee and administrator to sign an affidavit upon completion of the preservice orientation; requiring the assisted living facility to maintain the signed affidavit in each employee's work



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file; conforming a cross-reference; requiring the Agency for Health Care Administration to study the reliability of facility surveys and submit to the Governor and the Legislature its findings and recommendations; requiring the agency to propose a rating system of assisted living facilities for consumers and create content for the agency's website that makes available to consumers information regarding assisted living facilities; providing criteria for the content; providing an effective date.

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

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

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

(1) As used in this section, the term "mental health resident" ~~"mental health resident," for purposes of this section,~~ means an individual who receives social security disability income due to a mental disorder as determined by the Social Security Administration or receives supplemental security income due to a mental disorder as determined by the Social Security Administration and receives optional state supplementation.

(2) Medicaid prepaid behavioral health plans are responsible for enrolled mental health residents, and managing entities under contract with the department are responsible for



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145 mental health residents who are not enrolled with a Medicaid
146 prepaid behavioral health plan. Each responsible entity shall
147 ~~The department must~~ ensure that:

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

160 (b) A cooperative agreement, as required in s. 429.075, is
161 developed between the mental health care services provider that
162 serves a mental health resident and the administrator of the
163 assisted living facility with a limited mental health license in
164 which the mental health resident is living. ~~Any entity that~~
165 ~~provides Medicaid prepaid health plan services shall ensure the~~
166 ~~appropriate coordination of health care services with an~~
167 ~~assisted living facility in cases where a Medicaid recipient is~~
168 ~~both a member of the entity's prepaid health plan and a resident~~
169 ~~of the assisted living facility. If the entity is at risk for~~
170 ~~Medicaid targeted case management and behavioral health~~
171 ~~services, the entity shall inform the assisted living facility~~
172 ~~of the procedures to follow should an emergent condition arise.~~

173 (c) The community living support plan, as defined in s.



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

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

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

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



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

(3) The Secretary of Children and Family Services, in consultation with the Agency for Health Care Administration, shall ~~annually~~ require each district administrator to develop, with community input, a detailed annual plan that demonstrates ~~detailed plans that demonstrate~~ how the district will ensure the provision of state-funded mental health and substance abuse treatment services to residents of assisted living facilities that hold a limited mental health license. These plans must be consistent with the substance abuse and mental health district plan developed pursuant to s. 394.75 and must address case management services; access to consumer-operated drop-in centers; access to services during evenings, weekends, and holidays; supervision of the clinical needs of the residents; and access to emergency psychiatric care.

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

400.0074 Local ombudsman council onsite administrative assessments.—

(1) In addition to any specific investigation conducted pursuant to a complaint, the local council shall conduct, at least annually, an onsite administrative assessment of each nursing home, assisted living facility, and adult family-care home within its jurisdiction. This administrative assessment must be comprehensive in nature and must ~~shall~~ focus on factors



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affecting the rights, health, safety, and welfare of the residents. Each local council is encouraged to conduct a similar onsite administrative assessment of each additional long-term care facility within its jurisdiction.

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

(h) The local council shall conduct an exit consultation with the facility administrator or administrator designee to discuss issues and concerns in areas affecting the rights, health, safety, and welfare of the residents and make recommendations for improvement, if any.

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

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

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

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

429.07 License required; fee.—



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

(b) An extended congregate care license shall be issued to facilities that have been licensed as assisted living facilities for 2 or more years and that provide ~~providing~~, directly or through contract, services beyond those authorized in paragraph (a), including services performed by persons licensed under part I of chapter 464 and supportive services, as defined by rule, to persons who would otherwise be disqualified from continued residence in a facility licensed under this part. An extended congregate care license may also be issued to those facilities that have provisional extended congregate care licenses and meet the requirements for licensure under subparagraph 2. 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.

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



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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 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.



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319 2. If an assisted living facility has been licensed for
320 less than 2 years but meets all other licensure requirements for
321 an extended congregate care license, it shall be issued a
322 provisional extended congregate care license for a period of 6
323 months. Within the first 3 months after the provisional license
324 is issued, the licensee shall notify the agency when it has
325 admitted an extended congregate care resident, after which an
326 unannounced inspection shall be made to determine compliance
327 with requirements of an extended congregate care license. If the
328 licensee demonstrates compliance with all of the requirements of
329 an extended congregate care license during the inspection, the
330 licensee shall be issued an extended congregate care license. In
331 addition to sanctions authorized under this part, if violations
332 are found during the inspection and the licensee fails to
333 demonstrate compliance with all assisted living requirements
334 during a followup inspection, the licensee shall immediately
335 suspend extended congregate care services, and the provisional
336 extended congregate care license expires.

337 3.2. A facility that is licensed to provide extended
338 congregate care services shall maintain a written progress
339 report on each person who receives services which describes the
340 type, amount, duration, scope, and outcome of services that are
341 rendered and the general status of the resident's health. A
342 registered nurse, or appropriate designee, representing the
343 agency shall visit the facility at least twice a year ~~quarterly~~
344 to monitor residents who are receiving extended congregate care
345 services and to determine if the facility is in compliance with
346 this part, part II of chapter 408, and relevant rules. One of
347 the visits may be in conjunction with the regular survey. The



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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 held an extended congregate care license during the last 24 months, has had no class I or class II violations, has had and no uncorrected class III violations, and has had no confirmed ombudsman council complaints that resulted in a citation for licensure. The agency must first consult with the long-term care ombudsman council for the area in which the facility is located to determine if any complaints have been made and substantiated about the quality of services or care. The agency may not waive one of the required yearly monitoring visits if complaints have been made and substantiated.~~

4.3. A facility that is licensed to provide extended congregate care services must:

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

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

c. Have sufficient staff available, taking into account the physical plant and firesafety features of the building, to



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assist with the evacuation of residents in an emergency.

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

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

f. Implement the concept of managed risk.

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

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

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

~~5. The primary purpose of extended congregate care services is to allow residents, as they become more impaired, the option of remaining in a familiar setting from which they would~~



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~~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.~~

The agency may deny or revoke a facility's extended congregate care license for not meeting the standards of an extended congregate care license or for any of the grounds listed in this subsection.

(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



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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 licensure renewal ~~relicensure~~, or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with part II of chapter 408. An existing facility that qualifies ~~facilities qualifying~~ to provide limited nursing services must ~~shall~~ have maintained a standard license and may not have been subject to administrative sanctions that affect the health, safety, and welfare of residents for the previous 2 years or since initial licensure if the facility has been licensed for less than 2 years.

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



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has:

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

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

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

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

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

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

(1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected ~~deficiencies or~~ violations, and must ensure that, within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. 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



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II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training must ~~will~~ be provided by or approved by the Department of Children and Family Services.

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

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

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

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

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

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

(4) A facility that has ~~with~~ a limited mental health license may enter into a cooperative agreement with a private



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522 mental health provider. For purposes of the limited mental
523 health license, the private mental health provider may act as
524 the case manager.

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

527 429.14 Administrative penalties.—

528 (1) In addition to the requirements of part II of chapter
529 408, the agency may deny, revoke, and suspend any license issued
530 under this part and impose an administrative fine in the manner
531 provided in chapter 120 against a licensee for a violation of
532 any provision of this part, part II of chapter 408, or
533 applicable rules, or for any of the following actions by a
534 licensee, for the actions of any person subject to level 2
535 background screening under s. 408.809, or for the actions of any
536 facility staff ~~employee~~:

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

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

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

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

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

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



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

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

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

(g) Violation of a moratorium.

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

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

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

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

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

(3) The agency may deny or revoke a license of an ~~to any~~
applicant or controlling interest as defined in part II of



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

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

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

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

(c) The facility is cited for two or more class I violations arising from separate surveys or investigations within a 2-year period ~~that has two or more class I violations that are similar or identical to violations identified by the agency during a survey, inspection, monitoring visit, or complaint investigation occurring within the previous 2 years.~~

(5) An action taken by the agency to suspend, deny, or revoke a facility's license under this part or part II of chapter 408, in which the agency claims that the facility owner or an employee of the facility has threatened the health, safety, or welfare of a resident of the facility must be heard by the Division of Administrative Hearings of the Department of



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609 Management Services within 120 days after receipt of the
610 facility's request for a hearing, unless that time limitation is
611 waived by both parties. The administrative law judge shall ~~must~~
612 render a decision within 30 days after receipt of a proposed
613 recommended order.

614 (6) The agency shall impose an immediate moratorium, as
615 provided under s. 408.814, on an assisted living facility that
616 fails to provide the agency access to the facility or prohibits
617 the agency from conducting a regulatory inspection. The licensee
618 may not restrict agency staff in accessing and copying records
619 or in conducting confidential interviews with facility staff or
620 any individual who receives services from the facility provide
621 ~~to the Division of Hotels and Restaurants of the Department of~~
622 ~~Business and Professional Regulation, on a monthly basis, a list~~
623 ~~of those assisted living facilities that have had their licenses~~
624 ~~denied, suspended, or revoked or that are involved in an~~
625 ~~appellate proceeding pursuant to s. 120.60 related to the~~
626 ~~denial, suspension, or revocation of a license.~~

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

630 (8) If a facility is required to relocate some or all of
631 its residents due to agency action, that facility is exempt from
632 the 45 days' notice requirement in s. 429.28(1)(k). This
633 provision does not exempt the facility from any deadlines for
634 corrective action set by the agency.

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

637 429.178 Special care for persons with Alzheimer's disease



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or other related disorders.—

(2)(a) An individual who is employed by a facility that provides special care for residents with Alzheimer's disease or other related disorders, and who has regular contact with such residents, must complete up to 4 hours of initial dementia-specific training developed or approved by the department. The training must ~~shall~~ be completed within 3 months after beginning employment and satisfy ~~shall satisfy~~ the core training requirements of s. 429.52(3)(g) ~~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 9 months after beginning employment and satisfy ~~shall satisfy~~ the core training requirements of s. 429.52(3)(g) ~~s. 429.52(2)(g)~~.

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

429.19 Violations; imposition of administrative fines; grounds.—

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



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welfare of a resident of the facility.

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

(a) Class "I" violations are defined in s. 408.813. The agency shall impose an administrative fine of \$7,500 for each a cited class I violation in a facility that is licensed for fewer than 100 beds at the time of the violation ~~in an amount not less than \$5,000 and not exceeding \$10,000 for each violation~~. The agency shall impose an administrative fine of \$11,250 for each cited class I violation in a facility that is licensed for 100 or more beds at the time of the violation. If the noncompliance occurs within the prior 12 months, the fine must be levied for violations that are corrected before an inspection.

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

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



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

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

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

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

(g) Regardless of the class of violation cited, instead of the fine amounts listed in paragraphs (a)-(d), the agency shall



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impose an administrative fine of \$500 if a facility is found not to be in compliance with the background screening requirements as provided in s. 408.809.

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

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

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

~~(c) Any previous violations.~~

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

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

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

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

~~(5)(6)~~ A ~~Any~~ facility whose owner fails to apply for a



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change-of-ownership license in accordance with part II of chapter 408 and operates the facility under the new ownership is subject to a fine of \$5,000.

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

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

(8)~~(9)~~ The agency shall develop and disseminate an annual list of all facilities sanctioned or fined for violations of state standards, the number and class of violations involved, the penalties imposed, and the current status of cases. The list shall be disseminated, at no charge, to the Department of Elderly Affairs, the Department of Health, the Department of Children and Family Services, the Agency for Persons with Disabilities, the area agencies on aging, the Florida Statewide Advocacy Council, and the state and local ombudsman councils. The Department of Children and Family Services shall disseminate the list to service providers under contract to the department who are responsible for referring persons to a facility for residency. The agency may charge a fee commensurate with the cost of printing and postage to other interested parties requesting a copy of this list. This information may be provided electronically or through the agency's Internet site.



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Section 9. Subsections (2) and (6) of section 429.28, Florida Statutes, are amended to read:

429.28 Resident bill of rights.—

(2) The administrator of a facility shall ensure that a written notice of the rights, obligations, and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The ~~This~~ notice must ~~shall~~ include the name, address, and telephone numbers of the local ombudsman council and central abuse hotline and, if ~~when~~ applicable, Disability Rights Florida ~~the Advocacy Center for Persons with Disabilities, Inc., and the Florida local advocacy council~~, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the local ombudsman council, central abuse hotline, and Disability Rights Florida ~~Advocacy Center for Persons with Disabilities, Inc., and the Florida local advocacy council~~.

(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.



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Section 10. Section 429.34, Florida Statutes, is amended to read:

429.34 Right of entry and inspection.—

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

(2) Each licensed assisted living facility must be inspected by the agency at least once every 24 months to determine compliance with this chapter and related rules. If an assisted living facility is cited for one or more class I violations or two or more class II violations arising from separate surveys within a 60-day period or due to unrelated circumstances during the same survey, the agency must conduct an additional licensure inspection within 6 months. In addition to any fines imposed on the facility under s. 429.19, the licensee



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841 must pay a fee for the cost of the additional inspection
842 equivalent to the standard assisted living facility license and
843 per-bed fees, without exception for beds designated for
844 recipients of optional state supplementation. The agency shall
845 adjust the fee in accordance with s. 408.805.

846 Section 11. Present subsections (1) through (11) of section
847 429.52, Florida Statutes, are redesignated as subsections (2)
848 through (12), respectively, a new subsection (1) is added to
849 that section, and present subsection (9) of that section is
850 amended, to read:

851 429.52 Staff training and educational programs; core
852 educational requirement.—

853 (1) Effective October 1, 2013, each new assisted living
854 facility employee who has not previously completed core training
855 must attend a preservice orientation provided by the facility
856 before interacting with residents. The preservice orientation
857 must be at least 2 hours in duration and cover topics that help
858 the employee provide responsible care and respond to the needs
859 of residents of the facility. Upon completion, the employee and
860 the administrator of the facility must sign an affidavit stating
861 that the employee completed the required preservice orientation.
862 The facility must keep the affidavit in the employee's work
863 file.

864 (10) ~~(9)~~ The training required by this section must ~~shall~~ be
865 conducted by persons registered with the department as having
866 the requisite experience and credentials to conduct the
867 training. A person seeking to register as a trainer must provide
868 the department with proof of completion of the minimum core
869 training education requirements, successful passage of the



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competency test established under this section, and proof of compliance with the continuing education requirement in subsection (5)~~(4)~~.

Section 12. The Legislature finds that consistent regulation of assisted living facilities benefits residents and operators of such facilities. To determine whether surveys are consistent between surveys and surveyors, the Agency for Health Care Administration shall conduct a study of intersurveyor reliability for assisted living facilities. By November 1, 2013, the agency shall report to the Governor, the President of the Senate, and the Speaker of the House of Representatives its findings and make any recommendations to improve intersurveyor reliability.

Section 13. The Legislature finds that consumers need additional information on the quality of care and service in assisted living facilities in order to select the best facility for themselves or their loved ones. Therefore, the Agency for Health Care Administration shall:

(1) Propose a rating system for assisted living facilities. The proposal must include, but is not limited to, the data elements to be used, the method of collecting the data, the method of determining the rating, an estimate of the initial and ongoing costs of a rating system to both the agency and assisted living facilities, and a timetable for the implementation of the rating system for assisted living facilities. The agency shall submit its proposal to the Governor, the President of the Senate, and the Speaker of the House of Representatives by November 1, 2013.

(2) By January 1, 2014, create a content that is easily



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899 accessible through the front page of the agency's website. At a
900 minimum, the content must include:

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

903 1. The name and address of the facility.

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

905 3. The types of licenses held by the facility.

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

907 5. Other relevant information that the agency currently
908 collects.

909 (b) A list of the facility's cited violations with a
910 summary of each violation which is presented in a manner that is
911 understandable by the general public. If a facility has
912 challenged a violation under chapter 120, that violation may not
913 be published until imposed by final order.

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

916 (d) A monitored comment page, maintained by the agency,
917 which allows members of the public to anonymously comment on
918 assisted living facilities that are licensed to operate in the
919 state. This comment page must, at a minimum, allow members of
920 the public to post comments on their experiences with, or
921 observations of, an assisted living facility and to review other
922 people's comments. Comments posted to the agency's comment page
923 may not contain profanity and are intended to provide meaningful
924 feedback about the assisted living facility. The agency shall
925 provide for a webpage moderator to review comments for profane
926 content before the comments are posted to the page. An employee,
927 owner, or controlling interest in an assisted living facility is



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928 prohibited from posting comments on the page.

929 Section 14. This act shall take effect July 1, 2013.

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 Committee on Health Policy

BILL: CS/SB 646

INTRODUCER: Health Policy Committee; and Children, Families, and Elder Affairs Committee

SUBJECT: Assisted Living Facilities

DATE: March 7, 2013

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall	HP	Fav/CS
2.			JU	
3.				
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

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

I. Summary:

CS/SB 646 strengthens the enforcement of current regulations for Assisted Living Facilities (ALF or facility) by revising fines imposed for licensure violations, clarifying existing enforcement tools, and requiring an additional inspection for facilities with significant violations. Specifically, the bill would:

- Clarify who is responsible for assuring that mental health residents in an ALF receive necessary services.
- Clarify the duties of the state Long-Term Care Ombudsman Program.
- Create a provisional Extended Congregate Care (ECC) license for new ALFs and specify when the Agency for Health Care Administration (AHCA) may deny or revoke a facility's ECC license.
- Reduce by half the number of monitoring visits the AHCA must conduct for ALFs with Limited Nursing Services (LNS) licenses and ECC licenses.
- Require that facilities with one or more, rather than three or more, state supported mental health residents obtain a limited mental health (LMH) license.

- Allow the AHCA to revoke the license of a facility with a controlling interest that has or had a 25 percent or greater financial or ownership interest in a second facility which closed due to financial inability to operate or was the subject of other specified administrative sanctions.
- Clarify the criteria under which the AHCA must revoke or deny a facility's license.
- Specify circumstances under which the AHCA must impose an immediate moratorium¹ on a facility.
- Set fines for all classes of violations² to a fixed amount at the midpoint of the current range and multiply these new fine amounts for facilities licensed for 100 or more beds by 1.5 times.
- Allow the AHCA to impose a fine for a class I violation even if it is corrected before the AHCA inspects a facility.
- Double fines for repeated serious violations.
- Require that fines be imposed for repeat minor violations³ regardless of correction.
- Double the fines for minor violations if a facility is cited for the same minor violation three or more times over the course of three licensure inspections.
- Specify a fine amount of \$500 for ALFs that are not in compliance with background screening requirements.⁴
- Add certain responsible parties and agency personnel to the list of people who must report abuse or neglect to the Department of Children and Families' (the DCF) central abuse hotline.
- Require an additional inspection, within 6 months, of a facility cited for specified serious violations.
- Require new facility staff, who have not previously completed core training, to attend a 2 hour pre-service orientation before interacting with residents.
- Require the AHCA to conduct a study of inter-surveyor reliability in order to determine the consistency with which regulations are applied to facilities and report its findings and recommendations by November 1, 2013.
- Require the AHCA to propose a plan for an ALF rating system by November 1, 2013.
- Require the AHCA to revise its website used by consumers to select ALFs by January 1, 2014.

The bill has an insignificant fiscal impact on the Agency for Health Care Administration. The bill has an effective date of July 1, 2013.

The bill substantially amends sections 394.4574, 400.0074, 400.0078, 429.07, 429.075, 429.14, 429.178, 429.19, 429.28, 429.34, and 429.52 of the Florida Statutes and creates two new unnumbered sections of the Florida Statutes.

II. Present Situation:

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

¹ "Moratorium" means a prohibition on the acceptance of new clients. Section 408.803(10), F.S.

² The classes of violations can be found in s. 408.813, F.S.

³ Class III and class IV violations.

⁴ Background screening requirements are found in s. 408.809, F.S.

more adults who are not relatives of the owner or administrator.^{5,6} A personal service is direct physical assistance with, or supervision of, the activities of daily living and the self-administration of medication.⁷ Activities of daily living include: ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks.⁸

An ALF is required to provide care and services appropriate to the needs of the residents accepted for admission to the facility.⁹ The owner or facility administrator determines whether an individual is appropriate for admission to the facility based on a number of criteria.¹⁰ 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.¹¹

There are currently 3,036 licensed ALFs in Florida with 85,413 beds.¹² An ALF must have a standard license issued by the AHCA, pursuant to part I of ch. 429, F.S., and part II of ch. 408, F.S. In addition to a standard license, an ALF may have one or more specialty licenses that allow the ALF to provide additional care. These specialty licenses include: limited nursing services,¹³ limited mental health services,¹⁴ and extended congregate care services.¹⁵ There are 1,073 facilities with LNS licenses, 279 with ECC licenses, and 1,084 with LMH licenses.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 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.

Extended Congregate Care Specialty License

The primary purpose of ECC services is to allow residents to remain in a familiar setting, as they become more impaired with physical or mental limitations. An ECC specialty license enables a facility to provide, directly or through contract, services performed by licensed nurses and supportive services¹⁷ to persons who otherwise would be disqualified from continued residence

⁵ Section 429.02(5), F.S.

⁶ An ALF does not include an adult family-care home or a non-transient public lodging establishment.

⁷ Section 429.02(16), F.S.

⁸ Section 429.02(1), F.S.

⁹ For specific minimum standards see Rule 58A-5.0182, F.A.C.

¹⁰ Section 429.26, F.S., and Rule 58A-5.0181, F.A.C.

¹¹ Section 429.28, F.S.

¹² Agency for Health Care Administration, information provided to Senate Children, Families, and Elder Affairs Committee February 4, 2013.

¹³ Section 429.07(3)(c), F.S.

¹⁴ Section 429.075, F.S.

¹⁵ Section 429.07(3)(b), F.S.

¹⁶ Agency for Health Care Administration, information provided to Senate Children, Families, and Elder Affairs Committee February 4, 2013.

¹⁷ Supportive services include social service needs, counseling, emotional support, networking, assistance with securing

in an ALF.¹⁸ A facility 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, a facility with an ECC license still may not serve residents who require 24-hour nursing supervision.¹⁹

Limited Mental Health Specialty License

An ALF that serves three or more mental health residents must obtain an LMH specialty license.²⁰ 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).^{21,22} The DCF must ensure that a mental health resident is assessed and determined able to live in an ALF with an LMH license.²³

The administrator in a LMH facility must consult with a mental health resident and the resident's case manager to develop and help execute a community living support plan for the resident detailing the specific needs and services the resident requires.²⁴ The LMH licensee must also execute a cooperative agreement with 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.

Department of Elder Affairs Rules

In addition to ch. 429, F.S., ALFs are also subject to regulation under Rule 58A-5, of the Florida Administrative Code (F.A.C.). These rules are adopted by the Department of Elder Affairs (the DOEA) in consultation with the AHCA, the DCF, and the Department of Health (the DOH).²⁵ In June 2012, the DOEA initiated a process of negotiated rulemaking to revise many of their rules regarding ALFs. After multiple meetings, a committee that consisted of agency staff, consumer advocates, and industry representatives voted on numerous changes to Rule 58A-5, F.A.C. On

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.

¹⁸ 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.

¹⁹ Section 429.07(3)(b), F.S.

²⁰ Section 429.075, F.S.

²¹ Section 429.02(15), F.S.

²² 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 30, 2013).

²³ 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.

²⁴ Rule 58A-5.029(2)(c)3., F.A.C.

²⁵ Section 429.41(1), F.S.

November 28, 2012, the DOEA issued a proposed rule and held three public hearings on the proposed rule. The public comment period for the proposed rule ended on December 21, 2012, and the DOEA has not yet issued a final rule.²⁶

ALF Staff Training

Administrators and Managers

Administrators and other ALF staff must meet minimum training and education requirements established by the DOEA by rule.^{27,28} This training and education is intended to assist facilities to appropriately respond to the needs of residents, maintain resident care and facility standards, and meet licensure requirements.²⁹

The current ALF core training requirements established by the DOEA consist of a minimum of 26 hours of training and passing a competency test. Administrators and managers must successfully complete the core training requirements within 3 months after becoming a facility administrator or manager. The minimum passing score for the competency test is 75 percent.³⁰

Administrators and managers must participate in 12 hours of continuing education in topics related to assisted living every 2 years. A newly hired administrator or manager, who has successfully completed the ALF core training and continuing education requirements, is not required to retake the core training. An administrator or manager, who has successfully completed the core training but has not maintained the continuing education requirements, must retake the ALF core training and retake the competency test.³¹

Staff with Direct Care Responsibilities

Facility administrators or managers are required to provide or arrange for 6 hours of in-service training for facility staff who provide direct care to residents which covers various topics as mandated in rule.³² Staff training requirements must generally be met within 30 days after staff begin employment at the facility, however, staff must have at least 1 hour of infection control training before providing direct care to residents. Also, nurses, certified nursing assistants, and home health aides who are on staff with an ALF are exempt from many of the training requirements. In addition to the standard 6 hours of in-service training, staff must also complete 1 hour of elopement training and 1 hour of training on do not resuscitate orders, and may have to complete training on special topics such as self administration of medication and persons with Alzheimer's disease, if applicable.

²⁶The DOEA rule, documents, and dates for the negotiated rulemaking can be found at: http://elderaffairs.state.fl.us/doea/alf_rulemaking.php (Last visited on Jan. 29, 2013).

²⁷ Rule 58A-5.0191, F.A.C.

²⁸ Many of the training requirements in rule may be subject to change due to the recent the DOEA negotiated rulemaking process.

²⁹ Section 429.52(1), F.S.

³⁰ 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.

³¹ Rule 58A-5.0191, F.A.C.

³² See note 26.

ECC Specific Training

The administrator and ECC supervisor, if different from the administrator, must complete 4 hours of initial training in extended congregate care prior to the facility's receiving its ECC license or within 3 months after beginning employment in the facility as an administrator or ECC supervisor. They must also complete a minimum of 4 hours of continuing education every 2 years in topics relating to the physical, psychological, or social needs of frail elderly and disabled persons, or persons with Alzheimer's disease or related disorders.³³

All direct care staff providing care to residents in an ECC program must complete at least 2 hours of in-service training, provided by the facility administrator or ECC supervisor, within 6 months after beginning employment in the facility. The training must address ECC concepts and requirements, including statutory and rule requirements, and delivery of personal care and supportive services in an ECC facility.³⁴

LMH Specific Training

Administrators, managers, and staff, who have direct contact with mental health residents in a licensed LMH facility must receive a minimum of 6 hours of specialized training in working with individuals with mental health diagnoses and a minimum of 3 hours of continuing education dealing with mental health diagnoses or mental health treatment every 2 years.³⁵

Inspections and Surveys

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

- Prior to the issuance of a license.
- Prior to biennial renewal of a license.
- When there is a change of ownership.
- To monitor facilities licensed to provide LNS or ECC services, or facilities cited in the previous year for a class I or class II, or four or more uncorrected class III, violations.³⁶
- 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.³⁷

³³ Rule 58A-5.0191(7)(b), F.A.C.

³⁴ Rule 58A-5.0191(7)(c), F.A.C.

³⁵ Section 429.075, F.S. and Rule 58A-5.0191(8), F.A.C.

³⁶ See below information under subheading "Violations and Penalties" for a description of each class of violation.

³⁷ See s. 429.34, F.S., and Rule 58A-5.033, F.A.C.

Abbreviated Surveys

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.³⁸

An abbreviated survey allows for a quicker and less intrusive survey by narrowing the range of items the agency must inspect.³⁹ 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.⁴⁰

Monitoring Visits

Facilities with LNS or ECC licenses are subject to monitoring visits by the AHCA in which the agency inspects the facility for compliance with the requirements of the specialty license type. An LNS licensee is subject to monitoring inspections at least twice a year. At least one registered nurse must be included in the inspection team to monitor residents receiving LNS and to determine if the facility is complying with applicable regulatory requirements.⁴¹ An ECC licensee is subject to quarterly monitoring inspections. 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.⁴²

Violations and Penalties

Part II of ch. 408, F.S., provides 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 residents.

- Class I violations are those conditions that the AHCA determines present an imminent danger to residents or a substantial probability of death or serious physical or emotional harm. Examples include resident death due to medical neglect, risk of resident death due to inability to exit in an emergency, and the suicide of a mental health resident in an ALF

³⁸ Rule 58A-5.033(2), F.A.C.

³⁹ Rule 58A-5.033(2)(b)

⁴⁰ *Id.*

⁴¹ Section 429.07(3)(c), F.S.

⁴² Section 429.07(3)(b), F.S.

licensed for Limited Mental Health. The AHCA must fine a facility between \$5,000 and \$10,000 for each violation.

- Class II violations are those conditions that the AHCA determines directly threaten the physical or emotional health, safety, or security of the clients. Examples include no qualified staff in the facility, the failure to call 911 in a timely manner for resident in a semi-comatose state, and rodents in food storage area. The AHCA must fine a facility between \$1,000 and \$5,000 for each violation.
- Class III violations are those conditions that the AHCA determines indirectly or potentially threaten the physical or emotional health, safety, or security of clients. Examples include missing or incomplete resident assessments, erroneous documentation of medication administration, and failure to correct unsatisfactory DOH Food Service inspection findings in a timely manner. The AHCA must fine a facility between \$500 and \$1,000 for each violation, but no fine may be imposed if the facility corrects the violation.
- Class IV violations are those conditions that do not have the potential of negatively affecting clients. Examples include failure to file an adverse incident report, incorrect phone numbers posted for advocacy resources, and failure to post current menus. The AHCA can only fine a facility (between \$100 and \$200 for each violation) if the problem is not corrected.^{43,44}

In addition to financial penalties, AHCA can take other actions against a facility. The AHCA may deny, revoke, and suspend any license for any of the actions listed in s. 429.14(1)(a)-(k), F.S., the AHCA is required to deny or revoke the license of an ALF that has two or more class I violations that are similar to violations identified during a survey, inspection, monitoring visit, or complaint investigation occurring within the previous 2 years.⁴⁵ The AHCA may also impose an immediate moratorium or emergency suspension on any provider if it determines that any condition that presents a threat to the health, safety, or welfare of a client.⁴⁶ The AHCA is required to publicly post notification of a license suspension or revocation, or denial of a license renewal, at the facility.⁴⁷ Finally, Florida's Criminal Code, under ch. 825, F.S., provides criminal penalties for the abuse, neglect, and exploitation of elderly persons⁴⁸ and disabled adults.⁴⁹

Central Abuse Hotline

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

⁴³ When 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.

⁴⁴ Section 429.19(2), F.S.

⁴⁵ Section 429.14(4), F.S.

⁴⁶ Section 408.814, F.S.

⁴⁷ Section 429.14(7), F.S.

⁴⁸ "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.

⁴⁹ "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.

suspected abuse, neglect, or exploitation of a vulnerable adult⁵⁰ at any hour of the day or night, any day of the week.⁵¹ Persons listed in s. 415.1034, F.S., 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.⁵²

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.⁵³ In Florida, the program is a statewide, volunteer-based system of district councils that protect, defend, and advocate on behalf of long-term care facility residents, including residents of nursing homes, ALFs, and adult family-care homes. The ombudsman program is administratively housed in the DOEA and is headed by the State Long-Term Care Ombudsman, who is appointed by the Secretary of Elderly Affairs.⁵⁴ The ombudsman program is required to establish a statewide toll-free telephone number for receiving complaints concerning matters adversely affecting the health, safety, welfare, or rights of residents of ALFs, nursing homes, and adult family care homes. Every resident or representative of a resident must receive, upon admission to a long-term care facility, information regarding the program and the statewide toll-free telephone number for receiving complaints.⁵⁵ The names or identities of the complainants or residents involved in a complaint, including any problem identified by an ombudsman council as a result of an investigation, are confidential and exempt from Florida's public records laws, unless the complainant or resident, or the legal representative of the complainant or resident, consents to the disclosure, or the disclosure is required by court order.⁵⁶ In addition to investigating and resolving complaints, ombudsmen conduct unannounced visits to assess the quality of care in facilities, referred to as administrative assessments.

The Miami Herald Articles and the Governor's Assisted Living Workgroup

Beginning on April 30, 2011, the Miami Herald published a four-part series, titled "Neglected to Death," which detailed abuses occurring in ALFs and the state regulatory responses to such cases. The paper 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 series detailed examples of abuses, neglect, and even death that took place in facilities.⁵⁷ The series also criticized the state's regulatory and law

⁵⁰ "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.

⁵¹ The central abuse hotline is operated by the DCF to: accept reports for investigation when there is a reasonable cause to suspect that a vulnerable adult has been or is being abused, neglected, or exploited; determine whether the allegations require an immediate, 24-hour, or next-working-day response priority; when appropriate, refer calls that do not allege the abuse, neglect, or exploitation of a 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.

⁵² Section 415.1034, F.S.

⁵³ 42 U.S.C. 3058. *See also* s. 400.0061(1), F.S.

⁵⁴ Section 400.0063, F.S.

⁵⁵ Section 400.0078, F.S.

⁵⁶ Section 400.0077(1)(b), F.S.

⁵⁷ The Miami Herald, *Neglected to Death, Parts 1-3*, available at: <http://www.miamiherald.com/2011/04/30/2194842/once->

enforcement agencies' responses to the problems. The paper concluded that the state's agencies, and in particular the AHCA, failed to enforce existing laws designed to protect Florida's citizens who reside in ALFs.⁵⁸

Soon after the Miami Herald series, Governor Rick Scott vetoed HB 4045,⁵⁹ which reduced requirements relating to ALFs. The Governor then directed the AHCA to form a task force for the purpose of examining current assisted living regulations and oversight.⁶⁰ The task force, referred to as the Assisted Living Workgroup, held meetings and produced two reports, one in August of 2011 and one in October of 2012. In addition to public testimony and presentations, the Assisted Living Workgroup focused on assisted living regulation, consumer information and choice, and long term care services and access.⁶¹ The workgroup made numerous recommendations in its two reports.⁶²

III. Effect of Proposed Changes:

Section 1 amends s. 394.4574, F.S., to clarify that Medicaid prepaid behavioral health plans are responsible for enrolled state supported mental health residents and that managing entities under contract with the DCF are responsible for such residents who are not enrolled with a Medicaid prepaid behavioral health plan. This section requires a mental health resident's community living support plan be completed and provided to the administrator of the facility when the facility admits a mental health resident and be updated when there is a significant change to the resident's behavioral health status. The resident's case manager must keep a 2-year record of any face-to-face interaction with the resident. Finally, this section charges the entity responsible for a mental health resident to ensure that there is adequate and consistent monitoring of the community living support plan and to report any concerns about a regulated provider failing to provide services or otherwise acting in a manner with the potential to cause harm to the resident.

Section 2 amends s. 400.0074, F.S., to require the Long-Term Care Ombudsman Program's administrative assessments of ALFs be comprehensive in nature. This section also requires ombudsmen to conduct an exit interview with the facility to discuss issues and concerns from the visit in areas affecting the rights, health, safety, and welfare of residents, and recommend improvements if any.

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 31, 2013) (see left side of article to access weblinks to the three-part series).

⁵⁸ *Id.*

⁵⁹ HB 4045 (2011) repealed a requirement for the annual dissemination of a list of ALFs that had been sanctioned 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.

⁶⁰ The task force is now referred to as the "Assisted Living Workgroup." Membership details of the task force are available at <http://ahca.myflorida.com/SCHS/CommitteesCouncils/ALWG/wgmembers.shtml> (Last visited on January 31, 2013).

⁶¹ 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 31, 2013).

⁶² *Id.*

Section 3 amends s. 400.0078, F.S., to require that ALFs provide information to new residents upon admission to the facility that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right.

Section 4 amends s. 429.07, F.S., to make changes to improve the regulation of facilities with ECC and LNS specialty licenses. These changes include:

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

Section 5 amends s. 429.075, F.S., to require facilities with one or more state supported mentally ill residents to obtain a LMH license. This will expand the protections and services to all state supported mentally ill residents in ALFs.

Section 6 amends s. 429.14, F.S., to clarify the use of administrative penalties, to:

- Allow the AHCA to revoke, rather than just deny, a license for a facility with a controlling interest that has, or had, a 25 percent or greater financial or ownership interest in a second facility that closed due to financial inability to operate or was the subject of other specified administrative sanctions.
- Add additional criteria under which the AHCA must deny or revoke a facility's license.
- Cause the AHCA to impose an immediate moratorium on a facility that fails to provide the AHCA with access to the facility, prohibits a regulatory inspection, denies access to records, or prohibits the confidential interview of facility staff or residents.
- Exempt a facility from the 45-day notice requirement in s. 429.28(k), F.S., if that facility is required to relocate all or some of its residents due to action by the AHCA.

Section 7 amends s. 429.178, F.S., to make technical changes and to conform this section to other parts of the bill.

Section 8 amends s. 429.19, F.S., relating to the impositions of fines in order to reduce the discretion of the AHCA and to make such penalties more predictable. Specifically, the bill would:

- Fix the dollar amount for fines at \$7,500 for class I violations, \$3,000 for class II violations, \$750 for class III violations, and \$150 for class IV violations for facilities licensed for few than 100 beds at the time of the violation. This is the midpoint of the current ranges for fines in current law.
- Multiply fines amounts by 1.5 times for facilities licensed for 100 or more beds, so that the fine is \$11,250 for class I violations, \$4,500 for class II violations, \$1,125 for class IV violations, and \$225 for class IV violations.
- Allow the AHCA to impose a fine on a facility for a class I violation, even if the facility corrects the violation before the AHCA conducts an investigation. Facilities can still challenge such fines through an administrative hearing pursuant to ch. 120, F.S.
- Double the fines for facilities with repeat class I and class II violations.
- Impose a fine on facilities with repeat class III and class IV violations, regardless of correction. Current law prohibiting the AHCA from assessing fines for corrected class III and IV violations continues for the first survey finding such violations.
- Double the fines for class III or class IV violations if a facility is cited for two or more such violations, stemming from the same regulation, during the AHCA's last two licensure inspections.
- Fine a facility \$500 for failure to comply with background screening requirements. This fine will take the place of fines based on the class of the violation.

Section 9 amends s. 429.28, F.S., to require the notice of a resident's rights, obligations, and prohibitions specify that complaints to the ombudsman program, as well as the names and identities of the complainant and any residents involved, are confidential and that the notice must also contain information that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. This section also creates a fine of \$2,500 which is imposed if a facility cannot show good cause in state court for terminating the residency of an individual. The statute is updated to reflect the most recent name of Disability Rights Florida.

Section 10 amends s. 429.34, F.S., to require certain state officials, such as Medicaid Fraud investigators, staff from the Attorney General's Office, and state or local fire marshals report to the DCF central abuse hotline any knowledge or reasonable suspicion that a vulnerable adult has been or is being abused, neglected, or exploited. The bill provides that a facility with one or more class I violations, two or more class II violations cited within 60 days, or two or more unrelated class II violations cited during one survey be subject to an additional inspection within 6 months. The licensee must pay a fee to the AHCA to cover the cost of the additional inspection.

Section 11 amends s. 429.52, F.S., to require that, effective October 1, 2013, a facility provide a 2 hour pre-service orientation for new facility employees who have not previously completed core training. The preservice orientation must cover topics that help the employee provide responsible care and respond to the needs of the residents. The employee and the facility's administrator must sign an affidavit that the employee completed the orientation and the facility must keep the affidavit in the employee's work file.

Section 12 creates a new, unnumbered section of the Florida Statutes which requires the AHCA to conduct a study of inter-surveyor reliability to determine if different surveyors consistently

apply licensure standards. The AHCA must report its findings and make recommendations to the Governor, the President of the Senate, and the Speaker of the House by November 1, 2013.

Section 13 creates a new, unnumbered section of the Florida Statutes which finds that consumers need additional information in order to select an ALF. To facilitate this, the bill requires the AHCA to propose a rating system for ALFs. The AHCA must submit the proposal to the Governor, the President of the Senate, and the Speaker of the House by November 1, 2013. This section also requires the AHCA to create a consumer guide website with information on ALFs and a monitored comment section to be available by January 1, 2014. The purpose of the comments is to better inform consumers of the quality and care of services in ALFs.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

CS/SB 646 requires the AHCA to conduct a new survey of facilities within 6 months after finding a class I or two or more class II violations. The AHCA must assess a fee on the facility for the cost of the survey as is the case in other surveys. Facilities with serious violations that require this additional survey will pay this additional fee. It should be noted that according to the AHCA, current fees and fines from ALFs do not cover the cost of regulating such facilities statewide.

B. Private Sector Impact:

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

Facilities that remove residents without cause, as determined by a state court, would be assessed a fine of \$2,500. Facilities would also be assessed a fine for class I violations even if they are corrected when the AHCA visits the facility. Facilities violating the background screening requirements would be levied a fine of \$500. Currently, facilities are cited for a class II or III violation for not screening the background of facility staff so the fine amount can vary. All fines are subject to challenge through an administrative hearing under ch. 120, F.S. This due process is retained under the bill.

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

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

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

Facilities with significant uncorrected violations would be more likely to see their licenses suspended or revoked under the bill. Closing facilities with significant problems would improve the public's assessment of ALFs and could improve the financial success of those facilities that meet licensure standards.

C. Government Sector Impact:

CS.SB 646 would have an insignificant fiscal impact on the AHCA. Specifically, the bill rearranges the regulatory efforts of the agency. The additional 6 month survey for problem facilities will increase the work of the AHCA surveyors, while the reduction in monitoring visits for facilities with specialty licenses will reduce the workload. The bill requires the agency to redesign its existing website for health care facilities. The redesigned website must provide regulatory information in an understandable way and allow for the posting of comments from the public on assisted living facilities. The agency will have to monitor comments for profanity prior to posting to the redesigned website. The costs of these requirements would be insignificant.

The AHCA and the DOEA may have to revise their rules regulating assisted living facilities. The bill requires the AHCA to study the extent to which surveyors are consistent. The bill requires the AHCA to propose a rating system for assisted living facilities that would help consumers in selecting a facility. The cost of these requirements would be insignificant.

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 the Health Policy Committee on March 7, 2013:

This CS makes substantial changes to SB 646 to:

- Require a community living support plan for a mental health resident to be completed and submitted to the administrator of an ALF upon admission of that resident.
- Clarify that the Ombudsman must conduct an exit consultation with a facility's administrator only in the areas affecting the rights, health, safety, and welfare of the residents.
- Clarify that residents must receive information that retaliatory action cannot be taken against a resident for presenting grievances to the Ombudsman program or for exercising any other resident right.
- Return provisions regarding the revocation of a facility's license for intentional acts of facility staff to current law.
- Remove provisions that require the AHCA to deny or revoke the license of a facility which has been conditionally licensed for 180 or more consecutive days.
- Exempt facilities from the 45-day notice requirement in s. 429.28(k), F.S., if the facility is required to relocate some or all of its residents due to action by the AHCA.
- Specify that certain provisions that deal with repeat class III and IV violations are exempt from ss. 408.813(2)(c) and (d) and 408.832, F.S. in order to avoid conflicts with those sections.
- Clarify that the \$500 fine for not complying with background screening requirements is instead of the fines listed for class I through class IV violations.
- Mandate the AHCA post to its ALF website a list of an ALF's violations with, for each violation, an understandable summary, any sanction imposed by final order, and a summary of any corrective action taken.

B. Amendments:

None.

By the Committee on Children, Families, and Elder Affairs

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1 A bill to be entitled
2 An act relating to assisted living facilities;
3 amending s. 394.4574, F.S.; providing that Medicaid
4 prepaid behavioral health plans are responsible for
5 enrolled mental health residents; providing that
6 managing entities under contract with the Department
7 of Children and Families are responsible for mental
8 health residents who are not enrolled with a Medicaid
9 prepaid behavioral health plan; deleting a provision
10 to conform to changes made by the act; requiring the
11 community living support plan to be updated when there
12 is a significant change to the mental health
13 resident's behavioral health; requiring the case
14 manager assigned to a mental health resident of an
15 assisted living facility that holds a limited mental
16 health license to keep a record of the date and time
17 of face-to-face interactions with the resident and to
18 make the record available to the responsible entity
19 for inspection; requiring that the record be
20 maintained for a specified time; requiring the
21 responsible entity to ensure that there is adequate
22 and consistent monitoring and enforcement of community
23 living support plans and cooperative agreements and
24 that concerns are reported to the appropriate
25 regulatory oversight organization under certain
26 circumstances; amending s. 400.0074, F.S.; providing
27 that an administrative assessment conducted by a local
28 council be comprehensive in nature and focus on
29 factors affecting the rights, health, safety, and

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welfare of the residents of a nursing home; requiring
a local council to conduct an exit consultation with
the facility administrator or administrator designee
to discuss issues and concerns and make
recommendations for improvement; amending s. 400.0078,
F.S.; requiring that residents of long-term care
facilities 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. 429.07, F.S.; providing
that an extended congregate care license is issued to
certain facilities that have been licensed as assisted
living facilities under certain circumstances;
providing the purpose of an extended congregate care
license; providing that the initial extended
congregate care license of an assisted living facility
is provisional under certain circumstances; requiring
the licensee to notify the Agency for Health Care
Administration whenever it accepts a resident who
qualifies for extended congregate care services;
requiring the agency to inspect the facility for
compliance with the requirements of an extended
congregate care license; authorizing the agency to
waive one of the required yearly monitoring visits
under certain circumstances; authorizing the agency to
deny or revoke a facility's extended congregate care
license for certain reasons or on certain grounds;
requiring a registered nurse representing the agency
to visit the facility at least annually, rather than

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twice a year, to monitor residents who are receiving limited nursing services; providing that the agency's monitoring visits may be in conjunction with other agency inspections; authorizing the agency to waive one of the required yearly monitoring visits for certain facilities; amending s. 429.075, F.S.; requiring an assisted living facility that serves one or more mental health residents to obtain a limited mental health license; amending s. 429.14, F.S.; authorizing the agency to deny, revoke, or suspend a license of an assisted living facility for a negligent act of any facility staff which seriously affects the health, safety, or welfare of a resident; requiring the agency to deny or revoke the license of an assisted living facility under certain circumstances; requiring the agency to impose an immediate moratorium on the license of an assisted living facility under certain circumstances; deleting a provision requiring the agency to provide a list of facilities with denied, suspended, or revoked licenses to the Department of Business and Professional Regulation; amending s. 429.178, F.S.; conforming cross-references; amending s. 429.19, F.S.; revising the amounts and uses of administrative fines; requiring the agency to levy a fine for violations that are corrected before an inspection if noncompliance occurred within a specified period of time; deleting factors that the agency is required to consider to determine penalties and fines; amending s. 429.28,

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88 F.S.; requiring residents of facilities to be informed
89 about the confidentiality of the subject matter and
90 identity of the resident and complainant of a
91 complaint made to the State Long-Term Care Ombudsman
92 Program; providing that a facility that terminates an
93 individual's residency is fined if good cause is not
94 shown in court; amending s. 429.34, F.S.; requiring
95 certain persons to report elder abuse in assisted
96 living facilities; requiring the agency to regularly
97 inspect every licensed assisted living facility;
98 requiring the agency to conduct more frequent
99 inspections under certain circumstances; requiring the
100 licensee to pay a fee for the cost of additional
101 inspections; requiring the agency to adjust the fee;
102 amending s. 429.52, F.S.; requiring each newly hired
103 employee of an assisted living facility to attend a
104 preservice orientation provided by the assisted living
105 facility; requiring the employee and administrator to
106 sign an affidavit upon completion of the preservice
107 orientation; requiring the assisted living facility to
108 maintain the signed affidavit in each employee's work
109 file; conforming a cross-reference; requiring the
110 Agency for Health Care Administration to study the
111 reliability of facility surveys and submit to the
112 Governor and the Legislature its findings and
113 recommendations; requiring the agency to propose a
114 rating system of assisted living facilities for
115 consumers and create content for the agency's website
116 that makes available to consumers information

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117 regarding assisted living facilities; providing
118 criteria for the content; providing an effective date.
119

120 Be It Enacted by the Legislature of the State of Florida:
121

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

124 394.4574 ~~Department~~ Responsibilities for coordination of
125 services for a mental health resident who resides in an assisted
126 living facility that holds a limited mental health license.—

127 (1) As used in this section, the term "mental health
128 resident" ~~"mental health resident," for purposes of this~~
129 ~~section,~~ means an individual who receives social security
130 disability income due to a mental disorder as determined by the
131 Social Security Administration or receives supplemental security
132 income due to a mental disorder as determined by the Social
133 Security Administration and receives optional state
134 supplementation.

135 (2) Medicaid prepaid behavioral health plans are
136 responsible for enrolled mental health residents, and managing
137 entities under contract with the department are responsible for
138 mental health residents who are not enrolled with a Medicaid
139 prepaid behavioral health plan. Each responsible entity shall
140 ~~The department must~~ ensure that:

141 (a) A mental health resident has been assessed by a
142 psychiatrist, clinical psychologist, clinical social worker, or
143 psychiatric nurse, or an individual who is supervised by one of
144 these professionals, and determined to be appropriate to reside
145 in an assisted living facility. The documentation must be

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146 provided to the administrator of the facility within 30 days
147 after the mental health resident has been admitted to the
148 facility. An evaluation completed upon discharge from a state
149 mental hospital meets the requirements of this subsection
150 related to appropriateness for placement as a mental health
151 resident if it was completed within 90 days before ~~prior to~~
152 admission to the facility.

153 (b) A cooperative agreement, as required in s. 429.075, is
154 developed between the mental health care services provider that
155 serves a mental health resident and the administrator of the
156 assisted living facility with a limited mental health license in
157 which the mental health resident is living. ~~Any entity that~~
158 ~~provides Medicaid prepaid health plan services shall ensure the~~
159 ~~appropriate coordination of health care services with an~~
160 ~~assisted living facility in cases where a Medicaid recipient is~~
161 ~~both a member of the entity's prepaid health plan and a resident~~
162 ~~of the assisted living facility. If the entity is at risk for~~
163 ~~Medicaid targeted case management and behavioral health~~
164 ~~services, the entity shall inform the assisted living facility~~
165 ~~of the procedures to follow should an emergent condition arise.~~

166 (c) The community living support plan, as defined in s.
167 429.02, has been prepared by a mental health resident and a
168 mental health case manager of that resident in consultation with
169 the administrator of the facility or the administrator's
170 designee. The plan must be provided to the administrator of the
171 assisted living facility with a limited mental health license in
172 which the mental health resident lives. The support plan and the
173 agreement may be in one document.

174 (d) The assisted living facility with a limited mental

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175 health license is provided with documentation that the
176 individual meets the definition of a mental health resident.

177 (e) The mental health services provider assigns a case
178 manager to each mental health resident for whom the entity is
179 responsible ~~who lives in an assisted living facility with a~~
180 ~~limited mental health license~~. The case manager is responsible
181 for coordinating the development of and implementation of the
182 community living support plan defined in s. 429.02. The plan
183 must be updated at least annually, or when there is a
184 significant change to the resident's behavioral health status,
185 such as an inpatient admission or a change in behavioral status,
186 medications, level of service, or residence. Each case manager
187 shall keep a record of the date and time of any face-to-face
188 interaction with the resident and make the record available to
189 the responsible entity for inspection. The record must be
190 retained for at least 2 years after the date of the most recent
191 interaction.

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

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

199 (3) The Secretary of Children and Family Services, in
200 consultation with the Agency for Health Care Administration,
201 shall ~~annually~~ require each district administrator to develop,
202 with community input, a detailed annual plan that demonstrates
203 ~~detailed plans that demonstrate~~ how the district will ensure the

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provision of state-funded mental health and substance abuse treatment services to residents of assisted living facilities that hold a limited mental health license. These plans must be consistent with the substance abuse and mental health district plan developed pursuant to s. 394.75 and must address case management services; access to consumer-operated drop-in centers; access to services during evenings, weekends, and holidays; supervision of the clinical needs of the residents; and access to emergency psychiatric care.

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

400.0074 Local ombudsman council onsite administrative assessments.—

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

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

(h) The local council shall conduct an exit consultation with the facility administrator or administrator designee to discuss issues and concerns and make recommendations for

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improvement, if any.

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

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

(2) ~~Every resident or representative of a resident shall receive,~~ Upon admission to a long-term care facility, each resident or representative of a resident must receive information regarding the purpose of the State Long-Term Care Ombudsman Program, the statewide toll-free telephone number for receiving complaints, 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 4. Paragraphs (b) and (c) of subsection (3) of section 429.07, Florida Statutes, are amended to read:

429.07 License required; fee.—

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

(b) An extended congregate care license shall be issued to facilities that have been licensed as assisted living facilities for 2 or more years and that provide ~~providing~~, directly or through contract, services beyond those authorized in paragraph (a), including services performed by persons licensed under part

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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. 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.

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;

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

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

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

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

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

2. If an assisted living facility has been licensed for less than 2 years, the initial extended congregate care license must be provisional and may not exceed 6 months. Within the first 3 months after the provisional license is issued, the licensee shall notify the agency when it has admitted an extended congregate care resident, after which an unannounced inspection shall be made to determine compliance with requirements of an extended congregate care license. If the licensee demonstrates compliance with all of the requirements of an extended congregate care license during the inspection, the licensee shall be issued an extended congregate care license. In addition to sanctions authorized under this part, if violations are found during the inspection and the licensee fails to demonstrate compliance with all assisted living requirements

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during a followup inspection, the licensee shall immediately suspend extended congregate care services, and the provisional extended congregate care license expires.

~~3.2.~~ A facility that is licensed to provide extended congregate care services shall maintain a written progress report on each person who receives services which describes the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. A registered nurse, or appropriate designee, representing the agency shall visit the facility at least twice a year ~~quarterly~~ to monitor residents who are receiving extended congregate care services and to determine if the facility is in compliance with this part, part II of chapter 408, and relevant rules. One of the visits may be in conjunction with the regular survey. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall serve as part of the team that inspects the facility. The agency may waive one of the required yearly monitoring visits for a facility ~~that has 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 held an extended~~ congregate care license during the last 24 months, has had no class I or class II violations, has had and no uncorrected class III violations, and has had no confirmed ombudsman council complaints that resulted in a citation for licensure. The agency must first consult with the long-term care ombudsman council for the area in which the facility is located to determine if any

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~~complaints have been made and substantiated about the quality of services or care. The agency may not waive one of the required yearly monitoring visits if complaints have been made and substantiated.~~

4.3. A facility that is licensed to provide extended congregate care services must:

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

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

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

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

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

f. Implement the concept of managed risk.

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

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

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378 staff.

379 5.4. A facility that is licensed to provide extended
380 congregate care services is exempt from the criteria for
381 continued residency set forth in rules adopted under s. 429.41.
382 A licensed facility must adopt its own requirements within
383 guidelines for continued residency set forth by rule. However,
384 the facility may not serve residents who require 24-hour nursing
385 supervision. A licensed facility that provides extended
386 congregate care services must also provide each resident with a
387 written copy of facility policies governing admission and
388 retention.

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

398 6. Before the admission of an individual to a facility
399 licensed to provide extended congregate care services, the
400 individual must undergo a medical examination as provided in s.
401 429.26(4) and the facility must develop a preliminary service
402 plan for the individual.

403 7. If ~~When~~ a facility can no longer provide or arrange for
404 services in accordance with the resident's service plan and
405 needs and the facility's policy, the facility must ~~shall~~ make
406 arrangements for relocating the person in accordance with s.

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429.28(1)(k).

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

The agency may deny or revoke a facility's extended congregate care license for not meeting the standards of an extended congregate care license or for any of the grounds listed in this subsection.

(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 licensure renewal ~~relicensure~~, or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with part II of chapter 408. An existing facility that qualifies ~~facilities qualifying~~ to provide limited nursing services must ~~shall~~ have maintained a standard license and may not have been subject to administrative sanctions that affect the health, safety, and welfare of residents for the previous 2 years or since initial licensure if the facility has been licensed for less than 2 years.

2. A facility ~~Facilities~~ that is ~~are~~ licensed to provide limited nursing services shall maintain a written progress

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

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

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

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

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

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

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read:

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

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

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

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

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

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(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 that has ~~with~~ a limited mental health license.

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

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

(4) A facility that has ~~with~~ a limited mental health license may enter into a cooperative agreement with a private mental health provider. For purposes of the limited mental health license, the private mental health provider may act as the case manager.

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

429.14 Administrative penalties.—

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

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

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

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

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

534 (e) A citation of any of the following deficiencies as
535 specified in s. 429.19:

536 1. One or more cited class I deficiencies.

537 2. Three or more cited class II deficiencies.

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

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

543 (g) Violation of a moratorium.

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

548 (i) An intentional or negligent life-threatening act in
549 violation of the uniform firesafety standards for assisted
550 living facilities or other firesafety standards which ~~that~~
551 threatens the health, safety, or welfare of a resident of a

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552 facility, as communicated to the agency by the local authority
553 having jurisdiction or the State Fire Marshal.

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

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

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

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

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

577 (a) A resident's health, safety, or welfare has been
578 seriously affected by an intentional act of facility staff;

579 (b) There are two moratoria issued pursuant to this part,
580 or part II of chapter 408, which are imposed by final order

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581 within a 2-year period;

582 (c) The facility is conditionally licensed for 180 or more
583 consecutive days;

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

587 (e) The facility is cited for two or more class I
588 violations arising from separate surveys or investigations
589 within a 2-year period ~~that has two or more class I violations~~
590 ~~that are similar or identical to violations identified by the~~
591 ~~agency during a survey, inspection, monitoring visit, or~~
592 ~~complaint investigation occurring within the previous 2 years.~~

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

604 (6) The agency shall impose an immediate moratorium, as
605 provided under s. 408.814, on an assisted living facility that
606 fails to provide the agency access to the facility or prohibits
607 the agency from conducting a regulatory inspection. The licensee
608 may not restrict agency staff in accessing and copying records
609 or in conducting confidential interviews with facility staff or

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any individual who receives services from the facility ~~provide~~
~~to the Division of Hotels and Restaurants of the Department of~~
~~Business and Professional Regulation, on a monthly basis, a list~~
~~of those assisted living facilities that have had their licenses~~
~~denied, suspended, or revoked or that are involved in an~~
~~appellate proceeding pursuant to s. 120.60 related to the~~
~~denial, suspension, or revocation of a license.~~

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

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

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

(2)(a) An individual who is employed by a facility that
provides special care for residents with Alzheimer's disease or
other related disorders, and who has regular contact with such
residents, must complete up to 4 hours of initial dementia-
specific training developed or approved by the department. The
training must ~~shall~~ be completed within 3 months after beginning
employment and satisfy ~~shall satisfy~~ the core training
requirements of s. 429.52(3)(g) ~~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 9 months
after beginning employment and satisfy ~~shall satisfy~~ the core

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training requirements of s. 429.52(3)(g) ~~s. 429.52(2)(g)~~.

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

429.19 Violations; imposition of administrative fines; grounds.—

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

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

(a) Class "I" violations are defined in s. 408.813. The agency shall impose an administrative fine of \$7,500 for each a cited class I violation in a facility that is licensed for fewer than 100 beds at the time of the violation ~~in an amount not less than \$5,000 and not exceeding \$10,000 for each violation. The~~ agency shall impose an administrative fine of \$11,250 for each cited class I violation in a facility that is licensed for 100 or more beds at the time of the violation. If the noncompliance occurs within the prior 12 months, the fine must be levied for violations that are corrected before an inspection.

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

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

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

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

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

(g) In addition to the fines listed in paragraphs (a)-(d), the agency shall impose an administrative fine of \$500 if a facility is found not to be in compliance with the background screening requirements as provided in s. 408.809.

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

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

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

~~(c) Any previous violations.~~

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

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

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726 (3)~~(4)~~ Each day of continuing violation after the date
727 established by the agency ~~fixed for correction termination~~ of
728 the violation, ~~as ordered by the agency,~~ constitutes an
729 additional, separate, and distinct violation.

730 (4)~~(5)~~ An ~~Any~~ action taken to correct a violation shall be
731 documented in writing by the owner or administrator of the
732 facility and verified through followup visits by agency
733 personnel. The agency may impose a fine and, in the case of an
734 owner-operated facility, revoke or deny a facility's license
735 when a facility administrator fraudulently misrepresents action
736 taken to correct a violation.

737 (5)~~(6)~~ A ~~Any~~ facility whose owner fails to apply for a
738 change-of-ownership license in accordance with part II of
739 chapter 408 and operates the facility under the new ownership is
740 subject to a fine of \$5,000.

741 (6)~~(7)~~ In addition to any administrative fines imposed, the
742 agency may assess a survey fee, equal to the lesser of one half
743 of the facility's biennial license and bed fee or \$500, to cover
744 the cost of conducting initial complaint investigations that
745 result in the finding of a violation that was the subject of the
746 complaint or monitoring visits conducted under s. 429.28(3)(c)
747 to verify the correction of the violations.

748 (7)~~(8)~~ During an inspection, the agency shall make a
749 reasonable attempt to discuss each violation with the owner or
750 administrator of the facility, prior to written notification.

751 (8)~~(9)~~ The agency shall develop and disseminate an annual
752 list of all facilities sanctioned or fined for violations of
753 state standards, the number and class of violations involved,
754 the penalties imposed, and the current status of cases. The list

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shall be disseminated, at no charge, to the Department of Elderly Affairs, the Department of Health, the Department of Children and Family Services, the Agency for Persons with Disabilities, the area agencies on aging, the Florida Statewide Advocacy Council, and the state and local ombudsman councils. The Department of Children and Family Services shall disseminate the list to service providers under contract to the department who are responsible for referring persons to a facility for residency. The agency may charge a fee commensurate with the cost of printing and postage to other interested parties requesting a copy of this list. This information may be provided electronically or through the agency's Internet site.

Section 9. Subsections (2) and (6) of section 429.28, Florida Statutes, are amended to read:

429.28 Resident bill of rights.—

(2) The administrator of a facility shall ensure that a written notice of the rights, obligations, and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The ~~This~~ notice must ~~shall~~ include the name, address, and telephone numbers of the local ombudsman council 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 kept confidential pursuant to s. 400.0077. The facility must ensure a resident's access to a

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784 telephone to call the local ombudsman council, central abuse
785 hotline, Advocacy Center for Persons with Disabilities, Inc.,
786 and the Florida local advocacy council.

787 (6) A ~~Any~~ facility that ~~which~~ terminates the residency of
788 an individual who participated in activities specified in
789 subsection (5) must ~~shall~~ show good cause in a court of
790 competent jurisdiction. If good cause is not shown, the agency
791 shall impose a fine of \$2,500 in addition to any other penalty
792 assessed against the facility.

793 Section 10. Section 429.34, Florida Statutes, is amended to
794 read:

795 429.34 Right of entry and inspection.—

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

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

Section 11. Present subsections (1) through (11) of section 429.52, Florida Statutes, are redesignated as subsections (2) through (12), respectively, a new subsection (1) is added to that section, and present subsection (9) of that section is amended, to read:

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

(1) Effective October 1, 2013, each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of residents of the facility. Upon completion, the employee and the administrator of the facility must sign an affidavit stating

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that the employee completed the required preservice orientation.
The facility must keep the affidavit in the employee's work
file.

~~(10)-(9)~~ The training required by this section must ~~shall~~ be
conducted by persons registered with the department as having
the requisite experience and credentials to conduct the
training. A person seeking to register as a trainer must provide
the department with proof of completion of the minimum core
training education requirements, successful passage of the
competency test established under this section, and proof of
compliance with the continuing education requirement in
subsection ~~(5)-(4)~~.

Section 12. The Legislature finds that consistent
regulation of assisted living facilities benefits residents and
operators of such facilities. To determine whether surveys are
consistent between surveys and surveyors, the Agency for Health
Care Administration shall conduct a study of intersurveyor
reliability for assisted living facilities. By November 1, 2013,
the agency shall report to the Governor, the President of the
Senate, and the Speaker of the House of Representatives its
findings and make any recommendations to improve intersurveyor
reliability.

Section 13. The Legislature finds that consumers need
additional information on the quality of care and service in
assisted living facilities in order to select the best facility
for themselves or their loved ones. Therefore, the Agency for
Health Care Administration shall:

(1) Propose a rating system for assisted living facilities
similar to that used for nursing homes. The proposal must

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871 include, but is not limited to, the data elements to be used,
872 the method of collecting the data, the method of determining the
873 rating, an estimate of the initial and ongoing costs of a rating
874 system to both the agency and assisted living facilities, and a
875 timetable for the implementation of the rating system for
876 assisted living facilities. The agency shall submit its proposal
877 to the Governor, the President of the Senate, and the Speaker of
878 the House of Representatives by November 1, 2013.

879 (2) By January 1, 2014, create a content that is easily
880 accessible through the front page of the agency's website. At a
881 minimum, the content must include:

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

884 1. The name and address of the facility.

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

886 3. The types of licenses held by the facility.

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

888 5. Other relevant information that the agency currently
889 collects.

890 (b) A list of the facility's cited violations and a summary
891 of each violation which is presented in an understandable manner
892 to the general public.

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

895 (d) A monitored comment page, maintained by the agency,
896 which allows citizens to anonymously comment on assisted living
897 facilities that are licensed to operate in the state. This
898 comment page must, at a minimum, allow members of the public to
899 post comments on their experiences with, or observations of, an

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assisted living facility and to review other people's comments.
Comments posted to the agency's comment page may not contain
profanity and are intended to provide meaningful feedback about
the assisted living facility. The agency shall provide for a
webpage moderator to review comments for profane content before
the comments are posted to the page. An employee, owner, or
controlling interest in an assisted living facility is
prohibited from posting comments on the page.

Section 14. This act shall take effect July 1, 2013.

THE FLORIDA SENATE
APPEARANCE RECORD

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

3/7/13
Meeting Date

Topic ALFS

Bill Number 646
(if applicable)

Name JACK MERRAY

Amendment Barcode _____
(if applicable)

Job Title _____

Address 200 W. COLLEGE ST, #304
Street

Phone _____

TLH FL 32301
City State Zip

E-mail _____

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)

✓

THE FLORIDA SENATE
APPEARANCE RECORD

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

3-7-13

Meeting Date

Topic Assisted Living

Bill Number Le4He
(if applicable)

Name Pat Lange

Amendment Barcode _____
(if applicable)

Job Title Executive Director

Address ~~2447~~ 2447 Millcreek Ct
Tallahassee FL 32308
City State Zip

Phone 850-383-1159

E-mail pat1@falammail.org

Speaking: ☐ For ☐ Against ☒ Information

Representing Florida Assisted Living 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
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 Committee on Health Policy

BILL: SB 1258

INTRODUCER: Senator Grimsley

SUBJECT: Comprehensive Health Information System

DATE: March 4, 2013

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall	HP	Favorable
2.			AHS	
3.			AP	
4.				
5.				
6.				

I. Summary:

SB 1258 amends s. 408.05, F.S., to eliminate the Florida Center for Health Information and Policy Analysis (Florida Center, or Center) and replace it with the Florida Health Information Transparency Initiative (Initiative). In doing so, this bill:

- Directs the Agency for Health Care Administration (AHCA) to make available, in a manner that allows for and encourages multiple innovative uses for the data, state-collected data on health providers, facilities, services, and payment sources.
- Requires the AHCA, subject to the General Appropriations Act, to contract with one or more vendors to develop new methods to disseminate state-collected data and to convert data into an easily usable electronic format.
- Details, but does not limit, the types of information the AHCA must collect.
- States what functions the AHCA must perform while collecting and disseminating comprehensive health information and statistics.
- Mandates that the AHCA implement the Initiative in a manner that recognizes state-collected data as an asset and rewards taxpayer investment in information collection and management.
- Mandates that the AHCA ensure that any vendor who enters into a contract with the state under this section does not inhibit or impede consumer access to state-collected health data.
- Eliminates the State Consumer Health Policy Advisory Council.

This bill substantially amends sections 408.05, 381.026, 395.301, 465.0244, 627.6499, and 641.54, F.S.

II. Present Situation:

The Florida Center for Health Information and Policy Analysis

The Florida Center, housed within the AHCA, is responsible for collecting, compiling, coordinating, analyzing, and disseminating health related data and statistics for the purpose of developing public policy and promoting the transparency of consumer health care information.¹ The Center is divided into five offices each handling an area of Center responsibility:

- The Office of Data Collection and Quality Assurance collects patient discharge data from all licensed acute care hospitals (including psychiatric and comprehensive rehabilitation units), comprehensive rehabilitation hospitals, ambulatory surgical centers and emergency departments.²
- The Office of Risk Management and Patient Safety conducts in-depth analyses of reported incidents to determine what happened and how the involved facility responded to the incident.³
- The Office of Data Dissemination and Communication maintains the AHCA's health information website,⁴ provides technical assistance to data users, and creates consumer brochures and other publications.⁵
- The Office of Health Policy and Research conducts research and analysis of health care data from facilities and develops policy recommendations aimed at improving the delivery of health care services in Florida.⁶
- The Office of Health Information Exchange monitors innovations in health information technology, informatics, and the exchange of health information and provides a clearinghouse of technical resources on health information exchange, electronic prescribing, privacy and security, and other relevant issues.⁷

Florida Center Data Collection

The Florida Center electronically collects patient data from every Florida licensed inpatient hospital, ambulatory surgery center (ASC), emergency department, and comprehensive rehabilitation hospital on a quarterly basis. The data is validated for accuracy and maintained in

¹ Florida Center for Health Information and Policy Analysis, found at: <http://ahca.myflorida.com/SCHS/index.shtml>, last visited on Mar. 5, 2013.

² Office of Data Collection & Quality Assurance, found at: <http://ahca.myflorida.com/SCHS/division.shtml#DataC>, last visited on Mar. 5, 2013.

³ Office of Risk Management and Patient Safety, found at: <http://ahca.myflorida.com/SCHS/division.shtml#PatientSafety>, last visited on Mar. 5, 2013.

⁴ www.FloridaHealthFinder.gov

⁵ The Office of Data Dissemination and Communication, found at: <http://ahca.myflorida.com/SCHS/division.shtml#DataD>, last visited on Mar. 5, 2013.

⁶ The Office of Health Policy and Research, found at: http://ahca.myflorida.com/SCHS/division.shtml#Policy_Research, last visited on Mar. 5, 2013.

⁷ Office of Health Information Exchange, found at: <http://ahca.myflorida.com/SCHS/division.shtml#HIE>, last visited on Mar. 5, 2013.

three major databases including the hospital inpatient database, the ambulatory surgery database, and the emergency department database:⁸

- The hospital inpatient database contains records for each patient stay at Florida acute care facilities, including long-term care hospitals and psychiatric hospitals. These records contain extensive patient information including discharge records, patient demographics, admission information, medical information, and charge data.⁹ This database also includes comprehensive inpatient rehabilitation data on patient-level discharge information from Florida's licensed freestanding comprehensive inpatient rehabilitation hospitals and acute care hospital distinct part rehabilitation units.¹⁰
- The ambulatory surgery database contains "same-day surgery" data on reportable patient visits to Florida health care facilities, including freestanding ambulatory surgery centers, short-term acute care hospitals, lithotripsy centers, and cardiac catheterization laboratories.¹¹ Ambulatory surgery data records include, but are not limited to, patient demographics, medical information, and charge data.¹²
- The emergency department database collects reports of all patients who visited an emergency department, but were not admitted for inpatient care. Reports are electronically submitted to the AHCA and include the hour of arrival, the patient's chief complaint, principal diagnosis, race, ethnicity, and external causes of injury.¹³

In addition to these databases, the Office of Risk Management and Patient Safety collects adverse incident reports from health care providers including, hospitals, ambulatory surgical centers, nursing homes, and assisted living facilities.¹⁴

Florida Center Data Dissemination

The Office of Data Dissemination and Communication makes data collected by the Florida Center available in three ways: by updating and maintaining the AHCA's health information website at www.FloridaHealthFinder.gov, by issuing standard and ad hoc reports, and by responding to requests for de-identified data.¹⁵

www.FloridaHealthFinder.gov

The Florida Center maintains www.FloridaHealthFinder.gov (website) which was established to assist consumers in making informed health care decisions and lead to improvements in quality of care in Florida. The website provides a wide array of search and comparative tools to the public which allow easy access to information on hospitals, ambulatory surgery centers, emergency departments, hospice providers, physician volume, health plans, nursing homes, and prices for prescription drugs in Florida. The website also provides tools to researches and

⁸ Florida Center for Health Information and Policy Analysis, *2011 Annual Report*, p. 2, found at: http://edocs.dlis.state.fl.us/fldocs/ahca/schs/schs_ar2011.pdf, last visited on Mar. 5, 2013.

⁹ *Id.*, p. 3

¹⁰ *Id.*, p. 4

¹¹ *Id.*, p. 3

¹² *Id.*, p. 4

¹³ *Id.* p. 5

¹⁴ *Id.*

¹⁵ *Id.* pp. 6-9

professionals which allow specialized data queries that require users to have some knowledge of medical coding and terminology.¹⁶ Some of the features and data available on the website include a multimedia encyclopedia and symptoms navigator, hospital and ambulatory surgery centers performance data, data on mortality, complication, and infection rates for hospitals, and a facility/provider locator.¹⁷

Standard and Ad Hoc Reports

The Center disseminates three standard reports which detail hospital fiscal data including a prior year report, an audited financial statement, and hospital financial data report. Also, ad hoc reports may be requested for customers looking for very specific information not included on a standard report or for customers who do not wish to purchase an entire data set to obtain information. One example of an ad hoc report would be a request for the average length of stay of patients admitted to a hospital with diabetes as a principle or secondary diagnosis.¹⁸ The Center charges a set fee for standard reports¹⁹ and a variable fee based on the extensiveness of an ad hoc report.²⁰

Requests for De-identified Data

The Center also sells hospital inpatient, ambulatory surgery, and emergency department data to the general public in a non-confidential format. However, the requester must sign a limited set data use agreement which binds the requester to only using the data in a way specified in the agreement. Information not available in these limited data sets include: patient ID number, medical record number, social security number, dates of admission and discharge, visit beginning and end dates, age in days, payer, date of birth, and procedure dates.²¹

The State Consumer Health Information and Policy Advisory Council

Also created by s. 408.05, F.S., the State Consumer Health Information and Policy Advisory Council (Advisory Council) was established to make recommendations to the Florida Center for Health Information and Policy Analysis. The mission of the Advisory Council is to assist the Florida Center in reviewing the comprehensive health information system, including the identification, collection, standardization, sharing, and coordination of health-related data, fraud and abuse data, and professional and facility licensing data among federal, state, local, and private entities and to recommend improvements for purposes of public health, policy analysis, health information exchange and transparency of consumer health care information. The Advisory Council assists the AHCA in determining the method and format for the public disclosure of data collected by the Florida Center and also works with the Florida Center in the development and implementation of a long-range plan for making available health care quality measures and financial data that will allow consumers to compare health care services.²² The Advisory Council met three times in 2012, last meeting on November 29, and has a meeting

¹⁶ *Id.* p. 9

¹⁷ *Id.* pp. 9 -13

¹⁸ *Id.* p. 8

¹⁹ The price list for purchasing data from the Center is available at:

<http://floridahealthfinderstore.blob.core.windows.net/documents/researchers/OrderData/documents/PriceList%20Jan%20202011.pdf>, last visited on Mar. 5, 2013.

²⁰ *Supra* note 8, p. 7

²¹ *Id.* pp. 7 – 8, also see note 19 for a price list.

²² State Consumer Health Information and Policy Advisory Council, *Executive Summary*, found at:

<http://ahca.myflorida.com/SCHS/CommiteesCouncils/docs/AC-ExecutiveSummary0113.pdf>, last visited on Mar. 5, 2013.

scheduled for March 15, 2013. The Advisory Council's membership is detailed in s. 408.05(8), F.S., and includes:

- An employee of the Executive Office of the Governor.
- An employee of the Office of Insurance Regulation.
- An employee of the Department of Education.
- Ten persons appointed by the Secretary of Health Care Administration, representing other state and local agencies, state universities, business and health coalitions, local health councils.

III. Effect of Proposed Changes:

Section 1 amends s. 408.05, F.S., to:

- Eliminate the Florida Center for Health Information and Policy Analysis.
- Create the Florida Health Information Transparency Initiative.
- Direct the AHCA to make state-collected data on health providers, facilities, services, and payment sources available in a manner that allows for and encourages multiple innovative uses for the data.
- Require the AHCA, subject to the General Appropriations Act, to contract with one or more vendors to develop new methods of dissemination and to convert data into an easily usable electronic format.
- Detail the types of information the AHCA must collect including, but not limited to:
 - Health resources;
 - Utilization of health resources;
 - Health care costs and financing;
 - The extent, source, and type of public and private health insurance coverage in the state; and
 - Data necessary for measuring value and quality of care provided by various health care providers.
- State what functions the AHCA must perform in order to collect and disseminate comprehensive health information and statistics to the public and to support the development of policy recommendations, including:
 - Collecting and compiling data from all state agencies and programs involved in providing, regulating, and paying for health services.
 - Promoting data sharing through the development, dissemination, and evaluation of state-collected health data and making such data available, transferable, readily useable.
 - Developing written agreements with local, state, and federal agencies for the sharing of health-care-related data.
 - Enabling and facilitating the sharing and use of all state-collected health data to the maximum extent allowed by law.
 - Monitoring data collection procedures, testing data quality, and taking such corrective actions as may be necessary to ensure that data disseminated under the Initiative are accurate, valid, reliable and complete.
 - Initiating and maintaining the activities necessary to collect, edit, verify, archive and retrieve the data.

- Mandate that the AHCA implement the Initiative in a manner that recognizes state-collected data as an asset and rewards taxpayer investment in information collection and management.
- Mandate that the AHCA ensure that any vendor who enters into a contract with the state under this section does not inhibit or impede consumer access to state-collected health data.
- Strike significant portions of the statute regarding the Comprehensive Health Information System.
- Eliminate the State Consumer Health Policy Advisory Council.

Sections 2 – 6 amends various sections of the Florida Statutes to strike references made obsolete by the changes made to s. 408.05, F.S.

Section 7 creates an effective date of July 1, 2013.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The Initiative is intended to modernize health care data collection and dissemination functions to facilitate public access to this data for innovative uses. The AHCA will contract with one or more vendors, if funding is provided in the General Appropriations Act, to accomplish this objective.

C. Government Sector Impact:

Certain functions and responsibilities currently performed by staff in the Florida Center may be privatized. An analysis from the AHCA was not available at the time of this analysis was published.

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.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

By Senator Grimsley

21-01321B-13

20131258__

A bill to be entitled

An act relating to a comprehensive health information system; amending s. 408.05, F.S.; renaming the Florida Center for Health Information and Policy Analysis as the Florida Health Information Transparency Initiative; providing a statement of purpose for the initiative; providing the duties of the Agency for Health Care Administration; revising the data and information required to be included in the health information system; revising the functions that the agency must perform in order to collect and disseminate health information and statistics; deleting provisions that require the center to provide technical assistance to persons and organizations engaged in health planning activities; deleting provisions that require the center to provide widespread dissemination of data; requiring the agency to implement the transparency initiative in a manner that recognizes state-collected data as an asset and rewards taxpayer investment in information collection and management; authorizing the agency to apply for, receive, and accept grants, gifts, and other payments, including property and services, from a governmental or other public or private entity or person; requiring the agency to ensure that certain vendors do not inhibit or impede consumer access to state-collected health data and information; abolishing the State Consumer Health Information and Policy Advisory Council; amending ss. 381.026, 395.301, 465.0244,

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627.6499, and 641.54, F.S.; conforming provisions to
changes made by the act; providing an effective date.

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

Section 1. Section 408.05, Florida Statutes, is amended to
read:

408.05 Florida ~~Center for~~ Health Information Transparency
Initiative and Policy Analysis.—

(1) PURPOSE ESTABLISHMENT.—The agency shall coordinate
~~establish a Florida Center for Health Information and Policy~~
~~Analysis. The center shall establish a comprehensive health~~
information system to promote accessibility, transparency, and
utility of state-collected data and information about health
providers, facilities, services, and payment sources ~~provide for~~
~~the collection, compilation, coordination, analysis, indexing,~~
~~dissemination, and utilization of both purposefully collected~~
~~and extant health-related data and statistics. The agency center~~
shall be responsible for making data available in a manner that
allows for and encourages multiple and innovative uses of data
sets collected under the auspices of the state. Subject to the
General Appropriations Act, the agency shall contract with one
or more vendors to develop new methods of dissemination and to
convert data into easily useable electronic formats ~~staffed with~~
~~public health experts, biostatisticians, information system~~
~~analysts, health policy experts, economists, and other staff~~
~~necessary to carry out its functions.~~

(2) HEALTH-RELATED DATA.—The comprehensive health
information system ~~operated by the Florida Center for Health~~

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Information and Policy Analysis shall include, but may not be limited to, the following data and information ~~identify the best available data sources and coordinate the compilation of extant health-related data and statistics and purposefully collect data on:~~

~~(a) The extent and nature of illness and disability of the state population, including life expectancy, the incidence of various acute and chronic illnesses, and infant and maternal morbidity and mortality.~~

~~(b) The impact of illness and disability of the state population on the state economy and on other aspects of the well-being of the people in this state.~~

~~(c) Environmental, social, and other health hazards.~~

~~(d) Health knowledge and practices of the people in this state and determinants of health and nutritional practices and status.~~

(a)(e) Health resources, including licensed physicians, dentists, nurses, and other health professionals, licensed by specialty and type of practice and acute, long-term care and other institutional care facility supplies and specific services provided by hospitals, nursing homes, home health agencies, and other health care facilities, managed care organizations, and other health services regulated or funded by the state.

(b)(f) Utilization of health resources ~~care by type of provider.~~

(c)(g) Health care costs and financing, including Medicaid claims and encounter data and data from other public and private payors ~~trends in health care prices and costs, the sources of payment for health care services, and federal, state, and local~~

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88 ~~expenditures for health care.~~

89 ~~(h) Family formation, growth, and dissolution.~~

90 (d)(i) The extent, source, and type of public and private
91 health insurance coverage in this state.

92 (e)(j) The data necessary for measuring value and quality
93 of care provided by various health care providers, including
94 applicable credentials, accreditation status, utilization,
95 revenues and expenses, outcomes, site visits, and other
96 regulatory reports, and the results of administrative and civil
97 litigation.

98 (3) COORDINATION ~~COMPREHENSIVE HEALTH INFORMATION SYSTEM.~~
99 In order to collect and disseminate comprehensive ~~produce~~
100 ~~comparable and uniform~~ health information and statistics for the
101 public as well as for development of policy recommendations, the
102 agency shall perform the following functions:

103 (a) Collect and compile data from all state agencies and
104 programs involved in providing, regulating, and paying for
105 health services ~~Coordinate the activities of state agencies~~
106 ~~involved in the design and implementation of the comprehensive~~
107 ~~health information system.~~

108 (b) Promote data sharing through the ~~Undertake research,~~
109 development, dissemination, and evaluation of state-collected
110 health data and by making such data available, transferable, and
111 readily useable ~~respecting the comprehensive health information~~
112 ~~system.~~

113 ~~(c) Review the statistical activities of state agencies to~~
114 ~~ensure that they are consistent with the comprehensive health~~
115 ~~information system.~~

116 (c)(d) Develop written agreements with local, state, and

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117 federal agencies for the sharing of health-care-related data or
118 using the facilities and services of such agencies. State
119 agencies, local health councils, and other agencies under state
120 contract shall assist the agency center in obtaining, compiling,
121 and transferring health-care-related data maintained by state
122 and local agencies. ~~Written agreements must specify the types,~~
123 ~~methods, and periodicity of data exchanges and specify the types~~
124 ~~of data that will be transferred to the center.~~

125 (d) Enable and facilitate the sharing and use of all
126 state-collected health data to the maximum extent allowed by law
127 ~~Establish by rule the types of data collected, compiled,~~
128 ~~processed, used, or shared. Decisions regarding center data sets~~
129 ~~should be made based on consultation with the State Consumer~~
130 ~~Health Information and Policy Advisory Council and other public~~
131 ~~and private users regarding the types of data which should be~~
132 ~~collected and their uses. The center shall establish~~
133 ~~standardized means for collecting health information and~~
134 ~~statistics under laws and rules administered by the agency.~~

135 ~~(f) Establish minimum health care-related data sets which~~
136 ~~are necessary on a continuing basis to fulfill the collection~~
137 ~~requirements of the center and which shall be used by state~~
138 ~~agencies in collecting and compiling health care-related data.~~
139 ~~The agency shall periodically review ongoing health care data~~
140 ~~collections of the Department of Health and other state agencies~~
141 ~~to determine if the collections are being conducted in~~
142 ~~accordance with the established minimum sets of data.~~

143 ~~(g) Establish advisory standards to ensure the quality of~~
144 ~~health statistical and epidemiological data collection,~~
145 ~~processing, and analysis by local, state, and private~~

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146 organizations.

147 (e)-(h) Monitor data collection procedures, test data
148 quality, and take such corrective actions as may be necessary to
149 ensure that data and information disseminated under the
150 initiative are accurate, valid, reliable, and complete ~~Prescribe~~
151 ~~standards for the publication of health-care-related data~~
152 ~~reported pursuant to this section which ensure the reporting of~~
153 ~~accurate, valid, reliable, complete, and comparable data. Such~~
154 ~~standards should include advisory warnings to users of the data~~
155 ~~regarding the status and quality of any data reported by or~~
156 ~~available from the center.~~

157 (f)-(i) Initiate and maintain activities necessary to
158 collect, edit, verify, archive, and retrieve ~~Prescribe standards~~
159 ~~for the maintenance and preservation of the center's data. This~~
160 ~~should include methods for archiving data, retrieval of archived~~
161 ~~data, and data~~ compiled pursuant to this section ~~editing and~~
162 ~~verification.~~

163 ~~(j) Ensure that strict quality control measures are~~
164 ~~maintained for the dissemination of data through publications,~~
165 ~~studies, or user requests.~~

166 ~~(k) Develop, in conjunction with the State Consumer Health~~
167 ~~Information and Policy Advisory Council, and implement a long-~~
168 ~~range plan for making available health care quality measures and~~
169 ~~financial data that will allow consumers to compare health care~~
170 ~~services. The health care quality measures and financial data~~
171 ~~the agency must make available shall include, but is not limited~~
172 ~~to, pharmaceuticals, physicians, health care facilities, and~~
173 ~~health plans and managed care entities. The agency shall update~~
174 ~~the plan and report on the status of its implementation~~

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175 ~~annually. The agency shall also make the plan and status report~~
176 ~~available to the public on its Internet website. As part of the~~
177 ~~plan, the agency shall identify the process and timeframes for~~
178 ~~implementation, any barriers to implementation, and~~
179 ~~recommendations of changes in the law that may be enacted by the~~
180 ~~Legislature to eliminate the barriers. As preliminary elements~~
181 ~~of the plan, the agency shall:~~

182 ~~1. Make available patient-safety indicators, inpatient~~
183 ~~quality indicators, and performance outcome and patient charge~~
184 ~~data collected from health care facilities pursuant to s.~~
185 ~~408.061(1)(a) and (2). The terms "patient-safety indicators" and~~
186 ~~"inpatient quality indicators" shall be as defined by the~~
187 ~~Centers for Medicare and Medicaid Services, the National Quality~~
188 ~~Forum, the Joint Commission on Accreditation of Healthcare~~
189 ~~Organizations, the Agency for Healthcare Research and Quality,~~
190 ~~the Centers for Disease Control and Prevention, or a similar~~
191 ~~national entity that establishes standards to measure the~~
192 ~~performance of health care providers, or by other states. The~~
193 ~~agency shall determine which conditions, procedures, health care~~
194 ~~quality measures, and patient charge data to disclose based upon~~
195 ~~input from the council. When determining which conditions and~~
196 ~~procedures are to be disclosed, the council and the agency shall~~
197 ~~consider variation in costs, variation in outcomes, and~~
198 ~~magnitude of variations and other relevant information. When~~
199 ~~determining which health care quality measures to disclose, the~~
200 ~~agency:~~

201 ~~a. Shall consider such factors as volume of cases; average~~
202 ~~patient charges; average length of stay; complication rates;~~
203 ~~mortality rates; and infection rates, among others, which shall~~

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be ~~adjusted for case mix and severity, if applicable.~~

~~b. May consider such additional measures that are adopted by the Centers for Medicare and Medicaid Studies, National Quality Forum, the Joint Commission on Accreditation of Healthcare Organizations, the Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, or a similar national entity that establishes standards to measure the performance of health care providers, or by other states.~~

~~When determining which patient charge data to disclose, the agency shall include such measures as the average of undiscounted charges on frequently performed procedures and preventive diagnostic procedures, the range of procedure charges from highest to lowest, average net revenue per adjusted patient day, average cost per adjusted patient day, and average cost per admission, among others.~~

~~2. Make available performance measures, benefit design, and premium cost data from health plans licensed pursuant to chapter 627 or chapter 641. The agency shall determine which health care quality measures and member and subscriber cost data to disclose, based upon input from the council. When determining which data to disclose, the agency shall consider information that may be required by either individual or group purchasers to assess the value of the product, which may include membership satisfaction, quality of care, current enrollment or membership, coverage areas, accreditation status, premium costs, plan costs, premium increases, range of benefits, copayments and deductibles, accuracy and speed of claims payment, credentials of physicians, number of providers, names of network providers,~~

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and hospitals in the network. Health plans shall make available to the agency any such data or information that is not currently reported to the agency or the office.

3. Determine the method and format for public disclosure of data reported pursuant to this paragraph. The agency shall make its determination based upon input from the State Consumer Health Information and Policy Advisory Council. At a minimum, the data shall be made available on the agency's Internet website in a manner that allows consumers to conduct an interactive search that allows them to view and compare the information for specific providers. The website must include such additional information as is determined necessary to ensure that the website enhances informed decisionmaking among consumers and health care purchasers, which shall include, at a minimum, appropriate guidance on how to use the data and an explanation of why the data may vary from provider to provider.

4. Publish on its website undiscounted charges for no fewer than 150 of the most commonly performed adult and pediatric procedures, including outpatient, inpatient, diagnostic, and preventative procedures.

~~(4) TECHNICAL ASSISTANCE.~~

~~(a) The center shall provide technical assistance to persons or organizations engaged in health planning activities in the effective use of statistics collected and compiled by the center. The center shall also provide the following additional technical assistance services:~~

~~1. Establish procedures identifying the circumstances under which, the places at which, the persons from whom, and the methods by which a person may secure data from the center,~~

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including procedures governing requests, the ordering of requests, timeframes for handling requests, and other procedures necessary to facilitate the use of the center's data. To the extent possible, the center should provide current data timely in response to requests from public or private agencies.

2. Provide assistance to data sources and users in the areas of database design, survey design, sampling procedures, statistical interpretation, and data access to promote improved health-care-related data sets.

3. Identify health care data gaps and provide technical assistance to other public or private organizations for meeting documented health care data needs.

4. Assist other organizations in developing statistical abstracts of their data sets that could be used by the center.

5. Provide statistical support to state agencies with regard to the use of databases maintained by the center.

6. To the extent possible, respond to multiple requests for information not currently collected by the center or available from other sources by initiating data collection.

7. Maintain detailed information on data maintained by other local, state, federal, and private agencies in order to advise those who use the center of potential sources of data which are requested but which are not available from the center.

8. Respond to requests for data which are not available in published form by initiating special computer runs on data sets available to the center.

9. Monitor innovations in health information technology, informatics, and the exchange of health information and maintain a repository of technical resources to support the development

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291 ~~of a health information network.~~

292 ~~(b) The agency shall administer, manage, and monitor grants~~
293 ~~to not-for-profit organizations, regional health information~~
294 ~~organizations, public health departments, or state agencies that~~
295 ~~submit proposals for planning, implementation, or training~~
296 ~~projects to advance the development of a health information~~
297 ~~network. Any grant contract shall be evaluated to ensure the~~
298 ~~effective outcome of the health information project.~~

299 ~~(c) The agency shall initiate, oversee, manage, and~~
300 ~~evaluate the integration of health care data from each state~~
301 ~~agency that collects, stores, and reports on health care issues~~
302 ~~and make that data available to any health care practitioner~~
303 ~~through a state health information network.~~

304 ~~(5) PUBLICATIONS; REPORTS; SPECIAL STUDIES. The center~~
305 ~~shall provide for the widespread dissemination of data which it~~
306 ~~collects and analyzes. The center shall have the following~~
307 ~~publication, reporting, and special study functions:~~

308 ~~(a) The center shall publish and make available~~
309 ~~periodically to agencies and individuals health statistics~~
310 ~~publications of general interest, including health plan consumer~~
311 ~~reports and health maintenance organization member satisfaction~~
312 ~~surveys; publications providing health statistics on topical~~
313 ~~health policy issues; publications that provide health status~~
314 ~~profiles of the people in this state; and other topical health~~
315 ~~statistics publications.~~

316 ~~(b) The center shall publish, make available, and~~
317 ~~disseminate, promptly and as widely as practicable, the results~~
318 ~~of special health surveys, health care research, and health care~~
319 ~~evaluations conducted or supported under this section. Any~~

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publication by the center must include a statement of the limitations on the quality, accuracy, and completeness of the data.

~~(c) The center shall provide indexing, abstracting, translation, publication, and other services leading to a more effective and timely dissemination of health care statistics.~~

~~(d) The center shall be responsible for publishing and disseminating an annual report on the center's activities.~~

~~(e) The center shall be responsible, to the extent resources are available, for conducting a variety of special studies and surveys to expand the health care information and statistics available for health policy analyses, particularly for the review of public policy issues. The center shall develop a process by which users of the center's data are periodically surveyed regarding critical data needs and the results of the survey considered in determining which special surveys or studies will be conducted. The center shall select problems in health care for research, policy analyses, or special data collections on the basis of their local, regional, or state importance; the unique potential for definitive research on the problem; and opportunities for application of the study findings.~~

(4) (6) PROVIDER DATA REPORTING.—This section does not confer on the agency the power to demand or require that a health care provider or professional furnish information, records of interviews, written reports, statements, notes, memoranda, or data other than as expressly required by law.

(5) (7) HEALTH INFORMATION ENTERPRISE BUDGET; FEES.—

(a) The agency shall implement the transparency initiative

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349 in a manner that recognizes state-collected data as an asset and
350 rewards taxpayer investment in information collection and
351 management ~~Legislature intends that funding for the Florida~~
352 ~~Center for Health Information and Policy Analysis be~~
353 ~~appropriated from the General Revenue Fund.~~

354 (b) The agency ~~Florida Center for Health Information and~~
355 ~~Policy Analysis~~ may apply for, and receive, and accept grants,
356 gifts, and other payments, including property and services, from
357 a ~~any~~ governmental or other public or private entity or person
358 and make arrangements for ~~as to~~ the use of such funds ~~same,~~
359 including the undertaking of special studies and other projects
360 relating to health-care-related topics. ~~Funds obtained pursuant~~
361 ~~to this paragraph may not be used to offset annual~~
362 ~~appropriations from the General Revenue Fund.~~

363 (c) The agency shall ensure that a vendor who enters into a
364 contract with the state under this section does not inhibit or
365 impede consumer access to state-collected health data and
366 information ~~center may charge such reasonable fees for services~~
367 ~~as the agency prescribes by rule. The established fees may not~~
368 ~~exceed the reasonable cost for such services. Fees collected may~~
369 ~~not be used to offset annual appropriations from the General~~
370 ~~Revenue Fund.~~

371 ~~(8) STATE CONSUMER HEALTH INFORMATION AND POLICY ADVISORY~~
372 ~~COUNCIL.—~~

373 ~~(a) There is established in the agency the State Consumer~~
374 ~~Health Information and Policy Advisory Council to assist the~~
375 ~~center in reviewing the comprehensive health information system,~~
376 ~~including the identification, collection, standardization,~~
377 ~~sharing, and coordination of health-related data, fraud and~~

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378 ~~abuse data, and professional and facility licensing data among~~
379 ~~federal, state, local, and private entities and to recommend~~
380 ~~improvements for purposes of public health, policy analysis, and~~
381 ~~transparency of consumer health care information. The council~~
382 ~~shall consist of the following members:~~

383 ~~1. An employee of the Executive Office of the Governor, to~~
384 ~~be appointed by the Governor.~~

385 ~~2. An employee of the Office of Insurance Regulation, to be~~
386 ~~appointed by the director of the office.~~

387 ~~3. An employee of the Department of Education, to be~~
388 ~~appointed by the Commissioner of Education.~~

389 ~~4. Ten persons, to be appointed by the Secretary of Health~~
390 ~~Care Administration, representing other state and local~~
391 ~~agencies, state universities, business and health coalitions,~~
392 ~~local health councils, professional health-care-related~~
393 ~~associations, consumers, and purchasers.~~

394 ~~(b) Each member of the council shall be appointed to serve~~
395 ~~for a term of 2 years following the date of appointment, except~~
396 ~~the term of appointment shall end 3 years following the date of~~
397 ~~appointment for members appointed in 2003, 2004, and 2005. A~~
398 ~~vacancy shall be filled by appointment for the remainder of the~~
399 ~~term, and each appointing authority retains the right to~~
400 ~~reappoint members whose terms of appointment have expired.~~

401 ~~(c) The council may meet at the call of its chair, at the~~
402 ~~request of the agency, or at the request of a majority of its~~
403 ~~membership, but the council must meet at least quarterly.~~

404 ~~(d) Members shall elect a chair and vice chair annually.~~

405 ~~(e) A majority of the members constitutes a quorum, and the~~
406 ~~affirmative vote of a majority of a quorum is necessary to take~~

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407 ~~action.~~

408 ~~(f) The council shall maintain minutes of each meeting and~~
409 ~~shall make such minutes available to any person.~~

410 ~~(g) Members of the council shall serve without compensation~~
411 ~~but shall be entitled to receive reimbursement for per diem and~~
412 ~~travel expenses as provided in s. 112.061.~~

413 ~~(h) The council's duties and responsibilities include, but~~
414 ~~are not limited to, the following:~~

415 ~~1. To develop a mission statement, goals, and a plan of~~
416 ~~action for the identification, collection, standardization,~~
417 ~~sharing, and coordination of health-related data across federal,~~
418 ~~state, and local government and private sector entities.~~

419 ~~2. To develop a review process to ensure cooperative~~
420 ~~planning among agencies that collect or maintain health-related~~
421 ~~data.~~

422 ~~3. To create ad hoc issue-oriented technical workgroups on~~
423 ~~an as-needed basis to make recommendations to the council.~~

424 ~~(9) APPLICATION TO OTHER AGENCIES. Nothing in this section~~
425 ~~shall limit, restrict, affect, or control the collection,~~
426 ~~analysis, release, or publication of data by any state agency~~
427 ~~pursuant to its statutory authority, duties, or~~
428 ~~responsibilities.~~

429 Section 2. Paragraph (c) of subsection (4) of section
430 381.026, Florida Statutes, is amended to read:

431 381.026 Florida Patient's Bill of Rights and
432 Responsibilities.—

433 (4) RIGHTS OF PATIENTS.—Each health care facility or
434 provider shall observe the following standards:

435 (c) *Financial information and disclosure.*—

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436 1. A patient has the right to be given, upon request, by
437 the responsible provider, his or her designee, or a
438 representative of the health care facility full information and
439 necessary counseling on the availability of known financial
440 resources for the patient's health care.

441 2. A health care provider or a health care facility shall,
442 upon request, disclose to each patient who is eligible for
443 Medicare, before treatment, whether the health care provider or
444 the health care facility in which the patient is receiving
445 medical services accepts assignment under Medicare reimbursement
446 as payment in full for medical services and treatment rendered
447 in the health care provider's office or health care facility.

448 3. A primary care provider may publish a schedule of
449 charges for the medical services that the provider offers to
450 patients. The schedule must include the prices charged to an
451 uninsured person paying for such services by cash, check, credit
452 card, or debit card. The schedule must be posted in a
453 conspicuous place in the reception area of the provider's office
454 and must include, but is not limited to, the 50 services most
455 frequently provided by the primary care provider. The schedule
456 may group services by three price levels, listing services in
457 each price level. The posting must be at least 15 square feet in
458 size. A primary care provider who publishes and maintains a
459 schedule of charges for medical services is exempt from the
460 license fee requirements for a single period of renewal of a
461 professional license under chapter 456 for that licensure term
462 and is exempt from the continuing education requirements of
463 chapter 456 and the rules implementing those requirements for a
464 single 2-year period.

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465 4. If a primary care provider publishes a schedule of
466 charges pursuant to subparagraph 3., he or she must continually
467 post it at all times for the duration of active licensure in
468 this state when primary care services are provided to patients.
469 If a primary care provider fails to post the schedule of charges
470 in accordance with this subparagraph, the provider must ~~shall be~~
471 ~~required to~~ pay any license fee and comply with ~~any~~ continuing
472 education requirements for which an exemption was received.

473 5. A health care provider or a health care facility shall,
474 upon request, furnish a person, before the provision of medical
475 services, a reasonable estimate of charges for such services.
476 The health care provider or the health care facility shall
477 provide an uninsured person, before the provision of a planned
478 nonemergency medical service, a reasonable estimate of charges
479 for such service and information regarding the provider's or
480 facility's discount or charity policies for which the uninsured
481 person may be eligible. Such estimates by a primary care
482 provider must be consistent with the schedule posted under
483 subparagraph 3. To the extent possible, estimates shall, ~~to the~~
484 ~~extent possible,~~ be written in language comprehensible to an
485 ordinary layperson. Such reasonable estimate does not preclude
486 the health care provider or health care facility from exceeding
487 the estimate or making additional charges based on changes in
488 the patient's condition or treatment needs.

489 6. Each licensed facility not operated by the state shall
490 make available to the public on its Internet website or by other
491 electronic means a description of and a link to the performance
492 outcome and financial data that is published by the agency
493 ~~pursuant to s. 408.05(3)(k).~~ The facility shall place a notice

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in the reception area that such information is available electronically and the website address. The licensed facility may indicate that the pricing information is based on a compilation of charges for the average patient and that each patient's bill may vary from the average depending upon the severity of illness and individual resources consumed. The licensed facility may also indicate that the price of service is negotiable for eligible patients based upon the patient's ability to pay.

7. A patient has the right to receive a copy of an itemized bill upon request. A patient has a right to be given an explanation of charges upon request.

Section 3. Subsection (11) of section 395.301, Florida Statutes, is amended to read:

395.301 Itemized patient bill; form and content prescribed by the agency.—

(11) Each licensed facility shall make available on its Internet website a link to the performance outcome and financial data that is published by the Agency for Health Care Administration ~~pursuant to s. 408.05(3)(k)~~. The facility shall place a notice in the reception area that the information is available electronically and the facility's Internet website address.

Section 4. Section 465.0244, Florida Statutes, is amended to read:

465.0244 Information disclosure.—Every pharmacy shall make available on its Internet website a link to the performance outcome and financial data that is published by the Agency for Health Care Administration ~~pursuant to s. 408.05(3)(k)~~ and shall

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place in the area where customers receive filled prescriptions notice that such information is available electronically and the address of its Internet website.

Section 5. Subsection (2) of section 627.6499, Florida Statutes, is amended to read:

627.6499 Reporting by insurers and third-party administrators.—

(2) Each health insurance issuer shall make available on its Internet website a link to the performance outcome and financial data that is published by the Agency for Health Care Administration ~~pursuant to s. 408.05(3)(k)~~ and shall include in every policy delivered or issued for delivery to any person in the state or ~~any~~ materials provided as required by s. 627.64725 notice that such information is available electronically and the address of its Internet website.

Section 6. Subsection (7) of section 641.54, Florida Statutes, is amended to read:

641.54 Information disclosure.—

(7) Each health maintenance organization shall make available on its Internet website a link to the performance outcome and financial data that is published by the Agency for Health Care Administration ~~pursuant to s. 408.05(3)(k)~~ and shall include in every policy delivered or issued for delivery to any person in the state or ~~any~~ materials provided as required by s. 627.64725 notice that such information is available electronically and the address of its Internet website.

Section 7. This act shall take effect July 1, 2013.

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 Committee on Health Policy

BILL: CS/SB 258

INTRODUCER: Committee on Regulated Industries; and Senator Bradley and others

SUBJECT: Florida Clean Indoor Air Act

DATE: March 4, 2013

REVISED: 03/07/2013

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Oxamendi	Imhof	RI	Fav/CS
2.	Looke	Stovall	HP	Fav/1 amendment
3.			CA	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

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

I. Summary:

CS/SB 258 authorizes municipalities and counties to further restrict smoking above and beyond the provisions of chapter 386, F.S., at entrances to public indoor workplaces, outdoor areas of such workplaces, and on property owned or controlled by a municipality or county, including beaches, playgrounds, public parks, sports and recreation areas. Any county or municipal restriction must comply with the restrictions specified in the bill.

This bill substantially amends section 386.209, Florida Statutes.

II. Present Situation:

The Florida Clean Indoor Air Act (act) in part II of ch. 386, F.S., regulates the smoking of tobacco in Florida. The legislative purpose of the act is to protect people from the health hazards of secondhand tobacco smoke and to implement the Florida health initiative in s. 20, Art. X of the State Constitution.¹

¹ s. 386.202, F.S.

Florida Constitution

On November 5, 2002, Florida voters approved Amendment 6 to the State Constitution, which prohibits tobacco smoking in enclosed indoor workplaces. Section 20, Art. X of the Florida Constitution defines an “enclosed indoor workplace,” in part, as “any place where one or more persons engages in work, and which place is predominantly or totally bounded on all sides and above by physical barriers ... without regard to whether work is occurring at any given time” and defines “work” as “any employment or employment-type service for or at the request of another individual or individuals or any public or private entity, whether for compensation or not, whether full or part-time, whether legally or not.” Section 20, Art. X of the Florida Constitution provides limited exceptions for private residences, retail tobacco shops, designated smoking guest rooms at hotels and other public lodging establishments, and stand-alone bars. Section 20, Art. X of the Florida Constitution also directs the Legislature to implement its provisions “in a manner consistent with its broad purpose and stated terms” and provides that the Legislature may enact legislation more restrictive of tobacco smoking than that provided in the Florida Constitution.

Florida’s Clean Indoor Air Act

In 2003, the Legislature implemented s. 20, Art. X of the Florida Constitution by enacting ch. 2003-398, L.O.F., which amended part II of ch. 386, F.S., to create the “Florida Clean Indoor Air Act.” The act implements the restrictions in s. 20, Art. X of the Florida Constitution and specifically prohibits smoking in an enclosed indoor workplace,² adopts and implements the amendment’s definitions and adopts the amendment’s exceptions for private residences whenever not being used for certain commercial purposes;³ stand-alone bars;⁴ designated smoking rooms in hotels and other public lodging establishments;⁵ and retail tobacco shops, including businesses that manufacture, import or distribute tobacco products and tobacco loose leaf dealers.⁶

Section 386.207, F.S., provides for enforcement of the act by the Department of Health (DOH) and the Department of Business and Professional Regulation (DBPR) within each department’s specific areas of regulatory authority. Sections 386.207(1) and 386.2125, F.S., grant rulemaking authority to the DOH and the DBPR and require that the departments consult with the State Fire Marshal during the rulemaking process.

Section 386.207(3), F.S., provides penalties for violations of the act by proprietors or persons in charge of an enclosed indoor workplace.⁷ A fine for a first violation must be no less than \$250 and no more than \$750 and fines for subsequent violations must be no less than \$500 and no more than \$2,000. Fines imposed on individuals range from up to \$100 for a first violation to up to \$500 for subsequent violations.⁸

² s. 386.204, F.S.

³ s. 386.2045(1), F.S. *See also* definition of the term “private residence” in s. 386.203(1), F.S.

⁴ s. 386.2045(4), F.S. *See also* definition of the term “stand-alone bar” in s. 386.203(11), F.S.

⁵ s. 386.2045(3), F.S. *See also* definition of the term “designated guest smoking room” in s. 386.203(4), F.S.

⁶ s. 386.2045(2), F.S. *See also* definition of the term “retail tobacco shop” in s. 386.203(8), F.S.

⁷ The applicable penalties for violations by designated stand-alone bars are set forth in s. 561.695(8), F.S.

⁸ s. 386.208, F.S.

Smoking Prohibited Near School Property

Section 386.212(1), F.S., prohibits smoking by any person under the age of 18 in, on, or within 1,000 feet of the real property comprising a public or private elementary, middle, or secondary school between the hours of 6 a.m. and midnight. The prohibition does not apply to any person occupying a moving vehicle or within a private residence.

Enforcement

Section 386.212(2), F.S., authorizes law enforcement officers to issue citations in the form as prescribed by a county or municipality to any person violating the provisions of s. 386, F.S., and prescribes the information that must be included in the citation.

Receiving a citation under s. 386.212(2), F.S., constitutes a civil infraction punishable by a maximum civil penalty of \$25, 50 hours of community service or, where available, successful completion of a school-approved anti-tobacco “alternative to suspension” program.⁹

If a person fails to comply with the directions on the citation, the person waives his or her right to contest the citation and an order to show cause may be issued by the court.¹⁰

Regulation of Smoking Preempted to State

The act expressly preempts regulation of smoking to the state and supersedes any municipal or county ordinance on the subject except that school districts are permitted to further restrict smoking on school district property.¹¹

A recent Florida Attorney General Opinion concluded that the St. Johns Water Management District could not adopt a regulation prohibiting smoking by all persons on district property.¹² The Attorney General reasoned that s. 386.209, F.S., represents a clear expression of the legislative intent that the act preempts the field of smoking regulation for indoor and outdoor smoking. The Attorney General noted that a 2011 amendment of s. 386.209, F.S.,¹³ expressly granted school districts authority to prohibit smoking on school district property and concluded that further legislative authorization would be required for the water management district to regulate smoking on its property.

III. Effect of Proposed Changes:

Section 1 amends s. 386.209, F.S., to authorize municipalities and counties to restrict smoking at entrances to public indoor workplaces, outdoor areas of such workplaces, and property owned or

⁹ s. 386.212(3), F.S.

¹⁰ s. 386.212(4), F.S.

¹¹ s. 386.209, F.S.,

¹² Fla. AGO 2011-15 (July 21, 2011). *See also*, Fla. AGO 2005-63 (November 21, 2005), which opined that a municipality is preempted from regulating smoking in a public park other than as prescribed by the Legislature.

¹³ Ch. 2011-108, L.O.F.

controlled by a municipality or county, including beaches, playgrounds,¹⁴ public parks, and sports and recreation areas. The county or municipal restriction must comply with the restrictions specified in the bill including:

- Restricted areas must be identified by “No Smoking” signs that delineate the area where smoking is restricted.
- Municipalities and counties must provide designated smoking areas and those areas must be identified by signs that delineate the areas where smoking is authorized.
- Municipalities and counties may only restrict smoking on sidewalks or other footpaths that are located within a beach, playground, public park, or sports and recreation area.
- Municipalities and counties may restrict smoking at entrances to an enclosed public indoor workplace for a distance of no more than 75 feet from the entrance or more than 75 feet from air intakes for HVAC systems, operable windows, vents, or other openings through which smoke may enter the workplace.
- Municipalities and counties cannot limit the ability of a person to authorize smoking to the extent not prohibited by ch. 386, F.S.
- Municipalities and counties may require, as a condition for a lease on property that it owns or controls, that smoking be prohibited on the property.
- Municipalities and counties must require law enforcement officers to warn any violator to stop smoking and to advise him or her of the penalties for a violation before issuing a citation. If the violator continues to smoke, the officer must then ask the person to leave the premises. If the person refuses to leave the premises, the law enforcement officer may issue the citation, punishable as provided in s. 386.208, F.S.¹⁵

The bill defines the term “public indoor workplace” as any enclosed area owned or controlled by a municipality or county which is public property used for public and governmental purposes and to which the public is invited or allowed. The definition includes, but is not limited to, administrative facilities, educational facilities, cultural and civic centers, healthcare facilities, and recreational facilities.

Section 2 provides an effective date of July 1, 2013.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

¹⁴ Section 775.215(1)(c), F.S., relating to residency restriction for persons convicted of certain sex offenses, defines the term “playground” to mean “a designated independent area in the community or neighborhood that is designated solely for children and has one or more play structures.”

¹⁵ S. 386.208, F.S., provides that a violation of this section is a noncriminal violation punishable by a fine of no more than \$100 for a first violation and no more than \$500 for subsequent violations.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

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 Regulated Industries Committee on February 21, 2013:

The committee substitute substantially amends the bill. It authorizes municipalities and counties to restrict smoking at entrances to public indoor workplaces, outdoor areas of such workplaces, and on property owned or controlled by a municipality or county, including beaches, playgrounds, public parks, sports and recreation areas, and walkways within those areas. The county or municipal restriction must comply with the restrictions specified in the bill including requirements for no smoking signs, designated smoking areas, restriction of smoking on leased property, and procedures for issuing citations by law enforcement. It includes a definition for “public indoor workplace.”

B. Amendments:

Barcode 731142 by Health Policy on March 7, 2013:

The amendment modifies provisions in the bill to prevent local governments from adding smoking restrictions to the lease of a business located on public property during the term of a pre-existing lease, or during lease renewal, without the lessee’s consent.



731142

LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
03/08/2013	.	
	.	
	.	
	.	

The Committee on Health Policy (Braynon) recommended the following:

Senate Amendment

Delete lines 44 - 45
and insert:
may require, as a condition for granting a new lease, that
smoking be prohibited on such property. However, the smoking
restriction may not apply to such property during the term of a
pre-existing lease, including any renewal of such lease, without
the lessee's consent; and

By the Committee on Regulated Industries; and Senators Bradley,
Dean, and Hays

580-01741-13

2013258c1

A bill to be entitled
An act relating to the Florida Clean Indoor Air Act;
amending s. 386.209, F.S.; authorizing municipalities
and counties to restrict smoking on certain
properties; providing limitations on such
restrictions; authorizing a law enforcement officer to
issue a citation under certain circumstances;
providing a definition; providing an effective date.

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

Section 1. Section 386.209, Florida Statutes, is amended to
read:

386.209 Regulation of smoking preempted to state.—This part
expressly preempts regulation of smoking to the state and
supersedes any municipal or county ordinance on the subject,
except that:~~; however,~~

(1) School districts may further restrict smoking by
persons on school district property.

(2) Municipalities or counties may further restrict smoking
at entrances to public indoor workplaces and outdoor areas of
such workplaces, and property owned or controlled by a
municipality or county, including beaches, playgrounds as
defined in s. 775.215, public parks, and sports and recreation
areas, provided:

(a) The areas where smoking is restricted are identified by
“No Smoking” signs that delineate the area where smoking is
restricted;

(b) Designated smoking areas are provided and identified by

580-01741-13

2013258c1

signs that delineate the areas where smoking is authorized;

(c) Except as provided in paragraph (d), restrictions on sidewalks or other footpaths are limited to sidewalks or footpaths that are located within a beach, playground, public park, or sports and recreation area;

(d) Restricted areas at entrances to an enclosed public indoor workplace do not extend more than 75 feet from the entrance or more than 75 feet from air intakes for HVAC systems, operable windows, vents, or other openings through which smoke may enter the workplace;

(e) The smoking restriction does not limit the ability of a person to authorize smoking to the extent not prohibited by this chapter. However, if a business is located on property owned or operated by a municipality or county, the municipality or county may require, as a condition for granting a lease, that smoking be prohibited on such property; and

(f) A law enforcement officer, before issuing a citation for a violation of this subsection, first directs the violator to stop smoking and advises him or her of the penalties for a violation. If the person does not heed the directive, the officer must then ask the person to leave the premises. If the person refuses to leave the premises, a civil citation may be issued, punishable as provided in s. 386.208.

As used in this section, the term "public indoor workplace" means any enclosed area owned or controlled by a municipality or county which is public property used for public and governmental purposes and to which the public is invited or allowed and which includes, but is not limited to, administrative facilities,

580-01741-13

2013258c1

59 educational facilities, cultural and civic centers, healthcare
60 facilities, and recreational facilities.

61 Section 2. This act shall take effect July 1, 2013.



The Florida Senate

Committee Agenda Request

To: Senator Aaron Bean, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: February 21, 2013

I respectfully request that **Senate Bill # 258**, relating to Florida Clean Indoor Air Act, be placed on the:

- ☒ committee agenda at your earliest possible convenience.
- ☐ next committee agenda.

A handwritten signature in black ink, appearing to read "Rob Bradley".

Senator Rob Bradley
Florida Senate, District 7



File signed original with committee office

S-020 (03/2004)

 **ENTERED**
2nd Ref

THE FLORIDA SENATE
APPEARANCE RECORD

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

3/7/13

Meeting Date

Topic Regulation of Smoking

Bill Number 258
(if applicable)

Name Susan Harbin

Amendment Barcode _____
(if applicable)

Job Title Legislative Advocate

Address 110 S Monroe
Street
Tall FL 32301
City State Zip

Phone 850 922-4300

E-mail sharbin@fl-counties.com

Speaking: ☒ For ☐ Against ☐ Information

Representing FL Association of Counties

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)

Meeting Date _____

Topic CLEAN INDOOR AIR

Bill Number SB 258
(if applicable)

Name BETH LABASKY

Amendment Barcode _____
(if applicable)

Job Title DIR GOVT RELATIONS

Address 13211 BONEY RD
Street
JACKSONVILLE FLA 32226
City State Zip

Phone 850-322-7335

E-mail bethlabasky@
aol.com

Speaking: ☒ For ☐ Against ☐ Information

Representing Alpha One Program + COPD FOUNDATION

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.

THE FLORIDA SENATE
APPEARANCE RECORD

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

3/7/13

Meeting Date

Topic Smoking

Bill Number 258
(if applicable)

Name Warren Husband

Amendment Barcode 731142
(if applicable)

Job Title _____

Address PO Box 10909

Phone 850 205 9000

Street

Tallahassee FL 32302

City

State

Zip

E-mail _____

Speaking: ☒ For ☐ Against ☐ Information

Representing Fla. Restaurant and Lodging Assoc.

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.

THE FLORIDA SENATE
APPEARANCE RECORD



3/7/13

Meeting Date

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

Topic SB 258

Bill Number SB 258
(if applicable)

Name Casey Cook

Amendment Barcode _____
(if applicable)

Job Title Legislative Advocate

Address PO Box 1757
Street

Phone 850 701 3701

Tallahassee FL 32302
City State Zip

E-mail ccook@flcities.com

Speaking: ☒ For ☐ Against ☐ Information

Representing Florida League of Cities

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)

3-7-13

Meeting Date

Topic Smoking - Clean Indoor Air Act Bill Number 258
Name Marshall Hosack (if applicable)
Job Title Intergovernmental Relations Manager Amendment Barcode _____ (if applicable)
Address 1660 Ringling Blvd Phone 941 650-6968
Street City State Zip E-mail mhosack@segov.net
Sarasota Fl. 34236
Speaking: ☒ For ☐ Against ☐ Information
Representing Sarasota County
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)



3/7/13

Meeting Date

Topic _____

Bill Number 258
(if applicable)

Name Chris Noland

Amendment Barcode _____
(if applicable)

Job Title _____

Address 1000 Riverside Ave #115
Street
Jacksonville, FL 32204
City State Zip

Phone 904-355-1555

E-mail nolandc@aol.com

Speaking: ☒ For ☐ Against ☐ Information

Representing Florida Public Health 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
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 Committee on Health Policy

BILL: CS/SB 536

INTRODUCER: Health Policy Committee and Senator Detert

SUBJECT: Physical Therapy

DATE: March 7, 2013

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	McElheney	Stovall	HP	Fav/CS
2.			BI	
3.			RC	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

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

I. Summary:

CS/SB 536 amends the definition of the practice of physical therapy by adding an advanced registered nurse practitioner (ARNP) to the practitioners who may authorize a physical therapist to implement a plan of treatment provided for a patient.

This bill substantially amends section 486.021 of the Florida Statutes.

II. Present Situation:

Physical Therapy Practice

Physical therapy includes assessment of the function of the musculoskeletal or neuromuscular system, including range of motion of a joint, motor power, postural attitudes, biomechanical function, locomotion, or functional abilities and the treatment or rehabilitation of any disability, injury, disease, or other health condition of human beings. A variety of aids may be used in treatment or rehabilitation, including air, electricity, exercise, massage, acupuncture under certain conditions, radiant energy, ultrasound, water, and various apparatus and equipment.¹

¹ See s. 486.021(10) and (11), F.S.

Physical therapists are licensed under ch. 486, F.S., the Physical Therapy Practice Act (the Act). A physical therapist is a person who is licensed and who practices physical therapy in accordance with the provisions of the Act. The Board of Physical Therapy Practice (Board) established within the Department of Health is responsible for implementing and administering the Act.

Currently, a physical therapist may implement a plan of treatment for a patient for up to 21 days for a condition not previously assessed by a practitioner of record. A practitioner of record may be a chiropractor, podiatrist, dentist, or a practitioner licensed under the medical practice act or osteopathic medical practice act. If treatment is needed beyond 21 days, the plan must be reviewed and signed by a practitioner of record.

A physical therapist is required to refer a patient to or consult with a practitioner of record if a patient's condition is found to be outside the scope of physical therapy. In addition, a physical therapist may not implement a plan of treatment for a patient who is currently being treated in a facility licensed pursuant to chapter 395 (hospital).²

Current statutes do not specifically authorize a physical therapist to implement a plan of treatment (accept a referral) provided by an ARNP, although it is within the ARNP's scope of practice to order physical therapy pursuant to a standing protocol with the supervising physician. Since 1998, at least three Declaratory Statements have been received and addressed by the Board relating to the ability of physical therapists to accept referrals from an ARNP or from a physician assistant. In two of the instances, the Board indicated that physical therapists could accept referrals from an ARNP as well as a physician assistant. In the third and most recent statement, the Board indicated that s. 486.021, F.S., did not provide for accepting referrals from an ARNP.³

Advanced Registered Nurse Practitioners (ARNP)

An ARNP is defined in s. 464.003, F.S., to be any person licensed in this state to practice professional nursing and certified in advanced or specialized nursing practice, including certified registered nurse anesthetists, certified nurse midwives, and nurse practitioners. An ARNP may perform acts of nursing diagnosis and nursing treatment of alterations of the health status. An ARNP may also perform acts of medical diagnosis and treatment, prescription, and operation which are identified and approved by a joint committee appointed by the Board.⁴

An ARNP may perform the following functions within the framework of an established protocol with a supervising physician which is filed with the Board:

- Monitor and alter drug therapies.
- Initiate appropriate therapies for certain conditions.
- Perform additional functions as determined by rule.

² See Department of Health Bill Analysis for SB 536 (dated January 24, 2013) on file with the Senate Health Policy Committee.

³ Supra, fn 1

⁴ s. 464.003(2), F.S.

- Order diagnostic tests, *physical therapy*, and occupational therapy.⁵

III. Effect of Proposed Changes:

Section 486.021, F.S., authorizes a physical therapist to implement a plan of treatment ordered by an ARNP as well as a practitioner of record.

This bill does not expand the scope of practice of an ARNP. It also does not designate an ARNP as a practitioner of record for purposes of referrals that a physical therapist must make if a patient's condition is found to be outside the scope of physical therapy or when physical therapy treatment for a patient is required beyond 21 days for a condition not previously assessed by a practitioner of record.

The bill restructures the definition of "practice of physical therapy" for clarity and makes other grammatical improvements.

The effective date of the bill is July 1, 2013.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Physical therapists will be able to implement plans of treatment ordered by an ARNP. This will facilitate delivery of health care services in a more cost effective manner.

C. Government Sector Impact:

None.

⁵ See s. 464.012(3), F.S.

VI. Technical Deficiencies:

None.

VII. Related Issues:

An ARNP is not added to the definition of practitioner of record, which perpetuates the limitation on an ARNP's otherwise lawful scope of practice with respect to ordering physical therapy.

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 Policy on March 7, 2013:

The CS reinstates the authority for a physical therapist to implement a plan of treatment after his or her own assessment and authorizes a physical therapist to implement a plan of treatment issued by an ARNP.

- B. **Amendments:**

None.



340402

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/07/2013	.	
	.	
	.	
	.	

The Committee on Health Policy (Sobel) recommended the following:

Senate Amendment

Delete lines 32 - 35
and insert:

(a) A physical therapist may implement a plan of treatment developed by the physical therapist for a patient or provided for a patient by a practitioner of record or by an advanced registered nurse practitioner licensed under s. 464.012. The physical therapist shall refer the patient to or

By Senator Detert

28-00687-13

2013536__

1 A bill to be entitled
2 An act relating to physical therapy; amending s.
3 486.021, F.S.; authorizing physical therapists to
4 implement physical therapy treatment plans of a
5 specified duration which are provided by advanced
6 registered nurse practitioners; providing an effective
7 date.
8

9 Be It Enacted by the Legislature of the State of Florida:
10

11 Section 1. Subsection (11) of section 486.021, Florida
12 Statutes, is amended to read:

13 486.021 Definitions.—In this chapter, unless the context
14 otherwise requires, the term:

15 (11) "Practice of physical therapy" means the performance
16 of physical therapy assessments and the treatment of any
17 disability, injury, disease, or other health condition of human
18 beings, or the prevention of such disability, injury, disease,
19 or other condition of health, and rehabilitation as related
20 thereto by the use of the physical, chemical, and other
21 properties of air; electricity; exercise; massage; the
22 performance of acupuncture only upon compliance with the
23 criteria set forth by the Board of Medicine, when no penetration
24 of the skin occurs; the use of radiant energy, including
25 ultraviolet, visible, and infrared rays; ultrasound; water; the
26 use of apparatus and equipment in the application of the
27 foregoing or related thereto; the performance of tests of
28 neuromuscular functions as an aid to the diagnosis or treatment
29 of any human condition; or the performance of electromyography

28-00687-13

2013536__

as an aid to the diagnosis of any human condition only upon compliance with the criteria set forth by the Board of Medicine.

(a) A physical therapist may implement a plan of treatment provided for a patient by a practitioner of record or by an advanced registered nurse practitioner licensed under s. 464.012. The physical therapist shall refer the patient to or consult with a ~~health care practitioner of record licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466,~~ if the patient's condition is found to be outside the scope of physical therapy. If physical therapy treatment for a patient is required beyond 21 days for a condition not previously assessed by a practitioner of record, the physical therapist shall obtain a practitioner of record who will review and sign the plan. For purposes of this paragraph, a health care practitioner licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 and engaged in active practice is eligible to serve as a practitioner of record.

(b) The use of roentgen rays and radium for diagnostic and therapeutic purposes and the use of electricity for surgical purposes, including cauterization, are not ~~authorized under the term "physical therapy" for purposes of as used in~~ this chapter.

(c) The practice of physical therapy ~~as defined in this chapter~~ does not authorize a physical therapy practitioner to practice chiropractic medicine as defined in chapter 460, including specific spinal manipulation. For the performance of specific chiropractic spinal manipulation, a physical therapist shall refer the patient to a health care practitioner licensed under chapter 460.

(d) ~~Nothing in~~ This subsection does not authorize

28-00687-13

2013536__

59 ~~authorizes~~ a physical therapist to implement a plan of treatment
60 for a patient currently being treated in a facility licensed
61 pursuant to chapter 395.

62 Section 2. This act shall take effect July 1, 2013.

THE FLORIDA SENATE
APPEARANCE RECORD

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

3/7/13

Meeting Date

Topic _____

Bill Number 536
(if applicable)

Name Leslie Dughi

Amendment Barcode _____
(if applicable)

Job Title _____

Address _____
Street

Phone _____

City _____ State _____ Zip _____

E-mail dughi1@gtlaw.com

Speaking: ☒ For ☐ Against ☐ Information

Representing Associated Industries

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)

03/07/13

Meeting Date

Topic _____

Bill Number 536
(if applicable)

Name TAD Fisher

Amendment Barcode _____
(if applicable)

Job Title CEO

Address 2104 Delta Way, S-7
Street

Phone 850-222-1243

Tallahassee
City State Zip

E-mail TFisher@PTA.org

Speaking: ☒ For ☐ Against ☐ Information

Representing Florida Physical Therapy 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)



3/7/13

Meeting Date

Topic Physical Therapy

Bill Number SB 536
(if applicable)

Name Martha DeCastro

Amendment Barcode _____
(if applicable)

Job Title Vice President for Nursing

Address 306 East College Avenue
Street
Tallahassee Florida 32301
City State Zip

Phone 850-222-9800

E-mail martha@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)

3-7-13

Meeting Date

Topic PHYSICAL Therapy

Bill Number 536
(if applicable)

Name ALLISON CARVAJAL (CAR-VA-HALL)

Amendment Barcode _____
(if applicable)

Job Title Consultant

Address 120 S. MONROE ST.

Phone 727-7087

Street

TALLAHASSEE

FL.

32301

City

State

Zip

E-mail allison@rambaconsulting.com

Speaking: ☐ For ☐ Against ☒ Information

Representing FLORIDA Nurse Practitioner Network Waive in support

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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



THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:

Commerce and Tourism, *Chair*
Appropriations Subcommittee on Education
Appropriations Subcommittee on General
Government
Banking and Insurance
Children, Families, and Elder Affairs
Regulated Industries

JOINT COMMITTEE:

Joint Administrative Procedures Committee

SENATOR NANCY C. DETERT

28th District

March 7, 2013

The Honorable Aaron Bean
Chair
Senate Health Policy Committee
530 Knott Building
404 S. Monroe Street
Tallahassee, FL 32399-1100

Dear Mr. Chair:

I respectfully request that my legislative assistant, Charlie Anderson, be allowed to present Senate Bill 536 before the Senate Health Policy Committee this morning. I apologize that I cannot be present but I have two other bills up in Senate Community Affairs and one of them is a Commerce Committee bill.

Thank you for your consideration of this request.

Sincerely,

Nancy C. Detert

NCD/ca

cc: Sandra Stovall, Staff Director
Celia Georgiades

REPLY TO:

- ☐ 417 Commercial Court, Suite D, Venice, Florida 34292 (941) 480-3547 FAX: (941) 480-3549
- ☐ 416 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5028

Senate's Website: www.flsenate.gov

DON GAETZ
President of the Senate

GARRETT RICHTER
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 Committee on Health Policy

BILL: CS/SB 844

INTRODUCER: Health Policy Committee and Senator Grimsley

SUBJECT: Medicaid Fraud

DATE: March 7, 2013

REVISED: _____

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. Lloyd	Stovall	HP	Fav/CS
2. _____	_____	BI	_____
3. _____	_____	AHS	_____
4. _____	_____	AP	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

Please see Section VIII. for Additional Information:

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

I. Summary:

CS/SB 844 modifies existing statutory provisions relating to fraud and abuse, provider controls and accountability in the Medicaid program. These modifications include the following:

- Increasing the length of time for retaining all medical and Medicaid related records from 5 to 6 years for Medicaid providers;
- 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 “administrative fines” for purposes of liability for payment of such fines in the event of a change of ownership;
- Authorizing, rather than requiring, the AHCA to perform 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 that provider’s ability to provide services in compliance with the Medicaid program and professional regulations;
- Providing definition for principals of a provider with a controlling interest for hospitals and nursing homes for purposes of conducting criminal background checks;
- Removing certain exceptions to background screenings requirements for Medicaid providers;

- Expanding the list of offenses for which the AHCA may 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 their Medicaid provider number under certain circumstances;
- Requiring that when the AHCA determines that an overpayment has been made that the AHCA must base their determination solely on the information available before the issuance of an audit report and upon contemporaneous records;
- Clarifying when the interest rate accrues on provider payments paid by the AHCA that had been withheld on a suspicion of fraud or abuse, if it is determined that there was no fraud or abuse;
- Removing the 30 day time provision related to records that may be presented to contest an overpayment or sanction;
- Requiring overpayments or fines be paid to the AHCA within 30 days after the date of the final order and are not subject to further appeal; and,
- Clarifying the scope of immunity from civil liability for persons who report fraudulent acts or suspected fraudulent acts and providing a definition of fraudulent acts.

CS/SB 844 is not expected to have any fiscal impact on state government as AHCA reports that any workload increases can be absorbed within existing resources.

The act takes effect July 1, 2013.

This bill substantially amends, the following sections of the Florida Statutes: 409.907, 409.913, and 409.920.

II. Present Situation:

Health Care Fraud

In 2009, the Legislature passed CS/CS/CS/SB 1986, a comprehensive bill designed to address systematic 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 standards to keep fraudulent actors from obtaining a health care license in Florida; and created disincentives to commit 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.

With more than 3 years experience with the implementation of CS/CS/CS/SB 1986, some changes have been identified which would enhance Florida's efforts to prevent additional health care fraud and abuse in Florida's Medicaid program. This bill addresses some of the gaps in enforcement authority, strengthens the reporting requirements by Medicaid providers and Medicaid managed care organizations and defines the consequences for failure to comply with the requirements.

Agency Regulatory Authority

The AHCA regulates hospitals and nursing homes under the authority of chapters 395 and 400, F.S., respectively, along with dozens of other health care entities such as clinical laboratories, ambulatory surgical centers, hospices, and home health agencies. General licensing provisions for these providers are found in part II of ch. 408, F.S. The Bureau for Health Facility Regulation conducts the activities that certify and license the entities under the AHCA's jurisdiction.

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 costs of nursing facility care and other medical expenses. The AHCA is designated as the single state agency responsible for Medicaid. Medicaid serves approximately 3.3 million people in Florida. The statutory authority for the Medicaid program is contained in ch. 409, F.S.

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 Medicaid 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, authority for AHCA site visits of provider service locations, and surety bond requirements.

Under s. 409.913, F.S., the AHCA is responsible for overseeing the integrity of the Medicaid program, to ensure the 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. A person who provides the State with information about fraud or suspected fraud by a Medicaid provider, including a managed care organization, is immune from civil liability for providing that information unless the person knew the information was false or acted with reckless disregard for the truth or falsity of the information.¹

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 care medical assistance program. The law directs the AHCA to begin implementation of the long term managed care program by July 1, 2012, with full implementation in all regions of the State by October 1, 2013. The State received federal approval of this program on February 1, 2013.² Although the AHCA has

¹ See s. 409.920(8), F.S.

² Agency for Health Care Administration, *February 1, 2013 Waiver Approval Letter*, http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Signed_approval_FL0962_new_1915c_02-01-2013.pdf (Last visited on March 4, 2013).

received conditional approval,³ the AHCA is still awaiting final approval of the managed medical assistance program whose full implementation is anticipated by October 1, 2014.

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 screenings 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 408.809, 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.

III. Effect of Proposed Changes:

Section 1 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 the Health Insurance Portability and Accountability Act (HIPAA) of 1996 administrative simplification rules.⁴

The bill requires a Medicaid provider to report in writing any change of any principal of the provider whose ownership interest is equal to 5 percent or more to the AHCA no later than 30 days after the change occurs. The bill specifies who is included in the term “principal.” The definition of a controlling interest is already defined by statute under s. 408.803(7), F.S. and includes:

- The applicant or licensee,
- A person or entity that serves as an officer of, is on the board or has a 5 percent or greater ownership interest in the applicant or licensee; or,

³ Agency for Health Care Administration, *February 20, 2013 Agreement in Principle Letter*, http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/Letter_from_CMS_re_Agreement_in_Principle_2013-02-20.pdf (Last visited on March 4, 2013).

⁴ 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 March 1, 2013).

- A person or entity that serves as an officer of, is on the board or has a 5 percent or greater management interest in the management company or other entity, related or unrelated, that the applicant or licensee contracts with to manage the provider.
- The term does not include a voluntary board member.

The bill clarifies 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 that 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 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 Families, 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 existing surety bond requirements for certain Medicaid providers to clarify that the additional bond required by the AHCA, if a provider’s billing during the first year exceeds the bond amount, need not exceed \$50,000 for certain providers. A provider could have a bond greater than \$50,000, if the provider so elected.

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., under the general licensing provisions for health care facilities regulated by the AHCA.

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 2 amends s. 409.913, F.S., relating to oversight of the integrity of the Medicaid program. The bill amends the length of time that Medicaid providers are required to retain their records to be consistent with federal law. 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. The change will resolve a current conflict with the Administrative Procedures Act.⁵

The AHCA 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.

⁵ See s. 120.569(2)(n), F.S. which requires that "if any agency head finds that an immediate danger to the public health, safety, or welfare requires an immediate final order, it shall recite with particularity the facts underlying such finding in the final order, which shall be appealable or enjoined from the date ordered."

- 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 CS 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 it is going to be suspended or terminated, the provider is 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 the 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 a provider may not present records to contest a sanction that is not based upon contemporaneous records and, if requested during the audit process, were provided to the AHCA or its agent upon request. 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 clarify when interest accrues on provider payments withheld by the AHCA based on suspected fraud or criminal activity, if it is determined that there was no fraud or that a crime did not occur. Interest on provider payments to be paid after an investigation will accrue at 10 percent a year beginning after the 14th day. A provision relating to the placement of funds in a suspended account held by the AHCA is deleted and a payment deadline of 14 days to the provider is removed. 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 (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 pay 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 3 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 immunity from civil liability to include actual or suspected fraud and abuse, insurance fraud, licensure fraud or public insurance fraud; 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, including forums, and incorporates 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 4 provides an effective date of July 1, 2013.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Entities and individual health care providers under Medicaid currently exempt from background checks will be required to complete the same requirements as other Medicaid providers.

The total fee for a Level 2 background screening is \$64.50 (\$24.00 for the state portion, \$16.50 for the national portion, and \$24.00 for retention). There is an additional fee of \$11-\$16 for electronic screening, depending on the provider. The cost of the screening is borne by the individual provider.⁶

C. Government Sector Impact:

The agency reports no fiscal impact. Medicaid contract management believes there may be an increase in initial screenings of registered treating providers, but does not believe this will have a fiscal impact on the agency.⁷

The Department of Children and Families did not report any fiscal impact.

To the extent that a governmental entity has providers or is a provider that are not currently required to provide a completed background checks prior to Medicaid provider enrollment and not otherwise exempt, additional costs may be incurred to comply with this requirement.

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 Policy on March 7, 2013

CS/SB 844 deletes a separate requirement for Level 2 background checks of providers under contract with Medicaid managed care networks. All Medicaid providers participating under fee for service must still comply with this requirement. The CS removed a provision relating to the coordination of anti-fraud report reviews between the Department of Financial Services and the AHCA. The CS does not include the provision allowing the AHCA to consider information from non-Medicaid providers during an investigation. The CS also removed the 30-day provision related to records that may be presented to contest an overpayment or sanction. Interest payments to the providers that

⁶ Agency for Health Care Administration, *supra*, note 1 at 6.

⁷ Agency for Health Care Administration, *supra*, note 1 at 5.

had been withheld are reinstated in the CS and the timeframe for when interest is applied is clarified.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.



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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/07/2013	.	
	.	
	.	
	.	

The Committee on Health Policy (Grimsley) recommended the following:

Senate Amendment (with title amendment)

Delete lines 201 - 655
and insert:

(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



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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. 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.

(a) 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



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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 2. Subsections (9), (13), (15), (16), (21), (22), (25), (28), (30) and (31) of section 409.913, Florida Statutes, 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



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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



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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.

(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 must keep ~~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 interest in the provider equal to 5 percent or greater, has been



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convicted of a criminal offense under federal law or the law of any state relating to the practice of the provider's profession, or a criminal 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 take final agency action ~~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



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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



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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 an 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;



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(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 for ~~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 ranging ~~of~~ from more than 1 year to 20 years. Termination precludes ~~shall~~



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preclude participation in the Medicaid program, which includes any action that results in a claim for payment to the Medicaid program ~~for 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



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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 or an associated license, or allows the associated licensure to expire after receiving written notice that the agency is conducting, or has conducted, an audit, survey, inspection, or investigation and that a sanction of suspension or termination will or would be imposed for noncompliance discovered as a result of the audit, survey, inspection, 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



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occurred, the agency shall prepare and issue an audit report to the provider showing the calculation of overpayments. The agency's determination must 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. A provider may not present records to contest an overpayment or sanction unless such records are contemporaneous and, if requested during the audit process, were furnished to the agency or its agent upon request or were furnished within 30 days after the provider received the final audit report. This limitation does not apply to Medicaid cost report audits. 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



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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 must be made within 30 days after the date of the final order, which is not subject to further appeal, and all appeals have been exhausted ~~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.~~



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(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.

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

And the title is amended as follows:

Delete lines 13 - 21

and insert:

409.913, F.S.; increasing the number of years a



852784

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/07/2013	.	
	.	
	.	
	.	

The Committee on Health Policy (Garcia) recommended the following:

Senate Amendment to Amendment (861804)

Delete lines 321 - 327
and insert:
provider's business. A provider may not present records to
contest an overpayment or sanction unless such records are
contemporaneous and, if requested during the audit process, were
furnished to the agency or its agent upon request. This
limitation does not apply to Medicaid cost report audits.
Notwithstanding the applicable rules of



437058

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/07/2013	.	
	.	
	.	
	.	

The Committee on Health Policy (Garcia) recommended the following:

Senate Amendment to Amendment (861804) (with title amendment)

Delete lines 339 - 360
and insert:
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~~



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~~within 14 days.~~ Amounts not paid within 14 days accrue interest at the rate of 10 percent a year, beginning after the 14th day.

(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 final determination of the overpayment by the agency, and payment arrangements must be made within 30 days after the date of the final order, which is 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.~~

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

And the title is amended as follows:

Delete lines 379 - 381

and insert:

Delete lines 13 - 31

and insert:

409.913, F.S.; increasing the number of years a provider must keep records; revising provisions specifying grounds for terminating a provider from the program, for seeking certain remedies for violations, and for imposing certain sanctions; providing a limitation on the information the agency may consider when making a determination of overpayment; specifying



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42 the type of records a provider must present to contest
43 an overpayment; deleting the requirement that the
44 agency place payments withheld from a provider in a
45 suspended account and revising when a provider must
46 reimburse

By Senator Grimsley

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A bill to be entitled
An act relating to Medicaid fraud; amending s.
409.907, F.S.; increasing the number of years a
provider must keep records; adding an additional
provision relating to a change in principal that must
be included in a Medicaid provider agreement with the
Agency for Health Care Administration; adding
definitions for "administrative fines" and
"outstanding overpayment"; revising provisions
relating to the agency's onsite inspection
responsibilities; revising provisions relating to who
is subject to background screening; amending s.
409.91212, F.S.; requiring the agency to enter into an
interagency agreement with the Division of Insurance
Fraud regarding anti-fraud plans by managed care
plans; delaying the imposition of certain fines for
failing to report; amending s. 409.913, F.S.;
authorizing the agency to review and analyze sources
other than providers in order to carry out its duties
with respect to its Medicaid oversight
responsibilities; increasing the number of years a
provider must keep records; revising provisions
specifying grounds for terminating a provider from the
program, for seeking certain remedies for violations,
and for imposing certain sanctions; providing a
limitation on the information the agency may consider
when making a determination of overpayment; specifying
the type of records a provider must present to contest
an overpayment; deleting the requirement that the

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agency pay interest on certain payments withheld from a provider and revising when a provider must reimburse overpayments; revising venue requirements; adding provisions relating to the payment of fines; amending s. 409.920, F.S.; clarifying provisions relating to immunity from liability for persons who provide information about Medicaid fraud; providing an effective date.

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

Section 1. Paragraph (c) of subsection (3) of section 409.907, Florida Statutes, is amended and 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~~

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59 ~~period of 5~~ years to satisfy all necessary inquiries by the
60 agency.

61 (k) Report a change in any principal of the provider,
62 including any officer, director, agent, managing employee, or
63 affiliated person, or any partner or shareholder who has an
64 ownership interest equal to 5 percent or more in the provider,
65 to the agency in writing within 30 days after the change occurs.
66 For a hospital licensed under chapter 395 or a nursing home
67 licensed under part II of chapter 400, a principal of the
68 provider is one who meets the definition of a controlling
69 interest under s. 408.803.

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

74 (a) If there is ~~In the event of~~ a change of ownership, the
75 transferor remains liable for all outstanding overpayments,
76 administrative fines, and any other moneys owed to the agency
77 before the effective date of the change ~~of ownership~~. ~~In~~
78 ~~addition to the continuing liability of the transferor,~~ The
79 transferee is also liable to the agency for all outstanding
80 overpayments identified by the agency on or before the effective
81 date of the change of ownership. ~~For purposes of this~~
82 ~~subsection, the term "outstanding overpayment" includes any~~
83 ~~amount identified in a preliminary audit report issued to the~~
84 ~~transferor by the agency on or before the effective date of the~~
85 ~~change of ownership.~~ In the event of a change of ownership for a
86 skilled nursing facility or intermediate care facility, the
87 Medicaid provider agreement shall be assigned to the transferee

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88 if the transferee meets all other Medicaid provider
89 qualifications. In the event of a change of ownership involving
90 a skilled nursing facility licensed under part II of chapter
91 400, liability for all outstanding overpayments, administrative
92 fines, and any moneys owed to the agency before the effective
93 date of the change of ownership shall be determined in
94 accordance with s. 400.179.

95 (b) At least 60 days before the anticipated date of the
96 change of ownership, the transferor must ~~shall~~ notify the agency
97 of the intended change ~~of ownership~~ and the transferee must
98 ~~shall~~ submit to the agency a Medicaid provider enrollment
99 application. If a change of ownership occurs without compliance
100 with the notice requirements of this subsection, the transferor
101 and transferee are ~~shall be~~ jointly and severally liable for all
102 overpayments, administrative fines, and other moneys due to the
103 agency, regardless of whether the agency identified the
104 overpayments, administrative fines, or other moneys before or
105 after the effective date of the change ~~of ownership~~. The agency
106 may not approve a transferee's Medicaid provider enrollment
107 application if the transferee or transferor has not paid or
108 agreed in writing to a payment plan for all outstanding
109 overpayments, administrative fines, and other moneys due to the
110 agency. This subsection does not preclude the agency from
111 seeking any other legal or equitable remedies available to the
112 agency for the recovery of moneys owed to the Medicaid program.
113 In the event of a change of ownership involving a skilled
114 nursing facility licensed under part II of chapter 400,
115 liability for all outstanding overpayments, administrative
116 fines, and any moneys owed to the agency before the effective

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117 date of the change of ownership shall be determined in
118 accordance with s. 400.179 if the Medicaid provider enrollment
119 application for change of ownership is submitted before the
120 change ~~of ownership~~.

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

122 1. "Administrative fines" includes any amount identified in
123 a notice of a monetary penalty or fine which has been issued by
124 the agency or other regulatory or licensing agency that governs
125 the provider.

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

129 ~~(7) The agency may require,~~ As a condition of participating
130 in the Medicaid program and before entering into the provider
131 agreement, the agency may require ~~that~~ the provider to submit
132 information, in an initial and any required renewal
133 applications, concerning the professional, business, and
134 personal background of the provider and permit an onsite
135 inspection of the provider's service location by agency staff or
136 other personnel designated by the agency to perform this
137 function. Before entering into a provider agreement, the agency
138 ~~may shall~~ perform an a-random onsite inspection, ~~within 60 days~~
139 ~~after receipt of a fully complete new provider's application,~~ of
140 the provider's service location ~~prior to making its first~~
141 ~~payment to the provider for Medicaid services to determine the~~
142 ~~applicant's ability to provide the services~~ in compliance with
143 the Medicaid program and professional regulations ~~that the~~
144 ~~applicant is proposing to provide for Medicaid reimbursement.~~
145 ~~The agency is not required to perform an onsite inspection of a~~

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~~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 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

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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 the Federal Government.

(b) Information concerning any prior violation, fine, suspension, termination, or other administrative action taken under the Medicaid laws or ~~rules, or regulations~~ of this state or of any other state or the Federal Government; any prior violation of the laws or ~~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 or ~~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,

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including Medicaid managed care network providers, 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. 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.

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(a) 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 2. Subsections (1) and (6) of section 409.91212, Florida Statutes, are amended to read:

409.91212 Medicaid managed care fraud.—

(1) Each managed care plan, as defined in s. 409.920(1)(e), shall adopt an anti-fraud plan addressing the detection and prevention of overpayments, abuse, and fraud relating to the

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provision of and payment for Medicaid services and submit the plan to the Office of Medicaid Program Integrity within the agency for approval. The office shall enter into an interagency agreement with the Division of Insurance Fraud in the Department of Financial Services which delineates the responsibilities of the agency in reviewing and approving anti-fraud plans for entities that are also required to submit anti-fraud plans under s. 626.9891. At a minimum, the anti-fraud plan must include:

(a) A written description or chart outlining the organizational arrangement of the plan's personnel who are responsible for the investigation and reporting of possible overpayment, abuse, or fraud;

(b) A description of the plan's procedures for detecting and investigating possible acts of fraud, abuse, and overpayment;

(c) A description of the plan's procedures for the mandatory reporting of possible overpayment, abuse, or fraud to the Office of Medicaid Program Integrity within the agency;

(d) A description of the plan's program and procedures for educating and training personnel on how to detect and prevent fraud, abuse, and overpayment;

(e) The name, address, telephone number, e-mail address, and fax number of the individual responsible for carrying out the anti-fraud plan; and

(f) A summary of the results of the investigations of fraud, abuse, or overpayment which were conducted during the previous year by the managed care organization's fraud investigative unit.

(6) Each managed care plan shall report all suspected or

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confirmed instances of provider or recipient fraud or abuse within 15 calendar days after detection to the Office of Medicaid Program Integrity within the agency. At a minimum the report must contain the name of the provider or recipient, the Medicaid billing number or tax identification number, and a description of the fraudulent or abusive act. The office ~~of Medicaid Program Integrity in the agency~~ shall forward the report of suspected overpayment, abuse, or fraud to the appropriate investigative unit, including, but not limited to, the Bureau of Medicaid program integrity, the Medicaid fraud control unit, the Division of Public Assistance Fraud, the Division of Insurance Fraud, or the Department of Law Enforcement.

(a) Failure to timely report shall result in an administrative fine of \$1,000 per calendar day after the 60th ~~15th~~ day of detection.

(b) Failure to timely report may result in additional administrative, civil, or criminal penalties.

Section 3. Subsections (2), (9), (13), (15), (16), (21), (22), (25), (28), (29), (30) and (31) of section 409.913, Florida Statutes, 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

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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

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

359 (2) The agency shall conduct, or cause to be conducted by
360 contract or otherwise, reviews, investigations, analyses,
361 audits, or any combination thereof, to determine possible fraud,
362 abuse, overpayment, or recipient neglect in the Medicaid program
363 and ~~shall~~ report the findings of any overpayments in audit
364 reports as appropriate. At least 5 percent of all audits must
365 ~~shall~~ be conducted on a random basis. As part of its ongoing
366 fraud detection activities, the agency shall identify and
367 monitor, by contract or otherwise, patterns of overutilization
368 of Medicaid services based on state averages. The agency shall
369 track Medicaid provider prescription and billing patterns and
370 evaluate them against Medicaid medical necessity criteria and
371 coverage and limitation guidelines adopted by rule. Medical
372 necessity determination requires that service be consistent with
373 symptoms or confirmed diagnosis of illness or injury under
374 treatment and not in excess of the patient's needs. The agency
375 shall conduct reviews of provider exceptions to peer group norms
376 and ~~shall~~, using statistical methodologies, provider profiling,
377 and analysis of billing patterns, shall detect and investigate

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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 must keep ~~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 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 a criminal offense listed under s. 409.907(10), s. 408.809(4), or s. 435.04(2) ~~has been:~~

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~~(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 take final action ~~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

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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

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465 Medicaid provider enrollment application, a request for prior
466 authorization for Medicaid services, a drug exception request,
467 or a Medicaid cost report that contains materially false or
468 incorrect information;

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

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

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

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

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

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(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 for ~~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 ranging ~~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 for ~~as a result of~~ furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services.

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(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

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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 or an associated license, or allows the associated licensure to expire after receiving written notice that the agency is conducting, or has conducted, an audit, survey, inspection, or investigation and that a sanction of suspension or termination will or would be imposed for noncompliance discovered as a result of the audit, survey, inspection, 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 must be based solely upon information available to it before issuance of the audit report and, in the

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581 case of documentation obtained to substantiate claims for
582 Medicaid reimbursement, based solely upon contemporaneous
583 records.

584 (22) The audit report, supported by agency work papers,
585 showing an overpayment to a provider constitutes evidence of the
586 overpayment. A provider may not present or elicit testimony,
587 ~~either~~ on direct examination or cross-examination in any court
588 or administrative proceeding, regarding the purchase or
589 acquisition by any means of drugs, goods, or supplies; sales or
590 divestment by any means of drugs, goods, or supplies; or
591 inventory of drugs, goods, or supplies, unless such acquisition,
592 sales, divestment, or inventory is documented by written
593 invoices, written inventory records, or other competent written
594 documentary evidence maintained in the normal course of the
595 provider's business. A provider may not present records to
596 contest an overpayment or sanction unless such records are
597 contemporaneous and, if requested during the audit process, were
598 furnished to the agency or its agent upon request or were
599 furnished within 30 days after the provider received the final
600 audit report. This limitation does not apply to Medicaid cost
601 report audits. Notwithstanding the applicable rules of
602 discovery, all documentation to ~~that will~~ be offered as evidence
603 at an administrative hearing on a Medicaid overpayment or an
604 administrative sanction must be exchanged by all parties at
605 least 14 days before the administrative hearing or ~~must~~ be
606 excluded from consideration.

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

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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 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

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639 a superior right of payment. Upon receipt of such written
640 notification, the Medicare fiscal intermediary shall remit to
641 the state the sum claimed.

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

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

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

656 (30) The agency shall terminate a provider's participation
657 in the Medicaid program if the provider fails to reimburse an
658 overpayment or pay an agency-imposed fine that has been
659 determined by final order, not subject to further appeal, within
660 30 ~~35~~ days after the date of the final order, unless the
661 provider and the agency have entered into a repayment agreement.

662 (31) If a provider requests an administrative hearing
663 pursuant to chapter 120, such hearing must be conducted within
664 90 days following assignment of an administrative law judge,
665 absent exceptionally good cause shown as determined by the
666 administrative law judge or hearing officer. Upon issuance of a
667 final order, the outstanding balance of the amount determined to

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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 4. 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 ~~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. Such immunity extends to reports of fraudulent acts or suspected fraudulent acts conveyed to or from 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. For purposes of this subsection, the term "fraudulent acts" includes actual or suspected fraud and abuse, insurance fraud, licensure fraud, or public assistance fraud, including any fraud-related matters that a

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697 provider or health plan is required to report to the agency or a
698 law enforcement agency.

699 Section 5. This act shall take effect July 1, 2013.

THE FLORIDA SENATE
APPEARANCE RECORD

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

3/7/13

Meeting Date

Topic Medicaid Fraud

Bill Number HB 844
(if applicable)

Name Amy Christian

Amendment Barcode _____
(if applicable)

Job Title _____

Address 537 E Park Ave
Street

Phone _____

TLH FL 32301
City State Zip

E-mail amy@johnsonblanton.com

Speaking: ☒ For ☐ Against ☐ Information

Representing Florida Chamber of Commerce

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.

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 Committee on Health Policy

BILL: CS/SB 612

INTRODUCER: Health Policy Committee and Senator Galvano

SUBJECT: Health Care Practitioners

DATE: March 7, 2013

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Stovall	Stovall	HP	Fav/CS
2.			CJ	
3.			ACJ	
4.			AP	
5.				
6.				

Please see Section VIII. for Additional Information:

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

I. Summary:

CS/SB 612 provides additional grounds for licensure discipline if a person licensed under the Nurse Practice Act introduces himself or herself as “doctor” while rendering health care services but fails to orally disclose the appropriate title that corresponds with his or her nursing licensee.

This bill amends section 456.072 of the Florida Statutes.

II. Present Situation:

Chapter 464, F.S., is the Nurse Practice Act. The Board of Nursing, (board) created within the Department of Health is responsible for licensing and regulating nurses within the state. The board is under the Division of Medical Quality Assurance.

The following chart reflects the number of in-state active licenses by credential issued under the Nurse Practice Act as of June 30, 2012:¹

¹ Medical Quality Assurance 2011-2012 Annual Report, page 38, available at: <http://www.doh.state.fl.us/mqa/mqa2011-2012annualreport/> (Last visited Mar. 2, 2013).

Credential	In-State Active
Advanced Registered Nurse Practitioner (ARNP)	14,440
Advanced Registered Nurse Practitioner / Certified Nurse Specialist (ARNP/CNS)	21
Clinical Nurse Specialist (CNS)	87
Licensed Practical Nurse (LPN)	63,951
Registered Nurse (RN)	198,748
Certified Nursing Assistant (CNA) (part II of the Act)	<u>155,843</u>
Total in-state active licenses	433,090

Acts which constitute grounds for disciplinary sanctions specific to nurses are found in s. 464.018, F.S., for all nursing professions except for certified nursing assistants, which are found in s. 464.204, F.S. One of the grounds for disciplinary action in s. 464.018(g), F.S., is false, misleading, or deceptive advertising.²

The Nurse Practice Act also prohibits a person who does not hold a specific licensing credential referenced in the chart above from using the corresponding title or abbreviation.³ A violation of this law is classified as a misdemeanor of the first degree, punishable by a term of imprisonment not exceeding 1 year and / or a fine not to exceed \$1,000.

In addition to the regulation of nurses under the Nurse Practice Act, all health care practitioners in the state that are regulated under the Division of Medical Quality Assurance are subject to the general provisions under ch. 456, F.S. Acts which constitute grounds for disciplinary sanctions for all health care practitioners are found in s. 456.072, F.S. Two relevant grounds for disciplinary action under this section are:⁴

Making misleading, deceptive, or fraudulent representation in or related to the practice of the licensee's profession.

Failing to identify through written notice, which may include the wearing of a name tag, or orally to a patient the type of license under which the practitioner is practicing. Any advertisement for health care services naming the practitioner must identify the type of license the practitioner holds. However, this paragraph does not apply to a practitioner while the practitioner is providing services in a facility providing mental health or substance abuse services, hospitals and ambulatory surgical centers, nursing homes, or assisted living facilities.⁵

Administrative discipline may include letters of concern, reprimands, fines up to \$10,000, probation, and suspension or permanent revocation of a license. If the violation is for fraud or making a false or fraudulent representation, the board, or the department if there is no board, must impose a fine of \$10,000 per count or offense.⁶

² Disciplinary sanctions are administrative as provided in s. 456.072, F.S.

³ See s. 464.015, F.S.

⁴ s. 456.072(a) and (t), F.S.

⁵ Specifically excluded are facilities licensed under chapters 394, 395, 400, or 429, F.S.

⁶ s. 456.072(2)(d), F.S.

Under the Medical Practice Act, leading the public to believe that one is licensed as a medical doctor, or is engaged in the licensed practice of medicine, without holding a valid, active license is a misdemeanor of the first degree, punishable by a term of imprisonment not exceeding 1 year and / or a fine not to exceed \$1,000.⁷ A similar provision is not found under the Osteopathic Medical Practice Act.

Currently, nurses licensed under ch. 464, F.S., who have obtained a doctorate degree are not required to disclose that they are not a medical doctor or an osteopathic physician when rendering health care services.⁸

III. Effect of Proposed Changes:

The bill amends s. 456.072, F.S., pertaining to grounds for disciplinary action applicable to all health care practitioners regulated by the Division of Medical Quality Assurance. Another ground for disciplinary action is added if a nurse introduces himself or herself with the title of “doctor” while rendering health care services, without orally disclosing that he or she is a nurse practitioner, doctor of nursing practice, or the corresponding appropriate title that corresponds with the person’s license.

The effective date of this act is October 1, 2013.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

⁷ s. 458.327(2)(d), F.S.

⁸ Department of Health Bill Analysis for SB 612, dated February 18, 2013, on file with the Senate Health Policy Committee.

B. Private Sector Impact:

A nurses who introduces himself or herself as “doctor” without disclosing the appropriate licensure title may be subject to administrative penalties. Patients will be better informed as to the licensure credentials of the health care provider.

C. Government Sector Impact:

The Department of Health indicates the bill will require the board to adopt rules for disciplinary action and may also cause an increase in complaints and disciplinary actions; however these costs can be absorbed within current budget authority and resources.⁹

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 Policy on March 7, 2013:**

The CS removes the criminal violation and limits the action to introducing oneself as a doctor without orally disclosing the title of the licensee’s credential.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill’s introducer or the Florida Senate.

⁹ *Ibid.*



124818

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/07/2013	.	
	.	
	.	
	.	

The Committee on Health Policy (Grimsley) recommended the following:

Senate Amendment (with title amendment)

Delete lines 18 - 34
and insert:

(oo) Introducing oneself with the title of Doctor by a person licensed under chapter 464 while rendering health care services without orally disclosing that the licensee is a nurse practitioner, doctor of nursing practice or the corresponding appropriate title that corresponds with the person's license.

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

And the title is amended as follows:



124818

13 Delete lines 5 - 8
14 and insert:
15 introducing themselves as "Doctor" when rendering health
16 care; providing an effective date.

By Senator Galvano

26-00346A-13

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A bill to be entitled
An act relating to health care practitioners; amending
s. 456.072, F.S.; requiring that certain health care
practitioners make specified disclosures when
presenting themselves as "Doctor" or "Dr."; creating
s. 456.0675, F.S.; providing criminal penalties for
violations if there is an intent to mislead; providing
an effective date.

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

Section 1. Paragraph (oo) is added to subsection (1) of
section 456.072, Florida Statutes, to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which
the disciplinary actions specified in subsection (2) may be
taken:

(oo) Presenting oneself with the title of "Doctor" or the
abbreviation "Dr." as a name prefix by a person licensed under
chapter 464, whether orally or in writing, while rendering or
advertising health care services, without disclosing that the
licensee is not a medical doctor or an osteopathic physician.

Section 2. Section 456.0675, Florida Statutes, is created
to read:

456.0675 Penalty for misleading identification by a health
care practitioner.—In addition to, or in lieu of, any other
discipline imposed pursuant to s. 456.072, presenting oneself
with the title of "Doctor" or the abbreviation "Dr." as a name
prefix by a person licensed under chapter 464, while rendering

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30 or advertising health care services, without disclosing that the
31 licensee is not a medical doctor or an osteopathic physician,
32 and having intent to mislead, constitutes a felony of the third
33 degree, punishable as provided in s. 775.082, s. 775.083, or s.
34 775.084.

35 Section 3. This act shall take effect October 1, 2013.



THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Subcommittee on Education, *Chair*
Agriculture
Appropriations
Appropriations Subcommittee on Health
and Human Services
Education
Gaming
Health Policy
Regulated Industries
Rules

SENATOR BILL GALVANO
26th District

February 8, 2013

Senator Aaron Bean
302 Senate Office Building
404 South Monroe Street
Tallahassee, FL 32399

Dear Chairman Bean:

I respectfully request that SB 612, Health Care Practitioners, be scheduled for a hearing in the Committee on Health Policy at your earliest convenience.

If I may be of assistance to you on this or any other matter, please do not hesitate to contact me. Thank you for your consideration of this matter.

Sincerely,

Bill Galvano

cc: Sandra Stovall
Celia Georgiades

 **ENTERED**

REPLY TO:

- ☐ 1023 Manatee Avenue West, Suite 201, Bradenton, Florida 34205
- ☐ 326 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5026

Senate's Website: www.flsenate.gov

DON GAETZ
President of the Senate

GARRETT RICHTER
President Pro Tempore



THE FLORIDA SENATE
APPEARANCE RECORD

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

3-7-2013

Meeting Date

Topic HEALTH CARE PRACTITIONERS

Bill Number SB 612

(if applicable)

Name STEPHEN R. WINN

Amendment Barcode _____

(if applicable)

Job Title EXECUTIVE DIRECTOR

Address 2007 APALACHEE PARKWAY

Phone 878-7463

Street

TALLAHASSEE

FL

32301

City

State

Zip

Speaking:

☒ For

☐ Against

☐ Information

E-mail _____

WAIVE IN SUPPORT

Representing

FLORIDA OSTEOPATHIC MEDICAL 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.

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S-001 (10/20/11)

APPEARANCE RECORD

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3/7/13

Meeting Date

Topic _____

Bill Number 612

(if applicable)

Name Chris Nuland

Amendment Barcode _____

(if applicable)

Job Title _____

Address 1000 Riverside Ave #115

Phone 904-355-1555

Street

Jacksonville FL 32204

E-mail nulandlaw@aol.com

City

State

Zip

Speaking: ☒ For ☐ Against ☐ Information

Representing Florida Chapter, American College of Surgeons

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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THE FLORIDA SENATE

APPEARANCE RECORD

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Meeting Date _____

Topic _____ Bill Number 612 (if applicable)

Name MICHAEL ZIMMER Amendment Barcode _____ (if applicable)

Job Title PRESIDENT FLORIDA CHAPTER PHYSICIANS

Address AMERICAN COLLEGE Phone 727 549 759

Street 777 CAPITAL CT NE
City ST PETE State FL Zip 33703

E-mail THEFLORIDAZIMMERS
@MSN.COM

Speaking: ☒ For ☐ Against ☐ Information

Representing FL CHAPTER AMERICAN COLLEGE PHYSICIANS

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

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3/7/13

Meeting Date

Topic _____

Bill Number 612
(if applicable)

Name John Langdon, MD

Amendment Barcode _____
(if applicable)

Job Title _____

Address 412 POINCIANA
Street

Phone _____

WINTER PARK
City State Zip

E-mail Florida chapter American College of Physicians

Speaking: ☒ For ☐ Against ☐ Information

Representing FL Chapter American College of Physicians

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
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3-7-2013

Meeting Date

Topic Health Care Practitioners

Bill Number 0612
(if applicable)

Name Layne Smith

Amendment Barcode 124818
(if applicable)

Job Title Director, State Government Relations

Address 4500 San Pablo Road
Street
Jacksonville FL 32224
City State Zip

Phone 904-953-7334

E-mail smith.layne@mayo.edu

Speaking: ☒ For ☐ Against ☐ Information

Representing Mayo Clinic

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)

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3/8

Meeting Date

Amendment

Topic Nurses

Bill Number Q12
(if applicable)

Name Alisa Snow

Amendment Barcode _____
(if applicable)

Job Title _____

Address PO Box 1344

Phone 443-1319

TLH 32302
City State Zip

E-mail _____

Speaking: ☒ For ☐ Against ☐ Information

Representing Florida Nurses Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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3/7/13
Meeting Date

Topic _____

Bill Number 612

Name Chris Lyon

Amendment Barcode 124818
(if applicable)

Job Title Attorney

Address 315 S. Calhoun Street, Suite 830
Tallahassee FL 32301
City State Zip

Phone 222-5702

E-mail clyon@lw-law.com

Speaking: ☒ For ☐ Against ☐ Information

Representing Florida Assn. of Nurse Anesthetists

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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3/7/13

Meeting Date

Topic Health Care Practitioners

Bill Number 612
(if applicable)

Name Martha DeCastro

Amendment Barcode 861804
(if applicable)

Job Title Vice President for Nursing

Address 306 East College Avenue

Phone 850-222-9800

Street

Tallahassee

Florida

32301

City

State

Zip

E-mail martha@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.

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S-001 (10/20/11)

APPEARANCE RECORD

* Speaking on bill as amended.

3.7.13

Meeting Date

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Topic Health Care Practitioners

Bill Number 612
(if applicable)

Name Rebecca O'hara

Amendment Barcode _____
(if applicable)

Job Title VP of Govt. Affairs

Address PO BOX 10269

Phone 224-64910

Jaluy, FL 32302
City State Zip

E-mail rohara@fimedical.org

Speaking: ☒ For ☐ Against ☐ Information

Representing FL Medical Assoc.

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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3-7-13

Meeting Date

Topic Health Care Practitioners

Bill Number 612
(if applicable)

Name ALLISON CARVAJAL (CAR-VA-HALL)

Amendment Barcode 124818 Grimsley
(if applicable)

Job Title Consultant

Address 120 S. MONROE ST.
Street
TALLAHASSEE FL. 32301
City State Zip

Phone 727-7087

E-mail allison@rambaconsulting.com

Speaking: ☒ For ☐ Against ☐ Information

Waive in Support of
Amendment

Representing Florida Nurse Practitioner Network

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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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 Committee on Health Policy

BILL: SB 966

INTRODUCER: Senator Bean

SUBJECT: Health Care

DATE: March 1, 2013

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall	HP	Pre-meeting
2.			AP	
3.				
4.				
5.				
6.				

I. Summary:

SB 966 amends various sections of the Florida Statutes to update those sections with the most current names for CARF International and the Joint Commission. This bill also designates the Florida Hospital Sanford-Burnham Translational Research Institute for Metabolism and Diabetes (Institute) as a resource for research in the prevention and treatment of diabetes.

This bill substantially amends sections 154.11, 394.741, 395.3038, 397.403, 400.925, 400.9935, 402.7306, 408.05, 409.966, 409.967, 430.80, 440.13, 627.645, 627.668, 627.669, 627.736, 641.495, and 766.1015, F.S. This bill creates section 385.2035, F.S.

II. Present Situation:

CARF International

What is now known as CARF International was founded in 1966 as the Commission on Accreditation of Rehabilitation Facilities when the National Association of Sheltered Workshops and Homebound Programs and the Association of Rehabilitation Centers agreed to pool their interests.¹ CARF International is a nonprofit accreditor of health and human services providers in multiple areas including aging services, behavioral health, and medical rehabilitation. The CARF family of organizations currently accredits close to 50,000 programs in countries across the globe.² Currently, the Florida Statutes still refer to CARF - the Commission on Accreditation of Rehabilitation Facilities or something similar.

¹ History of CARF International, found at: <http://www.carf.org/About/History/>, last visited on Mar. 4, 2013.

² CARF International, can be found at: <http://www.carf.org/About/WhoWeAre/>, last visited on Mar. 4, 2013.

The Joint Commission

The Joint Commission is a non-profit organization that accredits and certifies more than 20,000 health care organizations and programs in the United States.³ The Joint Commission was established in 1951 as the Joint Commission on Accreditation of Hospitals. In 1987, the organization changed its name to the Joint Commission on Accreditation of Healthcare Organizations in order to reflect an expanded scope of activities. In 2007, the Joint Commission on Accreditation of Healthcare Organizations shortened its name to the Joint Commission in order to refresh its brand identity.⁴ Currently, the Florida Statutes refer to the Joint Commission on Accreditation of Healthcare Organizations.

Definition Change for “Accrediting Organizations”

In 2012 the Legislature enacted 2012-66, L.O.F., which substantially amended the definition of “accrediting organizations” in s. 395.002, F.S. Prior to the passage of 2012-66, L.O.F., the statutes defined “accrediting organizations” as the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, and the Accreditation Association for Ambulatory Health Care, Inc. Currently, the definition includes any national accreditation organizations that are approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state.

The Florida Hospital Sanford-Burnham Translational Research Institute for Metabolism and Diabetes

The Institute focuses on translational research and has established advanced technology resources and formed clinical and pharmaceutical research partnerships to drive their discoveries toward patient application.⁵ The Institute was designated as a resource for research in the prevention and treatment of diabetes in the 2012 Appropriations Act⁶ but has not been permanently designated as such in the Florida Statutes. According to Sanford-Burnham and Florida Hospital, such a designation will provide a competitive advantage for the Institute over research facilities in other states when applying for federal grants.⁷

III. Effect of Proposed Changes:

Sections 1 – 18 amend various sections of the Florida Statutes to update those sections with the most current names for CARF International and the Joint Commission and to make other technical revisions.

³ About the Joint Commission, found at: http://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx, last visited on Mar. 4, 2013.

⁴ The Joint Commission History, found at: http://www.jointcommission.org/assets/1/6/Joint_Commission_History.pdf, last visited on Mar. 4, 2013

⁵ About the Diabetes and Obesity Center, found at: <http://www.sanfordburnham.org/research/diabetes/Pages/doc.aspx>, last visited on Mar. 4, 2013.

⁶ 2012-118, L.O.F.

⁷ According to telephone conversations with Elizabeth Gianini, representing Sanford-Burnham, and Amy Christian, representing Florida Hospital, on Mar. 4, 2013.

Section 19 designates the Florida Hospital Sanford-Burnham Translational Research Institute for Metabolism and Diabetes as a resource for research in the prevention and treatment of diabetes.

Section 20 creates an effective date of July 1, 2013.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

Lines 6 – 9 of the title refer to conforming the provisions of this bill to provisions and terms in s. 395.002, F.S., relating to hospital licensing and regulation. The sections of law amended in this bill do not refer to s. 395.002, F.S. A title amendment is suggested to more directly title the subject matter of this bill.

Lines 57 – 58 and line 196 could be amended to improve readability and correct technical deficiencies.

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.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

By Senator Bean

4-00271A-13

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A bill to be entitled
An act relating to health care; amending ss. 154.11,
394.741, 395.3038, 397.403, 400.925, 400.9935,
402.7306, 408.05, 409.966, 409.967, 430.80, 440.13,
627.645, 627.668, 627.669, 627.736, 641.495, and
766.1015, F.S.; conforming provisions to a
redefinition of the term "accrediting organizations"
in s. 395.002, F.S., relating to hospital licensing
and regulation; creating s. 385.2035, F.S.;
designating the Florida Hospital Sanford-Burnham
Translational Research Institute for Metabolism and
Diabetes as a resource for diabetes research in this
state; providing an effective date.

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

Section 1. Paragraph (n) of subsection (1) of section
154.11, Florida Statutes, is amended to read:

154.11 Powers of board of trustees.—

(1) The board of trustees of each public health trust shall
be deemed to exercise a public and essential governmental
function of both the state and the county and in furtherance
thereof it shall, subject to limitation by the governing body of
the county in which such board is located, have all of the
powers necessary or convenient to carry out the operation and
governance of designated health care facilities, including, but
without limiting the generality of, the foregoing:

(n) To appoint originally the staff of physicians to
practice in a ~~any~~ designated facility owned or operated by the

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board and to approve the bylaws and rules to be adopted by the medical staff of a ~~any~~ designated facility owned and operated by the board, such governing regulations to be in accordance with the standards of the Joint Commission or a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state ~~on the Accreditation of Hospitals~~ which provide, among other things, for the method of appointing additional staff members and for the removal of staff members.

Section 2. Subsection (2) of section 394.741, Florida Statutes, is amended to read:

394.741 Accreditation requirements for providers of behavioral health care services.—

(2) Notwithstanding any provision of law to the contrary, accreditation shall be accepted by the agency and department in lieu of the agency's and department's facility licensure onsite review requirements and shall be accepted as a substitute for the department's administrative and program monitoring requirements, except as required by subsections (3) and (4), for:

(a) An ~~Any~~ organization from which the department purchases behavioral health care services which ~~that~~ is accredited by the Joint Commission, a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state, ~~on Accreditation of Healthcare Organizations~~ or the Council on Accreditation ~~for Children and Family Services,~~ or which obtains accreditation from CARF

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59 International for the ~~has those~~ services that are being
60 purchased by the department ~~accredited by CARF the~~
61 ~~Rehabilitation Accreditation Commission.~~

62 (b) A ~~Any~~ mental health facility licensed by the agency or
63 a ~~any~~ substance abuse component licensed by the department which
64 ~~that~~ is accredited by the Joint Commission, a national
65 accrediting organization that is approved by the Centers for
66 Medicare and Medicaid Services and whose standards incorporate
67 comparable licensure regulations required by the state, CARF
68 International ~~on Accreditation of Healthcare Organizations,~~
69 ~~CARF the Rehabilitation Accreditation Commission,~~ or the Council
70 on Accreditation ~~of Children and Family Services.~~

71 (c) A ~~Any~~ network of providers from which the department or
72 the agency purchases behavioral health care services accredited
73 by the Joint Commission, a national accrediting organization
74 that is approved by the Centers for Medicare and Medicaid
75 Services and whose standards incorporate comparable licensure
76 regulations required by the state, CARF International ~~on~~
77 ~~Accreditation of Healthcare Organizations, CARF the~~
78 ~~Rehabilitation Accreditation Commission,~~ the Council on
79 Accreditation ~~of Children and Family Services,~~ or the National
80 Committee for Quality Assurance. A provider organization that ~~7~~
81 ~~which~~ is part of an accredited network, is afforded the same
82 rights under this part.

83 Section 3. Section 395.3038, Florida Statutes, is amended
84 to read:

85 395.3038 State-listed primary stroke centers and
86 comprehensive stroke centers; notification of hospitals.—

87 (1) The agency shall make available on its website and to

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88 the department a list of the name and address of each hospital
89 that meets the criteria for a primary stroke center and the name
90 and address of each hospital that meets the criteria for a
91 comprehensive stroke center. The list of primary and
92 comprehensive stroke centers must ~~shall~~ include only those
93 hospitals that attest in an affidavit submitted to the agency
94 that the hospital meets the named criteria, or those hospitals
95 that attest in an affidavit submitted to the agency that the
96 hospital is certified as a primary or a comprehensive stroke
97 center by the Joint Commission or a national accrediting
98 organization that is approved by the Centers for Medicare and
99 Medicaid Services and whose standards incorporate comparable
100 licensure regulations required by the state ~~on Accreditation of~~
101 ~~Healthcare Organizations.~~

102 (2) (a) If a hospital no longer chooses to meet the criteria
103 for a primary or comprehensive stroke center, the hospital shall
104 notify the agency and the agency shall immediately remove the
105 hospital from the list.

106 (b)1. This subsection does not apply if the hospital is
107 unable to provide stroke treatment services for a period of time
108 not to exceed 2 months. The hospital shall immediately notify
109 all local emergency medical services providers when the
110 temporary unavailability of stroke treatment services begins and
111 when the services resume.

112 2. If stroke treatment services are unavailable for more
113 than 2 months, the agency shall remove the hospital from the
114 list of primary or comprehensive stroke centers until the
115 hospital notifies the agency that stroke treatment services have
116 been resumed.

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117 (3) The agency shall notify all hospitals in this state by
118 February 15, 2005, that the agency is compiling a list of
119 primary stroke centers and comprehensive stroke centers in this
120 state. The notice must ~~shall~~ include an explanation of the
121 criteria necessary for designation as a primary stroke center
122 and the criteria necessary for designation as a comprehensive
123 stroke center. The notice must ~~shall~~ also advise hospitals of
124 the process by which a hospital might be added to the list of
125 primary or comprehensive stroke centers.

126 (4) The agency shall adopt by rule criteria for a primary
127 stroke center which are substantially similar to the
128 certification standards for primary stroke centers of the Joint
129 Commission or a national accrediting organization that is
130 approved by the Centers for Medicare and Medicaid Services and
131 whose standards incorporate comparable licensure regulations
132 required by the state ~~on Accreditation of Healthcare~~
133 ~~Organizations.~~

134 (5) The agency shall adopt by rule criteria for a
135 comprehensive stroke center. However, if the Joint Commission or
136 a national accrediting organization that is approved by the
137 Centers for Medicare and Medicaid Services and whose standards
138 incorporate comparable licensure regulations required by the
139 state ~~on Accreditation of Healthcare Organizations~~ establishes
140 criteria for a comprehensive stroke center, the agency shall
141 establish criteria for a comprehensive stroke center which are
142 substantially similar to those criteria established by the Joint
143 Commission or such national accrediting organization ~~on~~
144 ~~Accreditation of Healthcare Organizations.~~

145 (6) This act is not a medical practice guideline and may

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not be used to restrict the authority of a hospital to provide services for which it is licensed ~~has received a license~~ under chapter 395. The Legislature intends that all patients be treated individually based on each patient's needs and circumstances.

Section 4. Subsection (3) of section 397.403, Florida Statutes, is amended to read:

397.403 License application.—

(3) The department shall accept proof of accreditation by CARF International, ~~the Commission on Accreditation of Rehabilitation Facilities (CARF)~~ or the Joint Commission, a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state, or through another ~~any other~~ nationally recognized certification process that is acceptable to the department and meets the minimum licensure requirements under this chapter, in lieu of requiring the applicant to submit the information required by paragraphs (1)(a)-(c).

Section 5. Subsection (1) of section 400.925, Florida Statutes, is amended to read:

400.925 Definitions.—As used in this part, the term:

(1) "Accrediting organizations" means the Joint Commission, a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state, ~~on Accreditation of Healthcare Organizations~~ or other national accrediting ~~accreditation~~ agencies whose standards for accreditation are comparable to those required by this part for

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175 licensure.

176 Section 6. Paragraph (g) of subsection (1) and subsection
177 (7) of section 400.9935, Florida Statutes, are amended to read:

178 400.9935 Clinic responsibilities.—

179 (1) Each clinic shall appoint a medical director or clinic
180 director who shall agree in writing to accept legal
181 responsibility for the following activities on behalf of the
182 clinic. The medical director or the clinic director shall:

183 (g) Conduct systematic reviews of clinic billings to ensure
184 that the billings are not fraudulent or unlawful. Upon discovery
185 of an unlawful charge, the medical director or clinic director
186 shall take immediate corrective action. If the clinic performs
187 only the technical component of magnetic resonance imaging,
188 static radiographs, computed tomography, or positron emission
189 tomography, and provides the professional interpretation of such
190 services, in a fixed facility that is accredited by the Joint
191 Commission ~~on Accreditation of Healthcare Organizations or~~, the
192 Accreditation Association for Ambulatory Health Care, Inc., a
193 national accrediting organization that is approved by the
194 Centers for Medicare and Medicaid Services and whose standards
195 incorporate comparable licensure regulations required by the
196 state, and the American College of Radiology; and if, in the
197 preceding quarter, the percentage of scans performed by that
198 clinic which was billed to all personal injury protection
199 insurance carriers was less than 15 percent, the chief financial
200 officer of the clinic may, in a written acknowledgment provided
201 to the agency, assume the responsibility for the conduct of the
202 systematic reviews of clinic billings to ensure that the
203 billings are not fraudulent or unlawful.

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(7)(a) Each clinic engaged in magnetic resonance imaging services must be accredited by the Joint Commission, a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state, ~~on Accreditation of Healthcare Organizations,~~ the American College of Radiology, or the Accreditation Association for Ambulatory Health Care, Inc., within 1 year after licensure. A clinic that is accredited by the American College of Radiology or that is within the original 1-year period after licensure and replaces its core magnetic resonance imaging equipment shall be given 1 year after the date on which the equipment is replaced to attain accreditation. However, a clinic may request a single, 6-month extension if it provides evidence to the agency establishing that, for good cause shown, such clinic cannot be accredited within 1 year after licensure, and that such accreditation will be completed within the 6-month extension. After obtaining accreditation as required by this subsection, each such clinic must maintain accreditation as a condition of renewal of its license. A clinic that files a change of ownership application must comply with the original accreditation timeframe requirements of the transferor. The agency shall deny a change of ownership application if the clinic is not in compliance with the accreditation requirements. When a clinic adds, replaces, or modifies magnetic resonance imaging equipment and the accrediting ~~accreditation~~ agency requires new accreditation, the clinic must be accredited within 1 year after the date of the addition, replacement, or modification but may request a single, 6-month extension if the clinic provides evidence of good cause

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233 to the agency.

234 (b) The agency may deny the application or revoke the
235 license of an ~~any~~ entity formed for the purpose of avoiding
236 compliance with the accreditation provisions of this subsection
237 and whose principals were previously principals of an entity
238 that was unable to meet the accreditation requirements within
239 the specified timeframes. The agency may adopt rules as to the
240 accreditation of magnetic resonance imaging clinics.

241 Section 7. Subsections (1) and (2) of section 402.7306,
242 Florida Statutes, are amended to read:

243 402.7306 Administrative monitoring of child welfare
244 providers, and administrative, licensure, and programmatic
245 monitoring of mental health and substance abuse service
246 providers.—The Department of Children and Family Services, the
247 Department of Health, the Agency for Persons with Disabilities,
248 the Agency for Health Care Administration, community-based care
249 lead agencies, managing entities as defined in s. 394.9082, and
250 agencies who have contracted with monitoring agents shall
251 identify and implement changes that improve the efficiency of
252 administrative monitoring of child welfare services, and the
253 administrative, licensure, and programmatic monitoring of mental
254 health and substance abuse service providers. For the purpose of
255 this section, the term "mental health and substance abuse
256 service provider" means a provider who provides services to this
257 state's priority population as defined in s. 394.674. To assist
258 with that goal, each such agency shall adopt the following
259 policies:

260 (1) Limit administrative monitoring to once every 3 years
261 if the child welfare provider is accredited by the Joint

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Commission, a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state, CARF International ~~the Commission on Accreditation of Rehabilitation Facilities~~, or the Council on Accreditation. If the accrediting body does not require documentation that the state agency requires, that documentation shall be requested by the state agency and may be posted by the service provider on the data warehouse for the agency's review. Notwithstanding the survey or inspection of an accrediting organization specified in this subsection, an agency specified in and subject to this section may continue to monitor the service provider as necessary with respect to:

(a) Ensuring that services for which the agency is paying are being provided.

(b) Investigating complaints or suspected problems and monitoring the service provider's compliance with ~~any~~ resulting negotiated terms and conditions, including provisions relating to consent decrees that are unique to a specific service and are not statements of general applicability.

(c) Ensuring compliance with federal and state laws, federal regulations, or state rules if such monitoring does not duplicate the accrediting organization's review pursuant to accreditation standards.

Medicaid certification and precertification reviews are exempt from this subsection to ensure Medicaid compliance.

(2) Limit administrative, licensure, and programmatic monitoring to once every 3 years if the mental health or

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substance abuse service provider is accredited by the Joint Commission, a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state, CARF International ~~the Commission on Accreditation of Rehabilitation Facilities~~, or the Council on Accreditation. If the services being monitored are not the services for which the provider is accredited, the limitations of this subsection do not apply. If the accrediting body does not require documentation that the state agency requires, that documentation, except documentation relating to licensure applications and fees, must be requested by the state agency and may be posted by the service provider on the data warehouse for the agency's review. Notwithstanding the survey or inspection of an accrediting organization specified in this subsection, an agency specified in and subject to this section may continue to monitor the service provider as necessary with respect to:

(a) Ensuring that services for which the agency is paying are being provided.

(b) Investigating complaints, identifying problems that would affect the safety or viability of the service provider, and monitoring the service provider's compliance with ~~any~~ resulting negotiated terms and conditions, including provisions relating to consent decrees that are unique to a specific service and are not statements of general applicability.

(c) Ensuring compliance with federal and state laws, federal regulations, or state rules if such monitoring does not duplicate the accrediting organization's review pursuant to accreditation standards.

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Federal certification and precertification reviews are exempt from this subsection to ensure Medicaid compliance.

Section 8. Paragraph (k) of subsection (3) of section 408.05, Florida Statutes, is amended to read:

408.05 Florida Center for Health Information and Policy Analysis.—

(3) COMPREHENSIVE HEALTH INFORMATION SYSTEM.—In order to produce comparable and uniform health information and statistics for the development of policy recommendations, the agency shall perform the following functions:

(k) Develop, in conjunction with the State Consumer Health Information and Policy Advisory Council, and implement a long-range plan for making available health care quality measures and financial data that will allow consumers to compare health care services. The health care quality measures and financial data the agency must make available includes ~~shall include~~, but is not limited to, pharmaceuticals, physicians, health care facilities, and health plans and managed care entities. The agency shall update the plan and report on the status of its implementation annually. The agency shall also make the plan and status report available to the public on its Internet website. As part of the plan, the agency shall identify the process and timeframes for implementation, ~~any~~ barriers to implementation, and recommendations of changes in the law that may be enacted by the Legislature to eliminate the barriers. As preliminary elements of the plan, the agency shall:

1. Make available patient-safety indicators, inpatient quality indicators, and performance outcome and patient charge

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349 data collected from health care facilities pursuant to s.
350 408.061(1)(a) and (2). The terms "patient-safety indicators" and
351 "inpatient quality indicators" have the same meaning as that
352 ascribed shall be as defined by the Centers for Medicare and
353 Medicaid Services, the National Quality Forum, the Joint
354 Commission ~~on Accreditation of Healthcare Organizations~~, a
355 national accrediting organization that is approved by the
356 Centers for Medicare and Medicaid Services and whose standards
357 incorporate comparable licensure regulations required by the
358 state, the Agency for Healthcare Research and Quality, the
359 Centers for Disease Control and Prevention, or a similar
360 national entity that establishes standards to measure the
361 performance of health care providers, or by other states. The
362 agency shall determine which conditions, procedures, health care
363 quality measures, and patient charge data to disclose based upon
364 input from the council. When determining which conditions and
365 procedures are to be disclosed, the council and the agency shall
366 consider variation in costs, variation in outcomes, and
367 magnitude of variations and other relevant information. When
368 determining which health care quality measures to disclose, the
369 agency:

370 a. Shall consider such factors as volume of cases; average
371 patient charges; average length of stay; complication rates;
372 mortality rates; and infection rates, among others, which shall
373 be adjusted for case mix and severity, if applicable.

374 b. May consider such additional measures that are adopted
375 by the Centers for Medicare and Medicaid Studies, National
376 Quality Forum, the Joint Commission ~~on Accreditation of~~
377 ~~Healthcare Organizations~~, a national accrediting organization

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378 that is approved by the Centers for Medicare and Medicaid
379 Services and whose standards incorporate comparable licensure
380 regulations required by the state, the Agency for Healthcare
381 Research and Quality, Centers for Disease Control and
382 Prevention, or a similar national entity that establishes
383 standards to measure the performance of health care providers,
384 or by other states.

385
386 When determining which patient charge data to disclose, the
387 agency shall include such measures as the average of
388 undiscounted charges on frequently performed procedures and
389 preventive diagnostic procedures, the range of procedure charges
390 from highest to lowest, average net revenue per adjusted patient
391 day, average cost per adjusted patient day, and average cost per
392 admission, among others.

393 2. Make available performance measures, benefit design, and
394 premium cost data from health plans licensed pursuant to chapter
395 627 or chapter 641. The agency shall determine which health care
396 quality measures and member and subscriber cost data to
397 disclose, based upon input from the council. When determining
398 which data to disclose, the agency shall consider information
399 that may be required by either individual or group purchasers to
400 assess the value of the product, which may include membership
401 satisfaction, quality of care, current enrollment or membership,
402 coverage areas, accreditation status, premium costs, plan costs,
403 premium increases, range of benefits, copayments and
404 deductibles, accuracy and speed of claims payment, credentials
405 of physicians, number of providers, names of network providers,
406 and hospitals in the network. Health plans shall make available

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407 to the agency ~~any~~ such data or information that is not currently
408 reported to the agency or the office.

409 3. Determine the method and format for public disclosure of
410 data reported pursuant to this paragraph. The agency shall make
411 its determination based upon input from the State Consumer
412 Health Information and Policy Advisory Council. At a minimum,
413 the data shall be made available on the agency's Internet
414 website in a manner that allows consumers to conduct an
415 interactive search that allows them to view and compare the
416 information for specific providers. The website must include
417 such additional information as is determined necessary to ensure
418 that the website enhances informed decisionmaking among
419 consumers and health care purchasers, which shall include, at a
420 minimum, appropriate guidance on how to use the data and an
421 explanation of why the data may vary from provider to provider.

422 4. Publish on its website undiscounted charges for no fewer
423 than 150 of the most commonly performed adult and pediatric
424 procedures, including outpatient, inpatient, diagnostic, and
425 preventative procedures.

426 Section 9. Paragraph (a) of subsection (3) of section
427 409.966, Florida Statutes, is amended to read:

428 409.966 Eligible plans; selection.—

429 (3) QUALITY SELECTION CRITERIA.—

430 (a) The invitation to negotiate must specify the criteria
431 and the relative weight of the criteria that will be used for
432 determining the acceptability of the reply and guiding the
433 selection of the organizations with which the agency negotiates.
434 In addition to criteria established by the agency, the agency
435 shall consider the following factors in the selection of

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436 eligible plans:

437 1. Accreditation by the National Committee for Quality
438 Assurance, the Joint Commission, a national accrediting
439 organization that is approved by the Centers for Medicare and
440 Medicaid Services and whose standards incorporate comparable
441 licensure regulations required by the state, or another
442 nationally recognized accrediting body.

443 2. Experience serving similar populations, including the
444 organization's record in achieving specific quality standards
445 with similar populations.

446 3. Availability and accessibility of primary care and
447 specialty physicians in the provider network.

448 4. Establishment of community partnerships with providers
449 that create opportunities for reinvestment in community-based
450 services.

451 5. Organization commitment to quality improvement and
452 documentation of achievements in specific quality improvement
453 projects, including active involvement by organization
454 leadership.

455 6. Provision of additional benefits, particularly dental
456 care and disease management, and other initiatives that improve
457 health outcomes.

458 7. Evidence that an eligible plan has written agreements or
459 signed contracts or has made substantial progress in
460 establishing relationships with providers before the plan
461 submitting a response.

462 8. Comments submitted in writing by an ~~any~~ enrolled
463 Medicaid provider relating to a specifically identified plan
464 participating in the procurement in the same region as the

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submitting provider.

9. Documentation of policies and procedures for preventing fraud and abuse.

10. The business relationship an eligible plan has with another ~~any other~~ eligible plan that responds to the invitation to negotiate.

Section 10. Paragraph (e) 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:

(e) *Continuous improvement*.—The agency shall establish specific performance standards and expected milestones or timelines for improving performance over the term of the contract.

1. Each managed care plan shall establish an internal health care quality improvement system, including enrollee satisfaction and disenrollment surveys. The quality improvement system must include incentives and disincentives for network providers.

2. Each plan must collect and report the Health Plan Employer Data and Information Set (HEDIS) measures, as specified by the agency. These measures must be published on the plan's website in a manner that allows recipients to reliably compare the performance of plans. The agency shall use the HEDIS measures as a tool to monitor plan performance.

3. Each managed care plan must be accredited by the

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494 National Committee for Quality Assurance, the Joint Commission,
495 a national accrediting organization that is approved by the
496 Centers for Medicare and Medicaid Services and whose standards
497 incorporate comparable licensure regulations required by the
498 state, or another nationally recognized accrediting body, or
499 have initiated the accreditation process, within 1 year after
500 the contract is executed. The agency shall suspend automatic
501 assignment under s. 409.977 and 409.984 for a ~~any~~ plan not
502 accredited within 18 months after executing the contract,~~the~~
503 ~~agency shall suspend automatic assignment under s. 409.977 and~~
504 ~~409.984.~~

505 4. By the end of the fourth year of the first contract
506 term, the agency shall issue a request for information to
507 determine whether cost savings could be achieved by contracting
508 for plan oversight and monitoring, including analysis of
509 encounter data, assessment of performance measures, and
510 compliance with other contractual requirements.

511 Section 11. Paragraph (b) of subsection (3) of section
512 430.80, Florida Statutes, is amended to read:

513 430.80 Implementation of a teaching nursing home pilot
514 project.—

515 (3) To be designated as a teaching nursing home, a nursing
516 home licensee must, at a minimum:

517 (b) Participate in a nationally recognized accrediting
518 ~~accreditation~~ program and hold a valid accreditation, such as
519 the accreditation awarded by the Joint Commission ~~on~~
520 ~~Accreditation of Healthcare Organizations, a national~~
521 accrediting organization that is approved by the Centers for
522 Medicare and Medicaid Services and whose standards incorporate

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comparable licensure regulations required by the state, or, at the time of initial designation, possess a Gold Seal Award as conferred by the state on its licensed nursing home;

Section 12. Paragraph (a) of subsection (2) of section 440.13, Florida Statutes, is amended to read:

440.13 Medical services and supplies; penalty for violations; limitations.—

(2) MEDICAL TREATMENT; DUTY OF EMPLOYER TO FURNISH.—

(a) Subject to the limitations specified elsewhere in this chapter, the employer shall furnish to the employee such medically necessary remedial treatment, care, and attendance for such period as the nature of the injury or the process of recovery may require, which is in accordance with established practice parameters and protocols of treatment as provided for in this chapter, including medicines, medical supplies, durable medical equipment, orthoses, prostheses, and other medically necessary apparatus. Remedial treatment, care, and attendance, including work-hardening programs or pain-management programs accredited by CARF International, ~~the Commission on Accreditation of Rehabilitation Facilities~~ the or Joint Commission, a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state, ~~on the Accreditation of Health Organizations~~ or pain-management programs affiliated with medical schools, shall be considered ~~as~~ covered treatment only when such care is given based on a referral by a physician as defined in this chapter. Medically necessary treatment, care, and attendance does not include chiropractic services in excess of 24 treatments or

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rendered 12 weeks beyond the date of the initial chiropractic treatment, whichever comes first, unless the carrier authorizes additional treatment or the employee is catastrophically injured.

Failure of the carrier to timely comply with this subsection shall be a violation of this chapter and the carrier shall be subject to penalties as provided for in s. 440.525.

Section 13. Subsection (1) of section 627.645, Florida Statutes, is amended to read:

627.645 Denial of health insurance claims restricted.—

(1) A ~~No~~ claim for payment under a health insurance policy or self-insured program of health benefits for treatment, care, or services in a licensed hospital that ~~which~~ is accredited by the Joint Commission, a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state, ~~on the Accreditation of Hospitals,~~ the American Osteopathic Association, or CARF International ~~the Commission on the Accreditation of Rehabilitative Facilities~~ may not ~~shall~~ be denied because such hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for treatment of physical disability.

Section 14. Paragraph (c) of subsection (2) of section 627.668, Florida Statutes, is amended to read:

627.668 Optional coverage for mental and nervous disorders required; exception.—

(2) Under group policies or contracts, inpatient hospital

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benefits, partial hospitalization benefits, and outpatient benefits consisting of durational limits, dollar amounts, deductibles, and coinsurance factors shall not be less favorable than for physical illness generally, except that:

(c) Partial hospitalization benefits shall be provided under the direction of a licensed physician. For purposes of this part, the term "partial hospitalization services" is defined as those services offered by a program accredited by the Joint Commission or a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state, ~~on Accreditation of Hospitals (JCAH)~~ or in compliance with equivalent standards. Alcohol rehabilitation programs accredited by the Joint Commission ~~on Accreditation of Hospitals~~ or approved by the state and licensed drug abuse rehabilitation programs shall also be qualified providers under this section. In a given ~~any~~ benefit year, if partial hospitalization services or a combination of inpatient and partial hospitalization are used ~~utilized~~, the total benefits paid for all such services may ~~shall~~ not exceed the cost of 30 days after ~~of~~ inpatient hospitalization for psychiatric services, including physician fees, which prevail in the community in which the partial hospitalization services are rendered. If partial hospitalization services benefits are provided beyond the limits set forth in this paragraph, the durational limits, dollar amounts, and coinsurance factors thereof need not be the same as those applicable to physical illness generally.

Section 15. Subsection (3) of section 627.669, Florida

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Statutes, is amended to read:

627.669 Optional coverage required for substance abuse impaired persons; exception.—

(3) The benefits provided under this section are ~~shall be~~ applicable only if treatment is provided by, or under the supervision of, or is prescribed by, a licensed physician or licensed psychologist and if services are provided in a program accredited by the Joint Commission or a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state, ~~on Accreditation of Hospitals~~ or approved by the state.

Section 16. Paragraph (a) of subsection (1) of section 627.736, Florida Statutes, is amended to read:

627.736 Required personal injury protection benefits; exclusions; priority; claims.—

(1) REQUIRED BENEFITS.—An insurance policy complying with the security requirements of s. 627.733 must provide personal injury protection to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in the motor vehicle, and other persons struck by the motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to subsection (2) and paragraph (4)(e), to a limit of \$10,000 in medical and disability benefits and \$5,000 in death benefits resulting from bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:

(a) *Medical benefits.*—Eighty percent of all reasonable expenses for medically necessary medical, surgical, X-ray,

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dental, and rehabilitative services, including prosthetic devices and medically necessary ambulance, hospital, and nursing services if the individual receives initial services and care pursuant to subparagraph 1. within 14 days after the motor vehicle accident. The medical benefits provide reimbursement only for:

1. Initial services and care that are lawfully provided, supervised, ordered, or prescribed by a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, or a chiropractic physician licensed under chapter 460 or that are provided in a hospital or in a facility that owns, or is wholly owned by, a hospital. Initial services and care may also be provided by a person or entity licensed under part III of chapter 401 which provides emergency transportation and treatment.

2. Upon referral by a provider described in subparagraph 1., followup services and care consistent with the underlying medical diagnosis rendered pursuant to subparagraph 1. which may be provided, supervised, ordered, or prescribed only by a physician licensed under chapter 458 or chapter 459, a chiropractic physician licensed under chapter 460, a dentist licensed under chapter 466, or, to the extent permitted by applicable law and under the supervision of such physician, osteopathic physician, chiropractic physician, or dentist, by a physician assistant licensed under chapter 458 or chapter 459 or an advanced registered nurse practitioner licensed under chapter 464. Followup services and care may also be provided by ~~any of~~ the following persons or entities:

a. A hospital or ambulatory surgical center licensed under

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chapter 395.

b. An entity wholly owned by one or more physicians licensed under chapter 458 or chapter 459, chiropractic physicians licensed under chapter 460, or dentists licensed under chapter 466 or by such practitioners and the spouse, parent, child, or sibling of such practitioners.

c. An entity that owns or is wholly owned, directly or indirectly, by a hospital or hospitals.

d. A physical therapist licensed under chapter 486, based upon a referral by a provider described in this subparagraph.

e. A health care clinic licensed under part X of chapter 400 which is accredited by the Joint Commission ~~on Accreditation of Healthcare Organizations~~, a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state, the American Osteopathic Association, CARF International ~~the Commission on Accreditation of Rehabilitation Facilities~~, or the Accreditation Association for Ambulatory Health Care, Inc., or

(I) Has a medical director licensed under chapter 458, chapter 459, or chapter 460;

(II) Has been continuously licensed for more than 3 years or is a publicly traded corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange; and

(III) Provides at least four of the following medical specialties:

(A) General medicine.

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(B) Radiography.

(C) Orthopedic medicine.

(D) Physical medicine.

(E) Physical therapy.

(F) Physical rehabilitation.

(G) Prescribing or dispensing outpatient prescription medication.

(H) Laboratory services.

3. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. up to \$10,000 if a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, a physician assistant licensed under chapter 458 or chapter 459, or an advanced registered nurse practitioner licensed under chapter 464 has determined that the injured person had an emergency medical condition.

4. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. is limited to \$2,500 if a ~~any~~ provider listed in subparagraph 1. or subparagraph 2. determines that the injured person did not have an emergency medical condition.

5. Medical benefits do not include massage as defined in s. 480.033 or acupuncture as defined in s. 457.102, regardless of the person, entity, or licensee providing massage or acupuncture, and a licensed massage therapist or licensed acupuncturist may not be reimbursed for medical benefits under this section.

6. The Financial Services Commission shall adopt by rule the form that must be used by an insurer and a health care provider specified in sub-subparagraph 2.b., sub-subparagraph

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2.c., or sub-subparagraph 2.e. to document that the health care provider meets the criteria of this paragraph. Such ~~which~~ rule must include a requirement for a sworn statement or affidavit.

Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and such insurer may not require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for providing such benefits. Insurers may not require that property damage liability insurance in an amount greater than \$10,000 be purchased in conjunction with personal injury protection. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. An insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice violates part IX of chapter 626, and such violation constitutes an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance. An insurer committing such violation is subject to the penalties provided under that part, as well as those provided elsewhere in the insurance code.

Section 17. Subsection (12) of section 641.495, Florida Statutes, is amended to read:

641.495 Requirements for issuance and maintenance of certificate.—

(12) The provisions of part I of chapter 395 do not apply to a health maintenance organization that, on or before January 1, 1991, provides not more than 10 outpatient holding beds for

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755 short-term and hospice-type patients in an ambulatory care
756 facility for its members, provided that such health maintenance
757 organization maintains current accreditation by the Joint
758 Commission ~~on Accreditation of Health Care Organizations~~, a
759 national accrediting organization that is approved by the
760 Centers for Medicare and Medicaid Services and whose standards
761 incorporate comparable licensure regulations required by the
762 state, the Accreditation Association for Ambulatory Health Care,
763 Inc., or the National Committee for Quality Assurance.

764 Section 18. Subsection (2) of section 766.1015, Florida
765 Statutes, is amended to read:

766 766.1015 Civil immunity for members of or consultants to
767 certain boards, committees, or other entities.—

768 (2) Such committee, board, group, commission, or other
769 entity must be established in accordance with state law, ~~or~~ in
770 accordance with requirements of the Joint Commission or a
771 national accrediting organization that is approved by the
772 Centers for Medicare and Medicaid Services and whose standards
773 incorporate comparable licensure regulations required by the
774 state ~~on Accreditation of Healthcare Organizations~~, established
775 and duly constituted by one or more public or licensed private
776 hospitals or behavioral health agencies, or established by a
777 governmental agency. To be protected by this section, the act,
778 decision, omission, or utterance may not be made or done in bad
779 faith or with malicious intent.

780 Section 19. Section 385.2035, Florida Statutes, is created
781 to read:

782 385.2035 Resource for research in the prevention and
783 treatment of diabetes.—The Florida Hospital Sanford-Burnham

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784 Translational Research Institute for Metabolism and Diabetes is
785 designated as a resource in this state for research in the
786 prevention and treatment of diabetes.

787 Section 20. This act shall take effect July 1, 2013.
788

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 Committee on Health Policy

BILL: SB 604

INTRODUCER: Senator Bean

SUBJECT: Practitioners

DATE: March 5, 2013

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	McElheney	Stovall	HP	Favorable
2.			JU	
3.			RC	
4.				
5.				
6.				

I. Summary:

SB 604 reorganizes the provisions relating to fees for organizations licensed or permitted and persons certified under part III of ch. 401, F.S., relating to medical transportation services. The bill directs fees collected for certification of emergency medical technicians (EMTs) and paramedics to be deposited into the Medical Quality Assurance Trust Fund rather than the Emergency Medical Services Trust Fund.

The bill clarifies that the Department of Financial Services (DFS) shall defend any claim, suit, action, or proceeding for injunctive, affirmative, or declaratory relief against an impaired practitioner consultant involving emergency interventions on behalf of impaired practitioners or students.

The bill expands access to the prescription drug monitoring program database to an impaired practitioner consultant upon consent of the impaired practitioner for the purpose of reviewing the impaired practitioner's controlled substance prescription history.

This bill substantially amends sections: 401.34, 456.076, 893.055, and 893.0551 of the Florida Statutes.

II. Present Situation:

Emergency Medical Services

Part III of ch. 401, F.S., pertains to medical transportation services. Among other things, this part provides for the certification of a person to act as an EMT, paramedic, or 911 public safety

telecommunicator; licensing of an organization to provide basic life support (BLS) service, advanced life support (ALS) service, or air ambulance service; and permitting of vehicles to be operated as a basic support or advance support transport vehicle or an ALS nontransport vehicle providing BLS or ALS. Organizationally, this program is under the Division of Emergency Preparedness and Community Support (EPCS) within the Department of Health (DOH).

Fees for certification, licensing, and permitting must be deposited into the Emergency Medical Services Trust Fund and applied solely for salaries and expenses of the department incurred in implementing and enforcing part III of ch. 401, F.S.¹

Currently, the fees are used to:

- Process EMT and paramedic certification, recertification and testing;
- Fund 66 percent of the state EMS medical director's contracted salary; and
- Fund a portion of the salaries of 10 EMS staff members to:
 - License, permit, and inspect 274 ALS, BLS, and air medical service providers with 4,335 permitted vehicles;
 - Approve and inspect 71 EMT and paramedic training programs;
 - Oversee 32 EMT and paramedic recertification training programs; and
 - Provide administrative support.

The 10 EMS staff, through additional funding sources, also investigate complaints and discipline EMS providers, training programs, and 911 public safety telecommunicators. According to the DOH funding provided by county courts per s. 318.21(2)(b), F.S., which is intended to fund 100 percent of the 10 EMS positions and the state EMS medical director are inadequate to support these positions. Revenue from licensing fees for the 2-year licensure cycle 2010-2012 totaled \$2,518,750 while expenses were approximately \$3,860,354.²

The EPCS and the Division of Medical Quality Assurance (MQA) have a Memorandum of Understanding in effect that authorizes the MQA to invoice EPCS for services relating to the licensure of EMTs and paramedics. The invoiced expenditures derived from the MQA regulatory functions exceed the amount of funding EPCS receives from licensing revenues of EMTs and paramedics. The DEPCS reimburses MQA with available funding.³

Medical Quality Assurance Trust Fund

Funds credited to the Medical Quality Assurance Trust Fund consist of fees and fines related to the licensing of health care professionals. Funds must be used for the purpose of providing administrative support for the regulation of health care professionals and for other such purposes as may be appropriate pursuant to legislative appropriation.⁴

¹ ss. 401.34 and 401.465(3), F.S.

² Department of Health Bill Analysis for SB 604 (dated March 1, 2013) on file with the Senate Health Policy Committee.

³ *Ibid.*

⁴ s. 20.435 (4), F.S.

Impaired Practitioner Treatment Program

Health care practitioners are regulated under various practice acts and the general regulatory provisions of ch. 456, F.S. Under s. 456.072(1)(z), F.S., disciplinary action may be taken against a licensed health care professional who is unable to practice with reasonable skill and safety due to illness; use of alcohol, drugs, narcotics, chemicals or any other type of material; or as the result of any mental or physical condition. The impaired practitioner treatment program was created to help treat practitioners who are impaired due to alcohol or substance abuse.

By entering and successfully completing the program, a practitioner may avoid formal disciplinary action by his or her board, if his or her only violation of the practice regulations is the impairment. Disciplinary action will not be taken if the practitioner acknowledges his or her impairment, voluntarily enrolls in an approved treatment program, and voluntarily withdraws from his or her practice or limits the scope of his or her practice as determined by the probable cause panel of the appropriate board until such time as the panel is satisfied that the practitioner has successfully completed the treatment program.⁵ To avoid discipline, the practitioner must also execute releases for medical records authorizing the release of all records of evaluation, diagnosis, and treatment to the impaired practitioner treatment program consultant.⁶

Section 456.076, F.S., requires the DOH to retain one or more impaired practitioner consultants to assist in determining whether a practitioner is impaired and to monitor the treatment of the impaired practitioner. An impaired practitioner consultant may also contract for services to be provided by a school for students enrolled in schools for licensure as allopathic physicians, physicians assistants, osteopathic physicians, nurses, or pharmacists who are alleged to be impaired as a result of the misuse or abuse of alcohol or drugs, or both, or due to a mental or physical condition.

The consultant must be a practitioner or recovered practitioner who is a Florida-licensed medical physician, osteopathic physician, physician assistant, anesthesiology assistant, or nurse. In the alternative, a consultant may be an entity employing a medical director who is so licensed. Consultants must refer impaired practitioners to department-approved treatment programs and providers.⁷ Although consultants do not provide medical treatment, they are required to make recommendations to the DOH regarding a practitioner's ability to practice.

The DOH currently contracts with the Intervention Project for Nurses (IPN) for licensed nurses and the Professional Resource Network (PRN) for all other licensed professions for impaired practitioner consultant services.

The relationship of PRN and IPN to the practitioner involves monitoring only and there is no doctor-patient relationship, therefore PRN and IPN consultants have no authority to access the Prescription Drug Monitoring Program database.

An impaired practitioner consultant, the consultant's officers and employees, and those acting at the direction of the consultant for the limited purpose of an emergency intervention on behalf of

⁵ s. 456.076(3)(a), F.S.

⁶ *Id.*

⁷ See s. 456.076, F.S.

a licensee or student when the consultant is unable to perform the intervention is considered an agent of the DOH for purposes of s. 768.28, F.S., (related to sovereign immunity) while acting within the scope of the consultant's duties under the contract with the DOH.⁸ The DFS currently defends any claim, suit, action or proceeding against the consultant for the limited purpose of an emergency intervention on behalf of a licensee or student when the consultant is unable to perform the intervention if the act or omission arises out of and is in the scope of the consultant's contractual duties.⁹

Prescription Drug Monitoring Program (PDMP)

Chapter 2009-197, L.O.F, established the PDMP in s. 893.005, F.S. The PDMP is a comprehensive electronic system to monitor the prescribing and dispensing of certain controlled substances. Dispensers of certain controlled substances must report specified information to the PDMP, including the patient's name to whom the controlled substance is dispensed and other dispensing information.

Direct access to the PDMP is presently limited to medical doctors, osteopathic physicians, dentists, podiatric physicians, advanced registered nurse practitioners, physician assistants, and pharmacists. Indirect access to the PDMP is provided to: (1) the DOH or its relevant health care regulatory boards; (2) the attorney general for Medicaid fraud cases; (3) a law enforcement agency; and (4) a patient or the legal guardian or designated health care surrogate of an incapacitated patient.

Section 893.0551, F.S., enacted at the same time, provides for a public records exemption for certain personal information of a patient and certain information concerning health care professionals. This section sets forth enumerated exceptions for disclosure of this information after the DOH ensures the legitimacy of the person's request for the information.

III. Effect of Proposed Changes:

Section 1 amends s. 401.34, F.S., reorganizing the provisions relating to license fees for EMTs and paramedics. All license fees for EMTs and paramedics that are currently deposited into the EMS trust fund would instead be deposited into the MQA trust fund.

Section 2 amends s. 456.076, F.S., providing that the DFS defend any claim suit, action, or proceeding, *including injunctive, affirmative, or declaratory relief*, against an impaired practitioner consultant involving emergency interventions on behalf of impaired practitioners when the consultant is unable to perform the intervention if the act or omission arises out of and is in the scope of the consultant's contractual duties.

Sections 3 and 4 amends s. 893.055 and s. 893.0551, F.S., respectively, to define "impaired practitioner consultant" and expand access to the PDMP to impaired practitioner consultants upon consent of the impaired practitioner for the purpose of reviewing the impaired practitioner's controlled substance prescription history. The bill authorizes impaired practitioner consultants to have direct access to the PDMP for the purpose of reviewing the controlled

⁸ s. 456.076(7)(a), F.S.

⁹ s. 456.076(7)(b), F.S.

substance prescription history of an impaired practitioner who has agreed to be evaluated or monitored through the PDMP by the consultant.

The effective date of the bill is July 1, 2013.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

Because this bill provides for release of information that is already confidential and exempt under s. 893.0551, F.S., to an impaired practitioner consultant, the bill is not subject to the requirements of s. 24, Art. I of the State Constitution and ch. 119, F.S., related to creating or expanding a public records exemption.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

SB 604 deposits fees into the MQA trust fund that currently are deposited into the EMS trust fund. The bill does not specify what the funds will be used for or otherwise revise specific duties and responsibilities of the EMS program or the MQA. Revenue from licensing fees for 2010-2011 and 2011-2012 totaled \$2,518,750. Expenditures are currently \$3,860,354 (average from 2006-2012) for a 2-year period. Revenue and expenditures vary dramatically during a recertification year so the revenue and expenditure amounts reflect a 2-year period to show appropriate numbers.¹⁰

B. Private Sector Impact:

If an action for injunctive, affirmative, or declaratory relief is filed against an impaired practitioner consultant, the DFS has clear statutory authority to defend the action.

Impaired practitioners in the impaired practitioner treatment program will be able to authorize the consultant to use the PDMP as another tool to monitor the practitioner's progress in the treatment program.

C. Government Sector Impact:

The licensure fees transferred to MQA under the bill will not be available to fund the EMS salary and other expenses currently incurred being incurred.

¹⁰ *Supra*, fn 2

The DOH indicates that the rule pertaining to accessing the PDMP will need to be amended to address access to the database by impaired practitioner consultants.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill authorizes the impaired practitioner consultant to access the PDMP for an impaired practitioner; however, it does not specifically authorize access for a student who is participating in the impaired practitioner treatment program. Given the sensitive nature of access to the PDMP, specifically including students participating in the impaired practitioner program might be appropriate if such access is contemplated.

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.

By Senator Bean

4-00173D-13

2013604__

1 A bill to be entitled
2 An act relating to practitioners; amending s. 401.34,
3 F.S.; reorganizing provisions relating to license fees
4 for certain practitioners; amending s. 456.076, F.S.;
5 providing that the Department of Financial Services
6 shall defend certain claims, suits, actions, or
7 proceedings for injunctive, affirmative, or
8 declaratory relief involving emergency interventions
9 on behalf of impaired practitioners; amending s.
10 893.055, F.S.; defining the term "impaired
11 practitioner consultant"; providing that impaired
12 practitioner consultants retained by the Department of
13 Health have access to information in the prescription
14 drug monitoring program's database in certain
15 circumstances; amending s. 893.0551, F.S.; defining
16 the term "impaired practitioner consultant"; allowing
17 impaired practitioner consultants access to certain
18 confidential information in the prescription drug
19 monitoring program's database when necessary to
20 evaluate or monitor a practitioner as part of a
21 treatment program for impaired practitioners;
22 providing an effective date.

23
24 Be It Enacted by the Legislature of the State of Florida:

25
26 Section 1. Subsections (2) through (7) of section 401.34,
27 Florida Statutes, are redesignated as subsections (3) through
28 (8), respectively, subsection (1) of that section is amended,
29 and a new subsection (2) is added, to read:

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401.34 Fees.—

(1) Each organization ~~or person~~ subject to this part must pay to the department the following nonrefundable fees:

(a) Basic life support service license application: \$660, to be paid biennially.

(b) Advanced life support service license application: \$1,375, to be paid biennially.

(c) Original or renewal vehicle permit application for basic or advanced life support: \$25, to be paid biennially.

(d) Air ambulance service application: \$1,375, to be paid biennially.

(e) Original or renewal aircraft permit application for air ambulance: \$25, to be paid biennially.

(2) Each person subject to this part must pay to the department the following nonrefundable fees, and these fees must be deposited into the Medical Quality Assurance Trust Fund:

(a) ~~(d)~~ Emergency medical technician certification examination application: \$40.

(b) ~~(e)~~ Emergency medical technician original certificate application: \$35.

(c) ~~(f)~~ Emergency medical technician renewal certificate application: \$20, to be paid biennially.

(d) ~~(g)~~ Paramedic certification examination application: \$40.

(e) ~~(h)~~ Paramedic original certificate application: \$45.

(f) ~~(i)~~ Paramedic renewal certificate application: \$45, to be paid biennially.

~~(j) Air ambulance service application: \$1,375, to be paid biennially.~~

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59 ~~(k) Original or renewal aircraft permit application for air~~
60 ~~ambulance: \$25, to be paid biennially.~~

61 Section 2. Paragraph (b) of subsection (7) of section
62 456.076, Florida Statutes, is amended to read:

63 456.076 Treatment programs for impaired practitioners.—

64 (7)

65 (b) In accordance with s. 284.385, the Department of
66 Financial Services shall defend any claim, suit, action, or
67 proceeding, including a claim, suit, action, or proceeding for
68 injunctive, affirmative, or declaratory relief, against the
69 consultant, the consultant's officers or employees, or those
70 acting at the direction of the consultant for the limited
71 purpose of an emergency intervention on behalf of a licensee or
72 student as described in subsection (2) when the consultant is
73 unable to perform such intervention, which claim, suit, action,
74 or proceeding is brought as a result of an ~~any~~ act or omission
75 by any of the consultant's officers and employees and those
76 acting under the direction of the consultant for the limited
77 purpose of an emergency intervention on behalf of the ~~a~~ licensee
78 or student ~~as described in subsection (2)~~ when the consultant is
79 unable to perform such intervention, if the ~~when such~~ act or
80 omission arises out of and is in the scope of the consultant's
81 duties under its contract with the department.

82 Section 3. Paragraphs (f) through (j) of subsection (1) of
83 section 893.055, Florida Statutes, are redesignated as
84 paragraphs (g) through (k), respectively, a new paragraph (f) is
85 added to that subsection, and paragraph (b) of subsection (7) of
86 that section is amended, to read:

87 893.055 Prescription drug monitoring program.—

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

(f) "Impaired practitioner consultant" means a consultant retained by the department under s. 456.076.

(7)

(b)1. A pharmacy, prescriber, or dispenser shall have access to information in the prescription drug monitoring program's database which relates to a 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.

2. An impaired practitioner consultant who is retained by the department shall have access to information in the prescription drug monitoring program's database, in a manner established by the department, if:

a. The impaired practitioner has a documented or has acknowledged history of controlled substance abuse.

b. The impaired practitioner agrees in writing to be evaluated and monitored through the prescription drug monitoring program.

c. The impaired practitioner consultant has access to only those records of impaired practitioners who have provided written consent.

3. 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

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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.

Section 4. Paragraphs (e) through (h) of subsection (1) of section 893.0551, Florida Statutes, are redesignated as paragraphs (f) through (i), respectively, a new paragraph (e) is added to that subsection, and paragraph (h) is added to subsection (3) of that section, to read:

893.0551 Public records exemption for the prescription drug monitoring program.—

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

(e) "Impaired practitioner consultant" has the same meaning as provided in s. 893.055.

(3) The department shall disclose such confidential and exempt information to the following entities after using a verification process to ensure the legitimacy of that person's or entity's request for the information:

(h) An impaired practitioner consultant who certifies in

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146 writing that the information is necessary to evaluate or monitor
147 a practitioner as part of a treatment program for impaired
148 practitioners.

149 Section 5. This act shall take effect July 1, 2013.

THE FLORIDA SENATE
APPEARANCE RECORD

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

3/7/13

Meeting Date

Topic Impaired Partitioners

Bill Number 604
(if applicable)

Name MATTHEW FARRAR

Amendment Barcode _____
(if applicable)

Job Title _____

Address 2910 Kerry Forest Pkwy D4-368
Street
Tallahassee FL 32369
City State Zip

Phone 850-832-1763

E-mail matt@himmmsconsulting.com

Speaking: ☒ For ☐ Against ☐ Information

Representing Intervention Project for Nurses

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.

THE FLORIDA SENATE
APPEARANCE RECORD

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

3-7-2013

Meeting Date

Topic PRACTITIONERS

Bill Number SB 604
(if applicable)

Name STEPHEN R. WINN

Amendment Barcode _____
(if applicable)

Job Title EXECUTIVE DIRECTOR

Address 2007 APALACHEE PARKWAY

Phone 878-7463

TALLAHASSEE FL 32301
Street City State Zip

E-mail _____

Speaking: ☒ For ☐ Against ☐ Information

WAIVE IN SUPPORT

Representing FLORIDA OSTEOPATHIC MEDICAL 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.

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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)

3-7-13
Meeting Date

Topic Practitioners

Bill Number 604
(if applicable)

Name Michelle Jacques

Amendment Barcode _____
(if applicable)

Job Title Dir. of legislative Advocacy

Address PO BOX 10269

Phone 251-2288

Tallah, FL 32302
City State Zip

E-mail mjacquis@fimedical.org

Speaking: ☒ For ☐ Against ☐ Information

WAIVE IN SUPPORT

Representing FL Medical Assoc.

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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THE FLORIDA SENATE
APPEARANCE RECORD

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

Meeting Date _____

Topic _____

Bill Number 604
(if applicable)

Name Judy Rivenbark, MD

Amendment Barcode _____
(if applicable)

Job Title Medical Director PRN

Address P.O. BOX 1020

Phone 800-888-8776

Street

Fernandina Beach, FL 32035

City

State

Zip

E-mail _____

Speaking: ☒ For ☐ Against ☐ Information

Representing PRN

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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THE FLORIDA SENATE
APPEARANCE RECORD

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

3/7/2013
Meeting Date

Topic _____

Bill Number 604
(if applicable)

Name Robert Watson

Amendment Barcode _____
(if applicable)

Job Title _____

Address 1020 Fernandina Beach
Street

Phone (850) 524-4957

City _____ State _____ Zip _____

E-mail robert.watson@med.flor.edu

Speaking: ☐ For ☐ Against ☒ Information

Representing PRN

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)

3.7.13
Meeting Date

Topic Practitioners

Bill Number SB 604
(if applicable)

Name Allison Finley

Amendment Barcode _____
(if applicable)

Job Title _____

Address 1430 E. Piedmont Dr.
Street

Phone _____

TLH FL 32308
City State Zip

E-mail afinley@fcaap.org

Speaking: ☒ For ☐ Against ☐ Information

Representing Florida Chapter of American Academy of
Pediatrics

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

Caption: Senate Health Policy Committee

Case:

Judge:

Type:

Started: 3/7/2013 8:01:31 AM

Ends: 3/7/2013 9:18:05 AM **Length:** 01:16:35

8:01:39 AM	Meeting called to order
8:02:27 AM	Opening Remarks by chair
8:03:13 AM	Presentation of SB 258 by Senator Bradley
8:03:35 AM	Sen. Joyner
8:04:19 AM	Chair Bean
8:05:29 AM	Florida League of Cities waives in support
8:05:43 AM	FI Restaurant and Lodging Assoc. waives in support
8:06:01 AM	Chair Bean
8:06:13 AM	Roll call on SB 258
8:06:38 AM	SB 422 by Sen. Benacquisto
8:08:07 AM	Sen. Benacquisto explains the bill
8:08:58 AM	Chair Bean
8:10:13 AM	Mrs. Pruitt - Public Testimony
8:12:30 AM	Chair Bean
8:12:41 AM	Karen Womack - Public Testimony
8:14:16 AM	Luke Webb - Public Testimony
8:17:14 AM	Rep. Mayfield - Public Testimony
8:19:50 AM	Chair Bean
8:20:06 AM	Dr. Wayne Taylor - Public Testimony
8:23:16 AM	Chair Bean
8:28:55 AM	Chair Bean recognizes public testimonies on SB 422
8:32:14 AM	Chair Bean
8:32:34 AM	Sen. Joyner
8:33:03 AM	Sen. Sobel
8:33:43 AM	Sen. Galvano
8:33:58 AM	Chair Bean
8:35:14 AM	Sen. Benacquisto closes on SB 422
8:36:21 AM	Roll call on SB 422
8:36:51 AM	Chair Bean
8:37:07 AM	Sen. Braynon
8:37:20 AM	Chair Bean
8:37:38 AM	SB 646 by Children, Families, and Elder Affairs
8:38:29 AM	Sen. Sobel presents the bill
8:42:40 AM	Chair Bean
8:44:13 AM	Amendments adopted
8:44:54 AM	Public Testimony
8:45:06 AM	Pat Lange - Florida Assited Living Assoc.
8:48:57 AM	Chair Bean
8:49:09 AM	Sen. Sobel closes on the bill
8:50:52 AM	Roll call on SB 646
8:51:12 AM	Chair Bean
8:51:16 AM	SB 1258 by Sen. Grimsley
8:51:37 AM	Sen. Grimsley presents the bill
8:52:31 AM	Chair Bean
8:52:37 AM	Roll call on SB 1258
8:53:00 AM	SB 536 by Sen. Detert
8:53:44 AM	Charlie Anderson (Sen. Detert's aide) presents the bill
8:54:29 AM	Chair Bean
8:54:58 AM	Public Testimony
8:55:42 AM	Roll call on SB 536
8:55:59 AM	Chair Bean
8:56:23 AM	SB 844 by Sen. Grimsley

8:56:31 AM	Sen. Grimsley presents the bill
8:57:41 AM	Amendments explained
8:58:12 AM	Chair Bean
8:59:07 AM	Sen. Garcia
8:59:39 AM	Chair Bean
8:59:51 AM	Amendments to the amendment adopted
9:00:34 AM	Chair Bean
9:00:48 AM	Amendment adopted
9:00:58 AM	Public Testimony
9:01:23 AM	Roll call on SB 844
9:02:06 AM	Chair Bean
9:02:09 AM	SB 612 by Sen. Galvano
9:02:21 AM	Sen. Galvano presents the bill
9:03:09 AM	Chair Bean
9:03:11 AM	Sen. Grimsley presents amendment
9:03:55 AM	Public Testimony
9:04:13 AM	Alisa Snow - Florida Nurses Association
9:04:57 AM	Chair Bean
9:05:38 AM	Public Testimony
9:06:56 AM	Sen. Sobel expresses support
9:08:28 AM	Sen. Brandes expresses concerns
9:10:03 AM	Sen. Grimsley states that there are already similar laws in place
9:10:48 AM	Sen. Garcia
9:11:45 AM	Sen. Galvano closes on the bill
9:12:41 AM	Chair Bean
9:13:13 AM	Roll call on SB 612
9:13:36 AM	Chair Bean
9:13:48 AM	SB 604 by Sen. Bean
9:13:56 AM	Sen. Bean presents the bill
9:16:01 AM	Chair Sobel
9:16:05 AM	Public Testimony
9:16:51 AM	Chair Sobel
9:17:01 AM	Sen. Bean closes on the bill
9:17:23 AM	Roll call on SB 604
9:17:37 AM	Chair Bean
9:17:50 AM	Sen. Braynon moves we rise