The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH REGULATION
Senator Garcia, Chair
Senator Sobel, Vice Chair

MEETING DATE: Monday, April 4, 2011
TIME: 3:15 —5:15 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Garcia, Chair; Senator Sobel, Vice Chair; Senators Altman, Bennett, Diaz de la Portilla, Fasano, Gaetz, Gardiner, Jones, Latvala, Norman, and Ring

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 1744** Storms (Compare H 1127)	Abortions; Requires that an ultrasound be performed on a woman obtaining an abortion. Provides exceptions. Requires that the ultrasound be reviewed with the patient before the woman gives informed consent for the abortion procedure. Requires that the woman certify in writing that she declined to review the ultrasound and did so of her own free will and without undue influence. Provides an exemption from the requirement to view the ultrasound for women who have a serious medical condition necessitating the abortion, etc. HR 03/28/2011 Not Considered HR 04/04/2011 BC	
2	**SB 1108** Storms (Identical H 851)	Use of Cigarette Tax Proceeds; Revises the payment and distribution of funds in the Cigarette Tax Collection Trust Fund. Provides specified purposes for the use of funds that are appropriated out of the trust fund. Authorizes moneys transferred to the Board of Directors of the H. Lee Moffitt Cancer Center and Research Institute to be used to secure financing to pay costs related to constructing, furnishing, equipping, and maintaining clinical facilities for cancer research. HR 03/28/2011 Not Considered HR 04/04/2011 BC	
3	**CS/SB 1366** Children, Families, and Elder Affairs / Storms (Compare CS/H 959)	Child Welfare/Mental Health/Substance Abuse; Requires the Department of Children and Family Services, the Department of Health, the Agency for Persons with Disabilities, the Agency for Health Care Administration, community-based care lead agencies, managing entities, and their contracted monitoring agents to adopt certain revised policies for the administrative monitoring of providers of child welfare services, mental health services, and substance abuse services. Conforms provisions to changes made by the act. CF 03/14/2011 Fav/CS HR 04/04/2011 BC	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
	A proposed committee substitute for the following bill (SB 1458) is expected to be considered:		
4	**SB 1458** Garcia (Identical H 1295, Compare CS/H 119, H 4045, H 4047, H 4049, H 4051, H 4053, H 4055, H 4199, S 688, S 690, S 692, S 694, S 696, S 698, CS/S 1736, S 1756)	Assisted Living Communities; Revises licensing requirements for registered pharmacists under contract with a nursing home and related health care facilities. Creates part I of ch. 429, F.S., the "Assisted Care Communities Licensing Procedures Act." Requires providers to have and display a license. Establishes license fees and conditions for assessment thereof. Provides procedures for change of ownership. Requires background screening of specified employees. Provides for inspections and investigations to determine compliance, etc. HR 03/28/2011 Not Considered HR 04/04/2011 CF BC	
	Consideration of proposed committee bill:		
5	**SPB 7232**	Ratification of Rules; Ratifies specified rules for the sole and exclusive purpose of satisfying any condition on effectiveness established by s. 120.541(3), F.S., which requires ratification of any rule that meets any of the specified thresholds that may likely have an adverse impact or excessive regulatory cost.	
6	**CS/SB 1426** Banking and Insurance / Hays (Identical CS/H 4101)	Repeal of Health Insurance Provisions; Repeals provisions relating to a requirement that the board of directors of the Florida Health Insurance Plan annually report to the Governor and the Legislature. Deletes a requirement that the Office of Insurance Regulation of the Department of Financial Services annually report to the Governor and the Legislature concerning the Small Employers Access Program. BI 03/16/2011 Fav/CS HR 04/04/2011 BC	
7	**SB 1454** Garcia (Identical H 1105)	Treatment of a Surrendered Newborn Infant; Presumes that the birth mother of a surrendered newborn infant is eligible for coverage under Medicaid as is the infant. HR 03/22/2011 Temporarily Postponed HR 03/28/2011 Not Considered HR 04/04/2011 BC	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
8	**SB 1268** Oelrich (Identical H 585)	Pharmacy; Revises the types of vaccines that pharmacists are authorized to administer. Authorizes pharmacy interns to administer the vaccines under certain circumstances. Authorizes pharmacists and pharmacy interns to administer an epinephrine autoinjection under certain circumstances. Revises protocol requirements for vaccine administration and the duties of supervising physicians under such protocols. Revises requirements for training programs, certifications, and patient records related to vaccine administration, etc. HR 04/04/2011 BC	
9	**SB 1358** Oelrich (Similar H 909)	Emergency Medical Services; Deletes the requirement for emergency medical technicians and paramedics to complete an educational course on the modes of transmission, infection control procedures, clinical management, and prevention of human immunodeficiency virus and acquired immune deficiency syndrome. Redefines the term "basic life support" for purposes of the Raymond H. Alexander, M.D., Emergency Medical Transportation Services Act. Revises the requirements for certification for an out-of-state trained emergency medical technician or paramedic, etc. HR 04/04/2011 BC	
10	**SB 1608** Ring (Compare H 1271)	Dentistry; Provides that an applicant who has maintained his or her dental license in good standing in another state for a specified number of years immediately before applying to take the licensing examinations to practice dentistry in this state is entitled to take such examinations. HR 04/04/2011 BC	
11	**SB 1410** Negron (Compare CS/CS/H 479, CS/H 935, S 1892, CS/S 1972)	Health Care Price Transparency; Requires primary care providers to publish and post a schedule of certain charges for medical services offered to patients. Requires a primary care provider's estimates of charges for medical services to be consistent with the posted schedule. Provides additional acts that constitute grounds for denial of a license or disciplinary action against certain physicians, osteopathic physicians, or podiatric physicians, to which penalties apply. Provides construction with respect to the doctrine of incorporation by reference, etc. HR 04/04/2011 BC	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
12	**CS/SB 1554** Transportation / Hays (Similar H 1135)	Emergency Vehicles; Increases the fine for the failure to comply with a provision relating to yielding to emergency vehicles. Conforms provisions to changes made by the act. TR 03/16/2011 Fav/CS HR 04/04/2011 MS	
13	**CS/SB 730** Education Pre-K - 12 / Flores (Similar CS/H 301, Compare S 1814)	Youth and Student Athletes; Requires independent sanctioning authorities to adopt policies to inform youth athletes and their parents of the nature and risk of certain head injuries. Requires that a signed consent form be obtained before the youth participates in athletic practices or competitions. Requires that a youth athlete be immediately removed from an athletic activity following a suspected head injury. Requires written clearance from a medical professional before the youth resumes athletic activities, etc. ED 03/17/2011 Fav/CS HR 04/04/2011 RC	
14	**SB 1676** Thrasher (Identical H 1393, Compare S 1924, CS/S 1972)	Sovereign Immunity; Provides that specified provisions relating to sovereign immunity for health care providers do not apply to certain affiliation agreements or contracts to provide certain comprehensive health care services. Expands the definition of the term "officer, employee, or agency" for purposes of sovereign immunity to include certain health care providers, etc. HR 04/04/2011 JU BC	
15	**SB 1770** Hays (Identical H 1247)	Parental Notice of Abortion; Revises notice requirements relating to the termination of pregnancy of a minor. Provides exceptions to the notice requirements. Revises procedure for judicial waiver of notice. Provides for the minor to petition for a hearing within a specified time. Provides that in a hearing relating to waiving the requirement for parental notice, the court consider certain additional factors, including whether the minor's decision to terminate her pregnancy was due to undue influence. Provides a procedure for appeal if judicial waiver of notice is not granted, etc. HR 04/04/2011 JU BC	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
16	**SB 1590** Hays (Compare CS/CS/H 479, S 1892, CS/S 1972)	Medical Malpractice Actions; Requires the Board of Medicine and the Board of Osteopathic Medicine to issue expert witness certificates to physicians licensed outside the state. Provides application and certification requirements. Revises the length of devoted, professional time required in order for a health care provider to qualify to give expert testimony regarding the prevailing professional standard of care. Requires that presuit notice for medical negligence claims be accompanied by an authorization for release of protected health information, etc. HR 03/30/2011 Not Considered HR 04/04/2011 BI BC	
17	**SB 1748** Flores (Similar CS/H 1397)	Abortions; Restricts the circumstances in which an abortion may be performed in the third trimester or after viability. Requires an abortion clinic to provide conspicuous notice on any form or medium of advertisement that the abortion clinic is prohibited from performing abortions in the third trimester or after viability. Prohibits a termination of pregnancy from being performed in a location other than a validly licensed hospital, abortion clinic, or physician's office, etc. HR 03/28/2011 Not Considered HR 04/04/2011 CJ BC	

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LEGISLATIVE ACTION

Senate . House

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

Senate Amendment (with title amendment)

Delete lines 47 - 173

and insert:

(I) The ultrasound must be performed by the physician who is to perform the abortion or by a person having documented evidence that he or she has completed a course in the operation of ultrasound equipment as prescribed by rule and who is working in conjunction with the physician.

(II) The person performing the ultrasound must allow the woman to view the live ultrasound images, and a physician or a registered nurse, licensed practical nurse, advanced registered

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nurse practitioner, or physician assistant working in conjunction with the physician must contemporaneously review and explain the live ultrasound images to the woman before the woman gives informed consent to having an abortion procedure performed. However, this sub-sub-subparagraph does not apply if, at the time the woman schedules or arrives for her appointment to obtain an abortion, a copy of a restraining order, police report, medical record, or other court order or documentation is presented which provides evidence that the woman is obtaining the abortion because the woman is a victim of rape, incest, domestic violence, or human trafficking or that the woman has been diagnosed as having a condition that, on the basis of a physician's good faith clinical judgment, would create a serious risk of substantial and irreversible impairment of a major bodily function if the woman delayed terminating her pregnancy.

(III) The woman has a right to decline to view the ultrasound images after she is informed of her right and offered an opportunity to view them. If the woman declines to view the ultrasound images, the woman shall complete a form acknowledging that she was offered an opportunity to view her ultrasound but that she rejected that opportunity. The form must also indicate that the woman's decision not to view the ultrasound was not based on any undue influence from any third party to discourage her from viewing the images and that she declined to view the images of her own free will.

c. The medical risks to the woman and fetus of carrying the pregnancy to term.

2. Printed materials prepared and provided by the department have been provided to the pregnant woman, if she

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chooses to view these materials, including:

a. A description of the fetus, including a description of the various stages of development.

b. A list of entities ~~agencies~~ that offer alternatives to terminating the pregnancy.

c. Detailed information on the availability of medical assistance benefits for prenatal care, childbirth, and neonatal care.

3. The woman acknowledges in writing, before the termination of pregnancy, that the information required to be provided under this subsection has been provided.

Nothing in this paragraph is intended to prohibit a physician from providing any additional information which the physician deems material to the woman's informed decision to terminate her pregnancy.

(b) If ~~In the event~~ a medical emergency exists and a physician cannot comply with the requirements for informed consent, a physician may terminate a pregnancy if he or she has obtained at least one corroborative medical opinion attesting to the medical necessity for emergency medical procedures and to the fact that to a reasonable degree of medical certainty the continuation of the pregnancy would threaten the life of the pregnant woman. If a ~~In the event no~~ second physician is not available for a corroborating opinion, the physician may proceed but shall document reasons for the medical necessity in the patient's medical records.

(c) Violation of this subsection by a physician constitutes grounds for disciplinary action under s. 458.331 or s. 459.015.

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Substantial compliance or reasonable belief that complying with the requirements of informed consent would threaten the life or health of the patient is a defense to any action brought under this paragraph.

Section 2. Paragraph (d) of subsection (3) of section 390.012, Florida Statutes, is amended to read:

390.012 Powers of agency; rules; disposal of fetal remains.—

(3) For clinics that perform or claim to perform abortions after the first trimester of pregnancy, the agency shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this chapter, including the following:

(d) Rules relating to the medical screening and evaluation of each abortion clinic patient. At a minimum, these rules shall require:

1. A medical history including reported allergies to medications, antiseptic solutions, or latex; past surgeries; and an obstetric and gynecological history.

2. A physical examination, including a bimanual examination estimating uterine size and palpation of the adnexa.

3. The appropriate laboratory tests, including:

a. ~~For an abortion in which an ultrasound examination is not performed before the abortion procedure,~~ Urine or blood tests for pregnancy performed before the abortion procedure.

b. A test for anemia.

c. Rh typing, unless reliable written documentation of blood type is available.

d. Other tests as indicated from the physical examination.

4. An ultrasound evaluation for all patients ~~who elect to~~

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~~have an abortion after the first trimester~~. The rules shall require that if a person who is not a physician performs an ultrasound examination, that person shall have documented evidence that he or she has completed a course in the operation of ultrasound equipment as prescribed in rule. The physician, registered nurse, licensed practical nurse, advanced registered nurse practitioner, or physician assistant shall review and explain~~, at the request of the patient,~~ the live ultrasound images ~~evaluation results~~, including an estimate of the probable gestational age of the fetus, with the patient before the abortion procedure is performed, unless the patient declines pursuant to s. 390.0111. If the patient declines to view the live ultrasound images, the rules shall require that s. 390.0111 be complied with in all other respects.

5. That the physician is responsible for estimating the gestational age of the fetus based on the ultrasound examination and obstetric standards in keeping with established standards of care regarding the estimation of fetal age as defined in rule and shall write the estimate in the patient's medical history. The physician shall keep original prints of each ultrasound examination of a patient in the patient's medical history file.

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

And the title is amended as follows:

Delete lines 3 - 22

and insert:

F.S.; requiring that an ultrasound be performed on a woman obtaining an abortion; specifying who must perform an ultrasound; requiring that the ultrasound

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be reviewed with the patient before the woman gives informed consent for the abortion procedure; specifying who must review the ultrasound with the patient; requiring that the woman certify in writing that she declined to review the ultrasound and did so of her own free will and without undue influence; providing an exemption from the requirement to view the ultrasound for women who are the victims of rape, incest, domestic violence, or human trafficking or for women who have a serious medical condition necessitating the abortion; revising requirements for written materials; amending s. 390.012, F.S.; requiring an ultrasound for all patients regardless of when the abortion is performed; requiring that live ultrasound images be reviewed and explained to the patient; requiring that all other provisions in s. 390.0111, F.S., be complied with if the patient declines to view her live ultrasound images; providing

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 1744
INTRODUCER:	Senator Storms
SUBJECT:	Abortions
DATE:	March 23, 2011
REVISED:	

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

I. Summary:

Except in a medical emergency, this bill provides that consent to a termination of pregnancy is voluntary and informed if a woman seeking an abortion has the gestational age of the fetus verified by an ultrasound, regardless of the woman's stage of pregnancy. The bill prescribes who is authorized to perform the ultrasound.

The bill prohibits an ultrasound from being performed if the woman seeking an abortion has official documentation evidencing that she is a victim of rape, incest, domestic violence, or human trafficking. The person performing the ultrasound must allow the woman to view the live ultrasound images and the ultrasound images must be explained contemporaneously to the woman before she gives informed consent to having the abortion procedure, unless this delay in the abortion procedure would cause substantial and irreversible impairment of a major bodily function of the woman.

The bill provides that a woman has a right to decline to view the ultrasound images after she has been offered an opportunity to view them. However, if the woman declines to view the ultrasound images, she is required to complete a form acknowledging her right to view the images, that she has declined to view the images, and that her refusal to view the images was of her own free will.

The bill provides that consent to a termination of pregnancy is voluntary and informed if, among other things, a description of the fetus, including a description of the various stages of development, has been provided to the woman.

The bill requires the Agency for Health Care Administration (AHCA) to adopt rules requiring a woman seeking an abortion to take a urine or blood test, regardless of whether she will have an ultrasound performed. The AHCA must also adopt rules requiring an ultrasound evaluation for each patient, unless the patient has documentary proof that she is a victim of rape, incest, domestic violence, or human trafficking.

The bill also includes a severability clause, which severs any provision of the bill that is held invalid.

This bill substantially amends the following sections of the Florida Statutes: 390.0111 and 390.012.

This bill creates an undesignated section of the Florida Statutes.

II. Present Situation:

Background

Under Florida law the term "abortion" means the termination of human pregnancy with an intention other than to produce a live birth or to remove a dead fetus.[1] "Viability" means that stage of fetal development when the life of the unborn child may, with a reasonable degree of medical probability, be continued indefinitely outside the womb.[2] Induced abortion can be elective (performed for nonmedical indications) or therapeutic (performed for medical indications). An abortion can be performed by surgical or medical means (medicines that induce a miscarriage).[3]

An abortion in Florida must be performed by a physician licensed to practice medicine or osteopathic medicine who is licensed under ch. 458, F.S., ch. 459, F.S., or a physician practicing medicine or osteopathic medicine in the employment of the United States.[4] No person who is a member of, or associated with, the staff of a hospital, or any employee of a hospital or physician in which, or by whom, the termination of a pregnancy has been authorized or performed, who states an objection to the procedure on moral or religious grounds is required to participate in the procedure. The refusal to participate may not form the basis for any disciplinary or other recriminatory action.[5]

According to the AHCA, for the calendar year 2009, a total of 81,916 abortions were performed by licensed physicians. During calendar year 2010, a total of 79,908 abortions were performed by licensed physicians.[6]

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[1] Section 390.011, F.S.
[2] Section 390.0111, F.S.
[3] Suzanne R. Trupin, M.D., *Elective Abortion*, December 21, 2010, available at: http://www.emedicine.com/med/TOPIC3312.HTM (Last visited on March 11, 2011).
[4] Section 390.0111(2), F.S.
[5] Section 390.0111(8), F.S.
[6] Agency for Health Care Administration, *2011 Bill Analysis & Economic Impact Statement for SB 1748*, on file with the Senate Health Regulation Committee.

Abortion Clinics

Abortion clinics are licensed and regulated by the AHCA under ch. 390, F.S., and part II of ch. 408, F.S. The AHCA has adopted rules in Chapter 59A-9, Florida Administrative Code, related to abortion clinics. Section 390.012, F.S., requires these rules to address the physical facility, supplies and equipment standards, personnel, medical screening and evaluation of patients, abortion procedures, recovery room standards, and follow-up care. The rules relating to the medical screening and evaluation of each abortion clinic patient, at a minimum, require:

- A medical history including reported allergies to medications, antiseptic solutions, or latex; past surgeries; and an obstetric and gynecological history;
- A physical examination, including a bimanual examination estimating uterine size and palpation of the adnexa;
- The appropriate laboratory tests, including:
  - For an abortion in which an ultrasound examination is not performed before the abortion procedure, urine or blood tests for pregnancy performed before the abortion procedure,
  - A test for anemia,
  - Rh typing, unless reliable written documentation of blood type is available, and
  - Other tests as indicated from the physical examination;
- An ultrasound evaluation for patients who elect to have an abortion after the first trimester. If a person who is not a physician performs the ultrasound examination, that person must have documented evidence that he or she has completed a course in the operation of ultrasound equipment. If a patient requests, the physician, registered nurse, licensed practical nurse, advanced registered nurse practitioner, or physician assistant must review the ultrasound evaluation results and the estimate of the probable gestational age of the fetus with the patient before the abortion procedure is performed; and
- The physician to estimate the gestational age of the fetus based on the ultrasound examination and obstetric standards in keeping with established standards of care regarding the estimation of fetal age and write the estimate in the patient's medical history. The physician must keep original prints of each ultrasound examination in the patient's medical history file.

The biennial fee for an abortion clinic is $514.00 and a level 2 (statewide and nationwide) background screen is required of the administrator responsible for the day to day operations of the clinic and the chief financial officer.[7]

The Woman's Right to Know Act

The Woman's Right to Know Act (Act), Florida's informed consent law related to the termination of pregnancy procedures, was enacted by the Legislature in 1997.[8] The Act requires that, except in the event of a medical emergency,[9] prior to obtaining a termination of pregnancy,

[7] Agency for Health Care Administration, *Abortion Clinic*, available at: http://www.fdhc.state.fl.us/mchq/health_facility_regulation/hospital_outpatient/abortion.shtml (Last visited on March 23, 2011).
[8] Chapter 97-151, L.O.F.
[9] Section 390.0111(3), F.S. "Medical emergency" means a condition that, on the basis of a physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate termination of her

a patient[10] must be provided the following information, in person, from the physician performing the procedure or the referring physician:

- The nature and risks of undergoing or not undergoing the proposed procedure that a reasonable patient would consider material to making a knowing and willful decision of whether to terminate a pregnancy.
- The probable gestational age of the fetus at the time the procedure is to be performed.
- The medical risks to the patient and fetus of carrying the pregnancy to term.

The patient must also be provided printed materials that include a description of the fetus; a list of agencies that offer alternatives to terminating the pregnancy; and detailed information about the availability of medical assistance benefits for prenatal care, childbirth, and neonatal care.[11] The written materials must be prepared and provided by the Department of Health, and the patient has the option to review the written materials provided.[12]

The patient must execute written acknowledgement that she has received all of the above information prior to the termination of pregnancy being performed.[13] The Act provides for disciplinary action against a physician who fails to comply.[14]

Litigation of the Woman's Right to Know Act

Shortly after the enactment of the Woman's Right to Know Act, its validity was challenged under the Florida and federal constitutions. The plaintiff physicians and clinics successfully enjoined the enforcement of the Act pending the outcome of the litigation, and the injunction was upheld on appeal.[15] Thereafter, the plaintiffs were successful in obtaining a summary judgment against the State on the grounds that the Act violated the right to privacy under Art. I., s. 23 of the Florida Constitution and was unconstitutionally vague under the federal and state constitutions. This decision was also upheld on appeal.[16] The State appealed this decision to the Florida Supreme Court.[17]

The Florida Supreme Court addressed two issues raised by the plaintiffs. With regard to whether the Act violated a woman's right to privacy, the Court determined that the information required to be provided to women in order to obtain informed consent was comparable to those informed consent requirements established in common law and by Florida statutory law[18] applicable to

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pregnancy to avert her death, or for which a delay in the termination of her pregnancy will create serious risk of substantial and irreversible impairment of a major bodily function. Section 390.01114(2)(d), F.S.

[10] The Act allows for the woman's guardian to receive the information, if she is mentally incompetent.

[11] Section 390.0111(3), F.S.

[12] *Id.*

[13] *Id.*

[14] Section 390.0111(3)(c), F.S. The Department of Health, or the appropriate board, may suspend or permanently revoke a license; restrict a practice or license, impose an administrative fine not to exceed $10,000 for each count or separate offense; issue a reprimand or letter of concern; place the licensee on probation for a period of time and subject it to conditions; take corrective action; impose an administrative fine for violations regarding patient rights; refund fees billed and collected from the patient or a third party on behalf of the patient; or require that the practitioner undergo remedial education. *See* s. 458.331 and s. 459.015, F.S.

[15] *Florida v. Presidential Women's Center*, 707 So. 2d 1145 (Fla. 4th Dist. Ct. App. 1998).

[16] *Florida v. Presidential Women's Center*, 884 So. 2d 526 (Fla. 4th Dist. Ct. App. 2004).

[17] *Florida v. Presidential Women's Center*, 937 So. 2d 114 (Fla. 2006).

[18] *Presidential Women's Center*, 937 So. 2d at 117-118. Section 766.103, F.S., is a general informed consent law for the medical profession, which requires that a patient receive information that would provide a "a reasonable individual" with a

other medical procedures.[19] Accordingly, the Court determined that the Act was not an unconstitutional violation of a woman's right to privacy.[20]

Second, the Supreme Court addressed the allegation that the term "reasonable patient," and the Act's reference to information about "risks" were unconstitutionally vague. The plaintiffs argued it was unclear whether the Act requires patients to receive information about "non-medical" risks, such as social, economic or other risks.[21] The Court rejected these arguments and held that ". . . .the Act constitutes a neutral informed consent statute that is comparable to the common law and to informed consent statutes implementing the common law that exist for other types of medical procedures…."[22]

Relevant Case Law

In 1973, the landmark case of *Roe v. Wade* established that restrictions on a woman's access to secure an abortion are subject to a strict scrutiny standard of review.[23] In *Roe*, the U.S. Supreme Court determined that a woman's right to have an abortion is part of the fundamental right to privacy guaranteed under the Due Process Clause of the Fourteenth Amendment of the U.S. Constitution, justifying the highest level of review.[24] Specifically, the Court concluded that: (1) during the first trimester, the state may not regulate the right to an abortion; (2) after the first trimester, the state may impose regulations to protect the health of the mother; and (3) after viability, the state may regulate and proscribe abortions, except when it is necessary to preserve the life or health of the mother.[25] Therefore, a state regulation limiting these rights may be justified only by a compelling state interest, and the legislative enactments must be narrowly drawn to express only legitimate state interests at stake.[26]

In 1992, in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the U.S. Supreme Court relaxed the standard of review in abortion cases involving adult women from strict scrutiny to unduly burdensome, while still recognizing that the right to an abortion emanates from the constitutional penumbra of privacy rights.[27] In *Planned Parenthood*, the Court determined that, prior to fetal viability, a woman has the right to an abortion without being unduly burdened by government interference.[28] The Court concluded that the state may regulate the abortion as long as the regulation does not impose an undue burden on a woman's decision to choose an abortion.[29] If the purpose of a provision of law is to place substantial obstacles in the path of a

general understanding of the procedure he or she will undergo, medically acceptable alternative procedures or treatments, and the substantial potential risks or hazards associated with the procedure. The court also refers to s. 458.324, F.S. (informed consent for patients who may be in high risk of developing breast cancer); s. 458.325, F.S. (informed consent for patients receiving electroconvulsive and psychosurgical procedures); and s. 945.48, F.S. (express and informed consent requirements for inmates receiving psychiatric treatment).

[19] *Id.*
[20] *Presidential Women's Center*, 937 So. 2d at 118, 120.
[21] *Presidential Women's Center*, 937 So. 2d at 118-119.
[22] *Id.* at 120.
[23] 410 U.S. 113 (1973).
[24] 410 U.S. 113, 154 (1973).
[25] 410 U.S. 113, 162-65 (1973).
[26] 410 U.S. 113, 152-56 (1973).
[27] 505 U.S. 833, 876-79 (1992).
[28] *Id.*
[29] *Id.*

woman seeking an abortion before viability, it is invalid; however, after viability the state may restrict abortions if the law contains exceptions for pregnancies endangering a woman's life or health.[30]

The unduly burdensome standard as applied in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, which is generally considered to be a hybrid between strict scrutiny and intermediate level scrutiny, shifted the Court's focus to whether a restriction creates a substantial obstacle to access. This is the prevailing standard today applied in cases in which abortion access is statutorily restricted.

However, the undue burden standard was held not to apply in Florida. The 1999 Legislature passed a parental notification law, the Parental Notice of Abortion Act, requiring a physician to give at least 48 hours of actual notice to one parent or to the legal guardian of a pregnant minor before terminating the pregnancy of the minor. Although a judicial waiver procedure was included, the act was never enforced.[31] In 2003, the Florida Supreme Court[32] ruled this legislation unconstitutional on the grounds that it violated a minor's right to privacy, as expressly protected under Article I, s. 23 of the Florida Constitution.[33] Citing the principle holding of *In re T.W.,*[34] the Court reiterated that, as the privacy right is a fundamental right in Florida, any restrictions on privacy warrant a strict scrutiny review, rather than that of an undue burden. Here, the Court held that the state failed to show a compelling state interest and therefore, the Court permanently enjoined the enforcement of the Parental Notice of Abortion Act.[35]

Ultrasound

An ultrasound is a technique involving the formation of a two-dimensional image used for the examination and measurement of internal body structures and the detection of bodily abnormalities.[36] It uses high frequency sound waves (ultrasound) to produce dynamic images (or sonograms) of organs, tissues, or blood flow inside the body. Ultrasound is used to examine many parts of the body, such as the abdomen, breast, reproductive system, heart, and blood vessels, and is increasingly being used to detect heart disease, vascular disease, and injuries to the muscles, tendons, and ligaments.[37]

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[30] *Id.*
[31] *See* s. 390.01115, F.S. (repealed by s. 1, ch. 2005-52, Laws of Florida). Ch. 2005-52, Laws of Florida created s. 390.01114, F.S., the revised Parental Notice of Abortion Act.
[32] *North Florida Women's Health and Counseling Services, Inc., et al., v. State of Florida*, 866 So. 2d 612, 619-20 (Fla. 2003)
[33] The constitutional right of privacy provision reads: "Every natural person has the right to be let alone and free from governmental intrusion into the person's private life except as otherwise provided herein. This section shall not be construed to limit the public's right of access to public records and meetings as provided by law." FLA. CONST. art. I, s. 23.
[34] 551 So. 2d 1186, 1192 (Fla. 1989).
[35] *North Florida Women's Health and Counseling Services, supra* note 16, at 622 and 639-40.
[36] Merriam-Webster, MedlinePlus, Medical Dictionary, available at: http://www2.merriam-webster.com/cgi-bin/mwmednlm?book=Medical&va=ultrasound, (last viewed March 23, 2011).
[37] Society of Diagnostic Medical Sonography, *Medical Ultrasound Fact Sheet* (2010), available at: http://www.sdms.org/resources/muam/MUAMkit.pdf (last viewed March 23, 2011).

Ultrasounds are considered to be a safe, non-invasive means of investigating a fetus during pregnancy.[38] An ultrasound may be used to detect fetal body measurements to determine the gestational age of the fetus.[39] If the date of a patient's last menstrual cycle is uncertain, then an ultrasound can be used to arrive at a correct "dating" for the patient.[40] Moreover, an ultrasound can be used to detect an ectopic pregnancy, which is a potentially fatal condition in which the fertilized egg implants outside a woman's uterus, such as in the fallopian tubes, ovaries, or abdomen.[41] Approximately one in every 50 pregnancies results in an ectopic pregnancy, and it is the leading cause of pregnancy-related death for women in their first trimester of pregnancy.[42] According to the National Abortion Federation, "[i]n the context of medical abortion, ultrasonography can help determine gestational age, assess the outcome of the procedure, and diagnose ectopic pregnancy and other types of abnormal pregnancy."[43]

Two forms of ultrasound used in pregnancy are transabdominal and transvaginal ultrasound, with advantages and disadvantages to each. Transabdominal ultrasound provides a panoramic view of the abdomen and pelvis, whereas transvaginal provides a more limited pelvic view. Transabdominal ultrasound is noninvasive, and transvaginal ultrasound requires insertion of a probe into the vagina.[44] The transabdominal method requires a full bladder for best viewing, which may be accomplished by the patient drinking several glasses of water prior to the examination. According to the National Abortion Federation, some patients find transvaginal ultrasound more comfortable than transabdominal because transvaginal does not require a distended bladder.[45] Transabdominal ultrasound cannot always detect pregnancies under 6 weeks' gestation, while transvaginal ultrasound can detect pregnancies at 4.5 to 5 weeks' gestation.[46]

In Florida, clinics providing pregnancy termination procedures in the second trimester are required to have ultrasound equipment and conduct ultrasounds on patients prior to the procedure.[47] This requirement is not contingent on the number of second trimester procedures performed by the clinic; if a clinic performs only one second trimester termination of pregnancy a year, that clinic must have ultrasound equipment on site and use it for that procedure. Current law also requires that the person performing the ultrasound must be either a physician or a person working in conjunction with the physician who has documented evidence of having completed a course in the operation of ultrasound equipment as prescribed by rule.[48]

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[38] Dr. Joseph S.K. Woo, *Obstetric Ultrasound, A Comprehensive Guide*, available at: http://www.ob-ultrasound.net/ (Last viewed March 23, 2011).
[39] *Id.*
[40] *Id.*
[41] *Id. See also* Melissa Conrad Stoppler, M.D., Charles C.P. Davis, MD, PhD, and William C. Sheil, Jr. MD, FACP, FACR; MedicineNet.com; *Ectopic Pregnancy*; available at: http://www.medicinenet.com/ectopic_pregnancy/article.htm (Last viewed March 23, 2011).
[42] *Id.*
[43] National Abortion Federation, *Early Options: Ultrasound Imagery in Early Pregnancy*, available at: http://www.prochoice.org/education/cme/online_cme/m4ultrasound.asp (last viewed March 23, 2011).
[44] *Id.*
[45] *Id. See also supra*, fn. 38.
[46] *Id.*
[47] Section 390.012(3)(d)4, F.S.
[48] *Id.*

A clinic is not currently required under the law to review the ultrasound results with the patient prior to the termination of pregnancy, unless the patient requests to review the results. Furthermore, the requested review is not required to be done with the patient as the ultrasound is being conducted.[49]

Current law does not require ultrasounds for first trimester pregnancy termination procedures. However, many providers in Florida voluntarily conduct ultrasounds prior to terminating a pregnancy during the first trimester.[50] For example, A Jacksonville Woman's Health Center, Inc., indicates on its website that ultrasounds are performed on every patient to confirm gestational age, rule out an ectopic pregnancy, and provide the physician with information necessary to perform the procedure.[51]

There are several states with various regulations concerning the use of ultrasounds prior to an abortion. Nine states require verbal counseling or written materials to include information on accessing ultrasound services. Eighteen states regulate the provision of ultrasound by abortion providers. Three states mandate that an abortion provider perform an ultrasound on each woman seeking an abortion and require the provider to offer the woman the opportunity to view the image. Two states require the abortion provider to perform an ultrasound on each woman obtaining an abortion after the first trimester and to offer the woman the opportunity to view the image. Ten states require that a woman be provided with the opportunity to view an ultrasound image if her provider performs the procedure as part of the preparation for an abortion. Four states require a woman to be provided with the opportunity to view an ultrasound image.[52]

III. Effect of Proposed Changes:

Except in a medical emergency, this bill provides that consent to a termination of pregnancy is voluntary and informed if a woman seeking an abortion has the gestational age of the fetus verified by an ultrasound, regardless of the woman's stage of pregnancy. The bill requires a physician who is to perform the abortion or a person who has completed a course in the operation of ultrasound equipment as prescribed by rule and works in conjunction with the performing physician to perform the ultrasound. However, the physician or the authorized person may not perform an ultrasound if, at the time the woman schedules or arrives for her appointment to obtain the abortion, documentation is provided (e.g. a restraining order, police report, medical record, or court order) evidencing that the woman is obtaining the abortion because she is a victim of rape, incest, domestic violence, or human trafficking.

The person performing the ultrasound must allow the woman to view the live ultrasound images and a physician, registered nurse, licensed practical nurse, advanced registered nurse practitioner, or physician assistant working in conjunction with the physician, must contemporaneously

[49] *Id.*
[50] *See, e.g.,* A Choice for Women Website at http://www.achoiceforwomen.com/services/services.asp; Eve Medical Center Website at http://www.eveabortioncarespecialists.com/1and2Trimester.html; North Florida Women's Health & Counseling Services, Inc.,Website at http://www.northfloridawomenshealth.com/abortion_services.html; and A Jacksonville Women's Health Center, Inc., Website at http://www.ajacksonvillewomenshealth.com/abortion.html; (all last viewed March 23, 2011).
[51] *See* A Jacksonville Women's Health Center, Inc., Website http://www.ajacksonvillewomenshealth.com/abortion.html (Last viewed on March 23, 2011).
[52] Guttmacher Institute, *State Policies in Brief: Requirements for Ultrasound*, March 1, 2011, available at: http://www.guttmacher.org/statecenter/spibs/spib_RFU.pdf (Last visited on March 23, 2011).

explain the ultrasound images to the woman before she gives informed consent to having the abortion procedure. However, if at the time the woman schedules or arrives for her appointment to obtain an abortion, a copy of a medical record or other documentation is presented, which evidences that the woman has been diagnosed as having a condition that, on the basis of a physician's good faith clinical judgment, would create a serious risk of substantial and impairment of a major bodily function of the woman, the ultrasound is not required to be provided or explained.

The bill provides that a woman has a right to decline to view the ultrasound images after she has been offered an opportunity to view them. However, if the woman declines to view the ultrasound images, she is required to complete a form acknowledging that she was offered an opportunity to view the ultrasound, that she has declined to view the images, and that her refusal to view the images was of her own free will and not based on any undue influence from any third party.

The bill provides that consent to a termination of pregnancy is voluntary and informed if, among other things, a written description of the fetus, including a description of the various stages of development, has been provided to the woman.

The bill requires the AHCA to adopt rules requiring a woman seeking an abortion in an abortion clinic to take a urine or blood test, regardless of whether she will have an ultrasound performed. The AHCA must also adopt rules requiring an ultrasound evaluation for each patient in an abortion clinic, unless the patient has documentary proof that she is a victim of rape, incest, domestic violence, or human trafficking.

The bill also includes a severability clause, which severs any provision of the bill that is held invalid.

The bill provides an effective date of July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

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

D. Other Constitutional Issues:

If the bill, should it become law, is challenged because of the ultrasound requirements, it will be subject to a strict scrutiny review, rather than that of an undue burden test pursuant to *North Florida Women's Health and Counseling Services, Inc., et al., v. State of Florida*,[53] as discussed above under the subheading, "Relevant Case Law."

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill requires clinics conducting only first trimester terminations of pregnancy to purchase ultrasound equipment, if such equipment is not currently available on premises. However, some providers that already perform ultrasounds regardless of the stage of pregnancy will not experience any increased costs.

A woman seeking to have an abortion may incur costs associated with the required ultrasound in addition to a urine or blood test to determine if the woman is pregnant.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Line 52 of the bill prevents a physician from performing an ultrasound if certain documentation is presented evidencing the woman is seeking the abortion because she is a victim of rape, incest, domestic violence, or human trafficking. This language does not provide an exception for instances when a woman requests the ultrasound despite the circumstances or where it may be the best practice of the physician to perform an ultrasound.

VIII. Additional Information:

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

None.

[53] 866 So. 2d 612 (Fla. 2003).

B. Amendments:

None.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 1108
INTRODUCER:	Senator Storms
SUBJECT:	The Use of Cigarette Tax Proceeds
DATE:	March 25, 2011 REVISED:

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

I. Summary:

The bill amends Florida Statutes related to the distribution of funds from the Cigarette Tax Collection Trust Fund to the H. Lee Moffitt Cancer Center and Research Institute (Moffitt Center) and the use of those funds.

Effective June 30, 2013, the bill discontinues the current cigarette tax revenue distribution to the Moffitt Center of 1.47 percent of the net collections and, effective July 1, 2013, provides for a distribution to the Moffitt Center of 5 percent of net collections through June 30, 2045. Under current law and the bill, the distribution amount cannot be less than the amount would have been in state fiscal year 2001-02 if distributed at the percentage amount specified in statute. The bill expands the allowable use of these funds to various additional functions at the Moffitt Center.

This bill substantially amends the following sections of the Florida Statutes: 210.20 and 210.201.

II. Present Situation:

The H. Lee Moffitt Cancer Center and Research Institute

Section 1004.43, F.S., establishes the Moffitt Center at the University of South Florida (USF). A not-for-profit corporation governs the Moffitt Center in accordance with an agreement with the State Board of Education for the use of facilities on the USF campus. The not-for-profit corporation, acting as an instrumentality of the state, operates the center in accordance with an agreement between the Board of Governors[1] and the corporation. A board of directors manages

[1] Under revisions to the statute made by ch. 2007-217, L.O.F., the original agreement between the State Board of Education

the corporation, and a chief executive officer, who serves at the pleasure of the board of directors, administers the center.

The Statewide Presence of the H. Lee Moffitt Cancer Center and Research Institute

The Moffitt Center is the only cancer research facility in Florida that is designated as a Comprehensive Cancer Center by the National Cancer Institute (NCI). According to NCI, the Comprehensive Cancer Centers "are expected to initiate and conduct early phase, innovative clinical trials and to participate in the NCI's cooperative groups by providing leadership and recruiting patients for trials."[2]

Comprehensive Cancer Centers must conduct outreach and educational activities for healthcare professionals and the public. The Moffitt Center operates a clinical care and research network called Total Cancer Care (TCC) in collaboration with 15 medical center affiliates in Florida and one in Georgia. The TCC project provides personalized therapy in a large research project with patients who consent for the center to follow them over their lifetime. The TCC network increases access to the Moffitt Center's cancer care and research expertise, including genetic profiling of patient specimens leading to personalized therapies, for patients being treated at one of the affiliated medical centers.

Cigarette Tax Revenues

Chapter 210, F.S., governs taxes on tobacco products. Cigarette tax collections received by the Division of Alcoholic Beverages and Tobacco in the Department of Business and Professional Regulation (DBPR) are deposited into the Cigarette Tax Collection Trust Fund.
Section 210.20(2), F.S., provides for monthly distributions as follows:

From total collections:
- 8.0 percent service charge to General Revenue Fund
- 0.9 percent to Alcoholic Beverage and Tobacco Trust Fund

From the remaining net collections:
- 2.9 percent to Revenue Sharing Trust Fund for Counties
- 29.3 percent to Public Medical Assistance Trust Fund
- 1.47 percent to the Moffitt Center ($5,691,995 per year minimum, or $474,332.96 monthly)[3]
- The remainder to the General Revenue Fund

and the center is now overseen by the Board of Governors.
[2] National Institutes of Health, National Cancer Institute, "NCI-designated Cancer Centers". See http://cancercenters.cancer.gov/cancer_centers/cancer-centers-list.html (last visited March 25, 2011).
[3] When the Moffitt Center's distribution was created in 1998 by ch. 98-286, L.O.F., the percentage was set at 2.59 percent, which was in effect until December 31, 2008. Other distributions were created in 2002 by ch. 2002-393, L.O.F., including an additional 1.47 percent distribution, which took effect July 1, 2004, on top of the 2.59 percent distribution. The 1.47 percent distribution expires June 30, 2020, under current law.

Use of Cigarette Tax Funds by the Moffitt Center

Section 210.20(b)2., F.S., which provides for the current 1.47 percent distribution to the Moffitt Center, specifies that the funds are to be used for the purpose of constructing, furnishing, and equipping a cancer research facility at USF adjacent to the Moffitt Center.

Section 210.201, F.S., further specifies that funds distributed to the Moffitt Center under s. 210.20, F.S., must be used to secure financing to pay costs related to constructing, furnishing, and equipping the cancer research facility. Such financing may include the issuance of tax-exempt bonds by a local authority, municipality, or county.

III. Effect of Proposed Changes:

Section 1 amends s. 210.20, F.S., to provide that, beginning with the distributions from the July 2013 net cigarette collections, and continuing monthly through June 30, 2045, the Moffitt Center's cigarette tax distribution will increase from 1.47 percent of the net collections to 5 percent, with a minimum of what would have been paid in state fiscal year 2001-02 had the distribution rate of 5 percent been in effect at that time.

The bill also expands the allowable uses for the Moffitt Center's distribution to specify that the funds must be used for lawful purposes that include:

- Constructing, furnishing, equipping, operating, and maintaining cancer center and clinical facilities;
- Furnishing, equipping, operating, and maintaining other properties owned or leased by the Moffitt Center; and
- Paying costs incurred for purchasing, operating, and maintaining equipment in or on any of those facilities or properties.

Reference to the cancer center facility being located at USF, adjacent to the Moffitt Center, is removed from statute.

The change to the distribution percentage does not become effective until July 1, 2013; however, the changes made to the allowable uses of the funds take effect on the bill's effective date, regardless of the distribution percentage.

Section 2 amends s. 210.201, F.S., to conform to the allowable uses specified by the amendment to s. 210.20, F.S., in Section 1 of the bill.

Section 3 provides an effective date for the bill of July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

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

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

Under current law, the statutory minimum cigarette tax distribution to the Moffitt Center is $5,691,995 annually or $474,332.96 monthly, based on the amount of the distribution percentage if that percentage had been in effect in state fiscal year 2001-02. The bill increases the minimum to $19,411,110 annually or $1,617,592.50 monthly, effective July 1, 2013. This means that, under the bill, the Moffitt Center's minimum distribution per year will increase by $13,719,115 beginning with the 2013-14 state fiscal year.[4]

By increasing the distribution percentage to the Moffitt Center as described above, there will be a corresponding decrease in revenue remaining to be distributed to the state General Revenue Fund, by an amount of $13,719,115 annually, beginning with the 2013-14 state fiscal year.[5]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

[4] Department of Business and Professional Regulation, *2011 Legislative Analysis: SB 1108,* on file with Senate Committee on Health Regulation staff.
[5] *Id.*

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.

109500

LEGISLATIVE ACTION

Senate . House

. .

. .

. .

. .

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 402.7306, Florida Statutes, is amended to read:

402.7306 Administrative monitoring of ~~for~~ child welfare providers, and administrative, licensure, and programmatic monitoring of mental health and substance abuse service providers.—The Department of Children and Family Services, the Department of Health, the Agency for Persons with Disabilities, the Agency for Health Care Administration, ~~and~~ community-based

care lead agencies, managing entities as defined in s. 394.9082, and agencies who have contracted with monitoring agents shall identify and implement changes that improve the efficiency of administrative monitoring of child welfare services, and the administrative, licensure, and programmatic monitoring of mental health and substance abuse service providers. For the purpose of this section, the term "mental health and substance abuse service provider" means a provider who provides services to this state's priority population as defined in s. 394.674. To assist with that goal, each such agency shall adopt the following policies:

(1) Limit administrative monitoring to once every 3 years if the child welfare provider is accredited by the Joint Commission ~~on Accreditation of Healthcare Organizations~~, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation ~~of Children and Family Services~~. 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 substance abuse service provider is accredited by the Joint Commission, 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 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.

Medicaid certification and precertification reviews are exempt from this subsection to ensure Medicaid compliance.

(3) ~~(2)~~ Allow private sector development and implementation of an Internet-based, secure, and consolidated data warehouse and archive for maintaining corporate, fiscal, and administrative records of child welfare, mental health, or substance abuse service providers. A service provider shall ensure that the data is up to date and accessible to the applicable agency under this section and the appropriate agency subcontractor. A service provider shall submit any revised, updated information to the data warehouse within 10 business days after receiving the request. An agency that conducts administrative monitoring of child welfare, mental health, or substance abuse service providers under this section must use the data warehouse for document requests. If the information provided to the agency by the provider's data warehouse is not current or is unavailable from the data warehouse and archive, the agency may contact the service provider directly. A service provider that fails to comply with an agency's requested documents may be subject to a site visit to ensure compliance. Access to the data warehouse must be provided without charge to

an applicable agency under this section. At a minimum, the records must include the service provider's:

(a) Articles of incorporation.

(b) Bylaws.

(c) Governing board and committee minutes.

(d) Financial audits.

(e) Expenditure reports.

(f) Compliance audits.

(g) Organizational charts.

(h) Governing board membership information.

(i) Human resource policies and procedures.

(j) Staff credentials.

(k) Monitoring procedures, including tools and schedules.

(l) Procurement and contracting policies and procedures.

(m) Monitoring reports.

Section 2. This act shall take effect upon becoming a law.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to administrative monitoring of providers of child welfare services, mental health services, and substance abuse services; amending s. 402.7306, F.S.; defining the term "mental health and substance abuse service provider" as it relates to the monitoring of providers of child welfare services, mental health services, and substance abuse services;

requiring the Department of Children and Family Services, the Department of Health, the Agency for Persons with Disabilities, the Agency for Health Care Administration, community-based care lead agencies, managing entities, and agencies that have contracted with monitoring agents to adopt certain revised policies for the administrative monitoring of child welfare service providers, mental health service providers, and substance abuse service providers; conforming provisions to changes made by the act; limiting the frequency of required administrative, licensure, and programmatic monitoring for mental health service providers and substance abuse service providers that are accredited by specified entities; providing certain exception to the limitations on monitoring; requiring that the corporate, fiscal, and administrative records of mental health service providers and substance abuse service providers be included in a consolidated data warehouse and archive; providing an effective date.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Health Regulation Committee

BILL: CS/SB 1366

INTRODUCER: Children, Families, and Elder Affairs Committee and Senator Storms

SUBJECT: Child Welfare/Mental Health/Substance Abuse

DATE: April 1, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Daniell	Walsh	CF	**Fav/CS**
2.	O'Callaghan	Stovall	HR	**Pre-meeting**
3.			BC	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

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

I. Summary:

The committee substitute (CS) for Senate Bill 1366 includes managing entities and their contracted monitoring agents among the entities who must identify and implement changes that improve the efficiency of administrative monitoring of child welfare, mental health, and substance abuse services.

To improve efficiency, these entities must limit administrative, licensure, and programmatic monitoring to once every three years if the provider of child welfare, mental health, or substance abuse services is accredited by the Joint Commission on the Accreditation of Healthcare Organizations (Joint Commission), the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA). These entities must also allow the private sector to develop and implement an Internet-based, secure, and consolidated data warehouse and archive for maintaining certain records of providers of child welfare, mental health, or substance abuse services and the entities must use the data warehouse to request documents.

The CS provides that the limitations on administrative, licensure, and programmatic monitoring apply only to providers of child welfare, mental health, or substance abuse services that are accredited for the services being monitored.

This CS substantially amends the following section of the Florida Statutes: 402.7306.

II. Present Situation:

Contract Monitoring

State agency procurement contracts typically include oversight mechanisms for contract management and program monitoring. Contract monitors ensure that contractually required services are delivered in accordance with the terms of the contract, approve corrective action plans for non-compliant providers, and withhold payment when services are not delivered or do not meet quality standards.

From November 1, 2008, to October 31, 2009, the Children's Home Society of Florida (CHS) surveyed[1] 174 programs,[2] in an effort to "assess the quantity of external contract monitoring of CHS programs" and "identify any potential areas of duplication across monitoring by state and designated lead agencies…" According to the responses:

- The 174 CHS programs were monitored 222 times by state and community-based agencies, and 1,348 documents were requested in advance of site monitoring visits.
- Of the document requests, 417 were requested by other state agencies or other divisions within a state agency.
- Professional program staff spent 966 cumulative hours on duplicative requests.

To address these concerns, in 2010, the Legislature enacted HB 5305,[3] which required that health and human services contracting agencies[4] limit administrative monitoring to once every three years, if the contracted provider of child welfare services is accredited by the Joint Commission, the CARF, or the COA.

In addition, the bill authorized private-sector development and implementation of an Internet-based, secure, and consolidated data warehouse for maintaining corporate, fiscal, and administrative records related to child welfare provider contracts, and required state agencies that contract with child welfare providers to access records from this database.

Entities not covered by the newly-enacted law — that is, entities other than child welfare providers — have expressed similar concerns about excessive monitoring and auditing by human services agencies. Meridian Behavioral Healthcare advises[5] that in a 12-month period ending February 2011, they were the subject of 17 audits, 14 of which were by state agencies. Other

[1] CHS, *Case Study- Contract Monitoring Survey*, (November 30, 2009), on file with the Senate Health Regulation Committee.
[2] There was a 100% response rate.
[3] Chapter 2010-158, Laws of Florida.
[4] "Contracting or funding agencies" are defined as a state agency or other non-profit organization (including community-based organizations) that contract state funds to a program. The contracting agencies include the Department of Children and Families, Department of Health, Agency for Persons with Disabilities, Agency for Health Care Administration, and community-based care lead agencies. *See* CHS, *Case Study- Contract Monitoring Survey*, (November 30, 2009).
[5] Audit Data. Meridian Behavioral Healthcare, on file with the Senate Health Regulation Committee.

than contract-specific data, all audited items are reviewed by CARF prior to Meridian's accreditation.[6]

Mental Health and Substance Abuse

Section 394.66(16), F.S., expresses the Legislature's intent that "the state agencies licensing and monitoring contracted [substance abuse and mental health service] providers perform in the most cost-efficient and effective manner with limited duplication and disruption to organizations providing services."

"Mental health services" are those therapeutic interventions and activities that help to eliminate, reduce, or manage symptoms or distress for persons who have severe emotional distress or a mental illness and to effectively manage the disability that often accompanies a mental illness so that the person can recover from the mental illness, become appropriately self-sufficient for his or her age, and live in a stable family or in the community. The term also includes those preventive interventions and activities that reduce the risk for, or delay, the onset of mental disorders, including treatment, rehabilitative, support, and case management services.[7]

"Substance abuse services" are those services designed to prevent or remediate the consequences of substance abuse, improve an individual's quality of life and self-sufficiency, and support long-term recovery. They include prevention, assessment, intervention, rehabilitation, and other ancillary services.[8]

In establishing behavioral health managing entities, the Legislature intended that:

> A management structure that places the responsibility for publicly financed behavioral health treatment and prevention services[9] within a single private, nonprofit entity at the local level will promote improved access to care, promote service continuity, and provide for more efficient and effective delivery of substance abuse and mental health services. [In addition] streamlining administrative processes will create cost efficiencies and provide flexibility to better match available services to consumers' identified needs.[10]

A managing entity is a nonprofit organization under contract with the Department of Children and Family Services (DCF) to manage the day-to-day operational delivery of behavioral health services through an organized system of care.[11] Their goal is to effectively coordinate, integrate, and manage the delivery of effective behavioral health services to persons who are experiencing a mental health or substance abuse crisis, who have a disabling disorder, and require extended services in order to recover, or who need brief treatment or longer-term supportive interventions to avoid a crisis or disability. In addition, the system enhances the continuity of care for all

[6] *Id.*
[7] Section 394.67(15), F.S.
[8] Section 394.67(24), F.S.
[9] Behavioral health services are mental health services and substance abuse prevention and treatment services provided using state and federal funds. Section 394.9082(2)(a), F.S.
[10] Section 394.9082(1), F.S.
[11] Section 394.9082(2)(d), F.S.

children, adolescents, and adults who enter the publicly funded behavioral health service system.[12]

Licensure Review

Child-placing agencies and residential child-caring agencies are licensed by the DCF.[13] Those entities may be monitored only once per year, and that monitoring may not duplicate the administrative monitoring conducted by their accreditation agency.[14]

Section 394,741, F.S., requires the DCF and the Agency for Health Care Administration (AHCA) to accept accreditation as a substitute for facility onsite licensure review and administrative and programmatic requirements for mental health and behavioral health services.

Section 397.411, F.S., requires DCF to accept, in lieu of its own inspections for licensure, the survey or inspection of an accrediting organization, if the provider is accredited according to the provisions of s. 394.741, F.S., and the DCF receives the report of the accrediting organization.

Substance abuse and mental health facilities are subject to licensure by the AHCA.[15] Section 408.811(2), F.S., provides that

> Inspections conducted in conjunction with certification, comparable licensure requirements, or a recognized or approved accreditation organization may be accepted in lieu of a complete licensure inspection. However, a licensure inspection may also be conducted to review any licensure requirements that are not also requirements for certification. (emphasis supplied)

III. Effect of Proposed Changes:

CS/SB 1366 includes managing entities and their contracted monitoring agents among the entities who must identify and implement changes that improve the efficiency of administrative monitoring of child welfare, mental health, and substance abuse services.

To improve efficiency, these entities must limit administrative, licensure, and programmatic monitoring to once every three years if the provider of child welfare, mental health, or substance abuse services is accredited by the Joint Commission, the CARF, or the COA. These entities must also allow the private sector to develop and implement an Internet-based, secure, and consolidated data warehouse and archive for maintaining certain records of providers of child welfare, mental health, or substance abuse services and the entities must use the data warehouse to request documents.

CS/SB 1366 provides that the limitations on administrative, licensure, and programmatic monitoring apply only to providers of child welfare, mental health, or substance abuse services that are accredited for the services being monitored.

[12] Section 394.9082(5), F.S.
[13] Section 409.175, F.S.
[14] Section 402.7305(4), F.S.
[15] Section 408.801, F.S., *et seq*.

The act is effective July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

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

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The private sector will experience fewer monitoring visits, thereby increasing the amount of time available to spend on providing direct services.

C. Government Sector Impact:

A limit on allowed administrative, licensure, and programmatic monitoring could potentially lead to a reduction in expenditures of certain state agencies and covered entities.

VI. Technical Deficiencies:

None.

VII. Related Issues:

As to licensees of the AHCA, it would appear that, for accredited substance abuse or mental health service providers, the provisions of CS/SB 1366 would not allow the AHCA to conduct licensure inspections for those licensure requirements not covered for certification, except once every three years.

The AHCA reports that federal guidelines require the AHCA to monitor a Medicaid managed care organization (MCO) and its network of mental health and substance abuse treatment

providers. Terms in the contracts between the AHCA and the MCOs require the plans to monitor their affiliated network of providers at least annually. Federal law under 42 CFR 438.360, allows states to avoid duplication of monitoring MCOs by using a private accreditation review to provide information in place of a Medicaid review. However, this rule does not address duplication of monitoring of providers.[16]

The DCF notes the following:[17]

- The bill prohibits agencies from monitoring for any requirements that are addressed by accreditation standards, regardless of how long it has been since the accreditation was awarded, which can be three to five years depending on the accrediting entity.
- The bill does not appear to be consistent with s. 409.175(6)(f), F.S., that requires annual fire safety inspections. Licensing issues that must be routinely inspected in child-caring agencies in order to ensure compliance and child safety include: medication dispensing, documentation and securing; safety and cleanliness of the facility and premises; fire prevention/fire inspections; health standards/health inspection; and transportation provisions.[18]

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 Children, Families and Elder Affairs on March 14, 2011:
The Committee adopted an amendment which clarified that the limitations on monitoring do not apply to services for which the provider is not accredited, and deleted unnecessary directory language.

B. Amendments:

None.

[16] AHCA, 2011 Bill Analysis & Economic Impact Statement, on file with the Senate Health Regulation Committee.
[17] Department of Children and Families Staff Analysis and Economic Impact SB 1366, March 4, 2011, on file with the Senate Health Regulation Committee.
[18] *Id.*

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HR.HR.03628

Proposed Committee Substitute by the Committee on Health Regulation

A bill to be entitled

An act relating to assisted care communities; amending s. 400.141, F.S.; deleting adult care communities from the standards and rules of the Agency for Health Care Administration which apply to registered pharmacists under contract with a nursing home and related health care facilities; amending s. 408.820, F.S.; providing that assisted living facilities are exempt from certain provisions authorizing the agency to impose administrative fines for violations of laws and applicable rules; amending s. 409.912, F.S.; requiring the agency to provide for the establishment of a demonstration project for a psychiatric facility in Miami-Dade County; amending s. 429.01, F.S.; revising legislative intent and the purposes of the Assisted Living Facilities Act; amending s. 429.02, F.S.; providing, revising, and deleting definitions; amending s. 429.04, F.S.; deleting provisions exempting a home health agency from licensure as an assisted living facility under certain circumstances; amending s. 429.07, F.S.; deleting limited nursing services as a category of care in which the agency may issue a license; revising the criteria and requirements for categories of care in which the agency may issue a license; revising the licensing fees; requiring the agency to conduct a survey to determine whether a facility must be monitored; providing that certain cited assisted living facilities are subject to unannounced monitoring activities; providing for a registered nurse to participate in monitoring visits within a certain time following a class I or class II violation involving

nursing care; amending s. 429.08, F.S.; requiring emergency medical technicians or paramedics to report the operations of an unlicensed assisted living facility; amending s. 429.11, F.S.; requiring the Agency for Health Care Administration to develop an abbreviated form for submission of proof of financial ability to operate an assisted living facility; amending s. 429.12, F.S.; deleting the provision that requires a transferor of an assisted living facility to advise the transferee that a plan of correction must be submitted by the transferee and approved by the agency within a specified period; amending s. 429.14, F.S.; deleting a provision that authorizes the agency to impose an administrative penalty due to the actions of a facility's employee; revising the actions for which the agency may impose an administrative penalty; conforming a provision to changes made by the act; deleting the provision that authorizes the agency to revoke or deny the license of an assisted living facility that has certain class I violations; deleting a provisions that requires the agency to provide to the Division of Hotels and Restaurants of the Department of Business and Professional Regulation a monthly list of assisted living facilities that have had their licenses denied, suspended, or revoked; amending s. 429.17, F.S.; conforming provisions to changes made by the act; revising requirements for a conditional license; amending s. 429.178, F.S.; providing safety requirements for facilities serving persons with Alzheimer's disease or other related disorders; deleting a provision relating to a facility's responsibility for the payment of certain training and education programs; amending s. 429.19, F.S.; revising procedures for the Agency for Health Care

Administration regarding the imposition of fines for violations of ch. 429, F.S., related to adult care communities; specifying the conditions or occurrences that constitute a class I, class II, class III, or class IV violation; amending s. 429.195, F.S.; prohibiting the licensee of an assisted living facility from contracting or promising to pay or receive any commission, bonus, kickback, or rebate or from engaging in any split-fee arrangement with any health care provider or health care facility; providing certain exceptions; amending s. 429.20, F.S.; prohibiting the solicitation of contributions of any kind in a threatening, coercive, or unduly forceful manner by or on behalf of an assisted living facility; deleting provisions specifying that the solicitation or receipt of contributions is grounds for denial, suspension, or revocation of a license for an assisted living facility; amending s. 429.23, F.S.; revising reporting requirements with respect to adverse incidents; amending s. 429.255, F.S.; permitting certain licensed persons to provide limited nursing services; deleting the provision that allows volunteers to perform duties within the scope of their license or certification in facilities that are licensed to provide extended congregate care; amending s. 429.256, F.S.; authorizing a facility to require certain dispensing systems for residents' prescriptions; revising criteria for assistance with self-administration of medication; amending s. 429.26, F.S.; removing a requirement that a facility notify a licensed physician when a resident exhibits certain signs of dementia, cognitive impairment, or change of condition; amending s. 429.27, F.S.; revising provisions relating to the property and personal effects of residents of a facility; requiring a

facility's licensee, owner, administrator, staff, or representative to execute a surety bond for each resident for whom power of attorney has been granted to the licensee, owner, administrator, or staff; deleting the provision that requires a governmental agency or private charitable agency to receive a statement of all funds and other property of a resident; deleting a provision that prohibits an administrator of a facility from levying an additional charge to the individual or the account for any supplies or services that the facility has agreed by contract to provide; repealing s. 429.275(4), F.S., relating to rulemaking authority of the Department of Elderly Affairs over financial records, personnel procedures, accounting procedures, reporting procedures, and insurance coverage for residents of assisted living facilities; amending s. 429.28, F.S., relating to the resident bill of rights; revising the number of days' notice for relocation or termination of residency at a facility; removing responsibilities of the agency for conducting compliance surveys and complaint investigations; revising the actions of a person for which a staff member or employee of a facility is prohibited from taking retaliatory action upon; prohibiting the administrator of a facility from terminating the residency of an individual under certain circumstances; amending s. 429.29, F.S.; providing that a resident who alleges negligence or a violation of rights has a cause of action against the licensee of an assisted living facility or its management company under certain circumstances; providing a limitation on noneconomic damages if the claimant elects to pursue damages for wrongful death; amending s. 429.293, F.S.; permitting the use of an arbitration process to

resolve a resident's claim of a rights violation or negligence; revising notification requirements; amending s. 429.294, F.S.; authorizing the release of copies of a resident's records to specified persons under certain circumstances; authorizing the facility to charge a fee to copy the records; providing limits on the frequency of the release of such records; amending s. 429.297, F.S.; revising procedures for bringing a claim for punitive damages against an assisted living facility; redefining the term "intentional misconduct"; amending s. 429.298, F.S.; revising the limits on the award for punitive damages; removing a provision that provides for a criminal investigation with a finding of liability for punitive damages; removing a provision that provides for admissibility of findings in subsequent civil and criminal actions; providing that the punitive damages awarded are not required to be divided equally between the claimant and the Quality of Long-Term Care Facility Improvement Trust Fund; revising the percentages of the division of the settlement amount; amending s. 429.41, F.S.; revising rulemaking authority regarding resident care and maintenance of facilities; requiring the State Fire Marshal, in cooperation with the agency, to establish and enforce firesafety standards; deleting the requirement for a facility to conduct a minimum number of resident elopement drills; requiring the agency to use an abbreviated biennial standard licensure inspection; requiring the agency, in consultation with the Department of Health, to develop, maintain, and update the key quality-of-care standards with input from the State Long-Term Care Ombudsman Council and representatives of associations and organizations representing assisted living facilities; amending s. 429.42, F.S.; removing a

provision that required a corrective plan for deficiencies related to assistance with the self-administration of medication or the administration of medication; deleting a requirement that the agency employ a certain number of pharmacists among its personnel who inspect assisted living facilities; amending s. 429.445, F.S.; removing a requirement that an assisted living facility submit certain information to the agency before commencing construction to expand the facility; amending s. 429.47, F.S.; authorizing an owner of an assisted living facility to advertise to the public while the facility is under construction or is seeking licensure; deleting a provision that prohibits a freestanding facility from advertising or implying that any part of it is a nursing home; amending s. 429.49, F.S.; conforming terminology to changes made by the act; amending s. 429.52, F.S.; revising training and education requirements for certain administrators, facility staff, and other licensed professionals; requiring training providers certified by the department to meet continuing education requirements and standards; providing conditions for the sanctioning of training providers and trainees; amending s. 429.53, F.S.; removing provisions relating to preconstruction approvals and reviews and agency consultations; repealing s. 429.54, F.S., relating to the collection of information regarding the actual cost of providing services in assisted living facilities and local subsidies; amending s. 429.71, F.S.; clarifying terminology; removing a provision authorizing the agency to request a plan to remedy violations by adult family-care homes; conforming terminology to changes made by the act; amending s. 429.81, F.S.; specifying that residency agreements require a resident to provide 30 days'

written notice of intent to terminate his or her residency; creating s. 430.081, F.S.; authorizing the Department of Elderly Affairs to sanction training providers and trainees for infractions involving any required training; providing training infractions; providing sanctions; amending s. 817.505, F.S.; providing that payments by an assisted living facility are not considered patient brokering under certain circumstances; providing an effective date.

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

Section 1. Paragraph (d) of subsection (1) of section 400.141, Florida Statutes, is amended to read:

400.141 Administration and management of nursing home facilities.—

(1) Every licensed facility shall comply with all applicable standards and rules of the agency and shall:

(d) Provide for resident use of a community pharmacy as specified in s. 400.022(1)(q). Any other law to the contrary notwithstanding, a registered pharmacist licensed in Florida, that is under contract with a facility licensed under this chapter ~~or chapter 429,~~ shall repackage a nursing facility resident’s bulk prescription medication which has been packaged by another pharmacist licensed in any state in the United States into a unit dose system compatible with the system used by the nursing facility, if the pharmacist is requested to offer such service. In order to be eligible for the repackaging, a resident or the resident’s spouse must receive prescription medication

benefits provided through a former employer as part of his or her retirement benefits, a qualified pension plan as specified in s. 4972 of the Internal Revenue Code, a federal retirement program as specified under 5 C.F.R. s. 831, or a long-term care policy as defined in s. 627.9404(1). A pharmacist who correctly repackages and relabels the medication and the nursing facility which correctly administers such repackaged medication under this paragraph may not be held liable in any civil or administrative action arising from the repackaging. In order to be eligible for the repackaging, a nursing facility resident for whom the medication is to be repackaged shall sign an informed consent form provided by the facility which includes an explanation of the repackaging process and which notifies the resident of the immunities from liability provided in this paragraph. A pharmacist who repackages and relabels prescription medications, as authorized under this paragraph, may charge a reasonable fee for costs resulting from the administration ~~implementation~~ of this provision.

Section 2. Subsection (13) of section 408.820, Florida Statutes, is amended to read:

408.820 Exemptions.—Except as prescribed in authorizing statutes, the following exemptions shall apply to specified requirements of this part:

(13) Assisted living facilities, as provided under part I of chapter 429, are exempt from ss. ~~s.~~ 408.810(10) and 408.813(2).

Section 3. Subsection (41) of section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.—The

agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain

populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers shall not be entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in

order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(41) The agency shall establish ~~provide for the development of~~ a demonstration project ~~by establishment~~ in Miami-Dade County of a long-term-care facility and a psychiatric facility licensed pursuant to chapter 395 to improve access to health care for a predominantly minority, medically underserved, and medically complex population and to evaluate alternatives to nursing home care and general acute care for such population. Such project is to be located in a health care condominium and collocated ~~colocated~~ with licensed facilities providing a continuum of care. These projects are ~~The establishment of this project is~~ not subject to the provisions of s. 408.036 or s. 408.039.

Section 4. Subsection (2) of section 429.01, Florida Statutes, is amended to read:

429.01 Short title; purpose.—

(2) The purpose of this act is to:

(a) Promote the availability of appropriate services for elderly persons and adults with disabilities in the least restrictive and most homelike environment;~~, to~~

(b) Encourage the development of facilities that promote the dignity, individuality, privacy, and decisionmaking ability of such persons;~~, to~~

(c) Provide for the health, safety, and welfare of residents of assisted living facilities in the state;~~, to~~

(d) Promote continued improvement of such facilities;~~,~~ to encourage the development of innovative and affordable facilities particularly for persons with low to moderate

incomes;~~, to~~

(e) Ensure that all agencies of the state cooperate in the protection of such residents;~~,~~ and ~~to~~

(f) Ensure that needed economic, social, mental health, health, and leisure services are made available to residents of such facilities through the efforts of the Agency for Health Care Administration, the Department of Elderly Affairs, the Department of Children and Family Services, the Department of Health, assisted living facilities, and other community agencies.

To the maximum extent possible, appropriate community-based programs must be available to state-supported residents to augment the services provided in assisted living facilities. The Legislature recognizes that assisted living facilities are an important part of the continuum of long-term care in the state as community-based social models that have a health component and not as medical or nursing facilities. In support of the goal of aging in place, the Legislature further recognizes that assisted living facilities should be operated ~~and regulated~~ as residential environments with supportive services and not as medical or nursing facilities and, as such, should not be subject to the same regulations as medical or nursing facilities but instead be regulated in a less restrictive manner that is appropriate for a residential, nonmedical setting. The services available in these facilities, either directly or through contract or agreement, are intended to help residents remain as independent as possible. Regulations governing these facilities must be sufficiently flexible to allow facilities to adopt

policies that enable residents to age in place when resources are available to meet their needs and accommodate their preferences.

Section 5. Section 429.02, Florida Statutes, is amended to read:

429.02 Definitions.—When used in this part, the term:

(1) "Activities of daily living" means functions and tasks for self-care, including ambulation, bathing, dressing, eating, grooming, and toileting, and other similar tasks.

(2) "Administrator" means an individual at least 21 years of age who is responsible for the operation and maintenance of an assisted living facility; for promoting the resident's dignity, autonomy, independence, and privacy in the least restrictive and most homelike setting consistent with the resident's preferences and physical and mental statuses; and for ensuring the appropriateness of continued placement of a resident, in consultation with the resident, resident's representative or designee, if applicable, and the resident's physician.

(3) "Agency" means the Agency for Health Care Administration.

(4) "Aging in place" or "age in place" means the process of providing increased or adjusted services to a person to compensate for the physical or mental decline that may occur with the aging process, in order to maximize the person's dignity and independence and permit them to remain in a familiar, noninstitutional, residential environment for as long as possible, as determined by the individual, his or her physician, and the administrator. Such services may be provided

by facility staff, volunteers, family, or friends, or through contractual arrangements with a third party.

(5) "Arbitration" means a process whereby a neutral third person or panel, called an arbitrator or arbitration panel, considers the facts and arguments presented by the parties and renders a decision that may be biding or nonbinding as provided for in chapter 44.

(6) ~~(5)~~ "Assisted living facility" means any residential setting that provides, directly or indirectly by means of contracts or arrangements, for a period exceeding 24 hours, ~~building or buildings, section or distinct part of a building, private home, boarding home, home for the aged, or other residential facility, whether operated for profit or not, which undertakes through its ownership or management to provide~~ housing, meals, and one or more personal services that meet the resident's changing needs and preferences ~~for a period exceeding 24 hours~~ to one or more adults who are not relatives of the owner or administrator. As used in this subsection, the term "residential setting" includes, but is not limited to, a building or buildings, section or distinct part of a building, private home, or other residence.

(7) ~~(6)~~ "Chemical restraint" means a pharmacologic drug that physically limits, restricts, or deprives an individual of movement or mobility, and is used for discipline or convenience and not required for the treatment of medical symptoms.

(8) ~~(7)~~ "Community living support plan" means a written document prepared by a mental health resident and the resident's mental health case manager, in consultation with the administrator or the administrator's designee, of an assisted

living facility with a limited mental health license ~~or the administrator's designee~~. A copy must be provided to the administrator. The plan must include information about the supports, services, and special needs of the resident which enable the resident to live in the assisted living facility and a method by which facility staff can recognize and respond to the signs and symptoms particular to that resident which indicate the need for professional services.

(9) ~~(8)~~ "Cooperative agreement" means a written statement of understanding between a mental health care provider and the administrator of the assisted living facility with a limited mental health license in which a mental health resident is living. The agreement must specify directions for accessing emergency and after-hours care for the mental health resident. A single cooperative agreement may service all mental health residents who are clients of the same mental health care provider.

(11) ~~(9)~~ "Department" means the Department of Elderly Affairs.

(12) ~~(10)~~ "Emergency" means a situation, physical condition, or method of operation which presents imminent danger of death or serious physical or mental harm to facility residents.

(13) ~~(11)~~ "Extended congregate care" means acts beyond those authorized in subsection (20) ~~(16)~~ that may be performed pursuant to part I of chapter 464 by persons licensed thereunder while carrying out their professional duties, and other supportive services which may be specified by rule. The purpose of such services is to enable residents to age in place in a residential environment despite mental or physical limitations

that might otherwise disqualify them from residency in a facility licensed under this part.

(14) ~~(12)~~ "Guardian" means a person to whom the law has entrusted the custody and control of the person or property, or both, of a person who has been legally adjudged incapacitated.

(15) "Licensed facility" means an assisted living facility for which a licensee has been issued a license pursuant to this part and part II of chapter 408.

(16) ~~(13)~~ "Limited nursing services" means acts that may be performed pursuant to part I of chapter 464 by persons licensed thereunder while carrying out their professional duties but limited to those acts which the department specifies by rule. Acts which may be specified by rule as allowable limited nursing services shall be for persons who meet the admission criteria established by the department for assisted living facilities and shall not be complex enough to require 24-hour nursing supervision and may include such services as the application and care of routine dressings, and care of casts, braces, and splints.

(17) ~~(14)~~ "Managed risk" means the process by which the facility staff discuss the service plan and the needs of the resident with the resident and, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact, in such a way that the consequences of a decision, including any inherent risk, are explained to all parties and reviewed periodically in conjunction with the service plan, taking into account changes in the resident's status and the ability of the facility to respond accordingly.

(18)~~(15)~~ "Mental health resident" 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.

(19) "Person" means any individual, partnership, corporation, association, or governmental unit.

(20)~~(16)~~ "Personal services" means direct physical assistance with or supervision of the activities of daily living and the self-administration of medication and other similar services which the department may define by rule. "Personal services" shall not be construed to mean the provision of medical, nursing, dental, or mental health services.

(21)~~(17)~~ "Physical restraint" means a device which physically limits, restricts, or deprives an individual of movement or mobility, including, but not limited to, a half-bed rail, a full-bed rail, a geriatric chair, and a posey restraint. The term "physical restraint" shall also include any device which was not specifically manufactured as a restraint but which has been altered, arranged, or otherwise used for this purpose. The term shall not include bandage material used for the purpose of binding a wound or injury.

(22)~~(18)~~ "Relative" means an individual who is the father, mother, stepfather, stepmother, son, daughter, brother, sister, grandmother, grandfather, great-grandmother, great-grandfather, grandson, granddaughter, uncle, aunt, first cousin, nephew, niece, husband, wife, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepson,

stepdaughter, stepbrother, stepsister, half brother, or half sister of an owner or administrator.

(23) ~~(19)~~ "Resident" means a person 18 years of age or older, residing in and receiving care from an assisted living ~~a~~ facility.

(24) ~~(20)~~ "Resident's representative or designee" means a person other than the owner, or an agent or employee of the assisted living facility, designated in writing by the resident, if legally competent, to receive notice of changes in the contract executed pursuant to s. 429.24; to receive notice of and to participate in meetings between the resident and the facility owner, administrator, or staff concerning the rights of the resident; to assist the resident in contacting the ombudsman council if the resident has a complaint against the facility; or to bring legal action on behalf of the resident pursuant to s. 429.29.

(25) ~~(21)~~ "Service plan" means a written plan, developed and agreed upon by the resident and, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact, if any, and the administrator or the administrator's designee representing the facility, which addresses the unique physical and psychosocial needs, abilities, and personal preferences of each resident receiving extended congregate care services. The plan shall include a brief written description, in easily understood language, of what services shall be provided, who shall provide the services, when the services shall be rendered, and the purposes and benefits of the services.

(26) ~~(22)~~ "Shared responsibility" means exploring the

options available to a resident within a facility and the risks involved with each option when making decisions pertaining to the resident's abilities, preferences, and service needs, thereby enabling the resident and, if applicable, the resident's representative or designee, or the resident's surrogate, guardian, or attorney in fact, and the facility to develop a service plan which best meets the resident's needs and seeks to improve the resident's quality of life.

(27) ~~(23)~~ "Supervision" means reminding residents to engage in activities of daily living and the self-administration of medication, and, when necessary, observing or providing verbal cuing to residents while they perform these activities. The term "supervision" does not include one-on-one observation.

(28) ~~(24)~~ "Supplemental security income," Title XVI of the Social Security Act, means a program through which the Federal Government guarantees a minimum monthly income to every person who is age 65 or older, or disabled, or blind and meets the income and asset requirements.

(29) ~~(25)~~ "Supportive services" means services designed to encourage and assist residents ~~aged persons or adults with disabilities~~ to remain in the least restrictive living environment and to maintain their independence as long as possible.

(30) ~~(26)~~ "Twenty-four-hour nursing supervision" means services that are ordered by a physician for a resident whose condition requires the supervision of a physician and continued monitoring of vital signs and physical status. Such services shall be: medically complex enough to require constant supervision, assessment, planning, or intervention by a nurse;

required to be performed by or under the direct supervision of licensed nursing personnel or other professional personnel for safe and effective performance; ~~required on a daily basis;~~ and consistent with the nature and severity of the resident's condition or the disease state or stage.

Section 6. Paragraphs (g) and (h) of subsection (2) of section 429.04, Florida Statutes, are amended to read:

429.04 Facilities to be licensed; exemptions.—

(2) The following are exempt from licensure under this part:

(g) Any facility certified under chapter 651, or a retirement community, may provide services authorized under this part ~~or part III of chapter 400~~ to its residents who live in single-family homes, duplexes, quadruplexes, or apartments located on the campus without obtaining a license to operate an assisted living facility if residential units within such buildings are used by residents who do not require staff supervision for that portion of the day when personal services are not being delivered and the owner obtains a home health license to provide such services. However, any building or distinct part of a building on the campus that is designated for persons who receive personal services and require supervision beyond that which is available while such services are being rendered must be licensed in accordance with this part. If a facility provides personal services to residents who do not otherwise require supervision and the owner is not licensed as a home health agency, the buildings or distinct parts of buildings where such services are rendered must be licensed under this part. A resident of a facility that obtains a home health

license may contract with a home health agency of his or her choice, provided that the home health agency provides liability insurance and workers' compensation coverage for its employees. Facilities covered by this exemption may establish policies that give residents the option of contracting for services and care beyond that which is provided by the facility to enable them to age in place. For purposes of this section, a retirement community consists of a facility licensed under this part or a facility licensed under part II of chapter 400, and apartments designed for independent living located on the same campus.

(h) Any residential unit for independent living which is located within a facility certified under chapter 651, or any residential unit for independent living which is collocated ~~colocated~~ with a nursing home licensed under part II of chapter 400 or collocated ~~colocated~~ with a facility licensed under this part in which services are provided through an outpatient clinic or a nursing home on an outpatient basis.

Section 7. Subsections (3) and (4) of section 429.07, Florida Statutes, are amended, and subsections (6) and (7) are added to that section, 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.

(a) A standard license shall be issued to a licensee for a facility ~~facilities~~ providing one or more of the personal

services identified in s. 429.02. ~~Such facilities may also employ or contract with a person licensed under part I of chapter 464 to administer medications and perform other tasks as specified in s. 429.255.~~

(b) An extended congregate care license shall be issued to a licensee for a facility ~~facilities~~ providing, directly or through contract, services beyond those authorized in paragraph (a), including services performed by persons licensed under part I of chapter 464 and supportive services, as defined by rule, to persons who would otherwise be disqualified from continued residence in a facility licensed under this part.

1. In order for extended congregate care services to be provided, the agency must first determine that all requirements established in law and rule are met and must specifically designate, on the facility's license, that such services may be provided and whether the designation applies to all or part of the facility. Such designation may be made at the time of initial licensure or relicensure, or upon request in writing by a licensee under this part and part II of chapter 408. The notification of approval or the denial of the request shall be made in accordance with part II of chapter 408. Existing facilities qualifying to provide extended congregate care services must have maintained a standard license and may not have been subject to administrative sanctions during the previous 2 years, or since initial licensure if the facility has been licensed for less than 2 years, for any of the following reasons:

a. A class I or class II violation;

~~b. Three or more repeat or recurring class III violations~~

~~of identical or similar resident care standards from which a pattern of noncompliance is found by the agency;~~

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

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

~~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~~

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

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

~~monitoring visits for a facility that has been licensed for at least 24 months to provide extended congregate care services, if, during the inspection, the registered nurse determines that extended congregate care services are being provided appropriately, and if the facility has no class I or class II violations and no uncorrected class III violations. The agency must first consult with the long-term care ombudsman council for the area in which the facility is located to determine if any complaints have been made and substantiated about the quality of services or care. The agency may not waive one of the required yearly monitoring visits if complaints have been made and substantiated.~~

3. A licensee ~~facility~~ that is licensed to provide extended congregate care services shall ~~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 residential setting ~~building~~, to assist with the evacuation of residents in an emergency.

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

e. Allow residents or, if applicable, a resident’s

representative, designee, surrogate, guardian, or attorney in fact to make a variety of personal choices, participate in developing service plans, and share responsibility in decisionmaking.

f. Implement the concept of managed risk.

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

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

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

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


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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 licensee ~~facility~~ must develop a preliminary service plan for the individual.

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

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

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

~~1. In order for limited nursing services to be provided in a facility licensed under this part, the agency must first determine that all requirements established in law and rule are met and must specifically designate, on the facility's license, that such services may be provided. Such designation may be made at the time of initial licensure or relicensure, or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with part II of chapter 408. Existing facilities qualifying to provide limited nursing services shall have maintained a standard license and may not have been subject to administrative sanctions that affect the health, safety, and welfare of residents for the previous 2 years or since initial licensure if the facility has been licensed for less than 2~~

~~years.~~

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

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

(4) In accordance with s. 408.805, an applicant or licensee shall pay a fee for each license application submitted under this part, part II of chapter 408, and applicable rules. The amount of the fee shall be established by rule.

(a) The biennial license fee required of a facility is $300 per license, with an additional fee of $71 ~~$50~~ per resident based on the total licensed resident capacity of the facility, except that no additional fee will be assessed for beds used by

~~designated for~~ recipients of Medicaid home and community-based waiver programs ~~optional state supplementation payments provided for in s. 409.212~~. The total fee may not exceed $13,443 ~~$10,000~~.

(b) In addition to the total fee assessed under paragraph (a), the agency shall require facilities that are licensed to provide extended congregate care services under this part to pay an additional fee per licensed facility. The amount of the biennial fee shall be $400 per license, with an additional fee of $10 per resident based on the total licensed resident capacity of the facility.

~~(c) In addition to the total fee assessed under paragraph (a), the agency shall require facilities that are licensed to provide limited nursing services under this part to pay an additional fee per licensed facility. The amount of the biennial fee shall be $250 per license, with an additional fee of $10 per resident based on the total licensed resident capacity of the facility.~~

(6) In order to determine whether the facility must participate in the monitoring activities during the 12-month period, the agency shall conduct a biennial survey to discuss the residents' experiences within the facility. This survey must include private, informal conversations with a sample of residents and a consultation with the ombudsman council in the planning and service area in which the facility is located.

(7) An assisted living facility that has been cited within the previous 24-month period for a class I violation or class II violation, regardless of the status of any enforcement or disciplinary action, is subject to periodic unannounced monitoring to determine if the facility is in compliance with

this part, part II of chapter 408, and applicable rules. Monitoring may occur through a desk review or an onsite assessment. If the class I violation or class II violation relates to providing or failing to provide nursing care, a registered nurse must participate in the monitoring visits during the 12-month period following the violation.

Section 8. Paragraph (a) of subsection (2) of section 429.08, Florida Statutes, is amended to read:

429.08 Unlicensed facilities; referral of person for residency to unlicensed facility; penalties.—

(2) It is unlawful to knowingly refer a person for residency to an unlicensed assisted living facility; to an assisted living facility the license of which is under denial or has been suspended or revoked; or to an assisted living facility that has a moratorium pursuant to part II of chapter 408.

(a) Any health care practitioner, as defined in s. 456.001, or emergency medical technician or paramedic certified under part III of chapter 401, who is aware of the operation of an unlicensed facility shall report that facility to the agency. Failure to report a facility that the practitioner knows or has reasonable cause to suspect is unlicensed shall be reported to the practitioner’s licensing board.

Section 9. Subsection (8) is added to section 429.11, Florida Statutes, to read:

429.11 Initial application for license; provisional license.—

(8) The agency shall develop an abbreviated form for submission of proof of financial ability to operate under s. 408.810(8) which is specific to applicants for a license to

operate an assisted living facility. The form must request information that demonstrates the applicant has adequate resources to sustain operations and has sufficient assets, credit, and projected revenues to cover liabilities and expenses of the facility based on the number of beds and services the applicant will provide.

Section 10. Section 429.12, Florida Statutes, is amended to read:

429.12 Sale or transfer of ownership of a facility.~~—It is the intent of the Legislature to protect the rights of the residents of an assisted living facility when the facility is sold or the ownership thereof is transferred. Therefore,~~ In addition to the requirements of part II of chapter 408, whenever a facility is sold or the ownership thereof is transferred, including leasing,~~÷~~

~~(1)~~ the transferee shall notify the residents, in writing, of the change of ownership within 7 days after receipt of the new license in order to protect the rights of the residents of an assisted living facility.

~~(2) The transferor of a facility the license of which is denied pending an administrative hearing shall, as a part of the written change-of-ownership contract, advise the transferee that a plan of correction must be submitted by the transferee and approved by the agency at least 7 days before the change of ownership and that failure to correct the condition which resulted in the moratorium pursuant to part II of chapter 408 or denial of licensure is grounds for denial of the transferee's license.~~

Section 11. 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 employee~~:

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

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

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

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

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

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

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

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

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

(f) ~~(g)~~ Violation of a moratorium.

(g) ~~(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.

(h) ~~(i)~~ An intentional or negligent life-threatening act in violation of the uniform firesafety standards for assisted living facilities or other firesafety standards 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.

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

(j) ~~(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 a licensee 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 a license to any applicant or controlling interest as defined in part II of chapter 408 which has or had a 25-percent or greater financial or ownership interest in any other facility licensed under this part, or in any entity licensed by this state or another state to provide

health or residential care, 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 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.~~

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

~~(6) The agency shall 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.~~

(5) ~~(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 12. Subsections (1), (4), and (5) of section 429.17, Florida Statutes, are amended to read:

429.17 Expiration of license; renewal; conditional license.—

(1) ~~Limited nursing,~~ Extended congregate care, and limited mental health licenses shall expire at the same time as the facility's standard license, regardless of when issued.

(4) In addition to the license categories available in s. 408.808, a conditional license may be issued to an applicant for license renewal if the applicant fails to meet all standards and requirements for licensure. A conditional license issued under this subsection shall be limited in duration to a specific period of time not to exceed 6 months, as determined by the agency~~, and shall be accompanied by an agency-approved plan of correction~~.

(5) When an extended congregate care ~~or limited nursing~~ license is requested during a facility's biennial license period, the fee shall be prorated in order to permit the additional license to expire at the end of the biennial license period. The fee shall be calculated as of the date the additional license application is received by the agency.

Section 13. Subsections (1), (6), (7), and (8) of section 429.178, Florida Statutes, are amended to read:

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

(1) A facility that ~~which~~ advertises that it provides

special care for persons with Alzheimer's disease or other related disorders must meet the following standards of operation:

(a)~~1.~~ ~~If the facility has 17 or more residents,~~ Have an awake staff member on duty at all hours of the day and night for each secured unit of the facility which houses any residents who have Alzheimer's disease or other related disorders.~~; or~~

~~2. If the facility has fewer than 17 residents, have an awake staff member on duty at all hours of the day and night or have mechanisms in place to monitor and ensure the safety of the facility's residents.~~

(b) Offer activities specifically designed for persons who are cognitively impaired.

(c) Have a physical environment that provides for the safety and welfare of the facility's residents.

(d) Employ staff who have completed the training and continuing education required in subsection (2).

For the safety and protection of residents who have Alzheimer's disease, related disorders, or dementia, a secured locked unit may be designated. The unit may consist of the entire building or a distinct part of the building. Exit doors shall be equipped with an operating alarm system that releases upon activation of the fire alarm. These units are exempt from specific life safety requirements to which assisted living facilities are normally subject. A staff member must be awake and present in the secured unit at all times.

(6) The department shall maintain and post on its website ~~keep~~ a current list of providers who are approved to provide

initial and continuing education for staff and direct care staff members of facilities that provide special care for persons with Alzheimer's disease or other related disorders.

~~(7) Any facility more than 90 percent of whose residents receive monthly optional supplementation payments is not required to pay for the training and education programs required under this section. A facility that has one or more such residents shall pay a reduced fee that is proportional to the percentage of such residents in the facility. A facility that does not have any residents who receive monthly optional supplementation payments must pay a reasonable fee, as established by the department, for such training and education programs.~~

(7) ~~(8)~~ The department shall adopt rules to establish standards for trainers and training and to implement this section.

Section 14. Subsections (1), (2), (5), (7), (8), and (9) of section 429.19, Florida Statutes, are amended to read:

429.19 Violations; imposition of administrative fines; grounds.—

(1) In addition to the requirements of part II of chapter 408, 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 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 those conditions or occurrences related to the operation and maintenance of a facility or to the care of residents which the agency determines present an imminent danger to the residents or a substantial probability that death or serious physical or emotional harm would result. The condition or practice that constitutes a class I violation must be abated or eliminated within 24 hours, unless a fixed period, as determined by the agency, is required for correction ~~defined in s. 408.813~~. The agency shall impose an administrative fine for a cited class I violation in an amount not less than $5,000 and not exceeding $10,000 for each violation. A fine shall be levied notwithstanding the correction of the violation.

(b) Class "II" violations are those conditions or occurrences related to the operation and maintenance of a facility or to the care of residents which the agency determines directly threaten the physical or emotional health, safety, or security of the residents, other than class I violations ~~defined in s. 408.813~~. The agency shall impose an administrative fine for a cited class II violation in an amount not less than $1,000 and not exceeding $5,000 for each violation. A fine shall be levied notwithstanding the correction of the violation.

(c) Class "III" violations are those conditions or occurrences related to the operation and maintenance of a

facility or to the care of residents which the agency determines indirectly or potentially threaten the physical or emotional health, safety, or security of residents, other than class I violations or class II violations ~~defined in s. 408.813~~. The agency shall impose an administrative fine for a cited class III violation in an amount not less than $500 and not exceeding $1,000 for each violation. If a class III violation is corrected within the time specified, a fine may not be imposed.

(d) Class "IV" violations are those conditions or occurrences related to the operation and maintenance of a facility or to required reports, forms, or documents which do not have the potential of negatively affecting residents. These violations are of a type that the agency determines do not threaten the health, safety, or security of residents ~~defined in s. 408.813~~. The agency shall impose an administrative fine for a cited class IV violation in an amount not less than $100 and not exceeding $200 for each violation. A citation for a class IV violation must specify the time within which the violation is required to be corrected. If a class IV violation is corrected within the time specified, a fine may not be imposed.

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

(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~~.

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

(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.

Section 15. Section 429.195, Florida Statutes, is amended to read:

429.195 Rebates prohibited; penalties.—

(1) It is unlawful for the licensee of any assisted living facility licensed under this part to contract or promise to pay or receive any commission, bonus, kickback, or rebate or engage in any split-fee arrangement in any form whatsoever with any health care provider or health care facility under s. 817.505 ~~physician, surgeon, organization, agency, or person, either directly or indirectly, for residents referred to an assisted living facility licensed under this part~~. ~~A facility may employ or contract with persons to market the facility, provided the employee or contract provider clearly indicates that he or she represents the facility. A person or agency independent of the facility may provide placement or referral services for a fee to individuals seeking assistance in finding a suitable facility; however, any fee paid for placement or referral services must be paid by the individual looking for a facility, not by the facility.~~

(2) A violation of this section shall be considered patient brokering and is punishable as provided in s. 817.505.

(3) This section does not apply to:

(a) Any individual with whom the facility employs or contracts with to market the facility if the employee or contract provider clearly indicates that he or she works with or for the facility.

(b) A referral service that provides information, consultation, or referrals to consumers to assist them in finding appropriate care or housing options for seniors or disabled adults if such referred consumers are not Medicaid recipients.

(c) A resident of an assisted living facility who refers to


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the assisted living facility a friend, a family member, or other individual with whom the resident has a personal relationship. Such a referral does not prohibit the assisted living facility from providing a monetary reward to the resident for making such a referral.

Section 16. Subsections (2) and (3) of section 429.20, Florida Statutes, are amended to read:

429.20 Certain solicitation prohibited; third-party supplementation.—

(2) Solicitation of contributions of any kind in a threatening, coercive, or unduly forceful manner by or on behalf of an assisted living facility or facilities by any agent, employee, owner, or representative of any assisted living facility or facilities is prohibited ~~grounds for denial, suspension, or revocation of the license of the assisted living facility or facilities by or on behalf of which such contributions were solicited~~.

(3) The admission or maintenance of assisted living facility residents whose care is supported, in whole or in part, by state funds may not be conditioned upon the receipt of any manner of contribution or donation from any person. ~~The solicitation or receipt of contributions in violation of this subsection is grounds for denial, suspension, or revocation of license, as provided in s. 429.14, for any assisted living facility by or on behalf of which such contributions were solicited.~~

Section 17. Section 429.23, Florida Statutes, is amended to read:

429.23 Internal risk management and quality assurance

program; adverse incidents and reporting requirements.—

(1) Every licensed facility ~~licensed under this part~~ may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, violations ~~deficiencies~~ cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences.

(2) Every licensed facility ~~licensed under this part~~ is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means:

(a) An event over which facility staff ~~personnel~~ could exercise control rather than as a result of the resident's condition and results in:

1. Death;

2. Brain or spinal damage;

3. Permanent disfigurement;

4. Fracture or dislocation of bones or joints;

5. Any condition that required medical attention to which the resident has not given his or her consent, excluding proceedings governed by part I of chapter 394, but including failure to honor advanced directives;

6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or

7. An event that is reported to law enforcement or its personnel for investigation; or

(b) Resident elopement, if the elopement places the resident at risk of harm or injury.

~~(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident.~~

(3)~~(4)~~ A licensed facility ~~Licensed facilities~~ shall provide within 15 business days after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a full report to the agency on the ~~all~~ adverse incident, including information regarding the identity of the affected resident, the type of adverse incident, and ~~incidents specified in this section. The report must include~~ the results of the facility's investigation into the adverse incident.

~~(5) Each facility shall report monthly to the agency any liability claim filed against it. The report must include the name of the resident, the dates of the incident leading to the claim, if applicable, and the type of injury or violation of rights alleged to have occurred. This report is not discoverable in any civil or administrative action, except in such actions brought by the agency to enforce the provisions of this part.~~

(4)~~(6)~~ Abuse, neglect, or exploitation must be reported to the Department of Children and Family Services as required under chapter 415.

(5)~~(7)~~ The information reported to the agency ~~pursuant to subsection (3)~~ which relates to persons licensed under chapter

458, chapter 459, chapter 461, chapter 464, or chapter 465 must ~~shall~~ be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.

(6)~~(8)~~ If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member ~~or employee~~ of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board.

(7)~~(9)~~ The adverse incident report ~~reports and preliminary adverse incident reports~~ required under this section is ~~are~~ confidential as provided by law and is ~~are~~ not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board.

(8)~~(10)~~ The Department of Elderly Affairs may adopt rules necessary to administer this section.

Section 18. Subsections (1) and (2) of section 429.255, Florida Statutes, are amended to read:

429.255 Use of personnel; emergency care.—

(1)(a) Persons under contract to the facility or~~,~~ facility

staff~~, or volunteers,~~ who are licensed according to part I of chapter 464, or those persons exempt under s. 464.022(1), and others as defined by rule, may administer medications to residents, take residents' vital signs, manage individual weekly pill organizers for residents who self-administer medication, give prepackaged enemas ordered by a physician, observe residents, document observations on the appropriate resident's record, report observations to the resident's physician, and contract or allow residents or a resident's representative, designee, surrogate, guardian, or attorney in fact to contract with a third party, provided residents meet the criteria for appropriate placement as defined in s. 429.26. Nursing assistants certified pursuant to part II of chapter 464 may take residents' vital signs as directed by a licensed nurse or physician. A person under contract to the facility or facility staff who is licensed under part I of chapter 464 may provide limited nursing services.

(b) All staff in facilities licensed under this part shall exercise their ~~professional~~ responsibility to observe residents, to document observations on the appropriate resident's record, and to report the observations to the administrator or the administrator's designee ~~resident's physician~~. ~~However,~~ The ~~owner or~~ administrator of the facility shall be responsible for determining that the resident receiving services is appropriate for residence in the assisted living facility.

~~(c) In an emergency situation, licensed personnel may carry out their professional duties pursuant to part I of chapter 464 until emergency medical personnel assume responsibility for care.~~


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(2) In facilities licensed to provide extended congregate care, persons under contract to the facility or~~,~~ facility staff~~, or volunteers,~~ who are licensed according to part I of chapter 464, or those persons exempt under s. 464.022(1), or those persons certified as nursing assistants pursuant to part II of chapter 464, may also perform all duties within the scope of their license or certification, as approved by the facility administrator and pursuant to this part.

Section 19. Subsections (2), (3), and (4) of section 429.256, Florida Statutes, are amended to read:

429.256 Assistance with self-administration of medication.—

(2) Residents who are capable of self-administering their own medications without assistance shall be encouraged and allowed to do so. However, an unlicensed person may, consistent with a dispensed prescription's label or the package directions of an over-the-counter medication, assist a resident whose condition is medically stable with the self-administration of routine, regularly scheduled medications that are intended to be self-administered. Assistance with self-medication by an unlicensed person may occur only upon a documented request by, and the written informed consent of, a resident or the resident's surrogate, guardian, or attorney in fact. To minimize the potential risk for improper dosage administration of prescription drugs, a facility may require standard-medication dispensing systems for residents' prescriptions, as specified by rule. For the purposes of this section, self-administered medications include both legend and over-the-counter oral dosage forms, topical dosage forms and topical ophthalmic, otic, and nasal dosage forms including solutions, suspensions, sprays, ~~and~~

inhalers, and continuous positive airway pressure machines.

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

(a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident.

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

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

(d) Applying topical medications.

(e) Returning the medication container to proper storage.

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

(g) Assisting a resident in holding a nebulizer.

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

(i) Assisting with the putting on and taking off anti-embolism stockings.

(j) Assisting with applying and removing an oxygen cannula.

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

(a) Mixing, compounding, converting, or calculating medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.

(b) The preparation of syringes for injection or the administration of medications by any injectable route.

~~(c) Administration of medications through intermittent~~

~~positive pressure breathing machines or a nebulizer.~~

(c) ~~(d)~~ Administration of medications by way of a tube inserted in a cavity of the body.

(d) ~~(e)~~ Administration of parenteral preparations.

(e) ~~(f)~~ Irrigations or debriding agents used in the treatment of a skin condition.

(f) ~~(g)~~ Rectal, urethral, or vaginal preparations.

(g) ~~(h)~~ Medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident.

(h) ~~(i)~~ Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.

Section 20. Subsections (3), (7), (8), (9), (10), and (11) of section 429.26, Florida Statutes, are amended to read:

429.26 Appropriateness of placements; examinations of residents.—

(3) Persons licensed under part I of chapter 464 who are employed by or under contract with a facility shall, on a routine basis or at least monthly, perform a nursing assessment of the residents for whom they are providing nursing services ordered by a physician, except administration of medication, and shall document such assessment, including any significant change ~~substantial changes~~ in a resident's status which may necessitate relocation to a nursing home, hospital, or specialized health care facility. Such records shall be maintained in the facility

for inspection by the agency and shall be forwarded to the resident's case manager, if applicable.

~~(7) The facility must notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition.~~

(7) ~~(8)~~ The Department of Children and Family Services may require an examination for supplemental security income and optional state supplementation recipients residing in facilities at any time and shall provide the examination whenever a resident's condition requires it. Any facility administrator; personnel of the agency, the department, or the Department of Children and Family Services; or long-term care ombudsman council member who believes a resident needs to be evaluated shall notify the resident's case manager, who shall take appropriate action. A report of the examination findings shall be provided to the resident's case manager and the facility administrator to help the administrator meet his or her responsibilities under subsection (1).

(8) ~~(9)~~ A terminally ill resident who no longer meets the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the administrator ~~facility~~; additional care is rendered through a

licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met.

(9) ~~(10)~~ Facilities licensed to provide extended congregate care services shall promote aging in place by determining appropriateness of continued residency based on a comprehensive review of the resident's physical and functional status; the ability of the facility, family members, friends, or any other pertinent individuals or agencies to provide the care and services required; and documentation that a written service plan consistent with facility policy has been developed and implemented to ensure that the resident's needs and preferences are addressed.

(10) ~~(11)~~ A ~~No~~ resident who requires 24-hour nursing supervision, except for a resident who is an enrolled hospice patient pursuant to part IV of chapter 400, may not ~~shall~~ be retained in a licensed facility ~~licensed under this part~~.

Section 21. Section 429.27, Florida Statutes, is amended to read:

429.27 Property and personal affairs of residents.—

(1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated incompetent or incapacitated under state law, managing his or her own affairs.

(b) The admission of a resident to a facility and his or her presence therein does ~~shall~~ not give ~~confer on~~ the facility or its licensee, owner, administrator, employees, or representatives any authority to manage, use, or dispose of any

property of the resident; nor shall such admission or presence give ~~confer on~~ any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident.

(2) The licensee, ~~A facility, or an~~ owner, administrator, employee of an assisted living facility, or representative thereof, may not act as the guardian, trustee, or conservator for any resident of the assisted living facility or any of such resident's property. A licensee, ~~An~~ owner, administrator, or staff member, or representative thereof, may not act as a competent resident's payee for social security, veteran's, or railroad benefits without the consent of the resident. Any facility whose licensee, owner, administrator, or staff, or representative thereof, serves as representative payee for any resident of the facility shall file a surety bond with the agency in an amount equal to twice the average monthly aggregate income or personal funds due to residents, or expendable for their account, which are received by a facility. Any facility whose licensee, owner, administrator, or staff, or a representative thereof, is granted power of attorney for any resident of the facility shall file a surety bond with the agency for each resident for whom such power of attorney is granted. The surety bond shall be in an amount equal to twice the average monthly income of the resident, plus the value of any resident's property under the control of the attorney in fact. The bond shall be executed by the facility's licensee, owner, administrator, or staff, or a representative thereof, ~~facility~~ as principal and a licensed surety company. The bond

shall be conditioned upon the faithful compliance of the licensee, owner, administrator, or staff, or a representative thereof, of the facility with this section and shall run to the agency for the benefit of any resident who suffers a financial loss as a result of the misuse or misappropriation by a licensee, owner, administrator, or staff, or representative thereof, of the facility of funds held pursuant to this subsection. Any surety company that cancels or does not renew the bond of any licensee shall notify the agency in writing not less than 30 days in advance of such action, giving the reason for the cancellation or nonrenewal. Any facility's licensee, ~~facility~~ owner, administrator, or staff, or representative thereof, who is granted power of attorney for any resident of the facility shall, on a monthly basis, be required to provide the resident a written statement of any transaction made on behalf of the resident pursuant to this subsection, and a copy of such statement given to the resident shall be retained in each resident's file and available for agency inspection.

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

(4) Any funds or other property belonging to or due to a resident, or expendable for his or her account, which is

received by the administrator ~~a facility~~ shall be trust funds which shall be kept separate from the funds and property of the facility and other residents or shall be specifically credited to such resident. Such trust funds shall be used or otherwise expended only for the account of the resident. Upon written request, at least once every 3 months, unless upon order of a court of competent jurisdiction, the administrator ~~facility~~ shall furnish the resident and his or her guardian, trustee, or conservator, if any, a complete and verified statement of all funds and other property to which this subsection applies, detailing the amount and items received, together with their sources and disposition. In any event, the administrator ~~facility~~ shall furnish such statement annually and upon the discharge or transfer of a resident. ~~Any governmental agency or private charitable agency contributing funds or other property to the account of a resident shall also be entitled to receive such statement annually and upon the discharge or transfer of the resident.~~

(5) Any personal funds available to facility residents may be used by residents as they choose to obtain clothing, personal items, leisure activities, and other supplies and services for their personal use. An administrator ~~A facility~~ may not demand, require, or contract for payment of all or any part of the personal funds in satisfaction of the facility rate for supplies and services beyond that amount agreed to in writing ~~and may not levy an additional charge to the individual or the account for any supplies or services that the facility has agreed by contract to provide as part of the standard monthly rate~~. Any service or supplies provided by the facility which are charged

separately to the individual or the account may be provided only with the specific written consent of the individual, who shall be furnished in advance of the provision of the services or supplies with an itemized written statement to be attached to the contract setting forth the charges for the services or supplies.

(6)(a) In addition to any damages or civil penalties to which a person is subject, any person who:

1. Intentionally withholds a resident's personal funds, personal property, or personal needs allowance, or who demands, beneficially receives, or contracts for payment of all or any part of a resident's personal property or personal needs allowance in satisfaction of the facility rate for supplies and services; or

2. Borrows from or pledges any personal funds of a resident, other than the amount agreed to by written contract under s. 429.24,

commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(b) Any <u>licensee,</u> facility owner, administrator, or staff, or representative thereof, who is granted power of attorney for any resident of the facility and who misuses or misappropriates funds obtained through this power commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(7) In the event of the death of a resident, a licensee shall return all refunds, funds, and property held in trust to the resident's personal representative, if one has been

appointed at the time the facility disburses such funds, and, if not, to the resident's spouse or adult next of kin named in a beneficiary designation form provided by the licensee ~~facility~~ to the resident. If the resident has no spouse or adult next of kin or such person cannot be located, funds due the resident shall be placed in an interest-bearing account, and all property held in trust by the licensee ~~facility~~ shall be safeguarded until such time as the funds and property are disbursed pursuant to the Florida Probate Code. Such funds shall be kept separate from the funds and property of the facility and other residents of the facility. If the funds of the deceased resident are not disbursed pursuant to the Florida Probate Code within 2 years after the resident's death, the funds shall be deposited in the Health Care Trust Fund administered by the agency.

(8) The department may by rule clarify terms and specify procedures and documentation necessary to administer the provisions of this section relating to the proper management of residents' funds and personal property and the execution of surety bonds.

Section 22. Subsection (4) of section 429.275, Florida Statutes, is repealed.

Section 23. Paragraph (k) of subsection (1) and subsections (3), (4), (5), (6), and (7) of section 429.28, Florida Statutes, are amended to read:

429.28 Resident bill of rights.—

(1) A ~~No~~ resident of a facility may not ~~shall~~ be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility.

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Every resident of a facility shall have the right to:

(k) At least 30 ~~45~~ days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally incapacitated, the guardian shall be given at least 30 ~~45~~ days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. ~~In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.~~

~~(3)(a) The agency shall conduct a survey to determine general compliance with facility standards and compliance with residents' rights as a prerequisite to initial licensure or licensure renewal.~~

~~(b) In order to determine whether the facility is adequately protecting residents' rights, the biennial survey shall include private informal conversations with a sample of residents and consultation with the ombudsman council in the planning and service area in which the facility is located to discuss residents' experiences within the facility.~~

~~(c) During any calendar year in which no survey is conducted, the agency shall conduct at least one monitoring visit of each facility cited in the previous year for a class I or class II violation, or more than three uncorrected class III violations.~~

~~(d) The agency may conduct periodic followup inspections as necessary to monitor the compliance of facilities with a history of any class I, class II, or class III violations that threaten the health, safety, or security of residents.~~

~~(c) The agency may conduct complaint investigations as warranted to investigate any allegations of noncompliance with requirements required under this part or rules adopted under this part.~~

(3) ~~(4)~~ The administrator shall ensure that ~~facility shall not hamper or prevent~~ residents may exercise ~~from exercising~~ their rights as specified in this section.

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

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

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

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

(5) ~~(6)~~ An administrator may not terminate ~~Any facility which terminates~~ the residency of an individual who participated in activities specified in subsection (4) ~~(5) shall show good cause in a court of competent jurisdiction~~.

(6) ~~(7)~~ Any person who submits or reports a complaint concerning a suspected violation of the provisions of this part or concerning services and conditions in facilities, or who testifies in any administrative or judicial proceeding arising from such a complaint, shall have immunity from any civil or

criminal liability therefor, unless such person has acted in bad faith or with malicious purpose or the court finds that there was a complete absence of a justiciable issue of either law or fact raised by the losing party.

Section 24. Section 429.29, Florida Statutes, is amended to read:

429.29 Civil actions to enforce rights.—

(1) A ~~Any person or~~ resident who alleges negligence or a violation of ~~whose~~ rights as specified in this part has ~~are violated shall have~~ a cause of action against the licensee or its management company, as identified in the state application for licensing as an assisted living facility. However, the cause of action may not be asserted individually against an officer, director, owner, including an owner designated as having a controlling interest on the state application for licensing as an assisted living facility, or agent of a licensee or management company unless, following an evidentiary hearing, the court determines there is sufficient evidence in the record or proffered by the claimant which establishes a reasonable basis for finding that the person or entity breached, failed to perform, or acted outside the scope of duties as an officer, director, owner, or agent, and that the breach, failure to perform, or action outside the scope of duties is a legal cause of actual loss, injury, death, or damage to the resident.

(2) The action may be brought by the resident or his or her guardian, or by a person or organization acting on behalf of a resident with the consent of the resident or his or her guardian, or by the personal representative of the estate of a deceased resident regardless of the cause of death.

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(3) If the action alleges a claim for the resident's rights or for negligence which: ~~that~~

(a) Caused the death of the resident, the claimant shall ~~be required to~~ elect ~~either~~ survival damages pursuant to s. 46.021 or wrongful death damages pursuant to s. 768.21. If the claimant elects damages for wrongful death, total noneconomic damages may not exceed $250,000, regardless of the number of claimants.

(b) ~~If the action alleges a claim for the resident's rights or for negligence that~~ Did not cause the death of the resident, the personal representative of the estate may recover damages for the negligence that caused injury to the resident.

(4) The action may be brought in any court of competent jurisdiction to enforce such rights and to recover actual damages, and punitive damages for violation of the rights of a resident or negligence.

(5) Any resident who prevails in seeking injunctive relief or a claim for an administrative remedy is entitled to recover the costs of the action and a reasonable attorney's fee assessed against the defendant not to exceed $25,000. Fees shall be awarded solely for the injunctive or administrative relief and not for any claim or action for damages whether such claim or action is brought together with a request for an injunction or administrative relief or as a separate action, except as provided under s. 768.79 or the Florida Rules of Civil Procedure. Sections 429.29-429.298 provide the exclusive remedy for a cause of action for recovery of damages for the personal injury or death of a resident arising out of negligence or a violation of rights specified in s. 429.28. This section does not preclude theories of recovery not arising out of negligence

or s. 429.28 which are available to a resident or to the agency. The provisions of chapter 766 do not apply to any cause of action brought under ss. 429.29-429.298.

(6) ~~(2)~~ If the ~~In any~~ claim brought pursuant to this part alleges ~~alleging~~ a violation of resident's rights or negligence causing injury to or the death of a resident, the claimant shall have the burden of proving, by a preponderance of the evidence, that:

(a) The defendant owed a duty to the resident;

(b) The defendant breached the duty to the resident;

(c) The breach of the duty is a legal cause of loss, injury, death, or damage to the resident; and

(d) The resident sustained loss, injury, death, or damage as a result of the breach.

~~Nothing in~~ This part does not ~~shall be interpreted to~~ create strict liability. A violation of the rights set forth in s. 429.28 or in any other standard or guidelines specified in this part or in any applicable administrative standard or guidelines of this state or a federal regulatory agency shall be evidence of negligence but shall not be considered negligence per se.

(7) ~~(3)~~ In any claim brought pursuant to this section, a licensee, person, or entity has ~~shall have~~ a duty to exercise reasonable care. Reasonable care is that degree of care which a reasonably careful licensee, person, or entity would use under like circumstances.

(8) ~~(4)~~ In any claim for resident's rights violation or negligence by a nurse licensed under part I of chapter 464, such

nurse has a ~~shall have the~~ duty to exercise care consistent with the prevailing professional standard of care for a nurse. The prevailing professional standard of care for a nurse is ~~shall be~~ that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar nurses.

(9) ~~(5)~~ Discovery of financial information for the purpose of determining the value of punitive damages may not be had unless the plaintiff shows the court by proffer or evidence in the record that a reasonable basis exists to support a claim for punitive damages.

(10) ~~(6)~~ In addition to any other standards for punitive damages, any award of punitive damages must be reasonable in light of the actual harm suffered by the resident and the egregiousness of the conduct that caused the actual harm to the resident.

(11) ~~(7)~~ The resident or the resident's legal representative shall serve a copy of any complaint alleging in whole or in part a violation of any rights specified in this part to the agency ~~for Health Care Administration~~ at the time of filing the initial complaint with the clerk of the court for the county in which the action is pursued. ~~The requirement of~~ Providing a copy of the complaint to the agency does not impair the resident's legal rights or ability to seek relief for his or her claim.

Section 25. Subsections (4) and (7) of section 429.293, Florida Statutes, are amended, present subsection (11) of that section is redesignated as subsection (12) and amended, and a new subsection (11) is added to that section, to read:

429.293 Presuit notice; investigation; notification of

violation of residents' rights or alleged negligence; claims evaluation procedure; informal discovery; review; settlement offer; mediation.—

(4) The notification of a violation of a resident's rights or alleged negligence shall be served within the applicable statute of limitations period; however, during the 75-day period, the statute of limitations is tolled as to all prospective defendants. Upon written stipulation by the parties, the 75-day period may be extended and the statute of limitations is tolled during any such extension. Upon receiving written notice by certified mail, return receipt requested, of termination of negotiations in an extended period, the claimant shall have 30 ~~60~~ days or the remainder of the period of the statute of limitations, whichever is greater, within which to file suit.

(7) Informal discovery may be used by a party to obtain unsworn statements and the production of documents or things, as follows:

(a) *Unsworn statements.*—Any party may require other parties to appear for the taking of an unsworn statement. Such statements may be used only for the purpose of claims evaluation and are not discoverable or admissible in any civil action for any purpose by any party. A party seeking to take the unsworn statement of any party must give reasonable notice in writing to all parties. The notice must state the time and place for taking the statement and the name and address of the party to be examined. Unless otherwise impractical, the examination of any party must be done at the same time by all other parties. Any party may be represented by counsel at the taking of an unsworn

statement. An unsworn statement may be recorded electronically, stenographically, or on videotape. The taking of unsworn statements is subject to the provisions of the Florida Rules of Civil Procedure and may be terminated for abuses.

(b) *Documents or things.*—Any party may request discovery of relevant documents or things relevant to evaluating the merits of the claim. The documents or things must be produced, at the expense of the requesting party, within 20 days after the date of receipt of the request. A party is required to produce relevant and discoverable documents or things within that party's possession or control, if in good faith it can reasonably be done within the timeframe of the claims evaluation process.

(11) An arbitration process as provided for in chapter 44 may be used to resolve a claim filed under this section.

(12) ~~(11)~~ Within 30 days after the claimant's receipt of the defendant's response to the claim, the parties or their designated representatives shall meet in mediation to discuss the issues of liability and damages in accordance with the mediation rules of practice and procedures adopted by the Supreme Court. Upon written stipulation of the parties, this 30-day period may be extended and the statute of limitations is tolled during the mediation and any such extension. At the conclusion of mediation, the claimant shall have 60 days or the remainder of the period of the statute of limitations, whichever is greater, within which to file suit.

Section 26. Section 429.294, Florida Statutes, is amended to read:

429.294 Availability of facility records for investigation

of resident's rights violations and defenses; penalty.—

(1) Unless expressly prohibited by a legally competent resident, an assisted living facility licensed under this part shall furnish to the spouse, guardian, surrogate, proxy, or attorney in fact, as provided in chapters 744 and 765, a copy of a resident's records that are in the possession of the facility within:

(a) Seven working days after receipt of a written request if the resident currently resides in the facility; or

(b) Ten working days after receipt of a written request if the resident formerly resided in the facility.

Such records must include medical and psychiatric records and any records concerning the care and treatment of the resident performed by the facility, except progress notes and consultation report sections of a psychiatric nature. Copies of such records are not considered part of a deceased resident's estate and may be made available before the administration of an estate, upon request, to the spouse, guardian, surrogate, proxy, or attorney in fact, as provided in chapters 744 and 765. A facility may charge a reasonable fee for the copying of a resident's records. Such fee shall not exceed $1 per page for the first 25 pages and 25 cents per page for each additional page in excess of 25 pages. The facility shall further allow any such spouse, guardian, surrogate, proxy, or attorney in fact, as provided in chapters 744 and 765, to examine the original records in its possession, or microfilms or other suitable reproductions of the records, upon such reasonable terms as shall be imposed, to help ensure that the records are not

damaged, destroyed, or altered.

(2) A person may not obtain copies of a resident's records under this section more often than once per month, except that a physician's report in the a resident's records may be obtained as often as necessary to effectively monitor the resident's condition.

(3) ~~(1)~~ Failure to provide complete copies of a resident's records, including, but not limited to, all medical records and the resident's chart, within the control or possession of the facility within 10 days, in accordance with the provisions of this section ~~s. 400.145~~, shall constitute evidence of failure of that party to comply with good faith discovery requirements and shall waive the good faith certificate and presuit notice requirements under this part by the requesting party.

(4) ~~(2)~~ A licensee may not ~~No facility shall~~ be held liable for any civil damages as a result of complying with this section.

Section 27. Subsections (1), (2), and (3) of section 429.297, Florida Statutes, are amended to read:

429.297 Punitive damages; pleading; burden of proof.—

(1) In any action ~~for damages~~ brought under this part, a ~~no~~ claim for punitive damages is not ~~shall be~~ permitted unless, based on admissible ~~there is a reasonable showing by~~ evidence ~~in the record or~~ proffered by the claimant, ~~which would provide~~ a reasonable basis for recovery of such damages is demonstrated upon applying the criteria set forth in this section. The defendant may proffer admissible evidence to refute the claimant's proffer of evidence to recover punitive damages. The trial judge shall conduct an evidentiary hearing and weigh the

admissible evidence proffered by the claimant and the defendant to ensure that there is a reasonable basis to believe that the claimant, at trial, will be able to demonstrate by clear and convincing evidence that the recovery of such damages is warranted. The claimant may move to amend her or his complaint to assert a claim for punitive damages as allowed by the rules of civil procedure. ~~The rules of civil procedure shall be liberally construed so as to allow the claimant discovery of evidence which appears reasonably calculated to lead to admissible evidence on the issue of punitive damages. No~~ Discovery of financial worth may not ~~shall~~ proceed until after the trial judge approves the pleading on ~~concerning~~ punitive damages ~~is permitted~~.

(2) A defendant, including the licensee or management company, against whom punitive damages is sought may be held liable for punitive damages only if the trier of fact, based on clear and convincing evidence, finds that a specific individual or corporate defendant actively and knowingly participated in intentional misconduct, or engaged in conduct that constituted gross negligence, and that conduct contributed to the loss, damages, or injury suffered by the claimant ~~the defendant was personally guilty of intentional misconduct or gross negligence~~. As used in this section, the term:

(a) "Intentional misconduct" means that the defendant against whom a claim for punitive damages is sought had actual knowledge of the wrongfulness of the conduct and the high probability that injury or damage to the claimant would result and, despite that knowledge, intentionally pursued that course of conduct, resulting in injury or damage.

(b) "Gross negligence" means that the defendant's conduct was so reckless or wanting in care that it constituted a conscious disregard or indifference to the life, safety, or rights of persons exposed to such conduct.

(3) In the case of vicarious liability of an employer, principal, corporation, or other legal entity, punitive damages may not be imposed for the conduct of an identified employee or agent unless ~~only if~~ the conduct of the employee or agent meets the criteria specified in subsection (2) and officers, directors, or managers of the actual employer corporation or legal entity condoned, ratified, or consented to the specific conduct as alleged by the claimant in subsection (2).~~÷~~

~~(a) The employer, principal, corporation, or other legal entity actively and knowingly participated in such conduct;~~

~~(b) The officers, directors, or managers of the employer, principal, corporation, or other legal entity condoned, ratified, or consented to such conduct; or~~

~~(c) The employer, principal, corporation, or other legal entity engaged in conduct that constituted gross negligence and that contributed to the loss, damages, or injury suffered by the claimant.~~

Section 28. Subsections (1) and (4) of section 429.298, Florida Statutes, are amended to read:

429.298 Punitive damages; limitation.—

(1)(a) ~~Except as provided in paragraphs (b) and (c),~~ An award of punitive damages may not exceed the greater of:

1. Three times the amount of compensatory damages awarded to each claimant entitled thereto, consistent with the remaining provisions of this section; or


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2. The sum of $250,000 ~~$1 million~~.

~~(b) Where the fact finder determines that the wrongful conduct proven under this section was motivated primarily by unreasonable financial gain and determines that the unreasonably dangerous nature of the conduct, together with the high likelihood of injury resulting from the conduct, was actually known by the managing agent, director, officer, or other person responsible for making policy decisions on behalf of the defendant, it may award an amount of punitive damages not to exceed the greater of:~~

~~1. Four times the amount of compensatory damages awarded to each claimant entitled thereto, consistent with the remaining provisions of this section; or~~

~~2. The sum of $4 million.~~

~~(c) Where the fact finder determines that at the time of injury the defendant had a specific intent to harm the claimant and determines that the defendant's conduct did in fact harm the claimant, there shall be no cap on punitive damages.~~

(b) ~~(d)~~ This subsection is not intended to prohibit an appropriate court from exercising its jurisdiction under s. 768.74 in determining the reasonableness of an award of punitive damages that is less than three times the amount of compensatory damages.

~~(e) In any case in which the findings of fact support an award of punitive damages pursuant to paragraph (b) or paragraph (c), the clerk of the court shall refer the case to the appropriate law enforcement agencies, to the state attorney in the circuit where the long-term care facility that is the subject of the underlying civil cause of action is located, and,~~

~~for multijurisdictional facility owners, to the Office of the Statewide Prosecutor; and such agencies, state attorney, or Office of the Statewide Prosecutor shall initiate a criminal investigation into the conduct giving rise to the award of punitive damages. All findings by the trier of fact which support an award of punitive damages under this paragraph shall be admissible as evidence in any subsequent civil or criminal proceeding relating to the acts giving rise to the award of punitive damages under this paragraph.~~

(4) Notwithstanding any other law to the contrary, the amount of punitive damages awarded pursuant to this section shall be ~~equally~~ divided between the claimant and the Quality of Long-Term Care Facility Improvement Trust Fund, in accordance with the following provisions:

(a) The clerk of the court shall transmit a copy of the jury verdict to the Chief Financial Officer by certified mail. In the final judgment, the court shall order the percentages of the award, payable as provided herein.

(b) A settlement agreement entered into between the original parties to the action after a verdict has been returned must provide a ~~proportionate~~ share payable to the Quality of Long-Term Care Facility Improvement Trust Fund specified herein. For purposes of this paragraph, the ~~a proportionate~~ share payable to the Quality of Long-Term Care Facility Improvement Trust Fund must be ~~is~~ a 75 percent ~~50-percent~~ share of that percentage of the settlement amount which the punitive damages portion of the verdict bore to the total of the compensatory and punitive damages in the verdict.

(c) The Department of Financial Services shall collect or

cause to be collected all payments due the state under this section. Such payments are made to the Chief Financial Officer and deposited in the appropriate fund specified in this subsection.

(d) If the full amount of punitive damages awarded cannot be collected, the claimant and the other recipient designated pursuant to this subsection are each entitled to a proportionate share of the punitive damages collected.

Section 29. Paragraphs (a), (d), (h), (i), (j), and (l) of subsection (1) and subsection (5) of section 429.41, Florida Statutes, are amended to read:

429.41 Rules establishing standards.—

(1) It is the intent of the Legislature that rules published and enforced pursuant to this section shall include criteria by which a reasonable and consistent quality of resident care and quality of life may be ensured and the results of such resident care may be demonstrated. Such rules shall also ensure a safe and sanitary environment that is residential and noninstitutional in design or nature. It is further intended that reasonable efforts be made to accommodate the needs and preferences of residents to enhance the quality of life in a facility. The agency, in consultation with the department, may adopt rules to administer the requirements of part II of chapter 408. In order to provide safe and sanitary facilities and the highest quality of resident care accommodating the needs and preferences of residents, the department, in consultation with the agency, the Department of Children and Family Services, and the Department of Health, shall adopt rules, policies, and procedures to administer this part, which must include

reasonable and fair minimum standards in relation to:

(a) The requirements for and maintenance of facilities, not in conflict with the provisions of chapter 553, relating to plumbing, heating, cooling, lighting, ventilation, living space, and other housing conditions, which will ensure the health, safety, and comfort of residents and protection from fire hazard, including adequate provisions for fire alarm and other fire protection suitable to the size of the structure. Uniform firesafety standards shall be established and enforced by the State Fire Marshal in cooperation with the agency~~, the department, and the Department of Health~~.

1. Evacuation capability determination.—

a. The provisions of the National Fire Protection Association, NFPA 101A, Chapter 5, 1995 edition, shall be used for determining the ability of the residents, with or without staff assistance, to relocate from or within a licensed facility to a point of safety as provided in the fire codes adopted herein. An evacuation capability evaluation for initial licensure shall be conducted within 6 months after the date of licensure. For existing licensed facilities that are not equipped with an automatic fire sprinkler system, the administrator shall evaluate the evacuation capability of residents at least annually. The evacuation capability evaluation for each facility not equipped with an automatic fire sprinkler system shall be validated, without liability, by the State Fire Marshal, by the local fire marshal, or by the local authority having jurisdiction over firesafety, before the license renewal date. If the State Fire Marshal, local fire marshal, or local authority having jurisdiction over firesafety

has reason to believe that the evacuation capability of a facility as reported by the administrator may have changed, it may, with assistance from the facility administrator, reevaluate the evacuation capability through timed exiting drills. Translation of timed fire exiting drills to evacuation capability may be determined:

(I) Three minutes or less: prompt.

(II) More than 3 minutes, but not more than 13 minutes: slow.

(III) More than 13 minutes: impractical.

b. The Office of the State Fire Marshal shall provide or cause the provision of training and education on the proper application of Chapter 5, NFPA 101A, 1995 edition, to its employees, to staff of the Agency for Health Care Administration who are responsible for regulating facilities under this part, and to local governmental inspectors. The Office of the State Fire Marshal shall provide or cause the provision of this training within its existing budget, but may charge a fee for this training to offset its costs. The initial training must be delivered within 6 months after July 1, 1995, and as needed thereafter.

c. The Office of the State Fire Marshal, in cooperation with provider associations, shall provide or cause the provision of a training program designed to inform facility operators on how to properly review bid documents relating to the installation of automatic fire sprinklers. The Office of the State Fire Marshal shall provide or cause the provision of this training within its existing budget, but may charge a fee for this training to offset its costs. The initial training must be

delivered within 6 months after July 1, 1995, and as needed thereafter.

d. The administrator of a licensed facility shall sign an affidavit verifying the number of residents occupying the facility at the time of the evacuation capability evaluation.

2. Firesafety requirements.—

a. Except for the special applications provided herein, effective January 1, 1996, the provisions of the National Fire Protection Association, Life Safety Code, NFPA 101, 1994 edition, Chapter 22 for new facilities and Chapter 23 for existing facilities shall be the uniform fire code applied by the State Fire Marshal for assisted living facilities, pursuant to s. 633.022.

b. Any new facility, regardless of size, that applies for a license on or after January 1, 1996, must be equipped with an automatic fire sprinkler system. The exceptions as provided in s. 22-2.3.5.1, NFPA 101, 1994 edition, as adopted herein, apply to any new facility housing eight or fewer residents. On July 1, 1995, local governmental entities responsible for the issuance of permits for construction shall inform, without liability, any facility whose permit for construction is obtained prior to January 1, 1996, of this automatic fire sprinkler requirement. As used in this part, the term "a new facility" does not mean an existing facility that has undergone change of ownership.

c. Notwithstanding any provision of s. 633.022 or of the National Fire Protection Association, NFPA 101A, Chapter 5, 1995 edition, to the contrary, any existing facility housing eight or fewer residents is not required to install an automatic fire sprinkler system, nor to comply with any other requirement in

Chapter 23, NFPA 101, 1994 edition, that exceeds the firesafety requirements of NFPA 101, 1988 edition, that applies to this size facility, unless the facility has been classified as impractical to evacuate. Any existing facility housing eight or fewer residents that is classified as impractical to evacuate must install an automatic fire sprinkler system within the timeframes granted in this section.

d. Any existing facility that is required to install an automatic fire sprinkler system under this paragraph need not meet other firesafety requirements of Chapter 23, NFPA 101, 1994 edition, which exceed the provisions of NFPA 101, 1988 edition. The mandate contained in this paragraph which requires certain facilities to install an automatic fire sprinkler system supersedes any other requirement.

e. This paragraph does not supersede the exceptions granted in NFPA 101, 1988 edition or 1994 edition.

f. This paragraph does not exempt a facility ~~facilities~~ from other firesafety provisions adopted under s. 633.022 and local building code requirements in effect before July 1, 1995.

g. A local government may charge fees only in an amount not to exceed the actual expenses incurred by local government relating to the installation and maintenance of an automatic fire sprinkler system in an existing and properly licensed assisted living facility structure as of January 1, 1996.

h. If a licensed facility undergoes major reconstruction or addition to an existing building on or after January 1, 1996, the entire building must be equipped with an automatic fire sprinkler system. Major reconstruction of a building means repair or restoration that costs in excess of 50 percent of the

value of the building as reported on the tax rolls, excluding land, before reconstruction. Multiple reconstruction projects within a 5-year period the total costs of which exceed 50 percent of the initial value of the building at the time the first reconstruction project was permitted are to be considered as major reconstruction. Application for a permit for an automatic fire sprinkler system is required upon application for a permit for a reconstruction project that creates costs that go over the 50 percent ~~50-percent~~ threshold.

i. Any facility licensed before January 1, 1996, that is required to install an automatic fire sprinkler system shall ensure that the installation is completed within the following timeframes based upon evacuation capability of the facility as determined under subparagraph 1.:

(I) Impractical evacuation capability, 24 months.

(II) Slow evacuation capability, 48 months.

(III) Prompt evacuation capability, 60 months.

The beginning date from which the deadline for the automatic fire sprinkler installation requirement must be calculated is upon receipt of written notice from the local fire official that an automatic fire sprinkler system must be installed. The local fire official shall send a copy of the document indicating the requirement of a fire sprinkler system to the Agency for Health Care Administration.

j. It is recognized that the installation of an automatic fire sprinkler system may create financial hardship for some facilities. The appropriate local fire official shall, without liability, grant two 1-year extensions to the timeframes for

installation established herein, if an automatic fire sprinkler installation cost estimate and proof of denial from two financial institutions for a construction loan to install the automatic fire sprinkler system are submitted. However, for any facility with a class I or class II, or a history of uncorrected class III, firesafety deficiencies, an extension must not be granted. The local fire official shall send a copy of the document granting the time extension to the Agency for Health Care Administration.

k. A facility owner whose facility is required to be equipped with an automatic fire sprinkler system under Chapter 23, NFPA 101, 1994 edition, as adopted herein, must disclose to any potential buyer of the facility that an installation of an automatic fire sprinkler requirement exists. The sale of the facility does not alter the timeframe for the installation of the automatic fire sprinkler system.

l. An existing facility ~~facilities~~ required to install an automatic fire sprinkler system as a result of construction-type restrictions in Chapter 23, NFPA 101, 1994 edition, as adopted herein, or evacuation capability requirements shall be notified by the local fire official in writing of the automatic fire sprinkler requirement, as well as the appropriate date for final compliance as provided in this subparagraph. The local fire official shall send a copy of the document to the Agency for Health Care Administration.

m. Except in cases of life-threatening fire hazards, if an existing facility experiences a change in the evacuation capability, or if the local authority having jurisdiction identifies a construction-type restriction, such that an

automatic fire sprinkler system is required, it shall be afforded time for installation as provided in this subparagraph.

Facilities that are fully sprinkled and in compliance with other firesafety standards are not required to conduct more than one of the required fire drills between the hours of 11 p.m. and 7 a.m., per year. In lieu of the remaining drills, staff responsible for residents during such hours may be required to participate in a mock drill that includes a review of evacuation procedures. Such standards must be included or referenced in the rules adopted by the State Fire Marshal. Pursuant to s. 633.022(1)(b), the State Fire Marshal is the final administrative authority for firesafety standards established and enforced pursuant to this section. All licensed facilities must have an annual fire inspection conducted by the local fire marshal or authority having jurisdiction.

3. Resident elopement requirements.—Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills which shall include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the drills are conducted in a manner consistent with the facility's resident elopement policies and procedures.

(d) All sanitary conditions within the facility and its surroundings which will ensure the health and comfort of residents. To ensure that inspections are not duplicative, the rules must clearly delineate the responsibilities of the agency regarding ~~agency's~~ licensure and survey inspections ~~staff~~, the

county health departments regarding food safety and sanitary inspections, and the local fire marshal regarding firesafety inspections ~~authority having jurisdiction over firesafety and ensure that inspections are not duplicative. The agency may collect fees for food service inspections conducted by the county health departments and transfer such fees to the Department of Health~~.

(h) The care ~~and maintenance~~ of residents, which must include, but is not limited to:

1. The supervision of residents;

2. The provision of personal services;

3. The provision of, or arrangement for, social and leisure activities;

4. The arrangement for appointments and transportation to appropriate medical, dental, nursing, or mental health services, as needed by residents;

5. The management of medication;

6. The food service ~~nutritional~~ needs of residents; and

7. Resident records.~~; and~~

~~8. Internal risk management and quality assurance.~~

(i) Facilities holding an ~~a limited nursing,~~ extended congregate care~~,~~ or limited mental health license.

(j) The establishment of specific criteria to define appropriateness of resident admission and continued residency in a facility holding a standard, ~~limited nursing,~~ extended congregate care, and limited mental health license.

~~(l) The establishment of specific policies and procedures on resident elopement. Facilities shall conduct a minimum of two resident elopement drills each year. All administrators and~~

~~direct care staff shall participate in the drills. Facilities shall document the drills.~~

(5) Beginning January 1, 2012, the agency shall ~~may~~ use an abbreviated biennial standard licensure inspection that consists of a review of key quality-of-care standards in lieu of a full inspection in a facility that has a good record of past performance. However, a full inspection must be conducted in a facility that has a history of class I or class II violations, uncorrected class III violations, confirmed ombudsman council complaints, or confirmed licensure complaints, within the previous licensure period immediately preceding the inspection or if a potentially serious problem is identified during the abbreviated inspection. The agency, in consultation with the department, shall develop, maintain, and update the key quality-of-care standards with input from the State Long-Term Care Ombudsman Council and representatives of associations and organizations representing assisted living facilities ~~provider groups~~ for incorporation into its rules.

Section 30. Section 429.42, Florida Statutes, is amended to read:

429.42 Pharmacy and dietary services.—

(1) Any assisted living facility in which the agency has documented a class I or class II violation ~~deficiency~~ or uncorrected class III violations ~~deficiencies~~ regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, or dietary services, or both, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under

s. 429.19, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or licensed dietitian, as applicable. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required.

~~(2) A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening.~~

~~(3) The agency shall employ at least two pharmacists licensed pursuant to chapter 465 among its personnel who biennially inspect assisted living facilities licensed under this part, to participate in biennial inspections or consult with the agency regarding deficiencies relating to medicinal drugs or over-the-counter preparations.~~

(2) ~~(4)~~ The department may by rule establish procedures and specify documentation as necessary to implement this section.

Section 31. Section 429.445, Florida Statutes, is amended to read:

429.445 Compliance with local zoning requirements. ~~No facility licensed under this part may commence any construction which will expand the size of the existing structure unless the licensee first submits to the agency proof that such construction will be in compliance with applicable local zoning requirements.~~ Facilities with a licensed capacity of less than 15 persons shall comply with the provisions of chapter 419.


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Section 32. Section 429.47, Florida Statutes, is amended to read:

429.47 Prohibited acts~~; penalties for violation~~.—

(1) While an assisted living ~~a~~ facility is under construction or is seeking licensure, the owner may advertise to the public prior to obtaining a license. Facilities that are certified under chapter 651 shall comply with the advertising provisions of s. 651.095 rather than those provided for in this subsection.

~~(2) A freestanding facility shall not advertise or imply that any part of it is a nursing home. For the purpose of this subsection, "freestanding facility" means a facility that is not operated in conjunction with a nursing home to which residents of the facility are given priority when nursing care is required. A person who violates this subsection is subject to fine as specified in s. 429.19.~~

(2)~~(3)~~ Any facility that ~~which~~ is affiliated with any religious organization or which has a name implying religious affiliation shall include in its advertising whether or not it is affiliated with any religious organization and, if so, which organization.

(3)~~(4)~~ A facility licensed under this part which is not part of a facility authorized under chapter 651 shall include the facility's license number as given by the agency in all advertising. A company or person owning more than one facility shall include at least one license number per advertisement. All advertising shall include the term "assisted living facility" before the license number.

Section 33. Subsection (1) of section 429.49, Florida

Statutes, is amended to read:

429.49 Resident records; penalties for alteration.—

(1) Any person who fraudulently alters, defaces, or falsifies any medical record or any resident's ~~other~~ record of an assisted living facility, or causes or procures any such offense to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 34. Subsections (3), (5), and (8) of section 429.52, Florida Statutes, are amended, present subsection (11) of that section is redesignated as subsection (12), and a new subsection (11) is added to that section, read:

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

(3) Effective January 1, 2004, a new facility administrator must complete the required training and education, including the competency test, within a reasonable time after being employed as an administrator, as determined by the department. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. ~~Other licensed professionals may be exempted, as determined by the department by rule.~~

(5) Staff involved with the management of medications and assisting with the self-administration of medications under s. 429.256 must complete a minimum of 4 additional hours of training provided by a registered nurse, licensed pharmacist, or department staff and must complete 2 hours of continuing education training annually. ~~The department shall establish by~~

~~rule the minimum requirements of this additional training.~~

(8) The department shall adopt rules related to these training requirements, the competency test, necessary procedures, and competency test fees and shall adopt or contract with another entity to develop a curriculum, which shall be used as the minimum core training requirements. The department shall consult with representatives of ~~stakeholder~~ associations, organizations representing assisted living facilities, and agencies in the development of the curriculum.

(11) A training provider certified by the department must continue to meet continuing education requirements and other standards as set forth in rules adopted by the department. A training provider or trainee may be sanctioned pursuant to s. 430.081 for failing to comply with the standards set forth in the rules.

Section 35. Subsections (1) and (2) of section 429.53, Florida Statutes, are amended to read:

429.53 Consultation by the agency.—

(1) The ~~area offices of licensure and certification of the~~ agency shall provide consultation to the following upon request:

(a) A licensee of a facility.

(b) A person interested in obtaining a license to operate a facility under this part.

(2) As used in this section, "consultation" includes:

(a) An explanation of the requirements of this part and rules adopted pursuant thereto;

(b) An explanation of the license application and renewal procedures; and

~~(c) The provision of a checklist of general local and state~~

~~approvals required prior to constructing or developing a facility and a listing of the types of agencies responsible for such approvals;~~

~~(d) An explanation of benefits and financial assistance available to a recipient of supplemental security income residing in a facility;~~

(c) ~~(e)~~ Any other information which the agency deems necessary to promote compliance with the requirements of this part.~~; and~~

~~(f) A preconstruction review of a facility to ensure compliance with agency rules and this part.~~

Section 36. Section 429.54, Florida Statutes, is repealed.

Section 37. Paragraph (a) of subsection (1) and subsections (5) and (6) of section 429.71, Florida Statutes, are amended to read:

429.71 Classification of deficiencies; administrative fines.—

(1) In addition to the requirements of part II of chapter 408 and ~~in addition to~~ any other liability or penalty provided by law, the agency may impose an administrative fine on a provider according to the following classification:

(a) Class I violations are those conditions or practices related to the operation and maintenance of an adult family-care home or to the care of residents which the agency determines present an imminent danger to the residents or guests of the adult family-care home ~~facility~~ or a substantial probability that death or serious physical or emotional harm would result therefrom. The condition or practice that constitutes a class I violation must be abated or eliminated within 24 hours, unless a

fixed period, as determined by the agency, is required for correction. A class I violation ~~deficiency~~ is subject to an administrative fine in an amount not less than $500 and not exceeding $1,000 for each violation. A fine may be levied notwithstanding the correction of the violation ~~deficiency~~.

~~(5) As an alternative to or in conjunction with an administrative action against a provider, the agency may request a plan of corrective action that demonstrates a good faith effort to remedy each violation by a specific date, subject to the approval of the agency.~~

(5)~~(6)~~ The department shall set forth, by rule, notice requirements and procedures for correction of violations ~~deficiencies~~.

Section 38. Subsection (3) is added to section 429.81, Florida Statutes, to read:

429.81 Residency agreements.—

(3) Each residency agreement must specify that the resident must give the provider a 30 days' written notice of intent to terminate his or her residency from the adult family-care home.

Section 39. Section 430.081, Florida Statutes, is created to read:

430.081 Sanctioning of training providers and trainees.—The Department of Elderly Affairs may sanction training providers and trainees for infractions involving any required training that the department has the authority to regulate under chapter 400, chapter 429, or chapter 430 in order to ensure that such training providers and trainees satisfy specific qualification requirements and adhere to training curricula that is approved by the department. Training infractions include, but are not


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limited to, falsification of training records, falsification of training certificates, falsification of a training provider's qualifications, failure to adhere to the required number of training hours, failure to use the required curriculum, failure to maintain the continuing education for the training provider's recertification, failure to obtain reapproval of a curriculum when required, providing false or inaccurate information, misrepresentation of the required materials, and use of a false identification as a training provider or trainee. Sanctions may be progressive in nature and may consist of corrective action measures; suspension or termination from participation as an approved training provider or trainee, including sitting for any required examination; and administrative fines not to exceed $1,000 per incident. One or more sanctions may be levied per incident.

Section 40. Paragraph (j) is added to subsection (3) of section 817.505, Florida Statutes, to read:

817.505 Patient brokering prohibited; exceptions; penalties.—

(3) This section shall not apply to:

(j) Any payments by an assisted living facility, as defined in s. 429.02, which are permitted under s. 429.195(3).

Section 41. Licensure fees adjusted by consumer price index increases prior to this act are not intended to be reset by this act and may continue to accrue as authorized in law.

Section 42. This act shall take effect July 1, 2011.

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LEGISLATIVE ACTION

Senate . House

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Paragraph (d) of subsection (1) of section 400.141, Florida Statutes, is amended to read:

400.141 Administration and management of nursing home facilities.—

(1) Every licensed facility shall comply with all applicable standards and rules of the agency and shall:

(d) Provide for resident use of a community pharmacy as specified in s. 400.022(1)(q). Any other law to the contrary

notwithstanding, a registered pharmacist licensed in Florida, that is under contract with a facility licensed under this chapter ~~or chapter 429~~, shall repackage a nursing facility resident's bulk prescription medication which has been packaged by another pharmacist licensed in any state in the United States into a unit dose system compatible with the system used by the nursing facility, if the pharmacist is requested to offer such service. In order to be eligible for the repackaging, a resident or the resident's spouse must receive prescription medication benefits provided through a former employer as part of his or her retirement benefits, a qualified pension plan as specified in s. 4972 of the Internal Revenue Code, a federal retirement program as specified under 5 C.F.R. s. 831, or a long-term care policy as defined in s. 627.9404(1). A pharmacist who correctly repackages and relabels the medication and the nursing facility which correctly administers such repackaged medication under this paragraph may not be held liable in any civil or administrative action arising from the repackaging. In order to be eligible for the repackaging, a nursing facility resident for whom the medication is to be repackaged shall sign an informed consent form provided by the facility which includes an explanation of the repackaging process and which notifies the resident of the immunities from liability provided in this paragraph. A pharmacist who repackages and relabels prescription medications, as authorized under this paragraph, may charge a reasonable fee for costs resulting from the administration ~~implementation~~ of this provision.

Section 2. Subsection (8) of section 408.810, Florida Statutes, is amended to read:

408.810 Minimum licensure requirements.—In addition to the licensure requirements specified in this part, authorizing statutes, and applicable rules, each applicant and licensee must comply with the requirements of this section in order to obtain and maintain a license.

(8) Upon application for initial licensure or change of ownership licensure, the applicant shall furnish satisfactory proof of the applicant's financial ability to operate in accordance with the requirements of this part, authorizing statutes, and applicable rules. The agency shall establish standards for this purpose, including information concerning the applicant's controlling interests. The agency shall also establish documentation requirements, to be completed by each applicant, that show anticipated provider revenues and expenditures, the basis for financing the anticipated cash-flow requirements of the provider, and an applicant's access to contingency financing. A current certificate of authority, pursuant to chapter 651, may be provided as proof of financial ability to operate. A facility licensed under part I of chapter 429 shall be required to submit only an assisted living facility statement of operation and an assets and liabilities atatement as proof of financial ability to operate. The agency may require a licensee to provide proof of financial ability to operate at any time if there is evidence of financial instability, including, but not limited to, unpaid expenses necessary for the basic operations of the provider.

Section 3. Subsection (13) of section 408.820, Florida Statutes, is amended to read:

408.820 Exemptions.—Except as prescribed in authorizing

statutes, the following exemptions shall apply to specified requirements of this part:

(13) Assisted living facilities, as provided under part I of chapter 429, are exempt from ss. ~~s.~~ 408.810(10) and 408.813(2).

Section 4. Subsection (2) of section 429.01, Florida Statutes, is amended to read:

429.01 Short title; purpose.—

(2) The purpose of this act is to promote the availability of appropriate services for elderly persons and adults with disabilities in the least restrictive and most homelike environment;~~,~~ to encourage the development of facilities that promote the dignity, individuality, privacy, and decisionmaking ability of such persons;~~,~~ to provide for the health, safety, and welfare of residents of assisted living facilities in the state, to promote continued improvement of such facilities;~~,~~ to encourage the development of innovative and affordable facilities particularly for persons with low to moderate incomes;~~,~~ to ensure that all agencies of the state cooperate in the protection of such residents;~~,~~ and to ensure that needed economic, social, mental health, health, and leisure services are made available to residents of such facilities through the efforts of the Agency for Health Care Administration, the Department of Elderly Affairs, the Department of Children and Family Services, the Department of Health, assisted living facilities, and other community agencies. To the maximum extent possible, appropriate community-based programs must be available to state-supported residents to augment the services provided in assisted living facilities. The Legislature recognizes that


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assisted living facilities are an important part of the continuum of long-term care in the state as community-based social models with a health component and not as medical or nursing facilities. In support of the goal of aging in place, the Legislature further recognizes that assisted living facilities should be operated ~~and regulated~~ as residential environments with supportive services and not as medical or nursing facilities and, as such, should not be subject to the same regulations as medical or nursing facilities but instead be regulated in a less restrictive manner that is appropriate for a residential, nonmedical setting. The services available in these facilities, either directly or through contract or agreement, are intended to help residents remain as independent as possible. Regulations governing these facilities must be sufficiently flexible to allow facilities to adopt policies that enable residents to age in place when resources are available to meet their needs and accommodate their preferences.

Section 5. Section 429.02, Florida Statutes, is amended to read:

429.02 Definitions.—When used in this part, the term:

(1) "Activities of daily living" means functions and tasks for self-care, including ambulation, bathing, dressing, eating, grooming, and toileting, and other similar tasks.

(2) "Administrator" means an individual at least 21 years of age who is responsible for the operation and maintenance of an assisted living facility; for promoting the resident's dignity, autonomy, independence, and privacy in the least restrictive and most homelike setting consistent with the resident's preferences and physical and mental status; and for


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ensuring the appropriateness of continued placement of a resident, in consultation with the resident, resident's representative or designee, if applicable, and the resident's physician.

(3) "Agency" means the Agency for Health Care Administration.

(4) "Aging in place" or "age in place" means the process of providing increased or adjusted services to a person to compensate for the physical or mental decline that may occur with the aging process, in order to maximize the person's dignity and independence and permit them to remain in a familiar, noninstitutional, residential environment for as long as possible, as determined by the individual, his or her physician and the administrator. Such services may be provided by facility staff, volunteers, family, or friends, or through contractual arrangements with a third party.

(5) "Arbitration" means a process whereby a neutral third person or panel, called an arbitrator or arbitration panel, considers the facts and arguments presented by parties and renders a decision which may be biding or nonbinding as provided for in chapter 44.

(6) ~~(5)~~ "Assisted living facility" means any residential setting that provides, directly or indirectly by means of contracts or arrangements, for a period exceeding 24 hours, ~~building or buildings, section or distinct part of a building, private home, boarding home, home for the aged, or other residential facility, whether operated for profit or not, which undertakes through its ownership or management to provide~~ housing, meals, and one or more personal services that meet the

resident's changing needs and preferences ~~for a period exceeding 24 hours~~ to one or more adults who are not relatives of the owner or administrator. As used in this subsection, the term "residential setting" includes, but is not limited to, a building or buildings, section or distinct part of a building, private home, or other residence.

(7) ~~(6)~~ "Chemical restraint" means a pharmacologic drug that physically limits, restricts, or deprives an individual of movement or mobility, and is used for discipline or convenience and not required for the treatment of medical symptoms.

(8) ~~(7)~~ "Community living support plan" means a written document prepared by a mental health resident and the resident's mental health case manager in consultation with the administrator, or the administrator's designee, of an assisted living facility with a limited mental health license ~~or the administrator's designee~~. A copy must be provided to the administrator. The plan must include information about the supports, services, and special needs of the resident which enable the resident to live in the assisted living facility and a method by which facility staff can recognize and respond to the signs and symptoms particular to that resident which indicate the need for professional services.

(9) "Controlling interest" means:

(a) The applicant or licensee; or

(b) A person or entity that has a 50 percent or greater ownership interest in the applicant or licensee.

(10) ~~(8)~~ "Cooperative agreement" means a written statement of understanding between a mental health care provider and the administrator of the assisted living facility with a limited


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mental health license in which a mental health resident is living. The agreement must specify directions for accessing emergency and after-hours care for the mental health resident. A single cooperative agreement may service all mental health residents who are clients of the same mental health care provider.

(11) ~~(9)~~ "Department" means the Department of Elderly Affairs.

(12) ~~(10)~~ "Emergency" means a situation, physical condition, or method of operation which presents imminent danger of death or serious physical or mental harm to facility residents.

(13) ~~(11)~~ "Extended congregate care" means acts beyond those authorized in subsection (16) that may be performed pursuant to part I of chapter 464 by persons licensed thereunder while carrying out their professional duties, and other supportive services which may be specified by rule. The purpose of such services is to enable residents to age in place in a residential environment despite mental or physical limitations that might otherwise disqualify them from residency in a facility licensed under this part.

(14) ~~(12)~~ "Guardian" means a person to whom the law has entrusted the custody and control of the person or property, or both, of a person who has been legally adjudged incapacitated.

(15) "Licensed facility" means an assisted living facility for which a licensee has been issued a license pursuant to this part and part II of chapter 408.

(16) ~~(13)~~ "Limited nursing services" means acts that may be performed pursuant to part I of chapter 464 by persons licensed thereunder while carrying out their professional duties but


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limited to those acts which the department specifies by rule. Acts which may be specified by rule as allowable limited nursing services shall be for persons who meet the admission criteria established by the department for assisted living facilities and shall not be complex enough to require 24-hour nursing supervision and may include such services as the application and care of routine dressings, and care of casts, braces, and splints.

(17) ~~(14)~~ "Managed risk" means the process by which the facility staff discuss the service plan and the needs of the resident with the resident and, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact, in such a way that the consequences of a decision, including any inherent risk, are explained to all parties and reviewed periodically in conjunction with the service plan, taking into account changes in the resident's status and the ability of the facility to respond accordingly.

(18) ~~(15)~~ "Mental health resident" 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.

(19) "Person" means any individual, partnership, corporation, association, or governmental unit.

(20) ~~(16)~~ "Personal services" means direct physical assistance with or supervision of the activities of daily living and the self-administration of medication and other similar

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services which the department may define by rule. "Personal services" shall not be construed to mean the provision of medical, nursing, dental, or mental health services.

(21) ~~(17)~~ "Physical restraint" means a device which physically limits, restricts, or deprives an individual of movement or mobility, including, but not limited to, a half-bed rail, a full-bed rail, a geriatric chair, and a posey restraint. The term "physical restraint" shall also include any device which was not specifically manufactured as a restraint but which has been altered, arranged, or otherwise used for this purpose. The term shall not include bandage material used for the purpose of binding a wound or injury.

(22) ~~(18)~~ "Relative" means an individual who is the father, mother, stepfather, stepmother, son, daughter, brother, sister, grandmother, grandfather, great-grandmother, great-grandfather, grandson, granddaughter, uncle, aunt, first cousin, nephew, niece, husband, wife, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepson, stepdaughter, stepbrother, stepsister, half brother, or half sister of an owner or administrator.

(23) ~~(19)~~ "Resident" means a person 18 years of age or older, residing in and receiving care from an assisted living ~~a~~ facility.

(24) ~~(20)~~ "Resident's representative or designee" means a person other than the owner, or an agent or employee of the assisted living facility, designated in writing by the resident, if legally competent, to receive notice of changes in the contract executed pursuant to s. 429.24; to receive notice of and to participate in meetings between the resident and the

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facility owner, administrator, or staff concerning the rights of the resident; to assist the resident in contacting the ombudsman council if the resident has a complaint against the facility; or to bring legal action on behalf of the resident pursuant to s. 429.29.

(25) ~~(21)~~ "Service plan" means a written plan, developed and agreed upon by the resident and, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact, if any, and the administrator or the administrator's designee representing the facility, which addresses the unique physical and psychosocial needs, abilities, and personal preferences of each resident receiving extended congregate care services. The plan shall include a brief written description, in easily understood language, of what services shall be provided, who shall provide the services, when the services shall be rendered, and the purposes and benefits of the services.

(26) ~~(22)~~ "Shared responsibility" means exploring the options available to a resident within a facility and the risks involved with each option when making decisions pertaining to the resident's abilities, preferences, and service needs, thereby enabling the resident and, if applicable, the resident's representative or designee, or the resident's surrogate, guardian, or attorney in fact, and the facility to develop a service plan which best meets the resident's needs and seeks to improve the resident's quality of life.

(27) ~~(23)~~ "Supervision" means reminding residents to engage in activities of daily living and the self-administration of medication, and, when necessary, observing or providing verbal

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cuing to residents while they perform these activities. Supervision does not include one-on-one observation.

(28) ~~(24)~~ "Supplemental security income," Title XVI of the Social Security Act, means a program through which the Federal Government guarantees a minimum monthly income to every person who is age 65 or older, or disabled, or blind and meets the income and asset requirements.

(29) ~~(25)~~ "Supportive services" means services designed to encourage and assist residents ~~aged persons or adults with disabilities~~ to remain in the least restrictive living environment and to maintain their independence as long as possible.

(30) ~~(26)~~ "Twenty-four-hour nursing supervision" means services that are ordered by a physician for a resident whose condition requires the supervision of a physician and continued monitoring of vital signs and physical status. Such services shall be: medically complex enough to require constant supervision, assessment, planning, or intervention by a nurse; required to be performed by or under the direct supervision of licensed nursing personnel or other professional personnel for safe and effective performance; ~~required on a daily basis;~~ and consistent with the nature and severity of the resident's condition or the disease state or stage.

Section 6. Paragraphs (g) and (h) of subsection (2) of section 429.04, Florida Statutes, are amended to read:

429.04 Facilities to be licensed; exemptions.—

(2) The following are exempt from licensure under this part:

(g) Any facility certified under chapter 651, or a

retirement community, may provide services authorized under this part ~~or part III of chapter 400~~ to its residents who live in single-family homes, duplexes, quadruplexes, or apartments located on the campus without obtaining a license to operate an assisted living facility if residential units within such buildings are used by residents who do not require staff supervision for that portion of the day when personal services are not being delivered and the owner obtains a home health license to provide such services. However, any building or distinct part of a building on the campus that is designated for persons who receive personal services and require supervision beyond that which is available while such services are being rendered must be licensed in accordance with this part. If a facility provides personal services to residents who do not otherwise require supervision and the owner is not licensed as a home health agency, the buildings or distinct parts of buildings where such services are rendered must be licensed under this part. A resident of a facility that obtains a home health license may contract with a home health agency of his or her choice, provided that the home health agency provides liability insurance and workers' compensation coverage for its employees. Facilities covered by this exemption may establish policies that give residents the option of contracting for services and care beyond that which is provided by the facility to enable them to age in place. For purposes of this section, a retirement community consists of a facility licensed under this part or a facility licensed under part II of chapter 400, and apartments designed for independent living located on the same campus.

(h) Any residential unit for independent living which is


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located within a facility certified under chapter 651, or any residential unit for independent living which is colocated with a nursing home licensed under part II of chapter 400 or colocated with a facility licensed under this part in which services are provided through an outpatient clinic or a nursing home on an outpatient basis.

Section 7. Subsections (3) and (4) of section 429.07, Florida Statutes, are amended, and subsections (6) and (7) are added to that section, 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.

(a) A standard license shall be issued to a licensee for a facility ~~facilities~~ providing one or more of the personal services identified in s. 429.02. ~~Such facilities may also employ or contract with a person licensed under part I of chapter 464 to administer medications and perform other tasks as specified in s. 429.255.~~

(b) An extended congregate care license shall be issued to a licensee for a facility ~~facilities~~ providing, directly or through contract, services beyond those authorized in paragraph (a), including services performed by persons licensed under part I of chapter 464 and supportive services, as defined by rule, to persons who would otherwise be disqualified from continued residence in a facility licensed under this part.

1. In order for extended congregate care services to be provided, the agency must first determine that all requirements established in law and rule are met and must specifically designate, on the facility's license, that such services may be provided and whether the designation applies to all or part of the facility. Such designation may be made at the time of initial licensure or relicensure, or upon request in writing by a licensee under this part and part II of chapter 408. The notification of approval or the denial of the request shall be made in accordance with part II of chapter 408. Existing facilities qualifying to provide extended congregate care services must have maintained a standard license and may not have been subject to administrative sanctions during the previous 2 years, or since initial licensure if the facility has been licensed for less than 2 years, for any of the following reasons:

a. A class I or class II violation;

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

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

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

~~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~~


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~~ownership interest; or~~

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

2. A licensee ~~facility~~ that is licensed to provide extended congregate care services shall maintain a written progress report for ~~on~~ each person who receives services, and the report must describe ~~which describes~~ the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. ~~A registered nurse, or appropriate designee, representing the agency shall visit the facility at least quarterly to monitor residents who are receiving extended congregate care services and to determine if the facility is in compliance with this part, part II of chapter 408, and relevant rules. One of the visits may be in conjunction with the regular survey. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall serve as part of the team that inspects the facility. The agency may waive one of the required yearly monitoring visits for a facility that has been licensed for at least 24 months to provide extended congregate care services, if, during the inspection, the registered nurse determines that extended congregate care services are being provided appropriately, and if the facility has no class I or class II violations and no uncorrected class III violations. The agency must first consult with the long-term care ombudsman council for the area in which the facility is located to determine if any complaints have been made and substantiated about the quality of services or care. The agency may not waive one of the required yearly monitoring visits if complaints have been made and~~

~~substantiated.~~

3. A licensee ~~facility~~ that is licensed to provide extended congregate care services shall ~~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 residential setting ~~building~~, to assist with the evacuation of residents in an emergency.

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

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

f. Implement the concept of managed risk.

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

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

4. A facility that is licensed to provide extended

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

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

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

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

~~8. Failure to provide extended congregate care services may~~

~~result in denial of extended congregate care license renewal.~~

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

~~1. In order for limited nursing services to be provided in a facility licensed under this part, the agency must first determine that all requirements established in law and rule are met and must specifically designate, on the facility's license, that such services may be provided. Such designation may be made at the time of initial licensure or relicensure, or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with part II of chapter 408. Existing facilities qualifying to provide limited nursing services shall have maintained a standard license and may not have been subject to administrative sanctions that affect the health, safety, and welfare of residents for the previous 2 years or since initial licensure if the facility has been licensed for less than 2 years.~~

~~2. Facilities that are licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services, which report describes the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. A registered nurse representing the agency shall visit such facilities at least twice a year to monitor residents who are receiving limited nursing services and to determine if the facility is in compliance with applicable provisions of this part, part II of chapter 408, and related rules. The monitoring~~


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~~visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall also serve as part of the team that inspects such facility.~~

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

(4) In accordance with s. 408.805, an applicant or licensee shall pay a fee for each license application submitted under this part, part II of chapter 408, and applicable rules. The amount of the fee shall be established by rule.

(a) The biennial license fee required of a facility is $371 ~~$300~~ per license, with an additional fee of $71 ~~$50~~ per resident based on the total licensed resident capacity of the facility, except that no additional fee will be assessed for beds used by ~~designated for~~ recipients of Medicaid home and community-based waiver programs ~~optional state supplementation payments provided for in s. 409.212~~. ~~The total fee may not exceed $10,000.~~

(b) In addition to the total fee assessed under paragraph (a), the agency shall require facilities that are licensed to provide extended congregate care services under this part to pay an additional fee per licensed facility. The amount of the biennial fee shall be $523 ~~$400~~ per license, with an additional fee of $10 per resident based on the total licensed resident capacity of the facility.

~~(c) In addition to the total fee assessed under paragraph~~

~~(a), the agency shall require facilities that are licensed to provide limited nursing services under this part to pay an additional fee per licensed facility. The amount of the biennial fee shall be $250 per license, with an additional fee of $10 per resident based on the total licensed resident capacity of the facility.~~

(6) In order to determine whether the facility must participate in the monitoring activities during the 12-month period, the agency shall conduct a biennial survey that includes private informal conversations with a sample of residents and consultation with the ombudsman council in the planning and service area in which the facility is located to discuss the residents' experiences within the facility.

(7) An assisted living facility that has been cited within the previous 24-month period for a class I or class II violation, regardless of the status of any enforcement or disciplinary action, is subject to periodic unannounced monitoring to determine if the facility is in compliance with this part, part II of chapter 408 and applicable rules. Monitoring may occur through a desk review or an onsite assessment. If the class I or class II violation relates to providing or failing to provide nursing care, a registered nurse must participate in the monitoring visits during the 12-month period following the violation.

Section 8. Paragraph (a) of subsection (2) of section 429.08, Florida Statutes, is amended to read:

429.08 Unlicensed facilities; referral of person for residency to unlicensed facility; penalties.—

(2) It is unlawful to knowingly refer a person for

residency to an unlicensed assisted living facility; to an assisted living facility the license of which is under denial or has been suspended or revoked; or to an assisted living facility that has a moratorium pursuant to part II of chapter 408.

(a) Any health care practitioner, as defined in s. 456.001, or emergency medical technician or paramedic certified pursuant to part III or chapter 401, who is aware of the operation of an unlicensed facility shall report that facility to the agency. Failure to report a facility that the practitioner knows or has reasonable cause to suspect is unlicensed shall be reported to the practitioner's licensing board.

Section 9. Subsection (8) is added to section 429.11, Florida Statutes, to read:

429.11 Initial application for license; provisional license.—

(8) The agency shall develop an abbreviated form for submission of proof of financial ability to operate under s. 408.810(8).

Section 10. Section 429.12, Florida Statutes, is amended to read:

429.12 Sale or transfer of ownership of a facility.—In order ~~It is the intent of the Legislature~~ to protect the rights of the residents of an assisted living facility ~~when the facility is sold or the ownership thereof is transferred. Therefore~~, in addition to the requirements of part II of chapter 408, whenever a facility is sold or the ownership thereof is transferred, including leasing, ~~:~~

~~(1)~~ the transferee shall notify the residents, in writing, of the change of ownership within 7 days after receipt of the

new license.

~~(2) The transferor of a facility the license of which is denied pending an administrative hearing shall, as a part of the written change-of-ownership contract, advise the transferee that a plan of correction must be submitted by the transferee and approved by the agency at least 7 days before the change of ownership and that failure to correct the condition which resulted in the moratorium pursuant to part II of chapter 408 or denial of licensure is grounds for denial of the transferee's license.~~

Section 11. 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 employee~~:

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

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

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


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

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

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

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

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

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

(f)~~(g)~~ Violation of a moratorium.

(g)~~(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.

(h)~~(i)~~ An intentional or negligent life-threatening act in violation of the uniform firesafety standards for assisted living facilities or other firesafety standards 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.

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

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


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(2) Upon notification by the local authority having jurisdiction or by the State Fire Marshal, the agency may deny or revoke the license of a licensee 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 a license to any applicant or controlling interest as defined in part II of chapter 408 which has or had a 25-percent or greater financial or ownership interest in any other facility licensed under this part, or in any entity licensed by this state or another state to provide health or residential care, 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 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.~~

(4)~~(5)~~ An action taken by the agency to suspend, deny, or revoke a licensee's ~~facility's~~ license under this part or part II of chapter 408, in which the agency claims that the facility owner or a staff member ~~an employee~~ of the facility has threatened the health, safety, or welfare of a resident of the facility must be heard by the Division of Administrative Hearings of the Department of Management Services within 120


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days after receipt of the facility's request for a hearing, unless that time limitation is waived by both parties. The administrative law judge must render a decision within 30 days after receipt of a proposed recommended order.

~~(6) The agency shall 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.~~

(5) ~~(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 12. Subsections (1), (4), and (5) of section 429.17, Florida Statutes, are amended to read:

429.17 Expiration of license; renewal; conditional license.—

(1) ~~Limited nursing,~~ Extended congregate care, and limited mental health licenses shall expire at the same time as the facility's standard license, regardless of when issued.

(4) In addition to the license categories available in s. 408.808, a conditional license may be issued to an applicant for license renewal if the applicant fails to meet all standards and requirements for licensure. A conditional license issued under this subsection shall be limited in duration to a specific period of time not to exceed 6 months, as determined by the agency~~, and shall be accompanied by an agency-approved plan of correction~~.

(5) When an extended congregate care ~~or limited nursing~~ license is requested during a facility's biennial license period, the fee shall be prorated in order to permit the additional license to expire at the end of the biennial license period. The fee shall be calculated as of the date the additional license application is received by the agency.

Section 13. Subsections (1), (6), (7), and (8) of section 429.178, Florida Statutes, are amended to read:

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

(1) A facility that ~~which~~ advertises that it provides special care for persons with Alzheimer's disease or other related disorders must meet the following standards of operation:

(a)~~1. If the facility has 17 or more residents,~~ Have an awake staff member on duty at all hours of the day and night for each secured unit of the facility that houses any residents who have Alzheimer's disease or other related disorders.~~; or~~

~~2. If the facility has fewer than 17 residents, have an awake staff member on duty at all hours of the day and night or have mechanisms in place to monitor and ensure the safety of the facility's residents.~~

(b) Offer activities specifically designed for persons who are cognitively impaired.

(c) Have a physical environment that provides for the safety and welfare of the facility's residents.

(d) Employ staff who have completed the training and continuing education required in subsection (2).


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For the safety and protection of residents who have Alzheimer's disease, related disorders, or dementia, a secured locked unit may be designated. The unit may consist of the entire building or a distinct part of the building. Exit doors shall be equipped with an operating alarm system that releases upon activation of the fire alarm. These units are exempt from specific life safety requirements to which assisted living residences are normally subject. A staff member must be awake and present in the secured unit at all times.

(6) The department shall maintain and post on its website ~~keep~~ a current list of providers who are approved to provide initial and continuing education for staff and direct care staff members of facilities that provide special care for persons with Alzheimer's disease or other related disorders.

~~(7) Any facility more than 90 percent of whose residents receive monthly optional supplementation payments is not required to pay for the training and education programs required under this section. A facility that has one or more such residents shall pay a reduced fee that is proportional to the percentage of such residents in the facility. A facility that does not have any residents who receive monthly optional supplementation payments must pay a reasonable fee, as established by the department, for such training and education programs.~~

(7) ~~(8)~~ The department shall adopt rules to establish standards for trainers and training and to implement this section.

Section 14. Subsections (1), (2), (5), (7), (8), and (9) of section 429.19, Florida Statutes, are amended to read:

429.19 Violations; imposition of administrative fines; grounds.—

(1) In addition to the requirements of part II of chapter 408, 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 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 those conditions or occurrences related to the operation and maintenance of a facility or to the care of residents which the agency determines present an imminent danger to the residents or a substantial probability that death or serious physical or emotional harm would result. The condition or practice constituting a class I violation shall be abated or eliminated within 24 hours, unless a fixed period, as determined by the agency, is required for correction ~~defined in s. 408.813~~. The agency shall impose an administrative fine for a cited class I violation in an amount not less than $5,000 and not exceeding $10,000 for each violation. A fine shall be levied notwithstanding the correction of the violation.

(b) Class "II" violations are those conditions or occurrences related to the operation and maintenance of a facility or to the care of residents which the agency determines directly threaten the physical or emotional health, safety, or security of the residents, other than class I violations ~~defined in s. 408.813~~. The agency shall impose an administrative fine for a cited class II violation in an amount not less than $1,000 and not exceeding $5,000 for each violation. A fine shall be levied notwithstanding the correction of the violation.

(c) Class "III" violations are those conditions or occurrences related to the operation and maintenance of a facility or to the care of residents which the agency determines indirectly or potentially threaten the physical or emotional health, safety, or security of residents, other than class I or class II violations ~~defined in s. 408.813~~. The agency shall impose an administrative fine for a cited class III violation in an amount not less than $500 and not exceeding $1,000 for each violation. If a class III violation is corrected within the time specified, a fine may not be imposed.

(d) Class "IV" violations are those conditions or occurrences related to the operation and maintenance of a facility or to required reports, forms, or documents that do not have the potential of negatively affecting residents. These violations are of a type that the agency determines do not threaten the health, safety, or security of residents ~~defined in s. 408.813~~. The agency shall impose an administrative fine for a cited class IV violation in an amount not less than $100 and not exceeding $200 for each violation. A citation for a class IV violation must specify the time within which the violation is

required to be corrected. If a class IV violation is corrected within the time specified, a fine may not be imposed.

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

(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~~.

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

(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.

Section 15. Section 429.195, Florida Statutes, is amended to read:

429.195 Rebates prohibited; penalties.—

(1) It is unlawful for the licensee of any assisted living facility licensed under this part to contract or promise to pay or receive any commission, bonus, kickback, or rebate or engage in any split-fee arrangement in any form whatsoever with any health care provider or health care facility under s. 817.505 ~~physician, surgeon, organization, agency, or person, either directly or indirectly, for residents referred to an assisted living facility licensed under this part~~. ~~A facility may employ or contract with persons to market the facility, provided the employee or contract provider clearly indicates that he or she represents the facility. A person or agency independent of the facility may provide placement or referral services for a fee to individuals seeking assistance in finding a suitable facility; however, any fee paid for placement or referral services must be paid by the individual looking for a facility, not by the facility.~~ Any agreement to market, promote, or provide referral services shall be in compliance with s. 817.505 and federal law.

(2) A violation of this section shall be considered patient

brokering and is punishable as provided in s. 817.505.

(3) This section does not apply to:

(a) A referral service that provides information, consultation, or referrals to consumers to assist them in finding appropriate care or housing options for seniors or disabled adults if such referred consumers are not Medicaid recipients.

(b) A resident of an assisted living facility who refers a friend, a family member, or other individual with whom the resident has a personal relationship to the assisted living facility, and does not prohibit the assisted living facility from providing a monetary reward to the resident for making such a referral.

Section 16. Subsections (2) and (3) of section 429.20, Florida Statutes, are amended to read:

429.20 Certain solicitation prohibited; third-party supplementation.—

(2) Solicitation of contributions of any kind in a threatening, coercive, or unduly forceful manner by or on behalf of an assisted living facility or facilities by any agent, employee, owner, or representative of any assisted living facility or facilities is prohibited ~~grounds for denial, suspension, or revocation of the license of the assisted living facility or facilities by or on behalf of which such contributions were solicited~~.

(3) The admission or maintenance of assisted living facility residents whose care is supported, in whole or in part, by state funds may not be conditioned upon the receipt of any manner of contribution or donation from any person. ~~The~~

~~solicitation or receipt of contributions in violation of this subsection is grounds for denial, suspension, or revocation of license, as provided in s. 429.14, for any assisted living facility by or on behalf of which such contributions were solicited.~~

Section 17. Section 429.23, Florida Statutes, is amended to read:

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

(1) Every licensed facility ~~licensed under this part~~ may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, violations ~~deficiencies~~ cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences.

(2) Every licensed facility ~~licensed under this part~~ is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means:

(a) An event over which facility staff ~~personnel~~ could exercise control rather than as a result of the resident's condition and results in:

1. Death;

2. Brain or spinal damage;

3. Permanent disfigurement;

4. Fracture or dislocation of bones or joints;

5. Any condition that required medical attention to which the resident has not given his or her consent, excluding

proceedings governed by part I of chapter 394, but including failure to honor advanced directives;

6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or

7. An event that is reported to law enforcement or its personnel for investigation; or

(b) Resident elopement, if the elopement places the resident at risk of harm or injury.

~~(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident.~~

(3)~~(4)~~ Licensed facilities shall provide within 15 business days after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a full report to the agency on the ~~all~~ adverse incident, including information regarding the identity of the affected resident, the type of adverse incident, and ~~incidents specified in this section. The report must include~~ the results of the facility's investigation into the adverse incident.

~~(5) Each facility shall report monthly to the agency any liability claim filed against it. The report must include the name of the resident, the dates of the incident leading to the claim, if applicable, and the type of injury or violation of~~

~~rights alleged to have occurred. This report is not discoverable in any civil or administrative action, except in such actions brought by the agency to enforce the provisions of this part.~~

(4)~~(6)~~ Abuse, neglect, or exploitation must be reported to the Department of Children and Family Services as required under chapter 415.

(5)~~(7)~~ The information reported to the agency ~~pursuant to subsection (3)~~ which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 must ~~shall~~ be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.

(6)~~(8)~~ If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member ~~or employee~~ of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board.

(7)~~(9)~~ The adverse incident report ~~reports and preliminary adverse incident reports~~ required under this section is ~~are~~ confidential as provided by law and is ~~are~~ not discoverable or admissible in any civil or administrative action, except in


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disciplinary proceedings by the agency or appropriate regulatory board.

(8) ~~(10)~~ The Department of Elderly Affairs may adopt rules necessary to administer this section.

Section 18. Subsections (1) and (2) of section 429.255, Florida Statutes, are amended to read:

429.255 Use of personnel; emergency care.—

(1)(a) Persons under contract to the facility or~~,~~ facility staff~~, or volunteers,~~ who are licensed according to part I of chapter 464, or those persons exempt under s. 464.022(1), and others as defined by rule, may administer medications to residents, take residents' vital signs, manage individual weekly pill organizers for residents who self-administer medication, give prepackaged enemas ordered by a physician, observe residents, document observations on the appropriate resident's record, report observations to the resident's physician, and contract or allow residents or a resident's representative, designee, surrogate, guardian, or attorney in fact to contract with a third party, provided residents meet the criteria for appropriate placement as defined in s. 429.26. Nursing assistants certified pursuant to part II of chapter 464 may take residents' vital signs as directed by a licensed nurse or physician. A person under contract to the facility or facility staff who are licensed under part I of chapter 464 may provide limited nursing services.

(b) All staff in facilities licensed under this part shall exercise their ~~professional~~ responsibility to observe residents, to document observations on the appropriate resident's record, and to report the observations to the administrator or the


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administrator's designee ~~resident's physician~~. ~~However,~~ The ~~owner or~~ administrator of the facility shall be responsible for determining that the resident receiving services is appropriate for residence in the assisted living facility.

~~(c) In an emergency situation, licensed personnel may carry out their professional duties pursuant to part I of chapter 464 until emergency medical personnel assume responsibility for care.~~

(2) In facilities licensed to provide extended congregate care, persons under contract to the facility or~~,~~ facility staff~~, or volunteers,~~ who are licensed according to part I of chapter 464, or those persons exempt under s. 464.022(1), or those persons certified as nursing assistants pursuant to part II of chapter 464, may also perform all duties within the scope of their license or certification, as approved by the facility administrator and pursuant to this part.

Section 19. Subsections (2), (3), and (4) of section 429.256, Florida Statutes, are amended to read:

429.256 Assistance with self-administration of medication.—

(2) Residents who are capable of self-administering their own medications without assistance shall be encouraged and allowed to do so. However, an unlicensed person may, consistent with a dispensed prescription's label or the package directions of an over-the-counter medication, assist a resident whose condition is medically stable with the self-administration of routine, regularly scheduled medications that are intended to be self-administered. Assistance with self-medication by an unlicensed person may occur only upon a documented request by, and the written informed consent of, a resident or the

resident's surrogate, guardian, or attorney in fact. To minimize the potential risk for improper dosage administration of prescription drugs, a facility may require standard medication dispensing systems for residents' prescriptions, as specified by rule. For the purposes of this section, self-administered medications include both legend and over-the-counter oral dosage forms, topical dosage forms and topical ophthalmic, otic, and nasal dosage forms including solutions, suspensions, sprays, ~~and~~ inhalers, and continuous positive airway pressure machines.

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

(a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident.

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

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

(d) Applying topical medications.

(e) Returning the medication container to proper storage.

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

(g) Assisting a resident in holding a nebulizer.

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

(i) Assisting with the putting on and taking off anti-embolism stockings.

(j) Assisting with applying and removing an oxygen cannula.


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

(a) Mixing, compounding, converting, or calculating medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.

(b) The preparation of syringes for injection or the administration of medications by any injectable route.

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

(c) ~~(d)~~ Administration of medications by way of a tube inserted in a cavity of the body.

(d) ~~(e)~~ Administration of parenteral preparations.

(e) ~~(f)~~ Irrigations or debriding agents used in the treatment of a skin condition.

(f) ~~(g)~~ Rectal, urethral, or vaginal preparations.

(g) ~~(h)~~ Medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident.

(h) ~~(i)~~ Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.

Section 20. Subsections (3), (7), (8), (9), (10), and (11) of section 429.26, Florida Statutes, are amended to read:

429.26 Appropriateness of placements; examinations of residents.—

(3) Persons licensed under part I of chapter 464 who are


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employed by or under contract with a facility shall, on a routine basis or at least monthly, perform a nursing assessment of the residents for whom they are providing nursing services ordered by a physician, except administration of medication, and shall document such assessment, including any significant change ~~substantial changes~~ in a resident's status which may necessitate relocation to a nursing home, hospital, or specialized health care facility. Such records shall be maintained in the facility for inspection by the agency and shall be forwarded to the resident's case manager, if applicable.

~~(7) The facility must notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition.~~

(7) ~~(8)~~ The Department of Children and Family Services may require an examination for supplemental security income and optional state supplementation recipients residing in facilities at any time and shall provide the examination whenever a resident's condition requires it. Any facility administrator; personnel of the agency, the department, or the Department of Children and Family Services; or long-term care ombudsman council member who believes a resident needs to be evaluated shall notify the resident's case manager, who shall take


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appropriate action. A report of the examination findings shall be provided to the resident's case manager and the facility administrator to help the administrator meet his or her responsibilities under subsection (1).

(8) ~~(9)~~ A terminally ill resident who no longer meets the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the administrator, ~~facility;~~ additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met.

(9) ~~(10)~~ Facilities licensed to provide extended congregate care services shall promote aging in place by determining appropriateness of continued residency based on a comprehensive review of the resident's physical and functional status; the ability of the facility, family members, friends, or any other pertinent individuals or agencies to provide the care and services required; and documentation that a written service plan consistent with facility policy has been developed and implemented to ensure that the resident's needs and preferences are addressed.

(10) ~~(11)~~ A ~~No~~ resident who requires 24-hour nursing supervision, except for a resident who is an enrolled hospice patient pursuant to part IV of chapter 400, may not ~~shall~~ be retained in a licensed facility ~~licensed under this part~~.

Section 21. Section 429.27, Florida Statutes, is amended to read:

429.27 Property and personal affairs of residents.—

(1)(a) A resident shall be given the option of using his or

her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated incompetent or incapacitated under state law, managing his or her own affairs.

(b) The admission of a resident to a facility and his or her presence therein does ~~shall~~ not give ~~confer on~~ the facility or its licensee, owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence give ~~confer on~~ any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident.

(2) The licensee, ~~A facility, or an~~ owner, administrator, employee of an assisted living facility, or representative thereof, may not act as the guardian, trustee, or conservator for any resident of the assisted living facility or any of such resident's property. A licensee, ~~An~~ owner, administrator, or staff member, or representative thereof, may not act as a competent resident's payee for social security, veteran's, or railroad benefits without the consent of the resident. Any facility whose licensee, owner, administrator, or staff, or representative thereof, serves as representative payee for any resident of the facility shall file a surety bond with the agency in an amount equal to twice the average monthly aggregate income or personal funds due to residents, or expendable for their account, which are received by a facility. Any facility whose licensee, owner, administrator, or staff, or a representative thereof, is granted power of attorney for any

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resident of the facility shall file a surety bond with the agency for each resident for whom such power of attorney is granted. The surety bond shall be in an amount equal to twice the average monthly income of the resident, plus the value of any resident's property under the control of the attorney in fact. The bond shall be executed by the facility's licensee, owner, administrator, or staff, or a representative thereof, ~~facility~~ as principal and a licensed surety company. The bond shall be conditioned upon the faithful compliance of the licensee, owner, administrator, or staff, or a representative thereof, of the facility with this section and shall run to the agency for the benefit of any resident who suffers a financial loss as a result of the misuse or misappropriation by a licensee, owner, administrator, or staff, or representative thereof, of the facility of funds held pursuant to this subsection. Any surety company that cancels or does not renew the bond of any licensee shall notify the agency in writing not less than 30 days in advance of such action, giving the reason for the cancellation or nonrenewal. Any facility's licensee, ~~facility~~ owner, administrator, or staff, or representative thereof, who is granted power of attorney for any resident of the facility shall, on a monthly basis, be required to provide the resident a written statement of any transaction made on behalf of the resident pursuant to this subsection, and a copy of such statement given to the resident shall be retained in each resident's file and available for agency inspection.

(3) A facility administrator, upon mutual consent with the resident, shall provide for the safekeeping in the facility of personal effects, including funds, not in excess of $500 ~~and~~


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

(4) Any funds or other property belonging to or due to a resident, or expendable for his or her account, which is received by the administrator ~~a facility~~ shall be trust funds which shall be kept separate from the funds and property of the facility and other residents or shall be specifically credited to such resident. Such trust funds shall be used or otherwise expended only for the account of the resident. Upon written request, at least once every 3 months, unless upon order of a court of competent jurisdiction, the administrator ~~facility~~ shall furnish the resident and his or her guardian, trustee, or conservator, if any, a complete and verified statement of all funds and other property to which this subsection applies, detailing the amount and items received, together with their sources and disposition. In any event, the administrator ~~facility~~ shall furnish such statement annually and upon the discharge or transfer of a resident. ~~Any governmental agency or private charitable agency contributing funds or other property to the account of a resident shall also be entitled to receive such statement annually and upon the discharge or transfer of the resident.~~

(5) Any personal funds available to facility residents may be used by residents as they choose to obtain clothing, personal items, leisure activities, and other supplies and services for

their personal use. An administrator ~~A facility~~ may not demand, require, or contract for payment of all or any part of the personal funds in satisfaction of the facility rate for supplies and services beyond that amount agreed to in writing ~~and may not levy an additional charge to the individual or the account for any supplies or services that the facility has agreed by contract to provide as part of the standard monthly rate~~. Any service or supplies provided by the facility which are charged separately to the individual or the account may be provided only with the specific written consent of the individual, who shall be furnished in advance of the provision of the services or supplies with an itemized written statement to be attached to the contract setting forth the charges for the services or supplies.

(6)(a) In addition to any damages or civil penalties to which a person is subject, any person who:

1. Intentionally withholds a resident’s personal funds, personal property, or personal needs allowance, or who demands, beneficially receives, or contracts for payment of all or any part of a resident’s personal property or personal needs allowance in satisfaction of the facility rate for supplies and services; or

2. Borrows from or pledges any personal funds of a resident, other than the amount agreed to by written contract under s. 429.24,

commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(b) Any licensee, facility owner, administrator, or staff,

or representative thereof, who is granted power of attorney for any resident of the facility and who misuses or misappropriates funds obtained through this power commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(7) In the event of the death of a resident, a licensee shall return all refunds, funds, and property held in trust to the resident's personal representative, if one has been appointed at the time the facility disburses such funds, and, if not, to the resident's spouse or adult next of kin named in a beneficiary designation form provided by the licensee ~~facility~~ to the resident. If the resident has no spouse or adult next of kin or such person cannot be located, funds due the resident shall be placed in an interest-bearing account, and all property held in trust by the licensee ~~facility~~ shall be safeguarded until such time as the funds and property are disbursed pursuant to the Florida Probate Code. Such funds shall be kept separate from the funds and property of the facility and other residents of the facility. If the funds of the deceased resident are not disbursed pursuant to the Florida Probate Code within 2 years after the resident's death, the funds shall be deposited in the Health Care Trust Fund administered by the agency.

(8) The department may by rule clarify terms and specify procedures and documentation necessary to administer the provisions of this section relating to the proper management of residents' funds and personal property and the execution of surety bonds.

Section 22. Subsection (4) of section 429.275, Florida Statutes, is repealed.

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Section 23. Paragraph (k) of subsection (1) and subsections (3), (4), (5), (6), and (7) of section 429.28, Florida Statutes, are amended to read:

429.28 Resident bill of rights.—

(1) A ~~No~~ resident of a facility may not ~~shall~~ be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:

(k) At least 30 ~~45~~ days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally incapacitated, the guardian shall be given at least 30 ~~45~~ days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. ~~In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.~~

~~(3)(a) The agency shall conduct a survey to determine general compliance with facility standards and compliance with residents' rights as a prerequisite to initial licensure or licensure renewal.~~

~~(b) In order to determine whether the facility is adequately protecting residents' rights, the biennial survey shall include private informal conversations with a sample of~~

~~residents and consultation with the ombudsman council in the planning and service area in which the facility is located to discuss residents' experiences within the facility.~~

~~(c) During any calendar year in which no survey is conducted, the agency shall conduct at least one monitoring visit of each facility cited in the previous year for a class I or class II violation, or more than three uncorrected class III violations.~~

~~(d) The agency may conduct periodic followup inspections as necessary to monitor the compliance of facilities with a history of any class I, class II, or class III violations that threaten the health, safety, or security of residents.~~

~~(e) The agency may conduct complaint investigations as warranted to investigate any allegations of noncompliance with requirements required under this part or rules adopted under this part.~~

(3) ~~(4)~~ The administrator shall ensure that ~~facility shall not hamper or prevent~~ residents may exercise ~~from exercising~~ their rights as specified in this section.

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

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

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

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

(5) ~~(6)~~ An administrator may not terminate ~~Any facility~~


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~~which terminates~~ the residency of an individual who participated in activities specified in subsection (4)~~(5) shall show good cause in a court of competent jurisdiction~~.

(6)~~(7)~~ Any person who submits or reports a complaint concerning a suspected violation of the provisions of this part or concerning services and conditions in facilities, or who testifies in any administrative or judicial proceeding arising from such a complaint, shall have immunity from any civil or criminal liability therefor, unless such person has acted in bad faith or with malicious purpose or the court finds that there was a complete absence of a justiciable issue of either law or fact raised by the losing party.

Section 24. Section 429.29, Florida Statutes, is amended to read:

429.29 Civil actions to enforce rights.—

(1) A ~~Any person or~~ resident ~~whose~~ who alleges negligence or a violation of rights as specified in this part has ~~are violated shall have~~ a cause of action against the licensee or its management company, as identified in the state application for assisted living facility licensure. However, the cause of action may not be asserted individually against an officer, director, owner, including an owner designated as having a controlling interest on the state application for assisted living facility licensure, or agent of a licensee or management company unless, following an evidentiary hearing, the court determines there is sufficient evidence in the record or proffered by the claimant which establishes a reasonable basis for finding that the person or entity breached, failed to perform, or acted outside the scope of duties as an officer,

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director, owner, or agent, and that the breach, failure to perform, or action outside the scope of duties is a legal cause of actual loss, injury, death, or damage to the resident.

(2) The action may be brought by the resident or his or her guardian, or by a person or organization acting on behalf of a resident with the consent of the resident or his or her guardian, or by the personal representative of the estate of a deceased resident regardless of the cause of death.

(3) If the action alleges a claim for the resident's rights or for negligence that:

(a) Caused the death of the resident, the claimant shall ~~be required to~~ elect ~~either~~ survival damages pursuant to s. 46.021 or wrongful death damages pursuant to s. 768.21. If the claimant elects wrongful death damages, total noneconomic damages may not exceed $250,000, regardless of the number of claimants.

(b) ~~If the action alleges a claim for the resident's rights or for negligence that~~ Did not cause the death of the resident, the personal representative of the estate may recover damages for the negligence that caused injury to the resident.

(4) The action may be brought in any court of competent jurisdiction to enforce such rights and to recover actual damages, and punitive damages for violation of the rights of a resident or negligence.

(5) Any resident who prevails in seeking injunctive relief or a claim for an administrative remedy is entitled to recover the costs of the action and a reasonable attorney's fee assessed against the defendant not to exceed $25,000. Fees shall be awarded solely for the injunctive or administrative relief and not for any claim or action for damages whether such claim or


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action is brought together with a request for an injunction or administrative relief or as a separate action, except as provided under s. 768.79 or the Florida Rules of Civil Procedure. Sections 429.29-429.298 provide the exclusive remedy for a cause of action for recovery of damages for the personal injury or death of a resident arising out of negligence or a violation of rights specified in s. 429.28. This section does not preclude theories of recovery not arising out of negligence or s. 429.28 which are available to a resident or to the agency. The provisions of chapter 766 do not apply to any cause of action brought under ss. 429.29-429.298.

(6) ~~(2)~~ If the ~~In any~~ claim brought pursuant to this part alleges ~~alleging~~ a violation of resident's rights or negligence causing injury to or the death of a resident, the claimant shall have the burden of proving, by a preponderance of the evidence, that:

(a) The defendant owed a duty to the resident;

(b) The defendant breached the duty to the resident;

(c) The breach of the duty is a legal cause of loss, injury, death, or damage to the resident; and

(d) The resident sustained loss, injury, death, or damage as a result of the breach.

~~Nothing in~~ This part does not ~~shall be interpreted to~~ create strict liability. A violation of the rights set forth in s. 429.28 or in any other standard or guidelines specified in this part or in any applicable administrative standard or guidelines of this state or a federal regulatory agency shall be evidence of negligence but shall not be considered negligence per se.


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(7)~~(3)~~ In any claim brought pursuant to this section, a licensee, person, or entity has ~~shall have~~ a duty to exercise reasonable care. Reasonable care is that degree of care which a reasonably careful licensee, person, or entity would use under like circumstances.

(8)~~(4)~~ In any claim for resident's rights violation or negligence by a nurse licensed under part I of chapter 464, such nurse has a ~~shall have the~~ duty to exercise care consistent with the prevailing professional standard of care for a nurse. The prevailing professional standard of care for a nurse is ~~shall be~~ that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar nurses.

(9)~~(5)~~ Discovery of financial information for the purpose of determining the value of punitive damages may not be had unless the plaintiff shows the court by proffer or evidence in the record that a reasonable basis exists to support a claim for punitive damages.

(10)~~(6)~~ In addition to any other standards for punitive damages, any award of punitive damages must be reasonable in light of the actual harm suffered by the resident and the egregiousness of the conduct that caused the actual harm to the resident.

(11)~~(7)~~ The resident or the resident's legal representative shall serve a copy of any complaint alleging in whole or in part a violation of any rights specified in this part to the agency ~~for Health Care Administration~~ at the time of filing the initial complaint with the clerk of the court for the county in which the action is pursued. ~~The requirement of~~ Providing a copy of

the complaint to the agency does not impair the resident's legal rights or ability to seek relief for his or her claim.

Section 25. Subsections (4) and (7) of section 429.293, Florida Statutes, are amended, subsection (11) is redesignated as subsection (12), and a new subsection (11) is added to that section, to read:

429.293 Presuit notice; investigation; notification of violation of residents' rights or alleged negligence; claims evaluation procedure; informal discovery; review; settlement offer; mediation.—

(4) The notification of a violation of a resident's rights or alleged negligence shall be served within the applicable statute of limitations period; however, during the 75-day period, the statute of limitations is tolled as to all prospective defendants. Upon written stipulation by the parties, the 75-day period may be extended and the statute of limitations is tolled during any such extension. Upon receiving written notice by certified mail, return receipt requested, of termination of negotiations in an extended period, the claimant shall have 30 ~~60~~ days or the remainder of the period of the statute of limitations, whichever is greater, within which to file suit.

(7) Informal discovery may be used by a party to obtain unsworn statements and the production of documents or things, as follows:

(a) *Unsworn statements.*—Any party may require other parties to appear for the taking of an unsworn statement. Such statements may be used only for the purpose of claims evaluation and are not discoverable or admissible in any civil action for


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any purpose by any party. A party seeking to take the unsworn statement of any party must give reasonable notice in writing to all parties. The notice must state the time and place for taking the statement and the name and address of the party to be examined. Unless otherwise impractical, the examination of any party must be done at the same time by all other parties. Any party may be represented by counsel at the taking of an unsworn statement. An unsworn statement may be recorded electronically, stenographically, or on videotape. The taking of unsworn statements is subject to the provisions of the Florida Rules of Civil Procedure and may be terminated for abuses.

(b) *Documents or things.*—Any party may request discovery of relevant documents or things relevant to evaluating the merits of the claim. The documents or things must be produced, at the expense of the requesting party, within 20 days after the date of receipt of the request. A party is required to produce relevant and discoverable documents or things within that party's possession or control, if in good faith it can reasonably be done within the timeframe of the claims evaluation process.

(11) An arbitration process as provided for in chapter 44 may be used to resolve a claim filed pursuant to this section.

(12) ~~(11)~~ Within 30 days after the claimant's receipt of the defendant's response to the claim, the parties or their designated representatives shall meet in mediation to discuss the issues of liability and damages in accordance with the mediation rules of practice and procedures adopted by the Supreme Court. Upon written stipulation of the parties, this 30-day period may be extended and the statute of limitations is

tolled during the mediation and any such extension. At the conclusion of mediation, the claimant shall have 60 days or the remainder of the period of the statute of limitations, whichever is greater, within which to file suit.

Section 26. Section 429.294, Florida Statutes, is amended to read:

429.294 Availability of facility records for investigation of resident's rights violations and defenses; penalty.—

(1) Unless expressly prohibited by a legally competent resident, an assisted living facility licensed under this part shall furnish to the spouse, guardian, surrogate, proxy, or attorney in fact, as provided in chapters 744 and 765, of a current, within 7 working days after receipt of a written request, or of a former resident, within 10 working days after receipt of a written request, a copy of that resident's records that are in the possession of the facility. Such records must include medical and psychiatric records and any records concerning the care and treatment of the resident performed by the facility, except progress notes and consultation report sections of a psychiatric nature. Copies of such records are not considered part of a deceased resident's estate and may be made available before the administration of an estate, upon request, to the spouse, guardian, surrogate, proxy, or attorney in fact, as provided in chapters 744 and 765. A facility may charge a reasonable fee for the copying of a resident's records. Such fee shall not exceed $1 per page for the first 25 pages and 25 cents per page for each additional page in excess of 25 pages. The facility shall further allow any such spouse, guardian, surrogate, proxy, or attorney in fact, as provided in chapters


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744 and 765, to examine the original records in its possession, or microfilms or other suitable reproductions of the records, upon such reasonable terms as shall be imposed, to help ensure that the records are not damaged, destroyed, or altered.

(2) A person may not obtain copies of a resident's records under this section more often than once per month, except that a physician's report in the a resident's records may be obtained as often as necessary to effectively monitor the resident's condition.

(3) ~~(1)~~ Failure to provide complete copies of a resident's records, including, but not limited to, all medical records and the resident's chart, within the control or possession of the facility within 10 days, in accordance with the provisions of this section ~~s. 400.145~~, shall constitute evidence of failure of that party to comply with good faith discovery requirements and shall waive the good faith certificate and presuit notice requirements under this part by the requesting party.

(4) ~~(2)~~ A licensee may not ~~No facility shall~~ be held liable for any civil damages as a result of complying with this section.

Section 27. Subsections (1), (2), and (3) of section 429.297, Florida Statutes, are amended to read:

429.297 Punitive damages; pleading; burden of proof.—

(1) In any action ~~for damages~~ brought under this part, a ~~no~~ claim for punitive damages is not ~~shall be~~ permitted unless, based on admissible ~~there is a reasonable showing by~~ evidence ~~in the record or~~ proffered by the claimant, ~~which would provide~~ a reasonable basis for recovery of such damages is demonstrated upon applying the criteria set forth in this section. The

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defendant may proffer admissible evidence to refute the claimant's proffer of evidence to recover punitive damages. The trial judge shall conduct an evidentiary hearing and weigh the admissible evidence proffered by the claimant and the defendant to ensure that there is a reasonable basis to believe that the claimant, at trial, will be able to demonstrate by clear and convincing evidence that the recovery of such damages is warranted. The claimant may move to amend her or his complaint to assert a claim for punitive damages as allowed by the rules of civil procedure. ~~The rules of civil procedure shall be liberally construed so as to allow the claimant discovery of evidence which appears reasonably calculated to lead to admissible evidence on the issue of punitive damages. No~~ Discovery of financial worth may not ~~shall~~ proceed until after the trial judge approves the pleading on ~~concerning~~ punitive damages ~~is permitted~~.

(2) A defendant, including the licensee or management company, against whom punitive damages is sought may be held liable for punitive damages only if the trier of fact, based on clear and convincing evidence, finds that a specific individual or corporate defendant actively and knowingly participated in intentional misconduct, or engaged in conduct that constituted gross negligence, and that conduct contributed to the loss, damages, or injury suffered by the claimant ~~the defendant was personally guilty of intentional misconduct or gross negligence~~. As used in this section, the term:

(a) "Intentional misconduct" means that the defendant against whom a claim for punitive damages is sought had actual knowledge of the wrongfulness of the conduct and the high

probability that injury or damage to the claimant would result and, despite that knowledge, intentionally pursued that course of conduct, resulting in injury or damage.

(b) "Gross negligence" means that the defendant's conduct was so reckless or wanting in care that it constituted a conscious disregard or indifference to the life, safety, or rights of persons exposed to such conduct.

(3) In the case of vicarious liability of an employer, principal, corporation, or other legal entity, punitive damages may not be imposed for the conduct of an identified employee or agent unless ~~only if~~ the conduct of the employee or agent meets the criteria specified in subsection (2) and officers, directors, or managers of the actual employer corporation or legal entity condoned, ratified, or consented to the specific conduct as alleged by the claimant in subsection (2).~~:~~

~~(a) The employer, principal, corporation, or other legal entity actively and knowingly participated in such conduct;~~

~~(b) The officers, directors, or managers of the employer, principal, corporation, or other legal entity condoned, ratified, or consented to such conduct; or~~

~~(c) The employer, principal, corporation, or other legal entity engaged in conduct that constituted gross negligence and that contributed to the loss, damages, or injury suffered by the claimant.~~

Section 28. Subsections (1) and (4) of section 429.298, Florida Statutes, are amended to read:

429.298 Punitive damages; limitation.—

(1)(a) ~~Except as provided in paragraphs (b) and (c),~~ An award of punitive damages may not exceed the greater of:


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1. Three times the amount of compensatory damages awarded to each claimant entitled thereto, consistent with the remaining provisions of this section; or

2. The sum of $250,000 ~~$1 million~~.

~~(b) Where the fact finder determines that the wrongful conduct proven under this section was motivated primarily by unreasonable financial gain and determines that the unreasonably dangerous nature of the conduct, together with the high likelihood of injury resulting from the conduct, was actually known by the managing agent, director, officer, or other person responsible for making policy decisions on behalf of the defendant, it may award an amount of punitive damages not to exceed the greater of:~~

~~1. Four times the amount of compensatory damages awarded to each claimant entitled thereto, consistent with the remaining provisions of this section; or~~

~~2. The sum of $4 million.~~

~~(c) Where the fact finder determines that at the time of injury the defendant had a specific intent to harm the claimant and determines that the defendant's conduct did in fact harm the claimant, there shall be no cap on punitive damages.~~

(b) ~~(d)~~ This subsection is not intended to prohibit an appropriate court from exercising its jurisdiction under s. 768.74 in determining the reasonableness of an award of punitive damages that is less than three times the amount of compensatory damages.

~~(e) In any case in which the findings of fact support an award of punitive damages pursuant to paragraph (b) or paragraph (c), the clerk of the court shall refer the case to the~~

~~appropriate law enforcement agencies, to the state attorney in the circuit where the long-term care facility that is the subject of the underlying civil cause of action is located, and, for multijurisdictional facility owners, to the Office of the Statewide Prosecutor; and such agencies, state attorney, or Office of the Statewide Prosecutor shall initiate a criminal investigation into the conduct giving rise to the award of punitive damages. All findings by the trier of fact which support an award of punitive damages under this paragraph shall be admissible as evidence in any subsequent civil or criminal proceeding relating to the acts giving rise to the award of punitive damages under this paragraph.~~

(4) Notwithstanding any other law to the contrary, the amount of punitive damages awarded pursuant to this section shall be ~~equally~~ divided between the claimant and the Quality of Long-Term Care Facility Improvement Trust Fund, in accordance with the following provisions:

(a) The clerk of the court shall transmit a copy of the jury verdict to the Chief Financial Officer by certified mail. In the final judgment, the court shall order the percentages of the award, payable as provided herein.

(b) A settlement agreement entered into between the original parties to the action after a verdict has been returned must provide a ~~proportionate~~ share payable to the Quality of Long-Term Care Facility Improvement Trust Fund specified herein. For purposes of this paragraph, the ~~a proportionate~~ share payable to the Quality of Long-Term Care Facility Improvement Trust Fund must be ~~is~~ a 75 percent ~~50-percent~~ share of that percentage of the settlement amount which the punitive damages

portion of the verdict bore to the total of the compensatory and punitive damages in the verdict.

(c) The Department of Financial Services shall collect or cause to be collected all payments due the state under this section. Such payments are made to the Chief Financial Officer and deposited in the appropriate fund specified in this subsection.

(d) If the full amount of punitive damages awarded cannot be collected, the claimant and the other recipient designated pursuant to this subsection are each entitled to a proportionate share of the punitive damages collected.

Section 29. Paragraphs (a), (d), (h), (i), (j), and (l) of subsection (1) and subsection (5) of section 429.41, Florida Statutes, are amended to read:

429.41 Rules establishing standards.—

(1) It is the intent of the Legislature that rules published and enforced pursuant to this section shall include criteria by which a reasonable and consistent quality of resident care and quality of life may be ensured and the results of such resident care may be demonstrated. Such rules shall also ensure a safe and sanitary environment that is residential and noninstitutional in design or nature. It is further intended that reasonable efforts be made to accommodate the needs and preferences of residents to enhance the quality of life in a facility. The agency, in consultation with the department, may adopt rules to administer the requirements of part II of chapter 408. In order to provide safe and sanitary facilities and the highest quality of resident care accommodating the needs and preferences of residents, the department, in consultation with

the agency, the Department of Children and Family Services, and the Department of Health, shall adopt rules, policies, and procedures to administer this part, which must include reasonable and fair minimum standards in relation to:

(a) The requirements for and maintenance of facilities, not in conflict with the provisions of chapter 553, relating to plumbing, heating, cooling, lighting, ventilation, living space, and other housing conditions, which will ensure the health, safety, and comfort of residents and protection from fire hazard, including adequate provisions for fire alarm and other fire protection suitable to the size of the structure. Uniform firesafety standards shall be ~~established and~~ enforced by the State Fire Marshal in cooperation with the agency~~, the department, and the Department of Health~~.

1. Evacuation capability determination.—

a. The provisions of the National Fire Protection Association, NFPA 101A, Chapter 5, 1995 edition, shall be used for determining the ability of the residents, with or without staff assistance, to relocate from or within a licensed facility to a point of safety as provided in the fire codes adopted herein. An evacuation capability evaluation for initial licensure shall be conducted within 6 months after the date of licensure. For existing licensed facilities that are not equipped with an automatic fire sprinkler system, the administrator shall evaluate the evacuation capability of residents at least annually. The evacuation capability evaluation for each facility not equipped with an automatic fire sprinkler system shall be validated, without liability, by the State Fire Marshal, by the local fire marshal, or by the local

authority having jurisdiction over firesafety, before the license renewal date. If the State Fire Marshal, local fire marshal, or local authority having jurisdiction over firesafety has reason to believe that the evacuation capability of a facility as reported by the administrator may have changed, it may, with assistance from the facility administrator, reevaluate the evacuation capability through timed exiting drills. Translation of timed fire exiting drills to evacuation capability may be determined:

(I) Three minutes or less: prompt.

(II) More than 3 minutes, but not more than 13 minutes: slow.

(III) More than 13 minutes: impractical.

b. The Office of the State Fire Marshal shall provide or cause the provision of training and education on the proper application of Chapter 5, NFPA 101A, 1995 edition, to its employees, to staff of the Agency for Health Care Administration who are responsible for regulating facilities under this part, and to local governmental inspectors. The Office of the State Fire Marshal shall provide or cause the provision of this training within its existing budget, but may charge a fee for this training to offset its costs. The initial training must be delivered within 6 months after July 1, 1995, and as needed thereafter.

c. The Office of the State Fire Marshal, in cooperation with provider associations, shall provide or cause the provision of a training program designed to inform facility operators on how to properly review bid documents relating to the installation of automatic fire sprinklers. The Office of the

State Fire Marshal shall provide or cause the provision of this training within its existing budget, but may charge a fee for this training to offset its costs. The initial training must be delivered within 6 months after July 1, 1995, and as needed thereafter.

d. The administrator of a licensed facility shall sign an affidavit verifying the number of residents occupying the facility at the time of the evacuation capability evaluation.

2. Firesafety requirements.—

a. Except for the special applications provided herein, effective January 1, 1996, the provisions of the National Fire Protection Association, Life Safety Code, NFPA 101, 1994 edition, Chapter 22 for new facilities and Chapter 23 for existing facilities shall be the uniform fire code applied by the State Fire Marshal for assisted living facilities, pursuant to s. 633.022.

b. Any new facility, regardless of size, that applies for a license on or after January 1, 1996, must be equipped with an automatic fire sprinkler system. The exceptions as provided in s. 22-2.3.5.1, NFPA 101, 1994 edition, as adopted herein, apply to any new facility housing eight or fewer residents. On July 1, 1995, local governmental entities responsible for the issuance of permits for construction shall inform, without liability, any facility whose permit for construction is obtained prior to January 1, 1996, of this automatic fire sprinkler requirement. As used in this part, the term “a new facility” does not mean an existing facility that has undergone change of ownership.

c. Notwithstanding any provision of s. 633.022 or of the National Fire Protection Association, NFPA 101A, Chapter 5, 1995

edition, to the contrary, any existing facility housing eight or fewer residents is not required to install an automatic fire sprinkler system, nor to comply with any other requirement in Chapter 23, NFPA 101, 1994 edition, that exceeds the firesafety requirements of NFPA 101, 1988 edition, that applies to this size facility, unless the facility has been classified as impractical to evacuate. Any existing facility housing eight or fewer residents that is classified as impractical to evacuate must install an automatic fire sprinkler system within the timeframes granted in this section.

d. Any existing facility that is required to install an automatic fire sprinkler system under this paragraph need not meet other firesafety requirements of Chapter 23, NFPA 101, 1994 edition, which exceed the provisions of NFPA 101, 1988 edition. The mandate contained in this paragraph which requires certain facilities to install an automatic fire sprinkler system supersedes any other requirement.

e. This paragraph does not supersede the exceptions granted in NFPA 101, 1988 edition or 1994 edition.

f. This paragraph does not exempt facilities from other firesafety provisions adopted under s. 633.022 and local building code requirements in effect before July 1, 1995.

g. A local government may charge fees only in an amount not to exceed the actual expenses incurred by local government relating to the installation and maintenance of an automatic fire sprinkler system in an existing and properly licensed assisted living facility structure as of January 1, 1996.

h. If a licensed facility undergoes major reconstruction or addition to an existing building on or after January 1, 1996,

the entire building must be equipped with an automatic fire sprinkler system. Major reconstruction of a building means repair or restoration that costs in excess of 50 percent of the value of the building as reported on the tax rolls, excluding land, before reconstruction. Multiple reconstruction projects within a 5-year period the total costs of which exceed 50 percent of the initial value of the building at the time the first reconstruction project was permitted are to be considered as major reconstruction. Application for a permit for an automatic fire sprinkler system is required upon application for a permit for a reconstruction project that creates costs that go over the 50-percent threshold.

i. Any facility licensed before January 1, 1996, that is required to install an automatic fire sprinkler system shall ensure that the installation is completed within the following timeframes based upon evacuation capability of the facility as determined under subparagraph 1.:

(I) Impractical evacuation capability, 24 months.

(II) Slow evacuation capability, 48 months.

(III) Prompt evacuation capability, 60 months.

The beginning date from which the deadline for the automatic fire sprinkler installation requirement must be calculated is upon receipt of written notice from the local fire official that an automatic fire sprinkler system must be installed. The local fire official shall send a copy of the document indicating the requirement of a fire sprinkler system to the Agency for Health Care Administration.

j. It is recognized that the installation of an automatic

fire sprinkler system may create financial hardship for some facilities. The appropriate local fire official shall, without liability, grant two 1-year extensions to the timeframes for installation established herein, if an automatic fire sprinkler installation cost estimate and proof of denial from two financial institutions for a construction loan to install the automatic fire sprinkler system are submitted. However, for any facility with a class I or class II, or a history of uncorrected class III, firesafety deficiencies, an extension must not be granted. The local fire official shall send a copy of the document granting the time extension to the Agency for Health Care Administration.

k. A facility owner whose facility is required to be equipped with an automatic fire sprinkler system under Chapter 23, NFPA 101, 1994 edition, as adopted herein, must disclose to any potential buyer of the facility that an installation of an automatic fire sprinkler requirement exists. The sale of the facility does not alter the timeframe for the installation of the automatic fire sprinkler system.

l. Existing facilities required to install an automatic fire sprinkler system as a result of construction-type restrictions in Chapter 23, NFPA 101, 1994 edition, as adopted herein, or evacuation capability requirements shall be notified by the local fire official in writing of the automatic fire sprinkler requirement, as well as the appropriate date for final compliance as provided in this subparagraph. The local fire official shall send a copy of the document to the Agency for Health Care Administration.

m. Except in cases of life-threatening fire hazards, if an

existing facility experiences a change in the evacuation capability, or if the local authority having jurisdiction identifies a construction-type restriction, such that an automatic fire sprinkler system is required, it shall be afforded time for installation as provided in this subparagraph.

Facilities that are fully sprinkled and in compliance with other firesafety standards are not required to conduct more than one of the required fire drills between the hours of 11 p.m. and 7 a.m., per year. In lieu of the remaining drills, staff responsible for residents during such hours may be required to participate in a mock drill that includes a review of evacuation procedures. Such standards must be included or referenced in the rules adopted by the State Fire Marshal. Pursuant to s. 633.022(1)(b), the State Fire Marshal is the final administrative authority for firesafety standards established and enforced pursuant to this section. All licensed facilities must have an annual fire inspection conducted by the local fire marshal or authority having jurisdiction.

3. Resident elopement requirements.—Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills which shall include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the drills are conducted in a manner consistent with the facility's resident elopement policies and procedures.

(d) All sanitary conditions within the facility and its surroundings which will ensure the health and comfort of


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residents. To ensure that inspections are not duplicative, the rules must clearly delineate the responsibilities of the agency regarding ~~agency's~~ licensure and survey inspections ~~staff~~, the county health departments regarding food safety and sanitary inspections, and the local fire marshal regarding firesafety inspections ~~authority having jurisdiction over firesafety and ensure that inspections are not duplicative. The agency may collect fees for food service inspections conducted by the county health departments and transfer such fees to the Department of Health~~.

(h) The care ~~and maintenance~~ of residents, which must include, but is not limited to:

1. The supervision of residents;

2. The provision of personal services;

3. The provision of, or arrangement for, social and leisure activities;

4. The arrangement for appointments and transportation to appropriate medical, dental, nursing, or mental health services, as needed by residents;

5. The management of medication;

6. The food service ~~nutritional~~ needs of residents; and

7. Resident records.~~; and~~

~~8. Internal risk management and quality assurance.~~

(i) Facilities holding an ~~a limited nursing,~~ extended congregate care~~,~~ or limited mental health license.

(j) The establishment of specific criteria to define appropriateness of resident admission and continued residency in a facility holding a standard, ~~limited nursing,~~ extended congregate care, and limited mental health license.

~~(l) The establishment of specific policies and procedures on resident elopement. Facilities shall conduct a minimum of two resident elopement drills each year. All administrators and direct care staff shall participate in the drills. Facilities shall document the drills.~~

(5) Beginning January 1, 2012, the agency shall ~~may~~ use an abbreviated biennial standard licensure inspection that consists of a review of key quality-of-care standards in lieu of a full inspection in a facility that has a good record of past performance. However, a full inspection must be conducted in a facility that has a history of class I or class II violations, uncorrected class III violations, confirmed ombudsman council complaints, or confirmed licensure complaints, within the previous licensure period immediately preceding the inspection or if a potentially serious problem is identified during the abbreviated inspection. The agency, in consultation with the department, shall develop, maintain, and update the key quality-of-care standards with input from the State Long-Term Care Ombudsman Council and representatives of associations and organizations representing assisted living facilities ~~provider groups~~ for incorporation into its rules.

Section 30. Section 429.42, Florida Statutes, is amended to read:

429.42 Pharmacy and dietary services.—

(1) Any assisted living facility in which the agency has documented a class I or class II violation ~~deficiency~~ or uncorrected class III violations ~~deficiencies~~ regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, or dietary

services, or both, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or licensed dietitian, as applicable. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required.

~~(2) A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening.~~

~~(3) The agency shall employ at least two pharmacists licensed pursuant to chapter 465 among its personnel who biennially inspect assisted living facilities licensed under this part, to participate in biennial inspections or consult with the agency regarding deficiencies relating to medicinal drugs or over-the-counter preparations.~~

(2)~~(4)~~ The department may by rule establish procedures and specify documentation as necessary to implement this section.

Section 31. Section 429.445, Florida Statutes, is amended to read:

429.445 Compliance with local zoning requirements.~~—No facility licensed under this part may commence any construction which will expand the size of the existing structure unless the licensee first submits to the agency proof that such~~


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~~construction will be in compliance with applicable local zoning requirements.~~ Facilities with a licensed capacity of less than 15 persons shall comply with the provisions of chapter 419.

Section 32. Section 429.47, Florida Statutes, is amended to read:

429.47 Prohibited acts~~; penalties for violation~~.—

(1) While an assisted living ~~a~~ facility is under construction or is seeking licensure, the owner may advertise to the public prior to obtaining a license. Facilities that are certified under chapter 651 shall comply with the advertising provisions of s. 651.095 rather than those provided for in this subsection.

(2) A freestanding facility may ~~shall~~ not advertise or imply that any part of it is a nursing home. For the purpose of this subsection, "freestanding facility" means a facility that is not operated in conjunction with a nursing home to which residents of the facility are given priority when nursing care is required. A person who violates this subsection is subject to fine as specified in s. 429.19.

(3) Any facility that ~~which~~ is affiliated with any religious organization or which has a name implying religious affiliation shall include in its advertising whether or not it is affiliated with any religious organization and, if so, which organization.

(4) A facility licensed under this part which is not part of a facility authorized under chapter 651 shall include the facility's license number as given by the agency in all advertising. A company or person owning more than one facility shall include at least one license number per advertisement. All

advertising shall include the term "assisted living facility" before the license number.

Section 33. Subsection (1) of section 429.49, Florida Statutes, is amended to read:

429.49 Resident records; penalties for alteration.—

(1) Any person who fraudulently alters, defaces, or falsifies any medical or other resident record of an assisted living facility, or causes or procures any such offense to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 34. Subsections (3), (5), and (8), of section 429.52, Florida Statutes, are amended, present subsection (11) of that section is redesignated as subsection (12), and a new subsection (11) is added to that section, read:

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

(3) Effective January 1, 2004, a new facility administrator must complete the required training and education, including the competency test, within a reasonable time after being employed as an administrator, as determined by the department. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. ~~Other licensed professionals may be exempted, as determined by the department by rule.~~

(5) Staff involved with the management of medications and assisting with the self-administration of medications under s. 429.256 must complete a minimum of 4 additional hours of

training provided by a registered nurse, licensed pharmacist, or department staff, and must complete 2 hours of continuing education training annually. ~~The department shall establish by rule the minimum requirements of this additional training.~~

(8) The department shall adopt rules related to these training requirements, the competency test, necessary procedures, and competency test fees and shall adopt or contract with another entity to develop a curriculum, which shall be used as the minimum core training requirements. The department shall consult with representatives of ~~stakeholder~~ associations, organizations representing assisted living facilities, and agencies in the development of the curriculum.

(11) A trainer certified by the department must continue to meet continuing education requirements and other standards as set forth in rules adopted by the department. Noncompliance with the standards set forth in the rules may result in the sanctioning of a trainer and trainees pursuant to s. 430.081.

Section 35. Subsections (1) and (2) of section 429.53, Florida Statutes, are amended to read:

429.53 Consultation by the agency.—

(1) The ~~area offices of licensure and certification of the~~ agency shall provide consultation to the following upon request:

(a) A licensee of a facility.

(b) A person interested in obtaining a license to operate a facility under this part.

(2) As used in this section, "consultation" includes:

(a) An explanation of the requirements of this part and rules adopted pursuant thereto;

(b) An explanation of the license application and renewal

procedures;

~~(c) The provision of a checklist of general local and state approvals required prior to constructing or developing a facility and a listing of the types of agencies responsible for such approvals;~~

~~(d) An explanation of benefits and financial assistance available to a recipient of supplemental security income residing in a facility;~~

(c) ~~(e)~~ Any other information which the agency deems necessary to promote compliance with the requirements of this part; and

~~(f) A preconstruction review of a facility to ensure compliance with agency rules and this part.~~

Section 36. Section 429.54, Florida Statutes, is repealed.

Section 37. Paragraphs (a) and (b) of subsection (1) and subsections (5) and (6) of section 429.71, Florida Statutes, are amended to read:

429.71 Classification of deficiencies; administrative fines.—

(1) In addition to the requirements of part II of chapter 408 and ~~in addition to~~ any other liability or penalty provided by law, the agency may impose an administrative fine on a provider according to the following classification:

(a) Class I violations are those conditions or practices related to the operation and maintenance of an adult family-care home or to the care of residents which the agency determines present an imminent danger to the residents or guests of the adult family-care home ~~facility~~ or a substantial probability that death or serious physical or emotional harm would result

therefrom. The condition or practice that constitutes a class I violation must be abated or eliminated within 24 hours, unless a fixed period, as determined by the agency, is required for correction. A class I violation ~~deficiency~~ is subject to an administrative fine in an amount not less than $500 and not exceeding $1,000 for each violation. A fine may be levied notwithstanding the correction of the violation ~~deficiency~~.

(b) Class II violations are those conditions or practices related to the operation and maintenance of an adult family-care home or to the care of residents which the agency determines directly threaten the physical or emotional health, safety, or security of the residents, other than class I violations. A class II violation is subject to an administrative fine in an amount not less than $250 and not exceeding $500 for each violation. A citation for a class II violation must specify the time within which the violation is required to be corrected. If a class II violation is corrected within the time specified, no civil penalty shall be imposed, unless it is a repeated offense.

~~(5) As an alternative to or in conjunction with an administrative action against a provider, the agency may request a plan of corrective action that demonstrates a good faith effort to remedy each violation by a specific date, subject to the approval of the agency.~~

(5)~~(6)~~ The department shall set forth, by rule, notice requirements and procedures for correction of violations ~~deficiencies~~.

Section 38. Subsection (3) is added to section 429.81, Florida Statutes, to read:

429.81 Residency agreements.—

(3) Each residency agreement must specify that the resident must give the provider a 30 days' written notice of intent to terminate his or her residency from the adult family-care home.

Section 39. Section 430.081, Florida Statutes, is created to read:

430.081 Sanctioning of training providers and trainees.—The Department of Elderly Affairs may sanction training providers and trainees for infractions involving any required training that the department has the authority to regulate under chapter 400, chapter 429, or chapter 430 in order to ensure that such training providers and trainees satisfy specific qualification requirements and adhere to training curricula that is approved by the department. Training infractions include, but are not limited to, falsification of training records, falsification of training certificates, falsification of a trainer's qualifications, failure to adhere to the required number of training hours, failure to use the required curriculum, failure to maintain the continuing education for the trainer's recertification, failure to obtain reapproval of a curriculum when required, providing false or inaccurate information, misrepresentation of the required materials and use of a false identification as a training provider or trainee. Sanctions may be progressive in nature and may consist of corrective action measures; suspension or termination from participation as an approved training provider or trainee, including sitting for any required examination; and administrative fines not to exceed $1,000 per incident. One or more sanctions may be levied per incident.

Section 40. Paragraph (j) is added to subsection (3) of

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section 817.505, Florida Statutes, to read:

817.505 Patient brokering prohibited; exceptions; penalties.—

(3) This section shall not apply to:

(j) Any payments by an assisted living facility, as defined in s. 429.02, which are permitted under s. 429.195(3).

Section 41. This act shall take effect July 1, 2011.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to assisted living communities; amending s. 400.141, F.S.; revising licensing requirements for registered pharmacists under contract with a nursing home and related health care facilities; amending s. 408.810, F.S.; providing additional licensing requirements for assisted living facilities; amending s. 408.820, F.S.; providing that certain assisted living facilities are exempt from requirements of part II of ch. 408, F.S., related to health care licensing; amending s. 429.01, F.S.; revising the purpose of the "Assisted Living Facilities Act"; amending s. 429.02, F.S.; providing, revising, and deleting definitions; amending ss. 429.04, 429.07, and 429.17, F.S.; revising provisions relating to licensing of assisted living facilities, including licensing fees; amending s. 429.08, F.S.;

requiring emergency medical technicians or paramedics to report the operations of an unlicensed assisted living facility; amending s. 429.11, F.S.; requiring the Agency for Health Care Administration to develop an abbreviated form for submission of proof of financial ability to operate an assisted living facility; amending s. 429.12, F.S.; revising provisions relating to the sale or transfer of ownership of an assisted living facility; amending s. 429.14, F.S.; revising provisions relating to administrative penalties; amending s. 429.178, F.S.; providing safety requirements for facilities serving persons with Alzheimer's disease or other related disorders; repealing a provision relating to a facility's responsibility for the payment of certain training fees; amending s. 429.19, F.S.; revising Agency for Health Care Administration procedures for the imposition of fines for violations of ch. 429, F.S.; amending s. 429.195, F.S.; permitting the licensee of an assisted living facility to provide monetary payments to a referral service under certain circumstances and to residents who refer certain individuals to the facility; amending s. 429.20, F.S.; prohibiting the solicitation of contributions of any kind in a threatening, coercive, or unduly forceful manner by or on behalf of an assisted living facility; amending s. 429.23, F.S.; revising adverse incidents reporting requirements; amending s. 429.255, F.S.; permitting certain licensed persons to provide limited

nursing services; deleting rulemaking authority of the Department of Elderly Affairs with regard to cardiopulmonary resuscitation in assisted living facilities; amending s. 429.256, F.S.; providing additional guidelines for the assistance with self-administration of medication; amending s. 429.26, F.S.; removing a requirement that a facility notify a licensed physician when a resident exhibits certain signs of dementia, cognitive impairment, or change of condition; revising the persons who are authorized to notify a resident's case manager about examining the resident; amending s. 429.27, F.S.; revising provisions relating to the property and personal effects of residents; repealing s. 429.275, F.S.; removing rulemaking authority of the Department of Elderly Affairs over financial records, personnel procedures, accounting procedures, reporting procedures, and insurance coverage for residents of assisted living facilities; amending s. 429.28, F.S., relating to the resident bill of rights; revising provisions relating to termination of residency; removing responsibilities of the agency for conducting compliance surveys and complaint investigations; amending s. 429.29, F.S.; providing that a resident who alleges negligence or a violation of rights has a cause of action against the licensee of an assisted living facility or its management company under certain circumstances; amending s. 429.293, F.S.; permitting the use of an arbitration process to

resolve a resident's claim of a rights violation or negligence; revising notification requirements; amending s. 429.294, F.S.; authorizing the release of copies of a resident's records to specified persons under certain conditions; providing limits on the frequency of the release of such records; amending s. 429.297, F.S.; revising procedures for bringing a claim for punitive damages against an assisted living facility; amending s. 429.298, F.S.; revising the limits on the amount of punitive damages; removing a provision that provides for a criminal investigation with a finding of liability for punitive damages; removing a provision that provides for admissibility of findings in subsequent civil and criminal actions; providing that the punitive damages awarded are not necessarily divided equally between the claimant and the Quality of Long-Term Care Facility Improvement Trust Fund; revising the percentages of the division of the settlement amount; amending s. 429.41, F.S.; revising rulemaking authority regarding resident care and maintenance of facilities; deleting the requirement for a facility to conduct a minimum number of resident elopement drills; requiring the agency to use an abbreviated biennial standard licensure inspection; requiring the agency, in consultation with the Department of Health, shall develop, maintain, and update the key quality-of-care standards with input from the State Long-Term Care Ombudsman Council and representatives of associations and organizations

representing assisted living facilities; amending s. 429.42, F.S.; revising provisions relating to pharmacy services; amending s. 429.445, F.S.; removing a requirement that assisted living facilities submit certain information to the agency before commencing construction to expand the facility; amending s. 429.47, F.S.; authorizing an owner of an assisted living facility to advertise to the public while the facility is under construction or is seeking licensure; amending s. 429.49, F.S.; conforming terminology; amending s. 429.52, F.S.; revising training and education requirements for certain administrators, facility staff, and other licensed professionals; requiring trainers certified by the department to meet continuing education requirements and standards; providing conditions for the sanctioning of a trainer and trainees; amending s. 429.53, F.S.; removing provisions relating to preconstruction approvals and reviews and agency consultations; repealing s. 429.54, F.S., relating to the collection of information regarding the actual cost of providing services in assisted living facilities and local subsidies; amending s. 429.71, F.S.; removing a provision authorizing the agency to request a plan to remedy violations by adult family-care homes; amending s. 429.81, F.S.; specifying that residency agreements require a resident to provide 30 days' written notice of intent to terminate residency; creating s. 430.081, F.S.; authorizing the Department

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of Elderly Affairs to sanction training providers and trainees for infractions involving any required training; providing training infractions; providing sanctions; amending s. 817.505, F.S.; providing that payments by an assisted living facility are not considered patient brokering under certain circumstances; providing an effective date.

235806

LEGISLATIVE ACTION

Senate . House

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

Senate Amendment to Amendment (423426) (with title amendment)

Between lines 75 and 76

insert:

Section 4. Subsection (41) of section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a

confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for

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

(41) The agency shall establish ~~provide for the development~~

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~~of~~ a demonstration project ~~by establishment~~ in Miami-Dade County of a long-term-care facility and a psychiatric facility licensed pursuant to chapter 395 to improve access to health care for a predominantly minority, medically underserved, and medically complex population and to evaluate alternatives to nursing home care and general acute care for such population. Such project is to be located in a health care condominium and collocated ~~colocated~~ with licensed facilities providing a continuum of care. These projects are ~~The establishment of this project is~~ not subject to the provisions of s. 408.036 or s. 408.039.

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

And the title is amended as follows:

Delete lines 2259 - 2268

and insert:

An act relating to assisted care communities; amending s. 400.141, F.S.; revising licensing requirements for registered pharmacists under contract with a nursing home and related health care facilities; amending s. 408.810, F.S.; providing additional licensing requirements for assisted living facilities; amending s. 408.820, F.S.; providing that certain assisted living facilities are exempt from requirements of part II of ch. 408, F.S., related to health care licensing; amending s. 409.912, F.S.; requiring the Agency for Health Care Administration to provide for the development of a demonstration project for a psychiatric facility in Miami-Dade County; amending s. 429.01, F.S.;

LEGISLATIVE ACTION

Senate . House

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

Senate Amendment (with directory and title amendments)

Between lines 6520 and 6521

insert:

(41) The agency shall establish ~~provide for the development of~~ a demonstration project ~~by establishment~~ in Miami-Dade County of a long-term-care facility and a psychiatric facility licensed pursuant to chapter 395 to improve access to health care for a predominantly minority, medically underserved, and medically complex population and to evaluate alternatives to nursing home

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care and general acute care for such population. Such project is to be located in a health care condominium and collocated ~~colocated~~ with licensed facilities providing a continuum of care. These projects are ~~The establishment of this project is~~ not subject to the provisions of s. 408.036 or s. 408.039.

====== D I R E C T O R Y C L A U S E A M E N D M E N T ======
And the directory clause is amended as follows:

Delete lines 6272 - 6273

and insert:

Section 116. Paragraph (b) of subsection (4) and subsections (36) and (41) of section 409.912, Florida Statutes, are amended to read:

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

Delete line 239

and insert:

references; requiring the agency to provide for the development of a psychiatric facility demonstration project in Miami-Dade County; providing an effective date.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 1458
INTRODUCER:	Senator Garcia
SUBJECT:	Assisted Living Communities
DATE:	March 26, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	O'Callaghan	Stovall	HR	**Pre-meeting**
2.			CF	
3.			BC	
4.				
5.				
6.				

I. Summary:

This bill moves the licensure requirements for assisted living facilities (ALFs), adult family-care homes, and adult day care centers, out of part II of ch. 408, F.S., and into a new part created within ch. 429, F.S., which is to be entitled the "Assisted Care Communities Licensing Procedures Act."

The provisions moved to ch. 429, F.S., include license fees, the license application process, change of ownership, licensing categories, background screening of specified employees, minimum licensure requirements, discontinuance of operation and surrender of license, provision of statewide toll-free numbers for reporting complaints and abuse, inspections, public records and record retention, unlicensed activity, administrative fines, moratorium or emergency suspension, denial or revocation of a license, injunctive proceedings, emergency operations, overcapacity, and provision of notice to residents.

This bill substantially amends the following sections of the Florida Statutes: 101.62, 101.655, 159.27, 196.1975, 202.125, 205.1965, 252.357, 252.385, 380.06, 381.006, 381.0072, 381.0303, 394.455, 394.4574, 394.462, 394.4625, 394.75, 394.9082, 400.0060, 400.0069, 400.0074, 400.0239, 400.141, 400.148, 400.1755, 400.464, 400.471, 400.474, 400.497, 400.506, 400.6045, 400.605, 400.609, 400.701, 400.925, 400.93, 405.01, 408.033, 408.802, 408.806, 408.820, 408.831, 408.832, 409.212, 409.221, 409.906, 409.907, 409.912, 410.031, 410.034, 410.502, 415.102, 415.1034, 415.1051, 415.107, 420.626, 429.01, 429.02, 429.04, 429.07, 429.075, 429.08, 429.11, 429.12, 429.14, 429.17, 429.174, 429.177, 429.178, 429.18, 429.19, 429.195, 429.20, 429.22, 429.23, 429.24, 429.255, 429.256, 429.26, 429.27, 429.275, 429.28, 429.293, 429.294, 429.298, 429.31, 429.34, 429.35, 429.41, 429.42, 429.44, 429.445, 429.47, 429.49, 429.52, 429.53, 429.65, 429.67, 429.69, 429.71, 429.73, 429.75, 429.81, 429.83, 429.85, 429.87,

429.901, 429.905, 429.907, 429.909, 429.911, 429.913, 429.915, 429.917, 429.919, 429.925, 429.927, 429.929, 430.071, 430.601, 456.053, 458.348, 459.025, 468.1695, 468.505, 553.73, 627.94073, 633.021, 633.022, 641.31, 651.083, 825.101, 893.055, and 893.13.

This bill creates the following sections of the Florida Statutes: 429.001, 429.002, 429.003, 429.004, 429.005, 429.006, 429.007, 429.008, 429.009, 429.0105, 429.011, 429.012, 429.013, 429.014, 429.015, 429.016, 429.017, 429.018, 429.019, 429.926,

This bill repeals s. 429.54, F.S.

II. Present Situation:

Assisted Living Facilities

An ALF is a residential establishment, or part of a residential establishment, that provides housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.[1, 2] A personal service is direct physical assistance with, or supervision of, the activities of daily living and the self-administration of medication.[3] Activities of daily living include: ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks.

The ALFs are licensed by the Agency for Health Care Administration (AHCA) pursuant to part I of ch. 429, F.S., relating to assisted care communities, and part II of ch. 408, F.S., relating to the general licensing provisions for health care facilities. The ALFs are also subject to regulation under Chapter 58A-5, Florida Administrative Code (F.A.C.). These rules are adopted by the Department of Elderly Affairs (DOEA) in consultation with the AHCA, the Department of Children and Family Services, and the Department of Health (DOH).[4] An ALF must also comply with the Uniform Fire Safety Standards for ALFs contained in Chapter 69A-40, F.A.C., and standards enforced by the DOH concerning food hygiene; physical plant sanitation; biomedical waste; and well, pool, or septic systems.[5]

There are currently 2,932 licensed ALFs in Florida.[6] In addition to a standard license, an ALF may have specialty licenses that authorize an ALF to provide limited nursing services (LNS), limited mental health (LMH) services,[7] and extended congregate care (ECC) services.

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[1] Section 429.02(5), F.S.

[2] An ALF does not include an adult family-care home or a nontransient public lodging establishment. An adult family-care home is regulated under ss. 429.60 – 429.87, F.S., and is defined as a full-time, family-type living arrangement in a private home where the person who owns or rents the home, lives in the home. An adult family-care home provides room, board, and personal care, on a 24-hour basis, for no more than five disabled adults or frail elders, who are not relatives. A nontransient establishment (a.k.a. boarding house) is regulated under part I of ch. 509, F.S., and is defined as any public lodging establishment that is rented or leased to guests by an operator whose intention is that the dwelling unit occupied will be the sole residence of the guest.

[3] Section 429.02(16), F.S.

[4] Section 429.41(1), F.S.

[5] *See* ch. 64E-12, ch. 64E-11, and 64E-16, F.A.C.

[6] Senate professional staff of the Health Regulation Committee received this information via email on March 25, 2011. A copy of the email is on file with the committee.

[7] An ALF that serves three or more mental health residents must obtain a limited mental health specialty license. A mental health resident is an individual who receives social security disability income (SSDI) due to a mental disorder or

An ALF is required to provide care and services appropriate to the needs of the residents accepted for admission to the facility. Generally, the care and services include at a minimum:

- Supervising the resident in order to monitor the resident's diet; being aware of the general health, safety, and physical and emotional well-being of the resident; and recording significant changes, illnesses, incidents, and other changes which resulted in the provision of additional services;
- Contacting appropriate persons upon a significant change in the resident or if the resident is discharged or moves out;
- Providing and coordinating social and leisure activities in keeping with each resident's needs, abilities, and interests;
- Arranging for health care by assisting in making appointments, reminding residents about scheduled appointments, and providing or arranging for transportation as needed; and
- Providing to the resident a copy of, and adhering to, the Resident Bill of Rights.

An unlicensed person who has received the appropriate training may assist a resident in an ALF with the self-administration of medication. Persons under contract to the ALF, employees, or volunteers,[8] who are licensed under the nurse practice act[9] and uncompensated family members or friends may:[10]

- Administer medications to residents;
- Take a resident's vital signs;
- Manage individual weekly pill organizers for residents who self-administer medication;
- Give prepackaged enemas ordered by a physician; and
- Observe residents, document observations on the appropriate resident's record, and report observations to the resident's physician.

Additionally, in an emergency situation, persons licensed under the nurse practice act may carry out their professional duties until emergency medical personnel assume responsibility for care. A resident may independently arrange, contract, and pay for additional services provided by a third party of the resident's choice.

The owner or facility administrator determines whether an individual is appropriate for admission to the facility based on an assessment of the strengths, needs, and preferences of the individual; the health assessment; the preliminary service plan; the facility's residency criteria; services offered or arranged for by the facility to meet resident needs; and the ability of the facility to meet the uniform fire safety standards.[11]

A resident who requires 24-hour nursing supervision[12] may not reside in an ALF, unless the resident is enrolled as a hospice patient. Continued residency of a hospice patient is conditioned

supplemental security income (SSI) due to a mental disorder, and receives OSS.

[8] An association spokesperson stated in an e-mail to Senate Health Regulation Committee professional staff that ALFs do not currently use volunteers for these purposes due to liability issues.

[9] Part I of ch. 464, F.S.

[10] Section 429.255, F.S.

[11] Section 429.255, F.S., s. 429.26, F.S., and Rule 58A-5.030, F.A.C.

[12] Twenty-four-hour nursing supervision means services that are ordered by a physician for a resident whose condition requires the supervision of a physician and continued monitoring of vital signs and physical status. Such services must be:

upon a mutual agreement between the resident and the facility, additional care being rendered through a licensed hospice, and the resident being under the care of a physician who agrees that the physical needs of the resident are being met.

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.[13]

Limited Nursing Services Specialty License

A limited nursing services (LNS) specialty license enables an ALF to provide, directly or through contract, a select number of nursing services in addition to the personal services that are authorized under the standard license.

The nursing services authorized to be provided with this license are limited to acts specified in administrative rules,[14] may only be provided as authorized by a health care provider's order, and must be conducted and supervised in accordance with ch. 464, F.S., relating to nursing, and the prevailing standard of practice in the nursing community. A nursing assessment, that describes the type, amount, duration, scope, and outcomes or services that are rendered and the general status of the resident's health, is required to be conducted at least monthly on each resident who receives a limited nursing service.

An LNS licensee is subject to monitoring inspections by the AHCA or its agents at least twice a year. At least one registered nurse must be included in the inspection team to monitor residents receiving LNS and to determine if the facility is complying with applicable regulatory requirements.[15]

The biennial fee for an LNS license is $304 per license with an additional fee of $10 per resident based on the total licensed resident capacity of the facility.[16] Ostensibly this fee covers the additional monitoring inspections currently required of facilities with an LNS license.

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medically complex enough to require constant supervision, assessment, planning, or intervention by a nurse; required to be performed by or under the direct supervision of licensed nursing personnel or other professional personnel for safe and effective performance; required on a daily basis; and consistent with the nature and severity of the resident's condition or disease state or stage. Definition found at s. 429.02(26), F.S.

[13] Section 429.28, F.S.

[14] Rule 58A-5.031, F.A.C. The additional nursing services that might be performed pursuant to the LNS license include: conducting passive range of motion exercises; applying ice caps or collars; applying heat, including dry heat, hot water bottle, heating pad, aquathermia, moist heat, hot compresses, sitz bath and hot soaks; cutting the toenails of diabetic residents or residents with a documented circulatory problem if the written approval of the resident's health care provider has been obtained; performing ear and eye irrigations; conducting a urine dipstick test; replacing an established self-maintained indwelling urinary catheter, or performing an intermittent urinary catheterization; performing digital stool removal therapies; applying and changing routine dressings that do not require packing or irrigation, but are for abrasions, skin tears and closed surgical wounds; caring for stage 2 pressure sores, (care for stage 3 or 4 pressure sores are not permitted); caring for casts, braces and splints, (care for head braces, such as a halo, is not permitted); assisting, applying, caring for, and monitoring the application of anti-embolism stockings or hosiery; administering and regulating portable oxygen; applying, caring for, and monitoring a transcutaneous electric nerve stimulator (TENS); performing catheter, colostomy, and ileostomy care and maintenance; conducting nursing assessments; and, for hospice patients, providing any nursing service permitted within the scope of the nurse's license, including 24-hour nursing supervision.

[15] Section 429.07(3)(c), F.S.

[16] Section 429.07(4)(c), F.S., as adjusted per s. 408.805(2), F.S.

Extended Congregate Care Specialty License

An extended congregate care (ECC) specialty license enables an ALF to provide, directly or through contract, services performed by licensed nurses and supportive services[17] to persons who otherwise would be disqualified from continued residence in an ALF.[18]

The primary purpose of ECC services is to allow residents, as they become more impaired with physical or mental limitations, to remain in a familiar setting. An ALF licensed to provide ECC services may also admit an individual who exceeds the admission criteria for a facility with a standard license, if the individual is determined appropriate for admission to the ECC facility. Facilities licensed to provide ECC services may adopt their own criteria and requirements for admission and continued residency in addition to the minimum criteria specified in law.

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 recording basic vital functions and weight;
- Dietary management, including providing special diets, monitoring nutrition, and observing the resident's food and fluid intake and output;
- 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 to health-related appointments.

An individual must undergo a medical examination before admission to an ALF with the intention of receiving ECC services or upon transfer within the same facility to that portion of the facility licensed to provide ECC services. The ALF must develop a service plan[19] that sets forth how the facility will meet the resident's needs and must maintain a written progress report on each resident who receives ECC services.

A supervisor, who may also be the administrator, must be designated to be responsible for the day-to-day management of the ECC program and ECC resident service planning. A nurse, provided as staff or by contract, must be available to provide nursing services as needed by ECC residents, participate in the development of resident service plans, and perform the monthly nursing assessment for each resident receiving ECC services. The ECC licensed ALF must provide awake staff to meet resident scheduled and unscheduled night needs.[20]

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[17] Supportive services include social service needs, counseling, emotional support, networking, assistance with securing social and leisure services, shopping service, escort service, companionship, family support, information and referral, assistance in developing and implementing self-directed activities, and volunteer services. *See* Rule 58A-5.030(8), F.A.C.

[18] Section 429.07(3)(b), F.S., and Rule 58A-5.030, F.A.C. *See also* AHCA, *2011 Bill Analysis & Economic Impact Statement for SB 1458*, on file with the committee.

[19] Section 429.02(21), F.S.

[20] Rule 58A-5.030, F.A.C.

Persons under contract to the ECC, employees, or volunteers, who are licensed under the nurse practice act,[21] including certified nursing assistants, may perform all duties within the scope of their license or certification, as approved by the facility administrator.[22] These nursing services must be authorized by a health care provider's order and pursuant to a plan of care; medically necessary and appropriate treatment for the condition; in accordance with the prevailing standard of practice in the nursing community and the resident's service plan; a service that can be safely, effectively, and efficiently provided in the facility; and recorded in nursing progress notes.[23]

An ECC licensee is subject to quarterly monitoring inspections by the AHCA or its agents. At least one registered nurse must be included in the inspection team. The AHCA may waive one of the required yearly monitoring visits for an ECC facility that has been licensed for at least 24 months, if the registered nurse who participated in the monitoring inspections determines that the ECC services are being provided appropriately and there are no serious violations or substantiated complaints about the quality of service or care.

Limited Mental Health Specialty License

An ALF that serves three or more mental health residents must obtain an LMH specialty license.[24]

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).[25] The DCF is responsible for ensuring that a mental health resident is assessed and determined able to live in the community in an ALF with an LMH license.[26]

An ALF licensed to provide LMH services must assist the mental health resident in carrying out the activities in the resident's community living support plan. The mental health resident's community living support plan, which is updated annually, includes:[27]

- The specific needs of the resident which must be met for the resident to live in the ALF and community;
- The clinical mental health services to be provided by the mental health care provider to help meet the resident's needs;
- Any other services and activities to be provided by or arranged for by the mental health care provider or mental health case manager to meet the resident's needs;
- Obligations of the ALF to facilitate and assist the resident in attending appointments and arranging transportation to appointments for the services and activities identified in the plan;
- A description of other services to be provided or arranged by the ALF; and

[21] Part I of ch. 464, F.S.
[22] Section 429.255(2), F.S.
[23] Rule 58A-5.030(8)(c), F.A.C.
[24] Section 429.075, F.S.
[25] Section 429.02(15), F.S.
[26] 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.
[27] Rule 58A-5.029, F.A.C.

- A list of factors pertinent to the care, safety, and welfare of the mental health resident and a description of the signs and symptoms particular to the resident that indicates the immediate need for professional mental health services.

The LMH licensee must execute a cooperative agreement between the ALF and the mental health care services provider. The cooperative agreement specifies, among other things, directions for the ALF accessing emergency and after-hours care for the mental health resident. The administrator, manager, and staff in direct contact with mental health residents in an LMH licensed facility must complete LMH training provided or approved by the DCF.[28]

Licensure Fees

The biennial licensure fees for the ALF standard license and specialty licenses are found in s. 429.07(4), F.S. This section refers to the general health care licensure provisions in part II of ch. 408, F.S. Section 408.805, F.S., provides for licensure fees to be adjusted annually by not more than the change in the Consumer Price Index (CPI) based on the 12 months immediately preceding the increase. The following chart reflects the licensure fees contained in s. 429.07(4), F.S., and the adjusted licensure fees based on the CPI that are currently in effect.[29]

Fee Description	Per s. 429.07(4), F.S.	CPI adjusted (current fee)
Standard ALF Application Fee	$300	$366
Standard ALF Per-Bed Fee (non-OSS)	$ 50	$ 61
Total Licensure fee for Standard ALF	$10,000	$13,443
ECC Application Fee	$400	$515
ECC Per-Bed Fee (licensed capacity)	$ 10	$ 10
LNS Application Fee	$250	$304
LNS Per-Bed Fee (licensed capacity)	$ 10	$ 10

Adult Family-Care Homes

Part II of ch. 429, F.S., consists of the Adult Family-Care Home Act. This act regulates the provision of care for disabled adults and frail elders in family-type living arrangements in private homes. Adult family-care homes provide housing and personal care for disabled adults and frail elders who choose to live with an individual or family in a private home. The personal care available in these homes, which may be provided directly or through contract or agreement, is intended to help residents remain as independent as possible in order to delay or avoid placement in a nursing home or other institution. Regulations governing adult family-care homes must be sufficiently flexible to allow residents to age in place if resources are available to meet their needs and accommodate their preferences.[30]

"Adult family-care home" means a full-time, family-type living arrangement, in a private home, under which a person who owns or rents the home provides room, board, and personal care, on a

[28] Rule 58A-5.0191(8), F.A.C.
[29] Found on the AHCA website at: http://ahca.myflorida.com/MCHQ/LONG_TERM_CARE/Assisted_living/alf/ALF_fee_increase.pdf, (Last visited on March 25, 2011).
[30] Section 429.63, F.S.

24-hour basis, for no more than five disabled adults or frail elders who are not relatives. The following family-type living arrangements are not required to be licensed as an adult family-care home:

- An arrangement whereby the person who owns or rents the home provides room, board, and personal services for not more than two adults who do not receive optional state supplementation under s. 409.212, F.S. The person who provides the housing, meals, and personal care must own or rent the home and reside therein.
- An arrangement whereby the person who owns or rents the home provides room, board, and personal services only to his or her relatives.
- An establishment that is licensed as an assisted living facility under this chapter.

A provider must be licensed by AHCA under part II of ch. 408, F.S., in order to operate an adult family-care home in Florida.

Access to a licensed adult family-care home must be provided at reasonable times for the appropriate officials of the DOEA, the DOH, the Department of Children and Family Services, the AHCA, and the State Fire Marshal, who are responsible for the development and maintenance of fire, health, sanitary, and safety standards, to inspect the facility to assure compliance with these standards. In addition, access to a licensed adult family-care home must be provided at reasonable times for the local long-term care ombudsman council.

The licensed maximum capacity of each adult family-care home is based on the service needs of the residents and the capability of the provider to meet the needs of the residents. Any relative who lives in the adult family-care home and who is a disabled adult or frail elder must be included in that limitation.

The resident's Bill of Rights for adult family-care homes is provided in s. 429.85, F.S.

Adult Day Care Centers

Part III of ch. 429, F.S., governs the regulation of adult day care centers. An "adult day care center" is any building, buildings, or part of a building, whether operated for profit or not, that provides for a part of a day basic services to three or more persons who are 18 years of age or older, who are not related to the owner or operator by blood or marriage, and who require such services. Basic services include providing a protective setting that is as noninstitutional as possible; therapeutic programs of social and health activities and services; leisure activities; self-care training; rest; nutritional services; and respite care.

A provider must be licensed by AHCA under part II of ch. 408, F.S., in order to operate an adult day care center in Florida and must furnish the AHCA with a description of the physical and mental capabilities and needs of the participants to be served and the availability, frequency, and intensity of basic services and of supportive and optional services to be provided and proof of adequate liability insurance coverage to obtain such licensure.

The AHCA or DOEA has the right to enter the premises of any licensed adult day care center, at any reasonable time, in order to determine the state of compliance with part III of ch. 429, F.S., part II of ch. 408, and any applicable rules.

Senate Interim Project Report 2010-118

During the 2009-2010 interim, professional staff of the Senate Committee on Health Regulation reviewed the licensure structure for ALFs. The recommendations in the resulting report are to repeal the LNS specialty license and authorize a standard-licensed ALF to provide the nursing services currently authorized under the LNS license; require an additional inspection fee, adjusted for inflation, for a facility that indicates that it intends to provide LNS; require each ALF to periodically report electronically information, as determined by rule, related to resident population, characteristics, and attributes; authorize the AHCA to determine the number of additional monitoring inspections required for an ALF that provides LNS based on the type of nursing services provided and the number of residents who received LNS as reported by the ALF; and repeal the requirement for the AHCA to inspect *all* the ECC licensees quarterly, instead targeting monitoring inspections for those facilities with residents receiving ECC services.

III. Effect of Proposed Changes:

This bill moves the licensure requirements for ALFs, adult family-care homes, and adult day care centers, out of part II of ch. 408, F.S., and into a new part created within ch. 429, F.S., which is to be entitled the "Assisted Care Communities Licensing Procedures Act."

Sections 1, 2, 3, 4, 5, and 6 amend the following sections of Florida Statutes to delete references to ch. 429, F.S., ALFs, adult family-care homes, and adult day care centers:

- s. 400.141, F.S., related to administration and management of nursing home facilities;
- s. 408.802, F.S., related to the applicability of part II of ch. 408, F.S., to require licensure for specified provider services;
- s. 408.806, F.S., related to the license application process;
- s. 408.820, F.S., related to certain exemptions;
- s. 408.831, F.S., related to the denial, suspension, or revocation of a license, registration, certificate, or application; and
- s. 408.832, F.S., related to conflicts between part II of ch. 408, F.S., and an authorizing statute governing the licensure of health care providers.

Section 7 designates current part I of ch. 429, F.S., which is entitled "Assisted Living Facilities" as part II of ch. 429, F.S., and this part is renamed "Assisted Living Residences."

Section 8 designates current part II of ch. 429, F.S., which is entitled "Adult Family-Care Homes" as part III of ch. 429, F.S.

Section 9 designates current part III of ch. 429, F.S., which is entitled "Adult Day Care Centers" as part IV of ch. 429, F.S.

Section 10 creates a new part I of ch. 429, F.S., which is to be entitled the "Assisted Care Communities Licensing Procedure Act."

This section provides legislative intent that, in order to provide appropriate services for elderly persons and adults in need of assistance with activities of daily living, allow those persons to remain in their own homes or reside in a residential homelike environment that is a community-based social model with a health component rather than a medical or nursing home facility, and maximize a person's dignity and independence, assisted care communities should be operated as residential homelike environments with supportive services and not as medical or nursing home facilities and should be regulated in a less restrictive manner than those facilities.

Definitions
This section provides definitions for the following terms: "agency," "applicant," "assisted care community," "change of ownership," "controlling interest," "department," "license," "licensee," "moratorium," "participant," and "resident."

"Assisted care community" means an assisted living residence, adult family-care home, or adult day care center.

The term "change of ownership" is defined as an event in which the licensee sells or otherwise transfers its ownership to a different individual or entity as evidenced by a change in the federal employer identification number or taxpayer identification number; or an event in which 51 percent or more of the ownership, shares, membership, or controlling interest of a licensee is in any manner transferred or otherwise assigned, but this definition does not include a licensee that is publicly traded on a recognized stock exchange.

The term "controlling interest" means the applicant or licensee or a person or entity that has a 51-percent or greater ownership interest in the applicant or licensee.

Licensure
This section prohibits operating an assisted care community without first obtaining a license and provides certain licensing requirements for an assisted care community including the following:

- The license must be displayed in a conspicuous place readily visible to the public who enter at the address that appears on the license and is valid only in the hands of the licensee to whom it is issued.
- The license may not be sold, assigned, or otherwise transferred, voluntarily or involuntarily and it is valid only for the licensee and the location for which the license is issued.
- An application for licensure must be made to the AHCA on forms furnished by the AHCA, submitted under oath, and accompanied by the appropriate fee in order to be accepted and considered timely. The application must contain information required under ch. 429, F.S., and applicable rules and must include:
    - The name, address, and social security number of: the applicant, the administrator or a similarly titled person who is responsible for the day-to-day operation of the assisted care community, the financial officer or similarly titled person who is responsible for the financial operation of the assisted care community, and each controlling interest if the applicant or controlling interest is an individual.
    - The name, address, and federal employer identification number or taxpayer identification number of the applicant and each controlling interest if the applicant or controlling interest is not an individual.
    - The name by which the assisted care community is to be known.

  - The total number of beds or capacity requested, as applicable.
  - The name of the person or persons under whose management or supervision the licensee will operate and the name of the administrator, if required.
  - Proof that the applicant has obtained a certificate of authority as required for operation under ch. 651, F.S., if the applicant offers continuing care agreements as defined in ch. 651, F.S.
  - Other information, including satisfactory inspection results, which the AHCA finds necessary to determine the ability of the applicant to carry out its responsibilities under part I of ch. 429, F.S., and applicable rules.
  - An affidavit, under penalty of perjury, as required in s. 435.05(3), F.S., stating compliance with the licensing requirements under part I of ch. 429, F.S., and ch. 435, F.S.
- The applicant for a renewal license must submit an application that must be received by the AHCA at least 60 days but no more than 120 days before the expiration of the current license and if received more than 120 days before the expiration of the current license it must be returned to the applicant. If the renewal application and fee are received before the license expiration date, the license shall not be deemed to have expired if the license expiration date occurs during the AHCA's review of the renewal application.
- The applicant for initial licensure due to a change of ownership must submit an application that must be received by the AHCA at least 60 days before the date of change of ownership.
- For any other application or request, the applicant must submit an application or request that must be received by the AHCA at least 60 days but no more than 120 days before the requested effective date and if received more than 120 days before the requested effective date it shall be returned to the applicant.
- The applicant must submit proof of compliance with the licensure requirements under s. 429.009, F.S.
- An applicant must demonstrate compliance with the requirements in ch. 429, F.S., and applicable rules during an inspection pursuant to s. 429.0105, F.S., as required by part II, part III, or part IV of ch. 429, F.S. If an inspection is required for a license application other than an initial application, the inspection must be unannounced. If a licensee is not available when an inspection is attempted, the application must be denied.

In addition to the licensure requirements specified above, this section requires each applicant and licensee to comply with the following requirements in order to obtain and maintain a license:

- An applicant for licensure must comply with the background screening requirements.
- An applicant for licensure must provide a description and explanation of any exclusions, suspensions, or terminations of the applicant from the Medicaid program.
- Unless otherwise specified in ch. 429, F.S., or applicable rules, any information required to be reported to the AHCA must be submitted within 21 calendar days after the report period or effective date of the information, whichever is earlier, including any change of information contained in the most recent application for licensure or required insurance or bonds.
- Whenever a licensee discontinues operation:
  - The licensee must inform the AHCA not less than 30 days before the discontinuance of operation and inform residents or participants of such discontinuance and immediately surrender the license to the AHCA and the license must be canceled.

  - The licensee shall remain responsible for retaining and appropriately distributing all records within certain timeframes. In addition, the licensee or, in the event of death or dissolution of a licensee, the estate or agent of the licensee must make arrangements to forward records for each resident to the resident or the resident's legal representative, the resident's attending physician, or the health care provider where the resident currently receives services; or cause a notice to be published in the newspaper of greatest general circulation in the county in which the licensee was located that advises residents of the discontinuance of the licensed operation. The notice must inform residents that they may obtain copies of their records and specify the name, address, and telephone number of the person from whom the copies of records may be obtained. The notice must appear at least once a week for 4 consecutive weeks.
- On or before the first day services are provided to a resident, a licensee must inform the resident and his or her immediate family or representative, if appropriate, of the right to report:
  - Complaints. The statewide toll-free telephone number for reporting complaints to the AHCA must be provided to residents in a manner that is clearly legible and must include the words: "To report a complaint regarding the services you receive, please call toll-free (phone number).
  - Abusive, neglectful, or exploitative practices. The statewide toll-free telephone number for the central abuse hotline must be provided to residents in a manner that is clearly legible and must include the words: "To report abuse, neglect, or exploitation, please call toll-free (phone number)."
  - Medicaid fraud. An agency-written description of Medicaid fraud and the statewide toll-free telephone number for the central Medicaid fraud hotline must be provided to residents in a manner that is clearly legible and must include the words: "To report suspected Medicaid fraud, please call toll-free (phone number)."
- An applicant must provide the AHCA with proof of the applicant's legal right to occupy the property before a license may be issued. Proof may include, but need not be limited to, copies of warranty deeds, lease or rental agreements, contracts for deeds, quitclaim deeds, or other such documentation.
- Proof of insurance must be provided if it is required by law.
- Upon application for initial licensure or change of ownership licensure, the applicant must furnish satisfactory proof of the applicant's financial ability to operate. The AHCA must establish standards that require the applicant to provide information concerning the applicant's controlling interests. The AHCA must also establish documentation requirements, to be completed by each applicant, that show anticipated revenues and expenditures, the basis for financing the anticipated cash-flow requirements of the licensee, and an applicant's access to contingency financing. A current certificate of authority, pursuant to chapter 651, may be provided as proof of financial ability to operate. The AHCA may require a licensee to provide proof of financial ability to operate at any time if there is evidence of financial instability, including, but not limited to, unpaid expenses necessary for the basic operations of the licensee.
- A controlling interest may not withhold from the AHCA any evidence of financial instability. Any person who withholds such information commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083 (maximum imprisonment of 60 days or maximum fine of $500). Each day of continuing violation is a separate offense.

This section provides for the application procedure for a license. The AHCA is required to notify the licensee by mail or electronically at least 90 days before the expiration of a license that a renewal license is necessary to continue operation. The failure to timely submit a renewal application and license fee shall result in a $50 per day late fee charged to the licensee by the AHCA; but the total late fee may not exceed 50 percent of the licensure fee or $500, whichever is less. If an application is received after the required filing date and exhibits a hand-canceled postmark obtained from a United States post office dated on or before the required filing date, no fine is to be levied. The AHCA is required to examine the application and, within 30 days after receipt, notify the applicant in writing or electronically of any apparent errors or omissions and request any additional information required.

Requested information omitted from an application for licensure, license renewal, or change of ownership, other than an inspection, must be filed with the AHCA within 21 days after the AHCA's request for omitted information or the application is deemed incomplete and withdrawn from further consideration and the fees are forfeited.

Within 60 days after the receipt of a complete application, the AHCA is required to approve or deny the application. The license issued is a biennial license, unless conditions of the license category specify a shorter license period. Each license issued must indicate the name of the licensee, the license type, the date the license is effective, the expiration date of the license, and the maximum capacity of the assisted care community.

The AHCA may establish procedures for the electronic notification and submission of required information, including: licensure applications, required signatures, payment of fees, and notarization of applications.

This section also requires a fee for licensure and such fees are nonrefundable. License fees must be reasonably calculated by the AHCA to cover its costs in carrying out its responsibilities under this chapter and applicable rules, including the cost of licensure, inspection, and regulation of assisted care communities and license fees must be adjusted to provide for biennial licensure under AHCA rules. The AHCA is required to annually adjust license fees, including fees paid per bed, by not more than the change in the Consumer Price Index based on the 12 months immediately preceding the increase.

When a change is reported that requires issuance of a license, a fee may be assessed. The fee must be based on the actual cost of processing and issuing the license. The AHCA may charge a fee when a licensee requests a duplicate license. The fee may not exceed the actual cost of duplication and postage and may not exceed $25. Total fees collected may not exceed the cost of administering ch. 429, F.S, and applicable rules.

Whenever a change of ownership occurs the transferor is required to notify the AHCA in writing at least 60 days before the anticipated date of the change of ownership and the transferee must apply to the AHCA for a license. The transferor is responsible and liable for the lawful operation of the licensee and the welfare of the residents served until the date the transferee is licensed by the AHCA and any and all penalties imposed against the transferor for violations occurring before the date of change of ownership. Any restriction on licensure, including a conditional license existing at the time of a change of ownership, is to remain in effect until the AHCA

determines that the grounds for the restriction are corrected. The transferee is required to maintain records of the transferor, including: all resident and participant records, inspection reports, and all other records required to be maintained.

This section provides for certain types of licensure. A standard license may be issued to an applicant at the time of initial licensure, license renewal, or change of ownership. A standard license is issued when the applicant is in compliance with all statutory requirements and the AHCA's rules. A standard license expires 2 years after the date of issue.

A provisional license is issued to an applicant applying for an initial license or for a change of ownership. A provisional license must be limited in duration to a specific period of time, up to 6 months, as determined by the AHCA.

A licensee may submit a request to the AHCA for an inactive license or to extend a previously approved inactive period. Such request must include a written justification for the inactive license with the beginning and ending dates of inactivity specified, a plan for the transfer of any residents, and the appropriate licensure fees. The AHCA may not accept a request that is submitted after initiating closure, after any suspension of service, or after notifying residents of closure or suspension of service, unless the action is a result of a disaster[31] at the licensed premises. All licensure fees must be current, must be paid in full, and may be prorated.

A temporary license must be issued to an applicant against whom a proceeding denying, suspending, or revoking a license is pending at the time of license renewal, which is effective until final action not subject to further appeal.

This section prohibits unlicensed activity of an entity that should be licensed as an assisted care community to perform such activities, other than an assisted care community under construction. Also, a licenseholder may not advertise or hold out to the public that he or she holds a license for other than that for which he or she actually holds the license. Unlicensed activity constitutes harm that materially affects the health, safety, and welfare of residents or participants and is a violation of ch. 429, F.S. The AHCA or any state attorney may, in addition to other remedies, bring an action for an injunction to restrain such violation, or to enjoin the future operation or maintenance of the unlicensed assisted care community, until compliance with ch. 429, F.S., and AHCA rules has been demonstrated to the satisfaction of the AHCA.

If after receiving notification from the AHCA, such person or entity fails to cease operation and apply for a license, the person or entity will be subject to certain prescribed penalties. Each day of continued operation is a separate offense. Any person or entity that fails to cease operation after the AHCA's notification may be fined $1,000 for each day of noncompliance. When a controlling interest or licensee has an interest in more than one entity and fails to license an entity rendering services that require licensure, the AHCA may revoke all licenses and impose actions under s. 429.013, F.S. (moratorium or emergency suspension), and a fine of $1,000 per day against each licensee until such time as the appropriate license is obtained for the unlicensed operation.

[31] "Disaster" means a sudden emergency occurrence beyond the control of the licensee, whether natural, technological, or manmade, which renders the licensee inoperable at the premises.

In addition to granting injunctive relief, if the AHCA determines that a person or entity is operating or maintaining an assisted care community requiring licensure without obtaining a license and determines that a condition exists that poses a threat to the health, safety, or welfare of a resident or participant of the person or entity, the person or entity is subject to the same actions and fines imposed against a licensee as specified in ch. 429, F.S., and AHCA rules.

Any person aware of the operation of an unlicensed person or entity must report that person or entity to the AHCA.

Background Screening
This section also requires background screenings of applicants or the employees of applicants. A level 2 background screening pursuant to ch. 435, F.S., must be conducted through the AHCA on each of the following persons:

- The licensee, if an individual.
- The administrator or a similarly titled person who is responsible for the day-to-day operation of the licensed assisted living community.
- The financial officer or similarly titled individual who is responsible for the financial operation of the licensee.
- Any person who is a controlling interest who has been convicted of any offense prohibited by s. 435.04, F.S. The licensee is required to submit to the AHCA a description and explanation of the conviction when applying for a license.
- Any person seeking employment with a licensee who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to residents or have access to resident funds, personal property, or living areas; and any person contracting with a licensee whose responsibilities require him or her to provide personal care or personal services directly to residents.

Every 5 years after his or her licensure, employment, or entry into a contract each person who was subject to a level 2 background check must submit to level 2 background rescreening as a condition of retaining a license or continuing in an employment or contractual status. All fingerprints must be provided in electronic format. Proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any licensee or professional licensure requirements of the AHCA, the DOH, the Agency for Persons with Disabilities, the Department of Children and Family Services, or the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651 satisfies the background screening requirements if the person subject to screening has not been unemployed for more than 90 days and such proof is accompanied, under penalty of perjury, by an affidavit of compliance with the provisions of ch. 435, F.S., and these background screening requirements using forms provided by the AHCA. A person, who serves as a controlling interest of, is employed by, or contracts with a licensee on July 31, 2011, who has been screened and qualified according to standards specified in s. 435.03, F.S., or s. 435.04, F.S., must be rescreened by July 31, 2016.

This section provides that an applicant or employee required to undergo a background screening must not have committed specific delineated crimes in order to be cleared for licensure or employment.

The AHCA is authorized to adopt rules to establish a schedule to stagger the implementation of the required rescreening over a 5-year period, beginning July 31, 2011, through July 31, 2016. If, upon rescreening, a person has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency within 30 days after receipt of the rescreening results by the person.

The AHCA may grant an exemption to a person who does not have an active professional license or certification from the DOH or has an active professional license or certification from the DOH but is not providing a service within the scope of that license or certification. Also, the appropriate regulatory board within the DOH, or the DOH if there is no board, may grant an exemption from disqualification to a person who has received a professional license or certification from the DOH or a regulatory board within the DOH and that person is providing a service within the scope of his or her licensed or certified practice.

This provides that there is no unemployment compensation or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under ch. 435, F.S., or in s. 429.008, F.S., terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the DOH or the AHCA.

Inspections and Investigations
This section also provides the AHCA with inspection and investigation authority. An authorized officer or employee of the AHCA may inspect or investigate, when deemed necessary by the AHCA, to determine compliance with ch. 492, F.S., and applicable rules. The right of inspection extends to any business that the AHCA has reason to believe is being operated without a license, but inspection of any business suspected of being operated without the appropriate license may not be made without the permission of the owner or person in charge unless a warrant is first obtained from a circuit court. Any application for a license issued under ch. 492, F.S., or applicable rules constitutes permission for an appropriate inspection to verify the information submitted on or in connection with the application.

All inspections must be unannounced, except as specified in s. 429.005, F.S, for an initial application for licensure. Inspections for relicensure must be conducted biennially. The AHCA is required to have access to all licensee records required during an inspection or other review at no cost to the AHCA, including records requested during an offsite review.

A violation must be corrected within 30 calendar days after the licensee is notified of inspection results unless an alternative timeframe is required or approved by the AHCA.
Each licensee is required to maintain records of all inspection reports pertaining to that licensee and make them available to the public unless those reports are exempt from or contain information that is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution or is otherwise made confidential by law. Copies of the reports must be retained in the records of the

licensee for at least 3 years following the date the reports are filed and issued, regardless of a change of ownership.

A licensee is required to furnish an applicant for admission, a person who is a resident, or any relative, spouse, or guardian of any such person, a copy of the last inspection report pertaining to the licensee that was issued by the AHCA, if requested by such person.

Penalties
As a penalty for any violation of ch. 429, F.S., or applicable rules, the AHCA may impose an administrative fine. In addition, the AHCA may impose an immediate moratorium or emergency suspension on any licensee if the AHCA determines that any condition related to the licensee presents a threat to the health, safety, or welfare of a resident or participant. A licensee, the license of which is denied or revoked, may be subject to immediate imposition of a moratorium or emergency suspension to run concurrently with licensure denial, revocation, or injunction. A moratorium or emergency suspension remains in effect after a change of ownership, unless the AHCA has determined that the conditions that created the moratorium, emergency suspension, or denial of licensure have been corrected. When a moratorium or emergency suspension is placed on a licensee, notice of the action must be posted and visible to the public at the location of the licensee until the action is lifted.

In addition to the grounds provided in part II, part III, or part IV of ch. 429, F.S., grounds that may be used by the AHCA for denying or revoking a license or change of ownership application include any of the following actions by a controlling interest:
- False representation of a material fact in the license application or omission of any material fact from the application.
- An intentional or negligent act materially affecting the health or safety of a resident or participant of an assisted care community.
- A violation of ch. 429, F.S., or applicable rules.
- A demonstrated pattern of violations.
- The applicant, licensee, or controlling interest has been or is currently excluded, suspended, or terminated, for cause, from participation in the Medicaid program.

If a licensee lawfully continues to operate while a denial or revocation is pending in litigation, the licensee must continue to meet all other requirements of ch. 429, F.S., and applicable rules and must file subsequent renewal applications for licensure and pay all licensure fees.

In addition to the grounds provided in authorizing statutes, the AHCA is required to deny an application for a license or license renewal if the applicant or a person having a controlling interest in an applicant has been:
- Convicted of, or enters a plea of guilty to, regardless of adjudication, a felony under ch. 409, F.S., ch. 817, F.S., or ch. 893, F.S., unless the sentence and any subsequent period of probation for such convictions or plea ended more than 15 years before the date of the application;
- Terminated for cause from the Florida Medicaid program, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5 years; or

- Terminated for cause, pursuant to the appeals procedures established by the Florida Medicaid program, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5 years and the termination occurred at least 20 years before the date of the application.

In addition to the other penalties that may be imposed by the AHCA, it may also institute injunction proceedings in a court of competent jurisdiction in the local jurisdiction of the residence to:

- Restrain or prevent the establishment or operation of a person or entity that does not have a license or is in violation of any provision of ch. 429, F.S., or applicable rules or when a violation of ch. 429, F.S., or applicable rules constitutes an emergency affecting the immediate health and safety of a resident.
- Enforce the provisions of ch. 429, F.S., or any minimum standard, rule, or order issued or entered into pursuant thereto when the attempt by the AHCA to correct a violation through administrative sanctions has failed or when the violation materially affects the health, safety, or welfare of residents or participants or involves any operation of an unlicensed assisted care community.
- Terminate the operation of a licensee when a violation of any provision ch. 429, F.S., or any standard or rule adopted pursuant thereto exists that materially affects the health, safety, or welfare of a resident or participant.

If action is necessary to protect a resident or participant of a licensee from an immediate, life-threatening situation, the court may allow a temporary injunction.

In addition to any other remedies provided by law, the AHCA may deny an application or suspend or revoke the license of an assisted care community:

- If the applicant, licensee, or a licensee subject to this part that shares a common controlling interest with the applicant has failed to pay all outstanding fines, liens, or overpayments assessed by final order of the AHCA, not subject to further appeal, unless a repayment plan is approved by the AHCA; or
- For failure to comply with any repayment plan.

In reviewing an application requesting a change of ownership or change of the licensee, the transferor is required to, before AHCA approval of the change, repay or make arrangements to repay any amounts owed to the AHCA. The issuance of a license to the transferee shall be delayed until the transferor repays or makes arrangements to repay the amounts owed.

Administrative proceedings challenging the AHCA's licensure enforcement action must be reviewed on the basis of the facts and conditions that resulted in the AHCA action.

Rulemaking Authority

This section provides the DOEA with the authority to adopt rules as necessary to administer part I of ch. 429, F.S. (See comment under Related Issues) Any licensee that is in operation at the time of adoption of any applicable rule must be given a reasonable time under the particular circumstances, not to exceed 6 months after the date of such adoption, within which to comply with that rule, unless otherwise specified by rule.

Emergency Management
This section requires a licensee to have an emergency operations plan, which must designate a safety liaison to serve as the primary contact for emergency operations. A licensee may temporarily exceed its licensed capacity to act as a receiving licensee in accordance with an approved emergency operations plan for up to 15 days. While in an overcapacity status, each licensee must furnish or arrange for appropriate care and services to all residents. In addition, the AHCA may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending licensees.

An inactive license may be issued to a licensee when the licensee is located in a geographic area in which a state of emergency was declared by the Governor, if the licensee:
- Suffered damage to its operation during the state of emergency;
- Is currently licensed;
- Does not have a provisional license; and
- Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months.

An inactive license may be issued for a period not to exceed 12 months but may be renewed by the AHCA for up to 12 additional months upon demonstration to the AHCA of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the AHCA, accompanied by written justification for the inactive license, and must state the beginning and ending dates of inactivity and include a plan for the transfer of any residents and appropriate licensure fees. Upon AHCA approval, the licensee must notify residents of any necessary discharge or transfer. The beginning of the inactive licensure period must be the date the licensee ceases operations and the end of the inactive period must become the license expiration date. All licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the AHCA of a renewal application, including payment of licensure fees and AHCA inspections indicating compliance with all requirements of this chapter and applicable rules and statutes.

Licensees providing residential services must utilize an online database approved by the AHCA to report information to the AHCA regarding the licensee's emergency status, planning, or operations.

Section 11 amends s. 429.01, F.S., to rename the "Assisted Living Facilities Act," the "Assisted Living Residences Act," and to replace any reference to facilities with "residences." This section also provides that the Legislature recognizes that assisted living residences are an important part of the continuum of long-term care in the state as community-based social models with a health component and not as medical or nursing facilities. In addition, such residences should be operated as residential environments with supportive services and should not be subject to the same regulations as medical or nursing facilities, but instead be regulated in a less restrictive manner that is appropriate for a residential, non-medical setting.

Section 12 amends s. 429.02, F.S., to redefine "administrator," "assisted living residence," "community living support plan," and "supervision." Additionally, the terms "arbitration," "licensed residence," and "person" are introduced and defined.

Sections 13, 15, 17, 21, 22, 24, 28, 30, 45, 47, 48, 52, 53, 54, 57, 59, 60, 61, 62, 63, 64, 65, 66, 67, 69, 70, 71, 73, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, and 140 of the bill make technical, conforming changes to the following sections of the Florida Statutes:

- s. 429.04, F.S., related to residences to be licensed and exemptions;
- s. 429.075, F.S., related to limited mental health licenses;
- s. 429.11, F.S., related to initial application for a license and provision licenses;
- s. 429.174, F.S., related to background screening;
- s. 429.177, F.S., related to patients with Alzheimer's disease and other related disorders;
- s. 429.18, F.S., related to disposition of fees and administrative fines;
- s. 429.22, F.S., related to receivership proceedings;
- s. 429.24, F.S., related to contracts;
- s. 429.44, F.S., related to construction and renovation;
- s. 429.47, F.S., related to prohibited acts and penalties for violations;
- s. 429.49, F.S., related to resident records and penalties for alteration;
- s. 429.65, F.S., related to definitions;
- s. 429.67, F.S., related to licensure;
- s. 429.69, F.S., related to denial, revocation, and suspension of a license;
- s. 429.75, F.S., related to training and education programs;
- s. 429.83, F.S., related to residents with Alzheimer's disease or other related disorders and certain disclosures;
- s. 429.85, F.S., related to residents' Bill of Rights;
- s. 429.87, F.S., related to civil actions to enforce rights;
- s. 429.901, F.S., related to definitions;
- s. 429.905, F.S., related to exemptions, monitoring of adult day care center programs colocated with assisted living residences or licensed nursing home facilities;
- s. 429.907, F.S., related to license requirement, fee, exemption, and display;
- s. 429.909, F.S., related to application for license;
- s. 429.911, F.S., related to denial, suspension, revocation of license, emergency action, administrative fines, investigations, and inspections;
- s. 429.913, F.S., related to administrative fines;
- s. 429.917, F.S., related to patients' with Alzheimer's disease or other related disorders, staff training requirements, and certain disclosures;
- s. 429.919, F.S., related to background screening;
- s. 429.925, F.S., related to discontinuance of operation of adult day care centers;
- s. 429.927, F.S., related to right of entry and inspection;
- s. 101.62, F.S., related to requests for absentee ballots;
- s. 101.655, F.S., related to supervised voting by absent electors in certain facilities;
- s. 159.27, F.S., related to definitions;
- s. 196.1975, F.S., related to exemptions for property used by nonprofit homes for the aged;
- s. 202.125, F.S., related to sales of communications services and specified exemptions;
- s. 205.1965, F.S., related to assisted living residences;

- s. 252.357, F.S., related to monitoring of nursing homes and assisted living residences.
- s. 252.385, F.S., related to public shelter space;
- s. 380.06, F.S., related to developments of regional impact;
- s. 381.006, F.S., related to environmental health;
- s. 381.0072, F.S., related to food service protection;
- s. 381.0303, F.S., related to special needs shelters;
- s. 394.455, F.S., related to definitions;
- s. 394.4574, F.S., related to department responsibilities for a mental health resident who resides in an assisted living residence that holds a limited mental health license;
- s. 394.462, F.S., related to transportation;
- s. 394.4625, F.S., related to voluntary admissions;
- s. 394.75, F.S., related to state and district substance abuse and mental health plans;
- s. 394.9082, F.S., related to behavioral health managing entities;
- s. 400.0060, F.S., related to definitions;
- s. 400.0069, F.S., related to local long-term care ombudsman councils, duties, and membership;
- s. 400.0074, F.S., related to local ombudsman council onsite administrative assessments;
- s. 400.0239, F.S., related to Quality of Long-Term Care Facility Improvement Trust Fund;
- s. 400.148, F.S., related to Medicaid "Up-or-Out" Quality of Care Contract Management Program;
- s. 400.1755, F.S., related to care for persons with Alzheimer's disease or related disorders;
- s. 400.464, F.S., related to home health agencies to be licensed, expiration of license, exemptions, unlawful acts, and penalties;
- s. 400.471, F.S., related to application for license and fee;
- s. 400.474, F.S., related to administrative penalties;
- s. 400.497, F.S., related to rules establishing minimum standards;
- s. 400.506, F.S., related to licensure of nurse registries, requirements, and penalties;
- s. 400.6045, F.S., related to patients with Alzheimer's disease or other related disorders;
- s. 400.605, F.S., related to administration, forms, fees, rules, inspections, and fines;
- s. 400.609, F.S., related to hospice services;
- s. 400.701, F.S., related to intermediate care facilities;
- s. 400.925, F.S., related to definitions;
- s. 400.93, F.S., related to licensure requirements, exemptions, unlawful acts, and penalties;
- s. 405.01, F.S., related to release of medical information to certain study groups;
- s. 408.033, F.S., related to local and state health planning;
- s. 409.212, F.S., related to optional supplementation;
- s. 409.221, F.S., related to consumer-directed care program;
- s. 409.906, F.S., related to Optional Medicaid services;
- s. 409.907, F.S., related to Medicaid provider agreements;
- s. 409.912, F.S., related to cost-effective purchasing of health care;
- s. 410.031, F.S., related to legislative intent;
- s. 410.034, F.S., related to department determination of fitness to provide home care;
- s. 410.502, F.S., related to housing and living arrangements, special needs of the elderly, and services;

- s. 415.102, F.S., related to definitions;
- s. 415.1034, F.S., related to mandatory reporting of abuse, neglect, or exploitation of vulnerable adults, and mandatory reporting of death;
- s. 415.1051, F.S., related to protective services interventions when capacity to consent is lacking, nonemergencies, emergencies, orders and limitations;
- s. 415.107, F.S., related to confidentiality of reports and records;
- s. 420.626, F.S., related to homelessness and discharge guidelines;
- s. 430.071, F.S., related to respite for elders living in everyday families;
- s. 430.601, F.S., related to home care for the elderly;
- s. 456.053, F.S., related to financial arrangements between referring health care providers and providers of health care services;
- s. 458.348, F.S., related to formal supervisory relationships, standing orders, and established protocols;
- s. 459.025, F.S., related to formal supervisory relationships, standing orders, and established protocols;
- s. 468.1695, F.S., related to licensure by examination;
- s. 468.505, F.S., related to exemptions and exceptions;
- s. 553.73, F.S., related to the Florida Building Code;
- s. 627.94073, F.S., related to notice of cancellation and grace period;
- s. 633.021, F.S., related to definitions;
- s. 633.022, F.S., related to uniform firesafety standards;
- s. 641.31, F.S., related to health maintenance contracts;
- s. 651.083, F.S., related to residents' rights;
- s. 825.101, F.S., related to definitions;
- s. 893.055, F.S., related to prescription drug monitoring program; and
- s. 893.13, F.S., related to prohibited acts and penalties.

Section 14 amends s. 429.07, F.S., to remove the LNS license from the list of licenses that may be issued by the AHCA to an assisted living residence. This section also removes the authority for assisted living residences to employ or contract with a licensed nurse to administer medications and perform other tasks and removes certain requirements an existing assisted living residence must meet to qualify for an extended congregate care services license. In addition, this section removes the requirement that a registered nurse monitor residents receiving extended congregate care services and the potential waiver of one of the required monitoring visits if the residence meets certain requirements. This section removes the penalty associated with failing to provide extended congregate care services.

This section also removes the procedures and qualifications for the AHCA to issue a LNS license and the recording and reporting requirement by residences that have obtained a LNS license. The admission requirements of a person receiving LNS are also deleted. The fee requirement for residences providing LNS is deleted.

This section requires, in order to determine whether the residence is adequately protecting residents' rights, the AHCA to conduct a biennial survey that includes private informal conversations with a sample of residents to discuss the residents' experiences within the residence. This section also provides that an assisted living residence that has been cited for

certain violations within the previous 24 month period is subject to periodic unannounced monitoring, which may occur though a desk review or an onsite assessment. If the violation relates to providing or failing to provide nursing care, a registered nurse is required to participate in at least two monitoring visits within a 12-month period.

Section 16 amends s. 429.08, F.S., to require not only a health care practitioner, but also an emergency medical technician or paramedic, who is aware of the operation of an unlicensed residence to report that residence to AHCA. This section removes the AHCA's authority to sanction any provider that knowingly discharges a patient or client to an unlicensed residence.

Section 18 amends s. 429.12, F.S., to remove the requirement that when there is a change of ownership a plan of correction must be submitted by the transferee and approved by the AHCA at least 7 days before the change of ownership and a failure to correct a condition, which resulted in a moratorium or denial of licensure is grounds for denial of the transferee's license.

Section 19 amends s. 429.14, F.S., to remove administrative penalties for the misappropriation or conversion of the property of a resident of the facility; for the failure to follow the criteria and procedures required by law relating to the transportation, voluntary admission, and involuntary examination of a facility resident; and for knowingly providing without a license any service for which a person must be licensed under ch. 429, F.S. or ch. 400, F.S. (nursing homes and other related facilities).

This section removes the requirement that the AHCA must deny or revoke the license of a residence if it has two or more class I violations that are similar or identical to violations identified by the AHCA during a survey, inspection, monitoring visit, or complaint investigation occurring within the previous 2 years.

This section also removes the requirement that the AHCA provide to the Division of Hotels and Restaurants of the Department of Business and Professional Regulation, on a monthly basis, a list of those residences that have had their licenses denied, suspended, or revoked or that are involved in an appellate proceeding related to the denial, suspension, or revocation of a license.

Section 20 amends s. 429.17, F.S., to delete the requirement that a LNS license expire at the same time as the residence's license. This section also removes the requirement that a license may only be renewed after the residence provides proof of its ability to operate and conduct the residence in accordance with the requirements of the Assisted Living Residences Act and any adopted rules.

The requirement that the AHCA adopt certain rules in consultation with the DOEA is deleted.

Section 23 amends s. 429.178, F.S., to remove the provision that a residence having 17 or more residents must have an awake staff member on duty at all hours of the day and night if that residence advertises that it provides special care for persons with Alzheimer's disease or a related disorder. This section also deletes the requirement that a facility have an awake staff member on duty at all hours of the day and night or have mechanisms in place to monitor and ensure the safety of the residents if the residence has fewer than 17 residents. However, this section requires instead that a residence of any size have an awake staff member on duty at all

hours of the day and night for each secured unit of the residence that houses any residents with Alzheimer's disease or other related disorders.

This section also provides that for the safety and protection of residents with Alzheimer's disease, related disorders, or dementia, a secured locked unit may be designated. The unit may consist of the entire building or a distinct part of the building. Exit doors must be equipped with an operating alarm system which releases upon activation of the fire alarm. These units are exempt from specific life safety requirements to which assisted living residences are normally subject. A staff member must be awake and present in the secured unit at all times.

This section deletes the prohibition that a caregiver may not receiving training for the required continuing education requirements under a topic that he or she has already received training under.

This section requires the DOEA to maintain and post on its website a current list of providers who are approved to provide initial and continuing education for staff and direct care staff members of residences.

This section removes the provisions that a facility having more than 90 percent of residents who receive monthly optional supplementation payments is not required to pay for the required training and education programs and a facility that has one or more such residents is required to pay a reduced fee that is proportional to the percentage of such residents in the facility. This section also removes the requirement that a facility that does not have any residents who receive monthly optional supplementation payments must pay a reasonable fee, as established by the DOEA for such training and education programs.

Section 25 amends s. 429.19, F.S., to define a "class I," "class II," "class III," and "class IV" violation, which mirrors the current definitions for these terms in s. 408.813, F.S. The section deletes the AHCA's authority to assess a survey fee to cover the cost of monitoring visits to verify a correction of a violation.

This section also deletes the requirement that the AHCA 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 to specified entities at no charge. Also deleted is the requirement that the Department of Children and Family Services disseminate the list to service providers under contract to the department who are responsible for referring persons to a facility for residency.

Section 26 amends s. 429.195, F.S., to exempt from the prohibition against referrals for compensation, residents of an assisted living residence who refer friends, family members, or other individuals with whom they have a personal relationship. This allows the licensee of the assisted living residence to provide a monetary reward to the resident for making a referral to the residence.

Section 27 amends s. 429.20, F.S., to remove the administrative penalties for the unlawful solicitation or receipt of contributions by an assisted living residence.

Section 29 amends s. 429.23, F.S., to clarify within one of the events that constitutes an adverse incident that a proceeding (Baker Act) under part I of ch. 394, F.S., the Florida Mental Health Act, which is undertaken without the resident's consent, is not an adverse incident that must be reported.

This section deletes the 1-day reporting requirement of an event and the follow-up if the event is not determined to be an adverse incident. Instead, the bill requires reporting within 7 days after the occurrence of an adverse incident. The section also deletes the reporting requirement by the assisted living residences to the AHCA when a liability claim has been filed against the residence.

Section 31 amends s. 429.255, F.S., to remove the ability of volunteers, who are licensed nurses, to administer medications to residents, take residents' vital signs, manage individual weekly pill organizers for residents, give prepackaged enemas, observe residents, document observations, or report observations to the resident's physician. This section provides that persons under contract to the residence or residence staff who are licensed nurses may provide LNS.

This section requires staff in residences to report observations of a resident to the administrator or the administrator's designee instead of to the resident's physician.

This section removes the authority of licensed nurses to carry out their professional duties when an emergency situation arises until emergency medical personnel assume responsibility for care.

This section removes the DOEA rulemaking authority to implement an order not to resuscitate.

Section 32 amends s. 429.256, F.S., to authorize a residence to require standard medication dispensing systems for residents' prescriptions to minimize the potential risk for improper dosage administration of prescription drugs.

This section adds to the list of activities that may be considered assistance with self-administration of medication to include preparing syringes for injection or the administration of medications by any injectable route, administering medications through intermittent positive pressure breathing machines or a nebulizer, using a glucometer to perform blood glucose checks, or assisting with the putting on and taking off ted hose.

Section 33 amends s. 429.26, F.S., to remove the requirement that a residence notify within 30 days a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to the dementia or impairment. Also deleted is the requirement that if an underlying condition is determined to exist, the facility must arrange, with the appropriate health care provider, the necessary care and services to treat the condition.

This section also deletes a requirement that a long-term care ombudsman who believes a resident needs to be evaluated to notify the resident's case manager.

Section 34 amends s. 429.27, F.S., to authorize the residence's licensee, owner, administrator, or staff, or other representative to execute a surety bond. The bond must be conditioned upon the

faithful compliance of such persons and must run to the AHCA for the benefit of a resident who suffers a financial loss as a result of the misuse or misappropriation of funds by such persons.

This section provides that a residence administrator may only provide for the safekeeping in the residence personal effects, including funds, not in excess of $500.

This section removes the authority of a governmental agency or private charitable agency contributing funds or other property to the account of a resident to obtain a financial statement of the account.

This section removes the prohibition that a residence may not levy an additional charge to the individual or the account of a resident for any supplies or services that the residence has agreed by contract to provide as part of the standard monthly rate.

Section 35 amends s. 429.275, F.S., to remove the DOEA rulemaking authority to clarify terms, establish requirements for financial records, accounting procedures, personnel procedures, insurance coverage, and reporting procedures, and specify documentation as necessary.

Section 36 amends s. 429.28, F.S., to reduce the number of days from 45 days to 30 days that notice of relocation or termination of residence from the residence must be provided to a resident or legal guardian. This section also deletes the requirement that the residence must show good cause in a court in order for the residence to terminate the residency of an individual without notice.

This section deletes the requirement that the AHCA conduct a survey to determine general compliance with facility standards and compliance with residents' rights, or when no survey is conducted, a monitoring visit. This section also removes the authority of the AHCA to conduct periodic follow-up inspections or complaint investigations.

This section removes the prohibition that a staff member or employee of a residence may not serve notice upon a resident to leave the residence or take other retaliatory action against a person who notifies a state attorney or the Attorney General of a possible violation of the Assisted Living Residences Act.

Section 37 amends s. 429.293, F.S., to require a written stipulation by parties to extend the statute of limitations within which a resident may allege a violation of the resident's rights or negligence. This section reduces the number of days from 60 days to 30 days that a resident may file suit if negotiations have been terminated.

This section provides that any party may request discovery of relevant documents or things, which must be relevant to evaluating the merits of a claim. This section also provides that an arbitration process may be used to resolve a claim filed by a resident. This section also reduces the number of days from 60 days to 30 days that a claimant has to file suit after the conclusion of mediation.

Section 38 amends s. 429.294, F.S., to provide that unless expressly prohibited by a legally competent resident, an assisted living residence must furnish to the spouse, guardian, surrogate,

proxy, or attorney in fact of a current resident, within 7 working days after receipt of a written request, or of a former resident, within 10 working days after receipt of a written request, a copy of that resident's records that are in the possession of the residence. These records are required to include medical and psychiatric records and any records concerning the care and treatment of the resident performed by the residence, except progress notes and consultation report sections of a psychiatric nature. Copies of these records must not be considered part of a deceased resident's estate and may be made available before the administration of an estate, upon request, to the spouse, guardian, surrogate, proxy, or attorney in fact. This section provides that a residence may charge a reasonable fee for the copying of resident records and the fee must not exceed $1 per page for the first 25 pages and 25 cents per page for each additional page in excess of 25 pages. The residence must allow any such spouse, guardian, surrogate, proxy, or attorney in fact to examine the original records in its possession, or microfilms or other suitable reproductions of the records to help ensure that the records are not damaged, destroyed, or altered.

This section also provides that a person must not be allowed to obtain copies of residents' records more often than once per month, except that physician's reports in the residents' records may be obtained as often as necessary to effectively monitor the residents' condition.

Section 39 amends s. 429.298, F.S., to reduce the amount of punitive damages that may be awarded from $1 million to $250,000. This section also prevents punitive damages from being awarded at all for wrongful and dangerous conduct proven to be motivated primarily by unreasonable financial gain, which was known by the manager or responsible party. The section also prevents any punitive damages from being awarded when the fact finder determines that at the time of injury the defendant had a specific intent to harm the claimant and the defendant did in fact harm the claimant.

This section also removes the requirement that in any case in which the findings of fact support an award of punitive damages, the clerk of the court must refer the case to the appropriate law enforcement agencies, to the state attorney in the circuit where the long-term care facility that is the subject of the underlying civil cause of action is located, and, for multijurisdictional facility owners, to the Office of the Statewide Prosecutor and removes the requirement that such agencies, state attorney, or Office of the Statewide Prosecutor initiate a criminal investigation into the conduct giving rise to the award of punitive damages. This section also deletes the requirement that all findings by the trier of fact which support an award of punitive damages be admissible as evidence in any subsequent civil or criminal proceeding relating to the acts giving rise to the award of punitive damages.

This section requires any punitive damages awarded to be divided between the claimant and the Health Care Trust fund and the claimant is entitled to 25 percent instead of 50 percent and the Health Care Trust Fund is to receive 75 percent instead of 50 percent of the damages.

Section 40 amends s. 429.31, F.S., to provide that when notice has been provide to the AHCA that there is a voluntary or involuntary termination of the operation of a residence, the AHCA or the receiver of the residence must monitor the transfer of residents to other facilities. This section also clarifies that the AHCA may levy a fine of up to $5,000 against a licensee or other persons that terminate an operation without providing the required notice.

Section 41 amends s. 429.34, F.S., to remove the authority of a member of the state or local long-term care ombudsman council to enter unannounced into a residence in order to determine the residence's compliance with the provisions of the Assisted Living Residences Act. This section also deletes the provision authorizing data collected by the state or local long-term care ombudsman councils or the state or local advocacy councils to be used by the AHCA in investigations involving violations of regulatory standards.

Section 42 amends s. 429.35, F.S., to delete the requirement that within 60 days after the date of the biennial inspection visit or within 30 days after the date of any interim visit, the AHCA must forward the results of an inspection to the local ombudsman council in whose planning and service area, the facility is located; to at least one public library or, in the absence of a public library, the county seat in the county in which the inspected assisted living facility is located; and, when appropriate, to the district Adult Services and Mental Health Program Offices.

Section 43 amends s. 429.41, F.S., to require uniform firesafety standards to be enforced, but not established, by the State fire Marshal in cooperation with the AHCA, but not the DOEA or the DOH.

This section also removes the requirement that the Office of the State Fire Marshal provide or cause the provision of training and education on the proper application of Chapter 5, NFPA 101A, 1995 edition, to its employees, to staff of the AHCA who are responsible for regulating residences, and to local governmental inspectors and deletes the requirement that the Office of the State Fire Marshal provide or cause the provision of this training within its existing budget. Also deleted is the requirement that the Office of the State Fire Marshal, in cooperation with provider associations, provide or cause the provision of a training program designed to inform facility operators on how to properly review bid documents relating to the installation of automatic fire sprinklers within its existing budget.

This section also removes outdated provision related to requiring certain notifications of automatic fire sprinkler requirements.

This section specifies that any existing residence housing eight or fewer residents that is classified as impractical to evacuate must install an automatic fire sprinkler system within the timeframes mutually agreed to by the local fire marshal and the AHCA.

This section deletes the provision that any existing facility that is required to install an automatic fire sprinkler system need not meet other firesafety requirements of Chapter 23, NFPA 101, 1994 edition, which exceed the provisions of NFPA 101, 1988 edition and that the mandate requiring certain facilities to install an automatic fire sprinkler system supersedes any other requirement.

This section also deletes provisions related to a local government's authority to charge fees for expenses incurred relating to the installation and maintenance of an automatic fire sprinkler system; to the requirement that if a licensed facility undergoes major reconstruction or addition to an existing building on or after January 1, 1996, the entire building must be equipped with an automatic fire sprinkler system; to the requirement that an application for a permit for an automatic fire sprinkler system is required upon application for a permit for a reconstruction project that creates costs that go over the 50-percent threshold. This section also deletes the

corresponding time frames that any facility licensed before January 1, 1996, is required to install an automatic fire sprinkler system.

This section deletes the authority of the appropriate local fire official to grant two 1-year extensions to the timeframes for installation of an automatic fire sprinkler in the cases of financial hardship.

This section also deletes the requirement that a facility owner whose facility is required to be equipped with an automatic fire sprinkler system under Chapter 23, NFPA 101, 1994 edition, must disclose to any potential buyer of the facility that an installation of an automatic fire sprinkler requirement exists.

This section deletes the requirement that a local emergency management agency ensures certain agencies or certain volunteer organizations are given an opportunity to review a residence's comprehensive emergency management plan.

This section provides that in order to ensure that inspections are not duplicative, the rules adopted regarding inspections must clearly delineate the responsibilities of the agency regarding agency's licensure and survey inspections staff, the county health departments regarding food safety and sanitary inspections, and the local fire marshal regarding firesafety inspections.

This section removes from the rulemaking requirement that must provide for the care of residents rules that relate to internal risk management and quality assurance.

This section removes the rulemaking requirement to establish specific policies and procedures on resident elopement, including the requirement that a residence conduct a minimum of two elopement drills each year.

This section deletes the requirement that the DOEA must submit a copy of proposed rules to the Speaker of the House of Representatives, the President of the Senate, and appropriate committees of substance for review and comment prior to the promulgation. Also deleted is the requirement that rules promulgated by the department shall encourage the development of homelike facilities which promote the dignity, individuality, personal strengths, and decisionmaking ability of residents.

This section removes from the considerations as to whether a full inspection of a residence must take place the consideration of confirmed ombudsman council complaints.

This section requires the AHCA, in consultation with the DOEA, to develop, maintain, and update the key quality-of-care standards with input from representatives of associations and organizations representing assisted living residences. The specific reference to the State Long-Term Care Ombudsman Council is deleted.

Section 44 amends s. 429.42, F.S., to delete the requirement that a residence develop and implement a corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the AHCA to be life-

threatening. This section also deletes the requirement that the AHCA must employ at least two licensed pharmacists among its personnel who biennially inspect assisted living residences, to participate in biennial inspections or consult with the AHCA regarding deficiencies relating to medicinal drugs or over-the-counter preparations.

Section 46 amends s. 429.47, F.S., to delete the requirement that a licensed residence must submit to the AHCA proof that construction to expand the residence is in compliance with applicable local zoning requirements prior to commencing the construction.

Section 49 amends s. 429.52, F.S., to remove the exemption for administrators of residences who are licensed in accordance with part II of ch. 468, F.S., and other professionals who are exempted by the DOEA from certain training and education requirements.

This section requires staff persons who are involved with the management of medications and assisting with the self-administration of medications to complete 2 hours of continuing education training annually.

This section requires the DOEA to consult with associations and organizations representing assisted living residences when developing a training curriculum for residence staff.

This section also requires a trainer certified by the DOEA to continue to meet continuing education requirements and other standards as set forth in rules adopted by the department. Noncompliance with the standards set forth in the rules may result in suspension or revocation of a trainer's certificate.

Section 50 amends s. 429.53, F.S., to redefine the term "consultation" to no longer include the provision of a checklist of general local and state approvals required prior to constructing or developing a facility and a listing of the types of agencies responsible for such approvals, an explanation of benefits and financial assistance available to a recipient of supplemental security income residing in a facility, and a preconstruction review of a facility to ensure compliance with the AHCA's rules and the Assisted Living Residences Act. The AHCA is required to provide consultation to certain persons upon request.

Section 51 repeals s. 429.54, F.S., which enables the DOEA to collect the information requested by the Legislature regarding the actual cost of providing room, board, and personal care in facilities, by conducting field visits and audits of facilities as necessary. Section 429.54, F.S., also requires owners of randomly sampled facilities to submit such reports, audits, and accountings of cost as the department may require by rule and any facility selected to participate in the study must cooperate with the department by providing cost of operation information to interviewers. Section 429.54, F.S., also authorizes local governments or organizations to contribute to the cost of care of local facility residents by further subsidizing the rate of state-authorized payment to such facilities, but implementation of local subsidy requires departmental approval and must not result in reductions in the state supplement.

Section 55 amends s. 429.71, F.S., to delete the authority of the AHCA to request a plan of corrective action from a licensee of an adult family-care home that demonstrates a good faith

effort to remedy each violation by a specific date as an alternative to, or in conjunction with, an administrative action against the licensee.

Section 56 amends s. 429.73, F.S., to require rules adopted by the DOEA to address requirements for the physical site and maintenance of the adult family-care home.

Section 58 amends s. 429.81, F.S., to require each residency agreement to specify that the resident must give the provider a 30 days' written notice of intent to terminate his or her residency from the adult family-care home.

Section 68 amends s. 429.915, F.S., to delete the requirement that a conditional license be accompanied by an approved plan of correction.

Section 72 creates s. 429.926, F.S., to provide that the minimum licensure requirements under s. 429.009(7)-(9), F.S., do not apply to licensed adult day care centers.

Section 74 amends s. 429.929, F.S., to provide that the AHCA must develop the key quality-of-care standards for adult day care centers, taking into consideration the comments and recommendations of the DOEA and of associations and organizations representing adult day care centers.

Section 141 provides an effective date of July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

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

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill significantly caps the amount of punitive damages that may be awarded to a claimant, who is an assisted living residence resident.

Residents would be eligible under the provisions of the bill to refer friends and family members to the assisted living residence for a monetary award.

C. Government Sector Impact:

Fees for ALFs will be reduced due to the elimination of the LNS license fees. Based on the number of LNS specialty licenses in January 2011 (1,038), the LNS specialty license generates approximately $586,762 biennially based upon $309 per license (1,038 x $309 = $320,742) and $10 per bed ($10 x 26,602 beds = $266,020). The per bed fee for ALFs are not adjusted to offset losses from elimination of the LNS license fees, therefore there would be a fiscal impact on state fee collections and reduction of $226,020 per year in the Health Care Trust Fund.[32]

Changing "assisted living facility" to "assisted living residence" throughout will require the revision of all AHCA forms and publications that currently state "assisted living facility." At a minimum, 19 forms and multiple publications will require revision. Additionally, and more significantly, this change would be imposed on all existing assisted living facility providers who used the term in their brochures, printed materials and advertisements.[33]

It will be necessary for staff to make revisions, review, post on the Agency's website and work with Information Technology, and coordinate with Multimedia and the Agency's mailroom, Call Center and website contractor.[34]

VI. Technical Deficiencies:

Line 839 of the bill requires the AHCA to publish a minimum of 90-day advance notice of a change in the toll-free telephone numbers to report complaints. However, it does not specify where the AHCA is supposed to publish such information.

On line 1417 of the bill it should read "part III" not "part II."

On lines 2013 through 2014 of the bill the phrase "limited nursing license" should be deleted to conform to other changes in the bill.

On line 4460 of the bill, the catch line should replace the term "deficiencies" with the term "violations" to conform to other changes in the bill.

[32] AHCA, *2011 Bill Analysis & Economic Impact Statement for SB 1458*, on file with the committee.
[33] *Id.*
[34] *Id.*

VII. Related Issues:

Line 1073 authorizes the DOEA to adopt rules as necessary to administer part I of ch. 429, F.S., the Assisted Care Communities licensing Procedure Act. However, licensing is a function of the AHCA.

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.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	PCS/SB 1458 (434272)
INTRODUCER:	Health Regulation Committee
SUBJECT:	Assisted Living Facilities
DATE:	April 1, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	O'Callaghan	Stovall		**Pre-meeting**
2.				
3.				
4.				
5.				
6.				

I. Summary:

This proposed committee substitute (PCS) makes substantial changes to part I of ch. 429, F.S., the Assisted Living Facilities Act. The changes made relate to legislative intent, definitions, standard and specialty licensure, licensure fees, monitoring activities, unlicensed activity, proof of financial ability to operate, administrative penalties, standards of operation, classes of violations and attendant penalties, referrals, solicitations, adverse incidents, administration of medication, assessment of residents, property of residents, resident Bill of Rights, civil actions, award of damages, presuit procedures, facility records and discovery, vicarious liability, fire safety, inspections to assess quality-of-care standards, corrective action plans, new construction and local zoning requirements, prohibited acts, staff training, Agency for Health Care Administration (AHCA) consultation, residency agreements, and training violations and penalties.

In addition, the PCS repeals two sections of law relating to recordkeeping, maintaining liability insurance, collecting information required by the Legislature, and local subsidies of assisted living facilities (ALFs).

This PCS substantially amends the following sections of the Florida Statutes: 400.141, 408.810, 408.820, 429.01, 429.02, 429.04, 429.07, 429.08, 429.11, 429.12, 429.14, 429.17, 429.178, 429.19, 429.195, 429.20, 429.23, 429.255, 429.256, 429.26, 429.27, 429.28, 429.29, 429.293, 429.294, 429.297, 429.298, 429.41, 429.42, 429.445, 429.47, 429.49, 429.52, 429.53, 429.71, 429.81, and 817.505.

This PCS creates the following sections of the Florida Statutes: 430.081.

This PCS repeals the following sections of the Florida Statutes: 429.275 and 429.54.

This PCS creates an undesignated section of the Florida Statutes.

II. Present Situation:

Assisted Living Facilities

An ALF is a residential establishment, or part of a residential establishment, that provides housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.[1, 2] A personal service is direct physical assistance with, or supervision of, the activities of daily living and the self-administration of medication.[3] Activities of daily living include: ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks.

The ALFs are licensed by the Agency for Health Care Administration (AHCA) pursuant to part I of ch. 429, F.S., relating to assisted care communities, and part II of ch. 408, F.S., relating to the general licensing provisions for health care facilities. The ALFs are also subject to regulation under Chapter 58A-5, Florida Administrative Code (F.A.C.). These rules are adopted by the Department of Elderly Affairs (DOEA) in consultation with the AHCA, the Department of Children and Family Services, and the Department of Health (DOH).[4] An ALF must also comply with the Uniform Fire Safety Standards for ALFs contained in Chapter 69A-40, F.A.C., and standards enforced by the DOH concerning food hygiene; physical plant sanitation; biomedical waste; and well, pool, or septic systems.[5]

There are currently 2,932 licensed ALFs in Florida.[6] In addition to a standard license, an ALF may have specialty licenses that authorize an ALF to provide limited nursing services (LNS), limited mental health (LMH) services,[7] and extended congregate care (ECC) services.

An ALF is required to provide care and services appropriate to the needs of the residents accepted for admission to the facility. Generally, the care and services include at a minimum:

- Supervising the resident in order to monitor the resident's diet; being aware of the general health, safety, and physical and emotional well-being of the resident; and recording

[1] Section 429.02(5), F.S.
[2] An ALF does not include an adult family-care home or a nontransient public lodging establishment. An adult family-care home is regulated under ss. 429.60 – 429.87, F.S., and is defined as a full-time, family-type living arrangement in a private home where the person who owns or rents the home, lives in the home. An adult family-care home provides room, board, and personal care, on a 24-hour basis, for no more than five disabled adults or frail elders, who are not relatives. A nontransient establishment (a.k.a. boarding house) is regulated under part I of ch. 509, F.S., and is defined as any public lodging establishment that is rented or leased to guests by an operator whose intention is that the dwelling unit occupied will be the sole residence of the guest.
[3] Section 429.02(16), F.S.
[4] Section 429.41(1), F.S.
[5] *See* ch. 64E-12, ch. 64E-11, and 64E-16, F.A.C.
[6] Senate professional staff of the Health Regulation Committee received this information via email on March 25, 2011. A copy of the email is on file with the committee.
[7] An ALF that serves three or more mental health residents must obtain a limited mental health specialty license. A mental health resident is an individual who receives social security disability income (SSDI) due to a mental disorder or supplemental security income (SSI) due to a mental disorder, and receives OSS.

significant changes, illnesses, incidents, and other changes which resulted in the provision of additional services;
- Contacting appropriate persons upon a significant change in the resident or if the resident is discharged or moves out;
- Providing and coordinating social and leisure activities in keeping with each resident's needs, abilities, and interests;
- Arranging for health care by assisting in making appointments, reminding residents about scheduled appointments, and providing or arranging for transportation as needed; and
- Providing to the resident a copy of, and adhering to, the Resident Bill of Rights.

An unlicensed person who has received the appropriate training may assist a resident in an ALF with the self-administration of medication. Persons under contract to the ALF, employees, or volunteers,[8] who are licensed under the nurse practice act[9] and uncompensated family members or friends may:[10]
- Administer medications to residents;
- Take a resident's vital signs;
- Manage individual weekly pill organizers for residents who self-administer medication;
- Give prepackaged enemas ordered by a physician; and
- Observe residents, document observations on the appropriate resident's record, and report observations to the resident's physician.

Additionally, in an emergency situation, persons licensed under the nurse practice act may carry out their professional duties until emergency medical personnel assume responsibility for care. A resident may independently arrange, contract, and pay for additional services provided by a third party of the resident's choice.

The owner or facility administrator determines whether an individual is appropriate for admission to the facility based on an assessment of the strengths, needs, and preferences of the individual; the health assessment; the preliminary service plan; the facility's residency criteria; services offered or arranged for by the facility to meet resident needs; and the ability of the facility to meet the uniform fire safety standards.[11]

A resident who requires 24-hour nursing supervision[12] may not reside in an ALF, unless the resident is enrolled as a hospice patient. Continued residency of a hospice patient is conditioned upon a mutual agreement between the resident and the facility, additional care being rendered

[8] An association spokesperson stated in an e-mail to Senate Health Regulation Committee professional staff that ALFs do not currently use volunteers for these purposes due to liability issues.
[9] Part I of ch. 464, F.S.
[10] Section 429.255, F.S.
[11] Section 429.255, F.S., s. 429.26, F.S., and Rule 58A-5.030, F.A.C.
[12] Twenty-four-hour nursing supervision means services that are ordered by a physician for a resident whose condition requires the supervision of a physician and continued monitoring of vital signs and physical status. Such services must be: medically complex enough to require constant supervision, assessment, planning, or intervention by a nurse; required to be performed by or under the direct supervision of licensed nursing personnel or other professional personnel for safe and effective performance; required on a daily basis; and consistent with the nature and severity of the resident's condition or disease state or stage. Definition found at s. 429.02(26), F.S.

through a licensed hospice, and the resident being under the care of a physician who agrees that the physical needs of the resident are being met.

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.[13]

Limited Nursing Services Specialty License

A limited nursing services (LNS) specialty license enables an ALF to provide, directly or through contract, a select number of nursing services in addition to the personal services that are authorized under the standard license.

The nursing services authorized to be provided with this license are limited to acts specified in administrative rules,[14] may only be provided as authorized by a health care provider's order, and must be conducted and supervised in accordance with ch. 464, F.S., relating to nursing, and the prevailing standard of practice in the nursing community. A nursing assessment, that describes the type, amount, duration, scope, and outcomes or services that are rendered and the general status of the resident's health, is required to be conducted at least monthly on each resident who receives a limited nursing service.

An LNS licensee is subject to monitoring inspections by the AHCA or its agents at least twice a year. At least one registered nurse must be included in the inspection team to monitor residents receiving LNS and to determine if the facility is complying with applicable regulatory requirements.[15]

The biennial fee for an LNS license is $304 per license with an additional fee of $10 per resident based on the total licensed resident capacity of the facility.[16] Ostensibly this fee covers the additional monitoring inspections currently required of facilities with an LNS license.

Extended Congregate Care Specialty License

An extended congregate care (ECC) specialty license enables an ALF to provide, directly or through contract, services performed by licensed nurses and supportive services[17] to persons who otherwise would be disqualified from continued residence in an ALF.[18]

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[13] Section 429.28, F.S.

[14] Rule 58A-5.031, F.A.C. The additional nursing services that might be performed pursuant to the LNS license include: conducting passive range of motion exercises; applying ice caps or collars; applying heat, including dry heat, hot water bottle, heating pad, aquathermia, moist heat, hot compresses, sitz bath and hot soaks; cutting the toenails of diabetic residents or residents with a documented circulatory problem if the written approval of the resident's health care provider has been obtained; performing ear and eye irrigations; conducting a urine dipstick test; replacing an established self-maintained indwelling urinary catheter, or performing an intermittent urinary catheterization; performing digital stool removal therapies; applying and changing routine dressings that do not require packing or irrigation, but are for abrasions, skin tears and closed surgical wounds; caring for stage 2 pressure sores, (care for stage 3 or 4 pressure sores are not permitted); caring for casts, braces and splints, (care for head braces, such as a halo, is not permitted); assisting, applying, caring for, and monitoring the application of anti-embolism stockings or hosiery; administering and regulating portable oxygen; applying, caring for, and monitoring a transcutaneous electric nerve stimulator (TENS); performing catheter, colostomy, and ileostomy care and maintenance; conducting nursing assessments; and, for hospice patients, providing any nursing service permitted within the scope of the nurse's license, including 24-hour nursing supervision.

[15] Section 429.07(3)(c), F.S.

[16] Section 429.07(4)(c), F.S., as adjusted per s. 408.805(2), F.S.

The primary purpose of ECC services is to allow residents, as they become more impaired with physical or mental limitations, to remain in a familiar setting. An ALF licensed to provide ECC services may also admit an individual who exceeds the admission criteria for a facility with a standard license, if the individual is determined appropriate for admission to the ECC facility. Facilities licensed to provide ECC services may adopt their own criteria and requirements for admission and continued residency in addition to the minimum criteria specified in law.

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 recording basic vital functions and weight;
- Dietary management, including providing special diets, monitoring nutrition, and observing the resident's food and fluid intake and output;
- 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 to health-related appointments.

An individual must undergo a medical examination before admission to an ALF with the intention of receiving ECC services or upon transfer within the same facility to that portion of the facility licensed to provide ECC services. The ALF must develop a service plan[19] that sets forth how the facility will meet the resident's needs and must maintain a written progress report on each resident who receives ECC services.

A supervisor, who may also be the administrator, must be designated to be responsible for the day-to-day management of the ECC program and ECC resident service planning. A nurse, provided as staff or by contract, must be available to provide nursing services as needed by ECC residents, participate in the development of resident service plans, and perform the monthly nursing assessment for each resident receiving ECC services. The ECC licensed ALF must provide awake staff to meet resident scheduled and unscheduled night needs.[20]

Persons under contract to the ECC, employees, or volunteers, who are licensed under the nurse practice act,[21] including certified nursing assistants, may perform all duties within the scope of their license or certification, as approved by the facility administrator.[22] These nursing services must be authorized by a health care provider's order and pursuant to a plan of care; medically necessary and appropriate treatment for the condition; in accordance with the prevailing standard

[17] Supportive services include social service needs, counseling, emotional support, networking, assistance with securing social and leisure services, shopping service, escort service, companionship, family support, information and referral, assistance in developing and implementing self-directed activities, and volunteer services. *See* Rule 58A-5.030(8), F.A.C.
[18] Section 429.07(3)(b), F.S., and Rule 58A-5.030, F.A.C. *See also* AHCA, *2011 Bill Analysis & Economic Impact Statement for SB 1458*, on file with the committee.
[19] Section 429.02(21), F.S.
[20] Rule 58A-5.030, F.A.C.
[21] Part I of ch. 464, F.S.
[22] Section 429.255(2), F.S.

of practice in the nursing community and the resident's service plan; a service that can be safely, effectively, and efficiently provided in the facility; and recorded in nursing progress notes.[23]

An ECC licensee is subject to quarterly monitoring inspections by the AHCA or its agents. At least one registered nurse must be included in the inspection team. The AHCA may waive one of the required yearly monitoring visits for an ECC facility that has been licensed for at least 24 months, if the registered nurse who participated in the monitoring inspections determines that the ECC services are being provided appropriately and there are no serious violations or substantiated complaints about the quality of service or care.

Limited Mental Health Specialty License

An ALF that serves three or more mental health residents must obtain a limited mental health (LMH) specialty license.[24]

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).[25] The DCF is responsible for ensuring that a mental health resident is assessed and determined able to live in the community in an ALF with an LMH license.[26]

An ALF licensed to provide LMH services must assist the mental health resident in carrying out the activities in the resident's community living support plan. The mental health resident's community living support plan, which is updated annually, includes:[27]

- The specific needs of the resident which must be met for the resident to live in the ALF and community;
- The clinical mental health services to be provided by the mental health care provider to help meet the resident's needs;
- Any other services and activities to be provided by or arranged for by the mental health care provider or mental health case manager to meet the resident's needs;
- Obligations of the ALF to facilitate and assist the resident in attending appointments and arranging transportation to appointments for the services and activities identified in the plan;
- A description of other services to be provided or arranged by the ALF; and
- A list of factors pertinent to the care, safety, and welfare of the mental health resident and a description of the signs and symptoms particular to the resident that indicates the immediate need for professional mental health services.

The LMH licensee must execute a cooperative agreement between the ALF and the mental health care services provider. The cooperative agreement specifies, among other things, directions for the ALF accessing emergency and after-hours care for the mental health resident.

[23] Rule 58A-5.030(8)(c), F.A.C.
[24] Section 429.075, F.S.
[25] Section 429.02(15), F.S.
[26] 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.
[27] Rule 58A-5.029, F.A.C.

The administrator, manager, and staff in direct contact with mental health residents in an LMH licensed facility must complete LMH training provided or approved by the DCF.[28]

Licensure Fees

The biennial licensure fees for the ALF standard license and specialty licenses are found in s. 429.07(4), F.S. This section refers to the general health care licensure provisions in part II of ch. 408, F.S. Section 408.805, F.S., provides for licensure fees to be adjusted annually by not more than the change in the Consumer Price Index (CPI) based on the 12 months immediately preceding the increase. The following chart reflects the licensure fees contained in s. 429.07(4), F.S., and the adjusted licensure fees based on the CPI that are currently in effect.[29]

Fee Description	Per s. 429.07(4), F.S.	CPI adjusted (current fee)
Standard ALF Application Fee	$300	$366
Standard ALF Per-Bed Fee (non-OSS)	$ 50	$ 61
Total Licensure fee for Standard ALF	$10,000	$13,443
ECC Application Fee	$400	$515
ECC Per-Bed Fee (licensed capacity)	$ 10	$ 10
LNS Application Fee	$250	$304
LNS Per-Bed Fee (licensed capacity)	$ 10	$ 10

Senate Interim Project Report 2010-118

During the 2009-2010 interim, professional staff of the Senate Committee on Health Regulation reviewed the licensure structure for ALFs. The recommendations in the resulting report are to repeal the LNS specialty license and authorize a standard-licensed ALF to provide the nursing services currently authorized under the LNS license; require an additional inspection fee, adjusted for inflation, for a facility that indicates that it intends to provide LNS; require each ALF to periodically report electronically information, as determined by rule, related to resident population, characteristics, and attributes; authorize the AHCA to determine the number of additional monitoring inspections required for an ALF that provides LNS based on the type of nursing services provided and the number of residents who received LNS as reported by the ALF; and repeal the requirement for the AHCA to inspect *all* the ECC licensees quarterly, instead targeting monitoring inspections for those facilities with residents receiving ECC services.

III. Effect of Proposed Changes:

Section 1 amends s. 400.141, F.S., to remove the requirement that a registered pharmacist licensed in Florida, who is under contract with a facility licensed under ch. 429, F.S., (ALFs, adult family-care homes, and adult day care centers) repackage a resident's bulk prescription medication into a unit dose system compatible with the system used by the assisted living facility, adult family-care home, or adult day care center, if requested. However, section 19 of

[28] Rule 58A-5.0191(8), F.A.C.

[29] Found on the AHCA website at: http://ahca.myflorida.com/MCHQ/LONG_TERM_CARE/Assisted_living/alf/ALF_fee_increase.pdf, (Last visited on March 25, 2011).

the PCS allows a facility to require standard medication dispensing systems for residents' prescriptions.

Section 2 amends s. 408.820, F.S., to exempt ALFs from classifications of violations, which is provided for in section 14 of the PCS.

Section 3 amends s. 409.912, F.S., to expand the demonstration project in Miami-Dade County to include a licensed psychiatric facility to improve access to health care for a predominantly minority, medically underserved, and medically complex population and to evaluate alternatives to nursing home care and general acute care for this population. The project is to be located in a health care condominium and collocated with licensed facilities providing a continuum of care. The project is not subject to a certificate of need review process.

Section 4 amends s. 429.01, F.S., to provide that the Legislature recognizes that ALFs are an important part of the continuum of long-term care in Florida as community-based social models with a health component and not as medical or nursing facilities and therefore, ALFs should not be subject to the same regulations as medical or nursing facilities but instead be regulated in a less restrictive manner that is appropriate for a residential, nonmedical setting.

Section 5 amends s. 429.02, F.S., to amend the definitions for the following terms: "administrator," "aging in place," "assisted living facility," and "supervision." This section also creates new definitions for the following terms: "arbitration," "licensed facility," and "person."

Section 6 amends s. 429.04, F.S., to remove the authority of a facility certified under ch. 651, F.S. (continuing care facility), or a retirement community to provide home health services to its resdients who live in certain homes located on campus without obtaining a license to operate an ALF under certain circumstances.

Section 7 amends s. 429.07, F.S., to remove the LNS license from the list of licenses that may be issued by the AHCA to an ALF. This section also removes the authority for ALFs to employ or contract with a licensed nurse to administer medications and perform other tasks and removes certain requirements an existing ALF must meet to qualify for an extended congregate care services license. In addition, this section removes the requirement that a registered nurse monitor residents receiving extended congregate care services and the potential waiver of one of the required monitoring visits if the residence meets certain requirements. This section removes the penalty associated with failing to provide extended congregate care services.

This section also removes the procedures and qualifications for the AHCA to issue a LNS license and the recording and reporting requirement by residences that have obtained a LNS license. The admission requirements of a person receiving LNS are also deleted. The fee requirement for residences providing LNS is deleted.

This section provides that the per bed fee for an ALF if $71 per resident and the total fee for standard licensure may not exceed $13,443. The current $50 per resident fee is increased to $71 in order to offset the repeal of the LNS license.

This section requires, in order to determine whether the facility must participate in the monitoring activities during the 12-month period, the AHCA to conduct a biennial survey that includes private informal conversations with a sample of residents and consultation with the ombudsman council in the planning and service area in which the facility is located, to discuss the residents' experiences within the facility. This section also provides that an ALF that has been cited for certain violations within the previous 24 month period is subject to periodic unannounced monitoring, which may occur though a desk review or an onsite assessment. If the violation relates to providing or failing to provide nursing care, a registered nurse is required to participate in the monitoring visits within a 12-month period.

Section 8 amends s. 429.08, F.S., to require not only a health care practitioner, but also an emergency medical technician or paramedic, who is aware of the operation of an unlicensed ALF to report that facility to the AHCA.

Section 9 amends s. 429.11, F.S., to require the AHCA to develop an abbreviated form for the submission of proof of financial ability to operate that is specific to applicants for an ALF. The form must request information that demonstrates the applicant has adequate resources to sustain operation and sufficient assets, credit, and projected revenues to cover liabilities and expenses of the facility based on the number of beds and services the applicant will provide.

Section 10 amends s. 429.12, F.S., to remove the requirement that when there is a change of ownership a plan of correction must be submitted by the transferee and approved by the AHCA at least 7 days before the change of ownership and a failure to correct a condition, which resulted in a moratorium or denial of licensure, is grounds for denial of the transferee's license.

Section 11 amends s. 429.14, F.S., to remove administrative penalties for the failure to follow the criteria and procedures required by law relating to the transportation, voluntary admission, and involuntary examination of a facility resident.

This section removes the requirement that the AHCA must deny or revoke the license of a residence if it has two or more class I violations that are similar or identical to violations identified by the AHCA during a survey, inspection, monitoring visit, or complaint investigation occurring within the previous 2 years.

This section also removes the requirement that the AHCA provide to the Division of Hotels and Restaurants of the Department of Business and Professional Regulation, on a monthly basis, a list of those residences that have had their licenses denied, suspended, or revoked or that are involved in an appellate proceeding related to the denial, suspension, or revocation of a license.

Section 12 amends s. 429.17, F.S., to delete the requirement that a LNS license expire at the same time as the residence's license. This section also deletes the requirement that a conditional license be accompanied by an AHCA-approved plan of correction.

Section 13 amends s. 429.178, F.S., to remove the provision that a residence having 17 or more residents must have an awake staff member on duty at all hours of the day and night if that residence advertises that it provides special care for persons with Alzheimer's disease or a related disorder. This section also deletes the requirement that a facility must have an awake staff

member on duty at all hours of the day and night or have mechanisms in place to monitor and ensure the safety of the residents if the residence has fewer than 17 residents. However, this section requires instead that a residence of any size have an awake staff member on duty at all hours of the day and night for each secured unit of the residence that houses any residents with Alzheimer's disease or other related disorders.

This section also provides that for the safety and protection of residents with Alzheimer's disease, related disorders, or dementia, a secured locked unit may be designated. The unit may consist of the entire building or a distinct part of the building. Exit doors must be equipped with an operating alarm system that releases upon activation of the fire alarm. These units are exempt from specific life safety requirements to which ALFs are normally subject. A staff member must be awake and present in the secured unit at all times.

This section requires the DOEA to maintain and post on its website a current list of providers who are approved to provide initial and continuing education for staff and direct care members of ALFs that provide special care for persons with Alzheimer's disease or other related disorders.

This section requires the DOEA to maintain and post on its website a current list of providers who are approved to provide initial and continuing education for staff and direct care staff members of residences.

This section removes the provisions that a facility having more than 90 percent of residents who receive monthly optional supplementation payments is not required to pay for the required training and education programs and a facility that has one or more such residents is required to pay a reduced fee that is proportional to the percentage of such residents in the facility. This section also removes the requirement that a facility that does not have any residents who receive monthly optional supplementation payments must pay a reasonable fee, as established by the DOEA for such training and education programs.

Section 14 amends s. 429.19, F.S., to remove the requirement that the AHCA impose an administrative fine for any violation committed by a facility employee. This section also defines a "class I," "class II," "class III," and "class IV" violation, which mirrors the current definitions for these terms in s. 408.813, F.S. The section deletes the AHCA's authority to assess a survey fee to cover the cost of monitoring visits to verify a correction of a violation.

This section also deletes the requirement that the AHCA 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 to specified entities at no charge. Also deleted is the requirement that the Department of Children and Family Services disseminate the list to service providers under contract to the DOEA who are responsible for referring persons to a facility for residency.

Section 15 amends s. 429.195, F.S., to exempt from the prohibition against referrals for compensation, any individual with whom the facility employs or contracts with to market the facility; a referral service that provides information, consultation, or referrals to consumers to assist them in finding appropriate care or housing options if such consumers are not Medicaid recipients; or residents of an ALF who refer friends, family members, or other individuals with

whom they have a personal relationship. This allows the licensee of the ALF to provide a monetary reward to the resident for making a referral to the residence.

Section 16 amends s. 429.20, F.S., to remove the administrative penalties for the unlawful solicitation or receipt of contributions by an ALF.

Section 17 amends s. 429.23, F.S., to clarify within one of the events that constitutes an adverse incident that a proceeding (Baker Act) under part I of ch. 394, F.S., the Florida Mental Health Act, which is undertaken without the resident's consent, is not an adverse incident that must be reported.

This section deletes the 1-day reporting requirement of an event and the follow-up, if the event is not determined to be an adverse incident. Instead, this section requires reporting within 15 business days after the occurrence of an adverse incident. The section also deletes the reporting requirement by the ALFs to the AHCA when a liability claim has been filed against the residence.

Section 18 amends s. 429.255, F.S., to remove the ability of volunteers, who are licensed nurses, to administer medications to residents, take residents' vital signs, manage individual weekly pill organizers for residents, give prepackaged enemas, observe residents, document observations, or report observations to the resident's physician. This section provides that persons under contract to the residence or residence staff who are licensed nurses may provide LNS.

This section requires staff in residences to report observations of a resident to the administrator or the administrator's designee instead of to the resident's physician.

This section removes the authority of licensed nurses to carry out their professional duties when an emergency situation arises until emergency medical personnel assume responsibility for care.

Section 19 amends s. 429.256, F.S., to authorize a residence to require standard medication dispensing systems for residents' prescriptions to minimize the potential risk for improper dosage administration of prescription drugs. This section also includes in the list of self-administered medications, continuous positive airway pressure machines.

This section adds to the list of activities that may be considered assistance with self-administration of medication to include assisting a resident in holding a nebulizer, using a glucometer to perform blood glucose checks, assisting with the putting on and taking off anti-embolism stockings (ted hose), and assisting with applying and removing an oxygen cannula.

Section 20 amends s. 429.26, F.S., to remove the requirement that a residence notify within 30 days a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to the dementia or impairment. Also deleted is the requirement that if an underlying condition is determined to exist, the facility must arrange, with the appropriate health care provider, the necessary care and services to treat the condition.

Section 21 amends s. 429.27, F.S., to authorize the residence's licensee, owner, administrator, or staff, or other representative to execute a surety bond. The bond must be conditioned upon the faithful compliance of such persons and must run to the AHCA for the benefit of a resident who suffers a financial loss as a result of the misuse or misappropriation of funds by such persons.

This section provides that a residence administrator may only provide for the safekeeping in the residence personal effects, including funds, not in excess of $500.

This section removes the authority of a governmental agency or private charitable agency contributing funds or other property to the account of a resident to obtain a financial statement of the account.

Section 22 repeals s. 429.275, F.S., which law requires the administrator or owner of a facility to maintain accurate business records that identify, summarize, and classify funds received and expenses disbursed and to use written accounting procedures and a recognized accounting system. This law also requires the administrator or owner of a facility to maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule and maintain liability insurance coverage that is in force at all times. This law also provides that the DOEA may by rule clarify terms, establish requirements for financial records, accounting procedures, personnel procedures, insurance coverage, and reporting procedures, and specify documentation as necessary.

Section 23 amends s. 429.28, F.S., to reduce the number of days from 45 days to 30 days that notice of relocation or termination of residence from the residence must be provided to a resident or legal guardian. This section also deletes the requirement that the residence must show good cause in a court in order for the residence to terminate the residency of an individual without notice.

This section deletes the requirement that the AHCA conduct a survey to determine general compliance with facility standards and compliance with residents' rights, or when no survey is conducted, a monitoring visit. This section also removes the authority of the AHCA to conduct periodic follow-up inspections or complaint investigations.

This section removes the prohibition that a staff member or employee of a residence may not serve notice upon a resident to leave the residence or take other retaliatory action against a person who notifies a state attorney or the Attorney General of a possible violation of the Assisted Living Facilities Act.

Section 24 amends s. 429.29, F.S., to specify that a resident who alleges negligence or a violation of rights as specified in this part has a cause of action against the licensee or its management company, as identified in the state application for assisted living facility licensure. However, the cause of action may not be asserted individually against an officer, director, owner, including an owner designated as having a controlling interest on the state application for assisted living facility licensure, or agent of a licensee or management company unless,

following an evidentiary hearing, the court determines there is sufficient evidence in the record or proffered by the claimant which establishes a reasonable basis for finding that the person or entity breached, failed to perform, or acted outside the scope of duties as an officer, director, owner, or agent, and that the breach, failure to perform, or action outside the scope of duties is a legal cause of actual loss, injury, death, or damage to the resident.

This section also provides that if a claimant elects to claim wrongful death damages instead of survival damages then the total noneconomic damages may not exceed $250,000, regardless of the number of claimants.

Section 25 amends s. 429.293, F.S., to require a written stipulation by parties to extend the statute of limitations within which a resident may allege a violation of the resident's rights or negligence. This section reduces the number of days from 60 days to 30 days that a resident may file suit if negotiations have been terminated.

This section provides that any party may request discovery of relevant documents or things, which must be relevant to evaluating the merits of a claim. This section also provides that an arbitration process may be used to resolve a claim filed by a resident.

Section 26 amends s. 429.294, F.S., to provide that unless expressly prohibited by a legally competent resident, an ALF must furnish to the spouse, guardian, surrogate, proxy, or attorney in fact of a current resident, within 7 working days after receipt of a written request, or of a former resident, within 10 working days after receipt of a written request, a copy of that resident's records that are in the possession of the residence. These records are required to include medical and psychiatric records and any records concerning the care and treatment of the resident performed by the residence, except progress notes and consultation report sections of a psychiatric nature. Copies of these records must not be considered part of a deceased resident's estate and may be made available before the administration of an estate, upon request, to the spouse, guardian, surrogate, proxy, or attorney in fact. This section provides that a residence may charge a reasonable fee for the copying of resident records and the fee must not exceed $1 per page for the first 25 pages and 25 cents per page for each additional page in excess of 25 pages. The residence must allow any such spouse, guardian, surrogate, proxy, or attorney in fact to examine the original records in its possession, or microfilms or other suitable reproductions of the records to help ensure that the records are not damaged, destroyed, or altered.

This section also provides that a person must not be allowed to obtain copies of residents' records more often than once per month, except that physician's reports in the residents' records may be obtained as often as necessary to effectively monitor the residents' condition.

Section 27 amends s. 429.297, F.S., to prohibit a claim for punitive damages unless, based on admissible evidence proffered by the claimant, a reasonable basis for recovery of such damages is demonstrated. The defendant may proffer admissible evidence to refute the claimant's proffer of evidence to recover punitive damages. The trial judge must conduct an evidentiary hearing and weigh the admissible evidence proffered by the claimant and the defendant to ensure that there is a reasonable basis to believe that the claimant, at trial, will be able to demonstrate by clear and convincing evidence that the recovery of such damages is warranted.

This section deletes the requirement that the rules of civil procedures must be liberally construed so as to allow the claimant discovery of evidence which appears reasonably calculated to lead to admissible evidence of the issue of punitive damages. Also, a defendant may be held liable for punitive damages only if the trier of fact, based on clear and convincing evidence, finds that a specific individual or corporate defendant actively and knowingly participated in intentional misconduct, or engaged in conduct that constituted gross negligence, and that conduct contributed to the loss, damages, or injury suffered by the claimant.

This section also provides that, in the case of vicarious liability of an employer, punitive damages may not be imposed for the conduct of an identified employee or agent unless the conduct of the employee or agent unless specific criteria is met and officers, directors, or managers of the actual employer corporation or legal entity condoned, ratified, or consented to the specific conduct as alleged by the claimant.

Section 28 amends s. 429.298, F.S., to reduce the amount of punitive damages that may be awarded from $1 million to $250,000. This section also prevents punitive damages from being awarded at all for wrongful and dangerous conduct proven to be motivated primarily by unreasonable financial gain, which was known by the manager or responsible party. The section also prevents any punitive damages from being awarded when the fact finder determines that at the time of injury the defendant had a specific intent to harm the claimant and the defendant did in fact harm the claimant.

This section also removes the requirement that in any case in which the findings of fact support an award of punitive damages, the clerk of the court must refer the case to the appropriate law enforcement agencies, to the state attorney in the circuit where the long-term care facility that is the subject of the underlying civil cause of action is located, and, for multijurisdictional facility owners, to the Office of the Statewide Prosecutor and removes the requirement that such agencies, state attorney, or Office of the Statewide Prosecutor initiate a criminal investigation into the conduct giving rise to the award of punitive damages. This section also deletes the requirement that all findings by the trier of fact which support an award of punitive damages be admissible as evidence in any subsequent civil or criminal proceeding relating to the acts giving rise to the award of punitive damages.

This section requires any punitive damages awarded to be divided between the claimant and the Quality of Long-Term Care Facility Improvement Trust Fund and the claimant is entitled to 25 percent instead of 50 percent and the Quality of Long-Term Care Facility Improvement Trust Fund is to receive 75 percent instead of 50 percent of the damages.

Section 29 amends s. 429.41, F.S., to provide that in order to ensure that inspections are not duplicative, the rules adopted regarding inspections must clearly delineate the responsibilities of the AHCA regarding the AHCA's licensure and survey inspections staff, the county health departments regarding food safety and sanitary inspections, and the local fire marshal regarding firesafety inspections. This section also deletes the requirement that the AHCA collect fees for food service inspections conducted by the county health departments and transfer such fees to the DOH.

This section removes from the rulemaking requirement that must provide for the care of residents rules that relate to internal risk management and quality assurance.

This section removes the rulemaking requirement to establish specific policies and procedures on resident elopement, including the requirement that a residence conduct a minimum of two elopement drills each year.

This section requires the AHCA, beginning January 1, 2012 to use an abbreviated biennial standard licensure inspection in a facility that has a good record of past performance. The AHCE is required to develop, in consultation with the DOEA, the key quality-of-care standards with input from the State Long-Term Care Ombudsman Council and representatives of associations and organizations representing ALFs.

Section 30 amends s. 429.42, F.S., to delete the requirement that a residence develop and implement a corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the AHCA to be life-threatening. This section also deletes the requirement that the AHCA must employ at least two licensed pharmacists among its personnel who biennially inspect ALFs, to participate in biennial inspections or consult with the AHCA regarding deficiencies relating to medicinal drugs or over-the-counter preparations.

Section 31 amends s. 429.445, F.S., to delete the requirement that a licensed ALF must submit to the AHCA proof that construction to expand the residence is in compliance with applicable local zoning requirements prior to commencing the construction.

Section 32 amends s. 429.47, F.S., to delete the requirement that freestanding facility may not advertise or imply that any part of it is a nursing home, the definition of "freestanding facility, and the penalty for violating the advertisement requirement.

Section 33 amends s. 429.49, F.S., to make a technical change.

Section 34 amends s. 429.52, F.S., to remove the exemption for administrators of residences who are licensed in accordance with part II of ch. 468, F.S., and other professionals who are exempted by the DOEA from certain training and education requirements.

This section requires staff persons who are involved with the management of medications and assisting with the self-administration of medications to complete 2 hours of continuing education training annually.

This section requires the DOEA to consult with associations and organizations representing ALFs when developing a training curriculum for residence staff.

This section also requires a trainer certified by the DOEA to continue to meet continuing education requirements and other standards as set forth in rules adopted by the DOEA. Noncompliance with the standards set forth in the rules may result sanctions that may be progressive in nature and may consist of corrective action measures; suspension or termination

from participation as an approved training provider or trainee, including sitting for any required examination; and administrative fines not to exceed $1,000 per incident. One or more sanctions may be levied per incident.

Section 35 amends s. 429.53, F.S., to redefine the term "consultation" to no longer include the provision of a checklist of general local and state approvals required prior to constructing or developing a facility and a listing of the types of agencies responsible for such approvals, an explanation of benefits and financial assistance available to a recipient of supplemental security income residing in a facility, and a preconstruction review of a facility to ensure compliance with the AHCA's rules and the Assisted Living Facilities Act.

Section 36 repeals s. 429.54, F.S., which enables the DOEA to collect the information requested by the Legislature regarding the actual cost of providing room, board, and personal care in facilities, by conducting field visits and audits of facilities as necessary. Section 429.54, F.S., also requires owners of randomly sampled facilities to submit such reports, audits, and accountings of cost as the department may require by rule and any facility selected to participate in the study must cooperate with the department by providing cost of operation information to interviewers. Section 429.54, F.S., also authorizes local governments or organizations to contribute to the cost of care of local facility residents by further subsidizing the rate of state-authorized payment to such facilities, but implementation of local subsidy requires departmental approval and must not result in reductions in the state supplement.

Section 37 amends s. 429.71, F.S., to delete the authority of the AHCA to request a plan of corrective action from a licensee of an adult family-care home that demonstrates a good faith effort to remedy each violation by a specific date as an alternative to, or in conjunction with, an administrative action against the licensee.

Section 38 amends s. 429.81, F.S., to require each residency agreement to specify that the resident must give the provider a 30 days' written notice of intent to terminate his or her residency from the adult family-care home.

Section 39 amends s. 430.081, F.S., to authorize the DOEA to sanction training providers and trainees for infractions involving any required training that the DOEA has the authority to regulate in order to ensure that such training providers and trainees satisfy specific qualification requirements and adhere to training curricula that is approved by the DOEA.

This section specifies that training infractions include, but are not limited to, falsification of training records, falsification of training certificates, falsification of a trainer's qualifications, failure to adhere to the required number of training hours, failure to use the required curriculum, failure to maintain the continuing education for the trainer's recertification, failure to obtain reapproval of a curriculum when required, providing false or inaccurate information, misrepresentation of the required materials, and use of a false identification as a training provider or trainee. Sanctions may be progressive in nature and may consist of corrective action measures; suspension or termination from participation as an approved training provider or trainee, including sitting for any required examination; and administrative fines not to exceed $1,000 per incident. One or more sanctions may be levied per incident.

Section 40 amends s. 817.505, F.S., to conform to other changes made by the PCS that allow ALFs to receive and pay for certain referrals.

Section 41 creates an undesignated section of the Florida Statutes to provide that licensure fees adjusted by consumer price index increases prior to this act are not intended to be reset by this act and may continue to accrue as authorized in law.

Section 42 provides an effective date of July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

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

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

The PCS changes the fees for standard licensure and for extended congregate care licensure to ensure that the fee amount remains at the amount currently assessed by the AHCA.

B. Private Sector Impact:

The PCS significantly caps the amount of punitive damages that may be awarded to a claimant, who is an ALF resident.

Residents would be eligible under the provisions of the PCS to refer friends and family members to the ALF for a monetary award. Additionally, individuals hired by an ALF to market the ALF or referral service businesses are authorized under the PCS to make referrals for compensation.

C. Government Sector Impact:

Fees for ALFs will be reduced due to the elimination of the LNS license fees. Based on the number of LNS specialty licenses in January 2011 (1,038), the LNS specialty license generates approximately $586,762 biennially based upon $309 per license (1,038 x $309

= $320,742) and $10 per bed ($10 x 26,602 beds = $266,020). If the per bed fee for ALFs are not adjusted to offset losses from elimination of the LNS license fees, there would be a fiscal impact on state fee collections and reduction of $226,020 per year in the Health Care Trust Fund.[30]

VI. Technical Deficiencies:

On line 2461 of the PCS, the catch line should replace the term "deficiencies" with the term "violations" to conform to other changes in the PCS.

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.

[30] AHCA, *2011 Bill Analysis & Economic Impact Statement for SB 1458*, on file with the committee.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SPB 7232
INTRODUCER:	For consideration by the Health Regulation Committee
SUBJECT:	Ratification of Rules
DATE:	March 31, 2011 REVISED:

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

I. Summary:

The bill ratifies two rules relating to the maximum number of prescriptions for certain controlled substances that may be written in a registered pain management clinic during any 24-hour period. These two rules were filed for adoption by the Department of Health, Board of Medicine and Board of Osteopathic Medicine.

This bill does not amend, create, or repeal any section of the Florida Statutes.

II. Present Situation:

Current Law

Chapter 2010-279, Laws of Florida (L.O.F.), became effective on November 17, 2010,[1] when the Legislature over-rode the Governor's Veto of CS/CS/HB 1565, which was passed during the 2010 Regular Session. This law requires a proposed administrative rule that has an adverse impact or regulatory costs that exceed certain thresholds to be submitted to the Legislature for ratification before the rule can take effect. The Legislature provided for a statement of estimated regulatory costs (SERC) as the tool to assess a proposed rule's impact.

[1] House Joint Resolution 9-A passed during the 2010A Special Session on November 16, 2010.

An agency proposing a rule is required to prepare a SERC of the proposed rule if the proposed rule:[2]

- Will have an adverse impact on small business; or

- Is likely to directly or indirectly increase regulatory costs in excess of $200,000 in the aggregate in this state within 1 year after the implementation of the rule.

A SERC is required to include:[3]

- An economic analysis showing whether the rule directly or indirectly:
  - Is likely to have an adverse impact on economic growth, private sector job creation or employment, or private sector investment in excess of $1 million in the aggregate within 5 years after the implementation of the rule;

  - Is likely to have an adverse impact on business competitiveness, including the ability of persons doing business in the state to compete with persons doing business in other states or domestic markets, productivity, or innovation in excess of $1 million in the aggregate within 5 years after the implementation of the rule; or

  - Is likely to increase regulatory costs, including any transactional costs, in excess of $1 million in the aggregate within 5 years after the implementation of the rule.

If the adverse impact or regulatory costs of the rule exceed any of these criteria, then the rule may not take effect until it is ratified by the Legislature;

- A good faith estimate of the number of individuals and entities likely to be required to comply with the rule, together with a general description of the types of individuals likely to be affected by the rule;

- A good faith estimate of the cost to the agency, and to any other state and local government entities, of implementing and enforcing the proposed rule, and any anticipated effect on state or local revenues;

- A good faith estimate of the transactional costs likely to be incurred by individuals and entities, including local government entities, required to comply with the requirements of the rule. "Transactional costs" are direct costs that are readily ascertainable based upon standard business practices, and include filing fees, the cost of obtaining a license, the cost of equipment required to be installed or used or procedures required to be employed in complying with the rule, additional operating costs incurred, the cost of monitoring and reporting, and any other costs necessary to comply with the rule;

- An analysis of the impact on small businesses,[4] and an analysis of the impact on small counties and small cities.[5] The impact analysis for small businesses must include the basis for

[2] *See* s. 120.54(3)(b)1., F.S.
[3] *See* s. 120.241(2), F.S.
[4] "Small business" is defined to mean an independently owned and operated business concern that employs 200 or fewer permanent full-time employees and that, together with its affiliates, has a net worth of not more than $5 million or any firm

the agency's decision not to implement alternatives that would reduce adverse impacts on small businesses;

- Any additional information that the agency determines may be useful; and

- A description of any regulatory alternative submitted by a substantially affected person and a statement adopting the alternative or a statement of the reasons for rejecting the alternative in favor of the proposed rule.

Regulation of Pain Management Clinics

The 2010 Legislature enacted CS/CS/SB 2272 and CS/CS/SB 2722[6] to help address the prescription drug abuse epidemic that is fueled by "pill mills." This law created ss. 458.3265 and 459.0137, F.S., to enhance a registration and inspection program for pain management clinics in which allopathic physicians and osteopathic physicians who primarily engage in the treatment of pain by prescribing or dispensing controlled substance medications may practice. These two sections of law are similar for the respective practice acts.

Among other things, this law requires each board to adopt a rule establishing the maximum number of prescriptions for Schedule II or Schedule III controlled substances or the controlled substance Alprazolam, which may be written at any one registered pain-management clinic during any 24-hour period.[7]

The two boards initiated rulemaking by publishing the Notice of Rule Development in the Florida Administrative Weekly on October 29, 2010. After completing the statutory requirements for rulemaking, the rules were filed for adoption with the Department of State on March 25, 2011.

The rules set the maximum number of prescriptions for Schedule II or Schedule III controlled substances or the controlled substance Alprazolam, which may be written at any one registered pain-management clinic during any 24-hour period at no more than an average of three prescriptions per patient per physician working at the pain-management clinic, up to a maximum of 150 prescriptions per physician. If a physician is working less than 8 hours per day in the pain-management clinic, the maximum number that may be written is pro-rated for the number of hours worked. The rule also provides that "do not fill before dated" prescription will not be counted toward the daily limit until the first date the prescription is eligible to be filled.

based in this state which has a Small Business Administration 8(a) certification. As applicable to sole proprietorships, the $5 million net worth requirement shall include both personal and business investments.

[5] "Small county" and "small city" are defined to mean any county that has an un-incarcerated population of 75,000 or less and any municipality that has an un-incarcerated population of 10,000 or less, respectively, according to the most recent decennial census.

[6] Ch. 2010-211, L.O.F.

[7] *See* s. 458.3265(4)(c), F.S., and s. 459.0137(4)(c), F.S.

SERC for Rule 64B8-9.0131

The Center for Economic Forecasting and Analysis (CEFA), part of the Florida State University Institute of Science and Public Affairs, was engaged to estimate the costs for the Department of Health and the pain-management clinics for proposed rules 64B8-9.0134 and 64B15-14.0054, for the Board of Medicine and the Board of Osteopathic Medicine, respectively. For purposes of determining whether the proposed rule requires Legislative ratification, the SERC indicates the proposed rule "is likely to increase regulatory costs, including any transactional costs, in excess of $1 million in the aggregate within 5 years after the implementation of the rule."[8]

Specifically, the SERCs indicate a total estimated statewide cost of $932,000 per year. This cost is arrived at by estimating $20 per clinic per week (for a 50-week year), for one hour of administrative time per week tracking the number of controlled substance prescriptions, including accounting for any "do not fill before" prescriptions, written by each physician practicing in the pain-management clinic. That equals $1,000 per clinic and when multiplied by the 932 clinics (as of December 9, 2010) totals $932,000 per year.

Controlled Substances

Chapter 893, F.S., sets forth the Florida Comprehensive Drug Abuse Prevention and Control Act. This chapter classifies controlled substances into five schedules in order to regulate the manufacture, distribution, preparation, and dispensing of the substances.

- A Schedule I substance has a high potential for abuse and no currently accepted medical use in treatment in the United States and its use under medical supervision does not meet accepted safety standards. Examples: heroin and methaqualone.

- A Schedule II substance has a high potential for abuse, a currently accepted but severely restricted medical use in treatment in the United States, and abuse may lead to severe psychological or physical dependence. Examples: cocaine and morphine.

- A Schedule III substance has a potential for abuse less than the substances contained in Schedules I and II, a currently accepted medical use in treatment in the United States, and abuse may lead to moderate or low physical dependence or high psychological dependence or, in the case of anabolic steroids, may lead to physical damage. Examples: lysergic acid; ketamine; and some anabolic steroids.

- A Schedule IV substance has a low potential for abuse relative to the substances in Schedule III, a currently accepted medical use in treatment in the United States, and abuse may lead to limited physical or psychological dependence relative to the substances in Schedule III. Examples: alprazolam; diazepam; and phenobarbital.

[8] *See* The SERC of Proposed Rules in Regulation of Pain Management Clinics in Florida, BOM 64B8-9.0134, Maximum Number of Prescriptions in Registered PMC, January 18, 2011, page 10, paragraph (a)3 and The SERC of Proposed Rules in Regulation of Pain Management Clinics in Florida, BOOM 64B15-14.0054, Maximum Number of Prescriptions in Registered PMC, January 18, 2011, page 10, paragraph (a)3. A copy of each SERC is on file in the Senate Health Regulation Committee.

- A Schedule V substance has a low potential for abuse relative to the substances in Schedule IV, a currently accepted medical use in treatment in the United States, and abuse may lead to limited physical or psychological dependence relative to the substances in Schedule IV. Examples: low dosage levels of codeine; certain stimulants; and certain narcotic compounds.

A prescription for a controlled substance listed in Schedule II may be dispensed only upon a written prescription of a practitioner, except that in an emergency situation, as defined by department rule, it may be dispensed upon oral prescription but is limited to a 72-hour supply. A prescription for a controlled substance listed in Schedule II may not be refilled.[9] A pharmacist may not dispense more than a 30-day supply of a controlled substance listed in Schedule III upon an oral prescription issued in this state.[10]

III. Effect of Proposed Changes:

The bill provides for Legislative ratification of the Board of Medicine's Rule 64B8-9.0134, Maximum Number of Prescriptions in Registered Pain Management Clinics and the Board of Osteopathic Medicine's Rule 64B15-14.0054, Maximum Number of Prescriptions in Registered Pain Management Clinics.

The act shall take effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

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

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

[9] s. 893.04(1)(f), F.S.
[10] s. 893.04(2)(e), F.S.

B. Private Sector Impact:

The SERC estimates that an average annual cost per clinic to track the number of prescriptions dispensed is $1,000. This takes into account tracking "do not fill before dated" prescriptions which are counted toward the daily limit on the first date the prescription is eligible to be filled.

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.)

None.

B. Amendments:

None.

PAM BONDI
ATTORNEY GENERAL
STATE OF FLORIDA

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March 25, 2011

The Honorable Mike Haridopolos, Senate President
Florida Senate
409, The Capitol
404 South Monroe Street
Tallahassee, Florida 32399

Re: Rule 64B8-9.0134 (Board of Medicine)
Rule 64B15-14.0054 (Board of Osteopathic Medicine)

Honorable Senator Haridopolos:

On behalf of the Florida Boards of Medicine and Osteopathic Medicine (Boards), the above-referenced pain management clinic rules relating to the maximum number of controlled substance prescriptions that may be written at a pain management clinic during a 24-hour period have been submitted today for final adoption with the Department of State. These rules are presented to the Legislature for consideration and ratification during the 2011 legislative session, pursuant to section 120.541(3), Florida Statutes. Because the proposed rules relate to issues of great importance for the protection of the health, safety, and welfare of the citizens of the State of Florida, the Boards have requested that the proposed rules be ratified by both the House and the Senate and have asked that after ratification they be sent to Governor Scott for his signature. Copies of the Statements of Estimated Regulatory Costs (SERCs) and copies of the rule adoption packets are enclosed.

We appreciate your consideration to this matter of great public importance. Should you have any questions, please feel free to contact us at your convenience.

Sincerely,

Edward A. Tellechea
Counsel to the Florida Board of Medicine

Donna C. McNulty
Donna Canzano McNulty
Counsel to the
Florida Board of Osteopathic Medicine

Enclosures

cc: Michael Chizner, M.D., Chair, Florida Board of Medicine
Joel Rose, D.O., Chair, Florida Board of Osteopathic Medicine
Sue Foster, Acting Executive Director, Florida Board of Medicine
Anthony Jusevitch, Executive Director, Florida Board of Osteopathic Medicine
Marjorie Holladay, Senior Attorney, Joint Administrative Procedures Committee

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March 25, 2011

The Honorable Dean Cannon, Speaker of the House
Florida House of Representatives
420, The Capitol
402 South Monroe Street
Tallahassee, Florida 32399

Re: Rule 64B8-9.0134 (Board of Medicine)
Rule 64B15-14.0054 (Board of Osteopathic Medicine)

Honorable Speaker Cannon:

On behalf of the Florida Boards of Medicine and Osteopathic Medicine (Boards), the above-referenced pain management clinic rules relating to the maximum number of controlled substance prescriptions that may be written at a pain management clinic during a 24-hour period have been submitted today for final adoption with the Department of State. These rules are presented to the Legislature for consideration and ratification during the 2011 legislative session, pursuant to section 120.541(3), Florida Statutes. Because the proposed rules relate to issues of great importance for the protection of the health, safety, and welfare of the citizens of the State of Florida, the Boards have requested that the proposed rules be ratified by both the House and the Senate and have asked that after ratification they be sent to Governor Scott for his signature. Copies of the Statements of Estimated Regulatory Costs (SERCs) and copies of the rule adoption packets are enclosed.

We appreciate your consideration to this matter of great public importance. Should you have any questions, please feel free to contact us at your convenience.

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Florida Board of Osteopathic Medicine

Enclosures

cc: Michael Chizner, M.D., Chair, Florida Board of Medicine
Joel Rose, D.O., Chair, Florida Board of Osteopathic Medicine
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March 25, 2011

Governor's Office of Fiscal Accountability
And Regulatory Reform
400 S. Monroe Street
Tallahassee, Florida 32399-0001

Re: Rule 64B8-9.0134 (Board of Medicine)
Rule 64B15-14.0054 (Board of Osteopathic Medicine)

Dear Sir or Madam,

On behalf of the Florida Boards of Medicine and Osteopathic Medicine (Boards), the above-referenced pain management clinic rules relating to the maximum number of controlled substance prescriptions that may be written at a pain management clinic during a 24-hour period have been submitted today for final adoption with the Department of State. These rules are presented to the Legislature for consideration and ratification during the 2011 legislative session, pursuant to section 120.541(3), Florida Statutes. Because the proposed rules relate to issues of great importance for the protection of the health, safety, and welfare of the citizens of the State of Florida, the Boards have requested that the proposed rules be ratified by both the House and the Senate and have asked that after ratification they be sent to Governor Scott for his signature. Copies of the Statements of Estimated Regulatory Costs (SERCs) and copies of the rule adoption packets are enclosed.

We appreciate your consideration to this matter of great public importance. Should you have any questions, please feel free to contact us at your convenience.

Sincerely,

Edward A. Tellechea
Counsel to the Florida Board of Medicine

Donna Canzano McNulty
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Florida Board of Osteopathic Medicine

Enclosures

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Joel Rose, D.O., Chair, Florida Board of Osteopathic Medicine
Sue Foster, Acting Executive Director, Florida Board of Medicine
Anthony Jusevitch, Executive Director, Florida Board of Osteopathic Medicine
Marjorie Holladay, Senior Attorney, Joint Administrative Procedures Committee

Center for Economic Forecasting and Analysis
Florida State University
3200 Commonwealth Blvd. Suite 153
Tallahassee, Florida 32303-2770

A Statement of Estimated Regulatory Cost (SERC) of Proposed Rules in Regulation of Pain Management Clinics in Florida

BOM 64B8-9.0134

Maximum Number of Prescriptions in Registered PMC

Florida Department of Health

January 18, 2011

Center for Economic Forecasting and Analysis
Florida State University
3200 Commonwealth Blvd.
Tallahassee, Fl. 32303

Project Timeline

12/15/2010 to 1/18/2011

Institutional Capacity

The Center for Economic Forecasting and Analysis (CEFA) is part of the Florida State University Institute of Science and Public Affairs (ISPA), which is a multi-disciplinary research institute. CEFA specializes in applying advanced, computer-based economic models and techniques to examine and help resolve pressing public policy issues across a spectrum of research areas. CEFA provides advanced research and training to students in the areas of health care, education, high technology, energy, and environmental economics, economic impact analysis, among others.

Scope and Deliverable

CEFA has estimated the costs for both the agencies and the Pain Management Clinics (PMC) that are required to comply with the following rules:

- BOM Rule: 64B8-9.0131 Standards of Practice for Physicians Practicing in PMC
- BOM Rule: 64B8-9.0132 Requirement for PMC Registration; Inspection or Accreditation
- BOM: 64B8-9.0131(Subparagraph (2)(n): Training Requirements
- BOM/BOOM: 64B8-9.0134/64B15-14.0054 Maximum Number of Prescriptions in Registered PMC.
- BOM/BOOM: 64B8-9.0133/64B15-14.0053 Approval of Nationally Recognized Pain Management Accrediting Organizations
- DOH: 64B-7.001: Pain Management Clinic Registration Requirements
- DOH: 64B-7.003: Counterfeit-Resistant Prescription Blanks

CEFA has estimated for each of the rules:

1. The number of individuals that are likely to be required to comply with the rule and a general description of the types of individuals likely to be affected by the rule.
2. The cost to state and local government entities of implementing and enforcing the proposed rules and their anticipated effect on state and local revenues.
3. The transaction costs likely to be incurred by individuals and government agencies, required to comply with the rules

The Florida Pain Management Clinic Industry Overview

Sections 458.3265, and 459.0137, F.S., created the registration and inspection of pain management clinics with the Department of Health and required the Boards of Medicine and Osteopathic Medicine to promulgate rules for the standards of practice of physicians practicing in pain management clinics and rules to implement certain other pain management clinic provisions. The Allopathic Medical Practice Act, Chapter 458, F.S. (MD) and the Osteopathic Medical Practice Act, Chapter 459, F.S. (DO) are similar and the proposed pain management clinic rules of both of these physician boards are also similar. Pain management clinics may have MD or DO licensed Florida physicians or a combination of both practicing at the clinic at any one time. The Board of Osteopathic Medicine has in effect a standards of practice rule, a training rule and a registration/inspection or accreditation rule which are similar to the proposed Board of Medicine rules being addressed in this SERC.

Below is an overview of the Pain Management Clinics in Florida. The data is from a December 9, 2010 download of the "Application Status" file from the Florida Department of Health. No changes since 12/09/2010 have been considered – therefore if an additional clinic was approved, or a clinic lost its "clear" status after December 9, 2010, they have not been accounted for in this study.
This data includes records for clinics adding locations, adding new physicians and some are in progress and haven't been approved as of December 9, 2010. Others are listed as withdrawn, "admin. revoked", closed, denied or under emergency suspension. The records that were not listed as "clear" were deleted. Then, all multiples for any clinic were deleted to give the final number of clinics with clear status as 932 on the December 9, 2010 date.

Clinic Locations: this table shows the number of registered Pain Management Clinics, ranked from largest to smallest, by county, for the top 10 counties as of 12/09/2010.

County	Clinics
BROWARD	117
HILLSBOROUGH	113
PALM BEACH	108
MIAMI-DADE	89
DUVAL	51
ORANGE	49
PINELLAS	47
PASCO	31
VOLUSIA	30
LEE	29

Density: To estimate the density of Pain Management Clinics by county, the number of clinics was divided by the population, 18 and over, in the county. This yields the following density figures, from highest to lowest for the top 10 counties.

County	Clinics/100k pop.
HILLSBOROUGH	12.52
PALM BEACH	10.68
FRANKLIN	10.63
BROWARD	8.61
PASCO	8.34
DUVAL	7.88
SARASOTA	7.74
VOLUSIA	7.50
NASSAU	7.31
HERNANDO	7.27
PUTNAM	7.15
MANATEE	7.14

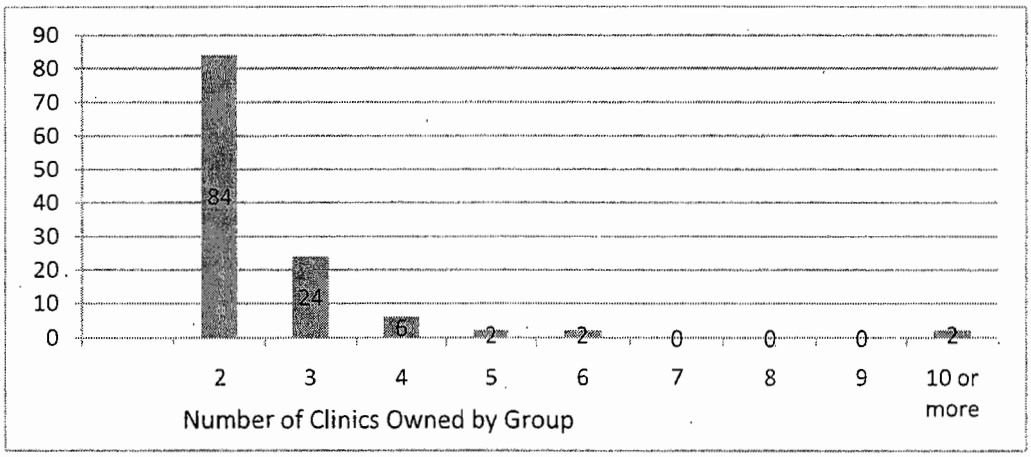
Appendix 1 shows the total for all counties that have at least 1 registered Pain Management Clinic.

Many of the clinics have physicians who are registered to dispense medication on the premises of the clinic. To do this, the physician must register with the Florida Department of Health and pay a $100 fee. The following table shows available data on the number of clinics whose Designated Physician is registered to dispense medication for the top 10 counties in Florida.

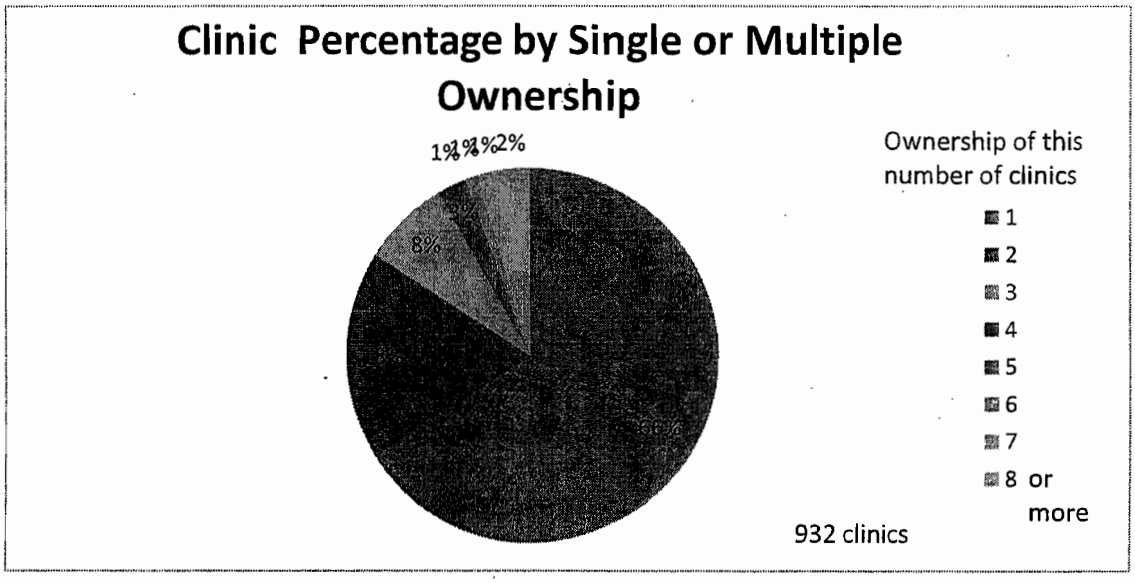
County	Clinics	Dispensing
PALM BEACH	108	77
BROWARD	117	73
MIAMI-DADE	89	50
HILLSBOROUGH	113	45
PINELLAS	47	32
DUVAL	51	31
ORANGE	49	29
PASCO	31	18
SARASOTA	24	18
LEE	29	16

Appendix 1 shows the total for the whole state.

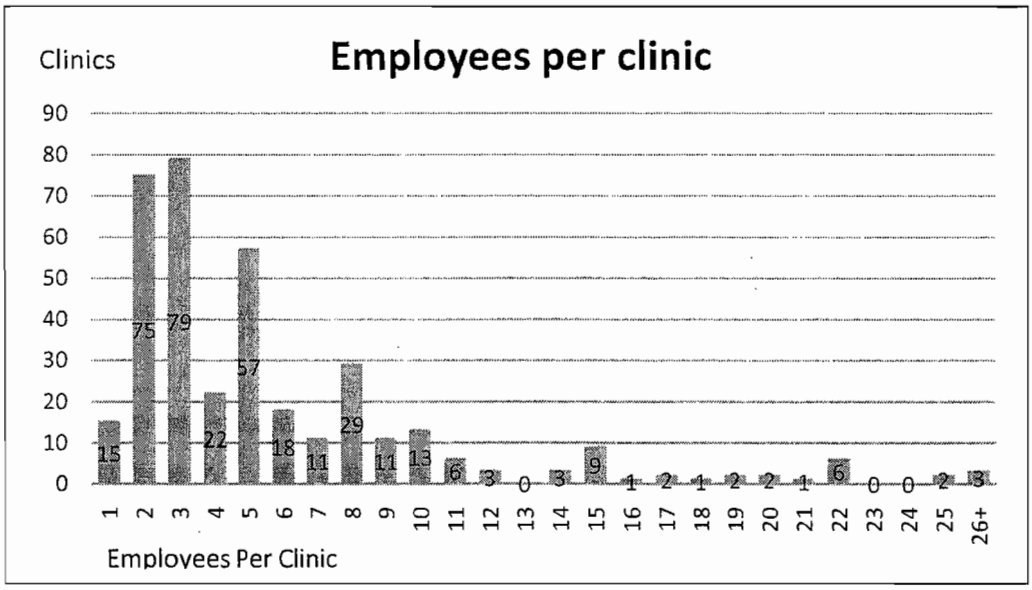
To check for concentration of ownership, the data was analyzed to see how many groups own more than one Pain Management Clinic in Florida. The number of clinics that are owned as an individual clinic is 615 clinics (66%). Of the remaining 317 clinics, the below graph shows that there are 84 groups that own 2 clinics, 24 that own 3 clinics, 6 that own 4 clinics, 2 that own 5 clinics, 2 that own 6 clinics and then one group that owns 10 clinics and one that appears to own 21 clinics. Checking the concentration, the clinics owned by groups that own four or less Pain Management Clinics compose 94.31% of the clinics. These were found by analyzing the data for common listed owners and common mailing addresses and are shown in the graph below.



The graph below shows the same information, by percentage of the total clinics.



To check for concentration in any given county or group of counties, the ownership groups were analyzed to see which counties they operated in. Appendix 2 shows the list of those groups owning three or more pain clinics and the counties that they operate in.
Data from the same database as above, as well as additional data from Dun & Bradstreet's Selectory database was obtained and analyzed. Cross-referencing the DOH data and the current Selectory database, 371 of the 932 clinics were found on the database. Information on the number of employees was recorded and analyzed. The median number of employees was 4 for this sample. The employee number was derived using Selectory data for total sales and sales per employee.



A majority, 248 of the 371 (66.8%) of the clinics found in the Selectory database have 5 employees or less. Those that have 3 or less employees (169 of 371) account for 45.5% of these clinics.

Estimating the Number of Physicians

Establishing an upper and lower bound: Physicians are allowed work at more than one clinic at a time, including working part-time at a Pain Management Clinic and having a separate practice. There is no requirement for all physicians working at a PMC to register with DOH. However, each clinic must register a Designated Physician that is responsible for the clinic.
To establish an upper and lower bound for the "actual number of physicians working" to estimate things like the number of patients seen and the number of prescriptions written, the lower bound will be 932 for physicians, one for each Pain Management Clinic.
Since data is not available, other methods are used to estimate physicians working in Pain Management Clinics. Data was obtained from an advertising website and analyzed. The number of clinics found on one marketing website was 366, showing 574 physicians. That website is Ucomparehealthcare.com.
Their data was analyzed and it showed the doctors per clinic in the below percentages:

Clinics with	Percentage
1 physician	74.90%
2 physicians	13.10%
3 physicians	7.10%
4 physicians	1.40%
5 physicians	1.40%
6 or more	0.02%

Although we cannot identify how similar this sample is to the rest of the population, the analysis of the above data yields 1.57 physicians per clinic. That would lead us to an estimate of 1462 physicians as an upper bound. This data is possibly skewed upward for a couple of reasons. First, it might be more likely that the larger businesses would seek opportunities to advertise. Most importantly, one of the groups in this sample shows 20 physicians working at their clinic. The clinic is, indeed registered as a Pain Management Clinic in Florida, yet having 20 physicians shown working at one clinic likely skews this sample upward.

Using this sample, there are 566 physicians that are known, although one cannot be sure what percentage of time each physician is working at that clinic. If one uses the minimum (one physician at the clinic) for the unknown clinics in addition to this number, one obtains a lower-bound estimate of 1140.

To estimate the actual number of physicians working at pain management clinics in Florida, a normal distribution was set up, with a 90% confidence interval between the lower and upper bounds. This resulted in a distribution with a mean of 1314 physicians and a standard deviation of 106.4.

The estimate that will be used for the number of physicians working full-time at registered Pain Management Clinics in Florida is a normal probability distribution function with a mean of 1314 and a standard deviation of 106.4. This yields an expectation of a 90% probability of the actual physician number being between 1140 and 1462.

Small business and number of PMCs affected: Most of the 932 registered PMCs in Florida will qualify as a small businesses under Florida 288.703.

Methods Used in this Study

Data was requested, purchased and gathered from various sources and then confirmed with physicians and industry professionals. Data that had a significant amount of uncertainty was estimated at upper and lower bounds, and then by statistical means. This study estimates some items and costs by the Monte Carlo method, where probability distributions are developed to use in the analysis. During each of the iterations of the model, values are drawn from the input probability distribution and used in calculating the range of the outputs.

Full-time is defined as 250 work days per year. When used, calculations use 40 hour work weeks and 50-week years.

Summary of Proposed Rule 64B8-9.0134/64B15-14.0054. Maximum Number of Prescriptions in Registered PMC.

This rule outlines the maximum number of prescriptions per physician at a Pain Management Clinic for Schedule II and Schedule III controlled substances and Alprazolam which may be written during a 24-hour period.

A copy of the complete proposed rule is shown below.

Total Estimated Statewide Cost: Estimated Statewide cost of $932,000 per year. On a per clinic basis, estimated $1,000 per clinic per year.

The proposed Rule 64B8-9.0134 is:
The maximum number of prescriptions for Schedule II or Schedule III controlled substances or the controlled substance Alprazolam, which may be written at any one registered pain management clinic during any 24-hour period shall be no more than an average of three prescriptions per patient per physician working at the pain management clinic up to a maximum of 150 prescriptions per physician. In the event that the physician is working less than 8 hours per day in the pain management clinic, the maximum number of prescriptions per physician shall be based upon the following formula: the number of hours worked divided by 8, then multiplied by 150 [(# of hours/8) X 150 = maximum # of prescriptions]. A "do not fill before dated" prescription will not be counted toward the daily limit until the first date the prescription is eligible to be filled.

To analyze the economic impact of this rule, one would need the actual number of prescriptions written by each physician working in a Pain Management Clinic (PMC) and the number of hours they worked. Neither piece of actual data is available.

To derive whether limiting a physician to prescribing 150 prescriptions per day is likely to be a limiting factor, and what the expected costs would be, one can start with an assumed number of patients per day. The average number of patients per week for all Florida physicians is 74[1]. One should note that number includes those physicians working less than fulltime. That number includes physicians that see from 0-25 patients per week up through those that see more than 200 per week.

Given that any physician practicing in a PMC, under statute, is required to do the physical examination of the patient on the same day he or she dispenses or prescribes a controlled substance, it is unlikely that physicians in Pain Management Clinics can comfortably see more than 30-35 patients per day. Given the maximum "no more than an average of three

[1] http://www.doh.state.fl.us/Workforce/Physicians_Workforce_Annual_Rpt_2009.pdf

prescriptions per patient", it is unlikely that most physicians will be affected by the 150 daily maximum.

Looking at "no more than an average of three prescriptions per patient" perhaps yields a different result. Physicians and clinic owners indicate that in some cases, a patient is prescribed a short-acting pain killer, a long-acting pain killer and a muscle relaxer.
Physicians are also allowed to write "do not fill before dated" prescriptions and the rule indicates that those prescriptions will count on the first day the prescriptions are eligible to be filled. Therefore, a physician who writes "do not fill before dated" prescriptions will have to be noted and accounted for on the date they are available to be filled.

It would appear that a PMC physician who is near the limits of an average of 3 controlled substance prescriptions per patient will have to track his or her numbers more closely than physicians at an average PMC. It would be the physicians with high patient count, the ones who use mostly pills and not interventional therapies, and ones that often write "do not fill before" prescriptions that would be in this category.

One possible result of this rule is that physicians will reduce the number of "do not fill before dated" prescriptions. This may occur because the physician or the clinic would not want to undertake tracking the hours each physician worked in the clinic, the number of patients seen, the number of prescriptions and the number of "do not fill before dated" prescriptions. This could also have the effect of requiring patients to visit the clinics more often and pay more in physician visit fees. This possible cost is not included in the study because the numbers vary widely depending on the type of practice, and are likely to affect only a small and unknown number of clinics.

To estimate the costs to an average clinic for this rule, the assumption will be that all clinics spend one additional hour of administrative time per week tracking the number of controlled substance prescriptions, including accounting for any "do not fill before" prescriptions. There are, no doubt, some clinics that will spend less time or more time than that. Some clinics will be nowhere near the limit and will spend little time tracking this and others will be near the limit and be required to spend more time. The following estimate uses one hour per week in additional time for the average clinic, at the previously noted $20 per hour, including benefits.

The calculation of $20 per clinic per week (for a 50-week year), for the 932 Pain Management Clinics in Florida equals: $932,000 per year. On a per-clinic basis, this is $1,000 per clinic per year.

Statement of Estimated Regulatory Costs:

a) **The above economic analysis shows that the proposed rule, directly or indirectly:**

1. Is not likely to have an adverse impact on economic growth, private-sector job creation of employment, or private-sector investment in excess of $1 million in the aggregate within 5 years after the implementation of the rule.
2. Is not likely to have an adverse impact on business competitiveness, including the ability of persons doing business in the state to compete with persons doing business in other states or domestic markets, productivity, or innovation in excess of $1 million in the aggregate within 5 years after the implementation of the rule.
3. Is likely to increase regulatory costs, including any transactional costs, in excess of $1 million in the aggregate within 5 years after the implementation of the rule.

b) **A good faith estimate of the number of individuals and entities likely to be required to comply with the rule, together with a general description of the types of individuals likely to be affected by the rule.**

This proposed rule would affect the estimated 1314 physicians and clinic owners of the estimated 932 Pain Management Clinics.

c) **A good faith estimate of the cost to the agency, and to any other state and local government entities, of implementing and enforcing the proposed rule, and any anticipated effect on state or local revenues.**

The Board has advised that the Department of Health, Division of Medical Quality Assurance, prepared a good faith estimate in its original SERC dated October 27, 2010 as follows:

> There will be no fiscal impact on this agency or other governmental entities.
> Enforcement costs are reimbursed by the Respondent when disciplined.

d) **A good faith estimate of the transactional costs likely to be incurred by individuals and entities, including government entities, required to comply with this rule.**

An estimated $1,000 per Pain Management Clinic per year, for a statewide total of $932,000 per year.

e) **An analysis of the impact on small businesses as defined by s. 288.703, and an analysis of the impact on small counties and small cities as defined in by s. 120.52. The impact analysis for small businesses must include the basis for the agency's decision not to implement alternatives that would reduce adverse impacts on small businesses.**

Most of the estimated 932 Pain Management Clinics are small businesses.
There are no expected costs to small counties or small cities.
In response to this inquiry, the Board has advised that during the course of all of its rule meetings and rule hearings it considered alternatives and suggested rule language by interested persons in arriving at the proposed rule language.

Appendix 1 – Clinic totals, density and dispensing, by county

County	Total Clinics	Clinics/100k population*	Dispensing**	% Dispensing***
ALACHUA	5	2.51	3	60.0%
BAY	4	3.14	2	50.0%
BREVARD	16	3.73	8	50.0%
BROWARD	117	8.61	73	62.4%
CHARLOTTE	7	5.23	4	57.1%
CITRUS	8	6.80	4	50.0%
CLAY	9	6.56	4	44.4%
COLLIER	15	5.91	9	60.0%
COLUMBIA	3	5.60	3	100.0%
DUVAL	51	7.88	31	60.8%
ESCAMBIA	10	4.22	2	20.0%
FLAGLER	3	4.07	2	66.7%
FRANKLIN	1	10.63	0	0.0%
HERNANDO	10	7.27	4	40.0%
HIGHLANDS	2	2.49	1	50.0%
HILLSBOROUGH	113	12.52	45	39.8%
INDIAN RIVER	5	4.58	3	60.0%
JACKSON	1	2.46	1	100.0%
LAKE	11	4.37	9	81.8%
LEE	29	6.21	16	55.2%
LEON	5	2.34	1	20.0%
LEVY	1	3.26	1	100.0%
MANATEE	18	7.14	12	66.7%
MARION	12	4.57	7	58.3%
MARTIN	6	5.27	5	83.3%
MIAMI-DADE	89	4.62	50	56.2%
MONROE	1	1.62	0	0.0%
NASSAU	4	7.31	3	75.0%
OKALOOSA	4	2.92	2	50.0%
OKEECHOBEE	2	6.64	1	50.0%
ORANGE	49	5.98	29	59.2%
OSCEOLA	13	6.60	5	38.5%
PALM BEACH	108	10.68	77	71.3%
PASCO	31	8.34	18	58.1%
PINELLAS	47	6.33	32	68.1%
POLK	13	2.94	5	38.5%
PUTNAM	4	7.15	2	50.0%
SANTA ROSA	8	6.90	4	50.0%
SARASOTA	24	7.74	18	75.0%
SEMINOLE	17	5.36	10	58.8%
ST. JOHNS	9	6.17	3	33.3%
ST. LUCIE	12	5.82	8	66.7%
SUMTER	3	4.48	2	66.7%
VOLUSIA	30	7.50	11	36.7%
WALTON	1	2.28	1	100.0%
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* Population over 18, U.S. Census Bureau estimate for 2008

** Dispensing means registered physician that is qualified to dispense

*** Percentage of clinics that have registered physician who is qualified to dispense

Appendix 2 – Groups owning 3 or more PMC, by common owners, partners, and/or billing addresses.

Clinic Name	# of Clinics	Counties of Clinics
Total Medical Express	3	Palm Beach
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Neurological Testing Centers of America	5	Broward(2), Miami-Dade(2)
Frank R. Collier, Jr. M.D., P.A.	3	Duval(2), Clay
Edwin Colon, M.D., P.A.	3	Pasco
Robert B. Dehgan, M.D., P.A.	3	Putnam, St. Johns, Duval
Southeastern Integrated Medical	5	Levy, Marion, Lake, Alachua, Columbia
Various Names (Dubravetz, owner)	4	Orange, Broward(2), St. Lucie
International Rehab/Comprehensive Pain Medicine/ Anesthesiology Assoc.	21	Miami-Dade(4), Broward(8), Palm Beach(3) Leon, Okaloosa, Escambia, Santa Rosa(2), Martin
Lescobar, P.A.	3	Broward(2), Miami-Dade
Physician Providers Group	3	Marion, Lake, Citrus
Premier Pain Care	3	Broward, Miami-Dade(2)
Institute of Pain Management	3	Duval(2), Clay
Spine Diagnostics Interventional Center	3	Collier(2), Hillsborough
Pain Care Management of....(Clearwater, Melbourne, Orlando)	3	Pinellas, Brevard, Orange
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Florida State University
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Tallahassee, Florida 32303-2770

A Statement of Estimated Regulatory Cost (SERC) of Proposed Rules in Regulation of Pain Management Clinics in Florida

BOOM 64B15-14.0054

Maximum Number of Prescriptions in Registered PMC

Florida Department of Health

January 18, 2011

Center for Economic Forecasting and Analysis
Florida State University
3200 Commonwealth Blvd.
Tallahassee, Fl. 32303

Project Timeline

12/15/2010 to 1/18/2011

Institutional Capacity

The Center for Economic Forecasting and Analysis (CEFA) is part of the Florida State University Institute of Science and Public Affairs (ISPA), which is a multi-disciplinary research institute. CEFA specializes in applying advanced, computer-based economic models and techniques to examine and help resolve pressing public policy issues across a spectrum of research areas. CEFA provides advanced research and training to students in the areas of health care, education, high technology, energy, and environmental economics, economic impact analysis, among others.

Scope and Deliverable

CEFA has estimated the costs for both the agencies and the Pain Management Clinics (PMC) that are required to comply with the following rules:

- BOM Rule: 64B8-9.0131 Standards of Practice for Physicians Practicing in PMC
- BOM Rule: 64B8-9.0132 Requirement for PMC Registration; Inspection or Accreditation
- BOM: 64B8-9.0131(Subparagraph (2)(n): Training Requirements
- BOM/BOOM: 64B8-9.0134/64B15-14.0054 Maximum Number of Prescriptions in Registered PMC.
- BOM/BOOM: 64B8-9.0133/64B15-14.0053 Approval of Nationally Recognized Pain Management Accrediting Organizations
- DOH: 64B-7.001: Pain Management Clinic Registration Requirements
- DOH: 64B-7.003: Counterfeit-Resistant Prescription Blanks

CEFA has estimated for each of the rules:

1. The number of individuals that are likely to be required to comply with the rule and a general description of the types of individuals likely to be affected by the rule.
2. The cost to state and local government entities of implementing and enforcing the proposed rules and their anticipated effect on state and local revenues.
3. The transaction costs likely to be incurred by individuals and government agencies, required to comply with the rules

The Florida Pain Management Clinic Industry Overview

Sections 458.3265, and 459.0137, F.S., created the registration and inspection of pain management clinics with the Department of Health and required the Boards of Medicine and Osteopathic Medicine to promulgate rules for the standards of practice of physicians practicing in pain management clinics and rules to implement certain other pain management clinic provisions. The Allopathic Medical Practice Act, Chapter 458, F.S. (MD) and the Osteopathic Medical Practice Act, Chapter 459, F.S. (DO) are similar and the proposed pain management clinic rules of both of these physician boards are also similar. Pain management clinics may have MD or DO licensed Florida physicians or a combination of both practicing at the clinic at any one time. The Board of Osteopathic Medicine has in effect a standards of practice rule, a training rule and a registration/inspection or accreditation rule which are similar to the proposed Board of Medicine rules being addressed in this SERC.

Below is an overview of the Pain Management Clinics in Florida. The data is from a December 9, 2010 download of the "Application Status" file from the Florida Department of Health. No changes since 12/09/2010 have been considered – therefore if an additional clinic was approved, or a clinic lost its "clear" status after December 9, 2010, they have not been accounted for in this study.
This data includes records for clinics adding locations, adding new physicians and some are in progress and haven't been approved as of December 9, 2010. Others are listed as withdrawn, "admin. revoked", closed, denied or under emergency suspension. The records that were not listed as "clear" were deleted. Then, all multiples for any clinic were deleted to give the final number of clinics with clear status as 932 on the December 9, 2010 date.

Clinic Locations: this table shows the number of registered Pain Management Clinics, ranked from largest to smallest, by county, for the top 10 counties as of 12/09/2010.

County	Clinics
BROWARD	117
HILLSBOROUGH	113
PALM BEACH	108
MIAMI-DADE	89
DUVAL	51
ORANGE	49
PINELLAS	47
PASCO	31
VOLUSIA	30
LEE	29

Density: To estimate the density of Pain Management Clinics by county, the number of clinics was divided by the population, 18 and over, in the county. This yields the following density figures, from highest to lowest for the top 10 counties.

County	Clinics/100k pop.
HILLSBOROUGH	12.52
PALM BEACH	10.68
FRANKLIN	10.63
BROWARD	8.61
PASCO	8.34
DUVAL	7.88
SARASOTA	7.74
VOLUSIA	7.50
NASSAU	7.31
HERNANDO	7.27
PUTNAM	7.15
MANATEE	7.14

Appendix 1 shows the total for all counties that have at least 1 registered Pain Management Clinic.

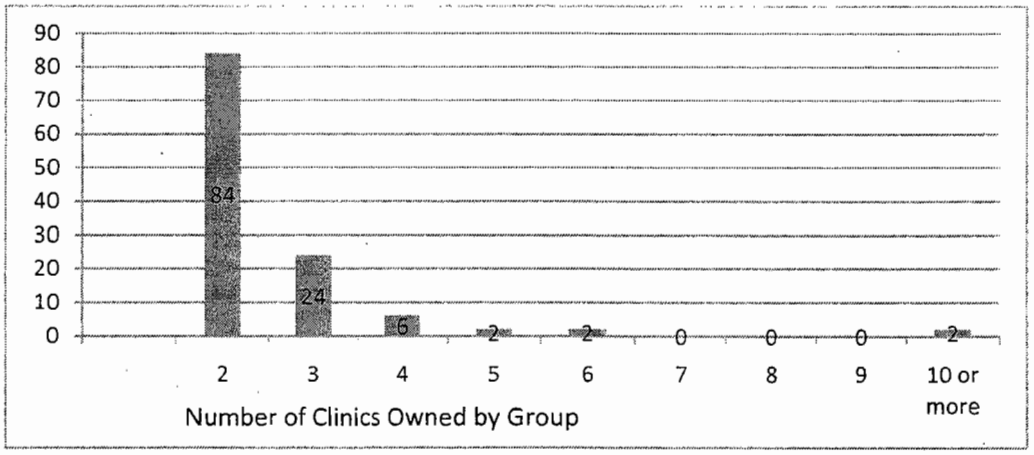
Many of the clinics have physicians who are registered to dispense medication on the premises of the clinic. To do this, the physician must register with the Florida Department of Health and pay a $100 fee. The following table shows the number of clinics whose Designated Physician is registered to dispense medication for the top 10 counties in Florida.

County	Clinics	Dispensing
PALM BEACH	108	77
BROWARD	117	73
MIAMI-DADE	89	50
HILLSBOROUGH	113	45
PINELLAS	47	32
DUVAL	51	31
ORANGE	49	29
PASCO	31	18
SARASOTA	24	18
LEE	29	16

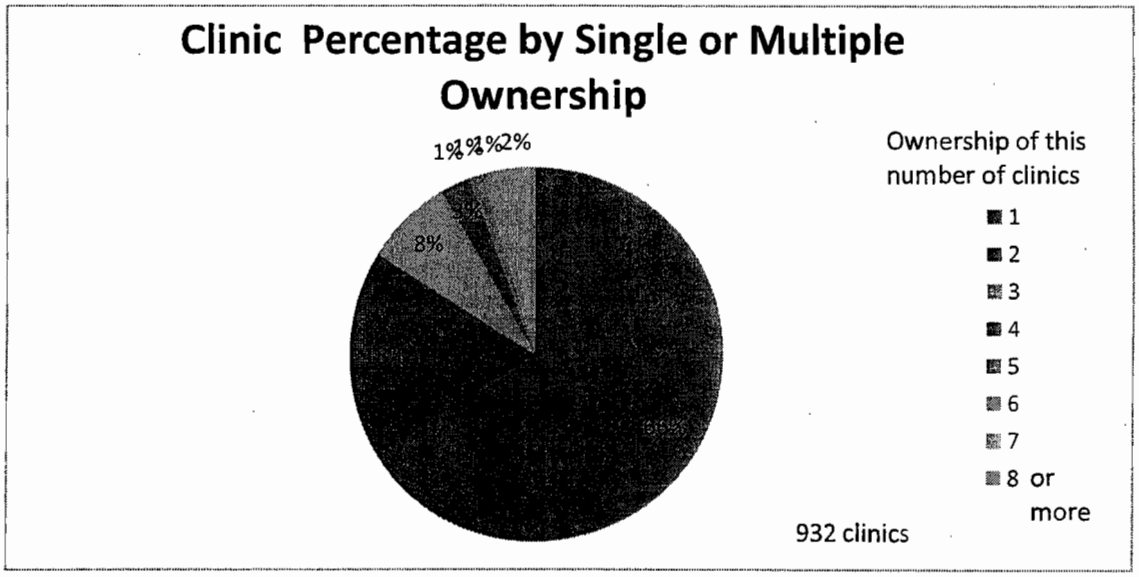
Appendix 1 shows the total for the whole state.

To check for concentration of ownership, the data was analyzed to see how many groups own more than one Pain Management Clinic in Florida. The number of clinics that are owned as an individual clinic is 615 clinics (66%). Of the remaining 317 clinics, the below graph shows that there are 84 groups that own 2 clinics, 24 that own 3 clinics, 6 that own 4 clinics, 2 that own 5 clinics, 2 that own 6 clinics and then one group that owns 10 clinics and one that appears to own 21 clinics. Checking the concentration, the clinics owned by groups that four or less Pain

Management Clinics compose 94.31% of the clinics. These were found by analyzing the data for common listed owners and common mailing addresses and are shown in the graph below.

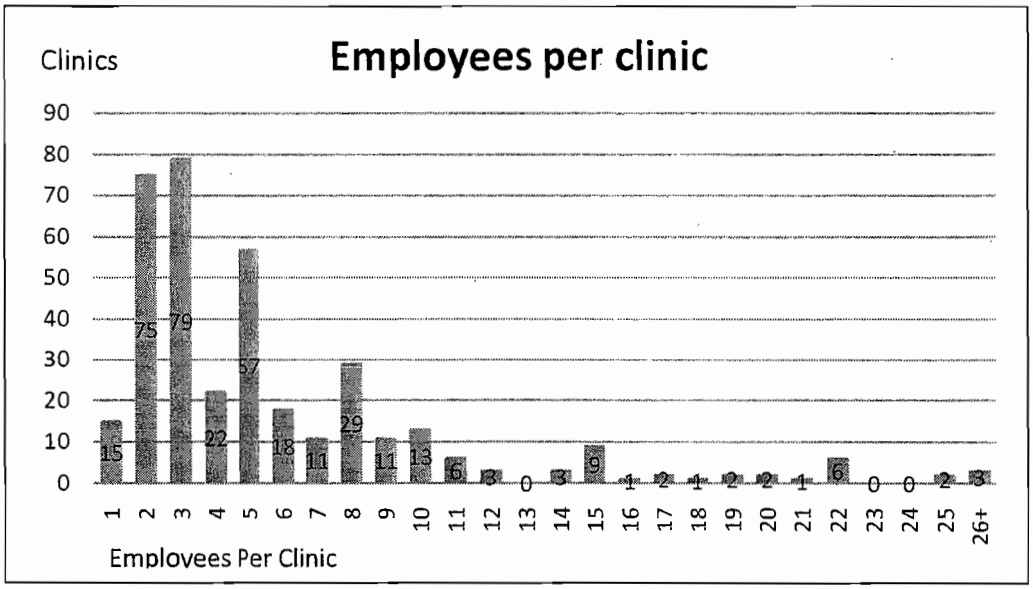


The graph below shows the same information, by percentage of the total clinics



To check for concentration in any given county or group of counties, the ownership groups were analyzed to see which counties they operated in. Appendix 2 shows the list of those groups owning three or more pain clinics and the counties that they operate in.
Data from the same database as above, as well as additional data from Dun & Bradstreet's Selectory database was obtained and analyzed. Cross-referencing the DOH data and the current Selectory database, 371 of the 932 clinics were found on the database. Information on the number of employees was recorded and analyzed. The median number of employees was 4 for

this sample. The employee number was derived using Selectory data for total sales and sales per employee.



A majority, 248 of the 371 (66.8%) of the clinics found in the Selectory database have 5 employees or less. Those that have 3 or less employees (169 of 371) account for 45.5% of these clinics.

Estimating the Number of Physicians

Establishing an upper and lower bound: Physicians are allowed work at more than one clinic at a time, including working part-time at a Pain Management Clinic and having a separate practice. There is no requirement for all physicians to register with DOH. However, each clinic must register a Designated Physician that is responsible for the clinic.

To establish an upper and lower bound for the "actual number of physicians working" to estimate things like the number of patients seen and the number of prescriptions written, the lower bound will be 932 for physicians, one for each Pain Management Clinic.

Since data is not available, other methods are used to estimate physicians working in Pain Management Clinics. Data was obtained from an advertising website and analyzed. The number of clinics found on one marketing website was 366, showing 574 physicians. That website is Ucomparehealthcare.com.

Their data was analyzed and it showed the doctors per clinic in the below percentages:

Clinics with	Percentage
1 physician	74.90%
2 physicians	13.10%
3 physicians	7.10%
4 physicians	1.40%
5 physicians	1.40%
6 or more	0.02%

Although we cannot identify how similar this sample is to the rest of the population, the analysis of the above data yields 1.57 physicians per clinic. That would lead us to an estimate of 1462 physicians as an upper bound. This data is possibly skewed upward for a couple of reasons. First, it might be more likely that the larger businesses would seek opportunities to advertise. Most importantly, one of the groups in this sample shows 20 physicians working at their clinic. The clinic is, indeed registered as a Pain Management Clinic in Florida, yet having 20 physicians shown working at one clinic likely skews this sample upward.

Using this sample, there are 566 physicians that are known, although one cannot be sure what percentage of time each physician is working at that clinic. If one uses the minimum (one physician at the clinic) for the unknown clinics in addition to this number, one obtains a lower-bound estimate of 1140.

To estimate the actual number of physicians working at Pain Management Clinics in Florida, a normal distribution was set up, with a 90% confidence interval between the lower and upper bounds. This resulted in a distribution with a mean of 1314 physicians and a standard deviation of 106.4.

The estimate that will be used for the number of physicians working full-time at registered Pain Management Clinics in Florida is a normal probability distribution function with a mean of 1314 and a standard deviation of 106.4. This yields an expectation of a 90% probability of the actual physician number being between 1140 and 1462.

Small business and number of PMCs affected: Most of the 932 registered PMCs in Florida will qualify as a small businesses under Florida 288.703.

Methods Used in this Study

Data was requested, purchased and gathered from various sources and then confirmed with physicians and industry professionals. Data that had a significant amount of uncertainty was estimated at upper and lower bounds, and then by statistical means. This study estimates some items and costs by the Monte Carlo method, where probability distributions are developed to use in the analysis. During each of the iterations of the model, values are drawn from the input probability distribution and used in calculating the range of the outputs.

Full-time is defined as 250 work days per year. When used, calculations use 40 hour work weeks and 50-week years.

Summary of Proposed Rule 64B8-9.0134/64B15-14.0054. Maximum Number of Prescriptions in Registered PMC.

This rule outlines the maximum number of prescriptions per physician at a Pain Management Clinic for Schedule II and Schedule III controlled substances and Alprazolam which may be written during a 24-hour period.

A copy of the complete proposed rule is shown below.

Total Estimated Statewide Costs: Estimated Statewide cost of $932,000 per year. On a per clinic basis, estimated $1,000 per clinic per year.

Proposed Rule 64B15-14.0054 states:
The maximum number of prescriptions for Schedule II or Schedule III controlled substances or the controlled substance Alprazolam, which may be written at any one registered pain management clinic during any 24-hour period shall be no more than an average of three prescriptions per patient per physician working at the pain management clinic up to a maximum of 150 prescriptions per physician. In the event that the physician is working less than 8 hours per day in the pain management clinic, the maximum number of prescriptions per physician shall be based upon the following formula: the number of hours worked divided by 8, then multiplied by 150 [(# of hours/8) X 150 = maximum # of prescriptions]. A "do not fill before dated" prescription will not be counted toward the daily limit until the first date the prescription is eligible to be filled.

To analyze the statewide cost of this rule, one would need the actual number of prescriptions written by each physician working in a Pain Management Clinic (PMC) and the number of hours they worked. Neither piece of actual data is available.

To derive whether limiting a physician to prescribing 150 prescriptions per day is likely to be a limiting factor, and what the expected costs would be, one can start with an assumed number of patients per day. The average number of patients per week for all Florida physicians is 74[1]. One should note that number includes those physicians working less than fulltime. That number includes physicians that see from 0-25 patients per week up through those that see more than 200 per week.

Given that any physician practicing in a PMC, under statute, is required to do the physical examination of the patient on the same day he or she dispenses or prescribes a controlled substance, it is unlikely that physicians in Pain Management Clinics can comfortably see more than 30-35 patients per day. Given the maximum "no more than an average of three

[1] http://www.doh.state.fl.us/Workforce/Physicians_Workforce_Annual_Rpt_2009.pdf

prescriptions per patient", it is unlikely that most physicians will be affected by the 150 daily maximum.

Looking at "no more than an average of three prescriptions per patient" perhaps yields a different result. Physicians and clinic owners indicate that in some cases, a patient is prescribed a short-acting pain killer, a long-acting pain killer and a muscle relaxer.
Physicians are also allowed to write "do not fill before dated" prescriptions and the rule indicates that those prescriptions will count on the first day the prescriptions are eligible to be filled. Therefore, a physician who writes "do not fill before dated" prescriptions will have to be noted and accounted for on the date they are available to be filled.

It would appear that a PMC physician who is near the limits of an average of 3 controlled substance prescriptions per patient will have to track his or her numbers more closely than physicians at an average PMC. It would be the physicians with high patient count, the ones who use mostly pills and not interventional therapies, and ones that often write "do not fill before" prescriptions that would be in this category.

One possible result of this rule is that physicians will reduce the number of "do not fill before dated" prescriptions. This may occur because the physician or the clinic would not want to undertake tracking the hours each physician worked in the clinic, the number of patients seen, the number of prescriptions and the number of "do not fill before dated" prescriptions. This could also have the effect of requiring patients to visit the clinics more often and pay more in physician visit fees. This possible cost is not included in the study because the numbers vary widely depending on the type of practice, and are likely to affect only a small and unknown number of clinics.

To estimate the costs to an average clinic for this rule, the assumption will be that all clinics spend one additional hour of administrative time per week tracking the number of controlled substance prescriptions, including accounting for any "do not fill before" prescriptions. There are, no doubt, some clinics that will spend less time or more time than that. Some clinics will be nowhere near the limit and will spend little time tracking this and others will be near the limit and be required to spend more time. The following estimate uses one hour per week in additional time for the average clinic, at the previously noted $20 per hour, including benefits.

The calculation of $20 per clinic per week (for a 50-week year), for the 932 Pain Management Clinics in Florida equals: $932,000 per year. On a per-clinic basis, this is $1,000 per clinic per year.

Statement of Estimated Regulatory Costs:

a) The above economic analysis shows that the proposed rule, directly or indirectly:

1. Is not likely to have an adverse impact on economic growth, private-sector job creation of employment, or private-sector investment in excess of $1 million in the aggregate within 5 years after the implementation of the rule.
2. Is not likely to have an adverse impact on business competitiveness, including the ability of persons doing business in the state to compete with persons doing business in other states or domestic markets, productivity, or innovation in excess of $1 million in the aggregate within 5 years after the implementation of the rule.
3. Is likely to increase regulatory costs, including any transactional costs, in excess of $1 million in the aggregate within 5 years after the implementation of the rule.

b) A good faith estimate of the number of individuals and entities likely to be required to comply with the rule, together with a general description of the types of individuals likely to be affected by the rule.

An estimated 1314 physicians and clinic owners of the estimated 932 Pain Management Clinics would be required to comply with this rule.

c) A good faith estimate of the cost to the agency, and to any other state and local government entities, of implementing and enforcing the proposed rule, and any anticipated effect on state or local revenues.

The Department has advised that there will be no fiscal impact on this agency or other governmental entities. Enforcement costs are reimbursed by the Respondent when disciplined.

d) A good faith estimate of the transactional costs likely to be incurred by individuals and entities, including government entities, required to comply with this rule.

An estimated $1,000 per Pain Management Clinic per year, for a statewide total of $932,000 per year.

e) An analysis of the impact on small businesses as defined by s. 288.703, and an analysis of the impact on small counties and small cities as defined in by s. 120.52. The impact analysis for small businesses must include the basis for the agency's decision not to implement alternatives that would reduce adverse impacts on small businesses.

Most of the estimated 932 Pain Management Clinics are small businesses.
There are no expected costs to small counties or small cities.
In response to this inquiry, the Department has advised that during the course of all of the rule meetings and rule hearings the Board considered alternatives and suggested rule language by interested persons in arriving at the proposed rule language.

Appendix 1 – Clinic totals, density and dispensing, by county

County	Total Clinics	Clinics/100k population*	Dispensing**	% Dispensing***
ALACHUA	5	2.51	3	60.0%
BAY	4	3.14	2	50.0%
BREVARD	16	3.73	8	50.0%
BROWARD	117	8.61	73	62.4%
CHARLOTTE	7	5.23	4	57.1%
CITRUS	8	6.80	4	50.0%
CLAY	9	6.56	4	44.4%
COLLIER	15	5.91	9	60.0%
COLUMBIA	3	5.60	3	100.0%
DUVAL	51	7.88	31	60.8%
ESCAMBIA	10	4.22	2	20.0%
FLAGLER	3	4.07	2	66.7%
FRANKLIN	1	10.63	0	0.0%
HERNANDO	10	7.27	4	40.0%
HIGHLANDS	2	2.49	1	50.0%
HILLSBOROUGH	113	12.52	45	39.8%
INDIAN RIVER	5	4.58	3	60.0%
JACKSON	1	2.46	1	100.0%
LAKE	11	4.37	9	81.8%
LEE	29	6.21	16	55.2%
LEON	5	2.34	1	20.0%
LEVY	1	3.26	1	100.0%
MANATEE	18	7.14	12	66.7%
MARION	12	4.57	7	58.3%
MARTIN	6	5.27	5	83.3%
MIAMI-DADE	89	4.62	50	56.2%
MONROE	1	1.62	0	0.0%
NASSAU	4	7.31	3	75.0%
OKALOOSA	4	2.92	2	50.0%
OKEECHOBEE	2	6.64	1	50.0%
ORANGE	49	5.98	29	59.2%
OSCEOLA	13	6.60	5	38.5%
PALM BEACH	108	10.68	77	71.3%
PASCO	31	8.34	18	58.1%
PINELLAS	47	6.33	32	68.1%
POLK	13	2.94	5	38.5%
PUTNAM	4	7.15	2	50.0%
SANTA ROSA	8	6.90	4	50.0%
SARASOTA	24	7.74	18	75.0%
SEMINOLE	17	5.36	10	58.8%
ST. JOHNS	9	6.17	3	33.3%
ST. LUCIE	12	5.82	8	66.7%
SUMTER	3	4.48	2	66.7%
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CERTIFICATE OF

BOARD OF OSTEOPATHIC MEDICINE ADMINISTRATIVE RULES

FILED WITH THE DEPARTMENT OF STATE

I hereby certify:

[xx] (1) That all statutory rulemaking requirements of Chapter 120, F.S., and all rulemaking requirements of the Department of State have been complied with; and

[xx] (2) That there is no administrative determination under subsection 120.56(2), F.S., pending on any rule covered by this certification; and

[xx] (3) All rules covered by this certification are filed within the prescribed time limitations of paragraph 120.54(3)(e), F.S. They are filed not less than 28 days after the notice required by paragraph 120.54(3)(a), F.S., and;

[xx] (a) Are filed not more than 90 days after the notice; or

[ ] (b) Are filed more than 90 days after the notice, but not more than 60 days after the administrative law judge files the final order with the clerk or until 60 days after subsequent judicial review is complete; or

[ ] (c) Are filed more than 90 days after the notice, but not less than 21 days nor more than 45 days from the date of publication of the notice of change; or

[ ] (d) Are filed more than 90 days after the notice, but not less than 14 nor more than 45 days after the adjournment of the final public hearing on the rule; or

[ ] (e) Are filed more than 90 days after the notice, but within 21 days after the date of receipt of all material authorized to be submitted at the hearing; or

[ ] (f) Are filed more than 90 days after the notice, but within 21 days after the date the transcript was received by this agency; or

[ ] (g) Are filed not more than 90 days after the notice, not including the days the adoption of the rule was postponed following notification from the Joint Administrative Procedures Committee that an objection to the rule was being considered; or

[ ] (h) Are filed more than 90 days after the notice, but within 21 days after a good faith written proposal for a lower cost regulatory alternative to a proposed rule is submitted which substantially accomplishes the objectives of the law being implemented; or

[ ] (i) Are filed more than 90 days after the notice, but within 21 days after a regulatory alternative is offered by the Small Business Regulatory Advisory Committee.

Attached are the original and two copies of each rule covered by this certification. The rules are hereby adopted by the undersigned agency by and upon their filing with the Department of State.

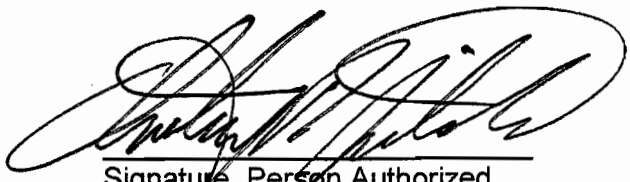
Rule No(s).

64B15-14.0054

Under the provision of subparagraph 120.54(3)(e)6., F.S., the rules take effect 20 days from the date filed with the Department of State or a later date as set out below:

Effective: _____

(Month) (Day) (Year)



Signature, Person Authorized
To Certify Rules

Executive Director
Title

1
Number of Pages Certified

DEPARTMENT OF HEALTH

BOARD OF OSTEOPATHIC MEDICINE

ADDITIONAL STATEMENT TO THE SECRETARY OF STATE

RULE TITLE: RULE NO.:

Maximum Number of Prescriptions

In Registered Pain Management Clinics 64B15-14.0054

SUMMARY: The proposed rule sets forth 150 as the maximum number of prescriptions which may be written by a physician for Schedule II or III controlled substances, or the controlled substance Alprazolam, at a pain management clinic during any 24-hour period. The rule additionally sets forth a formula for calculating the maximum number of prescriptions for those physicians who practice less than 8 hours a day in the pain management clinic.

SUMMARY OF THE HEARING ON THE RULE:

No timely request for a hearing was received and no hearing was held.

STATEMENT OF FACTS AND CIRCUMSTANCES JUSTIFYING RULE PROPOSAL:

The proposed rule is necessary to comply with the legislative mandate set forth in subsection 459.0137(4)(c), Florida Statutes, requiring the Board to set forth the maximum number of prescriptions for Schedule II or Schedule III controlled substances or the controlled substance Alprazolam which may be written at any one registered pain management clinic during any 24-hour period.

THE FULL TEXT OF THE PROPOSED RULE IS:

64B15-14.0054 Maximum Number of Prescriptions in Registered Pain Management Clinics. THE LIMIT ON THE MAXIMUM NUMBER OF PRESCRIPTIONS SET FORTH IN THIS RULE DOES NOT SUPERSEDE THE STANDARD OF CARE FOR THE USE OF CONTROLLED SUBSTANCES FOR THE TREATMENT OF PAIN.

The maximum number of prescriptions for Schedule II or Schedule III controlled substances or the controlled substance Alprazolam, which may be written at any one registered pain management clinic during any 24-hour period shall be no more than an average of three prescriptions per patient per physician working at the pain management clinic up to a maximum of 150 prescriptions per physician. In the event that the physician is working less than 8 hours per day in the pain management clinic, the maximum number of prescriptions per physician shall be based upon the following formula: the number of hours worked divided by 8, then multiplied by 150 [(# of hours/8) X 150 = maximum # of prescriptions]. A "do not fill before dated" prescription will not be counted toward the daily limit until the first date the prescription is eligible to be filled.

Rulemaking Authority: 459.0137(4)(c), F.S.

Law Implemented: 459.0137(4)(c), F.S.

History -- New _____.

CERTIFICATE OF

BOARD OF MEDICINE ADMINISTRATIVE RULES

FILED WITH THE DEPARTMENT OF STATE

I hereby certify:

[xx] (1) That all statutory rulemaking requirements of Chapter 120, F.S., and all rulemaking requirements of the Department of State have been complied with; and

[xx] (2) That there is no administrative determination under subsection 120.56(2), F.S., pending on any rule covered by this certification; and

[xx] (3) All rules covered by this certification are filed within the prescribed time limitations of paragraph 120.54(3)(e), F.S. They are filed not less than 28 days after the notice required by paragraph 120.54(3)(a), F.S., and;

[xx] (a) Are filed not more than 90 days after the notice; or

[ ] (b) Are filed more than 90 days after the notice, but not more than 60 days after the administrative law judge files the final order with the clerk or until 60 days after subsequent judicial review is complete; or

[ ] (c) Are filed more than 90 days after the notice, but not less than 21 days nor more than 45 days from the date of publication of the notice of change; or

[ ] (d) Are filed more than 90 days after the notice, but not less than 14 nor more than 45 days after the adjournment of the final public hearing on the rule; or

[ ] (e) Are filed more than 90 days after the notice, but within 21 days after the date of receipt of all material authorized to be submitted at the hearing; or

[ ] (f) Are filed more than 90 days after the notice, but within 21 days after the date the transcript was received by this agency; or

[ ] (g) Are filed not more than 90 days after the notice, not including the days the adoption of the rule was postponed following notification from the Joint Administrative Procedures Committee that an objection to the rule was being considered; or

[ ] (h) Are filed more than 90 days after the notice, but within 21 days after a good faith written proposal for a lower cost regulatory alternative to a proposed rule is submitted which substantially accomplishes the objectives of the law being implemented; or

[ ] (i) Are filed more than 90 days after the notice, but within 21 days after a regulatory alternative is offered by the Small Business Regulatory Advisory Committee.

Attached are the original and two copies of each rule covered by this certification. The rules are hereby adopted by the undersigned agency by and upon their filing with the Department of State.

Rule No(s).

64B8-9.0134

Under the provision of subparagraph 120.54(3)(e)6., F.S., the rules take effect 20 days from the date filed with the Department of State or a later date as set out below:

Effective: _____

(Month) (Day) (Year)

Signature, Person Authorized
To Certify Rules

Acting Executive Director
Title

1
Number of Pages Certified

DEPARTMENT OF HEALTH

BOARD OF MEDICINE

ADDITIONAL STATEMENT TO THE SECRETARY OF STATE

RULE TITLE:	RULE NO.:
Maximum Number of Prescriptions In Registered Pain Management Clinics	64B8-9.0134

SUMMARY: The proposed rule sets forth 150 as the maximum number of prescriptions which may be written by a physician for Schedule II or III controlled substances , or the controlled substance Alprazolam, at a pain management clinic during any 24-hour period. The rule additionally sets forth a formula for calculating the maximum number of prescriptions for those physicians who practice less than 8 hours a day in the pain management clinic.

SUMMARY OF THE HEARING ON THE RULE:

No timely request for a hearing was received and no hearing was held.

STATEMENT OF FACTS AND CIRCUMSTANCES JUSTIFYING RULE PROPOSAL:

The proposed rule is necessary to comply with the legislative mandate set forth in subsection 458.3265(4)(c), Florida Statutes, requiring the Board to set forth the maximum number of prescriptions for Schedule II or Schedule III controlled substances or the controlled substance Alprazolam which may be written at any one registered pain management clinic during any 24-hour period.

THE FULL TEXT OF THE PROPOSED RULE IS:

64B8-9.0134 Maximum Number of Prescriptions in Registered Pain Management Clinics. THE LIMIT ON THE MAXIMUM NUMBER OF PRESCRIPTIONS SET FORTH IN THIS RULE DOES NOT SUPERSEDE THE STANDARD OF CARE FOR THE USE OF CONTROLLED SUBSTANCES FOR THE TREATMENT OF PAIN. The maximum number of prescriptions for Schedule II or Schedule III controlled substances or the controlled substance Alprazolam, which may be written at any one registered pain management clinic during any 24-hour period shall be no more than an average of three prescriptions per patient per physician working at the pain management clinic up to a maximum of 150 prescriptions per physician. In the event that the physician is working less than 8 hours per day in the pain management clinic, the maximum number of prescriptions per physician shall be based upon the following formula: the number of hours worked divided by 8, then multiplied by 150 [(# of hours/8) X 150 = maximum # of prescriptions]. A "do not fill before dated" prescription will not be counted toward the daily limit until the first date the prescription is eligible to be filled.

Rulemaking Authority: 458.3265(4)(c), F.S.

Law Implemented: 458.3265(4)(c), F.S.

History -- New _____.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	CS/SB 1426
INTRODUCER:	Committee on Banking and Insurance; and Senator Hays
SUBJECT:	Repeal of Health Insurance Provisions
DATE:	March 30, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Burgess	Burgess	BI	**Fav/CS**
2.	Brown	Stovall	HR	**Pre-meeting**
3.			BC	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

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

I. Summary:

The bill deletes s. 627.64872(6), F.S., which currently requires the Board of Directors of the Florida Health Insurance Plan (FHIP) to submit to the Governor, the President of the Senate and the Speaker of the House of Representatives, an annual report which is to include an independent actuarial study.

The bill deletes s. 627.6699(15)(l), F.S., which currently requires the Office of Insurance Regulation (OIR) to submit to the Governor, the President of the Senate and the Speaker of the House of Representatives, an annual report which summarizes the activities of the Small Employer Access Program (SEAP), including written and earned premiums, program enrollment, administrative expenses, and paid and incurred losses.

The bill provides an effective date of July 1, 2011.

This bill substantially amends the following sections of the Florida Statutes: 627.64872, 627.6699.

II. Present Situation:

Florida Health Insurance Plan

In 1983, the Florida Legislature created the Florida Comprehensive Health Association (FCHA) as a high-risk insurance pool to cover individuals who were unable to purchase health insurance from the open market due to pre-existing conditions. The program is financed through premiums from the participants and assessments on insurance companies, but has been closed to new enrollment since 1991.[1]

In 2004, the Florida Legislature created the FHIP,[2] which was intended to replace the FCHA as the state's high-risk insurance pool.[3] The benefits provided by the FHIP are the same as the standard and basic plans for small employers.[4] The FHIP must also provide an option for the purchase of alternative coverage, such as catastrophic coverage which includes a minimum level of primary care coverage, and a high deductible plan that meets all the requirements for a health savings account. Eligibility for the plan is limited to individuals who have received two notices of rejection for coverage from health insurers and individuals covered under the FCHA at the time the FHIP was created.[5]

The FHIP was created to be run by a nine person Board of Directors, chaired by the Director of the OIR. Five Board members would be appointed by the Governor and one member each would be appointed by the President of the Senate, the Speaker of the House of Representatives, and the Chief Financial Officer.[6] The Board is required to submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives an annual report which is to include an independent actuarial study that must contain five elements specifically enumerated in s. 627.64872(6)(a)-(e), F.S.

According to the OIR, funds for the start-up of the FHIP have not been appropriated, and as a result, the FHIP is not in operation.[7] Therefore, the requirement that a report be provided that details, among other data, the number of people covered and projected to be covered, is moot.

Small Employers Access Program

In 1992, the Florida Legislature enacted the Employee Health Care Access Act (EHCAA).[8] The purpose of the act was to promote the availability of health insurance coverage to small

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[1] *See* Department of Financial Services website: myfloridacfo.com/consumers/InsuranceLibrary/Insurance/Residual_Markets/Residual_Markets – Florida_Comprehensive_Health_Association. htm; last visited March 12, 2011.
[2] Section 627.64872, F.S.
[3] *See* Department of Financial Services website:http://www.myfloridacfo.com/consumers/InsuranceLibrary/Insurance/Residual_Markets/Residual_Markets_-_The_Florida_Health_Insurance_Plan.htm; last visited March 12, 2011.
[4] *See* s. 627.6699(12), F.S.
[5] Section 627.64872(9), F.S.
[6] Section 627.64872(3), F.S.
[7] Florida Office of Insurance Regulation Bill Analysis for SB 1426 (March 9, 2011).
[8] Ch. 92-33, s. 117, L.O.F.

employers, regardless of claims experience or their employees' health status.[9] In 2004, the SEAP was created within the EHCAA.[10] The purpose of the SEAP was to provide additional health insurance options for small businesses consisting of up to 25 employees, including any municipality, county, school district, hospital located in a rural community, and any nursing home employer.[11] The OIR is required to submit an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives summarizing the activities of the program over the past year, including written and earned premiums, program enrollment, administrative expenses, and paid and incurred losses.[12]

According to OIR, the SEAP is not operational. The enacting legislation required a competitive bid for an insurer to administer the program. The OIR issued the required request for proposals in 2004, and no insurer submitted a bid. Therefore, the annual reporting requirement contained in the section is moot.[13]

III. Effect of Proposed Changes:

Section 1 repeals s. 627.64872(6), F.S., thereby eliminating the annual reporting requirement for the FHIP. The Board of Directors of the FHIP would no longer be required to submit an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Section 2 repeals s. 627.6699(15)(l), F.S., thereby eliminating the annual reporting requirement for the SEAP. The SEAP would no longer be required to submit an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Section 3 provides an effective date for the bill of July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

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

[9] Section 627.6699(2), F.S.
[10] Ch. 2004-297, s. 24, L.O.F.
[11] Section 627.6699(15)(b), F.S.
[12] Section 627.6699(15)(l), F.S.
[13] Florida Office of Insurance Regulation Bill Analysis for SB 1426 (March 9, 2011).

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 Senate Banking and Insurance Committee on 3/16/2011:
The original bill would have removed only one of the five specified elements that are required to be contained in the annual report submitted by the Board of Directors of the FHIP. The original bill would have continued to obligate the Board to submit the remaining four elements in an annual report. The CS removes altogether the requirement that the Board submit an annual report.

B. Amendments:

None.

830024

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
04/01/2011	.	
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	.	

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Subsection (5) of section 383.50, Florida Statutes, is amended to read:

383.50 Treatment of surrendered newborn infant.—

(5)(a) Except when there is actual or suspected child abuse or neglect, any parent who leaves a newborn infant with a firefighter, emergency medical technician, or paramedic at a fire station or emergency medical services station, or brings a newborn infant to an emergency room of a hospital and expresses

an intent to leave the newborn infant and not return, has the absolute right to remain anonymous and to leave at any time and may not be pursued or followed unless the parent seeks to reclaim the newborn infant.

(b) When an infant is born in a hospital and the mother expresses intent to leave the infant and not return:~~,~~

1. Upon the mother's request, the hospital or registrar shall complete the infant's birth certificate without naming the mother thereon.

2. If the mother considers applying for eligibility for the Medicaid program through the hospital as a qualified Medicaid provider, the hospital shall notify the mother that the act of applying for Medicaid will cause her personal information included on the Medicaid application to be submitted to the Department of Children and Family Services and that she will be contacted by the department or the Medicaid program, or both, about her Medicaid-eligibility status. The hospital shall confirm that the mother wishes to apply for Medicaid and understands this notification by obtaining her signature on a written acknowledgment.

3. If the mother has no creditable coverage as defined in s. 627.6561 and chooses not to apply for Medicaid under subparagraph 2. or is denied Medicaid eligibility, the hospital may seek compensation from Medicaid for care provided to the surrendered newborn infant and to the mother related to labor and delivery of the infant if the infant is determined by the Department of Children and Family Services to be eligible for Medicaid, as applicable. For care that is not reimbursable under Medicaid, the hospital may seek to classify the care as charity

care under s. 409.911(1)(c). The hospital may not seek payment for such care from the mother or from any individual who is financially responsible for the mother.

Section 2. Paragraph (c) of subsection (1) of section 409.911, Florida Statutes, is amended to read:

409.911 Disproportionate share program.—Subject to specific allocations established within the General Appropriations Act and any limitations established pursuant to chapter 216, the agency shall distribute, pursuant to this section, moneys to hospitals providing a disproportionate share of Medicaid or charity care services by making quarterly Medicaid payments as required. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(1) DEFINITIONS.—As used in this section, s. 409.9112, and the Florida Hospital Uniform Reporting System manual:

(c) "Charity care" or "uncompensated charity care" means that portion of hospital charges reported to the Agency for Health Care Administration for which there is no compensation, other than restricted or unrestricted revenues provided to a hospital by local governments or tax districts regardless of the method of payment, for:

1. Care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 200 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income; or

2. Care provided under conditions described in s.

830024

383.50(5)(b).

~~However, in no case shall the~~ Hospital charges for a patient whose family income exceeds four times the federal poverty level for a family of four may not be considered charity, except for care provided under conditions described in s. 383.50(5)(b).

Section 3. This act shall take effect July 1, 2011.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to surrendered newborn infants; amending s. 383.50, F.S.; providing for the mother of a newborn infant who surrenders her infant at a hospital to apply for Medicaid through the hospital as a qualified Medicaid provider; authorizing the hospital to seek compensation from Medicaid for care provided to the surrendered newborn infant and the mother if the mother has no creditable coverage; authorizing the hospital to classify the unreimbursed medical care as charity care; prohibiting the hospital from seeking payment for such care from the mother or an individual who is financially responsible for the mother; amending s. 409.911, F.S.; redefining the term "charity care" to include unreimbursed care provided to a surrendered newborn infant and the mother under

830024

certain circumstances; providing an effective date.

174036

LEGISLATIVE ACTION

Senate . House

. . . . .

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Subsection (5) of section 383.50, Florida Statutes, is amended to read:

383.50 Treatment of surrendered newborn infant.—

(5)(a) Except when there is actual or suspected child abuse or neglect, any parent who leaves a newborn infant with a firefighter, emergency medical technician, or paramedic at a fire station or emergency medical services station, or brings a

newborn infant to an emergency room of a hospital and expresses an intent to leave the newborn infant and not return, has the absolute right to remain anonymous and to leave at any time and may not be pursued or followed unless the parent seeks to reclaim the newborn infant.

(b) When an infant is born in a hospital and the mother expresses intent to leave the infant and not return:~~,~~

1. Upon the mother's request, the hospital or registrar shall complete the infant's birth certificate without naming the mother thereon.

2. If the mother considers applying for eligibility for the Medicaid program through the hospital as a qualified Medicaid provider, the hospital shall notify the mother that the act of applying for Medicaid will cause her personal information included on the Medicaid application to be submitted to the Department of Children and Family Services and that she will be contacted by the department or the Medicaid program, or both, about her Medicaid eligibility status. The hospital shall confirm that the mother wishes to apply for Medicaid and understands the notification by obtaining her signature on a written acknowledgment of having received notice, if she chooses to apply.

3. The hospital may seek reimbursement from Medicaid, as applicable, for care provided to a surrendered newborn infant and the mother of a surrendered newborn infant related to labor and delivery of the infant, if the infant is determined by the Department of Children and Family Services to be Medicaid eligible and if the hospital renders care not reimbursable by Medicaid under subparagraph 2. For such care not reimbursable

under Medicaid, the hospital may seek to classify the care as charity care under s. 409.911(1)(c). The hospital may not seek payment for such care from the mother of a surrendered newborn infant or from any individual financially responsible for the mother of a surrendered newborn infant.

Section 2. Paragraph (c) of subsection (1) of section 409.911, Florida Statutes, is amended to read:

409.911 Disproportionate share program.—Subject to specific allocations established within the General Appropriations Act and any limitations established pursuant to chapter 216, the agency shall distribute, pursuant to this section, moneys to hospitals providing a disproportionate share of Medicaid or charity care services by making quarterly Medicaid payments as required. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(1) DEFINITIONS.—As used in this section, s. 409.9112, and the Florida Hospital Uniform Reporting System manual:

(c) "Charity care" or "uncompensated charity care" means that portion of hospital charges reported to the Agency for Health Care Administration for which there is no compensation, other than restricted or unrestricted revenues provided to a hospital by local governments or tax districts regardless of the method of payment, for:

1. Care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 200 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the

174036

annual family income; or

2. Care provided under conditions described in s. 383.50(5)(b).

~~However, in no case shall the~~ Hospital charges for a patient whose family income exceeds four times the federal poverty level for a family of four may not be considered charity, except for care provided without compensation under conditions described in s. 383.50(5)(b).

Section 3. This act shall take effect July 1, 2011.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to surrendered newborn infants; amending s. 383.50, F.S.; providing that if the mother of a newborn infant considers applying for eligibility for the Medicaid program through the hospital as a qualified Medicaid provider, the hospital must notify the mother that the act of applying for Medicaid will cause her personal information included on the Medicaid application to be submitted to the Department of Children and Family Services; authorizing a hospital to seek reimbursement from Medicaid for care provided to a surrendered newborn infant and the mother of a surrendered newborn infant related to

labor and delivery of the infant, if the infant is determined by the Department of Children and Family Services to be Medicaid eligible; prohibiting the hospital from seeking payment for such care from the mother of a surrendered newborn infant or from any individual financially responsible for the mother of a surrendered newborn infant; amending s. 409.911, F.S.; redefining the definition of "charity care" for the disproportionate share program; providing that if a patient has income that exceeds a specified multiple of the federal poverty level, the care provided to the patient does not qualify as charity care unless the care is provided without compensation to a surrendered newborn infant or the person financially responsible for the mother of the surrendered newborn infant; providing an effective date.

260894

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
03/28/2011	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete line 16
and insert:
for coverage under Medicaid, subject to federal rules. If federal rules do not allow for the presumptive eligibility contemplated in this subsection, the Agency for Health Care Administration shall seek federal waiver authority to implement such presumptive eligibility.

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

260894

Delete line 6

and insert:

infant; requiring the Agency for Health Care Administration to seek a federal waiver under certain conditions; providing an effective date.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 1454
INTRODUCER:	Senator Garcia
SUBJECT:	Treatment of a Surrendered Newborn Infant
DATE:	March 17, 2011
REVISED:	

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

I. Summary:

The bill provides that when a surrendered newborn infant is admitted to a hospital under s. 383.50, F.S., the birth mother who bore the infant, until the time of discharge from the hospital, is presumed eligible for coverage under Medicaid, subject to federal rules. This presumptive Medicaid eligibility for the birth mother is provided in conjunction with the newborn infant's presumptive Medicaid eligibility under current law, which is also subject to federal rules.

This bill substantially amends the following sections of the Florida Statutes: 383.50.

II. Present Situation:

Infant "safe haven" legislation has been enacted in most states as "an incentive for mothers in crisis to safely relinquish their babies to designated locations where the babies are protected and provided with medical care until a permanent home is found."[1] Safe haven laws generally allow the parent to remain anonymous and avoid prosecution for abandonment or neglect in exchange for safely surrendering the baby.[2]

Florida passed newborn safe haven legislation in 2000.[3] Regarding the treatment of a surrendered newborn infant, current Florida law in s. 383.50, F.S., provides:

[1] Child Welfare Information Gateway, Infant Safe Haven Laws (May 2010), available at http://www.childwelfare.gov/systemwide/laws_policies/statutes/safehaven.pdf (last visited March 17, 2011).
[2] *Id.*
[3] *See* s. 1, ch. 2000-188, Laws of Florida.

- The term "newborn infant" means a child who a licensed physician reasonably believes is approximately 7 days old or younger at the time the child is left at a hospital, emergency medical services station, or fire station.
- The parent who leaves the newborn infant is presumed to have intended to leave the newborn infant and consented to termination of parental rights. If a parent seeks to claim the newborn after surrendering the infant, this presumption can be reversed until a Florida circuit court enters a judgment to terminate parental rights.
- Each emergency medical services station or fire station staffed with full-time firefighters, emergency medical technicians, or paramedics is required to accept any newborn infant left with a firefighter, emergency medical technician, or paramedic. Such personnel are required to provide emergency medical services to the extent he or she is trained to provide those services and to arrange for the immediate transportation of the newborn infant to the nearest hospital having emergency services.
- Except when there is actual or suspected child abuse or neglect, any parent who surrenders a newborn infant and expresses intent to leave the newborn infant and not return, has the absolute right to remain anonymous and to leave at any time and may not be pursued or followed unless the parent seeks to reclaim the newborn infant. When an infant is born in a hospital and the mother expresses intent to leave the infant and not return, upon the mother's request, the hospital or registrar shall complete the infant's birth certificate without naming the mother on the birth certificate.
- Any newborn infant admitted to a hospital in accordance with these provisions is presumed eligible for coverage under Medicaid, subject to federal rules.[4]
- A criminal investigation will not be initiated solely because a newborn infant is left at a hospital under these provisions unless there is actual or suspected child abuse or neglect.

The Department of Children and Families (DCF) does not collect statistical data that specifies how many infants come into state care after being surrendered under s. 383.50, F.S. According to the Gloria M. Silverio Foundation's website, "A Safe Haven for Newborns," 11 infants were left at safe havens (hospitals, emergency medical service stations, or fire stations) in Florida in 2010. A total of 156 newborns have been left since the implementation of the law in 2000.[5]

Presumptive Eligibility for Medicaid: Adults

The only provision for presumptive eligibility for Medicaid currently in effect in Florida is presumptive eligibility for pregnant women. Medicaid services for presumptively eligible pregnant women are restricted by federal statute to prenatal care only.

In order to be eligible for labor, delivery, or other Medicaid services in addition to prenatal care, the woman must be eligible under one of the full Medicaid coverage groups. As part of the presumptive eligibility determination process for a pregnant woman, an application for full

[4] *See* s. 383.50(8), F.S.
[5] *Safe Haven for Newborns Statistics,* available at http://www.asafehavenfornewborns.com//index.php?option=com_content&view=article&id=63&Itemid=165 (last visited March 17, 2011).

Medicaid benefits is filed with the DCF. The woman's presumptive eligibility period ends when the DCF approves or denies the application for full Medicaid benefits. If the application for full Medicaid benefits is approved for the pregnant woman, full Medicaid coverage is available for all covered services during the prenatal period, labor, delivery, and the two-month postpartum period.

There are currently no federal rules permitting presumptive eligibility for inpatient hospital care for adults.

Presumptive Eligibility for Medicaid: Children

Federal rules give states the option to provide presumptive eligibility to children; however, if a states chooses presumptive eligibility for children, it must be applied to *all* children. Florida has not chosen presumptive eligibility for children.

Under the provisions of s. 383.50, F.S., if federal Medicaid rules were to allow for *selective* presumptive eligibility for children, then surrendered newborn infants in Florida could be made presumptively eligible under current Florida policy.

Currently, if surrendered newborn infants come under state care, DCF policy provides for expedited Medicaid determinations. Upon a determination of eligibility, the eligibility is retroactive to the date the DCF received the application. Therefore, eligible infants under these circumstances become Medicaid eligible back to the date of application submission.

III. Effect of Proposed Changes:

Under current federal rules, Florida is unable to presumptively assume Medicaid eligibility on behalf of birth mothers who surrender their newborn infants. Federal rules currently only permit coverage of prenatal services for pregnant women. There is no provision in current federal rules to allow for presumptive eligibility of other adults for other services. Florida could do so only if federal rules change or if Florida were granted a federal waiver, and only then could the bill have any practical effect.

The Agency for Health Care Administration advises that even if federal policy were changed to permit presumptive eligibility for adults other than pregnant women, it is unlikely it would be limited solely to birth mothers of surrendered infants and solely for the period of hospitalization.

Additionally, given the provisions of s. 383.50, F.S., that grant the absolute right to remain anonymous to parents who safely surrender their newborn infants, Medicaid eligibility could be authorized only for those mothers who choose to forfeit their anonymity.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

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

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Under current federal rules, the bill would have no immediate effect, other than to allow for presumptive eligibility for birth mothers of surrendered infants as provided by the bill in case federal law ever does change in this regard. This is similar to the effects of the presumptive eligibility for surrendered newborns under the current provisions of s. 383.50(8), F.S., which provides for selective presumptive eligibility for those newborns, subject to federal rules that currently do not allow selective presumptive eligibility for children. In order for these provisions to have practical effect, the federal rules must change or Florida must be granted a waiver.

VIII. Additional Information:

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

None.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate . House

. . . . .

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

Senate Amendment (with title amendment)

Delete lines 23 - 104

and insert:

(1) A pharmacist ~~Pharmacists~~ may administer, ~~influenza virus immunizations to adults~~ within the framework of an established protocol under a supervising ~~supervisory practitioner who is a~~ physician licensed under chapter 458 or chapter 459, the following:

(a) Influenza vaccine to an adult 18 years of age or older.

(b) Varicella zoster vaccine to an adult 60 years of age or older.

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(c) Pneumococcal vaccine to an adult 65 years of age or older.

(d) Epinephrine using an autoinjector delivery system to an adult 18 years of age or older who is suffering an anaphylactic reaction.

The ~~Each~~ protocol must ~~shall~~ contain specific procedures for addressing any unforeseen adverse ~~allergic~~ reaction to the vaccine or epinephrine autoinjection ~~influenza virus immunizations~~.

(2) A pharmacist may not enter into a protocol unless he or she maintains at least $200,000 of professional liability insurance and has completed training on the vaccines and epinephrine autoinjection ~~in influenza virus immunizations~~ as provided in this section.

(3) A pharmacist who administers a vaccine or epinephrine autoinjection must ~~administering influenza virus immunizations shall~~ maintain and make available patient records using the same standards for confidentiality and maintenance of such records as those that are imposed on health care practitioners under s. 456.057. These records must ~~shall~~ be maintained for a minimum of 5 years.

(4) The decision by a supervising physician ~~supervisory practitioner~~ to enter into a protocol under this section is a professional decision on the part of the physician ~~practitioner~~, and a person may not interfere with a supervising physician's ~~supervisory practitioner's~~ decision to enter ~~as to entering~~ into such a protocol. A pharmacist may not enter into a protocol that is to be performed while acting as an employee without the

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written approval of the owner of the pharmacy. Pharmacists shall forward immunization records to the department for inclusion in the state registry of immunization information.

(5) Any pharmacist seeking to administer a vaccine or epinephrine autoinjection ~~influenza virus immunizations to adults~~ under this section must be certified to administer the vaccine or epinephrine autoinjection ~~influenza virus immunizations~~ pursuant to a certification program approved by the Board of Pharmacy in consultation with the Board of Medicine and the Board of Osteopathic Medicine. The certification program shall, at a minimum, require that the pharmacist attend at least 20 hours of continuing education classes approved by the board. The program shall have a curriculum of instruction concerning the safe and effective administration of the vaccines listed in subsection (1) and epinephrine autoinjection ~~influenza virus immunizations~~, including, but not limited to, potential adverse ~~allergic~~ reactions to the vaccines or epinephrine autoinjection ~~influenza virus immunizations~~.

(6) The written protocol between the pharmacist and supervising physician must include particular terms and conditions imposed by the supervising physician upon the pharmacist relating to the administration of a vaccine or epinephrine autoinjection ~~influenza virus immunizations~~ by the pharmacist. The written protocol must ~~shall~~ include, at a minimum, specific categories and conditions among patients for whom the supervising physician authorizes the pharmacist to administer a vaccine or epinephrine autoinjection ~~influenza virus immunizations~~. The terms, scope, and conditions set forth in the written protocol between the pharmacist and the

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supervising physician must be appropriate to the pharmacist's training and certification for the vaccine or epinephrine autoinjection ~~immunization~~. A pharmacist ~~Pharmacists~~ who is ~~have been~~ delegated the authority to administer a vaccine or epinephrine autoinjection ~~influenza virus immunizations~~ by the supervising physician must ~~shall~~ provide evidence of current certification by the Board of Pharmacy to the supervising physician. A supervising physician must ~~physicians shall~~ review the administration of the vaccine or epinephrine autoinjection ~~influenza virus immunizations~~ by the pharmacist ~~pharmacists~~ under such physician's

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

And the title is amended as follows:

Delete lines 4 - 7

and insert:

are authorized to administer; authorizing pharmacists to administer an epinephrine autoinjection

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 1268
INTRODUCER:	Senator Oelrich
SUBJECT:	Pharmacy
DATE:	April 1, 2011
REVISED:	

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

I. Summary:

This bill expands the types of vaccines that may be administered by a pharmacist and authorizes a pharmacy intern having proper certification and working under a pharmacist's supervision to also administer such vaccines. The bill also authorizes a pharmacist or a supervised and certified pharmacy intern to administer epinephrine autoinjections.

However, in order to administer a vaccine or an epinephrine autoinjection, the pharmacist and pharmacy intern must:

- Follow a written protocol during administration of the vaccine or epinephrine autoinjection, which must be approved by an allopathic or osteopathic physician and approved by the owner of the pharmacy employing the pharmacist;
- Maintain at least $200,000 of professional liability insurance (pharmacist only);
- Maintain and make available patient records for a minimum of 5 years;
- Be certified to administer the vaccines or epinephrine autoinjection pursuant to a certification program approved by the Board of Pharmacy (board);
- Have a supervising physician review the administration of the vaccine or epinephrine autoinjection; and
- Submit to the board a copy of the protocol to administer the vaccines or epinephrine autoinjection (pharmacist only).

This bill also amends the definition of the term "practice of the profession of pharmacy" to include the administration of certain vaccines and epinephrine autoinjections to adults.

This bill substantially amends the following sections of the Florida Statutes: 465.189 and 465.003.

II. Present Situation:

Pharmacists and Pharmacy Interns

Pharmacists and pharmacy interns are regulated under ch. 465, F.S., the Florida Pharmacy Act (Act), by the board within the Department of Health (DOH). A "pharmacist" is any person licensed under the Act to practice the profession of pharmacy.[1] A "pharmacy intern" is a person who is currently registered in, and attending, a duly accredited college or school of pharmacy, or who is a graduate of such a school or college of pharmacy, and who is duly and properly registered with the DOH as provided for under the DOH's rules.[2]

The practice of the profession of pharmacy includes: compounding, dispensing, and consulting concerning contents, therapeutic values, and uses of any medicinal drug; consulting concerning therapeutic values and interactions of patent or proprietary preparations, whether pursuant to prescriptions or in the absence and entirely independent of such prescriptions or orders; and other pharmaceutical services. Other pharmaceutical services include the monitoring of a patient's drug therapy, assisting the patient in the management of his or her drug therapy, and review of the patient's drug therapy and communication with the patient's prescribing health care provider or the provider's agent or other persons as specifically authorized by the patient, regarding the drug therapy. However, a person practicing pharmacy is not authorized to alter a prescriber's directions, the diagnosis or treatment of any disease, the initiation of any drug therapy, the practice of medicine, or the practice of osteopathic medicine, unless specifically permitted by law. A pharmacist is authorized to transmit information from persons authorized to prescribe medicinal drugs to their patients. The practice of the profession of pharmacy also includes the administration of influenza virus immunizations to adults.[3]

Any person desiring to be licensed as a pharmacist must apply to the DOH to take the licensure examination. The DOH must examine each applicant who the board certifies has:

- Completed an application form and remitted an examination fee set by the board not to exceed $100 plus the actual per applicant cost to the DOH for purchase of portions of the examination from the National Association of Boards of Pharmacy or a similar national organization.
- Submitted satisfactory proof that the applicant is not less than 18 years of age and is a recipient of a degree from a school or college of pharmacy accredited by an accrediting agency recognized and approved by the United States Office of Education; or is a graduate of a 4-year undergraduate pharmacy program of a school or college of pharmacy located outside the United States, has demonstrated proficiency in English by passing two English-speaking competency tests, has passed the Foreign Pharmacy Graduate Equivalency Examination that is approved by rule of the board, and has completed a minimum of 500 hours in a supervised work activity program within Florida under the supervision of a pharmacist licensed by the DOH, which program is approved by the board.

[1] Section 465.003(10), F.S.
[2] Section 465.003(12), F.S.
[3] Section 465.003(13), F.S.

- Submitted satisfactory proof that the applicant has completed an internship program approved by the board, which must not exceed 2,080 hours.

The passing of the examination does not automatically confer rights or privileges upon the applicant in connection with the practice of pharmacy in Florida. To obtain such rights or privileges the DOH must issue a license to practice pharmacy to the applicant who successfully completed the examination.

For pharmacy interns, a board may refuse to certify to the DOH or may revoke the registration of any intern for good cause, including grounds enumerated in ch. 465, F.S., for revocation of pharmacists' licenses. A pharmacy student or graduate is required to be registered by the DOH before being employed as an intern in a pharmacy in Florida. An intern may not perform any acts relating to the filing, compounding, or dispensing of medicinal drugs unless it is done under the direct and immediate personal supervision of a person actively licensed to practice pharmacy in Florida.[4]

Pharmacies utilized for the obtaining of internship experience must meet the following minimum requirements:

- The pharmacy must hold a current license or permit issued by the state in which they are operating and must have available all necessary equipment for professional services, necessary reference works, in addition to the official standards and current professional journals.
- The pharmacy must be operated at all times under the supervision of a pharmacist and must be willing to train persons desiring to obtain professional experience.
- The pharmacy must establish to the program's satisfaction that the pharmacy fills, compounds, and dispenses a sufficient number, kind, and variety of prescriptions during the course of a year so as to afford to an intern a broad experience in the filling, compounding, and dispensing of prescription drugs.
- The pharmacy must have a clear record as to observance of federal, state, and municipal laws and ordinances covering any phase of activity in which it is engaged.
- A pharmacist may not be responsible for the supervision of more than one intern at any one time.[5]

Administration of Influenza Virus Immunizations by Pharmacists

In Florida, pharmacists may administer influenza virus immunizations to adults within the framework of an established protocol under a supervisory practitioner who is an allopathic or osteopathic physician. Each protocol must contain specific procedures for addressing any unforeseen allergic reaction to influenza virus immunizations.[6]

A pharmacist may not enter into a protocol unless he or she maintains at least $200,000 of professional liability insurance and has completed training in influenza virus immunizations.

[4] Rule 64B16-26.2032, F.A.C.
[5] *Id.*
[6] Section 465.189, F.S.

A pharmacist administering influenza virus immunizations must maintain and make available patient records using the same standards for confidentiality and maintenance of such records as those that are imposed on health care practitioners under s. 456.057, F.S. These records are required to be maintained for a minimum of 5 years.[7]

The decision by a supervisory practitioner to enter into a protocol is a professional decision on the part of the practitioner, and a person may not interfere with a supervisory practitioner's decision as to entering into such a protocol. A pharmacist may not enter into a protocol that is to be performed while acting as an employee without the written approval of the owner of the pharmacy.[8]

Any pharmacist seeking to administer influenza virus immunizations to adults must be certified to administer influenza virus immunizations pursuant to a certification program approved by the board in consultation with the Board of Medicine and the Board of Osteopathic Medicine. The certification program must, at a minimum, require that the pharmacist attend at least 20 hours of continuing education classes approved by the board and the program must have a curriculum of instruction concerning the safe and effective administration of influenza virus immunizations, including, but not limited to, potential allergic reactions to influenza virus immunizations.[9]

The written protocol between the pharmacist and supervising physician must include particular terms and conditions imposed by the supervising physician upon the pharmacist, relating to the administration of influenza virus immunizations by the pharmacist. Supervising physicians are required to review the administration of influenza virus immunizations by the pharmacists under such physician's supervision pursuant to the written protocol, and this review must take place as outlined in the written protocol. The pharmacist must submit to the board a copy of his or her protocol or written agreement to administer influenza virus immunizations.[10]

Vaccines and Epinephrine Autoinjections

All 50 states authorize pharmacists to vaccinate persons.[11] Therefore, the most accessible healthcare provider can positively impact public health and prevent disease by making vaccinations more readily available and less expensive.

Although every state allows pharmacists to administer immunizations, each state approaches immunizations differently. Some states require specific education or certification. Some limit the types of immunizations that can be administered, while other states limit the age of patients. Some states require pharmacists to have a prescription before administering an immunization, while others allow administration pursuant to protocol. Finally, some states limit the routes of immunization administration.[12]

[7] *Id.*
[8] *Id.*
[9] *Id.*
[10] *Id.*
[11] Immunization Action Coalition, *Vaccination Information for Healthcare Professionals*, July 21, 2009, available at: http://www.immunize.org/laws/pharm.asp (Last visited on March 31, 2011).
[12] Laura Carpenter, RPh, JD; *Pharmacist-administered immunizations: Trends in state laws*; September 2009, available at: http://www.cedrugstorenews.com/userapp//lessons/page_view_ui.cfm?lessonuid=&pageid=B923321F24938AEE0854C1225838355F (Last visited on March 31, 2011).

Before being permitted to administer immunizations, most states require pharmacists to receive education in immunization administration. The most common educational requirements include completing state-specific courses in immunization administration, certificate programs in immunization administration, and immunization administration continuing education. Most states also require basic life support or cardiopulmonary resuscitation certification. Some states require ongoing continuing education and list specific timeframes for completion of the education, while other states require continuing education but give no specific guidelines for completion. Other states do not require any continuing education.[13]

The formulary of vaccines that can be administered by pharmacists also varies by state. Many states limit the formulary to the influenza and pneumococcal vaccines. Other states, such as Delaware, allow pharmacists to administer any injectable immunization or biologic contained in the *Orange Book*[14] that is administered in accordance with its Food and Drug Administration-approved indications. Still other states expand the scope of administration to include other routes of administration in addition to injection, such as oral or intranasal administration, while others allow pharmacists to administer immunizations by all routes of administration. Many states' laws limit administration to subcutaneous injection.[15]

Another variance between states is the minimum age restriction for which patients may receive the immunization in the protocol for a specific immunization. New York law allows pharmacists to administer the influenza or pneumococcal vaccines to patients 18 years of age or older. Oregon allows pharmacists to administer a large formulary of vaccines to patients older than 11 years of age. Some states do not set a minimum age limit.[16]

Influenza Vaccine

There are two types of vaccines to protect people from influenza (the flu):

- The "flu shot" — an inactivated vaccine (containing killed virus) that is given with a needle, usually in the arm. The flu shot is approved for use in people older than 6 months, including healthy people and people with chronic medical conditions.
- The nasal-spray flu vaccine —a vaccine made with live, weakened flu viruses that do not cause the flu is approved for use in healthy people 2 to 49 years of age who are not pregnant.[17]

The seasonal flu vaccine protects against three influenza viruses that research indicates will be most common during the upcoming season. The 2010-2011 flu vaccine will protect against 2009 H1N1, and two other influenza viruses (an H3N2 virus and an influenza B virus). The viruses in the vaccine change each year based on international surveillance and scientists' estimations about which types and strains of viruses will circulate in a given year. About 2 weeks after

[13] *Id.*
[14] The Electronic Orange Book for Approved Drug Products with Therapeutic Equivalence Evaluations is available on the U.S. Food and Drug Administration's website at: http://www.accessdata.fda.gov/scripts/cder/ob/default.cfm (Last visited on March 31, 2011).
[15] *Supra* fn. 12.
[16] *Id.*
[17] Centers for Disease Control and Prevention, *Seasonal Influenza (Flu)*, available at: http://www.cdc.gov/flu/protect/keyfacts.htm (Last visited on March 31, 2011).

vaccination, antibodies that provide protection against influenza virus infection develop in the body.

Varicella Zoster Vaccine

Varicella zoster virus is one of eight herpes viruses known to infect humans. It commonly causes chicken-pox in children and Herpes zoster (shingles) in adults and rarely in children.

The varicella vaccine is the best way to prevent chickenpox. Vaccination not only protects vaccinated persons, it also reduces the risk for exposure in the community for persons unable to be vaccinated because of illness or other conditions, including those who may be at greater risk for severe disease. While no vaccine is 100 percent effective in preventing disease, the chickenpox vaccine is very effective: about 8 to 9 of every 10 people who are vaccinated are completely protected from chickenpox. In addition, the vaccine almost always prevents severe disease. If a vaccinated person does get chickenpox, it is usually a very mild case lasting only a few days and involving fewer skin lesions (usually less than 50), mild or no fever, and few other symptoms.[18]

Almost 1 out of every 3 people in the United States will develop shingles. There are an estimated 1 million cases each year in the United States. Anyone who has recovered from chickenpox may develop shingles; even children can get shingles. However, the risk of disease increases as a person gets older. About half of all cases occur among men and women 60 years old or older.[19]

The only way to reduce the risk of developing shingles and the long-term pain that can follow shingles is to get vaccinated. A vaccine for shingles is licensed for persons aged 60 years and older.[20]

Pneumococcal Vaccine

Pneumococcal disease is an infection caused by a type of bacteria called Streptococcus pneumoniae (pneumococcus). There are different types of pneumococcal disease, such as pneumococcal pneumonia, bacteremia, meningitis, and otitis media. Pneumococcus is in many people's noses and throats and is spread by coughing, sneezing, or contact with respiratory secretions. Why it suddenly invades the body and causes disease is unknown.[21]

The symptoms of pneumococcal pneumonia include fever, cough, shortness of breath, and chest pain. The symptoms of pneumococcal meningitis include stiff neck, fever, mental confusion and disorientation, and visual sensitivity to light (photophobia). The symptoms of pneumococcal bacteremia (a bloodstream infection) may be similar to some of the symptoms of pneumonia and meningitis, along with joint pain and chills. The symptoms of otitis media (middle ear infection)

[18] Centers for Disease Control and Prevention, *Varicella (Chickenpox) Vaccination*, available at: http://www.cdc.gov/vaccines/vpd-vac/varicella/default.htm (Last visited on March 31, 2011).
[19] Centers for Disease Control and Prevention, *Shingles (Herpes Zoster): Overview*, available at: http://www.cdc.gov/shingles/about/overview.html (Last visited on March 31, 2011).
[20] Centers for Disease Control and Prevention, *Shingles (Herpes Zoster): Prevention and* Treatment, available at: http://www.cdc.gov/shingles/about/prevention-treatment.html (Last visited on March 31, 2011).
[21] Centers for Disease Control and Prevention, *Vaccines and Immunizations: Pneumococcal Disease In-Short*, available at: http://www.cdc.gov/vaccines/vpd-vac/pneumo/in-short-both.htm (March 31, 2011).

typically include a painful ear, a red or swollen eardrum, and sometimes sleeplessness, fever and irritability.[22]

Pneumococcal vaccine is very good at preventing severe disease, hospitalization, and death. However, it is not guaranteed to prevent infection and symptoms in all people. There are currently two types of pneumococcal vaccines: pneumococcal conjugate vaccine (PCV7 and PCV13) and pneumococcal polysaccharide vaccine (PPSV). PCV13 is replacing PCV7.[23]

Epinephrine Autoinjection

Epinephrine may be administered by a one-dose auto-injector, known as an EpiPen or Twinject. Epinephrine is used in emergencies to treat very serious allergic reactions (anaphylactic reaction) to insect stings or bites, foods, drugs, or other substances. Epinephrine acts quickly to improve breathing, stimulate the heart, raise a dropping blood pressure, reverse hives, and reduce swelling of the face, lips, and throat.[24]

Different brands of epinephrine have different directions for preparing the injector for administration. However, this medicine should be injected into the thigh only, through clothing if necessary. To avoid injecting into a vein, the medicine should be injected into the front outer thigh and never into the buttocks. The effects of epinephrine are rapid, but not long-lasting. After injecting epinephrine, a person should seek immediate medical attention.[25]

III. Effect of Proposed Changes:

This bill authorizes a pharmacist or a pharmacy intern, having proper certification and working under a pharmacist's supervision, to administer within the framework of an established protocol under a supervising physician licensed under ch. 458, F.S. (allopathic physician) or licensed under ch. 459, F.S. (osteopathic physician) the following:

- Influenza vaccines to adults 18 years of age or older.
- Varicella zoster (chickenpox) vaccines to an adult 60 years of age or older.
- Pneumococcal vaccines to an adult 65 years of age or older.
- Epinephrine using an autoinjector delivery system to an adult 18 years of age or older who is suffering from an anaphylactic reaction.

However, in order to administer a vaccine or an epinephrine autoinjection, the pharmacist and pharmacy intern must:

- Maintain at least $200,000 of professional liability insurance (pharmacist only);
- Maintain and make available patient records for a minimum of 5 years, using the same standards for confidentiality and maintenance of such records as those that are imposed on health care practitioners under s. 456.057, F.S.;
- Be certified to administer the vaccines or epinephrine autoinjection pursuant to a certification program approved by the board and proof of such certification must be shown to the supervising physician. The program must require that the pharmacist or pharmacy intern

[22] *Id.*
[23] *Id.*
[24] MedicineNet.com, *Epinephrine Auto-Injector*, available at: http://www.medicinenet.com/epinephrine_auto-injector/article.htm (Last visited on March 31, 2011).
[25] *Id.*

attend at least 20 hours of continuing education classes approved by the board and must include instruction concerning the safe and effective administration of the influenza, varicella zoster, and pneumococcal vaccines and the epinephrine autoinjection, including potential adverse reactions; and

- Have a supervising physician review the administration of the vaccine or epinephrine autoinjection.

The pharmacist or pharmacy intern must also follow a written protocol for the administration of vaccines or the epinephrine autoinjection. The protocol must include particular terms and conditions imposed by a supervising allopathic or osteopathic physician, which must be appropriate to the pharmacist's or the pharmacy intern's training and certification for the vaccine or epinephrine autoinjection; include specific categories and conditions among patients for whom the supervising physician authorizes the pharmacist or pharmacy intern to administer a vaccine or epinephrine autoinjection; be approved by the owner of the pharmacy employing the pharmacist; and contain specific procedures for addressing any unforeseen adverse reaction to the vaccine or epinephrine autoinjection. The pharmacist must submit to the board a copy of the protocol to administer the vaccines or epinephrine autoinjection.

This bill also amends the definition of the term "practice of the profession of pharmacy" to include the administration of influenza, varicella zoster, and pneumococcal vaccines and the epinephrine autoinjection to adults.

The bill provides an effective date of July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

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

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Pharmacies may generate additional revenue because they will be able to offer more vaccination services to customers.

C. Government Sector Impact:

The board may incur administrative costs associated with receiving additional protocols and may incur any costs associated with enforcement of the provisions of the bill (e.g. making sure vaccines are given to the age-appropriate people).

The DOH may incur additional costs related to investigating complaints, certifying pharmacy interns, and rulemaking.

VI. Technical Deficiencies:

The term "supervision" is used in lines 24, 86, 96, and 104 to require a pharmacist to supervise a pharmacy intern. It is not clear whether the pharmacist is required to provide "direct supervision." Rule 64B16-26.2032, Florida Administrative Code, relating to pharmacy interns, requires an intern to perform certain acts under the "direct and immediate personal supervision" of a pharmacist. If the intent of the bill is to require direct supervision by a pharmacist over a pharmacy intern, the language in this rule should be used for consistency.

VII. Related Issues:

The relationship between the physician and the pharmacy intern is unclear. For example, is the pharmacy intern required to enter into a protocol with the supervising physician? The pharmacy intern is not required to maintain professional liability insurance and it is not clear whether the intern would be covered under the pharmacist's policy or the physician's policy.

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.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 1358
INTRODUCER:	Senator Oelrich
SUBJECT:	Emergency Medical Services
DATE:	April 1, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Fernandez/O'Callaghan	Stovall	HR	**Pre-meeting**
2.			BC	
3.				
4.				
5.				
6.				

I. Summary:

This bill deletes the requirement for emergency medical technicians (EMTs), paramedics, and 911 public safety telecommunicators, certified under ch. 401, F.S., to complete a course approved by the Department of Health (DOH), regarding the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) as a condition of certification and recertification. The bill updates Florida EMTs and paramedics training requirements to reflect the new 2009 national training standards.

The bill redefines "basic life support" to include the name of the new National EMS Education Standards and changes the timetable for revision of the comprehensive state plan for emergency medical services and programs from biennially to every 5 years.

This bill substantially amends the following sections of the Florida Statutes: 381.0034, 401.23, 401.24, 401.27, and 401.2701

II. Present Situation:

HIV/AIDS

Acquired Immune Deficiency Syndrome is a physical disorder that results in the loss of immunity in affected persons. It is caused by a retrovirus known as the Human Immunodeficiency Virus. The HIV infection and AIDS remain leading causes of illness and death in the United States. Since the beginning of the HIV/AIDS epidemic in the early 1980s, it

is estimated that over 1 million persons in the United States have been diagnosed with AIDS.[1] According to the Centers for Disease Control and Prevention (CDC), the annual number of AIDS cases and deaths declined substantially after 1994, but stabilized during the period 1999-2004.[2] The number of HIV/AIDS cases among racial/ethnic minority populations and persons exposed to HIV through heterosexual contact has increased since 1994.[3] Florida ranks third among the states in the cumulative number of reported AIDS cases, with 121,161 cases reported through January 2011.[4]

Florida has comprehensive HIV testing and partner notification laws. Additionally Florida law requires certain health care practitioners who provide prenatal services to offer HIV testing along with the testing for other sexually transmissible diseases to pregnant women.

Emergency Medical Technicians/Paramedics, Standards and Certification

The Department of Health, Division of Emergency Operations regulates EMTs and paramedics. "Emergency Medical Technician" is defined under s. 401.23, F.S., to mean a person who is certified by the DOH to perform basic life support, which is the treatment of medical emergencies through the use of techniques described in the Emergency Medical Technician Basic Training Course Curriculum of the U.S. Department of Transportation. "Paramedic" means a person who is certified by the DOH to perform basic *and* advanced life support.

The DOH must establish, by rule, educational and training criteria and examinations for the certification and recertification of EMTs and paramedics.[5] An applicant for certification or recertification as an EMT or paramedic must have completed an appropriate training course as follows:

- For an EMT, an emergency medical technician training course equivalent to the most recent emergency medical technician basic training course of the U.S. Department of Transportation as approved by the DOH.
- For a paramedic, a paramedic training program equivalent to the most recent paramedic course of the U.S. Department of Transportation as approved by the DOH.

The DOH must also establish by rule, a procedure for biennial renewal certification of EMTs and paramedics. Such rules for EMTs must require a U.S. Department of Transportation refresher training program of at least 30 hours as approved by the DOH every 2 years. Rules for paramedics must require candidates for renewal to have taken at least 30 hours of continuing education units during the 2-year period.

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[1] HIV/AIDS in the United States. Revised August 2009. CDC. Available at: <http://www.cdc.gov/hiv/resources/factsheets/PDF/us.pdf> (Last visited April 1, 2011).
[2] CDC Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings. *MMWR (Morbidity and Mortality Weekly Report)* September 22, 2006; 55(RR 14):1-17. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm> (Last visited on April 1, 2011).
[3] *Ibid.*
[4] The Florida Division of Disease Control Surveillance Report (Hepatitis, HIV/AIDS, STD and TB). January 2011, No. 314. Available at: <http://www.doh.state.fl.us/disease_ctrl/aids/trends/msr/2011/MSR0111.pdf > (Last visited on April 1, 2011).
[5] s. 401.27, F.S.

911 Public Safety Telecommunicator[6]

"911 public safety telecommunicator" means a public safety dispatch or 911 operator whose duties include, among other things, answering, receiving, transferring, and dispatching functions related to 911 calls and dispatching law enforcement officers, fire rescue services, emergency medical services, and other public safety services to the scene of an emergency. Certain 911 public safety telecommunicators are required to be certified pursuant to s. 401.465, F.S. The DOH is to establish, by rule, educational and training criteria for the certification and recertification of 911 public safety telecommunicators.

Requirement for Instruction on HIV/AIDS

In 2006, the Legislature revised the requirements for the HIV/AIDS continuing education instruction in the general licensing provisions for health practitioners regulated by s. 456, 033, F.S.[7] Under s. 381.0034(3), F.S., the DOH must require applicants for initial licensure or certification as EMTs, paramedics, 911 public safety telecommunicator, midwives, radiologic technologists, or clinical laboratory personnel to complete an educational course on HIV and AIDS. These professions must complete a department-approved course on HIV/AIDS at the time of initial licensure or certification, or do so within 6 months of licensure or certification upon an affidavit showing good cause.

The course must cover modes of transmission, infection control procedures, clinical management, and prevention of HIV/AIDS. The course must also include information on current Florida law on AIDS and its impact on testing, confidentiality of test results, treatment of patients, and any protocols and procedures applicable to HIV counseling and testing, reporting, the offering of HIV testing to pregnant women, and partner notification. Failure to comply with the educational requirement is grounds for disciplinary action.[8]

Section 381.0034(1), F.S., also provides that the DOH must require, as a condition of biennial relicensure, persons certified or licensed as EMTs, paramedics, 911 public safety telecommunicator, midwives, radiologic technologists, and clinical laboratory personnel to complete an educational course approved by the DOH on HIV/AIDS. Each licensee or certificate holder is to submit confirmation of having completed the course when submitting fees or an application for each biennial renewal.

Emergency Medical Services Training Programs[9]

Any private or public institution in Florida desiring to conduct an approved program for the education of EMTs and paramedics must submit a completed application, which must include documentation verifying that the curriculum:

- Meets the course guides and instructor's lesson plans in the most recent Emergency Medical Technician-Basic National Standard Curricula for emergency medical technician programs

[6] S. 401.465, F.S.
[7] *See* 2006-251, L.O.F.
[8] S. 381.0034(2), F.S.
[9] S. 401.2701, F.S.

and Emergency Medical Technician-Paramedic National Standard Curricula for paramedic programs;
- Includes 2 hours of instruction on the trauma scorecard methodologies for assessment of adult trauma patients and pediatric trauma patients as specified by the DOH by rule; and
- Includes 4 hours of instruction on HIV/AIDS training consistent with the requirements of ch. 381, F.S.

Emergency Medical Services State Plan[10]

Under s. 401.24, F.S., the DOH is responsible for the improvement and regulation of basic and advanced life support programs and is required to biennially develop and revise a comprehensive state plan for basic and advanced life support services.

Emergency Medical Technician National Standard Curriculum[11]

The National Highway Traffic Safety Administration (NHTSA) has assumed responsibility for the development of training courses that are responsive to the standards established by the Highway Safety Act of 1966 (amended). Since these courses are designed to provide national guidelines for training, it is NHTSA's intention that they be of the highest quality and be maintained in a current and up-to-date status from the point of view of both technical content and instructional strategy.

In 1994, the NHTSA completed an extensive revision of the national standard Emergency Medical Technician-Basic Curriculum.[12] The EMT-Basic National Standard Curriculum is a core curriculum of minimum required information, to be presented within a 110-hour training program, intended to prepare a medically competent EMT-Basic to operate in the field. The 110-hour time constraint of the program, as recommended by the national emergency medical services community during the 1990 NHTSA *Consensus Workshop on Emergency Medical Services Training Programs*, necessitates the need for enrichment and continuing education in order to bring a student to full competency.[13]

The 1994 EMT-Basic: National Standard Curriculum Instructor's Course Guide[14] specifically mentions that: "It is important to understand that this curriculum does not provide students with extensive knowledge in hazardous materials, blood-borne pathogens, emergency vehicle operations or rescue practices in unusual environments. These areas are not core elements of education and practice as identified in the *National EMS Education and Practice Blueprint*. Identified areas of competency not specifically designed within the EMT-Basic: National Standard Curriculum should be taught in conjunction with this program as a local or state option."

[10] S. 401.24, F.S.
[11] National Standard Curricula available at: <www.nhtsa.gov/people/injury/ems/pub/emtbnsc.pdf > (Last visited on April 1, 2011).
[12] See NHTSA Emergency Medical Technician: Basic Refresher Curriculum, Instructor Course Guide. Available at: <http://www.nhtsa.dot.gov/people/injury/ems/pub/basicref.pdf> (Last visited on April 1, 2011).
[13] See NHTSA EMT-Basic: National Standard Curriculum, Instructor's Course Guide. Available at: <http://www.nhtsa.dot.gov/people/injury/ems/pub/emtbnsc.pdf> (Last visited on April 1, 2011).
[14] See NHTSA EMT-Standard: National Standard Curriculum, Instructor's Course Guide. Available at: <http://www.nhtsa.dot.gov/people/injury/ems/pub/emtbnsc.pdf> (Last visited on April 1, 2011).

The EMT-Paramedic: National Standard Curriculum represents the minimum required information to be presented within a course leading to certification as a paramedic. It is recognized that there is additional specific education that will be required of paramedics who operate in the field, i.e. ambulance driving, heavy and light rescue, basic extrication, special needs, and so on. It is also recognized that this information might differ from locality to locality, and that each training program or system should identify and provide special instruction for these training requirements.[15]

The 1998 EMT-Paramedic: National Standard Curriculum Introduction[16] also specifically mentions that: "It is important to recognize that this curriculum does not provide students with extensive knowledge in hazardous materials, blood-borne pathogens, emergency vehicle operations or rescue practices in unusual environments. These areas are not core elements of education and practice as identified in the *National EMS Education and Practice Blueprint*. Identified areas of competency not specifically designed within the EMT-Paramedic: National Standard Curriculum should be taught in conjunction with this program as a local or state option."

The National EMS Education Standards[17]

The National EMS Education Standards (Standards), led by the National Association of EMS Educators, replace the NHTSA National Standard Curricula at all licensure levels. The Standards define the competencies, clinical behaviors, and judgments that must be met by entry-level EMS personnel to meet practice guidelines defined in the National EMS Scope of Practice Model. Content and concepts defined in the National EMS Core Content are also integrated within the Standards.

The Standards comprise of four components:

1. Competency - This statement represents the minimum competency required for entry-level personnel at each licensure level.
2. Knowledge Required to Achieve Competency - This represents an elaboration of the knowledge within each competency (when appropriate) that entry-level personnel would need to master in order to achieve competency.
3. Clinical Behaviors/Judgments - This section describes the clinical behaviors and judgments essential for entry-level EMS personnel at each licensure level.
4. Educational Infrastructure - This section describes the support standards necessary for conducting EMS training programs at each licensure level.

Each statement in the Standards presumes that the expected knowledge and behaviors are within the scope of practice for that EMS licensure level, as defined by the National EMS Scope of Practice Model. Each competency applies to patients of all ages, unless a specific age group is identified.

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[15] EMT: Paramedic National Standard Curriculum. Available at: <http://www.nhtsa.gov/people/injury/ems/EMT-P/disk_1%5B1%5D/Intro.pdf> (Last visited on April 1, 2011).
[16] *Id.*
[17] *See* The national EMS Education Standards at:< http://www.ems.gov/pdf/811077a.pdf> (Last visited on April 1, 2011).

The Standards also assume there is a progression in practice from the Emergency Medical Responder level to the Paramedic level. That is, licensed personnel at each level are responsible for all knowledge, judgments, and behaviors at their level and at all levels preceding their level. For example, a Paramedic is responsible for knowing and doing everything identified in that specific area, as well as knowing and doing all tasks in the three preceding levels.

III. Effect of Proposed Changes:

Section 1 amends s. 381.0034, F.S., to remove the requirement for each person licensed or certified under ch. 401, F.S., Medical Telecommunications and Transportation, to complete an educational course about HIV and AIDS as a condition of certification.

Section 2 amends s. 401.23, F.S., to define "basic life support" as treatment of medical emergencies by a qualified person through the use of techniques described in the Emergency Medical Technician Basic Training Course Curriculum or the National EMS Education Standards of the United States Department of Transportation, s approved by the DOH.

Section 3 amends s. 401.24, F.S., relating to emergency medical services state plan, to require the DOH to develop and revise the comprehensive state plan every 5 years rather than every 2 years.

Section 4 amends s. 401.27, F.S., relating to personnel standards and certification, to require the completion of a training course equivalent to the most recent National EMS Education Standards, as approved by the DOH, in order for a person to apply for certification or recertification as an EMT or paramedic. The bill extends the timeframe to pass the examination to become certified as an EMT or paramedic from 1 to 2 years following successful course completion.

Section 5 amends s. 401.2701, F.S., to include the National EMS Education Standards as an option to teach EMT and paramedic training programs as approved by the department.

Section 6 provides an effective date of July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

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

D. Other Constitutional Issues:

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The DOH indicated that the bill would require the department to promulgate rules to remove the HIV/AIDS requirement in 64J-1.008 and 64J-1.009, F.A.C. In addition, DOH will need to revise a form. The DOH indicated that it will incur indeterminate costs.

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.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 1608
INTRODUCER:	Senator Ring
SUBJECT:	Dentistry
DATE:	April 1, 2011
REVISED:	

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

I. Summary:

This bill provides that an applicant, who has maintained his or her dental license in good standing in another state for 3 years immediately before applying to take the licensing examinations to practice dentistry in Florida, is entitled to take those examinations. This provision exempts such applicants, who have not graduated from an accredited dental college or from a school approved by the Board of Dentistry, from having to complete a program of study at an accredited American dental school and receive a D.D.S. or D.M.D. from such school or complete a 2-year supplemental dental education program at an accredited dental school and receive a dental diploma, degree, or certificate in order to take the examinations.

This bill substantially amends s. 466.006, F.S.

II. Present Situation:

Accredited Dental Schools

The American Dental Association, Commission on Dental Accreditation (CODA), established in 1975, is nationally recognized by the United States Department of Education to accredit dental and dental-related education programs conducted at the post-secondary level. The CODA functions independently and autonomously in matters of developing and approving accreditation standards, making accreditation decisions on educational programs and developing and approving procedures that are used in the accreditation process.[1]

[1] America Dental Association, *Dental Education: Schools & Programs*, available at: http://www.ada.org/103.aspx (last viewed March 31, 2011).

Dental education, dental assisting, dental hygiene, dental laboratory technology, and advanced dental education programs, including dental specialties, general practice residencies, and advanced education in general dentistry are evaluated in accordance with published accreditation standards by the CODA.[2]

Dental Schools in Florida

There are currently 56 accredited dental schools, approximately 240 dental hygiene programs, and 250 dental assisting programs in the U.S. Florida currently has 2 accredited dental schools—1 public and 1 private—that produced 182 graduates in 2003, 18 accredited dental hygiene programs, and 25 accredited dental assisting programs.[3] The schools are the University of Florida College of Dentistry (UFCD) and Nova Southeastern University College of Dental Medicine (Nova).[4] The Lake Erie College of Osteopathic Medicine plans on opening a School of Dental Medicine at the Bradenton campus in April of 2012. The program has received initial CODA accreditation.[5]

Additionally, there are 3 accredited pediatric dental residency programs in Florida that produce 14 graduates each year—Nova (6 graduates), UFCD (5 graduates), and Miami Children's Hospital (3 graduates).[6] Approximately 92 percent of Florida dental school graduates remain in the state after graduation.[7]

Foreign Trained Dentists

Section 466.08, F.S., provides guidelines for certifying foreign dental schools. The foreign schools must prove that their educational program is reasonably comparable to that of similar accredited institutions in the United States and that the program adequately prepares its students for the practice of dentistry.[8]

In Florida, any dentist who did not attend a CODA accredited dental program (e.g., foreign trained dentists) are required to complete a 2-year supplemental education program at a CODA accredited dental school before they can sit for the Florida dental licensure examinations.[9]

Four states and the U.S. Virgin Islands do not grant an unrestricted dental license by credentials (grant reciprocity): Delaware, Florida, Hawaii, and Nevada.[10]

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[2] *Id.*
[3] Florida Department of Health, *Health Practitioner Oral Healthcare Workforce Ad Hoc Committee Report* (February 2009), available at: http://www.doh.state.fl.us/Family/dental/OralHealthcareWorkforce/index.html (last viewed March 31, 2011).
[4] America Dental Association, Dental Education Program Search, available at: http://www.ada.org/267.aspx (last viewed March 31, 2011).
[5] Lake Erie College of Osteopathic Medicine, School of Dental Medicine, available at: http://lecom.edu/school-dental-medicine.php (last viewed March 31, 2011)
[6] *Supra* fn. 3.
[7] *Id.*
[8] Section 466.008(4), F.S.
[9] Section 466.006(3), F.S. and ch. 64B5-2.0146, F.A.C.
[10] American Dental Association, Department of State Government Affairs, April 6, 2009, available at: http://www.ada.org/sections/advocacy/pdfs/licensure_recognition.pdf (last viewed on March 31, 2011).

Other States Licensing Requirements

State boards of dentistry, licensure statutes, and rules can affect the population of eligible dental providers available in a state and some states have amended licensure regulations to attract dentists. Examples of some of these common practices are: allowing foreign dental school graduates who complete U.S. dental residencies to meet eligibility requirements for licensure; conveying reciprocity or licensure by credentials; granting special licenses; or providing incentives (e.g., limiting liability) for dentists who work in public health/safety net clinics.[11]

Other states such as Minnesota, Connecticut, Arkansas, Mississippi, and California have developed programs to utilize foreign-trained dentists as dentists and dental hygienists in facilities that care for special needs patients and public health settings.[12]

California enacted a law (Assembly Bill 1116) in 1997 that provided the California dental board with the authority to determine whether unaccredited international dental programs are equivalent to similar accredited institutions in the U.S. Enacted in 1998, the law enabled the dental board to approve dental education programs outside the U.S.[13]

With a law on the books giving the California dental board the authority to approve educational programs outside the U.S., the Universidad De La Salle Bajio in the city of Leon, Mexico, applied for approval for its new 2-year international program in 2006. The California board of dentistry granted provisional approval to Universidad De La Salle in August 2002 after the first site visit. Following its second site visit, De La Salle's 5-year pre-doctoral dental education program received full certification in November 2004. The College of Dental Surgery in Manipal, India, was also evaluated for board approval. Students who are admitted to the De La Salle's California-approved track program are required to sign a disclaimer stating that they know this program is not CODA-approved. They are also informed that they will only qualify to get a license to practice in California once all licensure requirements for the state of California are met.[14] The cost of Universidad De La Salle's International Dental Studies Program that satisfies the educational requirement for California-approved dental licensure track is $21,000 per semester, which totals $84,000 in tuition for the two-year program.[15]

Florida Dental Exam

The Florida Board of Dentistry (Board) administers the Florida dental licensure exams. The Board sets the number, dates, and locations of exams. Licensure examinations are given at least twice a year depending on the projected candidate population.[16] Applicants for examination or re-examination must have taken and successfully completed the National Board of Dental

[11] *Supra* fn. 3.
[12] *Id.*
[13] American Dental Association, *ADA News: International dental program in Mexico raises questions*, available at: http://www.ada.org/1901.aspx (last viewed March 31, 2011).
[14] *Id.*
[15] American Dental Association, *ADA News: Costs of De La Salle vs. other IDPs in California*, available at: http://www.ada.org/1899.aspx (last viewed March 31, 2011).
[16] Florida Department of Health, Division of Medical Quality Assurance, Board of Dentistry, *Applications and Forms*, available at: http://www.doh.state.fl.us/mqa/dentistry/dn_applications.html (last viewed March 31, 2011).

Examiner's dental examination and received a National Board Certificate within the past 10 years.[17]

Each applicant is required to complete the examinations as provided for in s. 466.006, F.S. The examinations for dentistry consist of:

- A written examination; [18]
- A practical or clinical examination;[19] and
- A diagnostic skills examination.

The applicant for licensure must successfully complete all three exams within a thirteen month period in order to qualify for licensure.[20] If the candidate fails to successfully complete all three examinations within the allotted timeframe, then the candidate must retake all three of the examinations.[21] Additionally, all examinations are required to be conducted in English.[22]

The practical or clinical examination requires the applicant to provide a qualified patient,[23] who will participate in the examination as the patient.[24] The practical or clinical examination consists of four parts and the applicant must receive a grade of at least 75 percent on each part:

- Part 1-requires a preparation procedure and a restoration procedure.
- Part 2-requires demonstration of periodontal skills on a patient to include definitive debridement (root planing, deep scaling/removal of subgingival calculus, and removal of plaque, stain and supragingival calculus).
- Part 3-requires demonstration of endodontic skills on specified teeth.
- Part 4-requires demonstration of prosthetics skills to include the preparation for a 3-unit fixed partial denture on a specified model and the preparation of an anterior crown.

If an applicant fails to achieve a final grade of 75 percent or better on each of the 4 parts of the Practical or Clinical Examination, the applicant shall be required to retake only that part(s) that the applicant has failed.[25]

There are two fees associated with the licensure examination—$1,700 to the Board of Dental Examiners for administration of the licensure examination and $760 to the Department of Health for the application fee, exam development, and licensure.[26] Additionally, the applicant must supply any live patients and assume all associated costs to ensure the patients are present at the exam. For applicants who have not taken the National Boards within the last 10 years (e.g. a

[17] Rule 64B5-2.013, F.A.C.
[18] A final grade of 75 or better is required to pass the Written Examination. *See* rule 64B5-2.013, F.A.C.
[19] The practical or clinical exam requires the applicant to provide a patient who is at least 18 years of age and whose medical history is consistent with that prescribed by the board in order for patients to qualify as a patient for the examination. *See* rule 64B5-2.013, F.A.C.
[20] Rule 64B5-2.013, F.A.C..
[21] *Id*.
[22] *Id*.
[23] The patient must be at least 18 years of age and have a medical history consistent with the parameters prescribed by the Board.
[24] *Supra* fn. 20.
[25] *Id*.
[26] *Supra* fn. 16.

licensed dentist from another state who may have been in practice for 10 years or more), he or she must also retake Part II of the National Boards.

Shortage of Dentists

The pool of dentists to serve a growing population of Americans is shrinking. The American Dental Association found that 6,000 dentists retire each year in the U.S., while there are only 4,000 dental school graduates each year to replace them. The projected shortage of dentists is even greater in rural America. Of the approximately 150,000 general dentists in practice in the U.S., only 14 percent practice in rural areas, 7.7 percent in large rural areas, 3.7 percent in small rural areas, and 2.2 percent in isolated rural areas. In 2003, there were 2,235 federally designated dental supply shortage areas, 74 percent of which were located in non-metropolitan areas. In contrast, dental hygiene is predicted to be one of the top ten fastest growing health care professions over the next decade, growing by a projected 43 percent between 2006 and 2020.[27]

In 2010, there were 9,373 practicing dentists in Florida, meaning the ratio of dentists to the population in Florida is approximately 1 dentist for every 2,016 residents.[28] The estimated underserved population in 2008, in Florida, was 2.9 million people or 15.8 percent of the population.[29]

III. Effect of Proposed Changes:

This bill provides that an applicant, who has maintained his or her dental license in good standing in another state for 3 years immediately before applying to take the licensing examinations to practice dentistry in Florida, is entitled to take those examinations. This provision exempts such applicants, who have not graduated from an accredited dental college or from a school approved by the Board, from having to complete a program of study at an accredited American dental school and receive a D.D.S. or D.M.D., from such school or complete a 2-year supplemental dental education program at an accredited dental school and receive a dental diploma, degree, or certificate in order to take the examinations.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

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[27] National Rural Health Association, *Issue Paper: Recruitment and Retention of a Quality Health Workforce in Rural Areas*, November 2006. A copy of this report is on file with the Senate Health Regulation Committee.

[28] Professional staff of the Senate Health Regulation Committee received this information via email from the Department of Health on March 11, 2011. A copy of the email is on file with the committee.

[29] The Henry J. Kaiser Family Foundation, *Florida: Estimated Underserved Population Living in Dental Health Professional Shortage Areas (HPSAs) as of September, 2008*, available at: http://www.statehealthfacts.org/profileind.jsp?ind=681&cat=8&rgn=11 (Last visited on March 31, 2011).

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

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

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

See below in "Private Sector Impact."

B. Private Sector Impact:

Applicants who apply for the licensure examination to practice dentistry in Florida will be subject to the examination fees ($1,700 to the Board of Dental Examiners for administration of the licensure examination and $760 to the Department of Health for the application fee, exam development, and licensure). However, the applicant will save any costs that he or she would have incurred if the applicant had to complete the additional education requirements to sit for the examinations.

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.)

None.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate . House

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Subsection (2) and paragraph (c) of subsection (4) of section 381.026, Florida Statutes, are amended to read:

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

(2) DEFINITIONS.—As used in this section and s. 381.0261, the term:

(a) "Department" means the Department of Health.

(b) "Health care facility" means a facility licensed under

chapter 395.

(c) "Health care provider" means a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, or a podiatric physician licensed under chapter 461.

(d) "Primary care provider" means a health care provider who provides medical services to patients which are commonly provided without referral from another health care provider, including a health care provider who practices family medicine, general medicine, general pediatrics, or general internal medicine.

(e) ~~(d)~~ "Responsible provider" means a health care provider who is primarily responsible for patient care in a health care facility or provider's office.

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

(c) *Financial information and disclosure.*—

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

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

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3. A primary care provider may publish a schedule of charges for the medical services that the provider offers to patients. The schedule must include the prices charged to an uninsured person paying for such services by cash, check, credit card, or debit card. The schedule must be posted in a conspicuous place in the reception area of the provider's office, and the posting must be at least 15 square feet in size. The schedule must include, but need not be limited to, the 50 services most frequently provided by that primary care provider. The schedule may group the services by three price levels, listing the services in each price level. A primary care provider who publishes and maintains such a schedule is exempt from the continuing education requirements of chapter 456 and rules implementing those requirements for a single 2-year period.

4.~~3.~~ A health care provider or a health care facility shall, upon request, furnish a person, before the ~~prior to~~ provision of medical services, a reasonable estimate of charges for such services. The health care provider or the health care facility shall provide an uninsured person, before ~~prior to~~ the provision of a planned nonemergency medical service, a reasonable estimate of charges for such service and information regarding the provider's or facility's discount or charity policies for which the uninsured person may be eligible. Such estimates by a primary care provider must be consistent with the prices listed on the schedule that is posted under subparagraph 3. Estimates must ~~shall~~, to the extent possible, be written in a language comprehensible to an ordinary layperson. Such reasonable estimate does ~~shall~~ not preclude the health care

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provider or health care facility from exceeding the estimate or making additional charges based on changes in the patient's condition or treatment needs.

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

6.~~5.~~ 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 2. This act shall take effect July 1, 2011.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to a patient's bill of rights and responsibilities; amending s. 381.026, F.S.; defining


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the term "primary care provider" as it relates to the Florida Patient's Bill of Rights and Responsibilities; authorizing a primary care provider to publish and post a schedule of certain charges for medical services offered to patients; providing requirements for the schedule; providing that the schedule may group the provider's services by price levels and list the services in each price level; providing an exemption from continuing education requirements for a primary care provider who posts such a schedule; requiring a primary care provider's estimates of charges for medical services to be consistent with the prices listed on the posted schedule; providing an effective date.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 1410
INTRODUCER:	Senator Negron
SUBJECT:	Health Care Price Transparency
DATE:	April 1, 2011
REVISED:	

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

I. Summary:

The bill amends the Patient's Bill of Rights to require a primary care provider to publish a schedule of charges for the medical services that the provider offers to patients. The schedule is to include the prices charged to an uninsured person paying by cash, check, credit card, or debit card.

If a person requests an estimate of charges for medical services before the services are provided, the estimate by a primary care provider must be consistent with the posted schedule.

Disciplinary action is authorized against an allopathic physician, osteopathic physician, and podiatric physician who is a primary care provider and who fails to publish or post the schedule of charges.

This bill substantially amends the following sections of the Florida Statutes: 381.026, 458.331, 459.015, and 461.013.

II. Present Situation:

The Florida Patient's Bill of Rights and Responsibilities

The Florida Patient's Bill of Rights and Responsibilities[1] is intended to promote better communication and eliminate misunderstandings between the patient and health care provider or

[1] Section 381.026, Florida Statutes.

health care facility.[2] The rights of patients include: standards related to individual dignity; information about the provider, facility, diagnosis, treatments, risks, etc.; financial information and disclosure; access to health care; experimental research; and patient's knowledge of rights and responsibilities. Patient responsibilities include giving the provider accurate and complete information regarding the patient's health, comprehending the course of treatment and following the treatment plan, keeping appointments, fulfilling financial obligations, and following the facility's rules and regulations affecting patient care and conduct.

Currently under the financial information and disclosure provisions:

- A health care provider or health care facility must disclose to a Medicare-eligible patient when requested whether the provider or facility accepts Medicare payment as full payment for medical services and treatment rendered in the provider's office or health care facility.
- A health care provider or health care facility is required to furnish to a person, upon request, an estimate of charges for medical services before providing the services. In addition, a health care provider or health care facility must provide an uninsured person, before planned nonemergency medical services, a reasonable estimate of the charges for the medical services and information regarding the provider's or facility's discount or charity policies for which the uninsured person may be eligible. These estimates are required to be written in a language that is comprehensible to an ordinary layperson. However, the provider or facility may exceed the estimates or make additional charges based on changes in the patient's condition or treatment needs.
- A licensed facility must place a notice in its reception area that financial information related to that facility is available on the Agency for Health Care Administration's (Agency) website.[3]
- The facility may indicate that the pricing information is based on a compilation of charges for the average patient and that an individual patient's charges may vary.
- A patient has the right to receive an itemized bill and explanation of the charges upon request.

Health care providers and health care facilities are required to make available to patients a summary of their rights. The applicable regulatory board or the Agency may impose an administrative fine when a provider or facility fails to make available to patients a summary of their rights.[4]

III. Effect of Proposed Changes:

Section 1 amends s. 381.026, F.S., relating to the Florida Patient's Bill of Rights and Responsibilities, to require a primary care provider, as defined in the bill, to publish a schedule of charges for the medical services that the provider offers. The schedule of charges must include

[2] A health care facility is a facility licensed under ch. 395, F.S., and a health care provider means a physician, osteopathic physician, or a podiatric physician licensed under chapters 458, 459, or 461, respectively.
[3] The Florida Center for Health Information and Policy Analysis (Florida Center) within the Agency is responsible for collecting, compiling, analyzing, and disseminating health-related data and statistics. The information is published on the FloridaHealthFinder website at http://www.floridahealthfinder.gov. This website currently discloses and allows price comparisons for certain inpatient and outpatient procedures in licensed health care facilities and certain prescription drugs. Long-range plans include the availability of similar price comparisons for physician services. *See* s. 408.05(3)(k), F.S.
[4] Section 381.0261, F.S.

the prices that the provider charges to an uninsured person paying by cash, check, credit card, or debit card. The schedule of charges must be posted in a conspicuous place in the reception area of the provider's office.

The bill defines a primary care provider as a medical physician licensed under ch. 458, F.S., an osteopathic physician licensed under ch. 459, F.S., or a podiatric physician licensed under ch. 461, F.S., who provides medical services to patients which are commonly provided without referral from another health care provider. The types of providers include those in family and general practice, general pediatrics, obstetrics and gynecology, and general internal medicine.

The bill requires that the estimate of charges furnished by a primary care provider pursuant to a request from an uninsured person before the medical services are provided must be consistent with the schedule posted in the reception area.

Sections 2, 3, and 4 amend ss. 458.331, 459.015, and 461.013, F.S., to provide an additional ground for disciplinary action for a medical physician, osteopath, or podiatrist who is a primary care provider and fails to publish or post the schedule of charges for the medical services offered to his or her patients.

Section 5 provides an effective date of July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

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

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The primary care physicians may incur an indeterminate cost to post and maintain the schedule of charges in the reception area. Uninsured patients of primary care physicians

will have ready access to the charges for certain health care services provided by that physician's office.

C. Government Sector Impact:

The DOH and the boards may experience an increase in the number of complaints and regulatory enforcement actions due to the schedule of charges not being published or not reflecting the current charges in the primary care provider's office.

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.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	CS/SB 1554
INTRODUCER:	Transportation Committee and Senator Hays
SUBJECT:	Emergency Vehicles
DATE:	April 1, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Sookhoo	Spalla	TR	**Fav/CS**
2.	Fernandez	Stovall	HR	**Pre-meeting**
3.			MS	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

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

I. Summary:

This bill increases the fine for a violation of section 316.126(1)(b)[1] of the Florida Statutes, from $30 to $100 in addition to any additional court costs. This increased fine has the potential to decrease the number of violations of s. 316.126(1)(b), F.S., and may increase the safety of parked emergency vehicle and wrecker operators.

This bill amends s. 318.18 of the Florida Statutes.

II. Present Situation:

Section 316.126(1)(b), F.S., relates to the operation of vehicles when approaching a parked emergency vehicle or a wrecker that is performing a recovery or a loading on the roadside. Currently, when a driver approaches an emergency vehicle or wrecker with engaged visual signals, drivers must yield the right-of-way and proceed to vacate the lane nearest the emergency vehicle or wrecker and move over if driving on a highway of two or more lanes moving in the same direction. Should this condition not be feasible, drivers are instructed to slow to a speed

[1] Section 316.126(1)(b), Florida Statutes, is more commonly known as the "Move Over Act" which passed during the 2002 Legislation.

that is 20 MPH less than the posted speed limit. If the posted speed is 20 MPH or less, drivers must slow to 5 MPH.

The current fine for a violation of s. 316.126(1)(b), F.S., is $30.

III. Effect of Proposed Changes:

This CS will increase the total fine for a violation of s. 316.126, F.S., from $30 to $100 plus additional court costs. In 2010, there were 2,438 citations written for s. 316.126(1)(b), F.S[2]. At the proposed fine of $100, revenues would increase by $170,660 based on the current level of citations being issued. However, due to an increased fine, there is a potential for a reduction in violations.

This bill will take effect July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

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

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Individuals violating s. 316.126(1)(b), F.S., will pay an increased fine of $100 for this offense.

[2] Department of Highway Safety and Motor Vehicles, *Senate Bill 1554 Agency Bill Analysis* (March 30, 2011) (on file with the Senate Committee on Health Regulation).

C. Government Sector Impact:

The proposed $70 fine increase is estimated to increase revenues for state and local government by $170,660 based on the current level of citations being issued. This bill has no fiscal impact on the Department of Highway Safety and Motor Vehicles.

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 Transportation on March 16, 2011:
This committee substitute decreased the proposed fine from $200 to $100 plus applicable court costs and fees.

B. Amendments:

None.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	CS/SB 730
INTRODUCER:	Committee on Education Pre-K - 12; Senators Flores, Altman, and others
SUBJECT:	Youth and Student Athletes
DATE:	March 31, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown	Matthews	ED	**Fav/CS**
2.	Brown/Fernandez	Stovall	HR	**Pre-meeting**
3.			RC	
4.				
5.				
6.				

I. Summary:

This bill requires independent sanctioning authorities of youth athletic teams, and the Florida High School Athletic Association, to adopt policies regarding educating administrators, parents, and athletes on sports-related concussions and head injuries.

Physicians or osteopaths are required to issue medical clearances, prior to a head-injured student's return to play. Health care practitioners are authorized to provide medical examinations and treatment for purposes of the clearances, in certain instances.

This bill substantially amends the following sections of the Florida Statutes: 943.0438 and 1006.20.

II. Present Situation:

Statutory Authority

An independent sanctioning authority is defined as a private, nongovernmental entity that organizes or operates youth athletic teams. This term does not apply to teams affiliated with private schools.[1]

The Florida High School Athletic Association (FHSAA), established in s. 1006.20, F.S., is the governing body of Florida public school athletics. Currently, the FHSAA governs 748 public and

[1] s. 943.0438(1)(b), F.S.

private member schools.[2] The Florida Legislature grants the FHSAA authority to adopt bylaws[3] to:

- Establish eligibility requirements for all students;
- Prohibit recruiting students for athletic purposes; and
- Require students participating in athletics to satisfactorily pass an annual medical evaluation.

Sports-related Head Injuries

According to the Brain Injury Association of Florida:

- More than 40 percent of serious head-injured high school athletes return to participate in sports before they are fully recovered;
- Approximately 400,000 high school athletes received concussions from sports activities during the 2005-08 school years and this number is likely much higher;
- During the timeframe from 1997-2007, the number of youth athletes seen with sports-related concussions in emergency rooms doubled and for those between 14-19 years old, it more than tripled;
- High school athletes with three or more concussions are 9 times more likely to have permanent mental changes; and
- Children and teens are more likely to get a concussion and take longer to recover than adults.[4]

The Centers for Disease Control and Prevention (CDC) define a concussion as a type of traumatic brain injury that is caused by a bump, blow, or jolt to the head that can change the way your brain normally works. Concussions can also occur from a blow to the body that causes the head to move rapidly back and forth. The CDC has created free tools for youth and high school sports coaches, parents, athletes, and health care professionals that provide important information on preventing, recognizing, and responding to a concussion.[5] The CDC estimate there are 135,000 emergency-room visits per year for traumatic brain injuries among people ages 5-18. But, it is believed that many more concussions go unreported or even undetected.[6]

The CDC estimates that there may be as many as 3.8 million sports and recreation-related concussions in the United States each year.[7]

Advocates of legislative protections for children receiving sports-related concussions promote the following three components:

- Education on the dangers of concussions;
- Removal from participation for head-injured players; and

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[2] http://www.fhsaa.org/about

[3] The FSHAA publishes their bylaws in an annual handbook, which is available online at the FHSA website, at: http://www.fhsaa.org/rules/fhsaa-handbook.

[4] *Youth Sports Concussion Awareness & Prevention*, Brain Injury Association of Florida (2011).

[5] Concussion in Sports, Centers for Disease Control and Prevention, *available at* http://www.cdc.gov/concussion/sports/index.html

[6] *Parents Concerned about Football Head Injuries*, NewsChief.com news story (November 4, 2010); A copy of this document is on file with the Senate Health Regulation Committee.

[7] Letter from Roger Goodell, National Football League, to Governor Charlie Crist (May 21, 2010). A copy of this document is on file with the Senate Health Regulation Committee.

- Delayed return until a medical professional provides a clearance.[8]

Named for a young football player who sustained serious injury after he returned to play too soon following a concussion, the "Zackery Lystedt Law" has been adopted in several states[9], including Washington and Oregon, and is under consideration in several other jurisdictions, including in Congress.[10,11]

Athletic Trainers

Athletic trainers are licensed under s. 468.701, F.S. The practice of athletic training refers to recognition, prevention and treatment of athletic injuries.[12] Athletic trainers require licensure, and must meet the following criteria to operate in the state of Florida:

- Apply, submit required fees, and pass a board exam;
- Be at least 21 years old;
- Hold a baccalaureate degree from an accredited college or university;
- Have current CPR certification; and
- Take a continuing education course on HIV/AIDS.[13]

III. Effect of Proposed Changes:

Sections 1 and 2 amend ss. 943.0438 and 1006.20, F.S., respectively, to require independent sanctioning authorities and the FHSAA to establish guidelines that provide information on concussions and head injuries to officials, administrators, coaches, parents and children.

In addition to requiring that guidelines be adopted, this bill requires independent sanctioning authorities and the FHSAA to adopt bylaws or policies regarding:

- Parental consent forms describing the nature and risk of concussions and head injuries, including the risk of continuing to play post-injury; and
- A requirement that the injured youth be immediately stopped from playing and not be allowed to return until a medical professional provides written clearance.

Qualifying medical professionals, for purposes of issuing medical clearances, are medical doctors and osteopaths. Medical doctors and osteopaths are authorized to delegate medical exams and treatment to specified health care practitioners, consisting of physician assistants, osteopathic physician assistants, advanced registered nurse practitioners, and athletic trainers, provided that the physician maintains a supervisory role or establishes written medical protocol. This bill authorizes physicians to consult with neuropsychologists or use testing established in that field.

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[8] Letter from Roger Goodell, National Football League, to Governor Charlie Crist (May 21, 2010). A copy of this document is on file with the Senate Health Regulation Committee.

[9] There are currently eleven states with laws that target youth sports-related head injuries. These states include Connecticut, Idaho, Maine, Massachusetts, New Jersey, New Mexico, Oklahoma, Oregon, Rhode Island, Virginia, and Washington.

[10] *Washington Boy's Case May Lead to Nationwide Sports Concussion Laws*, King5.com news story (February 1, 2010); available online at: http://www.king5.com/sports/high-school/Sports-Head-Injuries-83303332.html#.

[11] At the federal level, the ConTACT Act, which would require neurological baseline testing for each student athlete prior to the season, passed the House in September 2010.

[12] s. 468.701(5), F.S.

[13] s. 468.707, F.S.

Section 3 provides an effective date for the bill of July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

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

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Independent sanctioning authorities and the FHSAA would have to expend resources developing guidelines and bylaws or policies. This bill also would result in some recordkeeping duties. Provisions relating to informed consent and a prohibition on return to play until medically cleared may reduce liability for sports-related injuries, and therefore, have a positive impact.

Adoption of this legislation could lessen the severity of sports-related head injuries to youth and student athletes, with possible reduction of medical and other costs long-term.

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 Education Pre-K – 12 on March 17, 2011:
This committee substitute authorizes physicians, for purposes of medical clearances, to delegate examination and care to specified entities, including physician assistants, athletic trainers, and advanced registered nurse practitioners, provided that the physician maintains a supervisory role or establishes written protocol to be followed. Physicians may consult with neuropsychologists and rely on testing typically used by neuropsychologists.

B. Amendments:

None.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 1676
INTRODUCER:	Senator Thrasher
SUBJECT:	Sovereign Immunity
DATE:	March 31, 2011
REVISED:	

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

I. Summary:

The bill amends Florida Statutes to provide that, for the purposes of s. 768.28, F.S.,[1] any Florida not-for-profit college or university that owns or operates an accredited medical school or any of its employees or agents that have agreed in an affiliation agreement or other contract to provide patient services as agents of a public teaching hospital, are agents of the state and are immune from liability for torts in the same manner and to the same extent as the teaching hospital and its governmental owner or operator while acting within the scope of and pursuant to guidelines in the contract.

The bill also creates non-statutory provisions of law for legislative findings regarding the role of and the need for teaching hospitals and graduate medical education for Florida residents. The bill provides a legislative declaration that there is an overwhelming public necessity for the bill and that there is no alternative method of meeting such public necessity.

The bill takes effect upon becoming a law and applies to all claims accruing on or after that date.

This bill substantially amends the following sections of the Florida Statutes: 766.1115 and 768.28.

[1] The catch line for s. 768.28, F.S., reads, "Waiver of sovereign immunity in tort actions; recovery limits; limitation on attorney fees; statute of limitations; exclusions; indemnification; risk management programs."

II. Present Situation:

Sovereign Immunity

The term "sovereign immunity" originally referred to the English common law concept that the government may not be sued because "the King can do no wrong." Sovereign immunity bars lawsuits against the state or its political subdivisions for the torts of officers, employees, or agents of such governments unless the immunity is expressly waived.

Article X, s. 13, of the Florida Constitution recognizes the concept of sovereign immunity and gives the Legislature the right to waive such immunity in part or in full by general law. Section 768.28, F.S., contains the limited waiver of sovereign immunity applicable to the state.

Under this statute, officers, employees, and agents of the state will not be held personally liable in tort or named as a party defendant in any action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of her or his employment or function, unless such officer, employee, or agent acted in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.

Instead, the state steps in as the party litigant and defends against the claim. Subsection (5) limits the recovery of any one person to $100,000 for one incidence and limits all recovery related to one incidence to a total of $200,000.[2] For purposes of this analysis, when the term sovereign immunity is used, it means the application of sovereign immunity and the limited waiver of sovereign immunity as provided in s. 768.28, F.S.

Where the state's sovereign immunity applies, s 768.28(9), F.S., provides that the officers, employees, and agents of the state that were involved in the commission of the tort are not personally liable to an injured party.[3] Sovereign immunity extends to all subdivisions of the state, including counties and school boards.[4]

Whether sovereign immunity applies turns on the degree of control of the agent of the state retained by the state.[5] In *Stoll v. Noel*, the Florida Supreme Court explained that independent contractor physicians may be agents of the state for purposes of sovereign immunity:

> One who contracts on behalf of another and subject to the other's control except with respect to his physical conduct is an agent and also independent contractor.[6]

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[2] Section 1, ch. 2010-26, Laws of Florida, amended s. 768.28(5), F.S., effective October 1, 2011, to increase the limits to $200,000 for one person for one incidence and $300,000 for all recovery related to one incidence, to apply to claims arising on or after that effective date.

[3] Section 768.28(9)(a), F.S., provides that no officer, employee, or agent of the state or of any of its subdivisions shall be held personally liable in tort or named as a party defendant in any action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of her or his employment or function, *unless* such officer, employee, or agent acted in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.

[4] Section 768.28(2), F.S.

[5] *Stoll v. Noel*, 694 So.2d 701, 703 (Fla. 1997).

[6] *Stoll v. Noel*, 694 So.2d 701, 703 (Fla. 1997)(quoting The Restatement of Agency).

The court examined the employment contract between the physicians and the state to determine whether the state's right to control was sufficient to create an agency relationship and held that it did.[7] The court explained:

> Whether CMS physician consultants are agents of the state turns on the degree of control retained or exercised by CMS. This Court has held that the right to control depends upon the terms of the employment contract. *National Sur. Corp. v. Windham*, 74 So.2d 549, 550 (Fla.1954) ("The [principal's] right to control depends upon the terms of the contract of employment..."). CMS requires each consultant, as a condition of participating in the CMS program, to agree to abide by the terms published in its HRS[8] Manual and CMS Consultants Guide which contain CMS policies and rules governing its relationship with the consultants. The Consultant's Guide states that all services provided to CMS patients must be authorized in advance by the clinic medical director. The language of the HRS Manual ascribes to CMS responsibility to supervise and direct the medical care of all CMS patients and supervisory authority over all personnel. The manual also grants to the CMS medical director absolute authority over payment for treatments proposed by consultants. The HRS Manual and the Consultant's Guide demonstrate that CMS has final authority over all care and treatment provided to CMS patients, and it can refuse to allow a physician consultant's recommended course of treatment of any CMS patient for either medical or budgetary reasons.
>
> Our conclusion is buttressed by HRS's acknowledgment that the manual creates an agency relationship between CMS and its physician consultants, and despite its potential liability in this case, HRS has acknowledged full financial responsibility for the physicians' actions. HRS's interpretation of its manual is entitled to judicial deference and great weight.[9]

The sovereign immunity recovery caps do not prevent a plaintiff from obtaining a judgment in excess of the caps but the plaintiff cannot recover the excess damages without action by the Legislature.[10] The limits are constitutional.[11] In *Gerard v. Dept. of Transportation*, 472 So.2d 1170 (Fla. 1985), the Florida Supreme Court held that the recovery caps within s 768.28(5), F.S., did not prevent a plaintiff from seeking a judgment exceeding the recovery caps. However, the court noted that "even if he is able to obtain a judgment against the Department of Transportation in excess of the settlement amount and goes to the Legislature to seek a claims bill with the judgment in hand, this does not mean that the liability of the Department has been conclusively established. The Legislature will still conduct its own independent hearing to determine whether public funds would be expended, much like a non-jury trial. After all this, the Legislature, in its discretion, may still decline to grant him any relief."[12]

Chapter 766, F.S., provides current law on medical malpractice. Section 766.1115, F.S., provides that certain health care providers who contract with the state are considered agents of the state,

[7] *Stoll v. Noel*, 694 So.2d 701, 703 (Fla. 1997).
[8] Florida Department of Health and Rehabilitative Services
[9] *Stall v. Noel*, 694 So.2d 701,703 (Fla. 1997).
[10] Section 768.28(5), F.S.
[11] *Berek v. Metropolitan Dade County*, 422 So.2d 838 (Fla. 1982); *Cauley v. City of Jacksonville*, 403 So.2d 379 (Fla. 1981).
[12] *Gerard v. Department of Transportation*, 472 So.2d 1170, 1173 (Fla. 1985).

and thus entitled to the protection of sovereign immunity. The protection only applies where the contract contains specific conditions.

Section 768.28(9)(b)2., F.S., defines the term "officer, employee, or agent" for purposes of the sovereign immunity statute. Several identified groups are included in the definition, including health care providers when providing services pursuant to s. 766.1115, F.S.

Florida law confers sovereign immunity to a number of persons who perform public services, including:

- Persons or organizations providing shelter space without compensation during an emergency.[13]
- A health care entity providing services as part of a school nurse services contract.[14]
- Members of the Florida Health Services Corps who provide medical care to indigent persons in medically underserved areas.[15]
- A person under contract to review materials, make site visits or provide expert testimony regarding complaints or applications received by the Department of Health or the Department of Business and Professional Regulation.[16]
- Physicians retained by the Florida State Boxing Commission.[17]
- Health care providers under contract to provide uncompensated care to indigent state residents.[18]
- Health care providers or vendors under contract with the Department of Corrections to provide inmate care.[19]
- An operator, dispatcher, or other person or entity providing security or maintenance for rail services in the South Florida Rail Corridor, under contract with the Tri-County Commuter Rail Authority the Department of Transportation.[20]
- Professional firms that provide monitoring and inspection services of work required for state roadway, bridge or other transportation facility projects.[21]
- A provider or vendor under contract with the Department of Juvenile Justice to provide juvenile and family services.[22]
- Health care practitioners under contract with state universities to provide medical services to student athletes.[23]

III. Effect of Proposed Changes:

Section 1 creates 16 subsections of non-statutory law providing extensive legislative findings and intent to demonstrate that that there is an overwhelming public necessity for the sovereign

[13] *See* s. 252.51, F.S.
[14] *See* s. 381.0056(10), F.S.
[15] *See* s. 381.0302(11), F.S.
[16] *See* ss. 455.221(3) and 456.009(3), F.S.
[17] *See* s. 548.046(1), F.S.
[18] *See* s. 768.28(9)(b), F.S.
[19] *See* s. 768.28(10)(a), F.S.
[20] *See* s. 768.28(10)(d), F.S.
[21] *See* s. 768.28(10)(e), F.S.
[22] *See* s. 768.28(11)(a), F.S.
[23] *See* s. 768.28(12)(a), F.S.

immunity liability protection in the bill and that there is no alternative method of meeting such public necessity.

Section 2 amends s. 766.1115, F.S., to provide that any affiliation agreement or contract entered into by a medical school to provide comprehensive health care services to patients at public hospitals, which agreement or contract is subject to the sovereign immunity provisions in s. 768.28, F.S., is exempt from the provisions of s. 766.1115, F.S. – the Access to Health Care Act – which was created with legislative intent to ensure that health care professionals who contract to provide free quality medical services to underserved populations of the state as agents of the state are provided sovereign immunity.

Section 3 amends the definition of "officer, employee, or agent" in s. 768.28(9)(b), F.S., to include a Florida not-for-profit college, university, or medical school and its employees, under certain circumstances.

The bill creates s. 768.28(10)(f), F.S., to provide that any Florida not-for-profit college or university that owns or operates an accredited medical school or any of its employees or agents that have agreed in an affiliation agreement or other contract to provide patient services[24] as agents of a teaching hospital,[25] which is owned or operated by the state, a county, a municipality, a public health trust, a special taxing district, any other governmental entity having health care responsibilities, or a not-for-profit entity that operates such facilities as an agent of that governmental entity under a lease or other contract, are agents of the state and are immune from liability for torts in the same manner and to the same extent as a teaching hospital and its governmental owner or operator while acting within the scope of and pursuant to guidelines established in the contract.

Currently, the six teaching hospitals to which this bill would appear to apply are: Jackson Memorial in Miami, Mount Sinai Medical Center in Miami Beach, Shands Healthcare at the University of Florida in Gainesville, Shands Jacksonville Medical Center, Orlando Health in Orlando, and Tampa General Hospital.

The bill requires that the contract to provide patient services must provide for indemnification of the state by the agent for any liability incurred up to the limits set forth in ch. 768, F.S., to the extent caused by the negligence of the college, university, or medical school or its employees or agents. Current limits are $100,000 for any one person for one incident and limits all recovery related to one incident to a total of $200,000. Those amounts increase to $200,000 and $300,000, respectively, effective October 1, 2011.[26]

[24] The bill defines "patient services" as any comprehensive health care services; the training or supervision of medical students, interns, residents, or fellows; access to or participation in medical research protocols; or any related executive, managerial, or administrative services provided according to an affiliation agreement or other contract with the teaching hospital or its governmental owner or operator.
[25] Section 408.07(45), F.S., defines "teaching hospital" as any Florida hospital officially affiliated with an accredited Florida medical school which exhibits activity in the area of graduate medical education as reflected by at least seven different graduate medical education programs accredited by the Accreditation Council for Graduate Medical Education or the Council on Postdoctoral Training of the American Osteopathic Association and the presence of 100 or more full-time equivalent resident physicians.
[26] *Supra* note 2.

The bill provides that an employee or agent of a college, university, or its medical school[27] is not personally liable in tort and may not be named as a party defendant in any action arising from the provision of any such patient services except as provided in s. 768.28(9)(a), F.S.[28]

The bill requires that the public teaching hospital, the medical school, or its employees or agents must provide written notice to each patient, or the patient's legal representative, that the medical school and its employees are agents of the state and that the exclusive remedy for injury or damage suffered as a result of any act or omission of the public teaching hospital, the medical school, or an employee or agent of the medical school while acting within the scope of her or his duties pursuant to the affiliation agreement or other contract is by commencement of an action pursuant to s. 768.28, F.S. In order for the hospital, the medical school, or its employees or agents to fulfill this requirement, the patient or his or her legal representative must acknowledge in writing his or her receipt of the written notice.

The bill provides that an employee providing patient services under s. 768.28(10)(f), F.S., is not made an employee for purposes of the state's workers' compensation statute by virtue of s. 768.28(10)(f), F.S

Section 4 provides that the bill takes effect upon becoming a law and applies to all claims accruing on or after that date.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

By designating certain entities as agents of the state, the bill could render those entities subject to provisions of Article I, Section 24, of the Florida Constitution relating to access to public records and meetings. (See section VII. Related Issues.)

C. Trust Funds Restrictions:

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

D. Other Constitutional Issues:

If immunity from liability is legislatively accorded to a private entity, a potential constitutional challenge would be that the law violates the right of access to the courts. Article I, s. 21, of the Florida Constitution provides that the courts shall be open to all for redress for an injury. To impose a barrier or limitation on litigant's right to file certain

[27] The bill defines "employee or agent of a college, university, or medical school" as an officer, a member of the faculty, a health care practitioner or licensee defined in s. 456.001, or any other person who is directly or vicariously liable.
[28] *Supra* note 3.

actions, an extension of immunity from liability would have to meet the test announced by the Florida Supreme Court in *Kluger v. White*.[29] Under the test, the Legislature would have to provide a reasonable alternative remedy or commensurate benefit, or make a legislative showing of overpowering public necessity for the abolishment of the right and no alternative method of meeting such public necessity.

However, a substitute remedy does not need to be supplied by legislation that reduces but does not destroy a cause of action. When the Legislature extends sovereign immunity to a private entity, the cause of action is not constitutionally suspect as a violation of the access to courts provision of the State Constitution because the cause of action is not completely destroyed, although recovery for negligence may be more difficult.[30]

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The fiscal impact on the private sector is indeterminate.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill does not address what will happen in cases where a patient is unable to provide a written acknowledgment of having received the required notice, e.g. a patient who presents at the hospital emergency room seriously injured, unconscious, or otherwise incapacitated, and no legal representative is available.

In lines 275-289, it is not clear whether the college or university, the medical school, the employees or agents, or all of the above, must enter into the affiliation agreement or contract with the governmental entity in order to invoke the provisions of the bill regarding immunity from liability for torts.

Public Records

The Florida Supreme Court has addressed the issue of when a private entity under contract with a public agency falls under the purview of the public records and meeting provisions. The Court

[29] 281 So.2d 1 (Fla. 1973)
[30] *Id.* at 4.

looked to a number of factors which indicate a significant level of involvement by the public agency:

> The factors considered include, but are not limited to: (1) the level of public funding; (2) commingling of funds; (3) whether the activity was conducted on publicly owned property; (4) whether services contracted for are an integral part of the public agency's chosen decision-making process; (5) whether the private entity is performing a governmental function or a function which the public agency otherwise would perform; (6) the extent of the public agency's involvement with, regulation of, or control over the private entity; (7) whether the private entity was created by the public agency; (8) whether the public agency has a substantial financial interest in the private entity; and (9) for who's benefit the private entity is functioning.[31]

This bill provides that "any Florida not-for-profit college or university that owns or operates an accredited medical school or any of its employees or agents" that have an affiliation agreement or other contract to provide patient services as agents of a teaching hospital "which is owned or operated by the state, a county, a municipality, a public health trust, a special taxing district, any other governmental entity having health care responsibilities, or a not-for-profit entity that operates such facilities as an agent of that governmental entity under a lease" are agents of the state.

As noted previously, the bill is not clear whether the college or university, the medical school, the employees or agents, or all of the above, must enter into the affiliation agreement or contract with the governmental entity in order to invoke the provisions of the bill regarding immunity from liability for torts.

However, since one or more private entities (colleges, universities, medical schools, or employees or agents) will contract with the governmental entity under the bill, it could be argued that those private entities that *do* enter into the contract could be subject to the public records and meetings laws under *Schwab*. If the issue is litigated, the court would have to determine whether the factors set forth in *Schwab* apply. If the court were to find that the public records or meetings laws applied to the private entities, it would have to determine whether a statutory public records or meetings exemption applied.

One court noted a difficulty in determining which records are public records when a private corporation acts on behalf of the state:

> In holding that [private corporation] is subject to the public records act because it is acting on behalf of the [government entity], we emphasize that we are not ruling that all of its records are public. Some of its records may be subject to statutory exemptions or to valid claims of privacy. Likewise, we cannot rule that every function of this corporation is performed on behalf of the [government entity]. While we have seen little evidence of functions that might fall outside the realm of public access, the trial court is free to

[31] *News and Sun-Sentinel Company v. Schwab, Twitty & Hanser Architectural Group*, 596 So.2d 1029, 1031 (Fla. 1992).

review specific activities of the corporation on remand to determine whether they involve nongovernmental functions which fall outside the public disclosure requirements.[32]

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.

[32] *Sarasota Herald-Tribune Co. v. Community Health Corp., Inc.*, 582 So.2d 730, 734 (Fla. 2d DCA 1991)(footnote omitted).

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 1770
INTRODUCER:	Senator Hays
SUBJECT:	Parental Notice of Abortion
DATE:	April 1, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	O'Callaghan	Stovall	HR	**Pre-meeting**
2.			JU	
3.			BC	
4.				
5.				
6.				

I. Summary:

This bill amends s. 390.01114, F.S., relating to parental notification of an abortion to be performed on a minor. This bill amends the law as it relates to parental notification of an abortion by:

- Defining "constructive notice" to include notice by writing that must be mailed to a minor's parent or legal guardian prior to the abortion by certified mail *and* by first-class mail.
- Requiring notice that is given by telephone to a parent or legal guardian to be confirmed in writing, signed by the physician, and mailed to the parent or legal guardian of the minor by first-class and certified mail.
- Requiring a physician to make reasonable attempts to contact the parent or legal guardian, whenever possible, during a medical emergency that renders the abortion medically necessary, without endangering the minor.
- Requiring the physician to provide notice directly to a parent or legal guardian of the medical emergency requiring an abortion and any additional risks to the minor and if no notice is directly provided, then notice is required in writing to the parent or legal guardian, which must be mailed by first-class and certified mail.
- Providing that a parent or guardian's legal right to be noticed can only be waived if the written waiver is notarized, dated not more than 30 days before the abortion, and contains a specific waiver of the parent or legal guardian's right to notice of the minor's abortion.
- Reducing the number of courts in which a minor is able to file a petition for waiver of parental notice.
- Changing the time within which a court must rule on a minor's petition for a waiver of parental notice from 48 hours to 3 business days.
- Removing the automatic grant of a petition when a court fails to rule within a certain time.

- Providing that a minor may have her petition heard by a chief judge of the circuit within 48 hours of filing the petition when a circuit court has not ruled within 3 business days.
- Providing the minor with the right to appeal a court decision that does not grant judicial waiver of parental notice, providing the timeline within which the appellate court must rule, and providing the standard of review the appellate court must use.
- Requiring the court to consider specific factors when determining whether the minor is sufficiently mature to decide whether to terminate her pregnancy.
- Changing the standard upon which a court must find that the notification of a parent or guardian of the abortion is not in the best interest of the minor, from preponderance of the evidence to clear and convincing evidence.
- Providing that when the court considers what is in the best-interest of the minor, the court is not to consider financial implications for the minor or the minor's family.
- Requiring the final written order by the court to include its factual findings determining the maturity of the minor.
- Requiring the Office of State Courts Administrator to include in its annual report to the Governor and Legislature, regarding the number of petitions filed for a waiver of parental notice, the reason for each waiver of notice granted.

The bill also includes a severability clause, which severs any provision of the bill that is held invalid and saves the remaining provisions.

This bill substantially amends s. 390.01114, F.S.

This bill creates and undesignated section of the Florida Statutes.

II. Present Situation:

Background

Under Florida law the term "abortion" means the termination of human pregnancy with an intention other than to produce a live birth or to remove a dead fetus.[1] "Viability" means that stage of fetal development when the life of the unborn child may, with a reasonable degree of medical probability, be continued indefinitely outside the womb.[2] Induced abortion can be elective (performed for nonmedical indications) or therapeutic (performed for medical indications). An abortion can be performed by surgical or medical means (medicines that induce a miscarriage).[3] An abortion in Florida must be performed by a physician licensed to practice medicine or osteopathic medicine who is licensed under ch. 458, F.S., or ch. 459, F.S., or a physician practicing medicine or osteopathic medicine in the employment of the United States.[4] No person who is a member of, or associated with, the staff of a hospital, or any employee of a hospital or physician in which, or by whom, the termination of a pregnancy has been authorized or performed, who states an objection to the procedure on moral or religious grounds is required

[1] Section 390.011, F.S.
[2] Section 390.0111(4), F.S.
[3] Suzanne R. Trupin, M.D., *Elective Abortion*, December 21, 2010, *available at*: http://www.emedicine.com/med/TOPIC3312.HTM (Last visited March 31, 2011).
[4] Section 390.0111(2) and s. 390.011(7), F.S.

to participate in the procedure. The refusal to participate may not form the basis for any disciplinary or other recriminatory action.[5]

In 2007, a total of 91,954 abortions were performed in Florida: for 83,890 of those, the gestational age of the fetus was 12 weeks and under; for 8,063, the gestational age of the fetus was 13 to 24 weeks; and for 1, the gestational age was over 25 weeks.[6]

Parental Notice of Abortion Act[7]

In 1999, the Legislature enacted a law requiring parents of minors to be notified prior to the minor's termination of a pregnancy. This law was constitutionally challenged on grounds that the act violated a person's right to privacy under the Florida Constitution. The Florida Supreme Court concluded that the act violated Florida's constitutional right to privacy because the minor was not afforded a mechanism by which to bypass parental notification if certain exigent circumstances existed.[8] In response to the court's decision, the Legislature proposed a constitutional amendment authorizing the Florida Legislature, notwithstanding a minor's right to privacy under the Florida Constitution, to require a physician to notify a minor's parent or guardian prior to termination of the minor's pregnancy, which was subsequently ratified by Florida voters.[9] The amendment provides:

> The Legislature shall not limit or deny the privacy right guaranteed to a minor under the United States Constitution as interpreted by the United States Supreme Court. Notwithstanding a minor's right of privacy provided in Section 23 of Article I, the Legislature is authorized to require by general law for notification to a parent or guardian of a minor before the termination of the minor's pregnancy. The Legislature shall provide exceptions to such requirement for notification and shall create a process for judicial waiver of the notification.[10]

The Legislature responded to this authorization by enacting the Parental Notice of Abortion Act (Act).[11]

A physician performing an abortion must provide "actual notice"[12] to the parent or legal guardian of a minor[13] before performing an abortion on a minor. The notice may be given by a referring physician. The physician who performs the abortion must receive the written statement of the referring physician certifying that the referring physician has given actual notice. If actual notice

[5] Section 390.0111(8), F.S.
[6] Florida Vital Statistics Annual Report 2007, *available at:* http://www.flpublichealth.com/VSBOOK/VSBOOK.aspx# (Last visited on March 31, 2011).
[7] Section 390.01114, F.S.
[8] *North Florida Women's Health and Counseling Services v. State*, 866 So. 2d 612 (Fla. 2003).
[9] See FLA. CONST. art. X, s. 22.
[10] *Id.*
[11] Laws of Fla. 2005-52, s 2
[12] "Actual notice" means notice that is given directly, in person or by telephone, to a parent or legal guardian of a minor, by a physician, at least 48 hours before the inducement or performance of a termination of pregnancy, and documented in the minor's files. Section 390.01114(2)(a), F.S.
[13] A minor is a person under the age of 18 years. Section 390.01114(2)(f), F.S.

is not possible after a reasonable effort has been made, the physician performing the abortion or the referring physician must give "constructive notice."[14]

Notice given by the physician performing the abortion must include the name and address of the facility providing the abortion and the name of the physician providing the notice. Notice given by a referring physician must include the name and address of the facility where he or she is referring the minor and the name of the physician providing the notice.

If actual notice is provided by telephone, the physician must actually speak with the parent or guardian, and must record in the minor's medical file the name of the parent or guardian to whom the notice was provided, the phone number dialed, and the date and time of the call. If constructive notice is given, the physician must document that notice by placing copies of any document related to the constructive notice, including, but not limited to, a copy of the letter and the return receipt, in the minor's medical file.

There are several exceptions to the notice requirement. Notice is not required if:[15]

- In the physician's good faith clinical judgment, a medical emergency exists and there is insufficient time for the attending physician to comply with the notification requirements. If a medical emergency exists, the physician may proceed but must document reasons for the medical necessity in the patient's medical records.
- Notice is waived in writing by the person who is entitled to notice.
- Notice is waived by the minor who is or has been married or has had the disability of nonage removed under s. 743.015, F.S., or a similar statute of another state.
- Notice is waived by the patient because the patient has a minor child dependent on her.
- Notice is waived by judicial waiver.

A physician who violates any of the parental notice requirements may be subject to disciplinary action under s. 458.331 or s. 459.015, F.S.[16]

A minor may petition any circuit court within the jurisdiction of the District Court of Appeal in which she resides for a waiver of the parental notice requirement and may participate in proceedings on her own behalf. The petition may be filed under a pseudonym or through the use of initials, as provided by court rule. The petition must include a statement that the petitioner is pregnant and notice has not been waived. The court is required to advise the minor that she has a right to court-appointed counsel and must provide her with counsel upon her request at no cost to the minor.[17]

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[14] "Constructive notice" means notice that is given in writing, signed by the physician, and mailed at least 72 hours before the inducement or performance of the termination of pregnancy, to the last known address of the parent or legal guardian of the minor, by certified mail, return receipt requested, and delivery restricted to the parent or legal guardian. After the 72 hours have passed, delivery is deemed to have occurred. Section 390.01114(2)(c), F.S.

[15] Section 390.01114(3)(b), F.S.

[16] The Department of Health, or the appropriate board, may suspend or permanently revoke a license; restrict a practice or license, impose an administrative fine not to exceed $10,000 for each count or separate offense; issue a reprimand or letter of concern; place the licensee on probation for a period of time and subject it to conditions; take corrective action; impose an administrative fine for violations regarding patient rights; refund fees billed and collected from the patient or a third party on behalf of the patient; or require that the practitioner undergo remedial education.

[17] Section 390.01114(4)(a), F.S.

These court proceedings must be given precedence over other pending matters to the extent necessary to ensure that the court reaches a decision promptly. The court is required to rule, and issue written findings of fact and conclusions of law, within 48 hours[18] after the petition is filed, except that the 48-hour limitation may be extended at the request of the minor. If the court fails to rule within the 48-hour period and an extension has not been requested, the petition is granted, and the notice requirement is waived.[19]

If the court finds, by clear and convincing evidence, that the minor is sufficiently mature to decide whether to terminate her pregnancy, the court must issue an order authorizing the minor to consent to the abortion without the notification of a parent or guardian, otherwise the court must dismiss the petition.

If the court finds, by a preponderance of the evidence, that there is evidence of child abuse or sexual abuse of the petitioner by one or both of her parents or her guardian, or that the notification of a parent or guardian is not in the best interest of the petitioner, the court is required to issue an order authorizing the minor to consent to the abortion without the notification of a parent or guardian, otherwise the court must dismiss the petition. If the court finds evidence of child abuse or sexual abuse of the minor petitioner by any person, the court must report the evidence of child abuse or sexual abuse of the petitioner, as provided in s. 39.201, F.S.[20]

Section 390.01114, F.S., also provides for the court procedures, including an appeals process, for hearings on a petition for waiver of parental notice.[21]

The Supreme Court of Florida, through the Office of the State Courts Administrator, is required to report by February 1 of each year to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the number of petitions filed for a waiver of parental notice for the preceding year, and the timing and manner of disposal of such petitions by each circuit court.[22] The Office of the State Courts Administrator reports that from January through December 2010 there were 381 petitions filed for a waiver of parental notice; 371 of those petitions were granted, 10 of those petitions were dismissed, and none of the petitions were granted by default because the court did not enter an order within 48 hours.[23]

[18] The Florida Supreme Court defines "48 hours" as meaning exactly 48 hours from the filing of the petition and specifically includes weekends, holidays, and times after regular business hours of the court. Rule 8.820(d), Florida Rules of Juvenile Procedure.
[19] Section 390.01114(4)(b), F.S.
[20] Section 39.201, F.S., requires that that finding of such evidence must be reported to the Department of Children and Family Services.
[21] *See* s. 390.01114(4), F.S.
[22] Section 390.01114(6), F.S.
[23] Information received on March 23, 2011, from the Office of the State Courts Administrator via e-mail to Senate Health Regulation Committee professional staff. A copy of the email is on file with the committee.

Relevant Case Law

In 1973, the landmark case of *Roe v. Wade* established that restrictions on a woman's access to secure an abortion are subject to a strict scrutiny standard of review.[24] In *Roe*, the U.S. Supreme Court determined that a woman's right to have an abortion is part of the fundamental right to privacy guaranteed under the Due Process Clause of the Fourteenth Amendment of the U.S. Constitution, justifying the highest level of review.[25] Specifically, the Court concluded that: (1) during the first trimester, the state may not regulate the right to an abortion; (2) after the first trimester, the state may impose regulations to protect the health of the mother; and (3) after viability, the state may regulate and proscribe abortions, except when it is necessary to preserve the life or health of the mother.[26] Therefore, a state regulation limiting these rights may be justified only by a compelling state interest, and the legislative enactments must be narrowly drawn to express only legitimate state interests at stake.[27]

In 1992, in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the U.S. Supreme Court relaxed the standard of review in abortion cases involving adult women from strict scrutiny to unduly burdensome, while still recognizing that the right to an abortion emanates from the constitutional penumbra of privacy rights.[28] In *Planned Parenthood*, the Court determined that, prior to fetal viability, a woman has the right to an abortion without being unduly burdened by government interference.[29] The Court concluded that the state may regulate the abortion as long as the regulation does not impose an undue burden on a woman's decision to choose an abortion.[30] If the purpose of a provision of law is to place substantial obstacles in the path of a woman seeking an abortion before viability, it is invalid; however, after viability the state may restrict abortions if the law contains exceptions for pregnancies endangering a woman's life or health.[31]

The unduly burdensome standard as applied in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, which is generally considered to be a hybrid between strict scrutiny and intermediate level scrutiny, shifted the Court's focus to whether a restriction creates a substantial obstacle to access. This is the prevailing standard today applied in cases in which abortion access is statutorily restricted.

However, the undue burden standard was held not to apply in Florida. The 1999 Legislature passed a parental notification law, the Parental Notice of Abortion Act, requiring a physician to give at least 48 hours of actual notice to one parent or to the legal guardian of a pregnant minor before terminating the pregnancy of the minor. Although a judicial waiver procedure was included, the act was never enforced.[32] In 2003, the Florida Supreme Court[33] ruled this

[24] 410 U.S. 113 (1973).
[25] 410 U.S. 113, 154 (1973).
[26] 410 U.S. 113, 162-65 (1973).
[27] 410 U.S. 113, 152-56 (1973).
[28] 505 U.S. 833, 876-79 (1992).
[29] *Id.*
[30] *Id*.
[31] *Id.*
[32] *See* s. 390.01115, F.S. (repealed by s. 1, ch. 2005-52, Laws of Florida). Ch. 2005-52, Laws of Florida created s. 390.01114, F.S., the revised Parental Notice of Abortion Act.

legislation unconstitutional on the grounds that it violated a minor's right to privacy, as expressly protected under Article I, s. 23 of the Florida Constitution.[34] Citing the principle holding of *In re T.W.*,[35] the Court reiterated that, as the privacy right is a fundamental right in Florida, any restrictions on privacy warrant a strict scrutiny review, rather than that of an undue burden. Here, the Court held that the state failed to show a compelling state interest and therefore, the Court permanently enjoined the enforcement of the Parental Notice of Abortion Act.[36]

In the case of *In re Petition of Jane Doe,*[37] the Second District Court of Appeal of Florida provided an in-depth review of considerations by courts throughout the country in assessing maturity, for purposes of determining whether to permit a judicial waiver of the parental notification requirement for an abortion.

The *Jane Doe* case noted that the trial courts have drawn inferences from the minor's composure, analytic ability, appearance, thoughtfulness, tone of voice, expressions, and her ability to articulate her reasoning and conclusions.[38] The *Jane Doe* case also noted that another court,[39] in its attempt to define maturity, observed:

> Manifestly, as related to a minor's abortion decision, maturity is not solely a matter of social skills, level of intelligence or verbal skills. More importantly, it calls for experience, perspective and judgment. As to experience, the minor's prior work experience, experience in living away from home, and handling personal finances are some of the pertinent inquiries. Perspective calls for appreciation and understanding of the relative gravity and possible detrimental impact of each available option, as well as realistic perception and assessment of possible short term and long-term consequences of each of those options, particularly the abortion option. Judgment is of very great importance in determining maturity. The exercise of good judgment requires being fully informed so as to be able to weigh alternatives independently and realistically. Among other things, the minor's conduct is a measure of good judgment. Factors such as stress and ignorance of alternatives have been recognized as impediments to the exercise of proper judgment by minors, who because of those factors "may not be able intelligently to decide whether to have an abortion."

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[33] *North Florida Women's Health and Counseling Services, Inc., et al., v. State of Florida*, 866 So. 2d 612, 619-20 (Fla. 2003)

[34] The constitutional right of privacy provision reads: "Every natural person has the right to be let alone and free from governmental intrusion into the person's private life except as otherwise provided herein. This section shall not be construed to limit the public's right of access to public records and meetings as provided by law." FLA. CONST. art. I, s. 23.

[35] 551 So. 2d 1186, 1192 (Fla. 1989).

[36] *North Florida Women's Health and Counseling Services, supra* note 16, at 622 and 639-40.

[37] *In re Petition of Jane Doe*, 973 So. 2d 548 (Fla. 2d DCA 2008). The motion for rehearing en banc was denied. In this case, the court held that the juvenile failed to prove by clear and convincing evidence that she was sufficiently mature to warrant waiving the requirement for parental notification of abortion and also failed to establish that parental notification concerning abortion was not in her best interest.

[38] *Id.* at 552, citing *Ex parte Anonymous*, 806 So.2d 1269, 1274 (Ala. 2001).

[39] *Id.* at 551, citing *H.B. v. Wilkinson*, 639 F.Supp. 952, 954 (D.Utah 1986), which cited *Am. Coll. of Obstetricians & Gynecologists v. Thornburgh,* 737 F.2d 283, 296 (Pa. 3d Cir.1984), *affirmed* 476 U.S. 747 (1986).

The *Jane Doe* case further opined that another court similarly has stated that when evaluating maturity, pertinent factors include, but are not limited to, the minor's physical age, her understanding of the medical risks associated with the procedure as well as emotional consequences, her consideration of options other than abortion, her future educational and life plans, her involvement in civic activities, any employment, her demeanor and her seeking advice or emotional support from an adult.[40]

Finally, the *Jane Doe* case discussed that the Supreme Court of Texas, after surveying the decisions of other courts, wrote that those courts had inquired into how a minor might respond to certain contingencies, particularly assessing whether the minor will seek counseling in the event of physical or emotional complications. Many courts have assessed the minor's school performance and activities, as well as the minor's future and present life plans. A few courts have explicitly assessed the minor's character and judgment directly. Most of the decisions have also considered the minor's job experience and experience handling finances, particularly assessing whether the minor is aware of the financial obligations inherent in raising a child. Almost all courts conduct the maturity inquiry, either explicitly or implicitly, against the background circumstances of the minor's experience. These include the minor's relationship with her parents, whether she has social and emotional support, particularly from the male who would be a father, and other relevant life experiences.[41]

The *Jane Doe* case also addressed the contention that notification of the parent or guardian was not in the appellant's best interest. The court stated, some factors to be considered are: the minor's emotional or physical needs; the possibility of intimidation, other emotional injury, or physical danger to the minor; the stability of the minor's home and the possibility that notification would cause serious and lasting harm to the family structure; the relationship between the parents and the minor and the effect of notification on that relationship; and the possibility that notification may lead the parents to withdraw emotional and financial support from the minor.[42]

III. Effect of Proposed Changes:

This bill amends s. 390.01114, F.S., relating to parental notification of an abortion to be performed on a minor. This bill defines "constructive notice" to include notice by writing that must be mailed to a minor's parent or legal guardian 72 hours prior to the abortion by certified mail, return receipt requested with restricted delivery to the parent or legal guardian *and* by first-class mail.

The bill requires actual notice that is given by telephone to be confirmed in writing, signed by the physician, and mailed to the parent or legal guardian of the minor by first-class and by certified mail, return receipt requested, with delivery restricted to the parent or legal guardian. Furthermore, the bill requires a physician to make reasonable attempts to contact the parent or legal guardian, whenever possible, during a medical emergency that renders the abortion medically necessary, without endangering the minor. The physician providing such notice of the

[40] *Id.* at 551-552, citing *In re Doe*, 924 So.2d 935, 939 (Fla. 1st DCA 2006).
[41] *Id.* at 552, citing *In re Doe 2*, 19 S.W.3d 249, 256 (Tex. 2000).
[42] *Id.* at 553, citing *In re Doe*, 932 So.2d 278, at 285-86 (Fla. 2d DCA 2005); see also *In re Doe 2*, 166 P.3d 293, 296 (Colo. App. 2007); *In re Doe*, 19 Kan.App.2d 204, 866 P.2d 1069, 1075 (1994); *In re Doe 2*, 19 S.W.3d 278, 282 (Tex. 2000).

medical emergency must do so directly by telephone or in person and must provide the parent or legal guardian with the details of the medical emergency and any additional risks to the minor. If the parent or legal guardian has not been notified within 24 hours after the abortion, the physician must provide the notice in writing and the notice must be signed by the physician. The written notice must be mailed to the last known address of the parent or legal guardian of the minor, by first-class mail and by certified mail, return receipt requested, with delivery restricted to the parent or legal guardian.

A physician does not have to provide parental notice if a parent or guardian waives his or her right to be noticed and the written waiver is notarized, dated not more than 30 days before the abortion, and contains a specific waiver of the parent or legal guardian's right to notice of the minor's abortion.

The number of courts in which a minor is able to file a petition for waiver of the parental notice requirement is reduced because the bill authorizes a minor to petition any circuit court in which she resides rather than any circuit court within the jurisdiction of the District Court of Appeal in which she resides.

The bill also changes the time within which a court must rule on a minor's petition for a waiver of parental notice from 48 hours to 3 business days and removes the automatic grant of a petition when a court fails to rule within a certain time. If the court fails to rule within 3 business days after the filing of the petition, the minor may immediately petition the chief judge of the circuit for a hearing, which must be held within 48 hours of receiving the minor's petition. The chief judge must enter an order within 24 hours after the hearing.

The bill provides the minor with the right to appeal a court decision that does not grant judicial waiver of parental notice, and provides that the appellate court must rule within 7 days after receipt of the appeal. However, if the court rules to remand the case, a ruling must take place within 3 business days after the remand. The standard that must be used by the appellate court when overturning a ruling on appeal is an abuse of discretion standard and the decision may not be based on the weight of the evidence presented to the circuit court because the proceeding is not adversarial.

The bill provides specific factors that the court must consider when determining whether the minor is sufficiently mature to decide whether to terminate her pregnancy. The factors the court is required to consider include:

- The minor's age, overall intelligence, emotional development and stability, credibility and demeanor as a witness, ability to accept responsibility, ability to assess both the immediate and long-range consequences of the minor's choices, and ability to understand and explain the medical risks of terminating her pregnancy and to apply that understanding to her decision; and
- Whether there may be an undue influence by another on the minor's decision to have an abortion.

The bill also changes the standard upon which a court must find that the notification of a parent or guardian of the abortion is not in the best interest of the minor, from preponderance of the evidence to clear and convincing evidence. The bill provides that the best-interest standard used

by the court does not include financial best interest, financial considerations, or the potential financial impact on the minor or the minor's family if the minor does not terminate the pregnancy.

The bill requires the final written order by the court to include its factual findings determining the maturity of the minor.

The bill requires the Supreme Court, through the Office of State Courts Administrator, to include in its annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives, regarding the number of petitions filed for a waiver of parental notice, the reason for each waiver of notice granted.

The bill also includes a severability clause, which severs any provision of the bill that is held invalid and saves the remaining provisions.

The bill provides that it will take effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

Under s. 390.01116, F.S., any information in a court record, which could be used to identify a minor petitioning a circuit court for a judicial waiver of parental notice, is confidential and exempt from public disclosure.

C. Trust Funds Restrictions:

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

D. Other Constitutional Issues:

If the bill, should it become law, is challenged because of its additional parental notification requirements, it will be subject to a strict scrutiny review, rather than that of an undue burden test pursuant to *North Florida Women's Health and Counseling Services, Inc., et al., v. State of Florida*,[43] as discussed above under the subheading, "Relevant Case Law."

The bill may be challenged as encroaching on the Florida Supreme Court's specific constitutional authority to adopt rules for the practice and procedure in all courts. Section 3, Article II of the Florida Constitution provides that the powers of the state

[43] 866 So. 2d 612 (Fla. 2003).

government shall be divided into legislative, executive, and judicial branches. No person belonging to one branch shall exercise any powers appertaining to either of the other branches unless expressly provided herein.

Section 2, Article V, of the Florida Constitution provides, among other things, that the supreme court shall adopt rules for the practice and procedure in all courts including the time for seeking appellate review, the administrative supervision of all courts, the transfer to the court having jurisdiction of any proceeding when the jurisdiction of another court has been improvidently involved, and a requirement that no cause shall be dismissed because an improper remedy has been sought.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Physicians may incur additional administrative costs because the bill requires physicians to mail additional notifications.

C. Government Sector Impact:

The Office of the State Courts Administrator may incur administrative costs associated with changing its reporting requirements as required under the bill. It is indeterminate the impact, if any, the bill's requirements for additional court procedures will have on the state court system.

VI. Technical Deficiencies:

Lines 119 through 21 need clarification because a minor does not reside in a circuit court. An amendment might delete lines 119 through 120 and insert: (a) A minor may petition any circuit court in <u>the</u> ~~a~~ judicial circuit ~~within the jurisdiction of the District Court of Appeal~~.

VII. Related Issues:

Lines 144 through 152 of the bill provide for a minor's appellate rights and certain appellate procedures. Existing law, which can be found in lines 209 through 213 of the bill, already provide for a minor's right to appeal and provide that the Supreme Court is to provide the procedures for appellate review by rule. Therefore, these two provisions may conflict with each other.

The bill does not include an automatic waiver of the parental notice requirement if the court fails to rule after the Appellate Court remands for a ruling.

VIII. Additional Information:

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

None.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate . House

. . . . .

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

Senate Amendment (with title amendment)

Delete lines 198 - 614
and insert:
Section 6. Section 766.102, Florida Statutes, is amended to read:
766.102 Medical negligence; standards of recovery; expert witness.—
(1) In any action for recovery of damages based on the death or personal injury of any person in which it is alleged that such death or injury resulted from the negligence of a health care provider as defined in s. 766.202(4), the claimant

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shall have the burden of proving by the greater weight of evidence that the alleged actions of the health care provider represented a breach of the prevailing professional standard of care for that health care provider. The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

(2)(a) If the injury is claimed to have resulted from the negligent affirmative medical intervention of the health care provider, the claimant must, in order to prove a breach of the prevailing professional standard of care, show that the injury was not within the necessary or reasonably foreseeable results of the surgical, medicinal, or diagnostic procedure constituting the medical intervention, if the intervention from which the injury is alleged to have resulted was carried out in accordance with the prevailing professional standard of care by a reasonably prudent similar health care provider.

(b) The provisions of this subsection shall apply only when the medical intervention was undertaken with the informed consent of the patient in compliance with the provisions of s. 766.103.

(3) The existence of a medical injury shall not create any inference or presumption of negligence against a health care provider, and the claimant must maintain the burden of proving that an injury was proximately caused by a breach of the prevailing professional standard of care by the health care provider. However, the discovery of the presence of a foreign

body, such as a sponge, clamp, forceps, surgical needle, or other paraphernalia commonly used in surgical, examination, or diagnostic procedures, shall be prima facie evidence of negligence on the part of the health care provider.

(4) The Legislature is cognizant of the changing trends and techniques for the delivery of health care in this state and the discretion that is inherent in the diagnosis, care, and treatment of patients by different health care providers. The failure of a health care provider to order, perform, or administer supplemental diagnostic tests shall not be actionable if the health care provider acted in good faith and with due regard for the prevailing professional standard of care.

(5) A person may not give expert testimony concerning the prevailing professional standard of care unless that person is a licensed health care provider and meets the following criteria:

(a) If the health care provider against whom or on whose behalf the testimony is offered is a specialist, the expert witness must:

1. Specialize in the same specialty as the health care provider against whom or on whose behalf the testimony is offered; ~~or specialize in a similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients;~~ and

2. Have devoted professional time during the 2 ~~3~~ years immediately preceding the date of the occurrence that is the basis for the action to:

a. The active clinical practice of~~, or consulting with respect to,~~ the same ~~or similar~~ specialty that includes the

evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients;

b. Instruction of students in an accredited health professional school or accredited residency or clinical research program in the same ~~or similar~~ specialty; or

c. A clinical research program that is affiliated with an accredited health professional school or accredited residency or clinical research program in the same ~~or similar~~ specialty.

(b) If the health care provider against whom or on whose behalf the testimony is offered is a general practitioner, the expert witness must have devoted professional time during the 2 ~~5~~ years immediately preceding the date of the occurrence that is the basis for the action to:

1. The active clinical practice ~~or consultation~~ as a general practitioner;

2. The instruction of students in an accredited health professional school or accredited residency program in the general practice of medicine; or

3. A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the general practice of medicine.

(c) If the health care provider against whom or on whose behalf the testimony is offered is a health care provider other than a specialist or a general practitioner, the expert witness must have devoted professional time during the 2 ~~3~~ years immediately preceding the date of the occurrence that is the basis for the action to:

1. The active clinical practice of~~, or consulting with~~

~~respect to,~~ the same ~~or similar~~ health profession as the health care provider against whom or on whose behalf the testimony is offered;

2. The instruction of students in an accredited health professional school or accredited residency program in the same ~~or similar~~ health profession in which the health care provider against whom or on whose behalf the testimony is offered; or

3. A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the same ~~or similar~~ health profession as the health care provider against whom or on whose behalf the testimony is offered.

(6) A physician licensed under chapter 458 or chapter 459 who qualifies as an expert witness under subsection (5) and who, by reason of active clinical practice or instruction of students, has knowledge of the applicable standard of care for nurses, nurse practitioners, certified registered nurse anesthetists, certified registered nurse midwives, physician assistants, or other medical support staff may give expert testimony in a medical negligence action with respect to the standard of care of such medical support staff.

(7) Notwithstanding subsection (5), in a medical negligence action against a hospital, a health care facility, or medical facility, a person may give expert testimony on the appropriate standard of care as to administrative and other nonclinical issues if the person has substantial knowledge, by virtue of his or her training and experience, concerning the standard of care among hospitals, health care facilities, or medical facilities of the same type as the hospital, health care facility, or

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medical facility whose acts or omissions are the subject of the testimony and which are located in the same or similar communities at the time of the alleged act giving rise to the cause of action.

(8) If a health care provider described in subsection (5), subsection (6), or subsection (7) is providing evaluation, treatment, or diagnosis for a condition that is not within his or her specialty, a specialist trained in the evaluation, treatment, or diagnosis for that condition may give expert testimony concerning the prevailing professional standard of care ~~shall be considered a similar health care provider~~.

(9)(a) In any action for damages involving a claim of negligence against a physician licensed under chapter 458, osteopathic physician licensed under chapter 459, podiatric physician licensed under chapter 461, or chiropractic physician licensed under chapter 460 providing emergency medical services in a hospital emergency department, the court shall admit expert medical testimony only from physicians, osteopathic physicians, podiatric physicians, and chiropractic physicians who have had substantial professional experience within the preceding 2 ~~5~~ years while assigned to provide emergency medical services in a hospital emergency department.

(b) For the purposes of this subsection:

1. The term "emergency medical services" means those medical services required for the immediate diagnosis and treatment of medical conditions which, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death.

2. "Substantial professional experience" shall be

determined by the custom and practice of the manner in which emergency medical coverage is provided in hospital emergency departments in the same or similar localities where the alleged negligence occurred.

(10) In any action alleging medical negligence, an expert witness may not testify on a contingency fee basis.

(11) Any attorney who proffers a person as an expert witness pursuant to this section must certify that such person has not been found guilty of fraud or perjury in any jurisdiction.

(12) If the party against whom or on whose behalf the expert testimony concerning the prevailing professional standard of care is offered is a physician licensed under chapter 458 or chapter 459, the expert witness must be licensed in this state under chapter 458 or chapter 459 or possess an expert witness certificate as provided in s. 458.3175 or s. 459.0066. Expert testimony is not admissible unless the expert providing such testimony is licensed by this state or possesses an expert witness certificate as provided in s. 458.3175 or s. 459.0066.

(13) ~~(12)~~ This section does not limit the power of the trial court to disqualify or qualify an expert witness on grounds other than the qualifications in this section.

Section 7. Paragraph (a) of subsection (2), subsection (5), and paragraph (b) of subsection (6) of section 766.106, Florida Statutes, are amended to read:

766.106 Notice before filing action for medical negligence; presuit screening period; offers for admission of liability and for arbitration; informal discovery; review.—

(2) PRESUIT NOTICE.—

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(a) After completion of presuit investigation pursuant to s. 766.203(2) and prior to filing a complaint for medical negligence, a claimant shall notify each prospective defendant by certified mail, return receipt requested, of intent to initiate litigation for medical negligence. Notice to each prospective defendant must include, if available, a list of all known health care providers seen by the claimant for the injuries complained of subsequent to the alleged act of negligence, all known health care providers during the 2-year period prior to the alleged act of negligence who treated or evaluated the claimant, ~~and~~ copies of all of the medical records relied upon by the expert in signing the affidavit, and the executed authorization form provided in s. 766.1065. ~~The requirement of providing the list of known health care providers may not serve as grounds for imposing sanctions for failure to provide presuit discovery.~~

(5) DISCOVERY AND ADMISSIBILITY.—A ~~No~~ statement, discussion, written document, report, or other work product generated by the presuit screening process is not discoverable or admissible in any civil action for any purpose by the opposing party. All participants, including, but not limited to, physicians, investigators, witnesses, and employees or associates of the defendant, are immune from civil liability arising from participation in the presuit screening process. This subsection does not prevent a physician licensed under chapter 458 or chapter 459 who submits a verified written expert medical opinion from being subject to denial of a license or disciplinary action under s. 458.331(1)(oo) or s. 459.015(1)(qq).

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(6) INFORMAL DISCOVERY.—

(b) Informal discovery may be used by a party to obtain unsworn statements, the production of documents or things, and physical and mental examinations, as follows:

1. Unsworn statements.—Any party may require other parties to appear for the taking of an unsworn statement. Such statements may be used only for the purpose of presuit screening and are not discoverable or admissible in any civil action for any purpose by any party. A party desiring to take the unsworn statement of any party must give reasonable notice in writing to all parties. The notice must state the time and place for taking the statement and the name and address of the party to be examined. Unless otherwise impractical, the examination of any party must be done at the same time by all other parties. Any party may be represented by counsel at the taking of an unsworn statement. An unsworn statement may be recorded electronically, stenographically, or on videotape. The taking of unsworn statements is subject to the provisions of the Florida Rules of Civil Procedure and may be terminated for abuses.

2. Documents or things.—Any party may request discovery of documents or things. The documents or things must be produced, at the expense of the requesting party, within 20 days after the date of receipt of the request. A party is required to produce discoverable documents or things within that party’s possession or control. Medical records shall be produced as provided in s. 766.204.

3. Physical and mental examinations.—A prospective defendant may require an injured claimant to appear for examination by an appropriate health care provider. The

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prospective defendant shall give reasonable notice in writing to all parties as to the time and place for examination. Unless otherwise impractical, a claimant is required to submit to only one examination on behalf of all potential defendants. The practicality of a single examination must be determined by the nature of the claimant's condition, as it relates to the liability of each prospective defendant. Such examination report is available to the parties and their attorneys upon payment of the reasonable cost of reproduction and may be used only for the purpose of presuit screening. Otherwise, such examination report is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

4. Written questions.—Any party may request answers to written questions, the number of which may not exceed 30, including subparts. A response must be made within 20 days after receipt of the questions.

5. Ex parte interviews of treating health care providers.—A prospective defendant or his or her legal representative shall have access to interview the claimant's treating health care providers without notice to or the presence of the claimant or the claimant's legal representative.

6.~~5.~~ Unsworn statements of treating health care providers ~~Medical information release~~.~~ The claimant must execute a medical information release that allows~~ A prospective defendant or his or her legal representative may ~~to~~ take unsworn statements of the claimant's treating health care providers ~~physicians~~. The statements must be limited to those areas that are potentially relevant to the claim of personal injury or wrongful death. Subject to the procedural requirements of subparagraph 1., a

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prospective defendant may take unsworn statements from a claimant's treating physicians. Reasonable notice and opportunity to be heard must be given to the claimant or the claimant's legal representative before taking unsworn statements. The claimant or claimant's legal representative has the right to attend the taking of such unsworn statements.

Section 8. Section 766.1065, Florida Statutes, is created to read:

766.1065 Authorization form for release of protected health information.—

(1) Presuit notice of intent to initiate litigation for medical negligence under s. 766.106(2) must be accompanied by an authorization for release of protected health information in the form specified by this section, authorizing the disclosure of protected health information that is potentially relevant to the claim of personal injury or wrongful death. The presuit notice is void if this authorization does not accompany the presuit notice and other materials required by s. 766.106(2).

(2) If the authorization required by this section is revoked, the presuit notice under s. 766.106(2) shall be deemed retroactively void from the date of issuance, and any tolling effect that the presuit notice may have had on any applicable statute-of-limitations period is retroactively rendered void.

(3) The authorization required by this section shall be in the following form and shall be construed in accordance with the "Standards for Privacy of Individually Identifiable Health Information" in 45 C.F.R. parts 160 and 164:

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

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A. I, (...Name of patient or authorized representative...) [hereinafter "Patient"], authorize that (...Name of health care provider to whom the presuit notice is directed...) and his/her/its insurer(s), self-insurer(s), and attorney(s) may obtain and disclose (within the parameters set out below) the protected health information described below for the following specific purposes:

1. Facilitating the investigation and evaluation of the medical negligence claim described in the accompanying presuit notice; or

2. Defending against any litigation arising out of the medical negligence claim made on the basis of the accompanying presuit notice.

B. The health information obtained, used, or disclosed extends to, and includes, oral as well as the written information, and is described as follows:

1. The health information in the custody of the following health care providers who have examined, evaluated, or treated the Patient in connection with injuries complained of after the alleged act of negligence: (List the name and current address of all health care providers). This authorization extends to any additional health care providers that may in the future evaluate, examine, or treat the Patient for the injuries complained of.

2. The health information in the custody of the following health care providers who have examined,

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evaluated, or treated the Patient during a period commencing 2 years before the incident that is the basis of the accompanying presuit notice.

(List the name and current address of such health care providers, if applicable.)

C. This authorization does not apply to the following list of health care providers possessing health care information about the Patient because the Patient certifies that such health care information is not potentially relevant to the claim of personal injury or wrongful death which is the basis of the accompanying presuit notice.

(List the name of each health care provider to whom this authorization does not apply and the inclusive dates of examination, evaluation, or treatment to be withheld from disclosure. If none, specify "none.")

D. The persons or class of persons to whom the Patient authorizes such health information to be disclosed, or by whom such health information is to be used, includes:

1. Any health care provider providing care or treatment for the Patient.

2. Any liability insurer or self-insurer providing liability insurance coverage, self-insurance, or defense to any health care provider to

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whom presuit notice is given regarding the care and treatment of the Patient.

3. Any consulting or testifying expert employed by or on behalf of (name of health care provider to whom presuit notice was given) or his/her/its insurer(s), self-insurer(s), or attorney(s) regarding the matter of the presuit notice accompanying this authorization.

4. Any attorney (including secretarial, clerical, or paralegal staff) employed by or on behalf of (name of health care provider to whom presuit notice was given) regarding the matter of the presuit notice accompanying this authorization.

5. Any trier of the law or facts relating to any suit filed seeking damages arising out of the medical care or treatment of the Patient.

E. This authorization expires upon resolution of the claim or at the conclusion of any litigation instituted in connection with the matter of the presuit notice accompanying this authorization, whichever occurs first.

F. The Patient understands that, without exception, the Patient has the right to revoke this authorization in writing. The Patient further understands that the consequence of any such revocation is that the presuit notice under s. 766.106(2), Florida Statutes, is deemed retroactively void from the date of issuance, and any tolling effect that the presuit notice may have had on any applicable

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statute-of-limitations period is retroactively rendered void.

G. The Patient understands that signing this authorization is not a condition for continued treatment, payment, enrollment, or eligibility for health plan benefits.

H. The Patient understands that information used or disclosed under this authorization may be subject to additional disclosure by the recipient and may not be protected by federal HIPAA privacy regulations.

Signature of Patient/Representative: ....
Date: ....
Name of Patient/Representative: ....
Description of Representative's Authority: ....

Section 9. Subsection (2) of section 766.206, Florida Statutes, is amended to read:

766.206 Presuit investigation of medical negligence claims and defenses by court.—

(2) If the court finds that the notice of intent to initiate litigation mailed by the claimant does ~~is~~ not comply ~~in compliance~~ with the reasonable investigation requirements of ss. 766.201-766.212, including a review of the claim and a verified written medical expert opinion by an expert witness as defined in s. 766.202, or that the authorization form accompanying the notice of intent provided for in s. 766.1065 was not completed in good faith by the claimant, the court shall dismiss the claim, and the person who mailed such notice of intent, whether the claimant or the claimant's attorney, shall be personally

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liable for all attorney's fees and costs incurred during the investigation and evaluation of the claim, including the reasonable attorney's fees and costs of the defendant or the defendant's insurer.

Section 10. Subsections (3), (4), and (5) of section 463.002, Florida Statutes, are amended to read:

463.002 Definitions.—As used in this chapter, the term:

(3)(a) "Licensed practitioner" means a person who is a primary health care provider licensed to engage in the practice of optometry under the authority of this chapter.

(b) A licensed practitioner who is not a certified optometrist shall be required to display at her or his place of practice a sign which states, "I am a Licensed Practitioner, not a Certified Optometrist, and I am not able to prescribe ~~topical~~ ocular pharmaceutical agents."

(c) All practitioners initially licensed after July 1, 1993, must be certified optometrists.

(4) "Certified optometrist" means a licensed practitioner authorized by the board to administer and prescribe ~~topical~~ ocular pharmaceutical agents.

(5) "Optometry" means the diagnosis of conditions of the human eye and its appendages; the employment of any objective or subjective means or methods, including the administration of ~~topical~~ ocular pharmaceutical agents, for the purpose of determining the refractive powers of the human eyes, or any visual, muscular, neurological, or anatomic anomalies of the human eyes and their appendages; and the prescribing and employment of lenses, prisms, frames, mountings, contact lenses, orthoptic exercises, light frequencies, and any other means or

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methods, including topical ocular pharmaceutical agents, for the correction, remedy, or relief of any insufficiencies or abnormal conditions of the human eyes and their appendages.

Section 11. Paragraph (g) of subsection (1) of section 463.005, Florida Statutes, is amended to read:

463.005 Authority of the board.—

(1) The Board of Optometry has authority to adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this chapter conferring duties upon it. Such rules shall include, but not be limited to, rules relating to:

(g) Administration and prescription of ~~topical~~ ocular pharmaceutical agents.

Section 12. Section 463.0055, Florida Statutes, is amended to read:

463.0055 Administration and prescription of ~~topical~~ ocular pharmaceutical agents; committee.—

(1) Certified optometrists may administer and prescribe ~~topical~~ ocular pharmaceutical agents as provided in this section for the diagnosis and treatment of ocular conditions of the human eye and its appendages without the use of surgery or other invasive techniques. However, a licensed practitioner who is not certified may use topically applied anesthetics solely for the purpose of glaucoma examinations, but is otherwise prohibited from administering or prescribing ~~topical~~ ocular pharmaceutical agents.

(2)(a) There is hereby created a committee composed of two optometrists licensed pursuant to this chapter, appointed by the Board of Optometry, two board-certified ophthalmologists licensed pursuant to chapter 458 or chapter 459, appointed by

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the Board of Medicine, and one additional person with a doctorate degree in pharmacology who is not licensed pursuant to chapter 458, chapter 459, or this chapter, appointed by the State Surgeon General. The committee shall review requests for additions to, deletions from, or modifications of a formulary of ~~topical~~ ocular pharmaceutical agents for administration and prescription by certified optometrists and shall provide to the board advisory opinions and recommendations on such requests. The formulary shall consist of those ~~topical~~ ocular pharmaceutical agents which the certified optometrist is qualified to use in the practice of optometry. The board shall establish, add to, delete from, or modify the formulary by rule. Notwithstanding any provision of chapter 120 to the contrary, the formulary rule shall become effective 60 days from the date it is filed with the Secretary of State.

(b) The formulary may be added to, deleted from, or modified according to the procedure described in paragraph (a). Any person who requests an addition, deletion, or modification of an authorized ~~topical~~ ocular pharmaceutical agent shall have the burden of proof to show cause why such addition, deletion, or modification should be made.

(c) The State Surgeon General shall have standing to challenge any rule or proposed rule of the board pursuant to s. 120.56. In addition to challenges for any invalid exercise of delegated legislative authority, the administrative law judge, upon such a challenge by the State Surgeon General, may declare all or part of a rule or proposed rule invalid if it:

1. Does not protect the public from any significant and discernible harm or damages;

2. Unreasonably restricts competition or the availability of professional services in the state or in a significant part of the state; or

3. Unnecessarily increases the cost of professional services without a corresponding or equivalent public benefit.

However, there shall not be created a presumption of the existence of any of the conditions cited in this subsection in the event that the rule or proposed rule is challenged.

(d) Upon adoption of the formulary required by this section, and upon each addition, deletion, or modification to the formulary, the board shall mail a copy of the amended formulary to each certified optometrist and to each pharmacy licensed by the state.

(3) A certified optometrist shall be issued a prescriber number by the board. Any prescription written by a certified optometrist for a ~~topical~~ ocular pharmaceutical agent pursuant to this section shall have the prescriber number printed thereon.

Section 13. Subsection (3) of section 463.0057, Florida Statutes, is amended to read:

463.0057 Optometric faculty certificate.—

(3) The holder of a faculty certificate may engage in the practice of optometry as permitted by this section, but may not administer or prescribe ~~topical~~ ocular pharmaceutical agents unless the certificateholder has satisfied the requirements of s. 463.006(1)(b)4. and 5.

Section 14. Subsections (2) and (3) of section 463.006, Florida Statutes, are amended to read:

463.006 Licensure and certification by examination.—

(2) The examination shall consist of the appropriate subjects, including applicable state laws and rules and general and ocular pharmacology with emphasis on the ~~topical~~ application and side effects of ocular pharmaceutical agents. The board may by rule substitute a national examination as part or all of the examination and may by rule offer a practical examination in addition to the written examination.

(3) Each applicant who successfully passes the examination and otherwise meets the requirements of this chapter is entitled to be licensed as a practitioner and to be certified to administer and prescribe ~~topical~~ ocular pharmaceutical agents in the diagnosis and treatment of ocular conditions.

Section 15. Subsection (3) and paragraph (a) of subsection (4) of section 464.012, Florida Statutes, are amended to read:

464.012 Certification of advanced registered nurse practitioners; fees.—

(3) An advanced registered nurse practitioner shall perform those functions authorized in this section within the framework of an established protocol that is filed with the board upon biennial license renewal and within 30 days after entering into a supervisory relationship with a physician or changes to the protocol. The board shall review the protocol to ensure compliance with applicable regulatory standards for protocols. The board shall refer to the department licensees submitting protocols that are not compliant with the regulatory standards for protocols. A practitioner currently licensed under chapter 458, chapter 459, or chapter 466 shall maintain supervision for directing the specific course of medical treatment. Within the

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established framework, an advanced registered nurse practitioner may:

(a) Monitor, prescribe, and alter drug therapies, including controlled substances in Schedule II through Schedule IV under chapter 893.

(b) Initiate appropriate therapies for certain conditions.

(c) Perform additional functions as may be determined by rule in accordance with s. 464.003(2).

(d) Order diagnostic tests and physical and occupational therapy.

(4) In addition to the general functions specified in subsection (3), an advanced registered nurse practitioner may perform the following acts within his or her specialty:

(a) The certified registered nurse anesthetist may, to the extent authorized by established protocol approved by the medical staff of the facility in which the anesthetic service is performed, perform any or all of the following:

1. Determine the health status of the patient as it relates to the risk factors and to the anesthetic management of the patient through the performance of the general functions.

2. Based on history, physical assessment, and supplemental laboratory results, determine, with the consent of the responsible physician, the appropriate type of anesthesia within the framework of the protocol.

3. Order under the protocol preanesthetic medication.

4. Perform under the protocol procedures commonly used to render the patient insensible to pain during the performance of surgical, obstetrical, therapeutic, or diagnostic clinical procedures. These procedures include ordering and administering

regional, spinal, and general anesthesia; inhalation agents and techniques; intravenous agents and techniques; and techniques of hypnosis.

5. Order or perform monitoring procedures indicated as pertinent to the anesthetic health care management of the patient.

6. Support life functions during anesthesia health care, including induction and intubation procedures, the use of appropriate mechanical supportive devices, and the management of fluid, electrolyte, and blood component balances.

7. Recognize and take appropriate corrective action for abnormal patient responses to anesthesia, adjunctive medication, or other forms of therapy.

8. Recognize and treat a cardiac arrhythmia while the patient is under anesthetic care.

9. Participate in management of the patient while in the postanesthesia recovery area, including ordering the administration of fluids and drugs, which include drugs that are commonly used to alleviate pain.

10. Place special peripheral and central venous and arterial lines for blood sampling and monitoring as appropriate.

Section 16. Section 768.135, Florida Statutes, is amended to read:

768.135 Volunteer team physicians; immunity.—Any person licensed to practice medicine pursuant to chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466:

(1) Who is acting in the capacity of a volunteer team physician in attendance at an athletic event sponsored by a public or private elementary or secondary school; and

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(2) Who gratuitously and in good faith prior to the athletic event agrees to render emergency care or treatment to any participant in such event in connection with an emergency arising during or as the result of such event, without objection of such participant,

shall not be held liable for any civil damages as a result of such care or treatment or as a result of any act or failure to act in providing or arranging further medical treatment unless ~~when~~ such care or treatment was rendered in a wrongful manner ~~as a reasonably prudent person similarly licensed to practice medicine would have acted under the same or similar circumstances~~.

(3) As used in this section, the term "wrongful manner" means bad faith or with malicious purposes or in a manner exhibiting wanton and willful disregard of human rights, safety, or property, and shall be construed in conformity with the standard set forth in s. 768.28(9)(a).

Section 17. Subsection (20) of section 893.02, Florida Statutes, is amended to read:

893.02 Definitions.—The following words and phrases as used in this chapter shall have the following meanings, unless the context otherwise requires:

(20) "Practitioner" means a physician licensed pursuant to chapter 458, a dentist licensed pursuant to chapter 466, a veterinarian licensed pursuant to chapter 474, an osteopathic physician licensed pursuant to chapter 459, a naturopath licensed pursuant to chapter 462, a certified optometrist licensed pursuant to chapter 463, an advanced registered nurse


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practitioner licensed pursuant to chapter 464, or a podiatric physician licensed pursuant to chapter 461, if ~~provided~~ such practitioner holds a valid federal controlled substance registry number.

Section 18. Subsection (1) of section 893.05, Florida Statutes, is amended to read:

893.05 Practitioners and persons administering controlled substances in their absence.—

(1) A practitioner, in good faith and in the course of his or her professional practice only, may prescribe, administer, dispense, mix, or otherwise prepare a controlled substance, or the practitioner may cause the same to be administered by a licensed nurse or an intern practitioner under his or her direction and supervision only. A veterinarian may so prescribe, administer, dispense, mix, or prepare a controlled substance for use on animals only, and may cause it to be administered by an assistant or orderly under the veterinarian's direction and supervision only. A certified optometrist licensed under chapter 463 may not administer or prescribe ocular pharmaceutical agents listed under Schedule I or Schedule II of the Florida Comprehensive Drug Abuse Prevention and Control Act.

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

And the title is amended as follows:

Delete lines 2 - 50

and insert:

An act relating to health care; creating ss. 458.3175 and 459.0066, F.S.; requiring the Board of Medicine and the Board of Osteopathic Medicine to issue expert

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witness certificates to physicians licensed outside the state; providing application and certification requirements; establishing application fees; providing for validity and use of the certification; exempting a physician issued a certificate from certain licensure and fee requirements; requiring the boards to adopt rules; amending ss. 458.331 and 459.015, F.S.; providing additional acts that constitute grounds for denial of a license or disciplinary action to which penalties apply; amending s. 627.4147, F.S.; deleting a requirement that medical malpractice insurance contracts contain a clause authorizing the insurer to make and conclude certain offers within policy limits over the insured's veto; amending s. 766.102, F.S.; revising the criteria required in order for a health care provider to give expert testimony concerning the prevailing professional standard of care; authorizing certain specialists, rather than certain health care providers, to give expert testimony concerning the prevailing professional standard of care under certain circumstances; requiring an expert witness in certain medical negligence actions to be licensed under ch. 458 or ch. 459, F.S., or possess an expert witness certificate under certain conditions; providing that certain medical expert testimony is not admissible unless the expert witness meets certain requirements; amending s. 766.106, F.S.; requiring claimants for medical malpractice to execute an authorization form; deleting a provision prohibiting failure to provide

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certain presuit notice from serving as grounds for imposing sanctions; providing that certain immunity arising from participation in the presuit screening process does not prohibit certain physicians from being subject to certain penalties; allowing prospective medical malpractice defendants to interview a claimant's treating health care providers without notice to or the presence of the claimant or the claimant's legal representative; authorizing prospective defendants to take unsworn statements of a claimant's health care providers; creating s. 766.1065, F.S.; requiring that presuit notice for medical negligence claims be accompanied by an authorization for release of protected health information; providing requirements for the form of such authorization; amending s. 766.206, F.S.; requiring dismissal of a medical malpractice claim and payment of certain costs if such authorization form is not completed in good faith; amending s. 463.002, F.S.; redefining the terms "licensed practitioner," "certified optometrist," and "optometry" within the practice of optometry; amending s. 463.005, F.S.; authorizing the Board of Optometry to adopt rules pertaining to the administration and prescription of all ocular pharmaceutical agents; amending s. 463.0055, F.S.; expanding the type of ocular pharmaceuticals that are prescribed and administered; amending ss. 463.0057 and 463.006, F.S.; specifying certain persons who may or may not prescribe or

administer any ocular pharmaceutical agents; amending s. 464.012, F.S.; expanding the scope of practice to authorize an advanced registered nurse practitioner to order, administer, monitor, and alter any drug or drug therapies; expanding the scope of practice to authorize a certified registered nurse anesthetist to participate in management of a patient while in the postanesthesia recovery area, including ordering the administration of fluids and drugs that are commonly used to alleviate pain; amending s. 768.135, F.S.; providing the circumstance in which a volunteer team physician or person is liable for civil damages as a result of care or treatment or as a result of any act or failure to act in providing or arranging further medical treatment; defining the term "wrongful manner" as it relates to the immunity for volunteer team physicians; amending s. 893.02, F.S.; redefining the term "practitioner" as it relates to the Florida Comprehensive Drug Abuse Prevention and Control Act; amending s. 893.05, F.S.; prohibiting a certified optometrist from administering or prescribing certain ocular pharmaceutical agents;

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 1590
INTRODUCER:	Senators Hays and Gaetz
SUBJECT:	Medical Malpraictce Actions
DATE:	March 28, 2011
REVISED:	

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

I. Summary:

The bill requires a physician or osteopathic physician who provides expert testimony concerning the prevailing professional standard of care of a physician or osteopathic physician to be licensed in this state under ch. 458, The Medical Practice Act, or ch. 459, F.S., The Osteopathic Medical Practice Act, or possess an expert witness certificate issued by the Board of Medicine (BOM) or the Board of Osteopathic Medicine (BOOM).

The bill reduces the period of time immediately preceding the date of the occurrence that is the basis for the action within which the expert witness must have performed certain activities. The time frames and activities depend upon whether the health care provider against whom or on whose behalf the testimony is offered is a specialist, a general practitioner, other type of health care provider, or was providing emergency medical services in a hospital emergency department.

The bill requires a clause in an insurance policy or self-insurance policy for medical malpractice coverage to clearly state whether or not the insured has the exclusive right of veto of any admission of liability or offer of judgment. The bill repeals the authority for a self-insurance policy or insurance policy for medical malpractice to grant authority for the insurer to bring the case to closure without the permission of the insured if the action is within the policy limits.

The bill requires a claimant to submit, along with the other required information, an executed authorization form for the release of protected health information that is potentially relevant to the claim of personal injury or wrongful death when he or she notifies each prospective defendant of his or her intent to initiate litigation for medical negligence.

This bill substantially amends the following sections of the Florida Statutes: 458.331, 459.015, 6274147, 766.102, 766.106, and 766.206.

The bill creates the following sections of the Florida Statutes: 458.3175, 459.0066, and 766.1065.

II. Present Situation:

In any action for recovery of damages based on the death or personal injury of any person in which it is alleged that the death or injury resulted from the negligence of a health care provider, the claimant has the burden of proving by the greater weight of evidence that the alleged action of the health care provider represented a breach of the prevailing professional standard of care for that health care provider. The prevailing professional standard of care is that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.[1]

Presuit Investigation[2]

Prior to the filing of a lawsuit, the person allegedly injured by medical negligence or a party bringing a wrongful death action arising from an alleged incidence of medical malpractice (the claimant) and the defendant (the health care professional or health care facility) are required to conduct presuit investigations to determine whether medical negligence occurred and what damages, if any, are appropriate.

The claimant is required to conduct an investigation to ascertain that there are reasonable grounds to believe that:

- A named defendant in the litigation was negligent in the care or treatment of the claimant; and
- That negligence resulted in injury to the claimant.
  Corroboration of reasonable grounds to initiate medical negligence litigation must be provided by the claimant's submission of a verified written medical expert opinion from a medical expert.

Before the defendant issues his or her response, the defendant or his or her insurer or self-insurer is required to ascertain whether there are reasonable grounds to believe that:

- The defendant was negligent in the care or treatment of the claimant; and
- That negligence resulted in injury to the claimant.

Corroboration of the lack of reasonable grounds for medical negligence litigation must be provided by submission of a verified written medical expert opinion which corroborates reasonable grounds for lack of negligent injury sufficient to support the response denying negligent injury.

[1] S. 766.102, F.S.
[2] S. 766.203, F.S.

These expert opinions are subject to discovery. Furthermore, the opinion must specify whether any previous opinion by that medical expert has been disqualified and if so, the name of the court and the case number in which the ruling was issued.

Medical Experts[3]

A person may not give expert testimony concerning the prevailing professional standard of care unless that person is a licensed health care provider and meets the following criteria:

- If the health care provider against whom or on whose behalf the testimony is offered is a specialist, the expert witness must:
  - Specialize in the same specialty as the health care provider against whom or on whose behalf the testimony is offered; or specialize in a similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients; and
  - Have devoted professional time during the 3 years immediately preceding the date of the occurrence that is the basis for the action to:
    - The active clinical practice of, or consulting with respect to, the same or similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients;
    - Instruction of students in an accredited health professional school or accredited residency or clinical research program in the same or similar specialty; or
    - A clinical research program that is affiliated with an accredited health professional school or accredited residency or clinical research program in the same or similar specialty.
- If the health care provider against whom or on whose behalf the testimony is offered is a general practitioner, the expert witness must have devoted professional time during the 5 years immediately preceding the date of the occurrence that is the basis for the action to:
  - The active clinical practice or consultation as a general practitioner;
  - The instruction of students in an accredited health professional school or accredited residency program in the general practice of medicine; or
  - A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the general practice of medicine.
- If the health care provider against whom or on whose behalf the testimony is offered is a health care provider other than a specialist or a general practitioner, the expert witness must have devoted professional time during the 3 years immediately preceding the date of the occurrence that is the basis for the action to:
  - The active clinical practice of, or consulting with respect to, the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered;
  - The instruction of students in an accredited health professional school or accredited residency program in the same or similar health profession in which the health care provider against whom or on whose behalf the testimony is offered; or
  - A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered.

[3] S. 766.102(5), (9), and (12), F.S.

- If the claim of negligence is against a physician licensed under chapter 458, osteopathic physician licensed under chapter 459, podiatric physician licensed under chapter 461, or chiropractic physician licensed under chapter 460 providing emergency medical services in a hospital emergency department, the court shall admit expert medical testimony only from physicians, osteopathic physicians, podiatric physicians, and chiropractic physicians who have had substantial professional experience within the preceding 5 years while assigned to provide emergency medical services in a hospital emergency department.

These provisions do not limit the power of the trial court to disqualify or qualify an expert witness on grounds other than the qualifications in this section (s. 766.102, F.S.). Relevant portions of the Florida Evidence Code provide requirements for expert opinion testimony.[4] The Florida Rules of Civil Procedure define "expert witness" as a person duly and regularly engaged in the practice of a profession who holds a professional degree from a university or college and has had special professional training and experience, or one possessed of special knowledge or skill about the subject upon which called to testify.[5]

The court shall refuse to consider the testimony or opinion attached to any notice of intent or to any response rejecting a claim of an expert who has been disqualified three times.[6]

After Claimant's Presuit Investigation[7]

After completion of presuit investigation and prior to filing a complaint for medical negligence, a claimant shall notify each prospective defendant by certified mail, return receipt requested, of intent to initiate litigation for medical negligence. Notice to each prospective defendant must include, if available, a list of all known health care providers seen by the claimant for the injuries complained of subsequent to the alleged act of negligence, all known health care providers during the 2-year period prior to the alleged act of negligence who treated or evaluated the claimant, and copies of all of the medical records relied upon by the expert in signing the affidavit. The requirement of providing the list of known health care providers may not serve as grounds for imposing sanctions for failure to provide presuit discovery.

A suit may not be filed for a period of 90 days after notice is mailed to any prospective defendant. The statue of limitations is tolled during the 90-day period. During the 90-day period, the prospective defendant or the defendant's insurer or self-insurer shall conduct a presuit investigation to determine the liability of the defendant. Each insurer or self-insurer shall have a procedure for the prompt investigation, review, and evaluation of claims during the 90-day period.

Each insurer or self-insurer shall investigate the claim in good faith, and both the claimant and prospective defendant shall cooperate with the insurer in good faith. If the insurer requires, a claimant shall appear before a pretrial screening panel or before a medical review committee and shall submit to a physical examination, if required. Unreasonable failure of any party to comply

[4] Sections 90.702 and 90.704, F.S.
[5] Fla. R. Civ. P. 1.390(a).
[6] S. 766.206, F.S.
[7] S. 766.106, F.S.

with this section justifies dismissal of claims or defenses. There shall be no civil liability for participation in a pretrial screening procedure if done without intentional fraud.

At or before the end of the 90 days, the prospective defendant or the prospective defendant's insurer or self-insurer shall provide the claimant with a response:

- Rejecting the claim;
- Making a settlement offer; or
- Making an offer to arbitrate in which liability is deemed admitted and arbitration will be held only on the issue of damages. This offer may be made contingent upon a limit of general damages.

The response shall be delivered to the claimant if not represented by counsel or to the claimant's attorney, by certified mail, return receipt requested. Failure of the prospective defendant or insurer or self-insurer to reply to the notice within 90 days after receipt shall be deemed a final rejection of the claim for purposes of this section.

Discovery and Admissibility of Evidence

Statements, discussions, written documents, reports, or other work product generated by the presuit screening process are not discoverable or admissible in any civil action for any purpose by the opposing party. All participants, including, but not limited to, physicians, investigators, witnesses, and employees or associates of the defendant, are immune from civil liability arising from participation in the presuit screening process.[8]

Upon receipt by a prospective defendant of a notice of claim, the parties are required to make discoverable information available without undertaking formal discovery. Informational discovery may be used to obtain unsworn statements, the production of documents or things, and physical and mental examinations as follows:[9]

- Unsworn statements – Any party may require other parties to appear for the taking of an unsworn statement. Unsworn statements may be used only for the purpose of presuit screening and are not discoverable or admissible in any civil action for any purpose by any party.
- Documents or things – Any party may request discovery of documents or things. This includes medical records.
- Physical and mental examination – A prospective defendant may require an injured claimant to be examined by an appropriate health care provider. Unless otherwise impractical, a claimant is required to submit to only one examination of behalf of all potential defendants. The examination report is available to the parties and their attorney and may be used only for the purpose of presuit screening. Otherwise the examination is confidential.
- Written questions – Any party may request answers to written questions.
- Medical information release – The claimant must execute a medical information release that allows a prospective defendant or his or her legal representative to take unsworn statements of the claimant's treating physicians that address areas that are potentially relevant to the

[8] S. 766.106(5), F.S.
[9] S. 766.106(6), F.S.

claim of personal injury or wrongful death. The claimant or claimant's legal representative has the right to attend the taking of these unsworn statements.

The failure to cooperate on the part of any party during the presuit investigation may be grounds to strike any claim made, or defense raised in the suit.

III. Effect of Proposed Changes:

Section 1 and section 3 create s. 458.3175, F.S., and s. 459.0066, F.S., respectively, to authorize the BOM or the BOOM to issue a certificate to a physician or osteopathic physician who is licensed to practice medicine or osteopathic medicine in another state or a province of Canada to provide expert testimony in this state pertaining to medical negligence litigation against a physician. The expert witness certificate authorizes the physician or osteopathic physician to provide a verified written medical opinion for purposes of presuit investigation of medical negligence claims and provide expert testimony about the prevailing professional standard of care in connection with medical negligence litigation pending in this state against a physician licensed under ch. 458, F.S., or ch. 459, F.S.

A physician who is not licensed in this state but intends to provide expert testimony in this state must submit a completed application and pay an application fee in an amount not to exceed $50. The BOM or the BOOM may not issue a certificate to a physician who has had a previous expert witness certificate revoked by the BOM or the BOOM. The BOM or the BOOM is required to approve or deny the application within 5 business days after receipt of the completed application and fee, otherwise the application is approved by default. If a physician intends to rely on a certificate that is approved by default, he or she must notify the BOM or BOOM in writing. An expert witness certificate is valid for 2 years.

An expert witness certificate does not authorize the physician to practice medicine or osteopathic medicine in this state, and a physician who does not otherwise practice medicine in this state is not required to obtain a license to practice medicine in this state, or pay other fees, including the neurological injury compensation assessment.

The BOM and the BOOM are required to adopt rules to administer their respective section of law.

Section 2 and section 4 amend s. 458.331, F.S., and s. 459.015, F.S., respectively, to add that providing misleading, deceptive, or fraudulent expert witness testimony related to the practice of medicine is grounds for denial of a license or other disciplinary action against a physician or osteopathic physician.

Section 5 amends s. 627.4147, F.S., to repeal the authority for a self-insurance policy or insurance policy that provides coverage for medical malpractice to allow the insurer or self-insurer to determine, make, and conclude any offer of admission of liability and for arbitration, settlement offer, or offer of judgment if the offer is within the policy limits without the permission of the insured. The bill also repeals the statement that it is against public policy for an insurance or self-insurance policy to contain a clause giving the insured the exclusive right to veto an offer for admission of liability and for arbitration, settlement offer, or offer of judgment,

when the offer is within the policy limits. Instead, the bill requires a clause in the policy to clearly state whether or not the insured has the exclusive right of veto if the offer is within policy limits, which is currently the law that applies for dentists.

Section 6 amends s. 766.102, F.S., to reduce the period of time immediately preceding the date of the occurrence that is the basis for the action within which the expert witness must have performed certain activities. If the health care provider against whom or on whose behalf the testimony is offered is:

- A specialist, in addition, to other things, the expert witness must have devoted professional time during the 2 years, rather than 3 years, immediately preceding the date of the occurrence that is the basis for the action to:
  - The active clinical practice of, or consulting with respect to, the same or similar specialty,
  - Instructing students in an accredited health professional school or accrediting residency or clinical research program in the same or similar specialty, or
  - A clinical research program that is affiliated with an accredited health professional school or accredited residency or clinical research program in the same or similar specialty.
- A general practitioner, the expert witness must have devoted professional time during the 2 years, rather than 5 years, immediately preceding the date of the occurrence that is the basis for the action to:
  - The active clinic practice or consultation as a general practitioner,
  - Instructing students in an accredited health professional school or accrediting residency program in the general practice of medicine, or
  - A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the general practice of medicine.
- A health care provider other than a specialist or a general practitioner, the expert witness must have devoted professional time during the 2 years, rather than 3 years, immediately preceding the date of the occurrence that is the basis for the action to:
  - The active clinical practice of, or consulting with respect to, the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered,
  - Instructing students in an accredited health professional school or accrediting residency program in the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered, or
  - A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered.
- A physician, osteopathic physician, podiatric physician, or chiropractic physician providing emergency medical services in a hospital emergency department, the expert witness must have had substantial professional experience within the preceding 2 years, rather than 5 years, while assigned to provide emergency medical services in a hospital emergency department.

In addition, this section requires a physician or osteopathic physician who provides expert testimony concerning the prevailing professional standard of care of a physician or osteopathic physician to be licensed in this state under The Medical Practice Act or The Osteopathic Medical Practice Act, or possess an expert witness certificate issued by the BOM or the BOOM.

Section 7 amends s. 766.106, F.S., to require a claimant to submit, along with the other required information, an executed authorization form for the release of protected health information that is potentially relevant to the claim of personal injury or wrongful death when he or she notifies each prospective defendant of his or her intent to initiate litigation for medical negligence.

This section provides that notwithstanding the immunity from civil liability arising from participation in the presuit screening process that is currently afforded under the law, a physician who is licensed under the Medical Practice Act or the Osteopathic Medical Practice Act who submits a verified written expert medical opinion is subject to denial of a license or disciplinary action for providing misleading, deceptive, or fraudulent expert witness testimony related to the practice of medicine or osteopathic medicine.

The bill authorizes a prospective defendant or his or her legal representative access to interview the claimant's treating health care providers without notice to or the presence of the claimant or the claimant's legal representative. However, a prospective defendant or his or her legal representative who takes an unsworn statement from a claimant's treating physicians must provide reasonable notice and opportunity to be heard to the claimant or the claimant's legal representative before taking unsworn statements. Unsworn statements are used for presuit screening and are not discoverable or admissible in a civil action for any purpose by any party.

Section 8 creates s. 766.1065, F.S., to establish an authorization form for the release of protected health information that is potentially relevant to the claim of personal injury or wrongful death. The bill sets forth the specific content of the form, including identification of the parties; authorizing the disclosure of protected health information for specified purposes; description of the information and the health care providers from whom the information is available; identification of health care providers to whom the authorization for disclosure does not apply because the health care information is not potentially relevant to the claim of personal injury or wrongful death; the persons to whom the patient authorizes the information to be disclosed; a statement regarding the expiration of the authorization; acknowledgement that the patient understands that he or she has the right to revoke the authorization in writing, the consequences for the revocation, signing the authorization is not a condition for health plan benefits, and that the information authorized for disclosure may be subject to additional disclosure by the recipient and may not be protected by federal HIPAA privacy regulations;[10] and applicable signature by the patient or his or her representative.

The bill provides that the presuit notice is void if this authorization does not accompany the presuit notice and other materials required by s. 766.106(2), F.S. If the authorization is revoked, the presuit notice is deemed retroactively void from the date of issuance, and any tolling effect that the presuit notice may have had on the applicable statute-of-limitations period is retroactively rendered void.

Section 9 amends s. 766.206, F.S., to authorize the court to dismiss the claim if the court finds that the authorization form accompanying the notice of intent to initiate litigation for medical

[10] HIPAA is the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-194) and generally include the privacy rules adopted thereunder. With certain exceptions, the HIPAA privacy rules preempt contrary provisions in state law, unless the state law is more stringent than the federal rules. *See* 45 C.F.R. Part 164.

negligence was not completed in good faith by the claimant. If the court dismisses the claim, the claimant or the claimant's attorney is personally liable for all attorney's fees and costs incurred during the investigation and evaluation of the claim, including the reasonable attorney's fees and costs of the defendant or the defendant's insurer.

Section 10 provides an effective date of July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

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

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

The bill authorizes the BOM and the BOOM to establish an application fee not to exceed $50 for the expert witness certificate. The certificate is valid for 2 years.

B. Private Sector Impact:

Claimants that choose to use an expert witness who is not a physician or osteopathic physician licensed in this state may only use an expert witness who has a certificate from the Florida BOM or the Florida BOOM. This requirement, and the reduced timeframe in which substantial professional experience qualifies a person as an expert witness might limit or delay a claimant's ability to engage an expert witness to conduct a presuit investigation and proceed with a claim for medical negligence. The specific HIPAA-compliant form will facilitate the release and disclosure of protected health information and more clearly protect persons who release that information. The defense will have an additional discovery tool with the authorization to conduct ex parte interviews of treating health care providers. The changes to insurance and self-insurance policies provide physicians with greater control over the disposition of medical malpractice claims.

C. Government Sector Impact:

The BOM and the BOOM will be required to develop application forms and rules to administer the certification program for expert witnesses. Additional regulatory and enforcement activities may emerge as a result of the bill.

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.

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LEGISLATIVE ACTION

Senate . House

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

Senate Amendment (with title amendment)

Delete lines 74 - 123
and insert:
Section 1. Subsection (9) is added to section 390.011, Florida Statutes, to read:
390.011 Definitions.—As used in this chapter, the term:
(9) "Viability" means that stage of fetal development when the life of the unborn child may, with a reasonable degree of medical probability, be continued indefinitely outside the womb.
Section 2. Subsections (1), (2), (4), (7), and (10) of section 390.0111, Florida Statutes, are amended, and subsection

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(12) is added to that section, to read:

390.0111 Termination of pregnancies.—

(1) TERMINATION IN THIRD TRIMESTER OR AFTER VIABILITY; WHEN ALLOWED.—

(a) A ~~No~~ termination of pregnancy may not ~~shall~~ be performed after the period at which, in the best medical judgment of the physician, the fetus has attained viability, as defined in s. 390.011, or on any person ~~human being~~ in the third trimester of pregnancy unless:

1.~~(a)~~ Two physicians certify in writing to the fact that, to a reasonable degree of medical probability, the termination of pregnancy is necessary to prevent the death of the pregnant woman or the substantial and irreversible impairment of a major bodily function of the pregnant woman ~~save the life or preserve the health of the pregnant woman~~; or

2.~~(b)~~ The physician certifies in writing to the existence of a medical emergency, as defined in s. 390.01114(2)(d) ~~medical necessity for legitimate emergency medical procedures for termination of pregnancy in the third trimester~~, and another physician is not available for consultation.

(b) An abortion clinic must provide conspicuous notice on any form or medium of advertisement that the abortion clinic is prohibited from performing abortions in the third trimester or after viability.

(2) PHYSICIAN, LOCATION, AND CLINIC LICENSURE AND OWNERSHIP REQUIREMENTS ~~PERFORMANCE BY PHYSICIAN REQUIRED~~.—

(a) A ~~No~~ termination of pregnancy may not ~~shall~~ be performed at any time except by a physician as defined in s. 390.011. A physician who offers to perform or who performs

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terminations of pregnancy in an abortion clinic must annually complete a minimum of 3 hours of continuing education related to ethics.

(b) Except for procedures that must be conducted in a hospital or in emergency-care situations, a termination of pregnancy may not be performed in a location other than in a validly licensed hospital, abortion clinic, or physician's office.

(c) A person may not establish, conduct, manage, or operate an abortion clinic without a valid current license.

(d) A person may not perform or assist in performing an abortion on a person in the third trimester or after viability, other than in a hospital.

(e) Other than an abortion clinic licensed before October 1, 2011, an abortion clinic must be wholly owned and operated by a physician who has received training during residency in performing a dilation-and-curettage procedure or a dilation-and-evacuation procedure.

(f) A person who willfully violates paragraph (c), paragraph (d), or paragraph (e) commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(4) STANDARD OF MEDICAL CARE TO BE USED DURING VIABILITY.—If a termination of pregnancy is performed during viability, no person who performs or induces the termination of pregnancy shall fail to use that degree of professional skill, care, and diligence to preserve the life and health of the fetus which such person would be required to exercise in order to preserve the life and health of any fetus intended to be born and not

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aborted. ~~"Viability" means that stage of fetal development when the life of the unborn child may with a reasonable degree of medical probability be continued indefinitely outside the womb.~~ Notwithstanding the provisions of this subsection, the woman's life and health shall constitute an overriding and superior consideration to the concern for the life and health of the fetus when such concerns are in conflict.

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

And the title is amended as follows:

Delete lines 2 - 26

and insert:

An act relating to abortions; amending s. 390.011, F.S.; defining the term "viability" as it relates to the termination of a pregnancy; amending s. 390.0111, F.S.; restricting the circumstances in which an abortion may be performed in the third trimester or after viability; requiring an abortion clinic to provide conspicuous notice on any form or medium of advertisement that the abortion clinic is prohibited from performing abortions in the third trimester or after viability; providing certain physician, location, and clinic licensure and ownership requirements; requiring a physician who offers to perform or who performs terminations of pregnancy to complete continuing education related to ethics; prohibiting a termination of pregnancy from being performed in a location other than a validly licensed hospital, abortion clinic, or physician's office;


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prohibiting a person from establishing, conducting, managing, or operating an abortion clinic without a valid, current license; prohibiting a person from performing or assisting in performing an abortion on a person in the third trimester or after viability, in a location other than a hospital; requiring an abortion clinic to be owned and operated by a physician who has received training during residency in performing a dilation-and-curettage procedure or a dilation-and-evacuation procedure; providing a penalty; deleting the definition of the term "viability"; providing

450940

LEGISLATIVE ACTION

Senate . House

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

Senate Amendment (with title amendment)

Delete lines 172 - 174
and insert:
(1) The director of any medical facility or physician's office in which any pregnancy is terminated shall submit a ~~monthly~~ report each month to the agency on a

========== T I T L E A M E N D M E N T ==========
And the title is amended as follows:
Delete lines 43 - 45
and insert:

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390.0112, F.S.; requiring the director of a medical facility or physician's office to submit a monthly report to the agency on

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LEGISLATIVE ACTION

Senate . House

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

Senate Amendment (with title amendment)

Delete line 177

and insert:

Centers for Disease Control and Prevention. The submitted report must not contain any personal identifying information ~~which contains the~~

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

And the title is amended as follows:

Delete line 49

and insert:

795534

Prevention; requiring that the submitted report not contain any personal identifying information; requiring the agency to submit reported

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 1748
INTRODUCER:	Senator Flores
SUBJECT:	Abortions
DATE:	March 25, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	O'Callaghan	Stovall	HR	**Pre-meeting**
2.			CJ	
3.			BC	
4.				
5.				
6.				

I. Summary:

This bill prohibits abortions from being performed while a woman is in her third trimester of pregnancy or after a fetus has attained viability unless a medical emergency exists.

The bill provides that any abortion clinic that advertises its services must also advertise that the clinic is prohibited from performing abortions in the third trimester or after viability and requires the Agency for Health Care Administration (AHCA) to adopt rules to regulate such advertisements.

The bill requires any physician who performs abortions in an abortion clinic to annually complete at least 3 hours of continuing education that relate to ethics. The bill also provides for restrictions as to where an abortion may be performed.

This bill also provides that it is a misdemeanor of the second-degree if:

- A person establishes, conducts, manages, or operates an abortion clinic without a valid current license.
- A person performs or assists in performing an abortion on a person in the third trimester or after viability in a place other than in a hospital.
- After October 1, 2011, an abortion clinic is not wholly owned and operated by a physician who has received certain training during residency.

This bill increases the penalty for failure to properly dispose of fetal remains from a second-degree to a first-degree misdemeanor. It is also a misdemeanor of the first-degree for a person to advertise or facilitate an advertisement of services or drugs for the purpose of performing an

abortion in violation of ch. 390, F.S. A licensed health care practitioner who is guilty of a felony for providing unlawful abortion services is subject to licensure revocation.

This bill also requires a director of a medical facility or physician's office where abortions are performed to report to the AHCA specific information, which the AHCA must then submit to the Centers for Disease Control and Prevention (CDC) and make available on the AHCA website prior to each general legislative session. Additionally, the AHCA must provide an annual report to the Governor and Legislature, which contains such information. None of the reported or published information is to contain any personal indentifying information.

The bill transfers provisions concerning abortion from the Florida Criminal Code, under ch. 797, F.S., into ch. 390, F.S., and the bill contains a severability clause.

The effective date of the act is October 1, 2011.

This bill substantially amends the following sections of the Florida Statutes: 390.0111, 390.0112, 390.012, and 456.013.

This bill repeals the following sections of the Florida Statutes: 797.02 and 797.03.

This bill also creates an undesignated section of the Florida Statutes.

II. Present Situation:

Background

Under Florida law the term "abortion" means the termination of human pregnancy with an intention other than to produce a live birth or to remove a dead fetus.[1] "Viability" means that stage of fetal development when the life of the unborn child may, with a reasonable degree of medical probability, be continued indefinitely outside the womb.[2] Induced abortion can be elective (performed for nonmedical indications) or therapeutic (performed for medical indications). An abortion can be performed by surgical or medical means (medicines that induce a miscarriage).[3]

An abortion in Florida must be performed by a physician licensed to practice medicine or osteopathic medicine who is licensed under ch. 458, F.S., or ch. 459, F.S., or a physician practicing medicine or osteopathic medicine in the employment of the United States.[4] No person who is a member of, or associated with, the staff of a hospital, or any employee of a hospital or physician in which, or by whom, the termination of a pregnancy has been authorized or performed, who states an objection to the procedure on moral or religious grounds is required to

[1] Section 390.011, F.S.
[2] Section 390.0111(4), F.S.
[3] Suzanne R. Trupin, M.D., *Elective Abortion*, December 21, 2010, *available at* http://www.emedicine.com/med/TOPIC3312.HTM (last visited Mar. 23, 2011).
[4] Section 390.0111(2) and s. 390.011(7), F.S.

participate in the procedure. The refusal to participate may not form the basis for any disciplinary or other recriminatory action.[5]

According to the AHCA, for the calendar year 2009, a total of 81,916 abortions were performed by licensed physicians. During calendar year 2010, a total of 79,908 abortions were performed by licensed physicians.[6]

Abortion Clinics

Abortion clinics are licensed and regulated by the AHCA under ch. 390, F.S., and part II of ch. 408, F.S. The AHCA has adopted rules in Chapter 59A-9, Florida Administrative Code, related to abortion clinics. Section 390.012, F.S., requires these rules to address the physical facility, supplies and equipment standards, personnel, medical screening and evaluation of patients, abortion procedures, recovery room standards, and follow-up care. The rules relating to the medical screening and evaluation of each abortion clinic patient, at a minimum, shall require:

- A medical history, including reported allergies to medications, antiseptic solutions, or latex; past surgeries; and an obstetric and gynecological history;
- A physical examination, including a bimanual examination estimating uterine size and palpation of the adnexa;
- The appropriate laboratory tests, including:
  - For an abortion in which an ultrasound examination is not performed before the abortion procedure, urine or blood tests for pregnancy performed before the abortion procedure,
  - A test for anemia,
  - Rh typing, unless reliable written documentation of blood type is available, and
  - Other tests as indicated from the physical examination;
- An ultrasound evaluation for patients who elect to have an abortion after the first trimester. If a person who is not a physician performs the ultrasound examination, that person must have documented evidence that he or she has completed a course in the operation of ultrasound equipment. If a patient requests, the physician, registered nurse, licensed practical nurse, advanced registered nurse practitioner, or physician assistant must review the ultrasound evaluation results and the estimate of the probable gestational age of the fetus with the patient before the abortion procedure is performed; and
- The physician to estimate the gestational age of the fetus based on the ultrasound examination and obstetric standards in keeping with established standards of care regarding the estimation of fetal age and write the estimate in the patient's medical history. The physician must keep original prints of each ultrasound examination in the patient's medical history file.

Section 390.0111(4), F.S., provides for the standard of medical care to be used during viability. If a termination of pregnancy is performed during viability, a person who performs or induces the termination of pregnancy may not fail to use that degree of professional skill, care, and diligence to preserve the life and health of the fetus which the person would be required to exercise in order to preserve the life and health of any fetus intended to be born and not aborted.

[5] Section 390.0111(8), F.S.
[6] Agency for Health Care Administration, *2011 Bill Analysis & Economic Impact Statement for SB 1748*, on file with the Senate Health Regulation Committee.

The biennial license fee for an abortion clinic is $514. The administrator responsible for the day to day operations of the abortion clinic and the chief financial officer are required to submit to a level 2 (statewide and nationwide) background screening.[7]

Relevant Case Law

In 1973, the landmark case of *Roe v. Wade* established that restrictions on a woman's access to secure an abortion are subject to a strict scrutiny standard of review.[8] In *Roe*, the U.S. Supreme Court determined that a woman's right to have an abortion is part of the fundamental right to privacy guaranteed under the Due Process Clause of the Fourteenth Amendment of the U.S. Constitution, justifying the highest level of review.[9] Specifically, the Court concluded that: (1) during the first trimester, the state may not regulate the right to an abortion; (2) after the first trimester, the state may impose regulations to protect the health of the mother; and (3) after viability, the state may regulate and proscribe abortions, except when it is necessary to preserve the life or health of the mother.[10] Therefore, a state regulation limiting these rights may be justified only by a compelling state interest, and the legislative enactments must be narrowly drawn to express only legitimate state interests at stake.[11]

In 1992, in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the U.S. Supreme Court relaxed the standard of review in abortion cases involving adult women from strict scrutiny to unduly burdensome, while still recognizing that the right to an abortion emanates from the constitutional penumbra of privacy rights.[12] In *Planned Parenthood*, the Court determined that, prior to fetal viability, a woman has the right to an abortion without being unduly burdened by government interference.[13] The Court concluded that the state may regulate the abortion as long as the regulation does not impose an undue burden on a woman's decision to choose an abortion.[14] If the purpose of a provision of law is to place substantial obstacles in the path of a woman seeking an abortion before viability, it is invalid; however, after viability the state may restrict abortions if the law contains exceptions for pregnancies endangering a woman's life or health.[15]

The unduly burdensome standard as applied in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, which is generally considered to be a hybrid between strict scrutiny and intermediate level scrutiny, shifted the Court's focus to whether a restriction creates a substantial obstacle to access. This is the prevailing standard today applied in cases in which abortion access is statutorily restricted.

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[7] Agency for Health Care Administration, *Abortion Clinic*, *available at* http://www.fdhc.state.fl.us/mchq/health_facility_regulation/hospital_outpatient/abortion.shtml (Last visited on March 23, 2011).
[8] 410 U.S. 113 (1973).
[9] 410 U.S. 113, 154 (1973).
[10] 410 U.S. 113, 162-65 (1973).
[11] 410 U.S. 113, 152-56 (1973).
[12] 505 U.S. 833, 876-79 (1992).
[13] *Id.*
[14] *Id*.
[15] *Id.*

However, the undue burden standard was held not to apply in Florida. The 1999 Legislature passed a parental notification law, the Parental Notice of Abortion Act, requiring a physician to give at least 48 hours of actual notice to one parent or to the legal guardian of a pregnant minor before terminating the pregnancy of the minor. Although a judicial waiver procedure was included, the act was never enforced.[16] In 2003, the Florida Supreme Court[17] ruled this legislation unconstitutional on the grounds that it violated a minor's right to privacy, as expressly protected under Article I, s. 23 of the Florida Constitution.[18] Citing the principle holding of *In re T.W.*,[19] the Court reiterated that, as the privacy right is a fundamental right in Florida, any restrictions on privacy warrant a strict scrutiny review, rather than that of an undue burden. Here, the Court held that the state failed to show a compelling state interest and therefore, the Court permanently enjoined the enforcement of the Parental Notice of Abortion Act.[20]

Centers for Disease Control and Prevention (CDC)

The CDC began collecting abortion data (abortion surveillance) in 1969 to document the number and characteristics of women obtaining "legal induced" abortions. The CDC's surveillance system counts legal induced abortions only. For the CDC's surveillance purposes, legal abortion is defined as a procedure performed by a licensed physician, or a licensed advanced practice clinician acting under the supervision of a licensed physician, to induce the termination of a pregnancy.[21]

States and other territories voluntarily report data to the CDC for inclusion in its annual Abortion Surveillance Report.[22] The CDC's Division of Reproductive Health prepares surveillance reports as data becomes available. There is no national requirement for data submission or reporting.[23]

Those states requiring the reporting of information on induced abortions use various methods to collect the data. Some states include induced abortion reporting as a part of their fetal death reporting system, while a majority of states use a separate form, usually called Report of Induced Termination of Pregnancy, for the reporting of induced abortions. Regardless of the reporting system used, all states with reporting systems require the reporting of all induced abortions regardless of length of gestation.[24]

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[16] *See* s. 390.01115, F.S. (repealed by s. 1, ch. 2005-52, Laws of Florida). Ch. 2005-52, Laws of Florida created s. 390.01114, F.S., the revised Parental Notice of Abortion Act.

[17] *North Florida Women's Health and Counseling Services, Inc., et al., v. State of Florida*, 866 So. 2d 612, 619-20 (Fla. 2003)

[18] The constitutional right of privacy provision reads: "Every natural person has the right to be let alone and free from governmental intrusion into the person's private life except as otherwise provided herein. This section shall not be construed to limit the public's right of access to public records and meetings as provided by law." FLA. CONST. art. I, s. 23.

[19] 551 So. 2d 1186, 1192 (Fla. 1989).

[20] *North Florida Women's Health and Counseling Services, supra* note 16, at 622 and 639-40.

[21] Centers for Disease Control and Prevention, *CDC's Abortion Surveillance System FAQs*, available at: http://www.cdc.gov/reproductivehealth/Data_Stats/Abortion.htm (Last visited on March 23, 2011).

[22] Florida does not report abortion data to the CDC. *Supra* fn. 6.

[23] *Supra* fn. 21.

[24] Centers for Disease Control and Prevention, *Handbook on the Reporting of Induced Termination of Pregnancy*, April 1998, available at: http://www.cdc.gov/nchs/data/misc/hb_itop.pdf (Last visited on March 23, 2011).

The CDC has developed a Standard Report of Induced Termination of Pregnancy to serve as a model for use by states. The model report suggests that the state's report should include the:[25]

- Facility name where the induced termination of pregnancy occurred.
- City, town, or location where the pregnancy termination occurred.
- County where the pregnancy termination occurred.
- Hospital, clinic, or other patient identification number, which would enable the facility or physician to access the medical file of the patient.
- Age of the patient in years at her last birthday.
- Marital status of the patient.
- Date of the pregnancy termination.
- Place the patient actually and physically lives or resides, which is not necessarily a patient's home state, voting residence, mailing address, or legal residence.
- Name of the state, county, and city where the patient lives.
- Number of the ZIP code where the patient lives.
- Origin of the patient, if Hispanic.
- Ancestry of the patient.
- Race of the patient.
- Highest level of education completed by the patient.
- Date the patient's last normal menstrual period began.
- Length of gestation as estimated by the attending physician.
- Number of previous pregnancies, including live births and other terminations.
- Type of termination procedure used.
- Name of the attending physician.
- Name of the person completing the report.

The CDC reports that its surveillance data is used to:[26]

- Identify characteristics of women who are at high risk of unintended pregnancy.
- Evaluate the effectiveness of programs for reducing teen pregnancies and unintended pregnancy among women of all ages.
- Calculate pregnancy rates based on the number of pregnancies ending in abortion in conjunction with birth data and fetal loss estimates.
- Monitor changes in clinical practice patterns related to abortion, such as changes in the types of procedures used, and weeks of gestation at the time of abortion.

Additionally, demographers use information in the report to calculate pregnancy rates, which are combined estimates of births and fetal loss and managers of public health programs use this data to evaluate the programs' effectiveness to prevent unintended pregnancy. There have historically been other data uses; such as, the calculation of the mortality rate of specific abortion procedures.

The CDC reports that in 2007,[27] there were 827,609 legal induced abortions reported to the CDC from 49 reporting areas. This is a 2 percent decrease from the 846,181 abortions in 2006. The

[25] *Id.*
[26] *Supra* fn. 21.

abortion rate for 2007 was 16.0 abortions per 1,000 women aged 15 through 44 years. This also is a 2 percent decrease from 2006. The abortion ratio was 231 abortions per 1,000 live births in 2007. This is a 3 percent decrease from 2006. During 1998 through 2007, the reported abortion numbers, rates, and ratios decreased 6 percent, 7 percent, and 14 percent, respectively. During 1997 through 2006, women aged 20 to 29 years accounted for the majority of abortions. The majority (62.3 percent) of abortions in 2007 were performed at 8 weeks' gestation or less and 92 percent were performed at 13 weeks' gestation or less; 13.1 percent of all abortions were medical abortions.[28]

III. Effect of Proposed Changes:

Section 1 amends s. 390.0111, F.S., to prohibit abortions from being performed after the period at which, in the physician's best medical judgment, the fetus has attained viability or during the third trimester of pregnancy. However, an abortion may be performed after viability or during the third trimester of pregnancy if two physicians certify in writing as to the existence of a medical emergency[29] or one physician certifies in writing to the existence of a medical emergency and another physician is not available for consultation.

This section also requires:

- An abortion clinic that advertises its services to provide conspicuous notice on its advertisements that it is prohibited from performing abortions in the third trimester or after viability.
- Physicians who offer to perform or perform abortions in abortion clinics to annually complete at least 3 hours of continuing education that relate to ethics.
- Abortions to be performed in a validly licensed hospital, abortion clinic, or physician's office, unless the law specifically requires the abortion to be performed in a hospital or an emergency care situation exists.

This section provides that it is a misdemeanor of the second-degree punishable as provided in s. 775.082, F.S., or s. 775.083, F.S., (maximum imprisonment of 60 days or maximum fine of $500) if a person willfully:

- Establishes, conducts, manages, or operates an abortion clinic without a valid current license.
- Performs or assists in performing an abortion on a person in the third trimester or after viability in a place other than in a hospital.
- After October 1, 2011, operates or owns an abortion clinic and is not a physician who has received training during residency in performing a dilation-and-curettage procedure[30] or a dilation-and-evacuation procedure.[31]

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[27] This is the most recent data available on the CDC website, which is available at: http://www.cdc.gov/reproductivehealth/Data_Stats/Abortion.htm (Last visited on March 23, 2011).
[28] *Supra* fn. 21.
[29] Section 390.01114(2)(d), F.S., defines a "medical emergency" as a condition that, on the basis of a physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate termination of her pregnancy to avert her death, or for which a delay in the termination of her pregnancy will create serious risk of substantial and irreversible impairment of a major bodily function.
[30] Dilation-and-curettage is a medical procedure in which the uterine cervix is dilated and a curette is inserted into the uterus to scrape away the endometrium, also known as a D&C. Merriam-Webster, MedlinePlus Medical Dictionary, available at: http://www.merriam-webster.com/medlineplus/dilation-and-curettage (Last visited on March 23, 2011).

This section also increases the penalty for a person who fails to dispose of fetal remains in an appropriate manner. The penalty is increased from a misdemeanor of a second-degree to a misdemeanor of a first-degree, punishable as provided in s. 775.082, F.S., or s. 775.083, F.S. (maximum imprisonment of 1 year or maximum fine of $1,000). In addition, it is a misdemeanor of the first-degree for a person to advertise or facilitate an advertisement of services or drugs for the purpose of performing an abortion in violation of ch. 390, F.S.

The Department of Health is required to permanently revoke the license of a licensed health care practitioner who has been convicted or found guilty of, or entered a plea of guilty or nolo contendre to, regardless of adjudication, a felony criminal act for willfully performing an unlawful abortion.

The AHCA is required to report, prior to each general legislative session, aggregate statistical data that relates to abortions and does not contain any personal identifying information, which has been reported to the Division of Reproductive Health within the CDC, on its website. In addition, the AHCA must submit such information in an annual report the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Section 2 amends s. 390.0112, F.S., to require the director of any medical facility or physician's office in which an abortion is performed to submit a report to AHCA following each abortion. The report must be on a form developed by the AHCA which is consistent with the U.S. Standard Report of Induced Termination of Pregnancy from the CDC. The AHCA is required to submit this reported information to the Division of Reproductive Health within the CDC.

Section 3 amends s. 390.012, F.S., to require the AHCA to adopt rules to prescribe standards for advertisements used by an abortion clinic by requiring the clinic to provide conspicuous notice on its advertisement that it is prohibited from performing abortions in the third trimester or after viability.

Section 4 amends s. 456.013, F.S., to require physicians who offer to perform or perform abortions in an abortion clinic to annually complete a 3-hour course related to ethics as part of the licensure and renewal process as required in section 1 of the bill. This section clarifies that the 3-hour course must count toward the total number of continuing education hours required for the profession and the applicable board, or department if there is no board, must approve of the course.

Section 5 repeals s. 797.02, F.S., the provisions of which are transferred to ch. 390, F.S., in section 1 of the bill.

Section 6 repeals s. 797.03, F.S., the provisions of which are transferred to ch. 390, F.S., in section 1 of the bill.

[31] Dilation-and-evacuation is a surgical abortion that is typically performed midway during the second trimester of pregnancy and in which the uterine cervix is dilated and fetal tissue is removed using surgical instruments and suction, also called a D&E. Merriam-Webster, MedlinePlus Medical Dictionary, available at: http://www.merriam-webster.com/medlineplus/dilation-and-evacuation%20 (Last visited on March 23, 2011).

Section 7 is an undesignated section that provides for the severability of any provision in the bill that is held invalid.

Section 8 provides an effective date of October 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

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

D. Other Constitutional Issues:

If the bill, should it become law, is challenged as an invasion of privacy, it will be subject to a strict scrutiny review, rather than that of an undue burden test pursuant to *North Florida Women's Health and Counseling Services, Inc., et al., v. State of Florida*,[32] as discussed above under the subheading, "Relevant Case Law." Otherwise, any challenge that does not impinge on a constitutional fundamental right, will be subject to the "undue burden" standard announced in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.[33]

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Abortion clinics may incur an indeterminate amount of costs associated with complying with the advertisement requirements, ownership requirements, and report requirements provided for in the bill.

[32] 866 So. 2d 612 (Fla. 2003).
[33] 505 U.S. 833 (1992).

C. Government Sector Impact:

Because the bill requires the director of any medical facility or physician's office to submit a report after each abortion, instead of monthly, the AHCA has estimated that it will receive approximately 80,000 reports annually. The AHCA estimates that it will incur costs of approximately $50,000 in order to contract for services to develop a database to collect the additional data elements required by the bill.[34]

VI. Technical Deficiencies:

The term "viability" is defined in s. 390.0111(4), F.S. Lines 78, 82, 98, 114 and 217 of the bill use the term viability. However, the definition is not provided in a manner so that it applies to the whole chapter. In order for the definition of the term to apply to the whole chapter, including the use of the term in the aforementioned lines, the definition of viability should be moved to s. 390.011, F.S.

Line 131 of the bill should read "Except as provided in paragraph (f) of subsection (2) and subsections (3) and (7)" because paragraph (f) of subsection (2) contains misdemeanor penalties that should also be excluded from the felony provisions of subsection (10).

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.

[34] *Supra* fn. 6.