The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH REGULATION
Senator Garcia, Chair
Senator Sobel, Vice Chair

MEETING DATE: Monday, March 28, 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 1324** Bennett (Identical H 915)	Disposition of Human Remains; Transfers, renumbers, and amends provisions. Revises procedures for the reporting and disposition of unclaimed remains. Prohibits certain uses or dispositions of the remains of deceased persons whose identities are not known. Requires that local governmental contracts for the final disposition of unclaimed remains comply with certain federal regulations. Revises procedures for the anatomical board's retention of human remains before their use, etc. HR 03/28/2011 HE CA BC	
2	**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 BC	
3	**SB 1748** Flores (Similar 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 CJ BC	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**SB 1156** Garcia (Similar H 487)	Dextromethorphan; Cites this act as the "Andy Maxfield Dextromethorphan Act." Amends and reenacts provisions relating to penalties. Prohibits obtaining or delivering to an individual in a retail sale any nonprescription compound, mixture, or preparation containing dextromethorphan or related compounds in excess of specified amounts. Regulates retail display of products containing dextromethorphan or related compounds. Requires the training of retail employees. Provides limited civil immunity for the release of information to law enforcement officers, etc. HR 03/28/2011 CJ JU	
5	**SB 546** Hays (Similar H 367)	Dentists; Prohibits contracts between health insurers and dentists from containing certain fee requirements set by the insurer under certain circumstances. Prohibits contracts between prepaid limited health service organizations and dentists from containing certain fee requirements set by the organization under certain circumstances. Prohibits contracts between HMOs and dentists from containing certain fee requirements set by the organization under certain circumstances, etc. BI 03/09/2011 Favorable HR 03/28/2011 BC	
6	**SB 1396** Bogdanoff (Similar H 661, Compare S 1972)	Nursing Home Litigation Reform; Specifies conditions under which a nursing home resident has a cause of action against a licensee or management company. Requires the trial judge to conduct an evidentiary hearing before a claimant can assert a claim against certain interested parties. Provides a timeframe for a claimant to elect survival damages or wrongful death damages. Requires evidence of the basis for punitive damages. Provides limitations for admissibility of survey and licensure reports and the presentation of testimony or other evidence of staffing deficiencies, etc. HR 03/28/2011 JU BC	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
7	**SB 292** Dean (Identical H 847)	Mobile Home and Recreational Vehicle Parks; Specifies laws and rules to be enforced by the Department of Health. Provides that an operator of a mobile home park, lodging park, recreational vehicle park, or recreational camp who refuses to pay the operating permit fee required by law or who fails, neglects, or refuses to obtain an operating permit for the park commits a misdemeanor of the second degree. Provides a penalty for failure to depart from a park under certain circumstances, etc. TR 02/07/2011 Favorable HR 03/28/2011 CA BC	
8	**SB 1698** Dean (Compare H 13, H 167, H 1479, S 82, S 130, S 168)	Onsite Sewage Treatment and Disposal Systems; Deletes provisions requiring the Department of Health to administer an evaluation and assessment program of onsite sewage treatment and disposal systems and requiring property owners to have such systems evaluated at least once every 5 years. Deletes provisions prohibiting the land application of septage and requires the Department of Environmental Protection to recommend to the Governor and Legislature alternative methods for land application of septage. Requires the department to give to owners of systems at least 60 days' notice before and evaluation deadline, etc. HR 03/28/2011 EP BC	
9	**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 BC	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
10	**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, 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 CF BC	
11	**CS/SB 432** Criminal Justice / Evers (Similar CS/H 155)	Privacy of Firearms Owners; Provides that inquiries by physicians or other medical personnel concerning the ownership of a firearm by a patient or the family of a patient or the presence of a firearm in a private home or other domicile of a patient or the family of a patient violates the privacy of the patient or the patient's family members, respectively. Prohibits entry of certain information concerning firearms into medical records or disclosure of such information by specified individuals. Provides noncriminal penalties. Provides for prosecution of violations, etc. CJ 02/22/2011 Fav/CS HR 03/14/2011 Temporarily Postponed HR 03/22/2011 Temporarily Postponed HR 03/28/2011 JU BC	
12	**SB 1386** Bogdanoff (Compare H 7095, CS/CS/S 818)	Controlled Substances; Authorizes the Department of Health to obtain patient records pursuant to a subpoena and without notification to the patient from a controlled-substance medical clinic under certain circumstances. Renames pain-management clinics as "controlled-substance medical clinics." Revises the circumstances in which the department may revoke the certificate of registration for such a clinic. Revises the responsibilities of a physician and an osteopathic physician who provides professional services in such a clinic, etc. HR 03/28/2011 CJ BC	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
13	**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 BC	

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LEGISLATIVE ACTION

Senate . House

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

Senate Amendment

Delete line 260
and insert:
does not exceed 100 percent of the federal poverty

Delete line 697
and insert:
board from transporting human remains ~~specimens~~ outside or within the

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 1324
INTRODUCER:	Senator Bennett
SUBJECT:	Disposition of Human Remains
DATE:	March 25, 2011 REVISED:

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

I. Summary:

This bill transfers part II, of ch. 406, F.S., regarding the disposition of dead bodies, to ch. 497, F.S., the Florida Funeral, Cemetery, and Consumer Services Act.

The definitions of the terms "anatomical board," "indigent person," and "unclaimed remains" are transferred from ch. 406, F.S., to s. 497.005, F.S., and the definitions of these terms include some clarifications. The existing definition of the term "final disposition" in s. 497.005, F.S., is also clarified and changed to conform to the other changes made by the bill.

The bill requires any person or entity that comes into possession, charge, or control of unclaimed human remains, that are required to be buried at public expense, to immediately notify the anatomical board unless, among other things, the deceased person was a veteran, a spouse of the veteran, or a dependent child of a veteran, of the U.S. Armed Forces, U.S. Reserve Forces, or National Guard and is eligible for burial in a national cemetery.

The bill requires a person or entity in charge or control of human remains to make a reasonable effort to make certain determinations prior to the final disposition of the unclaimed remains. The bill defines "a reasonable effort" to include contacting the National Cemetery Scheduling Office.

The bill prescribes procedures for instances when no family exists or is available to take control or possession of human remains, when the remains of a deceased person's identity is unknown, and when the anatomical board does not accept unclaimed remains.

The bill also prescribes procedures for the anatomical board to store human remains and release claimed human remains. The bill permits a board of county commissioners to prescribe policies

and procedures for the final disposition of the unclaimed remains of an indigent person whose death occurred in that county and provides that a licensed person who cremates or buries a person at the written direction of the board of county commissioners is not liable for any damages resulting from the cremation or burial.

The bill prescribes when a county commission or designated county department is not required to notify the anatomical board of unclaimed human remains.

The bill specifies that the anatomical board may receive the body of a person who, with sound mind, executed a will leaving his or her remains for medical educational and research purposes and authorizes the anatomical board to loan human remains to recognized associations of license embalmers or funeral directors or medical or dental examining boards for educational or research purposes.

The bill authorizes the anatomical board to pay reasonable expenses, as determined by the anatomical board, incurred by a funeral establishment or removal service for delivering human remains to the anatomical board.

The bill provides that any person who sells or buys human remains or transmits or conveys or causes to be transmitted or conveyed human remains to any place outside or within Florida, commits a misdemeanor of the first degree.

This bill substantially amends s. 497.005, F.S.

This bill transfers ss. 406.50, 406.51, 406.52, 406.53, 406.55, 406.56, 406.57, 406.58, 406.59, 406.60, and 406.61, F.S., to the following respective sections, which are created within the Florida Statutes: 497.701, 497.703, 497.705, 497.707, 497.709, 497.711, 497.713, 497.715, 497.717, 497.719, and 497.721.

This bill repeals s. 406.54, F.S.

II. Present Situation:

Florida Funeral, Cemetery, and Consumer Services Act

Funeral and cemetery services are regulated under ch. 497, F.S., the "Florida Funeral, Cemetery, and Consumer Services Act" (act).[1] The Board of Funeral, Cemetery, and Consumer Services within the Department of Financial Services (department) is responsible for the administration and enforcement of the act. The Division of Funeral, Cemetery, and Consumer Services (division) performs the board's administrative functions. Chapter 497, F.S., refers to the board by the term "licensing authority."

The practices of funeral services is divided into three relevant licenses. Persons may be licensed as a funeral director,[2] an embalmer,[3] or with a combination license for the practice of funeral directing and embalming.[4]

[1] Section 497.001, F.S.
[2] Section 497.372, F.S.

The act dictates the preferential order to select a person responsible for determining the disposition of human remains. The act provides that a "legally authorized individual" [5] shall have the power to make this decision and the preferential order for choosing the person responsible for directing disposition is (in descending order):

- The decedent, when written *inter vivos* authorizations and directions are provided by the decedent;
- The person designated by the decedent as authorized to direct disposition pursuant to Pub. L. No. 109-163, s. 564, as listed on the decedent's United States Department of Defense Record of Emergency Data, DD Form 93, or its successor form, if the decedent died while serving military service as described in 10 U.S.C. s. 1481(a)(1)-(8) in any branch of the U.S. Armed Forces, U.S. Reserve Forces, or National Guard;
- The surviving spouse, unless the spouse has been arrested for committing against the deceased an act of domestic violence as defined in s. 741.28, F.S., that resulted in or contributed to the death of the deceased;
- A son or daughter who is 18 years of age or older;
- A parent;
- A brother or sister who is 18 years of age or older;
- A grandchild who is 18 years of age or older;
- A grandparent; or
- Any person in the next degree of kinship.

In addition, a "legally authorized individual" may include, if no family member exists or is available, the guardian of the dead person at the time of death; the personal representative of the deceased; the attorney in fact of the dead person at the time of death; the health surrogate of the dead person at the time of death; a public health officer; the medical examiner, county commission, or administrator acting under part II, ch. 406, F.S., or other public administrator; a representative of a nursing home or other health care institution in charge of final disposition; or a friend or other person not listed in this subsection who is willing to assume the responsibility as the legally authorized person. A funeral establishment must rely upon the authorization of any one legally authorized person if that person represents that she or he is not aware of any objection to the cremation of the deceased's human remains by others in the same class of the person making the representation or of any person in a higher priority class.

Part II, Chapter 406, F.S.-Disposition of Dead Bodies

Part II of ch. 406, F.S., pertains to the disposition of dead bodies and human remains. Section 406.50, F.S., governs the procedures for the disposition of unclaimed[6] dead bodies or human remains. These procedures apply to all public officers, agents, or employees of every county, city, village, town, or municipality and every person in charge of any prison, morgue, hospital, funeral parlor, or mortuary and all other persons coming into possession, charge, or

[3] Section 497.368, F.S.
[4] Section 497.376, F.S.
[5] Section 497.005(39), F.S.
[6] The term "unclaimed" means a dead body or human remains that are not claimed by a legally authorized person, as defined in s. 497.005, F.S., for interment at that person's expense.

control of any dead body or human remains, which are required to be buried or cremated at public expense.

A person or entity in possession, charge, or control of a dead body or human remains is required to immediately notify the anatomical board,[7] whenever any such body or remains come into its possession, charge, or control and must deliver the body or remains to the anatomical board as soon as possible after death.[8] Notification of, or delivery to, the anatomical board is not required if the death was caused by crushing injury, the deceased had a contagious disease, an autopsy was required to determine cause of death, the body was in a state of severe decomposition, or a family member objects to use of the body for medical education and research.[9]

The person or entity in charge or control of the dead body or human remains must make a reasonable effort[10] to determine the identity of the deceased person and contact any relatives of the deceased person. The person or entity must also make a reasonable effort to determine whether the deceased person is entitled to burial in a national cemetery as a veteran of the U.S. Armed Forces[11] and, if so, must make arrangements for the burial services in accordance with the provisions of 38 C.F.R.[12]

Despite the notification and delivery requirements under s. 406.50, F.S., a medical examiner has a right to hold the dead body or remains for the purpose of investigating the cause of death, and any court of competent jurisdiction may enter an order affecting the disposition of a body or remains.

In the event more than one legally authorized person claims a body for interment, the requests must be prioritized in accordance with s. 732.103, F.S.[13]

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[7] The "anatomical board" means the anatomical board of Florida located at the University of Florida Health Science Center.

[8] Any dead human body which has been delivered to the anatomical board may be claimed by any friend or any representative of a fraternal society of which the deceased was a member, or a representative of any charitable or religious organization. Upon receipt of such claim, the body or remains must be surrendered to the claimant by the anatomical board after the payment to the anatomical board for the expenses incurred in obtaining and handling such body or remains. Section 406.54, F.S.

[9] Section 406.50, F.S.

[10] A "reasonable effort" includes contacting the county veterans' service office or regional office of the United States Department of Veterans Affairs. Section 406.50(1)(b), F.S.

[11] Any contract by a local governmental entity for the disposal of unclaimed human remains must provide for compliance with s. 406.50(1), F.S., and require that the procedures in 38 C.F.R., relating to disposition of unclaimed deceased veterans, be followed. Section 406.51, F.S.

[12] If the body of a deceased veteran is unclaimed, there being no relatives or friends to claim the body, and there is burial allowance entitlement, the amount provided for burial and plot or interment allowance will be available for the burial upon receipt of a claim accompanied by a statement showing what efforts were made to locate relatives or friends. 38 C.F.R. §3.1603 Authority for burial of certain unclaimed bodies.

[13] Section 732.103, F.S., provides that the belongings of a deceased person who does not have a will pass to a surviving spouse and if there is not a surviving spouse then to the following people in descending order: (1) The descendants of the decedent. (2) The decedent's father and mother equally, or to the survivor of them. (3) The decedent's brothers and sisters and the descendants of deceased brothers and sisters. (4) One-half to the decedent's paternal, and the other half to the decedent's maternal, kindred in the following order: the grandfather and grandmother equally, or to the survivor of them; to uncles and aunts and descendants of deceased uncles and aunts of the decedent; to the other kindred who survive. (5) If there is no kindred of either part, the whole of the property shall go to the kindred of the last deceased spouse of the decedent. (6) If none of the foregoing, then to the descendants of the great-grandparents if the descendants were Holocaust victims.

All bodies received by the anatomical board must be retained in receiving vaults for a period of not less than 48 hours before allowing their use for medical science. If at any time more bodies are made available to the anatomical board than can be used for medical science under its jurisdiction, or if a body is deemed by the anatomical board to be unfit for anatomical purposes, the anatomical board may notify, in writing, the county commissioners or other legally authorized person in the county where such person died, in order for the body to be buried or cremated. However, prior to having any body buried or cremated, the county must make a reasonable effort to determine the identity of the body and contact any relatives of the deceased person. If a relative of the deceased person is contacted and expresses a preference for either burial or cremation, the county must make a reasonable effort to accommodate the request of the relative.

The anatomical board is not required to be notified of a death of an indigent[14] person if:

- The death was caused by crushing injury.
- The deceased had a contagious disease.
- An autopsy was required to determine cause of death.
- The body was in a state of severe decomposition.
- Any relative, by blood or marriage, claims the body for burial at the expense of such relative.
- Any friend or any representative of a fraternal society of which the deceased was a member, or a representative of any charitable or religious organization, or a governmental agency that was providing residential care to the indigent person at the time of his or her death claims the body for burial at his or her, its, or their expense.
- The deceased person was an honorably discharged member of the U.S. Armed Forces or the state who served during a period of wartime service.

When the Department of Health claims the body of a decedent, the department is required to assess fees for the burial against the estate.[15]

The anatomical board is specifically prohibited from entering into any contract, oral or written, whereby any sum of money is to be paid to any living person in exchange for a body to be delivered to the anatomical board when a living person dies.[16] However; if any person being of sound mind executes a will leaving his or her body to the anatomical board for the advancement of medical science and dies within Florida, the anatomical board is authorized to accept and receive the body.[17]

The anatomical board is required to take and receive the bodies delivered to it and distribute them equitably among the medical and dental schools, teaching hospitals, medical institutions, and health-related teaching programs that require cadaveric material for study or distribute them for examination or study purposes to recognized associations of licensed embalmers or funeral directors, or medical or dental examining boards[18] at the discretion of the anatomical board.[19]

[14] The term "indigent" means 100 percent of the federal poverty level recognized by the Federal Income Guidelines produced by the United States Department of Health and Human Services. Section 406.53(3), F.S.
[15] Section 402.33, F.S.
[16] Section 406.55, F.S.
[17] Section 406.56, F.S.
[18] A university, school, college, teaching hospital, institution, or association is not allowed or permitted to receive any body or bodies until its facilities have been inspected and approved by the anatomical board. All bodies received by a university,

Any person who sells or buys any body or parts of bodies or who transmits or conveys or causes to be transmitted or conveyed[20] a body or parts of bodies to any place outside of Florida commits a misdemeanor of the first degree, punishable as provided in ss. 775.082 and 775.083 (maximum imprisonment of 1 year or maximum fine of $1,000). However, the anatomical board is not prohibited from transporting human specimens outside the state for educational or scientific purposes and not prohibited from transporting bodies, parts of bodies, or tissue specimens in furtherance of lawful examination, investigation, or autopsy. Any person, institution, or organization that conveys bodies or parts of bodies into or out of Florida for medical education or research purposes is required to notify the anatomical board of such intent and must receive approval from the board.

Any entity accredited by the American Association of Museums may convey plastinated[21] bodies or parts of bodies into or out of Florida for exhibition and public educational purposes without the consent of the board if the accredited entity:

- Notifies the board of the conveyance and the duration and location of the exhibition at least 30 days before the intended conveyance.
- Submits to the board a description of the bodies or parts of bodies and the name and address of the company providing the bodies or parts of bodies.
- Submits to the board documentation that each body was donated by the decedent or his or her next of kin for purposes of plastination and public exhibition, or, in lieu of such documentation, an affidavit stating that each body was donated directly by the decedent or his or her next of kin for such purposes to the company providing the body and that such company has a donation form on file for the body.
- Submits an affidavit to the board stating that the body was legally acquired and that the company providing the body has acquisition documentation on file for the body, if a plastinated body was exhibited in Florida before July 1, 2009, by any entity accredited by the American Association of Museums.

Disposal of Remains of U.S. Military Service Members

During their period of military service, all service members in the Army, Navy, Air Force, and Marine Corps are required to complete the United States Department of Defense Record of

school, college, teaching hospital, institution, or association are to be used for no other purpose than the promotion of medical science. Section 406.59, F.S.

[19] Section 406.57, F.S. The anatomical board is authorized to collect fees from the institution or association to which the bodies are distributed or loaned to defray the costs of obtaining and preparing such bodies and may receive money from public or private sources in addition to the fees collected from the institution or association to defray the costs of embalming, handling, shipping, storage, cremation, and other costs relating to the obtaining and use of such bodies. A complete record of all fees and other financial transactions of the anatomical board must be kept and audited annually by the Department of Financial Services, and a report of the audit must be made annually to the University of Florida. Section 406.58, F.S.

[20] However a recognized Florida medical or dental school is authorized to make such a conveyance.

[21] "Plastination" or "polymer preservation" is a technique used to preserve bodies or body parts. The water and fat are replaced with curable polymers or plastics, yielding specimens that can be touched, do not smell or decay, and retain microscopic properties of the original specimen. Bodies Human Anatomy in Motion, available at: http://bodieshuman.com/plastination.html (Last visited on March 24, 2011).

Emergency Data form (DD Form 93).[22] The form is also applicable to members of the Coast Guard when operating as a service within the Department of the Navy.[23]

United States Department of Defense Record of Emergency Data, DD Form 93, requires United States military personnel to designate a person authorized to direct disposition (PADD). The form requires the service member to state the name of the person and the person's relationship to the service member. The instructions to the form limit the designated PADD to the surviving spouse, blood relative of legal age, or adoptive relatives of the decedent. If neither of these persons can be found, the service member may designate a person standing in *loco parentis*, i.e., in place of the parents. The DD Form 93 also allows the service member to indicate who the service member wishes to be contacted in case of death and to receive benefits-related information.

Federal law, in 10 U.S.C. s. 1481(a)(1)-(8), lists the persons whom the Secretary of Defense may provide for the recovery, care, and disposition of remains. The list includes any members of the armed forces who die while on active duty, any members of the reserves while on active duty or inactive-duty training, an accepted applicant for enlistment, any retired or active service members who die during continuous hospitalization that began while the person was on active duty, any military prisoner who dies while in custody, and any retired members of the armed services who dies while outside the U.S. or any individual who dies while outside the U.S. while a dependent of such service member.

III. Effect of Proposed Changes:

This bill transfers part II, of ch. 406, F.S., regarding the disposition of dead bodies, to ch. 497, F.S., the Florida Funeral, Cemetery, and Consumer Services Act.

Section 1 creates part VII of ch. 497, F.S., which is to be entitled "Unclaimed Human Remains; Anatomical Board."

Section 2 amends s. 497.005, F.S., to define the terms "anatomical board," "indigent person," and "unclaimed remains." The definition for "anatomical board" is clarified to mean the anatomical board of the state headquartered at the University of Florida Health Science Center. The definition for "indigent person" is clarified to mean a person whose family income does not exceed 100 percent of the current federal poverty guidelines prescribed for the family's household size by the United States Department of Health and Human Services. The term "unclaimed remains" is defined as human remains that are not claimed by a legally authorized person, other than a medical examiner or the board of county commissioners, for final disposition at the person's expense. The definition of the term "final disposition" is clarified to include that the final disposal of a dead human remains may be by burial, entombment, or anatomical donation.

Section 3 transfers the provisions of s. 406.50, F.S. to s. 497.701, F.S., and those provisions are amended to require a person or entity that comes into possession, charge, or control of unclaimed

[22] The execution of the DD Form 93 is required to be witnessed by a disinterested party.
[23] Department of Defense Instruction 1300.18, available at: http://www.dtic.mil/whs/directives/corres/pdf/130018p.pdf (Last visited March 24, 2011).

remains that are required to be buried or cremated at public expense to immediately notify the anatomical board, unless the unclaimed remains are decomposed or mutilated, an autopsy is performed on the remains, the remains contain a contagious disease, a legally authorized person objects to the use of the remains for medical education and research, or the deceased person was a veteran, a veteran's spouse, or a dependent child of a veteran of the U.S. Armed Forces, U.S. Reserve Forces, or National Guard and is eligible for burial in a national cemetery.

This section specifies that prior to the final disposition of unclaimed remains, a person or entity in charge or control of the human remains must make a reasonable effort to determine the identity of the deceased person and contact any of his or her relatives and determine whether the deceased person is eligible for burial in a national cemetery as a veteran of the U.S. Armed Forces. If a person determines the decedent is eligible for such a burial, the person must cause the deceased person's remains or cremated remains to be delivered to a national cemetery. "Reasonable effort" means contacting the National Cemetery Scheduling Office and the county veterans' service office or regional office of the U.S. Department of Veterans Affairs.

This section provides that when no family exists or is available, a funeral director licensed under ch. 497, F.S., may assume the responsibility of a legally authorized person and may, after 48 hours have elapsed from the time of death, authorize arterial embalming for the purposes of storage and delivery of unclaimed remains to the anatomical board. The funeral director is exempted from liability for performing such acts.

This section also provides that the remains of a deceased person whose identity is not known may not be cremated, donated as an anatomical gift, buried at sea, or removed from Florida.

This section authorizes the county commission or its designated county department to authorize and arrange for the burial or cremation of the remains if such remains were found in or the death occurred in that county and the anatomical board does not accept the unclaimed remains. The board of county commissioners is authorized to prescribe policies and procedures for final disposition of unclaimed remains by resolution or ordinance in accordance with applicable laws and rules.

The requirement that, in the event that one or more legally authorized person claims a body for interment, requests are to be prioritized in accordance with s. 732.103, F.S., is removed from this section.

Section 4 transfers the provisions of s. 406.51, F.S. to s. 497.703, F.S., and those provisions are amended to clarify that disposition means "final disposition," correct a cross-reference, and clarify that procedures under 38 C.F.R., s. 38.620, relating to disposition of unclaimed deceased veterans, are to be followed under any contract by a local government entity for the disposition of unclaimed remains.

Section 5 transfers the provisions of s. 406.52, F.S. to s. 497.705, F.S., and those provisions are amended to require the anatomical board to keep in storage all human remains received for at least 48 hours before allowing their use for medical education and research. The anatomical board is authorized to refuse any unclaimed remains or the remains of an indigent person.

Human remains delivered to the anatomical board may be claimed by a legally authorized person prior to the use of such remains for medical education or research. A board of county commissioners is authorized to prescribe policies and procedures for the final disposition of the unclaimed remains of an indigent person whose remains are found, or whose death occurred in the county, by resolution or ordinance.

This section also provides that a person licensed under ch. 497, F.S., is not liable for any damages resulting from cremating or burying human remains at the written direction of the board of county commissioners or its designee.

Section 6 transfers the provisions of s. 406.53, F.S. to s. 497.707, F.S., and those provisions are amended to provide that a county commission or designated county department is not required to notify the anatomical board of the unclaimed remains of an indigent person if:

- The indigent person's remains are decomposed or mutilated by wounds;
- A legally authorized person or relative by blood or marriage claims the remains for final disposition at his or her expense or, if such relative or legally authorized person is also an indigent person, in a manner consistent with policies and procedures of the board of county commissioners of the county in which the remains are found or the death occurred;
- The deceased person was a veteran, spouse of a veteran, or dependent child of a veteran of the U.S. Armed Forces, U.S. Reserve Forces, or National Guard and is eligible for burial in a national cemetery; or
- A funeral director licensed under ch. 497, F.S., certifies that the anatomical board has been notified and either accepted or declined the remains.

Section 7 transfers the provisions of s. 406.55, F.S. to s. 497.709, F.S., and those provisions are amended to make technical changes.

Section 8 transfers the provisions of s. 406.56, F.S. to s. 497.711, F.S., and those provisions are amended to specify that the anatomical board can accept human remains of a person who, having a sound mind, executed a will leaving his or her body to the anatomical board for the purpose of medical education and research.

Section 9 transfers the provisions of s. 406.57, F.S. to s. 497.713, F.S., and those provisions are amended to specify that the anatomical board may loan human remains to recognized associations of licensed embalmers or funeral directors, or medical or dental examining boards, for educational or research purposes.

Section 10 transfers the provisions of s. 406.58, F.S. to s. 497.715, F.S., and those provisions are amended to authorize the anatomical board to pay the reasonable expenses, as determined by the anatomical board, incurred by a funeral establishment or removal service licensed under ch. 497, F.S., for delivering human remains to the anatomical board.

Section 11 transfers the provisions of s. 406.59, F.S. to s. 497.717, F.S., and those provisions are amended to specify that human remains received by a university, school, college, teaching hospital, institution, or association may not be used for any purpose other than for medical education and research.

Section 12 transfers the provisions of s. 406.60, F.S. to s. 497.719, F.S., and those provisions are amended to make technical corrections.

Section 13 transfers the provisions of s. 406.61, F.S. to s. 497.721, F.S., and those provisions are amended to provide that any person who sells or buys human remains or any person, other than a recognized Florida medical or dental school, who transmits or conveys or causes to be transmitted or conveyed human remains to any place outside or within Florida, commits a misdemeanor of the first degree.

Section 14 repeals s. 406.54, F.S., which authorizes bodies to be claimed after delivery to anatomical board by any friend or representative of a fraternal society of which the deceased was a member, or a representative of any charitable or religious organization, if such friend, society, or representative pays for the expenses incurred by the anatomical board in obtaining and handling the human remains.

Section 15 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:

None.

C. Government Sector Impact:

If the provisions of part II, of ch. 406, F.S., are moved to ch. 497, F.S., the Division of Funeral, Cemetery, and Consumer Services will become the responsible entity for

enforcing the provisions moved to ch. 497, F.S. The division estimates it would need four new staff persons to enforce the transferred provisions at an estimated cost of $263,250.

VI. Technical Deficiencies:

In line 260 of the bill, the word "current" could be interpreted to mean that the intent is to define a person as indigent in accordance with the 2011 federal poverty guidelines and therefore, the amount will not fluctuate with time. If this is not the intent, the word "current" should be deleted.

VII. Related Issues:

Lines 689 through 696 of the bill make it a misdemeanor of the first degree if a person sells or buys human remains or if a person, other than a Florida medical or dental school, transmits or conveys human remains outside or within Florida. Lines 696 through 702 of the bill exempts the anatomical board from this penalty if it transports human remains outside of Florida for educational or scientific purposes. Because line 697 does not specify "or within" Florida, if the anatomical board transports human remains within Florida for educational or scientific purposes, it may be subject to criminal penalties.

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 (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.

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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.

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 1156
INTRODUCER:	Senator Garcia
SUBJECT:	Dextromethorphan
DATE:	March 23, 2011
REVISED:	

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

I. Summary:

The bill creates the "Andy Maxfield Dextromethorphan Act." The bill amends Florida Statutes relating to the retail sale of ephedrine and related compounds by including dextromethorphan in many provisions of current law that limit the conditions under which ephedrine and related compounds may be sold by commercial retailers, including those relating to the commission of misdemeanors and felonies under certain conditions.

This bill substantially amends the following section of the Florida Statutes: 893.1495.

II. Present Situation:

III. Ephedrine, Pseudoephedrine, Phenylpropanolamine, and Methamphetamine

Ephedrine, pseudoephedrine, and phenylpropanolamine are drugs found in both prescription and nonprescription products used to relieve nasal or sinus congestion caused by the common cold, sinusitis, hay fever, and other respiratory allergies. However, these chemicals are also used in the unlawful production of methamphetamine, a Schedule II controlled substance under state and federal law.[1]

Methamphetamine is a central nervous system stimulant drug that is similar in structure to amphetamine. Methamphetamine is a white, odorless, bitter-tasting crystalline powder that easily

[1] Section 893.03(2)(c)(4), F.S., and 21 C.F.R. s. 1308.12(d)(2). The drug "has limited medical uses for the treatment of narcolepsy, attention deficit disorders, and obesity." U.S. Drug Enforcement Administration, *Methamphetamine, available at* http://www.justice.gov/dea/concern/meth.html (citing by footnote to the National Institute on Drug Abuse, Research Report - Methamphetamine Abuse and Addiction, www.drugabuse.gov/) (last visited March 23, 2011).

dissolves in water or alcohol and is taken orally, intranasally (snorting the powder), by needle injection, or by smoking. Methamphetamine increases the release and blocks the reuptake of the brain chemical (or neurotransmitter) dopamine, leading to high levels of the chemical in the brain—a common mechanism for most drugs of abuse. Dopamine is involved in reward, motivation, the experience of pleasure, and motor function. Methamphetamine's ability to release dopamine rapidly in reward regions of the brain produces the intense euphoria, or "rush," that many users feel after snorting, smoking, or injecting the drug.[2]

Taking even small amounts of methamphetamine can result in many of the same physical effects as those of other stimulants, such as cocaine or amphetamines, including increased wakefulness, increased physical activity, decreased appetite, increased respiration, rapid heart rate, irregular heartbeat, increased blood pressure, and hyperthermia. Long-term methamphetamine abuse has many negative health consequences, including extreme weight loss, severe dental problems ("meth mouth"), anxiety, confusion, insomnia, mood disturbances, and violent behavior. Chronic methamphetamine abusers can also display a number of psychotic features, including paranoia, visual and auditory hallucinations, and delusions.[3]

Ephedrine, pseudoephedrine, and phenylpropanolamine are listed precursor chemicals under Florida law.[4] A "listed precursor chemical" is a chemical that may be used in manufacturing a controlled substance in violation of ch. 893, F.S., and is critical to the creation of the controlled substance, and includes any salt, optical isomer, or salt of an optical isomer, whenever the existence of such salt, optical isomer, or salt of optical isomer is possible within the specific chemical designation. These chemicals are also listed chemicals. A "listed chemical" is any precursor chemical or essential chemical named or described in s. 893.033, F.S.[5]

Ephedrine, pseudoephedrine, and phenylpropanolamine are also "list 1" chemicals under federal law.[6] A "list 1" chemical is a chemical specified by regulation of the U.S. Attorney General as a chemical that is used in manufacturing a controlled substance in violation of federal drug abuse prevention and control laws and is important to the manufacture of controlled substances, and includes (until otherwise specified by regulation of, or upon petition to, the U.S. Attorney General) ephedrine, pseudoephedrine, and phenylpropanolamine, and other listed chemicals.[7] These chemicals, including their salts, optical isomers, and salts of optical isomers, are also designated methamphetamine precursor chemicals.[8]

Current Florida law defines "ephedrine or related compounds" as ephedrine, pseudoephedrine, phenylpropanolamine, or any of their salts, optical isomers, or salts of optical isomers.[9] The law regulates the retail sale of ephedrine or related compounds by preventing persons from displaying products containing such compounds or offering them for retail sale other than behind

[2] U.S. Department of Health & Human Services, National Institute on Drug Abuse, *InfoFacts: Methamphetamine*, March 2010, p. 1.
[3] *Id.*
[4] Section 893.033(1)(f),(v), and (z), F.S.
[5] Section 893.02(13), F.S. The inclusion of a chemical as a listed precursor chemical does not bar, prohibit, or punish legitimate use of the chemical.
[6] 21 U.S.C. s. 802(34)(c)(I) and (K). Many of the federal list 1 chemicals are also precursor chemicals under s. 893.033, F.S.
[7] *Id.*
[8] 6 U.S.C. s. 220(c).
[9] *See* s. 893.1495(1), F.S.

a checkout counter where the public is not permitted or other such location that is not otherwise accessible to the general public.[10] The quantity of such products that may be purchased is strictly limited.[11] The owner or primary operator of a retail outlet that sells such products is required to properly train employees engaged in their sale.[12] Retailers are required, unless exempted, to utilize an electronic recordkeeping system, approved by the Florida Department of Law Enforcement (FDLE) for the purpose of recording and monitoring the real-time purchase of such products and for the purpose of monitoring this information in order to prevent or investigate illegal purchases of these products.[13] Violations of provisions of the law related to the sale or display of such products and employee training regarding the sale of such products, amount to misdemeanors or felonies, depending on the nature of the violation.[14]

In terms of restrictions on quantity, current law specifically provides that a person may not knowingly obtain or deliver to an individual in any retail OTC sale any nonprescription compound, mixture, or preparation containing ephedrine or related compounds in excess of the following amounts:

- In any single day, any number of packages that contain a total of 3.6 grams of ephedrine or related compounds;
- In any single retail OTC sale, three packages, regardless of weight, containing ephedrine or related compounds; or
- In any 30-day period, in any number of retail OTC sales, a total of 9 grams or more of ephedrine or related compounds.

Dextromethorphan

Dextromethorphan (DXM) is one of the most widely used antitussive (cough suppressant) agents worldwide. It was approved for use by the federal Food and Drug Administration (FDA) in 1958 as a non-prescription cough medication. Currently, DXM is found in more than 125 over-the-counter (OTC) patented products to treat cough and cold symptoms. Medications are available in pills, gel caps, lozenges, liquids, and syrups, either alone or in combination with other active ingredients such as antihistamines, decongestants, and/or expectorants.[15]

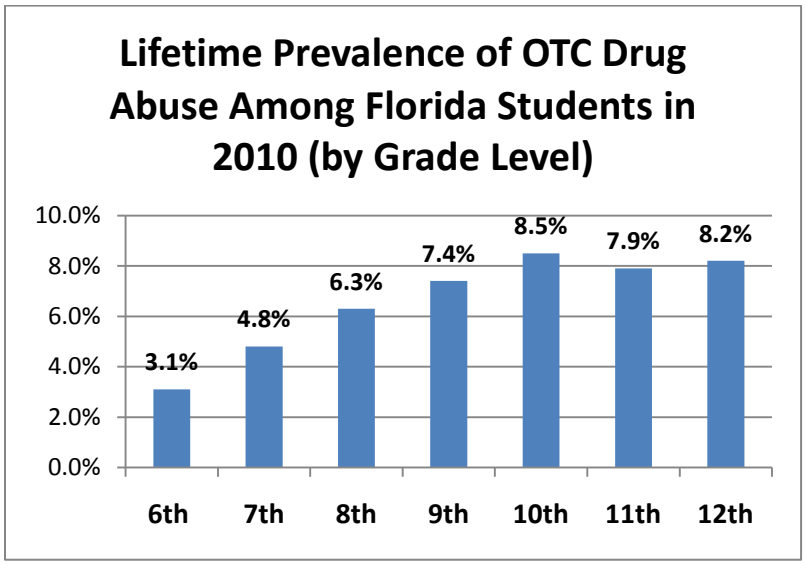
The U.S. Justice Department's Drug Enforcement Administration (DEA) has reported an increasing abuse of DXM in recent years, especially among adolescents.[16] DXM-containing cough suppressants are abused for their euphoriant, hallucinogenic, and "out-of-body experience" properties, which is generally associated with doses 10 to 20 times greater than the dose recommended for cough suppression (10-30 mg).[17] In high enough doses, the abuse of

[10] *See* s. 893.1495(3), F.S.
[11] *See* s. 893.1495(2), F.S.
[12] *See* s. 893.1495(4), F.S.
[13] *See* s. 893.1495(5), F.S.
[14] *See* s. 893.1495(11), F.S.
[15] U.S. Department of Justice, Drug Enforcement Administration, "Dextromethorphan: Drug Fact Sheet," July 14, 2010, p. 1, available at http://www.drugabuse.gov/pdf/infofacts/Methamphetamine10.pdf (last visited March 24, 2011).
[16] Section 877.111, F.S., makes it unlawful for any person to inhale or ingest, or to possess with intent to breathe, inhale, or drink, any compound, liquid, or chemical containing certain substances for the purpose of inducing a condition of intoxication or which distorts or disturbs the auditory, visual, or mental processes. DXM is not included in the statute's list of substances subject to this provision.
[17] *Supra,* note 15.

DXM can cause serious adverse events, such as psychosis, brain damage, seizure, loss of consciousness, irregular heartbeat, and even death.[18] Cases of long-term DXM abuse exhibit features of dependence, including tolerance and physical withdrawal symptoms.[19]

DXM is not presently a scheduled substance or listed precursor chemical under the Controlled Substances Act, nor is DXM a known precursor chemical in the production of methamphetamine. However, in August 2010, the DEA listed DXM as a drug and chemical of concern and federal authorities have indicated that DXM could be added to the Controlled Substances Act if warranted.[20]

The Department of Children and Families began surveying students in middle-school about their use of OTC drugs in 2008, with the Florida Youth Substance Abuse Survey (FYSAS).[21] Students were asked, "On how many occasions (if any) have you used drugs that can be purchased from a store without a prescription – such as cold and cough medication – in order to get high" in your lifetime and in the past 30 days? It is important to note that this question does not specifically ask about OTC drugs containing DXM and only cites "cold and cough medication" as one example. Since 2008, the FYSAS has indicated that approximately 5 percent of Florida's middle school students report that they used drugs like cold and cough medications to get high at least once in their lifetime. Among middle school students, the lifetime prevalence of OTC drug abuse is higher than nearly all illicit drugs on the survey. The same question was added to the high school survey in 2010, allowing comparisons of lifetime prevalence across all grade levels. As depicted in the figure below, the prevalence of OTC drug abuse increases across successively higher grade levels, with the highest lifetime prevalence (8.5 percent) reported by 10th graders:



[18] Terrie, Yvette C., "Dextromethorphan Abuse," *Pharmacy Times*, November 1, 2008.
[19] Chyka, P.A., Erdman, A.R., Manoguerra, A.S., et al., "Dextromethorphan Poisoning: An Evidence-based Consensus Guideline for Out-of-Hospital Management," *Clinical Toxicology*, 2007, vol. 45, no. 6, pp. 662-677.
[20] U.S. Dept. of Justice, Drug Enforcement Administration, "Drugs and Chemicals of Concern: Dextromethorphan," August 2010, available at http://www.deadiversion.usdoj.gov/drugs_concern/dextro_m/dextro_m.htm (last visited March 24, 2011).
[21] Results are available at http://www.dcf.state.fl.us/programs/samh/publications/fysas/ (last visited March 24, 2011).

IV. Effect of Proposed Changes:

Section 1 provides that this act may be cited as the "Andy Maxfield Dextromethorphan Act." Andy Maxfield was a Miami Lakes resident who died from an overdose of an OTC product containing DXM on August 6, 2010, at the age of 19, according to a web site created by his parents following his death.[22] Andy's death was the subject of a television news story in Miami and Fort Lauderdale.[23]

Section 2 amends s. 893.1495, F.S., to provide that the term "ephedrine, dextromethorphan, or related compounds" means ephedrine, pseudoephedrine, phenylpropanolamine, dextromethorphan, or any of their salts, optical isomers, or salts of optical isomers.

The bill goes on to change all instances of "ephedrine or related compounds" to "ephedrine, dextromethorphan, or related compounds" within the statute that are related to the sale or display of such products, and employee training regarding the sale of such products, except for one instance. In s. 893.1495(5), F.S., the bill separates DXM from ephedrine and its related compounds by maintaining the requirement that any person purchasing or acquiring any nonprescription product containing ephedrine or related compounds must sign his or her name on a record of the purchase, but persons purchasing or acquiring products containing DXM are not required to sign a record of the purchase. Those purchasing or acquiring DXM-containing products are required by the bill to be at least 18 years of age and produce a government-issued photo identification, as are persons purchasing or acquiring products containing ephedrine or its related compounds under current law.

The bill does not include DXM in any provisions of current law relating to the FDLE electronic recordkeeping system for products containing ephedrine or related compounds.

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

V. 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.

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[22] *See* http://www.andymaxfield.com/ (last visited March 23, 2011).
[23] *See* http://www.wsvn.com/features/articles/investigations/MI89843/ (last visited March 23, 2011).

VI. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill could cause an indeterminate increase in the cost of doing business for retailers who sell DXM-containing products due to the requirements in the bill related to product sales, product display, and employee training. (Also see section VII. Related Issues.)

C. Government Sector Impact:

To the extent that criminal violations of the bill's restrictions on DXM occur, the bill could cause an indeterminate increase of expenses and costs in the criminal justice system.

VII. Technical Deficiencies:

The bill eliminates the current-law definition of "ephedrine or related compounds" in favor of the bill's definition of "ephedrine, dextromethorphan, or related compounds." However, certain portions of s. 893.1495, F.S., that are not amended by the bill rely on the existing definition of "ephedrine or related compounds," and without that existing definition, those provisions would contain an undefined term if the bill becomes law. The provisions in question are:

- FDLE is required to approve an electronic recordkeeping system for the purpose of monitoring the real-time purchase of products containing ephedrine or related compounds.[24]
- In order to be granted an exemption from electronic reporting, a retailer must maintain a sales volume of less than 72 grams of ephedrine or related compounds in a 30-day period.[25]
- The electronic recordkeeping system must record the name of the product containing ephedrine or related compounds.[26]
- A nonprescription product containing any quantity of ephedrine or related compounds may not be sold over the counter unless reported to the FDLE electronic recordkeeping system.[27]
- The requirements of s. 893.1495, F.S., relating to the marketing, sale, or distribution of products containing ephedrine or related compounds supersede any local ordinance or regulation.[28]

VIII. Related Issues:

The bill places the same restrictions on the quantity of DXM-containing products that may be sold as are currently in law for products containing ephedrine or related compounds. However, the bill exempts the sale of DXM-containing products from the FDLE electronic recordkeeping system, which will leave retailers without a real-time mechanism for tracking the quantity of

[24] *See* s. 893.1495(5)(b), F.S.
[25] *Id.*
[26] *See* s. 893.1495(5)(b)3., F.S.
[27] *See* s. 893.1495(6), F.S.
[28] *See* s. 893.1495(9), F.S.

DXM-containing products sold to certain purchasers in any single day or over a 30-day period, as required by the bill. How retailers will keep track of those data in a reliable, practical, and affordable manner in order to comply with the requirements of the bill is indeterminate.

IX. 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.

344120

LEGISLATIVE ACTION

Senate . House

. .

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 627.6474, Florida Statutes, is amended to read:

627.6474 Provider contracts.—

(1) A health insurer may ~~shall~~ not require a contracted health care practitioner as defined in s. 456.001(4) to accept the terms of other health care practitioner contracts with the insurer or any other insurer, or health maintenance organization, under common management and control with the

insurer, including Medicare and Medicaid practitioner contracts and those authorized by s. 627.6471, s. 627.6472, s. 636.035, or s. 641.315, except for a practitioner in a group practice as defined in s. 456.053 who must accept the terms of a contract negotiated for the practitioner by the group, as a condition of continuation or renewal of the contract. Any contract provision that violates this section is void. A violation of this subsection ~~section~~ is not subject to the criminal penalty specified in s. 624.15.

(2)(a) A contract between a health insurer and a dentist licensed under chapter 466 for the provision of services to patients may not contain any provision that requires the dentist to provide services to the insured under such contract at a fee set by the health insurer unless such services are covered services under the applicable contract.

(b) As used in this subsection, the term "covered services" means services reimbursable under the applicable contract at not less than 50 percent of the usual, customary, and reasonable fee of similar providers in the zip code area where the services are provided, subject to such contractual limitations on benefits, such as deductibles, coinsurance, and copayments, as may apply. However, covered services do not include dental services that are provided by a dentist to an insured for dental services that are not listed as a benefit that the insured is entitled to receive under the contract.

(c) A contract may not contain a provision that prohibits a dentist from billing a patient the difference between the amount reimbursed by the insurer and the dentist's normal rate for the services if such services are not covered services as defined in

paragraph (b). A health insurer may not require as a condition of the contract that the dentist participate in a discount medical plan under part II of chapter 636.

Section 2. Subsection (13) is added to section 636.035, Florida Statutes, to read:

636.035 Provider arrangements.—

(13)(a) A contract between a prepaid limited health service organization and a dentist licensed under chapter 466 for the provision of services to subscribers of the prepaid limited health service organization may not contain any provision that requires the dentist to provide services to subscribers of the prepaid limited health service organization at a fee set by the prepaid limited health service organization unless such services are covered services under the applicable contract.

(b) As used in this subsection, the term "covered services" means services reimbursable under the applicable contract at not less than 50 percent of the usual, customary, and reasonable fee of similar providers in the zip code area where the services are provided, subject to such contractual limitations on benefits, such as deductibles, coinsurance, and copayments, as may apply. However, covered services do not include dental services that are provided by a dentist to an insured for dental services that are not listed as a benefit that the insured is entitled to receive under the contract.

(c) A prepaid limited health service organization may not require as a condition of the contract that the dentist participate in a discount medical plan under part II of this chapter.

Section 3. Subsection (11) is added to section 641.315,

Florida Statutes, to read:

641.315 Provider contracts.—

(11)(a) A contract between a health maintenance organization and a dentist licensed under chapter 466 for the provision of services to subscribers of the health maintenance organization may not contain any provision that requires the dentist to provide services to subscribers of the health maintenance organization at a fee set by the health maintenance organization unless such services are covered services under the applicable contract.

(b) As used in this subsection, the term "covered services" means services reimbursable under the applicable contract at not less than 50 percent of the usual, customary, and reasonable fee of similar providers in the zip code area where the services are provided, subject to such contractual limitations on benefits, such as deductibles, coinsurance, and copayments, as may apply. However, covered services do not include dental services that are provided by a dentist to an insured for dental services that are not listed as a benefit that the insured is entitled to receive under the contract.

(c) A health maintenance organization may not require as a condition of the contract that the dentist participate in a discount medical plan under part II of chapter 636.

Section 4. This act shall take effect July 1, 2011, and applies to contracts entered into or renewed on or after that date.

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

And the title is amended as follows:

344120

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to dentists; amending s. 627.6474, F.S.; prohibiting contracts between health insurers and dentists from containing certain fee requirements set by the insurer under certain circumstances; providing a definition; prohibiting a contract from containing a provision that prohibits a dentist from billing a patient the difference between the amount reimbursed by the insurer and the dentist's normal rate for services under certain circumstances; prohibiting a health insurer from requiring as a condition of a contract that a dentist participate in a discount medical plan; amending s. 636.035, F.S.; prohibiting contracts between prepaid limited health service organizations and dentists from containing certain fee requirements set by the organization under certain circumstances; providing a definition; prohibiting the prepaid limited health service organization from requiring as a condition of a contract that a dentist participate in a discount medical plan; amending s. 641.315, F.S.; prohibiting contracts between health maintenance organizations and dentists from containing certain fee requirements set by the organization under certain circumstances; providing a definition; prohibiting the health maintenance organization from requiring as a condition of a contract that a dentist participate in a discount

medical plan; providing for application of the act; 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 546
INTRODUCER:	Senator Hays
SUBJECT:	Dentists
DATE:	March 24, 2011
REVISED:	

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

I. Summary:

Senate Bill 546 prohibits an insurer, health maintenance organization (HMO), and prepaid limited health service organization from contracting with a licensed dentist to provide services to an insured or subscriber at a specified fee unless such services are "covered services" under the applicable contract. The bill also prohibits an insurer from requiring that a contracted health care provider accept the terms of other practitioner contracts with a prepaid limited health service organization that is under common management and control with the contracting insurer.

This bill substantially amends the following sections of the Florida Statutes: 627.6474, 636.035, and 641.315.

II. Present Situation:

Prohibition Against "All Products" Clauses in Health Care Provider Contracts

Section 627.6474, F.S., prohibits a health insurer from requiring that a contracted health care practitioner accept the terms of other practitioner contracts (including Medicare and Medicaid practitioner contracts) with the insurer or with an insurer, HMO, preferred provider organization, or exclusive provider organization that is under common management and control with the contracting insurer. The statute exempts practitioners in group practices who must accept the contract terms negotiated by the group. These contractual provisions are referred to as "all products" clauses, and, before being prohibited by the 2001 Legislature, typically required the health care provider, as a condition of participating in any of the health plan products, to participate in *all* of the health plan's current or future health plan products. The 2001 Legislature outlawed "all products" clauses after concerns were raised by physicians that the clauses: may

force providers to render services at below market rates; harm consumers through suppressed market competition; may require physicians to accept future contracts with unknown and unpredictable business risk; and may unfairly keep competing health plans out of the marketplace.

Prepaid Limited Health Service Organizations Contracts

Prepaid limited health service organizations (PLHSO) provide limited health service to enrollees through an exclusive panel of providers in exchange for a prepayment, and are authorized in s. 636.003, F.S. Limited health services are: ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services, and pharmaceutical services.

Provider arrangements for prepaid limited health service organizations are authorized in s. 636.035, F.S., and are subject to the following statutory requirements:

- The provider contract must be in writing.
- The subscriber is not liable to providers for services rendered except for deductibles and co-payments.
- If the PLHSO cannot meet its obligations to a provider, the subscriber is not liable for providing payment.
- The provider or PLHSO cancelling the provider contract must provide notice as detailed in statute.
- Prohibition against limiting the provider's ability to inform patients about medical treatment options.
- Prohibition against limiting the provider from contracting with other PLHSOs.
- Prohibition against "all products" clauses.

Health Maintenance Organization Provider Contracts

An HMO is an organization that provides a wide range of health care services, including emergency care, inpatient hospital care, physician care, ambulatory diagnostic treatment and preventive health care pursuant to contractual arrangements with preferred providers in a designated service area. Traditionally, an HMO member must use the HMO's network of health care providers in order for the HMO to make payment of benefits. The use of a health care provider outside the HMO's network generally results in the HMO limiting or denying the payment of benefits for out-of-network services rendered to the member.

Section 641.315, F.S., specifies requirements for the HMO provider contracts with "health care practitioners" as defined in s. 456.001(4), F.S. The requirements include provisions related to:

- Notice of the insurer or provider cancelling the provider contract.
- Procedures for billing and reimbursement.
- Prohibition against limiting the provider's ability to inform patients about medical treatment options.
- Prohibitions against limiting the provider or HMO from contracting with other parties.
- Procedures for authorizing the utilization of health care services.

- Prohibition against preventing providers from rendering services that are medically necessary and covered in a contracting hospital.
- Prohibition against "all products" clauses.

III. Effect of Proposed Changes:

Sections 1-3.

Inclusion of PLHSOs In Prohibition Against "All Products" Health Care Provider Contracts – Under current law, a health insurer cannot require that a contracted health care practitioner accept the terms of other practitioner contracts (including Medicare and Medicaid practitioner contracts) with the insurer or with an insurer, HMO, preferred provider organization, or exclusive provider organization that is under common management and control with the contracting insurer. The bill adds to that list by prohibiting the insurer from requiring that a contracted health care provider accept the terms of other practitioner contracts with a PLHSO that is under common management and control with the contracting insurer.

Dentist Provider Contracts: Prohibition Against Specifying Fees for Non-Covered Services – The bill prohibits insurers, HMOs, and PLHSOs from executing a contract with a licensed dentist that requires the dentist to provide services to an insured or subscriber at a specified fee unless such services are "covered services" under the applicable contract. A "covered service" is defined as a reimbursable service under the contract between the dentist and insurer, HMO, or PLHSO that may be subject to deductibles, coinsurance, and copayments. A "covered service" does not include services rendered to an insured or subscriber who has reached the periodic payment maximum established by the contract or dental services that are not listed as benefits under the contract. This will prevent such non-covered services from being subject to negotiated payment rates established by contract.

Section 4. The act is effective July 1, 2011, and applies to contracts entered into on or after that date.

Other Potential Implications:

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:

Representatives of health insurers, HMOs, and PLHSOs assert that their policyholders and subscribers will pay higher costs for dental care if the Legislature prohibits these entities from contracting with dentists to provide services that are not covered at a negotiated fee, especially since the bill classifies as non-covered services those services that are typically covered by the policy but for which benefit payments will no longer be made if the policyholder or subscriber has reached the periodic payment maximum. These representatives also assert that the bill unduly interferes with the freedom of two private entities to agree to their own contract terms.

Representatives of dentists assert that the Legislature should prohibit health insurers, HMOs, and PLHSOs from negotiating fees with dentists for services that are not covered because these provisions unfairly shift health care costs to dentists and potentially imperil the financial stability of dental practices. These representatives note that sixteen other states have passed similar legislation.

C. Government Sector Impact:

This bill does not appear to have a direct impact on the cost that the state incurs for the state employees' PPO Plan or the HMO plans. Members of the state dental coverage plans, however, could be affected if dentists have the ability to bill and charge amounts above contracted rates when members are financially responsible for the service in question.

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 1396
INTRODUCER:	Senator Bogdanoff
SUBJECT:	Nursing Home Litigation Reform
DATE:	March 25, 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 statutory provisions relating to civil causes of action against nursing homes, punitive damages, and a nursing home's compliance or noncompliance with minimum staffing requirements as it relates to civil actions against the nursing home. The bill:

- Requires the court to hold an evidentiary hearing to determine if there is a reasonable basis to find that an officer, director, or owner of a nursing home acted outside the scope of duties in order for a lawsuit to proceed against an officer, director, or owner of a nursing home;
- Provides a cap of $250,000 on noneconomic damages in any claim for wrongful death in nursing home lawsuits, regardless of the number of claimants or defendants;
- Requires a claimant to bring a lawsuit pursuant to either the statute relating to nursing home civil enforcement or the statute relating to abuse of vulnerable adults;
- Requires a claimant to elect survival damages or wrongful death damages not later than 60 days before trial;
- Requires the court to hold an evidentiary hearing before allowing a claim for punitive damages to proceed;
- Changes the method for calculating attorney fees in punitive damage cases and provides more situations where the punitive damages claim will be split between the claimant and the state; and
- Limits the use of federal and state survey reports in nursing home litigation.

This bill substantially amends the following sections of the Florida Statutes: 400.023, 400.0237, 400.0238, and 400.23.

II. Present Situation:

"Nursing Homes and Related Health Care Facilities" is the subject of ch. 400, F.S. Part I of ch. 400, F.S., establishes the Office of State Long-Term Care Ombudsman, the State Long-Term Care Ombudsman Council, and the local long-term care ombudsman councils. Part II of ch. 400, F.S., provides for the regulation of nursing homes, and part III of ch. 400, F.S., provides for the regulation of home health agencies.

The Agency for Health Care Administration (AHCA) is charged with the responsibility of developing rules related to the operation of nursing homes. Section 400.023, F.S., creates a statutory cause of action against nursing homes that violate the rights of residents specified in s. 400.022, F.S. The action may be brought in any court to enforce the resident's rights and to recover actual and punitive damages for any violation of the rights of a resident or for negligence.[1] Prevailing plaintiffs may be entitled to recover reasonable attorney fees plus costs of the action, along with actual and punitive damages.[2]

Sections 400.023-400.0238, F.S., provide the exclusive remedy for a cause of action for recovery of damages for the personal injury or death of a nursing home resident arising out of negligence or a violation of rights specified in s. 400.022, F.S. No claim for punitive damages may be permitted unless 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.[3] A defendant may be held liable for punitive damages only if the trier of fact, based on clear and convincing evidence, finds that the defendant was personally guilty of intentional misconduct or gross negligence as specified in s. 400.0237(2), F.S.[4]

In the case of an employer, principal, corporation, or other entity, punitive damages may be imposed for conduct of an employee or agent only if the conduct meets the criteria specified in s. 400.0237(2), F.S., and the employer actively and knowingly participated in the conduct, ratified or consented to the conduct, or engaged in conduct that constituted gross negligence and that contributed to the loss, damages, or injury suffered by the claimant.[5]

Named Defendants and Causes of Action in Nursing Home Cases

Section 400.023, F.S., provides that "any resident whose rights as specified in this part are violated shall have a cause of action." It does not indicate who may be named as a defendant. Current law in ss. 400.023 - 400.0238, F.S., provides the exclusive remedy for a cause of action for personal injury or death of a nursing home resident or a violation of the resident's rights statute. Current law further provides that s. 400.023, F.S., "does not preclude theories of recovery not arising out of negligence or s. 400.022, F.S., which are available to the resident or to the agency."

[1] Sections 400.023 and 400.0237, F.S.
[2] *Id.*
[3] Section 400.0237(1), F.S.
[4] Section 400.0237(2), F.S.
[5] Section 400.0237(3), F.S.

Liability of Employees, Officers, Directors, or Owners

In *Estate of Canavan v. National Healthcare Corp.*, 889 So.2d 825 (Fla. 2d DCA 2004), the court considered whether the managing member of a limited liability company could be held personally liable for damages suffered by a resident in a nursing home. The claimant argued the managing member, Friedbauer, could be held liable:

> [Claimant] argues that the concept of piercing the corporate veil does not apply in the case of a tort and that it presented sufficient evidence of Friedbauer negligence, by act or omission, for the jury to reasonably conclude that Friedbauer caused harm to Canavan. [Claimant] argues that Friedbauer had the responsibility of approving the budget for the nursing home. He also functioned as the sole member of the "governing body" of the nursing home, and pursuant to federal regulation, the governing body is legally responsible for establishing and implementing policies regarding the management and operation of the facility and for appointing the administrator who is responsible for the management of the facility. Friedbauer was thus required by federal mandate to create, approve, and implement the facility's policies and procedures. Because he ignored complaints of inadequate staffing while cutting the operating expenses, and because the problems Canavan suffered, pressure sores, infections, poor hygiene, malnutrition and dehydration, were the direct result of understaffing, [claimant] argues that a reasonable jury could have found that Friedbauer's elevation of profit over patient care was negligent.[6]

The trial court granted a directed verdict in favor of Freidbauer, finding that there was no basis upon which a corporate officer could be held liable. On appeal, the court reversed:

> We conclude that the trial court erred in granting the directed verdict because there was evidence by which the jury could have found that Friedbauer's negligence in ignoring the documented problems at the facility contributed to the harm suffered by Canavan. This was not a case in which the plaintiffs were required to pierce the corporate veil in order to establish individual liability because Friedbauer's alleged negligence constituted tortious conduct, which is not shielded from individual liability. We, therefore, reverse the order granting the directed verdict and remand for a new trial against Friedbauer.[7]

Limitations on Causes of Action for Violations of Criminal Statutes

Section 415.111, F.S., provides criminal penalties for failing to report abuse of a vulnerable adult, for making certain confidential information public, for refusing to grant access to certain records, and for filing false reports relating to abuse of a vulnerable adult. Section 415.111, F.S., does not specifically provide for a civil cause of action while s. 415.1111, F.S., provides for a civil cause of action in some situations.

[6] *Estate of Canavan v. National Healthcare Corp.*, 889 So.2d 825, 826 (Fla. 2d DCA 1994).
[7] *Estate of Canavan v. National Healthcare Corp.*, 889 So.2d 825, 826-827 (Fla. 2d DCA 1994)(citations omitted).

Section 415.1111, F.S., provides a cause of action where a vulnerable adult[8] who has been abused, neglected, or exploited has a cause of action and can recover damages, punitive damages, and attorney fees. However, any action brought against a licensee or entity that establishes, controls, manages, or operates a nursing home must be brought under s. 400.023, F.S.

One court has specifically held that no civil cause of action exists for failing to report abuse of vulnerable adult pursuant to s. 415.111, F.S. The court explained:

> It is evident that the legislature considered both civil and criminal penalties under this statute, but subjected only actual perpetrators of abuse to civil penalties. This is strong evidence of a legislative intent not to provide a civil cause of action for victims against those who fail to report the abuse as required by this act.[9]

Election of Damages

Section 400.023, F.S., requires that in cases where the action alleges a claim for resident's rights or for negligence that caused the death of the resident, a claimant must elect either survival damages[10] or wrongful death damages.[11] The statute does not provide a time certain for a claimant to make an election. In *In re Estate of Trollinger*, 9 So.3d 667 (Fla. 2d DCA 2009), the trial court forced a claimant to make an election at the time of the initial complaint and the appellate court held that certiorari review was not available because any error could be corrected by a subsequent appeal. The court noted that s. 400.023(1), F.S., is "silent as to whether the election of remedies must be made at the pleading stage or at the end of trial."[12]

Judge Altenbernd argued that the claimant should not have to make an election with the initial pleading:

> [The statute] requires the personal representative to elect to receive only one of the two different measures of damages that are available in such a case. The statute does not require the personal representative to choose to pursue only one of the two different causes of action available to the personal representative. It certainly does not state that the election must be made in the complaint...
>
> Even if one assumes that section 400.023(1) requires a plaintiff to elect one cause of action, this election of a claim would not logically occur at the pleading stage. If the plaintiff is required to elect one measure of damages, there is little reason why this

[8] "Vulnerable adult" means "means a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging." s. 415.102(27), F.S.
[9] *Mora v. South Broward Hosp. Dist.*, 710 So.2d 633, 634 (Fla. 4th DCA 1998).
[10] Section 46.021, F.S., provides that no cause of action dies with the person. Accordingly, if a resident brings a claim for a violation of resident's rights or negligence and dies during the pendency of the claim, the action may continue and the resident's estate may recover the damages that the resident could have recovered if the resident had lived until the end of the litigation.
[11] Section 768.21, F.S., provides for damages that may be recovered by the estate of a resident and the resident's family in a wrongful death action.
[12] *In re Estate of Trollinger*, 9 So.3d 667, 668 (Fla. 2d DCA 2009).

> election cannot take place after the jury returns its verdict. Election of remedies is a somewhat complex theory, but it is generally designed to prevent a double recovery, which can be avoided in this case even if the jury is presented with a verdict form containing both theories.
>
> The personal representative's two theories are factually and legally distinct. One theory requires proof that negligence caused only injury and the other theory requires proof that negligence caused death. In Florida, a standard verdict form asks the jury to decide whether there was negligence on the part of the defendant which was a legal cause of damage to the plaintiff. If the jury is instructed on only one of the causes of action and the damages appropriate under that theory, there is nothing in the verdict form to demonstrate that the verdict forecloses an action on the other theory for the damages available under the other theory. In other words, if a jury were to find that an act of negligence did not cause wrongful death damages, that verdict would not prevent another jury from finding that an act of negligence caused survivorship damages. Thus, whichever theory is tried first, the trial court is likely to be called upon to try the second theory later.[13] (internal citations omitted).

Cap on Noneconomic Damages

Current law provides no cap on the recovery of noneconomic damages in wrongful death actions brought under s. 400.023, F.S. "Economic" damages are damages such as loss of earnings, loss of net accumulations, medical expenses, and funeral expenses.[14] "Noneconomic damages" are damages for which there is no exact standard for fixing compensation such as mental pain and suffering and loss of companionship or protection.[15]

Attorney Fees in Actions for Injunctive Relief

A resident may bring an action seeking injunctive relief in court or bring an administrative action to force a licensee to take an action or cease taking some action. Current law provides that a resident is entitled to attorney fees not to exceed $25,000, plus costs, if the resident prevails when seeking injunctive relief.

Elements in a Civil Actions Under s. 400.023, F.S.

Section 400.023(2), F.S., provides that in any claim alleging a violation of resident's rights or alleging that negligence caused injury to or the death of a resident, the claimant must prove, by a preponderance of the evidence:

- The defendant owed a duty to the resident;
- The defendant breached the duty to the resident;
- The breach of the duty is a legal cause of loss, injury, death, or damage to the resident; and
- The resident sustained loss, injury, death, or damage as a result of the breach.

[13] *In re Estate of Trollinger*, 9 So.3d 667, 669 (Fla. 2d DCA 2009)(Altenbernd, J., concurring).
[14] *See generally* Florida Standard Jury Instructions in Civil Cases, s. 502.2. (accessed at http://www.floridasupremecourt.org/civ_jury_instructions/instructions.shtml#500).
[15] *See generally* Florida Standard Jury Instructions in Civil Cases, s. 502.2. (accessed at http://www.floridasupremecourt.org/civ_jury_instructions/instructions.shtml#500).

The Florida Supreme Court has set forth the elements of a negligence action:

> 1. A duty, or obligation, recognized by the law, requiring the [defendant] to conform to a certain standard of conduct, for the protection of others against unreasonable risks.
>
> 2. A failure on the [defendant's] part to conform to the standard required: a breach of the duty...
>
> 3. A reasonably close causal connection between the conduct and the resulting injury. This is what is commonly known as "legal cause," or "proximate cause," and which includes the notion of cause in fact.
>
> 4. **Actual loss** or damage...[16] (emphasis added).

Current law provides in any claim brought pursuant to s. 400.023, F.S., a licensee, person, or entity has the duty to exercise "reasonable care" and nurses have the duty to exercise care "consistent with the prevailing professional standard of care."[17] Standards of care are set forth in current law. Section 400.023(3), F.S., provides that a licensee, person, or entity shall have a duty to exercise reasonable care.[18] Nurses have the duty to "exercise care consistent with the prevailing professional standard of care for a nurse."[19]

Punitive Damages

Current law provides for recovery of punitive damages by a claimant. Punitive damages "are not compensation for injury. Instead, they are private fines levied by civil juries to punish reprehensible conduct and to deter its future occurrence."[20] Punitive damages are generally limited to three times the amount of compensatory damages or $1 million, whichever is greater.[21] Damages can exceed $1 million if the jury finds that the wrongful conduct 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.[22] If the jury finds that the defendant had a specific intent to harm the claimant and determines that the defendant's conduct did in fact harm the claimant, there is be no cap on punitive damages.[23]

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[16] *United States v. Stevens*, 994 So.2d 1062, 1066 (Fla. 2008).
[17] *See* s. 400.023(1), F.S.
[18] "Reasonable care" is defined as "that degree of care which a reasonably careful licensee, person, or entity would use under like circumstances." s. 400.023(3), F.S.
[19] "The prevailing professional standard of care for a nurse 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." s. 400.023(4), F.S.
[20] *Gertz v. Robert Welch, Inc.*, 418 U.S. 323, 350 (1974).
[21] *See* s. 400.0238(1)(a), F.S.
[22] *See* s. 400.0238(1)(b), F.S.
[23] *See* s. 400.0238(1)(c), F.S.

Evidentiary Requirements to Bring a Punitive Damages Claims

Section 400.0237(1), F.S., provides:

> In any action for damages brought under this part, no claim for punitive damages shall be permitted unless 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. 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 shall proceed until after the pleading concerning punitive damages is permitted.

A court discussed how a claimant can make a proffer to assert a punitive damage claim:

> [A] a 'proffer' according to traditional notions of the term, connotes merely an 'offer' of evidence and neither the term standing alone nor the statute itself calls for an adjudication of the underlying veracity of that which is submitted, much less for countervailing evidentiary submissions. Therefore, a proffer is merely a representation of what evidence the defendant proposes to present and is not actual evidence. A reasonable showing by evidence in the record would typically include depositions, interrogatories, and requests for admissions that have been filed with the court. Hence, an evidentiary hearing where witnesses testify and evidence is offered and scrutinized under the pertinent evidentiary rules, as in a trial, is neither contemplated nor mandated by the statute in order to determine whether a reasonable basis has been established to plead punitive damages.[24],[25]

Punitive damages claims are often raised after the initial complaint has been filed. Once a claimant has discovered enough evidence that the claimant believes justifies a punitive damage claim, the claimant files a motion to amend the complaint to add a punitive damage action. The trial judge considers the evidence presented and proffered by the claimant to determine whether the claim should proceed.

Individual Liability for Punitive Damages

Section 400.0237(2), F.S., provides:

> A defendant may be held liable for punitive damages only if the trier of fact, based on clear and convincing evidence, finds that the defendant was personally guilty of intentional misconduct[26] or gross negligence.[27]

[24] *Estate of Despain v. Avante Group, Inc.*, 900 So.2d 637, 642 (Fla. 5th DCA 2005)(internal citations omitted).
[25] The *Despain* court was discussing a prior version of the punitive damages statute relating to nursing home litigation but the language in that statute is the same in that statute and current law.
[26] "Intentional misconduct" is actual knowledge of the wrongfulness of the conduct and the high probability that injury or damage to the claimant will result and, despite that knowledge, intentionally pursuing a course of conduct that results in injury or damage. *See* s. 400.0237(2)(a), F.S.

Vicarious Liability for Punitive Damages

Punitive damages claims are sometimes brought under a theory of vicarious liability where an employer is held responsible for the acts of an employee. Section 400.0273(3), F.S., provides:

> In the case of an employer, principal, corporation, or other legal entity, punitive damages may be imposed for the conduct of an employee or agent only if the conduct of the employee or agent meets the criteria specified in subsection (2)[28] and:
> (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.

Attorney Fees in Punitive Damages Actions

Current law provides that to the extent a claimant's attorney's fees are based on punitive damages, the attorney fees are calculated based on the final judgment for punitive damages.[29],[30] The amount of punitive damages awarded is divided equally between the Quality of Long-Term Care Facility Improvement Trust Fund[31] and the claimant.[32] The statute also provides for a split of any settlement by the parties that is reached after the verdict.[33]

Current law does require that any portion of a punitive damages settlement that is reached before a verdict to be divided with the Quality of Long-Term Care Facility Improvement Trust Fund. According to the AHCA, no money has been collected for the Fund pursuant to s. 400.0238, F.S.

Nursing Home Surveys

Section 400.23, F.S., requires the AHCA to promulgate and enforce rules relating to the safety and care of nursing home residents. The AHCA is required to evaluate all facilities at least every 15 months.[34] The AHCA is specifically required to adopt rules relating to minimum staffing requirements.[35] Such requirements include a minimum weekly average of certified nursing assistants and licensed nursing staff, a minimum daily staffing of certified nursing assistants, specified staffing ratios, and specific amounts of care per resident per day.[36]

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[27] "Gross negligence" is conduct that is reckless or wanting in care such that it constitutes a conscious disregard or indifference to the life, safety, or rights of persons exposed to such conduct. *See* s. 400.0237(2)(b), F.S.
[28] Criteria are whether the defendant was personally guilty of intentional misconduct or gross negligence.
[29] Section 400.0238(2), F.S.
[30] A final judgment is an order entered by the trial judge after a jury verdict or a trial before the judge.
[31] Section 400.0239(1), F.S., creates the "Quality of Long-Term Care Facility Improvement Trust Fund." The Fund supports activities and programs directly related to improvement of the care of nursing home and assisted living facility residents.
[32] Section 400.0238(4), F.S.
[33] Section 400.0238(4)(b), F.S.
[34] Section 400.23(7), F.S.
[35] Section 400.23(3), F.S.
[36] Section 400.23(3), F.S.

When the AHCA does a survey to determine whether a nursing home is violating statutes or rules, it is required to classify the deficiencies according to the nature and scope of the deficiency.[37] The classifications are as follows:

- A class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility.
- A class II deficiency is a deficiency that the agency determines has compromised the resident's ability to maintain or reach his or her highest practicable physical, mental, and psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.
- A class III deficiency is a deficiency that the agency determines will result in no more than minimal physical, mental, or psychosocial discomfort to a resident or has the potential to compromise a resident's ability to maintain or reach his or her highest practical physical, mental, or psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.
- A class IV deficiency is a deficiency that the agency determines has the potential for causing no more than a minor negative impact on the resident. If the class IV deficiency is isolated, no plan of correction is required.[38]

The AHCA can cite violators and impose penalties including fines or revocation of licenses for violations. Evidence of understaffing is sometimes used to show negligence and show an entitlement to punitive damages.[39]

III. Effect of Proposed Changes:

Section 1 amends s. 400.023, F.S., as follows:

Named Defendants and Causes of Action in Nursing Home Cases

The bill provides that any resident who alleges negligence or a violation of rights has a cause of action against the "licensee or its management company, as specifically identified in the application for nursing home licensure" and its direct caregiver employees.

Current law in ss. 400.023 - 400.0238, F.S., provides the exclusive remedy for a cause of action for personal injury or death of a nursing home resident or a violation of the resident's rights statute. Current law further provides that s. 400.023, F.S., "does not preclude theories of recovery not arising out of negligence or s. 400.022, F.S., which are available to the resident or

[37] Section 400.023(8), F.S.
[38] Section 400.023(8), F.S.
[39] *See e.g. Estate of Despain v. Avante Group, Inc.*, 900 So.2d 637, 645 (Fla. 5th DCA 2005) ("As to the vicarious liability of the corporate entities, the record evidence and proffer shows that the facility was not adequately staffed, which contributed to the inability to provide the decedent with proper care, and that numerous records regarding the decedent's care were incomplete, missing, or had been fabricated, which made assessment, treatment, and referrals of the decedent much more difficult. We believe that this showing established a reasonable basis to conclude that the corporate entities were negligent." Accordingly, Despain established a reasonable basis to plead a claim for punitive damages based on the theory of vicarious liability).

to the agency." The bill removes that provision. The bill provides that ss. 400.023 - 400.0238, F.S., set forth the exclusive remedy in resident rights cases and cases involving the personal injury or wrongful death of resident. Any other claims would have to be brought outside of ss. 400.023 - 400.0238, F.S.

Liability of Employees, Officers, Directors, or Owners

The bill provides that a cause of action cannot be asserted against an "employee, officer, director, owner, including any designated as having a 'controlling interest'[40] on the application for nursing home licensure, or agent of licensee or management company" unless the court determines there is a reasonable basis that:

- The officer, director, owner, or agent breached, failed to perform, or acted outside the scope of duties as an officer, director, owner, or agent; and
- The breach, failure to perform, or conduct outside the scope of duties is a legal cause of the damage.

The court must make this finding at an evidentiary hearing after considering evidence in the record and evidence proffered by the claimant.

"Scope of duties as an officer, director, owner, or agent" is not defined by The bill. The parties would have to present evidence on what the "scope of duties" as an officer, director, owner, or agent are in each case and the trial judge would have to determine whether there is a reasonable basis for the jury to conclude that there was a breach of duty and damage to the claimant.

Limitations on Causes of Action for Violations of Criminal Statutes

The bill provides that if a cause of action is brought by or on behalf of a resident under Part II of ch. 400, F.S., then a cause of action may not be asserted under s. 415.111, F.S., against an employee, officer, director, owner, or agent of the licensee or management company.

Election of Damages

The bill amends s. 400.023(1), F.S., to require the claimant to choose between survival damages under s. 46.021, F.S., or wrongful death damages under s. 768.21, F.S., at the end of discovery but not later than 60 days before trial. As *Trollinger* indicates, current law is unclear. It might allow such an election to be made at the end of trial or might allow the trial court to require an election be made with the complaint.[41] The bill requires that the election be made by a time certain before trial.

[40] Section 400.071, F.S., governs applications for licensure for nursing homes. It references s. 408.803, F.S., where "controlling interest" is defined. "Controlling interest" means: "(a) The applicant or licensee; (b) A person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the applicant or licensee; or (c) A person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member." s. 408.803(7), F.S.

[41] The *Trollinger* court did not hold that the election must be made at the pleading stage. It held that certiorari review, a high standard, was not available. There is no subsequent appellate court decision resolving the issue left open in *Trollinger*.

Cap on Noneconomic Damages

The bill provides a cap of $250,000 on noneconomic damages in any claim for wrongful death brought under s. 400.023, F.S., regardless of the number of claimants or defendants. The bill does not cap noneconomic damages in negligence cases that do not involve a wrongful death brought under s. 400.023, F.S.

Attorney Fees in Actions for Injunctive Relief

The bill provides that a resident "may" recover attorney fees and costs if the resident prevails.

Elements in a Civil Actions Under s. 400.023, F.S.

The bill provides that in any claim brought pursuant to this part 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:

- The defendant breached the applicable standard of care; and
- The breach is a legal cause of actual loss, injury, death, or damage to the resident. (emphasis added).

The bill provides that a claimant bringing a claim pursuant to ch. 400, F.S., must show the defendant breached the applicable standard of care and that the breach is the legal cause of actual loss, injury, death, or damage. The "actual" loss addition to the statute is from Florida Supreme Court case law.

Section 2 amends s. 400.0237, F.S., as follows:

Evidentiary Requirements to Bring a Punitive Damages Claims

The bill provides that a claimant may not bring a claim for punitive damages unless there is a showing of admissible evidence proffered by the parties that provides a reasonable basis for recovery of punitive damages. The bill requires the trial judge to conduct an evidentiary hearing where both sides present evidence. The trial judge must find there is reasonable basis to believe the claimant will be able to demonstrate, by clear and convincing evidence, that the recovery of punitive damages is warranted. The effect of these requirements is: (1) to limit the trial judge's consideration to admissible evidence. Current law does not require a showing of admissibility at this stage of the proceedings; and (2) to provide that the claimant and defendant may present evidence and have the trial judge weigh the evidence to make its determination. Current law contemplates that the claimant will proffer evidence and the court, considering the proffer in the light most favorable to the claimant, will determine whether there is a reasonable basis to allow the claimant's punitive damages case to proceed.[42]

Current law provides that the rules of civil procedure are to be liberally construed to allow the claimant discovery of admissible evidence on the issue of punitive damages. The bill removes that provision from statute. Discovery in civil cases is governed by the Florida Rules of Civil

[42] *See Estate of Despain v.Avante Group, Inc.*, 900 So.2d 637, 644 (Fla. 5th DCA 2005).

Procedure. Since the rules govern discovery, it is not clear what effect, if any, removing this provision from statute would have on current practice.

Individual Liability for Punitive Damages

The bill provides that 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 contributed to the loss, damages, or injury" suffered by the claimant.

The current standard jury instructions provide for punitive damages if the defendant was "personally guilty of intentional misconduct."[43] The bill requires that the defendant "actively and knowingly participated in intentional misconduct."

Vicarious Liability for Punitive Damages

The bill provides that 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 employee or agent unless:

- A specifically identified employee or agent actively and knowingly participated in intentional misconduct or engaged in conduct that constituted gross negligence and contributed to the loss, damages, or injury suffered by the claimant; and
- An officer, director, or manager of the actual employer, corporation, or legal entity condoned, ratified, or consented to the specific conduct alleged.

Use of Survey Reports in Punitive Damages Actions

The bill provides that state or federal survey reports may not be used to establish an entitlement to punitive damages.

Section 3 amends s. 400.0238, F.S., as follows:

Attorney Fees in Punitive Damages Actions

The bill changes how attorney fees are calculated in punitive damages actions. It requires that attorney fees be calculated based on the claimant's share of punitive damages rather than the final judgment for punitive damages. The bill provides that if a claimant receives a final judgment for punitive damages or settles a case in which the claimant was granted leave to amend the complaint to add a punitive damages claim, the punitive award is divided equally between the claimant and the Quality of Long-Term Care Facility Improvement Trust Fund. The award is divided before any distribution to the claimant or claimant's counsel.

[43] Standard Jury Instructions in Civil Cases, 503.1, Punitive Damages - Bifurcated Procedure.

The bill further provides that if the parties enter into a settlement agreement at any point after the claimant is allowed to amend the agreement to add a count for punitive damages, 50 percent of the total settlement amount is considered to be the punitive award. The bill provides that the punitive award is divided equally between the claimant and the Quality of Long-Term Care Facility Improvement Trust Fund before any distribution for attorney fees and costs. The bill prohibits the parties from altering the allocation by agreement.

The bill provides that settlement of a claim after the claimant has been allowed to amend the complaint to add a punitive damages count is not an admission of liability and is not governed by s. 400.0238, F.S.

Section 4 amends s. 400.23, F.S., as follows:

Evidence of Relating to Compliance with Staffing Requirements

The bill provides that if the licensee demonstrates compliance with the minimum staffing requirements, the licensee is entitled to a presumption that appropriate staffing was provided and the claimant is not permitted to present any testimony or other evidence of understaffing. The testimony or other evidence is only permissible for days which it can be demonstrated that the licensee was not in compliance with the minimum staffing requirements.

The bill further provides that evidence that the licensee was staffed by an insufficient number of nursing assistants or licensed nurses may not be qualified or admitted on behalf of a resident who makes a claim, unless the licensee received a class I, class II, or uncorrected class III deficiency from AHCA for failure to comply with the minimum staffing requirements and the claimant resident was identified by AHCA as having suffered actual harm because of that failure.

Deficiencies Found in Nursing Home Surveys

The bill provides that a deficiency identified by the agency in a nursing home survey is generally not admissible in nursing home negligence litigation. However, the bill also provides two exceptions and allows the introduction of a survey if:

- The survey cites the resident on whose behalf the action is brought and AHCA determines the resident sustained actual harm as a result of the deficiency, or
- After an evidentiary hearing to determine its relevance, if the deficiency is found to have caused actual harm to residents and was widespread or if the deficiency is determined by the AHCA to be an uncorrected pattern of activity related to the injury sustained by the claimant.

The bill also provides that a survey may be admitted by the defendant if a claimant was a member of a survey resident roster or otherwise was the subject of any survey by AHCA and AHCA did not allege or determine that any deficiency occurred with respect to that claimant during that survey. The absence of a deficiency may be used by the licensee to refute an allegation of neglect or noncompliance with regulatory standards.

Section 5 provides an effective date for the bill of July 1, 2011.

Other Potential Implications:

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:

Section 4 of the bill contains provisions related the admissibility of evidence such as evidence of understaffing and evidence of survey deficiencies. The Florida Supreme Court has held that portions of the Florida Evidence Code are substantive and portions are procedural. To the extent the exclusion of evidence in this bill is procedural, a court could hold that the restriction violates Art. V, s. 2(a) of the Florida Constitution.

Lines 69-71 of the bill provide a cap on noneconomic damages in wrongful death actions brought under section 400.023, F.S. Caps on noneconomic damages are subject to review under Art. I, s. 21 of the Florida Constitution. The constitution provides that the courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay. In *Kluger v. White*, 281 So.2d 1 (Fla. 1973), the Florida Supreme Court held that:

> [w]here a right of access to the courts for redress for a particular injury has been provided…the Legislature is without power to abolish such a right without providing a reasonable alternative to protect the rights of the people of the State to redress for injuries, unless the Legislature can show an overpowering public necessity for the abolishment of such right, and no alternative method of meeting such public necessity can be shown.[44]

The Florida Supreme Court in *Kluger* invalidated a statute that required a minimum of $550 in property damages arising from an automobile accident before a lawsuit could be brought. Based upon the *Kluger* test, the Florida Supreme Court has also invalidated a portion of a tort reform statute that placed a cap on all noneconomic damages because the statute did not provide claimants with a commensurate benefit.[45] Thus, the Legislature

[44] *Kluger v. White*, 281 So2d 1, 4 (Fla. 1973).
[45] *See Smith v. Dept. of Insurance*, 507 So.2d 1080 (Fla. 1987).

cannot restrict damages by either enacting a minimum damage amount or a monetary cap on damages without meeting the *Kluger* test.

The caps on noneconomic damages in medical malpractice cases, found in ss. 766.207 and 766.209, F.S., have been found by the Florida Supreme Court to meet the *Kluger* test and are not violative of the access to courts provision in the Florida Constitution. In *University of Miami v. Echarte,* 618 So.2d 189 (Fla. 1993), the court ruled that the arbitration scheme met both prongs of the *Kluger* test. First, the court held that the arbitration scheme provided claimants with a commensurate benefit for the loss of the right to fully recover noneconomic damages as the claimant has the opportunity to receive prompt recovery without the risk and uncertainty of litigation or having to prove fault in a civil trial. Additionally, the claimant benefits from: reduced costs of attorney and expert witness fees which would be required to prove liability; joint and several liability of multiple defendants; prompt payment of damages after determination by the arbitration panel; interest penalties against the defendant for failure to promptly pay the arbitration award; and limited appellate review of the arbitration award.

Second, the court in *Echarte* ruled that, even if the medical malpractice arbitration statutes did not provide a commensurate benefit, the statutes satisfied the second prong of *Kluger* which requires a legislative finding that an overpowering public necessity exists, and further that no alternative method of meeting such public necessity can be shown. The court found that the Legislature's factual and policy findings of a medical malpractice crisis constituted an overpowering public necessity. The court also ruled that the record supported the conclusion that no alternative or less onerous method existed for meeting the public necessity of ending the medical malpractice crisis. The court explained, "…it is clear that both the arbitration statute, with its conditional limits on recovery of noneconomic damages, and the strengthened regulation of the medical profession are necessary to meet the medical malpractice insurance crisis."[46]

The bill limits the recovery of noneconomic damages. If the cap is challenged, the court would scrutinize this limitation based on the rulings in *Kluger* and its progeny. Accordingly, the court would have to determine whether this bill provided a claimant with a reasonable alternative to the right to recover full noneconomic damages. If not, the courts would look to see whether this bill was a response to an overpowering public necessity and that no alternative method of meeting such public necessity could have been shown.

Article I, s. 22 of the Florida Constitution provides for right to a trial by jury. The bill contains provisions that limit the admissibility of certain evidence unless AHCA has made certain findings. Specifically, lines 292 and 293 provide that evidence of understaffing cannot be admitted unless AHCA makes a finding that the claimant suffered harm due to a deficiency and lines 321 and 322 provide that certain evidence cannot be admitted unless AHCA finds that the claimant suffered actual harm. In *National Airlines, Inc. v. Florida Equipment Co. of Miami,* 71 So.2d 741, 744 (Fla. 1954), the Florida Supreme Court warned that it is "peculiarly within the province of the

[46] *University of Miami v. Echarte,* 618 So.2d 189, 195-197 (Fla. 1993).

jury" to draw inferences from facts and determine the ultimate facts. It could be argued that these provisions make AHCA, rather than the jury, the ultimate finder of fact if the issue in the case is whether the claimant suffered actual harm.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Due to the greater portion of settlements in punitive damages cases being distributed to the Quality of Long-Term Care Facility Improvement Trust Fund, claimants could see smaller awards in settlements. Attorneys could see lower attorney fees in such punitive damage cases.

C. Government Sector Impact:

The AHCA advises:
The fiscal impact to the Agency will arise out of the use of survey deficiencies to prove adequate staffing issues (see pages 10-11, lines 278-293 of bill) and the use of survey results to prove or rebute negligence (see pages 11-12, lines 316-337). Currently, the Agency already experiences complaints filed to bolster claims. Under this bill, Agency findings are a prerequisite to staffing claims and evidence for or against other negligence. It can be easily anticipated that complaints requiring surveyor time and expense will be filed for litigation purposes. It is also certain that in the case where such deficiencies might be settled by the Agency without formal hearing, litigating parties will require discovery and testimony in the civil actions from Agency surveyors to substantiate the survey findings. Additionally, virtually all presuit investigation will include a public records request. These will result in expense to the Agency. The fiscal impact cannot be determined at this time. If the bill were amended to require that the agency's survey findings must be accepted as written and prohibit the ability to depose agency staff, the impact to the agency would be reduced.[47]

VI. Technical Deficiencies:

None.

VII. Related Issues:

In Section 1 of the bill, lines 41-54 indicate that a cause of action may not be asserted individually against an "employee" unless the "officer, director, owner, or agent breached, failed to perform, or acted outside the scope of duties as an officer, director, owner, or agent," and when such behavior is the legal cause of loss, injury, death, or damage to the resident. This

[47] Agency for Health Care Administration, "2011 Bill Analysis and Economic Impact Statement: SB 1396," on file with Senate Health Regulation Committee staff.

seems to limit causes of action against an employee to situations in which another party has caused the harm.

In Section 3 of the bill, lines 258-262 provide that the settlement of a claim before a verdict is not an admission of liability and "is not governed" by s. 400.0238, F.S. Much of Section 3 of the bill provides for allocation of punitive damages in cases that settle before a verdict. The intent and effect of lines 261-262 are unclear.

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 (Fasano) recommended the following:

Senate Amendment

Delete lines 74 - 244
and insert:
Section 2. Section 513.012, Florida Statutes, is amended to read:
513.012 Public health laws; enforcement.—
(1) It is the intent of the Legislature that mobile home parks, lodging parks, recreational vehicle parks, and recreational camps be regulated under this chapter. As such, the department shall administer and enforce, with respect to such parks and camps, uniform laws and rules relating to sanitation,

control of communicable diseases, illnesses and hazards to health among humans and from animals to humans, and the general health of the people of the state.

(2) This chapter establishes uniform standards to be administered and enforced by the department for the issuing of permits for, and the operation of, mobile home parks, lodging parks, recreational vehicle parks, and recreational camps, which include:

(a) The design, location, and site sizes for sites in parks and camps;

(b) Sanitary standards for the issuing of permits for, and the operation of, parks and camps;

(c) The issuing of permits for parks and camps as required by this chapter;

(d) The inspection of parks and camps to enforce compliance with this chapter; and

(e) Permit requirements.

(3) This chapter establishes uniform standards for recreational vehicle parks and camps which apply to:

(a) The liability for property of guests left on sites;

(b) Separation and setback distances established at the time of initial approval;

(c) Unclaimed property;

(d) Conduct of transient guests;

(e) Theft of personal property;

(f) Evictions of transient guests;

(g) Writs of distress;

(h) The maintenance of guest registers;

(i) Occupancy standards for transient rentals; and

(j) Placement of recreational vehicles by size and type.

(4) Local governmental actions, ordinances, and resolutions must be consistent with the uniform standards established pursuant to this chapter and as implemented by rules of the department. This chapter does not limit the authority of a local government to adopt and enforce land use, building, firesafety, and other regulations.

(5) However, nothing in this chapter qualifies a mobile home park, a lodging park, a recreational vehicle park, or a recreational camp for a liquor license issued under s. 561.20(2)(a)1. Mobile home parks, lodging parks, recreational vehicle parks, and recreational camps regulated under this chapter are exempt from regulation under the provisions of chapter 509.

Section 3. Section 513.014, Florida Statutes, is amended to read:

513.014 Applicability of recreational vehicle park provisions to mobile home parks.—A mobile home park that has five or more sites set aside for recreational vehicles shall, for those sites set aside for recreational vehicles, comply with the recreational vehicle park requirements included in this chapter. This section does not require a mobile home park with spaces set aside for recreational vehicles to obtain two licenses. ~~However, a mobile home park that rents spaces to recreational vehicles on the basis of long-term leases is required to comply with the laws and rules relating to mobile home parks including but not limited to chapter 723, if applicable.~~

Section 4. Section 513.02, Florida Statutes, is amended to

read:

513.02 Permits ~~Permit~~.—

(1) A person may not establish or maintain a mobile home park, lodging park, recreational vehicle park, or recreational camp in this state without first obtaining an operating ~~a~~ permit from the department. ~~Such permit is not transferable from one place or person to another. Each permit must be renewed annually.~~

(2) Before the commencement of construction of a new park or camp or before any change to an existing park or camp which requires construction of new sanitary facilities or additional permitted sites, a person who operates or maintains such park or camp must contact the department to receive a review and approval. The items required to be submitted and the process for issuing a review and approval shall be set by department rule.

(3)(a) An operating permit is not transferable from one place or person to another. Each permit must be renewed annually.

(b) ~~(2)~~ The department may refuse to issue an operating ~~a~~ permit to, or refuse to renew the operating permit of, any park or camp that is not constructed or maintained in accordance with law and with the rules of the department.

(c) ~~(3)~~ The department may suspend or revoke an operating ~~a~~ permit issued to any person that operates or maintains such a park or camp if such person fails to comply with this chapter or the rules adopted by the department under this chapter.

(d) ~~(4)~~ An operating ~~A~~ permit for ~~the operation of~~ a park or camp may not be renewed ~~or transferred~~ if the permittee has an outstanding fine assessed pursuant to this chapter which is in


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final-order status and judicial reviews are exhausted~~, unless the transferee agrees to assume the outstanding fine~~.

(e)~~(5)~~ When a park or camp regulated under this chapter is sold ~~or its ownership transferred~~, the purchaser who continues operation of the park or camp ~~transferee~~ must apply to the department for an operating ~~a~~ permit within 30 days after ~~to the department before~~ the date of sale ~~transfer~~. The applicant must provide the department with a copy of the recorded deed or lease agreement before the department may issue an operating ~~a~~ permit to the applicant.

(4) Each person seeking department review of plans for a proposed park or camp may submit the plans to the department for an assessment of whether the plans meet the requirements of this chapter and the rules.

(5) Each person constructing a new park or camp or adding spaces to an existing park or camp must, before the construction, renovation, or addition, submit plans to the department for department review and approval.

Section 5. Section 513.03, Florida Statutes, is amended to read:

513.03 Application for and issuance of permit.—

(1) An application for an operating ~~a~~ permit must be made in writing to the department~~,~~ on a form prescribed by the department. The application must state the location of the existing or proposed park or camp;~~,~~ the type of park or camp;~~,~~ the number of mobile homes or recreational vehicles to be accommodated; ~~or~~ the number of recreational campsites, buildings, and sites set aside for group camping, including barracks, cabins, cottages, and tent spaces; the type of water

supply;~~,~~ the method of sewage disposal;~~,~~ and any other information the department requires.

(2) If the department is satisfied, after reviewing the application of the proposed or existing park or camp and causing an inspection to be made, that the park or camp complies with this chapter and is so located, constructed, and equipped as not to be a source of danger to the health of the general public, the department shall issue the necessary approval or operating permit, in writing, on a form prescribed by the department.

Section 6. Subsection (1) of section 513.045, Florida Statutes, is amended to read:

513.045 Permit fees.—

(1)(a) Each person seeking a permit to establish, operate, or maintain a mobile home park, lodging park, recreational vehicle park, or recreational camp must pay to the department a fee, the amount of which shall be set by rule of the department.

(b) Fees established pursuant to this subsection must be based on the actual costs incurred by the department in carrying out its responsibilities under this chapter.

(c) The fee for an annual operating ~~a~~ permit may not be set at a rate that is more than $6.50 per space or less than $3.50 per space. ~~Until rules setting these fees are adopted by the department, the permit fee per space is $3.50.~~ The annual operating permit fee for a nonexempt recreational camp shall be based on an equivalency rate for which two camp occupants equal one space. The total fee assessed to an applicant for an annual operating permit may not be more than $600 or less than $50, except that a fee may be prorated on a quarterly basis.

(d) ~~(c)~~ A recreational camp operated by a civic, fraternal,

educational, or religious organization that does not rent to the public is exempt from the fee requirements of this subsection.

Section 7. Section 513.05, Florida Statutes, is amended to read:

513.05 Rules.—The department may adopt rules pertaining to the location, construction, modification, equipment, and operation of mobile home parks, lodging parks, recreational vehicle parks, and recreational camps, except as provided in s. 633.022, as necessary to administer this chapter, pursuant to the provisions of this chapter and s. 381.006. Such rules may include definitions of terms; requirements for plan reviews of proposed and existing parks and camps; plan reviews of parks that consolidate or expand space or capacity or change space size; water supply; sewage collection and disposal; plumbing and backflow prevention; garbage and refuse storage, collection, and disposal; insect and rodent control; space requirements; heating facilities; food service; lighting; sanitary facilities; bedding; an occupancy equivalency to spaces for permits for recreational camps; sanitary facilities in recreational vehicle parks; and the owners' responsibilities at recreational vehicle parks and recreational camps.

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 292

INTRODUCER: Transportation Committee and Senator Dean

SUBJECT: Mobile Home and Recreational Vehicle Parks

DATE: March 28, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Eichin	Spalla	TR	**Favorable**
2.	Fernandez/O'Callaghan	Stovall	HR	**Pre-meeting**
3.			CA	
4.			BC	
5.				
6.				

I. Summary:

The bill specifies the sections of law within chapter 513, F.S., for which the Department of Health is responsible for establishing uniform laws. It establishes a department review and approval process for construction of a new mobile home park, lodging park, recreational vehicle park, or recreational camp; or certain changes to an existing park or camp. The bill establishes standards for separation distances between recreational vehicles and setback distances from the exterior property boundary of recreational vehicle parks.

The bill also revises the responsibilities of an operator of a recreational vehicle park related to personal property left on the premises. An additional criminal act is established when a person fails to depart from a recreational vehicle park under certain conditions.

The bill substantially amends the following sections of the Florida Statutes: 513.01; 513.012; 513.014; 513.02; 513.03; 513.045; 513.05; 513.054; 513.055; 513.10; 513.112; 513.115; and 513.13.

The bill repeals s. 513.111 of the Florida Statutes.

The bill creates s. 513.1115 of the Florida Statutes.

II. Present Situation:

The Department of Health (department) is the exclusive regulatory and permitting authority for sanitary standards for all mobile home parks, lodging parks, recreational vehicle parks and

recreational camps under ch. 513, F.S.[1] Pursuant to s. 513.05, F.S.,[2] the department has adopted rules in Ch. 64E-15, Florida Administrative Code (F.A.C.), pertaining to: minimum area requirements, water supply, sewage disposal, sanitary facilities, plumbing, garbage and refuse disposal, insect and rodent control, recreational camp standards, permits and fees, and owner's and operator's responsibilities.[3]

The Mobile Home and Recreational Vehicle Parks Program is administered within the department by the Division of Environmental Health. The program's primary objective is to minimize the risk of injury and illness by focusing on "safe drinking water supply, proper sewage disposal, a safe and disease free swimming pool (where provided), and assurances that the establishment is free from garbage, harmful insects, and rodent infestations." The county health departments are responsible for receiving and investigating environmental health and sanitation complaints; they also conduct routine inspections, plan reviews, educational programs, investigations, complaints, and enforcement actions. [4]

Currently, there are approximately 5,700 mobile home parks, lodging parks, recreational vehicle parks, and recreational camps in Florida.[5] Permits for mobile home and/or recreational vehicle parks and camps are issued annually by the department under s. 513.02, F.S. Permit fees are set by department rule at $4 per space and cumulatively not less than $100 or more than $600 annually.[6] Section 513.045, F.S., sets the permissible statutory range for permit fees at $3.50-$6.50 per space, and the total assessed fee at no less than $50 or more than $600, annually.[7]

III. Effect of Proposed Changes:

Section 1 amends s. 513.01, F.S., to revise the definition of "mobile home" and to define "occupancy." The definition of "mobile home" is modified to exclude a structure originally sold as a recreational vehicle. The term "occupancy" is defined to mean the length of time that a recreational vehicle is occupied by a transient guest and not the length of time that such a vehicle is located on the leased recreational site. Part of the current definition of "recreational vehicle" is moved to the definition of "occupancy".

Section 2 amends s. 513.012, F.S., to specify that the department is responsible for administering and enforcing uniform laws under ch. 513, F.S., creating subsection (2) to provide the specific instances when the department shall establish uniform standards to include:

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[1] Section 513.051, F.S.
[2] *See* s. 513.05, F.S., "The department may adopt rules pertaining to the location, construction, modification, equipment, and operation of mobile home parks, lodging parks, recreational vehicle parks, and recreational vehicle camps… as necessary to administer this chapter."
[3] *See* 64E-15.002-15.008, F.A.C.
[4] The Department of Health, Division of Environmental Health website, *Mobile Home and Recreational Vehicle Park Program*, located at: <http://www.doh.state.fl.us/environment/community/mobile/index.html> (Last visited on February 3, 2011).
[5] Mobile Home/RV Park Listing, Department of Health, Division of Environmental Health website, *Mobile Home and Recreational Vehicle Park Program*, located at: http://www.doh.state.fl.us/environment/community/mobile/index.html. (Last visited March 24, 2011).
[6] Rule 64E-15.010, F.A.C.
[7] Section 513.045, F.S.

- The design, location, and site sizes for sites in parks and camps;
- Sanitary standards for permitting and the operation of parks and camps;
- Occupancy standards for transient rentals in recreational vehicle parks and camps;
- Permitting of parks and camps as required by this chapter;
- Inspection of parks and camps to enforce compliance with this chapter;
- Permit requirements; and
- The maintenance of guest registers.

The bill also creates subsection (3) to establish that ch. 513, F.S., provides the uniform standards pertaining to:

- The liability for property of guests left on sites;
- Separation and setback distances established at the time of approval;
- Unclaimed property;
- Conduct of transient guests;
- Theft of personal property;
- Evictions of transient guests; and
- Writs of distress[8].

The bill requires that local government actions, ordinances and resolutions be consistent with the department's uniform standards, providing an exception for the authority of local governments to adopt and enforce local land use, building, fire safety, and other regulations.

Section 3 amends s. 513.014, F.S., to remove a redundant provision that a mobile home park that rents spaces to recreational vehicles for long term leases, must comply with the laws and rules relating to mobile home parks in ch. 723, F.S.

Section 4 amends s. 513.02, F.S., to require a person who maintains a mobile home park, lodging park, recreational vehicle park, or recreational camp who is going to construct a new park or camp, or change an existing park or camp that requires construction of new sanitary facilities or additional permitted sites to receive review and approval from the department prior to beginning construction or changes. The department shall identify by rule the procedures and items required to be submitted for review and approval. The terminology related to a permit and permitting requirements is modified to designate the permit as an *operating* permit. Inconsistent references to transferring permits are eliminated since permits are not transferrable. The bill requires the purchaser of a park or camp to apply for an operating permit within 30 days after the date of sale, rather than before the date of the sale.

Section 5 amends s. 513.03, F.S., to add information that must be submitted in an application for an operating permit to include the number of buildings and sites set aside for group camping, including barracks, cabins, cottages, and tent spaces. The department shall issue the necessary approval or operating permit, after reviewing the application and conducting an inspection, that

[8] Section 83.12, F.S. Defines a writ of distress—"A distress writ shall be issued by a judge of the court which has jurisdiction of the amount claimed. The writ shall enjoin the defendant from damaging, disposing of, secreting, or removing any property liable to distress from the rented real property after the time of service of the writ until the sheriff levies on the property, the writ is vacated, or the court otherwise orders."

the park or camp is not a source of danger to the health of the general public, within the criteria established under this law.

Section 6 amends s. 513.045, F.S., to clarify language related to the fees imposed for the operating permit. Obsolete language is repealed inasmuch as rules have been adopted by the department.

The bill authorizes a person to submit plans related to a proposed park or camp to the department for review for an assessment of whether the plans meet the requirements of this chapter. A person constructing a new park or camp or adding spaces or renovating an existing park or camp is required to submit plans to the department for review and approval. (See comment under Related Issues.)

Section 7 amends s. 513.05, F.S., to clarify the department's authority to adopt rules related to reviewing plans that consolidate or expand space or capacity.

Section 8 amends s. 513.054, F.S., to clarify that a person who does not obtain an *operating* permit for a mobile home park, lodging park, recreational vehicle park, or recreational camp or refuses to pay the *operating* permit fee commits a misdemeanor of the second degree.

Section 9 amends s. 513.055, F.S., to clarify that the permit referred to in this section related to the revocation or suspension of a permit applies to an *operating* permit.

Section 10 amends s. 513.10, F.S., to clarify that a person who maintains or operates a mobile home park, lodging park, recreational vehicle park, or recreational camp without first obtaining an *operating* permit or maintains or operates a park or camp after revocation of the operating permit commits a misdemeanor of the second degree.

Section 11 repeals s. 513.111, F.S., relating to posting or publishing site rates for a recreational vehicle park that rents by the day or week and the criminal penalties associated with this activity.

Section 12 creates s. 513.1115, F.S., to require the spacing of recreational vehicles to be maintained at the distances established at the time of the initial approval of the recreational vehicle park by the department and local government. In addition, this section requires setback distances from the exterior property boundary of a recreational vehicle park to be maintained in accordance with the setback distances established at the time of the initial approval by the department and the local government. The bill specifies that both of these sections do not limit the regulation of the uniform fire safety standards under s. 633.022, F.S.

Section 13 amends s. 513.112, F.S., to eliminate the requirement that the guest registry of a recreational vehicle park must be made available to the department for inspection.

Section 14 amends s. 513.115, F.S., to authorize an operator of a recreational vehicle park to dispose of property unclaimed for 90 days by a guest who has vacated the premises without notice to the operator and who has an outstanding account. An owner of a park is no longer required to provide written notice to any guest or owner of property left at the park prior to disposing of the property; however, the property must be held by the park for 90 days prior to

disposal. The bill specifies that any titled property, including a boat, recreational vehicle, or other vehicle, shall be disposed of in accordance with the requirements of ch. 715, F.S.

Section 15 amends s. 513.13, F.S., to provide that if an operator of a recreational vehicle park notifies a person to leave the park for a permissible reason, by either posting or personal delivery, in the presence of a law enforcement officer, and the person fails to depart from the park immediately, the person commits a misdemeanor of the second degree. Permissible reasons include: possessing or dealing in controlled substances, disturbing the peace and comfort of other persons, causing harm to the physical park, or failing to pay the rental rate as agreed. Additionally, an operator is not liable for damages to personal property left on the premises by a guest who has been removed from the park or arrested for the failure to leave the park after being notified to leave for a permissible reason.

Section 16 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:

According to an analysis[9] prepared by the Department of Health:

The proposed bill authorizes the department to pass a rule establishing occupancy standards for transient rentals in RV parks and camps but fails to provide ascertainable minimal standards and guidelines for the agency to base its rulemaking efforts. Such excessively broad discretion may be viewed as an unconstitutional delegation of authority from the legislative to the executive branch of government, and thus a violation of the doctrine of separation of powers. Sloban v. Florida Bd. of Pharmacy, 982 So.2d 26 (Fla. 1st DCA 2008).

[9] Department of Health, *Bill Analysis, Economic Statement and Fiscal Note: SB 292*, 9 (Jan. 12, 2011)

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

The bill removes obsolete language pertaining to interim fees and clarifies that the existing fee structure applies to *an annual operating* permit. There are no provisions for the late payment of the annual operating permit fee.

B. Private Sector Impact:

The bill affects parks and camps that will be newly constructed, existing parks or camps that will be expanded, and parks and camps that do not submit the required fees in a timely manner. The uniform standards related to design, operation, and occupancy imposed by the bill could minimize negative fiscal impacts to the industry which result from existing inconsistent local government rules.

C. Government Sector Impact:

The bill requires the department to adopt administrative rules and implement new requirements. The department is unable to estimate the fiscal impact at this time. However, the department noted that the bill does not authorize the department to assess fees sufficient to cover costs for plan reviews, approval of new construction, expansive remodeling, reinspection fees, or late fees.[10]

VI. Technical Deficiencies:

None.

VII. Related Issues:

Section 6 of the bill amends s. 513.045, F.S., relating to fees. Two new provisions in s. 513.045(b)2. and 3., F.S., do not provide for fees or relate to fees. Instead, these subparagraphs authorize and require the submission of a plan for the department to review. If fees are not contemplated for the department's review, these two provisions should be moved to a section that is more applicable substantively.

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.

[10] Department of Health, *Bill Analysis, Economic Statement and Fiscal Note: SB 292*, 7 (Jan. 12, 2011)

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LEGISLATIVE ACTION

Senate . House

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

Senate Amendment (with directory and title amendments)

Between lines 86 and 87

insert:

(2) DEFINITIONS.—As used in ss. 381.0065-381.0067, the term:

(b) "Bedroom" means a room that can be used for sleeping which, for site-built dwellings, has a minimum 70 square feet of conditioned space, or, for manufactured homes constructed to HUD standards, has a minimum square footage of 50 square feet of floor area and is located along an exterior wall, has a closet and a door or an entrance where a door could be reasonably

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installed, and an emergency means of escape and rescue opening to the outside. A room may not be considered a bedroom if it is used to access another room, unless the room that is accessed is a bathroom or closet and does not include a hallway, bathroom, kitchen, living room, family room, dining room, den, breakfast nook, pantry, laundry room, sunroom, recreation room, media/video room, or exercise room. For the purpose of determining system capacity, occupancy is calculated at a maximum of two persons per bedroom.

(4) PERMITS; INSTALLATION; AND CONDITIONS.—A person may not construct, repair, modify, abandon, or operate an onsite sewage treatment and disposal system without first obtaining a permit approved by the department. The department may issue permits to carry out this section, but shall not make the issuance of such permits contingent upon prior approval by the Department of Environmental Protection, except that the issuance of a permit for work seaward of the coastal construction control line established under s. 161.053 shall be contingent upon receipt of any required coastal construction control line permit from the Department of Environmental Protection. A construction permit is valid for 18 months from the issuance date and may be extended by the department for one 90-day period under rules adopted by the department. A repair permit is valid for 90 days from the date of issuance. An operating permit must be obtained prior to the use of any aerobic treatment unit or if the establishment generates commercial waste. Buildings or establishments that use an aerobic treatment unit or generate commercial waste shall be inspected by the department at least annually to assure compliance with the terms of the operating permit. The operating

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permit for a commercial wastewater system is valid for 1 year from the date of issuance and must be renewed annually. The operating permit for an aerobic treatment unit is valid for 2 years from the date of issuance and must be renewed every 2 years. If all information pertaining to the siting, location, and installation conditions or repair of an onsite sewage treatment and disposal system remains the same, a construction or repair permit for the onsite sewage treatment and disposal system may be transferred to another person, if the transferee files, within 60 days after the transfer of ownership, an amended application providing all corrected information and proof of ownership of the property. There is no fee associated with the processing of this supplemental information. A person may not contract to construct, modify, alter, repair, service, abandon, or maintain any portion of an onsite sewage treatment and disposal system without being registered under part III of chapter 489. A property owner who personally performs construction, maintenance, or repairs to a system serving his or her own owner-occupied single-family residence is exempt from registration requirements for performing such construction, maintenance, or repairs on that residence, but is subject to all permitting requirements. A municipality or political subdivision of the state may not issue a building or plumbing permit for any building that requires the use of an onsite sewage treatment and disposal system unless the owner or builder has received a construction permit for such system from the department. A building or structure may not be occupied and a municipality, political subdivision, or any state or federal agency may not authorize occupancy until the department approves the final

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installation of the onsite sewage treatment and disposal system. A municipality or political subdivision of the state may not approve any change in occupancy or tenancy of a building that uses an onsite sewage treatment and disposal system until the department has reviewed the use of the system with the proposed change, approved the change, and amended the operating permit.

(w) Any permit issued and approved by the department for the installation, modification, or repair of an onsite sewage treatment and disposal system shall transfer with the title to the property. A title is not encumbered at the time of transfer by new permit requirements by a governmental entity for an onsite sewage treatment and disposal system which differ from the permitting requirements in effect at the time the system was permitted, modified, or repaired.

(x) An onsite sewage treatment and disposal system is not considered abandoned if the properly functioning onsite sewage treatment and disposal system is disconnected from a structure that was made unusable or destroyed following a disaster and the system was not adversely affected by the disaster. The onsite system may be reconnected to a rebuilt structure if:

1. The reconnection of the onsite sewage treatment and disposal system is to the same type and approximate size of rebuilt structure that existed prior to the disaster;

2. The onsite sewage treatment and disposal system is not a sanitary nuisance; and

3. The onsite sewage treatment and disposal system has not been altered without prior authorization.

An onsite sewage treatment and disposal system that serves a

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property that is foreclosed upon is not an abandoned system.

(y) If an onsite sewage treatment and disposal system permittee receives, relies upon, and undertakes construction of a system based upon a validly issued construction permit under rules applicable at the time of construction, but a change to a rule occurs after the approval of the system for construction but before the final approval of the system, the rules applicable and in effect at the time of construction approval apply at the time of final approval if fundamental site conditions have not changed between the time of construction approval and final approval.

(z) A modification, replacement, or upgrade of an onsite sewage treatment and disposal system is not required for a remodeling addition to a single-family home if a bedroom is not added.

====== 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 64 - 66

and insert:

Section 1. Subsection (1), (5), (6), and (7) of s. 381.0065, Florida Statues, as amended by chapter 2010-283, Laws of Florida, are amended, present paragraphs (b) through (p) of subsection (2) of that section are redesignated as paragraphs (c) through (q), respectively, a new paragraph (b) is added to subsection (2), and paragraphs (w), (x), (y), and (z) are added to subsection (4) of that section, 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 4

and insert:

legislative intent; defining the term "bedroom"; providing for any permit issued and approved by the Department of Health for the installation, modification, or repair of an onsite sewage treatment and disposal system to transfer with the title of the property; providing circumstances in which an onsite sewage treatment and disposal system is not considered abandoned; providing for the validity of an onsite sewage treatment and disposal system permit if rules change before final approval of the constructed system; providing that a system modification, replacement, or upgrade is not required unless a bedroom is added to a single-family home; deleting provisions requiring the

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LEGISLATIVE ACTION

Senate . House

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

Senate Amendment

Delete lines 428 - 429

and insert:

organic waste composting toilets: a fee of not less than $15 ~~$50~~, or more than $30 ~~$150~~.

LEGISLATIVE ACTION

Senate . House

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

Senate Amendment (with title amendment)

Delete lines 243 - 371

and insert:

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

(1) Effective January 1, 2012, any county or municipality that does not opt out of this section shall develop and adopt by ordinance a local onsite sewage treatment and disposal system evaluation and assessment program within all or part of its geographic area which meets the requirements of this subsection. The county or municipality shall notify the Secretary of State


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by letter of the adoption of such an ordinance pursuant to this section. By a majority of the local elected body, a county or municipality may opt out of the requirements of this section at any time before January 1, 2012, by adopting a separate resolution. The resolution shall be directed to and filed with the Secretary of State and shall state the intent of the county or municipality not to adopt an onsite sewage treatment and disposal system evaluation and assessment program. A county or municipality may subsequently adopt an ordinance imposing an onsite sewage treatment and disposal system evaluation and assessment program if the program meets the requirements of this subsection. A county or municipality may repeal an ordinance adopted pursuant to this section if the county or municipality notifies the Secretary of State by letter of the repeal. The local ordinances may not deviate from or exceed the substantive requirements of this subsection. Such adopted ordinance shall provide for the following:

(a) *Evaluations.*—An evaluation of any septic tank within all or part of the county's or municipality's jurisdiction must take place once every 5 years to assess the fundamental operational condition of the system and to identify system failures. The ordinance may not mandate an evaluation at the point of sale in a real estate transaction and may not require a soil examination. The location of the system shall be identified. A tank and drainfield evaluation and a written assessment of the overall condition of the system pursuant to the assessment procedure prescribed in paragraph (2)(d) are required.

(b) *Qualified contractors.*—Each evaluation required under

this subsection must be performed by a septic tank contractor or master septic tank contractor registered under part III of chapter 489, a professional engineer having wastewater treatment system experience and licensed pursuant to chapter 471, or an environmental health professional certified under this chapter in the area of onsite sewage treatment and disposal system evaluation. Evaluations and pump outs may also be performed by an authorized employee working under the supervision of the individuals listed in this paragraph; however, all evaluation forms must be signed by a qualified contractor.

(c) *Repair of systems.*—A local ordinance may not require a repair, modification, or replacement of a system as a result of an evaluation unless the evaluation identifies a system failure. For purposes of this subsection, the term "system failure" is defined as a condition existing within an onsite sewage treatment and disposal system which results in the discharge of untreated or partially treated wastewater onto the ground surface or into surface water, or which results in a sanitary nuisance caused by the failure of building plumbing to discharge properly. A system is not a failure if the system does not have a minimum separation distance between the drainfield and the wet season water table, or if an obstruction in a sanitary line or an effluent screen or filter prevents effluent from flowing into a drainfield. If a system failure is identified and several remedial options are available to resolve the failure, the local ordinance may not require more than the least costly remedial measure to resolve the system failure. The homeowner may choose the remedial measure to fix the system. There may be instances in which a pump out is sufficient to resolve a system failure.


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Remedial measures to resolve a system failure must meet the requirements of the code in effect at the time the system was originally permitted and installed, and are not required to meet the current code requirements.

(d) *Exemptions*.—The local ordinance may exempt from the evaluation requirements any system that is required to obtain an operating permit or that is inspected by the department pursuant to the annual permit inspection requirements of chapter 513.

(e) *Notifications*.—The local ordinance must require that notice be given to the septic tank owner at least 60 days before the septic tank is due for an evaluation. The notice may include information on the proper maintenance of onsite sewage treatment and disposal systems.

(f) *Fees*.—The local ordinance may authorize the assessment of a fee not to exceed $30 paid by the owner of the septic tank in order to cover the costs of administering the evaluation program.

(g) *Penalties*.—The local ordinance must provide penalties for qualified contractors and septic tank owners who do not comply with requirements of the adopted ordinance.

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

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

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identifies the capacity of the tank and indicates that the condition of the tank is structurally sound and watertight. Visual inspection of the tank must be made when the tank is empty to detect cracks, leaks, or other defects. Baffles or tees must be checked to ensure that they are intact and secure. The evaluation shall note the presence and condition of outlet devices, effluent filters, and compartment walls; any structural defect in the tank; and the condition and fit of the tank lid, including manholes. If the tank, in the opinion of the qualified contractor, is in danger of being damaged by leaving the tank empty after inspection, the tank shall be refilled before concluding the inspection.

(b) *Drainfield evaluation*.—The drainfield evaluation must include a determination of the approximate size and location of the drainfield. The evaluation shall state the condition of surface vegetation, including whether there is any seepage visible or excessively lush vegetation; state whether there is ponding water within the drainfield; and identify the location of any downspout or drain that encroaches or drains into the drainfield area. The evaluation must contain an overall assessment of the drainfield.

(c) *Special circumstances*.—If the system contains pumps, siphons, or alarms, the following information must be provided:

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

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

3. Whether there are a check valve and purge hole; whether

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there is a high-water alarm, including whether the type of alarm is audio or visual or both, the location of the alarm, and its operational condition; and whether electrical connections appear satisfactory; and

4. Whether surface water can infiltrate into the tank and whether the tank was pumped out.

(d) *Assessment procedure.*—All evaluation procedures used by a qualified contractor shall be documented. The qualified contractor shall provide a copy of a written, signed evaluation report to the property owner, the county or municipality, and the county health department. A copy of the evaluation report shall be retained by the local county health department for a minimum of 5 years until a subsequent inspection report is filed. The front cover of the report must identify any system failure and include a clear and conspicuous notice to the owner that the owner has a right to have any remediation of the failure performed by a qualified contractor other than the contractor performing the evaluation. The report must further identify any crack, leak, improper fit or other defect in the tank, manhole, or lid, and any other damaged or missing component; any ponding of the drainfield or uneven distribution of effluent and the extent of such effluent; any downspout or other stormwater or source of water directed onto or toward the system, including recommendations that such sources be redirected away from the system; and any other maintenance need or condition of the system at the time of the evaluation which, in the opinion of the qualified contractor, would possibly interfere with or restrict any future repair or modification to the existing system. The report shall conclude with an overall

assessment of the fundamental operational condition of the system.

(e) *Tracking system.*—A county or municipality that adopts an evaluation program pursuant to this section shall develop, accumulate, and assimilate its own database and establish a computerized tracking system within its jurisdiction. Such information shall be based upon information obtained from written, signed evaluation reports given to property owners by qualified contractors and filed with the county or municipality and the county health department following an evaluation. The information tracked must include:

1. The addresses or locations of the onsite systems;

2. The number of onsite systems within the local jurisdiction;

3. The total number and types of system failures; and

4. Any other trends deemed relevant by the county or municipality resulting from an assessment of the overall condition of systems.

The computerized tracking system may be Internet-based and shall be used by the county or municipality to notify homeowners when evaluations are due. Data and information shall be recorded and updated as evaluations are conducted and reported to the county or municipality and the county health department.

(3) A county or municipality that adopts an onsite sewage treatment and disposal system evaluation and assessment program pursuant to this section shall notify the Secretary of Environmental Protection upon the adoption of an ordinance. The Department of Environmental Protection shall, within existing


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resources and upon receipt of such notice, notify the county or municipality of the potential use of, and access to, program funds under the Clean Water State Revolving Fund or s. 319 of the Clean Water Act. Upon request by a county or municipality, the Department of Environmental Protection shall provide direct technical assistance in the application process to receive moneys under the Clean Water State Revolving Fund or s. 319 of the Clean Water Act. The Department of Environmental Protection shall also, within existing resources and upon request by a county or municipality, provide advice and technical assistance to the county or municipality on how to establish a low-interest revolving loan program, how to model a revolving loan program after the low-interest loan program of the Clean Water State Revolving Fund, or how to provide low-interest loans to residents for the repair of failing systems. This subsection does not obligate the Department of Environmental Protection to provide any money to fund such programs.

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

And the title is amended as follows:

Delete lines 14 - 52

and insert:

requiring a county or municipality to adopt under certain circumstances a local ordinance creating a program for the periodic evaluation and assessment of onsite sewage treatment and disposal systems; requiring the county or municipality to notify the Secretary of State of the ordinance; authorizing a county or municipality, in specified circumstances, to

opt out of certain requirements by a specified date; authorizing a county or municipality to adopt or repeal, after a specified date, an ordinance creating an evaluation and assessment program; providing criteria for evaluations, qualified contractors, repair of systems, exemptions, notifications, fees, and penalties; requiring that certain procedures be used for conducting tank and drainfield evaluations; providing for certain procedures in special circumstances; providing for assessment procedures; requiring the county or municipality to develop a system for tracking the evaluations; providing criteria; requiring counties and municipalities to notify the Secretary of Environmental Protection that an evaluation program ordinance is adopted; requiring the department to notify those counties or municipalities of the use of, and access to, certain state and federal program funds; requiring the department to provide certain advice and technical assistance, within existing resources, upon request from a county or municipality; amending s.

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 1698
INTRODUCER:	Senator Dean
SUBJECT:	Onsite Sewage Treatment
DATE:	March 25, 2011 REVISED:

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

I. Summary:

This bill repeals the onsite sewage treatment and disposal system evaluation program, including program requirements, and the Department of Health's (DOH) attendant rulemaking authority to implement the program. The bill also repeals a prohibition against the land application of septage from onsite sewage and disposal systems along with a requirement that DOH provide a report to the Governor and Legislature recommending alternative methods of treatment and disposal and recommendations that would reduce the land application of septage.

This bill creates within the DOH, beginning January 1, 2012, an evaluation pilot program for onsite sewage and treatment and disposal systems. The pilot program is only to be implemented within certain counties identified by the Department of Environmental Protection (DEP). The bill provides the DOH with limited rulemaking authority to establish enforcement procedures, procedures to ensure consistent implementation, inspection and tracking procedures, and an evaluation form. The bill also provides the DOH with enforcement authority to administer the program.

This bill allows counties outside of the counties identified by the DEP to voluntarily participate in the pilot program, regardless if the participation is county-wide or in select areas of the county. The bill exempts counties from the program if the counties have their own inspection program by ordinance that has been in effect for at least 1 year.

This bill requires the owner of an onsite sewage treatment and disposal system within the county participating in the pilot program to have the system pumped out and evaluated at least once every 5 years. However, a pump out is not required if the owner can provide documentation to

show a pump out has been performed within the previous 5 years and the capacity and condition of the tank.

This bill requires an owner to repair, modify, or replace a system, depending on whether there is a system failure or obstruction and the owner is responsible for paying the cost of the repair, modification, or replacement.

This bill prescribes who is authorized to perform an evaluation or pump out. The system evaluator is required to collect and remit an evaluation report fee along with the required evaluation report to the DOH.

This bill requires the DOH to notify an owner of an onsite sewage treatment and disposal system within a certain time before the evaluation deadline that the owner's system is due for an evaluation. The DOH may include in its notice educational materials that provide information about the proper maintenance of onsite sewage treatment and disposal systems.

This bill requires the DOH and the DEP to collaborate to notify counties of federal program funds that are available under the Clean Water Act and collaborate to create a revolving loan program to provide low-interest loans to homeowners with failing systems.

This bill requires the DOH to contract with a qualified private entity to develop a uniform statewide computerized evaluation, tracking, and reporting system for each county participating in the pilot program. The system is to be continually updated and used to identify systems due for inspection.

This bill provides that a grant program will be available January 1, 2013 to assist low-income owners of onsite sewage treatment and disposal systems with the costs associated with any required inspection, pump out, repair, or system replacement. The bill also reduces the range of the fee amount that may be assessed by the DOH for an evaluation report.

This bill substantially amends the following sections of the Florida Statutes: 381.0065, 381.00656, and 381.0066.

This bill creates s. 381.00651, F.S.

II. Present Situation:

Nutrient Management in Florida's Water Bodies

With over 50,000 miles of rivers and streams, 7,800 lakes, and 4,000 square miles of estuaries, Florida has an abundance of surface waters that are used for a variety of purposes by the people who live and work in the state, by those who are visiting, and by the fish and wildlife that depend on these waters.[1]

[1] Florida Department of Environmental Protection, *Surface Water Quality Standards*, last updated on February 9, 2011, available at http://www.dep.state.fl.us/water/wqssp/index.htm (Last visited on March 24, 2011).

The Federal Clean Water Act[2] is the basis for state water quality standards programs. The federal regulatory requirements governing these programs are published in 40 CFR 131, the Water Quality Standards Regulation. States are responsible for reviewing, establishing, and revising water quality standards. Florida's surface water quality standards system is published in Chapter 62-302 and Rule 62-302.530 of the Florida Administrative Code (F.A.C.). The components of this system include: classifications; criteria, including site specific criteria; an anti-degradation policy; and special protection of certain waters.[3]

The DEP has initiated rulemaking to adopt quantitative nutrient water quality standards to facilitate the assessment of designated use attainment for its waters and to provide a better means to protect state waters from the adverse effects of nutrient pollution. The addition of excess nutrients, often associated with human alterations to watersheds, including leaking septic tanks,[4] can negatively impact water body health and interfere with designated uses of waters. Impacts include noxious tastes and odors in drinking water, algal blooms and excessive aquatic weeds in swimming and boating waters, and altering the natural community of flora and fauna.[5]

The DEP plans to develop numeric criteria for phosphorus and nitrogen and possibly for their response variables, recognizing the differences in Florida's hydrology and geology, the nutrient levels of the state's waters, and the variability in ecosystem response to nutrient concentrations. The DEP's preferred approach is to develop cause and affect relationships between nutrients and valued ecological attributes and to establish nutrient criteria that ensure that the designated uses of Florida's waters are maintained.[6]

Florida's law contains a narrative nutrient standard, which guides the management and protection of its waters. Rule 62-302.530, F.A.C., states, "In no case shall nutrient concentrations of a body of water be altered so as to cause an imbalance in natural populations of flora or fauna." The narrative criteria also states that, for all waters of the state, "the discharge of nutrients shall continue to be limited as needed to prevent violations of other standards contained in this chapter [Chapter 62-302, F.A.C.]. Man-induced nutrient enrichment (total nitrogen or total phosphorus) shall be considered degradation in relation to the provisions of Rules 62-302.300, 62-302.700, and 62-4.242, F.A.C."

The DEP has relied on this narrative for many years because nutrients are unlike any other "pollutant" regulated by the Federal Clean Water Act. Most water quality criteria are based on a toxicity threshold, evidenced by a dose-response relationship, where higher concentrations can be demonstrated to be harmful, and acceptable concentrations can be established at a level below

[2] 33 U.S.C. 1251 *et seq.*
[3] *Supra* fn. 1.
[4] Septic systems are designed to treat wastewater by separating solids from liquids and then draining the liquid into the ground. Sewage flows into the tank where settling and bacterial decomposition of larger particles takes place, while treated liquid filters into the soil. When system failures occur, untreated wastewater and sewage can be introduced into groundwater or nearby streams and water bodies. Source: *Pollution Prevention Fact Sheet: Septic System Controls*, available at http://www.stormwatercenter.net/Pollution_Prevention_Factsheets/SepticSystemControls.htm (Last visited on March 24, 2011).
[5] Florida Department of Environmental Protection, *Development of Numeric Nutrient Criteria for Florida's Waters*, last updated on November 15, 2010, available at http://www.dep.state.fl.us/water/wqssp/nutrients/ (Last visited on March 24, 2011).
[6] *Id.*

which adverse responses are seen. In contrast, nutrients are not only naturally present in aquatic systems, they are necessary for the proper functioning of life.[7]

The DEP actively worked with the U.S. Environmental Protection Agency (EPA) on the development of numeric nutrient criteria. The DEP submitted its initial Draft Numeric Nutrient Criteria Development Plan to the EPA in May 2002, and received mutual agreement on the Numeric Nutrient Criteria Development Plan from EPA in July 2004. The DEP revised its plan in September 2007 to more accurately reflect its evolved strategy and technical approach, and received mutual agreement on the 2007 revisions from the EPA.[8]

The Florida Wildlife Federation filed a lawsuit in 2008, seeking to require the EPA to promulgate numeric nutrient water quality standards for Florida waters. The EPA settled the lawsuit and entered into a consent decree with the Florida Wildlife Federation. After EPA's analyses of the facts in Florida, and discussions with the DEP on January 14, 2009, the EPA made a determination that numeric nutrient criteria in Florida were necessary to meet the requirements of the Federal Clean Water Act. The EPA determined that Florida's existing narrative criteria on nutrients in water was insufficient to ensure protection of the State's water bodies. The determination recognized that, despite Florida's intensive efforts to diagnose and control nutrient pollution, substantial water quality degradation from nutrient pollution remains a significant challenge in Florida and is likely to worsen with continued population growth and land-use changes. The January 14, 2009, EPA determination stated the EPA's intent to propose numeric nutrient standards for lakes and flowing waters in Florida within 12 months of the determination, and for estuaries and coastal waters, within 24 months of the determination.[9]

On November 14, 2010, EPA Administrator Lisa P. Jackson signed Final "Water Quality Standards for the State of Florida's Lakes and Flowing Waters." The final standards set numeric limits, or criteria, on the amount of nutrient pollution allowed in Florida's lakes, rivers, streams and springs. The final action seeks to improve water quality, protect public health, aquatic life and the long term recreational uses of Florida's waters, which are a critical part of Florida's economy. The rule will take effect on March 6, 2012 except for the site-specific alternative criteria (SSAC) provision, which is effective February 4, 2011. The EPA extended the effective date for the rule for 15 months to allow cities, towns, businesses and other stakeholders as well as the State of Florida a full opportunity to review the standards and develop flexible strategies for implementation.[10] The State of Florida is currently challenging the EPA standards in a lawsuit asking for declaratory and injunctive relief.[11]

There are several entities in Florida that research Florida's water quality or provide funding for such research. The Florida Water Pollution Control Financing Corporation (corporation) is a nonprofit public-benefit corporation that was created in 2001, to finance or refinance water

[7] *Id.*
[8] *Id.*
[9] U.S. Environmental Protection Agency, *Water Quality Standards for the State of Florida's Lakes and Flowing Waters*, January 2010, available at http://water.epa.gov/lawsregs/rulesregs/florida_factsheet.cfm (Last visited on March 24, 2011).
[10] *Id.*
[11] *State v. U.S. Environmental Protection Agency*, Case No. 3:10-cv-00503-RV-MD, U.S. District Court, Northern District of Florida, available at http://myfloridalegal.com/webfiles.nsf/WF/CRUE-8BWPPD/$file/epacompliant.pdf (Last visited on March 24, 2011).

pollution control activities.[12] The corporation's purpose is to issue bonds that increase the capacity of the State Revolving Fund to provide low-interest loans to local governments. Additionally, the University of Florida Water Institute (Institute) brings together talent from throughout the University of Florida to address complex water issues through innovative interdisciplinary research, education, and public outreach programs.[13] The Institute's vision is to create interdisciplinary teams, comprised of leading water researchers, educators, and students to develop scientific breakthroughs; engineer creative solutions for water problems; recommend policy and legal solutions for complex issues; and pioneer educational programs that are renowned for addressing state, national, and global water resource problems.[14]

Florida Senate Select Committee on Florida's Inland Waters

On October 7, 2009, Senate President Jeff Atwater created the Florida Senate Select Committee on Florida's Inland Waters. The task set before the committee was to travel the state and listen and learn from constituents. To that end, six meetings were scheduled around the state.[15]

In conjunction with the public hearings, the members of the committee and staff were invited on several site visits. Each site visited exemplified a unique challenge for Florida's water resources, from agricultural best-management practices to saltwater intrusion.[16]

At the end of the hearings, the select committee unanimously adopted a final report containing 13 recommendations, including the recommendation that the Legislature should consider the creation of regional management entities to effectuate a septic tank inspection and maintenance program and that counties and municipalities should have authority over the regional management entities.[17]

The Department of Health's Regulation of Septic Tanks

The DOH oversees an environmental health program as part of fulfilling the state's public health mission. The purpose of this program is to detect and prevent disease caused by natural and manmade factors in the environment. One component of the program is an onsite sewage treatment and disposal function.[18]

An "onsite sewage treatment and disposal system" is a system that contains a standard subsurface, filled, or mound drainfield system; an aerobic treatment unit; a graywater system tank; a laundry wastewater system tank; a septic tank; a grease interceptor; a pump tank; a solid or effluent pump; a waterless, incinerating, or organic waste-composting toilet; or a sanitary pit

[12] Chapter 2000-271, L.O.F.
[13] University of Florida Water Institute, *About*, last updated on December 15, 2010, available at http://waterinstitute.ufl.edu/about/index.html (Last visited on March 24, 2011).
[14] *Id.*
[15] Florida Senate Select Committee on Florida's Inland Waters, *Report on the Florida Senate Select Committee on Florida's Inland Waters*, Meeting Packet, March 11, 2010, available at http://waterinstitute.ufl.edu/symposium2010/downloads/FloridaSelectCommitteeonInlandWaterssummary.pdf (Last visited on March 24, 2011).
[16] *Id.*
[17] *Id.*
[18] Section 381.006, F.S. (2010).

privy that is installed or proposed to be installed beyond the building sewer on land of the owner or on other land to which the owner has the legal right to install a system. The term includes any item placed within, or intended to be used as a part of or in conjunction with, the system. The term does not include package sewage treatment facilities and other treatment works regulated under ch. 403, F.S.[19]

The DOH estimates there are approximately 2.6 million septic tanks in use statewide.[20] The DOH's Bureau of Onsite Sewage develops statewide rules and provides training and standardization for county health department employees responsible for permitting the installation and repair of onsite sewage treatment and disposal systems (septic tanks) within the state. The bureau also licenses septic tank contractors, approves continuing education courses and courses provided for septic tank contractors, funds a hands-on training center, and mediates onsite sewage treatment and disposal systems contracting complaints. The bureau manages a state-funded research program, prepares research grants, and reviews and approves innovative products and septic tank designs.[21]

In 2008, the Legislature directed the DOH to submit a report to the Executive Office of the Governor, the President of the Senate, and the Speaker of the House of Representatives by no later than October 1, 2008, which identifies the range of costs to implement a mandatory statewide 5-year septic tank inspection program to be phased in over 10 years pursuant to the DOH's procedure for voluntary inspection, including use of fees to offset costs.[22] This resulted in the "Report on Range of Costs to Implement a Mandatory Statewide 5-Year Septic Tank Inspection Program" (Report).[23] According to the report, three Florida counties, Charlotte, Escambia and Santa Rosa, have implemented mandatory septic tank inspections at a cost of $83.93 to $215 per inspection.

The Report stated that 99 percent of septic tanks in Florida are not under any management or maintenance requirements. Also, the Report found that while these systems were designed and installed in accordance with the regulations at the time of construction and installation, many are aging and by today's standards and may be under-designed. The DOH's statistics indicate that approximately 2 million septic tanks are 20 years or older, which is the average lifespan of a septic tank in Florida.[24] Because repairs of onsite systems were not regulated until 1987, many systems may have been unlawfully modified. Furthermore, 1.3 million onsite systems were installed prior to 1983 and a significant fraction of the pre-1983 systems may have been installed with a 6-inch separation from the bottom of the drainfield to the estimated seasonal high water

[19] Section 381.0065(2)(j), F.S. (2010).
[20] Florida Department of Health, *Onsite Sewage Treatment and Disposal Systems Installed in Florida*, available at http://www.myfloridaeh.com/ostds/statistics/newInstallations.pdf (Last visited on March 24, 2011).
[21] Department of Health Bureau of Onsite Sewage, *Description*, available at http://www.myfloridaeh.com/ostds/OSTDSdescription.html (Last visited on March 24, 2011).
[22] Chapter 2008-152, L.O.F.
[23] Florida Department of Health, *Report on Range of Costs to Implement a Mandatory Statewide 5-Year Septic Tank Inspection Program*, October 1, 2008, available at http://www.doh.state.fl.us/environment/ostds/pdfiles/forms/MSIP.pdf (Last visited on March 24, 2011).
[24] Department of Health, *Onsite Sewage Treatment and Disposal Systems in Florida (2010)*, available at http://www.doh.state.fl.us/Environment/ostds/statistics/newInstallations.pdf (Last visited on March 24, 2011). *See also* Department of Health, Bureau of Onsite Sewage, *What's New?*, available at http://www.doh.state.fl.us/environment/ostds/New.htm (Last visited on March 24, 2011).

table. The current water table separation requirement is 24 inches and is based on research findings compiled by the DOH in 1989 that indicate for septic tank effluent, the presence of at least 2 feet (24 inches) of unsaturated fine sandy soil is needed to provide a relatively high degree of treatment for most wastewater constituents. Therefore, Florida's pre-1983 systems may not provide the same level of protection expected from systems installed under current construction standards.[25]

Chapter 2010-205, Laws of Florida

In 2010, the Legislature enacted CS/CS/CS/SB 550, which became ch. 2010-205, Laws of Florida, and amended s. 381.0065, F.S. This newly enacted law provides for additional legislative intent on the importance of properly managing the State's septic tanks and creates a septic tank evaluation program. The DOH was to implement the evaluation program beginning January 1, 2011, with full implementation by January 1, 2016.[26] The evaluation program is to:

- Require all septic tanks to be evaluated for functionality at least once every 5 years.
- Provide proper notice to septic owners that their evaluations are due.
- Ensure proper separations from the wettest season water table.
- Specify the professional qualifications necessary to carry out an evaluation.

This law also establishes a grant program under s. 381.00656, F.S., for owners of septic tanks earning less than or equal to133 percent of the federal poverty level. The grant program is to provide funding for inspections, pump-outs, repairs, or system replacements. The DOH is authorized under the law to adopt rules to establish the application and award process for grant funds.

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

III. Effect of Proposed Changes:

SB 1698 effectively repeals the sections of ch. 2010-205, Laws of Florida, relating to the onsite sewage treatment and disposal system (septic tank) evaluation program. Instead, the bill creates a pilot program under which counties selected by the DEP must participate and under which other counties may elect to participate.

Section 1 amends s. 381.0056, F.S., by repealing legislative intent that proper management of onsite sewage treatment and disposal systems is paramount to the health, safety, and welfare of the public and legislative intent to have the DOH administer an evaluation program to ensure the proper operational condition of the State's onsite sewage treatment and disposal system and identify any failures of that system.

[25] *Id.*

[26] However, implementation was delayed until July 1, 2011, by the Legislature's enactment of SB 2-A (2010). *See also* ch. 2010-283, L.O.F.

This section also repeals the state-wide onsite sewage treatment and disposal system evaluation program, including the DOH's authority to administer, implement, and enforce the requirements of the program. Repealed provisions of the program also include the following program requirements:

- Owners of an onsite sewage treatment and disposal system, except those required to obtain an operating permit, must have the system evaluated at least once every 5 years to assess the functionality of the system or any failure within the system. However, those owners with documentation of a new installation, repair, or modification of their system within the last 5 years are exempt from the pump-out requirement, if such systems are determined not to be a public health nuisance.
- Evaluation procedures must be documented and include a tank and drainfield evaluation, a written assessment of the system's condition, and a disclosure statement if required by the DOH.
- Minimum separation standards from the bottom of the drainfield to the wettest season water table elevation for systems installed prior to January 1, 1983, and for systems installed on or after January 1, 1983.
- Owners are responsible for paying the cost of any system pump-out, repair, or replacement.
- Septic tank contractor professional requirements that must be met for an evaluation to be performed under the program.
- The payment of evaluation report fees to the DOH at the time the evaluation report is submitted.
- The DOH must provide a minimum 60 days' notice to owners that their systems must be evaluated.

This section also repeals a prohibition against the land application of septage from onsite sewage and disposal systems along with a requirement that DOH provide a report to the Governor and Legislature recommending alternative methods of treatment and disposal and recommendations that would reduce the land application of septage.

Section 2 creates s. 381.00651, F.S., to require the DOH, beginning January 1, 2012, to begin implementing and administering an evaluation pilot program for onsite sewage treatment and disposal systems in order to assess the fundamental operational condition of the systems and identify any system failures. The pilot program is only to be implemented within counties identified by the DEP as having a first magnitude spring[27] or an impaired watershed basin.

This section provides that the DOH has limited rulemaking authority to establish:

- Enforcement procedures for a system owner whose system does not comply with the evaluation program requirements or for a contractor who fails to timely submit the evaluation results to the DOH and the system owner.

[27] A "first-magnitude spring" means a spring that discharges at least 100 cubic feet of water per second (cfs), or about 64.6 million gallons per day (mgd). First-magnitude springs are the largest types of springs and there are 33 of these types of springs in Florida. This data is based on the January 2000 flyer from the Florida Department of Environmental Protection, *Status of the First Magnitude Springs in Florida*, compiled by Jim Stevenson and Frank Rupert, available at: http://apalacheehills.com/springs/Springbook/FirstMagnitude.htm (Last visited on March 24, 2011). *See also* Florida Geological Survey Open File Report No. 85, *First Magnitude Springs of Florida*, 2002, available at: http://publicfiles.dep.state.fl.us/FGS/WEB/listpubs/OFR-85.pdf (Last visited on March 24, 2011).

- Procedures necessary to ensure a uniform, orderly, and consistent implementation of the program by the DOH in affected counties, including volunteer counties.
- Inspection and tracking procedures and an evaluation form.

This section provides that the DOH has all of the enforcement powers granted under s. 381.0065(5), including the authority to issue citations and the right of entry to permitted entities or business premises; however, the DOH must obtain permission from the owner or occupant or secure an inspection warrant to gain entry to a residence or private building.

This section allows counties outside the pilot program area to elect to participate in the program, either county-wide or in specific areas of the county, by adopting an ordinance and providing written notice to the DOH. Counties that have established their own onsite sewage treatment and disposal inspection programs by ordinance, are not required to participate in the program. However, the county must show that the ordinance has been in effect for at least 1 year and it must provide written notice to the DOH.

This section requires any system owner subject to the program to have the system pumped out and evaluated at least once every 5 years to assess the fundamental operational condition of the system and to identify system failures. The term "system failure" is defined to mean a condition existing within an onsite sewage treatment and disposal system which results in the discharge of untreated or partially treated wastewater onto the ground surface or into surface water, or which results in the failure of building plumbing to discharge properly. A system failure does not exist solely because the system does not have the minimum separation distance between the drainfield and the wet season water table.

This section requires the DOH to adopt by rule an evaluation form that is developed by the DOH's technical review and advisory panel. The evaluation procedures must be documented by a contractor using the standardized form and at a minimum, the form must include a basic tank and drainfield evaluation and a written assessment of the condition of the system. The DOH is required to allow the contractor to submit the information required in the form via a secure Internet connection, which must be directly entered into a tracking and reporting database system.

This section provides that a pump out of a system is not required when a system owner provides documentation that the tank has been pumped out within the previous 5 years or the tank is a permitted new installation, repair, or modification of the system and the documentation states the capacity of the tank and that it is structurally sound and watertight.

This section also provides that the DOH must require a system to be repaired, modified, or replaced if the evaluation identifies a system failure, but the DOH must select the least costly remedial measure to repair or resolve the system failure. An obstruction in a sanitary line, an effluent screen, or a filter which prevents effluent from flowing into a drainfield is not a system failure. The system owner is responsible for paying for any required repair, modification, or replacement and such repair or modification must bring the system into compliance with the code in place at the time the system was originally permitted and installed.

This section requires evaluations or pump outs to be performed by a septic tank contractor or master septic tank contractor registered under part III of ch. 489, F.S.; a professional engineer licensed pursuant to ch. 471, F.S., who has experience with wastewater treatment systems; an environmental health professional certified under ch. 381, F.S., in the area of onsite sewage treatment and disposal system evaluation; or an employee working under the supervision of these individuals. The evaluator is required to remit the evaluation report along with the requisite fee to the DOH.

This section requires the DOH to provide notice to system owners at least 60 days before an evaluation deadline that their systems must be evaluated by the deadline. The DOH may include in its notice educational materials which provide information on the proper maintenance of onsite sewage treatment and disposal systems.

This section also requires the DOH and DEP to collaborate to notify counties of program funds available under s. 319 of the Clean Water Act and collaborate to create a revolving loan program modeled after the low-interest loan program of the state revolving fund which provides low-interest loans to residents for the repair of failing systems. Counties are encouraged to sponsor remediation of area-wide system failures and the DOH is required to provide assistance in the application process to those counties that participate in and establish low-interest loan programs for homeowners having failing systems.

This section requires the DOH to contract with a qualified private entity to develop a uniform statewide comprehensive computerized evaluation, tracking, and reporting system for each county that adopts a system evaluation program. The tracking system must identify within each county the address, location, and total number of onsite systems; document and categorize the number and types of failures; and assess the overall condition of systems using the information as reported and contained in the inspection form. The data collected must be continuously updated and used for the identification and categorization of onsite systems, used to identify systems due for inspection, and used to notify the DOH when the inspections are to take place.

Section 3 amends s. 381.00656, F.S., to require the DOH to administer a grant program, effective January 1, 2013, to assist low-income owners of onsite sewage treatment and disposal systems with the cost of required inspections, pump outs, repairs, or system replacements.

Section 4 amends s. 381.0066, F.S., to require system owners to pay a fee of not less than $10 or more than $15 to be used to fund the pilot program, including a fee up to $5 to be used toward the grant program under s. 381.00656, F.S.

Section 5 provides that the bill will take effect upon becoming a law.

Other Potential Implications:
If the onsite sewage treatment and disposal system evaluation program is not repealed, the DOH is statutorily required to implement the program beginning on July 1, 2011.[28]

[28] *Supra* fn. 26.

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:

Owners of onsite sewage treatment and disposal systems subject to the pilot program will have to pay to have their systems evaluated every 5 years, which would include an evaluation report fee up to $15 and any cost for pump-outs, repairs, or replacements of the system.

C. Government Sector Impact:

The cost of the pilot program is indeterminate as it depends on the number of counties that are identified by the DEP to be included in the program and the number of counties that elect to participate in the program. Any costs incurred by the DOH to implement the pilot program should be offset by the requisite evaluation report fee.

VI. Technical Deficiencies:

None.

VII. Related Issues:

This pilot program does not appear to have an expiration date or a date set for review of the program.

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 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.

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.

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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.

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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.;

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.

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LEGISLATIVE ACTION

Senate	.	House
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03/25/2011	.	
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The Committee on Health Regulation (Norman) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 790.338, Florida Statutes, is created to read:

790.338 Medical privacy concerning firearms; prohibitions; penalties; exceptions.—

(1)(a) A verbal or written inquiry by any public or private physician, nurse, or other medical staff person regarding the ownership of a firearm by a patient or the family of a patient or the presence of a firearm in a patient's home or other

domicile violates the privacy of the patient or the patient's family, respectively, and is prohibited.

(b) Any public or private physician, nurse, or other medical staff person may not condition receipt of medical treatment or medical care on a person's willingness or refusal to disclose personal and private information unrelated to medical treatment in violation of an individual's privacy as specified in this section.

(c) Any public or private physician, nurse, or other medical staff person may not intentionally, accidentally, or inadvertently enter any disclosed information concerning firearms into any record, whether written or electronic, or disclose such information to any other source.

(2)(a) A person who violates a provision of this section commits a noncriminal violation as defined in s. 775.08, punishable as provided in s. 775.082 or s. 775.083.

(b) If the court determines that the violation was knowing and willful or that the person committing the prohibited act, in the exercise of ordinary care, should have known the act was a violation, the court shall assess a fine of not less than $10,000 for the first offense, not less than $25,000 for the second offense, and not less than $100,000 for the third and subsequent offenses. The person found to have committed the violation shall be personally liable for the payment of all fines, costs, and fees assessed by the court for the noncriminal violation.

(3) The state attorney in the circuit where the violation is alleged to have occurred shall investigate complaints of noncriminal violations of this section and, where the state

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attorney determines probable cause that a violation exists, shall prosecute violators in the circuit court where the violation is alleged to have occurred. Any state attorney who fails to execute his or her duties under this section may be held accountable under the appropriate Florida rules of professional conduct.

(4) The state attorney shall notify the Attorney General of any fines assessed under this section, notwithstanding s. 28.246(6), and if a fine for a violation of this section remains unpaid after 90 days, the Attorney General shall bring a civil action to enforce the fine.

(5) Except as required by s. 16, Art. I of the State Constitution or the Sixth Amendment to the United States Constitution, public funds may not be used to defend the unlawful conduct of any person charged with a knowing and willful violation of this section.

(6) Notwithstanding any other provision of this section, it is not a violation for:

(a) Any psychiatrist as defined in s. 394.455, psychologist as defined in s. 490.003, school psychologist as defined in s. 490.003, clinical social worker as defined in s. 491.003, or public or private physician, nurse, or other medical personnel to make an inquiry prohibited by paragraph (1)(a) if the person making the inquiry in good faith believes that the possession or control of a firearm or ammunition by the patient or another member of the patient’s household would pose an imminent danger or threat to the patient or others.

(b) Any public or private physician, nurse, or other medical personnel to make an inquiry prohibited by paragraph

(1)(a) if such inquiry is necessary to treat a patient during the course and scope of a medical emergency which specifically includes, but is not limited to, a mental health or psychotic episode where the patient's conduct or symptoms reasonably indicate that the patient has the capacity of causing harm to himself, herself, or others.

(c) Any public or private physician, nurse, or other medical personnel to enter any of the information disclosed pursuant to paragraphs (a) and (b) into any record, whether written or electronic.

However, a patient's response to any inquiry permissible under this subsection shall be private and may not be disclosed to any third party not participating in the treatment of the patient other than a law enforcement officer conducting an active investigation involving the patient or the events giving rise to a medical emergency. The exceptions provided by this subsection do not apply to inquiries made due to a person's general belief that firearms or ammunition are harmful to health or safety.

(7) Medical records created on or before the effective date of this act do not violate this section, nor is it a violation of this section to transfer such records to another health care provider.

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:

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A bill to be entitled

An act relating to the privacy of firearms owners; creating s. 790.338, F.S.; prohibiting physicians or other medical personnel from inquiring, either verbally or in writing, about the ownership of a firearm by a patient or the family of a patient or the presence of a firearm in a patient's private home or other domicile; prohibiting conditioning the receipt of medical treatment or care on a person's willingness or refusal to disclose personal and private information unrelated to medical treatment in violation of an individual's privacy contrary to specified provisions; prohibiting entry of certain information concerning firearms into medical records or disclosure of such information by specified individuals; providing noncriminal penalties; providing for prosecution of violations; requiring informing the Attorney General of prosecution of violations; providing for collection of fines by the Attorney General in certain circumstances; providing exemptions; providing an effective date.

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LEGISLATIVE ACTION

Senate . House

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Paragraph (b) of subsection (4) of section 381.026, Florida Statutes, is amended to read:

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

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

(b) *Information.*—

1. A patient has the right to know the name, function, and

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qualifications of each health care provider who is providing medical services to the patient. A patient may request such information from his or her responsible provider or the health care facility in which he or she is receiving medical services.

2. A patient in a health care facility has the right to know what patient support services are available in the facility.

3. A patient has the right to be given by his or her health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis, unless it is medically inadvisable or impossible to give this information to the patient, in which case the information must be given to the patient's guardian or a person designated as the patient's representative. A patient has the right to refuse this information.

4. A patient has the right to refuse any treatment based on information required by this paragraph, except as otherwise provided by law. The responsible provider shall document any such refusal.

5. A patient in a health care facility has the right to know what facility rules and regulations apply to patient conduct.

6. A patient has the right to express grievances to a health care provider, a health care facility, or the appropriate state licensing agency regarding alleged violations of patients' rights. A patient has the right to know the health care provider's or health care facility's procedures for expressing a grievance.

7. A patient in a health care facility who does not speak

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English has the right to be provided an interpreter when receiving medical services if the facility has a person readily available who can interpret on behalf of the patient.

8. A patient may decline to answer or provide any information regarding the ownership of a firearm by the patient or by a family member of the patient or the presence of a firearm in a private home or other domicile of the patient or a family member of the patient. A patient's decision to decline to answer does not alter existing law regarding a physician's authorization to choose his or her patients.

9. A health care provider or health care facility shall respect a patient's legal right to own or possess a firearm and shall refrain from unnecessarily harassing a patient about firearm ownership during an examination.

Section 2. Paragraph (mm) is added to subsection (1) of section 456.072, Florida Statutes, to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(mm) Creating any type of list or database, without a patient's consent, relating to the lawful:

1. Ownership or possession of a firearm or ammunition;

2. Use of a firearm or ammunition; or

3. Storage of a firearm or ammunition.

For purposes of this paragraph, a list or database does not include an entry in a patient's individual medical record.

Section 3. Section 790.338, Florida Statutes, is created to

read:

790.338 Medical privacy concerning firearms; prohibitions; penalties; exceptions.—

(1) A health care provider licensed under chapter 456 or a health care facility licensed under chapter 395 may not intentionally enter any disclosed information concerning firearm ownership in a patient's medical record when the provider knows that such information is not relevant to the patient's medical care.

(2)(a) A person who violates this section commits a noncriminal violation as defined in s. 775.08, punishable as provided in s. 775.082 or s. 775.083.

(b) If the trial court determines that the violation was committed knowingly and willfully, the court shall assess a fine of not more than $5,000. The person who committed the violation is liable for the payment of all fines, costs, and fees assessed by the court for the noncriminal violation.

(c) The state attorney in the circuit where the violation is alleged to have occurred may investigate complaints of noncriminal violations of this section. If the state attorney determines probable cause that a violation exists, the state attorney may prosecute the violator in the circuit where the violation is alleged to have occurred.

Section 4. An insurer that issues any type of insurance policy or contract under chapter 627, Florida Statutes, may not deny coverage or increase any premium, or otherwise discriminate against any insured or applicant for insurance on the basis of, or upon reliance upon, the applicant's or insured's lawful:

(1) Ownership or possession of a firearm or ammunition; or

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(2) Use or storage of a firearm or ammunition.

Section 5. 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 privacy of firearm owners; amending s. 381.026, F.S.; providing that a patient may decline to answer or provide information to a health care facility or provider regarding firearm ownership; prohibiting a health care provider or facility from unnecessarily harassing a patient about firearm ownership; amending s. 456.072, F.S.; revising the list of grounds for which a health care practitioner may be disciplined to prohibit the creation of a list or database concerning the ownership, possession, use, or storage of a firearm by a patient; creating s. 790.338, F.S.; prohibiting certain health care providers and health care facilities from intentionally entering any disclosed information concerning firearm ownership in a patient's medical record under certain circumstances; providing a penalty; requiring the trial court to assess a fine if the health care provider or health care facility knowingly and willfully violates such prohibition; providing for payment of fines, costs, and fees that are assessed; authorizing the state attorney to

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investigate complaints of any violations and to prosecute any violators if there is probable cause; prohibiting certain insurers from denying insurance coverage or increasing their premiums based upon an applicant’s or insured’s lawful ownership or possession of a firearm or ammunition or the lawful use or storage of a firearm or ammunition; providing an effective date.

422568

LEGISLATIVE ACTION

Senate . House

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 790.338, Florida Statutes, is created to read:

790.338 Medical privacy concerning firearms; prohibitions; penalties, exceptions.—

(1) A health care provider licensed under chapter 456 or a health care facility licensed under chapter 395 may not intentionally enter any disclosed information concerning firearm ownership into the patient's medical record when the provider

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knows that such information is not relevant to the patient's medical care or safety.

(2) A health care provider licensed under chapter 456 or a health care facility licensed under chapter 395 shall respect a patient's right to privacy and should refrain from making a written inquiry or asking questions concerning the ownership of a firearm or ammunition by the patient or by a family member of the patient, or the presence of a firearm in a private home or other domicile of the patient or a family member of the patient. Notwithstanding this provision, a health care provider or health care facility that in good faith believes that this information is relevant to the patient's medical care or safety may make such a verbal or written inquiry.

(3) A patient may decline to answer or provide any information regarding ownership of a firearm by the patient or a family member of the patient, or the presence of a firearm in the domicile of the patient or a family member of the patient. A patient's decision not to answer a question relating to the presence or ownership of a firearm does not alter existing law regarding a physician's authorization to choose his or her patients.

(4) A health care provider licensed under chapter 456 or a health care facility licensed under chapter 395 may not discriminate against a patient based solely upon the patient's exercise of the constitutional right to own and possess firearms or ammunition.

(5) A health care provider licensed under chapter 456 or a health care facility licensed under chapter 395 shall respect a patient's legal right to own or possess a firearm and should

refrain from unnecessarily harassing a patient about firearm ownership during an examination.

(6) Violations of the provisions of subsections 1-4 of this section shall constitute grounds for disciplinary action under s. 456.072(2) and s. 395.1055.

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

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

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

(b) *Information.*—

1. A patient has the right to know the name, function, and qualifications of each health care provider who is providing medical services to the patient. A patient may request such information from his or her responsible provider or the health care facility in which he or she is receiving medical services.

2. A patient in a health care facility has the right to know what patient support services are available in the facility.

3. A patient has the right to be given by his or her health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis, unless it is medically inadvisable or impossible to give this information to the patient, in which case the information must be given to the patient's guardian or a person designated as the patient's representative. A patient has the right to refuse this information.

4. A patient has the right to refuse any treatment based on

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information required by this paragraph, except as otherwise provided by law. The responsible provider shall document any such refusal.

5. A patient in a health care facility has the right to know what facility rules and regulations apply to patient conduct.

6. A patient has the right to express grievances to a health care provider, a health care facility, or the appropriate state licensing agency regarding alleged violations of patients' rights. A patient has the right to know the health care provider's or health care facility's procedures for expressing a grievance.

7. A patient in a health care facility who does not speak English has the right to be provided an interpreter when receiving medical services if the facility has a person readily available who can interpret on behalf of the patient.

8. A health care provider or health care facility shall respect a patient's right to privacy and should refrain from making a written inquiry or asking questions concerning the ownership of a firearm or ammunition by the patient or by a family member of the patient, or the presence of a firearm in a private home or other domicile of the patient or a family member of the patient. Notwithstanding this provision, a health care provider or health care facility that in good faith believes that this information is relevant to the patient's medical care or safety may make such a verbal or written inquiry.

9. A patient may decline to answer or provide any information regarding ownership of a firearm by the patient or a family member of the patient, or the presence of a firearm in

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the domicile of the patient or a family member of the patient. A patient's decision not to answer a question relating to the presence or ownership of a firearm does not alter existing law regarding a physician's authorization to choose his or her patients.

10. A health care provider or health care facility may not discriminate against a patient based solely upon the patient's exercise of the constitutional right to own and possess firearms or ammunition.

11. A health care provider or health care facility shall respect a patient's legal right to own or possess a firearm and should refrain from unnecessarily harassing a patient about firearm ownership during an examination.

Section 3. Subsection (mm) is added to section 456.072(1), Florida Statutes, to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(mm) Violating any of the provisions of s. 790.338, Florida Statutes.

Section 4. Section 627.xxx, Florida Statutes, is created to read:

No insurer issuing any type of insurance policy pursuant to this chapter may deny coverage or increase any premium, or otherwise discriminate against any insured or applicant for insurance on the basis of, or upon reliance upon (i) the lawful ownership or possession of a firearm or ammunition or (ii) the lawful use or storage of a firearm or ammunition.


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Section 5. This act shall take effect upon becoming 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 the privacy of firearm owners; creating s. 790.338, F.S.; providing that a licensed medical care provider or health care facility may not record information regarding firearm ownership in a patient's medical record; providing an exception for relevance of the information to the patient's medical care or safety; providing that unless the information is relevant to the patient's medical care or safety, inquiries regarding firearm ownership or possession should not be made by licensed health care providers or health care facilities; providing that a patient may decline to provide information regarding the ownership or possession of firearms; clarifying that a physician's authorization to choose his or her patients is not altered by this subsection; prohibiting discrimination by licensed health care providers or facilities based solely upon a patient's firearm ownership or possession; prohibiting harassment of a patient regarding firearm ownership by a licensed health care provider or facility during an examination; providing for disciplinary action; amending s. 381.026, F.S.; providing that unless the

information is relevant to the patient's medical care or safety, inquiries regarding firearm ownership or possession should not be made by licensed health care providers or health care facilities; providing that a patient may decline to provide information regarding the ownership or possession of firearms; clarifying that a physician's authorization to choose his or her patients is not altered by this section; prohibiting discrimination by licensed health care providers or facilities based solely upon a patient's firearm ownership or possession; prohibiting harassment of a patient regarding firearm ownership during an examination by a licensed health care provider or facility; amending s. 456.072(1), F.S.; including the violation of the provisions of s. 790.338, F.S. as grounds for disciplinary action; creating an undesignated section of the Florida Statutes; prohibiting denial of insurance coverage, increased premiums, or any other form of discrimination by insurance companies issuing policies pursuant to ch. 627, F.S. on the basis of an insured's or applicant's ownership, possession, or storage of firearms or ammunition; 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 Criminal Justice Committee

BILL:	CS/SB 432
INTRODUCER:	Criminal Justice Committee and Senator Evers
SUBJECT:	Privacy of Firearm Owners
DATE:	February 22, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Cellon	Cannon	CJ	**Fav/CS**
2.			HR	
3.			JU	
4.			BC	
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 creates a noncriminal violation in circumstances where a public or private physician, nurse, or other medical staff person conditions receipt of medical treatment or care on a person's willingness or refusal to disclose "personal and private information unrelated to medical treatment" in violation of the privacy right created by the bill regarding ownership or possession of firearms.

The bill also creates a noncriminal violation where a public or private physician, nurse, or other medical staff person enters information concerning firearms into any record or otherwise discloses such information to any other source, whether intentionally, inadvertently, or accidentally.

The bill states that an inquiry of a patient or his or her family regarding the ownership or possession of firearms in the home by a public or private physician, nurse, or other medical staff person constitutes an invasion of privacy.

The state attorney is given responsibility for investigating and prosecuting the noncriminal violations.

The defendant may be assessed up to a $100,000 fine, on a third offense, if the court finds the violation is knowing and willful. The Attorney General is charged with filing suit to collect any fine that remains unpaid after 90 days.

Certain mental health care professionals as statutorily defined, and physicians, nurses, and other medical personnel are exempted from the provisions in the bill in cases where inquiries are reasonably necessary under emergency circumstances such as where the patient is exhibiting conduct that indicates the patient could pose an imminent threat to himself, herself, or others. The patient's response is private and shall not be disclosed to a third party, other than law enforcement conducting an active investigation, under the provisions of the bill.

The bill further exempts medical records created on or before the effective date of the bill from the prohibitions created by the bill.

This bill creates a new section of the Florida Statutes: 790.338.

II. Present Situation:

Physicians Inquiring About Firearms

In recent months, there has been media attention surrounding an incident in Ocala, Florida, where, during a routine doctor's visit, an Ocala pediatrician asked a patient's mother whether there were firearms in the home. When the mother refused to answer, the doctor advised her that she had 30 days to find a new pediatrician.[1] The doctor stated that he asked all of his patients the same question in an effort to provide safety advice in the event there was a firearm in the home.[2] He further stated that he asked similar questions about whether there was a pool at the home, and whether teenage drivers use their cell phone while driving for similar reasons – to give safety advice to patients. The mother, however, felt that the question invaded her privacy.[3] This incident has led many to question whether it should be an accepted practice for a doctor to inquire about a patient's firearm ownership.

Various professional medical groups have adopted policies that encourage or recommend that physicians ask patients about the presence of a firearm in the home. For example, the American Medical Association (AMA) encourages its members to inquire as to the presence of household firearms as a part of childproofing the home and to educate patients to the dangers of firearms to children.[4]

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[1] Family and pediatrician tangle over gun question, http://www.ocala.com/article/20100723/news/100729867/1402/news?p=1&tc=pg (last accessed January 27, 2011).
[2] *Id*.
[3] *Id*.
[4] H-145.990 Prevention of Firearm Accidents in Children https://ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=%2fama1%2fpub%2fupload%2fmm%2fPolicyFinder%2fpolicyfiles%2fHnE%2fH-145.990.HTM (last accessed January 28, 2011).

Additionally, the American Academy of Pediatrics (AAP) recommends that pediatricians incorporate questions about guns into their patient history taking.[5]

Florida law contains numerous provisions relating to the regulation of the medical profession, regulation of medical professionals, and the sale, purchase, possession, and carrying of firearms.[6] However, Florida law does not contain any provision that prohibits physicians or other medical staff from asking a patient whether he or she owns a firearm or whether there is a firearm in the patient's home.

Terminating the Doctor - Patient Relationship

The relationship between a physician and a patient is generally considered a private relationship and contractual in nature. According to the AMA, both the patient and the physician are free to enter into or decline the relationship.[7] Once a physician-patient relationship has been established, patients are free to terminate the relationship at any time.[8] Generally, doctors can only terminate existing relationships after giving the patient notice and a reasonable opportunity to obtain the services of another physician.[9] Florida's statutes do not currently contain any provisions that dictate when physicians and patients can terminate a doctor-patient relationship.

III. Effect of Proposed Changes:

The bill creates s. 790.338, F.S., entitled "Medical privacy concerning firearms." The bill specifies that a verbal or written inquiry by a public or private physician, nurse, or other medical staff person regarding the ownership of a firearm by a patient or the family of a patient or the presence of a firearm in a private home or other domicile of a patient or the family of a patient violates the privacy of the patient or the patient's family members.[10]

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[5] American Academy of Pediatrics: Firearm-Related Injuries Affecting the Pediatric Population. Pediatrics Vol. 105 No. 4 April 2000, pp. 888-895. http://aappolicy.aappublications.org/cgi/content/full/pediatrics;105/4/888 (last accessed January 28, 2011). See also American Academy of Pediatrics, Committee on Injury, Violence, and Poison Prevention, "TIIP (The Injury Prevention Program), A Guide to Safety Counseling in Office Practice", 1994.

[6] *See, e.g.*, Chapters 456, 458, 790, F.S.

[7] AMA Code of Medical Ethics, Opinion 9.12, *Patient-Physician Relationship: Respect for Law and Human Rights*, http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion912.shtml (last accessed February 7, 2011). Doctors who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, sexual orientation, gender identity, or any other basis that would constitute invidious discrimination.

[8] AMA's Code of Medical Ethics, Opinion 9.06 *Free Choice. http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion906.shtml* (last accessed February 7, 2011).

[9] A health care provider owes a duty to the patient to provide the necessary and appropriate medical care to the patient with due diligence and to continue providing those services until: 1) they are no longer needed by the patient; 2) the relationship is ended with the consent of or at the request of the patient; or 3) the health care provider withdraws from the relationship after giving the patient notice and a reasonable opportunity to obtain the services of another health care provider. The relationship typically terminates when the patient's medical condition is cured or resolved, and this often occurs at the last visit when the health care provider notes in his records that the patient is to return as needed. *See Saunders v. Lischkoff*, 188 So. 815 (Fla. 1939). *See also, Ending the Patient-Physician Relationship*, AMA White Paper http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/patient-physician-relationship-topics/ending-patient-physician-relationship.shtml (last accessed February 7, 2011); AMA's Code of Medical Ethics, Opinion 8.115 *Termination of the Physician-Patient Relationship. http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8115.shtml* (last accessed February 7, 2011).

[10] Invading someone's privacy is not a criminal act. However, there is a common law tort claim of invasion of privacy. *See Allstate Insurance Company v. Ginsberg*, 863 So.2d 156 (Fla. 2003) where the Florida Supreme Court reaffirms the four types of claims of invasion of privacy recognized by Florida courts: "As recognized in *Agency for Health Care*

The bill creates a noncriminal violation if a public or private physician, nurse, or other medical staff:

- Conditions receipt of medical treatment or care on a person's willingness or refusal to disclose personal and private information unrelated to medical treatment in violation of an individual's privacy, as specified in the bill.
- Enters any intentionally, accidentally, or inadvertently disclosed information concerning firearms into any record, whether written or electronic, or discloses such information to any other source.

The bill also provides that a person who violates s. 790.338, F.S., may be assessed a fine of no less than $10,000 for a first violation, $25,000 for a second violation, and $100,000 for a third violation if the court determines that the violation was knowing and willful.

The bill requires the state attorney with jurisdiction to investigate complaints of criminal violations of s. 790.338, F.S., and, if there is probable cause to indicate that a person may have committed a violation, to prosecute the violator and notify the Attorney General of the prosecution. The bill requires the Attorney General to bring a civil action to enforce any fine assessed if such fine is not paid after 90 days.

Certain mental health care professionals as statutorily defined, and physicians, nurses, and other medical personnel are exempted from the provisions in the bill in cases where inquiries are reasonably necessary under emergency circumstances such as where the patient is exhibiting conduct that indicates the patient could pose an imminent threat to himself, herself, or others. The patient's response is private and shall not be disclosed to a third party, other than law enforcement conducting an active investigation, under the provisions of the bill.

The bill further exempts medical records created on or before the effective date of the bill from the prohibitions created by the bill.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

Administration v. Associated Industries of Florida, Inc., 678 So.2d 1239, 1252 n. 20 (Fla.1996) (hereinafter *AHCA*), the four categories are: (1) appropriation-the unauthorized use of a person's name or likeness to obtain some benefit; (2) intrusion-physically or electronically intruding into one's private quarters; (3) public disclosure of private facts-the dissemination of truthful private information which a reasonable person would find objectionable; and (4) false light in the public eye-publication of facts which place a person in a false light even though the facts themselves may not be defamatory." As the dissenting opinion notes, the common law tort of invasion of privacy, or any common law tort is an area of the law that is subject to evolution. It would appear that SB 432 creates a new statutory category in the area of invasion of privacy torts.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

Although this bill states that inquiries by certain medical professionals about the ownership of a firearm or presence of a firearm in the home of a patient or his or her family violates the patient's or the family's privacy, it should not be forgotten that the individual's right to exercise free speech is only regulated in the most egregious of circumstances.

It should also be noted that any civil action that might ensue will likely raise issues surrounding personal, professional, and contractual obligations between the parties, and the weight given to a constitutionally-protected right (free speech) versus a right to privacy created by general law, as between the two parties.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

A public or private physician, nurse, or other medical staff person who is found to have violated the law created by the bill could be assessed up to a $100,000 fine for a third violation.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

The bill creates s. 790.338, F.S., to make it a noncriminal violation for a *public or private physician, nurse, or other medical staff* to do certain acts. The bill does not define these terms, nor are they defined in ch. 790, F.S. Defining these terms, or using a term already defined in Florida law such as "healthcare practitioner," would clarify to whom the penalties apply.

Also, the term "unrelated to medical treatment" on line 39 of the bill may create a loophole to prosecution in that the term invites challenge and argument as to what is or is not "unrelated."

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 Criminal Justice on February 22, 2011:

- Removes the criminal penalties from the bill and instead provides for noncriminal violations which could result in graduated fines for each successive violation of the prohibitions in the bill.
- Provides limited exemptions from the prohibitions in the bill in the course of emergency treatment, including mental health emergencies, and where certain mental health professionals believe it is necessary to inquire about firearm possession. The patient's response is only to be disclosed to others participating in the patient's treatment or to law enforcement conducting an active investigation of the events giving rise to a medical emergency.
- Provides an exemption for medical records created on or before the effective date of the bill.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate . House

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The Committee on Health Regulation (Diaz de la Portilla) recommended the following:

Senate Amendment

Delete lines 367 - 478
and insert:
2. The majority of the physicians who provide services in the clinic primarily provide interventional pain-management procedures or other surgical services;
3. The clinic is owned by a publicly held corporation whose shares are traded on a national exchange or on the over-the-counter market and whose total assets at the end of the corporation's most recent fiscal quarter exceeded $50 million;
4. The clinic is affiliated with an accredited medical

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school at which training is provided for medical students, residents, or fellows; or

~~5. The clinic does not prescribe or dispense controlled substances for the treatment of pain; or~~

5.~~6.~~ The clinic is owned by a corporate entity exempt from federal taxation under 26 U.S.C. s. 501(c)(3).

(b) Each clinic location shall be registered separately regardless of whether the clinic is operated under the same business name or management as another clinic.

(c) As a part of registration, a clinic must designate a physician who is responsible for complying with all requirements related to registration and operation of the clinic in compliance with this section. Within 10 days after termination of a designated physician, the clinic must notify the department of the identity of another designated physician for that clinic. The designated physician shall have a full, active, and unencumbered license under this chapter or chapter 459 and shall practice at the clinic location for which the physician has assumed responsibility. Failing to have a licensed designated physician practicing at the location of the registered clinic may be the basis for a summary suspension of the clinic registration certificate as described in s. 456.073(8) for a license or s. 120.60(6).

(d) The department shall deny registration to any clinic that is not fully owned by a physician licensed under this chapter or chapter 459 or a group of physicians, each of whom is licensed under this chapter or chapter 459; or that is not a health care clinic licensed under part X of chapter 400.

(e) The department shall deny registration to any

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controlled-substance medical ~~pain-management~~ clinic owned by or with any contractual or employment relationship with a physician:

1. Whose Drug Enforcement Administration number has ever been revoked.

2. Whose application for a license to prescribe, dispense, or administer a controlled substance has been denied by any jurisdiction.

3. Who has been convicted of or pleaded guilty or nolo contendere to, regardless of adjudication, an offense that constitutes a felony for receipt of illicit and diverted drugs, including a controlled substance listed in Schedule I, Schedule II, Schedule III, Schedule IV, or Schedule V of s. 893.03, in this state, any other state, or the United States.

(f) If the department finds probable cause that a controlled-substance medical ~~pain-management~~ clinic does not meet the requirement of paragraph (d) or is owned, directly or indirectly, by a person meeting any criteria listed in paragraph (e), the department shall revoke the certificate of registration previously issued by the department. As determined by rule, the department may grant an exemption to denying a registration or revoking a previously issued registration if more than 10 years have elapsed since adjudication. As used in this subsection, the term “convicted” includes an adjudication of guilt following a plea of guilty or nolo contendere or the forfeiture of a bond when charged with a crime.

(g) The department may revoke the clinic’s certificate of registration and prohibit all physicians associated with that controlled-substance medical ~~pain-management~~ clinic from

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practicing at that clinic location based upon an annual inspection and evaluation of the factors described in subsection (3) and upon a final determination by the probable cause panel of the appropriate board that any physician associated with that controlled-substance medical clinic knew or should have known of any violations of the factors described in subsection (3).

(h)1. If the registration of a controlled-substance medical ~~pain-management~~ clinic is revoked or suspended, the designated physician of the controlled-substance medical ~~pain-management~~ clinic, the owner or lessor of the controlled-substance medical ~~pain-management~~ clinic property, the manager, and the proprietor shall cease to operate the facility as a controlled-substance medical ~~pain-management~~ clinic as of the effective date of the suspension or revocation.

2. Notwithstanding subparagraph 1., the clinic's registration shall not be revoked or suspended if the clinic, within 24 hours after notification of suspension or revocation, appoints another designated physician who has a full, active, and unencumbered license under this chapter or chapter 459 to operate a controlled-substance medical clinic.

(i) If a controlled-substance medical ~~pain-management~~ clinic registration is revoked or suspended, the designated physician of the controlled-substance medical ~~pain-management~~ clinic, the owner or lessor of the clinic property, the manager, or the proprietor is responsible for removing all signs and symbols identifying the premises as a controlled-substance medical ~~pain-management~~ clinic.

(j) Upon the effective date of the suspension or revocation, the designated physician of the controlled-substance

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medical ~~pain-management~~ clinic shall advise the department of the disposition of the medicinal drugs located on the premises. The disposition is subject to the supervision and approval of the department. Medicinal drugs that are purchased or held by a controlled-substance medical ~~pain-management~~ clinic that is not registered may be deemed adulterated pursuant to s. 499.006.

(k) If the clinic's registration is revoked, any person named in the registration documents of the controlled-substance medical ~~pain-management~~ clinic, including persons owning or operating the controlled-substance medical ~~pain-management~~ clinic, may not, as an individual or as a part of a group, apply to operate a controlled-substance medical ~~pain-management~~ clinic for 5 years after the date the registration is revoked upon a finding of probable cause, and an opportunity to be heard, that the persons operating such clinic knew or should have known of the violations causing such revocation.

827164

LEGISLATIVE ACTION

Senate . House

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

Senate Amendment (with title amendment)

Delete lines 1102 - 1682

and insert:

Section 10. Section 893.055, Florida Statutes, is repealed.

Section 11. Section 893.0551, Florida Statutes, is repealed.

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

And the title is amended as follows:

Delete lines 72 - 127

and insert:

827164

repealing s. 893.055, F.S., relating to the prescription drug monitoring program; repealing s. 893.0551, F.S., relating to the public records exemption for the prescription drug monitoring program; providing an effective

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 1386
INTRODUCER:	Senator Bogdanoff
SUBJECT:	Controlled Substances
DATE:	March 24, 2011 REVISED:

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

I. Summary:

The bill changes the name of pain-management clinics to controlled-substance medical clinics (CS medical clinic). The bill revises the conditions requiring registration of a CS medical clinic. Under this bill a facility that employs a physician who prescribes on any given day more than 25 prescriptions of Schedule II and/or Schedule III controlled substances or employs a physician who dispenses controlled substances, with certain exceptions, must register. An additional exception for registration is provided when a majority of the physicians who provide services in the clinic primarily provide interventional pain procedures of the type routinely billed using surgical codes.

The bill prohibits a CS medical clinic from advertising services related to the dispensing of medication and adds provisions for a determination by a probable cause panel before the Department of Health (department) may take certain actions with respect to issuing a registration or revoking or suspending a registration. The bill prevents the department from revoking or suspending a CS medical clinic's registration if the clinic appoints, within a designated time frame, another designated physician to operate the clinic.

The bill authorizes an advanced registered nurse practitioner or a physician assistant to perform the patient's examination prior to and on the same day that the physician dispenses or prescribes controlled substances in a CS medical clinic. A physician is prohibited from dispensing more than a 30-day supply of controlled substances to any patient. The requirement to document in the patient's file the reason for prescribing or dispensing more than a 72-hour dose and the prohibition on dispensing more than a 72-hour supply of controlled substances in a clinic for a patient who pays for the medication by cash, check, or credit card are repealed. The bill also

repeals the requirement that effective July 1, 2012, physicians working in a clinic must have completed a pain medicine fellowship or a pain-medicine residency.

The bill requires a subpoena prior to the department obtaining patient records from a CS medical clinic when conducting investigations and a law enforcement agency must obtain a subpoena prior to accessing information in the Prescription Drug Monitoring Program (PDMP) database for investigations.

The bill authorizes the electronic transmission of patient advisory reports and requires certain health care professionals to review the reports before a controlled substance is dispensed to a patient. In addition, the PDMP database must be reviewed prior to prescribing or dispensing any controlled substance to a patient.

The time period for reporting that a controlled substance has been dispensed is reduced to 24-hours after the controlled substance is dispensed.

The bill extends until December 1, 2012, the date in which the prescription drug monitoring database is to be operational.

Reference to the Office of Drug Control and the director in the section of law relating to the PDMP are replaced with the department and the State Surgeon General.

The bill modifies the definition of a clinic under part X of ch. 400, F.S., so that the Agency for Health Care Administration (agency) may register clinics in which all health care services are paid for since currently the agency only licenses clinics that seek reimbursement from third parties.

This bill substantially amends, creates, or repeals the following sections of the Florida Statutes: 400.9905, 456.037, 456.057, 458.3265, 458.327, 458.331, 459.0137, 459.015, 465.0276, 893.055, and 893.0551.

II. Present Situation:

Prescription drug abuse is the most threatening substance abuse issue in the State of Florida.[1] The number of deaths caused by at least one prescription drug increased from 1,234 in 2003 to 2,488 in 2009 (a 102 percent increase). This translates to seven Floridians dying per day. The drugs that caused the most deaths were oxycodone; all benzodiazepines, including alprazolam; methadone; ethyl alcohol; cocaine; morphine; and hydrocodone.

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.

[1] *Florida Office of Drug Control 2010 Annual Report*, prepared by the Executive Office of the Governor.

- 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.
- 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.[2] 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.[3]

Dispensing, Prescribing, and Administering

"Dispense" means the transfer of possession of one or more doses of a medicinal drug by a pharmacist or other licensed practitioner to the ultimate consumer thereof or to one who represents that it is his or her intention not to consume or use the same but to transfer the same to the ultimate consumer or user for consumption by the ultimate consumer or user.[4]

"Prescribing" is issuing a prescription. For purposes of the bill, a "prescription" includes an order for drugs that is written, signed, or transmitted by word of mouth, telephone, telegram, or other means of communication by a practitioner licensed by the laws of the state to prescribe such drugs, issued in good faith and in the course of professional practice, intended to be filled or dispensed by another person licensed to do so.[5]

"Administer," for purposes of the bill, means the direct application of a controlled substance, whether by injection, inhalation, ingestion, or any other means, to the body of a person.[6]

[2] s. 893.04(1)(f), F.S.
[3] s. 893.04(2)(e), F.S.
[4] s. 893.02(7), F.S.
[5] s. 893.02(20), F.S.
[6] s. 893.02(1), F.S.

Dispensing Practitioner

Chapter 465, F.S., relating to the practice of pharmacy, contains the provisions for a dispensing practitioner.[7] Under this chapter, a practitioner authorized by law to prescribe drugs may dispense those drugs to his or her patients in the regular course of his or her practice. If a practitioner intends to dispense drugs for human consumption for a fee or remuneration of any kind, the practitioner must register with his or her professional licensing board as a dispensing practitioner, comply with and be subject to all laws and rules applicable to pharmacists and pharmacies, and give the patient a written prescription and advise the patient that the prescription may be filled in the practitioner's office or at any pharmacy.

A dispensing practitioner is prohibited from dispensing more than a 72-hour supply of a controlled substance for any patient in a pain-management clinic who pays for the medication by cash, check, or credit card, except if the controlled substance is dispensed:

- To a workers' compensation patient;
- To an insured patient who pays a copayment or deductible with cash, check, or credit card; or
- As a complimentary package to the practitioner's own patient without remuneration of any kind, whether direct or indirect.[8]

Practitioners in Florida who are authorized to prescribe prescription drugs include medical physicians, physician assistants, osteopathic physicians, advanced registered nurse practitioners, podiatrists, naturopathic physicians, dentists, and veterinarians.

However, s. 893.02, F.S., of the Florida Controlled Substances Act, defines which practitioners may prescribe a controlled substance under Florida law. A "practitioner" is defined to mean a licensed medical physician, dentist, veterinarian, osteopathic physician, naturopathic physician, or podiatrist, if such practitioner holds a valid federal controlled substance registry number. Accordingly, the prescribing of controlled substances is a privilege that is separate from the regulation of the practice of the prescribing practitioner.

Regulation of Pain-Management Clinics

Chapter 2010-211, Laws of Florida, (the pill mill bill) was enacted to more aggressively regulate pain-management clinics. The requirement to register pain-management clinics and initial regulation was enacted by the 2009 Legislature.[9]

The pill mill bill requires businesses that meet the definition of a pain-management clinic to register with the department, unless exempted from registration. Ownership of pain-management clinics is limited to allopathic physicians, osteopathic physicians, or groups of allopathic physicians and osteopathic physicians, and health care clinics that are licensed under part X of ch. 400, F.S.

[7] s. 465.0276, F.S.
[8] s. 465.0276(1)(b), F.S., enacted in 2010-211.
[9] *See* sections 3 and 4 of ch. 2009-198, L.O.F.

Each pain-management clinic must designate a physician who is responsible for complying with all requirements related to registration and operation of the clinic in compliance with the law. Only a physician licensed under ch. 458, F.S., relating to the practice of medicine, (The Medical Practice Act), or ch. 459, F.S., relating to the practice of osteopathic medicine may dispense a controlled substance on the premises of a registered pain-management clinic.

The pill mill bill requires allopathic physicians and osteopathic physicians practicing in a pain-management clinic to comply with specific provisions, including but not limited to:

- Performing a physical examination of a patient on the same day that he or she dispenses or prescribes a controlled substance;
- Documenting in a patient's record the reason for prescribing or dispensing more than a 72-hour dose of controlled substances for the treatment of chronic nonmalignant pain,[10] if he or she prescribes or dispenses in excess of that quantity; and
- Maintaining control and security of his or her prescription blanks and any other method used for prescribing controlled substances, and notifying the department within 24 hours following a theft, loss, or breach of these instruments.

The pill mill bill provides for various forms of enforcement against a pain-management clinic or practitioner through administrative means including fines and suspension or revocation of a license and through the imposition of criminal penalties. The additional criminal violations created include: a third degree felony to knowingly operate, own, or manage a non-registered pain-management clinic that is required to be registered; a first degree misdemeanor to knowingly prescribe or dispense, or cause to be prescribed or dispensed, controlled substances in an unregistered pain-management clinic that is required to be registered; and a third degree felony to dispense more than a 72-hour supply of controlled substances to a patient in a pain-management clinic who pays for the medication by cash, check, or credit card.

Prescription Drug Monitoring Program (PDMP)

Chapter 2009-197, L.O.F, established the PDMP in s. 893.005, F.S. This law requires the department, by December 1, 2010, to design and establish a comprehensive electronic system to monitor the prescribing and dispensing of certain controlled substances. Prescribers and dispensers of certain controlled substances must report specified information to the department for inclusion in the system. Vendor protests to the procurement process for a contractor to develop the PDMP have delayed implementation of the PDMP database.

Data regarding the dispensing of each controlled substance must be submitted to the department no more than 15 days after the date the drug was dispensed, by a procedure and in a format established by the department, and must include minimum information specified in s. 893.005, F.S. Any person who knowingly fails to report the dispensing of a controlled substance commits a first degree misdemeanor. This law provides exemptions from the data reporting requirements for controlled substances when specified acts of dispensing or administering occur.

[10] Chronic nonmalignant pain is defined as pain unrelated to cancer which persists beyond the usual course of the disease or the injury that is the cause of the pain or more than 90 days after surgery. *See* s. 458.3265(4), F.S., and s. 459.0137(4), F.S.

Section 893.0551, F.S., enacted at the same time, provides for a public records exemption for certain personal information of a patient and certain information concerning health care professionals. This section sets forth enumerated exceptions for disclosure of this information after the department ensures the legitimacy of the person's request for the information.

As of July 2010, 34 states have operational PDMPs that have the capacity to receive and distribute controlled substance prescription information to authorized users. States with operational programs include: Alabama, Arizona, California, Colorado, Connecticut, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Nevada, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, and Wyoming. Washington State's PDMP was operational but has been suspended due to fiscal constraints.[11]

Seven states, Alaska, Florida, Kansas, New Jersey, Oregon, South Dakota and Wisconsin and one U.S. territory (Guam) have enacted legislation to establish a PDMP, but are not fully operational. Delaware has legislation pending to establish a PDMP.

Health Care Clinics

Currently, cash-only health care clinics are not licensed by the agency. A "clinic" as defined in s. 400.9905(4), F.S., means an entity at which health care services are provided to individuals and which tenders charges for reimbursement for such services.… This definition applies only to clinics that seek reimbursement from third-party payers, such as insurance, Medicaid, Medicare, etc. Cash-only or point-of-sale clinics are not covered by this definition.

The agency indicates it has licensed approximately 200 health care clinics that are pain-management clinics which are not fully owned by medical or osteopathic physicians.[12]

III. Effect of Proposed Changes:

Section 1 amends s. 400.9905, F.S., to revise the definition of "clinic" and "portable equipment provider" for purposes of the licensure of health care clinics by the agency. "Clinic" is defined to mean an entity at which health care services are provided to individuals and which tenders charges for reimbursement *or payment* for such services, including a mobile clinic and a portable equipment provider. The definition of "portable medical equipment provider" deletes the modifier that a portable equipment provider bills third-party payors for providing portable equipment to multiple locations performing treatment or diagnostic testing of individuals.

Section 2 amends s. 456.037, F.S., to change the name of pain-management clinics to controlled-substance medical clinics.

Section 3 amends s. 456.057, F.S., to require the department to obtain a subpoena prior to obtaining patient records from a CS medical clinic when investigating a violation of the laws

[11] *Id.*

[12] Agency 2011 Bill Analysis & Economic Impact Statement for SB 818, on file with the Senate Health Regulation Committee. A similar

regulating CS medical clinics. The bill clarifies that neither patient authorization nor notification to the patient is required.

Section 4 and Section 7 amend s. 458.3265, F.S., and s. 459.0137, F.S., respectively, to change the definition of the conditions subjecting a facility to regulation as a CS medical clinic. A facility that employs a physician who prescribes on any given day more than 25 prescriptions of Schedule II or Schedule III controlled substance medications, or a combination thereof, or employs a physician, who dispenses controlled substances, must register. An additional exemption to registration is included for a clinic in which the majority of the physicians who provide services in the clinic primarily provide interventional pain-management procedures.

The exemption in existing law for a clinic that does not prescribe or dispense controlled substances for the treatment of pain is repealed since it is unnecessary due to the change in the criteria requiring registration.

The bill prohibits a CS medical clinic from advertising services related to the dispensing of medication.

The bill adds requirements for a hearing by the probable cause panel before the department may find that a CS medical clinic does not meet some of the criteria for registration or before the department may revoke a registration. The criteria for registration include:

- A CS medical clinic must be owned by an allopathic physician, osteopathic physician, or group thereof, or be licensed as a health care clinic by the AHCA and
- Registration is to be denied if a CS medical clinic is owned by or has a contractual or employment relationship with a physician:
  - Whose DEA number has ever been revoked,
  - Whose application for a license to prescribe, dispense, or administer a controlled substance has been denied by any jurisdiction, or
  - Who has been convicted of or pleaded guilty or nolo contendere to, regardless of adjudication, an offense that constitute a felony for receipt of illicit and diverted drugs, including any controlled substances in this state, any other state, or the United States.

The probable cause panel of the appropriate board must find that any physician associated with the CS medical clinic whose registration is under review for revocation, knew or should have know of any of the violations at the CS medical clinic related to the patient records or rules adopted by the boards or department related to CS medical clinics.

The bill prevents the department from revoking or suspending a CS medical clinic's registration if, within 24 hours after the clinic is notified of the suspension or revocation, the clinic appoints another designated physician to operate the CS medical clinic. In addition, if a CS medical clinic's registration is revoked, any person named in the registration documents may not apply to operate another CS medical clinic for 5 years after the date the registration is revoked upon a finding by the probable cause panel, and an opportunity to be heard, that the person operating the clinic whose registration was revoked knew or should have known of the violations causing the revocation.

The bill repeals the requirement that effective July 1, 2012, unless grandfathered in, a physician practicing in a pain-management clinic must have completed a pain-management fellowship or residency.

A physician, advanced registered nurse practitioner, or physician assistant must perform an appropriate medical examination prior to or on the same day that the physician dispenses or prescribes a controlled substance in a pain management clinic.

Instead of requiring a physician who prescribes or dispenses more than a 72-hour dose of controlled substances for the treatment of chronic nonmalignant pain to document in the patient's record the reason for prescribing or dispensing that quantity, a physician is prohibited from dispensing more than a 30-day supply of controlled substances to any patient.

The authority for the boards to adopt rules establishing the maximum number of prescriptions for Schedule II or Schedule III controlled substances or Alprazolam that may be written in a clinic during any 24-hour hour period is repealed. Also, the rulemaking authority for training requirements for all facility health care practitioners who are not regulated by another board is repealed.

Additional conforming changes are included in the bill.

Section 5 amends s. 458.327, F.S., related to penalties for violations, to conform this section to other changes made in the bill.

Section 6 and Section 8 amend s. 458.331, F.S., and s. 459.015, F.S., respectively, to repeal one of the grounds upon which disciplinary action may be taken against the designated physician of a CS medical clinic. This provision relates to being convicted of, or disciplined by a regulatory agency of the Federal Government or a regulatory agency of another state for, any offense that would constitute a violation of ch. 458, F.S., or ch. 459, F.S., as applicable to the licensed physician.

Section 9 amends s. 465.0276, F.S., relating to dispensing practitioners in the Pharmacy Practice Act to repeal the limitation on dispensing more than a 72-hour supply of a controlled substances in a pain-management clinic for a patient who pays for the medication by cash, check, or credit card.

Section 10 amends s. 893.055, F.S., related to the prescription drug monitoring program. The bill authorizes a patient advisory report from the prescription drug monitoring database to be provided electronically to a CS medical clinic and its employed physicians, an ARPN, PA, pharmacy or a patient. These persons are required to review each patient advisory report before any controlled substance is dispensed to a patient. The dispenser and practitioners employed at or practicing at a CS medical clinic also are required to review the prescription drug monitoring database before prescribing or dispensing any controlled substance to a patient. Further, if the dispenser identifies or has any issues or concerns regarding the dispensing of the controlled substances, the dispenser is required to immediately contact the prescriber before dispensing the controlled substances.

This section adds the same definition of a CS medical clinic as used in s. 458.3265, F.S., of the Medicaid Practice Act and s. 459.0137, F.S., of the Osteopathic Medicaid Practice Act. The bill extends until December 1, 2012, the date in which the prescription drug monitoring database is to be operational.

The responsibilities of the program manager for the PDMP are expanded to include developing rules, in consultation with others, that are appropriate for identifying indicators of the diversion of controlled substances.

The time period for reporting that a controlled substance has been dispensed is reduced from 15 days to 24 hours after the controlled substance is dispensed.

The conditions under which a law enforcement agency may request, and may be granted access by the program manager to, confidential information in the database is limited to upon determination that probably cause exists that a crime is being committed and issuance of a search warrant regarding the potential criminal activity, fraud, or theft regarding prescribed controlled substances. Current law authorizes the request and release during active investigations regarding potential criminal activity, fraud, or theft regarding prescribed controlled substances.

The bill authorizes the registration fees for CS medical clinics to help fund the administration of the PDMP.

References within this section of law to the Office of Drug Control and the director of that office are replaced with the department and the State Surgeon General. A provision for the reversion of moneys that are received from rentals of certain state facilities and properties which are authorized to be held in a separate depository account in the name of the direct-support organization is eliminated in the bill.

The deadline for the department's rulemaking to administer the PDMP is extended until December 1, 2011.

Section 11 amends s. 893.0551, F.S., to conform the provisions related to the public records exemption for the PDMP with the change made concerning access by a law enforcement agency to confidential information must be pursuant to a search warrant rather than as part of an active investigation.

Section 12 provides an effective date for the act 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 modify the conditions under which release of information that has been made confidential and exempt from the public records requirements of Art. I, s. 24(a) and (b) of the Florida Constitution may be made to a law enforcement agency.

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:

The advertising restriction in lines 352 through 356 may violate the First Amendment to the United States Constitution and Article I, Section 4 of the Florida Constitution.

The Central Hudson Test is the standard used for determining the constitutionality of a restriction on commercial speech.[13] The four prongs of the *Central Hudson* test, as modified by *Board of Trustees of State Univ. of New York v. Fox*, 492 U.S. 469, 109 S.Ct. 3028, 106 L.Ed.2d 388 (1989), are: (1) whether the speech at issue is not misleading and concerns lawful activity; (2) whether the government has a substantial interest in restricting that speech; (3) whether the regulation directly advances the asserted governmental interest; and (4) whether the regulation is narrowly tailored, but not necessarily the least restrictive means available, to serve the asserted governmental interest.

Article I, Section 4 of the Florida Constitution, related to Freedom of speech and press states:

> Every person may speak, write and publish sentiments on all subjects but shall be responsible for the abuse of that right. No law shall be passed to restrain or abridge the liberty of speech or of the press. In all criminal prosecutions and civil actions for defamation the trust may be given in evidence. If the matter charged as defamatory is true and was published with good motives, the party shall be acquitted or exonerated.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

The bill authorizes registration fees for CS medical clinics but does not set a fee or range of fees, or indicate the purpose of the registration fees.

[13] *See:* ***Central Hudson Gas*** *& Elec. Corp. v. Public Service Com'n*, 447 U.S. 557, 100 S.Ct. 2343, 65 L.Ed.2d 341 (1980)

B. Private Sector Impact:

The modification to the definition of clinics in section 1 of the bill might cause additional clinics to meet the criteria for mandatory registration or exclude certain clinic from registration.

Requiring certain findings by a probable cause panel or authorizing a CS medical clinic to replace its designated physician within 24 hours after notification of an intended suspension or revocation of the registration may provide some additional protections for a CS medical clinic obtaining or maintaining registration in order to conduct business in the state.

C. Government Sector Impact:

A law enforcement agency will be required to obtain a search warrant based on probable cause before being granted access to confidential information in the PDMP database. This may prolong an investigation of potential criminal activity, fraud, or theft regarding prescribed controlled substances. Similarly, the department is required to obtain a subpoena prior to obtaining patient records from a CS medical clinic when investigating a violation of the laws regulating CS medical clinics.

VI. Technical Deficiencies:

Section 459.013, F.S., relating to penalties for violations under the Osteopathic Medical Act refers to pain-management clinics, but this bill does not rename pain-management clinics in that section of law as controlled-substance medical clinics.

VII. Related Issues:

Lines 418-419 refer to the department making a finding upon a hearing by the probable cause panel. The department does not have probable cause panels; probable cause panels operate in conjunction with the boards.

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 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.

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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

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certain circumstances; providing an effective date.

260894

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
03/28/2011	.	
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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.