The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	CS/SB 1292
INTRODUCER:	Health Regulation Committee and Senator Bogdanoff
SUBJECT:	Health Care Facilities
DATE:	February 16, 2012 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Davlantes	Stovall	HR	**Fav/CS**
2.			CF	
3.			BC	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

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

I. Summary:

This bill revises certain definitions relating to nursing homes and deletes certain requirements relating to sharing programming and staff between nursing homes, continuing care facilities, and retirement communities offering home health, assisted living, or adult day care services. The bill provides various criteria for respite care in nursing home facilities. The bill allows any licensed nursing home to provide services, including respite care, therapeutic spa, and adult day care services to nonresidents, with certain requirements relating to adult day care services provided.

The bill provides clarification for the meaning of "day" as it relates to monitoring of adult day care center programs co-located with licensed nursing homes. The bill allows a continuing care facility to petition the agency to designate a certain number of its sheltered nursing home beds to provide assisted living, rather than extended congregate care, if the beds are in a distinct area of the facility which can be adapted to meet the requirements for an assisted living facility. The bill creates an exemption from the moratorium on issuing certificates of need to nursing homes to allow construction of a training nursing home meeting certain conditions. The bill simplifies the types of entities who may not give kickbacks to ALFs to include any person, health care provider, or health care facility and provides certain exceptions.

The bill excludes pain related to sickle-cell anemia from the definition of chronic nonmalignant pain in chs. 458 and 459, F.S., and allows clinics owned by certain types of physicians to be exempt from registration as pain management clinics under these chapters.

This bill amends ss. 400.021, 400.141, 408.036, 429.195, 429.905, 458.3265, 459.0137, 651.118, and 817.505, F.S. The bill creates s. 400.172, F.S.

II. Present Situation:

Licensed Practical Nurses

Licensed practical nurses are practitioners who perform selected acts— including the administration of treatments and medications in the care of the ill, injured, or infirm and the promotion of wellness, maintenance of health, and prevention of illness in others— under the direction of a registered nurse, licensed physician, licensed podiatrist, or licensed dentist. A practical nurse is responsible and accountable for making decisions that are based upon his or her educational preparation and experience in nursing.[1]

Resident Care Plans

Each resident in a nursing home[2] must have a resident care plan which includes a comprehensive assessment of his or her needs; the type and frequency of services required to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being; a list of services required within or outside the facility to meet those needs; and an explanation of service goals. The resident care plan must be developed by a registered nurse with participation from other facility staff, the resident, or the resident's designee and signed by the director of nursing or another registered nurse[3] and the resident or his or her designee.

The care plan must be reviewed by a registered nurse at least quarterly and updated as appropriate. Agency or temporary registered nurses may not serve as registered nurses for purposes of formulating, signing, or maintaining resident care plans.[4]

Services Provided by Nursing Homes[5]

A nursing home that has had no class I or class II deficiencies[6] during the past 2 years or has been awarded a Gold Seal[7] is permitted to provide services, including, but not limited to, respite

[1] Section 464.003(16) and (19), F.S.
[2] As defined in s. 400.021(7) and (12), F.S., a nursing home facility is any institution, building, residence, private home, or other place, whether operated for profit or not, which undertakes through its ownership or management to provide for a period exceeding 24-hour nursing care, personal care, or custodial care for three or more persons not related to the owner or manager by blood or marriage, who by reasons of illness, physical infirmity, or advanced age require such services, but does not include any place providing care and treatment primarily for the acutely ill. A facility offering services for fewer than three persons is within the meaning of this definition if it holds itself out to the public to be an establishment which regularly provides such services. A nursing home is licensed to offer services as defined in part I of ch. 464, F.S., the Nurse Practice Act.
[3] Such a nurse must be employed by the facility and have been delegated institutional responsibilities by the facility. The nature of any delegated responsibilities must be documented as part of the resident care plan.
[4] Section 400.021(16), F.S.
[5] Sections 400.141(1), F.S.

and adult day care services, which enable individuals to move in and out of the facility and may provide such services without meeting any requirements beyond those for standard licensing. Respite care means admission to a nursing home for the purpose of providing a short period of rest, relief, or emergency alternative care for the primary caregiver of an individual receiving care at home who, without home-based care, would otherwise require institutional care.[8] Adult day care means providing basic services— including providing a protective setting that is as non-institutional as possible, therapeutic programs of social and health activities and services, leisure activities, self-care training, rest, nutritional services, and respite care— for a part of a day to three or more adults who require such services and who are not related to the owner or operator of an adult day care center by blood or marriage.[9]

The agency must by rule adopt modified requirements for resident assessment, resident care plans, resident contracts, physician orders, and other provisions, as appropriate, for short-term or temporary nursing home services.[10] Staff and programming may be shared between normal nursing home residents and short-term or temporary residents unless the facility is cited for deficiencies in patient care. A person receiving either respite care for 24 hours or longer or adult day care services must be included when calculating minimum staffing for the facility.

Any licensed assisted living facility, hospital, or nursing home may provide services during the day which include, but are not limited to, social, health, therapeutic, recreational, nutritional, and respite services to adults who are not residents. Such a facility need not be licensed as an adult day care center unless it publicly advertises to be such a center.[11]

If the facility has a standard license or is a Gold Seal facility, exceeds the minimum required hours of licensed nursing and certified nursing assistant direct care per resident per day, and is part of a licensed continuing care[12] facility or a retirement community that offers home health,[13]

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[6] There are four classes of deficiencies for which nursing homes may be cited under ch. 400.23(8), F.S. A class I deficiency 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 compromises a 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 results in no more than minimal physical, mental, or psychosocial discomfort to the 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 has the potential for causing no more than a minor negative impact on the resident.

[7] To be given the Gold Seal award, a facility must demonstrate excellence in long-term care over a sustained period. Criteria for the award include no class I or class II deficiencies within the past 30 months; evidence of financial stability; demonstration of consumer satisfaction with the facility as collected from residents and family members; evidence of workforce stability, such as low rate of turnover among registered nurses and certified nursing assistants during the previous 30 months; and an outstanding record regarding the number and types of substantiated complaints made to the State Long-Term Care Ombudsman Council within the previous 30 months. Gold Seal facilities are subject to less frequent surveys and relicensure visits by the agency. *See* s. 400.235, F.S.

[8] Section 400.021(15), F.S.

[9] Section 429.901, F.S.

[10] No such rules currently exist in the Florida Administrative Code.

[11] Section 429.905(2), F.S.

[12] According to s. 651.011(2), F.S., continuing care means, pursuant to a contract, furnishing shelter and nursing or personal services to a resident of a facility, whether such nursing care or personal services are provided in the facility or in another setting designated in the contract for continuing care, by an individual not related by consanguinity or affinity to the resident, upon payment of an entrance fee.

assisted living,[14] or adult day care services on a single campus, such facilities are allowed to share programming and staff. At the time of inspection and in semiannual reports required to be submitted to the agency related to licensure renewal, any continuing care facility or retirement community that uses this option must demonstrate through staffing records that minimum staffing requirements were met.

All licensed nursing homes must submit reports to the agency, at least semiannually, but more often if requested by the agency, containing information regarding facility staff-to-resident ratios, staff turnover, and staff stability. A nursing home that has failed to comply with the state minimum-staffing requirements for 2 consecutive days is prohibited from accepting new admissions until the facility has achieved the minimum-staffing requirements for a period of 6 consecutive days, and failure to impose such an admissions moratorium constitutes a class II deficiency. A nursing home may be cited for violation of minimum staffing requirements in s. 400.23(3)(a)1.b. and c., F.S.,[15] if it has failed to meet those standards on 2 consecutive days or has failed to meet at least 97 percent of those standards on any one day. Additionally, the agency may take action against any nursing home which meets the minimum staffing requirements but does not have enough staff to meet its residents' needs.

Residents' Rights

All residents of nursing homes have certain rights listed in statute.[16] Such rights include:

- The right to civil and religious liberties, including knowledge of available choices and the right to make independent personal decisions;
- The right to private and uncensored communication;
- The right to reasonable access to legal, social, health, or other services;
- The right to present grievances to nursing home staff, government officials, or any other entity. Such grievances must be promptly addressed by nursing home staff;
- The right to participate in social, religious, and community activities that do not interfere with the rights of other residents;
- The right to examine the results of the most recent inspection of the nursing home;
- The right to manage personal financial affairs or to delegate such responsibility to the nursing home, but only to the extent of the funds held in trust by the nursing home or the resident. The facility may not require a resident to deposit personal funds with the facility;
- The right to be fully informed of services available in the facility and of any related charges for such services;

[13] According to s. 400.462(14), F.S., home health services are health and medical services and medical supplies furnished by an organization to an individual in the individual's home or place of residence.

[14] According to s. 429.02(5), F.S., an assisted living facility is a residential facility, whether operated for profit or not, which undertakes through its ownership or management to provide housing meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.

[15] These provisions give minimum staffing requirements for certified nursing assistants and licensed nurses in nursing homes. For certified nursing assistants, there must be a minimum of 2.5 hours of direct care per resident, per day and at least one certified nursing assistant per 20 residents. For licensed nurses, a minimum of one hour of direct care per resident, per day is required, and there must be at least one licensed nurse per 40 residents.

[16] Section 400.022, F.S.

- The right to be adequately informed of the resident's own medical conditions and proposed treatments and to participate in treatment planning, unless the resident is determined to be unable to provide informed consent under Florida law;
- The right to have privacy in treatment and in caring for personal needs;
- The right to security in storing and using personal possessions;
- The right to be treated courteously, fairly, and with the fullest measure of dignity and to be free from mental and physical abuse;
- The right to be transferred or discharged from a nursing home only for medical reasons or for the welfare of other residents and the right to be given at least 30 days' notice before any involuntary transfer or discharge, except in case of emergency. Nursing homes which provide services under Medicaid may not transfer or discharge a resident solely because the source of payment for care changes;
- The right to freedom of choice in selecting a personal physician and pharmacy and to participate in community-based activities programs;
- The right to receive notice before the resident's room in the nursing home is changed; and
- The right to be informed of the nursing home's bed reservation policy relating to resident hospitalization. Nursing home beds must be reserved during resident hospitalizations of up to 30 days for privately insured residents or 15 days for residents under Medicaid, provided that the nursing home receives reimbursement during this time.

The nursing home must provide a copy of such rights to each resident, his or her designee, and all facility staff. This statement of rights must also inform residents of their right to file a complaint with the agency or the local ombudsman council and must include contact information for the nearest ombudsman council and the central abuse hotline. Any violation of resident rights is grounds for disciplinary action by the agency.

Certificate of Need

Before construction may begin on any health care-related project, including the addition of beds to a nursing home, a facility must apply for and be awarded a certificate of need from the agency.[17] A certificate of need is a written statement which provides evidence that the community needs a new, converted, expanded, or otherwise significantly modified health care facility.[18] An application for a certificate of need must contain a detailed description of the proposed project and statement of its purpose, a statement of the financial resources needed by and available to the applicant to accomplish the proposed project, and an audited financial statement of the applicant.[19] In addition, the application *may* contain a statement of intent that a certain percentage of the annual patient days at the facility will be used by patients eligible for care under Medicaid; nursing homes may be issued certificates of need on the condition that they fulfill this requirement.[20] Preference for granting certificates of need will be given to nursing homes who have been awarded a Gold Seal.[21]

[17] Section 408.036(1), F.S.
[18] Section 408.032, F.S.
[19] Section 408.037(1), F.S.
[20] Section 408.040, F.S.
[21] Section 400.171(3), F.S.

The agency may also issue a certificate of need for the construction of nursing home beds in a continuing care facility for the exclusive use of the facility; such beds are known as sheltered nursing home beds.[22] The agency may approve one sheltered nursing home bed for every four proposed residential units in the facility, unless the facility owner demonstrates the need for additional beds based on actual utilization and demand by current residents. A facility owner may petition the agency to use a designated number of sheltered nursing home beds to provide extended congregate care[23] if the beds are in a distinct area of the nursing home which can be adapted to meet the requirements of extended congregate care. Such converted beds may not qualify for funding under the Medicaid waiver and may share common areas, services, and staff with beds designated for nursing home care. Construction may not begin until the facility has been issued a certificate of need from the agency and a certificate of authority[24] from the Office of Insurance Regulation. However, a continuing care facility may also apply for a certificate of need to construct regular nursing home beds which may be used by residents or non-residents of the continuing care facility.[25]

Certificates of need expire 18 months after they are granted unless construction for the project has begun, and a certificate may be revoked if construction has begun but is not proceeding along the timetable specified in the application.[26]

As of July 1, 2011,[27] certificates of need for additional nursing home beds may not be approved until Medicaid managed care is implemented statewide or until after October 1, 2016, whichever occurs earlier. This is because the Legislature has found that the continued growth in the Medicaid budget for nursing home care has constrained the ability of the state to meet the needs of its elderly residents through the use of less restrictive and less institutional methods of long-term care; fewer state funds will be appropriated to nursing home care during this time so that more home- and community-based methods of long-term care may be explored. This moratorium on certificates does not apply to:

- Sheltered nursing home beds in a continuing care retirement community;
- Counties with no community nursing home beds because all nursing homes in the county licensed on July 1, 2001, have since closed; or
- Nursing homes wishing to add ten total beds or ten percent of the number of total beds in the facility, whichever is greater. Such beds may be added provided that the facility meets certain occupancy rates and has no class I or II deficiencies.[28]

[22] Sheltered nursing home beds in continuing care facilities may be used for persons who are not residents of the continuing care facility and who are not parties to a continuing care contract for up to 5 years after the date of issuance of the initial nursing home license. This 5-year period may be extended by the agency under certain conditions. *See* s. 651.118(7), F.S.
[23] According to s. 429.02(11), F.S., extended congregate care means acts beyond personal services that may be performed under part I of ch. 464, F.S., the Nurse Practice Act, 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 an assisted living facility.
[24] A certificate of authority is required before any business may provide continuing care or construct any facility related to continuing care. Requirements for certificates of authority are listed in s. 651.023, F.S.
[25] Section 651.118, F.S.
[26] Section 408.040, F.S.
[27] Chapter 2011-135, L.O.F.
[28] Section 408.0435, F.S.

Physician Specialties

Physiatrists, or rehabilitation physicians, are medical doctors who specialize in nerve, muscle, and bone injuries and illnesses which affect the way patients move. Physiatrists focus on treating the whole patient, not just symptoms, and aim to restore maximum function after strokes, limb amputations, and other conditions. Physiatrists also treat patients with chronic pain and do not perform surgery.[29] To practice as a physiatrist, a physician must complete at least 3 years of residency training in physical medicine and rehabilitation.[30]

Rheumatologists are physicians who focus on diseases of the joints, muscles, and bones.[31] Rheumatologists mainly diagnose and manage the progress of immune-mediated or degenerative diseases, as opposed to physiatrists, who emphasize rehabilitation of patients following injuries. Common conditions treated by rheumatologists include osteoarthritis, rheumatoid arthritis, and lupus. Rheumatologists must complete 3 years of residency training in either pediatrics or internal medicine as well as a 2- to 3-year fellowship in rheumatology.[32]

Psychiatrists are physicians who specialize in the prevention, diagnosis, and treatment of mental, addictive, and emotional disorders. Psychiatrists are trained in the medical, psychological, and social components of mental, emotional, and behavioral disorders and utilize a broad range of treatment modalities to treat such disorders, including medication, psychotherapy, and support services for helping patients and their families cope with stress and crises.[33] Disorders managed by psychiatrists include autism, schizophrenia, and attention-deficit hyperactive disorder (ADHD). Residency training programs for psychiatry are 4 years in length.[34]

Pain Management Clinics

A pain management clinic is any facility that advertises pain management services or where a majority of patients are prescribed opioids, benzodiazepines, barbiturates, or carisoprodol for the treatment of chronic nonmalignant pain. Until January 1, 2016, all pain management clinics must register as such with the Department of Health (the department) and meet certain provisions concerning staffing, sanitation, recordkeeping, and quality assurance.[35] Clinics are exempt from these provisions if they are:

- Licensed under ch. 395, F.S., as a hospital, ambulatory surgical center, or mobile surgical facility;
- Staffed primarily by surgeons;

[29] American Academy of Physical Medicine and Rehabilitation, *What is a Physiatrist?*, available at: http://www.aapmr.org/patients/aboutpmr/pages/physiatrist.aspx (last visited on January 27, 2012).
[30] American Medical Association, *FREIDA Online Program Information*, available at: https://freida.ama-assn.org/Freida/user/programSearchDispatch.do (last visited on January 27, 2012).
[31] American College of Rheumatology, *What is a Rheumatologist?*, available at: http://www.rheumatology.org/practice/clinical/patients/rheumatologist.asp (last visited on January 27, 2012).
[32] *Supra* fn. 2.
[33] Michigan Psychiatric Society, *What is a Psychiatrist?*, available at: http://www.mpsonline.org/psychiatry/Pages/WhatisaPsychiatrist.aspx (last visited on January 27, 2012).
[34] *Supra* fn. 2.
[35] *See* ss. 458.3265 and 459.0137, F.S.

- Owned by a publicly held corporation whose shares are traded on a national exchange or on the over-the-counter market and whose total assets at the end of the corporation's most recent fiscal quarter exceeded $50 million;
- Affiliated with an accredited medical school at which training is provided for medical student, residents, or fellows;
- Not involved in prescribing controlled substances for the treatment of pain;
- Owned by a corporate entity exempt from federal taxation under 26 U.S.C. s. 501(c)(3); or
- Wholly owned and operated by anesthesiologists, physiatrists, or neurologists, or physicians holding certain credentials in pain medicine.

All clinics must be owned by at least one licensed physician or be licensed as a health care clinic under part X or ch. 400, F.S., to be eligible for registration. Physicians connected with a pain management clinic must be free of past disciplinary action against their medical licenses and DEA numbers in any jurisdiction as well as any convictions or pleas for illicit drug felonies within the past 10 years.

Pain management clinics are inspected annually by the department unless they hold current certification from a department-approved national accrediting agency. The department may suspend or revoke clinic registration or impose administrative fines of up to $5,000 per violation for any offenses against state pain management clinic provisions or related federal laws and rules.

If the registration for a pain management clinic is revoked for any reason, the clinic must cease to operate immediately, remove all signs or symbols identifying the facility as a pain management clinic, and dispose of any medication on the premises. No owner or operator of the clinic may own or operate another pain clinic for 5 years after revocation of registration.[36]

Board Certification Organizations

The gold standard for certification of a physician in a medical subspecialty is certification by the American Board of Medical Specialties (ABMS). ABMS member boards certify physicians in more than 150 different specialties and subspecialties. Major national healthcare organizations such as The Joint Commission, the National Committee for Quality Assurance, hospitals, and insurance companies use ABMS board certification as an essential tool to assess physician specialty credentials, and numerous studies have demonstrated that physicians who are board-certified by an ABMS member board deliver higher-quality care and have better patient outcomes than those certified by other organizations.[37] ABMS board certification is available to both allopathic and osteopathic physicians. Another gold standard of certification for osteopathic physicians is receiving a certificate of added qualification through the American Osteopathic Association (AOA).

[36] Section 458.3265, F.S. Similar language is found in s. 459.0137, F.S. Related rules are found in Rules 64B8-9 and 64B15-14, F.A.C.
[37] ABMS, *The Highest Standard*, available at: http://www.certificationmatters.org/about-board-certified-doctors/the-highest-standard.aspx (last visited on February 2, 2012).

III. Effect of Proposed Changes:

Section 1 amends s. 400.021, F.S. The definition of "geriatric outpatient clinic" is revised to allow such clinics to be staffed by licensed practical nurses working under the direct supervision of registered nurses, advanced registered nurse practitioners, physicians, or physician assistants. The definition of "resident care plan" is amended to remove the requirement that the plan be signed by the director of nursing or another registered nurse employed by the facility and the resident or his or her designee. The definition of "therapeutic spa services" is created to mean bathing, nail, and hair care services and other similar services related to personal hygiene.

Section 2 amends s. 400.141, F.S., to delete a reference to Gold Seal facilities from s. 400.141(1)(g), F.S. This paragraph currently allows a facility that has a standard license or is a Gold Star facility and meets certain other requirements to share programming and staff with a continuing care facility or a retirement community offering assisted living or adult day care services of which the nursing home is a part or with which it shares a campus. The reference to Gold Seal facilities is unnecessary as any facility with a standard license who meets the other requirements may share such programming.

The bill also deletes the requirements for facilities sharing programming and staff under this section to demonstrate in semiannual reports to the agency that minimum staffing requirements were met. Such compliance to minimum staffing requirements must still be demonstrated during agency inspections, however.

Section 3 creates s. 400.172, F.S., concerning criteria for providing respite care in nursing home facilities. For each person admitted for respite care, a nursing home facility must:

- Have a written abbreviated plan of care that, at a minimum, includes nutritional requirements, medication orders, physician orders, nursing assessments, and dietary preferences. The nursing or physician assessments may take the place of all other assessments required for full-time residents;
- Have a contract that, at a minimum, specifies the services to be provided to a resident receiving respite care and charges for such services. If multiple admissions for respite care are anticipated, this contract is valid for 1 year after it is executed; and
- Ensure that each resident is released to his or her caregiver or to an individual designated in writing by the caregiver.

Residents admitted under the respite care program will be exempt from Department of Children and Families rules relating to the discharge planning process. They will be entitled to resident rights under s. 400.022(1)(a)-(o) and (r)-(t), F.S.,[38] except that nursing homes are not permitted to manage the funds of any respite care resident until he or she has been in the facility for at least 14 consecutive days. They will reside in licensed nursing home beds and will be allowed to use

[38] Respite care residents do not have the right to be transferred or discharged only for medical reasons or for the welfare of other residents, the right to be given at least 30 days' notice before any involuntary transfer or discharge, the right to freedom of choice in selecting a personal physician or pharmacy, the right to participate in community-based activities programs unless medically contraindicated, the right to be informed of the bed reservation policy of the nursing home as it relates to resident hospitalization, or the right to challenge a resident discharge or transfer decision made by the facility. *See:* s. 400.022(1)(p), (q), (u), and (v), F.S.

personal medications during the stay, as long as a physician's order is obtained. Medications will be released with the resident upon discharge in accordance with the physician's orders.

A respite care resident may reside in a nursing home for a total of 60 days per year, with each separate stay lasting less than 14 days. If a person stays in respite care for longer than 14 days, the facility must comply with all assessment and care planning requirements applicable to nursing home residents.

Medical information from a physician, physician assistant, or nurse practitioner and any other information required by the facility must be submitted to the nursing home before any respite care resident may be admitted to a nursing home. Such medical information must include a physician's order for respite care and proof of a physical examination by a licensed physician, physician assistant, or nurse practitioner; such order and examination are valid for 1 year. Once a resident is admitted, the nursing home will assume primary caregiver duties for him or her, including arranging for the continuation of medically necessary services as needed.

Section 4 amends s. 400.141, F.S., to allow any licensed nursing home to provide services, including respite, therapeutic spa, and adult day care services to nonresidents. Currently, only licensed nursing homes with no class I or class II deficiencies during the last 2 years or with Gold Seal status are permitted to provide such services. Adult day care services must be administered according to s. 429.905(2), F.S., which states that all nursing homes providing adult day services must be monitored by the agency at least biennially to ensure adequate space and sufficient staff, unless the nursing home holds itself out to be an adult day care center, in which case it must meet all standards set in rule and law for such centers.

The bill also eliminates the requirement that the agency adopt rules related to short-term or temporary nursing home services.

Section 5 amends s. 408.036, F.S., to create a pilot project in a specific area of Jacksonville which involves the construction of a nursing home with 150 or fewer beds. The nursing home must be affiliated with a nursing school which offers bachelor's, master's, and doctorate degrees at a private university in Jacksonville,[39] be constructed on or near the property of such a university, and make positions available for the education and training of nursing students in the field of long-term care or geriatric nursing. The pilot project is exempt from the moratorium on issuance of certificates of need to nursing homes; construction must begin within 11 months after this exemption becomes law, and the exemption expires on June 30, 2014.

Section 6 amends s. 429.195, F.S., to prohibit any assisted living facility to provide any kickback, commission, or any other split-fee arrangement with any person, healthcare provider, or health care facility, as provided under s. 817.505, F.S.[40] These provisions do not apply to:

- An individual employed or contracted by the assisted living facility, if he or she clearly indicates such work status;
- Payments by an assisted living facility to a referral service for consumers, as long as the referred consumers are not Medicaid recipients; and

[39] Functionally, this refers to Jacksonville University.
[40] This section prohibits patient brokering.

- Residents of assisted living facilities who refer their personal contacts.

Current law authorizes a person to provide placement or referral services; however, the fee must be paid by the individual looking for a facility. This bill authorizes a facility to pay the referral fee.

Section 7 amends s. 429.905(2), F.S., relating to monitoring of adult day care center programs co-located with licensed nursing homes. The bill clarifies that, for purposes of this subsection, the term "day" means any portion of a 24-hour day.

Section 8 amends s. 458.3265, F.S., to amend the definition of "chronic nonmalignant pain" to exclude pain related to sickle-cell anemia. The following clinics are exempted from registration as pain-management clinics:

- Clinics wholly owned by one or more board-eligible or board-certified anesthesiologists, physiatrists, psychiatrists, rheumatologists, or neurologists. The requirement that the clinics must also be operated by one or more of these physicians is removed;
- Clinics wholly owned by one or more board-eligible medical specialists in areas already listed in statute. The requirement that the clinics must also be operated by one or more of these physicians is removed, and the American Board of Pain Medicine is added as an approved board for certification of pain medicine specialists;
- Clinics organized as physician-owned group practices as defined in 42 C.F.R. 411.352; and
- Clinics which, before June 1, 2011, were wholly owned by physicians who are not board-eligible or board-certified but who successfully completed residency programs in anesthesiology, physiatry, psychiatry, rheumatology, or neurology and who have 7 years of documented, full-time practice in pain medicine in this state. "Full-time" is defined as practicing an average of 20 hours per week each year in pain medicine.

Section 9 amends s. 459.0137, F.S., to amend the definition of "chronic nonmalignant pain" to exclude pain related to sickle-cell anemia. The following clinics are exempted from registration as pain-management clinics:

- Clinics wholly owned by one or more board-eligible or board-certified anesthesiologists, physiatrists, psychiatrists, rheumatologists, or neurologists. The requirement that the clinics must also be operated by one or more of these physicians is removed; and
- Clinics wholly owned by one or more board-eligible medical specialists who hold certain qualifications relating to pain medicine. The requirement that the clinics must also be operated by one or more of these physicians is removed, and the American Association of Physician Specialties and the American Board of Pain Medicine are added as approved boards for certification of pain medicine specialists.

Section 10 amends s. 651.118, F.S., to allow a continuing care facility to petition the agency to designate a certain number of its sheltered nursing home beds to provide assisted living, rather than extended congregate care, if the beds are in a distinct area of the facility which can be adapted to meet the requirements for an assisted living facility as defined in s. 429.02, F.S. Any sheltered beds used to provide assisted living may not qualify for funding under the Medicaid waiver and may share common areas, services, and staff with beds designated for nursing home care, as long as all of the beds are under common ownership.

Section 11 amends s. 817.505, F.S., to provide exceptions to prohibitions on patient brokering to conform to changes made by section 6 of this bill.

Section 12 provides an effective date of July 1, 2012.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

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

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Certain nursing homes would be able to provide additional services to residents and the public. Certain individuals will be able to receive monetary compensation from assisted living facilities for resident referrals. Certain physicians will be exempt from pain management clinic registration provisions.

C. Government Sector Impact:

The department may experience a decrease in workload related to applications for pain management clinic certifications from physician offices newly exempt from statutory requirements, although this will be offset by a corresponding decrease in fees related to these services. The department will also lose some oversight over the controlled substance prescribing activity of these physicians.

VI. Technical Deficiencies:

Lines 32-42 of the bill's title state that physicians fulfilling certain qualities are not required to register their clinics as pain management clinics under chs. 458 or 459, F.S. The title lists the

criteria for exemption as being the same for both allopathic and osteopathic physicians, although, as stated in the bill, such criteria are different.

Sections 2 and 4 of the bill both amend s. 400.141, F.S. It might be more concise to merge these two sections into one.

Lines 344-345 and 404-405 state that physicians who are board-certified in pain medicine by a board approved by the American Board of Pain Medicine may be exempt from registering their clinics as pain-management clinics under ch. 458, F.S. However, the American Board of Pain Medicine is itself a certifying board; it does not approve other boards for certification.

"Physiatry" as mentioned in line 354 is not the name of any residency program. Physiatrists complete their residency training in Physical Medicine and Rehabilitation.

Lines 403-404 state that certain physicians certified by the American Association of Physician Specialties are exempt from registering their clinics as pain management clinics under ch. 459, F.S. No such organization exists; perhaps this is intended to be the American Association of Physician Specialists. If this is the intention, this association also is not responsible for board certification of physicians; this is conducted by the American Board of Physician Specialists.

The definitions of "chronic nonmalignant pain" in chs. 458, and 459, F.S., are amended to read "pain unrelated to cancer, rheumatoid arthritis, or sickle cell anemia which persists beyond the usual course of disease or beyond the injury that is the cause of the pain or which persists more than 90 days after surgery." The second "beyond" in that definition should be deleted for clarity.

VII. Related Issues:

Lines 58-60 allow a licensed practical nurse working under the direct supervision of a registered nurse, advanced registered nurse practitioner, physician assistant, or physician to staff a geriatric outpatient clinic. However, the definition of "licensed practical nurse" in ch. 464, F.S., the Nurse Practice Act, only allows such practitioners to work under the supervision of registered nurses, physicians, podiatrists, or dentists.

Lines 140-141 state that respite care residents are exempt from department rules related to the discharge planning process. The Department of Children and Families, the department which has authority under ch. 400, F.S., applies, does not have any such rules. However, the agency does have rules related to patient discharge from health care facilities.

Lines 223-247 provide an exemption from the moratorium on issuing certificates of need for construction of nursing homes to allow a certain nursing home to be built in Jacksonville. This nursing home is exempt from the moratorium, but any entity wishing to construct it must still apply and be granted a certificate of need from the agency.

The bill allows certain board-certified or board-eligible physicians to be exempted from registering their offices as pain-management clinics under chs. 458 or 459, F.S. Board certification in a medical specialty is an industry-recognized standard for expertise in that specialty. To become board-certified, physicians must complete residency and sometimes

fellowship training in specialty areas, pass a rigorous examination, hold a valid medical license in a state, and meet certain practice requirements. It is unclear how many of these criteria a physician must fulfill to be considered "board-eligible" by statute.

Language in sections 1, 2, and 3 of the bill references board-certified physicians, although the specifications for which boards must certify them are inconsistent or sometimes absent. For example, line 337 exempts board-certified anesthesiologists, physiatrists, psychiatrists, and rheumatologists from registering their offices as pain management clinics under ch. 458, F.S., but there is no mention of what board must certify such individuals. This language is in current statute, and a similar problem exists in lines 394.

Furthermore, criteria for exempting physicians from registering their clinics as pain-management clinics are inconsistent between allopathic and osteopathic physicians. Clinics organized as physician-group practices, owned by physicians board-eligible or board-certified in pain medicine by a board approved by the American Board of Pain Medicine, or owned by certain anesthesiologists, physiatrists, rheumatologists, or neurologists prior to June 1, 2011, are exempt from registration as pain-management clinics under ch. 458, F.S. However, such clinics are not eligible for exemption from registration under ch. 459, F.S. Clinics owned by physicians board-eligible or board-certified in pain medicine by a board approved by the American Association of Physician Specialties are eligible for exemption, although these are not eligible for exemption under ch. 458, F.S.

VIII. Additional Information:

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

CS by Health Regulation on February 16, 2012:
The CS:

- Amends ss. 458.3265 and 459.0137, F.S., to exclude pain related to sickle-cell anemia from the definition of chronic nonmalignant pain and allows clinics owned by certain types of physicians to be exempt from registration as pain management clinics;
- Adds the American Association of Physician Specialties to the boards which may certify certain physicians in provisions related to the exemption of certain clinics from registration as pain management clinics under ch. 459, F.S.;
- Simplifies the types of entities who may not give kickbacks to ALFs to include any person, health care provider, or health care facility and provides certain exceptions;
- Deletes language relating to the moratorium on nursing home certificates of need from the bill; and
- Creates an exemption from the moratorium on issuing certificates of need to nursing homes to allow for construction of a nursing home meeting certain conditions.

B. Amendments:

None.