HOUSE OF REPRESENTATIVES
FINAL BILL ANALYSIS

BILL #:	CS/CS/HB 787 (CS/SB 1292)	**FINAL HOUSE FLOOR ACTION:**	
SPONSOR(S):	Health & Human Services Committee; Health & Human Services Quality Subcommittee; Trujillo (Health Regulation; Bogdanoff)	80 **Y's**	33 **N's**
COMPANION BILLS:	CS/SB 1292	**GOVERNOR'S ACTION:**	Approved

SUMMARY ANALYSIS

CS/CS/HB 787 passed the House on February 23, 2012. The bill was amended by the Senate on March 9, 2012, and subsequently passed the House on March 9, 2012. The bill amends the Health Care Licensing Procedures Act and the authorizing statutes of nursing homes to reduce, streamline, and clarify regulations for those providers. The bill also amends regulation of home health agencies, hospices, clinical laboratories, urgent care centers, teaching hospitals, pain management clinics, health care clinics, and the Medicaid program. The bill:

- Amends various nursing home licensure provisions, including those related to bankruptcy notifications, licensure renewal notices, billing complaints, licensure application document submissions, staffing in geriatric outpatient clinics, medical records, property statements, AHCA inspection staff, litigation notices;
- Expands the ability of nursing homes to provide additional services to nonresidents of nursing home facilities;
- Allows all licensed nursing homes to provide additional services, without limitation based on prior deficiencies or recognition as a Gold Seal facility, including respite, adult day services, and therapeutic spa services;
- Creates regulations and provisions for overnight respite care in nursing homes;
- Removes the requirement for resident care plans to be signed by the director of nursing or another registered nurse employed by the facility;
- Eliminates the requirement for nursing homes to prove compliance with staffing ratios in the semiannual report.
- Removes the requirement for nursing homes to be a Gold Seal facility to be able to share programming and staff;
- Allows nursing homes to use a portion of their sheltered nursing home beds to provide assisted living services without giving up their CON for those beds;
- Revises the definition of "remuneration" to allow home health agencies to distribute certain novelty items with a value of up to $15 that are intended solely for promotional and advertising purposes;
- Revises the definition of "hospice" to include limited liability companies;
- Clarifies what constitutes an illegal kickback by prohibiting placement of a laboratory specimen collector in a physician's office;
- Requires urgent care centers to post a schedule of charges for medical services offered to patients;
- Exempts urgent care centers owned and operated by employers for the exclusive use of their employees and their dependents;
- Provides an exemption from the application process for a public teaching hospital that operates facilities on separate premises under a single license and that has a level 1 trauma center;
- Revises prescription drug regulations and provides registration exemptions for certain pain management clinics;
- Creates additional exemptions from licensure under the Health Care Clinic Act; and
- Requires Medicaid to post online the prior authorization and step edit criteria, protocol, and updates to the list of drugs that are subject to prior authorization.

The bill does not appear to have a significant fiscal impact on state or local government.

The bill was approved by the Governor on April 27, 2012, ch. 2012-160, Laws of Florida. The effective date of the bill is July 1, 2012.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Present Situation

The Agency for Health Care Administration (AHCA) regulates over 41,000 health care providers under various regulatory programs. Regulated providers include:

- Laboratories authorized to perform testing under the Drug-Free Workplace Act (ss. 112.0455, 440.102, F.S.).
- Birth centers (Ch. 383, F.S.).
- Abortion clinics (Ch. 390, F.S.).
- Crisis stabilization units (Pts. I and IV of Ch. 394, F.S.).
- Short-term residential treatment facilities (Pt. I and IV of Ch. 394, F.S.).
- Residential treatment facilities (Pt. IV of Ch. 394, F.S.).
- Residential treatment centers for children and adolescents (Pt. IV of Ch. 394, F.S.).
- Hospitals (Part I of Ch. 395, F.S.).
- Ambulatory surgical centers (Pt. I of Ch. 395, F.S.).
- Mobile surgical facilities (Pt. I of Ch. 395, F.S.).
- Health care risk managers (Pt. I of Ch. 395, F.S.).
- Nursing homes (Pt. II of Ch. 400, F.S.).
- Assisted living facilities (Pt. I of Ch. 429, F.S.).
- Home health agencies (Pt. III of Ch. 400, F.S.).
- Nurse registries (Pt. III of Ch. 400, F.S.).
- Companion services or homemaker services providers (Pt. III of Ch. 400, F.S.).
- Adult day care centers (Pt. III of Ch. 429, F.S.).
- Hospices (Pt. IV of Ch. 400, F.S.).
- Adult family-care homes (Pt. II of Ch. 429, F.S.).
- Homes for special services (Pt. V of Ch. 400, F.S.).
- Transitional living facilities (Pt. V of Ch. 400, F.S.).
- Prescribed pediatric extended care centers (Pt. VI of Ch. 400, F.S.).
- Home medical equipment providers (Pt. VII of Ch. 400, F.S.).
- Intermediate care facilities for persons with developmental disabilities (Pt. VIII of Ch. 400, F.S.).
- Health care services pools (Pt. IX of Ch. 400, F.S.).
- Health care clinics (Pt. X of Ch. 400, F.S.).
- Clinical laboratories (Pt. I of Ch. 483, F.S.).
- Multi-phasic health testing centers (Pt. II of Ch. 483, F.S.).
- Organ, tissue, and eye procurement organizations (Pt. V of Ch. 765, F.S.).

<u>Health Care Licensing Procedures Act</u>

Providers are regulated under the Health Care Licensing Procedures Act (Act) in part II of chapter 408, F.S. The Act provides uniform licensing procedures and standards applicable to most AHCA-regulated entities. The Act contains basic licensing standards for 29 provider types in areas such as licensure application requirements, ownership disclosure, staff background screening, inspections, administrative sanctions, license renewal notices, and bankruptcy and eviction notices.

In addition to the Act, each provider type has an authorizing statute which includes unique provisions for licensure beyond the uniform criteria. Pursuant to s. 408.832, F.S., in the case of conflict between the Act and an individual authorizing statute, the Act prevails. There are several references in

authorizing statutes that conflict with or duplicate provisions in the Act, including references to the classification of deficiencies, penalties for an intentional or negligent act by a provider, provisional licenses, proof of financial ability to operate, inspection requirements and plans of corrections from providers. Chapter 2009-223, L.O.F., made changes to part II of chapter 408, F.S., which supersede components of the specific licensing statutes.

This bill repeals obsolete or duplicative provisions in licensing and related statutes, including expired reports and regulations and provisions that exist in other sections of law like the Act. The bill also makes changes to the Act to reduce, streamline, or clarify regulations for certain providers regulated by AHCA.

The bill changes individual licensing statutes to reflect updates to the uniform standards in the Act. The bill makes corresponding changes to provider licensing statutes to reflect the changes made to the Act to eliminate conflicts and obsolete language.

Certificates of Need

A certificate of need (CON) is a written statement issued by AHCA providing evidence of community need for a new, converted, expanded, or otherwise significantly modified health care facility, health service, or hospice.[1] Section 408.037, F.S., requires the applicants for CON to be audited. According to AHCA, the applicant is frequently a sub-entity of a larger corporation and usually has no operations yet.[2] Therefore, the applicant has to go through the expense of getting a separate audit on the sub-entity company to meet the filing requirement.[3]

License Renewal Notices

Section 408.806, F.S., requires AHCA to notify licensees by mail or electronically when it is time to renew their licenses. AHCA mails renewal notices to over 30,000 providers every two years. While the statute does not specify the manner of mailing notices, AHCA sends them by certified mail to verify receipt by the providers. The cost of certified mail is approximately $56,000 annually. According to AHCA, some certified mail is returned, as providers do not pick it up or the post office is unable to obtain necessary signatures for delivery. AHCA has also encountered situations in which licensees did not timely renew their licenses and claimed that their lack of receipt of a renewal reminder was a reason for that failure.

Classification and Fines for Violations

Section 408.813, F.S., includes criteria for the classification of deficiencies for all providers licensed by AHCA. Some authorizing statutes also contain criteria for the classification of deficiencies, some of which do not match the provisions contained in the Act. The provisions in the Act legally supersede conflicting provisions in the authorizing statutes. However, the dual provisions may be confusing, and some conflicts still exist. Additionally, authorizing statutes are inconsistent related to fines for unclassified deficiencies such as failure to maintain insurance or exceeding licensed bed capacity.

Billing Complaint Authority

The Act provides authority to review billing complaints across all programs and gives the impression that AHCA can take licensure action regarding billing practices. Section 408.10(2), F.S., requires AHCA to investigate consumer complaints regarding billing practices and determine if the facility has engaged in billing practices which are unreasonable and unfair to the consumer. However, the Act does not provide specific standards for billing practices which AHCA can use to cite violations and

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[1] S. 408.032(2), F.S.
[2] AHCA, *Staff Analysis and Economic Impact, House Bill Number 1419* (January 20, 2012).
[3] Id.

discipline a provider's license. Nor does the Act define what activities would be unreasonable and unfair. Several providers' authorizing statutes do include billing standards, including nursing homes and assisted living facilities.[4] However, other authorizing statutes are silent on billing standards, including hospitals, labs, crisis stabilization units and residential treatment facilities.

For calendar year 2011, AHCA received 436 complaints that alleged billing-related issues.[5] Of those, 126 were for providers that have billing standards in their licensure statutes. The remaining 310 were related to billing issues for which no regulatory authority existed for billing matters. When the agency receives a billing complaint regarding one of the providers which does not have statutory billing standards, it is the agency's policy to review the complaint and encourage the parties to work together to resolve the problem. However, the provider is not cited or disciplined due to lack of authority.

License Display

Section 408.804, F.S., makes it unlawful to provide or offer services that require licensure without first obtaining a license. This section of law also makes licenses valid only for entities and locations for which they are issued. Licensees are required to display licenses in a conspicuous place readily visible to the clients. The Act does not currently address falsification of license documents.

Hospitals

Private Utilization Review

A private review agent is a person or entity that performs utilization review services for third party payers on a contractual basis for outpatient or inpatient services.[6] Prior to 2009, s. 395.0199, F.S., required private review agents to be registered by AHCA to conduct utilization reviews for third-party payers concerning the medical necessity or appropriateness in the allocation of health care services offered by hospitals.[7] This process required the private review agents to make an initial denial determination if the services being furnished were found to be inappropriate, not medically necessary, or not reasonable.[8] In 2009, the Legislature repealed this requirement.[9]

Certificates of Need

The Certificate of Need (CON) regulatory review process under chapter 408, F.S., requires that, before specified health care services and facilities may be offered to the public, they must be approved by AHCA. Pursuant to s. 408.036(1), F.S., the establishment of tertiary health services,[10] such as adult interventional cardiology,[11] in hospitals is generally subject to such review. Section 408.036(3), F.S., provides certain exemptions from the CON review requirements.

Hospitals without an approved adult open-heart-surgery program may submit a request for a CON exemption. The applicant must certify that it will meet and maintain all requirements adopted by AHCA for the provision of these services. Applicants must have a written transfer agreement with a hospital with an adult-open-heart-surgery program, and written transport protocols must be in place to ensure safe and efficient transfer of a patient within 60 minutes.[12]

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[4] S. 400.23, F.S., (Nursing Homes) and s. 429.19, F.S., (Assisted Living Facilities).
[5] AHCA, *Staff Analysis and Economic Impact, House Bill Number 1419* (January 20, 2012).
[6] S. 395.002(24), F.S.
[7] S. 395.002(31), F.S.
[8] S. 395.002(14), F.S.
[9] Ch. 2009-223, L.O.F.
[10] A "tertiary health service" is one which is highly intense, complex, specialized or of limited applicability, and costly. Accordingly, the Legislature has determined that, in order to maintain quality and cost-effectiveness, its availability should be limited. *See* s. 408.032(17), F.S.
[11] See, generally, Rule 59A-3.2085, F.A.C.
[12] S. 408.036(3)(n), F.S.

In 2004 the legislature revised s. 408.0361, F.S., to require AHCA to adopt administrative rules for the licensure of diagnostic cardiac catheterization services and adult interventional cardiology services in hospitals.[13] This licensure revised the regulation of adult interventional cardiology services to create licensure of this service, rather than a service that is authorized through an exemption from CON review. AHCA has promulgated rules establishing standards based on the guidelines of the American College of Cardiology and the American Heart Association Guidelines for Cardiac Catheterization and Cardiac Catheterization Laboratories. In order to be licensed as a Level I adult interventional cardiology program, hospitals must:

- Provide a minimum of 300 adult inpatient and outpatient diagnostic cardiac catheterizations in the most recent 12 month period; or discharge or transfer at least 300 inpatients with the principal diagnosis of ischemic heart disease;

In addition, such hospitals must have a formal, written transfer agreement with a hospital that has a Level II program, including transport protocols ensuring safe and efficient patient transfer within 60 minutes.

Urgent Care Centers

In 2011, the Legislature passed CS/CS/HB 935, which was signed by the Governor.[14] The law requires an urgent care center[15] to publish and post a schedule of medical services provided and the cost of each service, grouped into three pricing levels.[16] The charges posted must be those fees charged to an uninsured patient who is paying for medical treatment by cash, check, credit card or debit card.[17] The schedule must be posted in a conspicuous place in the reception area of the office in an area of 15 square feet or more.[18] The schedule must list the 50 most frequently performed services provided by the urgent care center.[19] A primary care provider[20] (PCP) may post the same schedule of medical services provided.[21] If a PCP chooses to post a schedule of medical services, the schedule is subject to the same size and text requirements as an urgent care center.[22]

A health care provider or health care facility is required to provide a reasonable estimate of charges for non-emergency medical treatment to a patient.[23] The law also requires that the estimate comply with posted charges for medical treatment.[24]

Section 408.05, F.S., requires AHCA to establish the Florida Center for Health Information and Policy Analysis (the Center).[25] The Center was required to create "a comprehensive health information system to provide for the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of both purposefully collected and extant health-related data and statistics."[26] Specifically, the Center makes available to consumers health care quality measures and financial data of

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[13] S. 408.0361(3) (a), F.S., provides an explanation of two hospital program licensure levels: a level I program authorizing the performance of adult percutaneous cardiac intervention without onsite cardiac surgery and a Level II program authorizing the performance of percutaneous cardiac intervention with onsite cardiac surgery.
[14] *See* Chapter 2011-122, Laws of Fla.
[15] S. 395.002(30), F.S., defines "urgent care center" as a facility or clinic that provides immediate but not emergent ambulatory medical care to patients with or without an appointment. It does not include the emergency department of a hospital.
[16] S. 395.107, F.S.
[17] *Id.*
[18] *Id.*
[19] *Id.*
[20] *See supra* at FN 3.
[21] S. 381.026(4)(c)3., F.S.
[22] *Id.*
[23] S. 381.026(4)(c)5., F.S.
[24] *Id.*
[25] S. 408.05, F.S.
[26] S. 408.05(1), F.S.

physicians, health care facilities, and other entities to enable the comparison of health care services.[27] The database includes certain health care quality measures such as average patient charges, the average of undiscounted charges on frequently performed procedures and preventive diagnostic procedures, and a range of charges for procedures from highest to lowest.[28]

Nursing Homes

Administrator Licensure

Nursing home administrators are licensed by the Department of Health (DOH) and the Board of Nursing Home Administrators (board), pursuant to s. 468.1695, F.S., and DOH Rule 64B10-11, F.A.C. Applicants must either:[29]

- Hold a baccalaureate degree from an accredited college or university with a major in health care administration or have credit in at least 60 semester hours in subjects, as prescribed by rule of the board;[30] and complete a college-affiliated or university-affiliated internship or a 1,000-hour nursing home administrator-in-training program approved by the board; or,

- Hold a baccalaureate degree from an accredited college or university; and
    - Complete a 2,000-hour nursing home administrator-in-training program approved by the board; or
    - Have one year of management experience in performing executive duties and skills, including the staffing, budgeting, and directing of resident care, dietary, and bookkeeping departments within a skilled nursing facility, hospital, hospice, assisted living facility with a minimum of 60 licensed beds, or geriatric residential treatment program.

Nursing home administrator applicants are examined by DOH once the board certifies that they have completed the application form and remitted an examination fee. The examination is given two times each year and includes questions on the various subjects of nursing home administration.[31] The board approves the nursing home administrators examination developed and administered by the National Association of Boards of Examiners of Nursing Home Administrators. In addition to the national examination, each applicant must also take an examination on the laws and regulations of the State of Florida which governs the practice of nursing home administrators.[32]

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[27] S. 408.05(3)(k), F.S.
[28] S. 408.05(3)(k)1., F.S.; *see also* 2009 Hospital Financial Data, AHCA, data compiled September 2, 2010- available at http://ahca.myflorida.com/MCHQ/CON_FA/Publications/index.shtml (includes the most recent financial data for hospitals, including costs of daily hospital services, ambulatory services, and other total patient charges); *see also* http://www.floridahealthfinder.gov/CompareCare/CompareFacilities.aspx (provides the range of charges for specific procedures at various facilities throughout Florida, broken down by category, condition or procedure, and age group).
[29] S. 468.1695(2), F.S.; Rule 64B10-11.002, F.A.C.
[30] Florida Department of Health Rule 64B10-11.007, F.A.C.
[31] S. 468.1695(1), F.S.
[32] Rule 64B10-11.002, F.A.C.

Administration and Management

Section 400.021(16), F.S., defines “resident care plan” as a written plan developed, maintained, and reviewed not less than quarterly by a registered nurse, which includes a comprehensive assessment of the needs of an individual resident. The resident care plan is required to be signed by the director of nursing or another registered nurse employed by the facility.

Section 400.141(1)(j), F.S., requires licensees to maintain full patient records. AHCA Rule 59A-4.118, F.A.C., establishes certain requirements regarding the credentials of nursing home records personnel. Specifically, the rule requires nursing homes to employ or contract with a person who is eligible for certification as a registered record administrator or an accredited record technician by the American Health Information Management Association or is a graduate of a school of medical record science that is accredited jointly by the Council on Medical Education of the American Medical Association and the American Health Information Management Association. AHCA Rule 59A-4.118, F.A.C., was promulgated in 1994 and the credentialing organizations referred to in the rule presently do not exist as listed. There is also no authorizing statute that requires nursing homes to contract with a medical records consultant.

Nursing homes are required to maintain records of all grievances, and to report to the agency, upon licensure renewal, various data regarding those grievances.[33] The bill retains the requirement for nursing homes to maintain all grievance records, but removes the requirement that nursing homes report the grievance information at the time of relicensure. The bill requires nursing homes to maintain a report, subject to inspection by AHCA, of the total number of grievances handled.

Resident Transfer and Discharge

The landlord tenant laws under Part II of Chapter 83, F.S., apply generally to the rental of a dwelling unit.[34] Nursing home facilities are governed by the specific transfer and discharge requirements contained in s. 400.0255, F.S, which apply to transfers and discharges that are initiated by the nursing home facility. Facilities are required to provide at least 30 days advance notice of a proposed transfer or discharge to the resident.[35] The notice must be in writing and must contain all information required by state and federal law, rules, or regulations applicable to Medicaid or Medicare cases.[36] Residents are entitled to a fair hearing to challenge a facility’s proposed transfer or discharge.[37] The Department of Children and Family Services’ Office of Appeals Hearings is tasked with conducting the hearings. A hearing decision must be rendered within 90 days after receipt of request for the hearing.[38]

Staffing Requirements

Nursing homes must comply with staff-to-resident ratios requirements. Under s. 400.141(1)(o), F.S., nursing homes are required to semiannually submit to AHCA information regarding facility staff-to-resident ratios, staff turnover, and staff stability, including information regarding certified nursing assistants, licensed nurses, the director of nursing, and the facility administrator. The ratio must be reported as an average of the most recent calendar quarter. Staff turnover must be reported for the most recent 12-month period. The formula for determining staff stability is the total number of employees that have been employed for more than 12 months, divided by the total number of employees employed at the end of the most recent calendar quarter, and expressed as a percentage.

[33] S. 400.1183(2), F.S.
[34] S. 83.41, F.S.
[35] S. 400.0255(7), F.S.
[36] S. 400.0255(8), F.S.
[37] S. 400.0255(10)(a), F.S.
[38] S. 400.0255(15), F.S.

If a nursing home fails to comply with minimum staffing requirements for two consecutive days, the facility must cease new admissions until the staffing ratio has been achieved for six consecutive days. Failure to self-impose this moratorium on admissions results in a Class II deficiency cited by AHCA. All other citations for a Class II deficiency represent current ongoing non-compliance that AHCA determines has compromised a resident's ability to maintain or reach his or her highest practicable physical, mental, and psychosocial well-being. Classifying a failure to cease admissions as a "Class II" deficiency is inconsistent with all other violations in this class. No nursing homes were cited for this violation in 2010.

Pediatric Staffing Requirements

Section 400.23(5), F.S., requires AHCA, in collaboration with the Division of Children's Medical Services within the Department of Health (DOH), to adopt rules for minimum standards of care for persons under 21 years of age who reside in nursing home facilities. In 1997, Rule 59A-4.1295, F.A.C., was adopted to provide these additional standards of care for pediatric nursing homes which consist of the following:

- For residents who require **skilled care**, each nursing home must provide an average of 3.5 hours of nursing care per patient per day. A maximum of 1.5 hours may be provided by a certified nursing assistant (CNA), and no less than 1 hour of care must be provided by a licensed nurse.
- For residents who are **fragile,** each nursing home must provide an average of 5 hours of direct care per patient per day. A maximum of 1.5 hours of care may be provided by a CNA, and no less than 1.7 hours of care must be provided by a licensed nurse.

Do Not Resuscitate Orders

Section 400.142, F.S., requires AHCA to develop rules relating to implementation of do not resuscitate orders (DNRs) for nursing home residents. Criteria for DNRs are found in s. 401.45, F.S., which allows for emergency pre-hospital treatment to be provided by any licensee and provides that resuscitation may be withheld from a patient by an emergency medical technician (EMT) or paramedic if evidence of a DNR is presented.[39] Section 401.45, F.S., also provides rule-making authority to DOH to implement this section and requires DOH, in consultation with the Department of Elderly Affairs and AHCA, to develop a standardized DNR identification system with devices that signify, when carried or worn, that the patient has been issued an order not to administer cardiopulmonary resuscitation by a physician.[40]

DOH developed rule 64J-2.018, F.A.C., which became effective October, 1 2008, while AHCA has yet to promulgate any rules relating to the implementation of DNRs. Rule 64J-2.018, F.A.C., provides the following:[41]

- An EMT or paramedic must withhold or withdraw cardiopulmonary resuscitation if presented with an original or completed copy of DH Form 1896 (Florida DNR Form).
- The DNR Order form must be printed on yellow paper and have the words "DO NOT RESUSCITATE ORDER" printed in black.
- A patient identification device is a miniature version of DH Form 1896 and is a voluntary device intended to provide convenient and portable DNR order form.
- The DNR order form and patient identification device must be signed by the patient's physician.
- An EMT or paramedic must verify the identity of the patient in possession of the DNR order form or patient identification device by means of the patient's drivers' license or a witness in the presence of the patient.

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[39] Section 401.45, F.S.
[40] *Id.*
[41] Florida Department of Health Rule 64J-2.018, F.A.C.

- During transport, the EMT must ensure that a copy of the DNR order form or the patient identification device accompanies the live patient.
- A DNR may be revoked at any time by the patient.

Inspections and Surveys

AHCA employs surveyors to inspect nursing homes. Pursuant to s. 400.275, F.S., newly hired nursing home surveyors must spend two days in a nursing home as part of basic training in a non-regulatory role. Federal regulations prescribe an extensive training process for nursing home inspection staff. Staff must pass the federal Surveyor Minimum Qualifications Test. Federal regulations prohibit an AHCA staff person who formerly worked in a nursing home from inspecting a nursing home within two years of employment with that home; state law requires a five year lapse.

Internal Risk Management and Quality Assurance Program

Sections 400.147(10) and 400.0233, F.S., require nursing homes to report civil notices of intent to litigate and civil complaints filed with clerks of courts by a resident or representative of a resident. This information has been used to produce the Semi-Annual Report on Nursing Homes required by s. 400.195, F.S. However, s. 400.195, F.S., was repealed in 2010.

Section 400.147(7), F.S., requires nursing homes to initiate an investigation and notify AHCA within one business day after the risk manager has received an incident report. The notification must be made in writing and be provided electronically, by facsimile device or overnight mail delivery.

Notice of Bankruptcy and Eviction

Currently, nursing homes are required to notify AHCA of bankruptcy filing pursuant to s. 400.141(1)(r), F.S. However, nursing homes are not required to notify AHCA of eviction, and there is no statutory requirement for other types of facility providers to notify AHCA if served with an eviction notice or of bankruptcy filing.

Geriatric Outpatient Clinics

A geriatric outpatient clinic is a site for providing outpatient health care to individuals at least 60 years of age. Geriatric outpatient clinics must be staffed by a registered nurse, or a physician assistant.[42]

Shared Programming and Staff

Currently, nursing home facilities that meet the following requirements are allowed to share programming and staff:[43]

- Be a part of a continuing care facility or a retirement community that operates on a single campus;
- Have a standard license or have been awarded a Gold Seal; and
- Exceed the minimum required hours of licensed nursing and certified nursing assistant direct care.

If the above requirements are met, licensed nurses and certified nursing assistants who work in the facility may be used to provide services elsewhere on campus. Facilities that choose to do so must be able to demonstrate compliance with the minimum staffing ratios at the time of inspection and in the semiannual report.

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[42] S. 400.021(8), F.S.
[43] S. 400.141(1)(g), F.S.

Respite Care

Section 400.141(1)(f), F.S., allows nursing homes to provide other needed services, including, but not limited to, adult day services, and respite care for people needing short-term or temporary nursing home services. 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.[44] Only nursing homes with standard licensure status with no Class I or Class II deficiencies in the past two years or having Gold Seal status may provide respite services. Respite care is required to be provided in accordance with rules adopted by the Agency for Health Care Administration (AHCA) and AHCA may modify requirements by rule for resident assessment, resident care plans, resident contracts, physician orders, and other provisions for short term or temporary nursing home services.

Sheltered Beds

Section 651.118, F.S., contains provisions relating to AHCA's ability to issue certificates of need for sheltered nursing home beds. Sheltered nursing home beds are those for which a certificate of need has been issued to construct nursing home beds for the exclusive use of the prospective residents of the facility.[45]

Currently, AHCA allows sheltered nursing home beds to be used as extended congregate care beds.[46] Extended congregate care means assistance and care that is beyond that of personal services.[47] The beds must be in a distinct area of the nursing home which can be adapted to meet the requirements for extended congregate care.

Home Health Agencies

A home health agency is an organization that provides home health services and staffing services.[48] Home health agencies are regulated by AHCA pursuant to part III of chapter 400, F.S. Florida law regulates the business relationships of home health agencies, prohibiting "self-referral" situations, in which home health agencies provide monetary incentives for referrals. Section 400.474(6), F.S., provides AHCA the authority to deny, revoke, or suspend the license of a home health agency and impose a fine of $5,000 against a home health agency that gives remuneration to:

- Another home health agency with which it has formal or informal patient-referral transactions or arrangements for staffing services;
- A health services pool with which it has formal or informal patient-referral transactions or arrangements for staffing services;
- A physician without a medical director contract, and the home health agency has received a patient referral in the preceding 12 months from that physician;
- A physician, and the home health agency has more than one medical director contract in effect at one time, and the home health agency has received a patient referral in the preceding 12 months from that physician;
- A member of the physician's office staff, and the home health agency has received a patient referral in the preceding 12 months from that physician; or
- An immediate family member of the physician, and the home health agency has received a patient referral in the preceding 12 months from that physician.

[44] S. 400.021(15), F.S.
[45] S. 651.118(3), F.S.
[46] S. 651.118(8), F.S.
[47] S. 429.02(11), F.S.
[48] S. 400.462(12), F.S.

Remuneration is defined as any payment or other benefit made directly or indirectly, overtly or covertly, in cash or in kind.[49]

Homemaker and Companion Organizations

Section 400.509, F.S., requires the registration of organizations that provide homemaker and companion or sitter services to disabled adults and elderly persons. Homemakers provide services such as housekeeping, errands, shopping, and meal preparation. Companions or sitters keep people company and take them to recreational activities, shopping or appointments. Homemakers and companions cannot provide any hands-on personal care.[50] Personal care must be provided by home health aides and CNAs that work for licensed home health agencies and nurse registries.

There are currently 2,303 registered organizations providing homemaker and companion services.[51] Of that total, 503 are contractors of the Agency for Persons with Disabilities (APD) who provide companion services through the Developmental Disabilities Medicaid Waiver.[52] APD requires training and experience as well as background screening, while AHCA only requires background screening prior to registration.

The 1999 Florida Legislature exempted from home health agency and nurse registry licensure, the companion and sitter organizations that were registered by AHCA on January 1, 1999, and were authorized to provide personal services to developmentally disabled persons on January 1, 1999, and permitted the organizations to continue to provide services to any past, present and future clients who need personal care services.[53] Currently there are seven organizations that are exempt under this law.[54]

Nurse Registries

A nurse registry is defined as any person that procures, offers, promises, or attempts to secure health-care-related contracts for registered nurses, licensed practical nurses, CNAs, home health aides, companions, or homemakers, who are compensated by fees as independent contractors to provide services to patients, or staffing services to facilities.[55] Nurse registries are regulated by AHCA pursuant to part III of chapter 400, F.S.

Hospice

Section 400.601(3), F.S., defines “hospice” as a centrally administered corporation providing a continuum of palliative and supportive care for a terminally ill patient and his or her family.

Section 408.810(8) F.S., requires any hospice initial or change of ownership applicant show anticipated provider revenue and expenditures, the basis for financing anticipated cash flow requirements and access to contingency financing. Section 400.606(1)(l), F.S., requires that an annual operating budget be submitted, which duplicates the financial information now required in the Act.

The hospice authorizing statutes and federal regulations require that hospices have inpatient beds for pain control, symptom management, and respite care. Inpatient beds may be in a hospital, skilled nursing facility or a freestanding inpatient facility operated by a hospice. Section 408.043, F.S.,

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[49] S. 400.462(27), F.S.
[50] S. 400.462(7),(16), F.S.
[51] AHCA, *Staff Analysis and Economic Impact, House Bill Number 1419* (January 20, 2012).
[52] *Id.*
[53] S. 400.464(5)(b)4, F.S.
[54] AHCA, *Staff Analysis and Economic Impact, House Bill Number 1419* (January 20, 2012).
[55] S. 400.462(21), F.S.

requires that there be a certificate of need for a hospice freestanding facility "primarily engaged in providing inpatient care and related services." This provision is repeated in the Act.

Home Medical Equipment

Section 400.931(2), F.S., allows a bond be posted as an alternative to submitting proof of financial ability to operate as a home medical equipment provider. Section 408.8065, F.S., requires the submission of financial statements demonstrating the ability to fund start up costs, working capital, and contingency requirements.

Health Care Clinics

Pursuant to the Health Care Clinic Act, AHCA licenses entities that meet the definition of a "clinic": "an entity at which health care services are provided to individuals and which tenders charges for reimbursement for such services…".[56]

Although all clinics must be licensed, s. 400.9905(4), F.S., contains a listing of entities that are not considered a "clinic" for purposes of licensure, including:

- Entities licensed or registered by the state under one or more specified practice acts and that only provide services within the scope of their license, and entities that own such entities, and entities under common ownership with such entities;
- Entities that are exempt from federal taxation under 26 U.S.C. sec. 501(c)(3) or sec. 501(c)(4);
- Community college and university clinics;
- Entities owned or operated by the federal or state government;
- Clinical facilities affiliated with an accredited medical school which provides certain training;
- Entities that provide only oncology or radiation therapy services by physicians and are owned by publicly-traded corporations;
- Clinical facilities affiliated with an accredited certain college of chiropractic which provides certain training;
- Entities that provide a certain amount of practitioner staffing or anesthesia services to hospitals; and
- Orthotic or prosthetic facilities owned by publicly-traded corporations.

Local Health Councils

Local health councils are established in s. 408.033, F.S., as public or private nonprofit agencies to provide certain health related services to the counties of a district. Funding for local health councils is provided in s. 408.033(2), F.S., which states the cost of local health councils is to be borne by assessments on selected health care facilities subject to facility licensure by AHCA. Currently there is no timetable in statute addressing when fees are to be paid.

Assisted Living Facilities

Section 429.195, F.S., prohibits ALFs from contracting to pay or receive any commission, bonus, kickback, or rebate with any person for resident referrals. These actions are considered patient brokering and are punishable as a third degree felony as provided in s. 817.505, F.S.

Adult Day Care Services

Section 429.905(2), F.S., allows licensed assisted living facilities (ALFs), hospitals, and nursing homes to provide adult day care services during the day to adults who are not residents of the facility without

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[56] Section 400.9905(4), F.S.

being licensed as an adult day care center. AHCA is required to monitor the facility during the regular inspection and at least biennially to ensure adequate space and sufficient staff is provided. However, if an ALF, hospital, or nursing home holds itself out to the public as an adult day care center, it must be licensed as such.

Section 429.901, F.S., defines "adult day care center" as providing basic services, *for a part of the day*, to three or more individuals who are at least 18 years of age, who are not related to the owner or operator by blood or marriage, and who require such services. Currently, AHCA interprets the provision of day care services to be services rendered during a *business* day.[57] Rule 58A-6.002, F.A.C., defines "daily attendance" as the number of participants who, during any one *calendar or business day*, attend the center. According to AHCA, they have informed the public, and denied request for centers wishing to provide services during late-night hours.[58]

Controlled Substance Regulation

Prescribing

As of January 1, 2012, every physician, podiatrist, or dentist who prescribes controlled substances to treat chronic nonmalignant pain must register as a controlled substance prescribing practitioner and comply with certain practice standards. "Chronic nonmalignant pain" is pain unrelated to cancer or rheumatoid arthritis which persists beyond the usual course of disease or the injury causing the pain or more than 90 days after surgery.[59]

The statutory practice standards require the practitioner to document the nature of the pain, success of past treatments, any underlying health problems, and any history of alcohol and substance abuse. The practitioner must write a plan for assessing the patient's risk for aberrant drug-related behavior and monitor such behavior throughout the course of controlled substance treatment. The practitioner must also enter into a controlled substance agreement with each patient, which must include the risks and benefits of controlled substance use, including the risk for addiction or dependence; the number and frequency of permitted prescriptions and refills; a statement of reasons for discontinuation of therapy, including violation of the agreement; and the requirement that the patient's pain only be treated by one practitioner at a time unless otherwise authorized and documented. This agreement must be signed by the patient or his or her legal representative and by the prescribing practitioner.[60]

Such patients must be seen by their prescribing practitioners at least once every 3 months to monitor progress and compliance, and the prescriber must maintain detailed medical records. Patients at special risk for drug abuse, or with a psychiatric disorder, require consultation with or referral to an addictionologist or a psychiatrist. "Addictionologist" is not defined.

Board-certified anesthesiologists, physiatrists, neurologists, and certain surgeons are exempt from these provisions. Similarly, certain board-certified specialists, who are also board-certified in pain medicine by a board approved by the American Board of Medical Specialties (ABMS)[61] or the American Osteopathic Association[62], are also exempt.

[57] AHCA, *Staff Analysis and Economic Impact, House Bill Number 787* (January 28, 2012); Rule 58A-6.002(g), F.A.C.
[58] *Id.*
[59] S. 456.44, F.S.
[60] *Id.*
[61] The American Board of Medical Specialties (ABMS) certifies physicians in medical subspecialties. Established in 1933, ABMS assists 24 member specialty boards in developing and implementing standards in the ongoing evaluation and certification of physicians. ABMS member boards certify physicians in more than 150 different specialties and subspecialties. ABMS board certification is available to both allopathic and osteopathic physicians. *See* American Board of Medical Specialties, *About ABMS,* available at http://www.abms.org. (last viewed February 20, 2012).
[62] The American Osteopathic Association issues certificates of added qualification. *See* American Osteopathic Association, *Certification of Osteopathic Physicians,* available at http://www.osteopathic.org/osteopathic-health/about-dos/do-certification/Pages/default.aspx (last viewed February 20, 2012).

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. Pain-management clinics are regulated by the physician practice acts in s. 458.3265, F.S., and s. 459.0137, F.S. All pain management clinics must register with DOH and meet certain provisions concerning staffing, sanitation, recordkeeping, and quality assurance. Clinics are exempt from registration if they are:

- Licensed as a hospital, ambulatory surgical center, or mobile surgical facility;
- Staffed primarily by surgeons;
- 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 students, 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);
- Wholly owned and operated by board-certified anesthesiologists, physiatrists, or neurologists; or
- Wholly owned and operated by certain board-certified specialists who have completed certain fellowships or who are board-certified in pain medicine by a board approved by ABMS.

All clinics must be owned by at least one licensed physician or be licensed as a health care clinic under part X of ch. 400, F.S., to be eligible for registration. DOH is prohibited from registering an entity:

- Not owned by 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 have been convicted of certain drug-related crimes in any jurisdiction.

<u>Clinical Laboratories – Prohibited Kickbacks</u>

Section 483.245, F.S., prohibits clinical laboratories from providing any commission, bonus, kickback, or rebate to any person or organization in return for patient referrals and requires AHCA to adopt rules that assess administrative penalties for such acts. Current law does not define what constitutes a rebate, commission, bonus, split-fee arrangement or kickback. AHCA rule defines a "kickback" as any:

> compensation arrangement or incentive to refer any individual or specimen to a laboratory; an actual payment or investment interest; provision of test kits, systems or other laboratory supplies; or provision of personnel or assistance of any kind to perform any duties for the collection or processing of specimens.[63]

A collection station is a facility operated by a clinical laboratory where materials or specimens are withdrawn or collected from patients for subsequent delivery to another location for examination.[64] AHCA Rule 59A-7.024, F.A.C., authorizes clinical laboratories to maintain one or more collection stations provided they first obtain written approval from AHCA and they can only forward specimens to the clinical laboratory by which they are maintained.

In 2008, AHCA was petitioned for a declaratory statement related to the placing of specimen collectors in physician's offices without a lease agreement, and whether laboratories could provide free specimen

[63] Rule 59A-7.020(14), F.A.C.
[64] S. 483.041(5), F.S.

cups when they also provide an on-site clinical laboratory test.[65] The declaratory statement was issued by AHCA on July 8, 2008, declaring that the placement of specimen collectors in a physician's office was a violation of this regulation, as was the provision of free specimen cups that offer physicians an instant test reading on-site.[66]

Further, AHCA issued a letter to providers in 2011 restating the general rule that the collection of specimens by laboratory staff at physician's offices is not permitted unless appropriate payment is made for the service. The letter also addressed lease arrangements, which must be for "a commercially reasonable business purpose" and not for the purpose of inducing referrals.[67] AHCA is currently engaged in administrative litigation related to its interpretation of what constitutes a kickback.[68]

Medicaid – Prescription Drug Prior Authorization

Prior authorizations are currently used when a physician does not use the Medicaid preferred drug list when prescribing medication. A prior authorization is required to ensure there is an appropriate reason for Medicaid to pay for a drug not on the Medicaid preferred drug list. When a prior authorization is requested it is reviewed and tested for compliance with certain criteria.

Physicians are required to provide information to AHCA about the rationale and supporting medical evidence for the use of a drug. Currently, AHCA is authorized but not required to electronically post prior authorization criteria, protocol, and updates to the list of drugs that are subject to prior authorization without amending its rule or engaging in additional rulemaking.

Effect of Proposed Changes

Health Care Licensing Procedures Act

License Renewal Notices

The bill clarifies that renewal notices are courtesy reminders only and do not excuse the licensees from the requirement to file timely licensure applications. The revised language gives AHCA flexibility to use or not use certified mail to send courtesy renewal reminders.

Classification and Fines for Violations

The bill establishes uniform sanction authority for unclassified deficiencies of up to $500 per violation. Examples of unclassified deficiencies include failure to maintain insurance and other administrative requirements, exceeding licensed capacity, or violating a moratorium. Without fine authority, AHCA would be required to initiate revocation action for violations against those providers that do not have general fine authority. These violations may not warrant such a severe sanction.

Billing Complaint Authority

The bill repeals AHCA's independent authority related to billing complaints in the Act. However, a review for regulatory compliance will continue to be conducted when a billing complaint is received for

[65] AHCA, *Staff Analysis and Economic Impact, House Bill Number 1419* (January 20, 2012).
[66] *In Re: Petition for Declaratory Statement of Dominion Diagnostics, LLC.,* Fraes No. 2008008228, available at http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Laboratory_Licensure/docs/FinalOrderDominion2008.pdf (last viewed February 1, 2012).
[67] AHCA "Letter to Laboratory Directors Regarding Kickbacks in Clinical Laboratories", August 5, 2011, available at http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Laboratory_Licensure/kickback.shtml (last viewed February 1, 2012).
[68] *Ameritox, Ltd., v. AHCA*, DOAH Case No. 11-006205. At issue is whether a clinical laboratory may obtain a separate permit for a collection station located in a physician's office.

one of the providers over which AHCA has well-defined statutory authority. This review could possibly result in citations and discipline.

License Display

The bill makes it a second degree misdemeanor to knowingly alter, deface, or falsify a license and is punishable by up to 60 days in jail and a fine of up to $500. The bill makes it an administrative violation for a licensee to display an altered, defaced, or falsified license. Such violations are subject to licensure revocation and a fine of up to $1,000 per day.

Hospitals

Private Utilization Review

The bill removes private review agents from the list of entities to which the Health Care Licensing Procedures Act applies, in s. 408.802, F.S. This conforms the section to the 2009 repeal of this regulatory function.

Certificates of Need

The bill provides an exception to the 60-minute transfer requirement, as it relates to both the CON requirements in s. 408.036, F.S., and the licensure requirements for hospitals seeking a Level I adult interventional cardiology program license pursuant to s. 408.0361, F.S. Hospitals located more than 100 miles from the closest Level II adult cardiovascular services program do not need to meet the 60-minute transfer time protocol if the hospital demonstrates that it has a written transfer agreement with a hospital that has a Level II program.

The bill modifies s. 408.037, F.S., to allow audited financial statements of an applicant's parent corporation instead of the audited financial statements of an applicant when such statements do not exist.

Urgent Care Centers

The bill amends the definition of "urgent care center" to include any entity that holds itself out to the general public, in any manner, as a facility or clinic where immediate, but not emergent, care is provided, expressly including:

- Offsite facilities of hospitals or hospital-physician joint ventures; and
- Licensed health care clinics that operate in three or more locations.

The schedule of charges for medical services posted by an urgent care center must describe each medical service in language comprehensible to a layperson. This provision prevents a center from using medical or billing codes, Latin phrases, or technical medical jargon as the only description of each medical service. The bill also requires the text of the schedule of medical charges to fill at least 12 square feet of the total 15 square feet area of the posted schedule, and allows use of an electronic device for the posting. The device must measure at least three square feet in size and be accessible to all consumers during business hours.

The bill exempts an urgent care center that is operated and used exclusively for employees and dependents of employees of the business that owns, or contracts to operate, the urgent care center from the posting requirements of s. 395.107, F.S., outlined above.

In situations in which the care center is affiliated with a facility licensed under chapter 395, F.S.,[69] the schedule of medical charges must include a statement, in a font which is the same size as other text on the schedule and in a contrasting color, explaining whether charges for medical care received at the care center will be the same as, or more than, the charges for medical care received at the facility licensed under chapter 395. The statement must be included in all advertisements for the care facility and must be in language comprehensible to a layperson.

Nursing Homes

Administrator Licensure

The bill amends s. 468.1695(2), F.S., to revise the education requirements for nursing home administrators to include applicants with a health services administration or equivalent major.

Administration and Management

The bill removes the requirement that the director of nursing or other administrative nurse sign the resident care plan.

The bill amends s. 440.141(1)(j), F.S., to include federal language regarding maintenance of medical records consistent with federal medical records regulations contained in Title 42, Code of Federal Regulations. Specifically, the federal regulations require nursing homes to maintain medical records in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized.[70] The addition of these federal standards will require the repeal of AHCA Rule 59A-4.118, F.A.C., related to the credentials of medical records personnel.

Resident Transfer and Discharge

The bill adds language to clarify that nursing home residents are excluded from the landlord tenant laws found under part II of chapter 83, F.S. The transfer and discharge procedures under s. 400.0255, F.S., govern all transfers and discharges for residents of all facilities licensed under part II of chapter 400, F.S.

Staffing Requirements

The bill removes the requirements under s. 400.141(1)(o), F.S., for reporting staff-to-resident ratio information semiannually to AHCA.

The bill modifies the penalty for nursing homes that fail to self-impose an admissions moratorium for insufficient staffing to a fine of $1,000 instead of a Class II deficiency.

Pediatric Staffing Requirements

The bill codifies in law the current AHCA rule on pediatric staffing requirements for nursing homes that serve individuals less than 21 years of age. Further, the bill provides that these rules are to apply in lieu of the standards contained in s. 400.23(3)(a), F.S. The staffing requirements are as follows:

- For individuals under age 21 who require **skilled** care, each nursing home facility must provide a minimum combined average of licensed nurses, respiratory therapists, respiratory care

[69] S. 395.002(12), F.S., (hospital); s. 395.002(3), F.S., (ambulatory surgical center); s. 395.002(21), F.S., (mobile surgical facility); s. 395.002(28), F.S., (specialty hospital).
[70] 42 C.F.R. 483.75.

practitioners and CNAs of 3.9 hours of direct care per resident per day. The 3.9 hours must consist of:
  - No less than 1 hour of licensed nursing care; and
  - No more than 1.5 hours of CNA care.

- For individuals under age 21 who are **fragile**, each nursing home must include a minimum combined average of licensed nurses, respiratory therapists, respiratory care practitioners and CNAs of 5.0 hours of direct care per resident per day. The 5 hours must consist of:
  - No less than 1.7 hours of licensed nursing care; and
  - No more than 1.5 hours of CNA care.

The bill requires one registered nurse to be on duty 24 hours per day for both skilled nursing and medically fragile facilities.

Do Not Resuscitate Orders

The bill removes the requirement for AHCA to promulgate rules related to the implementation of DNRs for nursing home residents. This requirement appears to be duplicative of DOH rulemaking authority in s. 401.45(5), F.S.

Inspections and Surveys

The bill removes the requirement for new AHCA nursing home inspection staff to spend two days in a nursing home as part of basic training and aligns staff requirements with federal regulations. AHCA nursing home staff must still be fully qualified under federal requirements for the Surveyor Minimum Qualifications Test.

Internal Risk Management and Quality Assurance Program

The bill eliminates the requirement to report notices of intent to litigate and civil complaints. The bill also eliminates the requirement that nursing homes notify AHCA in writing when they initiate an investigation. However, providers must still initiate their own evaluation within one day. A full report is still required to be sent to AHCA within 15 calendar days after the adverse incident occurs.

Notice of Bankruptcy and Eviction

The bill amends s. 408.810, F.S., to require providers' controlling interests to notify AHCA within 10 days after a court action to initiate bankruptcy, foreclosure, or eviction proceedings. This requirement applies to any such action to which the controlling interest is a petitioner or defendant.

Geriatric Outpatient Clinics

The bill adds to the list of professionals authorized to staff a geriatric outpatient clinic. Currently, geriatric outpatient clinics must be staffed by a registered nurse or a physician assistant. The bill allows a licensed practical nurse under the direct supervision of a registered nurse, advanced registered nurse practitioner, physician assistant, or physician to staff a geriatric outpatient clinic.

Shared Programming and Staff

Facilities that choose to share programming and staff are required to prove compliance with minimum staffing requirements at the time of inspection and in the semiannual report. The bill eliminates the requirement to prove compliance with staffing requirements in the semiannual report. Facilities will still be required to demonstrate at the time of inspection that minimum staffing requirements are met. The

bill also removes the requirement for the facility to be a Gold Seal facility to be able to share programming and staff. This will allow more facilities with a standard license to participate in shared staffing and be able to move staff to areas where they feel they are needed, provided they are in compliance with the minimum staffing requirements.

Respite Care

The bill amends s. 400.141, F.S., to expand the ability of nursing homes to provide additional services to nonresidents of nursing home facilities.

Currently, nursing homes must have a standard license, have no class I or class II deficiencies in the previous two years, or have been awarded a Gold Seal to provide additional services including, but not limited to, respite, and adult day services. The bill allows all licensed nursing homes to provide additional services without limitation based on prior deficiencies or recognition as a Gold Seal facility. As a result, more facilities with a standard license will have the opportunity to provide these services to clients.

In addition to respite, and adult day services the bill allows for the provision of therapeutic spa services, and defines such services to mean bathing, nail, hair care, and other similar services related to personal hygiene.

The bill creates s. 400.172, F.S., to include the following regulations and provisions for overnight respite care in nursing homes:

- Requires facilities to have a written abbreviated plan of care and a contract;
- Requires prospective respite care recipients to provide medical information to the facility;
- Allows respite care recipients to bring their medications from home if permitted by the facility; and
- Allows respite care recipients to reside in the facility for 60 days within a contract or calendar year, provided each stay does not exceed 14 consecutive days.

Sheltered Beds

The bill amends s. 651.118(8), F.S., to allow sheltered beds to be used not only to provide extended congregate care, but standard and limited nursing services as well. This will result in nursing homes being able to utilize their sheltered beds to provide care to individuals with various levels of acuity.

Home Health Agencies

The bill amends s. 400.462(27), F.S., revising the definition of "remuneration" to allow home health agencies to distribute items with an individual value of up to $15 and which include, but are not limited to, plaques, certificates, trophies, or novelties that are intended solely for promotional, recognition, or advertising purposes.

Homemaker and Companion Organizations

The bill amends s. 400.509, F.S., to exempt organizations that only provide companion services to developmentally disabled persons under contract with APD from registration by AHCA. The exemption is expected to result in estimated annual savings to providers of $123,486.[71]

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[71] AHCA, *Staff Analysis and Economic Impact, House Bill Number 1419* (January 20, 2012).

Nurse Registries

The bill amends s. 400.506, F.S., to authorize an administrator of a nurse registry to manage up to five registries if all five registries have identical controlling interests and are located within one AHCA-geographic service area or an immediately contiguous county. The administrator must designate in writing a qualified alternate administrator to serve at each licensed entity when the administrator is not present.

Hospice Licensure

The bill amends s. 400.601(3), F.S., to include limited liability companies in the definition of "hospice".

The bill removes the requirement for hospice licensure applicants to submit a projected annual operating budget. Financial projections are already submitted as part of the proof of financial ability to operate as required in the Act; therefore, this removes duplicative requirements.

The bill amends the hospice authorizing statutes related to certificates of need for inpatient hospice facilities. The bill eliminates the modifier "primarily" to provide that any provision of inpatient hospice care, in any facility not already licensed as a health care facility (like a hospital or nursing home), requires a certificate of need. However, the bill does not make the same changes to the parallel provision in the Act, making the effect of the bill change unclear.[72]

Home Medical Equipment

The bill deletes the provisions of s. 400.931, F.S., related to the ability to submit a bond as an alternative to submitting proof of financial ability to operate. Due to 2009 legislative changes, financial oversight is now addressed in the Act. In addition, the bill requires out-of-state home medical equipment providers to be accredited to be licensed in Florida.

Health Care Clinics

The bill creates exemptions from licensure for:

- Entities owned by a corporation generating more than $250 million in annual sales and which have at least one owner who is a health care practitioner; and
- Entities that employ 50 or more licensed health care practitioners where the billing for medical services is under a single tax identification number.

Local Health Councils

The bill requires fees to be collected prospectively at the time of licensure renewal and prorated for the licensure period.

Assisted Living Facilities

The bill amends s. 429.195(3), F.S., providing that the following activities are not prohibited patient brokering by ALFs and are not punishable as third degree felonies:

- Employing or contracting for marketing services;
- Referral services which provide information, consultation, or referrals to consumers; and
- Referrals to an ALF by residents of the ALF.

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[72] S. 408.043(2), F.S.

Adult Day Care Services

The bill amends s. 429.905(2), F.S., defining the term "day" as any portion of a 24-hour day. As a result, ALFs, hospitals and nursing homes will be able to provide adult day services at any time during a 24-hour day. According to AHCA, adult day care centers are inspected during day-time hours.[73] The change will also require inspections of centers and facilities during non-daytime hours, including evenings and weekends. AHCA currently inspects various facility types during evening and weekend hours, but this would require inspections during the hours these facilities choose to perform such services.

Controlled Substance Regulation

Prescribing

The bill amends regulation of controlled substance prescribing. The definition of "addiction medicine specialist" is revised to include a board-certified psychiatrist and delete reference to a board-certified physiatrist. The definition of "board-certified pain management physician" is amended to include a physician certified in pain management by the ABMS.[74]

The bill requires registration as a controlled substance prescriber only if the physician prescribes controlled substances in schedules II-IV, rather than any schedule.

The bill revises the standard of care for patients especially at risk for substance abuse, to require consultation and referral to an addiction medicine specialist and a psychiatrist, rather than an addictionologist or a physiatrist.

The bill creates additional exemptions from the registration and standards of practice requirements. It exempts board-certified rheumatologists, and excludes pain related to rheumatoid arthritis from the definition of "chronic nonmalignant pain". The bill also expands the current exemption for certain board-certified practitioners to include board eligible practitioners, defines "board-eligible", and adds certification by the American Board of Pain Medicine to the list of valid certifications. In addition, the bill excludes physicians who prescribe medically necessary controlled substances for a patient during a hospital inpatient stay.

Pain Management Clinics

The bill amends regulation of pain clinics. The bill amends s. 458.3265, F.S., and s. 459.0137, F.S., to add the following exemptions from registration as a pain-management clinic:

- Clinics wholly owned and operated by one or more board-certified rheumatologists;
- Clinics wholly owned and operated by one or more board-eligible anesthesiologists, physiatrists, rheumatologists, or neurologists; and
- Clinics wholly owned and operated by board-eligible or board-certified medical specialists in a multi-specialty practice in which one or more of the specialists has completed a fellowship in pain medicine approved by certain accrediting organizations or is also board-certified in pain medicine, recognized by certain accrediting organizations, and performs interventional pain procedures.

[73] AHCA, *Staff Analysis and Economic Impact, House Bill Number 787* (January 28, 2012).
[74] However, the term "board-certified pain management physician" is not used in current law or in the bill.

The bill adds American Board of Pain Medicine[75], the American Association of Physician Specialists, and the American Osteopathic Association to the list of board-certification or approval entities valid for clinic exemption purposes.

The bill defines "board-eligible" and revises the definition of "chronic nonmalignant pain" to include pain related to rheumatoid arthritis.

Clinical Laboratories – Prohibited Kickbacks

The bill amends s. 483.245(1), F.S., to prohibit a clinical laboratory from providing personnel to perform any functions or duties in a physician's office for any purpose, including the collection of handling specimens, unless the clinical lab and the physician's office are owned and operated by the same entity. The bill requires AHCA to investigate all complaints of non-compliance and authorizes AHCA to impose a fine of $5,000 for each separate violation.

Medicaid – Prescription Drug Prior Authorization

The bill amends s. 409.912, F.S., to require AHCA to electronically post prior authorization and step edit criteria, protocol, and updates to the list of drugs that are subject to prior authorization on their website. In addition, the bill requires AHCA to post the information on their website within 21 days after the prior authorization and step edit information is approved by AHCA. The bill provides a definition of the term "step edit" as an automatic review of certain medications subject to prior authorization.

According to AHCA, posting prior authorization criteria may make it easier for physicians to circumvent prior authorizations protocols, which could result in a cost increase to the program.[76]

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

[75] The American Board of Pain Medicine (ABPM) administers a psychometrically developed and practice-related examination in the field of pain medicine to qualified candidates. Physicians who have successfully completed the ABPM credentialing process and examination are issued certificates as specialists in the field of pain medicine and designated as Diplomates of ABPM. *See* American Board of Pain Medicine, *About ABPM*, available at http://www.abpm.org/about (last viewed on February 23, 2012).

[76] AHCA, *Staff Analysis and Economic Impact, House Bill Number 1419* (January 20, 2012).

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill is expected to result in combined annual savings of approximately $2,102,176 for providers and applicants.[77]

The following provisions are expected to save providers an estimated $1,402,176 annually:

- Removing the requirement for nursing homes to employ or contract with a medical records consultant – saving $335,000;
- Allowing nurse registries to share an administrator for up to five nurse registries with common controlling interests – saving $943,690; and
- Removing the requirement for companion organizations that are also contractors of the Agency for Persons with Disabilities to be registered with AHCA – saving $123,486.

Modifying certificate of need requirements to allow audited financial statements of an applicant's parent corporation is expected to result in savings of $700,000 annually for applicants.

D. FISCAL COMMENTS:

None.

[77] AHCA, *Staff Analysis and Economic Impact, House Bill Number 1419* (January 20, 2012).