Health & Human Services Quality Subcommittee

Wednesday, April 6, 2011
8:00 AM
306 HOB

Dean Cannon
Speaker

John Wood
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health & Human Services Quality Subcommittee

Start Date and Time: Wednesday, April 06, 2011 08:00 am

End Date and Time: Wednesday, April 06, 2011 11:00 am

Location: 306 HOB
Duration: 3.00 hrs

Consideration of the following bill(s):

HB 393 Treatment Programs for Impaired Practitioners by Davis
HB 471 Cord Blood Banking by Nuñez
HB 585 Pharmacy by Broxson
HB 831 High School Athletic Trainers by Rooney
HB 1037 Continuing Care Retirement Communities by Bembry, Passidomo
HB 1289 Medicaid Eligibility by Ahern

Pursuant to rule 7.12, the deadline for amendments to bills on the agenda by non-appointed members shall be 6:00 p.m., Tuesday, April 5, 2011.

By request of the chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Tuesday, April 5, 2011.

NOTICE FINALIZED on 04/04/2011 16:24 by Iseminger.Bobbye

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 471 Cord Blood Banking
SPONSOR(S): Nuñez
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health & Human Services Quality Subcommittee		Prater	Calamas
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

This bill amends Section 381.06015, F.S., relating to the Public Cord Blood Tissue Bank, requiring the Department of Health (DOH) and the Agency for Health Care Administration (AHCA) to encourage health care providers to disseminate information and options for umbilical cord blood banking to a pregnant woman before the third trimester of pregnancy. The bill also requires the state Surgeon General to post an internet link on the Department's website containing resources and information related to cord blood. The bill also states that a health care facility or health care provider may not be held liable in any manner or be subject to criminal penalties for providing information regarding umbilical cord blood banking.

This bill appears to have no fiscal impact.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

After a baby is born and the umbilical cord is cut, some blood remains in the blood vessels of the placenta and the portion of the umbilical cord that remains attached to it.[1] After birth, the baby no longer needs this extra blood. This blood is called placental blood or umbilical cord blood.[2]

Umbilical cord blood contains rich amounts of stem cells known as hematopoietic progenitor cells (HPCs).[3] When transplanted, these cells have been shown to be effective in the treatment of blood disorders such as leukemia, lymphoma, and sickle cell anemia.[4] Although HPCs can also be obtained from bone marrow, obtaining them from umbilical cord blood poses less risk to the donor and carries a lower potential for infectious disease transmission. In addition, umbilical cord blood is more readily available than other HPC sources.[5]

There are several options for handling cord blood available to parents:

1. Donating to a public cord blood bank. The blood can then be used by any patient who needs a transplant. Donating to a public cord blood bank is free.[6]
2. Storing it in a private family cord blood bank. People who use a family cord blood bank to store their baby's cord blood for exclusive use by their family are charged a fee for collection, as well as annual storage fees.[7] The typical collection fee ranges from $1,600 to $2,000, and the typical annual storage fee is $125.[8]
3. Save it for a sibling that has a medical need. When a biological sibling has a disease that may be treated with a bone marrow or cord blood transplant, parents can choose to save their baby's cord blood for directed donation. Collecting and storing cord blood for directed donation is often offered at little or no cost through some public and family cord blood banks.[9]
4. Donating it for research studies. Laboratories and technology companies conduct studies to help improve the transplant process for future patients. The collection process for research is free.[10]

The American Medical Association issued an opinion relating to cord blood stating that the utility of umbilical cord blood stem cells is greater when the donation is to a public rather than private bank and that physicians should encourage women wishing to donate cord blood, to donate to a public bank, if one is available. Further, they suggest that private banking should be considered only in the unusual

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[1] National Cord Blood Program, *see* www.nationalcordbloodprogram.org/qa/ (last viewed on March 25, 2011).
[2] *Id.*
[3] The National Institute of Health, *see* http://stemcells.nih.gov/info/scireport/chapter5.asp (last viewed on March 25, 2011).
[4] Health Resources and Services Administration, U.S. Department of Health and Human Services, *see* http://bloodcell.transplant.hrsa.gov/ABOUT/index.html (last viewed on March 25, 2011).
[5] Cord Blood: Establishing a National Hematopoietic Stem Cell Bank Program, Executive Summary: Institute of Medicine
[6] National Marrow Donor Program, Options for Umbilical Cord Blood, s*ee* http://www.marrow.org/HELP/Donate_Cord_Blood_Share_Life/Options_for_Umbilical_Cord_Blo/index.html (last viewed on March 25, 2011.
[7] *Id.*
[8] Cyro-Cell, Stem Cell Storage Plans, *see* http://www.cryo-cell.com/services/pricing.asp (last viewed on March 25, 2011); ViaCord, Pricing & Storage Plans, *see* http://www.viacord.com/pricing-storage-plans.htm (last viewed on March 25, 2011); Cord Use, Pricing and Payment Plans, *see* https://familycordbloodbank.corduse.com/enrollment-cord-use-pricing.php (last viewed on March 25, 2011); and Cbr cord blood registry, Pricing and Payment Options, *see* http://www.cordblood.com/pricing/index.asp (last viewed on March 25, 2011).
[9] National Marrow Donor Program, Options for Umbilical Cord Blood, s*ee* http://www.marrow.org/HELP/Donate_Cord_Blood_Share_Life/Options_for_Umbilical_Cord_Blo/index.html (last viewed on March 25, 2011.
[10] *Id.*

circumstance when there is a family predisposition to a condition in which umbilical cord stem cells are needed and that private banking should not be recommended to low-risk families.[11]

Cord blood is collected by clamping the baby's umbilical cord after birth and collecting blood from the umbilical cord and placenta into a sterile bag. With public donation, the blood sample is given an identification number and stored temporarily. A sample of the mother's blood is then tested for infectious diseases, and within one or two days, the cord blood unit is delivered to the public cord blood bank.[12] ViaCord, a private cord blood banking company, provides a kit to the parents. The kit is then given to the medical staff that is delivering the baby and the cord blood is collected and given back to the parents. ViaCord then arranges a medical courier to come to the hospital and pick up the cord blood. The cord blood is then transported to a ViaCord processing laboratory where it is tested and stored.[13]

While private cord blood banking can be done from anywhere in the country, public cord blood donation can only occur in participating hospitals.[14] Public cord blood banks cover the costs to collect, test and store umbilical cord blood. However, because of funding limitations, cord blood cannot be donated at every hospital.[15] There are less than 200 hospitals that collect cord blood donations in the US.[16] In Florida, there are only 6 hospitals that participate in public cord blood banking.[17] However, in some circumstances, public cord blood banks can collect donations from non-participating hospitals, although only limited donations of this kind are accepted.[18] Public cord blood banks are funded through the sale of their samples, which are used for transplants, often paid for by the insurance company of the person receiving the transplant.[19]

During the 2000 Legislative Session, legislation was approved to create the Public Cord Blood and Tissue Bank. The Public Cord Blood and Tissue Bank was created as a consortium made up of 3 Florida Universities and the Mayo Clinic. The consortium was to collaborate together and within their communities to analyze and store umbilical cord blood as a resource to the public. The consortium was directed to conduct research outreach activities specifically aimed at minority populations.[20] The legislation directed the consortium participants, AHCA, and DOH to seek private or federal funds to initiate the program. However, the Public Cord and Tissue Bank was never created.

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[11] American Medical Association, Code of Medical Ethics, Opinion 2.165, *see* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2165.page (last viewed on March 25, 2011).
[12] National Marrow Donor Program, Options for Umbilical Cord Blood, *see* http://www.marrow.org/HELP/Donate_Cord_Blood_Share_Life/Options_for_Umbilical_Cord_Blo/index.html (last viewed on March 25, 2011.
[13] ViaCord, Our Services, Frequently Asked Questions, *see* http://www.viacord.com/general-faq.htm#Does%20the%20hospital%20need%20to%20provide%20any%20materials%20for%20collection? (last viewed on March 25, 2011).
[14] National Marrow Donor Program, Where to donate cord blood, *see* http://www.marrow.org/HELP/Donate_Cord_Blood_Share_Life/How_to_Donate_Cord_Blood/CB_Participating_Hospitals/nmdp_cord_blood_hospitals.pl (last viewed on March 25, 2011).
[15] *Id.*
[16] Parents Guide to Cord Blood Foundation, Public Cord Blood Banks in the U.S., *see* http://www.parentsguidecordblood.com/content/usa/banklists/publicbanks_new.shtml (last viewed on March 25, 2011).
[17] North Florida Regional Medical Center, Gainesville; Shands Teaching Hospital at University of Florida, Gainesville; Memorial Regional Hospital, Hollywood; Winnie Palmer Hospital for Women and Babies, Orlando; Memorial Hospital West, Pembrooke Pines; South Miami Hospital, Miami, *see* http://www.marrow.org/HELP/Donate_Cord_Blood_Share_Life/How_to_Donate_Cord_Blood/CB_Participating_Hospitals/nmdp_cord_blood_hospitals.pl (last viewed on March 25, 2011).
[18] *See* http://www.marrow.org/HELP/Donate_Cord_Blood_Share_Life/How_to_Donate_Cord_Blood/CB_Participating_Hospitals/nmdp_cord_blood_hospitals.pl (last viewed on March 25, 2011).
[19] The Parent's Guide to Cord Blood Foundation, *see* http://www.parentsguidecordblood.com/content/usa/society/cost.shtml (last viewed on March 25, 2011).
[20] S. 381.06015 (1), F.S.

The U.S. Congress passed, and President Bush approved, the Stem Cell Therapeutic and Research Act of 2005.[21] The act is administered by the U.S. Department of Health and Human Services and consists of 2 components. The first is to increase the number of bone marrow and cord blood donors and to serve patients in need of a bone marrow or cord blood transplant. The other component is the National Cord Blood Inventory which collects and stores cord blood units to treat patients and to provide cord blood units for research.[22]

Effect of Proposed Changes

This bill requires DOH to place on its website resources relating to umbilical cord blood and an internet link to the "Parent's Guide to Cord Blood Foundation" website. The primary mission of the Parent's Guide to Cord Blood Foundation is to educate parents with accurate and current information about cord blood medical research and cord blood storage options.[23] The bill requires DOH to provide, on its website, the following information:

- An explanation of the potential value and use of umbilical cord blood for those that are related and not related to the donor;
- An explanation of the difference between using one's own cord blood cells and using related and unrelated cord blood cells in the treatment of disease;
- An explanation of the differences between public and private umbilical cord blood banking;
- The options available to a mother relating to stem cells that are contained in the umbilical cord blood after the delivery of her newborn;
- The medical processes involved in the collection of cord blood;
- Criteria for medical or family history that can impact a family's consideration of umbilical cord blood banking;
- Options for ownership and future use of donated umbilical cord blood;
- The average cost of public and private umbilical cord blood banking;
- The availability of public and private cord blood banks to residents of this state; and
- An explanation of which racial and ethnic groups are in particular need of publicly donated cord blood samples.

Some of the required information listed above is either not found on the Parent's Guide to Cord Blood Foundation website or is difficult to find. Therefore, DOH would be required to research and provide the missing or unclear information which are required by the provisions of the bill. According to DOH, it will be able to accomplish the additional work within existing resources.[24]

Additionally, the bill requires DOH to encourage health care providers that provide services to pregnant women to make the information listed above available before the woman's third trimester of pregnancy. If the provider does not see the patient until after the third trimester of pregnancy, this information can be made available at the patient's first visit. According to DOH, it does not currently provide information to clients or providers regarding umbilical cord blood, but that this requirement could be accomplished within existing resources.[25]

The bill provides that a health care provider or health care facility cannot be held liable for damages in civil action or subject to criminal penalties for complying with the provisions listed above.

The bill requires AHCA and DOH to seek private or federal funds for fiscal year 2011-2012 to implement the provisions of this bill. DOH indicated that the provisions of the bill can be accomplished within existing resources.[26]

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[21] Pub. L. No. 109-129 (2005).
[22] Health Resources and Services Administration, U.S. Department of Health and Human Services, *see* http://bloodcell.transplant.hrsa.gov/ABOUT/index.html (last viewed on March 25, 2011).
[23] Parent's Guide to Cord Blood Foundation, *see* http://www.parentsguidecordblood.org/ (last viewed on March 30, 2011).
[24] Department of Health, Bill Analysis, HB 471, 2011
[25] *Id.*
[26] *Id.*

B. SECTION DIRECTORY:

Section 1: Amends s. 381.06015, F.S., relating to public cord blood tissue bank.
Section 2: Provides an effective date of July 1, 2011.

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.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill requires DOH to provide an internet link on their website to the Parent's Guide to Cord Blood Foundation website. The bill provides specific detailed information regarding umbilical cord blood that is to be made available and appears to imply that all of this information is contained within the Parent's

Guide to Cord Blood Foundation website. However, some of the information required is difficult to find, unclear, or missing from the Parent's Guide to Cord Blood Foundation website.

The DOH analysis indicates that the Foundation's website is copyrighted and requires permission from the copyright owner to repeat the information contained on the website. DOH will need to include a disclaimer on its website stating that access to the website through DOH does not give the viewer of the information permission to copy or redistribute any information from the Foundation's website.[27]

The bill amends a section of statute that is obsolete[28] and current legislation has been filed to repeal it.[29]

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[27] Department of Health, Bill Analysis, HB 471, 2011
[28] S. 381.06015, F.S.
[29] HB 7093, 2011.

A bill to be entitled

An act relating to cord blood banking; amending s. 381.06015, F.S.; providing for the education of pregnant women regarding umbilical cord blood banking; requiring the State Surgeon General to publish specified information relating to umbilical cord blood banking on the Department of Health's Internet website; providing immunity from liability for a health care facility or health care provider that provides information regarding cord blood banking; providing an effective date.

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

Section 1. Section 381.06015, Florida Statutes, is amended to read:

381.06015 Public Cord Blood Tissue Bank.—

(1) There is established a statewide consortium to be known as the Public Cord Blood Tissue Bank. The Public Cord Blood Tissue Bank is established as a nonprofit legal entity to collect, screen for infectious and genetic diseases, perform tissue typing, cryopreserve, and store umbilical cord blood as a resource to the public. The University of Florida, the University of South Florida, the University of Miami, and the Mayo Clinic, Jacksonville shall jointly form the collaborative consortium, each working with community resources such as regional blood banks, hospitals, and other health care providers to develop local and regional coalitions for the purposes set forth in this section ~~act~~. The consortium participants shall

align their outreach programs and activities to all geographic areas of the state, covering the entire state. The consortium is encouraged to conduct outreach and research for Hispanics, African Americans, Native Americans, and other ethnic and racial minorities.

(2) The Agency for Health Care Administration and the Department of Health shall encourage health care providers, including, but not limited to, hospitals, birthing facilities, county health departments, physicians, midwives, and nurses, to disseminate information about the Public Cord Blood Tissue Bank and the options for umbilical blood cord banking outlined in this subsection to a pregnant woman before the third trimester of pregnancy or at the time of her first visit to her health care provider. The State Surgeon General shall make publicly available, by posting on the Internet website of the Department of Health, resources and an Internet website link to materials relating to cord blood that have been developed by the Parent's Guide to Cord Blood Foundation, including:

(a) An explanation of the potential value and uses of umbilical cord blood, including cord blood cells and stem cells, for individuals who are and individuals who are not biologically related to a mother or her newborn infant.

(b) An explanation of the differences between using one's own cord blood cells and using biologically related or biologically unrelated cord blood stem cells in the treatment of disease.

(c) An explanation of the differences between public and private cord blood banking.

(d) The options available to a pregnant woman with regard to stem cells that are contained in the umbilical cord blood after the delivery of her newborn infant, including:

1. Donating the stem cells to a public umbilical cord blood bank when those facilities are available.

2. Storing the stem cells in a private family umbilical cord blood bank for use by family members.

3. Storing the stem cells for use by family members through a family or sibling donor banking program that provides free collection, processing, and storage when there is an existing medical need.

4. Discarding the stem cells.

(e) The medical processes involved in the collection of cord blood.

(f) Family social or medical history criteria that may impact a family's consideration of umbilical cord blood banking, including the likelihood of using cord blood to serve as a match for a family member who has a medical condition.

(g) Options for ownership and future use of donated cord blood.

(h) The average cost of public and private cord blood banking.

(i) The availability of public and private cord blood banks to citizens of the state, including:

1. A list of public cord blood banks and the hospitals served by such blood banks.

2. A list of private cord blood banks that are available.

3. The availability of free family cord blood banking and

sibling donor programs when a family member has an existing medical need.

(j) An explanation of which racial and ethnic groups are in particular need of publicly donated cord blood samples based upon medical data developed by the Health Resources and Services Administration of the United States Department of Health and Human Services.

(3) Nothing in this section creates a requirement of any health care or services program that is directly affiliated with a bona fide religious denomination that includes as an integral part of its beliefs and practices the tenet that blood transfer is contrary to the moral principles the denomination considers to be an essential part of its beliefs.

(4) Any health care facility or health care provider receiving financial remuneration for the collection of umbilical cord blood shall provide written disclosure of this information to any woman postpartum or parent of a newborn from whom the umbilical cord blood is collected prior to the harvesting of the umbilical cord blood.

(5) A woman admitted to a hospital or birthing facility for obstetrical services may be offered the opportunity to donate umbilical cord blood to the Public Cord Blood Tissue Bank. A woman may not be required to make such a donation.

(6) The consortium may charge reasonable rates and fees to recipients of cord blood tissue bank products.

(7) A health care facility or health care provider may not be held liable in any manner for damages and is not subject to criminal penalties for providing information relating to options

for umbilical cord blood banking.

(8) ~~(7)~~ In order to fund the provisions of this section the consortium participants, the Agency for Health Care Administration, and the Department of Health shall seek private or federal funds to initiate program actions for fiscal year 2011-2012 ~~2000-2001~~.

Section 2. This act shall take effect July 1, 2011.

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health & Human Services Quality Subcommittee

Representative(s) Nuñez offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Section 381.06016, Florida Statutes, is created to read:

381.06016 Umbilical cord blood awareness.—

(1) The Department of Health shall make publicly available, by posting on its Internet website, resources and an Internet website link to materials relating to umbilical cord blood which have been developed by the Parent's Guide to Cord Blood Foundation, Inc., including:

(a) An explanation of the potential value and uses of umbilical cord blood, including cord blood cells and stem cells, for individuals who are, as well as individuals who are not, biologically related to a mother or her newborn child.

(b) An explanation of the differences between using one's own cord blood cells and using biologically related or biologically unrelated cord blood stem cells in the treatment of disease.

(c) An explanation of the differences between public and private umbilical cord blood banking.

(d) The options available to a mother relating to stem cells that are contained in the umbilical cord blood after the delivery of her newborn, including:

1. Donating the stem cells to a public umbilical cord blood bank where facilities are available;

2. Storing the stem cells in a private family umbilical cord blood bank for use by immediate and extended family members;

3. Storing the stem cells for use by family members through a family or sibling donor banking program that provides free collection, processing, and storage if there is an existing medical need; and

4. Discarding the stem cells.

(e) The medical processes involved in the collection of cord blood.

(f) Criteria for medical or family history that can impact a family's consideration of umbilical cord blood banking, including the likelihood of using a baby's cord blood to serve as a match for a family member who has a medical condition.

(g) Options for ownership and future use of donated umbilical cord blood.

(h) The average cost of public and private umbilical cord blood banking.

(i) The availability of public and private cord blood banks to residents of this state, including:

1. A list of public cord blood banks and the hospitals served by such blood banks;

2. A list of private cord blood banks that are available; and

3. The availability of free family banking and sibling donor programs if there is an existing medical need by a family member.

(j) An explanation of which racial and ethnic groups are in particular need of publicly donated cord blood samples based upon medical data developed by the Health Resources and Services Administration of the United States Department of Health and Human Services.

(2) The Department of Health shall encourage health care providers who provide health care services that are directly related to a woman's pregnancy to make available to a pregnant patient before her third trimester of pregnancy, or, if later, at the first visit of such patient to the provider, information listed under subsection (1) which relates to the patient's options regarding umbilical cord blood banking.

(3) A health care provider or a health care facility, or any employee or agent thereof, is not liable for damages in a civil action, subject to prosecution in a criminal proceeding, or subject to disciplinary action by the appropriate regulatory

board for acting in good faith to comply with the provisions of this section.

Section 2. This act shall take effect July 1, 2011.

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

Remove the entire title and insert:

A bill to be entitled

An act relating to umbilical cord blood banking; creating s. 381.06016, F.S.; requiring the Department of Health to post on its website certain resources and a website link to specified materials regarding umbilical cord blood banking; requiring the department to encourage certain health care providers to make available to their pregnant patients information related to umbilical cord blood banking; providing that a health care provider or health care facility and its employees or agents are not liable for damages in a civil action, subject to prosecution in a criminal proceeding, or subject to disciplinary action by the appropriate regulatory board for acting in good faith to comply with the act; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 393 Treatment Programs for Impaired Practitioners
SPONSOR(S): Davis
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health & Human Services Quality Subcommittee		Batchelor	Calamas
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

House Bill 393 amends s. 456.076, F.S., relating to treatment programs for impaired practitioners. Specifically, the bill amends s. 456.076, F.S., to include the term "occupations" to this section of law, allowing occupations to use impaired practitioner programs. The bill expands persons eligible for the impaired practitioner program to include students enrolled in any school for licensure to be either a health care practitioner under chapter 456 or a veterinarian under chapter 474, if the school makes a request for services.

The bill provides that suspension of hospital staff privileges due to impairment does not constitute a complaint for the purposes of the impaired practitioner program, such that suspension would not, on its own, lead to a referral to the program.

The bill modifies requirements for emergency suspension orders issued by DOH, by requiring DOH to recommend an emergency suspension if an impaired practitioner consultant concludes the impairment is an immediate, serious danger to the public.

The bill provides greater specificity to the current law requiring the Department of Financial Services to defend impaired practitioner consultants against all lawsuits. The bill expressly includes proceedings for injunctive, affirmative or declaratory relief.

The bill amends s. 456.0635, F.S., allowing persons that were subject to addiction or impairment at the time of a crime, regardless of the disposition of any charges resulting from the crime, be exempt from restrictions on obtaining or renewing a license if they entered and completed, or are enrolled in, an impaired practitioner program.

The Department of Financial Services estimates a recurring fiscal impact for increased court cases of $1.25 million in the Risk Management Trust Fund.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

The Impaired Practitioner Program – Department of Health

The impaired practitioner treatment program was created to help rehabilitate various health care practitioners regulated by the Division of Medical Quality Assurance (division), within the Department of Health (DOH)[1]. Practitioners who are impaired as a result of drugs or alcohol, abuse, or because of mental or physical conditions, which could affect their ability to practice with skill and safety are eligible for the program.[2] By entering and successfully completing the impaired practitioner treatment program, a practitioner may avoid formal disciplinary action, if the only violation of the licensing statute under which the practitioner is regulated is the impairment.[3] If the practitioner is unable to complete the program, DOH has authority to issue an emergency order suspending or restricting the license of the health care practitioner.[4]

DOH is authorized[5] to contract with impaired practitioner consultants for services relating to intervention, evaluation, referral, and monitoring of impaired practitioners who have voluntarily agreed to treatment through an impaired practitioner program.[6] There are two impaired practitioner programs, the Intervention Project for Nurses (IPN)[7] and the Professionals Resource Network (PRN) for other health care professions.[8] Practitioners usually enter a PRN or IPN program based on a complaint and subsequent finding of impairment.[9]

Once in the program, the licensee is monitored by an impairment consultant. The consultant is required to monitor the licensee's participation and ensure compliance.[10] Consultants do not provide medical treatment, nor do they have the authority to render decisions relating to licensure of a particular practitioner. However, the consultant is required to make recommendations to DOH regarding a practitioner patient's ability to practice.[11] PRN and IPN consultants provide services in intervention, evaluation, referral and case management of licensed practitioners who may be suffering from mental or physical disability or abuse of chemical substances with dependency liability.[12] Consultants are required by department rules to refer practitioner patients to department-approved treatment programs and providers.[13].

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[1] Section 456.076, (1), F.S.
[2] Section 456.076 (3)(a)
[3] Section 456.076(3)(a), F.S.
[4] Section 456.074, F.S.
[5] Section 456.076, F.S.
[6] Rules 64B31-10.10.001 and 64B31-10.002, F.A.C.
[7] Department of Health Bill Analysis, Economic Statement and Fiscal Note HB 393 (2011).
[8] Department of Health Bill Analysis, Economic Statement and Fiscal Note HB 393 (2011).
[9] Section 456.076(4), F.S.
[10] Department of Health Contract with PRN 10/2008 (on file with committee staff).
[11] Section 456.076(5)(a), F.S.
[12] Department of Health Contract with PRN 10/2008 (on file with committee staff).
[13] Rules 64B31-10.10.001 F.A.C

Currently, DOH licenses over 40 health care professions[14] and provides impaired practitioner services to the following:[15]

Medical Doctors	Chiropractic Physicians
Physician Assistants	Clinical Social Workers
Osteopathic Physicians	Marriage and Family Therapists
Pharmacists	Mental Health Counselors
Podiatric Physicians	Optometrists
Psychologists	Nursing Home Administrators
Dentists	Medical Physicists
Opticians	Dieticians
Occupational Therapists	Nutritionists
Physical Therapists	Respiratory Therapists
Electrologists	Midwives
Acupuncturists	Speech Language Pathologists
Audiologists	Clinical Laboratory Personnel
Massage Therapists	Athletic Trainers
Orthotists	Orthotists
Prosthetists	Hearing Aid Specialists
Radiologic Technologists,	Pharmacy Technicians
Anesthesia Assistants	

According to DOH there are approximately 2,853 participants enrolled in the programs: 1,784 in the IPN and 1,069 in the PRN.[16]

Impaired Practitioner Program - Department of Business and Professional Regulation

The Board of Veterinary Medicine and the Board of Pilot Commissioners, within the Department of Business and Professional Regulation (DBPR), provide impaired practitioner treatment programs for licensees. Section 474.221, F.S., provides that licensed veterinarians shall be governed by the treatment of impaired practitioner provisions as if they were under the jurisdiction of the Division of Medical Quality Assurance at DOH. Currently, DBPR has a contract with PRN to provide consultant services for impaired veterinarians. The contract provides for compensation of $48,132 per year to PRN. During Fiscal Year 2009-2010, an average of 29 licensees participated in the program.[17]

Department of Financial Services Sovereign Immunity

DFS and the Division of Risk Management are required to defend any claim, suit, action or proceeding against an impaired practitioner consultant acting as an agent of DOH, per s.456.076(7)(a), F.S. Current law requires consultants to indemnify the state for any liabilities incurred up to the sovereign immunity limits.[18]

[14] Department of Health, Medical Quality Assurance, Annual Report, July 2009-June 2010. http://www.doh.state.fl.us/Mqa/reports.htm (last visited on 3/31/2011)
[15] Department of Health Contract with PRN 10/2008 (on file with committee staff).
[16] Intervention Project for Nurses Monthly Report February 2011 & Professionals Resource Network Monthly Report for February 2011.
[17] DBPR Office of Legislative Affairs 2011 Legislative Analysis Form SB 1742 (2011).
[18] Section 768.28, F.S.

Confidentiality

DOH rule requires that consultants within impaired practitioner programs serve as the official records custodians of the licensees they monitor.[19] An approved treatment provider must provide information regarding the impairment of a licensee and the licensee's participation in a treatment program to a consultant on request. The information obtained by the consultant is confidential and exempt from public records requirements.[20] If a treatment provider fails to provide such information to the consultant, the treatment provider may no longer provide services under the program.[21] Recently, there was litigation in the Sixth Circuit, in which a medical doctor sued PRN for the production of the investigative file relation to the practitioner's participation in a treatment program.[22] The court held that because there was not a disciplinary proceeding by the board against the practitioner, the release of information was prohibited and the claim was dismissed with prejudice in October, 2010.[23]

Effect of Proposed Changes

The bill amends s. 456.076, F.S., relating to treatment programs for impaired practitioners. Specifically, the bill adds the term "occupations" to this section of law, allowing occupations to use impaired practitioner programs. However, the definition of "occupation" is not defined. This section also clarifies that a licensee that provides consultant services for DOH's impaired practitioner program does not need to be registered as a substance abuse or mental health provider pursuant to chapters 394, 395, or 397, as consultants do not provide medical treatment.

The bill provides that any student enrolled in any school for licensure to be either a health care practitioner under chapter 456 or a veterinarian under chapter 474 be eligible for the impaired practitioner program if the school makes a request for services. All complaint information that is received by DOH relating to the impairment of a student that is preparing for licensure as an allopathic physician or allopathic physician's assistant per chapter 458, or as an osteopathic physician or osteopathic physician's assistant per chapter 459 must be reported to the impaired practitioner consultant.

Further, the bill requires that if DOH receives information regarding the impairment of a licensee, but has not received a complaint on other grounds, any information regarding the practitioner and the impairment, must be provided to the impaired practitioner consultant. If an emergency suspension order is deemed necessary, the bill provides that the suspension order contain the consultants' conclusions for immediate review by the State Surgeon General. The bill clarifies that impaired practitioner consultants shall serve as record custodians for any licensee they monitor, and any records they maintain shall not be shared with the impaired licensee or a designee unless a disciplinary proceeding is pending.

The bill provides greater specificity to the current law requiring the Department of Financial Services to defend impaired practitioner consultants against all lawsuits. The bill expressly includes proceedings for injunctive, affirmative or declaratory relief.

The bill amends s. 456.0635, F.S., allowing persons that were subject to addiction or impairment at the time of a crime in which the person was either convicted, entered a plea of not guilty, or plead nolo contendere to, a felony under chapter 893, F.S., to be exempt from restrictions on obtaining a license, or renewing a license if they entered and completed or are enrolled in an impaired practitioner program. The bill also provides that an exemption from disqualification does not prohibit or permit DOH from taking action against a license, certificate or registration for disciplinary purposes.

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[19] Rules 64B31-10.10.004, F.A.C.
[20] Section 456.076(5)(a), F.S.
[21] *Id*
[22] *Doe, MD v. Rivernbark*, 10-6495-CI-21 (6th Cir., Oct. 2010)
[23] *Id.*

B. SECTION DIRECTORY:

Section 1: Amends s. 456.076, F.S., relating to treatment programs for impaired practitioners
Section 2: Amends s. 456.0635, F.S., relating to Medicaid fraud, disqualification for license, certificate, or registration.
Section 3: Provides an effective date of July 1, 2011.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

DFS would be required to defend lawsuits against impaired practitioner consultants seeking injunctive, affirmative, or declaratory relief. DFS estimates that an increase of 50 cases per year could be expected at $25,000 per case, or $1.25 million per year.[24] DFS estimates that the funds will be needed for defense attorney fees and the actual cost of trying the case in court.[25] DFS has existing staff to absorb the increase in workload.[26]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

B. RULE-MAKING AUTHORITY:

None.

[24] Department of Financial Services Bill Analysis HB 393 (2011)
[25] Email from Ashley Mayer, DFS, HB 393, 4/4/2011, on file with committee staff.
[26] *Id*

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill adds the term "occupations" to s. 456.076, F.S., however, the bill does not provide a definition for "occupations".

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to treatment programs for impaired practitioners; amending s. 456.076, F.S.; exempting entities retained as impaired practitioner consultants from certain licensing requirements under certain circumstances; revising circumstances under which impaired practitioner consultants may contract for certain services; limiting liability of certain medical schools and schools that prepare certain health care practitioners and veterinarians for licensure under certain circumstances related to services provided by impaired practitioner consultants; revising procedures for processing complaints against impaired licensees; revising requirements for forwarding information about impaired licensees and certain students preparing for licensure to impaired practitioner consultants; providing for recommendations to the State Surgeon General for emergency suspension orders under certain circumstances; clarifying the types of legal proceedings related to services provided by impaired practitioner consultants against which the Department of Financial Services shall defend; revising requirements for the maintenance and disclosure to impaired licensees of confidential information by impaired practitioner consultants and the Department of Health; amending s. 456.0635, F.S.; excluding persons subject to addiction or impairment under certain circumstances from disqualification requirements related to examinations, licenses, certificates, and registrations

for health professions and occupations; providing an effective date.

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

Section 1. Subsections (1), (2), and (3), paragraph (b) of subsection (5), and paragraph (b) of subsection (7) of section 456.076, Florida Statutes, are amended, and subsection (8) is added to that section, to read:

456.076 Treatment programs for impaired practitioners.—

(1) For professions or occupations that do not have impaired practitioner programs provided for in their practice acts, the department shall, by rule, designate approved impaired practitioner programs under this section. The department may adopt rules setting forth appropriate criteria for approval of treatment providers. The rules may specify the manner in which the consultant, retained as set forth in subsection (2), works with the department in intervention, requirements for evaluating and treating a professional, requirements for continued care of impaired professionals by approved treatment providers, continued monitoring by the consultant of the care provided by approved treatment providers regarding the professionals under their care, and requirements related to the consultant's expulsion of professionals from the program.

(2)(a) The department shall retain one or more impaired practitioner consultants who are each licensees~~. The consultant shall be a licensee~~ under the jurisdiction of the Division of Medical Quality Assurance within the department and who must be:

1. A practitioner or recovered practitioner licensed under chapter 458, chapter 459, or part I of chapter 464; ~~,~~ or

2. An entity employing a medical director, or employing a registered nurse as an executive director, who is ~~must be~~ a practitioner or recovered practitioner licensed under chapter 458, chapter 459, or part I of chapter 464.

(b) An entity retained as a consultant that employs a medical director, or employs a registered nurse as an executive director, is not required to be licensed as a substance abuse provider or mental health treatment provider pursuant to chapter 394, chapter 395, or chapter 397 to operate as a consultant under this section if it employs or contracts with licensed professionals to perform or appropriately supervise any specific treatment or evaluation that requires individual licensing or supervision.

(c) The consultant shall assist the probable cause panel and department in carrying out the responsibilities of this section. This shall include working with department investigators to determine whether a practitioner is, in fact, impaired. The consultant may contract for services to be provided, for appropriate compensation, if requested by a ~~the~~ school or program, for students enrolled in any school ~~schools~~ for licensure as a health care practitioner under chapter 456 or a veterinarian under chapter 474 ~~allopathic physicians or physician assistants under chapter 458, osteopathic physicians or physician assistants under chapter 459, nurses under chapter 464, or pharmacists under chapter 465~~ who are alleged to be impaired as a result of the misuse or abuse of alcohol or drugs,

or both, or due to a mental or physical condition.

(d) The department is not responsible under any circumstances for paying the costs of care provided by approved treatment providers, and the department is not responsible for paying the costs of consultants' services provided for such students.

(e) A medical school accredited by the Liaison Committee on Medical Education of the Commission on Osteopathic College Accreditation, or another ~~other~~ school providing for the education of students enrolled in preparation for licensure as a health care practitioner under chapter 456 or a veterinarian under chapter 474 ~~allopathic physicians under chapter 458 or osteopathic physicians under chapter 459~~, which school is governed by accreditation standards requiring notice and the provision of due process procedures to students, is not liable in any civil action for referring a student to the consultant retained by the department or for disciplinary actions that adversely affect the status of a student when the disciplinary actions are instituted in reasonable reliance on the recommendations, reports, or conclusions provided by such consultant, if the school, in referring the student or taking disciplinary action, adheres to the due process procedures adopted by the applicable accreditation entities and if the school committed no intentional fraud in carrying out ~~the provisions of~~ this section.

(3)(a) Whenever the department receives a written or oral legally sufficient complaint alleging that a licensee under the jurisdiction of the Division of Medical Quality Assurance within

the department is impaired as a result of the misuse or abuse of alcohol or drugs, or both, or due to a mental or physical condition which could affect the licensee's ability to practice with skill and safety, but the department has not received a ~~and no~~ complaint against the licensee on grounds other than impairment ~~exists~~, the reporting of such information shall not constitute grounds for discipline pursuant to s. 456.072 or the corresponding grounds for discipline within the applicable practice act if the probable cause panel of the appropriate board, or the department when there is no board, finds:

1. The licensee has acknowledged the impairment problem.

2. The licensee has voluntarily enrolled in an appropriate, approved treatment program.

3. The licensee has voluntarily withdrawn from practice or limited the scope of practice as required by the consultant, in each case, until such time as the panel, or the department when there is no board, is satisfied the licensee has successfully completed an approved treatment program.

4. The licensee has executed releases for medical records, authorizing the release of all records of evaluations, diagnoses, and treatment of the licensee, including records of treatment for emotional or mental conditions, to the consultant. The consultant shall make no copies or reports of records that do not regard the issue of the licensee's impairment and his or her participation in a treatment program.

(b) If, however, the department has not received a legally sufficient complaint and the licensee agrees to withdraw from practice until such time as the consultant determines the

licensee has satisfactorily completed an approved treatment program or evaluation, the probable cause panel, or the department when there is no board, shall not become involved in the licensee's case.

(c) Inquiries related to impairment treatment programs designed to provide information to the licensee and others and which do not indicate that the licensee presents a danger to the public do ~~shall~~ not constitute a complaint within the meaning of s. 456.073 and are ~~shall be~~ exempt from ~~the provisions of~~ this subsection. In addition, a suspension from hospital staff privileges due to impairment does not constitute a complaint for purposes of this section.

(d) Whenever the department receives information regarding the possible impairment of a licensee but has not received a ~~legally sufficient complaint alleging that a licensee is impaired as described in paragraph (a) and no~~ complaint against the licensee on grounds other than impairment ~~exists~~, or receives information regarding the possible impairment of a student enrolled in preparation for licensure as an allopathic physician or physician assistant under chapter 458 or an osteopathic physician or physician assistant under chapter 459, the appropriate board, the executive director of that board, or the department shall forward all information in its possession regarding the impaired licensee or student to the consultant. ~~For the purposes of this section, a suspension from hospital staff privileges due to the impairment does not constitute a complaint.~~

(e) The probable cause panel, or the department when there

is no board, shall work directly with the consultant, and all information concerning a practitioner obtained from the consultant by the panel, or the department when there is no board, shall remain confidential and exempt from the provisions of s. 119.07(1), subject to the provisions of subsections (5) and (6).

(f) A finding of probable cause shall not be made as long as the panel, or the department when there is no board, is satisfied, based upon information it receives from the consultant and the department, that the licensee is progressing satisfactorily in an approved impaired practitioner program and no other complaint against the licensee exists.

(5)

(b) If in the opinion of the consultant, after consultation with the treatment provider, an impaired licensee has not progressed satisfactorily in a treatment program, all information regarding the issue of a licensee's impairment and participation in a treatment program in the consultant's possession shall be disclosed to the department. Such disclosure shall constitute a complaint pursuant to the general provisions of s. 456.073. Whenever the consultant concludes that impairment affects a licensee's practice and constitutes an immediate, serious danger to the public health, safety, or welfare, the department ~~that conclusion~~ shall recommend an emergency suspension order that contains the consultant's conclusions ~~be communicated~~ to the State Surgeon General for immediate review.

(7)

(b) In accordance with s. 284.385, the Department of

Financial Services shall defend any claim, suit, action, or proceeding, including a claim, suit, action, or proceeding for injunctive, affirmative, or declaratory relief, against the consultant, the consultant's officers or employees, or those acting at the direction of the consultant for the limited purpose of an emergency intervention on behalf of a licensee or student as described in subsection (2) when the consultant is unable to perform such intervention which is brought as a result of any act or omission by any of the consultant's officers and employees and those acting under the direction of the consultant for the limited purpose of an emergency intervention on behalf of a licensee or student as described in subsection (2) when the consultant is unable to perform such intervention when such act or omission arises out of and in the scope of the consultant's duties under its contract with the department.

(8) An impaired practitioner consultant shall serve as the official records custodian for any impaired licensee that the consultant monitors. The consultant may not, except to the extent necessary for carrying out the consultant's duties under this section, disclose to the impaired licensee or his or her designee any information disclosed to or obtained by the consultant that is confidential under paragraph (5)(a). When a disciplinary proceeding is pending, an impaired licensee may obtain such information from the department under s. 456.073(10).

Section 2. Subsection (2) of section 456.0635, Florida Statutes, is amended to read:

456.0635 Medicaid fraud; disqualification for license,

certificate, or registration.—

(2) Each board within the jurisdiction of the department, or the department if there is no board, shall refuse to admit a candidate to any examination and refuse to issue or renew a license, certificate, or registration to any applicant if the candidate or applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant~~,~~ has been:

(a) Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, unless the sentence and any subsequent period of probation for such conviction or pleas ended more than 15 years before ~~prior to~~ the date of the application;

(b) Terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5 years; or

(c) Terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from any other state Medicaid program or the federal Medicare program, unless the applicant has been in good standing with a state Medicaid program or the federal Medicare program for the most recent 5 years and the termination occurred at least 20 years before ~~prior to~~ the date of the application.

The disqualification set forth in this subsection does not apply to a person who was subject to addiction or impairment at the

time of the violation for which the person was convicted of, or entered a plea of guilty or nolo contendere to, a felony under chapter 893 if the person subsequently enrolled in and either continues to successfully participate in or has subsequently successfully completed an impaired practitioner program approved under s. 456.076(1) or an equivalent program in another jurisdiction. However, this exception from disqualification does not prohibit or require action against the license, certificate, or registration of the person pursuant to the disciplinary provisions of this chapter or the appropriate practice act.

Section 3. This act shall take effect July 1, 2011.

Amendment No.1

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health & Human Services Quality Subcommittee

Representative(s) Davis offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Subsection (10) is added to section 20.165, Florida Statutes, to read:

20.165 Department of Business and Professional Regulation.—There is created a Department of Business and Professional Regulation.

(10) The Department of Business and Professional Regulation may require a person licensed by or applying for a license from the department to be governed by the provisions of s. 456.076 as if the person was under the jurisdiction of the Division of Medical Quality Assurance. The Department of Business and Professional Regulation may exercise any of the powers granted to the Department of Health by s. 456.076, and

the term "board" means the board from which the license was granted or is sought.

Section 2. Subsection (4) of section 456.001, Florida Statutes, is amended to read:

456.001 Definitions.—As used in this chapter, the term:

(4) "Health care practitioner" means any person licensed under part III of chapter 401; chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 462; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part II, part III, part IV, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part III or part IV of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491.

Section 3. Subsection (2) of section 456.0635, Florida Statutes, is amended to read:

456.0635 Medicaid fraud; disqualification for license, certificate, or registration.—

(2) Each board within the jurisdiction of the department, or the department if there is no board, shall refuse to admit a candidate to any examination and refuse to issue or renew a license, certificate, or registration to any applicant if the candidate or applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant, has been:

(a) Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, unless the sentence and any subsequent

period of probation for such conviction or pleas ended more than 15 years before ~~prior to~~ the date of the application. The disqualification set forth in this paragraph does not apply to any person who is determined to have been suffering from an addiction or impairment at the time of the conduct for which the person was convicted, or who entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 893 and who subsequently enrolled in and continues to successfully participate in or has subsequently successfully completed an impaired practitioner program as set forth in s. 456.076(1) or the equivalent of such program in another jurisdiction. This exception from disqualification does not prohibit or require action against the license, certificate, or registration of such person pursuant to the disciplinary provisions of this chapter or the appropriate practice act;

(b) Terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5 years; or

(c) Terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from any other state Medicaid program or the federal Medicare program, unless the applicant has been in good standing with a state Medicaid program or the federal Medicare program for the most recent 5 years and the termination occurred at least 20 years before ~~prior to~~ the date of the application.

Section 4. Subsection (5) is added to section 456.074, Florida Statutes, to read:

456.074 Certain health care practitioners; immediate suspension of license.—

(5) If a treatment program for impaired practitioners which is retained by the department pursuant to s. 456.076 discloses to the department that:

(a) A licensed health care practitioner as defined in s. 456.001(4) is not progressing satisfactorily in that treatment program; and

(b) The health care practitioner's impairment affects his or her practice and constitutes an immediate, serious danger to the public health, safety, or welfare,

the State Surgeon General shall review the matter within 10 business days after receiving the disclosure, and, if warranted, shall issue an emergency order suspending or restricting the health care practitioner's license.

Section 5. Subsection (2), paragraph (d) of subsection (3), and paragraph (b) of subsection (7) of section 456.076, Florida Statutes, are amended, and subsection (8) is added to that section, to read:

456.076 Treatment programs for impaired practitioners.—

(2)(a) The department shall retain one or more impaired practitioner consultants who are each licensees~~. The consultant shall be a licensee~~ under the jurisdiction of the Division of Medical Quality Assurance within the department and who must be:

1. A practitioner or recovered practitioner licensed under chapter 458, chapter 459, or part I of chapter 464;~~,~~ or

2. An entity employing a medical director or employing a registered nurse as an executive director, who must be a practitioner or recovered practitioner licensed under chapter 458, chapter 459, or part I of chapter 464.

(b) An entity that is retained as a consultant under this section and employs a medical director or registered nurse as an executive director is not required to be licensed as a substance abuse provider or mental health treatment provider under chapter 394, chapter 395, or chapter 397 in order to operate as a consultant under this section if the entity employs or contracts with licensed professionals to perform or appropriately supervise any specific treatment or evaluation that requires individual licensing or supervision.

(c) The consultant shall assist the probable cause panel and department in carrying out the responsibilities of this section. This includes ~~shall include~~ working with department investigators to determine whether a practitioner is, in fact, impaired. The consultant may contract for services to be provided, for appropriate compensation, if requested by a ~~the~~ school or program, for students enrolled in a school ~~schools~~ for licensure as a health care practitioner under chapter 456 or a veterinarian under chapter 474 ~~allopathic physicians or physician assistants under chapter 458, osteopathic physicians or physician assistants under chapter 459, nurses under chapter 464, or pharmacists under chapter 465~~ who are alleged to be impaired as a result of the misuse or abuse of alcohol or drugs, or both, or due to a mental or physical condition.

(d) The department is not responsible under any circumstances for paying the costs of care provided by approved treatment providers, and the department is not responsible for paying the costs of consultants' services provided for such students.

(e) A medical school accredited by the Liaison Committee on Medical Education of the Commission on Osteopathic College Accreditation, or another ~~other~~ school providing for the education of students enrolled in preparation for licensure as a health care practitioner under chapter 456 or a veterinarian under chapter 474 ~~allopathic physicians under chapter 458 or osteopathic physicians under chapter 459~~, which school is governed by accreditation standards requiring notice and the provision of due process procedures to students, is not liable in any civil action for referring a student to the consultant retained by the department or for disciplinary actions that adversely affect the status of a student when the disciplinary actions are instituted in reasonable reliance on the recommendations, reports, or conclusions provided by such consultant, if the school, in referring the student or taking disciplinary action, adheres to the due process procedures adopted by the applicable accreditation entities and if the school committed no intentional fraud in carrying out the provisions of this section.

(3)

(d) Whenever the department receives a legally sufficient complaint alleging that a licensee or applicant is impaired as described in paragraph (a) and no complaint against the licensee

or applicant other than impairment exists, the appropriate board, the board's designee, or the department shall forward all information in its possession regarding the impaired licensee or applicant to the consultant. For the purposes of this section, a suspension from hospital staff privileges due to the impairment does not constitute a complaint.

(7)

(b) In accordance with s. 284.385, the Department of Financial Services shall defend any claim, suit, action, or proceeding, including a claim, suit, action, or proceeding for injunctive, affirmative, or declaratory relief, against the consultant, the consultant's officers or employees, or those acting at the direction of the consultant for the limited purpose of an emergency intervention on behalf of a licensee or student as described in subsection (2) when the consultant is unable to perform such intervention which is brought as a result of any act or omission by any of the consultant's officers and employees and those acting under the direction of the consultant for the limited purpose of an emergency intervention on behalf of a licensee or student as described in subsection (2) when the consultant is unable to perform such intervention when such act or omission arises out of and in the scope of the consultant's duties under its contract with the department.

(8) An impaired practitioner consultant is the official custodian of records concerning any impaired licensee monitored by that consultant. The consultant may not, except to the extent necessary for carrying out the consultant's duties under this section, disclose to the impaired licensee or his or her

designee any information that is disclosed to or obtained by the consultant and is confidential under paragraph (5)(a). If a disciplinary proceeding is pending, an impaired licensee may obtain such information from the department under s. 456.073(10).

Section 6. This act shall take effect July 1, 2011.

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

Remove the entire title and insert:

An act relating to the regulation of professions; amending s. 20.165, F.S.; authorizing the Department of Business and Professional Regulation to require a person licensed by or applying for a license from the department to be governed by provisions providing programs for impaired practitioners under the jurisdiction of the Division of Medical Quality Assurance within the Department of Health; authorizing the Department of Business and Professional Regulation to exercise any of the powers granted to the Department of Health with respect to such programs; amending s. 456.001, F.S.; redefining the term "health care practitioner" as it relates to the regulation of health care professions to include those persons certified or licensed to provide medical transportation services or radiological services; amending s. 456.0635, F.S.; exempting a health care practitioner from disqualification for a license, certificate, or registration if the practitioner was suffering from an addiction or impairment at the time of the disqualifying conduct

and subsequently completes an impaired practitioner program; amending s. 456.074, F.S.; requiring the State Surgeon General to issue an emergency order suspending or restricting a health care practitioner's license under certain circumstances; amending s. 456.076, F.S.; exempting an entity retained by the Department of Health as an impaired practitioner consultant from certain licensing requirements if the entity employs or contracts with licensed professionals; revising the schools or programs that may contract for impaired practitioner consulting services; limiting the liability of certain medical schools and schools that prepare health care practitioners and veterinarians for licensure for referring a student to an impaired practitioner consultant; clarifying the types of legal proceedings related to services provided by impaired practitioner consultants which are defended by the Department of Financial Services; clarifying requirements for an impaired practitioner consultant to maintain as confidential certain information concerning an impaired practitioner; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1037 Continuing Care Retirement Communities
SPONSOR(S): Bembry and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1340

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health & Human Services Quality Subcommittee		Poche	Calamas
2) Insurance & Banking Subcommittee			
3) Appropriations Committee			
4) Health & Human Services Committee			

SUMMARY ANALYSIS

House Bill 1037 allows continuing care at-home contracts to be offered to consumers in Florida. Continuing care at-home contracts and programs allow seniors to receive services offered by a continuing care retirement center in their own homes while reserving the right to shelter to be provided by the retirement center at a later date. Continuing care at-home contracts specify the exact services to be provided to an individual by a provider, in exchange for an initial fee and a recurring monthly premium. Continuing care at-home contracts provide seniors the flexibility of receiving services in their home until they are ready to move to a traditional continuing care retirement center.

The bill creates s. 651.057, F.S., relating to continuing care at-home contracts, creates a new regulatory scheme for these contracts. The provisions of the bill closely reflect the provisions regulating continuing care contracts found throughout chapter 651, F.S. The bill also establishes criteria for providers seeking provisional certificates of authority and certificates of authority, as required to offer continuing care at-home contracts. The bill provides the Office of Insurance Regulation with authority to regulate the issuance of provisional certificates of authority and certificates of authority, and the approval of continuing care at-home contracts for use in Florida. The bill makes numerous conforming changes to reflect the provisions of the bill.

The bill does not appear to have a fiscal impact.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Continuing Care Retirement Communities (CCRCs)

A CCRC is a facility that provides seniors with a lifetime "continuum of care". Residents of a CCRC pay a one-time entrance fee, which can vary widely depending on geographic location and services offered, and continuing monthly payments in exchange for housing, services and nursing care, usually in one location, enabling seniors to age in place.[1] The services provided by the CCRC and purchased by the resident are governed by contract, or resident service agreement. Entry fees can range from $20,000 to more than $1,000,000. The average CCRC entrance fee nationally was $248,000 in 2010, up from a national average of $238,600 in 2009. Monthly payments can range from $1,000 to $3,000, depending on location and the type of services desired. The average age of a person who moved into a CCRC in 2009 was 81.[2]

There are nearly 1,900 CCRCs in the United States.[3] The typical CCRC has fewer than 300 total units; about one third have more than 300 units; and only 8 percent of CCRCs have more than 500 units.[4] The majority of CCRCs in the U.S. were built for the specific purpose of being a CCRC. Other CCRCs evolved from nursing homes. Roughly half of the CCRCs in the U.S. are faith-based. Others are sponsored by a university, health system, military group or fraternal organization. Lastly, the majority of CCRCs are part of a multi-site system, offering different levels of care.[5]

CCRCs feature a combination of living arrangements and nursing beds. The typical accommodations and services are:

- Independent living units- a cottage, townhouse, cluster home, or apartment; the resident is generally healthy and requires little, or no, assistance with activities of daily living
- Assisted living- a studio or one-bedroom apartment designed for frail individuals who can still maintain a level of independence but need some assistance with activities of daily living
- Nursing- nursing services are offered on-site or nearby the CCRC to provide constant care for recovery from a short-term injury or illness, treatment of a chronic condition, or higher levels of services
- Memory-care support- offers dedicated cognitive support care with the goal of maximizing function, maintaining dignity, preserving sense of self, and optimizing independence

There are 64 CCRCs in the state of Florida with 2,493 sheltered nursing home beds.[6] Three of the 64 CCRCs have more than 100 beds.[7] There are 15 CCRCs with 790 sheltered nursing home beds that meet the criteria for extension. The current law allows these 15 CCRCs to extend the use of 30 percent of the facility's existing licensed beds to residents who are not CCRC contract holders. Therefore, 237 beds are currently open to non-CCRC residents.

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[1] State of Connecticut General Assembly, Office of Legislative Research, Research Report, *Continuing Care Retirement Community "At Home" Programs,* February 21, 2008, available at http://www.cga.ct.gov/2008/rpt/2008-R-0110.htm.
[2] Margaret Wylde, PhD., ProMature Group, for American Seniors Housing Association, *Independent Living Report 2009.*
[3] The Ziegler National CCRC Listing & Profile, 2009 lists 1,861 CCRCs.
[4] *Id.*
[5] *Id.*
[6] Agency for Health Care Administration, *2011 Bill Analysis and Economic Impact Statement for HB 1037/SB 1340,* March 18, 2011.
[7] *Id.*

In order to offer continuing care[8] services in Florida, a provider must be licensed by obtaining a certificate of authority (COA).[9] To obtain a COA, each applicant must first apply for and obtain a provisional COA.[10] The Office of Insurance Regulation (OIR) is responsible for receiving, reviewing and approving or denying applications for provisional COAs within a specified time period.[11] Upon receipt of a provisional COA, a provider may collect entrance fees and reservation deposits from prospective residents of a proposed continuing care facility.[12]

To obtain a COA, each provider holding a provisional COA must submit additional documentation regarding financing of the proposed facility, receipt of aggregate entrance fees from prospective residents, completed financial audit statements, and other specific information.[13] OIR is required to issue a COA once it determines that a provider meets all requirements of law, has submitted all necessary information required by statute, has met all escrow requirements, and has paid appropriate fees set out in s. 651.015(2), F.S.[14] Also, a COA will only be issued once a provider submits proof to OIR that a minimum of 50 percent of the units available, for which entrance fees are being charged, are reserved.[15] After receiving a COA, a provider can request the release of entrance fees held in escrow.[16] Once in possession of a COA, a provider may fully market its continuing care facility and begin operations of the facility.

Continuing care services are governed by a contract between the facility and the resident of a CCRC. In Florida, continuing care contracts are considered an insurance product, and are reviewed and approved for the market by OIR.[17] By law, each contract for continuing care services must:

- Provide for continuing care of one resident, or two residents living in a double occupancy room, under regulations set out by the provider.
- List all property transferred to the facility by the resident upon moving to the CCRC, including amounts paid or payable by the resident.
- Specify all services to be provided by the provider to each resident, including, but not limited to, food, shelter, personal services, nursing care, drugs, burial and incidentals.
- Describe terms and conditions for cancellation of the contract given a variety of circumstances.
- Describe all other relevant terms and conditions included in statute.[18]

Continuing Care At-Home (CCAH)

CCAH programs allow a resident that resides outside the CCRC the right to future access to shelter, nursing care or personal services by contracting with the CCRC for services while remaining in their home.[19] Participants pay a one-time entrance fee and monthly premiums for access to a varying range of home-based services, including care coordination, routine home maintenance, in-home assistance with activities of daily living, nursing services, transportation, meals, and other social programs.[20] CCAH programs give participants the ability to use personal, health care and other concierge services

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[8] S. 651.011(2), F.S., "...furnishing shelter or nursing care or personal services as defined in s. 492.02, whether such nursing care or personal services are provided in the facility or in another setting designated by the contract for continuing care, to an individual not related by consanguinity or affinity to the provider furnishing such care, upon payment of an entrance fee."
[9] S. 651.011(8), F.S.
[10] S. 651.022, F.S.; *see also* s. 651.022(2) and (3), F.S., for detailed description of information, reports and studies required to be submitted with an application for a provisional COA.
[11] S. 651.022(5) and (6), F.S.
[12] S. 651.022(7), F.S., which requires the fee to be deposited into escrow or place in deposit with the department until a COA is issued by OIR.
[13] S. 651.023(1), F.S.
[14] S. 651.023(2)(a), F.S.
[15] *Id.*
[16] S. 651.023(4), F.S.
[17] S. 651.055(1), F.S.
[18] *Id.*
[19] *See supra* at FN 1.
[20] *Id.*

offered by the CCRC until they are ready to move to the CCRC. CCAH programs are generally much less expensive than the cost of moving to a CCRC.

To qualify for a CCAH program, new members must meet age requirements, be in good health, and not require services at the time of enrollment. While the goal of a CCAH program is to provide services within the client's home, most programs provide nursing or assisted living facility care, if needed.[21]

New Jersey, Pennsylvania, Ohio, Tennessee, and Maryland are among the states that offer CCAH programs. Regulation of CCAH programs vary widely. For instance, Maryland and Pennsylvania require CCAH contract providers to meet the same requirements as CCRCs. Ohio and Tennessee do not regulate CCAH programs. Connecticut passed a law in 2008 allowing for CCAH contracts. New Hampshire and Maine passed legislation establishing CCAH contracts effective January 2011.

Florida does not specifically provide for CCAH contracts in current law.

Florida Task Force on CCAH Programs

A task force composed of individuals from the Florida Association of Homes and Services for the Aging, the Florida Life Care Residents Association, and representatives of the Office of Insurance Regulation (OIR) began meeting in August 2010. The task force was charged with determining if any changes to chapter 651, F.S., were required to allow a CCRC to offer CCAH program contracts to consumers. The bill is a result of the work of the task force.

Effect of Proposed Changes

The bill creates s. 651.057, F.S., governing CCAH contracts. The bill creates authority to allow providers of continuing care services to offer CCAH contracts. The bill also creates a regulatory scheme to govern CCAH contracts, which is closely related to the regulation of CCRCs and continuing care contracts.

In addition to the provisions of s. 651.055, F.S., a provider offering CCAH contracts must disclose the following information in the contract:

- Whether transportation will be provided to residents for travel to and from the facility for services;
- That the facility is not liable to residents living outside of the facility beyond the delivery of services and future access to care;
- The mechanism for monitoring residents living outside of the facility;
- The policy for a resident relocating to a difference residence and no longer in need of services from the current facility

A provider offering CCAH contracts must also ensure that subcontractors providing services to residents are properly licensed or certified according to applicable law; include operating expenses in the calculation of the operating reserve; and include operating activities for CCAH contracts in the total operation of the facility when submitting financial reports to OIR.

A provider who possesses a COA and wishes to offer CCAH contracts must:

- Submit a business plan with specific information, including, but not limited to, a description of services to be provided, fees to be charged, a copy of the CCAH contract, an actuarial study presenting the impact of providing CCAH contracts on the overall operation of the facility, a market feasibility study and sufficient documented interest in CCAH contracts to support the program, and a specific feasibility study.
- Demonstrate to OIR that offering CCAH contracts will not put the provider in an unsound financial condition.

[21] *See supra* at FN 1.

- Comply with s. 651.021(2), F.S., but allowing for an actuarial study to be substituted for a feasibility study
- Comply with all other requirements of chapter 651, F.S.

A provider offering CCAH contracts must have a facility licensed under chapter 651, F.S., and be in good standing to offer CCAH contracts. The facility must also have accommodations for independent living which are intended for individuals who do not require supervision. The combined total of outstanding continuing care and CCAH contracts allowed at a facility may be up to 1.5 times the combined number of independent living units, assisted living units, and nursing home units, unless the facility's provisional COA was issued on December 21, 2005.[22] The number of independent living units at a facility must be equal to or greater than 10 percent of the combined total of continuing care contracts and CCAH contracts issued by the facility.

The bill exempts the residences of residents living outside of the facility pursuant to a CCAH contract from inclusion in approval of on sheltered nursing home bed for every four proposed residential units by AHCA. A provider may seek approval from AHCA for an extension of the number of beds to offer to persons who are not residents of the CCRC and who are not a party to a continuing care contract not to exceed 30 percent of the total sheltered nursing home beds or 30 sheltered beds, whichever is greater, if the use of the beds by residents of the facility is not sufficient to cover operating expenses.

The bill amends s. 651.021, F.S., to require any person engaging in the business of issuing contracts for continuing care at-home or constructing a facility for the purpose of providing continuing care to obtain a COA from OIR. Written approval is required from OIR before constructing a new facility or marketing an expansion of an existing facility equivalent to the addition of at least 20 percent of existing units or 20 percent or more in the number of CCAH contracts. The 20 percent figure can be calculated based on the total of existing units and existing CCAH contracts. Expansion is defined as the construction of additional units or offering additional CCAH contracts, or a combination of both. If the expansion is solely for CCAH contracts, an actuarial study presenting the financial impact of the expansion may substitute for a feasibility study required of proposals for new construction.

The bill amends s. 651.022, F.S., to include CCAH contracts as eligible for a provisional COA governed by the section. The bill amends section 651.023, F.S., to require certain information to be included in reports to be submitted to OIR for a COA if the report is completed by a certified public accountant and in the instance where the report is completed by an independent consulting actuary. The bill also requires a provider seeking a COA or expansion under a previous statutory section for CCAH contracts to meet the same minimum reserve requirements[23] for continuing care and CCAH contracts, independent of each other.

In cases of an expansion of existing CCRC units or CCAH contracts, the bill requires a minimum of 75 percent of moneys paid for all or any part of an entrance fee for a CCRC and 50 percent of moneys paid for all or any part of an initial fee for a CCAH contract to be place in escrow or on deposit with the department pursuant to s. 651.033, F.S.

The bill permits contracts for continuing care and CCAH to include agreements to provide care for any duration. The bill also requires a provider to submit proof of compliance with a residency contract entered into prior to issuance of the COA within 90 days of receipt of a letter from OIR requesting same.

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[22] One facility in Tallahassee, Wescott Lakes at Southwood, was issued a provisional COA on December 21, 2005 that included approval for the facility to offer CCAH contracts, even though there is no specific provision in Florida law allowing for these contracts to be offered to consumers. It appears that OIR interpreted current law to allow for CCAH contracts to be marketed in Florida by this particular facility. The exemption included in the bill is designed to preserve the rights of the facility included in the provisional COA issued on the specific date.

[23] S. 651.035, F.S., requires CCRCs to maintain, in escrow, a minimum liquid reserve consisting of various reserves. For instance, each provider must maintain a debt service reserve equal to the amount of all principal and interest payments due during the fiscal year on any mortgage loan or other long-term financing of the facility. Also, a provider must maintain an operating reserve equal to 30 percent of the total operating expenses projected in the feasibility study required by s. 651.023, F.S., for the first 12 months of operation. The statute includes additional details related to the composition of the minimum liquid reserve.

The bill adds the term "continuing care at-home" to many provisions throughout chapter 651, F.S., where the term "continuing care" is found. The bill adds the definitions of "continuing care at-home", "nursing care", "personal services" and "shelter" to s. 651.011, F.S. Also, the bill expands the definition of "facility" to mean a place where continuing care is furnished and may include one or more physical plants on a primary or contiguous site or an immediately accessible site. The bill defines "primary or contiguous site" and "immediately accessible site". The added definitions are consistent with the provisions of the bill that allow for continuing care at-home and allow for services to be provided at a CCRC.

The bill provides for three residents who hold continuing care contracts or CCAH contracts to be members of the Continuing Care Advisory Council, established under s. 651.121, F.S.

B. SECTION DIRECTORY:

Section 1: Amends s. 651.011, F.S., relating to definitions.
Section 2: Amends s. 651.012, F.S., relating to exempted facility; written disclosure of exemption.
Section 3: Amends s. 651.013, F.S., relating to chapter exclusive; applicability of other laws.
Section 4: Amends s. 651.021, F.S., relating to COA required.
Section 5: Amends s. 651.022, F.S., relating to provisional COA; application.
Section 6: Amends s. 651.023, F.S., relating to COA; application.
Section 7: Amends s. 651.033, F.S., relating to escrow accounts.
Section 8: Amends s. 651.035, F.S., relating to minimum liquid reserve requirements.
Section 9: Amends s. 651.055, F.S., relating to contracts; right to rescind.
Section 10: Creates s. 651.057, F.S., relating to continuing care at-home contracts.
Section 11: Amends s. 651.071, F.S., relating to contracts as preferred claims on liquidation or receivership.
Section 12: Amends s. 651.091, F.S., relating to availability, distribution, and posting of reports and records; requirement of full disclosure.
Section 13: Amends s. 651.106, F.S., relating to grounds for discretionary refusal, suspension, or revocation of COA.
Section 14: Amends s. 651.114, F.S., relating to delinquency proceedings; remedial rights.
Section 15: Amends s. 651.118, F.S., relating to Agency for Health Care Administration; certificates of need; sheltered beds; community beds.
Section 16: Amends s. 651.121, F.S., relating to Continuing Care Advisory Council.
Section 17: Amends s. 651.125, F.S., relating to criminal penalties; injunctive relief.
Section 18: Provides an effective date of July 1, 2011.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

OIR advises that the costs for updating and modifying technology programs to accommodate amended form filings can be absorbed within current budgetary resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Providers choosing to offer continuing care at-home contracts have another source of revenue. Some continuing care providers will be able to receive additional revenue from utilizing empty skilled nursing beds for non-continuing care residents. These service changes may create competition between CCRCs and skilled nursing home providers.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

OIR has sufficient rule-making authority to implement the provisions of the bill related to the annual report, periodic reports and application forms.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill title references the "Office of Financial Regulation". The correct term is "Office of Insurance Regulation".

Section 651.011(2), F.S., defines "continuing care" as furnishing, pursuant to a contract, shelter and either nursing care or personal services as defined in s. 429.02, F.S. Rule 69O-193.002(25), F.A.C., specifically states that the term "shelter", as used in s. 651.011(2), F.S., means an independent living unit, room, apartment, cottage, villa, personal care unit, nursing bed, or other living area within a facility set aside for the exclusive use of one or more identified residents. The requirement that shelter be provided within a facility conflicts with the bill provisions allowing the term "shelter" to include a resident's home.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to continuing care retirement communities; providing for the provision of continuing care at-home; amending s. 651.011, F.S.; revising definitions; defining "continuing care at-home," "nursing care," "personal services," and "shelter"; amending s. 651.012, F.S.; conforming a cross-reference; amending s. 651.013, F.S.; conforming provisions to changes made by the act; amending s. 651.021, F.S., relating to the requirement for certificates of authority; requiring that a person in the business of issuing continuing care at-home contracts obtain a certificate of authority from the Office of Financial Regulation; requiring written approval from the Office of Financial Regulation for a 20 percent or more expansion in the number of continuing care at-home contracts; providing that an actuarial study may be substituted for a feasibility study in specified circumstances; amending s. 651.022, F.S., relating to provisional certificates of authority; conforming provisions to changes made by the act; amending s. 651.023, F.S., relating to an application for a certificate of authority; specifying the content of the feasibility study that is included in the application for a certificate; requiring the same minimum reservation requirements for continuing care at-home contracts as continuing care contracts; requiring that a certain amount of the entrance fee collected for contracts resulting from an expansion be placed in an escrow account or on deposit

with the department; amending ss. 651.033, 651.035, and 651.055, F.S.; requiring a facility to provide proof of compliance with a residency contract; conforming provisions to changes made by the act; creating s. 651.057, F.S.; providing additional requirements for continuing care at-home contracts; requiring that a provider who wishes to offer continuing care at-home contracts submit certain additional documents to the office; requiring that the provider comply with certain requirements; limiting the number of continuing care and continuing care at-home contracts at a facility based on the types of units at the facility; amending ss. 651.071, 651.091, 651.106, 651.114, 651.118, 651.121, and 651.125, F.S.; conforming provisions to changes made by the act; providing an effective date.

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

Section 1. Section 651.011, Florida Statutes, is amended to read:

651.011 Definitions.—As used in ~~For the purposes of~~ this chapter, the term:

(1) "Advertising" means the dissemination of written, visual, or electronic information by a provider, or any person affiliated with or controlled by a provider, to potential residents or their representatives for the purpose of inducing such persons to subscribe to or enter into a contract for continuing care or continuing care at-home ~~to reside in a~~

~~continuing care community that is subject to this chapter~~.

(2) "Continuing care" or "care" means, pursuant to a contract, furnishing to a resident who resides in a facility shelter and nursing care or personal services ~~as defined in s. 429.02~~, whether such nursing care or personal services are provided in the facility or in another setting designated in ~~by~~ the contract for continuing care, by ~~to~~ an individual not related by consanguinity or affinity to the resident ~~provider furnishing such care~~, upon payment of an entrance fee. ~~Other personal services provided must be designated in the continuing care contract. Contracts to provide continuing care include agreements to provide care for any duration, including contracts that are terminable by either party.~~

(3) "Continuing Care Advisory Council" or "advisory council" means the council established in s. 651.121.

(4) "Continuing care at-home" means, pursuant to a contract, furnishing to a resident who resides outside the facility the right to future access to shelter and nursing care or personal services, whether such services are provided in the facility or in another setting designated in the contract, by an individual not related by consanguinity or affinity to the resident, upon payment of an entrance fee.

(5) ~~(4)~~ "Entrance fee" means an initial or deferred payment of a sum of money or property made as full or partial payment for continuing care or continuing care at-home ~~to assure the resident a place in a facility~~. An accommodation fee, admission fee, member fee, or other fee of similar form and application are considered to be an entrance fee.

(6)~~(5)~~ "Facility" means a place where ~~that provides~~ continuing care is furnished and may include one or more physical plants on a primary or contiguous site or an immediately accessible site. As used in this subsection, the term "immediately accessible site" means a parcel of real property separated by a reasonable distance from the facility as measured along public thoroughfares, and "primary or contiguous site" means the real property contemplated in the feasibility study required by this chapter.

(7)~~(6)~~ "Generally accepted accounting principles" means those accounting principles and practices adopted by the Financial Accounting Standards Board and the American Institute of Certified Public Accountants, including Statement of Position 90-8 with respect to any full year to which the statement applies.

(8)~~(7)~~ "Insolvency" means the condition in which the provider is unable to pay its obligations as they come due in the normal course of business.

(9)~~(8)~~ "Licensed" means that the provider has obtained a certificate of authority from the department.

(10) "Nursing care" means those services or acts rendered to a resident by an individual licensed or certified pursuant to chapter 464.

(11) "Personal services" has the same meaning as in s. 429.02.

(12)~~(9)~~ "Provider" means the owner or operator, whether a natural person, partnership or other unincorporated association, however organized, trust, or corporation, of an institution,

building, residence, or other place, whether operated for profit or not, which owner or operator provides continuing care or continuing care at-home for a fixed or variable fee, or for any other remuneration of any type, whether fixed or variable, for the period of care, payable in a lump sum or lump sum and monthly maintenance charges or in installments. The term~~, but~~ does not apply to ~~mean~~ an entity that has existed and continuously operated a facility located on at least 63 acres in this state providing residential lodging to members and their spouses for at least 66 years on or before July 1, 1989, and has the residential capacity of 500 persons, is directly or indirectly owned or operated by a nationally recognized fraternal organization, is not open to the public, and accepts only its members and their spouses as residents.

(13)~~(10)~~ "Records" means the permanent financial, directory, and personnel information and data maintained by a provider pursuant to this chapter.

(14)~~(11)~~ "Resident" means a purchaser of, a nominee of, or a subscriber to a continuing care or continuing care at-home contract ~~agreement~~. Such contract ~~agreement~~ does not give the resident a part ownership of the facility in which the resident is to reside, unless expressly provided ~~for~~ in the contract ~~agreement~~.

(15) "Shelter" means an independent living unit, room, apartment, cottage, villa, personal care unit, nursing bed, or other living area within a facility set aside for the exclusive use of one or more identified residents.

Section 2. Section 651.012, Florida Statutes, is amended

to read:

651.012 Exempted facility; written disclosure of exemption.—Any facility exempted under ss. 632.637(1)(e) and 651.011(12) ~~651.011(9)~~ must provide written disclosure of such exemption to each person admitted to the facility after October 1, 1996. This disclosure must be written using language likely to be understood by the person and must briefly explain the exemption.

Section 3. Section 651.013, Florida Statutes, is amended to read:

651.013 Chapter exclusive; applicability of other laws.—

(1) Except as herein provided, providers of continuing care and continuing care at-home are ~~shall be~~ governed by the provisions of this chapter and are ~~shall be~~ exempt from all other provisions of the Florida Insurance Code.

(2) In addition to other applicable provisions cited in this chapter, the office has the authority granted under ss. 624.302 and 624.303, 624.308-624.312, 624.319(1)-(3), 624.320-624.321, 624.324, and 624.34 of the Florida Insurance Code to regulate providers of continuing care and continuing care at-home.

Section 4. Section 651.021, Florida Statutes, is amended to read:

651.021 Certificate of authority required.—

(1) No person may engage in the business of providing continuing care, ~~or~~ issuing contracts for continuing care or continuing care at-home, or constructing ~~agreements or construct~~ a facility for the purpose of providing continuing care in this

state without a certificate of authority ~~therefor~~ obtained from the office as provided in this chapter. This subsection does ~~shall~~ not ~~be construed to~~ prohibit the preparation of a ~~the~~ construction site or construction of a model residence unit for marketing purposes, or both. The office may allow the purchase of an existing building for the purpose of providing continuing care if the office determines that the purchase is not being made to circumvent ~~for the purpose of circumventing~~ the prohibitions ~~contained~~ in this section.

(2)~~(a)~~ Written approval must be obtained from the office before commencing ~~commencement of~~ construction or marketing for an ~~any~~ expansion of a certificated facility equivalent to the addition of at least 20 percent of existing units or 20 percent or more in the number of continuing care at-home contracts~~, written approval must be obtained from the office~~. This provision does not apply to construction for which a certificate of need from the Agency for Health Care Administration is required.

(a) For providers that offer both continuing care and continuing care at-home, the 20 percent is based on the total of both existing units and existing contracts for continuing care at-home. For purposes of this subsection, an expansion includes increases in the number of constructed units or continuing care at-home contracts or a combination of both.

(b) The application for such approval shall be on forms adopted by the commission and provided by the office. The application must ~~shall~~ include the feasibility study required by s. 651.022(3) or s. 651.023(1)(b) and such other information as

required by s. 651.023. If the expansion is only for continuing care at-home contracts, an actuarial study prepared by an independent actuary in accordance with standards adopted by the American Academy of Actuaries which presents the financial impact of the expansion may be substituted for the feasibility study.

(c) In determining whether an expansion should be approved, the office shall use ~~utilize~~ the criteria provided in ss. 651.022(6) and 651.023(4) ~~651.023(2)~~.

Section 5. Paragraphs (d) and (g) of subsection (2) and subsections (4) and (6) of section 651.022, Florida Statutes, are amended to read:

651.022 Provisional certificate of authority; application.—

(2) The application for a provisional certificate of authority shall be on a form prescribed by the commission and shall contain the following information:

(d) The contracts ~~agreements~~ for continuing care and continuing care at-home to be entered into between the provider and residents which meet the minimum requirements of s. 651.055 or s. 651.057 and which include a statement describing the procedures required by law relating to the release of escrowed entrance fees. Such statement may be furnished through an addendum.

(g) The forms of the ~~continuing care~~ residency contracts, reservation contracts, escrow agreements, and wait list contracts, if applicable, which are proposed to be used by the provider in the furnishing of care. ~~If~~ The office shall approve

~~finds that the continuing care~~ contracts and escrow agreements that comply with ss. 651.023(1)(c), 651.033, ~~and~~ 651.055, and 651.057 ~~it shall approve them~~. Thereafter, no other form of contract or agreement may be used by the provider until it has been submitted to the office and approved.

(4) If an applicant has or proposes to have more than one facility offering continuing care or continuing care at-home, a separate provisional certificate of authority and a separate certificate of authority must ~~shall~~ be obtained for each facility.

(6) Within 45 days after ~~from~~ the date an application is deemed ~~to be~~ complete~~,~~ as set forth in paragraph (5)(b), the office shall complete its review and ~~shall~~ issue a provisional certificate of authority to the applicant based upon its review and a determination that the application meets all requirements of law, ~~and~~ that the feasibility study was based on sufficient data and reasonable assumptions, and that the applicant will be able to provide continuing care or continuing care at-home as proposed and meet all financial obligations related to its operations, including the financial requirements of this chapter ~~to provide continuing care as proposed~~. If the application is denied, the office shall notify the applicant in writing, citing the specific failures to meet the provisions of this chapter. Such denial entitles ~~shall entitle~~ the applicant to a hearing pursuant to ~~the provisions of~~ chapter 120.

Section 6. Section 651.023, Florida Statutes, is amended to read:

651.023 Certificate of authority; application.—

(1) After issuance of a provisional certificate of authority, the office shall issue to the holder of such provisional certificate ~~of authority~~ a certificate of authority if~~; provided, however, that no certificate of authority shall be issued until~~ the holder of the ~~such~~ provisional certificate ~~of authority~~ provides the office with the following information:

(a) Any material change in status with respect to the information required to be filed under s. 651.022(2) in the application for the ~~a~~ provisional certificate ~~of authority~~.

(b) A feasibility study prepared by an independent consultant which contains all of the information required by s. 651.022(3) and ~~contains~~ financial forecasts or projections prepared in accordance with standards adopted ~~promulgated~~ by the American Institute of Certified Public Accountants or ~~financial forecasts or projections prepared~~ in accordance with standards for feasibility studies or continuing care retirement communities adopted ~~promulgated~~ by the Actuarial Standards Board.

1. The study must also contain an independent evaluation and examination opinion, or a comparable opinion acceptable to the office, by the consultant who prepared the study, of the underlying assumptions used as a basis for the forecasts or projections in the study and that the assumptions are reasonable and proper and ~~that~~ the project as proposed is feasible.

2. The study must ~~shall~~ take into account project costs, actual marketing results to date and marketing projections, resident fees and charges, competition, resident contract provisions, and any other factors which affect the feasibility

of operating the facility.

3. If the study is prepared by an independent certified public accountant, it must contain an examination opinion for the first 3 years of operations and financial projections having a compilation opinion for the next 3 years. If the study is prepared by an independent consulting actuary, it must contain mortality and morbidity data and an actuary's signed opinion that the project as proposed is feasible and that the study has been prepared in accordance with standards adopted by the American Academy of Actuaries.

(c) Subject to ~~the requirements of~~ subsection (4) ~~(2)~~, a provider may submit an application for a certificate of authority and any required exhibits upon submission of proof that the project has a minimum of 30 percent of the units reserved for which the provider is charging an entrance fee. ~~;~~ ~~however,~~ This does ~~provision shall~~ not apply to an application for a certificate of authority for the acquisition of a facility for which a certificate of authority was issued before ~~prior to~~ October 1, 1983, to a provider who subsequently becomes a debtor in a case under the United States Bankruptcy Code, 11 U.S.C. ss. 101 et seq., or to a provider for which the department has been appointed receiver pursuant to ~~the provisions of~~ part II of chapter 631.

(d) Proof that commitments have been secured for both construction financing and long-term financing or a documented plan acceptable to the office has been adopted by the applicant for long-term financing.

(e) Proof that all conditions of the lender have been

satisfied to activate the commitment to disburse funds other than the obtaining of the certificate of authority, the completion of construction, or the closing of the purchase of realty or buildings for the facility.

(f) Proof that the aggregate amount of entrance fees received by or pledged to the applicant, plus anticipated proceeds from any long-term financing commitment, plus funds from all other sources in the actual possession of the applicant, equal at least ~~not less than~~ 100 percent of the aggregate cost of constructing or purchasing, equipping, and furnishing the facility plus 100 percent of the anticipated startup losses of the facility.

(g) Complete audited financial statements of the applicant, prepared by an independent certified public accountant in accordance with generally accepted accounting principles, as of the date the applicant commenced business operations or for the fiscal year that ended immediately preceding the date of application, whichever is later, and complete unaudited quarterly financial statements attested to by the applicant after ~~subsequent to~~ the date of the last audit.

(h) Proof that the applicant has complied with the escrow requirements of subsection (5) ~~(3)~~ or subsection (7) ~~(5)~~ and will be able to comply with s. 651.035.

(i) Such other reasonable data, financial statements, and pertinent information as the commission or office may require with respect to the applicant or the facility, to determine the financial status of the facility and the management capabilities of its managers and owners.

(2) ~~(j)~~ Within 30 days after ~~of the~~ receipt of the information required under subsection (1) ~~paragraphs (a)-(h)~~, the office shall examine such information and ~~shall~~ notify the provider in writing, specifically requesting any additional information the office is permitted by law to require. Within 15 days after receipt of all of the requested additional information, the office shall notify the provider in writing that all of the requested information has been received and the application is deemed to be complete as of the date of the notice. Failure to ~~so~~ notify the applicant in writing within the 15-day period constitutes ~~shall constitute~~ acknowledgment by the office that it has received all requested additional information, and the application shall be deemed ~~to be~~ complete for purposes of review on ~~upon~~ the date of ~~the~~ filing ~~of~~ all of the required additional information.

(3) ~~(k)~~ Within 45 days after an application is deemed complete as set forth in subsection (2) ~~paragraph (j)~~, and upon completion of the remaining requirements of this section, the office shall complete its review and ~~shall~~ issue~~,~~ or deny a certificate of authority~~,~~ to the holder of a provisional certificate of authority ~~a certificate of authority~~. If a certificate of authority is denied, the office must ~~shall~~ notify the holder of the provisional certificate ~~of authority~~ in writing, citing the specific failures to satisfy the provisions of this chapter. If denied, the holder of the provisional certificate is ~~of authority shall be~~ entitled to an administrative hearing pursuant to chapter 120.

(4) ~~(2)(a)~~ The office shall issue a certificate of

authority upon determining ~~its determination~~ that the applicant meets all requirements of law and has submitted all of the information required by this section, that all escrow requirements have been satisfied, and that the fees prescribed in s. 651.015(2) have been paid.

(a) Notwithstanding satisfaction of the 30-percent minimum reservation requirement of paragraph (1)(c), a ~~no~~ certificate of authority may not ~~shall~~ be issued until the project has a minimum of 50 percent of the units reserved for which the provider is charging an entrance fee, and proof ~~thereof~~ is provided to the office. If a provider offering continuing care at-home is applying for a certificate of authority or approval of an expansion pursuant to s. 651.021(2), the same minimum reservation requirements must be met for the continuing care and continuing care at-home contracts, independently of each other.

(b) In order for a unit to be considered reserved under this section, the provider must collect a minimum deposit of 10 percent of the then-current entrance fee for that unit, and ~~must~~ assess a forfeiture penalty of 2 percent of the entrance fee due to termination of the reservation contract after 30 days for any reason other than the death or serious illness of the resident, the failure of the provider to meet its obligations under the reservation contract, or other circumstances beyond the control of the resident that equitably entitle the resident to a refund of the resident's deposit. The reservation contract must ~~shall~~ state the cancellation policy and the terms of the continuing care or continuing care at-home contract to be entered into.

(5) ~~(3)~~ Up to ~~No more than~~ 25 percent of the moneys paid

for all or any part of an initial entrance fee may be included or pledged for the construction or purchase of the facility~~,~~ or ~~included or pledged~~ as security for long-term financing. The term "initial entrance fee" means the total entrance fee charged by the facility to the first occupant of a unit.

(a) A minimum of 75 percent of the moneys paid for all or any part of an initial entrance fee collected for continuing care or continuing care at-home shall be placed in an escrow account or on deposit with the department as prescribed in s. 651.033.

(b) For an expansion as provided in s. 651.021(2), a minimum of 75 percent of the moneys paid for all or any part of an initial entrance fee collected for continuing care and 50 percent of the moneys paid for all or any part of an initial fee collected for continuing care at-home shall be placed in an escrow account or on deposit with the department as prescribed in s. 651.033.

(6)~~(4)~~ The provider is ~~shall be~~ entitled to secure release of the moneys held in escrow within 7 days after receipt by the office of an affidavit from the provider, along with appropriate copies to verify, and notification to the escrow agent by certified mail, that the following conditions have been satisfied:

(a) A certificate of occupancy has been issued.

(b) Payment in full has been received for at least ~~no less than~~ 70 percent of the total units of a phase or of the total of the combined phases constructed. If a provider offering continuing care at-home is applying for a release of escrowed

entrance fees, the same minimum requirement must be met for the continuing care and continuing care at-home contracts, independently of each other.

(c) The consultant who prepared the feasibility study required by this section or a substitute approved by the office certifies within 12 months before the date of filing for office approval that there has been no material adverse change in status with regard to the feasibility study~~, with such statement dated not more than 12 months from the date of filing for office approval~~. If a material adverse change exists ~~should exist~~ at the time of submission, ~~then~~ sufficient information acceptable to the office and the feasibility consultant must ~~shall~~ be submitted which remedies the adverse condition.

(d) Proof that commitments have been secured or a documented plan adopted by the applicant has been approved by the office for long-term financing.

(e) Proof that the provider has sufficient funds to meet the requirements of s. 651.035, which may include funds deposited in the initial entrance fee account.

(f) Proof as to the intended application of the proceeds upon release and proof that the entrance fees when released will be applied as represented to the office.

Notwithstanding ~~any provision of~~ chapter 120, no person, other than the provider, the escrow agent, and the office, may ~~shall~~ have a substantial interest in any office decision regarding release of escrow funds in any proceedings under chapter 120 or this chapter regarding release of escrow funds.

(7)~~(5)~~ In lieu of the provider fulfilling the requirements in subsection (5) ~~(3)~~ and paragraphs (6)(b) ~~(4)(b)~~ and (d), the office may authorize the release of escrowed funds to retire all outstanding debts on the facility and equipment upon application of the provider and upon the provider's showing that the provider will grant to the residents a first mortgage on the land, buildings, and equipment that constitute the facility, and that the provider has satisfied ~~satisfies the requirements of~~ paragraphs (6)(a) ~~(4)(a)~~, (c), and (e). Such mortgage shall secure the refund of the entrance fee in the amount required by this chapter. The granting of such mortgage is ~~shall be~~ subject to the following:

(a) The first mortgage is ~~shall be~~ granted to an independent trust that ~~which~~ is beneficially held by the residents. The document creating the trust must include ~~shall contain~~ a provision that ~~it~~ agrees to an annual audit and will furnish to the office all information the office may reasonably require. The mortgage may secure payment on bonds issued to the residents or trustee. Such bonds are ~~shall be~~ redeemable after termination of the residency contract in the amount and manner required by this chapter for the refund of an entrance fee.

(b) Before granting a first mortgage to the residents, all construction must ~~shall~~ be substantially completed and substantially all equipment must ~~shall~~ be purchased. No part of the entrance fees may be pledged as security for a construction loan or otherwise used for construction expenses before the completion of construction.

(c) If the provider is leasing the land or buildings used

by the facility, the leasehold interest must ~~shall~~ be for a term of at least 30 years.

(8) ~~(6)~~ The timeframes provided under s. 651.022(5) and (6) apply to applications submitted under s. 651.021(2). The office may not issue a certificate of authority ~~under this chapter~~ to a ~~any~~ facility that ~~which~~ does not have a component that ~~which~~ is to be licensed pursuant to part II of chapter 400 or to part I of chapter 429 or that does ~~which will~~ not offer personal services or nursing services through written contractual agreement. A ~~Any~~ written contractual agreement must be disclosed in the ~~continuing care~~ contract for continuing care or continuing care at-home and is subject to the provisions of s. 651.1151, relating to administrative, vendor, and management contracts.

(9) ~~(7)~~ The office may ~~shall~~ not approve an application that ~~which~~ includes in the plan of financing any encumbrance of the operating reserves required by this chapter.

Section 7. Paragraphs (a) and (d) of subsection (3) of section 651.033, Florida Statutes, are amended to read:

651.033 Escrow accounts.—

(3) In addition, when entrance fees are required to be deposited in an escrow account pursuant to s. 651.022, s. 651.023, or s. 651.055:

(a) The provider shall deliver to the resident a written receipt. The receipt must ~~shall~~ show the payor's name and address, the date, the price of the care contract, and the amount of money paid. A copy of each receipt, together with the funds, shall be deposited with the escrow agent or as provided

in paragraph (c). The escrow agent shall release such funds to the provider ~~upon the expiration of~~ 7 days after the date of receipt of the funds by the escrow agent if the provider, operating under a certificate of authority issued by the office, has met the requirements of s. 651.023(6) ~~651.023(4)~~. However, if the resident rescinds the contract within the 7-day period, the escrow agent shall release the escrowed fees to the resident.

(d) A provider may assess a nonrefundable fee, which is separate from the entrance fee, for processing a prospective resident's application for continuing care or continuing care at-home.

Section 8. Subsections (2) and (3) of section 651.035, Florida Statutes, are amended to read:

651.035 Minimum liquid reserve requirements.—

(2)(a) In facilities where not all residents are under continuing care or continuing care at-home contracts, the reserve requirements of subsection (1) shall be computed only with respect to the proportional share of operating expenses that ~~which~~ are applicable to residents ~~as defined in s. 651.011~~. For purposes of this calculation, the proportional share shall be based upon the ratio of residents under continuing care or continuing care at-home contracts to those residents who do not hold such contracts.

(b) In facilities that have voluntarily and permanently discontinued marketing continuing care and continuing care at-home contracts, the office may allow a reduced debt service reserve as required in subsection (1) based upon the ratio of

residents under continuing care or continuing care at-home contracts to those residents who do not hold such contracts if the office finds that such reduction is not inconsistent with the security protections intended by this chapter. In making this determination, the office may consider such factors as the financial condition of the facility, the provisions of ~~the~~ outstanding continuing care and continuing care at-home contracts, the ratio of residents under continuing care or continuing care at-home contracts ~~agreements~~ to those residents who do not hold such contracts ~~a continuing care contract~~, the current occupancy rates, the previous sales and marketing efforts, the life expectancy of the remaining residents ~~contract holders~~, and the written policies of the board of directors of the provider or a similar board.

(3) If principal and interest payments are paid to a trust that is beneficially held by the residents as described in s. 651.023(7) ~~651.023(5)~~, the office may waive all or any portion of the escrow requirements for mortgage principal and interest contained in subsection (1) if the office finds that such waiver is not inconsistent with the security protections intended by this chapter.

Section 9. Section 651.055, Florida Statutes, is amended to read:

651.055 Continuing care contracts; right to rescind.—

(1) Each continuing care contract and each addendum to such contract shall be submitted to and approved by the office before ~~prior to~~ its use in this state. Thereafter, no other form of contract shall be used by the provider until ~~unless~~ it has

been submitted to and approved by the office. Each contract must ~~shall~~:

(a) Provide for the continuing care of only one resident, or for two persons occupying space designed for double occupancy, under appropriate regulations established by the provider, and must ~~shall~~ list all properties transferred and their market value at the time of transfer, including donations, subscriptions, fees, and any other amounts paid or payable by, or on behalf of, the resident or residents.

(b) Specify all services that ~~which~~ are to be provided by the provider to each resident, including, in detail, all items that ~~which~~ each resident will receive, whether the items will be provided for a designated time period or for life, and whether the services will be available on the premises or at another specified location. The provider shall indicate which services or items are included in the contract for continuing care and which services or items are made available at or by the facility at extra charge. Such items ~~shall~~ include, but are not limited to, food, shelter, personal services or nursing care, drugs, burial, and incidentals.

(c) Describe the terms and conditions under which a contract for continuing care may be canceled by the provider or by a resident and the conditions, if any, under which all or any portion of the entrance fee will be refunded in the event of cancellation of the contract by the provider or by the resident, including the effect of any change in the health or financial condition of a person between the date of entering a contract for continuing care and the date of initial occupancy of a

living unit by that person.

(d) Describe the health and financial conditions required for a person to be accepted as a resident and to continue as a resident, once accepted, including the effect of any change in the health or financial condition of the person between the date of submitting an application for admission to the facility and entering into a continuing care contract. If a prospective resident signs a contract but postpones moving into the facility, the individual is deemed to be occupying a unit at the facility when he or she pays the entrance fee or any portion of the fee, other than a reservation deposit, and begins making monthly maintenance fee payments. Such resident may rescind the contract and receive a full refund of any funds paid, without penalty or forfeiture, within 7 days after executing the contract as specified in subsection (2).

(e) Describe the circumstances under which the resident will be permitted to remain in the facility in the event of financial difficulties of the resident. The stated policy may not be less than the terms stated in s. 651.061.

(f) State the fees that will be charged if the resident marries while at the designated facility, the terms concerning the entry of a spouse to the facility, and the consequences if the spouse does not meet the requirements for entry.

(g) Provide that the contract may be canceled by giving at least 30 days' written notice of cancellation by the provider, the resident, or the person who provided the transfer of property or funds for the care of such resident.~~,~~ However, if a contract is canceled because there has been a good faith

determination that a resident is a danger to himself or herself or others, only such notice as is reasonable under the circumstances is required.

1. The contract must also provide in clear and understandable language, in print no smaller than the largest type used in the body of the contract, the terms governing the refund of any portion of the entrance fee.

2. For a resident whose contract with the facility provides that the resident does not receive a transferable membership or ownership right in the facility, and who has occupied his or her unit, the refund shall be calculated on a pro rata basis with the facility retaining up to 2 percent per month of occupancy by the resident and up to a 5 percent ~~5 percent~~ processing fee. Such refund must be paid within 120 days after giving the notice of intention to cancel.

3. In addition to a processing fee, if the contract provides for the facility to retain up to 1 percent per month of occupancy by the resident, it may provide that such refund will be paid from the proceeds of the next entrance fees received by the provider for units for which there are no prior claims by any resident until paid in full or, if the provider has discontinued marketing continuing care contracts, within 200 days after the date of notice.

4. Unless subsection (5) applies, for any prospective resident, regardless of whether or not such a resident receives a transferable membership or ownership right in the facility, who cancels the contract before occupancy of the unit, the entire amount paid toward the entrance fee shall be refunded,

less a processing fee of up to 5 percent of the entire entrance fee; however, the processing fee may not exceed the amount paid by the prospective resident. Such refund must be paid within 60 days after giving ~~the~~ notice of intention to cancel. For a resident who has occupied his or her unit and who has received a transferable membership or ownership right in the facility, the foregoing refund provisions do not apply but are deemed satisfied by the acquisition or receipt of a transferable membership or an ownership right in the facility. The provider may not charge any fee for the transfer of membership or sale of an ownership right.

(h) State the terms under which a contract is canceled by the death of the resident. These terms may contain a provision that, upon the death of a resident, the entrance fee of such resident is ~~shall be~~ considered earned and becomes ~~shall become~~ the property of the provider. If ~~When~~ the unit is shared, the conditions with respect to the effect of the death or removal of one of the residents must ~~shall~~ be included in the contract.

(i) Describe the policies that ~~which~~ may lead to changes in monthly recurring and nonrecurring charges or fees for goods and services received. The contract must ~~shall~~ provide for advance notice to the resident, of at least ~~not less than~~ 60 days, before any change in fees or charges or the scope of care or services is ~~may be~~ effective, except for changes required by state or federal assistance programs.

(j) Provide that charges for care paid in one lump sum may ~~shall~~ not be increased or changed during the duration of the agreed upon care, except for changes required by state or

federal assistance programs.

(k) Specify whether ~~or not~~ the facility is, or is affiliated with, a religious, nonprofit, or proprietary organization or management entity; the extent to which the affiliate organization will be responsible for the financial and contractual obligations of the provider; and the provisions of the federal Internal Revenue Code, if any, under which the provider or affiliate is exempt from the payment of federal income tax.

(2) A resident has the right to rescind a continuing care contract and receive a full refund of any funds paid, without penalty or forfeiture, within 7 days after executing the contract. A resident may not be required to move into the facility designated in the contract before the expiration of the 7-day period. During the 7-day period, the resident's funds must be held in an escrow account unless otherwise requested by the resident pursuant to s. 651.033(3)(c).

(3) The contract must ~~shall~~ include or ~~shall~~ be accompanied by a statement, printed in boldfaced type, which reads: "This facility and all other continuing care facilities in the State of Florida are regulated by chapter 651, Florida Statutes. A copy of the law is on file in this facility. The law gives you or your legal representative the right to inspect our most recent financial statement and inspection report before signing the contract."

(4) Before the transfer of any money or other property to a provider by or on behalf of a prospective resident, the provider shall present a typewritten or printed copy of the

contract to the prospective resident and all other parties to the contract. The provider shall secure a signed, dated statement from each party to the contract certifying that a copy of the contract with the specified attachment, as required pursuant to this chapter, was received.

(5) Except for a resident who postpones moving into the facility but is deemed to have occupied a unit as described in paragraph (1)(d), if a prospective resident dies before occupying the facility or, through illness, injury, or incapacity, is precluded from becoming a resident under the terms of the continuing care contract, the contract is automatically canceled, and the prospective resident or his or her legal representative shall receive a full refund of all moneys paid to the facility, except those costs specifically incurred by the facility at the request of the prospective resident and set forth in writing in a separate addendum, signed by both parties, to the contract.

(6) In order to comply with this section, a provider may furnish information not contained in his or her continuing care contract through an addendum.

(7) Contracts to provide continuing care, including contracts that are terminable by either party, may include agreements to provide care for any duration.

(8) ~~(7)~~ Those contracts entered into after ~~subsequent to~~ July 1, 1977, and before the issuance of a certificate of authority to the provider are valid and binding upon both parties in accordance with their terms. Within 90 days after receipt of a letter from the office, the facility must submit

proof to the office of compliance with an approved residency contract. All current contracts remain in force until resolved by the office and the facility.

(9)~~(8)~~ The provisions of this section ~~shall~~ control over any conflicting provisions contained in part II of chapter 400 or in part I of chapter 429.

Section 10. Section 651.057, Florida Statutes, is created to read:

651.057 Continuing care at-home contracts.—

(1) In addition to the requirements of s. 651.055, a provider offering contracts for continuing care at-home must:

(a) Disclose the following in the continuing care at-home contract:

1. Whether transportation will be provided to residents when traveling to and from the facility for services;

2. That the provider has no liability for residents residing outside the facility beyond the delivery of services specified in the contract and future access to nursing care or personal services at the facility or in another setting designated in the contract;

3. The mechanism for monitoring residents who live outside the facility;

4. The process that will be followed to establish priority if a resident wishes to exercise his or her right to move into the facility; and

5. The policy that will be followed if a resident living outside the facility relocates to a different residence and no longer avails himself or herself of services provided by the

facility.

(b) Ensure that persons employed by or under contract with the provider who assist in the delivery of services to residents residing outside the facility are appropriately licensed or certified as required by law.

(c) Include operating expenses for continuing care at-home contracts in the calculation of the operating reserve required by s. 651.035(1)(c).

(d) Include the operating activities for continuing care at-home contracts in the total operation of the facility when submitting financial reports to the office as required by s. 651.026.

(2) A provider that holds a certificate of authority and wishes to offer continuing care at-home must also:

(a) Submit a business plan to the office with the following information:

1. A description of the continuing care at-home services that will be provided, the market to be served, and the fees to be charged;

2. A copy of the proposed continuing care at-home contract;

3. An actuarial study prepared by an independent actuary in accordance with the standards adopted by the American Academy of Actuaries which presents the impact of providing continuing care at-home on the overall operation of the facility;

4. A market feasibility study that meets the requirements of s. 651.022(3) and documents that there is sufficient interest in continuing care at-home contracts to support such a program;

and

5. A feasibility study prepared by an independent certified public accountant which includes an examination opinion for the first 3 years operations and financial projections having a compilation opinion for the next 3 years. In lieu of a feasibility study, a provider may submit the actuarial study referenced in subparagraph 3., along with a statement from the actuary who prepared the actuarial study, dated within 12 months after the date of filing for office approval, indicating that there will be no material adverse change in the facility's status as a result of offering in-home contracts. If a material adverse change exists at the time of submission, sufficient information acceptable to the office and the actuary which remedies the adverse condition must be submitted;

(b) Demonstrate to the office that the proposal to offer continuing care at-home contracts to individuals who do not immediately move into the facility will not place the provider in an unsound financial condition;

(c) Comply with the requirements of s. 651.021(2), except that an actuarial study may be substituted for the feasibility study; and

(d) Comply with the requirements of this chapter.

(3) Contracts to provide continuing care at-home, including contracts that are terminable by either party, may include agreements to provide care for any duration.

(4) A provider offering continuing care at-home contracts must, at a minimum, have a facility that is licensed under this

chapter and has accommodations for independent living which are primarily intended for residents who do not require staff supervision. The facility need not offer assisted living units licensed under part I of chapter 429 or nursing home units licensed under part II of chapter 400 in order to be able to offer continuing care at-home contracts.

(a) The combined total of outstanding continuing care and continuing care at-home contracts allowed at a facility may be up to 1.5 times the combined total of independent living units, assisted living units, and nursing home units licensed under part II of chapter 400 at the facility, unless the facility's provisional certificate of authority was issued on December 21, 2005; and

(b) The number of independent living units at the facility must be equal to or greater than 10 percent of the combined total of outstanding continuing care and continuing care at-home contracts issued by that facility.

Section 11. Subsection (1) of section 651.071, Florida Statutes, is amended to read:

651.071 Contracts as preferred claims on liquidation or receivership.—

(1) In the event of receivership or liquidation proceedings against a provider, all continuing care and continuing care at-home contracts executed by a provider shall be deemed preferred claims against all assets owned by the provider; however, such claims are ~~shall be~~ subordinate to those priority claims set forth in s. 631.271 and any secured claim ~~as defined in s. 631.011~~.

Section 12. Paragraph (h) of subsection (2) and subsection (3) of section 651.091, Florida Statutes, are amended to read:

651.091 Availability, distribution, and posting of reports and records; requirement of full disclosure.—

(2) Every continuing care facility shall:

(h) Upon request, deliver to the president or chair of the residents' council a copy of any newly approved continuing care or continuing care at-home contract within 30 days after approval by the office.

(3) Before entering into a contract to furnish continuing care or continuing care at-home, the provider undertaking to furnish the care, or the agent of the provider, shall make full disclosure, and provide copies of the disclosure documents to the prospective resident or his or her legal representative, of the following information:

(a) The contract to furnish continuing care or continuing care at-home.

(b) The summary listed in paragraph (2)(b).

(c) All ownership interests and lease agreements, including information specified in s. 651.022(2)(b)8.

(d) In keeping with the intent of this subsection relating to disclosure, the provider shall make available for review, master plans approved by the provider's governing board and any plans for expansion or phased development, to the extent that the availability of such plans do ~~will~~ not put at risk real estate, financing, acquisition, negotiations, or other implementation of operational plans and thus jeopardize the success of negotiations, operations, and development.

(e) Copies of the rules and regulations of the facility and an explanation of the responsibilities of the resident.

(f) The policy of the facility with respect to admission to and discharge from the various levels of health care offered by the facility.

(g) The amount and location of any reserve funds required by this chapter, and the name of the person or entity having a claim to such funds in the event of a bankruptcy, foreclosure, or rehabilitation proceeding.

(h) A copy of s. 651.071.

(i) A copy of the resident's rights as described in s. 651.083.

Section 13. Section 651.106, Florida Statutes, is amended to read:

651.106 Grounds for discretionary refusal, suspension, or revocation of certificate of authority.—The office~~, in its discretion,~~ may deny, suspend, or revoke the provisional certificate of authority or the certificate of authority of any applicant or provider if it finds that any one or more of the following grounds applicable to the applicant or provider exist:

(1) Failure by the provider to continue to meet the requirements for the authority originally granted.

(2) Failure by the provider to meet one or more of the qualifications for the authority specified by this chapter.

(3) Material misstatement, misrepresentation, or fraud in obtaining the authority, or in attempting to obtain the same.

(4) Demonstrated lack of fitness or trustworthiness.

(5) Fraudulent or dishonest practices of management in the

conduct of business.

(6) Misappropriation, conversion, or withholding of moneys.

(7) Failure to comply with, or violation of, any proper order or rule of the office or commission or violation of any provision of this chapter.

(8) The insolvent condition of the provider or the provider's being in such condition or using such methods and practices in the conduct of its business as to render its further transactions in this state hazardous or injurious to the public.

(9) Refusal by the provider to be examined or to produce its accounts, records, and files for examination, or refusal by any of its officers to give information with respect to its affairs or to perform any other legal obligation under this chapter when required by the office.

(10) Failure by the provider to comply with the requirements of s. 651.026 or s. 651.033.

(11) Failure by the provider to maintain escrow accounts or funds as required by this chapter.

(12) Failure by the provider to meet the requirements of this chapter for disclosure of information to residents concerning the facility, its ownership, its management, its development, or its financial condition or failure to honor its continuing care <u>or continuing care at-home</u> contracts.

(13) Any cause for which issuance of the license could have been refused had it then existed and been known to the office.

(14) Having been found guilty of, or having pleaded guilty or nolo contendere to, a felony in this state or any other state, without regard to whether a judgment or conviction has been entered by the court having jurisdiction of such cases.

(15) In the conduct of business under the license, engaging in unfair methods of competition or in unfair or deceptive acts or practices prohibited under part IX of chapter 626.

(16) A pattern of bankrupt enterprises.

Revocation of a certificate of authority under this section does not relieve a provider from the provider's obligation to residents under the terms and conditions of any continuing care or continuing care at-home contract between the provider and residents or the provisions of this chapter. The provider shall continue to file its annual statement and pay license fees to the office as required under this chapter as if the certificate of authority had continued in full force, but the provider may ~~shall~~ not issue any new ~~continuing care~~ contracts. The office may seek an action in the circuit court of Leon County to enforce the office's order and the provisions of this section.

Section 14. Subsection (8) of section 651.114, Florida Statutes, is amended to read:

651.114 Delinquency proceedings; remedial rights.—

(8)(a) The rights of the office described in this section are ~~shall be~~ subordinate to the rights of a trustee or lender pursuant to the terms of a resolution, ordinance, loan agreement, indenture of trust, mortgage, lease, security

agreement, or other instrument creating or securing bonds or notes issued to finance a facility, and the office, subject to the provisions of paragraph (c), may ~~shall~~ not exercise its remedial rights provided under this section and ss. 651.018, 651.106, 651.108, and 651.116 with respect to a facility that is subject to a lien, mortgage, lease, or other encumbrance or trust indenture securing bonds or notes issued in connection with the financing of the facility, if the trustee or lender, by inclusion or by amendment to the loan documents or by a separate contract with the office, agrees that the rights of residents under a continuing care or continuing care at-home contract will be honored and will not be disturbed by a foreclosure or conveyance in lieu thereof as long as the resident:

1. Is current in the payment of all monetary obligations required by the ~~continuing care~~ contract;

2. Is in compliance and continues to comply with all provisions of the ~~resident's continuing care~~ contract; and

3. Has asserted no claim inconsistent with the rights of the trustee or lender.

(b) ~~Nothing in~~ This subsection does not require ~~requires~~ a trustee or lender to:

1. Continue to engage in the marketing or resale of new continuing care or continuing care at-home contracts;

2. Pay any rebate of entrance fees as may be required by a resident's continuing care or continuing care at-home contract as of the date of acquisition of the facility by the trustee or lender and until expiration of the period described in paragraph (d);

3. Be responsible for any act or omission of any owner or operator of the facility arising before ~~prior to~~ the acquisition of the facility by the trustee or lender; or

4. Provide services to the residents to the extent that the trustee or lender would be required to advance or expend funds that have not been designated or set aside for such purposes.

(c) Should the office determine, at any time during the suspension of its remedial rights as provided in paragraph (a), that the trustee or lender is not in compliance with ~~the provisions of~~ paragraph (a), or that a lender or trustee has assigned or has agreed to assign all or a portion of a delinquent or defaulted loan to a third party without the office's written consent, the office shall notify the trustee or lender in writing of its determination, setting forth the reasons giving rise to the determination and specifying those remedial rights afforded to the office which the office shall then reinstate.

(d) Upon acquisition of a facility by a trustee or lender and evidence satisfactory to the office that the requirements of paragraph (a) have been met, the office shall issue a 90-day temporary certificate of authority granting the trustee or lender the authority to engage in the business of providing continuing care or continuing care at-home and to issue continuing care or continuing care at-home contracts subject to the office's right to immediately suspend or revoke the temporary certificate of authority if the office determines that any of the grounds described in s. 651.106 apply to the trustee

or lender or that the terms of the contract ~~agreement~~ used as the basis for the issuance of the temporary certificate of authority by the office have not been or are not being met by the trustee or lender since the date of acquisition.

Section 15. Subsections (4), (7), (9), and (11) of section 651.118, Florida Statutes, are amended to read:

651.118 Agency for Health Care Administration; certificates of need; sheltered beds; community beds.—

(4) Not including the residences of residents residing outside the facility pursuant to a continuing care at-home contract, the Agency for Health Care Administration shall approve one sheltered nursing home bed for every four proposed residential units, including those that are licensed under part I of chapter 429, in the continuing care facility unless the provider demonstrates the need for a lesser number of sheltered nursing home beds based on proposed utilization by prospective residents or demonstrates the need for additional sheltered nursing home beds based on actual utilization and demand by current residents.

(7) Notwithstanding ~~the provisions of~~ subsection (2), at the discretion of the ~~continuing care~~ provider, sheltered nursing home beds 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 ~~a period of~~ up to 5 years after the date of issuance of the initial nursing home license. A provider whose 5-year period has expired or is expiring may request an extension from the Agency for Health Care Administration ~~for an extension~~, not to exceed 30 percent of the total sheltered

nursing home beds or 30 sheltered beds, whichever is greater, if the utilization by residents of the nursing home facility in the sheltered beds will not generate sufficient income to cover nursing home facility expenses, as evidenced by one of the following:

(a) The nursing home facility has a net loss for the most recent fiscal year as determined under generally accepted accounting principles, excluding the effects of extraordinary or unusual items, as demonstrated in the most recently audited financial statement.~~; or~~

(b) The nursing home facility would have had a pro forma loss for the most recent fiscal year, excluding the effects of extraordinary or unusual items, if revenues were reduced by the amount of revenues from persons in sheltered beds who were not residents, as reported ~~on~~ by a certified public accountant.

The agency may ~~shall be authorized to~~ grant an extension to the provider based on the evidence required in this subsection. The agency may request a continuing care facility to use up to 25 percent of the patient days generated by new admissions of nonresidents during the extension period to serve Medicaid recipients for those beds authorized for extended use if there is a demonstrated need in the respective service area and if funds are available. A provider who obtains an extension is prohibited from applying for additional sheltered beds under ~~the provision of~~ subsection (2), unless additional residential units are built or the provider can demonstrate need by continuing care facility residents to the agency ~~for Health Care~~

~~Administration~~. The 5-year limit does not apply to up to five sheltered beds designated for inpatient hospice care as part of a contractual arrangement with a hospice licensed under part IV of chapter 400. A continuing care facility that uses such beds after the 5-year period shall report such use to the agency ~~for Health Care Administration~~. For purposes of this subsection, "resident" means a person who, upon admission to the continuing care facility, initially resides in a part of the continuing care facility not licensed under part II of chapter 400, or who contracts for continuing care at-home.

(9) This section does not preclude a ~~continuing care~~ provider from applying to the Agency for Health Care Administration for a certificate of need for community nursing home beds or a combination of community and sheltered nursing home beds. Any nursing home bed located in a continuing care facility which ~~that~~ is or has been issued for nonrestrictive use retains ~~shall retain~~ its legal status as a community nursing home bed unless the provider requests a change in status. Any nursing home bed located in a continuing care facility and not issued as a sheltered nursing home bed before ~~prior to~~ 1979 must be classified as a community bed. The agency ~~for Health Care Administration~~ may require continuing care facilities to submit bed utilization reports for the purpose of determining community and sheltered nursing home bed inventories based on historical utilization by residents and nonresidents.

(11) For a provider issued a provisional certificate of authority after July 1, 1986, to operate a facility not previously regulated under this chapter, the following criteria

must ~~shall~~ be met in order to obtain a certificate of need for sheltered beds pursuant to subsections (2), (3), (4), (5), (6), and (7):

(a) Seventy percent or more of the current residents hold continuing care or continuing care at-home contracts ~~agreements pursuant to s. 651.011(2)~~ or, if the facility is not occupied, 70 percent or more of the prospective residents will hold such contracts ~~continuing care agreements pursuant to s. 651.011(2)~~ as projected in the feasibility study and demonstrated by the provider's marketing practices; and

(b) The continuing care or continuing care at-home contracts ~~agreements~~ entered into or to be entered into by 70 percent or more of the current residents or prospective residents must ~~pursuant to s. 651.011(2) shall~~ provide nursing home care for a minimum of 360 cumulative days, and such residents ~~the holders of the continuing care agreements~~ shall be charged at rates that ~~which~~ are 80 percent or less than the rates charged by the provider to persons receiving nursing home care who have not entered into such contracts ~~continuing care agreements pursuant to s. 651.011(2)~~.

Section 16. Subsection (1) of section 651.121, Florida Statutes, is amended to read:

651.121 Continuing Care Advisory Council.—

(1) The Continuing Care Advisory Council to the office is created consisting ~~to consist~~ of 10 members who are residents of this state appointed by the Governor and geographically representative of this state. Three members shall be administrators of facilities that hold valid certificates of

authority under this chapter and shall have been actively engaged in the offering of continuing care contracts ~~agreements~~ in this state for 5 years before appointment. The remaining members include:

(a) A representative of the business community whose expertise is in the area of management.

(b) A representative of the financial community who is not a facility owner or administrator.

(c) A certified public accountant.

(d) An attorney.

(e) Three residents who hold continuing care or continuing care at-home contracts ~~agreements~~ with a facility certified in this state.

Section 17. Subsection (1) of section 651.125, Florida Statutes, is amended to read:

651.125 Criminal penalties; injunctive relief.—

(1) Any person who maintains, enters into, or, as manager or officer or in any other administrative capacity, assists in entering into, maintaining, or performing any continuing care or continuing care at-home contract ~~agreement~~ subject to this chapter without doing so in pursuance of a valid certificate of authority or renewal thereof, as contemplated by or provided in this chapter, or who otherwise violates any provision of this chapter or rule adopted in pursuance of this chapter, is guilty of a felony of the third degree, punishable as provided in s. 775.082 or s. 775.083. Each violation of this chapter constitutes a separate offense.

Section 18. This act shall take effect July 1, 2011.

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED ____ (Y/N)

ADOPTED AS AMENDED ____ (Y/N)

ADOPTED W/O OBJECTION ____ (Y/N)

FAILED TO ADOPT ____ (Y/N)

WITHDRAWN ____ (Y/N)

OTHER

Committee/Subcommittee hearing bill: Health & Human Services Quality Subcommittee

Representative Bembry offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Section 651.011, Florida Statutes, is amended to read:

651.011 Definitions.—As used in ~~For the purposes of~~ this chapter, the term:

(1) "Advertising" means the dissemination of written, visual, or electronic information by a provider, or any person affiliated with or controlled by a provider, to potential residents or their representatives for the purpose of inducing such persons to subscribe to or enter into a contract for continuing care or continuing care at-home ~~to reside in a continuing care community that is subject to this chapter~~.

(2) "Continuing care" or "care" means, pursuant to a contract, furnishing shelter and nursing care or personal

services to a resident who resides in a facility ~~as defined in s. 429.02~~, whether such nursing care or personal services are provided in the facility or in another setting designated in ~~by~~ the contract for continuing care, by ~~to~~ an individual not related by consanguinity or affinity to the resident ~~provider furnishing such care~~, upon payment of an entrance fee. ~~Other personal services provided must be designated in the continuing care contract. Contracts to provide continuing care include agreements to provide care for any duration, including contracts that are terminable by either party.~~

(3) "Continuing Care Advisory Council" or "advisory council" means the council established in s. 651.121.

(4) "Continuing care at-home" means, pursuant to a contract other than a contract described in subsection (2), furnishing to a resident who resides outside the facility the right to future access to shelter and nursing care or personal services, whether such services are provided in the facility or in another setting designated in the contract, by an individual not related by consanguinity or affinity to the resident, upon payment of an entrance fee.

(5) ~~(4)~~ "Entrance fee" means an initial or deferred payment of a sum of money or property made as full or partial payment for continuing care or continuing care at-home ~~to assure the resident a place in a facility~~. An accommodation fee, admission fee, member fee, or other fee of similar form and application are considered to be an entrance fee.

(6) ~~(5)~~ "Facility" means a place where ~~that provides~~ continuing care is furnished and may include one or more

physical plants on a primary or contiguous site or an immediately accessible site. As used in this subsection, the term "immediately accessible site" means a parcel of real property separated by a reasonable distance from the facility as measured along public thoroughfares, and "primary or contiguous site" means the real property contemplated in the feasibility study required by this chapter.

(7) ~~(6)~~ "Generally accepted accounting principles" means those accounting principles and practices adopted by the Financial Accounting Standards Board and the American Institute of Certified Public Accountants, including Statement of Position 90-8 with respect to any full year to which the statement applies.

(8) ~~(7)~~ "Insolvency" means the condition in which the provider is unable to pay its obligations as they come due in the normal course of business.

(9) ~~(8)~~ "Licensed" means that the provider has obtained a certificate of authority from the department.

(10) "Nursing care" means those services or acts rendered to a resident by an individual licensed or certified pursuant to chapter 464.

(11) "Personal services" has the same meaning as in s. 429.02.

(12) ~~(9)~~ "Provider" means the owner or operator, whether a natural person, partnership or other unincorporated association, however organized, trust, or corporation, of an institution, building, residence, or other place, whether operated for profit or not, which owner or operator provides continuing care or

continuing care at-home for a fixed or variable fee, or for any other remuneration of any type, whether fixed or variable, for the period of care, payable in a lump sum or lump sum and monthly maintenance charges or in installments. The term~~, but~~ does not apply to ~~mean~~ an entity that has existed and continuously operated a facility located on at least 63 acres in this state providing residential lodging to members and their spouses for at least 66 years on or before July 1, 1989, and has the residential capacity of 500 persons, is directly or indirectly owned or operated by a nationally recognized fraternal organization, is not open to the public, and accepts only its members and their spouses as residents.

(13) ~~(10)~~ "Records" means the permanent financial, directory, and personnel information and data maintained by a provider pursuant to this chapter.

(14) ~~(11)~~ "Resident" means a purchaser of, a nominee of, or a subscriber to a continuing care or continuing care at-home contract ~~agreement~~. Such contract ~~agreement~~ does not give the resident a part ownership of the facility in which the resident is to reside, unless expressly provided ~~for~~ in the contract ~~agreement~~.

(15) "Shelter" means an independent living unit, room, apartment, cottage, villa, personal care unit, nursing bed, or other living area within a facility set aside for the exclusive use of one or more identified residents.

Section 2. Section 651.012, Florida Statutes, is amended to read:

651.012 Exempted facility; written disclosure of exemption.—Any facility exempted under ss. 632.637(1)(e) and 651.011(12)~~(9)~~ must provide written disclosure of such exemption to each person admitted to the facility after October 1, 1996. This disclosure must be written using language likely to be understood by the person and must briefly explain the exemption.

Section 3. Section 651.013, Florida Statutes, is amended to read:

651.013 Chapter exclusive; applicability of other laws.—

(1) Except as herein provided, providers of continuing care and continuing care at-home are ~~shall be~~ governed by the provisions of this chapter and are ~~shall be~~ exempt from all other provisions of the Florida Insurance Code.

(2) In addition to other applicable provisions cited in this chapter, the office has the authority granted under ss. 624.302 and 624.303, 624.308-624.312, 624.319(1)-(3), 624.320-624.321, 624.324, and 624.34 of the Florida Insurance Code to regulate providers of continuing care and continuing care at-home.

Section 4. Section 651.021, Florida Statutes, is amended to read:

651.021 Certificate of authority required.—

(1) No person may engage in the business of providing continuing care, ~~or~~ issuing contracts for continuing care or continuing care at-home, or constructing ~~agreements or construct~~ a facility for the purpose of providing continuing care in this state without a certificate of authority ~~therefor~~ obtained from the office as provided in this chapter. This subsection does

~~shall~~ not ~~be construed to~~ prohibit the preparation of a ~~the~~ construction site or construction of a model residence unit for marketing purposes, or both. The office may allow the purchase of an existing building for the purpose of providing continuing care if the office determines that the purchase is not being made to circumvent ~~for the purpose of circumventing~~ the prohibitions ~~contained~~ in this section.

(2)~~(a)~~ Written approval must be obtained from the office before commencing ~~commencement of~~ construction or marketing for an ~~any~~ expansion of a certificated facility equivalent to the addition of at least 20 percent of existing units or 20 percent or more in the number of continuing care at-home contracts~~, written approval must be obtained from the office~~. This provision does not apply to construction for which a certificate of need from the Agency for Health Care Administration is required.

(a) For providers that offer both continuing care and continuing care at-home, the 20 percent is based on the total of both existing units and existing contracts for continuing care at-home. For purposes of this subsection, an expansion includes increases in the number of constructed units or continuing care at-home contracts or a combination of both.

(b) The application for such approval shall be on forms adopted by the commission and provided by the office. The application must ~~shall~~ include the feasibility study required by s. 651.022(3) or s. 651.023(1)(b) and such other information as required by s. 651.023. If the expansion is only for continuing care at-home contracts, an actuarial study prepared by an

independent actuary in accordance with standards adopted by the American Academy of Actuaries which presents the financial impact of the expansion may be substituted for the feasibility study.

(c) In determining whether an expansion should be approved, the office shall use ~~utilize~~ the criteria provided in ss. 651.022(6) and 651.023(4) ~~(2)~~.

Section 5. Paragraphs (d) and (g) of subsection (2) and subsections (4) and (6) of section 651.022, Florida Statutes, are amended to read:

651.022 Provisional certificate of authority; application.—

(2) The application for a provisional certificate of authority shall be on a form prescribed by the commission and shall contain the following information:

(d) The contracts ~~agreements~~ for continuing care and continuing care at-home to be entered into between the provider and residents which meet the minimum requirements of s. 651.055 or s. 651.057 and which include a statement describing the procedures required by law relating to the release of escrowed entrance fees. Such statement may be furnished through an addendum.

(g) The forms of the ~~continuing care~~ residency contracts, reservation contracts, escrow agreements, and wait list contracts, if applicable, which are proposed to be used by the provider in the furnishing of care. ~~If~~ The office shall approve ~~finds that the continuing care~~ contracts and escrow agreements that comply with ss. 651.023(1)(c), 651.033, ~~and~~ 651.055, and

651.057 ~~it shall approve them~~. Thereafter, no other form of contract or agreement may be used by the provider until it has been submitted to the office and approved.

(4) If an applicant has or proposes to have more than one facility offering continuing care or continuing care at-home, a separate provisional certificate of authority and a separate certificate of authority must ~~shall~~ be obtained for each facility.

(6) Within 45 days after ~~from~~ the date an application is deemed ~~to be~~ complete~~,~~ as set forth in paragraph (5)(b), the office shall complete its review and ~~shall~~ issue a provisional certificate of authority to the applicant based upon its review and a determination that the application meets all requirements of law, ~~and~~ that the feasibility study was based on sufficient data and reasonable assumptions, and that the applicant will be able to provide continuing care or continuing care at-home as proposed and meet all financial obligations related to its operations, including the financial requirements of this chapter ~~to provide continuing care as proposed~~. If the application is denied, the office shall notify the applicant in writing, citing the specific failures to meet the provisions of this chapter. Such denial entitles ~~shall entitle~~ the applicant to a hearing pursuant to ~~the provisions of~~ chapter 120.

Section 6. Section 651.023, Florida Statutes, is amended to read:

651.023 Certificate of authority; application.—

(1) After issuance of a provisional certificate of authority, the office shall issue to the holder of such

provisional certificate ~~of authority~~ a certificate of authority if~~; provided, however, that no certificate of authority shall be issued until~~ the holder of the ~~such~~ provisional certificate ~~of authority~~ provides the office with the following information:

(a) Any material change in status with respect to the information required to be filed under s. 651.022(2) in the application for the ~~a~~ provisional certificate ~~of authority~~.

(b) A feasibility study prepared by an independent consultant which contains all of the information required by s. 651.022(3) and ~~contains~~ financial forecasts or projections prepared in accordance with standards adopted ~~promulgated~~ by the American Institute of Certified Public Accountants or ~~financial forecasts or projections prepared~~ in accordance with standards for feasibility studies or continuing care retirement communities adopted ~~promulgated~~ by the Actuarial Standards Board.

1. The study must also contain an independent evaluation and examination opinion, or a comparable opinion acceptable to the office, by the consultant who prepared the study, of the underlying assumptions used as a basis for the forecasts or projections in the study and that the assumptions are reasonable and proper and ~~that~~ the project as proposed is feasible.

2. The study must ~~shall~~ take into account project costs, actual marketing results to date and marketing projections, resident fees and charges, competition, resident contract provisions, and any other factors which affect the feasibility of operating the facility.

3. If the study is prepared by an independent certified public accountant, it must contain an examination opinion for the first 3 years of operations and financial projections having a compilation opinion for the next 3 years. If the study is prepared by an independent consulting actuary, it must contain mortality and morbidity data and an actuary's signed opinion that the project as proposed is feasible and that the study has been prepared in accordance with standards adopted by the American Academy of Actuaries.

(c) Subject to ~~the requirements of~~ subsection (4)~~(2)~~, a provider may submit an application for a certificate of authority and any required exhibits upon submission of proof that the project has a minimum of 30 percent of the units reserved for which the provider is charging an entrance fee.~~;~~ ~~however,~~ This does ~~provision shall~~ not apply to an application for a certificate of authority for the acquisition of a facility for which a certificate of authority was issued before ~~prior to~~ October 1, 1983, to a provider who subsequently becomes a debtor in a case under the United States Bankruptcy Code, 11 U.S.C. ss. 101 et seq., or to a provider for which the department has been appointed receiver pursuant to ~~the provisions of~~ part II of chapter 631.

(d) Proof that commitments have been secured for both construction financing and long-term financing or a documented plan acceptable to the office has been adopted by the applicant for long-term financing.

(e) Proof that all conditions of the lender have been satisfied to activate the commitment to disburse funds other

than the obtaining of the certificate of authority, the completion of construction, or the closing of the purchase of realty or buildings for the facility.

(f) Proof that the aggregate amount of entrance fees received by or pledged to the applicant, plus anticipated proceeds from any long-term financing commitment, plus funds from all other sources in the actual possession of the applicant, equal at least ~~not less than~~ 100 percent of the aggregate cost of constructing or purchasing, equipping, and furnishing the facility plus 100 percent of the anticipated startup losses of the facility.

(g) Complete audited financial statements of the applicant, prepared by an independent certified public accountant in accordance with generally accepted accounting principles, as of the date the applicant commenced business operations or for the fiscal year that ended immediately preceding the date of application, whichever is later, and complete unaudited quarterly financial statements attested to by the applicant after ~~subsequent to~~ the date of the last audit.

(h) Proof that the applicant has complied with the escrow requirements of subsection (5) ~~(3)~~ or subsection (7) ~~(5)~~ and will be able to comply with s. 651.035.

(i) Such other reasonable data, financial statements, and pertinent information as the commission or office may require with respect to the applicant or the facility, to determine the financial status of the facility and the management capabilities of its managers and owners.

(2) ~~(j)~~ Within 30 days after ~~of the~~ receipt of the information required under subsection (1) ~~paragraphs (a)-(h)~~, the office shall examine such information and ~~shall~~ notify the provider in writing, specifically requesting any additional information the office is permitted by law to require. Within 15 days after receipt of all of the requested additional information, the office shall notify the provider in writing that all of the requested information has been received and the application is deemed to be complete as of the date of the notice. Failure to ~~so~~ notify the applicant in writing within the 15-day period constitutes ~~shall constitute~~ acknowledgment by the office that it has received all requested additional information, and the application shall be deemed ~~to be~~ complete for purposes of review on ~~upon~~ the date of ~~the~~ filing ~~of~~ all of the required additional information.

(3) ~~(k)~~ Within 45 days after an application is deemed complete as set forth in subsection (2) ~~paragraph (j)~~, and upon completion of the remaining requirements of this section, the office shall complete its review and ~~shall~~ issue~~,~~ or deny a certificate of authority~~,~~ to the holder of a provisional certificate of authority ~~a certificate of authority~~. If a certificate of authority is denied, the office must ~~shall~~ notify the holder of the provisional certificate ~~of authority~~ in writing, citing the specific failures to satisfy the provisions of this chapter. If denied, the holder of the provisional certificate is ~~of authority shall be~~ entitled to an administrative hearing pursuant to chapter 120.

(4)~~(2)(a)~~ The office shall issue a certificate of authority upon determining ~~its determination~~ that the applicant meets all requirements of law and has submitted all of the information required by this section, that all escrow requirements have been satisfied, and that the fees prescribed in s. 651.015(2) have been paid.

(a) Notwithstanding satisfaction of the 30-percent minimum reservation requirement of paragraph (1)(c), no certificate of authority shall be issued until the project has a minimum of 50 percent of the units reserved for which the provider is charging an entrance fee, and proof ~~thereof~~ is provided to the office. If a provider offering continuing care at-home is applying for a certificate of authority or approval of an expansion pursuant to s. 651.021(2), the same minimum reservation requirements must be met for the continuing care and continuing care at-home contracts, independently of each other.

(b) In order for a unit to be considered reserved under this section, the provider must collect a minimum deposit of 10 percent of the then-current entrance fee for that unit, and ~~must~~ assess a forfeiture penalty of 2 percent of the entrance fee due to termination of the reservation contract after 30 days for any reason other than the death or serious illness of the resident, the failure of the provider to meet its obligations under the reservation contract, or other circumstances beyond the control of the resident that equitably entitle the resident to a refund of the resident's deposit. The reservation contract must ~~shall~~ state the cancellation policy and the terms of the continuing care or continuing care at-home contract to be entered into.

(5)~~(3)~~ Up to ~~No more than~~ 25 percent of the moneys paid for all or any part of an initial entrance fee may be included or pledged for the construction or purchase of the facility~~,~~ or ~~included or pledged~~ as security for long-term financing. The term "initial entrance fee" means the total entrance fee charged by the facility to the first occupant of a unit.

(a) A minimum of 75 percent of the moneys paid for all or any part of an initial entrance fee collected for continuing care or continuing care at-home shall be placed in an escrow account or on deposit with the department as prescribed in s. 651.033.

(b) For an expansion as provided in s. 651.021(2), a minimum of 75 percent of the moneys paid for all or any part of an initial entrance fee collected for continuing care and 50 percent of the moneys paid for all or any part of an initial fee collected for continuing care at-home shall be placed in an escrow account or on deposit with the department as prescribed in s. 651.033.

(6)~~(4)~~ The provider is ~~shall be~~ entitled to secure release of the moneys held in escrow within 7 days after receipt by the office of an affidavit from the provider, along with appropriate copies to verify, and notification to the escrow agent by certified mail, that the following conditions have been satisfied:

(a) A certificate of occupancy has been issued.

(b) Payment in full has been received for at least ~~no less than~~ 70 percent of the total units of a phase or of the total of the combined phases constructed. If a provider offering

continuing care at-home is applying for a release of escrowed entrance fees, the same minimum requirement must be met for the continuing care and continuing care at-home contracts, independently of each other.

(c) The consultant who prepared the feasibility study required by this section or a substitute approved by the office certifies within 12 months before the date of filing for office approval that there has been no material adverse change in status with regard to the feasibility study~~, with such statement dated not more than 12 months from the date of filing for office approval~~. If a material adverse change exists ~~should exist~~ at the time of submission, ~~then~~ sufficient information acceptable to the office and the feasibility consultant must ~~shall~~ be submitted which remedies the adverse condition.

(d) Proof that commitments have been secured or a documented plan adopted by the applicant has been approved by the office for long-term financing.

(e) Proof that the provider has sufficient funds to meet the requirements of s. 651.035, which may include funds deposited in the initial entrance fee account.

(f) Proof as to the intended application of the proceeds upon release and proof that the entrance fees when released will be applied as represented to the office.

Notwithstanding ~~any provision of~~ chapter 120, no person, other than the provider, the escrow agent, and the office, may ~~shall~~ have a substantial interest in any office decision regarding

release of escrow funds in any proceedings under chapter 120 or this chapter regarding release of escrow funds.

(7) ~~(5)~~ In lieu of the provider fulfilling the requirements in subsection (5) ~~(3)~~ and paragraphs (6)(b) ~~(4)(b)~~ and (d), the office may authorize the release of escrowed funds to retire all outstanding debts on the facility and equipment upon application of the provider and upon the provider's showing that the provider will grant to the residents a first mortgage on the land, buildings, and equipment that constitute the facility, and that the provider has satisfied ~~satisfies the requirements of~~ paragraphs (6)(a) ~~(4)(a)~~, (c), and (e). Such mortgage shall secure the refund of the entrance fee in the amount required by this chapter. The granting of such mortgage is ~~shall be~~ subject to the following:

(a) The first mortgage is ~~shall be~~ granted to an independent trust that ~~which~~ is beneficially held by the residents. The document creating the trust must include ~~shall contain~~ a provision that ~~it~~ agrees to an annual audit and will furnish to the office all information the office may reasonably require. The mortgage may secure payment on bonds issued to the residents or trustee. Such bonds are ~~shall be~~ redeemable after termination of the residency contract in the amount and manner required by this chapter for the refund of an entrance fee.

(b) Before granting a first mortgage to the residents, all construction must ~~shall~~ be substantially completed and substantially all equipment must ~~shall~~ be purchased. No part of the entrance fees may be pledged as security for a construction

loan or otherwise used for construction expenses before the completion of construction.

(c) If the provider is leasing the land or buildings used by the facility, the leasehold interest must ~~shall~~ be for a term of at least 30 years.

(8) ~~(6)~~ The timeframes provided under s. 651.022(5) and (6) apply to applications submitted under s. 651.021(2). The office may not issue a certificate of authority ~~under this chapter~~ to a ~~any~~ facility that ~~which~~ does not have a component that ~~which~~ is to be licensed pursuant to part II of chapter 400 or to part I of chapter 429 or that does ~~which will~~ not offer personal services or nursing services through written contractual agreement. A ~~Any~~ written contractual agreement must be disclosed in the ~~continuing care~~ contract for continuing care or continuing care at-home and is subject to the provisions of s. 651.1151, relating to administrative, vendor, and management contracts.

(9) ~~(7)~~ The office may ~~shall~~ not approve an application that ~~which~~ includes in the plan of financing any encumbrance of the operating reserves required by this chapter.

Section 7. Paragraphs (a) and (d) of subsection (3) of section 651.033, Florida Statutes, are amended to read:

651.033 Escrow accounts.—

(3) In addition, when entrance fees are required to be deposited in an escrow account pursuant to s. 651.022, s. 651.023, or s. 651.055:

(a) The provider shall deliver to the resident a written receipt. The receipt must ~~shall~~ show the payor's name and

address, the date, the price of the care contract, and the amount of money paid. A copy of each receipt, together with the funds, shall be deposited with the escrow agent or as provided in paragraph (c). The escrow agent shall release such funds to the provider ~~upon the expiration of~~ 7 days after the date of receipt of the funds by the escrow agent if the provider, operating under a certificate of authority issued by the office, has met the requirements of s. 651.023(6) ~~(4)~~. However, if the resident rescinds the contract within the 7-day period, the escrow agent shall release the escrowed fees to the resident.

(d) A provider may assess a nonrefundable fee, which is separate from the entrance fee, for processing a prospective resident's application for continuing care or continuing care at-home.

Section 8. Subsections (2) and (3) of section 651.035, Florida Statutes, are amended to read:

651.035 Minimum liquid reserve requirements.—

(2)(a) In facilities where not all residents are under continuing care or continuing care at-home contracts, the reserve requirements of subsection (1) shall be computed only with respect to the proportional share of operating expenses that ~~which~~ are applicable to residents ~~as defined in s. 651.011~~. For purposes of this calculation, the proportional share shall be based upon the ratio of residents under continuing care or continuing care at-home contracts to those residents who do not hold such contracts.

(b) In facilities that have voluntarily and permanently discontinued marketing continuing care and continuing care at-

home contracts, the office may allow a reduced debt service reserve as required in subsection (1) based upon the ratio of residents under continuing care or continuing care at-home contracts to those residents who do not hold such contracts if the office finds that such reduction is not inconsistent with the security protections intended by this chapter. In making this determination, the office may consider such factors as the financial condition of the facility, the provisions of ~~the~~ outstanding continuing care and continuing care at-home contracts, the ratio of residents under continuing care or continuing care at-home contracts ~~agreements~~ to those residents who do not hold such contracts ~~a continuing care contract~~, the current occupancy rates, the previous sales and marketing efforts, the life expectancy of the remaining residents ~~contract holders~~, and the written policies of the board of directors of the provider or a similar board.

(3) If principal and interest payments are paid to a trust that is beneficially held by the residents as described in s. 651.023(7) ~~(5)~~, the office may waive all or any portion of the escrow requirements for mortgage principal and interest contained in subsection (1) if the office finds that such waiver is not inconsistent with the security protections intended by this chapter.

Section 9. Section 651.055, Florida Statutes, is amended to read:

651.055 Continuing care contracts; right to rescind.—

(1) Each continuing care contract and each addendum to such contract shall be submitted to and approved by the office

before ~~prior to~~ its use in this state. Thereafter, no other form of contract shall be used by the provider until ~~unless~~ it has been submitted to and approved by the office. Each contract must ~~shall~~:

(a) Provide for the continuing care of only one resident, or for two persons occupying space designed for double occupancy, under appropriate regulations established by the provider, and must ~~shall~~ list all properties transferred and their market value at the time of transfer, including donations, subscriptions, fees, and any other amounts paid or payable by, or on behalf of, the resident or residents.

(b) Specify all services that ~~which~~ are to be provided by the provider to each resident, including, in detail, all items that ~~which~~ each resident will receive, whether the items will be provided for a designated time period or for life, and whether the services will be available on the premises or at another specified location. The provider shall indicate which services or items are included in the contract for continuing care and which services or items are made available at or by the facility at extra charge. Such items ~~shall~~ include, but are not limited to, food, shelter, personal services or nursing care, drugs, burial, and incidentals.

(c) Describe the terms and conditions under which a contract for continuing care may be canceled by the provider or by a resident and the conditions, if any, under which all or any portion of the entrance fee will be refunded in the event of cancellation of the contract by the provider or by the resident, including the effect of any change in the health or financial

condition of a person between the date of entering a contract for continuing care and the date of initial occupancy of a living unit by that person.

(d) Describe the health and financial conditions required for a person to be accepted as a resident and to continue as a resident, once accepted, including the effect of any change in the health or financial condition of the person between the date of submitting an application for admission to the facility and entering into a continuing care contract. If a prospective resident signs a contract but postpones moving into the facility, the individual is deemed to be occupying a unit at the facility when he or she pays the entrance fee or any portion of the fee, other than a reservation deposit, and begins making monthly maintenance fee payments. Such resident may rescind the contract and receive a full refund of any funds paid, without penalty or forfeiture, within 7 days after executing the contract as specified in subsection (2).

(e) Describe the circumstances under which the resident will be permitted to remain in the facility in the event of financial difficulties of the resident. The stated policy may not be less than the terms stated in s. 651.061.

(f) State the fees that will be charged if the resident marries while at the designated facility, the terms concerning the entry of a spouse to the facility, and the consequences if the spouse does not meet the requirements for entry.

(g) Provide that the contract may be canceled by giving at least 30 days' written notice of cancellation by the provider, the resident, or the person who provided the transfer of

property or funds for the care of such resident.~~:~~ However, if a contract is canceled because there has been a good faith determination that a resident is a danger to himself or herself or others, only such notice as is reasonable under the circumstances is required.

1. The contract must also provide in clear and understandable language, in print no smaller than the largest type used in the body of the contract, the terms governing the refund of any portion of the entrance fee.

2. For a resident whose contract with the facility provides that the resident does not receive a transferable membership or ownership right in the facility, and who has occupied his or her unit, the refund shall be calculated on a pro rata basis with the facility retaining up to 2 percent per month of occupancy by the resident and up to a 5 percent ~~5 percent~~ processing fee. Such refund must be paid within 120 days after giving the notice of intention to cancel.

3. In addition to a processing fee, if the contract provides for the facility to retain up to 1 percent per month of occupancy by the resident, it may provide that such refund will be paid from the proceeds of the next entrance fees received by the provider for units for which there are no prior claims by any resident until paid in full or, if the provider has discontinued marketing continuing care contracts, within 200 days after the date of notice.

4. Unless subsection (5) applies, for any prospective resident, regardless of whether or not such a resident receives a transferable membership or ownership right in the facility,

who cancels the contract before occupancy of the unit, the entire amount paid toward the entrance fee shall be refunded, less a processing fee of up to 5 percent of the entire entrance fee; however, the processing fee may not exceed the amount paid by the prospective resident. Such refund must be paid within 60 days after giving ~~the~~ notice of intention to cancel. For a resident who has occupied his or her unit and who has received a transferable membership or ownership right in the facility, the foregoing refund provisions do not apply but are deemed satisfied by the acquisition or receipt of a transferable membership or an ownership right in the facility. The provider may not charge any fee for the transfer of membership or sale of an ownership right. A prospective resident, resident, or resident's estate is not entitled to interest of any type on a deposit or entrance fee unless it is specified in the continuing care contract.

(h) State the terms under which a contract is canceled by the death of the resident. These terms may contain a provision that, upon the death of a resident, the entrance fee of such resident is ~~shall be~~ considered earned and becomes ~~shall become~~ the property of the provider. If ~~When~~ the unit is shared, the conditions with respect to the effect of the death or removal of one of the residents must ~~shall~~ be included in the contract.

(i) Describe the policies that ~~which~~ may lead to changes in monthly recurring and nonrecurring charges or fees for goods and services received. The contract must ~~shall~~ provide for advance notice to the resident, of at least ~~not less than~~ 60 days, before any change in fees or charges or the scope of care

or services is ~~may be~~ effective, except for changes required by state or federal assistance programs.

(j) Provide that charges for care paid in one lump sum may ~~shall~~ not be increased or changed during the duration of the agreed upon care, except for changes required by state or federal assistance programs.

(k) Specify whether ~~or not~~ the facility is, or is affiliated with, a religious, nonprofit, or proprietary organization or management entity; the extent to which the affiliate organization will be responsible for the financial and contractual obligations of the provider; and the provisions of the federal Internal Revenue Code, if any, under which the provider or affiliate is exempt from the payment of federal income tax.

(2) A resident has the right to rescind a continuing care contract and receive a full refund of any funds paid, without penalty or forfeiture, within 7 days after executing the contract. A resident may not be required to move into the facility designated in the contract before the expiration of the 7-day period. During the 7-day period, the resident's funds must be held in an escrow account unless otherwise requested by the resident pursuant to s. 651.033(3)(c).

(3) The contract must ~~shall~~ include or ~~shall~~ be accompanied by a statement, printed in boldfaced type, which reads: "This facility and all other continuing care facilities in the State of Florida are regulated by chapter 651, Florida Statutes. A copy of the law is on file in this facility. The law gives you or your legal representative the right to inspect our

most recent financial statement and inspection report before signing the contract."

(4) Before the transfer of any money or other property to a provider by or on behalf of a prospective resident, the provider shall present a typewritten or printed copy of the contract to the prospective resident and all other parties to the contract. The provider shall secure a signed, dated statement from each party to the contract certifying that a copy of the contract with the specified attachment, as required pursuant to this chapter, was received.

(5) Except for a resident who postpones moving into the facility but is deemed to have occupied a unit as described in paragraph (1)(d), if a prospective resident dies before occupying the facility or, through illness, injury, or incapacity, is precluded from becoming a resident under the terms of the continuing care contract, the contract is automatically canceled, and the prospective resident or his or her legal representative shall receive a full refund of all moneys paid to the facility, except those costs specifically incurred by the facility at the request of the prospective resident and set forth in writing in a separate addendum, signed by both parties, to the contract.

(6) In order to comply with this section, a provider may furnish information not contained in his or her continuing care contract through an addendum.

(7) Contracts to provide continuing care, including contracts that are terminable by either party, may include agreements to provide care for any duration.

(8) ~~(7)~~ Those contracts entered into after ~~subsequent to~~ July 1, 1977, and before the issuance of a certificate of authority to the provider are valid and binding upon both parties in accordance with their terms. Within 30 days of receipt of a letter from the office notifying the provider of a noncompliant residency contract, the provider shall file a new residency contract for approval that complies with Florida law. Pending review and approval of the new residency contract, the provider may continue to use the previously-approved contract.

(9) ~~(8)~~ The provisions of this section ~~shall~~ control over any conflicting provisions contained in part II of chapter 400 or in part I of chapter 429.

Section .10. Section 651.057, Florida Statutes, is created to read:

651.057 Continuing care at-home contracts.—

(1) In addition to the requirements of s. 651.055, a provider offering contracts for continuing care at-home must:

(a) Disclose the following in the continuing care at-home contract:

1. Whether transportation will be provided to residents when traveling to and from the facility for services;

2. That the provider has no liability for residents residing outside the facility beyond the delivery of services specified in the contract and future access to nursing care or personal services at the facility or in another setting designated in the contract;

3. The mechanism for monitoring residents who live outside the facility;

4. The process that will be followed to establish priority if a resident wishes to exercise his or her right to move into the facility; and

5. The policy that will be followed if a resident living outside the facility relocates to a different residence and no longer avails himself or herself of services provided by the facility.

(b) Ensure that persons employed by or under contract with the provider who assist in the delivery of services to residents residing outside the facility are appropriately licensed or certified as required by law.

(c) Include operating expenses for continuing care at-home contracts in the calculation of the operating reserve required by s. 651.035(1)(c).

(d) Include the operating activities for continuing care at-home contracts in the total operation of the facility when submitting financial reports to the office as required by s. 651.026.

(2) A provider that holds a certificate of authority and wishes to offer continuing care at-home must also:

(a) Submit a business plan to the office with the following information:

1. A description of the continuing care at-home services that will be provided, the market to be served, and the fees to be charged;

2. A copy of the proposed continuing care at-home contract;

3. An actuarial study prepared by an independent actuary in accordance with the standards adopted by the American Academy of Actuaries which presents the impact of providing continuing care at-home on the overall operation of the facility;

4. A market feasibility study that meets the requirements of s. 651.022(3) and documents that there is sufficient interest in continuing care at-home contracts to support such a program; and

(b) Demonstrate to the office that the proposal to offer continuing care at-home contracts to individuals who do not immediately move into the facility will not place the provider in an unsound financial condition;

(c) Comply with the requirements of s. 651.021(2), except that an actuarial study may be substituted for the feasibility study; and

(d) Comply with the requirements of this chapter.

(3) Contracts to provide continuing care at-home, including contracts that are terminable by either party, may include agreements to provide care for any duration.

(4) A provider offering continuing care at-home contracts must, at a minimum, have a facility that is licensed under this chapter and has accommodations for independent living which are primarily intended for residents who do not require staff supervision. The facility need not offer assisted living units licensed under part I of chapter 429 or nursing home units licensed under part II of chapter 400 in order to be able to offer continuing care at-home contracts.

(a) The combined number of outstanding continuing care (CCRC) and continuing care at-home (CCAH) contracts allowed at the facility may be the greater of:

1. One and one-half times the combined number of independent living units (ILU), assisted living units (ALF) that are licensed under part I of chapter 429, and nursing home units licensed under part II of chapter 400 at the facility; or

2. Four times the combined number of assisted living units (ALF) that are licensed under part I of chapter 429 and nursing home units that are licensed under part II of chapter 400 at that facility.

(b) The number of independent living units at the facility must be equal to or greater than 10 percent of the initial 100 continuing care (CCRC)and continuing care at-home (CCAH) contracts and 5 percent of the combined number of outstanding continuing care (CCRC) and continuing care at home (CCAH) contracts in excess of 100 issued by that facility.

Section 11. Subsection (1) of section 651.071, Florida Statutes, is amended to read:

651.071 Contracts as preferred claims on liquidation or receivership.—

(1) In the event of receivership or liquidation proceedings against a provider, all continuing care and continuing care at-home contracts executed by a provider shall be deemed preferred claims against all assets owned by the provider; however, such claims are ~~shall be~~ subordinate to those priority claims set forth in s. 631.271 and any secured claim ~~as defined in s. 631.011~~.

Section 12. Paragraph (h) of subsection (2) and subsection (3) of section 651.091, Florida Statutes, are amended to read:

651.091 Availability, distribution, and posting of reports and records; requirement of full disclosure.—

(2) Every continuing care facility shall:

(h) Upon request, deliver to the president or chair of the residents' council a copy of any newly approved continuing care or continuing care at-home contract within 30 days after approval by the office.

(3) Before entering into a contract to furnish continuing care or continuing care at-home, the provider undertaking to furnish the care, or the agent of the provider, shall make full disclosure, and provide copies of the disclosure documents to the prospective resident or his or her legal representative, of the following information:

(a) The contract to furnish continuing care or continuing care at-home.

(b) The summary listed in paragraph (2)(b).

(c) All ownership interests and lease agreements, including information specified in s. 651.022(2)(b)8.

(d) In keeping with the intent of this subsection relating to disclosure, the provider shall make available for review, master plans approved by the provider's governing board and any plans for expansion or phased development, to the extent that the availability of such plans do ~~will~~ not put at risk real estate, financing, acquisition, negotiations, or other implementation of operational plans and thus jeopardize the success of negotiations, operations, and development.

(e) Copies of the rules and regulations of the facility and an explanation of the responsibilities of the resident.

(f) The policy of the facility with respect to admission to and discharge from the various levels of health care offered by the facility.

(g) The amount and location of any reserve funds required by this chapter, and the name of the person or entity having a claim to such funds in the event of a bankruptcy, foreclosure, or rehabilitation proceeding.

(h) A copy of s. 651.071.

(i) A copy of the resident's rights as described in s. 651.083.

Section 13. Section 651.106, Florida Statutes, is amended to read:

651.106 Grounds for discretionary refusal, suspension, or revocation of certificate of authority.—The office~~, in its discretion,~~ may deny, suspend, or revoke the provisional certificate of authority or the certificate of authority of any applicant or provider if it finds that any one or more of the following grounds applicable to the applicant or provider exist:

(1) Failure by the provider to continue to meet the requirements for the authority originally granted.

(2) Failure by the provider to meet one or more of the qualifications for the authority specified by this chapter.

(3) Material misstatement, misrepresentation, or fraud in obtaining the authority, or in attempting to obtain the same.

(4) Demonstrated lack of fitness or trustworthiness.

(5) Fraudulent or dishonest practices of management in the conduct of business.

(6) Misappropriation, conversion, or withholding of moneys.

(7) Failure to comply with, or violation of, any proper order or rule of the office or commission or violation of any provision of this chapter.

(8) The insolvent condition of the provider or the provider's being in such condition or using such methods and practices in the conduct of its business as to render its further transactions in this state hazardous or injurious to the public.

(9) Refusal by the provider to be examined or to produce its accounts, records, and files for examination, or refusal by any of its officers to give information with respect to its affairs or to perform any other legal obligation under this chapter when required by the office.

(10) Failure by the provider to comply with the requirements of s. 651.026 or s. 651.033.

(11) Failure by the provider to maintain escrow accounts or funds as required by this chapter.

(12) Failure by the provider to meet the requirements of this chapter for disclosure of information to residents concerning the facility, its ownership, its management, its development, or its financial condition or failure to honor its continuing care <u>or continuing care at-home</u> contracts.

(13) Any cause for which issuance of the license could have been refused had it then existed and been known to the office.

(14) Having been found guilty of, or having pleaded guilty or nolo contendere to, a felony in this state or any other state, without regard to whether a judgment or conviction has been entered by the court having jurisdiction of such cases.

(15) In the conduct of business under the license, engaging in unfair methods of competition or in unfair or deceptive acts or practices prohibited under part IX of chapter 626.

(16) A pattern of bankrupt enterprises.

Revocation of a certificate of authority under this section does not relieve a provider from the provider's obligation to residents under the terms and conditions of any continuing care or continuing care at-home contract between the provider and residents or the provisions of this chapter. The provider shall continue to file its annual statement and pay license fees to the office as required under this chapter as if the certificate of authority had continued in full force, but the provider shall not issue any new ~~continuing care~~ contracts. The office may seek an action in the circuit court of Leon County to enforce the office's order and the provisions of this section.

Section 14. Subsection (8) of section 651.114, Florida Statutes, is amended to read:

651.114 Delinquency proceedings; remedial rights.—

(8)(a) The rights of the office described in this section are ~~shall be~~ subordinate to the rights of a trustee or lender pursuant to the terms of a resolution, ordinance, loan agreement, indenture of trust, mortgage, lease, security agreement, or other instrument creating or securing bonds or notes issued to finance a facility, and the office, subject to the provisions of paragraph (c), shall not exercise its remedial rights provided under this section and ss. 651.018, 651.106, 651.108, and 651.116 with respect to a facility that is subject to a lien, mortgage, lease, or other encumbrance or trust indenture securing bonds or notes issued in connection with the financing of the facility, if the trustee or lender, by inclusion or by amendment to the loan documents or by a separate contract with the office, agrees that the rights of residents under a continuing care or continuing care at-home contract will be honored and will not be disturbed by a foreclosure or conveyance in lieu thereof as long as the resident:

1. Is current in the payment of all monetary obligations required by the ~~continuing care~~ contract;

2. Is in compliance and continues to comply with all provisions of the ~~resident's continuing care~~ contract; and

3. Has asserted no claim inconsistent with the rights of the trustee or lender.

(b) ~~Nothing in~~ This subsection does not require ~~requires~~ a trustee or lender to:

1. Continue to engage in the marketing or resale of new continuing care or continuing care at-home contracts;

2. Pay any rebate of entrance fees as may be required by a resident's continuing care or continuing care at-home contract as of the date of acquisition of the facility by the trustee or lender and until expiration of the period described in paragraph (d);

3. Be responsible for any act or omission of any owner or operator of the facility arising before ~~prior to~~ the acquisition of the facility by the trustee or lender; or

4. Provide services to the residents to the extent that the trustee or lender would be required to advance or expend funds that have not been designated or set aside for such purposes.

(c) Should the office determine, at any time during the suspension of its remedial rights as provided in paragraph (a), that the trustee or lender is not in compliance with ~~the provisions of~~ paragraph (a), or that a lender or trustee has assigned or has agreed to assign all or a portion of a delinquent or defaulted loan to a third party without the office's written consent, the office shall notify the trustee or lender in writing of its determination, setting forth the reasons giving rise to the determination and specifying those remedial rights afforded to the office which the office shall then reinstate.

(d) Upon acquisition of a facility by a trustee or lender and evidence satisfactory to the office that the requirements of paragraph (a) have been met, the office shall issue a 90-day temporary certificate of authority granting the trustee or lender the authority to engage in the business of providing

continuing care or continuing care at-home and to issue continuing care or continuing care at-home contracts subject to the office's right to immediately suspend or revoke the temporary certificate of authority if the office determines that any of the grounds described in s. 651.106 apply to the trustee or lender or that the terms of the contract ~~agreement~~ used as the basis for the issuance of the temporary certificate of authority by the office have not been or are not being met by the trustee or lender since the date of acquisition.

Section 15. Subsections (4), (7), (9), and (11) of section 651.118, Florida Statutes, are amended to read:

651.118 Agency for Health Care Administration; certificates of need; sheltered beds; community beds.—

(4) Not including the residences of residents residing outside the facility pursuant to a continuing care at-home contract, the Agency for Health Care Administration shall approve one sheltered nursing home bed for every four proposed residential units, including those that are licensed under part I of chapter 429, in the continuing care facility unless the provider demonstrates the need for a lesser number of sheltered nursing home beds based on proposed utilization by prospective residents or demonstrates the need for additional sheltered nursing home beds based on actual utilization and demand by current residents.

(7) Notwithstanding ~~the provisions of~~ subsection (2), at the discretion of the ~~continuing care~~ provider, sheltered nursing home beds 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 ~~a period of~~ up to 5 years after the date of issuance of the initial nursing home license. A provider whose 5-year period has expired or is expiring may request an extension from the Agency for Health Care Administration ~~for an extension~~, not to exceed 30 percent of the total sheltered nursing home beds or 30 sheltered beds, whichever is greater, if the utilization by residents of the nursing home facility in the sheltered beds will not generate sufficient income to cover nursing home facility expenses, as evidenced by one of the following:

(a) The nursing home facility has a net loss for the most recent fiscal year as determined under generally accepted accounting principles, excluding the effects of extraordinary or unusual items, as demonstrated in the most recently audited financial statement.~~; or~~

(b) The nursing home facility would have had a pro forma loss for the most recent fiscal year, excluding the effects of extraordinary or unusual items, if revenues were reduced by the amount of revenues from persons in sheltered beds who were not residents, as reported ~~on~~ by a certified public accountant.

The Agency for Health Care Administration may ~~shall be authorized to~~ grant an extension to the provider based on the evidence required in this subsection. The Agency for Health Care Administration may request a continuing care facility to use up to 25 percent of the patient days generated by new admissions of nonresidents during the extension period to serve Medicaid recipients for those beds authorized for extended use if there

is a demonstrated need in the respective service area and if funds are available. A provider who obtains an extension is prohibited from applying for additional sheltered beds under ~~the provision of~~ subsection (2), unless additional residential units are built or the provider can demonstrate need by continuing care facility residents to the Agency for Health Care Administration. The 5-year limit does not apply to up to five sheltered beds designated for inpatient hospice care as part of a contractual arrangement with a hospice licensed under part IV of chapter 400. A continuing care facility that uses such beds after the 5-year period shall report such use to the Agency for Health Care Administration. For purposes of this subsection, "resident" means a person who, upon admission to the continuing care facility, initially resides in a part of the continuing care facility not licensed under part II of chapter 400, or who contracts for continuing care at-home.

(9) This section does not preclude a ~~continuing care~~ provider from applying to the Agency for Health Care Administration for a certificate of need for community nursing home beds or a combination of community and sheltered nursing home beds. Any nursing home bed located in a continuing care facility which ~~that~~ is or has been issued for nonrestrictive use retains ~~shall retain~~ its legal status as a community nursing home bed unless the provider requests a change in status. Any nursing home bed located in a continuing care facility and not issued as a sheltered nursing home bed before ~~prior to~~ 1979 must be classified as a community bed. The Agency for Health Care Administration may require continuing care facilities to submit

bed utilization reports for the purpose of determining community and sheltered nursing home bed inventories based on historical utilization by residents and nonresidents.

(11) For a provider issued a provisional certificate of authority after July 1, 1986, to operate a facility not previously regulated under this chapter, the following criteria must ~~shall~~ be met in order to obtain a certificate of need for sheltered beds pursuant to subsections (2), (3), (4), (5), (6), and (7):

(a) Seventy percent or more of the current residents hold continuing care or continuing care at-home contracts ~~agreements pursuant to s. 651.011(2)~~ or, if the facility is not occupied, 70 percent or more of the prospective residents will hold such contracts ~~continuing care agreements pursuant to s. 651.011(2)~~ as projected in the feasibility study and demonstrated by the provider's marketing practices; and

(b) The continuing care or continuing care at-home contracts ~~agreements~~ entered into or to be entered into by 70 percent or more of the current residents or prospective residents must ~~pursuant to s. 651.011(2) shall~~ provide nursing home care for a minimum of 360 cumulative days, and such residents ~~the holders of the continuing care agreements~~ shall be charged at rates that ~~which~~ are 80 percent or less than the rates charged by the provider to persons receiving nursing home care who have not entered into such contracts ~~continuing care agreements pursuant to s. 651.011(2)~~.

Section 16. Subsection (1) of section 651.121, Florida Statutes, is amended to read:

651.121 Continuing Care Advisory Council.—

(1) The Continuing Care Advisory Council to the office is created consisting ~~to consist~~ of 10 members who are residents of this state appointed by the Governor and geographically representative of this state. Three members shall be administrators of facilities that hold valid certificates of authority under this chapter and shall have been actively engaged in the offering of continuing care contracts ~~agreements~~ in this state for 5 years before appointment. The remaining members include:

(a) A representative of the business community whose expertise is in the area of management.

(b) A representative of the financial community who is not a facility owner or administrator.

(c) A certified public accountant.

(d) An attorney.

(e) Three residents who hold continuing care or continuing care at-home contracts ~~agreements~~ with a facility certified in this state.

Section 17. Subsection (1) of section 651.125, Florida Statutes, is amended to read:

651.125 Criminal penalties; injunctive relief.—

(1) Any person who maintains, enters into, or, as manager or officer or in any other administrative capacity, assists in entering into, maintaining, or performing any continuing care or continuing care at-home contract ~~agreement~~ subject to this chapter without doing so in pursuance of a valid certificate of authority or renewal thereof, as contemplated by or provided in

this chapter, or who otherwise violates any provision of this chapter or rule adopted in pursuance of this chapter, is guilty of a felony of the third degree, punishable as provided in s. 775.082 or s. 775.083. Each violation of this chapter constitutes a separate offense.

Section 18. This act shall take effect July 1, 2011.

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

Remove the entire title and insert:

A bill to be entitled

An act relating to continuing care retirement communities; providing for the provision of continuing care at-home; amending s. 651.011, F.S.; revising definitions; defining "continuing care at-home," "nursing care," "personal services," and "shelter"; amending s. 651.012, F.S.; conforming a cross-reference; amending s. 651.013, F.S.; conforming provisions to changes made by the act; amending s. 651.021, F.S., relating to the requirement for certificates of authority; requiring that a person in the business of issuing continuing care at-home contracts obtain a certificate of authority from the Office of Insurance Regulation; requiring written approval from the Office of Insurance Regulation for a 20 percent or more expansion in the number of continuing care at-home contracts; providing that an actuarial study may be substituted for a feasibility study in specified

circumstances; amending s. 651.022, F.S., relating to provisional certificates of authority; conforming provisions to changes made by the act; amending s. 651.023, F.S., relating to an application for a certificate of authority; specifying the content of the feasibility study that is included in the application for a certificate; requiring the same minimum reservation requirements for continuing care at-home contracts as continuing care contracts; requiring that a certain amount of the entrance fee collected for contracts resulting from an expansion be placed in an escrow account or on deposit with the department; amending ss. 651.033, 651.035, and 651.055, F.S.; requiring a facility to provide proof of compliance with a residency contract; conforming provisions to changes made by the act; creating s. 651.057, F.S.; providing additional requirements for continuing care at-home contracts; requiring that a provider who wishes to offer continuing care at-home contracts submit certain additional documents to the office; requiring that the provider comply with certain requirements; limiting the number of continuing care and continuing care at-home contracts at a facility based on the types of units at the facility; amending ss. 651.071, 651.091, 651.106, 651.114, 651.118, 651.121, and 651.125, F.S.; conforming provisions to changes made by the act; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 585 Pharmacy
SPONSOR(S): Broxson
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health & Human Services Quality Subcommittee		Poche	Calamas
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

House Bill 585 permits a pharmacist, or a pharmacy intern, with proper certification and working under the supervision of a pharmacist, to administer the following:

- Influenza vaccine to an adult 18 years of age or older;
- Varicella zoster (chickenpox, shingles) vaccine to an adult 60 years of age or older;
- Pneumococcal vaccine to an adult 65 years of age or older; and
- Epinephrine using an autoinjector delivery system to an adult who is suffering an anaphylactic reaction.

The bill requires any pharmacist or pharmacy intern to be certified to administer the vaccines and epinephrine through a program approved by the Board of Pharmacy. The program must include 20 hours of continuing education classes regarding the safe and effective administration of the vaccines and epinephrine and the potential adverse reactions to the vaccines and epinephrine.

The bill amends the definition of "practice of the profession of pharmacy" to include the administration of certain vaccines and epinephrine autoinjection. The bill also makes other changes to s. 465.189, F.S., and s. 465.003, F.S., to reflect the addition of "pharmacy intern" and "vaccines and epinephrine autoinjection" to other provisions in the bill.

The bill does not appear to have a fiscal impact.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Influenza and Vaccine Immunization

Influenza, commonly called the "flu," is caused by the influenza virus that infects the respiratory tract. There are three types of influenza viruses: A, B and C. Human influenza A and B viruses are the cause of the seasonal outbreaks of the flu in the United States.[1] Human influenza C virus causes mild illness, but is not thought to cause seasonal outbreaks of the flu.[2]

The virus is typically spread from person to person when an infected person coughs or sneezes the virus into the air. Transmission rates are greatest for individuals in highly populated areas, such as in schools and residences with crowded living conditions. Influenza can cause severe illness and lead to serious and life-threatening complications in all age groups. Influenza is a major cause of illness and death in the United States- between 5 percent and 20 percent of the population gets the flu.[3] Illness caused by influenza leads to over 200,000 hospitalizations and an average of 23,600 deaths each year.[4] Ninety percent of these deaths occur among individuals aged 65 years or older.[5]

Influenza vaccine is the primary method for preventing the flu and its severe complications. Vaccines are effective in protecting individuals against illness or serious complications of flu, particularly those individuals who are at high risk for developing serious complications from the disease.
The Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention recommends that, when vaccine is available, persons in high-risk groups, including individuals age 65 or older, and people with chronic diseases of the heart, lung, or kidneys, diabetes, immunosuppression, or severe forms of anemia, should be vaccinated against the flu.[6]

Pneumococcal Disease and Vaccine Immunization

Pneumococcal disease is an infection caused by the bacteria called *Streptococcus pneumoniae*.[7] Pneumococcal disease is the leading cause of serious illness in children and adults throughout the world.[8] Bacteria can invade different organs of the body, causing pneumonia in the lungs, bacteremia in the bloodstream, meningitis in the brain, middle ear infections, and sinusitis.[9] There are more than 90 known pneumococcal types; the ten most common types cause 62 percent of invasive disease worldwide.[10] Each year in the U.S., there are 175,000 cases of pneumococcal pneumonia, more than

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[1] Centers for Disease Control and Prevention, *Types of Influenza Viruses*, available at http://www.cdc.gov/flu/about/viruses/types.htm. (last viewed March 31, 2011).
[2] *Id.*
[3] U.S. Department of Health and Human Services, *The Current Flu Situation*, available at http://www.flu.gov/individualfamily/about/current/index.html.
[4] *Id.*
[5] Centers for Medicare and Medicaid Services, *2010-2011 Immunizers' Question & Answer Guide to Medicare Part B & Medicaid Coverage of Seasonal Influenza and Pneumococcal Vaccinations,* available at www.cms.gov/AdultImmunizations/Downloads/20102011ImmunizersGuide.pdf.
[6] Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, *Antiviral Agents for the Treatment and Chemoprophylaxis of Influenza, Recommendations of the Advisory Committee on Immunization Practices (ACIP)*, Vol. 60, No.1, January 21, 2011, available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6001a1.htm?s_cid=rr6001a1_e.
[7] National Center for Immunization and Respiratory Diseases, Centers for Disease Control and Prevention, *Pneumococcal Disease In-Short*, available at http://www.cdc.gov/vaccines/vpd-vac/pneumo/in-short-both.htm. (last viewed March 31, 2011).
[8] National Foundation for Infectious Diseases, *Facts About Pneumococcal Disease*, available at http://www.nfid.org/factsheets/pneumofacts.shtml. (last viewed March 31, 2011).
[9] *Id.*
[10] *Id.*

50,000 cases of bacteremia, and between 3,000 and 6,000 cases of meningitis.[11] According to the Centers for Disease Control and Prevention, invasive pneumococcal disease causes 6,000 deaths each year.[12]

Symptoms of pneumococcal infection, depending on the location of the infection, include fever, cough, shortness of breath and chest pain (pneumonia); stiff neck, fever, mental confusion, disorientation and sensitivity to light (meningitis); joint pains and chills (bacteremia); and a painful ear, a red or swollen eardrum, sleeplessness, fever and irritability (middle ear infection).[13] Pneumococcal disease can result in long term damage, such as hearing loss, loss of a limb, and brain damage; pneumococcal disease can also result in death.[14]

The best way to protect against pneumococcal disease is through vaccination. The vaccination is very good at preventing severe pneumococcal disease, but it is not guaranteed to protect against infection and symptoms in all people.[15] Persons aged 65 years or older are considered to be at high risk for pneumococcal disease or its complications. It is recommended that persons 65 years old or older be vaccinated against pneumococcal disease.[16]

Varicella Zoster Virus and Vaccine Immunization

Varicella Zoster virus (VZV) causes chickenpox and shingles. Chickenpox is a common childhood disease, characterized by a blister-like rash over the torso and face, itching, tiredness, and fever. Before a vaccine was developed, approximately 10,600 persons were hospitalized and 100 to 150 died each year in the U.S. as a result of contracting chickenpox.[17] Since the development of a vaccine, the occurrence rate and severity of chickenpox has decreased.[18]

Shingles, a painful localized skin rash often with blisters, is caused by the reactivation of the VZV in the body of a person who contracted chickenpox, often years after suffering from the disease. Almost one out of every three people in the U.S. will develop shingles.[19] There are 1 million estimated cases of shingles every year in the U.S., and half of those cases occur in persons over the age of 60.[20] The only way to reduce the risk of developing shingles is to get vaccinated.[21]

Anaphylaxis and the Use of an Epinephrine Auto-Injector Delivery System

Anaphylaxis is a severe, whole body allergic reaction to a chemical that has become an allergen.[22] The human body releases chemicals during anaphylaxis that can cause shock, resulting in a sudden drop in blood pressure and the release of histamines, which restrict breathing.[23] Symptoms of anaphylaxis include a rapid, weak pulse, skin rash, nausea and vomiting.[24] Common causes include drug allergies, food allergies, insect bites or stings and exposure to latex.[25] The severely allergic population has

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[11] *Id.*
[12] *Id.*
[13] *See supra* at FN 7.
[14] *Id.*
[15] *Id.*
[16] *Id.*
[17] National Center for Immunization and Respiratory Diseases, Centers for Disease Control and Prevention, *Varicella Disease Questions & Answers*, available at http://www.cdc.gov/vaccines/vpd-vac/varicella/dis-faqs-gen.htm. (last viewed April1, 2011).
[18] *Id.*
[19] National Center for Immunization and Respiratory Diseases, Division of Viral Diseases, Centers for Disease Control and Prevention, *Shingles-Overview*, available at http://www.cdc.gov/shingles/about/overview.html. (last viewed April 1, 2011).
[20] *Id.*
[21] National Center for Immunization and Respiratory Diseases, Centers for Disease Control and Prevention, *Shingles-Prevention & Treatment*, available at http://www.cdc.gov/shingles/about/prevention-treatment.html. (last viewed April 1, 2011).
[22] National Center for Biotechnology Information, U.S. National Library of Medicine, U.S. National Institute of Health, *Anaphylaxis*, available at http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001847/ (last viewed March 31, 2011).
[23] Mayo Foundation for Medical Education and Research, *Anaphylaxis*, available at http://www.mayoclinic.cpm/health/analphylaxis/DS00009. (last viewed March 31, 2011).
[24] *Id.*
[25] *Id.; see also supra* FN 9.

increased significantly during that last ten years, with the current incidence rate estimated to be 49.8 per 100,000 person-years.[26]

Anaphylaxis is an emergency situation that requires immediate medical attention. If anaphylaxis is not treated, it will lead to unconsciousness and possible death. Initial treatment of anaphylaxis includes the administration of epinephrine, also known as adrenaline, to improve breathing by relaxing muscles in the airways, stimulate the heart, and tighten the blood vessels to reduce swelling. Epinephrine is classified as a sympathomimetic drug, meaning its effects mimic those of the stimulated sympathetic nervous system, which stimulates the heart and narrows the blood vessels. It is available through a prescription from a physician.

Many individuals with severe allergies that have resulted in, or can result in, anaphylaxis carry epinephrine auto-injector delivery system. Common brands of the auto-injector delivery system include EpiPen and Twinject. The autoinjector delivery system consists of a syringe prefilled with an appropriate dose of epinephrine and a retractable needle to prevent injury or reuse, protected by a safety guard. There are two dosages available for the autoinjector delivery system- for children weighing between 33 and 66 pounds, the dosage is .15 mg; for children and adults weighing more than 66 pounds, the dosage is .30 mg.[27] When injected into the top of the thigh, epinephrine eases the symptoms of anaphylaxis until professional medical treatment is obtained.

Pharmacy Practice

Chapter 465, F.S., governs the practice of the profession of pharmacy. The Board of Pharmacy (Board) is authorized to adopt rules to implement the duties conferred upon it under the Florida Pharmacy Act.[28]

Section 465.003(13), F.S., defines the "practice of the profession of pharmacy" to include compounding, dispensing, and consulting concerning contents, therapeutic values, and uses of any medicinal drug; consulting concerning therapeutic values and interactions of patent and proprietary preparations, whether pursuant to prescriptions or in the absence and entirely independent of such prescriptions or orders; and other pharmaceutical services. The practice of pharmacy also includes any other act, service, operation, research, or transaction incidental to, or forming a part of, any of the foregoing acts, requiring, involving, or employing the science or art of any branch of the pharmaceutical profession, study, or training, and expressly permits a pharmacist to transmit information from persons authorized to prescribe medicinal drugs to their patients.

To become a licensed pharmacist in Florida, a person must apply to the Board to take the licensure examination. Prior to sitting for the examination, a person must submit satisfactory proof to the Board that he or she is 18 years of age or older, is a recipient of a degree from an accredited school or college of pharmacy in the U.S., and completed an internship program approved by the Board prior to graduation from a school or college of pharmacy.[29] A graduate of a school or college of pharmacy located outside of the U.S. must submit proof that he or she graduated from a 4 year undergraduate pharmacy program, demonstrated proficiency in the English language by passing both the Test of English as a Foreign Language (TOEFL) and the Test of Spoken English (TSE), passed the Foreign Pharmacy Graduate Equivalency Examination approved by the Board, and completed a minimum of 500 hours of supervised work activity program within the state, under the supervision of a licensed pharmacist, and approved by the Board.[30] Every person seeking to take the licensure examination must complete the application form and remit a fee not to exceed $100.[31] Upon successful passage of

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[26] Stephanie Guerlain, PhD, et al., *A comparison of 4 epinephrine autoinjector delivery systems: usability and patient preference*, NIH Public Access Author Manuscript, available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2892620/. , citing Decker WW, Campbell, RL, Luke A, et al., *The etiology and incidence of anaphylaxis in Rochester, Minnesota: a report from the Rochester Epidemiology Project,* J Allergy Clin Immunol., 2008;122:1161-1165.

[27] Dey Pharma, L.P., *EpiPen Prescribing Information*, available at http://files.epipen.gethifi.com/footer-pdfs/patient-packaging-insert-pdf/Prescribing-Information.pdf. (last viewed April 3, 2011).

[28] S. 465.005, F.S.

[29] S. 465.007(1), F.S.

[30] S. 465.007(1)(a)2., F.S.

[31] S. 465.007(1)(a), F.S.

the licensure examination by an applicant, as determined by the Board, DOH shall issue a license to practice pharmacy to the applicant.[32] A pharmacy license is renewed every two years by submitting an application and a renewal fee set by the Board not to exceed $250.[33] Also, a pharmacist seeking renewal of his or her license must submit proof of completion of at least 30 hours of continuing professional pharmaceutical education during the two years prior to application for renewal.[34]

To become a pharmacy intern, a person must be certified by the Board as enrolled in an intern program at an accredited school or college of pharmacy or certified as a graduate of an accredited school or college of pharmacy and not yet licensed as a pharmacist in Florida.[35] The Board may refuse to certify, or revoke the registration of, any intern for good cause, including acts or omissions deemed grounds for disciplinary action against licensed pharmacists included in s. 465.016, F.S.[36] The Board has developed detailed rules for the registration of pharmacy interns and internship program requirements for U.S. pharmacy students or graduates and foreign pharmacy graduates.[37]

In Florida, a licensed pharmacist retains the professional and personal responsibility for any act performed a registered pharmacy intern in the employment of the pharmacist and under his or her supervision.[38] Therefore, the pharmacist's professional liability insurance will likely cover the acts or omissions of the pharmacy intern. However, this rule does not shield a pharmacy intern from the possibility of being named as a defendant in a negligence lawsuit. Several insurance companies offer professional liability insurance policies designed for student pharmacists and pharmacy interns.[39]

In 2007, the Florida Legislature passed the Pharmacist Kevin Coit Memorial Act (Act).[40] The Act amended s. 465.003(13), F.S., to include in the definition of the practice of the profession of pharmacy the administration of influenza virus immunizations to adults, pursuant to s. 465.189, F.S., which was also created by the Act. Section 465.189, F.S., sets out the terms and conditions under which a pharmacist may administer influenza virus immunizations to adults. Specifically, a pharmacist must enter into a written protocol with a physician licensed under chapter 458 or chapter 459 of Florida Statutes. The physician will serve as the supervisory practitioner and dictate, through the written protocol, which types and categories of patients to which the pharmacist may administer the influenza vaccine. A pharmacist must also maintain at least $200,000 of professional liability insurance, and complete 20 hours of continuing education credits concerning the safe and effective administration of influenza virus immunizations.[41]

As of June 2009, all states allow pharmacists to immunize patients.[42]

Immunization Administration in Florida

In addition to Florida-licensed medical physicians, osteopathic physicians, physician assistants, and nurses, paramedics may administer immunizations. Section 401.272, F.S., authorizes a paramedic to administer immunizations after his or her medical director has verified and documented that the paramedic has received sufficient training and experience to administer immunizations. Also, pharmacists may administer influenza virus immunizations to adults pursuant to s. 465.189, F.S.

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[32] S. 465.007(3), F.S.
[33] S. 465.008, F.S.
[34] S. 465.009, F.S.
[35] S. 465.013, F.S.
[36] *Id.*
[37] *See* Rule 64B16-26.2032, F.A.C. (U.S. pharmacy students/graduates); *see also* Rule 64B16-26.2033, F.A.C. (foreign pharmacy graduates).
[38] Rule 64B16-27.430, F.A.C.
[39] *See, e.g.,* Pharmacists Mutual Insurance Company, at http://www.phmic.com/phmc/productlines/personal/Pages/IndividualPharmacistProfessionalLiability.aspx
[40] Ch. 2007-152, Laws of Fla. (2007).
[41] Rule 64B16-26.1031, F.A.C.
[42] *See* map available at http://www.pharmacist.com/AM/TemplateRedirect.cfm?Template=/CM/ContentDisplay.cfm&ContentID=21623.

Confidentiality of and Access to Patient Records

Chapter 456, F.S., specifies the general regulatory provisions for health care professions within the Department of Health (DOH). Section 456.057, F.S., deals with the confidentiality of, and patient's access to, medical records created by specified health care practitioners. "Records owner" is defined to mean any health care practitioner who creates a medical record following treatment of a patient, a health care practitioner to whom records are transferred by a previous treating health care practitioner, or an employee of a health care practitioner identified as the records owner. It is important to note that the patient is not considered the owner of his or her medical records.

For purposes of s. 456.057, F.S., the terms "records owner," "health care practitioner," and "health care practitioner's employer" do not include any of the following persons or entities: certified nursing assistants; pharmacists and pharmacies; dental hygienists; nursing home administrators; respiratory therapists; athletic trainers; electrologists; clinical laboratory personnel; medical physicists; opticians and optical establishments; and persons or entities practicing under s. 627.736(7), F.S., relating to personal injury protection claims. The persons or entities specified in the section are not authorized to acquire or own medical records, but are authorized under the confidentiality and disclosure requirements of s. 456.057, F.S., to maintain those documents required by the part or chapter under which they are licensed or regulated.

Confidentiality of and Access to Pharmacy Records

Section 465.017, F.S., provides that, except upon written authorization of the patient, a pharmacist is authorized to release patient prescription records only to the patient, the patient's legal representatives, and the patient's spouse if the patient is incapacitated, to DOH, or upon the issuance of a subpoena. The section also specifies other exceptions for the release of records maintained in a pharmacy relating to the filling of prescriptions and dispensing of drugs. Pharmacists are subject to discipline for using or releasing a patient's records, except as authorized by ch. 456, F.S., and ch. 465, F.S.

Effect of Proposed Changes

The bill authorizes a pharmacist or a pharmacy intern, with proper certification and working under the pharmacist's supervision, to administer:

- Influenza vaccines to adults 18 years of age or older;
- Varicella zoster vaccines to adults 60 years of age or older;
- Pneumococcal vaccines to adults 65 years of age or older; and
- Epinephrine using an autoinjector delivery system to an adult 18 years of age or older who is suffering an anaphylactic reaction.

The bill requires a pharmacist or pharmacy intern to complete 20 hours of continuing education classes approved by the Board of Pharmacy concerning the safe and effective administration of the vaccines listed in the bill and epinephrine autoinjection and potential adverse reactions to the vaccines and epinephrine.

A pharmacist or pharmacy intern who administers a vaccine or autoinjection must maintain and make available patient records related to the administration of a vaccine or autoinjection pursuant to the standards and requirements imposed on health care practitioners in s. 456.057, F.S. The records must be maintained for 5 years.

The bill amends the definition of "practice of the profession of pharmacy" to include the administration of certain vaccines and epinephrine autoinjection. The bill makes other changes to s. 465.189, F.S., and s. 465.003, F.S., to delete references to "influenza virus immunizations" and include the terms "pharmacy intern" and "vaccine or epinephrine autoinjection".

The bill expands the scope of practice of pharmacy to include the administration of three different vaccines and epinephrine using an autoinjector delivery system. Currently, pharmacists are permitted to administer the influenza vaccine. The bill allows pharmacists to administer two additional vaccines and epinephrine through an autoinjector delivery system to individuals over the age of 18 suffering an anaphylactic reaction. The bill also allows pharmacy interns, under the employ and supervision of a licensed pharmacist, to administer the same vaccines and epinephrine injection. Pharmacy interns have not been permitted to administer any treatment or medication directly to a person previously in Florida.

B. SECTION DIRECTORY:

Section 1: Amends s. 465.189, F.S., relating to administration of influenza virus immunizations.
Section 2: Amends s. 465.003, F.S., relating to definitions.
Section 3: Provides an effective date of July 1, 2011.

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.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Pharmacies that opt to allow its pharmacists and pharmacy interns to administer the vaccinations and epinephrine specified in the bill will realize a positive economic impact as customers seeking the vaccinations and epinephrine injection will pay the pharmacy to perform the task rather than seeking the vaccinations and epinephrine from some other health care provider.

D. FISCAL COMMENTS:

The DOH will experience a recurring increase in workload to certify pharmacy interns to administer vaccines and epinephrine following completion of the requisite number of continuing education classes. Also, DOH will incur non-recurring costs associated with amending its rules. According to DOH, current budget authority is adequate to absorb the costs associated with each activity.[43]

[43] *Department of Health Bill Analysis, Economic Statement, and Fiscal Note for HB 585*, March 1, 2011, a copy of which is on file with the Health and Human Services Quality Subcommittee.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

DOH has appropriate rule-making authority to amend its rules related to immunization vaccination administration.

C. DRAFTING ISSUES OR OTHER COMMENTS:

It is unclear whether a pharmacy intern must enter into his or her own written protocol with a supervisory physician to administer vaccines or epinephrine or if the written protocol of the supervising pharmacist will govern the administration of vaccines or epinephrine by the pharmacy intern. Also, the bill does not address whether or not a pharmacy intern will be required to carry his or her own professional liability insurance to administer vaccines or epinephrine.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to pharmacy; amending s. 465.189, F.S.; revising the types of vaccines that pharmacists are authorized to administer; authorizing pharmacy interns to administer the vaccines under certain circumstances; authorizing pharmacists and pharmacy interns to administer an epinephrine autoinjection under certain circumstances; revising protocol requirements for vaccine administration and the duties of supervising physicians under such protocols; revising requirements for training programs, certifications, and patient records related to vaccine administration; amending s. 465.003, F.S.; revising terminology to conform to changes made by the act; providing an effective date.

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

Section 1. Section 465.189, Florida Statutes, is amended to read:

465.189 Administration of vaccines and epinephrine autoinjection ~~influenza virus immunizations~~.—

(1) A pharmacist, and a pharmacy intern having proper certification and working under the pharmacist's supervision, ~~Pharmacists~~ may administer, ~~influenza virus immunizations to adults~~ within the framework of an established protocol under a supervising ~~supervisory practitioner who is a~~ physician licensed under chapter 458 or chapter 459, the following:

(a) Influenza vaccine to an adult 18 years of age or

older.

(b) Varicella zoster vaccine to an adult 60 years of age or older.

(c) Pneumococcal vaccine to an adult 65 years of age or older.

(d) Epinephrine using an autoinjector delivery system to an adult 18 years of age or older who is suffering an anaphylactic reaction.

The ~~Each~~ protocol must ~~shall~~ contain specific procedures for addressing any unforeseen adverse ~~allergic~~ reaction to the vaccine or epinephrine autoinjection ~~influenza virus immunizations~~.

(2) A pharmacist may not enter into a protocol unless he or she maintains at least $200,000 of professional liability insurance and has completed training on the vaccines and epinephrine autoinjection ~~in influenza virus immunizations~~ as provided in this section.

(3) A pharmacist who administers, or whose pharmacy intern administers, a vaccine or epinephrine autoinjection must ~~administering influenza virus immunizations shall~~ maintain and make available patient records using the same standards for confidentiality and maintenance of such records as those that are imposed on health care practitioners under s. 456.057. These records must ~~shall~~ be maintained for a minimum of 5 years.

(4) The decision by a supervising physician ~~supervisory practitioner~~ to enter into a protocol under this section is a professional decision on the part of the physician ~~practitioner~~,

and a person may not interfere with a supervising physician's ~~supervisory practitioner's~~ decision to enter ~~as to entering~~ into such a protocol. A pharmacist may not enter into a protocol that is to be performed while acting as an employee without the written approval of the owner of the pharmacy. Pharmacists shall forward immunization records to the department for inclusion in the state registry of immunization information.

(5) Any pharmacist or pharmacy intern seeking to administer a vaccine or epinephrine autoinjection ~~influenza virus immunizations to adults~~ under this section must be certified to administer the vaccine or epinephrine autoinjection ~~influenza virus immunizations~~ pursuant to a certification program approved by the Board of Pharmacy in consultation with the Board of Medicine and the Board of Osteopathic Medicine. The certification program shall, at a minimum, require that the pharmacist or pharmacy intern attend at least 20 hours of continuing education classes approved by the board. The program shall have a curriculum of instruction concerning the safe and effective administration of the vaccines listed in subsection (1) and epinephrine autoinjection ~~influenza virus immunizations~~, including, but not limited to, potential adverse ~~allergic~~ reactions to the vaccines or epinephrine autoinjection ~~influenza virus immunizations~~.

(6) The written protocol between the pharmacist and supervising physician must include particular terms and conditions imposed by the supervising physician upon the pharmacist relating to the administration of a vaccine or epinephrine autoinjection ~~influenza virus immunizations~~ by the

pharmacist or pharmacy intern working under the pharmacist's supervision. The written protocol must ~~shall~~ include, at a minimum, specific categories and conditions among patients for whom the supervising physician authorizes the pharmacist or pharmacy intern to administer a vaccine or epinephrine autoinjection ~~influenza virus immunizations~~. The terms, scope, and conditions set forth in the written protocol between the pharmacist and the supervising physician must be appropriate to the pharmacist's or pharmacy intern's training and certification for the vaccine or epinephrine autoinjection ~~immunization~~. A pharmacist, or pharmacy intern working under the pharmacist's supervision, ~~Pharmacists~~ who is ~~have been~~ delegated the authority to administer a vaccine or epinephrine autoinjection ~~influenza virus immunizations~~ by the supervising physician must ~~shall~~ provide evidence of current certification by the Board of Pharmacy to the supervising physician. A supervising physician must ~~physicians shall~~ review the administration of the vaccine or epinephrine autoinjection ~~influenza virus immunizations~~ by the pharmacist, or a pharmacy intern working under the pharmacist's supervision, ~~pharmacists~~ under such physician's supervision pursuant to the written protocol, and this review shall take place as outlined in the written protocol. The process and schedule for the review shall be outlined in the written protocol between the pharmacist and the supervising physician.

(7) The pharmacist shall submit to the Board of Pharmacy a copy of his or her protocol or written agreement to administer the vaccine or epinephrine autoinjection ~~influenza virus~~

~~immunizations~~.

Section 2. Subsection (13) of section 465.003, Florida Statutes, is amended to read:

465.003 Definitions.—As used in this chapter, the term:

(13) "Practice of the profession of pharmacy" includes compounding, dispensing, and consulting concerning contents, therapeutic values, and uses of any medicinal drug; consulting concerning therapeutic values and interactions of patent or proprietary preparations, whether pursuant to prescriptions or in the absence and entirely independent of such prescriptions or orders; and other pharmaceutical services. For purposes of this subsection, "other pharmaceutical services" means the monitoring of the patient's drug therapy and assisting the patient in the management of his or her drug therapy, and includes review of the patient's drug therapy and communication with the patient's prescribing health care provider as licensed under chapter 458, chapter 459, chapter 461, or chapter 466, or similar statutory provision in another jurisdiction, or such provider's agent or such other persons as specifically authorized by the patient, regarding the drug therapy. However, ~~nothing in~~ this subsection does not ~~may be interpreted to~~ permit an alteration of a prescriber's directions, the diagnosis or treatment of any disease, the initiation of any drug therapy, the practice of medicine, or the practice of osteopathic medicine, unless otherwise permitted by law. The term "practice of the profession of pharmacy" ~~also~~ includes any other act, service, operation, research, or transaction incidental to, or forming a part of, any of the foregoing acts, requiring, involving, or employing

the science or art of any branch of the pharmaceutical profession, study, or training, and shall expressly permit a pharmacist to transmit information from persons authorized to prescribe medicinal drugs to their patients. The term ~~practice of the profession of pharmacy~~ also includes the administration of certain vaccines and epinephrine autoinjection ~~influenza virus immunizations~~ to adults pursuant to s. 465.189.

Section 3. This act shall take effect July 1, 2011.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1289 Medicaid Eligibility
SPONSOR(S): Ahern and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1356

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health & Human Services Quality Subcommittee		Prater	Calamas
2) Rulemaking & Regulation Subcommittee			
3) Health Care Appropriations Subcommittee			
4) Health & Human Services Committee			

SUMMARY ANALYSIS

The bill amends s. 409.902, F.S., relating to Medicaid eligibility.

Currently, some individuals applying for long-term care Medicaid services are using various methods to shelter their assets in order to become eligible for Medicaid.

The bill requires the Department of Children and Families (DCF) to apply additional asset transfer limitations for individuals applying for Medicaid nursing facility services, institutional hospice services, and home and community-based waiver programs.

- The bill provides certain restrictions on personal services contracts, which are used to transfer assets to a family member or caregiver in return for specific services.
- The bill also provides certain conditions that must be met for a spouse that refuses make their financial resources available to the spouse receiving Medicaid long-term care services.

The bill requires the Agency for Health Care Administration (AHCA) to seek recovery of all Medicaid-covered expenses and pursue court-ordered medical support in instances of a spouse refusing to make their resources available to a spouse seeking Medicaid long-term care services.

The bill has a potential significant positive fiscal impact to the state through imposing stricter regulations on eligibility requirements for Medicaid long-term care. The bill directs AHCA to seek recovery of improper Medicaid payments which could require significant Agency resources. See Fiscal Comments.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Medicaid Overview

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by AHCA and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including DCF, the Agency for Persons with Disabilities (APD), and the Department of Elderly Affairs (DOEA).

The structure of each state's Medicaid program varies, but what states must pay for are largely determined by the federal government, as a condition of receiving federal funds. Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections.

Florida Medicaid is the second largest single program in the state behind public education, representing 28 percent of the total FY 2010-11 budget. Medicaid general revenue expenditures represent 17 percent of the total General Revenue funds appropriated in FY 2010-11. Florida's program is the 4th largest in the nation, and the 5th largest in terms of expenditures. Current estimates indicate the program will cost $20.3 billion in FY 2011-2012. By FY 2013-2014, the estimated program cost is $23.6 billion.

Medicaid Long-Term Care

Long-term care is currently provided to elderly and disabled Medicaid recipients though nursing home placement and through home and community based services. Home and community based services provide care in a community setting instead of a nursing home or other institution. Home and community based services are provided through six Medicaid waiver programs and one state plan program administered by DOEA in partnership with AHCA. These waiver programs are administered through contracts with the 11 Aging Resource Centers[1] and local service providers, and provide alternative, less restrictive long-term care options for elders who qualify for skilled nursing home care.

The Medicaid eligibility income threshold for institutional care placement, home and community based care services, and hospice services, is 300 percent of the Supplemental Security Income (SSI) federal benefit rate.[2] The current SSI federal benefit rate is $674 for an individual,[3] therefore, individuals with incomes under $2,022 per month are eligible for Medicaid long-term care services.

Medicaid Long-Term Care Planning

A 2009 study by the National Alliance for Caregiving and AARP found that about 43.5 million Americans look after someone age 50 or older, which is a 28 percent increase from 2004.[4] Some individuals, with assistance from financial planners and attorneys, have developed methods of arranging assets in such a way that they are not countable when Medicaid eligibility is determined. Elder law attorneys across the country actively advertise services to assist elderly individuals with

[1] The 2004 Legislature created the Aging Resource Center initiative to reduce fragmentation in the elder services system. To provide easier access to elder services, the Legislature directed DOEA to establish a process to help the 11 area agencies on aging transition to Aging Resource Centers.
[2] Ch. 65A-1.713, F.A.C.
[3] Social Security Administration, *see* http://www.ssa.gov/oact/cola/SSI.html (last viewed on April 2, 2011).
[4] National Alliance for Caregiving in collaboration with AARP, Caregiving in the U.S., Executive Summary, 2009. *See* http://www.caregiving.org/pubs/data.htm (last viewed on April 5, 2011).

personal service contracts and other asset protection methods. For example, the website of a South Florida law firm prominently displays the following sentences on their website:

- "Asset Protection For People With Too Much Income or Assets to Qualify for Government Programs;" and
- "For ten years we have successfully helped families preserve their assets and qualify for Florida Nursing Home Medicaid benefits and Assisted Living public benefits."[5]

Another example is from a 2006 article published by the New York State Bar Association authored by a Florida elder law attorney. The article advises New York attorneys on how to assist their "snowbird" clients. The author states: "...you should know that the spousal refusal option is working well in Florida, although change may be coming. Many Florida spouses today are able to protect themselves from impoverishment by exercising their right of spousal refusal."[6]

Transfer of Assets

According to DCF, some individuals, prior to entering a nursing facility or enrolling in a Medicaid home and community based service waiver program, transfer accumulated assets to a relative through a contract which provides that the relative will provide personal services to the individual for a specified period of time.[7] Current DCF policy does not preclude the transfer of funds to relatives when contracts are drawn up to prepay for future personal services.[8] According to DCF, many of the contracted services incorporated into the contracts are services that close relatives would normally provide without charge such as visitation, transportation, entertainment, and oversight of medical care.[9] If a transfer of assets was made in the form of a personal services contract, within a 36 month (3 year) look back period, DCF must make a determination if the contracted services were for fair market value.[10] The look back period is calculated from the date of application for Medicaid.[11] If a transfer of assets for less than fair market value is found, the state must withhold payment for nursing facility care and other long-term care services for a period of time referred to as the penalty period. The length of the penalty period is determined by dividing the value of the transferred asset by the average monthly private-pay rate for nursing facility care in the state.[12]

Spousal Impoverishment

Section 1924 of the Social Security Act provides requirements to prevent "spousal impoverishment," which can leave the spouse who is still living at home in the community with little or no income or resources.[13] When the couple applies for Medicaid, an assessment of their resources is made and a protected resource amount of $109,560[14] is set aside for the community spouse and the remainder is considered available for the individual applying for Medicaid.[15]

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[5] *See* http://www.buxtonlaw.com/flmedicaidplanning.shtml (last viewed on April 2, 2011).
[6] New York State Bar Association, Elder Law Attorney, Fall 2006, Vol. 16, No. 4. *See* www.elderlawassociates.com/.../snowbirdnews-NYSBA-fall2006.pdf (last viewed on April 4, 2011).
[7] Department of Children and Families, Staff Analysis and Economic Impact, HB 1289 (on file with the Subcommittee).
[8] *Id.*
[9] *Id.*
[10] Department of Children and Families, Policy Manual, 1640.0609.01, Identifying Potential Transfers of Assets or Income (on file with the Subcommittee).
[11] *Id.*
[12] *See* https://www.cms.gov/MedicaidEligibility/10_TransferofAssets.asp (last viewed on April 2, 2011).
[13] Department of Health and Human Services, Centers for Medicare and Medicaid Services, Spousal Impoverishment, *see* https://www.cms.gov/MedicaidEligibility/09_SpousalImpoverishment.asp (last viewed on April 4, 2011).
[14] This is an amount set by the federal government and is contained in the Social Security Act. *See* https://www.cms.gov/MedicaidEligibility/09_SpousalImpoverishment.asp (last viewed on April 3, 2011).
[15] Agency for Health Care Administration, 2011 Bill Analysis & Economic Impact Statement, HB 1289 (on file with the Subcommittee).

Additionally, section 1924 of the Social Security Act[16] provides that an individual applying for Medicaid cannot be determined ineligible for assistance based on assets of their spouse when:

- The applicant assigns his or her rights to support from the community spouse[17] to the state;
- The applicant is physically or mentally unable to assign his right by the state has the right to bring a support proceeding against the community spouse; or
- The state determines the denial of eligibility would work an undue hardship.

According to DCF, when an applicant signs a document assigning his or her rights to the state, the state has the authority to seek financial support from the community spouse for Medicaid funds spent on the spouse of the nursing facility.[18] While DCF indicates that it has authority to seek financial support from the community spouse under these circumstances, there is no mechanism to actually recover funds from the community spouse.[19]

Deficit Reduction Act

The Federal Deficit Reduction Act of 2005(DRA)[20] contained provisions aimed at discouraging the use of "Medicaid planning" techniques and to impose penalties on transactions which are intended to protect wealth while enabling access to public benefits.[21] The Congressional Budget Office (CBO) estimated that the DRA would reduce federal Medicaid spending by $11.5 billion over the first five years and $43.2 billion within ten years. The DRA made changes to:

- Medicaid transfer of asset rules;
- Medicaid annuity rules;
- spousal impoverishment rules;
- home equity rules; and
- rules pertaining to treatment of continuing care retirement community entrance fees.

Transfer of Assets

The Act extended the "look-back period" for any transfers of assets from 36 months to 60 months, on or after February 8, 2006. In addition, the Act changed the start date of the penalty period, which is the period during which and individual is ineligible for Medicaid payment for long-term care services because of a transfer of assets for less than fair market value.[22] The Act changed the start date of the penalty period from the month of the transfer of assets to the date of application for Medicaid.[23]

Spousal Impoverishment

When a couple applies for Medicaid, an assessment of their resources is made and a protected resource amount of $109,560[24] is set aside for the community spouse and the remainder is considered

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[16] Social Security Act, Section 1924, Treatment of Income and Resources for Certain Institutionalized Spouses, *see* http://www.ssa.gov/OP_Home/ssact/title19/1924.htm (last viewed on April 4, 2011).
[17] A "community spouse" means the spouse that remains at home or in the community when the other spouse enters nursing facility care. *See* https://www.cms.gov/MedicaidEligibility/09_SpousalImpoverishment.asp (last viewed on April 4, 2011).
[18] Department of Children and Families, Staff Analysis and Economic Impact, HB 1289 (on file with the Subcommittee).
[19] Agency for Health Care Administration, 2011 Bill Analysis & Economic Impact Statement, HB 1289 (on file with the Subcommittee); Department of Children and Families, Staff Analysis and Economic Impact, HB 1289 (on file with the Subcommittee).
[20] P.L. 109-171 (2005).
[21] Department of Health and Human Services, Centers for Medicare and Medicaid, The Deficit Reduction Act: Important Facts for State Government Officials. *See* https://www.cms.gov/**DeficitReductionAct**/Downloads/Checklist1.pdf (last viewed on April 4, 2011).
[22] *Id.*
[23] *Id.*
[24] This is an amount set by the federal government and is contained in the Social Security Act. *See* https://www.cms.gov/MedicaidEligibility/09_SpousalImpoverishment.asp (last viewed on April 3, 2011).

available for the individual applying for Medicaid.[25] This protected amount is known as the Community Spouse Resource Allowance (CSRA). The DRA provided that an increase in the CSRA cannot be granted until the maximum available income of the institutionalized spouse is allocated to the community spouse.[26]

Medicaid Long-Term Care Costs

The average cost of long-term care varies depending on the type of care the individual receives. The statewide average annual cost of nursing home care is $76,876, while hospice care is $53,483. The average cost annual cost of the various home and community based care waivers is $13,471. As of December 2010, there were 103,405 individuals receiving Medicaid long-term care services through nursing homes, hospice, and home and community based waivers.[27]

Recovery of Medicaid-Covered Expenses

Federal regulations[28] and the Florida Third Party Liability (TPL) Act[29] allow for recovery of amounts paid for medical expenses by Medicaid for which there is another liable third party (i.e., the recipient has other insurance coverage, such as private insurance or Medicare). AHCA has a current contract with a Medicaid third party liability vendor, Affiliated Computer Services (ACS). It is the role of the ACS to identify potential third party payors and to recoup from them costs that have been paid by Medicaid.

According to DCF, New York pursues recovery of Medicaid expenses from spouses with some success in select counties. New York's public assistance programs are county-administered. The individual counties have attorneys assigned to the public welfare agency responsible for Medicaid eligibility and each county is responsible for pursuit of the spousal support and recovery of Medicaid-covered expenses.[30]

Effect of Proposed Changes

The bill requires DCF to apply additional asset transfer limitations for individuals applying for Medicaid nursing facility services, institutional hospice services, and home and community-based waiver programs. The new limitations apply to asset transfers made after July 1, 2011.

The bill applies the following new conditions to individuals who enter into personal services contracts:

- The contracted services must not duplicate services that would be available through other sources or providers, such as Medicaid, Medicare, private insurance, or another legally obligated third party;
- The contracted services must directly benefit the individual and are not services that are normally provided out of consideration for the individual;
- The cost to deliver the services must be computed in a manner that reflects the actual number of hours to be expended and the contract must clearly identify each specific service and the average number of hours required to deliver each service each month;
- The hourly rate for each contracted service must be equal to or less than the amount normally charged by a professional who traditionally provides the same or similar services;
- The cost of contracted services must be provided on a prospective basis only and does not apply to services provided before July 1, 2011; and

[25] Agency for Health Care Administration, 2011 Bill Analysis & Economic Impact Statement, HB 1289 (on file with the Subcommittee).
[26] *Id.*
[27] Email from AHCA Medicaid staff, received April 1, 2011 (on file with Subcommittee).
[28] 42 U.S.C. §1396k(a).
[29] S. 409.910, F.S.
[30] Department of Children and Families, Staff Analysis and Economic Impact, HB 1289 (on file with the Subcommittee).

- The contract must provide fair compensation to the individual during her or his lifetime as set forth in the life expectancy tables published by the Office of the Actuary of the Social Security Administration.

The bill applies the following new conditions to a community spouse who refuses to make her or his resources available to the institutional spouse:

- Requiring proof that an estrangement existed between the spouses during the months before the individual submitted an application for institutional care services. If the individuals have not lived separate and apart without cohabitation and without interruption for at least 36 months, all resources of both individuals must be considered to determine eligibility.
- Transfer of assets between spouses that are in excess of the Community Spouse Resource Allowance must be considered. If such a transfer was made within the look back period, it is considered a transfer of assets for less than fair market value and therefore subject to a penalty period.
- An undue hardship does not exist when the individual, or person acting on his or her behalf, transfers resources to the community spouse and the community spouse refuses to make her or his resources available to the institutional spouse.
- The institutional spouse must be determined ineligible for Medicaid if she or he, or the person acting on her or his behalf, refuses to provide information about the community spouse or cooperate in the pursuit of court-ordered medical support or the recovery of Medicaid expenses paid by the state on her or his behalf.

The bill requires AHCA to seek recovery of all Medicaid-covered expenses and pursue court-ordered medical support from the community spouse when she or he refuses to make her or his assets available to the institutional spouse.

The bill provides DCF sufficient rule-making authority to implement the provisions of this bill.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.902, F.S., relating to designated single state agency; payment requirements; program title; release of medical records

Section 2: Provides an effective date of July 1, 2011.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The bill could result in savings to the state by applying stricter asset transfer limitations for certain individuals applying for nursing facility services under the Medicaid program.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Nursing home and Medicaid waiver providers may experience a positive fiscal impact if a greater number of individuals are required to pay for their care with private pay, rather than Medicaid.

D. FISCAL COMMENTS:

The bill directs AHCA to seek recovery from the community spouse for monies paid by Medicaid on behalf of the eligible recipient which is to be accomplished by pursuing court-ordered medical support from the community spouse. AHCA indicates this pursuit could be accomplished through its contract with a third party liability vendor by amending their current contract. AHCA further indicates that this would require significant information sharing between DCF and AHCA as well as possible investigations into financial activities to determine spousal resources. AHCA states that it is unable to determine the fiscal impact of these changes.[31]

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rule-making authority to DCF to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

AHCA indicates that it does not have the information necessary to identify individuals that are Medicaid eligible due to impoverishment and that the third party liability vendor does not currently receive information regarding assignment of spousal support. Additionally, AHCA indicates that it has little information regarding community spouses in terms of assets and finances, or their current marital status. Additionally, community spouse asset information, for those that have any substantial amounts would quite likely be concealed and would require financial investigations.[32]

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[31] Agency for Health Care Administration, 2011 Bill Analysis & Economic Impact Statement, HB 1289 (on file with the Subcommittee).

[32] Agency for Health Care Administration, 2011 Bill Analysis & Economic Impact Statement, HB 1289 (on file with the Subcommittee).

A bill to be entitled

An act relating to Medicaid eligibility; amending s. 409.902, F.S.; providing asset transfer limitations for determination of eligibility for certain nursing facility services under the Medicaid program after a specified date; requiring the Department of Children and Family Services to take certain actions if a community spouse refuses to make certain resources available to the institutional spouse; authorizing the Agency for Health Care Administration to recover certain Medicaid expenses; authorizing the Department of Children and Family Services to adopt rules; providing an effective date.

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

Section 1. Section 409.902, Florida Statutes, is amended to read:

409.902 Designated single state agency; payment requirements; program title; release of medical records; eligibility requirements.—

(1) The Agency for Health Care Administration is designated as the single state agency authorized to make payments for medical assistance and related services under Title XIX of the Social Security Act. These payments shall be made, subject to any limitations or directions provided for in the General Appropriations Act, only for services included in the program, shall be made only on behalf of eligible individuals, and shall be made only to qualified providers in accordance with

federal requirements for Title XIX of the Social Security Act and the provisions of state law. This program of medical assistance is designated the "Medicaid program." The Department of Children and Family Services is responsible for Medicaid eligibility determinations, including, but not limited to, policy, rules, and the agreement with the Social Security Administration for Medicaid eligibility determinations for Supplemental Security Income recipients, as well as the actual determination of eligibility. As a condition of Medicaid eligibility, subject to federal approval, the Agency for Health Care Administration and the Department of Children and Family Services shall ensure that each recipient of Medicaid consents to the release of her or his medical records to the Agency for Health Care Administration and the Medicaid Fraud Control Unit of the Department of Legal Affairs.

(2) In determining eligibility for nursing facility services, including institutional hospice services and home and community-based waiver programs under the Medicaid program, the Department of Children and Family Services shall apply the asset transfer limitations specified in subsection (3) for transfers made after July 1, 2011.

(3) Individuals who enter into a personal services contract with a relative shall be considered to have transferred assets without fair compensation to qualify for Medicaid unless all of the following criteria are met:

(a) The contracted services do not duplicate services available through other sources or providers, such as Medicaid,

Medicare, private insurance, or another legally obligated third party.

(b) The contracted services directly benefit the individual and are not services normally provided out of consideration for the individual.

(c) The actual cost to deliver services is computed in a manner that clearly reflects the actual number of hours to be expended and the contract clearly identifies each specific service and the average number of hours required to deliver each service each month.

(d) The hourly rate for each contracted service is equal to or less than the amount normally charged by a professional who traditionally provides the same or similar services.

(e) The cost of contracted services is provided on a prospective basis only and does not apply to services provided before July 1, 2011.

(f) The contract for services provides fair compensation to the individual during her or his lifetime as set forth in the life expectancy tables published by the Office of the Actuary of the Social Security Administration.

(4) When determining eligibility for nursing facility services, including institutional hospice services and home and community-based waiver programs under the Medicaid program, if a community spouse refuses to make her or his resources available to her or his institutional spouse, the Department of Children and Family Services shall:

(a) Require proof that estrangement existed during the months before the individual submitted an application for

institutional care services. If the individuals have not lived separate and apart without cohabitation and without interruption for at least 36 months, all resources of both individuals shall be considered to determine eligibility.

(b) Consider transfer of assets between spouses in excess of the Community Spouse Resource Allowance within the look-back period to be a transfer of assets for less than fair market value and therefore subject to a penalty period.

(c) Determine that undue hardship does not exist when the individual, or the person acting on her or his behalf, transfers resources to the community spouse and the community spouse refuses to make her or his resources available to the institutional spouse.

(d) Determine the institutional spouse to be ineligible for Medicaid if she or he, or the person acting on her or his behalf, refuses to provide information about the community spouse or cooperate in the pursuit of court-ordered medical support or the recovery of Medicaid expenses paid by the state on her or his behalf.

(5) The Agency for Health Care Administration shall seek recovery of all Medicaid-covered expenses and pursue court-ordered medical support from the community spouse when she or he refuses to make her or his assets available to the institutional spouse.

(6) The Department of Children and Family Services may adopt rules governing the administration of this section pursuant to ss. 120.536(1) and 120.54.

Section 2. This act shall take effect July 1, 2011.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 1289 (2011)

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health & Human Services Quality Subcommittee

Representative(s) Ahern offered the following:

Amendment

Remove line 111 and insert:

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 831 High School Athletic Trainers
SPONSOR(S): Rooney, Jr. and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1176

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health & Human Services Quality Subcommittee		Holt LH	Calamas CEC
2) K-20 Innovation Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Athletic Trainers are regulated and licensed pursuant to part XIII of ch. 768, F.S. Athletic training is the recognition, prevention, and treatment of athletic injuries.

HB 831 amends s. 1012.46, F.S., to encourage the use and employment of licensed, certified athletic trainers by school districts for schools that participate in sports. The bill, in effect, codifies the Department of Health's current practice of allowing license applicants to satisfy the exam requirement through the Board of Certification for the National Athletic Trainer's Association. Current law provides that neither a board nor the DOH if there is no board, may administer a state-developed written examination if a national examination has been certified by the DOH.

The bill provides a legislative goal that at least one full-time athletic trainer should be available in each high school that participates in sports, and encourages the use of an entity which can coordinate placement of licensed, certified athletic trainers to provide a standard of care to prevent and rehabilitate high school sports-related injuries.

The bill provides a rebuttable presumption that a school district is not negligent in employing an athletic trainer if it made a good faith effort to comply with the requirements of s. 1012.46, F.S. The presumption applies in any civil action for the death, injury or damage to an individual who has received treatment for a sports injury from a licensed certified athletic trainer that is allegedly a result of negligence.

The bill does not appear to have a fiscal impact on the state or local governments.

The bill takes effect July 1, 2011.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Athletic Trainers

Athletic Trainers are regulated by the Florida Department of Health, Division of Medical Quality Assurance and the Board of Athletic Training[1], pursuant to part XIII of ch. 768, F.S. Athletic training is the recognition, prevention, and treatment of athletic injuries.[2] An athletic injury is an injury sustained during an athletic activity which affects the athlete's ability to participate or perform.[3] An athletic activity includes the participation in an event that is conducted by an educational institution, a professional athletic organization, or an amateur athletic organization, involving exercises, sports, games, or recreation requiring any of the physical attributes of strength, agility, flexibility, range of motion, speed, and stamina.[4]

In 1994, the Legislature began fully regulating and licensing the practice of athletic training to protect the public and ensure that athletes are assisted by individuals adequately trained to recognize, prevent, and treat physical injuries sustained during athletic activities.[5]

As of June 30, 2010, there were 1,507 active in-state licensed athletic trainers.[6] Between July 1, 2009 and June 30, 2010, the department received 166 applications from individuals seeking initial licensure as an athletic trainer.

Applicants seeking licensure as an athletic trainer must:[7]

- Complete the application form and remitted the required fees;[8]
- Be at least 21 years of age;
- Posses a baccalaureate degree from a United States Department of Education or the Commission on Recognition of Postsecondary Accreditation accredited college or university, or a program approved by the board;
- Complete an approved athletic training curriculum from a college or university accredited by an accrediting agency recognized and approved by the United States Department of Education or the Commission on Recognition of Postsecondary Accreditation, or approved by the board;
- Be certified in cardiovascular pulmonary resuscitation from the American Red Cross, the American Heart Association, or an equivalent certification entity as determined by the board;
- Submit proof of taking a two-hour course on the prevention of medical errors;
- Submit a certified copy of the National Athletic Trainers Association Board of Certification certificate or a notarized copy of examination results.[9]

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[1] The Board of Athletic Training is composed of nine members who are Governor appointed and confirmed by the Senate. Five of the members must be licensed athletic trainers, one must be a physician, and two are consumer-residents who are not affiliated with the industry or licensed health-care practice. *See* s. 768.703, F.S.

[2] S. 468.701(5). F.S.

[3] S. 468.701(3), F.S.

[4] S. 468.701(2), F.S.

[5] Ch. 94-119, L.O.F. and s. 468.70, F.S.

[6] Florida Department of Health, Division of Medical Quality Assurance: Annual Report July 1, 2009 to June 30, 2010, *available* at: http://www.doh.state.fl.us/mqa/reports.htm (last viewed April 4, 2011).

[7] S. 468.707, F.S.

[8] The application fee is $100 and the initial licensure fee for even years is $125 and in odd years is $75. The license for the profession of athletic training is renewed September 30 of each even year. *See* chapters 64B33-9.001 and 64B33-3.001, F.A.C.

[9] Florida Department of Health, Division of Medical Quality Assurance, Athletic Training: Application & Licensure Requirements, *available* at: http://www.doh.state.fl.us/mqa/athtrain/at_lic_req.html (last viewed April 4, 2011).

Each applicant for licensure is required to complete a continuing education course on HIV/AIDS as part of initial licensure and one hour for biannual licensure renewal.[10]

Additionally, licensed athletic trainers are required to complete 24 hours of continuing education courses biannually. The courses must focus on the prevention of athletic injuries; the recognition, evaluation, and immediate care of athletic injuries; rehabilitation and reconditioning of athletic injuries; health care administration; or professional development and responsibility of athletic trainers.[11]

An athletic trainer is required to practice within a written protocol established with a supervising physician.[12] The written protocol must include:[13]

- The athletic trainer's name, license number, and curriculum vitae;
- The supervising physician's name, license number, and curriculum vitae;
- Method of contacting the supervising physician, specifically delineating the method to report new injuries as soon as practicable;
- The patient population to be treated (e.g., specific scholastic athletic programs, patients of a specific clinic, patients with specific physician referral);
- The method of assessment of a patient's status and treatment;
- Delineation of the items considered within the scope of practice for the athletic trainer to include the use of modalities/equipment that may be initiated by the athletic trainer or require a physician's order;
- Identification of resources for emergency patient care (e.g., nearest hospital with emergency services, ambulance service).

The protocol must be reviewed by September 30 of each even year and the protocol must be available for inspection upon request.[14]

Scope of Practice

The following principles, methods and procedures are considered within the scope of a licensed athletic trainer's practice:[15]

- Injury prevention;
- Injury recognition and evaluation;
- First aid;
- Emergency care;
- Injury management/treatment and disposition;
- Rehabilitation through the use of safe and appropriate physical rehabilitation practices, including those techniques and procedures following injury and recovery that restore and maintain normal function status;
- Conditioning;
- Performance of tests and measurements to prevent, evaluate and monitor acute and chronic injuries;
- Selection of preventive and supportive devices, temporary splinting and bracing, protective equipment, strapping, and other immobilization devices and techniques to protect an injured structure, facilitate ambulation and restore normal functioning;
- Organization and administration of facilities within the scope of the profession; and
- Education and counseling to the public regarding the care and prevention of athletic injuries.

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[10] S. 456.034, F.S. and ch. 64B33-2.003, F.A.C.
[11] Ch. 64B33-2.003, F.A.C
[12] The physician must be licensed under chapter 458 (allopathic physician), 459 (osteopathic physician), or 460 (chiropractic physician), F.S.
[13] S. 468.713, F.S. and ch. 64B33-4.001, F.A.C.
[14] *Id.*
[15] Ch. 64B33-4.001, F.A.C.

A licensed athletic trainer may administer the following in the course of treatment and rehabilitation of muscle skeletal injuries:[16]

- Therapeutic Exercise;
- Massage;
- Mechanical Devices;
- Cryotherapy (e.g., ice, cold packs, cold water immersion, spray coolants);
- Thermotherapy (e.g., topical analgesics, moist/dry hot packs, heating pads, paraffin bath); and
- Other therapeutic agents with the properties of:
  - Water (e.g., whirlpool);
  - Electricity (e.g., electrical stimulation, diathermy[17]);
  - Light (e.g., infrared, ultraviolet); or
  - Sound (e.g., ultrasound).
- Topical prescription medications (e.g., steroid preparation for phonopheresis[18]) only at the direction of a physician.

Administration of Examinations for Licensure

Section 456.017, F.S., requires the board[19] or the Department of Health (DOH) if there is no board, to approve by rule the use of one or more national examinations that the DOH has certified as meeting the requirements of national examinations and generally accepted testing standards. Furthermore, neither a board nor the DOH if there is no board, may administer a state-developed written examination if a national examination has been certified by the DOH.[20]

National Athletic Trainers Association and National Board of Certification

The National Athletic Trainers' Association (NATA) is a professional membership association for certified athletic trainers.[21] Originating in 1950, today the NATA boasts greater than 37,000 members.

The National Board of Certification (BOC), established in 1989, provides a voluntary international certification program for the National Athletic Trainers Association to include the administration of the national examination required for certification. Students are eligible for BOC certification if they have attended athletic training degree program (Bachelor's or entry-level Master's) accredited by the Commission on Accreditation of Athletic Training Education (CAATE).[22] Currently, there are 14 schools located in Florida accredited by CAATE.[23] Florida recognizes passage of the BOC examination for state licensing purposes.[24]

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[16] *Id.*

[17] Diathermy is a method of physical therapy that involves using high-frequency electric current, ultrasound, or microwaves to deliver heat to muscles and ligaments.

[18] Phonophoresis has been used in an effort to enhance the absorption of topically applied analgesics and anti-inflammatory agents through the therapeutic application of ultrasound.

[19] A board is a statutorily created entity that is authorized to exercise regulatory or rulemaking functions within the DOH, Division of Medical Quality Assurance. *See* s. 456.001(1), F.S.

[20] S. 456.017(1)(c)2., F.S.

[21] National Athletic Trainers Association, About, *available* at: http://www.nata.org/aboutNATA (last viewed April 4, 2011).

[22] National Athletic Trainers Association, Board for Certification, What is an Athletic Trainer, *available* at: http://www.bocatc.org/index.php?option=com_content&view=article&id=100&Itemid=105 (last viewed April 4, 2011).

[23] Barry University, Florida Gulf Coast University, Florida International University, Florida Southern College, Florida State University, Nova Southeastern University, Palm Beach Atlantic University, University of Central Florida, University of Florida, University of Miami, University of North Florida, University of South Florida, University of Tampa, and University of West Florida. *See* Commission on Accreditation of Athletic Training Education, Accredited Programs: Florida, available at: http://www.caate.net/iMIS15/CAATE/Accredited_Programs/Core/directory.aspx?hkey=b91f27b1-2a93-4ed1-b1e6-55cc82ac0fc3 (last viewed April 4, 2011).

[24] S. 456.017, F.S. and Florida Department of Health, Division of Medical Quality Assurance, Athletic Training: Application & Licensure Requirements, *available* at: http://www.doh.state.fl.us/mqa/athtrain/at_lic_req.html (last viewed April 4, 2011).

In order to qualify as a candidate for the BOC certification exam, an individual must meet the following requirements: [25]

- Endorsement of the exam application by the recognized Program Director of the CAATE accredited education program; and
- Proof of current certification in emergency cardiac care (ECC) (Note: ECC certification must be current at the time of initial application and any subsequent exam retake registration.)

The BOC testing year runs from March 1 to February 28/29 of the following year.[26] The BOC offers candidates five two-week testing windows during the testing year: March/April, May/June, July/August, November, and January/February. During each testing window, two forms of the examination are delivered. Candidates who fail are not restricted in their retakes during the testing year. In 2009-2010, the pass rate for first-time test takers of the BOC examination was 43 percent.[27] Individuals who successfully pass the BOC examination are qualified to use the designation certified athletic trainer (ATC). The BOC has recertification requirements that have to be met in order to maintain certification that include: continuing education courses, ECC certification, BOC recertification fee and adherence to the BOC Standards of Professional Practice.[28]

School Districts and Athletic Trainers

Section 1012.46, F.S., provides school districts the authority to establish and implement an athletic injuries prevention and treatment program. That section provides that the program should focus on the employment and availability of persons trained in the prevention and treatment of physical injuries that may occur during athletic activities. The program should reflect minimum standards and opportunities for progressive advancement and compensation in employment as a licensed athletic trainer. Individuals considered for progressive advancement and compensation may also hold a certificate as a substitute teacher, certified educator, or adjunct teacher. Furthermore, s. 1012.46(2), F.S., states that the goal of the Legislature is to have school districts employ and have available a full-time athletic trainer in each high school in the state.

Presumptions in Law

A presumption is defined under the Florida Evidence Code as an assumption of fact that the law makes from the existence of another fact or group of facts found or otherwise established.[29] The law provides that, except for presumptions that are conclusive under the law from which they arise, a presumption is rebuttable. Every rebuttable presumption is either:

- A presumption affecting the burden of producing evidence and requiring the trier of fact to assume the existence of the presumed fact, unless credible evidence sufficient to sustain a finding of the nonexistence of the presumed fact is introduced, in which event, the existence or nonexistence of the presumed fact shall be determined from the evidence without regard to the presumption; or

- A presumption affecting the burden of proof that imposes upon the party against whom it operates the burden of proof concerning the nonexistence of the presumed fact. All rebuttable presumptions that are not defined as presumptions affecting the burden of producing evidence are presumptions affecting the burden of proof.

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[25] Board of Certification Examination for Athletic Trainers, Examination Review for 2009-2010 Testing Year, *available* at: http://www.bocatc.org/index.php?option=com_content&view=article&id=103&Itemid=109 (last viewed April 4, 2011).
[26] *Id.*
[27] *Id.*
[28] National Athletic Trainers Association, Get Certified, *available* at: http://www.nata.org/get-certified (last viewed April 4, 2011).
[29] *See* ss. 90.303 and 90.304, F.S.

Effects of the Bill

This bill encourages the use and employment of licensed certified athletic trainers (ATC) by school districts for schools that participate in sports. This requirement in effect codifies the DOH's current practice of satisfying the exam requirement for licensure through the BOC for the NATA. The bill clarifies that one full-time athletic trainer should be available in each high school that participates in sports.

This bill encourages the use of an entity which can coordinate placement of licensed, certified athletic trainers to provide a standard of care to prevent and rehabilitate high school sports-related injuries.

The bill provides a rebuttable presumption that a school district is not negligent in employing an athletic trainer if it made a good faith effort to comply with the requirements of s. 1012.46, F.S. The presumption applies in any civil action for the death, injury or damage to an individual who has received treatment for a sports injury from a licensed certified athletic trainer that is allegedly a result of negligence.

B. SECTION DIRECTORY:

Section 1. Amends s. 1012.46, F.S., relating to athletic trainers.
Section 2. Provides an effective date of July 1, 2011.

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.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

No additional rule making authority is necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to high school athletic trainers; amending s. 1012.46, F.S.; encouraging school districts to employ at least one full-time certified athletic trainer at each high school in this state; requiring athletic trainers at high schools to be certified by the Board of Certification of the National Athletic Trainers' Association; providing a rebuttable presumption that a school district did not negligently employ an athletic trainer for purposes of a civil action for negligence by the athletic trainer if the school district made a good faith effort to comply with the certification requirements for athletic trainers; providing legislative intent; providing an effective date.

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

Section 1. Section 1012.46, Florida Statutes, is amended to read:

1012.46 Athletic trainers.—

(1) School districts may establish and implement an athletic injuries prevention and treatment program. Central to this program should be the employment and availability of <u>licensed athletic trainers who are certified by the Board of Certification of the National Athletic Trainers' Association and</u> ~~persons~~ trained in the prevention and treatment of physical injuries that may occur during athletic activities. The program should reflect opportunities for progressive advancement and compensation in employment as provided in subsection (2) and

meet certain other minimum standards developed by the Department of Education. The goal of the Legislature is to have School districts employ and have available at least one ~~a~~ full-time athletic trainer in each high school in the state that participates in sports.

(2) To qualify as an athletic trainer, a person must be certified by the Board of Certification and licensed as required by part XIII of chapter 468 and may possess a professional, temporary, part-time, adjunct, or substitute certificate pursuant to s. 1012.35, s. 1012.56, or s. 1012.57.

(3) In a civil action against a school district for the death of, or injury or damage to, an individual which was allegedly caused by the negligence of an athletic trainer and which relates to the treatment of a sports injury by the athletic trainer, there is a rebuttable presumption that the school district was not negligent in employing the athletic trainer if the school district made a good faith effort to comply with the provisions of this section prior to such employment.

(4) It is the intent of this section to create and ensure a designated standard of care for the recognition, prevention, and rehabilitative treatment of high school athletic injuries in this state. To ensure compliance with this standard of care, the management and implementation of this program should be administered by an entity that has the ability to work with local facilities and school districts to coordinate the training, development, and placement of licensed athletic trainers who are certified by the Board of Certification.

Section 2. This act shall take effect July 1, 2011.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health & Human Services Quality Subcommittee

Representative(s) Rooney offered the following:

Amendment

Remove line 57 and insert:

Section 2. This act shall take effect August 1, 2011.