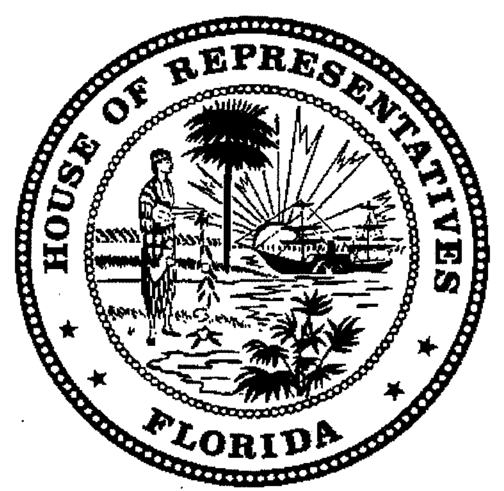

Healthcare Council

Tuesday, March 25, 2008
10:00 AM – 12:00 PM
Morris Hall

Marco Rubio
Speaker

Aaron Bean
Chair

Council Meeting Notice

HOUSE OF REPRESENTATIVES

Speaker Marco Rubio

Healthcare Council

Start Date and Time: Tuesday, March 25, 2008 10:00 am

End Date and Time: Tuesday, March 25, 2008 12:00 pm

Location: Morris Hall (17 HOB)
Duration: 2.00 hrs

Consideration of the following proposed council bill(s):

PCB HCC 08-23 -- Prescription Drug Donation Program

Consideration of the following bill(s):

HB 121 Special Observances by Brisé
HB 153 Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome Educational Requirements by Cusack
HB 243 Automated External Defibrillators by Anderson
HB 247 Nursing Facilities by Murzin
HB 333 Developmental Disabilities Institutions by Nehr
HB 341 Treatment Programs for Impaired Practitioners by Holder
HB 637 Electronic Health Records by Grimsley
HB 731 Personal Care Attendant Program by Gardiner
HB 989 Physician Assistants by Bogdanoff

Budget Workshop

Pursuant to rule 7.12, the deadline for amendments to bills on the agenda by non-appointed members shall be 6:00 p.m., Monday, March 24, 2008.

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., Monday, March 24, 2008.

NOTICE FINALIZED on 03/21/2008 16:12 by BAI

PCB HCC 08-23

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCC 08-23 Prescription Drug Donation Program
SPONSOR(S): Healthcare Council
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.: Healthcare Council		Owen	Gormley
1)			
2)			
3)			
4)			
5)			

SUMMARY ANALYSIS

The Proposed Council Bill amends the existing Cancer Drug Donation Program within the Department of Health, renaming it the Prescription Drug Donation Program. The proposed bill expands the type of drugs that may be donated, from cancer drugs and supplies to all non-schedule prescription drugs and supplies. The proposed bill expands the facilities that participate in the program, from a class II hospital pharmacy to any pharmacy or dispensing practitioner.

The proposed bill appears to have an insignificant fiscal impact to the Drug, Device, and Cosmetic Trust Fund (see fiscal analysis).

The proposed bill is effective July 1, 2008.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

The proposed bill does not seem to implicate any of the House Principles.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

Cancer Drug Donation Program
In 2006, the Legislature adopted the "Cancer Drug Donation Program Act."[1] The Department of Health (department) maintains the program under which a donor may donate cancer drugs or supplies used to administer cancer drugs to a participant facility for dispensing to eligible recipients.

Section 499.029(8), F.S., authorizes the department to adopt rules relating to recipient eligibility criteria, standards and procedures for participant facilities, forms for administration of the program, fees charged by a participant facility, categories of cancer drugs and supplies accepted in the program, and maintenance and distribution of the participant facility registry.

Recipient Eligibility Requirements
A Florida resident who is diagnosed with cancer and has a valid prescription from their physician is eligible to receive drugs or supplies through the Cancer Drug Donation Program (program). A person is ineligible to participate in the program if he or she is eligible to receive cancer drugs or supplies through the Medicaid program, third-party insurer, or any other prescription drug program funded in whole or in part by the Federal Government, unless these benefits have been exhausted, or a certain cancer drug or supply need is not covered by the program.[2]

According to the department, three people have received donated cancer drugs since the program began its operation.

Donor Eligibility Requirements
Cancer drugs and supplies may be donated to a participant facility by the following individuals or entities located within Florida:[3]

- A patient or a patient representative, donated through a closed drug delivery system[4] by the facility where the patient is receiving treatment;
- Health care facilities, nursing homes, hospices, or hospitals with a closed drug delivery system;
- Pharmacies, drug manufacturers, medical device manufacturers or suppliers, or wholesalers of drugs or supplies; or
- A licensed allopathic or osteopathic physician who receives cancer drugs or supplies directly from a pharmacy, drug manufacturer, or drug wholesaler.

Standards and Procedures for Participant Facilities
A Class II Institutional Pharmacy[5] (pharmacy) that accepts, stores, and dispenses donated cancer drugs and supplies may participate in the program.[6] Participation is voluntary. A pharmacy that elects

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[1] Ch. 2006-310, Laws of Florida
[2] Rule 64F-12.026, F.A.C. and section 499.029(9), F.S.
[3] Section 499.029(3)(d), F.S.
[4] Section 499.029(3)(b), F.S., defines a "closed drug delivery system" as a system in which the actual control of the unit-dose medication package is maintained by the facility rather than by the individual patient.
[5] Section 465.019(2)(b), F.S., defines "class II institutional pharmacies" as those institutional pharmacies which employ the services of a registered pharmacist who…shall provide dispensing and consulting services on the premises to patients of that institution, for use

to participate in the program must complete and submit a notice of participation form to the department. Likewise, a pharmacy may discontinue their participation in the program by completing and submitting to the department a notice of withdrawal form.

A participant pharmacy may decline to accept a donation. A cancer drug or supply may not be donated to a specific cancer patient.[7] A dispenser of donated cancer drugs or supplies is not allowed to submit a claim or seek reimbursement for donated products dispensed under the program. However, a participant pharmacy may charge the recipient of the drug or supply a handling fee of no more than 300% of the Medicaid dispensing fee or no more than $15, whichever is less, for each cancer drug or supply dispensed.[8]

The pharmacy must store the donated cancer drugs and supplies in a secure storage area under appropriate environmental conditions and may not be stored with non-donated inventory.[9] All donations must be dispensed by a licensed pharmacist. Prior to being dispensed, a pharmacist must inspect the cancer drug or supplies to determine that they do not appear to be tampered with or mislabeled.[10]

A donation form must be signed by the donor when cancer drugs or supplies are donated to a participant pharmacy. Before a cancer drug or supply is dispensed, the recipient must sign a form and be notified both orally and in writing that the product may have been previously dispensed.[11] These forms include the donor or recipient's name; the recipient or dispensing pharmacy's name; the medication; medication strength, expiration date, lot number, and quantity. Each time the pharmacy destroys a donated drug or supply, the person destroying the product must complete a destruction form that includes the medication name, strength, expiration date, lot number, and quantity. The pharmacy is required to keep all donor, recipient, and destruction records on file for at least three years.[12]

According to the department, as of March 20, 2008, there are three participating pharmacies: Lee Memorial Hospital, Inc., in Ft. Myers, Halifax Medical Center in Daytona Beach, and Florida Hospital Celebration Health in Celebration. Lee Memorial Hospital has received a total of four eligible cancer drug donations as of March 18, 2008 and Halifax Medical Center has received a total of three eligible cancer drug donations as of January 17, 2008. Florida Hospital Celebration Health was approved to participate on February 20, 2008, so they do not have any data to report to date. A total of seven eligible cancer drugs have been donated to participating pharmacies statewide.[13]

Standards and Categories of Cancer Drugs and Supplies Accepted in the Program

A cancer drug is eligible for donation under this program only if the drug:[14]

- Is in its original, unopened, sealed container, or in a tamper-evident[15] unit-dose packaging;
  - Single-unit dose drugs may be accepted if the single-unit dose packaging is unopened
- Has never been in the actual control of the patient, but rather has been maintained by a health care facility in a closed drug delivery system;
- Will not expire until at least six months after the donation is made;
- Is accompanied by a completed Cancer Drug Donation Program Donation and Destruction Record that is signed by the donor or that person's authorized representative.

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on the premises of that institution." However, section 499.029(4), F.S. states that a participant facility may provide dispensing and consulting services to individuals who are not patients of the hospital.

[6] Rule 64F-12.026(3), F.A.C.

[7] Section 499.029(4), F.S. and Rule 64F-12.026(3)(e)5., F.A.C.

[8] Section 499.029(7)(b), F.S. and Rule 64F-12.026(5), F.A.C.

[9] Rule 64F-12.026(3)(d), F.A.C.

[10] Section 499.029(5)(c), F.S.

[11] Rule 64F-12.026(3)(e)3., F.A.C.

[12] Rule 64F-12.026(f), F.A.C.

[13] Department of Health presentation to the House Health Quality Committee, February 19, 2008.

[14] Section 499.029(6)(a)-(b), F.S.

[15] Tamper evident packaging means a package that seals an individual pill in a plastic bubble typically with a foil backing.

Cancer drugs billed to and paid for by Medicaid in long-term care facilities are not eligible for donation unless they are not reimbursable by Medicaid. Controlled substances, such as morphine, oxycodone, or lorazepam, are not eligible for donation.[16]

Participant Facility Registry

The department is required in s. 499.029(10), F.S., to establish and maintain a participant facility registry on their website[17] which includes the participant facility's name, address, and telephone number. The department's website is also required to contain links to cancer drug manufacturers that offer drug assistance programs or free medication.[18]

Liability

Any donor of cancer drugs or participant in the program who exercises reasonable care in participating in the program is immune from civil or criminal liability and from professional disciplinary action for any injury, death, or loss to person or property relating to the program. A pharmaceutical manufacturer is not liable for a claim or injury arising from the transfer of a cancer drug donation.[19]

Insurance Status of Floridians

Lack of health insurance and other barriers to health care prevent many Floridians from receiving optimal medical care. According to the 2005 national health insurance survey data, there are approximately 3.7 million Floridians (or 21% of the population) who lack health insurance.

Health Insurance Coverage of the Total Population (2005-2006)

Source of Insurance	FL Population	%	U.S. Population	%
Employer	8,407,430	47%	158,515,473	54%
Individual	927,973	5%	14,515,865	5%
Medicaid	1,809,230	10%	37,994,482	13%
Medicare	2,778,367	16%	35,049,875	12%
Other Public	276,997	2%	2,986,514	1%
Uninsured	3,722,263	21%	46,994,627	16%
Total	17,922,260	100%	296,056,836	100%

(Source: Kaiser Foundation - Florida: Health Insurance Coverage of the Total Population, states 2005-2006, U.S. 2006)

Prescription Drug Donation Programs in Other States

A total of 26 states have authorized a prescription drug repository program (see Figure 1). Of those states, seven (including Florida) limit their program to cancer drugs. The other states have authorized different variations of prescription drug repository programs. For example, the state of Ohio allows all prescription drugs, except controlled substances and drug samples, which have been kept in a closed drug delivery system to be donated to a participating pharmacy, hospital, or nonprofit clinic.[20] And the state of Oklahoma allows all prescription drugs, except controlled substances, which have been kept in a closed drug delivery system to be transferred from residential care homes, nursing facilities, assisted living centers, public intermediate care facilities for people with mental retardation, or pharmaceutical manufacturers to pharmacies operated by a county.[21]

[16] Rule 64F-12.026(c)1., F.A.C.
[17] Found at http://www.doh.state.fl.us/mqa/DDC/Cancer/info_registry.pdf (last visited March 20, 2008).
[18] Found at http://www.doh.state.fl.us/mqa/DDC/Cancer/info_drugprogram.pdf (last visited March 20, 2008).
[19] Section 499.029(11) and (12), F.S.
[20] Rule 4729-35-02 and Rule 4729-35-04, Ohio Administrative Code
[21] Section 59-367.3, Oklahoma Statute

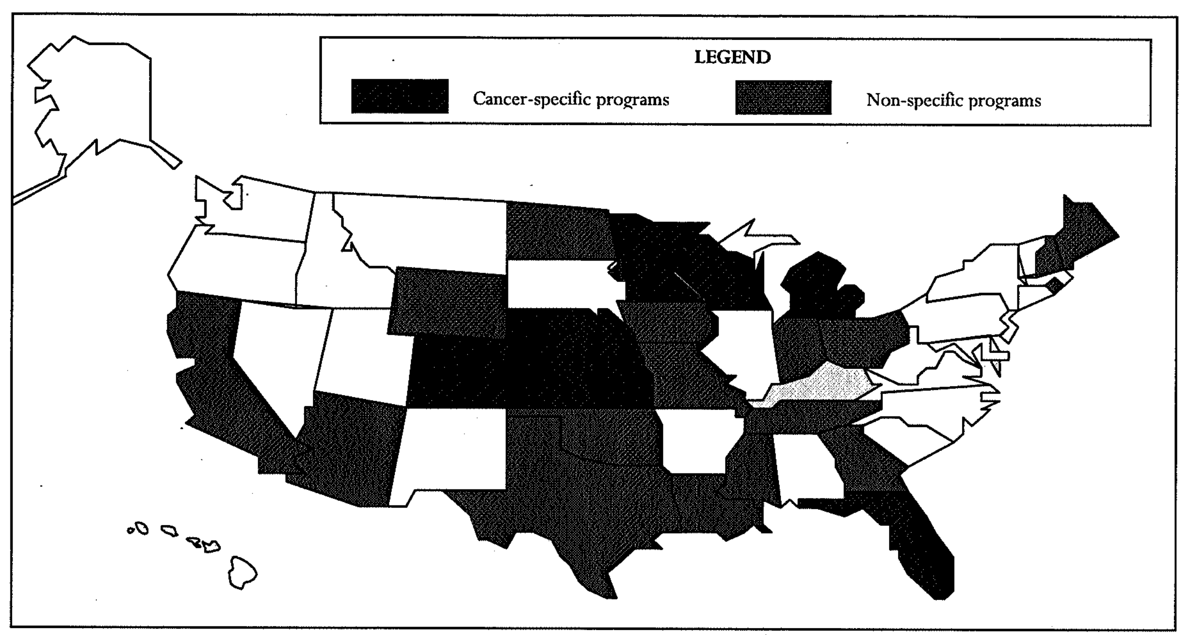

Figure 1[22]

Effect of Proposed Changes

The proposed bill amends the existing Cancer Drug Donation Program within the department by:
- Expanding the types of drugs that may be donated, from cancer drugs and supplies to all non-schedule prescription drugs and supplies.
- Expanding the facilities that participate in the program, from a class II hospital pharmacy to any pharmacy or dispensing practitioner.

The proposed bill deletes the definition of "department", as this term is defined for all of part I of chapter 499 in s. 499.003, F.S.

The proposed bill deletes the definition of "health care clinic", as this term is not substantively used in the statute creating the Cancer Drug Donation Program.

C. SECTION DIRECTORY:

Section 1: Amends s. 499.029, relating to the Prescription Drug Donation Program.

Section 2: Provides an effective date of July 1, 2008.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See fiscal comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

[22] Department of Health presentation to the House Health Quality Committee, February 19, 2008.

1. Revenues:

   None

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Pharmacies that participate will incur costs associated with processing, storage, dispensing, and disposal of the donated drugs and supplies. This cost could be recovered fully or in part by the handling fee authorized in the bill. However, if the donation program is not covered under an insurance program or coverage is exhausted a patient would incur the cost of the handling fee. Program participants may directly benefit through any reduced drug treatment costs and access to medications/supplies that they may not otherwise be able to afford.

D. FISCAL COMMENTS:

In 2006 the department was appropriated 1 full-time equivalent position, salary rate 42,715, and $65,308 from the Drug, Device, and Cosmetic Trust Fund to create and maintain the registry, to provide consultation and technical assistance, and to perform other administrative functions. Because of the extended scope of the bill, additional staff may be needed to support the program depending upon the rate of participation. However, there is very limited participation in the current program. As of January 2008, there were only two participating facilities and they have processed a total of seven donations.

In addition, the Medicaid program may realize a higher incidence of medications being credited back to the program because of the expansion.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenues.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill appears to provide adequate rulemaking authority for the department.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The Department of Health suggested the following amendments:

- The term "dispensing practitioner" is not otherwise defined in chapter 499, part I, F.S.

  Remove line 32 and insert:

  (b) "Dispensing Practitioner" means a practitioner authorized by law to prescribe drugs, and may dispense such drugs to his or her patients in the regular course of his or her practice as provided in s. 465.0276.

  (c) "Donor" means a patient or patient representative

- A pharmacist or dispensing practitioner provide dispensing and "counseling" services. As written, the proposed bill provides that the participant may provide dispensing and counseling services to an individual who is not a patient of the participant. This amendment is offered to clarify that the individual must be an "eligible recipient" under this program.

  Remove lines 85 - 86 and insert:

  participant ~~facility~~ may provide dispensing and counseling ~~consulting~~ services to an eligible recipient ~~individuals~~ who is ~~are~~ not a patient

D. STATEMENT OF THE SPONSOR

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to the Prescription Drug Donation Program;
3 amending s. 499.029, F.S.; expanding the drugs and
4 supplies that may be donated under the program; expanding
5 the types of facilities that may participate in the
6 program; providing an effective date.
7
8 Be It Enacted by the Legislature of the State of Florida:
9
10 Section 1. Section 499.029, Florida Statutes, is amended
11 to read:
12 499.029 Prescription ~~Cancer~~ Drug Donation Program.--
13 (1) This section may be cited as the "Prescription ~~Cancer~~
14 Drug Donation Program Act."
15 (2) There is created a Prescription ~~Cancer~~ Drug Donation
16 Program within the department ~~of Health~~ for the purpose of
17 authorizing and facilitating the donation of prescription ~~cancer~~
18 drugs and supplies to eligible patients.
19 (3) As used in this section:
20 ~~(a) "Cancer drug" means a prescription drug that has been~~
21 ~~approved under s. 505 of the federal Food, Drug, and Cosmetic~~
22 ~~Act and is used to treat cancer or its side effects or is used~~
23 ~~to treat the side effects of a prescription drug used to treat~~
24 ~~cancer or its side effects. "Cancer drug" does not include a~~
25 ~~substance listed in Schedule II, Schedule III, Schedule IV, or~~
26 ~~Schedule V of s. 893.03.~~
27 (a) ~~(b)~~ "Closed drug delivery system" means a system in
28 which the actual control of the unit-dose medication package is

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

V

29 maintained by the facility rather than by the individual
30 patient.
31 ~~(c) "Department" means the Department of Health.~~
32 (b) ~~(d)~~ "Donor" means a patient or patient representative
33 who donates prescription ~~cancer~~ drugs or supplies needed to
34 administer prescription ~~cancer~~ drugs that have been maintained
35 within a closed drug delivery system; health care facilities,
36 nursing homes, hospices, or hospitals with closed drug delivery
37 systems; or pharmacies, drug manufacturers, medical device
38 manufacturers or suppliers, or wholesalers of drugs or supplies,
39 in accordance with this section. "Donor" includes a physician
40 licensed under chapter 458 or chapter 459 who receives cancer
41 drugs or supplies directly from a drug manufacturer, drug
42 wholesaler, or pharmacy.
43 (c) ~~(e)~~ "Eligible patient" means a person who the
44 department determines is eligible to receive prescription ~~cancer~~
45 drugs from the program.
46 (d) ~~(f)~~ "Health care facility" means a health care facility
47 licensed under chapter 395.
48 ~~(g) "Health care clinic" means a health care clinic~~
49 ~~licensed under part X of chapter 400.~~
50 (e) ~~(h)~~ "Hospice" means a corporation licensed under part
51 IV of chapter 400.
52 (f) ~~(i)~~ "Hospital" means a facility as defined in s.
53 395.002 and licensed under chapter 395.
54 (g) ~~(j)~~ "Nursing home" means a facility licensed under part
55 II of chapter 400.

56 (h)~~(k)~~ "Participant ~~facility~~" means a ~~class II hospital~~
57 pharmacy or dispensing practitioner that has elected to
58 participate in the program and that accepts donated prescription
59 ~~cancer~~ drugs and supplies under the rules adopted by the
60 department for the program.
61 (i)~~(l)~~ "Pharmacist" means a person licensed under chapter
62 465.
63 (j)~~(m)~~ "Pharmacy" means an entity licensed under chapter
64 465.
65 (k)~~(n)~~ "Prescribing practitioner" means a physician
66 licensed under chapters ~~chapter~~ 458 or 459 or any other medical
67 professional with authority under state law to prescribe drugs
68 ~~cancer medication~~.
69 (l)~~(o)~~ "Prescription drug" does not include a substance
70 listed in Schedule II, Schedule III, Schedule IV, or Schedule V
71 of s. 893.03.~~means a drug as defined in s. 465.003(8).~~
72 (m)~~(p)~~ "Program" means the Prescription ~~Cancer~~ Drug
73 Donation Program created by this section.
74 (n)~~(q)~~ "Supplies" means any supplies used in the
75 administration of a prescription ~~cancer~~ drug.
76 (4) Any donor may donate ~~cancer~~ drugs or supplies to a
77 participant ~~facility~~ that elects to participate in the program
78 and meets criteria established by the department for such
79 participation. Prescription ~~Cancer~~ drugs or supplies may not be
80 donated to a specific ~~cancer~~ patient, and donated prescription
81 drugs or supplies may not be resold by the participant ~~program~~.
82 Prescription ~~Cancer~~ drugs billed to and paid for by Medicaid in
83 long-term care facilities that are eligible for return to stock

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

84 under federal Medicaid regulations shall be credited to Medicaid
85 and are not eligible for donation under the program. A
86 participant ~~facility~~ may provide dispensing and consulting
87 services to an individual ~~individuals~~ who is ~~are~~ not a patient
88 ~~patients~~ of the participant ~~hospital~~.
89 (5) The prescription ~~cancer~~ drugs or supplies donated to
90 the program may be prescribed only by a prescribing practitioner
91 for use by an eligible patient and may be dispensed only by a
92 pharmacist or a dispensing practitioner.
93 (6)(a) A prescription ~~cancer~~ drug may only be accepted or
94 dispensed under the program if the drug is in its original,
95 unopened, sealed container, or in a tamper-evident unit-dose
96 packaging, except that a prescription ~~cancer~~ drug packaged in
97 single-unit doses may be accepted and dispensed if the outside
98 packaging is opened but the single-unit-dose packaging is
99 unopened with tamper-resistant packaging intact.
100 (b) A prescription ~~cancer~~ drug may not be accepted or
101 dispensed under the program if the drug bears an expiration date
102 that is less than 6 months after the date the drug was donated
103 or if the drug appears to have been tampered with or mislabeled
104 as determined in paragraph (c).
105 (c) Prior to being dispensed to an eligible patient, the
106 prescription ~~cancer~~ drug or supplies donated under the program
107 shall be inspected by a pharmacist or dispensing practitioner to
108 determine that the drug and supplies do not appear to have been
109 tampered with or mislabeled.
110 (d) A dispenser of donated prescription ~~cancer~~ drugs or
111 supplies may not submit a claim or otherwise seek reimbursement

112 from any public or private third-party payor for donated
113 prescription ~~cancer~~ drugs or supplies dispensed to any patient
114 under the program, and a public or private third-party payor is
115 not required to provide reimbursement to a dispenser for donated
116 prescription ~~cancer~~ drugs or supplies dispensed to any patient
117 under the program.
118 (7)(a) A donation of prescription ~~cancer~~ drugs or supplies
119 shall be made only at a participant's ~~participant~~ facility. A
120 participant ~~facility~~ may decline to accept a donation. A
121 participant ~~facility~~ that accepts donated prescription ~~cancer~~
122 drugs or supplies under the program shall comply with all
123 applicable provisions of state and federal law relating to the
124 storage and dispensing of the donated prescription ~~cancer~~ drugs
125 or supplies.
126 (b) A participant ~~facility~~ that voluntarily takes part in
127 the program may charge a handling fee sufficient to cover the
128 cost of preparation and dispensing of prescription ~~cancer~~ drugs
129 or supplies under the program. The fee shall be established in
130 rules adopted by the department.
131 (8) The department, upon the recommendation of the Board
132 of Pharmacy, shall adopt rules to carry out the provisions of
133 this section. Initial rules under this section shall be adopted
134 no later than 90 days after the effective date of this act. The
135 rules shall include, but not be limited to:
136 (a) Eligibility criteria, including a method to determine
137 priority of eligible patients under the program.

138 (b) Standards and procedures for participants ~~participant~~
139 ~~facilities~~ that accept, store, distribute, or dispense donated
140 prescription ~~cancer~~ drugs or supplies.
141 (c) Necessary forms for administration of the program,
142 including, but not limited to, forms for use by entities that
143 donate, accept, distribute, or dispense prescription ~~cancer~~
144 drugs or supplies under the program.
145 (d) The maximum handling fee that may be charged by a
146 participant ~~facility~~ that accepts and distributes or dispenses
147 donated prescription ~~cancer~~ drugs or supplies.
148 (e) Categories of prescription ~~cancer~~ drugs and supplies
149 that the program will accept for dispensing; however, the
150 department may exclude any drug based on its therapeutic
151 effectiveness or high potential for abuse or diversion.
152 (f) Maintenance and distribution of the participant
153 ~~facility~~ registry established in subsection (10).
154 (9) A person who is eligible to receive prescription
155 ~~cancer~~ drugs or supplies under the state Medicaid program or
156 under any other prescription drug program funded in whole or in
157 part by the state, by any other prescription drug program funded
158 in whole or in part by the Federal Government, or by any other
159 prescription drug program offered by a third-party insurer,
160 unless benefits have been exhausted, or a certain prescription
161 ~~cancer~~ drug or supply is not covered by the prescription drug
162 program, is ineligible to participate in the program created
163 under this section.
164 (10) The department shall establish and maintain a
165 participant ~~facility~~ registry for the program. The participant

166 ~~facility~~ registry shall include the participant's ~~participant~~
167 ~~facility's~~ name, address, and telephone number. The department
168 shall make the participant ~~facility~~ registry available on the
169 department's website to any donor wishing to donate prescription
170 ~~cancer~~ drugs or supplies to the program. The department's
171 website shall also contain links to prescription ~~cancer~~ drug
172 manufacturers that offer drug assistance programs or free
173 medication.
174 (11) Any donor of prescription ~~cancer~~ drugs or supplies,
175 or any participant in the program, who exercises reasonable care
176 in donating, accepting, distributing, or dispensing prescription
177 ~~cancer~~ drugs or supplies under the program and the rules adopted
178 under this section shall be immune from civil or criminal
179 liability and from professional disciplinary action of any kind
180 for any injury, death, or loss to person or property relating to
181 such activities.
182 (12) A pharmaceutical manufacturer is not liable for any
183 claim or injury arising from the transfer of any prescription
184 ~~cancer~~ drug under this section, including, but not limited to,
185 liability for failure to transfer or communicate product or
186 consumer information regarding the transferred drug, as well as
187 the expiration date of the transferred drug.
188 (13) If any conflict exists between the provisions in this
189 section and the provisions in this chapter or chapter 465, the
190 provisions in this section shall control the operation of the
191 ~~Cancer Drug Donation~~ program.
192 Section 2. This act shall take effect July 1, 2008.

Amendment No. 01 (for drafter's use only)

Bill No. **PCB HCC 08-23**

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)
ADOPTED AS AMENDED __ (Y/N)
ADOPTED W/O OBJECTION __ (Y/N)
FAILED TO ADOPT __ (Y/N)
WITHDRAWN __ (Y/N)
OTHER ______

---

1 Council/Committee hearing bill: Healthcare Council
2 Representative Harrell offered the following:
3
4 **Amendment**
5 Remove line 32 and insert:
6 (c) "Dispensing Practitioner" means a practitioner
7 registered under s. 465.0276.
8 d) "Donor" means a patient or patient representative
9
10

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 02 (for drafter's use only)

Bill No. **PCB HCC 08-23**

COUNCIL/COMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	____	

Council/Committee hearing bill: Healthcare Council

Representative Harrell offered the following:

Amendment

Remove lines 85-86 and insert:

participant ~~facility~~ may provide dispensing and counseling ~~consulting~~ services to an eligible patient ~~individuals~~ who is ~~are~~ not a patient

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 121 Special Observances
SPONSOR(S): Brisé
TIED BILLS: **IDEN./SIM. BILLS:** SB 78

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Healthy Families	8 Y, 0 N	Preston	Schoolfield
2) Healthcare Council		Preston	Gormley
3)			
4)			
5)			

SUMMARY ANALYSIS

The bill designates the second Monday in May of each year as "Child Welfare Professionals Recognition Day," to recognize the efforts of all professionals who work with abused children and dysfunctional families. The bill encourages the Department of Children and Family Services and other agencies, as well as local governments, to sponsor events to promote awareness of the child welfare system and to recognize those individuals who work in this area.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

The bill does not appear to implicate any of the House Principles.

B. EFFECT OF PROPOSED CHANGES:

Chapter 683, Florida Statutes, relates to legal holidays and special observances. Section 683.01, Florida Statutes, designates 21 legal holidays,[1] while other provisions in ss. 683.04-683.325, Florida Statutes, designate special observances[2] or explain the significance of certain legal holidays.[3] Additionally, legal holidays for specific counties in the state are listed in the chapter.[4] Section 683.01, Florida Statutes, does not authorize state offices to be closed, nor does it authorize the designated days as paid holidays for state employees. The nine holidays that are paid holidays for state employees are listed in s.110.117, Florida Statutes.[5]

The bill designates the second Monday in May of each year as "Child Welfare Professionals Recognition Day," to recognize the efforts of all professionals who work with abused children and dysfunctional families. The bill encourages the Department of Children and Family Services and other agencies, as well as local governments, to sponsor events to promote awareness of the child welfare system and to recognize those individuals who work in this area.

C. SECTION DIRECTORY:

Section 1. Creates s. 683.34, Florida Statutes, relating to "Child Welfare Professionals Recognition Day."

Section 2. Provides for an effective date of upon becoming law.

---

[1] The legal holidays named in s. 683.01, F.S., are: (a) Sunday, the first day of each week; (b) New Year's Day, January 1; (c) Birthday of Martin Luther King, January 15; (d) Birthday of Robert E. Lee, January 19; (e) Lincoln's Birthday, February 12; (f) Susan B. Anthony's Birthday, February 15; (g) Washington's Birthday, the third Monday in February; (h) Good Friday; (i) Pascua Florida Day, April 2; (j) Confederate Memorial Day, April 26; (k) Memorial Day, the last Monday in May; (l) Birthday of Jefferson Davis, June 3; (m) Flag Day, June 14; (n) Independence Day, July 4; (o) Labor Day, the first Monday in September; (p) Columbus Day and Farmers' Day, the second Monday in October; (q) Veterans' Day, November 11; (r) General Election Day; (s) Thanksgiving Day, the fourth Thursday in November; (t) Christmas Day, December 25; and (u) Shrove Tuesday.

[2] See Section 683.04, F.S. (Arbor Day), Section 683.05, F.S. (Pan-American Day), Section 683.10, F.S. (Grandmother's Day), Section 683.11, F.S. (Law Enforcement Appreciation Month), Section 683.115, F.S. (Law Enforcement Memorial Day), Section 683.13, F.S. (National Day of Mourning), Section 683.14, F.S. (Patriots' Day), Section 683.145, F.S. (I Am An American Day), Section 683.15, F.S. (Teacher's Day), Section 683.16, F.S. (Retired Teachers' Day), Section 683.17, F.S. (Children's Day), Section 683.18, F.S. (Save the Florida Panther Day), Section 683.21, F.S. (Juneteenth Day), Section 683.22, F.S. (Law Day and Law Week), Section 683.23, F.S. (Florida Missing Children's Day), Section 683.24 F.S. (Florida Alzheimer's Disease Day); Section 683.25 (Bill of Rights Day); and 683.325 (Homeless Persons' Memorial Day).

[3] See Section 683.06 (discussing Pascua Florida Day), and Section 683.19, F.S. (providing that the chief judge in each judicial circuit may declare Rosh Hashanah, Yom Kippur, and Good Friday as legal holidays for the courts within the circuit).

[4] See Section 683.08, F.S. (designating Gasparilla Day as a legal holiday in Hillsborough County), Section 683.09, F.S. (designating Desoto Day as a legal holiday in Manatee County), and Section 683.12, F.S. (designating Parade Day as a legal holiday in Hillsborough County).

[5] The following holidays are paid holidays observed by all state branches and agencies: (a) New Year's Day; (b) Birthday of Martin Luther King, third Monday in January; (c) Memorial Day; (d) Independence Day; (e) Labor Day; (f) Veterans' Day, November 11; (g) Thanksgiving Day; (h) Friday after Thanksgiving; and (i) Christmas Day.

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 phrase "abused children and dysfunctional families" on lines 14-15 of the bill may not accurately or adequately capture those individuals served by child welfare professionals.

It is unclear who would be included in the category of "professionals" and "personnel" on lines 14 and 18 of the bill, respectively.

D. STATEMENT OF THE SPONSOR

No sponsor statement was submitted.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to special observances; creating s.
3 683.34, F.S.; designating the second Monday in May as
4 "Child Welfare Professionals Recognition Day"; providing
5 an effective date.
6
7 Be It Enacted by the Legislature of the State of Florida:
8
9 Section 1. Section 683.34, Florida Statutes, is created to
10 read:
11 683.34 Child Welfare Professionals Recognition Day.--The
12 second Monday in May of each year is designated as "Child
13 Welfare Professionals Recognition Day" to recognize the efforts
14 of all professionals who work with abused children and
15 dysfunctional families. The Department of Children and Family
16 Services, local governments, and other agencies are encouraged
17 to sponsor events to promote awareness of the child welfare
18 system and recognize the personnel who work in the system.
19 Section 2. This act shall take effect upon becoming a law.

Bill No. **121**

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)
ADOPTED AS AMENDED __ (Y/N)
ADOPTED W/O OBJECTION __ (Y/N)
FAILED TO ADOPT __ (Y/N)
WITHDRAWN __ (Y/N)
OTHER ______

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1 Council hearing bill: Healthcare Council
2 Representative Brise offered the following:
3
4 **Amendment (with title amendment)**
5 Remove everything after the enacting clause and insert:
6 Section 1. Section 683.34, Florida Statutes, is created to
7 read:
8 683.34 Child Welfare Professionals Recognition Day.-- The
9 second Monday in May of each year is designated as "Child
10 Welfare Professionals Recognition Day" to recognize the efforts
11 of all professionals who work with children and families who
12 have been, or are at risk of being, affected by abuse,
13 abandonment, or neglect. The Department of Children and Family
14 Services, local governments, and other agencies are encouraged
15 to sponsor events to promote awareness of the child welfare
16 system and recognize the professionals who work in the system.
17 Section 2. This act shall take effect upon becoming a law.
18
19
20 ---
21 **T I T L E A M E N D M E N T**
22 Remove the entire title and insert:

Amendment No. 1 (for drafter's use only)

23 An act relating to special observances; creating s. 683.34,
24 F.S.; designating the second Monday in May as "Child Welfare
25 Professionals Recognition Day"; providing an effective date.
26

HB 153

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 153 Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome Educational Requirements
SPONSOR(S): Cusack and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 646

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Health Quality	12 Y, 0 N	Owen	Lowell
2) Healthcare Council		Owen	Gormley
3) Policy & Budget Council			
4)			
5)			

SUMMARY ANALYSIS

This bill modifies the requirement for completion of a continuing educational course on HIV and AIDS from biennial to one-time for employees and clients of developmental disability facilities, mental health facilities, or substance abuse facilities, and employees of hospitals, nursing homes, home health agencies, hospices, or assisted living facilities.

The bill specifies that an employee who has completed an HIV and AIDS educational course is not required to repeat the course upon changing employment to a different facility. The educational course requirement does not apply to acupuncturists, physicians, osteopathic physicians, chiropractors, podiatrists, optometrists, nurses, pharmacists, dentists, dental hygienists, nursing home administrators, occupational therapists, respiratory therapists, dieticians, nutritionists, or physical therapists, who must follow the requirements for instruction on HIV and AIDS found in s. 456.033, F.S.

The bill also requires each nurse registry to obtain proof of completion of a continuing educational course on HIV and AIDS in the application form of every applicant for contract.
The bill does not appear to have a fiscal impact on state or local governments.

The bill takes effect July 1, 2008.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

The bill does not appear to implicate any of the House principles.

B. EFFECT OF PROPOSED CHANGES:

Present Situation:

Continuing Educational Course on HIV and AIDS

All employees and clients of facilities licensed under chapters 393 (developmental disability facilities), 394 (mental health facilities), or 397 (substance abuse facilities), F.S., and employees of facilities licensed under chapter 395 (hospitals), F.S., part II (nursing homes), part III (home health agencies), or part IV (hospices) of chapter 400, F.S., or part I (assisted living facilities) of chapter 429, F.S., are required by the Department of Health (department) to biennially complete a continuing educational course on the transmission, infection control procedures, clinical management, and prevention of HIV and AIDS. New employees are also required to complete a similar educational course on HIV and AIDS.

In 2006,[1] the Legislature repealed the biennial educational course on HIV/AIDS as a requirement of re-licensure for certain health care practitioners licensed under chapter 456, F.S.,[2] and, instead, required a one-time educational course on HIV/AIDS. However, the requirement for facility employees to complete the biennial educational course on HIV/AIDS remained in statute. Consequently, those health care practitioners who are employed in certain facilities are still required to complete the biennial HIV and AIDS course, despite the fact that the requirement was repealed for most professions in 2006.

Licensure of Nurse Registries

Nurse registries provide skilled and personal care. Nurse registries are set-up differently than home health agencies in that they hire independent contractors who are registered nurses, certified nurse assistants (CNA), home health aides, licensed practical nurses, homemakers, or companions to provide services to patients in their homes. These individuals are not direct employees of the nurse registry, but are independent contractors. A patient contracts with a nurse registry and the independent contractors for services. The patient makes a direct contract with the individual contractor sent from the nurse registry.

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[1] House Bill 699; Chapter 2006-251, L.O.F.

[2] Health care professionals who are required in s. 456.033, F.S. to complete a one-time HIV/AIDS educational course include: acupuncturists (chapter 457, F.S.), physicians (chapter 458, F.S.), osteopathic physicians (chapter 459, F.S.), chiropractors (chapter 460, F.S.), podiatrists (chapter 461, F.S.), optometrists (chapter 463, F.S.), nurses (part I of chapter 464, F.S.), pharmacists (chapter 465, F.S.), dentists and dental hygienists (chapter 466, F.S.), nursing home administrators (part II of chapter 468, F.S.), occupational therapists (part III of chapter 468, F.S.), respiratory therapists (part V of chapter 468, F.S.), dieticians and nutritionists (part X of chapter 468, F.S.), and physical therapists (chapter 486, F.S.). However, s. 456.034, F.S., maintains the biennial HIV/AIDS educational course requirement for athletic trainers and massage therapists.

A nurse registry is required to obtain the following information from the independent contractors they refer: name, address, date of birth, and social security number; educational background and employment history; number and date of the applicable license or certification and renewal information.

On April 10, 2006, the Joint Administrative Procedures Committee (JAPC) sent a letter to the Agency for Health Care Administration (agency) providing comments on the agency's proposed amendment to Rule 59A-18.0081(11). This proposed amendment required CNA's and home health aides referred by nurse registries to have completed a continuing education course biennially on HIV/AIDS pursuant to s. 381.0035, F.S. The JAPC advised the agency that s. 381.0035, F.S., states "The department [of health] may adopt rules to carry out the provisions of this section." Accordingly, the JAPC requested the agency to "provide the specific rulemaking authority to adopt rules to implement this statute." Following the JAPC inquiry, the agency changed its proposed rule to strike this course requirement.

Effect of Proposed Changes:

This bill amends s. 381.0035, F.S., to require all employees and clients of facilities licensed under chapters 393, 394, or 397, F.S., and employees of facilities licensed under chapter 395, F.S., part II, part III, or part IV of chapter 400, F.S., or part I of chapter 429, F.S., to complete a one-time educational course on the transmission, infection control procedures, clinical management, and prevention of HIV and AIDS. The proposed changes in this bill will standardize the HIV and AIDS course requirement for most health care practitioners and employees of health care facilities.

The bill exempts an employee from repeating the HIV and AIDS educational course upon changing employment to a different facility. The bill also exempts an employee who is subject to the HIV and AIDS course requirements found in s. 456.033, F.S, from the course requirements in the bill.

The bill also amends s. 400.506, F.S., to direct each nurse registry to require every applicant for contract to include proof of completion of a continuing educational course on HIV and AIDS in their application form.

C. SECTION DIRECTORY:

Section 1. Amends s. 381.0035, F.S., relating to educational courses on HIV and AIDS for employees and clients of specified licensed health care facilities.

Section 2. Amends s. 400.506, F.S., relating to licensure of nurse registries.

Section 3. Provides an effective date of July 1, 2008.

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:

There is a potential revenue loss to entities that provide an HIV and AIDS course for a fee.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable because the bill does not appear to require counties or cities to spend funds or take action requiring the expenditure of funds; reduce the authority that cities or counties have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with cities or counties.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The agency and department have sufficient rulemaking authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

D. STATEMENT OF THE SPONSOR

I am proud to sponsor this good bill. It provides consistency in training for healthcare professionals regardless of where they work. It makes it easier for individuals who work in the various types of facilities and healthcare settings to follow the same rules and guidelines for HIV/AIDS education.

Based on the recommendation of committee staff, I will be offering a technical amendment to HB 153 which clarifies that an employee, whether new or an existing staff member, will have the same HIV/AIDS training requirement. However, employers if they prefer will have the flexibility to offer more training to employees than is mandated by my bill.

I appreciate the opportunity to present this important legislation.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

On December 11, 2007, the Health Quality Committee adopted one amendment to the bill. The amendment removes the reference to "new employees" and clarifies that the one-time HIV/AIDS course requirement applies to all employees of the facilities listed. It also removes the reference to a certificate received by those who complete the course. Finally, the amendment clarifies that the bill does not apply to an employee subject to the educational requirements of s. 456.033, F.S.
The bill was reported favorably with recommended Council Substitute.

1 A bill to be entitled
2 An act relating to human immunodeficiency virus and
3 acquired immune deficiency syndrome educational
4 requirements; amending s. 381.0035, F.S.; revising
5 requirements relating to educational courses on HIV and
6 AIDS for certain employees and clients of specified
7 licensed health care facilities; specifying applicability;
8 amending s. 400.506, F.S.; revising requirements with
9 respect to educational courses on HIV and AIDS for nurse
10 registries; providing an effective date.
11
12 Be It Enacted by the Legislature of the State of Florida:
13
14 Section 1. Section 381.0035, Florida Statutes, is amended
15 to read:
16 381.0035 Educational course on HIV and AIDS; employees and
17 clients of certain health care facilities.--
18 (1) The Department of Health shall require all employees
19 and clients of facilities licensed under chapter ~~chapters~~ 393,
20 chapter 394, or chapter ~~and~~ 397 and employees of facilities
21 licensed under chapter 395, part ~~parts~~ II, part III, or part ~~and~~
22 IV of chapter 400, or ~~and~~ part I of chapter 429 to complete~~,~~
23 ~~biennially,~~ a one-time ~~continuing~~ educational course on the
24 modes of transmission, infection control procedures, clinical
25 management, and prevention of human immunodeficiency virus and
26 acquired immune deficiency syndrome with an emphasis on
27 appropriate behavior and attitude change. Such instruction shall
28 include information on current Florida law and its impact on

29 testing, confidentiality of test results, and treatment of
30 patients and any protocols and procedures applicable to human
31 immunodeficiency counseling and testing, reporting, the offering
32 of HIV testing to pregnant women, and partner notification
33 issues pursuant to ss. 381.004 and 384.25.
34 (2) New employees shall be required to complete or provide
35 proof that they have completed a course on human
36 immunodeficiency virus and acquired immune deficiency syndrome,
37 with instruction to include information on current Florida law
38 and its impact on testing, confidentiality of test results, and
39 treatment of patients. Upon completing training on human
40 immunodeficiency virus and acquired immune deficiency syndrome,
41 a certificate shall be issued. The certificate shall be evidence
42 of completion of training, and the employee is not required to
43 repeat training in that topic upon changing employment to a
44 different facility licensed under chapter 393, chapter 394,
45 chapter 395, or chapter 397, part II, part III, or part IV of
46 chapter 400, or part I of chapter 429.
47 (3) Facilities licensed under chapter ~~chapters~~ 393,
48 chapter 394, chapter 395, or chapter ~~and~~ 397, part ~~parts~~ II,
49 part III, or part ~~and~~ IV of chapter 400, or ~~and~~ part I of
50 chapter 429 shall maintain a record of employees and dates of
51 attendance at human immunodeficiency virus and acquired immune
52 deficiency syndrome educational courses.
53 (4) The department shall have the authority to review the
54 records of each facility to determine compliance with the
55 requirements of this section. The department may adopt rules to
56 carry out the provisions of this section.

57 (5) This section does not apply to an employee who is
58 licensed or certified under chapter 458, chapter 459, chapter
59 461, part I of chapter 464, part II of chapter 468, or chapter
60 486. However, the employee must comply with the human
61 immunodeficiency virus and acquired immune deficiency syndrome
62 educational requirements for the employee's profession.
63 Section 2. Paragraph (e) is added to subsection (8) of
64 section 400.506, Florida Statutes, to read:
65 400.506 Licensure of nurse registries; requirements;
66 penalties.--
67 (8) Each nurse registry must require every applicant for
68 contract to complete an application form providing the following
69 information:
70 (e) Proof of completion of a continuing educational course
71 on modes of transmission, infection control procedures, clinical
72 management, and prevention of human immunodeficiency virus and
73 acquired immune deficiency syndrome with an emphasis on
74 appropriate behavior and attitude change. Such instruction shall
75 include information on current Florida law and its impact on
76 testing, confidentiality of test results, and treatment of
77 patients and any protocols and procedures applicable to human
78 immunodeficiency counseling and testing, reporting, offering HIV
79 testing to pregnant women, and partner notification issues
80 pursuant to ss. 381.004 and 384.25.
81 Section 3. This act shall take effect July 1, 2008.

Bill No. **153**

COUNCIL/COMMITTEE ACTION

ADOPTED ___ (Y/N)

ADOPTED AS AMENDED ___ (Y/N)

ADOPTED W/O OBJECTION ___ (Y/N)

FAILED TO ADOPT ___ (Y/N)

WITHDRAWN ___ (Y/N)

OTHER ______

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1 Council/Committee hearing bill: Healthcare Council
2 Committee on Health Quality offered the following:
3
4 **Amendment (with directory and title amendments)**
5 Remove line(s) 33-62 and insert:
6 issues pursuant to ss. 381.004 and 384.25. An employee who has
7 completed the educational course required in this subsection is
8 not required to repeat the course upon changing employment to a
9 different facility licensed under chapter 393, chapter 394,
10 chapter 395, or chapter 397, part II, part III, or part IV of
11 chapter 400, or part I of chapter 429.
12 ~~(2) New employees shall be required to complete a course~~
13 ~~on human immunodeficiency virus and acquired immune deficiency~~
14 ~~syndrome, with instruction to include information on current~~
15 ~~Florida law and its impact on testing, confidentiality of test~~
16 ~~results, and treatment of patients.~~
17 (2) ~~(3)~~ Facilities licensed under chapter ~~chapters~~ 393,
18 chapter 394, chapter 395, or chapter ~~and~~ 397, part ~~parts~~ II,
19 part III, or part ~~and~~ IV of chapter 400, or ~~and~~ part I of
20 chapter 429 shall maintain a record of employees and dates of

This amendment was adopted in HQ on 12/11/07 and is traveling with the bill and requires no further action.

21 attendance at human immunodeficiency virus and acquired immune
22 deficiency syndrome educational courses.
23 (3) ~~(4)~~ The department shall have the authority to review
24 the records of each facility to determine compliance with the
25 requirements of this section. The department may adopt rules to
26 carry out the provisions of this section.
27 (4) This section does not apply to an employee who is
28 subject to the requirements of s. 456.033.
29
30
31
32

This amendment was adopted in HQ on 12/11/07 and is traveling with the bill and requires no further action.

Amendment No. 02 (for drafter's use only)

Bill No. **153**

COUNCIL/COMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	____	

---

1 Council/Committee hearing bill: Healthcare Council
2 Representative Cusack offered the following:
3
4 **Amendment**
5 Remove line 78 and insert:
6 immunodeficiency virus counseling and testing, reporting,
7 offering HIV
8
9

HB 243

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 243 Automated External Defibrillators
SPONSOR(S): Anderson and others
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Health Quality	11 Y, 0 N	Owen	Lowell
2) Healthcare Council		Owen	Gormley
3)			
4)			
5)			

SUMMARY ANALYSIS

An Automated External Defibrillator (AED) is a small, lightweight device used to assess a person's heart rhythm and, if necessary, administer an electronic shock to restore a normal heart rhythm in a victim of cardiac arrest.

The bill broadens the scope of those who are required to receive training in the use of an AED by removing provisions requiring a person who uses an AED to obtain proper training that includes demonstrated proficiency in the use of an AED and, instead, requires any "person or entity in possession" of an AED to properly maintain and test the device and provide training to anyone who is expected to be a potential user of the AED.

The bill encourages persons who possess an AED to notify, rather than register with, the local emergency medical services director of the location of the device.

The bill broadens the civil immunity provided under the Cardiac Arrest Survival Act for harm resulting from the use of an AED by removing several provisions which specify instances when a person and an acquirer of the device are not immune from civil liability.

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

The bill provides an effective date of July 1, 2008.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

This bill does not appear to implicate any of the House Principles.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

Use of an AED

The American Heart Association (AHA) describes cardiac arrest as "the sudden, abrupt loss of heart function. The victim may or may not have diagnosed heart disease. It's also called sudden cardiac arrest or unexpected cardiac arrest. Sudden death (also called sudden cardiac death) occurs within minutes after symptoms appear."

According to the AHA, brain death and permanent death start to occur within four to six minutes after someone experiences cardiac arrest. Cardiac arrest can be reversed if it is treated within a few minutes with an electric shock to the heart to restore a normal heartbeat - a process called defibrillation. The AHA states that a victim's chances of survival are reduced by seven to ten percent with every passing minute without cardiopulmonary resuscitation and defibrillation, and few attempts at resuscitation succeed after ten minutes.

An automated external defibrillator (AED) is an electronic device that can shock a person's heart back into rhythm when he or she is having a cardiac arrest. The AHA estimates that more than 95 percent of cardiac arrest victims die before reaching the hospital. In situations where defibrillation is provided within five to seven minutes, the survival rate from sudden cardiac arrest can be up to 49 percent.

Section 401.2915, Florida Statutes, requires any person who uses an AED to:

- Obtain appropriate training, including completion of a course in cardiopulmonary resuscitation or completion of a basic first aid course that includes cardiopulmonary resuscitation training, and demonstrated proficiency in the use of an AED; and
- Activate the emergency medical services system as soon as possible upon use of the AED.

In addition, this section encourages any person or entity in possession of an AED to register the existence and location of the AED with the local emergency medical services medical director.

Tort Liability

Section 768.13, F.S., the Good Samaritan Act, among other provisions, provides immunity from any civil damages for a person who renders emergency care, without objection of the injured victim, as long as the person has acted as an ordinary reasonably prudent person would have acted under the same or similar circumstances.

Section 768.1325, F.S., the Cardiac Arrest Survival Act, provides immunity from civil liability for a person who uses or attempts to use, without the objection of the victim, an AED in a perceived medical emergency. In addition, any person who acquired the device, including a community association, is immune from civil liability, if the harm was not due to the failure of the acquirer of the AED to:

- Notify the local emergency medical services medical director of the most recent placement of the device within a reasonable period of time after the device was placed;
- Properly maintain and test the device; or

- Provide adequate training in the use of the device to an employee or agent of the acquirer when the employee or agent was the person who used the device on the victim, except that the training requirement does not apply if:
    - The employee or agent was not someone who would have been reasonably expected to use the device.
    - The period of time elapsing between the person's employment date and the occurrence of the harm, or between the acquisition of the AED and the occurrence of the harm was not a reasonably sufficient period in which to provide the training.

However, s. 768.1325(4), F.S., states that the immunity does not apply to a person if:

- The harm was caused by that person's willful or criminal misconduct, gross negligence, reckless disregard or misconduct, or a conscious, flagrant indifference to the rights or safety of the victim who was harmed;
- The person is a licensed or certified health professional who used the AED while acting within the scope of their license or certification and within the scope of their employment or agency;
- The person is a hospital, clinic, or other health care entity, and the harm was caused by an employee or agent of the entity who used the AED while acting within the scope of the employment or agency of the employee or agent;
- The person is an acquirer of the AED who leased the device to a health care entity and the harm was caused by an employee or agent of the entity who used the device while acting within the scope of the employment or agency of the employee or agent; or
- The person is the manufacturer of the device.

Effect of Proposed Changes

House Bill 243 broadens the scope of those who are required to receive training in the use of an AED by removing provisions requiring a person who uses an AED to obtain proper training that includes demonstrated proficiency in the use of an AED and, instead, requiring any "person or entity in possession" of an AED to properly maintain and test the device and provide training in cardiopulmonary resuscitation and AED proficiency from the American Heart Association or the American Red Cross, or a substantially similar program from another provider, to any of its employees or agents who are reasonably expected to be potential users of the AED.

The bill encourages a person or entity in possession of an AED to notify, rather than register with, the local emergency medical services medical director of the location of the device.

The bill broadens the civil immunity provided under the Cardiac Arrest Survival Act, s. 768.1325(3), F.S., by first removing the requirement that the victim of the perceived medical emergency not object to the use of the AED. Second, the bill removes several provisions that specify instances in which the acquirer of the AED is not immune from civil liability. These provisions specify that the harm must not be due to the failure of acquirer of the device to:

- Notify the local emergency medical services director of the most recent placement of the device.
- Properly maintain and test the device; or
- Provide adequate training in the use of the device to an employee or agent of the acquirer when the employee or agent was the person who used the device on the victim, except that such requirement of training does not apply if:
    - The employee or agent was not someone who would have been reasonably expected to use the device.
    - The period of time elapsing between the person's employment date and the occurrence of the harm, or between the acquisition of the AED and the occurrence of the harm was not a reasonably sufficient period in which to provide the training.

However, the bill does not amend s. 768.1325(4), F.S., which, as previously discussed, provides additional instances in which a person is not immune from civil liability.

C. SECTION DIRECTORY:

Section 1. Amends s. 401.2915, F.S., revising provisions relating to maintenance and training requirements and notice to the local emergency medical services medical director.

Section 2. Amends s. 768.1325, F.S., revising requirements for civil immunity for use or attempted use of a defibrillator on a victim of a perceived medical emergency.

Section 3. Provides an effective date of July 1, 2008.

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:

There is a potential impact to private businesses that possess an AED. The bill requires these entities to provide training to any employees or agents who are reasonably expected to be users of the AED. The exact economic impact to the private sector is unknown.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable because the bill does not appear to require counties or cities to spend funds or take action requiring the expenditure of funds; reduce the authority that cities or counties have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with cities or counties.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

N/A.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

D. STATEMENT OF THE SPONSOR

The intention of this bill is to limit liability to Good Samaritans trying to resuscitate individuals using an Automated External Defibrillator (AED) which will encourage more usage, thus saving more lives.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

On January 22, 2008, the Health Quality Committee adopted one amendment to the bill. The amendment removes the reference to "the American Heart Association or the American Red Cross, or a substantially similar program from another provider" when directing a person or entity in possession of an AED to provide CPR and AED proficiency training to its employees or agents.
The bill was reported favorably with recommended Council Substitute.

1 A bill to be entitled
2 An act relating to automated external defibrillators;
3 amending s. 401.2915, F.S.; revising provisions relating
4 to maintenance and training requirements and notice to the
5 local emergency medical services medical director;
6 amending s. 768.1325, F.S.; revising requirements for
7 civil immunity for use or attempted use of a defibrillator
8 on a victim of a perceived medical emergency; providing an
9 effective date.
10
11 Be It Enacted by the Legislature of the State of Florida:
12
13 Section 1. Paragraphs (a) and (b) of subsection (2) of
14 section 401.2915, Florida Statutes, are amended to read:
15 401.2915 Automated external defibrillators.--It is the
16 intent of the Legislature that an automated external
17 defibrillator may be used by any person for the purpose of
18 saving the life of another person in cardiac arrest. In order to
19 achieve that goal, the Legislature intends to encourage training
20 in lifesaving first aid and set standards for and encourage the
21 use of automated external defibrillators.
22 (2) In order to ensure public health and safety:
23 (a) Any person or entity in possession of an automated
24 external defibrillator shall:
25 1. Properly maintain and test the device.
26 2. Provide training in cardiopulmonary resuscitation and
27 automated external defibrillator proficiency from the American
28 Heart Association or the American Red Cross, or a substantially

similar program from another provider, to any of its employees or agents who are reasonably expected to be potential users of the defibrillator. ~~All persons who use an automated external defibrillator must obtain appropriate training, to include completion of a course in cardiopulmonary resuscitation or successful completion of a basic first aid course that includes cardiopulmonary resuscitation training, and demonstrated proficiency in the use of an automated external defibrillator.~~

(b) Any person or entity in possession of an automated external defibrillator is encouraged to notify ~~register with~~ the local emergency medical services medical director of the ~~existence and~~ location of the automated external defibrillator.

Section 2. Subsection (3) of section 768.1325, Florida Statutes, is amended to read:

768.1325 Cardiac Arrest Survival Act; immunity from civil liability.--

(3) Notwithstanding any other provision of law to the contrary, and except as provided in subsection (4), any person who uses or attempts to use an automated external defibrillator device on a victim of a perceived medical emergency~~, without objection of the victim of the perceived medical emergency,~~ is immune from civil liability for any harm resulting from the use or attempted use of such device. In addition, any person who acquired the device, including, but not limited to, a community association organized under chapter 617, chapter 718, chapter 719, chapter 720, chapter 721, or chapter 723, is immune from such liability.~~, if the harm was not due to the failure of such acquirer of the device to:~~

57 ~~(a) Notify the local emergency medical services medical~~
58 ~~director of the most recent placement of the device within a~~
59 ~~reasonable period of time after the device was placed;~~
60 ~~(b) Properly maintain and test the device; or~~
61 ~~(c) Provide appropriate training in the use of the device~~
62 ~~to an employee or agent of the acquirer when the employee or~~
63 ~~agent was the person who used the device on the victim, except~~
64 ~~that such requirement of training does not apply if:~~
65 ~~1. The employee or agent was not an employee or agent who~~
66 ~~would have been reasonably expected to use the device; or~~
67 ~~2. The period of time elapsing between the engagement of~~
68 ~~the person as an employee or agent and the occurrence of the~~
69 ~~harm, or between the acquisition of the device and the~~
70 ~~occurrence of the harm in any case in which the device was~~
71 ~~acquired after engagement of the employee or agent, was not a~~
72 ~~reasonably sufficient period in which to provide the training.~~
73 Section 3. This act shall take effect July 1, 2008.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

hb0243-00

Amendment No. 1 (for drafter's use only)

Bill No. **243**

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)

ADOPTED AS AMENDED __ (Y/N)

ADOPTED W/O OBJECTION __ (Y/N)

FAILED TO ADOPT __ (Y/N)

WITHDRAWN __ (Y/N)

OTHER ____

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1 Council/Committee hearing bill: Healthcare Council

2 Committee on Health Quality offered the following:

3

4 **Amendment**

5 Remove lines 27-29 and insert:

6 automated external defibrillator proficiency to any of its

7 employees

8

9

This amendment was adopted in HQ on 1/22/08 with recommended council substitute.

Bill No. **0243**

COUNCIL/COMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	____	

Council/Committee hearing bill: Healthcare Council

Representative Anderson offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Subsection (2) of section 401.2915, Florida Statutes, is amended to read:

401.2915 Automated external defibrillators.--It is the intent of the Legislature that an automated external defibrillator may be used by any person for the purpose of saving the life of another person in cardiac arrest. In order to achieve that goal, the Legislature intends to encourage training in lifesaving first aid and set standards for and encourage the use of automated external defibrillators.

(2) In order to promote ~~ensure~~ public health and safety:

(a) All persons who use an automated external defibrillator are encouraged to ~~must~~ obtain appropriate training, to include completion of a course in cardiopulmonary resuscitation or successful completion of a basic first aid course that includes cardiopulmonary resuscitation training, and

22 demonstrated proficiency in the use of an automated external
23 defibrillator.
24 (b) Any person or entity in possession of an automated
25 external defibrillator is encouraged to notify ~~register with~~ the
26 local emergency medical services medical director of the
27 ~~existence and~~ location of the automated external defibrillator.
28 (c) Any person who uses an automated external
29 defibrillator shall activate the emergency medical services
30 system as soon as possible upon use of the automated external
31 defibrillator.
32 Section 2. Subsection (3) of section 768.1325, Florida
33 Statutes, is amended to read:
34 768.1325 Cardiac Arrest Survival Act; immunity from civil
35 liability.--
36 (3) Notwithstanding any other provision of law to the
37 contrary, and except as provided in subsection (4), any person
38 who uses or attempts to use an automated external defibrillator
39 device on a victim of a perceived medical emergency, without
40 objection of the victim of the perceived medical emergency, is
41 immune from civil liability for any harm resulting from the use
42 or attempted use of such device. In addition, notwithstanding
43 any other provision of law to the contrary, and except as
44 provided in subsection (4), any person who acquired the device
45 and makes it available for use, including, but not limited to, a
46 community association organized under chapter 617, chapter 718,
47 chapter 719, chapter 720, chapter 721, or chapter 723, is immune
48 from such liability, if the harm was not due to the failure of
49 such person ~~acquirer of the device~~ to:
50 ~~(a) Notify the local emergency medical services medical~~
51 ~~director of the most recent placement of the device within a~~
52 ~~reasonable period of time after the device was placed;~~

(a)~~(b)~~ Properly maintain and test the device; or

(b)~~(c)~~ Provide appropriate training in the use of the device to an employee or agent of the acquirer when the employee or agent was the person who used the device on the victim, except that such requirement of training does not apply if:

1. The device is equipped with audible, visual, or written instructions on its use, including any such visual or written instructions posted on or adjacent to the device;

2.~~1.~~ The employee or agent was not an employee or agent who would have been reasonably expected to use the device; or

3.~~2.~~ The period of time elapsing between the engagement of the person as an employee or agent and the occurrence of the harm, or between the acquisition of the device and the occurrence of the harm in any case in which the device was acquired after engagement of the employee or agent, was not a reasonably sufficient period in which to provide the training.

Section 3. This act shall take effect July 1, 2008.

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 automated external defibrillators; amending s. 401.2915, F.S.; revising provisions relating to the maintenance of and training requirements for the use of automated external defibrillators; revising provisions encouraging notice to the local emergency medical services medical director; amending s. 768.1325, F.S.; revising requirements for civil immunity for the use

83 or attempted use of a defibrillator on a victim of a
84 perceived medical emergency; providing an effective date.

HB 247

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 247 Nursing Facilities
SPONSOR(S): Murzin and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 686

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Healthy Seniors	8 Y, 0 N	DePalma	Ciccone
2) Healthcare Council		DePalma	Gormley
3) Policy & Budget Council			
4)			
5)			

SUMMARY ANALYSIS

HB 247 amends several provisions contained in Part II of Chapter 400, F.S., relating to the licensure, regulation, and maintenance of state nursing home facilities.

Specifically, the bill reduces the frequency of visits made by quality-of-care monitors to nursing home facilities from quarterly to annually. The bill continues to require quarterly quality-of-care monitoring for conditionally-licensed facilities – and other facilities as determined by the Agency for Health Care Administration (the "agency") – and allows individual facilities to request quarterly visits if not conditionally-licensed.

The bill also permits nursing homes operating under a standard license to develop a plan to provide training for certified nursing assistants (CNAs), and provides for agency approval of such training programs. The bill redefines what constitutes an "adverse incident" and removes the requirement that facilities notify the agency within one business day of a risk manager's receipt of a report detailing an adverse incident.

The bill clarifies that the last survey conducted within a six-month survey cycle may be counted as a "licensure survey" under certain circumstances where a facility's original deficiencies are administratively overturned. Finally, the bill provides that a facility's compliance with federal posting requirements sufficiently satisfies state posting requirements, and eliminates certain requirements relating to licensed nurses performing CNA duties for purposes of computing minimum staffing requirements for CNAs.

The legislation appears to have no fiscal impact to state or local governments.

The bill provides an effective date of July 1, 2008.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government – This bill reduces the frequency of visits made by quality-of-care monitors to certain nursing home facilities from quarterly to annually.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

Quality-of-Care Monitoring

In 1999, the Florida Legislature established the Nursing Home Quality of Care Monitoring Program.[1] Quality-of-care monitors are licensed nurses possessing training and experience in nursing facility regulation, standards of practice in long-term care, and in the evaluation of patient care. Their statutorily-prescribed role is to "assess the overall quality of life in the nursing facility and ... assess specific conditions in the facility directly related to resident care, including the operations of internal quality improvement and risk management programs and adverse incident reports."[2] Additionally, monitors conduct formal and informal interviews with residents, family members, facility staff, resident guests, volunteers, other regulatory staff, and representatives of a long-term care ombudsman council or Florida advocacy council.

Quality-of-care monitors are responsible for monitoring all nursing facilities in their respective districts "on a regular, unannounced, aperiodic basis, including nights, evenings, weekends, and holidays."[3] At a minimum, this entails quarterly monitoring visits.

Findings of a monitoring visit – both positive and negative – are provided orally and in writing to the facility administrator, and may include recommendations for procedural or policy changes within the facility. Conditions observed by a quality-of-care monitor evidencing a threat to the health or safety of a facility resident are required to be immediately reported to the agency and, as appropriate or as required by law, to law enforcement, adult protective services, or other responsible agencies.

Gold Seal Designation

The Governor's Panel on Excellence in Long-Term Care is the entity charged with implementing and administering the state's Gold Seal Program, an award and recognition program for nursing facilities that demonstrate excellence in long-term care over a sustained period. The panel considers the quality of care provided to facility residents during its evaluation for Gold Seal designation. Additionally, a facility must:[4]

- not have class I or II deficiencies within the 30 months preceding application;

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[1] Ch. 99-394, L.O.F.

[2] S. 400.118(2)(a), F.S.

[3] *Id.*

[4] S. 400.235, F.S.

- evidence financial soundness and stability according to standards adopted by the agency in administrative rule;
- participate in a consumer satisfaction process;
- evidence the involvement of families and community members in the facility on a regular basis;
- maintain a stable workforce, as demonstrated by a relatively low rate of turnover among CNAs and licensed nurses within the 30 months preceding application;
- evidence an outstanding record regarding the number and types of substantiated complaints reported to the State Long-Term Care Ombudsman Council within the 30 months preceding application; and
- provide targeted in-service training provided to meet training needs identified by internal or external quality assurance efforts.
-

Presently, there are 15 state nursing homes operating under a Gold Seal designation.[5]

CNA Training

Presently, nursing homes designated as Gold Seal facilities are permitted to develop a plan to provide certified nursing assistant training as prescribed by federal regulations and state rules. A facility wishing to provide CNA training must not have been either cited for substandard quality-of-care, terminated from the Medicare/Medicaid program, or had an enforcement action instituted against the facility to satisfy certain federal requirements. The state is required to withdraw its approval of a training program if any of these and/or other specified conditions occur.[6]

In Florida, CNA training is subject to approval by the Board of Nursing within the Department of Health, following certification by the Department of Education. Currently, there are approximately five state nursing homes that are certified by the Department of Education to offer CNA training.[7]

Incident Reporting

Each nursing home facility must notify the agency in writing within one business day of any adverse incident, as they are presently defined by statute.[8] Subsequently, the facility must initiate an investigation and provide a complete report to the agency within 15 calendar days of the event giving rise to the investigation. If, following a complete investigation, the facility's risk manager determines that the event in question does not constitute an "adverse incident", the facility must include this information in the report submitted to the agency.

Licensure Evaluation and Facility Licensure Status

At least every 15 months, the agency is required to evaluate each nursing home facility to determine the degree of compliance with state licensure requirements. Following this evaluation, a nursing home is assigned either a standard or conditional licensure status. A "standard" licensure indicates that a facility has no class I or II deficiencies, and has successfully corrected all class III deficiencies within the time established by the agency. A "conditional" license is provided to a nursing facility that is not in substantial compliance with licensure standards at the time of the survey, due to the presence of one or

[5] Agency for Health Care Administration's *Nursing Home Guide*, available at: http://ahcaxnet.fdhc.state.fl.us/nhcguide/. Information retrieved January 25, 2008 and revised by agency staff.

[6] 42 C.F.R. 483.151

[7] Agency for Health Care Administration Agency Analysis, January 2008, record maintained by committee staff.

[8] S. 400.147(7), F.S.

more class I or II deficiencies, or to class III deficiencies left uncorrected within the time prescribed by the agency.[9]

The various classes of deficiencies are defined as follows:[10]

- Class I – a deficiency that the agency determines requires immediate corrective action because the nursing home's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in the nursing home.
- Class II – a deficiency that the agency determines has compromised a resident's ability to maintain or reach his or her highest practicable physical, mental, and psychological well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.
- Class III – a deficiency that the agency determines will result in no more than minimal physical, mental, or psychological discomfort to the resident, or one that has the potential to compromise a resident's ability to maintain or reach his or her highest practicable physical, mental, or psychological well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.
- Class IV – a deficiency that the agency determines has the potential for causing no more than a minor negative impact on a resident.

Additionally, a facility may be placed on a six-month survey cycle for a period of two years if it has been cited for a class I deficiency, two or more class II deficiencies from separate surveys/investigations within a 60-day period, or has received three substantiated complaints within a six-month period, each resulting in at least one class I or II deficiency.

State Nursing Home Posting Requirements

Under state law,[11] each nursing home is required to document compliance with the staffing standard requirements imposed by s. 400.23(3)(a), F.S., and post daily the names of staff on duty for the benefit of facility residents and the public.

Effect of Proposed Changes

HB 247 reduces the frequency of visits made by quality-of-care monitors to nursing home facilities from quarterly to annually. The bill continues to require quarterly quality-of-care monitoring for conditionally-licensed facilities – and other facilities as determined by the agency – and permits individual facilities to request quarterly visits if not conditionally-licensed. The bill further specifies that such a request applies only to a facility's current licensure period, and must be resubmitted at the time of license renewal in order to be continued.

The bill also permits nursing homes operating under a standard license to develop a plan to provide CNA training, and provides for agency approval of such training programs.

Moreover, the bill specifies when an event reported to law enforcement constitutes an "adverse incident" by providing that only events reported to a law enforcement agency for further investigation

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[9] S. 400.23(7), F.S.

[10] S. 400.23(8), F.S.

[11] S. 400.23(3)(a)3, F.S.

are adverse incidents within the meaning of s. 400.147(5)(a)7, F.S. The bill also removes the requirement that facilities notify the agency within one business day of a risk manager's receipt of a report detailing an adverse incident. The facility would continue to submit a 15-day final report to the agency.[12]

The bill clarifies that the last survey conducted within a six-month survey cycle may be counted as a "licensure survey" under certain circumstances where a facility's original deficiencies are administratively overturned.

The bill provides that a facility's compliance with federal posting requirements sufficiently satisfies state posting requirements. The relevant federal posting requirement[13] specifies that nursing facilities must post the following information on a daily basis:

- Facility name;
- The current date;
- The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (1) registered nurses, (2) licensed practical nurses or licensed vocational nurses (as defined under State law), and (3) certified nurse aides; and
- Resident census.

In its agency analysis, AHCA notes that the state and federal posting requirements serve a similar intent, and "either would be appropriate for providing information to the public about nursing home staffing."[14]

Finally, the bill eliminates certain requirements relating to licensed nurses performing CNA duties for purposes of computing minimum staffing requirements for CNAs.

C. SECTION DIRECTORY:

Section 1. Amends s. 400.118(2)(a), F.S., requiring quality-of-care monitors to visit state nursing facilities annually instead of quarterly, to visit each conditionally-licensed nursing facility at least quarterly, and to visit other facilities as directed by the agency; providing for quarterly visits of facilities which are not conditionally-licensed upon a request by the facility; and clarifying that such requests apply only to a facility's current licensure period.

[12] AHCA notes that, "based on adverse incidents submitted during 2006, 77.1% of the one-day adverse incident [reports] were determined not to meet the definition of an adverse incident by the facility upon completing the final 15-day report." Noting that there is a similar federal five-day adverse incident report requirement, the agency continues, "[f]ederal nursing home regulations include the requirement to immediately report to the agency all [instances] of abuse, neglect, and exploitation. Based upon the continued requirement to submit the 15-day report and the federal reporting requirement, the elimination of the one-day report would not create significant gaps in monitoring regulatory compliance." Agency for Health Care Administration Agency Analysis, January 2008, record maintained by committee staff.

[13] 42 C.F.R. 483.30(e); note that postings must also be made in a "clear and readable format" and in a "prominent place readily accessible to residents and visitors." Additionally, the facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard, and must also maintain such nursing staff data for a minimum of 18 months, or as required by State law, whichever is greater.

[14] Agency for Health Care Administration Agency Analysis, January 2008, record maintained by committee staff.

Section 2. Amends s. 400.141, F.S., permitting nursing facilities maintaining a standard license to develop a plan to provide certified nursing assistant training, and to apply to the agency for program approval; granting rulemaking authority to the agency.

Section 3. Amends s. 400.147, F.S., clarifying that the term "adverse incident" applies to events reported to law enforcement only where such event is reported to a law enforcement agency for investigation; and eliminating the facility requirement to notify the agency within one business day of a risk manager's receipt of a report detailing an adverse incident.

Section 4. Amends s. 400.19(3), F.S., permitting the last survey conducted within a six-month survey cycle to be counted as a "licensure survey" in the event that the administrative action giving rise to the six-month survey cycle results in the original deficiencies being overturned.

Section 5. Amends s. 400.195(1)(d), F.S., correcting a statutory cross-reference.

Section 6. Amends s. 400.23, F.S., providing that a facility's compliance with certain federal posting requirements satisfies the state posting requirements contained in Chapter 400, F.S.; eliminating certain requirements relating to licensed nurses performing certified nursing assistant duties for purposes of computing minimum staffing requirements for certified nursing assistants.

Section 7. Provides an effective date of July 1, 2008.

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:

In its agency analysis, AHCA notes that, while there is no direct fiscal impact on the agency, "original staffing for adverse incident reporting was based upon an estimate of 3,600 nursing home and assisted living facility adverse incidents per year; however, this estimate fell significantly short of actual adverse incidents received each year. During Fiscal Year 2006-07, 4,728 adverse incidents were processed by the agency, approximately 30% higher than [the number originally] estimated. The agency has previously allocated necessary resources to handle this higher-than-anticipated workload from adverse incident reports, and will require all existing resources to continue to manage the remaining activities."[15]

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This legislation does not appear to require counties or municipalities to spend funds or take any action requiring the expenditure of funds; reduce the authority that municipalities or counties have to raise revenue in the aggregate; or reduce the percentage of a state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

D. STATEMENT OF THE SPONSOR

No statement submitted.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

On February 5, 2008, the Committee on Healthy Seniors adopted two amendments by the bill sponsor. These amendments:

- Removed section 1 of the original bill, thereby making no changes to existing law regarding quality-of-care monitoring visits.
- Clarified that federal reporting requirements remain in place.

The committee reported the bill favorably with two amendments.

[15] *Id.*

1 A bill to be entitled
2 An act relating to nursing facilities; amending s.
3 400.118, F.S.; revising the frequency of visits to nursing
4 facilities by quality-of-care monitors from the Agency for
5 Health Care Administration; amending s. 400.141, F.S.;
6 authorizing certain licensed nursing facilities to develop
7 a plan to provide certain training for nursing assistants;
8 providing for rules relating to agency approval of
9 training programs; amending s. 400.147, F.S.; redefining
10 the term "adverse incident"; deleting the requirement that
11 a nursing facility notify the agency of an adverse
12 incident; deleting notification requirements; requiring
13 that a risk manager determine if an incident was an
14 adverse incident; amending s. 400.19, F.S.; providing that
15 the most recent survey is a licensure survey under certain
16 conditions for purposes of future survey scheduling;
17 amending s. 400.195, F.S.; conforming a cross-reference;
18 amending s. 400.23, F.S.; requiring that federal posting
19 requirements for staffing standards comply with state
20 posting requirements; revising provisions relating to a
21 facility's use of licensed nurses to meet certain minimum
22 staffing requirements; providing an effective date.
23
24 Be It Enacted by the Legislature of the State of Florida:
25
26 Section 1. Paragraph (a) of subsection (2) of section
27 400.118, Florida Statutes, is amended to read:
28 400.118 Quality assurance; early warning system;

29 monitoring; rapid response teams.--
30 (2)(a) The agency shall establish within each district
31 office one or more quality-of-care monitors, based on the number
32 of nursing facilities in the district, to monitor all nursing
33 facilities in the district on a regular, unannounced, aperiodic
34 basis, including nights, evenings, weekends, and holidays.
35 Quality-of-care monitors shall visit each nursing facility
36 annually, shall visit each conditionally licensed nursing
37 facility at least quarterly, and shall visit other facilities as
38 directed by the agency. However, upon the request of a facility,
39 the agency shall make quarterly visits to a nursing home that is
40 not conditionally licensed. The request applies only to the
41 current licensure period and must be made again by the facility
42 at the time of license renewal in order to be continued.
43 Priority for additional monitoring visits shall be given to
44 nursing facilities that have ~~with~~ a history of resident care
45 deficiencies. Quality-of-care monitors shall be registered
46 nurses who are trained and experienced in nursing facility
47 regulation, standards of practice in long-term care, and
48 evaluation of patient care. Individuals in these positions may
49 ~~shall~~ not be deployed by the agency as a part of the district
50 survey team in the conduct of routine, scheduled surveys, but
51 shall function solely and independently as quality-of-care
52 monitors. Quality-of-care monitors shall assess the overall
53 quality of life in the nursing facility and shall assess
54 specific conditions in the facility directly related to resident
55 care, including the operations of internal quality improvement
56 and risk management programs and adverse incident reports. The

57 quality-of-care monitor shall include in an assessment visit
58 observation of the care and services rendered to residents and
59 formal and informal interviews with residents, family members,
60 facility staff, resident guests, volunteers, other regulatory
61 staff, and representatives of a long-term care ombudsman council
62 or Florida advocacy council.
63 Section 2. Section 400.141, Florida Statutes, is amended
64 to read:
65 400.141 Administration and management of nursing home
66 facilities.--Every licensed facility shall comply with all
67 applicable standards and rules of the agency and shall:
68 (1) Be under the administrative direction and charge of a
69 licensed administrator.
70 (2) Appoint a medical director licensed pursuant to
71 chapter 458 or chapter 459. The agency may establish by rule
72 more specific criteria for the appointment of a medical
73 director.
74 (3) Have available the regular, consultative, and
75 emergency services of physicians licensed by the state.
76 (4) Provide for resident use of a community pharmacy as
77 specified in s. 400.022(1)(q). Any other law to the contrary
78 notwithstanding, a registered pharmacist licensed in Florida,
79 that is under contract with a facility licensed under this
80 chapter or chapter 429, shall repackage a nursing facility
81 resident's bulk prescription medication which has been packaged
82 by another pharmacist licensed in any state in the United States
83 into a unit dose system compatible with the system used by the
84 nursing facility, if the pharmacist is requested to offer such

85 service. In order to be eligible for the repackaging, a resident
86 or the resident's spouse must receive prescription medication
87 benefits provided through a former employer as part of his or
88 her retirement benefits, a qualified pension plan as specified
89 in s. 4972 of the Internal Revenue Code, a federal retirement
90 program as specified under 5 C.F.R. s. 831, or a long-term care
91 policy as defined in s. 627.9404(1). A pharmacist who correctly
92 repackages and relabels the medication and the nursing facility
93 which correctly administers such repackaged medication under the
94 provisions of this subsection shall not be held liable in any
95 civil or administrative action arising from the repackaging. In
96 order to be eligible for the repackaging, a nursing facility
97 resident for whom the medication is to be repackaged shall sign
98 an informed consent form provided by the facility which includes
99 an explanation of the repackaging process and which notifies the
100 resident of the immunities from liability provided herein. A
101 pharmacist who repackages and relabels prescription medications,
102 as authorized under this subsection, may charge a reasonable fee
103 for costs resulting from the implementation of this provision.
104 (5) Provide for the access of the facility residents to
105 dental and other health-related services, recreational services,
106 rehabilitative services, and social work services appropriate to
107 their needs and conditions and not directly furnished by the
108 licensee. When a geriatric outpatient nurse clinic is conducted
109 in accordance with rules adopted by the agency, outpatients
110 attending such clinic shall not be counted as part of the
111 general resident population of the nursing home facility, nor
112 shall the nursing staff of the geriatric outpatient clinic be

113 counted as part of the nursing staff of the facility, until the
114 outpatient clinic load exceeds 15 a day.
115 (6) Be allowed and encouraged by the agency to provide
116 other needed services under certain conditions. If the facility
117 has a standard licensure status, and has had no class I or class
118 II deficiencies during the past 2 years or has been awarded a
119 Gold Seal under the program established in s. 400.235, it may be
120 encouraged by the agency to provide services, including, but not
121 limited to, respite and adult day services, which enable
122 individuals to move in and out of the facility. A facility is
123 not subject to any additional licensure requirements for
124 providing these services. Respite care may be offered to persons
125 in need of short-term or temporary nursing home services.
126 Respite care must be provided in accordance with this part and
127 rules adopted by the agency. However, the agency shall, by rule,
128 adopt modified requirements for resident assessment, resident
129 care plans, resident contracts, physician orders, and other
130 provisions, as appropriate, for short-term or temporary nursing
131 home services. The agency shall allow for shared programming and
132 staff in a facility which meets minimum standards and offers
133 services pursuant to this subsection, but, if the facility is
134 cited for deficiencies in patient care, may require additional
135 staff and programs appropriate to the needs of service
136 recipients. A person who receives respite care may not be
137 counted as a resident of the facility for purposes of the
138 facility's licensed capacity unless that person receives 24-hour
139 respite care. A person receiving either respite care for 24
140 hours or longer or adult day services must be included when

141 calculating minimum staffing for the facility. Any costs and
142 revenues generated by a nursing home facility from
143 nonresidential programs or services shall be excluded from the
144 calculations of Medicaid per diems for nursing home
145 institutional care reimbursement.
146 (7) If the facility has a standard license or is a Gold
147 Seal facility, exceeds the minimum required hours of licensed
148 nursing and certified nursing assistant direct care per resident
149 per day, and is part of a continuing care facility licensed
150 under chapter 651 or a retirement community that offers other
151 services pursuant to part III of this chapter or part I or part
152 III of chapter 429 on a single campus, be allowed to share
153 programming and staff. At the time of inspection and in the
154 semiannual report required pursuant to subsection (15), a
155 continuing care facility or retirement community that uses this
156 option must demonstrate through staffing records that minimum
157 staffing requirements for the facility were met. Licensed nurses
158 and certified nursing assistants who work in the nursing home
159 facility may be used to provide services elsewhere on campus if
160 the facility exceeds the minimum number of direct care hours
161 required per resident per day and the total number of residents
162 receiving direct care services from a licensed nurse or a
163 certified nursing assistant does not cause the facility to
164 violate the staffing ratios required under s. 400.23(3)(a).
165 Compliance with the minimum staffing ratios shall be based on
166 total number of residents receiving direct care services,
167 regardless of where they reside on campus. If the facility
168 receives a conditional license, it may not share staff until the

169 conditional license status ends. This subsection does not
170 restrict the agency's authority under federal or state law to
171 require additional staff if a facility is cited for deficiencies
172 in care which are caused by an insufficient number of certified
173 nursing assistants or licensed nurses. The agency may adopt
174 rules for the documentation necessary to determine compliance
175 with this provision.
176 (8) Maintain the facility premises and equipment and
177 conduct its operations in a safe and sanitary manner.
178 (9) If the licensee furnishes food service, provide a
179 wholesome and nourishing diet sufficient to meet generally
180 accepted standards of proper nutrition for its residents and
181 provide such therapeutic diets as may be prescribed by attending
182 physicians. In making rules to implement this subsection, the
183 agency shall be guided by standards recommended by nationally
184 recognized professional groups and associations with knowledge
185 of dietetics.
186 (10) Keep full records of resident admissions and
187 discharges; medical and general health status, including medical
188 records, personal and social history, and identity and address
189 of next of kin or other persons who may have responsibility for
190 the affairs of the residents; and individual resident care plans
191 including, but not limited to, prescribed services, service
192 frequency and duration, and service goals. The records shall be
193 open to inspection by the agency.
194 (11) Keep such fiscal records of its operations and
195 conditions as may be necessary to provide information pursuant
196 to this part.

197 (12) Furnish copies of personnel records for employees
198 affiliated with such facility, to any other facility licensed by
199 this state requesting this information pursuant to this part.
200 Such information contained in the records may include, but is
201 not limited to, disciplinary matters and any reason for
202 termination. Any facility releasing such records pursuant to
203 this part shall be considered to be acting in good faith and may
204 not be held liable for information contained in such records,
205 absent a showing that the facility maliciously falsified such
206 records.
207 (13) Publicly display a poster provided by the agency
208 containing the names, addresses, and telephone numbers for the
209 state's abuse hotline, the State Long-Term Care Ombudsman, the
210 Agency for Health Care Administration consumer hotline, the
211 Advocacy Center for Persons with Disabilities, the Florida
212 Statewide Advocacy Council, and the Medicaid Fraud Control Unit,
213 with a clear description of the assistance to be expected from
214 each.
215 (14) Submit to the agency the information specified in s.
216 400.071(1)(b) for a management company within 30 days after the
217 effective date of the management agreement.
218 (15) Submit semiannually to the agency, or more frequently
219 if requested by the agency, information regarding facility
220 staff-to-resident ratios, staff turnover, and staff stability,
221 including information regarding certified nursing assistants,
222 licensed nurses, the director of nursing, and the facility
223 administrator. For purposes of this reporting:
224 (a) Staff-to-resident ratios must be reported in the

225 categories specified in s. 400.23(3)(a) and applicable rules.
226 The ratio must be reported as an average for the most recent
227 calendar quarter.
228 (b) Staff turnover must be reported for the most recent
229 12-month period ending on the last workday of the most recent
230 calendar quarter prior to the date the information is submitted.
231 The turnover rate must be computed quarterly, with the annual
232 rate being the cumulative sum of the quarterly rates. The
233 turnover rate is the total number of terminations or separations
234 experienced during the quarter, excluding any employee
235 terminated during a probationary period of 3 months or less,
236 divided by the total number of staff employed at the end of the
237 period for which the rate is computed, and expressed as a
238 percentage.
239 (c) The formula for determining staff stability is the
240 total number of employees that have been employed for more than
241 12 months, divided by the total number of employees employed at
242 the end of the most recent calendar quarter, and expressed as a
243 percentage.
244 (d) A nursing facility that has failed to comply with
245 state minimum-staffing requirements for 2 consecutive days is
246 prohibited from accepting new admissions until the facility has
247 achieved the minimum-staffing requirements for a period of 6
248 consecutive days. For the purposes of this paragraph, any person
249 who was a resident of the facility and was absent from the
250 facility for the purpose of receiving medical care at a separate
251 location or was on a leave of absence is not considered a new
252 admission. Failure to impose such an admissions moratorium

253 constitutes a class II deficiency.
254 (e) A nursing facility which does not have a conditional
255 license may be cited for failure to comply with the standards in
256 s. 400.23(3)(a)1.a. only if it has failed to meet those
257 standards on 2 consecutive days or if it has failed to meet at
258 least 97 percent of those standards on any one day.
259 (f) A facility which has a conditional license must be in
260 compliance with the standards in s. 400.23(3)(a) at all times.
261
262 Nothing in this section shall limit the agency's ability to
263 impose a deficiency or take other actions if a facility does not
264 have enough staff to meet the residents' needs.
265 (16) Report monthly the number of vacant beds in the
266 facility which are available for resident occupancy on the day
267 the information is reported.
268 (17) Notify a licensed physician when a resident exhibits
269 signs of dementia or cognitive impairment or has a change of
270 condition in order to rule out the presence of an underlying
271 physiological condition that may be contributing to such
272 dementia or impairment. The notification must occur within 30
273 days after the acknowledgment of such signs by facility staff.
274 If an underlying condition is determined to exist, the facility
275 shall arrange, with the appropriate health care provider, the
276 necessary care and services to treat the condition.
277 (18) If the facility implements a dining and hospitality
278 attendant program, ensure that the program is developed and
279 implemented under the supervision of the facility director of
280 nursing. A licensed nurse, licensed speech or occupational

281 therapist, or a registered dietitian must conduct training of
282 dining and hospitality attendants. A person employed by a
283 facility as a dining and hospitality attendant must perform
284 tasks under the direct supervision of a licensed nurse.
285 (19) Report to the agency any filing for bankruptcy
286 protection by the facility or its parent corporation,
287 divestiture or spin-off of its assets, or corporate
288 reorganization within 30 days after the completion of such
289 activity.
290 (20) Maintain general and professional liability insurance
291 coverage that is in force at all times. In lieu of general and
292 professional liability insurance coverage, a state-designated
293 teaching nursing home and its affiliated assisted living
294 facilities created under s. 430.80 may demonstrate proof of
295 financial responsibility as provided in s. 430.80(3)(h).
296 (21) Maintain in the medical record for each resident a
297 daily chart of certified nursing assistant services provided to
298 the resident. The certified nursing assistant who is caring for
299 the resident must complete this record by the end of his or her
300 shift. This record must indicate assistance with activities of
301 daily living, assistance with eating, and assistance with
302 drinking, and must record each offering of nutrition and
303 hydration for those residents whose plan of care or assessment
304 indicates a risk for malnutrition or dehydration.
305 (22) Before November 30 of each year, subject to the
306 availability of an adequate supply of the necessary vaccine,
307 provide for immunizations against influenza viruses to all its
308 consenting residents in accordance with the recommendations of

309 the United States Centers for Disease Control and Prevention,
310 subject to exemptions for medical contraindications and
311 religious or personal beliefs. Subject to these exemptions, any
312 consenting person who becomes a resident of the facility after
313 November 30 but before March 31 of the following year must be
314 immunized within 5 working days after becoming a resident.
315 Immunization shall not be provided to any resident who provides
316 documentation that he or she has been immunized as required by
317 this subsection. This subsection does not prohibit a resident
318 from receiving the immunization from his or her personal
319 physician if he or she so chooses. A resident who chooses to
320 receive the immunization from his or her personal physician
321 shall provide proof of immunization to the facility. The agency
322 may adopt and enforce any rules necessary to comply with or
323 implement this subsection.
324 (23) Assess all residents for eligibility for pneumococcal
325 polysaccharide vaccination (PPV) and vaccinate residents when
326 indicated within 60 days after the effective date of this act in
327 accordance with the recommendations of the United States Centers
328 for Disease Control and Prevention, subject to exemptions for
329 medical contraindications and religious or personal beliefs.
330 Residents admitted after the effective date of this act shall be
331 assessed within 5 working days of admission and, when indicated,
332 vaccinated within 60 days in accordance with the recommendations
333 of the United States Centers for Disease Control and Prevention,
334 subject to exemptions for medical contraindications and
335 religious or personal beliefs. Immunization shall not be
336 provided to any resident who provides documentation that he or

337 she has been immunized as required by this subsection. This
338 subsection does not prohibit a resident from receiving the
339 immunization from his or her personal physician if he or she so
340 chooses. A resident who chooses to receive the immunization from
341 his or her personal physician shall provide proof of
342 immunization to the facility. The agency may adopt and enforce
343 any rules necessary to comply with or implement this subsection.
344 (24) Annually encourage and promote to its employees the
345 benefits associated with immunizations against influenza viruses
346 in accordance with the recommendations of the United States
347 Centers for Disease Control and Prevention. The agency may adopt
348 and enforce any rules necessary to comply with or implement this
349 subsection.
350
351 Facilities having a standard license ~~that have been awarded a~~
352 ~~Gold Seal under the program established in s. 400.235~~ may
353 develop a plan to provide certified nursing assistant training
354 as prescribed by federal regulations and state rules and may
355 apply to the agency for approval of their program. The agency
356 may adopt rules relating to the approval, suspension, or
357 termination of a certified nursing assistant training program.
358 Section 3. Subsections (5) through (15) of section
359 400.147, Florida Statutes, are amended to read:
360 400.147 Internal risk management and quality assurance
361 program.--
362 (5) For purposes of reporting to the agency under this
363 section, the term "adverse incident" means:
364 (a) An event over which facility personnel could exercise

365 control and which is associated in whole or in part with the
366 facility's intervention, rather than the condition for which
367 such intervention occurred, and which results in one of the
368 following:
369 1. Death;
370 2. Brain or spinal damage;
371 3. Permanent disfigurement;
372 4. Fracture or dislocation of bones or joints;
373 5. A limitation of neurological, physical, or sensory
374 function;
375 6. Any condition that required medical attention to which
376 the resident has not given his or her informed consent,
377 including failure to honor advanced directives; or
378 7. Any condition that required the transfer of the
379 resident, within or outside the facility, to a unit providing a
380 more acute level of care due to the adverse incident, rather
381 than the resident's condition prior to the adverse incident;
382 (b) Abuse, neglect, or exploitation as defined in s.
383 415.102;
384 (c) Abuse, neglect and harm as defined in s. 39.01;
385 (d) Resident elopement; or
386 (e) An event that is reported to a law enforcement agency
387 for investigation.
388 (6) The internal risk manager of each licensed facility
389 shall:
390 (a) Investigate every allegation of sexual misconduct
391 which is made against a member of the facility's personnel who
392 has direct patient contact when the allegation is that the

393 sexual misconduct occurred at the facility or at the grounds of
394 the facility;
395 (b) Report every allegation of sexual misconduct to the
396 administrator of the licensed facility; and
397 (c) Notify the resident representative or guardian of the
398 victim that an allegation of sexual misconduct has been made and
399 that an investigation is being conducted.
400 (7)(a) The facility shall initiate an investigation ~~and~~
401 ~~shall notify the agency~~ within 1 business day after the risk
402 manager or his or her designee has received a report pursuant to
403 paragraph (1)(d). ~~The notification must be made in writing and~~
404 ~~be provided electronically, by facsimile device or overnight~~
405 ~~mail delivery. The notification must include information~~
406 ~~regarding the identity of the affected resident, the type of~~
407 ~~adverse incident, the initiation of an investigation by the~~
408 ~~facility, and whether the events causing or resulting in the~~
409 ~~adverse incident represent a potential risk to any other~~
410 ~~resident. The notification is confidential as provided by law~~
411 ~~and is not discoverable or admissible in any civil or~~
412 ~~administrative action, except in disciplinary proceedings by the~~
413 ~~agency or the appropriate regulatory board. The agency may~~
414 ~~investigate, as it deems appropriate, any such incident and~~
415 ~~prescribe measures that must or may be taken in response to the~~
416 ~~incident. The agency shall review each incident and determine~~
417 ~~whether it potentially involved conduct by the health care~~
418 ~~professional who is subject to disciplinary action, in which~~
419 ~~case the provisions of s. 456.073 shall apply.~~
420 (b)~~(8)(a)~~ Each facility shall complete the investigation

421 and submit an adverse incident report to the agency for each
422 adverse incident within 15 calendar days after its occurrence.
423 If, after a complete investigation, the risk manager determines
424 that the incident was ~~not~~ an adverse incident as defined in
425 subsection (5), the facility shall include this information in
426 the report. The agency shall develop a form for reporting this
427 information.
428 (c) ~~(b)~~ The information reported to the agency pursuant to
429 paragraph (b) ~~(a)~~ which relates to persons licensed under
430 chapter 458, chapter 459, chapter 461, or chapter 466 shall be
431 reviewed by the agency. The agency shall determine whether any
432 of the incidents potentially involved conduct by a health care
433 professional who is subject to disciplinary action, in which
434 case the provisions of s. 456.073 shall apply.
435 (d) ~~(c)~~ The report submitted to the agency must also
436 contain the name of the risk manager of the facility.
437 (e) ~~(d)~~ The adverse incident report is confidential as
438 provided by law and is not discoverable or admissible in any
439 civil or administrative action, except in disciplinary
440 proceedings by the agency or the appropriate regulatory board.
441 (8) ~~(9)~~ By the 10th of each month, each facility subject to
442 this section shall report any notice received pursuant to s.
443 400.0233(2) and each initial complaint that was filed with the
444 clerk of the court and served on the facility during the
445 previous month by a resident or a resident's family member,
446 guardian, conservator, or personal legal representative. The
447 report must include the name of the resident, the resident's
448 date of birth and social security number, the Medicaid

449 identification number for Medicaid-eligible persons, the date or
450 dates of the incident leading to the claim or dates of
451 residency, if applicable, and the type of injury or violation of
452 rights alleged to have occurred. Each facility shall also submit
453 a copy of the notices received pursuant to s. 400.0233(2) and
454 complaints filed with the clerk of the court. This report is
455 confidential as provided by law and is not discoverable or
456 admissible in any civil or administrative action, except in such
457 actions brought by the agency to enforce the provisions of this
458 part.
459 (9)~~(10)~~ The agency shall review, as part of its licensure
460 inspection process, the internal risk management and quality
461 assurance program at each facility regulated by this section to
462 determine whether the program meets standards established in
463 statutory laws and rules, is being conducted in a manner
464 designed to reduce adverse incidents, and is appropriately
465 reporting incidents as required by this section.
466 (10)~~(11)~~ There is no monetary liability on the part of,
467 and a cause of action for damages may not arise against, any
468 risk manager for the implementation and oversight of the
469 internal risk management and quality assurance program in a
470 facility licensed under this part as required by this section,
471 or for any act or proceeding undertaken or performed within the
472 scope of the functions of such internal risk management and
473 quality assurance program if the risk manager acts without
474 intentional fraud.
475 (11)~~(12)~~ If the agency, through its receipt of the adverse
476 incident reports prescribed in subsection (7), or through any

477 investigation, has a reasonable belief that conduct by a staff
478 member or employee of a facility is grounds for disciplinary
479 action by the appropriate regulatory board, the agency shall
480 report this fact to the regulatory board.
481 (12) ~~(13)~~ The agency may adopt rules to administer this
482 section.
483 (13) ~~(14)~~ The agency shall annually submit to the
484 Legislature a report on nursing home adverse incidents. The
485 report must include the following information arranged by
486 county:
487 (a) The total number of adverse incidents.
488 (b) A listing, by category, of the types of adverse
489 incidents, the number of incidents occurring within each
490 category, and the type of staff involved.
491 (c) A listing, by category, of the types of injury caused
492 and the number of injuries occurring within each category.
493 (d) Types of liability claims filed based on an adverse
494 incident or reportable injury.
495 (e) Disciplinary action taken against staff, categorized
496 by type of staff involved.
497 (14) ~~(15)~~ Information gathered by a credentialing
498 organization under a quality assurance program is not
499 discoverable from the credentialing organization. This
500 subsection does not limit discovery of, access to, or use of
501 facility records, including those records from which the
502 credentialing organization gathered its information.
503 Section 4. Subsection (3) of section 400.19, Florida
504 Statutes, is amended to read:

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

505 400.19 Right of entry and inspection.--
506 (3) The agency shall every 15 months conduct at least one
507 unannounced inspection to determine compliance by the licensee
508 with statutes, and with rules adopted ~~promulgated~~ under the
509 provisions of those statutes, governing minimum standards of
510 construction, quality and adequacy of care, and rights of
511 residents. The survey shall be conducted every 6 months for the
512 next 2-year period if the facility has been cited for a class I
513 deficiency, has been cited for two or more class II deficiencies
514 arising from separate surveys or investigations within a 60-day
515 period, or has had three or more substantiated complaints within
516 a 6-month period, each resulting in at least one class I or
517 class II deficiency. In addition to any other fees or fines in
518 this part, the agency shall assess a fine for each facility that
519 is subject to the 6-month survey cycle. The fine for the 2-year
520 period shall be $6,000, one-half to be paid at the completion of
521 each survey. The agency may adjust this fine by the change in
522 the Consumer Price Index, based on the 12 months immediately
523 preceding the increase, to cover the cost of the additional
524 surveys. If such deficiencies are overturned as the result of
525 administrative action but additional surveys have already been
526 conducted pursuant to this section, the most recent survey shall
527 be considered a licensure survey for purposes of scheduling
528 future surveys. The agency shall verify through subsequent
529 inspection that any deficiency identified during inspection is
530 corrected. However, the agency may verify the correction of a
531 class III or class IV deficiency unrelated to resident rights or
532 resident care without reinspecting the facility if adequate

533 written documentation has been received from the facility, which
534 provides assurance that the deficiency has been corrected. The
535 giving or causing to be given of advance notice of such
536 unannounced inspections by an employee of the agency to any
537 unauthorized person shall constitute cause for suspension of not
538 fewer than 5 working days according to the provisions of chapter
539 110.
540 Section 5. Paragraph (d) of subsection (1) of section
541 400.195, Florida Statutes, is amended to read:
542 400.195 Agency reporting requirements.--
543 (1) For the period beginning June 30, 2001, and ending
544 June 30, 2005, the Agency for Health Care Administration shall
545 provide a report to the Governor, the President of the Senate,
546 and the Speaker of the House of Representatives with respect to
547 nursing homes. The first report shall be submitted no later than
548 December 30, 2002, and subsequent reports shall be submitted
549 every 6 months thereafter. The report shall identify facilities
550 based on their ownership characteristics, size, business
551 structure, for-profit or not-for-profit status, and any other
552 characteristics the agency determines useful in analyzing the
553 varied segments of the nursing home industry and shall report:
554 (d) Information regarding deficiencies cited, including
555 information used to develop the Nursing Home Guide WATCH LIST
556 pursuant to s. 400.191, and applicable rules, a summary of data
557 generated on nursing homes by Centers for Medicare and Medicaid
558 Services Nursing Home Quality Information Project, and
559 information collected pursuant to <u>s. 400.147(8)</u> ~~s. 400.147(9)~~,
560 relating to litigation.

CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

561 Section 6. Paragraph (a) of subsection (3) of section
562 400.23, Florida Statutes, is amended to read:
563 400.23 Rules; evaluation and deficiencies; licensure
564 status.--
565 (3)(a)1. The agency shall adopt rules providing minimum
566 staffing requirements for nursing homes. These requirements
567 shall include, for each nursing home facility:
568 a. A minimum certified nursing assistant staffing of 2.6
569 hours of direct care per resident per day beginning January 1,
570 2003, and increasing to 2.7 hours of direct care per resident
571 per day beginning January 1, 2007. Beginning January 1, 2002, a
572 ~~no~~ facility may not ~~shall~~ staff below one certified nursing
573 assistant per 20 residents, and must provide a minimum licensed
574 nursing staffing of 1.0 hour of direct care per resident per day
575 but never below one licensed nurse per 40 residents.
576 b. Beginning January 1, 2007, a minimum weekly average
577 certified nursing assistant staffing of 2.9 hours of direct care
578 per resident per day. For the purpose of this sub-subparagraph,
579 a week is defined as Sunday through Saturday.
580 2. Nursing assistants employed under s. 400.211(2) may be
581 included in computing the staffing ratio for certified nursing
582 assistants only if their job responsibilities include only
583 nursing-assistant-related duties.
584 3. Each nursing home must document compliance with
585 staffing standards as required under this paragraph and post
586 daily the names of staff on duty for the benefit of facility
587 residents and the public. Compliance with federal posting
588 requirements satisfies the posting requirements in this

589 <u>subparagraph.</u>
590 4. The agency shall recognize the use of licensed nurses
591 for compliance with minimum staffing requirements for certified
592 nursing assistants, provided that the facility otherwise meets
593 the minimum staffing requirements for licensed nurses and that
594 the licensed nurses are performing the duties of a certified
595 nursing assistant. ~~Unless otherwise approved by the agency,~~
596 Licensed nurses counted toward the minimum staffing requirements
597 for certified nursing assistants must exclusively perform the
598 duties of a certified nursing assistant ~~for the entire shift~~ and
599 not also be counted toward the minimum staffing requirements for
600 licensed nurses. ~~If the agency approved a facility's request to~~
601 ~~use a licensed nurse to perform both licensed nursing and~~
602 ~~certified nursing assistant duties,~~ The facility must allocate
603 the amount of staff time specifically spent on certified nursing
604 assistant duties for the purpose of documenting compliance with
605 minimum staffing requirements for certified and licensed nursing
606 staff. In no event may the hours of a licensed nurse with dual
607 job responsibilities be counted twice.
608 Section 7. This act shall take effect July 1, 2008.

Bill No. **HB 247**

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)
ADOPTED AS AMENDED __ (Y/N)
ADOPTED W/O OBJECTION __ (Y/N)
FAILED TO ADOPT __ (Y/N)
WITHDRAWN __ (Y/N)
OTHER ______

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1 Council/Committee hearing bill: Healthcare Council
2 Committee on Healthy Seniors offered the following:
3
4 **Amendment (with title amendment)**
5 Remove lines 26-62
6
7 ---
8 **T I T L E A M E N D M E N T**
9 Remove line(s) 2-5 and insert:
10 An act relating to nursing facilities amending s. 400.141, F.S.;
11
12

This amendment was adopted in HS on 2/5/08 and is travelling with the bill and requires no further action.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No.2 (for drafter's use only)

Bill No. **HB 247**

COUNCIL/COMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	______	

---

1 Council/Committee hearing bill: Healthcare Council

2 Committee on Healthy Seniors offered the following:

3

4 **Amendment (with directory and title amendments)**

5 Between line(s) 440 and 441 insert:

6 <u>(f) Nothing herein shall affect any federal reporting</u>

7 <u>requirements.</u>

8

9

This amendment was adopted in HS on 2/5/08 and is travelling with the bill and requires no further action.

Amendment No. 3 (for drafter's use only)

Bill No. **HB 247**

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)

ADOPTED AS AMENDED __ (Y/N)

ADOPTED W/O OBJECTION __ (Y/N)

FAILED TO ADOPT __ (Y/N)

WITHDRAWN __ (Y/N)

OTHER ______

---

1 Council/Committee hearing bill: Health Care Council

2 Representative Murzin offered the following:

3

4 **Amendment (with title amendments)**

5 Remove line(s) 587-589 and insert:

6 residents and the public.

7

8

9 ---

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

11 Remove line(s) 18-20 and insert:

12 amending s. 400.23, F.S.; revising provisions relating to a

13

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 4 (for drafter's use only)

Bill No. **HB 247**

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)

ADOPTED AS AMENDED __ (Y/N)

ADOPTED W/O OBJECTION __ (Y/N)

FAILED TO ADOPT __ (Y/N)

WITHDRAWN __ (Y/N)

OTHER ______

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1 Council/Committee hearing bill: Health Care Council

2 Representative Murzin offered the following:

3

4 **Amendment**

5 Remove line 598 and insert:

6 duties of a certified nursing assistant for the entire shift and

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 333 Developmental Disabilities Institutions
SPONSOR(S): Nehr
TIED BILLS: **IDEN./SIM. BILLS:** SB 862

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Healthy Families	6 Y, 0 N	Schoolfield	Schoolfield
2) Healthcare Council		Schoolfield	Gormley
3)			
4)			
5)			

SUMMARY ANALYSIS

The bill requires the Agency for Persons with Disabilities to prepare plans for review and comment if there is an announced intent to close or reduce census by 20 percent or more at either Tacachale or Sunland Developmental Disabilities Institution. The plans must ensure proper notification to residents and others, involvement of residents in planning their transition, and planning for quality and safety of residents during a transition from the institution. A detailed description of the required report/plan is included in the bill.

The bill requires the Governor to approve or disapprove any closure or reduction in census plans, after receiving comments from the Speaker of the House and President of the Senate.

The bill also requires quarterly reports by the agency on progress of closure or reduction in census at an institution.

The effective date of the bill is July 1, 2008.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Safeguard Individual Liberty: The bill seeks to ensure individuals have adequate choices of residential setting and services when institutions for persons with developmental disabilities are closed or their populations significantly reduced.

Empower Families: The bill requires the Agency for Persons with Developmental Disabilities to ensure residents and their families, are informed and participate in the planning to receive services as they go through transition to another placement when the institutions where they live is closed or significantly reduced in population.

B. EFFECT OF PROPOSED CHANGES:

This bill requires the Agency for Persons with Disabilities to provide a report to the Senate President, Speaker of the House and the Governor subsequent to an announcement of intent to close or reduce census by 20 percent or more at either the Sunland (Marianna, Fl.) or Tacachale (Gainesville, FL) developmental disabilities institution. The Senate and House will have 90 days to provide comments prior to the Governor's decision on whether to approve or disapprove plans to close or reduce census at the developmental disabilities institution.

The bill also expresses Legislative intent that the Agency provide timely notification to residents, guardians and others when there is an intent to close or reduce census. The intent language also directs the agency to provide assurances to residents that they will be involved in planning their transition, that the planning process will be thorough and that the agency will ensure health and safety of the residents during transition.

The bill specifies that the report include at a minimum, plans to address:

- notification of residents, family, guardian or designees regarding closure or census reduction;
- education of institution staff, residents, families and guardians about placement opportunities in the community;
- providing services and residential placements to residents who move to the community;
- assessing the capacity of providers in the community to meet service needs for residents who transition;
- recruitment of providers to ensure adequate capacity in the community;
- monitoring of residents to ensure quality and safety after they leave the institution ;
- the process for support plan development;
- the appeals process for residents and guardians on the support plan process;
- adjustments to staffing levels at the institutions as they are closed or reduced;
- the timeline for closure or reduction including a financial plan;
- ongoing communication with interested parties during closure or reduction;
- the responsibilities of each agency involved and the disposition of property at the physical plant.

This bill also requires quarterly progress reports by the agency on closure or census reduction at a developmental disability institution. The content of the quarterly report is specified in the bill.

PRESENT SITUATION

The Agency for Persons with Disabilities currently operates three developmental disabilities institutions. These include Tacachale in Gainesville, Sunland in Marianna and Gulf Coast Center in Leigh High Acres. As of October 2007, there were 866 people residing in these facilities. Gulf Coast Center is currently being phased down to closure by June 30, 2010. Another institution, the Community of Landmark in Miami-Dade was closed in 2005. The Agency for Persons with Disabilities reports there are no plans to close the two remaining developmental disabilities institutions (Sunland and Tacachale).

The closure of Landmark in Miami-Dade County in 2005, and the planned closure of Gulf Coast Center by 2010, are part of the agency's 1998 settlement agreement in the federal Brown v. Bush lawsuit initiated by the Advocacy Center for Persons with Disabilities. The agency developed detailed plans for the closure of Landmark and Gulf Coast to ensure the health and safety of residents. The Legislative oversight for the closure of these institutions is currently through the budget process. During the closure process for Gulf Coast Center and Landmark the downsizing of these facilities was reflected in reductions in appropriations and personnel in the agency's budget request and subsequent Legislative appropriations.

The choice of where to live is an important part of the Medicaid program which provides the federal funding to these institutions. Federal law gives residents the right to choose the treatment setting. The closure of an institution does not obligate an individual or guardian to choose a home and community-based waiver placement if the individual, in fact, wants an institutional placement. In addition, federal law, 42 C.F.R. 431.220, provides that an individual retains the right to challenge placement decisions through the fair hearing process. If a resident of an institution that is closing has the desire to remain in an institution, they would have the choice of other public or private institutions for persons with developmental disabilities. The location of an institutional placement could be anywhere in the state and would depend on vacancies and the ability of the specific institution to adequately meet the needs of the resident.

Florida Statute 393.062 states that "The Legislature finds and declares that existing state programs for the treatment of individuals with developmental disabilities, which often unnecessarily place clients in institutions, are unreasonably costly, are ineffective in bringing the individual client to his or her maximum potential, and are in fact debilitating to many clients" The Office of Program Policy Analysis and Government Accountability (OPPAGA) of the Florida Legislature conducted a review of the Developmental Disabilities Program in 2000 (Report No: 00 -17). The report found "Many clients who currently live in state institutions and private intermediate care facilities could be appropriately served in less costly settings, saving about $35 million per year. Closing one or more of the state institutions could save another $4 million annually, although some investment in community-based services would be needed to expand services for these clients."

C. SECTION DIRECTORY:

Section 1. Creates section 393.35, Florida Statutes, regarding closure of developmental disabilities institutions.

Section 2. Provides an effective date of July 1, 2008.

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:

None.

D. STATEMENT OF THE SPONSOR

No statement submitted.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to developmental disabilities
3 institutions; creating s. 393.35, F.S.; providing
4 legislative intent; requiring the Agency for Persons with
5 Disabilities to submit a plan to the Governor and the
6 Legislature if the agency or the Legislature proposes to
7 close or reduce by a certain percentage the resident
8 population of a developmental disabilities institution;
9 providing for content of the plan; requiring the Governor
10 to approve or disapprove the plan to close or reduce the
11 population of an institution; providing that the
12 Governor's decision is not binding on the Legislature;
13 requiring the agency to provide quarterly reports;
14 providing for content of the reports; providing an
15 effective date.
16
17 Be It Enacted by the Legislature of the State of Florida:
18
19 Section 1. Section 393.35, Florida Statutes, is created to
20 read:
21 393.35 Developmental disabilities institutions.--
22 (1) LEGISLATIVE INTENT.--It is the intent of the
23 Legislature that:
24 (a) The agency timely notify residents and guardians of
25 residents of the Marianna Sunland developmental disabilities
26 institution or the Tacachale developmental disabilities
27 institution when the agency or the Legislature announces its
28 intent to close or reduce the census by 20 percent or more at

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

29 either the Marianna Sunland institution or the Tacachale
30 institution. For purposes of this section, "census reduction" or
31 "reduce the census" means to reduce the current resident
32 population of an institution over a 1-year period that begins on
33 July 1 and ends on June 30 annually. Residents placed in the
34 institution under court order and residents or their guardians
35 who have requested in writing to leave the institution shall not
36 be included in the census reduction calculation.
37 (b) The agency provide assurance to residents and their
38 guardians that planning for transition to another residential
39 setting shall be conducted with the involvement of the residents
40 and their guardians, designated family members, or designees and
41 shall address the needs of the resident in the most appropriate
42 setting.
43 (c) The agency ensure the health and safety of the
44 residents of a developmental disabilities institution during a
45 transition to closure of or a census reduction of 20 percent or
46 more at the institution.
47 (d) The agency conduct a thorough planning process for
48 activities associated with closure of or a census reduction of
49 20 percent or more at a developmental disabilities institution
50 and comply with the provisions of this section.
51 (2) INTENT TO CLOSE OR REDUCE CENSUS OF MARIANNA SUNLAND
52 OR TACACHALE DEVELOPMENTAL DISABILITIES INSTITUTIONS.--
53 (a) If the agency or the Legislature announces its intent
54 to close or reduce the census by 20 percent or more at either
55 the Marianna Sunland developmental disabilities institution or
56 the Tacachale developmental disabilities institution after July

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

57 1, 2008, the agency must first provide a report regarding plans
58 related to closure of or census reduction at the developmental
59 disabilities institution to the Governor, the President of the
60 Senate, and the Speaker of the House of Representatives. The
61 President of the Senate and the Speaker of the House of
62 Representatives shall have 90 days to provide comments to the
63 Governor after receipt of notification of intent to close or
64 reduce the census by 20 percent or more at the institution. The
65 report shall include, but not be limited to, the following
66 activities:
67 1. A plan for providing notification of closure or census
68 reduction. The agency shall notify each affected resident of the
69 institution, the resident's guardian, designated members of the
70 resident's family, or a designee of the intent to close or
71 reduce the census at the institution. The notice must be
72 delivered by registered mail and include the reasons for closure
73 or census reduction, the timeline for closure or census
74 reduction activities, and contact information for the recipient
75 of the notice to obtain additional information.
76 2. A plan for providing education to staff and to
77 residents and their guardians, family members, or designees
78 about residential placement opportunities available to residents
79 after leaving the institution.
80 3. A plan for providing services and other residential
81 placements for residents after they leave the institution.
82 4. An assessment of the capacity of service providers and
83 their ability to meet the needs of the residents in the
84 communities where residents will likely reside after they leave

85 the institution.
86 5. A plan for service provider recruitment, development,
87 and training, as needed, to ensure that adequate services are
88 available to residents as they make the transition into the
89 community.
90 6. A plan for monitoring and ensuring safety and service
91 quality for residents after they have left the institution.
92 7. A process for developing a support plan that includes
93 consultation with the residents and their guardians and provides
94 a community living plan for delivering services to those
95 residents.
96 8. A process for residents and their guardians to appeal
97 the services planned through the support planning process.
98 9. A plan for adjusting employee staffing levels during
99 the census reduction or transition to closure to ensure the
100 safety of and quality of care for residents and assistance for
101 employees seeking new employment.
102 10. A complete timeline for closure of or census reduction
103 at the institution that includes a financial plan for the
104 closure or census reduction and the projected savings associated
105 with the closure or census reduction.
106 11. A communications plan to keep residents, guardians of
107 residents, designated family members, employees, and designees
108 informed of the progress of the closure or census reduction.
109 12. The responsibility of each state agency involved in
110 the closure of or census reduction at the institution.
111 13. A plan for closure activities and the disposition of
112 property of the physical plant of the institution.

113 (b) After consideration of comments from the President of
114 the Senate and the Speaker of the House of Representatives and
115 other evidence, the Governor shall approve or disapprove the
116 plan of the agency to close or reduce the census by 20 percent
117 or more at the developmental disabilities institution. The
118 Governor's approval or disapproval of the closure of or census
119 reduction at an institution is not binding on the Legislature.
120 (3) REPORTS ON CLOSURE ACTIVITIES OR CENSUS REDUCTION.--
121 (a) The agency shall provide a quarterly report to the
122 Governor, the President of the Senate, and the Speaker of the
123 House of Representatives on the progress of the closure of or
124 census reduction at an institution and shall post the report on
125 the agency's Internet website. This report requirement shall
126 apply to the closure of the Gulf Coast Center and any other
127 developmental disabilities institution closure or census
128 reduction activities approved after July 1, 2008.
129 (b) The report shall document the progress of the plan,
130 including, but not limited to, the requirements in subsection
131 (2), and shall also include the following:
132 1. The number of residents, guardians, designated family
133 members, and designees that have been notified and have yet to
134 be notified of the planned closure or census reduction
135 activities.
136 2. Current resident population compared to targeted census
137 reduction.
138 3. The locations of residential placements by number and
139 type of facilities.
140 4. The number of significant reportable events for

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

141 residents in the institution.
142 5. Statistics that indicate the successful placement of
143 residents in locations in the community or in other institutions
144 chosen by those residents or their guardians and an assessment
145 of the efforts made by the agency in assisting residents and
146 their guardians in making those choices.
147 Section 2. This act shall take effect July 1, 2008.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 1(for drafter's use only)

Bill No. 333

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)

ADOPTED AS AMENDED __ (Y/N)

ADOPTED W/O OBJECTION __ (Y/N)

FAILED TO ADOPT __ (Y/N)

WITHDRAWN __ (Y/N)

OTHER ______

---

1 Council/Committee hearing bill: Healthcare Council

2 Representative(s) Nehr offered the following:

3

4 **Amendment (with directory and title amendments)**

5 Remove line(s) 27 and insert:

6 institution when the agency announces its

7

8

9 ---

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

11 Remove line(s) 6 and insert:

12 Legislature if the agency proposes to

13

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 2(for drafter's use only)

Bill No. **333**

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)

ADOPTED AS AMENDED __ (Y/N)

ADOPTED W/O OBJECTION __ (Y/N)

FAILED TO ADOPT __ (Y/N)

WITHDRAWN __ (Y/N)

OTHER ______

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1 Council/Committee hearing bill: Healthcare Council

2 Representative(s) Nehr offered the following:

3

4 **Amendment (with directory and title amendments)**

5 Remove line(s) 53 and insert:

6 (a) If the agency announces its intent

7

8

9 ---

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

11 Remove line(s) 6 and insert:

12 Legislature if the agency proposes to

13

14

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 3(for drafter's use only)

Bill No. **333**

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)

ADOPTED AS AMENDED __ (Y/N)

ADOPTED W/O OBJECTION __ (Y/N)

FAILED TO ADOPT __ (Y/N)

WITHDRAWN __ (Y/N)

OTHER ______

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1 Council/Committee hearing bill: Healthcare Council

2 Representative(s) Nehr offered the following:

3

4 **Amendment**

5 Remove lines 80-81

6

7

Amendment No. 4 (for drafter's use only)

Bill No. **333**

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)

ADOPTED AS AMENDED __ (Y/N)

ADOPTED W/O OBJECTION __ (Y/N)

FAILED TO ADOPT __ (Y/N)

WITHDRAWN __ (Y/N)

OTHER ______

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1 Council/Committee hearing bill: Healthcare Council

2 Representative(s) Nehr offered the following:

3

4 **Amendment (with directory and title amendments)**

5 Remove line(s) 92-95 and insert:

6 7. A process for developing a support plan that includes

7 consultation with the residents and their guardians for

8 providing services and other residential placement plans for

9 residents after they leave the institution.

10

11

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 5 (for drafter's use only)

Bill No. 333

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)
ADOPTED AS AMENDED __ (Y/N)
ADOPTED W/O OBJECTION __ (Y/N)
FAILED TO ADOPT __ (Y/N)
WITHDRAWN __ (Y/N)
OTHER ______

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1 Council/Committee hearing bill: Healthcare Council
2 Representative(s) Nehr offered the following:
3
4 **Amendment (with directory and title amendments)**
5 Remove line(s) 96-97

HB 341

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 341 Treatment Programs for Impaired Practitioners
SPONSOR(S): Holder and others
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Health Quality	10 Y, 0 N	Owen	Lowell
2) Healthcare Council		Owen	Gormley
3) Policy & Budget Council			
4)			
5)			

SUMMARY ANALYSIS

HB 341 revises provisions relating to the impaired practitioner program within the Department of Health. The bill authorizes the Department of Health to contract with impaired practitioner program consultants to provide services to students enrolled in schools that provide training for health care practitioners licensed under Chapter 456, F. S., if the school requests such services. The bill provides immunity to the schools from a civil action for the referral of a student to a consultant or for disciplinary actions that adversely affect the status of a student.

The bill grants sovereign immunity to an impaired practitioner consultant, its officers, employees, and persons acting at the direction of the consultant for the limited purpose of an emergency intervention, when the consultant is unable to perform the intervention, for actions taken within the scope of a contract with the Department of Health. The bill specifies contractual conditions that must exist in order for sovereign immunity to be granted.

This bill may implicate Article I, section 21 of the Florida Constitution, the right of access to the courts, by barring a civil recovery against schools that provide training for health care practitioners licensed under chapter 456, F.S., under specific circumstances.

The bill appears to have a significant negative fiscal impact on the Medical Quality Assurance Trust Fund (see fiscal analysis).

The bill provides for an effective date of July 1, 2008.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government – this bill will grant sovereign immunity to contractor consultants for actions taken within the scope of a contract with the Department of Health.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

Impaired Practitioner Programs
Healthcare professions are established within individual practice acts and are governed by Chapter 456, Florida Statutes, within the Department of Health (department) in the Division of Medical Quality Assurance (division). Section 456.076, Florida Statutes, authorizes the department 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.[1] Impaired practitioner programs are available to all healthcare practitioners licensed under Chapter 456, F.S. as well as other licensed professionals regulated by the department.

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 the department regarding a practitioner patient's ability to practice.[2] Consultants are required by department rules to refer practitioner patients to department-approved treatment programs and providers. They have specified case management duties with regards to practitioner patient progress in a treatment program. Further, the consultant acts as the records custodian for all treatment information on the practitioner patients they are contracted to monitor. A typical contract between a consultant and an impaired practitioner under treatment is 5 years.

Currently, the department contracts with two groups for impaired practitioner consulting services: the Intervention Project for Nurses (IPN) for nurses licensed under Chapter 464, F.S., and the Professionals Resource Network (PRN) for all other licensed health care professionals. According to the department, there are approximately 2,700 participants enrolled in the programs: 1,600 in the IPN and 1,100 in the PRN.

Sovereign Immunity
Sovereign immunity is the legal doctrine which provides that a government may not be sued for a claim without its consent. However, the federal government and most states have waived their immunity from suit in varying degrees in certain cases. Article X, section 13 of the Florida Constitution establishes that laws may be enacted in the statutes for suits to be brought against the state for its liabilities. Accordingly, s. 768.28(1), F.S., provides that the state "waives sovereign immunity for liability for torts, but only to the extent specified in this act."

Specifically, the act provides that the state has limited its financial liability for a tort action by any one person to $100,000 or to $200,000 for additional claims and judgments arising from the same incident or occurrence. If a judgment is rendered by a court in excess of those amounts, the plaintiff may pursue a claim bill in the Legislature for the amount in excess of the statutory limit.

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[1] Rules 64B31-10.10.001 and 64B31-10.002, F.A.C.
[2] Section 456.076(5)(a), F.S.

The act further provides that the exclusive remedy for injury or damage suffered as a result of an act, event, or omission of an officer, employee, or agent of the state is an action against the governmental entity, the head of such entity in his or her official capacity, or the constitutional officer of which the officer, employee, or agent is an employee, unless the act or omission was committed in bad faith, with malicious purpose, or in a manner exhibiting wanton and willful disregard of human rights, safety, or property. "Officer, employee or agent" is defined to include any health care provider providing services pursuant to s. 766.1115, F.S.,[3] any member of the Florida Health Services Corps, as defined in s. 381.0302, F.S., who provides uncompensated care to medically indigent persons referred by the department, and any public defender or his or her employee or agent, including among others, an assistant public defender and an investigator.

In addition, an officer, employee, or agent of the state or any of its subdivisions may not be held personally liable or named as a defendant for an injury or damage if the act occurred in the scope of his or her employment unless the officer, employee, or agent acted in bad faith, with malicious purpose, or in a manner that exhibited a wanton and willful disregard of human rights, safety, or property.

The Bureau of State Liability Claims within the Department of Financial Services provides protection against general liability claims and suits filed pursuant to Section 768.28, F.S.[4]

Effect of Proposed Changes

The bill increases the qualifications required for impaired practitioner program consultants by requiring that each consultant, instead of at least one, be a practitioner or recovered practitioner licensed under chapters 458, 459, or Part I of 464, or an entity that employs a medical director who is a practitioner or recovered practitioner licensed as an allopathic or osteopathic physician or nurse under chapters 458, 459 or part I of 464, F.S., respectively.

The bill authorizes the department to contract with impaired practitioner program consultants to provide services to students enrolled in schools that provide training for health care practitioners licensed under Chapter 456, F.S.,[5] if the school requests such services. In addition, the bill provides civil immunity to the schools that refer a student to an impaired practitioner program consultant or take disciplinary actions that adversely affect the status of a student, provided the school adheres to due process procedures adopted by the applicable accreditation entities and does not act with intentional fraud.

The bill provides sovereign immunity to an impaired practitioner consultant, its officers, employees, and persons acting at the direction of the consultant for the limited purpose of an emergency intervention, when the consultant is unable to perform the intervention, for actions taken within the scope of a contract with the Department of Health. The bill specifies contractual conditions that must exist in order for sovereign immunity to be granted.

The bill requires the Department of Financial Services to defend the consultant, its officers, employees, and persons acting at the direction of the consultant for the limited purpose of an emergency intervention, when the consultant is unable to perform the intervention, from any legal action brought as a result of contracted program activities.

C. SECTION DIRECTORY:

Section 1. Amends s. 456.076, F.S., revising provisions relating to treatment for impaired practitioners.

Section 2. Provides an effective date of July 1, 2008.

[3] Otherwise known as the "Access to Health Care Act."
[4] http://www.fldfs.com/Risk/SLC/index.htm.
[5] According to the department, while there are 95 healthcare licenses issued by the department, it is unknown how many educational institutions offer curricula that may lead to licensure in these professions.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   As of 2008, there were 96,423 students enrolled in a health program[6] within a state community college or state university in Florida.[7] The Professional Resource Network has determined that approximately 3 percent of currently licensed health practitioners may be eligible for treatment services.[8] If the assumption is made that the Department of Health enters into contracts with consultants and 3 percent of the student population seeks treatment services provided by either the IPN or PRN program, participation may increase upwards of 2,393 participants annually.

   The current contract with IPN and PRN costs $1,046 per participant annually. However, additional participants may increase the annual contract amount per participant.

Estimated Recurring Expenditures	1st Year	2nd Year
Medical Quality Assurance Trust Fund	$3,025,754	$3,025,754

   The Medical Quality Assurance (or MQA) Trust Fund is funded by fees collected from all licensed practitioners under chapter 456, F.S. Currently, students do not pay fees until they are licensed. However, the MQA Trust Fund will pay for the consultant/vendor fees associated with providing treatment services to eligible students. As of December 2007, there were 4 medical students receiving services provided by PRN and 14 nursing students receiving services provided by IPN.[9]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Approved treatment providers may experience an increase in demand for services with the addition of students enrolled in schools that provide training for students licensed under chapter 456, F.S., in impaired practitioner programs.

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[6] Not all enrolled students may be in a health discipline that leads to licensure regulated under chapter 456, F.S.
[7] 2008 Fact Book Tables 10 and 11 (http://www.fldoe.org/arm/cctcmis/pubs/factbook/default.asp) and 2007-08 Baccalaureate Program Enrollment Reports emailed by Dept of Education to House staff on 1/14/08.
[8] *Impaired Practitioners Program of Florida: Professionals Resource Network, Inc.*, Monthly report prepared for the Department of Health (December 2007).
[9] *Impaired Practitioners Program of Florida: Professional Resource Network, Inc.*, and *Intervention Project for Nurses* Monthly Reports prepared for the Department of Health (December 2007).

Students who are found impaired are eligible to enter into a contract to receive services offered by the PRN or IPN program. Based on impairment contracts for licensed practitioners, a student may be required to enter into a contract for up to 5-years. While in an impairment program a student is required to pay for all treatment services such as initial evaluations, urinalysis testing and ongoing psychotherapy. Initial evaluations can range from $300-$500 and up to $1000 if chronic pain evaluation is required. The average cost is $42 per urinalysis, the number per month varies depending upon the recovery process. The cost of four group therapy meetings per month can range from $50- $150 per month. If the impairment is found to be physical, then the cost may be nominal. All participants are required to have a primary care physician, but no visits are required. The PRN program offers a loan forgiveness option to eligible participants. All treatment services are paid directly to the provider or third party administrator and not through the PRN program.

D. FISCAL COMMENTS:

Currently, impaired practitioner consultants are not statutorily designated as agents of the department; rather, they are considered vendors/consultants. Generally, if a claim is brought against a vendor it is currently the responsibility of the vendor/consultant to pay for all costs associated with defending any claim, suit, or proceeding.

The bill will require the Department of Financial Services to defend claims against a vendor/consultant, its officers, employees, and persons acting at the direction of the consultant for the limited purpose of an emergency intervention by making them agents of the department. The potential fiscal impact is indeterminate. The department would be liable for a maximum of $200,000 per incident unless the Legislature approves a claims bill for the incident.

The Department of Health has stated that the MQA Trust Fund would have to reimburse the Department of Financial Services for all costs associated with defending any claim, suit, or proceeding against an impaired practitioner consultant.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenues.

2. Other:

This bill may implicate Article I, section 21 of the Florida Constitution, which states that the courts "shall be open to every person for redress of any injury, and justice shall be administered without sale, denial, or delay." The test for ensuring the right of access to the courts was declared in *Kluger v. White*, 281 So.2d 1 (Fla. 1973), in which the Florida Supreme Court held that the Legislature is without power to abolish or otherwise restrict a statutory law right that predated the adoption of the constitution or a common law right without providing a reasonable alternative remedy, unless there is a showing of an overpowering public necessity to limit or abolish such right and no alternative remedy of meeting such public necessity exists.

The Florida Supreme Court refined the *Kluger* test in *Smith v. Department of Ins.*, 507 So.2d 1080 (Fla. 1986). There, comprehensive tort reform legislation capping non-economic damages at $450,000 was challenged on the basis that it denied claimants access to the courts. In that case, the

Court noted the *Kluger* test requires either (1) providing a reasonable alternative remedy or commensurate benefit, or (2) a legislative showing of overpowering public necessity for the abolishment of the right *and* no alternative method of meeting such public necessity. The Court noted that the right to sue and recover non-economic damages of any amount existed at the time the Florida Constitution was adopted. Consequently, the Court found the cap on non-economic damages unconstitutional as the Legislature did not provide an alternative remedy or commensurate benefit and the parties did not assert the existence of an overpowering public necessity.

B. RULE-MAKING AUTHORITY:

No additional rulemaking authority is required as a result of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

It appears that the bill may be overbroad with respect to the extension of sovereign immunity to impaired practitioner consultants' officers, employees, and persons acting at the direction of the consultant for the limited purpose of an emergency intervention, when the consultant is unable to perform the intervention. Extension of sovereign immunity to this degree places the state at risk for the actions of individuals that the state does not have direct control over, such as persons other than a contracted consultant performing emergency interventions.

The Department of Health has recommended three amendments:

- The first amendment is recommended to ensure that the department has sufficient rulemaking authority for all aspects of the impaired practitioner programs.

  On lines 30-32, deletes those lines and insert:
  treating a professional, and 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, as well as requirements related to the consultant's expulsion of professionals from the program ~~evaluating and treating a professional, and requirements for the continued care and monitoring of a professional by the consultant by an approved treatment provider~~.

- The second amendment is recommended to clarify that the treatment of impaired students, who may leave the state after graduation, is the responsibility of the State Board of Education and not the licensed professionals who pay licensing fees.

  On lines 45-47, deletes those lines and insert:
  practitioner is, in fact, impaired. The department may use a consultant or contract with its consultants, for appropriate compensation from the school or from the State Board of Education, for services to be provided, if requested by a school located in Florida with approval from the State Board of Education, for students

- The third amendment is recommended to require consultants to indemnify the state for liabilities incurred under chapter 768 (sovereign immunity).

  On line 73, delete that line and insert:
  this section. The contract must provide:
  1. For the indemnification of the state by the consultant for any liabilities incurred up to the limits set out in chapter 768.

D. STATEMENT OF THE SPONSOR

I will be introducing a strike all amendment during the Committee meeting that will address the concerns mentioned in the analysis. I look forward to discussing the bill with all of the Committee members.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

On January 22, 2008, the Health Quality Committee adopted one amendment to the bill. The strike-all amendment narrowed the scope of the bill to apply only to those students in schools in preparation for licensure as allopathic physicians under chapter 458 or osteopathic physicians under chapter 459.

The bill was reported favorably with a recommended Council Substitute.

1 A bill to be entitled
2 An act relating to treatment programs for impaired
3 practitioners; amending s. 456.076, F.S.; revising
4 requirements for program consultants; authorizing the
5 Department of Health to contract with consultants to
6 provide treatment services for allopathic and osteopathic
7 physician students alleged to be impaired; providing
8 certain schools with absence of liability in civil actions
9 when referring students to such consultants or taking
10 certain actions without intentional fraud; providing
11 limited sovereign immunity for certain program consultants
12 under specific contractual conditions; requiring the
13 Department of Financial Services to defend actions against
14 program consultants; providing an effective date.
15
16 Be It Enacted by the Legislature of the State of Florida:
17
18 Section 1. Subsections (1) and (2) of section 456.076,
19 Florida Statutes, are amended, and subsection (7) is added to
20 that section, to read:
21 456.076 Treatment programs for impaired practitioners.--
22 (1) For professions that do not have impaired practitioner
23 programs provided for in their practice acts, the department
24 shall, by rule, designate approved impaired practitioner
25 programs under this section. The department may adopt rules
26 setting forth appropriate criteria for approval of treatment
27 providers. The rules may specify the manner in which the
28 consultant, retained as set forth in subsection (2), works with

29 the department in intervention, requirements for evaluating and
30 treating a professional, and requirements for ~~the~~ continued care
31 and monitoring ~~of a professional~~ by the consultant ~~by an~~
32 ~~approved treatment provider~~.
33 (2) The department shall retain one or more impaired
34 practitioner consultants. The ~~A~~ consultant shall be a licensee
35 under the jurisdiction of the Division of Medical Quality
36 Assurance within the department who~~, and at least one consultant~~
37 must be a practitioner or recovered practitioner licensed under
38 chapter 458, chapter 459, or part I of chapter 464 or shall be
39 an entity that employs a medical director who must be a
40 practitioner or recovered practitioner licensed under chapter
41 458, chapter 459, or part I of chapter 464. The consultant shall
42 assist the probable cause panel and department in carrying out
43 the responsibilities of this section. This shall include working
44 with department investigators to determine whether a
45 practitioner is, in fact, impaired. The department may contract
46 with the consultant, for appropriate compensation, for services
47 to be provided, if requested by the school, for students
48 enrolled in schools for licensure under this chapter who are
49 alleged to be impaired as a result of the misuse or abuse of
50 alcohol or drugs, or both, or due to a mental or physical
51 condition. No school that is governed by accreditation standards
52 that require notice and the provision of due process procedures
53 to students shall be held liable in any civil action for
54 referring a student to the consultant retained by the department
55 or for disciplinary actions that adversely affect the status of
56 a student when the disciplinary actions are instituted in

57 reasonable reliance on the recommendations, reports, or
58 conclusions provided by such consultant, provided that the
59 school, in referring the student or taking disciplinary action,
60 adheres to the due process procedures adopted by the applicable
61 accreditation entities and provided that the school committed no
62 intentional fraud in carrying out the provisions of this
63 section.
64 (7)(a) A consultant retained pursuant to subsection (2), a
65 consultant's officers and employees, and those acting at the
66 direction of the consultant for the limited purpose of an
67 emergency intervention on behalf of a licensee or student as
68 described in subsection (2) when the consultant is unable to
69 perform such intervention shall be considered agents of the
70 department for purposes of s. 768.28 while acting within the
71 scope of the consultant's duties under the contract with the
72 department if the contract complies with the requirements of
73 this section. The contract must provide that:
74 1. The consultant establish a quality assurance program to
75 monitor services delivered under the contract.
76 2. The consultant's quality assurance program, treatment,
77 and monitoring records be evaluated quarterly.
78 3. The consultant's quality assurance program be subject
79 to review and approval by the department.
80 4. The consultant operate under policies and procedures
81 approved by the department.
82 5. The consultant provide to the department for approval a
83 policy and procedure manual that comports with all statutes,
84 rules, and contract provisions approved by the department.

85 6. The department be entitled to review the records
86 relating to the consultant's performance under the contract for
87 the purpose of management audits, financial audits, or program
88 evaluation.
89 7. All performance measures and standards be subject to
90 verification and approval by the department.
91 8. The department be entitled to terminate the contract
92 with the consultant for noncompliance with the contract.
93 (b) In accordance with s. 284.385, the Department of
94 Financial Services shall defend any claim, suit, action, or
95 proceeding against the consultant, the consultant's officers or
96 employees, or those acting at the direction of the consultant
97 for the limited purpose of an emergency intervention on behalf
98 of a licensee or student as described in subsection (2) when the
99 consultant is unable to perform such intervention brought as a
100 result of any act or omission of action of any of the
101 consultant's officers and employees and those acting at the
102 direction of the consultant for the limited purpose of an
103 emergency intervention on behalf of a licensee or student as
104 described in subsection (2) when the consultant is unable to
105 perform such intervention when such act or omission arises out
106 of and in the scope of the consultant's duties under its
107 contract with the department.
108 (c) If the consultant retained pursuant to subsection (2)
109 is retained by any other state agency, and if the contract
110 between such state agency and the consultant complies with the
111 requirements of this section, the consultant, the consultant's
112 officers and employees, and those acting at the direction of the

113 consultant for the limited purpose of an emergency intervention
114 on behalf of a licensee or student as described in subsection
115 (2) when the consultant is unable to perform such intervention
116 shall be considered agents of the state for the purposes of this
117 section while acting within the scope of and pursuant to
118 guidelines established in the contract between such state agency
119 and the consultant.
120 Section 2. This act shall take effect July 1, 2008.

Amendment No. 1

Bill No. **341**

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	____

Council/Committee hearing bill: Healthcare Council
Committee on Health Quality offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

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

456.076 Treatment programs for impaired practitioners.--

(1) For professions 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, and requirements for ~~the~~ continued care and monitoring ~~of a professional~~ by the consultant ~~by an approved treatment provider~~.

The strike all amendment was adopted in HQ on 1/22/08 with recommended council substitute.

21 (2) The department shall retain one or more impaired
22 practitioner consultants. The ~~A~~ consultant shall be either a
23 licensee under the jurisdiction of the Division of Medical
24 Quality Assurance within the department who~~, and at least one~~
25 ~~consultant~~ must be a practitioner or recovered practitioner
26 licensed under chapter 458, chapter 459, or part I of chapter
27 464 or an entity that employs a medical director who must be a
28 practitioner or recovered practitioner licensed under chapter
29 458, chapter 459, or part I of chapter 464. The consultant shall
30 assist the probable cause panel and department in carrying out
31 the responsibilities of this section. This shall include working
32 with department investigators to determine whether a
33 practitioner is, in fact, impaired. The department may contract
34 with the consultant, for appropriate compensation, for services
35 to be provided, if requested by the school, for students
36 enrolled in schools in preparation for licensure as allopathic
37 physicians under chapter 458 or osteopathic physicians under
38 chapter 459 who are alleged to be impaired as a result of the
39 misuse or abuse of alcohol or drugs, or both, or due to a mental
40 or physical condition. No medical school accredited by the
41 Liaison Committee on Medical Education or Commission on
42 Osteopathic College Accreditation, or other school that provides
43 for the education of students enrolled in preparation for
44 licensure as allopathic physicians under chapter 458 or
45 osteopathic physicians under chapter 459, which is governed by
46 accreditation standards that require notice and the provision of
47 due process procedures to students shall be held liable in any
48 civil action for referring a student to the consultant retained
49 by the department or for disciplinary actions that adversely
50 affect the status of a student when the disciplinary actions are

51 instituted in reasonable reliance on the recommendations,
52 reports, or conclusions provided by such consultant, provided
53 that the school, in referring the student or taking disciplinary
54 action, adheres to the due process procedures adopted by the
55 applicable accreditation entities and provided that the school
56 committed no intentional fraud in carrying out the provisions of
57 this section.

58 (7)(a) A consultant retained pursuant to subsection (2),
59 and its officers and employees and those acting at the direction
60 of the consultant for the limited purpose of an emergency
61 intervention of a licensee or student as described in subsection
62 (2) when the consultant is unable to perform such intervention,
63 shall be considered agents of the department for purposes of s.
64 768.28 while acting within the scope of the contractor's duties
65 under the contract with the department if the contract complies
66 with the requirements of this section. The contract must
67 provide:

68 1. That the consultant establish a quality assurance
69 program to monitor services delivered under the contract.

70 2. That the consultant's quality assurance program,
71 treatment, and monitoring records be evaluated quarterly.

72 3. That the consultant's quality assurance program be
73 subject to review and approval by the department.

74 4. That the consultant operate under policies and
75 procedures approved by the department.

76 5. That the consultant provide to the department for
77 approval a policy and procedure manual that comports with all
78 statutes, rules, and contract provisions approved by the
79 department.

80 6. That the department be entitled to review the records
81 relating to the consultant's performance under the contract for
82 the purpose of management audits, financial audits, or program
83 evaluation.
84 7. That all performance measures and standards be subject
85 to verification and approval by the department.
86 8. That the department be entitled to terminate the
87 contract with the consultant for noncompliance with the
88 contract.
89 (b) In accordance with s. 284.385, the Department of
90 Financial Services shall defend any claim, suit, action, or
91 proceeding against the consultant, or its officers or employees
92 or those acting at the direction of the consultant for the
93 limited purpose of an emergency intervention of a licensee or
94 student as described in subsection (2) when the consultant is
95 unable to perform such intervention, brought as a result of any
96 act or omission of action of any of its officers and employees
97 and those acting at the direction of the consultant for the
98 limited purpose of an emergency intervention of a licensee or
99 student as described in subsection (2) when the consultant is
100 unable to perform such intervention, when such act or omission
101 arises out of and in the scope of the consultant's duties under
102 its contract with the department.
103 (c) If the consultant retained pursuant to subsection (2)
104 is retained by any other state agency, and if the contract
105 between such state agency and the consultant complies with the
106 requirements of this section, then the consultant, and its
107 officers and employees and those acting at the direction of the
108 consultant for the limited purpose of an emergency intervention
109 of a licensee or student as described in subsection (2) when the

110 consultant is unable to perform such intervention, shall be
111 considered agents of the state for the purposes of this section,
112 while acting within the scope of and pursuant to guidelines
113 established in the contract between such state agency and the
114 consultant.
115 Section 2. This act shall take effect July 1, 2008.
116
117
118 ---
119 **T I T L E A M E N D M E N T**
120 Remove the entire title and insert:
121 A bill to be entitled
122 An act relating to treatment programs for impaired
123 practitioners; amending s. 456.076, F.S.; revising
124 requirements for program consultants; authorizing the
125 Department of Health to contract with consultants to
126 provide treatment services for allopathic and osteopathic
127 physician students alleged to be impaired; providing for
128 absence of liability in civil actions of certain schools
129 for referring students to such consultants or taking
130 certain actions without intentional fraud; providing
131 limited sovereign immunity for certain program consultants
132 under specific contractual conditions; requiring the
133 Department of Financial Services to defend actions against
134 program consultants; providing an effective date.
135

The strike all amendment was adopted in HQ on 1/22/08 with recommended council substitute.

HB 637

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 637 Electronic Health Records
SPONSOR(S): Grimsley and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1998

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Healthcare Council		Owen	Gormley
2) Policy & Budget Council			
3)			
4)			
5)			

SUMMARY ANALYSIS

The bill creates the "Florida eHealth Initiative Act" to "promote and coordinate the establishment of a secure, privacy-protected, and interconnected statewide health information exchange." The bill amends the agency's authority to provide grants to RHIOs by requiring dollar for dollar match of state funds with local or private funds and issuance of grants in three categories: development, operation, and collaboration. The bill also creates an Electronic Medical Records System Adoption Loan Program. The agency is required to provide one-time, no-interest loans to physicians or business entities whose shareholders are physicians for the initial costs of implementing an electronic medical records system.

The bill creates the Florida Health Information Exchange Advisory Council, composed of 12 members, to promote participation in health information exchanges, conduct outreach to stakeholders, and provide guidance regarding the effective use of health information exchanges and standards for privacy and security.

The bill clarifies that a patient's records held by a hospital may be disclosed without the consent of the patient, or his or her legal representative, to health care practitioners and providers involved in the care or treatment of the patient. The bill also clarifies that clinical lab results may be provided by a lab to other health care practitioners and providers involved in the care or treatment of the patient for use in connection with the treatment of the patient.

The bill requires the agency to maintain on its internet website information regarding federal and private sector health information exchange funding programs and a clearinghouse of state and national legislative, regulatory, and public awareness activities related to health information exchanges.

The bill requires the agency to develop and implement a plan to promote participation in health information exchanges and the adoption of electronic medical record systems by physicians in consultation with the council and professional associations.

Finally, the bill requires the OPPAGA to complete an independent evaluation of the grants program administered by the agency. The report must be provided to the Governor and the Legislature by July 1, 2009.

The bill has an indeterminate fiscal impact on the agency (see fiscal analysis).

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government – the bill creates a loan program to encourage and to provide incentives for the use of electronic medical records by physicians.

B. EFFECT OF PROPOSED CHANGES:

<u>Present Situation</u>

Widespread adoption of electronic medical records holds the promise of improving patient safety and reducing the cost of health care by preventing unnecessary procedures. However, in a recent report, the National Center for Health Statistics (NCHS) within the United States Centers for Disease Control and Prevention noted that adoption of information technology within the health care sector is trailing behind other sectors in the economy of the United States.[1] The adoption of electronic medical records (EMRs) by hospitals and physicians has been particularly slow. As part of its annual National Health Care Survey, NCHS found that, from 2001 through 2003:

- The most frequent IT application used in physician offices was an electronic billing system. Nearly three-fourths (73 percent) of physicians submitted claims electronically. Electronic submission of claims was more likely among physicians in the Midwest and South, in nonmetropolitan areas, among physicians under 50 years of age, and for physicians with 10 or more managed care contracts. Physicians in medical specialties such as psychiatry, dermatology, or sports medicine (among others) were least likely to submit claims electronically.
- EMRs were used more frequently in hospital settings (31 percent in emergency departments) than in physician offices (17 percent). Among physician office practices, there were no statistically significant differences in EMR use by region, metropolitan status, specialty, physician age, type of practice, or number of managed care contracts.

Federal

On April 27, 2004, President George W. Bush issued an Executive Order[2] in order to encourage the development of a nationwide interoperable health information technology infrastructure. The Executive Order directed the Secretary of Health and Human Services to establish within the Office of the Secretary the position of National Health Information Technology Coordinator. The Office of the National Coordinator (ONC) is tasked with developing, maintaining, and implementing a strategic plan to guide the nationwide implementation of interoperable health information technology in both the public and private health care sectors in order to reduce medical errors, improve quality, and produce greater value for health care expenditures.

In 2004, President Bush also set the goal for most Americans to have access to an interoperable electronic medical record by the year 2014. In order to accomplish this goal, the United States Department of Health and Human Services (HHS) created a "Strategic Framework",[3] which outlines the vision and goals of HHS' health information technology initiative. The plan of action consists of four sequential main goals; each goal is supported by three major strategies. The four goals are diagramed in Figure 1.[4]

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[1] C.W. Burt and E. Hing, *Use of Computerized Clinical Support Systems in Medical Settings: United States, 2001–03*, Advance Data from Vital and Health Statistics no. 353, March 15, 2005.

[2] *Executive Order: Incentives for the Use of Health Information Technology and Establishing the Position of the National Health Information Technology Coordinator* (visited December 4, 2007) http://www.whitehouse.gov/news/releases/2004/04/20040427-4.html

[3] U.S. Department of Health and Human Services, "Summary of Strategic Framework," (visited December 13, 2007) www.hhs.gov/healthit/framework.html.

[4] *Id.*

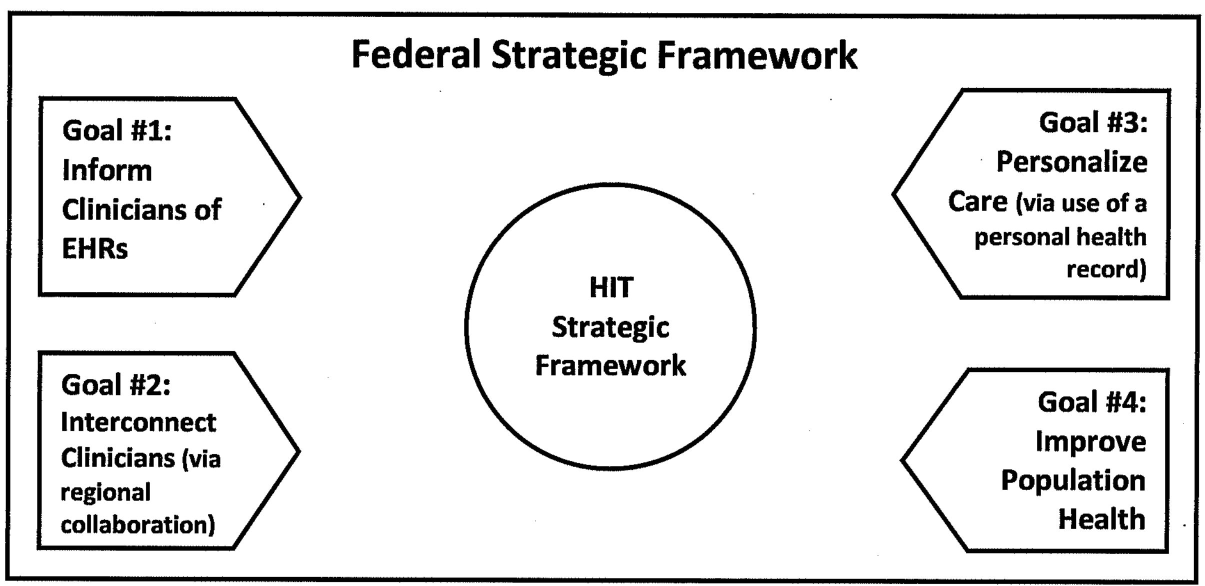

Figure 1

The federal government has taken an active role in ensuring the necessary steps are taken to achieve the outlined goals. The ONC awarded multiple contracts in 2005 to entities conducting work in the field of health information technology (HIT). Project goals included:

- Identifying interoperability standards (such as to facilitate the exchange of patient health data), through a contract with the Healthcare Information Technology Standards Panel (HITSP).
- Defining a certification process for health IT products, through a contract with the Certification Commission for Healthcare Information Technology (CCHIT).
- Designing and evaluating standards-based prototype architectures for the Nationwide Health Information Network (NHIN).

State and federal governments are both actively working to set technical interoperability standards, though for different purposes. Technical interoperability standards are important to state governments to enable the multiple participating entities to connect to each other, whether through a statewide HIE or other means. The federal government is pursuing technical interoperability standards to enable states to communicate with each other through the NHIN. Both state and federal government technical standards are equally important to overall HIE and should complement each other.

The federal government has also created a program aimed at increasing the adoption of electronic health records (EHR) among physician practices. The five-year project, which will begin in the spring of 2008, will provide annual bonuses to physician groups using nationally certified EHR systems to meet clinically qualified measures. During the five year project, it is estimated that 3.6 million consumers will be directly affected as their primary care physicians adopt certified EHRs in their practices.[5]

Other States

States across the nation have recognized the potential benefit of HIT and many are moving forward with HIT efforts. However, states differ in their vision of incorporating HIT into their healthcare system and the roadmap to achieve their vision. Smaller states are better positioned to create a statewide health information exchange (HIE), due to the fact that they have smaller, centrally-located populations and fewer healthcare stakeholders to coordinate, while larger states tend to have a greater number of stakeholders and a larger, more diverse population.[6] Regional health information organizations

[5] U.S. Department of Health and Human Services, "HHS Announces Project to Help 3.6 Million Consumers Reap Benefits of Electronic Health Records," October 30, 2007.

[6] Avalere Health, "Evolution of State Health Information Exchange, A Study of Vision, Strategy, and Progress, as prepared for the Agency for Healthcare Research and Quality," AHRQ Publication No. 06-0057, January 2006, 5.

(RHIOs) across states are many and varied, with minimal inter-RHIO connection. Many states have multiple RHIOs, but their participants, organization, structure, and activities are as varied as the communities they represent.[7]

The state plays a variety of roles in statewide HIE projects across the nation, including:

- The main cross-stakeholder facilitator.
- A primary driver of the project.
- A funding resource.
- A data resource.[8]

Some states have partnered in creating a legal entity, such as a 501(c)(3), to implement a roadmap to statewide HIE, while others have formed a steering committee, advisory council, or task force to continue to research the process by which statewide interoperability should be achieved. One commonality across states is the presence of a statewide advisory body to oversee the process by which a state reaches interoperability. Figure 2 illustrates the varied level of HIE adoption across the nation.[9]

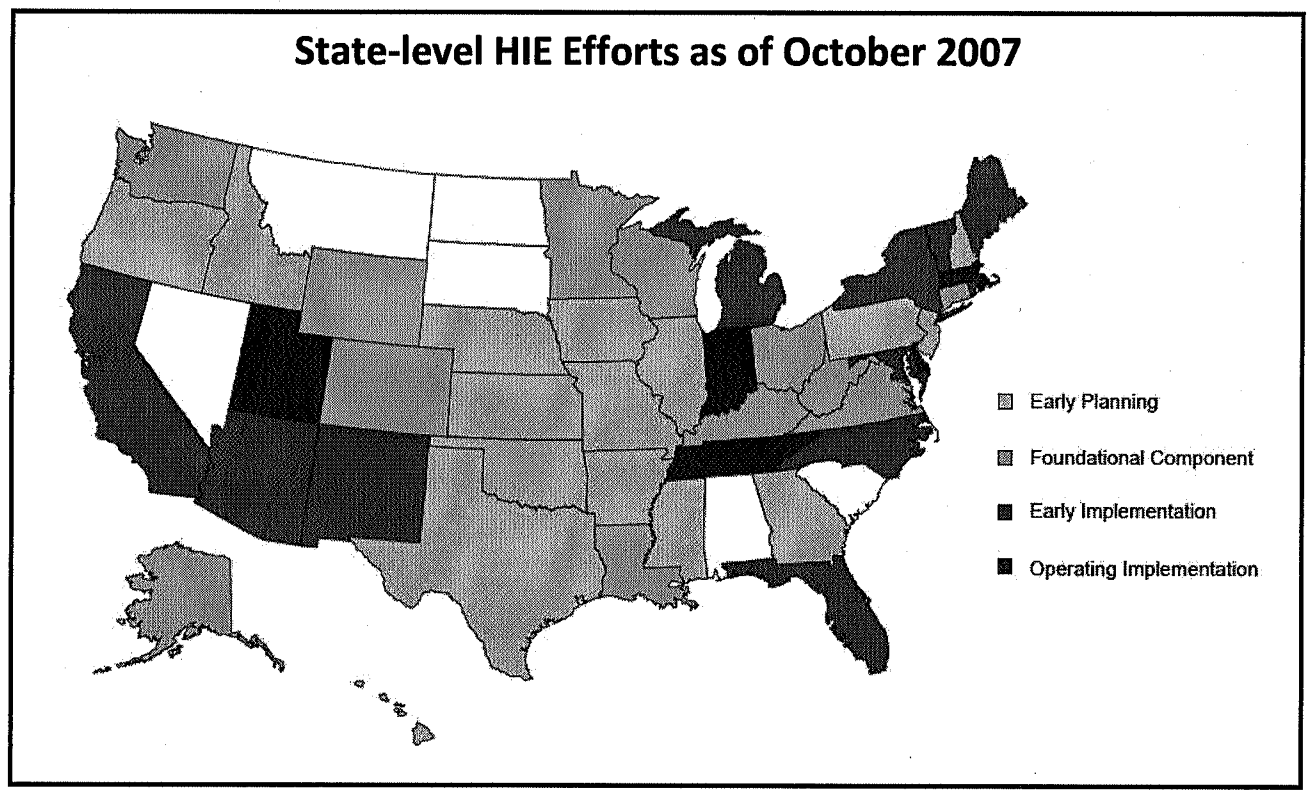

Figure 2

For example, the state of Georgia has formed an advisory board to advise the state Department of Community Health in establishing a statewide strategy that will enable health information to be available across the full continuum of care.[10] Georgia also administers a grants program to foster health information exchange, which awarded $853,088 in grants in 2007.[11] The state of Minnesota has formed

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[7] *Id.*

[8] *Id.* at 7.

[9] American Health Information Management Association's Foundation of Research and Education, "Building Sustainable Health Information Exchange: Roles for State Level Public-Private Partnerships," State-Level HIE Consensus Project, Consensus Conference, November 5-6, 2007, 15.

[10] Executive Order of Georgia Governor Sonny Perdue, October 17, 2006.

[11] Press release, Georgia Department of Community Health, "Four Georgia Health Partnerships Receive $853,088 in Grants," November 5, 2007.

a public-private collaborative to enhance the statewide HIE infrastructure, which is scheduled to go live in early 2008.[12] Minnesota also operates an EHR adoption grant program aimed at supporting the adoption and use of EHRs by healthcare providers in rural and underserved areas of the state.[13]

The state of Kentucky's roadmap to statewide HIE is very similar to the previously proposed Florida Health Information Network. The state approved the creation of the Kentucky e-Health Corporation which is an independent public-private entity responsible for managing the development and operations of the statewide Kentucky e-Health Network currently under development.

According to the e-Health Initiative, the top sources of upfront funding in the United States for health information exchange initiatives in 2007 were hospitals (53%), federal government grants and contracts (44%), state government grants and contracts (43%), private payers (32%), and philanthropic sources (31%).[14]

Florida
In Florida, the development of a statewide HIE began on May 4, 2004, when Governor Jeb Bush created the Governor's Health Information Infrastructure Advisory Board (board) by executive order.[15] The executive order required the board to "advise and support the Agency for Health Care Administration as it develops and implements a strategy for the adoption and use of electronic health records and creates a plan to promote the development and implementation of a Florida health information infrastructure." Complementing the Governor's Executive Order was the passage of the 2004 Affordable Health Care for Floridians Act, which directed the agency to "develop and implement a strategy for the adoption and use of electronic health records."[16]

The board issued an interim report to Governor Bush in 2005 that called for, among other recommendations, the immediate development of the Florida Health Information Network (FHIN) in order to encourage the adoption of electronic health records.[17] The vision for the FHIN is outlined in the board's white paper, "Florida Health Information Network, Architectural Considerations for State Infrastructure".[18] The model outlined by the board relies heavily on the RHIO as the vehicle for statewide HIE. The FHIN will act as the conductor of health information among healthcare providers and has two main components: regional HIE (through RHIOs) and a statewide infrastructure that will connect the RHIOs to enable statewide HIE.[19] The report also recognized two main obstacles facing the development of the FHIN: the low number of healthcare providers who have adopted electronic health record systems, and the lack of an infrastructure to share health information effectively.

Over the course of three years, the board and the agency worked together to implement recommendations related to advancing the adoption and utilization of EHRs and establishing RHIOs and regional HIE.[20] The board published its final report to Governor Charlie Crist on July 6, 2007.[21]

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[12] Press release, Minnesota Office of the Governor, "Minnesota Health Information Exchange to be among largest 'e-initiatives' in the nation," September 10, 2007.
[13] Minnesota Department of Health, "Minnesota e-Health Initiative Funding Opportunities," http://www.health.state.mn.us/e-health/funding.html (visited January 5, 2008).
[14] e-Health Initiative, "Fourth Annual Survey of Health Information Exchange at the State, Regional, and Community Levels," December 19, 2007, http://www.ehealthinitiative.org/2007HIESurvey/Financing.asp (visited January 5, 2008).
[15] Executive Order Number 04-93 (2004), available at http://www.fdhc.state.fl.us/dhit/Board/executive_order.pdf. (visited December 17, 2007).
[16] Chapter 2004-297, L.O.F., s. 408.062(5), F.S.
[17] Governor's Health Information Infrastructure Advisory Board, "First Interim Report to Governor Jeb Bush," http://ahca.myflorida.com/dhit/Board/interim_rept_gov.pdf (visited December 17, 2007).
[18] Governor's Health Information Infrastructure Advisory Board, "Florida Health Information Network, Architectural Considerations for State Infrastructure," Version 6.2, April 19, 2007.
[19] Florida Health Policy Center, "Florida's Health Information Network: What will it cost to develop?," February 2007, http://www.floridahealthpolicycenter.org/research/pdfs/FHIN%20brief.pdf (visited December 19, 2007).
[20] Florida Center for Health Information and Policy Analysis, "Privacy and Security Solutions for Interoperable Health Information Exchange, Florida Implementation and Impact Report," December 3, 2007, 4.

The report said that the foundation for a statewide network is in place and recommended the following actions to Governor Crist to implement the FHIN:

- Promote and support the continuing development of the state's local health information exchanges.
- Establish a new advisory board as soon as possible to guide the direction and development of the FHIN.
- Require action on specific steps to assist in developing the network from Florida Medicaid, the Department of Health, and the Department of Management Services, and possibly other state agencies.
- Insist on a "bias in favor of action" on this initiative by members of the administration, placing an emphasis on data exchange operations over the occasional government tendency to conduct further studies before taking substantive action.

The board was not extended by Executive Order and ceased to operate on June 30, 2007. In January 2008, agency Secretary Andrew Agwunobi appointed a 14-member Health Information Exchange Coordinating Committee. The committee is organized "to advise and support the agency in developing and implementing a strategy to establish a privacy-protected, secure and integrated statewide network for the exchange of electronic health records among authorized physicians."[22]

FHIN Grants Program

In 2006, the Legislature authorized the agency to administer a grants program to advance the development of a health information network.[23] According to the agency, grants are currently awarded in three categories:[24]

- Assessment and planning grants, which support engaging appropriate healthcare stakeholders to develop a strategic plan for health information exchange in their communities.
- Operations and evaluation grants, which support projects that demonstrate health information exchange among two or more competing provider organizations.
- Training and technical assistance grants, which support practitioner training and technical assistance activities designed to increase physician and dentist use of electronic health record systems.

From Fiscal Year 2005-2006 through Fiscal Year 2007-2008, a total of $5.5 million has been appropriated by the legislature to fund the grants program.

Approximately half of the RHIOs that have received state grants are operational in exchanging data within their region, but on a very limited basis. The scope of the exchange and number of users participating in the exchange is still relatively small. The remaining RHIOs that have received state grants are pre-operational and continuing to develop and test various elements of their HIE. The RHIOs and their aggregate funding levels include:

- Big Bend RHIO – $810,422
- Central Florida RHIO – $200,000
- Community Health Informatics Organization – $222,384
- Healthy Ocala – no funding sought
- Northeast Florida Health Information Consortium – $406,944
- Northwest Florida RHIO – $776,589
- Palm Beach County Community Health Alliance – $692,812
- South Florida Health Information Initiative – $742,151
- Tampa Bay RHIO – $1,043,957

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[21] Governor's Health Information Infrastructure Advisory Board, "Final Report of the Governor's Health Information Infrastructure Advisory Board," July 6, 2007, http://ahca.myflorida.com/dhit/Board/Brdmtg63007.pdf (visited December 19, 2007).
[22] Agency for Health Care Administration, http://ahca.myflorida.com/dhit/Governance/HIECCIndex.shtml (visited January 21, 2008).
[23] Section 408.05(4)(b), F.S.
[24] Agency for Health Care Administration, "FY 2007-2008 Grants Program Requirements," http://ahca.myflorida.com/dhit/FHINgrantsProgram/FGPSched0708.pdf (visited January 21, 2008).

- Veterans' Health Information Exchange Network – $70,614

Health Information and Security Privacy Collaboration Project
The Health Insurance Portability and Accountability Act (HIPAA) established baseline health care privacy requirements for protected health information and established security requirements for electronic protected health information.[25] However, many states vary on their application of HIPAA -- some have not adopted policies stronger than HIPAA, while some have adopted policies that are stronger than HIPAA. The inconsistency in the way in which HIPAA is interpreted and applied and the differences between state privacy laws and HIPAA have caused great concern amongst those interested in a nationwide HIE.

RTI, Inc. (RTI), a private, nonprofit corporation, was awarded a contract from HHS in 2005 totaling $11.5 million. The purpose of the project was to asses variations in organization-level business practices, policies, and state laws that affect HIE and to identify and propose practical ways to reduce the variation to those "good" practices that will permit interoperability while preserving the necessary privacy and security requirements set by the local community.[26] RTI sub-contracted with 34 states and territories to complete the project. The state of Florida was among the sub-contract recipients.

The state teams were required to convene steering committees comprised of both public and private leaders and work groups with specific charges through which all research and recommendations would be made.

The project enabled states to engage stakeholders on a local level to identify the barriers to electronic health information exchange specific to their location. The final report issued by RTI in June of 2007, "Assessment of Variation and Analysis of Solutions", outlines issues that state project teams all identified as possibly affecting a private and secure nationwide HIE along with possible solutions to the identified challenges, both at the state and national levels.

Among the challenges identified were: differing interpretations and applications of HIPAA privacy rule requirements, misunderstandings and differing applications of the HIPAA security rule, trust in the security of health information exchange, fragmented and conflicting state laws relating to privacy and security of health information exchange, and disclosure of personal health information. Among the solutions to the challenges identified by the participating states were: creation of uniform state policy as it relates to the interpretation and application of the HIPAA rules, consolidation of state statutes related to health information exchange, creation of national standards for a master patient index or record locater to accurately match records to the appropriate patient, and education of consumers and healthcare professionals about federal and state privacy law.[27]

With regard to Florida law, the agency's Privacy and Security Project Legal Work Group identified several barriers to health information exchange in statutory law, including:
- Inconsistent language regarding the disclosure of patient records without consent in the hospital and physician patient records sections.[28]
- Lack of authority for treating physicians to access lab results directly from the clinical lab under chapter 483, F.S.[29]

Effect of Proposed Changes

[25] The MITRE Corporation, "ONC- NIH Analysis Report to the National Institutes of Health, National Center for Research Resources," March 2006, 11.
[26] Dimitropoulos, Linda L., "Privacy and Security Solutions for Interoperable Health Information Exchange, Assessment of Variation and Analysis of Solutions," June 30, 2007, 2-1.
[27] *Id.* at ES-5 through ES-8.
[28] Sections 395.3025 and 456.057, F.S., respectively.
[29] Section 483.181, F.S.

The bill clarifies that a patient's records held by a hospital may be disclosed without the consent of the patient, or his or her legal representative, to health care practitioners and providers involved in the care or treatment of the patient. The bill also clarifies that lab results may be provided by a clinical laboratory to other health care practitioners and providers involved in the care or treatment of the patient for use in connection with the treatment of the patient.

The bill creates the "Florida eHealth Initiative Act" to "promote and coordinate the establishment of a secure, privacy-protected, and interconnected statewide health information exchange." The bill amends the agency's authority to provide grants to RHIOs by requiring:

- Dollar for dollar match of state funds with local or private funds.
- Issuance of grants in three categories: development, operation, and collaboration.
- Establishment of specific eligibility criteria to qualify for a grant in each area, including demonstration of local or private matching dollars and policies and procedures to protect the privacy and security of electronic medical records.

The bill requires grants to be awarded in consultation with the Florida Health Information Exchange Advisory Council. The agency is prohibited from awarding a grant to a recipient for more than 2 years within each grant category (i.e., a total of 6 years of funding is available).

The bill creates an Electronic Medical Records System Adoption Loan Program. The agency is required to provide one-time, no-interest loans to physicians or business entities whose shareholders are physicians for the initial costs of implementing an electronic medical records system. The agency is prohibited from providing a loan to an applicant who has:

- Been found guilty of violating s. 456.072(1) or been disciplined under the applicable licensing chapter in the previous 5 years.
- Been found guilty of or entered a plea of guilty or nolo contendere to a violation of ss. 409.920 or 409.9201, F.S. (Medicaid fraud).
- Been sanctioned pursuant to s. 409.913 for fraud or abuse (Medicaid fraud).

The agency is authorized to distribute the loan in a lump-sum amount, and the loan proceeds may be used to purchase hardware and software, as well as subscription services, professional consultations, and staff training. The agency is required to provide loan recipients a list of electronic medical record systems recognized or certified by national standards-setting entities. The agency is further required to distribute a minimum of 25 percent of loan funds to physicians or business entities operating within a rural county. The loan must be repaid within 6 years and payments must commence within 3 months of the funding of the loan.

The physician or business entity must further provide the following security for the loan:

- An irrevocable letter of credit in an amount equal to the amount of the loan;
- An escrow account in an amount equal to the amount of the loan; or
- A pledge of the accounts receivable of the physician or business entity.

If a physician or business entity defaults, and the default continues for 30 days, the entire balance of the loan becomes due and payable, subject to an interest rate of 18 percent annually.

The bill creates the Florida Health Information Exchange Advisory Council adjunct to the agency. The stated purpose of the council is to promote participation in health information exchanges, conduct outreach to inform stakeholders of the benefits of using a health information exchange, and provide guidance to stakeholders regarding the effective use of health information exchanges and standards for protecting the privacy and security of electronic medical records.

The council is composed of 12 members:

- The Secretary of the agency, or his or her designee.
- The State Surgeon General, or his or her designee.

- Two members appointed by and serving at the pleasure of the Governor:
  - A person from the health insurance industry.
  - A consumer who is a resident of the state.
- Four members appointed by and serving at the pleasure of the President o the Senate:
  - A person from a public hospital utilizing an electronic medical records system.
  - A physician utilizing an electronic medical records system in his or her practice.
  - A representative of an operating health information organization in the state.
  - A person from a federally-qualified health center or other rural health organization utilizing an electronic medical records system.
- Four members appointed by and serving at the pleasure of the Speaker of the House of Representatives:
  - A person from a public hospital utilizing an electronic medical records system.
  - A physician utilizing an electronic medical records system in his or her practice.
  - A representative of an operating health information organization in the state.
  - A person from a federally-qualified health center or other rural health organization utilizing an electronic medical records system.

Members serve for a term of 4 years. The council must meet at least quarterly and may be held via teleconference or other electronic means.

The duties of the council include developing recommendations to:
- Establish standards for all state-funded health information exchange efforts.
- Remove barriers that limit participation by health care providers and facilities and health insurers in health information exchanges.
- Remove barriers that prevent consumers from accessing their electronic medical records.
- Provide incentives to promote participation by health care providers and facilities and health insurers in health information exchanges.
- Identify health care data held by state agencies and remove barriers to making that data available to authorized recipients through health information exchanges.
- Increase state agency participation in health information exchanges.
- Partner with other state, regional, and federal entities to promote and coordinate health information exchange efforts.
- Create a long-term plan for an interoperable statewide network of health information organizations.

The council is required, beginning July 1, 2009, to annual provide a report to the Governor and the Legislature recommendations regarding the council's duties described above. In addition, the council must, by July 1, 2012, recommend a long-term plan to create an interoperable statewide network of health information organizations to the Governor and the Legislature.

The council is repealed effective July 1, 2012.

The bill requires the agency to maintain on its internet website information regarding:
- Federal and private sector health information exchange funding programs.
- A clearinghouse of state and national legislative, regulatory, and public awareness activities related to health information exchanges.

In addition, the agency is required to develop and implement a plan to promote participation in health information exchanges and the adoption of electronic medical record systems by physicians in consultation with the council and professional associations.

Finally, the bill requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) to complete and independent evaluation of the grants program administered by the agency, including assessments of the distribution process, the spending of grant dollars, the level of

participation by entities within each grantee's project; the extent of clinical data exchange among entities within each grantee's project; the sources of funding for each grantee; and the feasibility of each grantee achieving long-term sustainability without state funding. The report must be provided to the Governor and the Legislature by July 1, 2009.

C. SECTION DIRECTORY:

Section 1. Amends s. 395.3025, F.S, relating to patient and personnel records.

Section 2. Amends s. 408.05, F.S., relating to the Florida Center for Health Information and Policy Analysis.

Section 3. Creates s. 408.051, F.S., relating to the Florida eHealth Initiative Act.

Section 4. Amends s. 408.062, relating to research, analyses, studies, and reports.

Section 5. Amends s. 483.181, relating to acceptance, collection, identification, and examination of specimens.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None

2. Expenditures:

   The agency has requested four positions to review and process loan applications, monitor loan repayments, and conduct outreach activities. According to the agency, the bill will have a $380,981 fiscal impact on the agency in Fiscal Year 2008-09 and $282,861 in Fiscal Year 2009-10, apart from funding for the loan program.

   Healthcare Council staff believes that the fiscal impact of the bill is indeterminate, as it is not clear that four positions are justified in light of the unknown, but likely small, number of applications and loan recipients.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None

2. Expenditures:

   None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill will provide one-time, no-interest loans to physicians or business entities whose shareholders are physicians for the initial costs of implementing an electronic medical records system.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenues.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The agency is provided rulemaking authority to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

D. STATEMENT OF THE SPONSOR

While all other sectors of our economy have reaped the enormous benefits of information technology, the healthcare sector is lagging behind. Healthcare needs an injection of transformative information technology solutions like electronic medical records to revolutionize the delivery and quality of patient care.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to electronic health records; amending s.
3 395.3025, F.S.; expanding access to a patient's medical
4 records to facilitate electronic exchange of data between
5 certain health care facilities, practitioners, and
6 providers and attending physicians; revising terminology
7 regarding disclosure of patient records to conform to
8 changes made by the act; amending s. 408.05, F.S.;
9 removing responsibility of the Agency for Health Care
10 Administration for monitoring certain grants and health
11 care data; creating s. 408.051, F.S.; creating the
12 "Florida eHealth Initiative Act"; providing legislative
13 intent; providing definitions; requiring the agency to
14 award and monitor grants to certain health information
15 organizations; providing rulemaking authority regarding
16 establishment of eligibility criteria; establishing the
17 Electronic Medical Records System Adoption Loan Program;
18 providing eligibility criteria; providing rulemaking
19 authority regarding terms and conditions for the granting
20 of loans; creating the Florida Health Information Exchange
21 Advisory Council; providing for purpose, membership, terms
22 of office, and duties of the council; requiring the
23 Florida Center for Health Information and Policy Analysis
24 to provide staff support; requiring reports to the
25 Governor and Legislature; providing for future repeal of
26 s. 408.051, F.S., and abolition of the council; providing
27 duties of the agency with regard to availability of
28 specified information on the agency's Internet website;

29 requiring the agency to develop and implement a plan to
30 promote participation in regional and statewide health
31 information exchanges; requiring the Office of Program
32 Policy Analysis and Government Accountability to complete
33 an independent evaluation of the grants program
34 administered by the agency and submit the report to the
35 Governor and Legislature; amending s. 408.062, F.S.;
36 removing responsibility of the agency for developing an
37 electronic health information network; amending s.
38 483.181, F.S.; expanding access to laboratory reports to
39 facilitate electronic exchange of data between certain
40 health care practitioners and providers; providing an
41 effective date.
42
43 Be It Enacted by the Legislature of the State of Florida:
44
45 Section 1. Paragraphs (a), (e), and (f) of subsection (4)
46 of section 395.3025, Florida Statutes, are amended to read:
47 395.3025 Patient and personnel records; copies;
48 examination.--
49 (4) Patient records are confidential and must not be
50 disclosed without the consent of the patient or his or her legal
51 representative ~~person to whom they pertain~~, but appropriate
52 disclosure may be made without such consent to:
53 (a) Licensed facility personnel, ~~and~~ attending physicians,
54 or other health care practitioners and providers involved in the
55 care or treatment of the patient for use in connection with the
56 treatment of the patient.

57 (e) The department ~~agency~~ upon subpoena issued pursuant to
58 s. 456.071, but the records obtained thereby must be used solely
59 for the purpose of the department ~~agency~~ and the appropriate
60 professional board in its investigation, prosecution, and appeal
61 of disciplinary proceedings. If the department ~~agency~~ requests
62 copies of the records, the facility shall charge no more than
63 its actual copying costs, including reasonable staff time. The
64 records must be sealed and must not be available to the public
65 pursuant to s. 119.07(1) or any other statute providing access
66 to records, nor may they be available to the public as part of
67 the record of investigation for and prosecution in disciplinary
68 proceedings made available to the public by the department
69 ~~agency~~ or the appropriate regulatory board. However, the
70 department ~~agency~~ must make available, upon written request by a
71 practitioner against whom probable cause has been found, any
72 such records that form the basis of the determination of
73 probable cause.
74 (f) The department ~~of Health~~ or its agent, for the purpose
75 of establishing and maintaining a trauma registry and for the
76 purpose of ensuring that hospitals and trauma centers are in
77 compliance with the standards and rules established under ss.
78 395.401, 395.4015, 395.4025, 395.404, 395.4045, and 395.405, and
79 for the purpose of monitoring patient outcome at hospitals and
80 trauma centers that provide trauma care services.
81 Section 2. Subsection (4) of section 408.05, Florida
82 Statutes, is amended to read:
83 408.05 Florida Center for Health Information and Policy
84 Analysis.--

85 (4) TECHNICAL ASSISTANCE.--

86 ~~(a)~~ The center shall provide technical assistance to
87 persons or organizations engaged in health planning activities
88 in the effective use of statistics collected and compiled by the
89 center. The center shall also provide the following additional
90 technical assistance services:

91 (a)~~1.~~ Establish procedures identifying the circumstances
92 under which, the places at which, the persons from whom, and the
93 methods by which a person may secure data from the center,
94 including procedures governing requests, the ordering of
95 requests, timeframes for handling requests, and other procedures
96 necessary to facilitate the use of the center's data. To the
97 extent possible, the center should provide current data timely
98 in response to requests from public or private agencies.

99 (b)~~2.~~ Provide assistance to data sources and users in the
100 areas of database design, survey design, sampling procedures,
101 statistical interpretation, and data access to promote improved
102 health-care-related data sets.

103 (c)~~3.~~ Identify health care data gaps and provide technical
104 assistance to other public or private organizations for meeting
105 documented health care data needs.

106 (d)~~4.~~ Assist other organizations in developing statistical
107 abstracts of their data sets that could be used by the center.

108 (e)~~5.~~ Provide statistical support to state agencies with
109 regard to the use of databases maintained by the center.

110 (f)~~6.~~ To the extent possible, respond to multiple requests
111 for information not currently collected by the center or
112 available from other sources by initiating data collection.

(g)~~7.~~ Maintain detailed information on data maintained by other local, state, federal, and private agencies in order to advise those who use the center of potential sources of data which are requested but which are not available from the center.

(h)~~8.~~ Respond to requests for data which are not available in published form by initiating special computer runs on data sets available to the center.

(i)~~9.~~ Monitor innovations in health information technology, informatics, and the exchange of health information and maintain a repository of technical resources to support the development of a health information exchange ~~network~~.

~~(b) The agency shall administer, manage, and monitor grants to not-for-profit organizations, regional health information organizations, public health departments, or state agencies that submit proposals for planning, implementation, or training projects to advance the development of a health information network. Any grant contract shall be evaluated to ensure the effective outcome of the health information project.~~

~~(c) The agency shall initiate, oversee, manage, and evaluate the integration of health care data from each state agency that collects, stores, and reports on health care issues and make that data available to any health care practitioner through a state health information network.~~

Section 3. Section 408.051, Florida Statutes, is created to read:

408.051 Florida eHealth Initiative Act.--

(1) SHORT TITLE.--This section may be cited as the "Florida eHealth Initiative Act."

141 (2) LEGISLATIVE INTENT.--The Legislature recognizes that
142 the exchange of electronic medical records will benefit
143 consumers by increasing the quality and efficiency of health
144 care throughout the state. It is the intent of the Legislature
145 that the state promote and coordinate the establishment of a
146 secure, privacy-protected, and interconnected statewide health
147 information exchange.
148 (3) DEFINITIONS.--As used in this section, the term:
149 (a) "Electronic medical record" means a record of a
150 person's medical treatment created by a licensed health care
151 provider and stored in an interoperable and accessible digital
152 format.
153 (b) "Electronic medical record system" means an
154 application environment composed of at least two of the
155 following systems: a clinical data repository; clinical decision
156 support; controlled medical vocabulary; computerized provider
157 order entry; pharmacy; or clinical documentation. The
158 application must be used by health care practitioners to
159 document, monitor, and manage health care delivery within a
160 health care delivery system and must be capable of
161 interoperability within a health information exchange.
162 (c) "Health information exchange" means an electronic
163 system used to acquire, process, and transmit electronic medical
164 records that can be shared in real time among authorized health
165 care providers, health care facilities, health insurers, and
166 other recipients, as authorized by law, to facilitate the
167 provision of health care services.

168 (d) "Health information organization" means an entity with
169 a formal structure and established policies and procedures that
170 serves as a neutral convener of local stakeholders to enable the
171 secure and reliable exchange of electronic medical records among
172 authorized health care stakeholders within a defined geographic
173 region to facilitate improvements in health care quality,
174 safety, and coordination of care.
175 (4) MATCHING GRANTS.--
176 (a) Subject to a specific appropriation, the agency shall
177 award and monitor matching grants to health information
178 organizations that submit proposals that advance the development
179 of a statewide health information exchange. Funds awarded under
180 this subsection shall be awarded on the basis of matching each
181 $1 of state funds with $1 of local or private funds. Local or
182 private funds may be provided in the form of cash or in-kind
183 support or services. Grants may be awarded within the following
184 categories: development, operation, and collaboration.
185 (b) The agency shall, by rule, establish specific
186 eligibility criteria for a health information organization to
187 qualify for a grant under this subsection. These criteria shall
188 include, at a minimum, documentation of the following:
189 1. For development grants, the proposed organizational
190 structure, the level of community support, including a list of
191 key participants, a demonstration of available local or private
192 matching funds, a timeline for development of the health
193 information exchange, and proposed goals and metrics.
194 2. For operation grants, a demonstration of available
195 local or private matching funds and a detailed business plan,

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196 which shall include a timeline for implementation of the health
197 information exchange, policies and procedures to protect the
198 privacy and security of electronic medical records, and proposed
199 goals and metrics.
200 3. For collaboration grants, a demonstration of available
201 local or private matching funds, memoranda of understanding
202 between at least two health information organizations for the
203 exchange of electronic medical records, a demonstration of
204 consistent utilization of the health information exchange by
205 members within each participating health information
206 organization, and a detailed business plan, which shall include
207 a timeline for the implementation of the exchange of electronic
208 medical records between participating health information
209 organizations, policies and procedures to protect the privacy
210 and security of electronic medical records, and proposed goals
211 and metrics.
212 (c) Beginning July 1, 2008, the agency shall not award a
213 health information organization more than 2 years of funding
214 within each grant category.
215 (d) The agency shall award grants in consultation with the
216 Florida Health Information Exchange Advisory Council.
217 (5) ELECTRONIC MEDICAL RECORDS SYSTEM ADOPTION LOAN
218 PROGRAM.--
219 (a) There is created an Electronic Medical Records System
220 Adoption Loan Program within the agency for the purpose of
221 providing a one-time, no-interest loan to eligible physicians
222 licensed under chapter 458 or chapter 459 or to an eligible
223 business entity whose shareholders are licensed under chapter

224 458 or chapter 459 for the initial costs of implementing an
225 electronic medical records system.
226 (b) In order to be eligible for a loan under this
227 subsection, each physician must demonstrate that he or she has
228 practiced continuously within the state for the previous 3
229 years.
230 (c) The agency shall not provide a loan to a physician who
231 has or a business entity whose physician has:
232 1. Been found guilty of violating s. 456.072(1) or been
233 disciplined under the applicable licensing chapter in the
234 previous 5 years.
235 2. Been found guilty of or entered a plea of guilty or
236 nolo contendere to a violation of s. 409.920 or s. 409.9201.
237 3. Been sanctioned pursuant to s. 409.913 for fraud or
238 abuse.
239 (d) A loan may be provided to an eligible physician or
240 business entity in a lump-sum amount to pay for the costs of
241 purchasing hardware and software, subscription services,
242 professional consultation, and staff training. The agency shall
243 provide guidance to loan recipients by providing, at a minimum,
244 a list of electronic medical record systems recognized or
245 certified by national standards-setting entities as capable of
246 being used to communicate with a health information exchange.
247 (e) The agency shall distribute a minimum of 25 percent of
248 funds appropriated to this program to physicians or business
249 entities operating within a rural county as defined in s.
250 288.106(1)(r).
251 (f) The agency shall, by rule, develop standard terms and

252 conditions for use in this program. At a minimum, these terms
253 and conditions shall require:
254 1. Loan repayment by the physician or business entity
255 within a reasonable period of time, which may not be longer than
256 72 months after the funding of the loan.
257 2. Equal periodic payments that commence within 3 months
258 after the funding of the loan.
259 3. The eligible physician or business entity to execute a
260 promissory note and a security agreement in favor of the state.
261 The security agreement shall be a purchase-money security
262 interest pledging as collateral for the loan the specific
263 hardware and software purchased with the loan proceeds. The
264 agency shall prepare and record a financing statement under
265 chapter 679. The physician or business entity shall be
266 responsible for paying the cost of recording the financing
267 statement. The security agreement shall further require that the
268 physician or business entity pay all collection costs, including
269 attorney's fees.
270 (g) The agency shall further require the physician or
271 business entity to provide additional security under one of the
272 following subparagraphs:
273 1. An irrevocable letter of credit, as defined in chapter
274 675, in an amount equal to the amount of the loan.
275 2. An escrow account consisting of cash or assets eligible
276 for deposit in accordance with s. 625.52 in an amount equal to
277 the amount of the loan. If the escrow agent is responsible for
278 making the periodic payments on the loan, the required escrow
279 balance may be diminished as payments are made.

280 3. A pledge of the accounts receivables of the physician
281 or business entity. This pledge shall be reflected on the
282 financing statement.
283 (h) All payments received from or on behalf of a physician
284 or business entity under this program shall be deposited into
285 the agency's Administrative Trust Fund to be used to fund new
286 loans.
287 (i) If a physician or business entity that has received a
288 loan under this section ceases to provide care or services to
289 patients, or if the physician or business entity defaults in any
290 payment and the default continues for 30 days, the entire loan
291 balance shall be immediately due and payable and shall bear
292 interest from that point forward at the rate of 18 percent
293 annually. Upon default, the agency may offset any moneys owed to
294 the physician or business entity from the state and apply the
295 offset against the outstanding balance.
296 (j) If a physician defaults in any payment and if the
297 default continues for 30 days, the default shall constitute
298 grounds for disciplinary action under chapter 458 or chapter 459
299 and s. 456.072(1)(k).
300 (6) FLORIDA HEALTH INFORMATION EXCHANGE ADVISORY
301 COUNCIL.--
302 (a) The Florida Health Information Exchange Advisory
303 Council is created as an adjunct to the agency. The council is
304 subject to the requirements of s. 20.052, except that only state
305 officers and employees shall be reimbursed for per diem and
306 travel expenses pursuant to s. 112.061.
307 (b) The purpose of the council is to:

308 1. Promote participation in regional and statewide health
309 information exchanges and adoption of health information
310 technology to support the infrastructure capacity for regional
311 and statewide health information exchanges.
312 2. Conduct outreach and convene forums to educate
313 stakeholders regarding the benefits of utilizing a health
314 information exchange.
315 3. Provide guidance to stakeholders regarding the
316 effective use of health information exchanges and standards for
317 protecting the privacy and security of electronic medical
318 records.
319 (c) The council shall consist of the following members:
320 1. The Secretary of Health Care Administration, or his or
321 her designee.
322 2. The State Surgeon General, or his or her designee.
323 3. Two members appointed by and serving at the pleasure of
324 the Governor, of which:
325 a. One member must be from the health insurance industry.
326 b. One member must be a consumer who is a resident of the
327 state.
328 4. Four members appointed by and serving at the pleasure
329 of the President of the Senate, of which:
330 a. One member must be from a public hospital utilizing an
331 electronic medical records system.
332 b. One member must be a physician utilizing an electronic
333 medical records system in his or her practice.
334 c. One member must be a representative of an operating
335 health information organization in the state.

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336 d. One member must be from a federally qualified health
337 center or other rural health organization utilizing an
338 electronic medical records system.
339 5. Four members appointed by and serving at the pleasure
340 of the Speaker of the House of Representatives, of which:
341 a. One member must be from a public hospital utilizing an
342 electronic medical records system.
343 b. One member must be a physician utilizing an electronic
344 medical records system in his or her practice.
345 c. One member must be a representative of an operating
346 health information organization in the state.
347 d. One member must be from a federally qualified health
348 center or other rural health organization utilizing an
349 electronic medical records system.
350 (d) A member who is a representative of an operating
351 health information organization in the state must recuse himself
352 or herself during discussion, evaluation, or recommendation of a
353 grant application.
354 (e) Each member of the council subject to appointment
355 shall be appointed to serve for a term of 4 years following the
356 date of appointment. A vacancy shall be filled by appointment
357 for the remainder of the term. Appointments shall be made within
358 45 days after the effective date of this section.
359 (f) The council may meet at the call of the chair or at
360 the request of a majority of its membership, but the council
361 must meet at least quarterly. Meetings of the council may be
362 held via teleconference or other electronic means.
363 (g) Members shall elect a chair and vice chair annually.

364 (h) A majority of the members constitutes a quorum and the
365 affirmative vote of a majority of a quorum is necessary to take
366 action.
367 (i) The council's duties and responsibilities include, but
368 are not limited to, developing recommendations to:
369 1. Establish standards for all state-funded health
370 information exchange efforts. Such standards shall include, but
371 are not limited to, policies and procedures to protect the
372 privacy and security of electronic medical records.
373 2. Remove barriers, including, but not limited to,
374 technological, regulatory, and financial barriers, that limit
375 participation by health care providers, health care facilities,
376 and health insurers in a health information exchange.
377 3. Remove barriers that prevent consumers from having
378 access to their electronic medical records.
379 4. Provide incentives to promote participation by health
380 care providers, health care facilities, and health insurers in
381 health information exchanges.
382 5. Identify health care data held by state agencies and
383 remove barriers to making that data available to authorized
384 recipients through health information exchanges in a private and
385 secure manner.
386 6. Increase state agency participation in health
387 information exchanges.
388 7. Partner with other state, regional, and federal
389 entities to promote and coordinate health information exchange
390 efforts.

391 8. Create a long-term plan for an interoperable statewide
392 network of health information organizations.
393
394 The council shall establish ad hoc issue-oriented technical
395 workgroups on an as-needed basis to make recommendations to the
396 council.
397 (j) The Florida Center for Health Information and Policy
398 Analysis within the agency shall provide, within existing
399 resources, staff support to enable the council to carry out its
400 responsibilities under this section.
401 (k) Beginning July 1, 2009, the council shall annually
402 provide a report to the Governor, the President of the Senate,
403 the Speaker of the House of Representatives, and the chairs of
404 the appropriate substantive committees of the Senate and the
405 House of Representatives that includes, but is not limited to,
406 the recommendations regarding the council's duties and
407 responsibilities. In addition, by July 1, 2012, the council
408 shall recommend a long-term plan to create an interoperable
409 statewide network of health information organizations to the
410 Governor, the President of the Senate, the Speaker of the House
411 of Representatives, and the chairs of the appropriate
412 substantive committees of the Senate and the House of
413 Representatives.
414 (l) This section is repealed and the council shall stand
415 abolished July 1, 2012, unless reviewed and saved from repeal
416 through reenactment by the Legislature.
417 (7) AGENCY FOR HEALTH CARE ADMINISTRATION; DUTIES.--

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

418 (a) The agency shall develop and maintain on its Internet
419 website the following information:
420 1. Federal and private sector health information exchange
421 funding programs, including analyses of successful local and
422 state recipients of the programs, as well as unsuccessful local
423 and state applicants of the programs.
424 2. A clearinghouse of state and national legislative,
425 regulatory, and public awareness activities related to health
426 information exchanges.
427 (b) The agency shall develop and implement a plan that
428 promotes, at a minimum, participation in regional and statewide
429 health information exchanges and the adoption of electronic
430 medical record systems by physicians through the Electronic
431 Medical Records System Adoption Loan Program, in consultation
432 with the Florida Health Information Exchange Advisory Council,
433 organizations representing allopathic and osteopathic practicing
434 physicians, the Board of Medicine, and the Board of Osteopathic
435 Medicine.
436 (8) PROGRAM EVALUATION; REPORT.--The Office of Program
437 Policy Analysis and Government Accountability shall complete an
438 independent evaluation of the grants program administered by the
439 agency. The evaluation must include, at a minimum, assessments
440 of the grant evaluation and distribution process; the way in
441 which grant dollars are spent; the level of participation by
442 entities within each grantee's project; the extent of clinical
443 data exchange among entities within each grantee's project; the
444 sources of funding for each grantee; and the feasibility of each
445 grantee achieving long-term sustainability without state grant

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446 funding. The evaluation must assess the level at which the
447 current grants program is advancing the development of a
448 statewide health information exchange and recommend other
449 programs that may accomplish the same goal. The report shall be
450 submitted to the Governor, the President of the Senate, the
451 Speaker of the House of Representatives, and the chairs of the
452 relevant committees in the Senate and the House of
453 Representatives no later than July 1, 2009.
454 Section 4. Subsection (5) of section 408.062, Florida
455 Statutes, is amended to read:
456 408.062 Research, analyses, studies, and reports.--
457 ~~(5) The agency shall develop and implement a strategy for~~
458 ~~the adoption and use of electronic health records, including the~~
459 ~~development of an electronic health information network for the~~
460 ~~sharing of electronic health records among health care~~
461 ~~facilities, health care providers, and health insurers. The~~
462 ~~agency may develop rules to facilitate the functionality and~~
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465 ~~Representatives, and the President of the Senate on legislative~~
466 ~~recommendations to protect the confidentiality of electronic~~
467 ~~health records.~~
468 Section 5. Subsection (2) of section 483.181, Florida
469 Statutes, is amended to read:
470 483.181 Acceptance, collection, identification, and
471 examination of specimens.--
472 (2) The results of a test must be reported directly to the
473 licensed practitioner or other authorized person who requested

474 it, and appropriate disclosure may be made by the clinical
475 laboratory without a patient's consent to other health care
476 practitioners and providers involved in the care or treatment of
477 the patient for use in connection with the treatment of the
478 patient. The report must include the name and address of the
479 clinical laboratory in which the test was actually performed,
480 unless the test was performed in a hospital laboratory and the
481 report becomes an integral part of the hospital record.
482 Section 6. This act shall take effect upon becoming a law.

Bill No. **637**

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	____

Council/Committee hearing bill: Healthcare Council

Representative Grimsley offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Paragraphs (a), (e), and (f) of subsection (4) of section 395.3025, Florida Statutes, are amended to read:

395.3025 Patient and personnel records; copies; examination.--

(4) Patient records are confidential and must not be disclosed without the consent of the patient or his or her legal representative ~~person to whom they pertain~~, but appropriate disclosure may be made without such consent to:

(a) Licensed facility personnel, ~~and~~ attending physicians, or other health care practitioners and providers currently involved in the care or treatment of the patient for use only in connection with the treatment of the patient.

(e) The department ~~agency~~ upon subpoena issued pursuant to s. 456.071, but the records obtained thereby must be used solely for the purpose of the department ~~agency~~ and the appropriate professional board in its investigation, prosecution, and appeal of disciplinary proceedings. If the department ~~agency~~ requests

copies of the records, the facility shall charge no more than its actual copying costs, including reasonable staff time. The records must be sealed and must not be available to the public pursuant to s. 119.07(1) or any other statute providing access to records, nor may they be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the department ~~agency~~ or the appropriate regulatory board. However, the department ~~agency~~ must make available, upon written request by a practitioner against whom probable cause has been found, any such records that form the basis of the determination of probable cause.

(f) The department ~~of Health~~ or its agent, for the purpose of establishing and maintaining a trauma registry and for the purpose of ensuring that hospitals and trauma centers are in compliance with the standards and rules established under ss. 395.401, 395.4015, 395.4025, 395.404, 395.4045, and 395.405, and for the purpose of monitoring patient outcome at hospitals and trauma centers that provide trauma care services.

Section 2. Subsection (4) of section 408.05, Florida Statutes, is amended to read:

408.05 Florida Center for Health Information and Policy Analysis.--

(4) TECHNICAL ASSISTANCE.--

~~(a)~~ The center shall provide technical assistance to persons or organizations engaged in health planning activities in the effective use of statistics collected and compiled by the center. The center shall also provide the following additional technical assistance services:

(a)~~1.~~ Establish procedures identifying the circumstances under which, the places at which, the persons from whom, and the

54 methods by which a person may secure data from the center,
55 including procedures governing requests, the ordering of
56 requests, timeframes for handling requests, and other procedures
57 necessary to facilitate the use of the center's data. To the
58 extent possible, the center should provide current data timely
59 in response to requests from public or private agencies.

60 (b) ~~2.~~ Provide assistance to data sources and users in the
61 areas of database design, survey design, sampling procedures,
62 statistical interpretation, and data access to promote improved
63 health-care-related data sets.

64 (c) ~~3.~~ Identify health care data gaps and provide technical
65 assistance to other public or private organizations for meeting
66 documented health care data needs.

67 (d) ~~4.~~ Assist other organizations in developing statistical
68 abstracts of their data sets that could be used by the center.

69 (e) ~~5.~~ Provide statistical support to state agencies with
70 regard to the use of databases maintained by the center.

71 (f) ~~6.~~ To the extent possible, respond to multiple requests
72 for information not currently collected by the center or
73 available from other sources by initiating data collection.

74 (g) ~~7.~~ Maintain detailed information on data maintained by
75 other local, state, federal, and private agencies in order to
76 advise those who use the center of potential sources of data
77 which are requested but which are not available from the center.

78 (h) ~~8.~~ Respond to requests for data which are not available
79 in published form by initiating special computer runs on data
80 sets available to the center.

81 (i) ~~9.~~ Monitor innovations in health information
82 technology, informatics, and the exchange of health information
83 and maintain a repository of technical resources to support the
84 development of a statewide health information exchange ~~network~~.

85 ~~(b) The agency shall administer, manage, and monitor~~
86 ~~grants to not-for-profit organizations, regional health~~
87 ~~information organizations, public health departments, or state~~
88 ~~agencies that submit proposals for planning, implementation, or~~
89 ~~training projects to advance the development of a health~~
90 ~~information network. Any grant contract shall be evaluated to~~
91 ~~ensure the effective outcome of the health information project.~~
92 (c) The agency shall initiate, oversee, manage, and
93 evaluate the integration of health care data from each state
94 agency that collects, stores, and reports on health care issues
95 and make that data available to any health care practitioner
96 through a statewide health information exchange ~~network~~.
97 Section 3. Section 408.051, Florida Statutes, is created
98 to read:
99 408.051 Florida eHealth Initiative Act.--
100 (1) SHORT TITLE.--This section may be cited as the
101 "Florida eHealth Initiative Act."
102 (2) LEGISLATIVE INTENT.--The Legislature recognizes that
103 the exchange of electronic medical records will benefit
104 consumers by increasing the quality and efficiency of health
105 care throughout the state. It is the intent of the Legislature
106 that the state promote and coordinate the establishment of a
107 secure, privacy-protected, and interconnected statewide health
108 information exchange.
109 (3) DEFINITIONS.--As used in this section, the term:
110 (a) "Electronic medical record" means a record of a
111 person's medical treatment created by a licensed health care
112 provider and stored in an interoperable and accessible digital
113 format.
114 (b) "Electronic medical records system" means an
115 application environment composed of at least two of the

116 following systems: a clinical data repository; clinical decision
117 support; controlled medical vocabulary; computerized provider
118 order entry; pharmacy; or clinical documentation. The
119 application must be used by health care practitioners to
120 document, monitor, and manage health care delivery within a
121 health care delivery system and must be capable of
122 interoperability within a health information exchange.
123 (c) "Health information exchange" means an electronic
124 system used to acquire, process, and transmit electronic medical
125 records that can be shared in real time among authorized health
126 care providers, health care facilities, health insurers, and
127 other recipients, as authorized by law, to facilitate the
128 provision of health care services.
129 (d) "Health information organization" means an entity with
130 a formal structure and established policies and procedures that
131 serves as a neutral convener of local stakeholders to enable the
132 secure and reliable exchange of electronic medical records among
133 authorized health care stakeholders within a defined geographic
134 region to facilitate improvements in health care quality,
135 safety, and coordination of care.
136 (4) MATCHING GRANTS.--
137 (a) Subject to a specific appropriation, the agency shall
138 award and monitor matching grants to health information
139 organizations that submit proposals that advance the development
140 of a statewide health information exchange. Funds awarded under
141 this subsection shall be awarded on the basis of matching each
142 $1 of state funds with $1 of local or private funds. Local or
143 private funds may be provided in the form of cash or in-kind
144 support or services. Grants may be awarded within the following
145 categories: development, operation, and collaboration.

146 (b) The agency shall, by rule, establish specific
147 eligibility criteria for a health information organization to
148 qualify for a grant under this subsection. These criteria shall
149 include, at a minimum, documentation of the following:
150 1. For development grants, the proposed organizational
151 structure, the level of community support, including a list of
152 key participants, a demonstration of available local or private
153 matching funds, a timeline for development of the health
154 information exchange, and proposed goals and metrics.
155 2. For operation grants, a demonstration of available
156 local or private matching funds and a detailed business plan,
157 which shall include a timeline for implementation of the health
158 information exchange, policies and procedures to protect the
159 privacy and security of electronic medical records, and proposed
160 goals and metrics.
161 3. For collaboration grants, a demonstration of available
162 local or private matching funds, memoranda of understanding
163 between at least two health information organizations for the
164 exchange of electronic medical records, a demonstration of
165 consistent utilization of the health information exchange by
166 members within each participating health information
167 organization, and a detailed business plan, which shall include
168 a timeline for the implementation of the exchange of electronic
169 medical records between participating health information
170 organizations, policies and procedures to protect the privacy
171 and security of electronic medical records, and proposed goals
172 and metrics.
173 (c) Beginning July 1, 2008, the agency shall not award a
174 health information organization more than 6 aggregate years of
175 funding.

176 (d) The agency shall award grants in consultation with the
177 Florida Health Information Exchange Advisory Council.
178 (5) ELECTRONIC MEDICAL RECORDS SYSTEM ADOPTION LOAN
179 PROGRAM.--
180 (a) Subject to a specific appropriation, the agency shall
181 operate an Electronic Medical Records System Adoption Loan
182 Program for the purpose of providing a one-time, no-interest
183 loan to eligible physicians licensed under chapter 458 or
184 chapter 459 or to an eligible business entity whose shareholders
185 are licensed under chapter 458 or chapter 459 for the initial
186 costs of implementing an electronic medical records system.
187 (b) In order to be eligible for a loan under this
188 subsection, each physician must demonstrate that he or she has
189 practiced continuously within the state for the previous 3
190 years.
191 (c) The agency shall not provide a loan to a physician who
192 has or a business entity whose physician has:
193 1. Been found guilty of violating s. 456.072(1) or been
194 disciplined under the applicable licensing chapter in the
195 previous 5 years.
196 2. Been found guilty of or entered a plea of guilty or
197 nolo contendere to a violation of s. 409.920 or s. 409.9201.
198 3. Been sanctioned pursuant to s. 409.913 for fraud or
199 abuse.
200 (d) A loan may be provided to an eligible physician or
201 business entity in a lump-sum amount to pay for the costs of
202 purchasing hardware and software, subscription services,
203 professional consultation, and staff training. The agency shall
204 provide guidance to loan recipients by providing, at a minimum,
205 a list of electronic medical record systems recognized or

206 certified by national standards-setting entities as capable of
207 being used to communicate with a health information exchange.
208 (e) The agency shall distribute a minimum of 25 percent of
209 funds appropriated to this program to physicians or business
210 entities operating within a rural county as defined in s.
211 288.106(1)(r).
212 (f) The agency shall, by rule, develop standard terms and
213 conditions for use in this program. At a minimum, these terms
214 and conditions shall require:
215 1. Loan repayment by the physician or business entity
216 within a reasonable period of time, which may not be longer than
217 72 months after the funding of the loan.
218 2. Equal periodic payments that commence within 3 months
219 after the funding of the loan.
220 3. The eligible physician or business entity to execute a
221 promissory note and a security agreement in favor of the state.
222 The security agreement shall be a purchase-money security
223 interest pledging as collateral for the loan the specific
224 hardware and software purchased with the loan proceeds. The
225 agency shall prepare and record a financing statement under
226 chapter 679. The physician or business entity shall be
227 responsible for paying the cost of recording the financing
228 statement. The security agreement shall further require that the
229 physician or business entity pay all collection costs, including
230 attorney's fees.
231 (g) The agency shall further require the physician or
232 business entity to provide additional security under one of the
233 following subparagraphs:
234 1. An irrevocable letter of credit, as defined in chapter
235 675, in an amount equal to the amount of the loan.

236 2. An escrow account consisting of cash or assets eligible
237 for deposit in accordance with s. 625.52 in an amount equal to
238 the amount of the loan. If the escrow agent is responsible for
239 making the periodic payments on the loan, the required escrow
240 balance may be diminished as payments are made.
241 3. A pledge of the accounts receivables of the physician
242 or business entity. This pledge shall be reflected on the
243 financing statement.
244 (h) All payments received from or on behalf of a physician
245 or business entity under this program shall be deposited into
246 the agency's Administrative Trust Fund to be used to fund new
247 loans.
248 (i) If a physician or business entity that has received a
249 loan under this section ceases to provide care or services to
250 patients, or if the physician or business entity defaults in any
251 payment and the default continues for 30 days, the entire loan
252 balance shall be immediately due and payable and shall bear
253 interest from that point forward at the rate of 18 percent
254 annually. Upon default, the agency may offset any moneys owed to
255 the physician or business entity from the state and apply the
256 offset against the outstanding balance.
257 (j) If a physician defaults in any payment and if the
258 default continues for 30 days, the default shall constitute
259 grounds for disciplinary action under chapter 458 or chapter 459
260 and s. 456.072(1)(k).
261 (6) FLORIDA HEALTH INFORMATION EXCHANGE ADVISORY
262 COUNCIL.--
263 (a) The Florida Health Information Exchange Advisory
264 Council is created as an adjunct to the agency. The council is
265 subject to the requirements of s. 20.052, except that only state

266 officers and employees shall be reimbursed for per diem and
267 travel expenses pursuant to s. 112.061.
268 (b) The purpose of the council is to:
269 1. Promote participation in regional and statewide health
270 information exchanges and adoption of health information
271 technology to support the infrastructure capacity for regional
272 and statewide health information exchanges.
273 2. Conduct outreach and convene forums to educate
274 stakeholders regarding the benefits of utilizing a health
275 information exchange.
276 3. Provide guidance to stakeholders regarding the
277 effective use of health information exchanges and standards for
278 protecting the privacy and security of electronic medical
279 records.
280 (c) The council shall consist of the following members:
281 1. The Secretary of Health Care Administration, or his or
282 her designee.
283 2. The State Surgeon General, or his or her designee.
284 3. Two members appointed by and serving at the pleasure of
285 the Governor, of which:
286 a. One member must be from the health insurance industry.
287 b. One member must be a consumer who is a resident of the
288 state.
289 4. Four members appointed by and serving at the pleasure
290 of the President of the Senate, of which:
291 a. One member must be from a hospital utilizing an
292 electronic medical records system.
293 b. One member must be a physician utilizing an electronic
294 medical records system in his or her practice.
295 c. One member must be a representative of an operating
296 health information organization in the state.

297 d. One member must be from a federally qualified health
298 center or other rural health organization utilizing an
299 electronic medical records system.
300 5. Four members appointed by and serving at the pleasure
301 of the Speaker of the House of Representatives, of which:
302 a. One member must be from a hospital utilizing an
303 electronic medical records system.
304 b. One member must be a physician utilizing an electronic
305 medical records system in his or her practice.
306 c. One member must be a representative of an operating
307 health information organization in the state.
308 d. One member must be from a federally qualified health
309 center or other rural health organization utilizing an
310 electronic medical records system.
311 (d) A member who is a representative of an operating
312 health information organization in the state must recuse himself
313 or herself during discussion, evaluation, or recommendation of a
314 grant application.
315 (e) Each member of the council subject to appointment
316 shall be appointed to serve for a term of 4 years following the
317 date of appointment. A vacancy shall be filled by appointment
318 for the remainder of the term. Appointments shall be made within
319 45 days after the effective date of this section.
320 (f) The council may meet at the call of the chair or at
321 the request of a majority of its membership, but the council
322 must meet at least quarterly. Meetings of the council may be
323 held via teleconference or other electronic means.
324 (g) Members shall elect a chair and vice chair annually.
325 (h) A majority of the members constitutes a quorum and the
326 affirmative vote of a majority of a quorum is necessary to take
327 action.

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329 are not limited to, developing recommendations to:
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335 technological, regulatory, and financial barriers, that limit
336 participation by health care providers, health care facilities,
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346 secure manner.
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350 entities to promote and coordinate health information exchange
351 efforts.
352 8. Create a long-term plan for an interoperable statewide
353 network of health information organizations.
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355 The council shall establish ad hoc issue-oriented technical
356 workgroups on an as-needed basis to make recommendations to the
357 council.

358 (j) The Florida Center for Health Information and Policy
359 Analysis within the agency shall provide, within existing
360 resources, staff support to enable the council to carry out its
361 responsibilities under this section.
362 (k) Beginning July 1, 2009, the council shall annually
363 provide a report to the Governor, the President of the Senate,
364 the Speaker of the House of Representatives, and the chairs of
365 the appropriate substantive committees of the Senate and the
366 House of Representatives that includes, but is not limited to,
367 the recommendations regarding the council's duties and
368 responsibilities. In addition, by July 1, 2010, the council
369 shall recommend a long-term plan to create an interoperable
370 statewide network of health information organizations to the
371 Governor, the President of the Senate, the Speaker of the House
372 of Representatives, and the chairs of the appropriate
373 substantive committees of the Senate and the House of
374 Representatives.
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376 abolished July 1, 2012, unless reviewed and saved from repeal
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384 and state applicants of the programs.
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388 (b) The agency shall develop and implement a plan that
389 promotes, at a minimum, participation in regional and statewide
390 health information exchanges and the adoption of electronic
391 medical record systems by physicians through the Electronic
392 Medical Records System Adoption Loan Program, in consultation
393 with the Florida Health Information Exchange Advisory Council,
394 organizations representing allopathic and osteopathic practicing
395 physicians, the Board of Medicine, and the Board of Osteopathic
396 Medicine.
397 (8) PROGRAM EVALUATION; REPORT.--The Office of Program
398 Policy Analysis and Government Accountability shall complete an
399 independent evaluation of the grants program administered by the
400 agency. The evaluation must include, at a minimum, assessments
401 of the grant evaluation and distribution process; the way in
402 which grant dollars are spent; the level of participation by
403 entities within each grantee's project; the extent of clinical
404 data exchange among entities within each grantee's project; the
405 sources of funding for each grantee; and the feasibility of each
406 grantee achieving long-term sustainability without state grant
407 funding. The evaluation must assess the level at which the
408 current grants program is advancing the development of a
409 statewide health information exchange and recommend other
410 programs that may accomplish the same goal. The report shall be
411 submitted to the Governor, the President of the Senate, the
412 Speaker of the House of Representatives, and the chairs of the
413 relevant committees in the Senate and the House of
414 Representatives no later than July 1, 2009.
415 Section 4. Subsection (5) of section 408.062, Florida
416 Statutes, is amended to read:
417 408.062 Research, analyses, studies, and reports.--

418 ~~(5) The agency shall develop and implement a strategy for~~
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428 ~~health records.~~
429 Section 5. Subsection (2) of section 483.181, Florida
430 Statutes, is amended to read:
431 483.181 Acceptance, collection, identification, and
432 examination of specimens.--
433 (2) The results of a test must be reported directly to the
434 licensed practitioner or other authorized person who requested
435 it, and appropriate disclosure may be made by the clinical
436 laboratory without a patient's consent to other health care
437 practitioners and providers involved in the care or treatment of
438 the patient for use in connection with the treatment of the
439 patient. The report must include the name and address of the
440 clinical laboratory in which the test was actually performed,
441 unless the test was performed in a hospital laboratory and the
442 report becomes an integral part of the hospital record.
443 Section 6. This act shall take effect upon becoming a law.
444
445
446
447 ---
448 T I T L E A M E N D M E N T

449 Remove the entire title and insert:
450 An act relating to electronic health records; amending s.
451 395.3025, F.S.; expanding access to a patient's medical records
452 to facilitate electronic exchange of data between certain health
453 care facilities, practitioners, and providers and attending
454 physicians; revising terminology regarding disclosure of patient
455 records to conform to changes made by the act; amending s.
456 408.05, F.S.; removing responsibility of the Agency for Health
457 Care Administration for monitoring certain grants; creating s.
458 408.051, F.S.; creating the "Florida eHealth Initiative Act";
459 providing legislative intent; providing definitions; requiring
460 the agency to award and monitor grants to certain health
461 information organizations; providing rulemaking authority
462 regarding establishment of eligibility criteria; establishing
463 the Electronic Medical Records System Adoption Loan Program;
464 providing eligibility criteria; providing rulemaking authority
465 regarding terms and conditions for the granting of loans;
466 creating the Florida Health Information Exchange Advisory
467 Council; providing for purpose, membership, terms of office, and
468 duties of the council; requiring the Florida Center for Health
469 Information and Policy Analysis to provide staff support;
470 requiring reports to the Governor and Legislature; providing for
471 future repeal of s. 408.051, F.S., and abolition of the council;
472 providing duties of the agency with regard to availability of
473 specified information on the agency's Internet website;
474 requiring the agency to develop and implement a plan to promote
475 participation in regional and statewide health information
476 exchanges; requiring the Office of Program Policy Analysis and
477 Government Accountability to complete an independent evaluation
478 of the grants program administered by the agency and submit the
479 report to the Governor and Legislature; amending s. 408.062,

480 F.S.; removing responsibility of the agency for developing an
481 electronic health information network; amending s. 483.181,
482 F.S.; expanding access to laboratory reports to facilitate
483 electronic exchange of data between certain health care
484 practitioners and providers; providing an effective date.
485

HB 731

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 731 Personal Care Attendant Program

SPONSOR(S): Gardiner

TIED BILLS: **IDEN./SIM. BILLS:** SB 370

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Healthy Seniors	9 Y, 0 N	Ciccone/Massengale	Ciccone
2) Healthcare Council		Ciccone	Gormley
3) Policy & Budget Council			
4)			
5)			

SUMMARY ANALYSIS

House Bill 731 amends the existing Personal Care Attendant (PCA) program and expands participant eligibility to provide personal care attendants to persons who have severe and chronic disabilities of all kinds. The bill names the program the "James Patrick Memorial Work Incentive Personal Attendant Services Program."

The bill merges the Cross Disability Pilot program that provides personal care attendants to the significantly disabled in Orange, Osceola, Lake and Seminole counties with the PCA program and specifies that all persons who are enrolled in the existing PCA and the Cross Disability pilot projects on June 30, 2008, are automatically eligible for and enrolled in the revised program.

The bill places the administration of the program within the Florida Association of Centers for Independent Living (FACIL) and provides that FACIL receive 15 percent of the funds that are deposited in the Florida Endowment Foundation for Vocational Rehabilitation from the Tax Collection Enforcement Diversion Program and the Motorcycle Specialty License Tab to administer the program.

The bill deletes obsolete language regarding eligibility criteria, training and program development. The bill establishes a program oversight group and requires the FACIL to work with the oversight group to provide training to program participants regarding hiring and managing personal care attendants and to adopt and revise policies and procedures governing the program.

The bill increases the allocation to the PCA program and redirects 90 percent of the sales tax collections obtained through the Tax Collection Enforcement Diversion program from the General Revenue Fund to the Able Trust as one source of funding for the expanded PCA program. The Revenue Estimating Conference analysis dated February 29, 2008, estimates the fiscal impact of the bill to be $1M from the General Revenue Fund in Fiscal Year 2008-09.

The bill takes effect July 1, 2008.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Ensure Lower Taxes – House Bill 731 does not propose any additional taxes or fees; however the proposal redirects 90 percent of the sales tax collections obtained through the tax collection enforcement diversion program from the General Revenue Fund to the Able Trust as one source of funding for the expanded personal care attendant program.

Promote Personal Responsibility – House Bill 731 provides personal care attendants to disabled persons who, without such assistance, would be unable to obtain or maintain employment or who would otherwise be in need of government assistance.

B. EFFECT OF PROPOSED CHANGES:

Background

Personal Care Attendant Program

The Personal Care Attendant (PCA) program was established to assist eligible persons, who are disabled because of a traumatic spinal cord injury, to return to work in their communities by providing personal care attendants. The PCA program was initially established as a pilot program in 2002 in select counties in Florida. [1] Under the pilot project, the law required the Department of Revenue (DOR) in coordination with the Florida Association of Centers for Independent Living (FACIL) and the Florida Prosecuting Attorneys Association, to select counties in which to operate the pilot project. [2] The following counties currently participate in the program: Miami-Dade, Broward, Palm Beach, Hillsborough and Duval.

Responsibility for implementation and administration of the program is with the Personal Care Attendant Program Oversight Workgroup established by the Department of Health (DOH.) The workgroup consists of: one representative from the Brain and Spinal Cord Injury Program in the DOH; one representative from the Department of Revenue (DOR); one representative from the Florida Medicaid program in the AHCA; one representative from the Florida Endowment Foundation for Vocational Rehabilitation (FEFVR); one representative from the Florida Association of Centers for Independent Living (FACIL); one representative from the Division of Vocational Rehabilitation (VR) of the Department of Education (DOE); and two members who are persons with traumatic spinal cord injuries or are family members of persons with traumatic spinal cord injuries.[3]

Persons eligible to participate in the program must:

- Be at least 18 years of age who are significantly disabled because of a traumatic spinal cord injury;

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[1] Ch.2002-286, L.O.F., established the PCA program as a pilot; the program was made permanent in Ch. 2005-172, L.O.F

[2] Ch.2002-286 section 2, L.O.F.

[3] S. 413.402(6), F.S.

- Require a personal care attendant for bathing, dressing, bowel and bladder management, and transportation;
- Require a personal care attendant to obtain or maintain substantial gainful employment;
- Be able to hire and supervise a personal care attendant; and
- Meet one of the following requirements:
  - Live in a nursing home;
  - Have recently moved out of a nursing home to participate in a Medicaid home; and community-based waiver program targeted to persons with brain or spinal cord injuries; or
  - Presently be employed, but because of a loss of a caregiver, will lose employment and potentially return to a nursing home.[4]

The PCA program consists of two major components:

- Recruiting, screening, selecting, and training candidates as personal care attendants; and
- Selecting eligible individuals for participation in the program and providing financial assistance to eligible participants. Program participants are provided approximately $670 per month ($8,000 per year) as reimbursement for the cost of his or her personal care attendant.[5]

Current enrollment in the program is as follows:

Date	Enrollment
January 2006	3
January 2007	22
January 2008	30

Program Care Attendant Program Funding

There are two funding sources for the PCA program: proceeds from the Tax Collection Enforcement Diversion Program, and from the Motorcycle Specialty License Tag.[6]

Tax Collection Enforcement Diversion Program

In conjunction with establishing the personal care attendant program, the Legislature directed the FACIL and the State Attorney's offices in the participating counties to implement a Tax Collection Enforcement Diversion program, which collects revenue from persons who have not remitted their sales taxes. Section 413.4021(1), F.S., specifies that 50 percent of those collections are to be remitted by the DOR to the Able Trust of the Florida Endowment Foundation for Vocational Rehabilitation to be used to implement the PCA program, with the other 50 percent going to the General Revenue Fund. The Able Trust, in turn, remits funds to the FACIL to administer and operate the PCA program.

There are currently five Florida State Attorney's offices operating a program in which un-remitted sales tax is collected from delinquent business owners. These collections generate approximately $80,000 per month for the personal care attendant program. According to the DOR, in FY 2005-06 the Tax Collection Enforcement Diversion programs in the five participating counties collected, and the DOR remitted, the following to the Able Trust:

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[4] S. 413.402, F.S.

[5] Personal Care Attendant Program Procedures

[6] Sections 413.402, F.S. and s. 320.08068, F.S.

County	Total Collected FY 2006-07	Able Trust 50 Percent	General Revenue 50 Percent
Broward	$ 481,402	$ 240,701	$ 240,701
Duval	511,841	255,921	255,921
Hillsborough	825,128	412,564	412,564
Miami-Dade	235,134	117,567	117,567
Palm Beach	245,431	122,715	122,715
Specialty Tag		*55,807*	
Other Contributions		*50*	
Interest		*61,399*	
TOTAL	**$2,298,936**	***$1,266,727**	**$1,149,468**

***Includes County collections in italics.**

Motorcycle Specialty (Bikers Care) Tag

Since 2003, the Department of Highway Safety and Motor Vehicles has offered a specialty tag to the owner or lessee of any motorcycle who chooses to pay the additional cost. Pursuant to s. 320.08068(4), F.S., a $20.00 annual fee is collected from the sale of each specialty license plate under this section. These fees are distributed to the Able Trust as the custodial agent of the funds.[7] The Able Trust may retain up to 10 percent of these funds for administrative costs and the remaining funds are distributed as follows:

- Twenty percent to the Brain and Spinal Cord Injury Program Trust Fund;
- Twenty percent to Prevent Blindness Florida;
- Twenty percent to the Blind Services Foundation of Florida;
- Twenty percent to the Foundation for Vocational Rehabilitation to support the Personal Care Attendant Program pursuant to s. 413,402, F.S.; and,
- Twenty percent to the FACIL to be used to leverage additional funding and new sources of revenue for the centers for independent living in Florida.

In FY 2006-07, the FACIL received approximately $56,000 from the Able Trust as their share of the specialty tag proceeds.

Cross Disability Pilot Program

In 2006, the Legislature appropriated $400,000 in non-recurring general revenue to establish a pilot personal care attendant project in Orange, Osceola, Lake and Seminole counties.[8] In contrast to the statutory PCA program, which serves only those who suffer from traumatic spinal cord injuries, the Cross Disability pilot project is intended to serve persons who are significantly physically or mentally disabled without regard to the underlying cause of the disability. Such individuals who need the

[7] Prior to July 1, 2006, the share allotted to the personal care attendant program was 25 percent. See ch. 2006-169, L.O.F.
[8] See Specific Appropriation 340, General Appropriations Act, ch. 2006-25, L.O.F. These funds were appropriated to the Department of Children and Families and are being distributed to the FACIL pursuant to grant agreements.

assistance of a personal care attendant to accept or maintain employment are eligible to enroll in the pilot project.

Operating procedures for the Cross Disability pilot project are based on the experiences of the existing PCA program. The Cross Disability pilot project provides each participant up to $1,500 per month to pay for a personal care attendant. The maximum reimbursable amount is based on a formula that takes into account a participant's income. Among current enrollees, those maximums range from $1,238.15 to $1,500; however, in no case may a participant be reimbursed for more than the amount actually paid to his or her personal care attendant. The pilot project began enrollment in January 2007 and currently has 11 individuals participating.

Because the appropriation establishing the pilot project specified non-recurring general revenue, the Cross Disability pilot project is operating under the original appropriation in 2006. The Department of Children and Families was permitted to carry forward the unspent balance of the original appropriation to fund the program's operations in FY 2007-08.[9] Without new funding, the program will not continue after July 2008.

Effect of Proposed Legislation

House Bill 731 amends the existing Personal Care Attendant program (PCA) to expand participant eligibility to persons who have severe and chronic disabilities of all kinds, not just those with traumatic spinal cord injuries. The bill names the revised program the "James Patrick Memorial Work Incentive Personal Attendant Services Program." The bill derives from the experience of the Cross Disability Pilot program providing personal care attendants to the significantly disabled in Orange, Osceola, Lake and Seminole counties and provides that all persons who are enrolled in the existing PCA and the Cross Disability pilot project on June 30, 2008, are automatically eligible for and enrolled in the revised program.

The effect of this proposal is to combine the existing PCA program and the Cross Disability Pilot program into a single cross-disability PCA program for individuals with severe and chronic disabilities who require a personal care attendant to go to work.

The bill requires the Florida Endowment Foundation for Vocational Rehabilitation to enter into an agreement with the Florida Association of Centers for Independent Living (FACIL) to administer the new program and provides that FACIL receive 15 percent of the funds in the Florida Endowment Foundation for Vocational Rehabilitation received from the Tax Collection Enforcement Diversion Program and the Motorcycle Specialty License Tab to administer the program. The bill increases the percentage of revenue collected from the Tax Collection Enforcement Diversion program from 50 percent to 90 percent, changing the 50/50 distribution to 90/10 (program funding/general revenue.)

The bill deletes obsolete language regarding eligibility criteria and program development, and deletes provisions allowing nurse registries to recruit and screen candidates to act as fiscal intermediaries to make payments to personal care attendants. The bill establishes a new program oversight group and requires that FACIL work with this group to review and revise policies and procedures governing the combined program.

[9] Section 19 in the General Appropriations Act for FY 2007-08 authorizes DCF to carry forward the unexpended balance of the FY 2006-07 appropriation of $400,000. The actual carry-forward amount was $202,000 in non-recurring funds.

C. SECTION DIRECTORY:

Section 1: Amends s. 413.402, F.S., requires the Florida Endowment Foundation for Vocational Rehabilitation to contract with the FACIL to administer the newly designated "James Patrick Memorial Work Incentive Personal Attendant Services Program" to provide personal care attendants to persons having severe and chronic disabilities of all kinds; provides that, effective July 1, 2008, FACIL will receive administrative funds from deposits with the Able Trust to administer the program; amends program eligibility standards; deletes requirements relating to recruitment, screening and selection of personal care attendants; requires FACIL to provide certain training to program participants; establishes an oversight group and provides membership.

Section 2. Amends s. 413.4021, F.S., increases the percentage of revenue collected to operate the program; repeals the provision that the Florida Endowment Foundation for Vocational Rehabilitation shall select the entity to administer the Personal Care Attendant program.

Section 3. Creates an undesignated section of law providing for automatic eligibility for and enrollment in the Personal Care Attendant program for certain persons.

Section 4. Provides an effective date of July 1, 2008.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The bill decreases the percent of collected sales tax received from the Tax Collection Enforcement Diversion program that would be deposited in the General Revenue Fund. Currently, 50 percent is deposited in General Revenue – in Fiscal Year 2006-2007, that amount was $1,149,468. The bill decreases that percentage to 10 percent. The Revenue Estimating Conference analysis dated February 29, 2008, estimates the fiscal impact resulting from this decrease to the General Revenue Fund to be $1M in Fiscal Year 2008-09.

2. Expenditures:

The Department of Revenue reports that it anticipates increased State Attorney participation in the Tax Collection Enforcement Diversion Program by at least two judicial circuits because of this bill. DOR prepared diversion cases and refers these cases to the participating state Attorney. In support of the current effort, the DOR has an investigator and the equivalent of one additional staff member in each of the five judicial circuits where the Diversion Program operates. If two new Diversion Programs were added, DOR would need two Investigators (Pay Grade 18) to prepare these cases and two Revenue Specialists III's (Pay Grade 17) to make adjustments to the DOR's integrated tax system (SUNTAX.) [10]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

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[10] Department of Revenue Analysis, dated February 16, 2008 on file with the committee.

Not applicable

2. Expenditures:

   Not applicable

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Individuals with disabilities will have the opportunity to hire a personal care attendant to assist him or her in order to obtain or maintain gainful employment.

D. FISCAL COMMENTS:

As noted in the staff analysis, the current PCA program provides participants approximately $670 per month ($8,000) per year. FACIL advises that the proposal to combine the PCA and Cross Disability pilot programs may provide participants with up to $1,500 per month for his or her personal care attendant. The maximum reimbursable amount is based on a formula which takes into account a participant's income. Among current enrollees, those maximums range from $1,238 to $1,500 per month; in no case, however, may a participant be reimbursed for more than the amount actually paid to his or her personal care attendant.

House Bill 731 provides that all persons enrolled in the PCA program and the Cross Disability pilot on June 30, 2008 are automatically enrolled in the new program. Currently there are 30 PCA program participants and 11 Cross Disability pilot participants totaling 41. The estimate for available revenue to the Able Trust is $1,266,724 for Fiscal Year 2006-2007. Program expenses in that year were $318,936, leaving $947,788 available for payments to program participants. Using these figures, if each participant were to receive the maximum payment of $1,500 per month under the provisions of the bill, approximately 52 participants could be served through the program created in this bill.

There are also expenses associated with the Diversion Program, which is one source of funding for the PCA Program.

As reported by FACIL, for the first year of the PCA project, the Brain and Spinal Cord Injury program (BSCIP) provided a $50,000 loan to the State Attorney's Office in each of the sites to establish a Tax Collection Enforcement Diversion Program office. To re-pay the loan, each program site is required to pay 25 percent of each quarter's earnings to the PCIP until they have paid back the full $50,000. After the first year and the loan payments are made, the rest of the collections up to an amount of $50,000 per year are given back to the state attorney offices to support the cost of the diversion program. The remaining funds are then available to pay for personal care attendants for program participants.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   The 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:

Not applicable

B. RULE-MAKING AUTHORITY:

Not applicable

C. DRAFTING ISSUES OR OTHER COMMENTS:

None

D. STATEMENT OF THE SPONSOR

No statement submitted.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

On March 4, 2008, the Committee on Healthy Seniors adopted one amendment by the bill sponsor. The amendment:

- Revises the proposed general revenue/program distribution in the bill from 90/10 percent to current law which is 50/50 percent, thereby removing the $1M fiscal impact and conforming the House bill to the Senate bill.

The committee reported the bill favorably with one amendment.

1 A bill to be entitled
2 An act relating to the personal care attendant program;
3 amending s. 413.402, F.S.; revising provisions governing a
4 program to provide personal care attendants for persons
5 who have disabilities; requiring the Florida Endowment
6 Foundation for Vocational Rehabilitation to enter into an
7 agreement with the Florida Association of Centers for
8 Independent Living to administer a program to provide such
9 attendants to persons who have severe and chronic
10 disabilities; naming the program the "James Patrick
11 Memorial Work Incentive Personal Attendant Services
12 Program"; providing for payment for the administration of
13 the program; removing a provision requiring interagency
14 memoranda of agreement; revising eligibility requirements
15 for participation in the personal care attendant program;
16 removing provisions concerning the training, selection,
17 and recruitment of personal care attendants; providing for
18 training of program participants concerning hiring and
19 managing an attendant; providing for the adoption and
20 revision of program policies and procedures by the
21 association in cooperation with an oversight group;
22 providing for membership in the oversight group; amending
23 s. 413.4021, F.S.; increasing the percentage of revenues
24 collected from persons who fail to remit sales tax which
25 is deposited in the operating account of the Florida
26 Endowment Foundation for Vocational Rehabilitation to
27 administer the program; deleting a provision requiring
28 that the Florida Endowment Foundation for Vocational

29 Rehabilitation select an entity to administer the program;
30 providing for automatic enrollment in the program for
31 certain persons; providing an effective date.
32
33 Be It Enacted by the Legislature of the State of Florida:
34
35 Section 1. Section 413.402, Florida Statutes, is amended
36 to read:
37 413.402 Personal care attendant program.--The personal
38 care attendant program created under this section shall be cited
39 as the "James Patrick Memorial Work Incentive Personal Attendant
40 Services Program." The Florida Endowment Foundation for
41 Vocational Rehabilitation shall enter into an agreement with the
42 Florida Association of Centers for Independent Living to
43 administer the James Patrick Memorial Work Incentive Personal
44 Attendant Services~~, in conjunction with the Brain and Spinal~~
45 ~~Cord Injury Program in the Department of Health, shall develop a~~
46 Program to provide personal care attendants to persons who have
47 severe and chronic disabilities of all kinds and who are
48 eligible under ~~pursuant to~~ subsection (1). Effective July 1,
49 2008, the Florida Association of Centers for Independent Living
50 shall receive 15 percent of the funds to be deposited with the
51 Florida Endowment Foundation for Vocational Rehabilitation
52 pursuant to ss. 320.08068(4)(d) and 413.4021(1) to administer
53 the program. ~~The association and the Department of Health shall~~
54 ~~jointly develop memoranda of understanding with the Department~~
55 ~~of Revenue, the Florida Medicaid program in the Agency for~~
56 ~~Health Care Administration, the Florida Endowment Foundation for~~

57 ~~Vocational Rehabilitation, and the Division of Vocational~~
58 ~~Rehabilitation of the Department of Education.~~
59 (1) In order to be ~~Persons~~ eligible to participate in the
60 program, a person must:
61 (a) Be at least 18 years of age, be a resident of this
62 state for at least 12 months immediately prior to application to
63 the program, and be significantly and chronically disabled ~~due~~
64 ~~to a traumatic spinal cord injury~~;
65 (b) Require a personal care attendant for assistance with
66 or support for at least two activities of daily living as
67 defined in s. 429.02, as determined by a physician or
68 psychiatrist ~~bathing, dressing, bowel and bladder management,~~
69 ~~and transportation~~;
70 (c) Require a personal care attendant in order to accept a
71 job or maintain substantial gainful employment; and
72 (d) Be able to acquire ~~hire~~ and direct ~~supervise~~ a
73 personal care attendant.~~; and~~
74 ~~(e) Meet one of the following requirements:~~
75 ~~1. Live in a nursing home;~~
76 ~~2. Have moved out of a nursing home within the preceding~~
77 ~~180 days due to participation in a Medicaid home and community-~~
78 ~~based waiver program targeted to persons with brain or spinal~~
79 ~~cord injuries; or~~
80 ~~3. Presently be employed but, because of a loss of a~~
81 ~~caregiver, will lose employment and potentially return to a~~
82 ~~nursing home.~~
83 (2)(a) ~~The association, in cooperation with the Department~~
84 ~~of Health and the Florida Endowment Foundation for Vocational~~

85 ~~Rehabilitation, shall develop a program to recruit, screen, and~~
86 ~~select candidates to be trained as personal care attendants.~~
87 ~~(b) The services of a nurse registry licensed pursuant to~~
88 ~~s. 400.506 may be utilized to recruit and screen candidates and~~
89 ~~to operate as a fiscal intermediary through which payments are~~
90 ~~made to individuals performing services as personal care~~
91 ~~attendants under the program. The Department of Health and the~~
92 ~~Agency for Health Care Administration shall seek any federal~~
93 ~~waivers necessary to implement this provision.~~
94 ~~(3)~~ The Florida Association of Centers for Independent
95 Living ~~association and the Department of Health, in cooperation~~
96 ~~with the Florida Endowment Foundation for Vocational~~
97 ~~Rehabilitation,~~ shall provide ~~develop a~~ training to program
98 participants on hiring and managing a personal care attendant
99 and, in cooperation with the oversight group described in
100 paragraph (b), adopt and revise the policies and procedures
101 governing the personal care attendant program and the training
102 program.
103 (b) The oversight group shall include, but need not be
104 limited to, a member of the Florida Association of Centers for
105 Independent Living, a person who is participating in the
106 program, and one representative each from the Department of
107 Revenue, the Department of Children and Family Services, the
108 Division of Vocational Rehabilitation in the Department of
109 Education, the Medicaid program in the Agency for Health Care
110 Administration, the Florida Endowment Foundation for Vocational
111 Rehabilitation, and the Brain and Spinal Cord Injury Program in
112 the Department of Health ~~program for personal care attendants~~.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

113 ~~(4) The association, in cooperation with the Department of~~
114 ~~Health and the Florida Endowment Foundation for Vocational~~
115 ~~Rehabilitation, shall establish procedures for selecting persons~~
116 ~~eligible under subsection (1) to participate in the program.~~
117 ~~(5) The association, in cooperation with the Department of~~
118 ~~Revenue, the Brain and Spinal Cord Injury Program in the~~
119 ~~Department of Health, the Florida Medicaid program in the Agency~~
120 ~~for Health Care Administration, a representative from the state~~
121 ~~attorney's office in each of the judicial circuits participating~~
122 ~~in the program, the Florida Endowment Foundation for Vocational~~
123 ~~Rehabilitation, and the Division of Vocational Rehabilitation of~~
124 ~~the Department of Education, shall develop a plan for~~
125 ~~implementation of the program.~~
126 ~~(6) The Department of Health shall establish an oversight~~
127 ~~workgroup for the personal care attendant program to oversee the~~
128 ~~implementation and administration of the program. The workgroup~~
129 ~~shall be composed of one representative from the Brain and~~
130 ~~Spinal Cord Injury Program in the Department of Health, one~~
131 ~~representative from the Department of Revenue, one~~
132 ~~representative from the Florida Medicaid Program in the Agency~~
133 ~~for Health Care Administration, one representative from the~~
134 ~~Florida Endowment Foundation for Vocational Rehabilitation, one~~
135 ~~representative from the Florida Association of Centers for~~
136 ~~Independent Living, one representative from the Division of~~
137 ~~Vocational Rehabilitation of the Department of Education, and~~
138 ~~two members who are persons with traumatic spinal cord injuries~~
139 ~~or are family members of persons with traumatic spinal cord~~
140 ~~injuries.~~

141 Section 2. Subsections (1) and (2) of section 413.4021,
142 Florida Statutes, are amended to read:
143 413.4021 Program participant selection; tax collection
144 enforcement diversion program.--The Department of Revenue, in
145 coordination with the Florida Association of Centers for
146 Independent Living and the Florida Prosecuting Attorneys
147 Association, shall select judicial circuits in which to operate
148 the program. The association and the state attorneys' offices
149 shall develop and implement a tax collection enforcement
150 diversion program, which shall collect revenue due from persons
151 who have not remitted their collected sales tax. The criteria
152 for referral to the tax collection enforcement diversion program
153 shall be determined cooperatively between the state attorneys'
154 offices and the Department of Revenue.
155 (1) Notwithstanding the provisions of s. 212.20, 90 ~~50~~
156 percent of the revenues collected from the tax collection
157 enforcement diversion program shall be deposited into the
158 operating account of the Florida Endowment Foundation for
159 Vocational Rehabilitation, to be used to administer the personal
160 care attendant program and to contract with the state attorneys
161 participating in the tax collection enforcement diversion
162 program in an amount of not more than $50,000 for each state
163 attorney.
164 (2) The program shall operate only from funds deposited
165 into the operating account of the Florida Endowment Foundation
166 for Vocational Rehabilitation. ~~The Florida Endowment Foundation~~
167 ~~for Vocational Rehabilitation shall select the entity to~~
168 ~~administer the personal care attendant program.~~

169 Section 3. Notwithstanding any other law, each person
170 enrolled in the personal care attendant program under s.
171 413.402, Florida Statutes, on June 30, 2008, and each person
172 enrolled in the pilot personal care attendant program in Lake,
173 Orange, Osceola, and Seminole Counties as authorized in Specific
174 Appropriation 340, chapter 2006-25, Laws of Florida, on June 30,
175 2008, is automatically eligible for and enrolled in the personal
176 care attendant program, as amended by this act, on July 1, 2008.
177 Section 4. This act shall take effect July 1, 2008.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 1

Bill No. **HB 731**

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)

ADOPTED AS AMENDED __ (Y/N)

ADOPTED W/O OBJECTION __ (Y/N)

FAILED TO ADOPT __ (Y/N)

WITHDRAWN __ (Y/N)

OTHER ______

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1 Council/Committee hearing bill: Healthcare Council

2 Committee on Healthy Seniors offered the following:

3

4 **Amendment**

5 On line 155 remove:

6 (1) Notwithstanding the provisions of s. 212.20, 90 ~~50~~

7 and insert:

8 (1) Notwithstanding the provisions of s. 212.20, 50

This amendment was adopted in HS on 3/4/08 and is travelling with the bill and requires no further action.

HB 989

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 989 Physician Assistants
SPONSOR(S): Bogdanoff
TIED BILLS: **IDEN./SIM. BILLS:** SB 1106

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Health Quality	9 Y, 0 N	Owen	Lowell
2) Healthcare Council		Owen	Gormley
3)			
4)			
5)			

SUMMARY ANALYSIS

HB 989 deletes antipsychotics and parenteral preparations from the formulary of drugs that a physician assistant is prohibited from prescribing.

The bill appears to have an insignificant negative fiscal impact to the Medical Quality Assurance Trust Fund (see fiscal comments).

The bill is effective July 1, 2008.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

The bill does not appear to implicate any of the House Principles.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

Licensure of Physician Assistants

Chapter 458, F.S., governs the practice of medicine in Florida. Chapter 459, F.S., similarly governs the practice of osteopathic medicine. Physician assistants (PAs) are licensed under ch. 458 and ch. 459, F.S.,[1] are authorized to provide health care services under the supervision of a medical physician or osteopathic physician.

Licenses are renewed biennially and each licensed PA is required to complete 100 hours of continuing medical education biennially or hold a current certificate issued by the National Commission on Certification of Physician Assistants.

Once employed, the PA must notify the department in writing within 30 days of employment or after changes in the supervising physician. The Boards of Medicine and Osteopathic Medicine have the power to impose penalties upon a PA if the PA or the supervising physician is found guilty of or is being investigated for any act that constitutes a violation of Chapters 456, 458, or 459.[2]

According to the department's 2007 Medical Quality Assurance Annual Report, there are 4,476 active physician assistants licensed in Florida.

Supervising Physician

For purposes of the regulation of PAs, "supervision" is defined in ss. 458.347 and 459.022, F.S., to mean responsible supervision and control. Except for cases of emergency, supervision requires the easy availability or physical presence of the licensed physician for consultation and direction of the actions of the PA. "Easy availability" is defined to include the ability to communicate by way of telecommunication. The Board of Medicine and the Board of Osteopathic have adopted, pursuant to s. 458.347(4)(f)4., F.S., identical administrative rules that define "direct supervision" to mean the presence of the supervising physician on the premises so that the supervising physician is immediately available to the PA when needed.[3] "Indirect supervision" is defined under the rules to mean the easy availability of the supervising physician to the PA, which includes the availability to communicate by telecommunications. The supervising physician must also be within reasonable physical proximity.[4]

The physician or group of physicians supervising a PA must be qualified in the medical areas in which the PA is to perform and must be individually or collectively responsible and liable for the performance and the acts and omissions of the PA. A physician may not supervise more than four PAs at any one time.

A supervising physician is authorized to delegate to a PA that he or she supervises the authority to perform medical acts of diagnosis, treatment, and prescription. A supervising physician may delegate

[1] Sections 458.347 and 459.022, F.S.

[2] Sections 458.347(7)(g) and 459.022(7)(f), F.S.

[3] See Rules 64B8-30.001(3) and 64B15-6.001(4), Florida Administrative Code.

[4] See Rules 64B8-30.001(5) and 64B15-6.001(5), F.A.C.

to a fully licensed PA the authority to prescribe any medication used in the supervising physician's practice unless the medication is listed on the formulary established under s. 458.347(4)(f), F.S.

<u>Physicians Assistant Formulary</u>
The PA formulary is a list of medications a PA is not allowed to prescribe and is developed by a five-member council, the Council on Physician Assistants (council). The council is comprised of 3 medical doctors appointed by the Board of Medicine, 1 osteopathic doctor appointed by the Board of Osteopathic Medicine, and 1 PA appointed by the State Surgeon General. The council recommends the formulary to the Board of Medicine and the Board of Osteopathic Medicine; the boards then pass the recommended formulary into administrative rule. The formulary of medications a PA is not allowed to prescribe must include controlled substances, antipsychotics, general anesthetics, radiographic contrast materials, and all parenteral preparations,[5] except insulin and epinephrine.

A PA may only prescribe or dispense medication under the following circumstances:[6]

- The PA must clearly identify to the patient that he or she is a PA and that the patient has the right to see the physician prior to any prescription being prescribed or dispensed by the PA;
- The supervising physician must notify the department of his or her intent to delegate the authority to dispense to a PA;
- The PA must file evidence with the department that he or she has completed a continuing education course of at least three classroom hours in prescriptive practice;
- The PA must file evidence with the department that he or she has a minimum of three months of clinical experience in the specialty area of the supervising physician;
- The PA must file a signed affidavit with the department that he or she has completed a minimum of ten continuing medical education hours in the specialty practice in which the PA has prescriptive privileges with each licensure renewal;
- The department must issue a license and a prescriber number to the PA granting authority for the prescribing of medicinal drugs;
- The prescription must be written in a format that complies with chapter 499 and must contain the supervising physician's name, address, and telephone number, in addition to the PA's prescriber number; and
- The PA must note the prescription or dispensing of medication in the appropriate patient medical record, and the supervising physician must review and sign each notation.

Effect of Proposed Changes

The bill deletes antipsychotics and parenteral preparations from the formulary of drugs that a physician assistant is prohibited from prescribing. There are several drugs included under each of class.

For example, a PA may be allowed to prescribe injectables such as:

- Forteo, which may be used to treat symptoms of severe osteoporosis.
- Emitrex, which may be used to treat migraine headaches.
- Lovenox, which may be used to prevent blood clots.

Also, a PA may be allowed to prescribe antipsychotics such as:

- Saraquel, which may be used to treat Alzheimer patients.
- Abilify, which may be used to treat bi-polar disorder.
- Other non-controlled substances such as Haldol, Resperdol, Thorazine, and Lithium.

The bill grants authority to the PA Council to change the PA formulary; it does not mandate any change to the formulary.

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[5] "Parenteral preparations" are sterile preparations intended for administration by injection, infusion or implantation.
[6] S. 458.347(4)(e), F.S.

C. SECTION DIRECTORY:

Section 1: Amends s. 458.347, F.S., revising the requirements for the physician assistant formulary.

Section 2: Provides an effective date of July 1, 2008.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

A patient would be able to receive certain prescriptions from PAs, in lieu of a physician, who may bill at a lower rate.

D. FISCAL COMMENTS:

Whenever the formulary is revised, the department will incur costs to mail a copy of the amended formulary to each PA and pharmacy licensed by the state. According to the 2007 Medical Quality Assurance Annual Report, there are 4,828 licensed PAs and 7,628 licensed Pharmacy Establishments in Florida. Therefore, 12,456 notices would have to be mailed. The cost would be at least $5,107 (@$0.41 each for postage), but may be higher depending on the weight. However, the fiscal impact to the Medical Quality Assurance Trust Fund would be insignificant.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenues.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The department appears to have sufficient rule-making authority to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

According to the department, the PA Council met on January 31, 2008 and discussed HB 989. At that meeting, the PA Council as well as the Board of Medicine voted to support the provisions of the bill.

D. STATEMENT OF THE SPONSOR

No statement submitted.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to physician assistants; amending s.
3 458.347, F.S.; revising the requirements for the formulary
4 established by the Council on Physician Assistants in
5 order to allow physician assistants to prescribe
6 antipsychotics and parenteral preparations; providing an
7 effective date.
8
9 Be It Enacted by the Legislature of the State of Florida:
10
11 Section 1. Paragraph (f) of subsection (4) of section
12 458.347, Florida Statutes, is amended to read:
13 458.347 Physician assistants.--
14 (4) PERFORMANCE OF PHYSICIAN ASSISTANTS.--
15 (f)1. The council shall establish a formulary of medicinal
16 drugs that a fully licensed physician assistant, licensed under
17 this section or s. 459.022, may not prescribe. The formulary
18 must include controlled substances as defined in chapter 893,
19 ~~antipsychotics,~~ general anesthetics, and radiographic contrast
20 materials~~, and all parenteral preparations except insulin and~~
21 ~~epinephrine~~.
22 2. In establishing the formulary, the council shall
23 consult with a pharmacist licensed under chapter 465, but not
24 licensed under this chapter or chapter 459, who shall be
25 selected by the State Surgeon General.
26 3. Only the council shall add to, delete from, or modify
27 the formulary. Any person who requests an addition, deletion, or
28 modification of a medicinal drug listed on such formulary has

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

29 the burden of proof to show cause why such addition, deletion,
30 or modification should be made.
31 4. The boards shall adopt the formulary required by this
32 paragraph, and each addition, deletion, or modification to the
33 formulary, by rule. Notwithstanding any provision of chapter 120
34 to the contrary, the formulary rule shall be effective 60 days
35 after the date it is filed with the Secretary of State. Upon
36 adoption of the formulary, the department shall mail a copy of
37 such formulary to each fully licensed physician assistant,
38 licensed under this section or s. 459.022, and to each pharmacy
39 licensed by the state. The boards shall establish, by rule, a
40 fee not to exceed $200 to fund the provisions of this paragraph
41 and paragraph (e).
42 Section 2. This act shall take effect July 1, 2008.

Budget Workshop

	FY 2008-09 General Revenue Base Budget	% of Healthcare Budget	5% Reduction	7.5% Reduction	10% Reduction
Veterans' Affairs	$13,930,987	0.19%	$696,549	$1,044,824	$1,393,099
Children & Family Services	$1,532,986,901	20.52%	$76,649,345	$114,974,018	$153,298,690
Health	$565,710,781	7.57%	$28,285,539	$42,428,309	$56,571,078
Elderly Affairs	$134,832,480	1.81%	$6,741,624	$10,112,436	$13,483,248
Persons with Disabilities	$499,659,238	6.69%	$24,982,962	$37,474,443	$49,965,924
Health Care Admininstration	$4,722,752,671	63.22%	$236,137,634	$354,206,450	$472,275,267
TOTALS	$7,469,873,058	100.00%	$373,493,653	$560,240,479	$746,987,306

MEDICAID IMPACT CONFERENCE
SFY2008/09 March 12, 2008

Row		Issue	Action	Proposed Start Date	General Revenue	Trust Fund	Total
1	REIMBURSEMENT						
2	1	Private Duty Nursing Rate Increase	Rate increase of $10 per hour for Private Duty Nursing funded by an off-set in Hospital Inpatient Services length of stay.	Pending	Pending	Pending	Pending
3	2	Birthing Centers Rate Increase	Birthing center reimbursement increase for discussion.	1/1/2009	$462,002	$572,968	$1,034,970
4	3	Expand Prior Authorization of Inpatient Hospital Services to include Elective Cesarean Sections	Provide estimate of the savings if there was a prior authorization required for elective Cesarean services.	7/1/2008	($1,455,126)	($1,807,489)	($3,262,615)
5	6	Non-Emergency Transportation	Reduce contract by 1%.	7/1/2008	($326,034)	($404,983)	($731,017)
6	7	Payment for Preventable Hospital Errors	Provide an estimate of savings by adopting the Medicare policy of no longer reimbursing hospitals for preventable errors.	7/1/2008	($96,179)	($119,468)	($215,647)
7	11	HCBS Rates	Provide the estimated savings by reducing all HCBS waiver rates by 1%. Include all waivers. List estimates by waiver.	7/1/2008	($169,100)	($12,187,869)	($12,356,969)
8	18	Reduce Pharmacy Reimbursement	Provide estimated savings by reducing reimbursement of prescribed drugs from AWP minus 15.4%- to AWP minus 16.4%; and WAC plus 5.75% to WAC plus 4.75%.	7/1/2008	($4,343,431)	($5,395,197)	($9,738,628)
9	22	County Health Department Rates	Savings associated with reducing County Health Department Rates to County Hospital Billing Rates and creating a special payment to CPHU to exempt rates up to 95% of Costs if the county has sufficient county dollars to use a match or IGTs.	7/1/2008	($24,478,992)	($31,381,008)	($55,860,000)
10	23	County Health Department Rate Freeze/Reduction	Freeze reimbursement rate at the June 30, 2008 level. Provide a mechanism to calculate a % rate reduction in addition to the freeze.	7/1/2008	($5,187,647)	($6,562,828)	($11,750,475)
11	24	County Health Department Reduction	Provide the estimated savings by reducing the FY 2008-09 rates by 1%. Provide a mechanism to calculate the reduction.	7/1/2008	($644,184)	($825,816)	($1,470,000)
12	27	Nursing Home Rate Freeze/Reduction	Provide estimated savings by freezing nursing home rates at the June 30, 2008 level. Provide a mechanism to calculate a % rate reduction in addition to the freeze. Include impact on Hospice Rates (Include impact to 2.9 staffing regulation).	7/1/2008	($79,789,507)	($99,353,504)	($179,143,011)
13	28	Nursing Home Rate Reduction	Provide the estimated savings by reducing the FY 2008-09 Nursing Home rates by 1%. Provide a mechanism to calculate the reduction. Include impact on Hospice rates. Include impact on 2.9 staffing regulation.	7/1/2008	($12,256,503)	($15,261,466)	($27,518,228)
14	29	Nursing Staffing Hours	Provide Savings associated with reducing Nurse Staffing Ratios from 2.9 to 2.6 Hours	Indeterminate	Indeterminate	Indeterminate	Indeterminate
15	32	HMO Rate Freeze/Reduction	Provide estimated savings by freezing HMO rates at the June 30, 2008 level. Provide a mechanism to calculate a % rate reduction in addition to the freeze.	7/1/2008	($68,861,398)	($87,180,391)	($156,041,398)
16	33	HMO Rate Reduction	Provide the estimated savings by reducing the FY 2008-09 HMO rates by 1%. Provide a mechanism to calculate the reduction.	7/1/2008	($9,884,739)	($12,466,079)	($22,350,818)
17	34	Exclude retroactive claims from HMO rates	Provide the estimated savings by eliminating retroactive claims from HMO capitation rates.	Annualized	($10,339,538)	($12,874,512)	($23,214,050)
18	37	Hospital IP Rate Freeze & Reduction	Freeze reimbursement rate at the June 30, 2008 level. Provide a mechanism to calculate a % rate reduction in addition to the freeze. Include impact to HMO Rates.	7/1/2008	($40,643,596)	($50,707,553)	($91,351,149)
19	38	Hospital IP Reduction Only	Provide the estimated savings by reducing the FY 2008-09 Hospital Inpatient rates by 1%. Provide a mechanism to calculate the reduction. Include impact to HMO rates.	7/1/2008	($12,299,587)	($15,603,786)	($27,903,373)

MEDICAID IMPACT CONFERENCE
SFY2008/09 March 12, 2008

Row		Issue	Action	Proposed Start Date	General Revenue	Trust Fund	Total
20	42	Hospital OP Rate Freeze & Reduction	Freeze reimbursement rate at the June 30, 2008 level. Provide a mechanism to calculate a % rate reduction in addition to the freeze. Include impact to HMO rates.	7/1/2008	($38,547,079)	($48,036,953)	($86,191,803)
21	43	Hospital OP Reduction Only	Provide the estimated savings by reducing the FY 2008-09 Hospital Outpatient rates by 1%. Provide a mechanism to calculate the reduction. Include impact to HMO rates.	7/1/2008	($3,185,990)	($4,057,116)	($7,243,106)
22	39	Rural Hospital IP Exemptions	Provide the estimated expenditures between the exempt rate and the county ceiling target rate.	7/1/2008	($8,884,344)	($11,063,297)	($19,946,641)
23	44	Rural Hospital OP Exemptions	Provide the estimated expenditures between the exempt rate and the county ceiling target rate.	7/1/2008	($287,146)	($356,679)	($643,825)
24	40a	Reduce Hospital OP Cap to $1,400	Provide the percent of adults subject to the cap that are spending up to the cap. Also provide estimates of savings due to reducing the cap from $1,500 to $1,400	7/1/2008	($172,515)	($215,640)	($388,155)
25	40b	Reduce Hospital OP Cap to $1,300	Provide the percent of adults subject to the cap that are spending up to the cap. Also provide estimates of savings due to reducing the cap from $1,500 to $1,300	7/1/2008	($577,174)	($721,458)	($1,298,632)
26	40c	Reduce Hospital OP Cap to $1,200	Provide the percent of adults subject to the cap that are spending up to the cap. Also provide estimates of savings due to reducing the cap from $1,500 to $1,200	7/1/2008	($1,245,184)	($1,556,460)	($2,801,644)
27	40d	Reduce Hospital OP Cap to $1,100	Provide the percent of adults subject to the cap that are spending up to the cap. Also provide estimates of savings due to reducing the cap from $1,500 to $1,100	7/1/2008	($2,222,413)	($2,777,981)	($5,000,394)
28	40e	Reduce Hospital OP Cap to $1,000	Provide the percent of adults subject to the cap that are spending up to the cap. Also provide estimates of savings due to reducing the cap from $1,500 to $1,000	7/1/2008	($3,547,079)	($4,433,793)	($7,980,872)
29	45	Eliminate Medipass $3 Encounter Payment	Provide Savings associated with eliminating the $3 MediPass Encounter Payment	Annualized	($10,648,108)	($13,346,738)	($23,994,846)
30	47	KidCare 10% Requirement	Provide the estimated impact of removing the 10% enrollment requirement for full-pay enrollees.	Pending	Pending	Pending	Pending
31	48	KidCare PL/WL & FFP	Provide a breakout of KidCare FY 2008-09 estimates by Price Level and Workload and associate FMAP change.	Pending	Pending	Pending	Pending
32	49	FHK Rate Freeze	Freeze FHK capitation rates at the June 30, 2008 level.	7/1/2008	($11,373,055)	($19,587,306)	($30,960,361)
33	50	Reduce Kidcare Rate	Reduce 2008-09 KidCare Capitation rates by 1%.	7/1/2008	($1,453,943)	($3,357,253)	($4,811,196)
34	51	Dental Services Fee Increase	Issue requests a 20% increase in Dental Rates. (As reflected in 2008 Gov. budget)	7/1/2008	$9,376,471	$12,441,805	$21,818,276
35	52	Home Health & PDN Increase	Issue requests a 5% increase in fees for these providers. (As reflected in 2008 Gov. budget)	7/1/2008	$5,134,948	$6,726,591	$11,861,539
36	53	Physician Specialty Fee Increase	Issue requests increasing current fees halfway to the Medicare rate. (As reflected in 2008 Gov. budget)	7/1/2008	$6,842,446	$9,042,567	$15,885,013
37	SERVICES						
38	4	Home Health Services	Provide the estimated savings from decreasing the prior authorization period of home health aides health services.	N/A	$0	$0	$0
39	8	Developmental Disability Waiver Services Provided by State Plan in lieu of Waiver.	Provide an estimate of the savings achieved by providing waiver services provided to individuals under age 21 through the Medicaid state plan.	7/1/2008	$515,037	$678,007	$1,193,044
40	9	Eliminate Optional Services for Adults (including HCBS)	Provide the estimated savings by eliminating all optional services for adults including HCBS.	Annualized	($1,464,547,690)	($3,222,730,101)	($4,687,277,791)

Row		Issue	Action	Proposed Start Date	General Revenue	Trust Fund	Total
41	10	Eliminate Optional Services for Adults (excluding HCBS)	Provide the estimated savings by eliminating all optional services for adults excluding HCBS.	Annualized	($1,449,075,232)	($2,269,492,910)	($3,718,568,142)
42	20	Pharmaceutical Expense Assistance	Provide an analysis of estimated savings due to reducing the appropriation for this program to the amount needed to fund the program for SFY08/09.	N/A	($152,135)	$0	($152,135)
43	30	Nursing Home Diversion Increase	Provide an estimate to increase the Nursing Home Diversion program by 1,000 slots.	7/1/2008	($3,322,733)	($4,137,376)	($7,460,109)
44	46a	Medipass Conversion 1 - Transfer Medipass to Managed Care Plans to Fullest Extent Possible (#1)	In non-reform counties containing two or more Medicaid managed care plans, provide the estimated savings by requiring new Medicaid recipients to choose managed care plans, and requiring existing Medipass recipients in such counties to transfer out of Medipass into managed care plans upon their re-determination over a period of 12 months. This would apply only to recipients who are subject to mandatory managed care enrollment. Assume the 65/35 ratio currently found in ss. 409.9122(2)(f) and 409.9122(2)(k) are removed from statute. If these conditions were put into effect in certain counties on October 1, 2008, provide a savings estimate for FY 2008-09, and provide an annualized (post-phase-in) savings estimate separately, for each AHCA service area individually (not including Reform counties).	10/1/2008	($6,222,439)	($7,845,743)	($14,068,182)
45	46b	Medipass Conversion 2 - Transfer Existing MediPass Recipients Convert to Managed Care Plans Upon Re-determination If They Don't Choose to Stay in MediPass (#2)	In non-reform counties, provide the estimated savings when existing MediPass recipients who do not express a choice of coverage after being given 30 days to choose MediPass or a managed care plan upon re-determination, are assigned to managed care plans instead of remaining in MediPass. This would apply only to MediPass recipients who are subject to mandatory managed care enrollment and who fail to make a choice of coverage upon re-determination. For continuity of care, such recipients who are receiving health care treatment in an institution or facility on an inpatient basis during their 30-day choice period would be excluded. Assume the 65/35 ratio currently found in ss. 409.9122(2)(f) and 409.9122(2)(k) are removed from statute. If these conditions were put into effect on October 1, 2008, provide a savings estimate for FY 2008-09, and provide an annualized savings estimate separately, for each AHCA service area individually (not including Reform counties). If necessary, provide a range of savings based on various assumptions about the percentage of existing MediPass recipients who would fail to choose (e.g. 20%, 35%, 50%, 65%, 80%).	N/A	$0	$0	$0
46	46c	Combination of Medipass conversion (Refer to 46a and 46b)	What savings would be produced by implementing 46a only in AHCA areas 6 and 7, combined with implementing 46b in all other non-Reform counties?	Annual	($1,650,279)	($2,080,801)	($3,731,080)
47	54	Automated Point of Service Verification System	Provide an estimate of savings that may be generated by requiring in-home Medicaid providers to use a toll-free phone number to record check-in/check-out times and to document the services that have been provided.	Pending	Pending	Pending	Pending
48	ELIGIBILITY						
49	12	Eliminate Optional Eligibility Groups	Provide estimated savings by eliminating optional eligibility groups. Provide an individual estimate by each optional eligibility group.	Annualized	($1,232,684,940)	($1,851,735,430)	($3,084,420,370)
50	13	Pregnant Women 150-185%	Provide the estimated savings from eliminating the pregnant women eligibility group from 150-185% FPL.	Annualized	($23,238,005)	($38,088,869)	($61,326,874)
51	14	Medically Needy (Ambulatory)	Provide the estimated savings by limiting the medically needy eligibility group to ambulatory services only.	Annualized	($100,733,533)	($125,430,663)	($226,164,196)

MEDICAID IMPACT CONFERENCE
SFY2008/09 March 12, 2008

Row		Issue	Action	Proposed Start Date	General Revenue	Trust Fund	Total
52	15	Reduce Medically Needy to Children and PW (All Services)	Provide estimated savings by eliminating medically needy except for children and pregnant woman. (provide all services)	Annualized	($147,847,060)	($201,084,443)	($348,931,503)
53	16	Reduce Medically Needy to Children and PW (Ambulatory Services Only)	Provide estimated savings by eliminating medically needy except for children and pregnant woman. (provide ambulatory services only)	Annualized	($170,678,248)	($229,513,220)	($400,191,468)
54	17	Eliminate MEDS AD Waiver	Provide estimated savings from eliminating MEDS AD waiver.	Annualized	($152,615,855)	($202,815,121)	($355,430,976)
55	REVENUE						
56	5	Premiums	Provide an estimate of savings from imposing premiums for adults as approved under the Deficit Reduction Act (DRA)	7/1/2009	($3,000,420)	$3,000,420	$0
57	19	Estimate of Rebates for Physician Administered Drugs	Provide the estimated increase in rebates through collecting federal and supplemental rebates on physician administered drugs.	4/1/2008	$0	$0	$0
58	21	ICF/DD Assessment	Provide an estimate of revenue generated by requiring an assessment of 1% net revenue to ICF/DD facilities.	Annualized	($3,198,044)	$3,198,044	$0
59	25a	NH County Billing Increase 5%	Provide estimated savings by increasing the nursing home county contribution increase of 5%;	Annualized	($1,048,008)	$1,048,008	$0
60	25b	NH County Billing increase 10%	Provide estimated savings by increasing the nursing home county contribution increase of 10%;	Annualized	($2,096,016)	$2,096,016	$0
61	25c	NH County Billing Increase 15%	Provide estimated savings by increasing the nursing home county contribution increase of 15%;	Annualized	($2,794,688)	$2,794,688	$0
62	25d	NH County Billing Increase 20%	Provide estimated savings by increasing the nursing home county contribution increase of 20%;	Annualized	($3,842,696)	$3,842,696	$0
63	26	Nursing Home Provider Assessment	Provide an estimate of revenue generated by reestablishing the nursing home assessment from Chapter 92-319 Laws of Florida.	Annualized	($39,734,939)	$39,734,939	$0
64	31	HMO Assessment	Provide an estimate of revenue by requiring an assessment of 1% of net revenue on HMO's in the state.	Annualized	($78,574,571)	$78,574,571	$0
65	35	Hospital County Contributions	Provide the estimated savings by increasing the county contributions for hospital reimbursement by one day.	Annualized	($11,721,954)	$11,721,954	$0
66	36a	Hospital IP Assessment to 1.75%	Provide an estimate of revenue generated from increasing the inpatient hospital assessment to1.75%.	Annualized	($49,169,004)	$49,169,004	$0
67	36b	Hospital IP Assessment to 2%	Provide an estimate of revenue generated from increasing the inpatient hospital assessment to 2%.	Annualized	($98,338,008)	$98,338,008	$0
68	41a	Hospital OP Assessment to 1.25%	Provide an estimate of revenue generated from increasing the outpatient hospital assessment to 1.25%	Annualized	($23,508,266)	$23,508,266	$0
69	41b	Hospital OP Assessment to 1.50%	Provide an estimate of revenue generated from increasing the outpatient hospital assessment to 1.50%	Annualized	($47,016,532)	$47,016,532	$0

Medicaid Provider Rates
Reduction Issues and Proposed Policies

Provider Type	FY 07-08 Appropriation	Special Session C	SB 1852
Hospital Inpatient	$2,351.6	(68.8)	(91.4)
Hospital Outpatient	$672.2	(17.2)	(26.4)
Nursing Homes	$2,636.3	(75.2)	(139.3)
County Health Depts	107.6 million		(10.4)
ICF/DDs	$235.3 million		(6.2)
Prepaid Health Plans	$2,233.4	(23.1)	(41.0)
TOTAL	$8,236.4	(184.1)	(316.0)

<u>Hospital Inpatient</u>

- State funds supporting hospital reimbursement include $165.7 million in GR; additional state funds come from the PMATF and intergovernmental transfers.
- Prospective reimbursement systems were studied years ago; it may be worthwhile to reconsider this approach.
- The amount of Medicaid caseload varies considerably among hospitals.
- Children's hospitals have very high proportions of Medicaid patients and limited ability to shift costs to other payers.
- State payments to hospitals are made through several programs: FFS reimbursement, disproportionate share, and low income pool; these funding mechanisms should be considered together.
- Changes in eligibility also affect hospitals which are obligated under state and federal law to provide emergency services.

<u>Hospital Outpatient</u>

- Outpatient payments are limited to $1500 per person per year.

<u>Nursing Homes</u>

- Current rate setting methodology is complex.
- Proportionate application of any reduction is a fair method.
- Reductions will impact facilities ability to maintain compliance with the staffing requirements.
- Additional flexibility regarding staffing would help facilities respond to changes in reimbursement.
- Cost based reimbursement does not provide incentive for efficiencies

- Current rate setting method does not fully account for differences in acuity levels of facility caseloads.
- Over time, a price freeze erodes the validity of the reimbursement rate making it more vulnerable to legal challenge.

Health Maintenance Organizations

- Capitation rates are lowered when FFS rates are lowered
- HMO rates reflect a 9 percent discount from FFS spending levels
- Rates must be actuarially sound

Intermediate Care Facilities for Developmentally Disabled

- 100% of ICF/DD patients are Medicaid reimbursed; no ability to cost shift;
- Over time, a price freeze erodes the validity of the reimbursement rate making it more vulnerable to legal challenge
- Proportionate allocation of the effect of any freeze or rate reduction is a fair to implement this policy;
- For many of these patients, ICF/DDs are the only appropriate care facility;

County Health Departments

- Rates are cost-based and current levels represent 100% of costs
- Rates vary among counties but range from a low of $79 in Bradford County to a high of $300 per visit in St. Lucie County
- Cost based rates are intended to fund county health departments for unreimbursed services

Medicaid Eligibility Groups

Mandatory	Optional
Infants < 150% of Federal Poverty Level (FPL)	Infants between 150% - 200% FPL
Children ages 1-5 < 133% of FPL	
Children ages 6-18 < 100% of FPL	
Pregnant Women < 150% of FPL	Pregnant Women between 150% - 200% of FPL
Low-Income Families < 23.2% of FPL	Family Planning
Supplemental Security Income Recipients	MEDS A/D < 88% of FPL
Qualified Medicare Beneficiaries	Medically Needy
	Refugees

Medicaid Services

Mandatory	Optional
Advanced Registered Nurse Practitioner Services	Adult Health Screening
Child Health Check-Up (EPSDT)	Adult Dental/Hearing/Vision Services
Family Planning	Ambulatory Surgical Centers
Federally Qualified Health Centers	Assistive Care Services
Home Health Services	Birth Center Services
Hospital Inpatient Services	Capitated Nursing Home Diversion Waiver
Hospital Outpatient Services	Case Management (Adult MH/CMS/Disease Mgt)
Independent Lab Services	Community Mental Health Services
Physician Services	Chiropractic/Podiatric Services
Portable X-Ray Services	County Health Department Clinic Services
Private Duty Nursing Services	Developmental/Early Intervention Services
Rural Health Clinics Services	Freestanding Dialysis Centers
Skilled Nursing Home Care	General/Intermediate Nursing Home Care
Supplemental Medical Insurance	Healthy Start Services
Therapeutic Services for Children	Home/Community Based Services
	Hospice Services
	Intermediate Care Facilities/Developmentally Disabled
	Occupational/Physical/Respiratory/Speech Therapies (except for children)
	Physician Assistant Services
	Prepaid Health Plans
	Prescribed Medicine
	Primary Case Management (MediPass)
	Psychiatric Hospital Services for Children
	School Based Services for Children
	State Mental Health Hospitals