Health Quality Subcommittee

Wednesday, March 27, 2013
8:00 AM - 10:00 AM
306 HOB

Will Weatherford
Speaker

Kenneth L. "Ken" Roberson
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health Quality Subcommittee

Start Date and Time:	Wednesday, March 27, 2013 08:00 am
End Date and Time:	Wednesday, March 27, 2013 10:00 am
Location:	306 HOB
Duration:	2.00 hrs

Consideration of the following bill(s):

HB 281 Surgical Assistants and Surgical Technologists by Gaetz
HB 639 Practitioners by Harrell
HB 735 Needle and Syringe Exchange Program by Pafford
HB 817 Health Care Providers by Gaetz
HB 969 Recreational Vehicle Parks by Raburn
HB 1093 Volunteer Health Services by Hudson
HB 1161 Clinical, Counseling, & Psychotherapy Services by Baxley

Consideration of the following proposed committee bill(s):

PCB HQS 13-01 -- Quality Cancer Care and Research

Pursuant to rule 7.12, the deadline for amendments to bills on the agenda by non-appointed members is 6:00 p.m., Tuesday, March 26, 2013.

By request of the chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Tuesday, March 26, 2013.

NOTICE FINALIZED on 03/25/2013 16:18 by Iseminger.Bobbye

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 281 Surgical Assistants and Surgical Technologists
SPONSOR(S): Gaetz
TIED BILLS: **IDEN./SIM. BILLS:** SB 360

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee		Holt	O'Callaghan
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The bill creates an unnumbered section of law to prohibit hospitals and ambulatory surgical centers licensed by the Agency for Health Care Administration (AHCA) from employing or contracting with surgical assistants who do not hold current and valid certifications issued by a national board or association. The bill provides an exemption for:

- Surgical assistants or surgical technologists working between July 1, 2012 to January 1, 2013, or trained in the military;
- Students performing surgical assistant functions or surgical technologist functions under the direct supervision of certain health care practitioners;
- Physicians engaging in the full scope of their practice for which they are licensed;
- A person performing surgical procedures in an office-based setting; and
- A person who completes a training program to become a surgical assistant or surgical technologist before July 1, 2014. After completion of the training program, the surgical assistant or surgical technologist may practice for 1 year.

The bill directs AHCA to ensure compliance with the staffing requirements by accepting, under certain conditions, survey or inspection reports conducted by an accrediting organization. The bill also provides AHCA with rulemaking authority and defines the following terms: agency, surgical assistant, surgical technologist, and office-based setting.

The bill amends s. 627.419, F.S., to expand surgical first assisting benefits or services as it relates to insurance policies, health plans and other payment contracts to include surgical assistants, but specifies that a surgical assistant is not required to be reimbursed if the health care facility employs the surgical assistant and pays for the surgical services performed.

The bill appears to have an insignificant fiscal impact on the state and no fiscal impact on local governments.

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Surgery

Surgery is performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is a part of the practice of medicine.[1]

Surgery is also the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue, which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reduction for major dislocations and fractures, or otherwise altered by any mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system is also considered to be surgery (this does not include administration by nursing personnel of some injections, such as subcutaneous, intramuscular, and intravenous when ordered by a physician).[2]

All of these surgical procedures are invasive, including those that are performed with lasers, and the risks of any surgical intervention are not eliminated by using a light knife or laser in place of a metal knife or scalpel.[3]

There are numerous health practitioners who collaborate to create a surgical team:[4]

An overview of the surgical team

Role		Who Performs	Who Manages	Tasks
Sterile				
	Surgeon	Surgeon, Dentist, Podiatrist	Surgeon	Perform surgery, manage procedure
	Assistant at Surgery	Surgeon, Physician, Physician Assistant, Resident, Registered Nurse, Surgical Assistant, Surgical Technologist, Licensed Practical Nurse	Surgeon	Provide exposure, control bleeding, close wounds, apply dressing
	Scrub Person	Surgical Technologist, Registered Nurse, Licensed Practical Nurse	Circulating Nurse/Surgeon	Maintain sterile field, pass and count instruments, prepare supplies
Non-sterile				
	Anesthesia Provider	Anesthesiologist, Certified Registered Nurse Anesthetists, Dentist, Physician, Physician Assistant Anesthesiologist Assistant	Anesthesia Provider	Provide and maintain anesthesia, maintain vitals
	Circulator	Registered Nurse	Circulating Nurse	Patient advocate, patient comfort, manage team members, maintain sterile field, emergency assistance

Source: Study into the Need to Regulate, Surgical Assistants & Surgical Technologists in the Commonwealth of Virginia, July 2010.

[1] American College of Surgeons, Statement on Surgery Using Lasers, Pulsed Light, Radiofrequency Devices, or Other Techniques, *available at*: http://www.facs.org/fellows_info/statements/st-11.html (last viewed March 24, 2013).
[2] *Id.*
[3] *Id.*
[4] Study into the Need to Regulate: Surgical Assistants & Surgical Technologist in the Commonwealth of Virginia, July 2010, *available at*: www.dhp.virginia.gov (last viewed March 24, 2013).

State Regulations

Hospitals, ambulatory surgical centers, and other medical businesses such as physician offices where surgical procedures are performed may choose to employ persons as surgical assistants, surgical technologists, scrub techs or similarly titled positions to assist with surgical procedures. No state licensure exists for these individuals.

Hospitals, ambulatory surgical centers, and mobile surgical facilities are regulated by the Agency for Health Care Administration (AHCA) under ch. 395, F.S.

Section 395.1055(1)(a), F.S., requires AHCA to adopt rules to ensure that sufficient numbers and qualified types of personnel and occupational disciplines are on duty and available at all times in a licensed facility to provide necessary and adequate care and safety.

Section 395.0197(1)(b) 3., F.S., prohibits unlicensed persons from assisting or participating in any surgical procedure unless the licensed facility has authorized the person to do so following a competency assessment. Assistance or participation must be done under the direct and immediate supervision of a licensed physician and must not be an activity that may only be performed by a licensed health care practitioner.

In 2006[5], the Legislature required hospitals to comply with the requirements of the Centers for Medicare and Medicaid Services (CMS), Conditions of Participation (CoPs) for Hospitals, as they apply to registered nurses who perform circulating duties in the operating room.[6] Section 395.0191(1)(d), F.S., also provides that a circulating nurse must be in the operating room for the duration of a surgical procedure.

The CMS regulations provide that hospitals must be in compliance with the federal requirements which are set forth in the Medicare Conditions of Participation, 42 CFR Part 482, in order to receive Medicare or Medicaid payments. The CoPs state that:

- Hospitals must have an organized nursing service that provides 24-hour nursing services. The services must be furnished or supervised by a registered nurse.[7]
- The operating room must be supervised by an experienced registered nurse or a doctor of medicine or osteopathy.[8]
- Licensed practical nurses (LPNs) and surgical technologists may serve as "scrub nurses" under the supervision of a registered nurse.[9]
- Qualified registered nurses may perform circulating duties in the operating room.[10]
- LPNs and surgical technologists may assist in circulatory duties under the supervision of a qualified registered nurse who is immediately[11] available to respond to emergencies.[12]

Surgical Assistants

American College of Surgeons defines "surgical assistants" as those who provide aid in exposure, hemostasis, closure and other operative technical functions that help the surgeon carry out a safe operation with optimal results. Some of the specific tasks include: making initial incisions (opening),

[5] Ch. 2006-37, L.O.F.
[6] Section 395.0191(1)(d), F.S.
[7] 42 CFR Part 482.23.
[8] 42 CFR Part 482.51(a)(1).
[9] 42 CFR Part 482.51(a)(2).
[10] 42 CFR Part 482.51(a)(3).
[11] According to CMS, the supervising RN would not be considered immediately available if the RN was located outside the operating suite or engaged in other activities/duties which prevent the RN from immediately intervening and assuming whatever circulating activities/duties that were being provided by the LPN or surgical tech.
[12] 42 CFR Part 482.51 (a)(3).

exposing the surgical site (retracting), stemming blood flow (hemostasis), reconnecting tissue (suturing) and completing the operation by reconnecting external tissue (closing). Additionally, surgical assistants should possess knowledge of sterility requirements, aseptic techniques, draping procedures, operating room equipment, drain placement and cauterization, and dressing techniques.

Surgical technologists are individuals with specialized education who function as members of the surgical team in the role of "scrub person." With additional education and training, some surgical technologists function in the role of surgical first assistant.[13]

The use of non-physician practitioners and unlicensed persons in surgery as an assistant-at-surgery is increasing due to:[14]

- A restriction on resident duty hours promulgated by the Accreditation Council on Graduate Medical Education (ACGME) in 2003,
- Changing reimbursement strategies by CMS and other third-party payers,
- Increased demands on physician and surgeon time, and
- The availability of skilled and experienced unlicensed personnel, particularly those trained in the military.

According to the U.S. Department of Labor's Bureau of Labor Statistics' *2012-13 Occupational Outlook Handbook*, there were approximately 93,600 surgical technologist jobs in the United States. The median annual income of surgical technologists in 2010 was $39,920, or $19.19 per hour.[15]

According to the Association of Surgical Assistants, a surgical assistant can't enroll in Medicare, and can't be paid by Medicare as an assistant-at-surgery. Medicare will pay for assistants-at-surgery only when the person reporting the service is a physician or the person bears the designation of physician assistant, nurse practitioner, nurse midwife, or clinical nurse specialist. If the person who assists at surgery is a surgical technologist or bears any title other than those listed, the service is not payable by Medicare.[16]

Educational Training

Currently, there is a wide range of non-physician health professionals trained as surgical assistants or technologists in a variety of programs. According to the U.S. Department of Labor, most employers prefer to hire surgical assistants or technologists who are certified. Surgical assistants or technologists may obtain certification by graduating from an accredited program and passing a national certification examination.[17]

Accredited programs may be offered in community and junior colleges, vocational and technical schools, the military, universities, and structured hospital programs in surgical technology. The accredited programs vary from nine to fifteen months for a diploma or certificate to two years for an associate's degree.[18]

The Commission on Accreditation for Allied Health Education Programs (CAAHEP) is the largest programmatic accreditor in the health sciences field. In collaboration with its Committees on

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[13] American College of Surgeons, Statement on Surgical Technology Training and Certification, available at: http://www.facs.org/fellows_info/statements/st-47.html (last viewed March, 2013).
[14] *Supra* fn 4.
[15] U.S. Department of Labor, Occupational Handbook, Surgical Technologists, available at: http://www.bls.gov/ooh/Healthcare/Surgical-technologists.htm (last viewed March 22, 2013).
[16] Association of Surgical Assistants, ASA Statement on Medicare Reimbursement, available at: http://www.surgicalassistant.org/wp-content/uploads/ASA_Statement_Medicare_Reimbursement_5.27.doc (last viewed March 22, 2013).
[17] *Supra* fn 13.
[18] *Id.*

Accreditation, CAAHEP reviews and accredits over 2000 educational programs in 23 health science occupations.[19] Currently, there are 35 accredited CAAHEP programs located in Florida that offer an associate's degree, certificate, or diploma in surgical technology.[20] According to the CAAHEP, there is one school located in Florida that offers a diploma or associate's degree in surgical assisting.[21]

Certifying Bodies

There are at least four national organizations offering certification credentials to qualifying surgical technologists or surgical assistants. The organizations are: the American Board of Surgical Assistants, the National Board of Surgical Technology and Surgical Assisting, the National Surgical Assistant Association and the American Surgical Assistants.

The American Board of Surgical Assistants (ABSA), was founded in 1987, by Paul F. Weeks, M.D. as a national credentialing organization, for surgical assistants. The ABSA administers a national certification examination, for surgical assistants, covering all surgical disciplines and all areas of perioperative medicine.[22]

The National Board of Surgical Technology and Surgical Assisting (NBSTSA), was established in 1974 as the certifying agency for surgical technologists. NBSTSA is solely responsible for all decisions regarding certification; from determining eligibility to maintaining, denying, granting and renewing the designation. The NBSTSA is the only examination program for certifying surgical technologists (CST) and surgical first assistants (CSFA) accredited by the National Commission for Certifying Agencies in the nation.[23]

The National Surgical Assistant Association (NSAA) was created in 1979, when a group of Surgical Assistants banded together to form the Virginia Association of Surgical Assistants, created a job description for surgical assistants, and established standards of practice. This group saw a need for surgical assistants and the need for education. The Eastern Virginia Medical School then became the home for the surgical assistant program. In 1983, the Virginia Association of Surgical Assistants became the National Surgical Assistant Association. [24]

The American Surgical Assistants was formed in 1999 in Houston, Texas from the merger of two of the leading surgical assistant companies in the industry. In June of 2005, American Surgical Assistants became the first surgical assistant professional services company in the country to be awarded the certification of The Joint Commission, the highest recognition in the industry. American Surgical Assistants has continued to grow over the years, with a current staff of over 150 surgical assistants.[25]

Professional Regulation and the Florida Sunrise Act

There are three different types or levels of regulation:[26]

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[19] Commission on Accreditation for Allied Health Education Programs, available at: http://www.caahep.org/ (last viewed March 22, 2013).
[20] Commission on Accreditation for Allied Health Education Programs, available at: http://www.caahep.org/Find-An-Accredited-Program/# (last viewed March 22, 2013).
[21] *Id.*
[22] American Board of Surgical Assistants, "The ABSA," available at: http://www.absa.net/ (last viewed March 22, 2013).
[23] National Board of Surgical Technology and Surgical Assisting, "About NBSTSA," available at: http://nbstsa.org/about/index.html (last viewed March 22, 2013).
[24] National Surgical Assistant Association, "About NSAA," http://nsaa.net/about.php (last visited March 22, 2013).
[25] American Surgical Assistants, "About Us," available at: http://www.americansurgicalassistants.com/about-us/ (last viewed March 22, 2013).
[26] Schmitt, K. & Shimberg, B. (1996). Demystifying Occupational and Professional Regulation: Answers to Questions You May Have Been Afraid to Ask. *Council on Licensure, Enforcement, and Regulation.*

1. Licensure is the most restrictive form of state regulation. Under licensure laws, it is illegal for a person to practice a profession without first meeting all of the standards imposed by the state.

2. Certification grants title protection to those who meet training and other standards. Those who do not meet certification standards cannot use the title, but can still perform the services.

3. Registration is the least restrictive form of regulation, and usually only requires individuals to file their name, address, and qualifications with a government agency before practicing the occupation.

Section 456.003, F.S., specifies that health care professions must be regulated only for the preservation of the health, safety, and welfare of the public under the police powers of the state. Such professions are required to be regulated when:

- Their unregulated practice can harm or endanger the health, safety, and welfare of the public, and when the potential for such harm is recognizable and clearly outweighs any anticompetitive impact which may result from regulation;
- The public is not effectively protected by other means, including, but not limited to, other state statutes, local ordinances, or federal legislation; and
- Less restrictive means of regulation are not available.

Section 11.62, F.S., the Sunrise Act, provides legislative intent regarding the regulation of new professions and occupations:[27]

- No profession or occupation is subject to regulation by the state unless the regulation is necessary to protect the public health, safety, or welfare from significant and discernible harm or damage and that the police power of the state must be exercised only to the extent necessary for that purpose; and
- No profession or occupation is regulated by the state in a manner that unnecessarily restricts entry into the practice of the profession or occupation or adversely affects the availability of the professional or occupational services to the public.

In determining whether to regulate a profession or occupation, section 11.62(3), F.S., requires the Legislature to consider the following:

- Whether the unregulated practice of the profession or occupation will substantially harm or endanger the public health, safety, or welfare, and whether the potential for harm is recognizable and not remote;
- Whether the practice of the profession or occupation requires specialized skill or training, and whether that skill or training is readily measurable or quantifiable so that examination or training requirements would reasonably assure initial and continuing professional or occupational ability;
- Whether the regulation will have an unreasonable effect on job creation or job retention in the state or will place unreasonable restrictions on the ability of individuals who seek to practice or who are practicing a given profession or occupation to find employment;
- Whether the public is or can be effectively protected by other means; and
- Whether the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers, will be favorable.

The Sunrise Act requires proponents of the regulation to submit information documenting the need for the proposed regulation. In 2010, the Florida State Assembly of the Association of Surgical

[27] Section 11.62(2), F.S.

Technologist completed a sunrise questionnaire and estimated that fewer than 5,980 surgical technologists (also known by other terms such as operating room technician, "scrub nurse," and surgical technician) would be affected by creating a mandatory regulatory scheme.[28]

Generally, regulatory provisions include the following components: oversight conducted by a governing board or council, penalties allowing for enforcement, licensure by endorsement, title protection, defined supervisory relationships, identified delegable tasks, grounds for disciplinary action, and initial and renewal licensure fees.

Since 2010, there have been several bills filed proposing ways to regulate the surgical profession.

Effect of Proposed Changes

The bill places employment limitations on *surgical assistants*, such that a hospital or an ambulatory surgical center may not employ, contract with, or grant surgical privileges to a person who does not possess a certification issued by one of the following three organizations: the American Board of Surgical Assistants, the National Board of Surgical Technology and Surgical Assisting, or the National Surgical Assistant Association.

The bill defines a "surgical assistant" as a person who, under the direct supervision of a person licensed under chapters 458, 459, and 461, F.S.,[29] performs significant surgical tasks, including manipulating tissues or organs, inserting sutures, placing hemostatic agents, injecting local anesthesia, harvesting veins, or implanting devices.

Likewise, the bill places employment limitations on *surgical technologists*, such that a hospital or an ambulatory surgical center may not employ or contract with a person who does not successfully complete a nationally accredited surgical technology program and does not have the credential of a nationally certified surgical technologist.

The bill defines "surgical technologist" a person who under the supervision of a person licensed under ch. 458, 459, 461, and part I of 464, F.S.,:[30]

- Maintains the integrity of the surgical instruments within the surgical field during surgical procedures;
- Performs surgical support tasks, including the transfers and counts of instruments and equipment and the management of fluids, specimens, and supplies;
- Identifies and corrects sepsis; and
- Performs other surgical tasks as directed.

The bill provides an exemption from the certification requirement for persons who:

- Are licensed under chapters 458, 459, and 461, F.S., and practicing within the full scope of their license;
- Practiced on or at any time during the 6 months preceding January 1, 2013;
- Successfully completed training in the uniformed services;

[28] Sunrise Questionnaire: Surgical Technology Regulation, prepared by the Florida State Assembly of the Association of Surgical Technologist, September 10, 2010, on file with the Health Quality Subcommittee staff.

[29] Persons licensed under ch. 458 or 458, F.S., include medical doctors, doctors of osteopathic medicine, physician assistants, medical assistants and anesthesiology assistants. Persons licensed under ch. 461, F.S., include certified podiatric x-ray assistants and podiatric physicians.

[30] Persons licensed under ch. 458 or 458, F.S., includes medical doctors, doctors of osteopathic medicine, physician assistants, medical assistants and anesthesiology assistants. Persons licensed under ch. 461, F.S., include certified podiatric x-ray assistants and podiatric physicians. Persons licensed under part 1 of ch. 464, F.S., include advanced registered nurse practitioners, clinical nurse specialists, registered nurse, or licensed practical nurses.

- Are students performing within the scope of their training, the functions of a surgical assistant under the direct supervision of a physician, physician assistant, or podiatrist;
- Are students performing within the scope of their training, the functions of a surgical technologist under the direct supervision of a physician or podiatrist, advanced registered nurse practitioner, clinical nurse specialist, registered nurse, or licensed practical nurse;
- Perform surgical procedures in an office-based setting; or
- Complete a training program to become a surgical assistant or surgical technologist prior to July 1, 2014, and may continue practice for 1 year after program completion.

The bill defines an office setting to be any setting other than a health care facility or a facility directly maintained and operated by the Federal Government.

The bill requires AHCA to accept, in lieu of its own periodic inspections, a survey or inspection conducted by an accrediting organization as documentation of compliance if:

- The licensed health care facility does not have provisional accreditation;
- The licensed health care facility releases the organization's survey or inspection, and
- AHCA receives the accrediting organization's survey or inspection.

According to AHCA, hospitals and ambulatory surgical centers licensed by AHCA, pursuant to ch. 395, F.S., will have the added administrative function of ensuring each non-licensed person working within their operating rooms have the appropriate certification and this information is provided upon licensure or accreditation inspections.[31] The bill requirements appear to apply to employees of the facility and non-licensed persons brought into the facility by the physician or other health care practitioners.[32] .

The majority of Florida hospitals and ambulatory surgical centers are accredited, and will require no additional oversight activity by AHCA. However, 28 hospitals in the state are not accredited such that:

- 15 are psychiatric, rehabilitation, or other specialty hospitals without operating room services;
- 2 are general hospitals that are expected to be accredited soon;
- 1 is within a state-owned prison; and
- 10 are small rural facilities surveyed by AHCA on an annual basis.

There are 58 unaccredited ambulatory surgical centers surveyed on an annual basis by AHCA.[33]

The bill amends s. 627.419, F.S., requiring a health insurance policy, health care service plan, or other contract to make payment to a certified surgical assistant, if the policy, plan, or contract provides for payment for surgical first assisting benefits or services. The bill provides that the reimbursement to a certified surgical assistant is not required if the surgical assistant is employed by and paid by a hospital or ambulatory surgical center.

Lastly, the bill provides AHCA rulemaking authority to implement the provisions of the bill.

B. SECTION DIRECTORY:

Section 1. Creates an unnumbered section of law relating to surgical assistants and surgical technologists.
Section 2. Amends s. 627.419, F.S., relating to construction of policies.
Section 3. Provides an effective date of July 1, 2013.

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[31] Agency for Health Care Administration, 2013 Bill Analysis & Economic Impact Statement for HB 281, on file with the Health Quality Subcommittee staff.
[32] *Id.*
[33] *Id.*

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill appears to have an insignificant fiscal impact to AHCA associated with rule development, which may be absorbed within existing resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill appears to have an indeterminate, but likely insignificant, fiscal impact on hospitals because the majority of hospitals hire certified or licensed personnel.[34]

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

No additional rule making is necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Currently, s. 395.0161, F.S., gives the AHCA the authority to accept accreditation reports in lieu of conducting its own inspections for facility licensure. The bill duplicates this language.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[34] Per telephone conversation with staff representing the Florida Hospital Association.

A bill to be entitled

An act relating to surgical assistants and surgical technologists; providing definitions; prohibiting a health care facility from employing, contracting with, or granting surgical privileges to a person who does not hold a current and valid certification as a surgical assistant; prohibiting a health care facility from employing or contracting with a person who has not completed a nationally and programmatically accredited surgical technology program and who does not have the credential of certified surgical technologist; providing that certain persons are exempt from having a certification as a surgical assistant or surgical technologist; providing a definition; authorizing a person who completes a training program to become a surgical assistant or a surgical technologist before a specified date to continue to practice as a surgical assistant or surgical technologist for 1 year after completing such program; requiring the Agency for Health Care Administration to accept, in lieu of its own periodic inspections for licensure, the survey or inspection of an accrediting organization under certain circumstances; requiring the agency to adopt rules; amending s. 627.419, F.S.; requiring a health insurance policy, health care services plan, or other contract to provide for payment to a certified surgical assistant or to an employer of a certified

surgical assistant if the policy, plan, or contract provides for payment for surgical first assisting benefits or services and reimbursement for a physician assistant is covered; providing that reimbursement to a certified surgical assistant is not required under certain circumstances; providing an effective date.

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

Section 1. Surgical assistants and surgical technologists.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Agency" means the Agency for Health Care Administration.

(b) "Health care facility" means a hospital as defined in s. 395.002, Florida Statutes, or an ambulatory surgical center as defined in s. 395.002, Florida Statutes.

(c) "Surgical assistant" means a person who, under the direct supervision of a person who is licensed under chapter 458, chapter 459, or chapter 461, Florida Statutes, performs significant surgical tasks, including manipulating tissues or organs, manipulating or inserting sutures, placing hemostatic agents, injecting local anesthesia, harvesting veins, or implanting devices.

(d) "Surgical technologist" means a person who, under the supervision of a person who is licensed under chapter 458, chapter 459, chapter 461, or part I of chapter 464, Florida Statutes:

1. Maintains the integrity of surgical instruments within the surgical field during surgical procedures;

2. Performs surgical support tasks, including the transfers and counts of instruments and equipment and the management of fluids, specimens, and supplies;

3. Identifies and corrects sepsis; and

4. Performs other surgical tasks as directed.

(2) EMPLOYMENT LIMITATIONS; SURGICAL ASSISTANTS.—A health care facility may not employ, contract with, or grant surgical privileges to a person who does not hold a current and valid certification as a surgical assistant which is issued by the American Board of Surgical Assistants, the National Board of Surgical Technology and Surgical Assisting, or the National Surgical Assistant Association.

(3) EMPLOYMENT LIMITATIONS; SURGICAL TECHNOLOGISTS.—A health care facility may not employ or contract with a person who:

(a) Has not successfully completed a nationally and programmatically accredited surgical technology program; and

(b) Does not have the credential of certified surgical technologist which is issued by a nationally accredited credentialing body.

(4) EXEMPTIONS.—Subsections (2) and (3) do not apply to the following persons:

(a) A person who practices as a surgical assistant or surgical technologist on or at any time during the 6 months before January 1, 2013.

(b) A person who successfully completes training as a

surgical assistant or surgical technologist in the uniformed services.

(c) A student who performs, within the scope of the student's training, the functions of a surgical assistant under the direct supervision of a person who is licensed under chapter 458, chapter 459, or chapter 461, Florida Statutes.

(d) A student who performs, within the scope of the student's training, the functions of a surgical technologist under the direct supervision of a person who is licensed under chapter 458, chapter 459, chapter 461, or part I of chapter 464, Florida Statutes.

(e) A person who is licensed under chapter 458, chapter 459, or chapter 461, Florida Statutes, and who engages in the full scope of practice for which he or she is licensed.

(f) A person who performs surgical procedures in an office-based setting. As used in this paragraph, the term "office-based setting" means any setting other than a health care facility or a facility directly maintained and operated by the Federal Government.

(g) A person who completes a training program to become a surgical assistant or surgical technologist before July 1, 2014. This person may continue to practice as a surgical assistant or surgical technologist for 1 year after completing such program notwithstanding any other provision of this section.

(5) INSPECTIONS.—To ensure compliance with this section, the agency shall accept, in lieu of its own periodic inspections for licensure, the survey or inspection of an accrediting organization if:

(a) The accreditation of the licensed health care facility is not provisional;

(b) The licensed health care facility authorizes release of the accrediting organization's survey or inspection; and

(c) The agency receives the accrediting organization's survey or inspection.

(6) RULES.—The agency shall adopt rules to administer this section.

Section 2. Subsection (6) of section 627.419, Florida Statutes, is amended to read:

627.419 Construction of policies.—

(6) Notwithstanding any other provision of law, if a ~~when any~~ health insurance policy, health care services plan, or other contract provides for payment for surgical first assisting benefits or services, the policy, plan, or contract shall ~~is to~~ be construed as providing for payment to:

(a) A registered nurse first assistant or a surgical assistant who is certified by the American Board of Surgical Assistants, the National Board of Surgical Technology and Surgical Assisting, or the National Surgical Assistant Association; or

(b) An employer ~~employers~~ of a physician assistant, surgical assistant, or registered nurse first assistant who performs such services that are within the scope of the ~~a~~ physician assistant's or the ~~a~~ registered nurse first assistant's professional license or the surgical assistant's certification as a surgical assistant.

~~The provisions of~~ This subsection applies ~~apply~~ only if reimbursement for an assisting physician, licensed under chapter 458 or chapter 459, would be covered and a physician assistant, a surgical assistant, or a registered nurse first assistant who performs such services is used as a substitute. This subsection does not require reimbursement to a surgical assistant if the assistant is employed by and is paid, or will be paid, by the health care facility for the surgical services performed.

Section 3. This act shall take effect July 1, 2013.

Amendment No. 1

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

Committee/Subcommittee hearing bill: Health Quality Subcommittee

Representative Gaetz offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Subsection (11) is added to section 395.0191, Florida Statutes, to read:

(11) Surgical assistants and surgical technologists.—

(a) DEFINITIONS.—As used in this subsection, the term:

1. "Certified surgical assistant" means a surgical assistant who maintains valid and active one of the following certifications:

a. Certified Surgical First Assistant from the National Board of Surgical Technology and Surgical Assisting.

b. Certified Surgical Assistant from the National Surgical Assistant Association.

c. Surgical Assistant-Certified from the American Board of Surgical Assistants.

2. "Certified surgical technologist" means a surgical

technologist who maintains valid and active certification as a Certified Surgical Technologist from the National Board of Surgical Technology and Surgical Assisting.

3. "Surgeon" means any health care practitioner as defined in chapter 456 whose scope of practice includes performing surgery and who is listed as the primary surgeon in the operative record.

4. "Surgical assistant" means a person providing aid under the supervision of a surgeon in exposure, hemostasis, closures, and other intra-operative technical functions that assist the surgeon in performing a safe operation with optimal results for the patient.

5. "Surgical technologist" means a person who assists and practices under the supervision of a surgeon to ensure that the operating room environment is safe, that proper equipment is available, and that the operative procedure is conducted efficiently. Surgical technologist duties include, but are not limited to, maintaining sterility during a surgical procedure, handling and ensuring the availability of necessary equipment and supplies, and maintaining visibility of the operative site.

(b) EMPLOYMENT LIMITATIONS.—

1. A facility may not employ or contract with any person to perform the duties of a surgical assistant unless the person is a certified surgical assistant.

2. A facility may not employ or contract with any person to perform the duties of a surgical technologist unless the person is a certified surgical technologist.

3. Subparagraphs 1. and 2. do not apply to:

a. A person who was employed or contracted to perform the duties of a surgical technologist or a surgical assistant at any

time between January 1, 2013, and July 1, 2013.

b. Any health care practitioner as defined in chapter 456 or any student, if the duties he or she performs fall within the scope of the practitioner's or the student's training and practice.

c. Any person enrolled in a surgical technology or surgical assisting training program accredited by the Commission on Accreditation of Allied Health Education Programs, the Accrediting Bureau of Health Education Schools, or another accrediting body recognized by the United States Department of Education, on July 1, 2013. A person may practice as a surgical technologist or a surgical assistant for one year after completion of such a training program before he or she is required to meet the criteria in subparagraphs 1. or 2.

Section 2. This act shall take effect July 1, 2013.

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

Remove everything before the enacting clause and insert:

A bill to be entitled

An act relating to surgical assistants and surgical technologists; amending s. 395.0191, F.S.; providing definitions; providing requirements for health care facilities employing or contracting with surgical first assistants and surgical technologists; providing exceptions to these requirements; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 639 Practitioners
SPONSOR(S): Harrell
TIED BILLS: **IDEN./SIM. BILLS:** SB 604

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

SUMMARY ANALYSIS

House Bill 639 directs certain fees collected by the Department of Health (DOH) for examination, certification, and recertification of emergency medical technicians and paramedics to be deposited into the Medical Quality Assurance Trust Fund.

The bill requires the Department of Financial Services (DFS) to provide legal representation to an impaired practitioner consultant, under contract with DOH to provide services under the impaired practitioner program, and certain agents in any action or proceeding for injunctive, affirmative, or declaratory relief as a result of an act or omission, if that act or omission occurred within the scope of the contract. DFS is currently required to provide legal representation to the same parties in other specific legal actions.

The bill grants an impaired practitioner consultant access to the prescription drug monitoring program (PDMP) database in the following circumstances:

- The impaired practitioner has a documented or acknowledged history of controlled substance abuse;
- The impaired practitioner agrees in writing to be monitored through the PDMP; and
- The impaired practitioner consultant has access only to those records of impaired practitioners who provided written consent to evaluation and monitoring through the PDMP.

DOH is required to disclose confidential and exempt documents from the PDMP to an impaired practitioner consultant if consultant certifies, in writing, the disclosure is necessary to evaluate and monitor an impaired practitioner under a treatment program.

The bill appears to have a minimal fiscal impact on state government. See Fiscal Comments.

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Medical Transportation Services

Part III of ch. 401, F.S., applies to medical transportation services, and provides for:

- Training and certification of emergency medical technicians (EMTs) and paramedics.[1]
- Licensure of emergency medical service (EMS) providers and permitting of EMS vehicles.[2]
- Development of a comprehensive state plan for basic and advanced life support services, the EMS grants program, trauma centers, the injury control program, and medical disaster preparedness.[3]
- Approval of any program for the education of EMTs and paramedics at any public or private institution.[4]
- Establishing the Emergency Medical Services Advisory Council and detailing its duties.[5]
- Examination and inspection of licensees.[6]
- Imposing fees for certain organizations and persons.[7]

Florida currently has 38,053 certified EMTs and 28,191 certified paramedics.[8] There are 274 licensed EMS providers in the state, with more than 4,300 permitted vehicles.[9] Under the provisions of part I, chapter 401, F.S., 136 EMS providers were inspected in 2012.[10]

Fees Imposed for Medical Transportation Services

Section 401.34, F.S., establishes the following fee schedule payable by personnel, programs, or services subject to part I, chapter 401, F.S.:

- Basic life support service license application- $660, biennially;
- Advanced life support service license application- $1,375, biennially;
- Original or renewal vehicle permit application for basic or advanced life support- $25, biennially;
- EMT certification examination application- $40;
- EMT original certificate application- $35;
- EMT renewal certificate application- $20, biennially;
- Paramedic certification examination application- $40;
- Paramedic original certificate application- $45;
- Paramedic renewal certificate application- $45, biennially;
- Air ambulance service application- $1,375, biennially; and

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[1] S. 401.27, F.S.
[2] SS. 401.25, 401.251, and 401.26, F.S.
[3] S. 401.24, F.S.
[4] S. 401.2701, F.S.
[5] S. 401.245, F.S.
[6] S. 401.31, F.S.
[7] S. 401.34, F.S.
[8] Florida Department of Health, Emergency Medical Services Program, *EMS Program Highlights-January 2013*, page 1, available at www.doh.state.fl.us/demo/ems/EMSAC/ACPDFS/SBRHighlightsJan2013.pdf.
[9] Id.
[10] Id. at page 2.

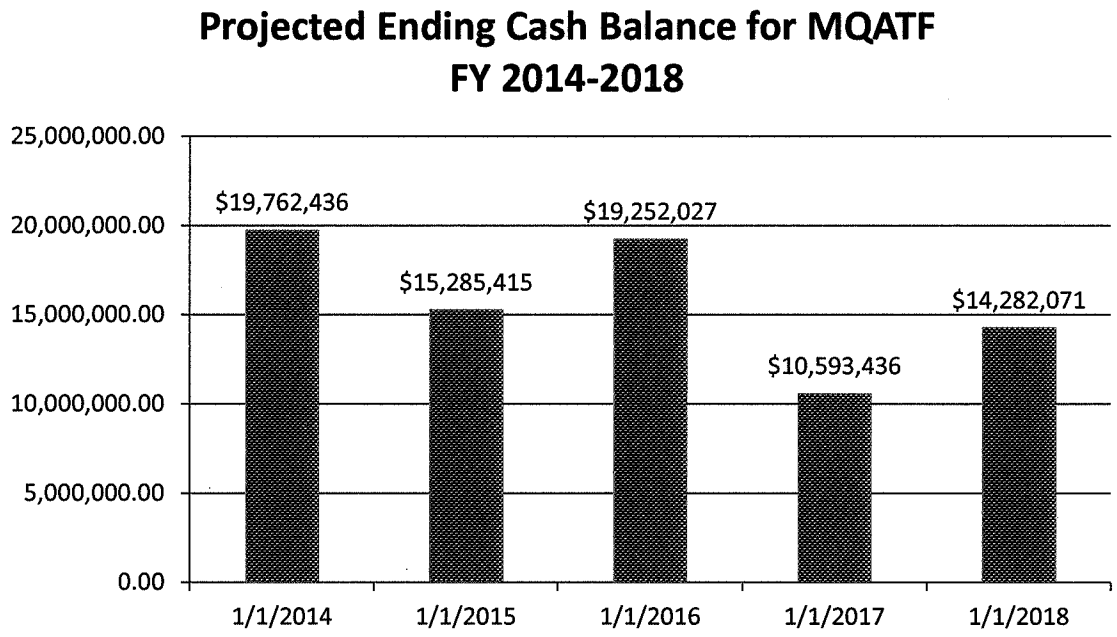
- Original or renewal aircraft permit application for air ambulance- $25, biennially.

All fees must be deposited into the Emergency Medical Services Trust Fund and used only for salaries and expenses incurred by the Department of Health (DOH) in administering part I of chapter 401, F.S.[11]

Medical Quality Assurance Trust Fund

The Medical Quality Assurance Trust Fund (MQATF) was created in 1997 and re-created as required by law in subsequent years.[12] The MQATF is administered by DOH and funded with fees and fines related to the licensing of health care professionals.[13] Funds in the MQATF must be used for administrative support for the regulation of health care professionals and other appropriate purposes.[14] For fiscal year 2012-2013, budget appropriations from the MQATF totaled $58,904,271; more than half of the appropriations were dedicated to funding 600 Full-Time Equivalents (FTEs) within the Division of Medical Quality Assurance (MQA).[15] As of March 19, 2013, the MQATF had undisbursed appropriations totaling $34,208,442.67.[16]

The following chart shows the projected ending cash balance for the MQATF for the next five fiscal years:



Health Care Professions

DOH is created under the authority of s. 20.43, F.S., which outlines the composition of the agency structure to include the MQA. MQA is statutorily responsible for the following boards and professions established within the division:

- The Board of Acupuncture, created under chapter 457.
- The Board of Medicine, created under chapter 458.

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[11] S. 401.34(2), F.S.

[12] S. 1, ch. 97-119, L.O.F.; the MQATF was subsequently recreated in 2000 (s. 1, ch. 2000-47), and 2004 (s.1, ch. 2004-176). In 2004, a provision requiring that the MQATF be terminated on a date certain appears to have been written out of s. 20.435, F.S. The MQATF has been in effect continuously since 2004.

[13] S. 20.435(4)(a), F.S.

[14] Id.

[15] S. 3, ch. 2012-118, L.O.F. (lines 562-572).

[16] *2012-13 Trust Fund Detail-Cash/Investment Balance*, available at http://www.transparencyflorida.gov/TrustFundDetailReport.aspx?FY=13&RT=TF&Option=&BE=64&Fund=2352.

- The Board of Osteopathic Medicine, created under chapter 459.
- The Board of Chiropractic Medicine, created under chapter 460.
- The Board of Podiatric Medicine, created under chapter 461.
- Naturopathy, as provided under chapter 462.
- The Board of Optometry, created under chapter 463.
- The Board of Nursing, created under part I of chapter 464.
- Nursing assistants, as provided under part II of chapter 464.
- The Board of Pharmacy, created under chapter 465.
- The Board of Dentistry, created under chapter 466.
- Midwifery, as provided under chapter 467.
- The Board of Speech-Language Pathology and Audiology, created under part I of chapter 468.
- The Board of Nursing Home Administrators, created under part II of chapter 468.
- The Board of Occupational Therapy, created under part III of chapter 468.
- Respiratory therapy, as provided under part V of chapter 468.
- Dietetics and nutrition practice, as provided under part X of chapter 468.
- The Board of Athletic Training, created under part XIII of chapter 468.
- The Board of Orthotists and Prosthetists, created under part XIV of chapter 468.
- Electrolysis, as provided under chapter 478.
- The Board of Massage Therapy, created under chapter 480.
- The Board of Clinical Laboratory Personnel, created under part III of chapter 483.
- Medical physicists, as provided under part IV of chapter 483.
- The Board of Opticianry, created under part I of chapter 484.
- The Board of Hearing Aid Specialists, created under part II of chapter 484.
- The Board of Physical Therapy Practice, created under chapter 486.
- The Board of Psychology, created under chapter 490.
- School psychologists, as provided under chapter 490.
- The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under chapter 491.
- Emergency medical technicians and paramedics, as provided under part III of chapter 401.

DOH regulates most health care practitioners and professions.[17] Each practitioner or profession is governed by an individual practice act and by ch. 456, F.S., which is considered the core licensure statute for all health care practitioners within MQA.

Section 456.001(4), F.S., defines "health care practitioner" to mean any person licensed under: ch. 457, F.S., (acupuncture); ch. 458, F.S., (medicine); ch. 459, F.S., (osteopathic medicine); ch. 460, F.S., (chiropractic medicine); ch. 461, F.S., (podiatric medicine); ch. 462, F.S., (naturopathic medicine); ch. 463, F.S., (optometry); ch. 464, F.S., (nursing); ch. 465, F.S., (pharmacy); ch. 466, F.S., (dentistry and dental hygiene); ch. 467, F.S., (midwifery); parts I, II, III, V, X, XIII, and XIV of ch. 468, F.S., (speech-language pathology and audiology, nursing home administration, occupational therapy, respiratory therapy, dietetics and nutrition practice, athletic trainers, and orthotics, prosthetics, and pedorthics); ch. 478, F.S., (electrology or electrolysis); ch. 480, F.S., (massage therapy); parts III and IV of ch. 483, F.S., (clinical laboratory personnel or medical physics); ch. 484, F.S., (opticianry and hearing aid specialists); ch. 486, F.S., (physical therapy); ch. 490, F.S., (psychology); and ch. 491, F.S. (psychotherapy).

The definition of health care practitioner does not include EMTs, paramedics[18] or radiology technologists.[19] However, s. 456.001, F.S., defines the term "profession" to mean any activity, occupation, profession, or vocation regulated by the DOH within MQA, and EMTs and paramedics are

[17] The Department of Business and Professional Regulation regulates veterinarians pursuant to ch. 474, F.S.
[18] EMT and paramedics are governed by part III of ch. 401, F.S.
[19] Radiation technologists are governed by part IV of ch. 468, F.S.

listed as a "profession" regulated by MQA under s. 20.43, F.S. Therefore, EMTs and paramedics are a *profession* governed by ch. 456, F.S.

The Impaired Practitioner Program – Department of Health

The impaired practitioner treatment program (program) was created to help rehabilitate health care practitioners regulated by the MQA, within the DOH.[20] Health care practitioners (practitioners) who are impaired as a result of drugs or alcohol, abuse, or because of mental or physical conditions, which could affect their ability to practice with skill and safety are eligible for the program.[21] By entering and successfully completing the impaired practitioner treatment program, a practitioner may avoid formal disciplinary action, if the only violation of the licensing statute under which the practitioner is regulated is the impairment.[22] If the practitioner is unable to complete the program, DOH has authority to issue an emergency order suspending or restricting the license of the practitioner.[23]

DOH is authorized 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 a program.[24] The cost of the actual treatment is the responsibility of the impaired person.[25] Currently, there are two vendors under contract with DOH to support the program- the Intervention Project for Nurses (IPN) and the Professionals Resource Network (PRN).[26] The PRN provides services to all eligible professions except nurses.

Currently, the DOH licenses over 40 health care professions and has a contract with PRN to provide services to the following professions:[27]

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

Referrals to the program must be based upon at least one of the following criteria:

[20] S. 456.076(1), F.S.
[21] S. 456.076(3)(a), F.S.
[22] Id.
[23] S. 456.074, F.S.
[24] S. 456.076(2), F.S., and Rules 64B31-10.10.001 and 64B31-10.002, F.A.C.
[25] S. 456.076(2), F.S.
[26] Florida Department of Health, *Bill Analysis-HB 639*, page 2 (March 1, 2013) (on file with Health Quality Subcommittee staff).
[27] Florida Department of Health, Division of Medical Quality Assurance, *MQA 2011-2012 Annual Report and Long Range Plan,* page 30 (November 1, 2012) (available at www.doh.fl.us/mqa/mqa2011-2012annualreport/).

- An identified informant has observed specific behavior of a licensee or has knowledge of other evidence suggesting impairment of the licensee.
- The informant identifies a witness who knows the licensee and has observed the licensee's behavior and that witness corroborates the information provided.
- Admission of impairment by the licensee, which corroborates the information provided.[28]

Once in the program, the licensee is monitored by an impairment consultant. The consultant is required to monitor the practitioner's participation and ensure compliance.[29] Consultants do not provide medical treatment, nor do they have the authority to render decisions relating to licensure of a particular practitioner. However, the consultant is required to make recommendations to DOH regarding the practitioner's ability to practice.[30]

In Fiscal Year 2012-2013, there were approximately 1,088 practitioners enrolled in the PRN program.[31] In the month of January, IPN had 1,648 individuals licensed under ch. 464, F.S., the Practice of Nursing, enrolled in the program.[32]

Currently, DOH has a 3-year contract with PRN to provide consultant services for impaired practitioners for $5,415,615.00 for the contract term of July 1, 2010 to June 20, 2013. The current contract with IPN to provide consultant services to impaired nurses is for $4,670,097.00 for the contract term of July 1, 2012 to June 30, 2015. The funds to support these contracts come from the MQATF.

Impaired Practitioners in Veterinary Medicine – Department of Business and Professional Regulation

Currently, the Board of Veterinary Medicine, within the Department of Business and Professional Regulation (DBPR), provide impaired practitioner treatment programs for licensees. Section 474.221, F.S., provides that licensed veterinarians shall be governed by the treatment of impaired practitioner provisions as if they were under the jurisdiction of the MQA at DOH.

Currently, DBPR has a contract with PRN to provide consultant services for impaired veterinarians. In 2012, the DBPR contract with PRN was $48,132 annually. In Fiscal Year 2011-2012, an average of 25 licensees participated in the program.[33] The contract is in the process of being amended to reflect an annual payment of $42,121.20.[34]

Prescription Drug Monitoring Program

Chapter 2009-197, L.O.F, established the Prescription Drug Monitoring Program (PDMP) in s. 893.055, F.S. The PDMP uses a comprehensive electronic system/database to monitor the prescribing and dispensing of certain controlled substances.[35] Dispensers of certain controlled substances must report specified information to the PDMP database, including the name of the prescriber, the date the prescription was filled and dispensed, and the name, address, and date of birth of the person to whom the controlled substance is dispensed.[36]

Direct access to the PDMP database is presently limited to medical doctors, osteopathic physicians, dentists, podiatric physicians, advanced registered nurse practitioners, physician assistants, and pharmacists.[37] Indirect access to the PDMP database is provided to:

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[28] Rule 64B31-10.002, F.A.C.
[29] Department of Health Contract with PRN, signed July 01, 2010 (on file with Health Quality Subcommittee staff).
[30] Section 456.076(5)(a), F.S.
[31] Email correspondence with MQA staff dated March 1, 2013 (on file with the Health Quality Subcommittee staff).
[32] Id.
[33] Email correspondence with DBPR staff dated February 18, 2013 (on file with the Health Quality Subcommittee staff).
[34] Id.
[35] S. 893.055(2)(a), F.S.
[36] S. 893.055(3)(a)-(c), F.S.
[37] S. 893.055(7)(b), F.S.

- DOH or its relevant health care regulatory boards;
- The Attorney General for Medicaid fraud cases;
- A law enforcement agency; and
- A patient or the legal guardian, or designated health care surrogate of an incapacitated patient.[38]

Section 893.0551, F.S., provides an exemption from public records for personal information of a patient and certain information concerning health care professionals outlined in the statute.[39] The statute details exceptions for disclosure of information after DOH ensures the legitimacy of the person's request for the information.[40]

The PDMP became operational on September 1, 2011, when it began receiving prescription data from pharmacies and dispensing practitioners.[41] Health care practitioners began accessing the PDMP on October 17, 2011.[42] Law enforcement began requesting data from the PDMP in support of active criminal investigations on November 14, 2011.[43]

Between 2011 and 2012, physicians and pharmacists used the PDMP database at least 2.6 million times.[44] Nearly 5,000 pharmacists entered 56 million prescriptions into the database.[45] Law enforcement queried the PDMP database more than 20,000 times in conjunction with active criminal investigations.[46]

The PDMP is currently funded through fiscal year 2012-2013.[47]

Effect of Proposed Changes

The bill revises s. 401.34, F.S., to redirect the payment of certain fees to the MQATF. Currently, all fees required to be paid by organizations or persons under part I of chapter 401, F.S., must be deposited into the Emergency Medical Services Trust Fund. The bill requires all fees to be paid by EMTs and paramedics relating to examination and initial and renewal certification to be deposited into the MQATF. Fees required to be paid by organizations for certain service applications and permits will continue to be deposited into the Emergency Medical Services Trust Fund.

The bill requires DFS to defend an impaired practitioner consultant, the consultant's officers and employees, and any person acting at the direction of the consultant in certain emergency intervention situations when the consultant is not available against a claim, suit, action, or proceeding for injunctive, affirmative, or declaratory relief arising out of an act or omission committed by the specified actors, if the act or omission is within the scope of the consultant's duties under the contract with DOH. Current law requires DFS to defend the same parties against any claim, suit, action, or proceeding arising out of identical circumstances. The proposed requirement that DFS defend the parties in additional legal proceedings offers a near comprehensive range of representation in actions that could be brought against an impaired practitioner consultant, or its agents, for acting or not acting under the contract to provide services to impaired practitioners.

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[38] S. 893.055(7)(c)1.-4., F.S.
[39] S. 893.0551(2)(a)-(h), F.S.
[40] S. 893.0551(3)(a)-(g), F.S.
[41] See supra, FN 36 at page 4.
[42] Id.
[43] Id.
[44] Id. at page 1.
[45] Id.
[46] Id.
[47] Florida Department of Health, *Florida's Prescription Drug Monitoring Program*, Presentation to the Senate Health Policy Committee, January 23, 2013, slide 5 (on file with Health Quality Subcommittee staff).

As part of evaluating and monitoring an impaired practitioner in a treatment program, the bill grants an impaired practitioner consultant access to the PDMP database if all of the following criteria are met:

- The impaired practitioner has a documented or acknowledged history of controlled substance abuse;
- The impaired practitioner agrees in writing to be monitored through the PDMP; and
- The impaired practitioner consultant has access only to those records of impaired practitioners who provided written consent to evaluation and monitoring through the PDMP.

The bill also requires the PDMP to provide certain confidential and exempt records regarding an impaired practitioner to a consultant only when the consultant certifies in writing that the records are necessary to evaluate or monitor an impaired practitioner as part of the treatment program.

The bill provides an effective date of July 1, 2013.

B. SECTION DIRECTORY:

Section 1: Amends s. 401.34, F.S., relating to fees.
Section 2: Amends s. 456.076, F.S., relating to treatment programs for impaired practitioners.
Section 3: Amends s. 893.055, F.S., relating to the prescription drug monitoring program.
Section 4: Amends s. 893.0551, F.S., relating to public records exemption for the prescription drug monitoring program.
Section 5: Provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The bill requires the Department of Financial Services (DFS) to defend an impaired practitioner consultant, the consultant's officers or employees, or a person acting at the direction of the consultant in limited circumstances against a claim, suit, action, or proceeding for injunctive, affirmative, or declaratory relief arising out of an act or omission in the scope of the consultant's duties under the contract with the DOH. DFS may need to hire, purchase, or otherwise obtain additional legal resources, including attorneys, paralegals, administrative assistants, computer hardware and software, office space, office supplies, and other personnel and equipment in order to provide the legal representation required under the bill.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

The bill requires certain fees payable by EMTs and paramedics for application, certification, and recertification to be deposited into the MQATF. These fees are currently paid into the Emergency Medical Services Trust Fund. The DOH may need to internally realign its trust fund authority to maintain funding for current FTEs in order to avoid reductions in services associated with the proposed redirection of fee revenue from the Emergency Medical Services Trust Fund to the MQATF. The bill does not cause any loss of funding to either the EMS program or the MQA program.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

DOH has appropriate rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

In s. 401.34(2), F.S., all fees collected under the section are required to be paid into the Emergency Medical Services Trust Fund and yet, the bill directs certain funds to be paid into the MQATF, which creates a conflict within the statute. It is recommended that current subsection (2) be stricken. Also, it is recommended that language be added to proposed subsection (1) to clarify that the funds collected under that proposed subsection are to be deposited into the Emergency Medical Services Trust Fund.

DOH will need to amend Rule 64K-1.003, F.A.C., regarding access to the PDMP database, to permit impaired practitioner consultants to consult certain confidential information in the database to evaluate or monitor an impaired practitioner as part of his or her treatment plan in the impaired practitioner program.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to practitioners; amending s. 401.34, F.S.; reorganizing provisions relating to license fees for certain practitioners; amending s. 456.076, F.S.; providing that the Department of Financial Services shall defend certain claims, suits, actions, or proceedings for injunctive, affirmative, or declaratory relief involving emergency interventions on behalf of impaired practitioners; amending s. 893.055, F.S.; defining the term "impaired practitioner consultant"; providing that impaired practitioner consultants retained by the Department of Health have access to information in the prescription drug monitoring program's database in certain circumstances; amending s. 893.0551, F.S.; defining the term "impaired practitioner consultant"; allowing impaired practitioner consultants access to certain confidential information in the prescription drug monitoring program's database when necessary to evaluate or monitor a practitioner as part of a treatment program for impaired practitioners; providing an effective date.

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

Section 1. Subsections (2) through (7) of section 401.34, Florida Statutes, are renumbered as subsections (3) through (8), respectively, and subsection (1) of that section is reorganized

and amended, and a new subsection (2) is created, to read:

401.34 Fees.—

(1) Each organization ~~or person~~ subject to this part must pay to the department the following nonrefundable fees:

(a) Basic life support service license application: $660, to be paid biennially.

(b) Advanced life support service license application: $1,375, to be paid biennially.

(c) Original or renewal vehicle permit application for basic or advanced life support: $25, to be paid biennially.

(d) ~~(j)~~ Air ambulance service application: $1,375, to be paid biennially.

(e) ~~(k)~~ Original or renewal aircraft permit application for air ambulance: $25, to be paid biennially.

(2) Each person subject to this part must pay to the department the following nonrefundable fees, and these fees must be deposited into the Medical Quality Assurance Trust Fund:

(a) ~~(d)~~ Emergency medical technician certification examination application: $40.

(b) ~~(e)~~ Emergency medical technician original certificate application: $35.

(c) ~~(f)~~ Emergency medical technician renewal certificate application: $20, to be paid biennially.

(d) ~~(g)~~ Paramedic certification examination application: $40.

(e) ~~(h)~~ Paramedic original certificate application: $45.

(f) ~~(i)~~ Paramedic renewal certificate application: $45, to be paid biennially.

Section 2. Paragraph (b) of subsection (7) of section 456.076, Florida Statutes, is amended to read:

456.076 Treatment programs for impaired practitioners.—

(7)

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

Section 3. Paragraphs (f) through (j) of subsection (1) of section 893.055, Florida Statutes, are redesignated as paragraphs (g) through (k), respectively, a new paragraph (f) is added to that subsection, and paragraph (b) of subsection (7) of that section is amended, to read:

893.055 Prescription drug monitoring program.—

(1) As used in this section, the term:

(f) "Impaired practitioner consultant" means a consultant retained by the department under s. 456.076.

(7)

(b)1. A pharmacy, prescriber, or dispenser shall have access to information in the prescription drug monitoring program's database which relates to a patient of that pharmacy, prescriber, or dispenser in a manner established by the department as needed for the purpose of reviewing the patient's controlled substance prescription history.

2. An impaired practitioner consultant who is retained by the department shall have access to information in the prescription drug monitoring program's database, in a manner established by the department, if:

a. The impaired practitioner has a documented or has acknowledged history of controlled substance abuse.

b. The impaired practitioner agrees in writing to be evaluated and monitored through the prescription drug monitoring program.

c. The impaired practitioner consultant has access to only those records of impaired practitioners who have provided written consent.

3. Other access to the program's database shall be limited to the program's manager and to the designated program and support staff, who may act only at the direction of the program manager or, in the absence of the program manager, as authorized. Access by the program manager or such designated staff is for prescription drug program management only or for management of the program's database and its system in support

of the requirements of this section and in furtherance of the prescription drug monitoring program. Confidential and exempt information in the database shall be released only as provided in paragraph (c) and s. 893.0551. The program manager, designated program and support staff who act at the direction of or in the absence of the program manager, and any individual who has similar access regarding the management of the database from the prescription drug monitoring program shall submit fingerprints to the department for background screening. The department shall follow the procedure established by the Department of Law Enforcement to request a statewide criminal history record check and to request that the Department of Law Enforcement forward the fingerprints to the Federal Bureau of Investigation for a national criminal history record check.

Section 4. Paragraphs (e) through (h) of subsection (1) of section 893.0551, Florida Statutes, are redesignated as paragraphs (f) through (i), respectively, a new paragraph (e) is added to that subsection, and paragraph (h) is added to subsection (3) of that section, to read:

893.0551 Public records exemption for the prescription drug monitoring program.—

(1) For purposes of this section, the term:

(e) "Impaired practitioner consultant" has the same meaning as provided in s. 893.055.

(3) The department shall disclose such confidential and exempt information to the following entities after using a verification process to ensure the legitimacy of that person's or entity's request for the information:

(h) An impaired practitioner consultant who certifies in writing that the information is necessary to evaluate or monitor a practitioner as part of a treatment program for impaired practitioners.

Section 5. This act shall take effect July 1, 2013.

Amendment No.

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

Committee/Subcommittee hearing bill: Health Quality Subcommittee

Representative Harrell offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Subsection (1) of section 401.34, Florida Statutes, is reorganized and amended, subsection (2) of that section is deleted and a new subsection (2) is created, to read:

401.34 Fees.—

(1) Each organization ~~or person~~ subject to this part must pay to the department the following nonrefundable fees, and these fees must be deposited into the Emergency Medical Services Trust Fund to be applied solely for salaries and expenses of the department incurred in implementing and enforcing this part:

(a) Basic life support service license application: $660, to be paid biennially.

(b) Advanced life support service license application: $1,375, to be paid biennially.

(c) Original or renewal vehicle permit application for basic or advanced life support: $25, to be paid biennially.

(d) ~~(j)~~ Air ambulance service application: $1,375, to be paid biennially.

(e) ~~(k)~~ Original or renewal aircraft permit application for air ambulance: $25, to be paid biennially.

(2) Each person subject to this part must pay to the department the following nonrefundable fees, and these fees must be deposited into the Medical Quality Assurance Trust Fund:

(a) ~~(d)~~ Emergency medical technician certification examination application: $40.

(b) ~~(e)~~ Emergency medical technician original certificate application: $35.

(c) ~~(f)~~ Emergency medical technician renewal certificate application: $20, to be paid biennially.

(d) ~~(g)~~ Paramedic certification examination application: $40.

(e) ~~(h)~~ Paramedic original certificate application: $45.

(f) ~~(i)~~ Paramedic renewal certificate application: $45, to be paid biennially.

~~(2) Fees collected under this section must be deposited to the credit of the Emergency Medical Services Trust Fund and must be applied solely for salaries and expenses of the department incurred in implementing and enforcing this part.~~

Section 2. Paragraph (b) of subsection (7) of section 456.076, Florida Statutes, is amended to read:

456.076 Treatment programs for impaired practitioners.—

(7)

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

Section 3. This act shall take effect July 1, 2013.

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

Remove lines 9-21 and insert:

on behalf of impaired practitioners;

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 735 Needle and Syringe Exchange Program
SPONSOR(S): Pafford
TIED BILLS: **IDEN./SIM. BILLS:** SB 808

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee		Holt	O'Callaghan
2) Criminal Justice Subcommittee			
3) Health Care Appropriations Subcommittee			
4) Health & Human Services Committee			

SUMMARY ANALYSIS

The bill authorizes Department of Health (DOH) to establish an exchange program to offer free, clean, and unused needles and hypodermic syringes as a means to prevent the transmission of HIV/AIDS and other blood-borne diseases among intravenous drug users.

The exchange program must:

- Provide maximum security of the exchange site and equipment;
- Account for needles and syringes in use and in storage;
- Adopt any measure to control the use and dispersal of sterile needles and syringes; and
- Strive for a 1 sterile to 1 used exchange ratio.

Additionally, the bill requires DOH to make available: educational materials, HIV counseling and testing services, referral services targeted to education regarding HIV/AIDS transmission and drug use prevention and treatment.

The bill provides that the possession, distribution, or exchange of needles or syringes as part of an exchange program established by DOH does not violate the Florida Comprehensive Drug Abuse Prevention and Control Act regulated under ch. 893, F.S., or any other law. However, the exchange program staff or participant is not immune from prosecution for the possession or redistribution of needles or syringes in any form or needles or syringes that are not part of the exchange program.

Moreover, the bill includes a severability clause.

The bill appears to have a significant fiscal impact on DOH and no fiscal impact on local governments.

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Needle and syringe exchange programs (NSEPs) provide sterile needles and syringes in exchange for used syringes to reduce the transmission of human immunodeficiency virus (HIV) and other bloodborne infections associated with reuse of contaminated syringes by injection-drug users (IDUs).

Federal Ban on Funding

In 2009, Congress passed the FY 2010 Consolidated Appropriations Act, which contained language that removed the ban on federal funding of NSEPs. In July 2010, the Department of Health and Human Services issued implementation guidelines for programs interested in using federal dollars for NSEPs.[1]

However, on December 23, 2011, President Obama signed the FY2012 Omnibus spending bill that, among other things, reinstated the ban on the use of federal funds for NSEPs; this step reversed the 111th Congress's decision to allow federal funds to be used for NSEPs.[2]

Safe Sharps Disposal

Improperly discarded sharps pose a serious risk for injury and infection to sanitation workers and the community. "Sharps" is a medical term for devices with sharp points or edges that can puncture or cut skin.

Examples of sharps include:

- Needles – hollow needles used to inject drugs (medication) under the skin.
- Syringes – devices used to inject medication into or withdraw fluid from the body.
- Lancets, also called "fingerstick" devices – instruments with a short, two-edged blade used to get drops of blood for testing. Lancets are commonly used in the treatment of diabetes.
- Auto Injectors, including epinephrine and insulin pens – syringes pre-filled with fluid medication designed to be self-injected into the body.
- Infusion sets – tubing systems with a needle used to deliver drugs to the body.
- Connection needles/sets – needles that connect to a tube used to transfer fluids in and out of the body. This is generally used for patients on home hemodialysis.

On November 8, 2011, the Federal Drug Administration (FDA) launched a new website[3] for patients and caregivers on the safe disposal of sharps that are used at home, at work and while traveling.[4]

According to the FDA, used needles and other sharps are dangerous to people and pets if not disposed of safely because they can injure people and spread infections that cause serious health conditions. The most common infections are:[5]

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[1] A History of The Ban on Federal Funding for Syringe Exchange Programs, available at: http://www.smartglobalhealth.org/blog/entry/a-history-of-the-ban-on-federal-funding-for-syringe-exchange-programs/ (last viewed March 24, 2013); NPR, Ban Lifted on Federal Funding for Needle Exchange, available at: http://www.npr.org/templates/story/story.php?storyId=121511681 (last viewed March 24, 2013).

[2] *Id.*

[3] Food and Drug Administration, Needles and Other Sharps (Safe Disposal Outside of Health Care Settings), available at: http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/HomeHealthandConsumer/ConsumerProducts/Sharps/ucm20025647.htm (last viewed March 24, 2013).

[4] *Id.*

- Hepatitis B (HBV),
- Hepatitis C (HCV), and
- Human Immunodeficiency Virus (HIV).

Moreover, injections of illicit drugs have been estimated to represent approximately one-third of the estimated 2-3 billion injections occurring outside of health-care settings in the United States each year, second only to insulin injections by persons with diabetes.[6]

For these reasons, communities are trying to manage the disposal of sharps within the illicit drug population. In San Francisco in 2000, approximately 2 million syringes were recovered at NSEPs, and an estimated 1.5 million syringes were collected through a pharmacy-based program that provided free-of-charge sharps containers and accepted filled containers for disposal. As a result, an estimated 3.5 million syringes were recovered from community syringe users and safely disposed of as infectious waste.[7] Other NSEPs offer methods for safe disposal of syringes after hours. For example, in Santa Cruz, California, the Santa Cruz Needle Exchange Program, in collaboration with the Santa Cruz Parks and Recreation Department, installed 12 steel sharps containers in public restrooms throughout the county.[8]

National Data & Survey Results

According to the Centers for Disease Control and Prevention (CDC), NSEPs can help prevent bloodborne pathogen transmission by increasing access to sterile syringes among IDUs and enabling safe disposal of used syringes. Often, programs also provide other public health services, such as HIV testing, risk-reduction education, and referrals for substance-abuse treatment.[9]

In 2002, staff from the Beth Israel Medical Center in New York City and the North American Syringe Exchange Network mailed surveys asking the directors of 148 NSEPs about syringes exchanged and returned, services provided, budgets, and funding. The survey found for the first time in 8 years, the number of NSEPs, the number of localities with NSEPs, and that public funding for NSEPs decreased nationwide; however, the number of syringes exchanged and total budgets across all programs continued to increase.[10]

The survey identified the largest NSEPs are: Chicago Recovery Alliance (2.7 million syringes), Chicago, Illinois; San Francisco AIDS Foundation HIV Prevention Project (2.5 million), San Francisco, California; Seattle-King County Department of Public Health Needle Exchange Program, Seattle, Washington (1.0 million); Harm Reduction Institute, Indianapolis, Indiana (1.0 million); Point Defiance AIDS Project, Tacoma, Washington (0.9 million); San Diego Clean Needle Exchange Program, San Diego, California (0.9 million); Street Outreach Services, Seattle, Washington (0.8 million); Prevention Point Philadelphia, Pennsylvania (0.7 million); HIV Education and Prevention Project of Alameda, Oakland, California (0.6 million); Needle Exchange Emergency Distribution, Berkeley, California (0.5 million); and one NSEP that wanted program information kept confidential.[11]

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[5] *Id.*

[6] American Association of Diabetes Educators, American Diabetes Association, American Medical Association, American Pharmaceutical Association, Association of State and Territorial Health Officials, National Alliance of State and Territorial AIDS Directors. Safe community disposal of needles and other sharps. Houston, TX: Coalition for Safe Community Needle Disposal; 2002, available at: http://www.safeneedledisposal.org/CalltoActionltrASTHOfinal.pdf (last viewed March 24, 2013).

[7] Drda B, Gomez J, Conroy R, Seid M, Michaels J. San Francisco Safe Needle Disposal Program, 1991--2001. J Am Pharm Assoc. 2002;42 (Suppl 2):S115—6, available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3036677/ (last viewed March 24, 2013).

[8] Santa Cruz Sentinel, Dealing with drug needles, available at: http://www.santacruzlive.com/blogs/dmillereditor/2013/02/08/dealing-with-drug-needles/ (last viewed March 24, 2013).

[9] The Centers for Disease Control, MMWR Weekly, Update: Syringe Exchange Programs in US, 2002, *available* at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5427a1.htm (last viewed March 24, 2013).

[10] *Id.*

[11] *Id.*

Moreover, the following states receive public funding from state governments:[12] California, Colorado, Connecticut, Hawaii, Illinois, Massachusetts, New Mexico, New York, Oregon, Rhode Island, Vermont, and Washington. Public funding from county governments: Clark, Cowlitz, King, Skagit, Snohomish, Spokane, Tacoma, and Thurston, Washington; Alameda, Santa Clara, and Santa Cruz, California; Dane and Milwaukee, Wisconsin; Boulder, Colorado; Cook, Illinois; and Multnomah, Oregon. Public funding from city governments: Berkeley, Los Angeles, Reseda, San Francisco, and Santa Monica, California; Coupeville and Seattle, Washington; Chicago, Illinois; Milwaukee, Wisconsin; Portland, Oregon; New York, New York; and Philadelphia, Pennsylvania.

In 2011, the Beth Israel Medical Center conducted another survey, which is the most comprehensive survey of NSEPs in the U.S. to date. The survey was published in the CDC's Morbidity and Mortaility Weekly Report.[13] The results revealed that the most frequent drug being used by participants was heroin followed by cocaine and usually the problems NSEPs encountered had to do with the lack of resources and staff shortages.[14]

Florida Comprehensive Drug Abuse Prevention and Control Act

Section 893.147, F.S., regulates the use or possession of drug paraphernalia. Currently, it is unlawful for any person to use, or to possess with intent to use, drug paraphernalia:

- To plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, or conceal a controlled substance in violation of this chapter; or
- To inject, ingest, inhale, or otherwise introduce into the human body a controlled substance in violation of this chapter.

Any person who violates this provision is guilty of a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.[15]

Moreover, it is unlawful for any person to deliver, possess with intent to deliver, or manufacture with intent to deliver drug paraphernalia, knowing, or under circumstances where one reasonably should know, that it will be used:[16]

- To plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, or conceal a controlled substance in violation of this act; or
- To inject, ingest, inhale, or otherwise introduce into the human body a controlled substance in violation of this act.

Any person who violates this provision is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.[17]

Effect of Proposed Changes

The bill authorizes DOH to establish an exchange program to offer free, clean, and unused needles and hypodermic syringes as a means to prevent the transmission of HIV/AIDS and other blood-borne diseases among intravenous drug users.

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[12] *Id.*

[13] North American Syringe Exchange Network, 2011 Beth Israel Survey, Results Summary, available: http://www.nasen.org/news/2012/nov/29/2011-beth-israel-survey-results-summary/ (last viewed March 24, 2013).

[14] *Id.*

[15] For a misdemeanor of the first degree, by a definite term of imprisonment not exceeding 1 year or a fine not to exceed $1,000.

[16] Section 893.147(2), F.S.

[17] For a felony of the third degree, by a term of imprisonment not exceeding 5 years or a fine not to exceed $5,000

The exchange program must:

- Provide maximum security of the exchange site and equipment;
- Account for needles and syringes in use and in storage;
- Adopt any measure to control the use and dispersal of sterile needles and syringes; and
- Strive for a 1 sterile to 1 used exchange ratio.

Additionally, the bill requires DOH to make available: educational materials, HIV counseling and testing services, referral services targeted to education regarding HIV/AIDS transmission and drug use prevention and treatment.

The bill provides that the possession, distribution, or exchange of needles or syringes as part of an exchange program established by DOH does not violate the Florida Comprehensive Drug Abuse Prevention and Control Act regulated under ch. 893, F.S., or any other provision in law. However, the exchange program staff or participant is not immune from prosecution for the possession or redistribution of needles or syringes in any form or needles or syringes that are not part of the exchange program.

Moreover, the bill includes a severability clause.[18]

B. SECTION DIRECTORY:

Section 1. Amends s. 381.0038, F.S., relating to education; needle and syringe exchange program.
Section 2. Creates an unnumbered section to provide a severability clause.
Section 3. Provides that the bill takes effect July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill appears to have a significant fiscal impact on DOH to create a statewide NSEP.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None identified.

D. FISCAL COMMENTS:

[18] "Severability clause" is defined as a provision that keeps the remaining provisions of a contract or statute in force if any portion of that contract or statute is judicially declared void or unconstitutional. Courts may hold a law constitutional in one part and unconstitutional in another. Under such circumstances, a court may sever the valid portion of the law from the remainder and continue to enforce the valid portion. *See Carter v. Carter Coal Co.*, 298 U.S. 238 (1936); *Florida Hosp. Waterman, Inc. v. Buster,* 984 So.2d 478 (Fla. 2008); *Ray v. Mortham*, 742 So.2d 1276 (Fla. 1999); and *Wright v. State*, 351 So.2d 708 (Fla. 1977).

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

Severability clause

Courts may hold a law constitutional in one part and unconstitutional in another. Under such circumstances, a court may sever the valid portion of the law from the remainder and continue to enforce the valid portion.[19] A court may not sever invalid portions of the law if doing so would negate the purpose of the law. Similarly, a court may not sever unconstitutional parts of a statute if the statute would be unworkable after the severance.[20]

B. RULE-MAKING AUTHORITY:

The bill does not provide DOH the authority to promulgate rules to implement the provisions of the bill and current law does not provide DOH blanket authority.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill does not provide DOH rulemaking authority to implement the program.

On lines 43-47, the bill provides an exemption to the Florida Comprehensive Drug Abuse Prevention and Control Act (act) pursuant to ch. 893, F.S., however, the provision is not cross-referenced within the act.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[19] *Carter v. Carter Coal Co.*, 298 U.S. 238 (1936); *Florida Hosp. Waterman, Inc. v. Buster,* 984 So.2d 478 (Fla. 2008); *Ray v. Mortham*, 742 So.2d 1276 (Fla. 1999); and *Wright v. State*, 351 So.2d 708 (Fla. 1977).
[20] *State ex rel. Boyd v. Green*, 355 So.2d 789 (Fla. 1978).

A bill to be entitled

An act relating to a needle and syringe exchange program; amending s. 381.0038, F.S.; authorizing the Department of Health to establish a needle and syringe exchange program; providing criteria for the program; providing that the distribution of needles and syringes under the program is not a violation of the Florida Comprehensive Drug Abuse Prevention and Control Act or any other law; providing conditions under which a program staff member or participant may be prosecuted; providing for severability; providing an effective date.

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

Section 1. Subsection (4) is added to section 381.0038, Florida Statutes, to read:

381.0038 Education; needle and syringe exchange program.—The Department of Health shall establish a program to educate the public about the threat of acquired immune deficiency syndrome.

(4) The department may establish a program offering the free exchange of clean, unused needles and hypodermic syringes for used needles and hypodermic syringes as a means to prevent the transmission of the human immunodeficiency virus (HIV), AIDS, and other blood-borne diseases among intravenous drug users.

(a) The needle and syringe exchange program must meet the

following criteria:

1. The program shall provide for maximum security of exchange sites and equipment, including an accounting of the number of needles and syringes in use, the number of needles and syringes in storage, and any other measure that may be required to control the use and dispersal of sterile needles and syringes.

2. The program shall strive for a one-to-one exchange, whereby the participant shall receive one sterile needle and syringe unit in exchange for each used one.

3. The department shall make available educational materials, HIV counseling and testing, and referral services targeted to education regarding HIV/AIDS transmission and drug use prevention and treatment.

(b) Notwithstanding any other provision of law, the possession, distribution, or exchange of needles or syringes as part of a needle and syringe exchange program established by the department is not a violation of any part of chapter 893 or any other law.

(c) A needle and syringe exchange program staff member or participant is not immune from criminal prosecution for:

1. The possession of needles or syringes that are not a part of the exchange program; or

2. Redistribution of needles or syringes in any form.

Section 2. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or

application, and to this end the provisions of this act are severable.

Section 3. This act shall take effect July 1, 2013.

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health Quality Subcommittee

Representative Pafford offered the following:

Amendment (with title amendment)

Remove lines 16-52 and insert:

Section 1. Subsection (4) is added to section 381.0038, Florida Statutes, to read:

381.0038 Education; needle and exchange pilot program.—The Department of Health shall establish a program to educate the public about the threat of acquired immune deficiency syndrome.

(4) The department shall establish a sterile needle and syringe exchange pilot program within Miami-Dade County. The program shall be administered by the department or the department's designees. The department is authorized to designate one of the following entities to operate the program at a fixed location or through a mobile health unit: a hospital licensed under chapter 395, a health care clinic licensed under part X of chapter 400, a substance abuse treatment program, an

HIV or AIDS service organization, or another nonprofit entity designated by the department. The pilot program shall offer the free exchange of clean unused needles and hypodermic syringes for used needles and hypodermic syringes as a means to prevent the transmission of HIV, AIDS, viral hepatitis, or other blood-borne diseases among intravenous drug users and their sexual partners and offspring.

(a) The needle and syringe exchange program shall:

1. Provide for maximum security of exchange sites and equipment, including an accounting of the number of needles and syringes in use, the number of needles and syringes in storage, safe disposal of returned needles, and any other measure that may be required to control the use and dispersal of sterile needles and syringes.

2. Strive for a one-to-one exchange, whereby the participant shall receive one sterile needle and syringe unit in exchange for each used one.

3. Make available educational materials; HIV counseling and testing; referral services to provide education regarding HIV, AIDS, and viral hepatitis transmission; and drug use prevention and treatment.

(b) Notwithstanding any other provision of law, the possession, distribution, or exchange of needles or syringes as part of a needle and syringe exchange program established by the department or the department's designee is not a violation of any part of chapter 893 or any other law.

(c) A needle and syringe exchange program staff member, volunteer, or participant is not immune from criminal prosecution for:

1. The possession of needles or syringes that are not a part of the exchange program; or

2. Redistribution of needles or syringes in any form, if acting outside the program.

(d) The program shall collect data for annual and final reporting purposes, which shall include information on the number of participants served, the number of needles and syringes exchanged and distributed, the demographic profiles of the participants served, the number of participants entering drug counseling and treatment, the number of participants receiving HIV or hepatitis testing, and other data deemed necessary for the program. However, no personal identifying information may be collected from a participant for any purpose.

(e) State funds may not be used to operate the program. The program shall be funded through grants and donations from private resources and funds.

(f) The program shall expire July 1, 2018. Six months before the program expires, the Office of Program Policy Analysis and Government Accountability shall submit a report to the President of the Senate and the Speaker of the House of Representatives that includes the data collection requirements established in this subsection; the rates of HIV, AIDS, viral hepatitis, or other blood-borne diseases before the program began and every subsequent year thereafter; and a recommendation on whether to continue the program.

(g) The department has the authority to adopt and develop rules to implement the provisions of subsection (4).

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

Remove lines 3-11 and insert:

program; amending s. 381.0038, F.S.; requiring the Department of Health to establish a sterile needle and syringe exchange pilot program in Miami-Dade County; establishing program criteria; providing for expiration of the program; requiring a report to the Legislature; providing rulemaking authority; providing for severability; providing

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 817 Health Care Providers
SPONSOR(S): Gaetz
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee		Holt	O'Callaghan
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

This bill creates section 456.0125, F.S., establishing the Standardized Credentials Collection and Verification Program (program) within the Department of Health (DOH).

The bill contains the legislative intent for establishing the program and for designating an entity to act as a repository for the core credentials data of health care practitioners. The designated credentials collections and verification entity (CCVE) must enter into a contract with the DOH to implement the program and ensure that core credentials data is collected only once unless a correction, update, or modification to the data is required. Additionally, the bill provides that the DOH, health care entities, and health care practitioners must work cooperatively to ensure the integrity and accuracy of the program.

Participation in the program is mandatory for health care practitioners; insurance companies operating in accordance with chapter 624, F.S., that offer health insurance coverage under part VI of chapter 627, F.S.; health management organizations as defined in s. 641.19, F.S.; or any entity licensed under chapter 395, F.S. The bill provides for specific reporting requirements by health care practitioners to the CCVE and provides for disciplinary action for failure to meet those reporting requirements. The bill prohibits a health care entity from requesting core credentials data directly from the health care practitioner.

The bill defines the following terms: "accredited" or "certified," "core credentials data," "credential" or "credentialing," "credentials collection and verification entity," "health care entity," "health care practitioner," "national accrediting organization," "primary source verification," "professional training," and "specialty board certification."

The bill provides the DOH rulemaking authority to implement the provisions of the bill.

The bill appears to have an indeterminate, likely significant fiscal impact to the Medical Quality Assurance Trust Fund within the DOH and no fiscal impact to local governments.

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Standardized Credentials Collection and Verification

Currently, the Division of Medical Quality Assurance (MQA) within the Department of Health (DOH) licenses and regulates medical doctors pursuant to ch. 458, F.S., and osteopathic physicians pursuant to ch. 459, F.S. Proof of state licensure as a physician is one of several credentials health care entities evaluate when deciding whether to grant staff appointments, reappointments, clinical privileges, etc., or enter into other contractual relationships with physicians. Currently, MQA verifies licensure and disciplinary history, but does not credential physicians.

Section 456.077, F.S., provides that citations may be issued when authorized by rule of the board[1] or the DOH. Rules are promulgated by the board or the DOH through the rulemaking process to identify violations that may be resolved by citation, including fines or other penalties to be imposed.

CoreSTAT

In 1998, a credentialing collection and verification program, which became known as the CoreSTAT, was created by legislative mandate to standardize the process for health care practitioners regulated by MQA.[2] However, on July 1, 2002, the legislative mandate was repealed and health care practitioners were no longer required to report core credentials data to the DOH.[3] By November 30, 2003, CoreSTAT was disabled and subscribers were no longer able to access the collected practitioner data.[4]

At the time the CoreSTAT program was created, it was used as an internal MQA program, and a work unit was established to manage the program. The credentialing process initially included medical doctors, osteopathic physicians, chiropractic physicians, and podiatric physicians, and allowed for the addition of other health care practitioners. But in 1999, CoreSTAT was expanded to include all health care practitioners and required the DOH to charge a fee to access the core credentials data.[5] Additionally, a thirteen-member Credentials Verification Advisory Council was created to assist with the development of guidelines for establishment of the standardized credentials verification program. In 2000, the Credentials Verification Advisory Council was repealed.[6]

Contracted vendors were also solicited to implement the statutory requirements of the CoreSTAT program. Over the four years it operated, the total cost of the CoreSTAT program was $14,712,566 and the total revenues collected for the program was $173,815. The CoreSTAT program was funded by the MQA Trust Fund.[7] Difficulty with implementing the system is believed to have been the reason for repeal.[8]

Credential Verification Entities in Florida

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[1] "Board" is defined in s. 456.001(1), F.S.
[2] Chapter 98-226, L.O.F.
[3] Department of Health, Changes to CoreSTAT, *available* at: http://www.doh.state.fl.us/mqa/corestat/index.htm, (last visited on Mar. 14, 2013).
[4] *Id.*
[5] Chapter 99-397, L.O.F.
[6] Chapters 2000-318 and 2000-153, L.O.F.
[7] Department of Health bill analysis for amendment 373656 for SB 966, dated March 13, 2013, on file with the House Health Quality Subcommittee staff.
[8] *Id.*

Currently, there are several credentialing entities utilized by health care facilities operating in Florida.

Reptrax

Reptrax is a web driven software service that aids in the credentialing and monitoring of sales/service representatives in healthcare environments. It allows hospitals to enforce their policies throughout their vendor community, and for vendors to maintain compliance with those policies. Reptrax has over 6,500 vendor companies. Reptrax does 100% of the document management.[9] Currently, there are 107 hospitals using Reptrax in Florida.[10]

Vendor Credentialing Service

Vendor Credentialing Service (VCS) is a third party credentialing provider. VCS is a web-based credentialing and compliance management program. The program credentials representatives and suppliers. The program can be deployed in a few hours and it is available to all hospitals at no cost. The VCS program is used by leading healthcare institutions nationwide. VCS partners include Group Purchasing Organizations (GPOs), multi-hospital systems, 1000+ bed hospitals, surgery centers, physician offices and offsite medical offices. Additionally, the VCS program is supported by suppliers nationwide and currently credentials thousands of suppliers and representatives.[11] Currently, there are 15 hospitals using VCS in Florida.[12]

Vendormate

Vendormate bridges healthcare providers and suppliers to ensure both sides know more about who they are doing business with and who they should do business with. Vendormate leverages its vendor credentialing network to deliver software-as-a-service (SaaS) applications that give buyers and sellers increased transparency and information control as a foundation for collaborative and strategic relationships. Vendormate: manages vendor access and influence permissions, monitors sanction and financial details, and credentials all levels including entities, directors, and representatives.[13] Currently, there are 30 hospitals using Vendormate in Florida.[14]

Effects of Proposed Changes

The bill creates a new section of law within ch. 456, F.S., which contains the core licensure provisions for health care practitioners regulated by the DOH. The bill requires the DOH to administer the Standardized Credentials Collection and Verification Program (program). The bill specifically requires the DOH to designate an entity to act as a repository for the core licensure data of health care practitioners and ensure that the information collected by an entity is requested only once of a health care practitioner. The bill defines the "credentials collection and verification entity (CCVE)" to be an organization controlled by a statewide association of Florida licensed physicians that has been in existence since July 1, 2003. Based on this definition, the ability for the DOH to designate a qualified entity is confined to a small pool of potential vendors.

The bill defines "health care practitioner" to mean any person licensed under: ch. 457, F.S., (acupuncture); ch. 458, F.S., (medicine); ch. 459, F.S., (osteopathic medicine); ch. 460, F.S., (chiropractic medicine); ch. 461, F.S., (podiatric medicine); ch. 462, F.S., (naturopathic medicine); ch. 463, F.S., (optometry); ch. 464, F.S., (nursing); ch. 465, F.S., (pharmacy); ch. 466, F.S., (dentistry and dental hygiene); ch. 467, F.S., (midwifery); parts I, II, III, V, X, XIII, and XIV of ch. 468, F.S., (speech-

[9] Reptrax, About Reptrax, available at: https://www.reptrax.com/ (last viewed March 25, 2013).
[10] Hospital Vendor Credentialing, A directory, available at: http://www.hospitalvendorcredentialing.com/state/stateList.cgi?state=Florida (last viewed March 25, 2013).
[11] Vendor Credentialing Service, About Us, available at: http://www.vcsdatabase.com/index.php (last viewed March 25, 2013).
[12] *Supra* fn 10.
[13] Vendormate, Company: Overview, available at: http://vendormate.com/company_oview.html (last viewed March 25, 2013).
[14] *Supra* fn 10.

language pathology and audiology, nursing home administration, occupational therapy, respiratory therapy, dietetics and nutrition practice, athletic trainers, and orthotics, prosthetics, and pedorthics); ch. 478, F.S., (electrology or electrolysis); ch. 480, F.S., (massage therapy); parts III and IV of ch. 483, F.S., (clinical laboratory personnel or medical physics); ch. 484, F.S., (opticianry and hearing aid specialists); ch. 486, F.S., (physical therapy); ch. 490, F.S., (psychology); and ch. 491, F.S. (psychotherapy).[15]

The bill requires a health care practitioner to report all core credentials data to the CCVE and notify the CCVE within 45 days after any correction, update, or modification is made to any core credentials data. Core credentials data is defined to include the following verified primary source documents: professional education, professional training, licensure, current Drug Enforcement Administration certification, specialty board certification, Educational Commission for Foreign Medical Graduates certification, and any final report of disciplinary action. If a licensee or a person applying for initial licensure fails to report and update information to the CCVE, the DOH may: refuse to issue a license, or issue a citation and assess a fine pursuant to s. 456.077, F.S. Section 456.077, F.S., grants the board, or the DOH if there is no board, the authority to adopt rules to permit the issuance of citations. Thus, the cost to promulgate rules to issue a citation would vary by practice act.

The bill specifies that the following must participate in the program: a health care practitioner, an insurance company operating under the Florida Insurance Code that offers health insurance coverage under part VI of ch. 627, F.S., a health maintenance organization (HMO), a hospital, an ambulatory surgical center, or a mobile surgical facility. Moreover, the bill defines "health care entity," to include:

- a health care facility licensed by ch. 395, F.S., which includes a hospital, ambulatory surgical center, or mobile surgical facility;
- an accredited medical school in the state; or
- an entity licensed by the Department of Insurance as a:
    - prepaid health plan;
    - HMO; or
    - An insurer that provides coverage for health care services through a network of health care providers or similar organizations licensed under chapters 627 (Insurance Rates and Contracts), 636 (Prepaid Limited and Discount Medical Plans), 641 (Health Care Service Programs) or 651 (Continuing Care Contracts).

The bill provides that a health care entity must use the CCVE to obtain core credentials data, to include corrections, updates, and modifications to the data, about any health care practitioner who may be considered for or renewing their membership, privileges, or participation with any plan or program operated by a health care entity. The bill provides that a health care entity may not request core credential data from the health care practitioner. The effect of the aforementioned prohibition is unclear, since the DOH has no legal oversight of a health care entity as defined by the bill.

The bill defines the following terms: "accredited" or "certified," "core credentials data," "credential" or "credentialing," "credentials collection and verification entity," "health care entity," "health care practitioner," "national accrediting organization," "primary source verification," "professional training," and "specialty board certification."

The bill provides the DOH with the necessary authority to adopt rules to develop and implement the program.

B. SECTION DIRECTORY:

Section 1. Creates s. 456.0125, F.S., relating to Standardized Credentials Collection and Verification program for health care providers.

Section 2. Provides an effective date of July 1, 2013.

[15] Section 456.001(4), F.S.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The DOH will incur costs associated with rulemaking and the development and management of the CCVE program. The cost and workload impact is indeterminate at this time, yet anticipated to be substantial and similar to the cost and workload of the CoreSTAT program that was legislatively mandated in FY98-99.[16]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Health care entities and health care practitioners would be required to participate in the CCVE program. It is unclear how the costs, or to whom the program costs, will be assessed.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill provides the DOH with sufficient rulemaking authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

On line 71 of the bill, the reference to the "Department of Insurance" is outdated, and should be changed to reflect the proper reference to the "Office of Insurance Regulation."

On line 111 of the bill, the bill references the term "licensee," which is undefined in the newly created section of law. However, this term is defined in s. 456.001(6), F.S., to mean any person or entity issued a permit, registration, certificate, or license, including a provisional license by the DOH. The bill defines

[16] *Supra* fn 7.

the term "health care practitioner" pursuant to s. 456.001(4), F.S., which is narrower in scope than the definition of "licensee." Thus, it is unclear if the intent is to capture the entire population of individuals who receive a license issued by the DOH or just licensed health care practitioners.

Line 112 of the bill states that the licensee or person must "report" and "update information," but does not specify to whom the licensee must report or what information is to be updated. It may be more appropriate to utilize the defined terms of the bill to require reporting to the "CCVE" and update "core credentials data."

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to health care providers; creating s. 456.0125, F.S.; providing legislative intent; providing definitions; creating the Standardized Credentials Collection and Verification program for health care providers; providing procedures and requirements with respect to the program; authorizing the Department of Health to adopt rules to develop and implement the program; providing an effective date.

WHEREAS, the Legislature recognizes that an efficient and effective health care practitioner credentialing program helps ensure access to quality health care and the demand for health care practitioner credentialing activities has increased as a result of health care reform and recent changes affecting the delivery of and reimbursement for health care, and

WHEREAS, the resulting duplication of health care practitioner credentialing activities is costly and cumbersome for both the practitioner and the entity granting practice privileges, NOW, THEREFORE,

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

Section 1. Section 456.0125, Florida Statutes, is created to read:

456.0125 Standardized Credentials Collection and Verification Program for health care providers.—

(1) It is the intent of the Legislature to establish the

Standardized Credentials Collection and Verification program and designate an entity to act as a repository for the core credentials data of health care practitioners and ensure that this information is collected only once unless a correction, update, or modification to the data is required. The Legislature further intends that the credentials collection and verification entity, the department, and health care practitioners work cooperatively to ensure the integrity and accuracy of the program. A health care practitioner as defined in s. 456.001(4), an insurance company operating in accordance with chapter 624 that offers health insurance coverage under part VI of chapter 627, a health maintenance organization as defined in s. 641.19(12), or an entity licensed under chapter 395 must participate in the program.

(2) As used in this section, the term:

(a) "Accredited" or "certified" means approved by a national accrediting organization as defined in paragraph (g), or other nationally recognized and accepted organization authorized by the department to assess and certify a credentials collection and verification program, or another entity or organization that verifies the credentials of a health care practitioner.

(b) "Core credentials data" means data that is verified by a primary source as described in paragraph (h) and includes professional education, professional training, licensure, current Drug Enforcement Administration certification, specialty board certification, Educational Commission for Foreign Medical Graduates certification, and final disciplinary action reported

pursuant to s. 456.039(1)(a)8. or s. 456.0391(1)(a)8.

(c) "Credential" or "credentialing" means the process by which the qualifications of a licensed health care practitioner or an applicant for licensure as a health care provider are assessed and verified.

(d) "Credentials collection and verification entity" or "CCVE" means an organization controlled by a statewide association of physicians licensed pursuant to chapter 458 or chapter 459 that has been in existence since July 1, 2003, and was selected by the department to collect and store credentialing data, documents, and information.

(e) "Health care entity" means:

1. A health care facility licensed pursuant to chapter 395;

2. An entity licensed by the Department of Insurance as a prepaid health care plan, a health maintenance organization, or an insurer that provides coverage for health care services through a network of health care providers or similar organizations licensed under chapter 627, chapter 636, chapter 641, or chapter 651; or

3. An accredited medical school in the state.

(f) "Health care practitioner" means a person licensed or, for credentialing purposes only, a person applying for licensure as a health care practitioner as defined in s. 456.001(4).

(g) "National accrediting organization" means an organization that awards accreditation or certification to hospitals, managed care organizations, credentials collection and verification entities, or other health care entities,

including, but not limited to, the Joint Commission, the American Accreditation HealthCare Commission (URAC), and the National Committee for Quality Assurance (NCQA).

(h) "Primary source verification" means verification of professional qualifications based on evidence obtained directly from the issuing source of the applicable qualification, any other source deemed as a primary source for verification by the department, or an accrediting organization as defined in paragraph (g) approved by the department.

(i) "Professional training" means any internship, residency, or fellowship related to the profession for which the health care practitioner is licensed or seeking licensure.

(j) "Specialty board certification" means certification in a specialty issued by a specialty board that is recognized by a board as defined in s. 456.001(1) and that regulates the profession for which the health care practitioner is licensed or seeking licensure.

(3) The Standardized Credentials Collection and Verification program is established and shall be administered by the department, as follows:

(a) Each health care practitioner shall report all core credentials data to the CCVE and notify the CCVE within 45 days after any corrections, updates, or modifications are made to the core credentials data. Failure to report and update information as required under this paragraph constitutes a ground for disciplinary action under the respective licensing chapter and s. 456.072(1)(k). If a licensee or person applying for initial licensure fails to report and update information as required

under this paragraph, the department or board, as appropriate, may:

1. For a person applying for initial licensure, refuse to issue a license.

2. For a licensee, issue a citation pursuant to s. 456.077 and assess a fine, as determined by rule by the board or department.

(b) The department:

1. Shall contract with one CCVE to collect and store credentialing data, documents, and information. When authorized by a health care practitioner, the department shall furnish such data, documents, and information to a designated health care entity. The CCVE must be fully accredited or certified by a national accrediting organization. If a CCVE fails to maintain full accreditation or certification or provide data authorized by a health care practitioner, the department may terminate the contract with the CCVE.

2. Shall require the CCVE to maintain liability insurance sufficient to meet the certification or accreditation requirements established under this section.

3. Shall develop standardized forms on which a health care practitioner may initially report and authorize the release of core credentials data and subsequently report corrections, updates, and modifications to that data.

4. May designate by rule additional elements of the core credentials data required under this section.

(c) The CCVE shall:

1. Maintain a complete current file of applicable core

credentials data on each health care practitioner.

2. If authorized by the health care practitioner, release the core credentials data and any corrections, updates, and modifications to the data that are otherwise confidential or exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution to a health care entity.

(d) A health care entity:

1. Shall use the CCVE to obtain core credentials data, including corrections, updates, and modifications to the data, about any health care practitioner considered for or renewing membership in, privileges with, or participation in any plan or program with the health care entity.

2. May not request core credentials data from the health care practitioner.

(4) This section may not restrict the authority of a health care entity to credential, approve, or deny an application for hospital staff membership, clinical privileges, or participation in a managed care network.

(5) A health care entity may rely upon any data that has been verified by the CCVE to meet the primary source verification requirements of a national accrediting organization.

(6) The department shall adopt rules necessary to develop and implement the program established under this section.

Section 2. This act shall take effect July 1, 2013.

Amendment No. 1

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

Committee/Subcommittee hearing bill: Health Quality Subcommittee

Representative Gaetz offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Subsection (1) of section 456.031, Florida Statutes, is amended to read:

456.031 Requirement for instruction on domestic violence.—

(1)(a) The appropriate board shall require each person licensed or certified under chapter 458, chapter 459, part I of chapter 464, chapter 466, chapter 467, chapter 490, or chapter 491 to complete no later than upon first renewal a 2-hour continuing education course, approved by the board, on domestic violence, as defined in s. 741.28~~, as part of every third biennial relicensure or recertification~~. Those individuals who have previously completed an approved domestic violence continuing education course are exempt from this section. Those individuals, who have yet to take the domestic violence continuing education course and have passed their first renewal,

must complete the course prior to their next renewal. The course shall consist of information on the number of patients in that professional's practice who are likely to be victims of domestic violence and the number who are likely to be perpetrators of domestic violence, screening procedures for determining whether a patient has any history of being either a victim or a perpetrator of domestic violence, and instruction on how to provide such patients with information on, or how to refer such patients to, resources in the local community, such as domestic violence centers and other advocacy groups, that provide legal aid, shelter, victim counseling, batterer counseling, or child protection services. Persons licensed or certified under chapters 458 or 459 shall obtain and complete the course from a statewide professional association of physicians in this state accredited to provide educational activities designated for the American Medical Association Physician's Recognition Award (AMA PRA Category 1) credit.

(b) Each such licensee or certificateholder shall submit confirmation of having completed such course, on a form provided by the board, when submitting fees for first renewal ~~every third biennial renewal~~.

(c) Except for persons licensed under chapters 458 or 459, the ~~The~~ board may approve additional equivalent courses that may be used to satisfy the requirements of paragraph (a). Each licensing board that requires a licensee to complete an educational course pursuant to this subsection may include the hour required for completion of the course in the total hours of continuing education required by law for such profession unless

the continuing education requirements for such profession consist of fewer than 30 hours biennially.

Section 2. Subsections (1), (2), and (3) of section 456.033, Florida Statutes, are amended to read:

456.033 Requirement for instruction for certain licensees on HIV and AIDS.—The following requirements apply to each person licensed or certified under chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 463; part I of chapter 464; chapter 465; chapter 466; part II, part III, part V, or part X of chapter 468; or chapter 486:

(1) Each person shall be required by the appropriate board to complete no later than upon first renewal a continuing educational course, approved by the board, on human immunodeficiency virus and acquired immune deficiency syndrome as part of biennial relicensure or recertification. The course shall consist of education on the modes of transmission, infection control procedures, clinical management, and prevention of human immunodeficiency virus and acquired immune deficiency syndrome. Such course shall include information on current Florida law on acquired immune deficiency syndrome and its impact on testing, confidentiality of test results, treatment of patients, and any protocols and procedures applicable to human immunodeficiency virus counseling and testing, reporting, the offering of HIV testing to pregnant women, and partner notification issues pursuant to ss. 381.004 and 384.25. <u>Persons licensed or certified under chapters 458 or 459 shall obtain and complete the course from a statewide professional association of physicians in this state accredited</u>

to provide educational activities designated for the American Medical Association Physician's Recognition Award (AMA PRA Category 1 Credit).

(2) Each person shall submit confirmation of having completed the course required under subsection (1), on a form as provided by the board, when submitting fees for first renewal.

(3) Except for persons licensed or certified under chapter 458 or 459, the ~~The~~ board shall have the authority to approve additional equivalent courses that may be used to satisfy the requirements in subsection (1). Each licensing board that requires a licensee to complete an educational course pursuant to this section may count the hours required for completion of the course included in the total continuing educational requirements as required by law.

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

Remove everything before the enacting clause and insert:

An act relating to continuing education; amending s. 456.031, F.S., requiring domestic violence continuing education upon first renewal; providing an exemption for domestic violence continuing education for certain individuals; deleting the requirement for domestic violence continuing education every third biennial; requiring certain persons to complete domestic violence continuing education course offered by a certain association; prohibits the certain boards from deeming equivalent courses equivalent; amending s. 456.033, F.S.,

requiring certain persons to complete a human immunodeficiency virus and acquired immune deficiency syndrome continuing education course offered by a certain association; prohibits the certain boards from deeming equivalent courses equivalent; provides and effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 969 Recreational Vehicle Parks
SPONSOR(S): Raburn
TIED BILLS: **IDEN./SIM. BILLS:** SB 938

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee		Guzzo	O'Callaghan
2) Local & Federal Affairs Committee			
3) Health Care Appropriations Subcommittee			
4) Health & Human Services Committee			

SUMMARY ANALYSIS

The Department of Health (DOH) is the exclusive regulatory and permitting authority for the sanitary standards of all mobile home parks, lodging parks, recreational vehicle (RV) parks, and recreational camps. Currently, there is no statutory guidance relating to uniform standards of operation for DOH to regulate these RV parks and recreational camps.

The bill requires local government ordinances, resolutions, codes, policies, or regulations, which relate to the permitting and design of RV parks and recreational camps, to be consistent with uniform standards adopted by DOH pursuant to ch. 513, F.S.

The bill clarifies that the requirement to abide by uniform standards established by DOH does not limit a local government's authority to adopt and enforce land use, building, fire-safety, or other regulations.

The bill provides standards for separation distances between RV vehicle sites and setback distances from the exterior property boundary of RV parks. The bill provides that the separation and set-back distance provisions do not limit the regulation of the uniform fire-safety standards established in s. 633.022, F.S.

The bill also defines "occupancy" to clarify that the term means the length of time the RV is occupied by a transient guest and not the length of time the RV is located on a leased RV site. The definition also clarifies that the attachment of the RV and any appurtenances to the ground with removable attachment devices do not render the RV a permanent part of the RV site.

Lastly, the bill repeals s. 513.111, F.S., which requires the posting of rental rates in a certain manner and regulates advertising by RV parks.

The bill does not appear to have a fiscal impact.

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Chapter 513, F.S., and Rule 64E-15, F.A.C., provide regulations for mobile home parks, lodging parks, recreational vehicle (RV) parks, and recreational camps.

The Department of Health (DOH) is required under s. 381.006, F.S., to conduct an environmental health program as part of fulfilling the state's public health mission. The mission of the environmental health program is to detect and prevent disease caused by natural and manmade factors in the environment. The environmental health program includes the oversight of mobile home parks, lodging parks, RV parks, and recreational camps, as provided in ch. 513, F.S.

Chapter 513, F.S., provides that DOH is the exclusive regulatory and permitting authority for sanitary standards for all mobile home parks, lodging parks, RV parks and recreational camps. In addition to permit and sanitation requirements, ch. 513, F.S., requires each RV park, renting by the day or week to post its rates, regulate the manner in which the rates are advertised, and requires each operator of a recreational vehicle park to maintain a guest register and a copy of ch. 513, F.S.

Pursuant to s. 513.05, F.S.,[1] DOH has adopted rules in Chapter 64E-15, Florida Administrative Code, pertaining to: minimum area requirements, water supply, sewage disposal, sanitary facilities, plumbing, garbage and refuse disposal, insect and rodent control, recreational camp standards, permits and fees, and owner's and operator's responsibilities.[2]

Chapter 513, F.S., also provides for:

- The liability of an operator of a RV park;
- The disposition of unclaimed property;
- The establishment of park rules and regulations;
- The right of a park operator to refuse accommodations or service in certain circumstances;
- Criminal penalties for persons obtaining park accommodations through fraud;
- Criminal penalties for theft of property belonging to the park;
- The eviction of transient guests; and
- Writs of distress.[3]

Applications and Permits

Before establishing or maintaining a mobile home park, lodging park, RV park, or recreational camp, a permit must be obtained from the DOH.[4] The permit must be renewed annually and a new permit is required when a park or camp is sold or its ownership is transferred.[5] If a person maintains or operates

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[1] *See* s. 513.05, F.S., "The DOH may adopt rules pertaining to the location, construction, modification, equipment, and operation of mobile home parks, lodging parks, recreational vehicle parks, and recreational vehicle camps… as necessary to administer this chapter."

[2] *See* 64E-15.002-15.008, F.A.C.

[3] According to s. 83.12, F.S., "a distress writ shall be issued by a judge of the court which has jurisdiction of the amount claimed. The writ shall enjoin the defendant from damaging, disposing of, secreting, or removing any property liable to distress from the rented real property after the time of service of the writ until the sheriff levies on the property, the writ is vacated, or the court otherwise orders." Section 513.151, F.S., authorizes an operator of a recreational vehicle park to levy a lien against the property of a guest if a guest vacates the premises with an outstanding account.

[4] S. 513.02(1), F.S.

[5] S. 513.02(5), F.S.

any of these entities without first obtaining a permit, he or she is guilty of a second degree misdemeanor.[6]

When applying to DOH for a permit, in addition to any information required by DOH, the camp or park must include the following information:

- The type of camp or park;
- The number of mobile homes or RVs to be accommodated or the number of recreational campsites;
- The type of water supply; and
- The method of sewage disposal.[7]

Parks and camps must also submit a valid set of plans to the county public health unit at the time of permit application. The plans must include:

- A drawing of the park or camp that includes the area and dimensions of the tract of land;
- The space number or other designation of the space;
- The location and size of all mobile home spaces, recreational vehicle spaces, and tent spaces; and
- The location of all roadways.[8]

The drawing does not have to be drawn to scale or completed by an engineer if the space dimensions are shown. For permanent buildings located within the park or camp, a floor plan must also be submitted showing the number, types, and distribution of all plumbing fixtures.[9]

Once DOH reviews the application and inspects the park or camp, a permit is issued, if it is determined that the park or camp complies with ch. 513, F.S., and that it is not a source of danger to the health of the general public.[10]

Currently, there are approximately 5,500 mobile home parks, lodging parks, RV parks, and recreational camps in Florida.[11] Permits for mobile home parks, lodging parks, RV parks, and recreational camps are issued annually by DOH under s. 513.02, F.S. Section 513.045, F.S., sets the permissible statutory range for permit fees at $3.50-$6.50 per space, and the total assessed fee at no less than $50 or more than $600, annually.[12] Permit fees are set by DOH rule at $4 per space and cumulatively not less than $100 or more than $600 annually.[13]

RVs are typically installed in an RV park in the same manner as a manufactured home with tie downs and ground anchors. The RV also typically occupies a site for the term of a one year lease. Occupancy by the owner is always limited in the lease to a term of six months or less, in order to maintain the statutory presumption that it is a transient occupancy not subject to part II of ch. 83, F.S., the "Florida Residential Landlord and Tenant Act." Notwithstanding the limitation on occupancy, the RV does not move, but is stored in place on the rented RV site.

Some local governments have adopted ordinances that do not allow the RV owner to stay in the RV on the site for more than six months. After the six-month period, the RV must be moved to a storage

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[6] S. 513.10(1), F.S.
[7] S. 513.03(1), F.S.
[8] Rule 64E-15.010(2)(b), F.A.C.
[9] *Id.*
[10] S. 513.03(2), F.S.
[11] The Department of Health, Division of Environmental Health, *Mobile Home and Recreational Vehicle Park Program,* available at: <http://www.doh.state.fl.us/environment/community/mobile/index.html> (Last visited on March 22, 2013).
[12] S. 513.045, F.S.
[13] Rule 64E-15.010, F.A.C.

area. In this instance, "occupancy" of the home relates to the time that the RV is on the site, not to the actual occupancy by the owner. For example, the Monroe County ordinance states that upon vacation of the RV, the RV must be moved to an RV storage compound and not maintained on a rented site. This practice prohibits long term clients from maintaining their homes in the community. Charlotte County[14] has adopted an ordinance that defines a "mobile home" as a vehicle exceeding 8 feet in width and 32 feet in overall length, which contradicts with s. 513.01(3), F.S., which defines a mobile home as a residential structure that is 8 body feet (2.4 meters) or more in width and over 35 feet in length with the hitch. Volusia County[15] splits the definition of "mobile recreational shelters and vehicles" into multiple categories, some of which provide for different length and width requirements.[16] There are significant costs associated with moving and relocating an RV that has been installed on an RV site with anchors, tie downs and other temporary structures.

Mobile Home and Recreational Vehicle Parks Program

The Mobile Home and Recreational Vehicle Parks Program is administered within DOH by the Division of Environmental Health. The program is administered through the 67 county health departments. The program's primary objective is to minimize the risk of injury and illness by conducting routine inspections of parks and camps. DOH inspects each park or camp at least annually.[17] The inspections focus on proper sewage disposal, safe drinking water, safe solid waste collection and disposal, and safe and disease-free swimming pools to minimize the risk of certain diseases and minimize infestations of harmful insects and rodents. The county health departments are responsible for receiving and investigating environmental health and sanitation complaints; they also conduct routine inspections, plan reviews, educational programs, investigations, complaints, and enforcement actions.[18]

DOH's enforcement actions may include citations, fines, or suspension or revocation of an operating permit.[19] However, DOH may only use a single enforcement procedure for any one violation.[20] Certain violations of ch. 513, F.S., are also subject to criminal penalties.[21]

Effect of Proposed Changes

The bill defines "occupancy" in the context of mobile homes and RV parks to mean the length of time that an RV is occupied by a transient guest and not the length of time that the vehicle is located on the leased RV site. An RV may be stored and tied down on the RV site when not in use to accommodate the needs of the guest. The bill clarifies in the definition that the attachment of an RV to the ground with tie-downs or other removable fasteners and the attachment of carports, porches, screen rooms, and similar appurtenances with removable attaching devices, do not render the RV a permanent part of the vehicle site. The change in the definition of "occupancy" of an RV should alleviate concerns by local government that there is permanent housing being provided. The "continuous occupancy" in an RV unit can be determined by the guest register, required under s. 513.112, F.S. Action can be taken by local government to prohibit continuous occupancy of an RV without imposing the cost and expense of requiring a move of the RV every six months.

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[14] Ordinances of Charlotte County, Florida, Part III: *Land Development and Growth Management*, Ch. 3-4 "Mobile Homes," S. 3-4-1, "Definitions," available at: http://library.municode.com/HTML/10526/level2/PTIIILADEGRMA_CH3-4MOHO.html#PTIIILADEGRMA_CH3-4MOHO_S3-4-1DE (Last visited on March 7, 2012).

[15] Volusia County Code of Ordinances, Ch. 72: *Land Planning*, "Definitions," available at: http://library.municode.com/index.aspx?clientid=11665 (Last visited on March 7, 2012).

[16] *See* s. 316.515, F.S.

[17] S. 513.052, F.S.

[18] *See supra* at FN 10.

[19] Ss. 513.055 and 513.065, F.S.

[20] S. 513.065(6), F.S.

[21] Ss. 513.054 (second-degree misdemeanor for specified offenses by an operator of a camp or park), 513.10 (second-degree misdemeanor for operating without a permit), 513.111 (second-degree misdemeanor for an advertising violation), and 513.122, F.S. (third-degree felony for theft of guest property by park employee).

The bill amends s. 513.051, F.S., to require RV parks and recreational camps to be regulated uniformly statewide under ch. 513, F.S. Such uniform standards relate to sanitation, control of communicable diseases, illnesses, and hazards to health among humans, hazards to health from animals to humans, and the general health of the people of the state. The uniform standards also regulate:

- The design, location, and site sizes for sites in parks and camps, including separation and setback distances established at the time of initial approval;
- Permit requirements;
- The inspection of parks and camps to enforce compliance with ch. 513, F.S.; and
- Standards and procedures for the operation of parks and camps relating to a guest register, occupancy standards, conduct of transient guests, eviction procedures, writs of distress, theft of personal property, liability for personal property left on site, and disposal of unclaimed property.

The bill also requires local governmental action, ordinances, and resolutions be consistent with the provisions in ch. 513, F.S., with exceptions for land use, building, fire-safety and other regulations.

The bill creates s. 513.51115, F.S., to require that separation distances between recreational vehicle sites on lots in permitted parks be the distances established at the time of the initial approval of the RV park by DOH and the local government. The bill also requires that setback distances from the exterior property boundary of the recreational vehicle park be the setback distances established at the time of the initial approval by DOH and the local government. The bill specifies that these requirements do not limit the regulations of the uniform fire safety standards in s. 633.022, F.S.

Finally, the bill repeals s. 513.111, F.S., which regulates site rates, the posting of signs, and advertising in and for RV parks and establishes penalties for violating those regulations.

B. SECTION DIRECTORY:

Section 1: Amends s. 513.01, F.S., relating to definitions.
Section 2: Amends s. 513.051, F.S., relating to preemption.
Section 3: Creates s. 513.1115, F.S., relating to placement of recreational vehicles on lots in permitted parks.
Section 4: Repeals s. 513.111, F.S., relating to site rates, posting, advertising, and penalties.
Section 5: Provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Department of Health reports that there is insufficient rulemaking authority to implement the provisions of the bill.[22]

C. DRAFTING ISSUES OR OTHER COMMENTS:

Subsection (3) of s. 513.013, F.S., created by section 2 of the bill, states that all local government actions, ordinances, and resolutions must be consistent with the uniform standards established by ch. 513, F.S. However, this subsection also exempts certain local government regulations including an undefined catch-all phrase "other regulations." This catch-all phrase may allow local governments to ignore the requirement to comply with the uniform standards by stating all of their new actions that are inconsistent with the uniform standard fall under the category of "other regulations."

A part of the definition of "recreational vehicle" in s. 513.01(9), F.S., is included in the newly created definition of "occupancy" in the bill, which appears to make that portion of the new definition redundant.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[22] Department of Health, Bill Analysis of SB 938 (Similar to HB 969), February 25, 2013, on file with Health Quality Subcommittee staff.

A bill to be entitled

An act relating to recreational vehicle parks; amending s. 513.01, F.S.; defining the term "occupancy"; amending s. 513.051, F.S.; providing for the uniform regulation of recreational vehicle parks and recreational camps; providing uniform standards; providing for applicability; creating s. 513.1115, F.S.; providing requirements for the establishment of separation and setback distances in parks; repealing s. 513.111, F.S., relating to the posting of site rental rates, advertising, and penalties; providing an effective date.

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

Section 1. Present subsections (5) through (11) of section 513.01, Florida Statutes, are renumbered as subsections (6) through (12), respectively, and a new subsection (5) is added to that section to read:

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

(5) "Occupancy" means the length of time that a recreational vehicle is occupied by a transient guest and not the length of time that such vehicle is located on the leased recreational vehicle site. A recreational vehicle may be stored and tied down on site when not in use to accommodate the needs of the guest. The attachment of a recreational vehicle to the ground with tie-downs or other removable fasteners, and the attachment of carports, porches, screen rooms, and similar

appurtenances with removable attaching devices, do not render the recreational vehicle a permanent part of the recreational vehicle site.

Section 2. Section 513.051, Florida Statutes, is amended to read:

513.051 Preemption.—

(1) The department is the exclusive regulatory and permitting authority for sanitary standards for all mobile home parks, lodging parks, recreational vehicle parks, and recreational camps in accordance with the provisions of this chapter.

(2) The regulation of permitting and design of recreational vehicle parks and recreational camps, including site sizes for recreational camps and recreational vehicle parks, separation and setback distances for recreational vehicles in recreational vehicle parks, and occupancy standards for transient rentals, must be consistent with the uniform standards established by this chapter.

(3) A local government ordinance, resolution, code, policy, or regulation must be consistent with the uniform standards established by this chapter. This subsection does not limit the authority of a local government to adopt and enforce land use, building, firesafety, or other regulations.

Section 3. Section 513.1115, Florida Statutes, is created to read:

513.1115 Placement of recreational vehicles on lots in permitted parks.—

(1) Separation distances between recreational vehicle

sites must be the distances established at the time of the initial approval of the recreational vehicle park by the department and the local government.

(2) Setback distances from the exterior property boundary of the recreational vehicle park must be the setback distances established at the time of the initial approval by the department and the local government.

(3) This section does not limit the regulation of the uniform firesafety standards established under s. 633.022.

Section 4. Section 513.111, Florida Statutes, is repealed.

Section 5. This act shall take effect July 1, 2013.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 969 (2013)

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health Quality Subcommittee

Representative Raburn offered the following:

Amendment (with title amendment)

Remove lines 32-57 and insert:

Section 2. Section 513.1115, Florida Statutes, is created to read:

513.1115 Placement of recreational vehicles on lots in permitted parks.—

(1) Separation distances between recreational vehicle sites within a recreational vehicle park must be the distances established at the time of the

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

Remove lines 4-7 and insert:

"occupancy"; creating s. 513.1115,

HB 1093

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1093 Volunteer Health Services
SPONSOR(S): Hudson
TIED BILLS: **IDEN./SIM. BILLS:** SB 1690

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee		McElroy CM	O'Callaghan MO
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Pursuant to s. 766.1115, F.S., the Access to Health Care Act (Act), a governmental contractor, who contracts with a health care provider to provide volunteer and uncompensated health care services to low-income individuals, retains exclusive control and oversight over patient eligibility, referral determinations, and patient care. The bill amends the Act to remove the governmental contractor's control and oversight and instead authorizes the health care provider to determine patient eligibility, referrals, and care.

The bill creates a requirement for the Department of Health (DOH) to provide an online listing of all health care providers volunteering under this program, along with the number of hours and patient visits each provided.

The bill creates a continuing education credit for health care providers who provide health care services in accordance with the Act.

The bill appears to have a substantial fiscal impact on state government.

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

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Access to Health Care Act

Section 766.1115, F.S., is entitled the "Access to Health Care Act" (Act).[1] The Act was enacted in 1992 to encourage health care providers to provide care to low-income persons.[2] This section extends sovereign immunity to health care providers who execute a contract with a governmental contractor and who provide volunteer, uncompensated health care services to low-income individuals as an agent of the state. These health care providers are considered agents of the state under s. 768.28(9), F.S., for purposes of extending sovereign immunity while acting within the scope of duties required under the Act.

Health care providers under the Act include:[3]

- A birth center licensed under chapter 383.
- An ambulatory surgical center licensed under chapter 395.
- A hospital licensed under chapter 395.
- A physician or physician assistant licensed under chapter 458.
- An osteopathic physician or osteopathic physician assistant licensed under chapter 459.
- A chiropractic physician licensed under chapter 460.
- A podiatric physician licensed under chapter 461.
- A registered nurse, nurse midwife, licensed practical nurse, or advanced registered nurse practitioner licensed or registered under part I of chapter 464 or any facility which employs nurses licensed or registered under part I of chapter 464 to supply all or part of the care delivered under this section.
- A dentist or dental hygienist licensed under chapter 466.
- A midwife licensed under chapter 467.
- A health maintenance organization certificated under part I of chapter 641.
- A health care professional association and its employees or a corporate medical group and its employees.
- Any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers nonsurgical human medical treatment, and which includes an office maintained by a provider.
- A free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income recipients.
- Any other health care professional, practitioner, provider, or facility under contract with a governmental contractor, including a student enrolled in an accredited program that prepares the student for licensure as a health care professional.
- Any nonprofit corporation qualified as exempt from federal income taxation under s. 501(a) of the Internal Revenue Code, and described in s. 501(c) of the Internal Revenue Code, which delivers health care services provided by the listed licensed professionals, any federally funded community health center, and any volunteer corporation or volunteer health care provider that delivers health care services.

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[1] Chapter 64I-2, F.A.C., refers to the Access to Health Care Act as the "Volunteer Health Care Provider Program."

[2] Low-income persons are defined in the Act as a person who is Medicaid-eligible, a person who is without health insurance and whose family income does not exceed 200 percent of the federal poverty level, or any eligible client of the Department of Health who voluntarily chooses to participate in a program offered or approved by the department.

[3] Section 766.1115, F.S.

A health care provider may not subcontract for the provision of services.[4]

A governmental contractor is defined in the Act as the DOH, a county health department, a special taxing district with health care responsibilities, or a hospital owned and operated by a governmental entity.[5]

The definition of "contract" under the Act provides that the contract must be for volunteer, uncompensated services. For services to qualify as volunteer, uncompensated services, the health care provider must receive no compensation from the governmental contractor for any services provided under the contract and must not bill or accept compensation from the recipient, or any public or private third-party payor, for the specific services provided to the low-income recipients covered by the contract.[6]

The Act further specifies contract requirements. The contract must provide that:

- The governmental contractor retains the right of dismissal or termination of any health care provider delivering services under the contract.
- The governmental contractor has access to the patient records of any health care provider delivering services under the contract.
- The health care provider must report adverse incidents and information on treatment outcomes.
- The governmental contractor must make patient selection and initial referrals.
- The health care provider must accept all referred patients, however the contract may specify limits on the number of patients to be referred and patients may not be transferred to the provider based on a violation of the antidumping provisions of the Omnibus Budget Reconciliation Acts.
- Patient care, including any follow-up or hospital care, is subject to approval by the governmental contractor.
- The health care provider is subject to supervision and regular inspection by the governmental contractor.

The governmental contractor must provide written notice to each patient, or the patient's legal representative, receipt of which must be acknowledged in writing, that the provider is covered under s. 768.28, F.S., for purposes of actions related to medical negligence.[7]

The individual accepting services through the contracted provider must not have medical or dental care coverage for the illness, injury, or condition in which medical or dental care is sought.[8] The health care provider cannot perform experimental procedures and clinically unproven procedures.[9] The governmental contractor must determine whether or not a procedure is authorized under the Act.[10]

The DOH has adopted rules that specify required methods of determination and approval of patient eligibility and referral, as well as services and procedures authorized to be provided by the health care provider. These rules include, but are not limited to the following:

- The provider must accept all patients referred by the DOH. The number of patients that must be accepted may be limited in the contract.
- The provider shall comply with DOH rules regarding determination and approval of the patient eligibility and referral.
- The provider shall complete training by the DOH regarding compliance with the approved methods of determination and approval of patient eligibility and referral.

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[4] Rule 64I-2.004, F.A.C.
[5] *Id.*
[6] *Id.*
[7] *Id.*
[8] Rule 64I-2.002, F.A.C.
[9] Rule 64I-2.006, F.A.C.
[10] *Id.*

- The DOH shall retain review oversight authority of the patient eligibility and referral determination.[11]

As of June 30, 2012, there were 12,867 licensed, contracted volunteer providers in the state.[12]

Annually, the DOH reports a summary to the Legislature of the efficacy of access and treatment outcomes from the provision of health care services for low-income persons under the Act.[13]

Sovereign Immunity

The term "sovereign immunity" originally referred to the English common law concept that the government may not be sued because "the King can do no wrong." Sovereign immunity bars lawsuits against the state or its political subdivisions for the torts of officers, employees, or agents of such governments unless the immunity is expressly waived.

Article X, s. 13, of the Florida Constitution recognizes the concept of sovereign immunity and gives the Legislature the right to waive such immunity in part or in full by general law. Section 768.28, F.S., contains the limited waiver of sovereign immunity applicable to the state. Under this statute, officers, employees, and agents of the state will not be held personally liable in tort or named as a party defendant in any action for any injury or damage suffered as a result of any act, event or omission of action in the scope of his or her employment or function, unless such officer, employee, or agent acted in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.

Instead, the state steps in as the party litigant and defends against the claim. In addition, the law limits the recovery of any one person to $200,000 for one incident and limits all recovery related to one incident to a total of $300,000. The sovereign immunity recovery caps do not prevent a plaintiff from obtaining a judgment in excess of the caps but the plaintiff cannot recover the excess damages without action by the Legislature.[14]

The Florida Supreme Court, in *Stoll v. Noel* set forth the test to be utilized in determining whether a health care provider is entitled to sovereign immunity.[15] Specifically, whether a health care provider is entitled to sovereign immunity turns on the degree of control retained or exercised by the governmental entity.[16] The degree of control over a health care provider necessary for agency status cannot be established through contractual language but rather must be based upon the actual relationship between the parties.[17]

Effect of Proposed Changes

Under s. 766.1115, F.S., the "Access to Health Care Act" (Act), a governmental contractor, who contracts with a health care provider to provide volunteer and uncompensated health care services to low-income individuals, retains exclusive control and oversight over patient eligibility, referral determinations, and patient care. Patient selection and initial referral must be made solely by the governmental contractor and the health care provider must accept all referred patients.[18] Patient care, including any follow-up or hospital care, is subject to approval by the governmental contractor.[19]

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[11] Section 766.1115 (10), F.S.
[12] *Id.*
[13] Department of Health, Volunteer Health Services Program Annual Report 2010-2011, available at: http://doh.state.fl.us/workforce/vhs/index.html (last visited on March 23, 2013).
[14] Section 768.28(5), F.S.
[15] *Stoll v. Noel,*694 So.2d 701 (Fla. 1997)
[16] *Id.*
[17] *Robinson v. Linzer,* 758 So.2d 1163 (Fla. 4th DCA 2000).
[18] Section 766.1115, F.S.
[19] *Id.*

The bill amends the Act to remove the governmental contractor's control and oversight and instead authorizes the health care provider to determine patient eligibility, referrals, and care.

Whether health care providers are agents of the state turns on the degree of control retained or exercised by governmental contractors, including the DOH.[20] Currently, exclusive control for patient eligibility and patient care rests with the governmental contractors. As long as the health care providers are working within the scope of their duties under the contract, they are agents of the state and are entitled to sovereign immunity.[21] This eliminates any questions of fact and agency can be established as a matter of law in any legal proceeding brought against a provider. Thus, although litigation related to the medical services provided under the Act still occurs, it is generally resolved through summary judgment. As such, fewer lawsuits are filed and those which are filed are generally resolved in a relatively quick manner.

The bill eliminates the governmental contractors' exclusive control for eligibility determinations and patient care, which potentially creates an issue of fact as to whether a particular health care provider is an agent of the state. Issues of fact cannot be resolved through summary judgment but rather must be fully litigated, if not dismissed or settled. Thus, the potential exists for an increase in the number and duration of lawsuits filed against health care providers who deliver services under the Act.

The bill creates a requirement for the DOH to provide an online listing of all providers volunteering under the Act, along with the number of hours and patient visits each provided. There is currently no reporting requirement for this information either online or in the annual report required under the Act.

The bill creates a continuing education credit for health care providers who provide services under the Act. Specifically, health care providers can earn one credit hour for every one hour volunteered up to a maximum of 8 credit hours.

B. SECTION DIRECTORY:

Section 1. Amends s. 766.1115, F.S., relating to health care providers; creation of relationship with governmental contractors.
Section 2. Provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill will likely create a substantial fiscal impact on the DOH.[22]

The bill authorizes health care providers providing services under the Act to render eligibility and referral determinations. The DOH anticipates that it will need additional staff to monitor compliance with eligibility and referrals of patients through the approximately 12,000 providers in the program.[23]

The collection and online reporting of volunteer provider hours and patient visits will also create a substantial fiscal impact.[24] The DOH believes the implementation of this online system could cost between $200,000 and $500,000, based on estimates from the creation of other databases.[25]

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[20] *Supra* fn 16.
[21] Section 766.1115, F.S.
[22] Email from the DOH dated March 22, 2013 (on file with House of Rep., Health Quality Subcommittee staff).
[23] *Id.*
[24] *Id.*

The bill eliminates the exclusive control for eligibility determinations and patient care previously held by the governmental contractors. This potentially creates an issue of fact as to whether a particular provider is an agent of the state. This could potentially increase the number and duration of lawsuits filed against health care providers who deliver services under the Act. Governmental contractors would be obligated to defend these lawsuits until such time as the case is resolved or it is determined that sovereign immunity does not exist.[26]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill eliminates the exclusive control for eligibility determinations and patient care previously held by the governmental contractors. This potentially creates an issue of fact as to whether a particular provider is an agent of the state. This could potentially increase the number and duration of lawsuits filed against health care providers who deliver services under the Act. The health care providers would be required to defend these matters if it is determined that sovereign immunity does not exist.[27]

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill creates a continuing education credit for health care providers who provide services under the Act. Specifically, health care providers can earn one credit hour for every one hour volunteered up to a maximum of 8 credit hours. The bill however fails to cross-reference s. 766.1116 or s. 456.013(9), F.S., which allow the DOH to waive up to 25% of the continuing education hours required for licensure renewal if the health care practitioner provides health care services to low-income or indigent individuals, or underserved populations, for at least 160 hours during the renewal cycle. This omission

[25] *Id.*
[26] Section 766.1115, F.S.
[27] Section 766.1115, F.S.

may confuse health care providers as to their eligibility for these credit hours, and whether the newly established continuing education credit is in addition to the existing credit.

The bill creates a requirement for the DOH to provide an online listing of all providers volunteering under this program along with the number of hours and patient visits each provided. It is unclear as to what "hours" refers to in this section. The bill does not specify how, or the frequency of which, this information is to be reported to the DOH. Additionally, the bill does not provide an enforcement mechanism for the DOH to collect this information from non-responsive providers.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to volunteer health services; amending s. 766.1115, F.S.; revising requirements for patient referral under the "Access to Health Care Act"; eliminating a requirement that the governmental contractor approve all followup or hospital care; requiring the Department of Health to post specified information online concerning volunteer providers; permitting volunteer providers to earn continuing education credit for participation in the program up to a specified amount; deleting provisions requiring the department to make specified rules concerning methods for determination and approval of patient eligibility and referral; providing an effective date.

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

Section 1. Subsections (10) and (11) of section 766.1115, Florida Statutes, are renumbered as sections (11) and (12), respectively, a new subsection (10) is added to that section, and paragraphs (d), (f), and (g) of subsection (4) and present subsections (8) and (10) of that section are amended, to read:

766.1115 Health care providers; creation of agency relationship with governmental contractors.—

(4) CONTRACT REQUIREMENTS.—A health care provider that executes a contract with a governmental contractor to deliver health care services on or after April 17, 1992, as an agent of the governmental contractor is an agent for purposes of s.

768.28(9), while acting within the scope of duties under the contract, if the contract complies with the requirements of this section and regardless of whether the individual treated is later found to be ineligible. A health care provider under contract with the state may not be named as a defendant in any action arising out of medical care or treatment provided on or after April 17, 1992, under contracts entered into under this section. The contract must provide that:

(d) Patient selection and initial referral may ~~must~~ be made ~~solely~~ by the governmental contractor or the provider~~, and the provider must accept all referred patients. However, the number of patients that must be accepted may be limited by the contract, and patients may not be transferred to the provider based on a violation of the antidumping provisions of the Omnibus Budget Reconciliation Act of 1989, the Omnibus Budget Reconciliation Act of 1990, or chapter 395~~.

~~(f) Patient care, including any followup or hospital care, is subject to approval by the governmental contractor.~~

(f)~~(g)~~ The provider is subject to supervision and regular inspection by the governmental contractor.

A governmental contractor that is also a health care provider is not required to enter into a contract under this section with respect to the health care services delivered by its employees.

(8) REPORTING ~~REPORT TO THE LEGISLATURE~~.—

(a) Annually, the department shall report to the President of the Senate, the Speaker of the House of Representatives, and the minority leaders and relevant substantive committee

chairpersons of both houses, summarizing the efficacy of access and treatment outcomes with respect to providing health care services for low-income persons pursuant to this section.

(b) The department shall provide an online listing of all providers volunteering under this program with their hours and the number of patient visits each provided.

(10) CONTINUING EDUCATION CREDIT.—A provider may fulfill 1 hour of continuing education credit by performing 1 hour of volunteer services to the indigent as provided in this section, up to a maximum of eight credits per licensure period for that provider.

(11) ~~(10)~~ RULES.—The department shall adopt rules to administer this section in a manner consistent with its purpose to provide and facilitate access to appropriate, safe, and cost-effective health care services and to maintain health care quality. ~~The rules may include services to be provided and authorized procedures. Notwithstanding the requirements of paragraph (4)(d), the department shall adopt rules that specify required methods for determination and approval of patient eligibility and referral and the contractual conditions under which a health care provider may perform the patient eligibility and referral process on behalf of the department. These rules shall include, but not be limited to, the following requirements:~~

~~(a) The provider must accept all patients referred by the department. However, the number of patients that must be accepted may be limited by the contract.~~

~~(b) The provider shall comply with departmental rules~~

~~regarding the determination and approval of patient eligibility and referral.~~

~~(c) The provider shall complete training conducted by the department regarding compliance with the approved methods for determination and approval of patient eligibility and referral.~~

~~(d) The department shall retain review and oversight authority of the patient eligibility and referral determination.~~

Section 2. This act shall take effect July 1, 2013.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 1093 (2013)

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health Quality Subcommittee

Representative Hudson offered the following:

Amendment

Remove lines 39-44 and insert:

~~the provider must accept all referred patients~~. ~~However, the number of patients that must be accepted may be limited by the contract, and~~ Patients may not be transferred to the provider based on a violation of the antidumping provisions of the Omnibus Budget Reconciliation Act of 1989, the Omnibus Budget Reconciliation Act of 1990, or chapter 395.

Amendment No. 2

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health Quality Subcommittee

Representative Hudson offered the following:

Amendment (with title amendment)

Remove lines 73-78 and insert:

~~authorized procedures.~~ Notwithstanding the requirements of paragraph (4)(d), the department shall adopt rules that specify required methods for determination and approval of patient eligibility and referral by government contractors and providers. The rules adopted by the department pursuant to this subsection shall give providers the greatest flexibility possible in order to serve eligible patients. The department shall retain review and oversight authority of the patient eligibility and referral determination ~~and the contractual conditions under which a health care provider may perform the patient eligibility and referral process on behalf of the department~~. ~~These rules~~

Amendment No. 2

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

Remove lines 11-14 and insert:

to a specified amount; providing that rules adopted by the department give providers the greatest flexibility possible in order to serve eligible patients; providing an effective date.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 1093 (2013)

Amendment No. 3

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

Committee/Subcommittee hearing bill: Health Quality Subcommittee

Representative Nelson offered the following:

Amendment (with title amendment)

Remove line 32 and insert:

later found to be ineligible. A health care provider shall continue to be an agent for purposes of s. 768.28(9), for 30 days after a determination of ineligibility to allow for treatment until the individual transitions to treatment by another health care provider. A health care provider under

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

Remove line 4 and insert:

referral under the "Access to Health Care Act"; providing for an agency relationship for a specified duration after a determination of ineligibility;

Amendment No. 3

21

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1161 Clinical, Counseling, & Psychotherapy Services
SPONSOR(S): Baxley
TIED BILLS: **IDEN./SIM. BILLS:** SB 1368

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee		Holt	O'Callaghan
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The bill makes substantial changes to the Clinical, Counseling, and Psychotherapy Services Practice Act (act), to update the provisions to current practice, training, and education standards. The act regulates the following professions: clinical social worker, marriage and family therapist, mental health counselor, psychotherapist, and social worker.

The bill creates s. 491.017, F.S., to provide a presumption of good faith for court-appointed mental health professionals regulated by the act, when developing a parenting plan recommendation in the instances of dissolution of marriage, domestic violence, and paternity matters involving the relationship of a child and parent. The bill requires administrative complaints or legal actions to be filed in a certain manner if filed against a court-appointed mental health professional. The bill also provides for the assignment of costs and fees associated with the complaint or legal action.

The bill provides that a person, who is registered to practice as an intern under the act, must remain under supervision for clinical hours to count toward full licensure. Additionally, licenses issued before July 1, 2013, may not be renewed or reissued and expire within 60 months after the date of issue. Any licensees issued after July 1, 2013, are valid for 5 years and the bill grants the board the authority to adopt by rule, the eligibility requirements for reapplying for an internship. The bill provides that a person who holds a provisional license may not apply for intern registration in the same profession; which closes an avenue that may be utilized by some to lengthen the time period to practice in the field, once the intern registration expires in 5 years, without obtaining full licensure.

The bill makes several changes to the educational standards to increase coursework requirements for marriage and family therapists and mental health counselors. The bill repeals a dual licensure provision on a specified future date.

Additionally, the bill removes: obsolete dates, out-of-date references to accrediting organizations, and unnecessary rule-making. The bill makes substantial changes to the structure of the act to improve readability.

The bill appears to have an insignificant fiscal impact on the Medical Quality Assurance Trust Fund within the Department of Health and no fiscal impact on local governments.

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling

The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling (board) implements and enforces rules related to clinical, counseling, and psychotherapy. The board is composed of nine members appointed by the Governor and confirmed by the Senate within the Department of Health (DOH).[1] Presently there are:[2]

- 7,092 licensed clinical social workers;
- 1,512 marriage and family therapists; and
- 7,795 mental health counselors in the state.

Scope of Practice

Clinical social work is defined as the use of scientific and applied knowledge, theories, and methods for the purpose of describing, preventing, evaluating, and treating individual, couple, marital, family, or group behavior, to prevent undesired behavior and to better mental health. The practice is based on the person-in-situation perspective of psychosocial development, normal and abnormal behavior, psychopathology, unconscious motivation, interpersonal relationships, environmental stress, differential assessment, differential planning, and data gathering. Clinical social work incorporates psychotherapy, hypnotherapy, and sex therapy.[3]

Marriage and family therapy is defined as the use of scientific and applied marriage and family theories, methods, and procedures for the purpose of describing, evaluating, and modifying marital, family, and individual behavior, within the context of marital and family systems. Practice involves marriage and family systems theory, marriage and family development, human development, normal and abnormal behavior, psychopathology, human sexuality, psychotherapeutic and marriage and family therapy theories and techniques. Marriage and family therapy incorporates marriage and family therapy, psychotherapy, including behavioral family therapy, hypnotherapy, and sex therapy.[4]

Mental health counseling is defined as the use of scientific and applied behavioral science theories, methods, and techniques for the purpose of describing, preventing, and treating undesired behavior and enhancing mental health and human development. The practice is based on the person-in-situation perspectives derived from research and theory in personality, family, group, and organizational dynamics and development, career planning, cultural diversity, human growth and development, human sexuality, normal and abnormal behavior, psychopathology, psychotherapy, and rehabilitation. Mental health counseling incorporates psychotherapy, hypnotherapy, and sex therapy.[5]

Licensure Requirements

An applicant seeking licensure as a *certified master social worker* must:[6]

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[1] Section 491.004, F.S.
[2] Department of Health Bill Analysis of HB 1161, dated March 4, 2013, on file with Health Quality Subcommittee staff.
[3] Section 491.003(7), F.S.
[4] Section 491.003(8), F.S.
[5] Section 491.003(9), F.S.
[6] Section 491.005(1) and (2), F.S.

- Submit an application and pay the appropriate fees;
- Possess a doctoral or master's degree in social work from an agency accredited by the Council on Social Work Education or an equivalent program;
- Complete a program that emphasized direct clinical patient or client health care services;
- Complete supervised field placement where the applicant provided direct clinical services to clients;
- Complete 24 semester hours in theory of human behavior and practice methods as courses in clinically oriented services;
- Complete at least two years of post-master's level clinical social work experience requirements, under supervision of a licensed clinical social worker who is qualified by the board;
- Pass a board approved examination; and
- Demonstrate knowledge of laws and rules governing practice.

An applicant seeking licensure as a *marriage and family therapist* must:[7]

- Submit an application and pay appropriate fees;
- Receive a minimum of a master's degree program with major emphasis in marriage and family therapy, or a closely related field;
- Complete thirty-six semester hours of graduate coursework in specified areas;
- Complete a minimum of one graduate-level course in legal, ethical, and professional standards issues in the practice of marriage and family therapy or a course determined by the board to be equivalent;
- Complete minimum of 180 direct client contact hours in a supervised clinical practicum, internship, or field experience in a marriage and family counseling setting;
- Complete at least two years of clinical of post-master's level experience where 50 percent of the applicant's clients were receiving marriage and family therapy services, under the supervision of a licensed mental health counselor with at least five years of experience who is qualified by the board;
- Pass a board-approved examination; and
- Demonstrate knowledge of laws and rules governing the practice.

An applicant seeking licensure as a *mental health counselor* must:[8]

- Submit an application and pay the appropriate fees;
- Possess a master's degree from a program accredited by the Council for the Accreditation of Counseling and Related Educational Programs that consists of at least 60 semester hours of clinical and didactic instruction;
- Complete thirty-three semester hours of graduate coursework that includes a minimum of three semester hours of graduate-level coursework in legal, ethical, and professional standards issues in the practice of mental health counseling;
- Complete at least 1,000 hours of university-sponsored supervised clinical practicum, internship at a school accredited by the Council for the Accreditation of Counseling and Related Educational Programs;
- Complete at least two years of clinical experience in mental health counseling at the post-masters level under the supervision of a licensed mental health counselor or the equivalent who is a qualified supervisor as determined by the board;
- Pass a board approved examination; and
- Demonstrate knowledge of laws and rules governing the practice.

[7] Section 491.005(3), F.S.
[8] Section 491.005(4), F.S.

Dual Licensure

An individual may apply for a marriage and family therapy dual license if he or she passes an examination in marriage and family therapy and holds an active license for at least three years as a: a psychologist, clinical social worker, mental health counselor, or advanced registered nurse practitioner who is determined by the Board of Nursing to be a specialist in psychiatric mental health.[9]

Licensure by Endorsement[10]

Section 491.006, F.S., allows an applicant who possesses an active, valid license from another state an avenue for licensure. The applicant must have actively practiced in the profession in another state for three of the last five preceding years, passed an equivalent licensing exam and education requirements, held a license in good standing, and must not be under investigation for anything that would violate Florida law.

Provisional Licensure

A provisional license allows individual practice, under supervision a licensed mental health professional, while not meeting all of the clinical experience requirements. Individuals must met minimum coursework requirements, and possess the respective graduate degree. A provisional license is valid for 2 years.[11]

Internship

In Florida, an individual may register as an intern in the following areas: clinical social work, marriage and family therapy, or mental health counseling. Registering as an intern enables an individual to gain the required postgraduate or postmaster's clinical experience that is required for full licensure. Currently, 1,500 hours of face-to-face psychotherapy is required, which may not be accrued in less than 100 weeks.[12]

An applicant seeking registration as an intern must: [13]

- Submit the application form and the nonrefundable fee;
- Complete the education requirements;
- Submit an acceptable supervision plan for meeting the practicum, internship, or field work required for licensure that was not satisfied by graduate studies; and
- Identify a qualified supervisor.

Currently, an intern may renew their registration every biennium, with no limit on the number of times a registration may be renewed.[14] According to DOH, there are 2,708 clinical social work interns, 726 marriage and family therapist interns, and 3,394 mental health counseling interns.[15]

Promotional Material

A licensed clinical social worker, marriage and family therapist, mental health counselor, or certified master social worker conspicuously displays the valid license issued by the DOH or a copy of the license at each location at which the licensee practices. All promotional materials, including cards,

[9] Section 491.0057, F.S.
[10] Section 491.006, F.S.
[11] Section 491.0046, F.S. and Rule 64B-3.0075, F.A.C.
[12] Rule 64B4-2.001, F.A.C.
[13] Section 491.005, F.S.
[14] *Supra* fn 2.
[15] *Supra* fn 2.

brochures, stationery, advertisements, and signs, naming the licensee must be provided. Currently, none of these requirements for the professional promotional materials includes social media.[16]

Effect of Proposed Changes

The bill makes substantial changes to the Clinical, Counseling, and Psychotherapy Services Practice Act (act), to update the provisions to current practice, training, and education standards. The act regulates the following professions: clinical social worker, marriage and family therapist, mental health counselor, psychotherapist, and social worker.

Parenting Plan

The bill creates s. 491.017, F.S., requiring a court-appointed mental health professional regulated by ch. 491, F.S., to develop a parenting plan recommendation in the following types of cases:

- Dissolution of marriage;
- Domestic violence; and
- Paternity matters involving the relationship of a child and a parent, including time-sharing.

The bill provides a presumption of good faith if the court-appointed mental health professional's recommendation is reached under the standards that a reasonable mental health professional would use to develop a parenting plan recommendation. Moreover, if an administrative complaint is filed against a court-appointed mental health professional, the filer's name, address, and telephone number must be included. A parent who wishes to file a legal action against a court-appointed mental health professional must petition the judge who presided over the case and show good cause before another mental health professional is appointed. Additionally, the court is responsible for determining who is responsible for all court costs and attorney fees associated with making an appointment. If a legal action is filed, whether civil or criminal, the claimant is responsible for all reasonable costs and reasonable attorney fees associated with the action for both parties if the mental health professional is not held liable. If the mental health professional is held liable in civil court, than he or she must pay all reasonable costs and attorney fees for the claimant.

Presently there is no statute to protect a court-appointed mental health professional acting in good faith under standards of licensure, who develops a parenting plan recommendation in a dissolution of marriage, a case of domestic violence, or a paternity matter involving the relationship of child and parent including time sharing of children. There is no provision that prevents anonymous filings of administrative complaints against court-appointed mental health professionals. There is also no law for petitioning the judge and determining responsibilities, fees, and costs associated with civil, criminal, or administrative proceedings. However, similar language is contained in s. 61.122, F.S., which deals with the dissolution of marriage and court-appointed psychologists.

Intern Registration

The bill rewords current law in numerous sections to clarify that a licensed mental health professional is required to be on the premises when clinical services are provided by an intern in a private practice setting, and the intern may not engage in his or her own independent practice.

The bill provides that a person, who is registered to practice as an intern, must remain under supervision for clinical hours to count toward full licensure. Additionally, those interns registered before July 1, 2013, may not have their registration renewed or reissued and the registration is to expire within 60 months after the date of issue. Any registration issued after July 1, 2013, is valid for 5 years and the bill grants the board the authority to adopt by rule, the eligibility requirements for reapplying for registration as an intern. According to DOH, there are 3,042 clear, active registered clinical social work

[16] Section 491.0149, F.S.

interns, 983 of them have been registered for over five years. There are currently 811 active registered marriage and family therapy interns; of these, 237 have been registered for over 5 years. There are currently 3,937 active registered mental health counselor interns, of these, 756 have been in this status for over 5 years. As of March 1, 2013, there were 7,790 total registered interns; of these 1,976 having been in intern status for over 5 years.[17]

The bill deletes the renewal fee for interns. The fee is unnecessary because the intern registration may not be renewed; instead interns must reapply.

Provisional License

The bill provides that a person who holds a provisional license may not apply for intern registration in the same profession; which closes an avenue that may be utilized by some to lengthen the time period to practice in the field, once the intern license expires in 5 years, without obtaining full licensure.

The bill restructures the current prerequisite training requirements for persons applying for provisional licenses to ease readability.

Educational Standards

The bill amends the educational standards for persons seeking full licensure such that for:

- *Marriage and Family Therapy* – the university sponsored requirements are increased from 48 to 80 quarter hours and 36 to 60 semester hours in coursework from an accredited and board-approved program; direct client contact hours are increased from 180 to 400 hours.

- *Mental Health Counseling* – the university sponsored clinical practicum, internship, or field experience is decreased from 1,000 to 700 hours, and the 700 hours must include 280 hours of direct client services. According to DOH, this change will make the requirements the same regardless of whether the person graduated from an accredited program or non-accredited program.[18] Moreover, effective July 1, 2020, an applicant for licensure must hold a master's degree from an accredited institution consisting of at least 60 semester hours or 80 quarter hours, and the coursework must include 3 semester hours or 4 quarter hours in differential diagnosis and the use of current diagnostic tools.

Dual Licensure

The bill repeals s. 491.0057, F.S., on July 1, 2020, which currently allows for dual licensure for Marriage and Family Therapists. According to DOH, since 1997, the following have been dually licensed as marriage and family therapists: 12 advanced registered nurse practitioners; 8 licensed clinical social workers; and 48 licensed mental health counselors.[19]

Out of State Applicants

The bill amends s. 491.006, F.S., the licensure by endorsement provisions for out-of-state applicants, by removing the requirement that applicants must have actively practiced the profession in another state within three of the last five immediately preceding years. Additionally, the bill authorizes the board to determine by rule, what educational requirements are required to demonstrate completion of substantially equivalent education.

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[17] Supra fn 2.
[18] *Id.*
[19] *Id.*

Disciplinary Action

The bill amends s. 491.009(2), F.S., to re-affirm the board's jurisdiction in the case of certified master social workers, such that DOH may enter orders denying licensure or imposing penalties for any applicant or licensee who is found guilty of violating any provisions of the law. According to DOH, the board determines the disciplinary action for the mental health professionals and DOH determines the disciplinary action for the certified master social workers.

Furthermore, the bill removes references to psychologists, because the profession is regulated by the Board of Psychology under chapter 490, F.S.

Display of License

The bill amends s. 491.0149, F.S., to add social media to the list of materials in which a person regulated by ch. 491, F.S., must include his or her name and appropriate title.

Other Provisions

The bill updates in numerous provisions the names of accrediting institutions that approve training programs under ch. 491, F.S., to include: the Council for Accreditation of Counseling and Related Educational Programs, the Commission on Accreditation for Marriage and Family Therapy Education, and the Council for Higher Education.

The bill amends s. 491.005(4), F.S., to update the name of the national examination entity for Mental Health Counselors from the Professional Examination for the National Academy of Certified Clinical Mental Health Counselors to the National Clinical Mental Health Counselors.

The bill amends the applicability of s. 491.0112(1), F.S., relating to psychotherapist misconduct to include a broader term of "sexual misconduct" instead of the more limited term of "sexual contact."

The bill deletes a provision in s. 491.0006(1), F.S., providing that fees paid by an applicant for certification as a Master Social Worker is nonrefundable.

The bill amends s. 491.012, F.S., to add "mental health coach" to the list of titles that a person may not use without a license.

The bill removes: obsolete dates, out-of-date references to the U.S. Department of Education and the Council for Higher Education, and unnecessary rule-making.

The bill makes substantial changes to the structure of existing law to simplify provisions and improve readability.

B. SECTION DIRECTORY:

Section 1. Amends s. 491.004, F.S., relating to the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling.
Section 2. Amends s. 491.0045, F.S., relating to intern registration and requirements.
Section 3. Amends s. 491.0046, F.S., relating to provisional license and requirements.
Section 4. Amends s.491.005, F.S., relating to Clinical Social Work.
Section 5. Amends s. 491.0057, F.S., relating to dual licensure as a marriage and family therapist.
Section 6. Amends s. 491.006, F.S., relating to licensure or certification by endorsement.
Section 7. Amends s. 491.007, F.S., relating to renewal of license, registration, or certificate.
Section 8. Amends s. 491.009, F.S., relating to discipline.
Section 9. Amends s. 491.0112, F.S., relating to sexual misconduct by a psychotherapist and penalties.
Section 10. Amends s. 491.012, F.S., relating to violations, penalties, and injunctions.

Section 11. Amends s. 491.0145, F.S., relating to certified master social worker.
Section 12. Amends s. 491.0149, F.S., relating to display of license, and use of professional title.
Section 13. Creates s. 491.017, F.S., relating to parenting plan recommendation; presumption of good faith; prerequisite to parent's filing suit; and award of fees, costs, and reimbursement.
Section 14. Provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill appears to have an insignificant fiscal impact on the Medical Quality Assurance Trust Fund associated with rule promulgation and workload, which may be absorbed within current resources.[20]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None identified.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The DOH has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

On lines 297-301, the bill adds language that duplicates training requirements included in lines 306-318. The new language on lines 297-301 seems to try and streamline the training requirements for a

[20] *Supra* fn 2.

provisional license, but may cause confusion due to statutory construction as to whether an applicant for full licensure would have to take additional coursework.

On line 132, the bill refers to a "registered intern license" while amending s. 491.0045, F.S. The use of the term "license" appears to conflict with the remainder of s. 491.0045, F.S., which only provides for intern "registration." Moreover, the remainder of ch. 491, F.S., only refers to registration in the context of interns and does not include any licensure provision for becoming an intern.

To be consistent with lines 231 and 405 of the bill, it appears that on line 542 of the bill the word "private" should be inserted between "independent" and "practice."

Section 13 of the bill, creates, within a practice act, a legal presumption of good faith for court-appointed mental health professionals who are appointed by a court to develop a parenting plan recommendation. It might be more appropriate to place this type of provision within ch. 61, F.S., or another section of law related to civil procedure.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to clinical, counseling, and psychotherapy services; amending s. 491.004, F.S.; deleting an obsolete provision; conforming provisions; amending s. 491.0045, F.S.; requiring registered interns to remain under supervision while maintaining registered intern status; providing for noncompliance; providing for the expiration of intern registrations and registered intern licenses; prohibiting specified persons from applying for an intern registration; amending s. 491.0046, F.S.; correcting cross-references; prohibiting specified persons from applying for a provisional license; amending s. 491.005, F.S.; revising the requirements for a clinical social worker license, a marriage and family therapist license, and a mental health counselor license; deleting a provision requiring certain registered interns to be certified as having met specified licensure requirements; amending s. 491.0057, F.S.; providing for future repeal of provisions providing for dual licensure as a marriage and family therapist; amending s. 491.006, F.S.; revising requirements of licensure or certification by endorsement; amending s. 491.007, F.S.; deleting a provision providing certified master social workers a limited exemption from continuing education requirements; deleting a provision requiring the Board of Clinical Social Work, Marriage and Family Therapy,

and Mental Health Counseling to establish a procedure for the biennial renewal of intern registrations; amending s. 491.009, F.S.; revising acts constituting grounds for the denial of a license or disciplinary action; authorizing the board and the Department of Health to deny licensure or impose specified penalties against an applicant or licensee for certain violations; amending s. 491.0112, F.S.; revising a provision providing that a psychotherapist who commits sexual misconduct with a client or former client commits a felony of the third degree; amending s. 491.012, F.S.; prohibiting a person from using the title "mental health counselor coach" without a valid mental health counselor license; deleting an obsolete provision; amending s. 491.0145, F.S.; providing certified master social workers a limited exemption from continuing education requirements; amending s. 491.0149, F.S.; requiring the use of applicable professional titles by licensees, provisional licensees, and registrants on social media and other specified materials; creating s. 491.017, F.S.; providing a presumption of good faith for the actions of a court-appointed mental health professional who develops a parenting plan recommendation; prohibiting anonymous complaints; providing prerequisites for a parent to bring a suit against a mental health professional; providing for the awarding of attorney fees and court costs; providing an effective date.

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

Section 1. Subsections (3) through (7) of section 491.004, Florida Statutes, are amended to read:

491.004 Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling.—

~~(3) No later than January 1, 1988, the Governor shall appoint nine members of the board as follows:~~

~~(a) Three members for terms of 2 years each.~~

~~(b) Three members for terms of 3 years each.~~

~~(c) Three members for terms of 4 years each.~~

(3)~~(4)~~ As the terms of the ~~initial~~ members expire, the Governor shall appoint successors for terms of 4 years; and those members shall serve until their successors are appointed.

(4)~~(5)~~ The board shall adopt rules ~~pursuant to ss. 120.536(1) and 120.54~~ to implement and enforce the provisions of this chapter.

(5)~~(6)~~ All applicable provisions of chapter 456 relating to activities of regulatory boards shall apply to the board.

(6)~~(7)~~ The board shall maintain its official headquarters in the City of Tallahassee.

Section 2. Section 491.0045, Florida Statutes, is amended to read:

491.0045 Intern registration; requirements.—

(1) ~~Effective January 1, 1998,~~ An individual who has not satisfied ~~intends to practice in Florida to satisfy~~ the postgraduate or post-master's level experience requirements, as

specified in s. 491.005(1)(c), (3)(c), or (4)(c), must register as an intern in the profession for which he or she is seeking licensure before ~~prior to~~ commencing the post-master's experience requirement. ~~or~~ An individual who intends to satisfy part of the required graduate-level practicum, internship, or field experience, outside the academic arena for any profession, must register as an intern in the profession for which he or she is seeking licensure before ~~prior to~~ commencing the practicum, internship, or field experience.

(2) The department shall register as a clinical social worker intern, marriage and family therapist intern, or mental health counselor intern each applicant who the board certifies has:

(a) Completed the application form and remitted a nonrefundable application fee not to exceed $200, as set by board rule;

(b)1. Completed the education requirements as specified in s. 491.005(1)(c), (3)(c), or (4)(c) for the profession for which he or she is applying for licensure, if needed; and

2. Submitted an acceptable supervision plan, as determined by the board, for meeting the practicum, internship, or field work required for licensure that was not satisfied in his or her graduate program.

(c) Identified a qualified supervisor.

(3) An individual registered under this section must remain under supervision while practicing under registered intern status ~~until he or she is in receipt of a license or a letter from the department stating that he or she is licensed to~~

~~practice the profession for which he or she applied~~.

~~(4) An individual who has applied for intern registration on or before December 31, 2001, and has satisfied the education requirements of s. 491.005 that are in effect through December 31, 2000, will have met the educational requirements for licensure for the profession for which he or she has applied.~~

(4)~~(5)~~ ~~Individuals who have commenced the experience requirement as specified in s. 491.005(1)(c), (3)(c), or (4)(c) but failed to register as required by subsection (1) shall register with the department before January 1, 2000.~~ Individuals who fail to comply with this section ~~subsection~~ shall not be granted a license under this chapter, and any time spent by the individual completing the experience requirement as specified in s. 491.005(1)(c), (3)(c), or (4)(c) before ~~prior to~~ registering as an intern shall not count toward completion of the ~~such~~ requirement.

(5) Intern registration shall be valid for 5 years. Any subsequent intern registration must result from applying for and meeting the requirements adopted by the board by rule.

(6) A registered intern license issued before July 1, 2013, shall expire 60 months after the date it was issued and may not be renewed or reissued. Any subsequent intern registration shall be issued at the discretion of the board.

(7) A person who has held a provisional license issued by the board may not apply for an intern registration in the same profession.

Section 3. Paragraph (c) of subsection (2) of section 491.0046, Florida Statutes, is amended, and subsection (5) is

added to that section, to read:

491.0046 Provisional license; requirements.—

(2) The department shall issue a provisional clinical social worker license, provisional marriage and family therapist license, or provisional mental health counselor license to each applicant who the board certifies has:

(c) Has met the following minimum coursework requirements:

1. For clinical social work, a minimum of 15 semester hours or 22 quarter hours of the coursework required by s. 491.005(1)(b)2.b.

2. For marriage and family therapy, 10 of the courses required by s. 491.005(3)(b)1.a. ~~491.005(3)(b)1.a.-c.~~, as determined by the board, and at least 6 semester hours or 9 quarter hours of the course credits must have been completed in the area of marriage and family systems, theories, or techniques.

3. For mental health counseling, a minimum of seven of the courses required under s. 491.005(4)(b)1.a. ~~491.005(b)1.a.-c.~~

(5) A person who has held an intern registration issued by the board may not apply for a provisional license in the same profession.

Section 4. Section 491.005, Florida Statutes, is amended to read:

491.005 Licensure by examination.—

(1) CLINICAL SOCIAL WORK.—Upon verification of documentation and payment of a fee not to exceed $200, as set by board rule, plus the actual per applicant cost to the department for purchase of the examination from the American Association of

State Social Worker's Boards or a similar national organization, the department shall issue a license as a clinical social worker to an applicant who the board certifies:

(a) Has submitted an ~~made~~ application ~~therefor~~ and paid the appropriate fee.

(b)1. Has received a doctoral degree in social work from a graduate school of social work which at the time the applicant graduated was accredited by an accrediting agency recognized by the United States Department of Education or has received a master's degree in social work from a graduate school of social work which at the time the applicant graduated:

a. Was accredited by the Council on Social Work Education;

b. Was accredited by the Canadian Association of Schools of Social Work; or

c. Has been determined to have been a program equivalent to programs approved by the Council on Social Work Education by the Foreign Equivalency Determination Service of the Council on Social Work Education. An applicant who graduated from a program at a university or college outside of the United States or Canada must present documentation of the equivalency determination from the council in order to qualify.

2. The applicant's graduate program must have emphasized direct clinical patient or client health care services, including, but not limited to, coursework in clinical social work, psychiatric social work, medical social work, social casework, psychotherapy, or group therapy. The applicant's graduate program must have included all of the following coursework:

a. A supervised field placement which was part of the applicant's advanced concentration in direct practice, during which the applicant provided clinical services directly to clients.

b. Completion of 24 semester hours or 32 quarter hours in theory of human behavior and practice methods as courses in clinically oriented services, including a minimum of one course in psychopathology, and no more than one course in research, taken in a school of social work accredited or approved pursuant to subparagraph 1.

3. If the course title which appears on the applicant's transcript does not clearly identify the content of the coursework, the applicant shall be required to provide additional documentation, including, but not limited to, a syllabus or catalog description published for the course.

(c) Has had at least ~~not less than~~ 2 years of clinical social work experience, which took place subsequent to completion of a graduate degree in social work at an institution meeting the accreditation requirements of this section, under the supervision of a licensed clinical social worker or the equivalent who is a qualified supervisor as determined by the board. An individual who intends to practice in Florida to satisfy clinical experience requirements must register pursuant to s. 491.0045 before ~~prior to~~ commencing practice. If the applicant's graduate program was not a program which emphasized direct clinical patient or client health care services as described in subparagraph (b)2., the supervised experience requirement must take place after the applicant has completed a

minimum of 15 semester hours or 22 quarter hours of the coursework required. A doctoral internship may be applied toward the clinical social work experience requirement. A licensed mental health professional must be on the premises when clinical services are provided by a registered intern in a private practice setting. A registered intern may not engage in his or her own independent private practice. ~~The experience requirement may be met by work performed on or off the premises of the supervising clinical social worker or the equivalent, provided the off-premises work is not the independent private practice rendering of clinical social work that does not have a licensed mental health professional, as determined by the board, on the premises at the same time the intern is providing services.~~

(d) Has passed a theory and practice examination provided by the department for this purpose.

(e) Has demonstrated, in a manner designated by rule of the board, knowledge of the laws and rules governing the practice of clinical social work, marriage and family therapy, and mental health counseling.

(2) CLINICAL SOCIAL WORK.—

(a) Notwithstanding the provisions of paragraph (1)(b), coursework which was taken at a baccalaureate level shall not be considered toward completion of education requirements for licensure unless an official of the graduate program certifies in writing on the graduate school's stationery that a specific course, which students enrolled in the same graduate program were ordinarily required to complete at the graduate level, was waived or exempted based on completion of a similar course at

the baccalaureate level. If this condition is met, the board shall apply the baccalaureate course named toward the education requirements.

(b) An applicant from a master's or doctoral program in social work which did not emphasize direct patient or client services may complete the clinical curriculum content requirement by returning to a graduate program accredited by the Council on Social Work Education or the Canadian Association of Schools of Social Work, or to a clinical social work graduate program with comparable standards, in order to complete the education requirements for examination. However, a maximum of 6 semester or 9 quarter hours of the clinical curriculum content requirement may be completed by credit awarded for independent study coursework as defined by board rule.

(3) MARRIAGE AND FAMILY THERAPY.—Upon verification of documentation and payment of a fee not to exceed $200, as set by board rule, plus the actual cost to the department for the purchase of the examination from the Association of Marital and Family Therapy Regulatory Board, or its successor ~~similar national organization~~, the department shall issue a license as a marriage and family therapist to an applicant who the board certifies:

(a) Has submitted an ~~made~~ application ~~therefor~~ and paid the appropriate fee.

(b)1. Has a minimum of a master's degree from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education, from a mental health counseling program with a marriage and family track from a university in

this state accredited by the Council for Accreditation of Counseling and Related Educational Programs, from a program accepted by the board as meeting these coursework requirements ~~with major emphasis in marriage and family therapy~~, or a program in a closely related field as determined by the board, and has completed all of the following requirements:

a. Sixty ~~Thirty-six~~ semester hours or 80 ~~48~~ quarter hours ~~of graduate coursework, which must include a minimum of 3 semester hours or 4 quarter hours~~ of graduate-level coursework ~~course credits~~ in ~~each of~~ the following ~~nine~~ areas: dynamics of marriage and family systems; marriage therapy and counseling theory and techniques; family therapy and counseling theory and techniques; individual human development theories throughout the life cycle; personality theory or general counseling theory and techniques; psychopathology; human sexuality theory and counseling techniques; psychosocial theory; ~~and~~ substance abuse theory and counseling techniques; legal, ethical, and professional standards issues in the practice of marriage and family therapy; individual evaluation, assessment, and testing; and behavioral research which focuses on the interpretation and application of research data as it applies to clinical practice. ~~Courses in research, evaluation, appraisal, assessment, or testing theories and procedures; thesis or dissertation work; or practicums, internships, or fieldwork may not be applied toward this requirement.~~

b. A minimum of one graduate-level course of 3 semester hours or 4 quarter hours in legal, ethical, and professional standards issues in the practice of marriage and family therapy

or a course determined by the board to be equivalent.

c. A minimum of one graduate-level course of 3 semester hours or 4 quarter hours in diagnosis, appraisal, assessment, and testing for individual or interpersonal disorder or dysfunction; and a minimum of one 3-semester-hour or 4-quarter-hour graduate-level course in behavioral research which focuses on the interpretation and application of research data as it applies to clinical practice. Credit for thesis or dissertation work, practicums, internships, or fieldwork may not be applied toward this requirement.

d. A minimum of one supervised clinical practicum, internship, or field experience in a marriage and family counseling setting, during which the student provided 400 ~~180~~ direct client contact hours of marriage and family therapy services under the supervision of an individual who met the requirements for supervision under paragraph (c). This requirement may be met by a supervised practice experience which took place outside the academic arena, but which is certified as equivalent to a graduate-level practicum or internship program which required a minimum of 400 ~~180~~ direct client contact hours of marriage and family therapy services currently offered within an academic program of a college or university accredited by an accrediting agency approved by the United States Department of Education, or an institution which is publicly recognized as a member in good standing with the Association of Universities and Colleges of Canada or a training institution accredited by the Commission on Accreditation for Marriage and Family Therapy Education ~~recognized by the United States Department of~~

~~Education~~. Certification shall be required from an official of such college, university, or training institution.

2. If the course title which appears on the applicant's transcript does not clearly identify the content of the coursework, the applicant shall be required to provide additional documentation, including, but not limited to, a syllabus or catalog description published for the course.

The required master's degree must have been received in an institution of higher education which at the time the applicant graduated was: fully accredited by a regional accrediting body recognized by the Commission on Recognition of Postsecondary Accreditation; publicly recognized as a member in good standing with the Association of Universities and Colleges of Canada; or an institution of higher education located outside the United States and Canada, which at the time the applicant was enrolled and at the time the applicant graduated maintained a standard of training substantially equivalent to the standards of training of those institutions in the United States which are accredited by a regional accrediting body recognized by the Commission on Recognition of Postsecondary Accreditation. Such foreign education and training must have been received in an institution or program of higher education officially recognized by the government of the country in which it is located as an institution or program to train students to practice as professional marriage and family therapists or psychotherapists. The burden of establishing that the requirements of this provision have been met shall be upon the applicant, and the

board shall require documentation, such as, but not limited to, an evaluation by a foreign equivalency determination service, as evidence that the applicant's graduate degree program and education were equivalent to an accredited program in this country. An applicant with a master's degree from a program which did not emphasize marriage and family therapy may complete the coursework requirement in a training institution fully accredited by the Commission on Accreditation for Marriage and Family Therapy Education or the Council for Accreditation of Counseling and Related Educational Programs ~~recognized by the United States Department of Education~~.

(c) Has had at least ~~not less than~~ 2 years of clinical experience during which 50 percent of the applicant's clients were receiving marriage and family therapy services, which must be at the post-master's level under the supervision of a licensed marriage and family therapist with at least 5 years of experience, or the equivalent, who is a qualified supervisor as determined by the board. An individual who intends to practice in Florida to satisfy the clinical experience requirements must register pursuant to s. 491.0045 before ~~prior to~~ commencing practice. If a graduate has a master's degree with a major emphasis in marriage and family therapy or a closely related field that did not include all the coursework required under sub-subparagraph (b)1.a. ~~sub-subparagraphs (b)1.a.-c.~~, credit for the post-master's level clinical experience shall not commence until the applicant has completed coursework in at least ~~a minimum of~~ 10 of the areas ~~courses~~ required under sub-subparagraph (b)1.a. ~~sub-subparagraphs (b)1.a.-c.~~, as determined

by the board, and at least 6 semester hours or 9 quarter hours of the course credits must have been completed in the area of marriage and family systems, theories, or techniques. Within the 2 ~~3~~ years of required experience, the applicant shall provide direct individual, group, or family therapy and counseling, to include the following categories of cases: unmarried dyads, married couples, separating and divorcing couples, and family groups including children. A doctoral internship may be applied toward the clinical experience requirement. A licensed mental health professional must be on the premises when clinical services are provided by a registered intern in a private practice setting. A registered intern may not engage in his or her own independent private practice ~~The clinical experience requirement may be met by work performed on or off the premises of the supervising marriage and family therapist or the equivalent, provided the off-premises work is not the independent private practice rendering of marriage and family therapy services that does not have a licensed mental health professional, as determined by the board, on the premises at the same time the intern is providing services~~.

(d) Has passed a theory and practice examination designated ~~provided~~ by the board ~~department~~ for this purpose.

(e) Has demonstrated~~, in a manner designated by rule of the board,~~ knowledge of the laws and rules governing the practice of clinical social work, marriage and family therapy, and mental health counseling as determined by the board.

(f) For the purposes of dual licensure, the department shall license as a marriage and family therapist any person who

meets the requirements of s. 491.0057. Fees for dual licensure shall not exceed those stated in this subsection. This paragraph expires July 1, 2020.

(4) MENTAL HEALTH COUNSELING.—Upon verification of documentation and payment of a fee not to exceed $200, as set by board rule, plus the actual per applicant cost to the department for purchase of the National Clinical Mental Health Counselor Examination ~~from the Professional Examination Service for the National Academy of Certified Clinical Mental Health Counselors or a similar national organization~~, an examination managed by the National Board of Certified Counselors or its successor, the department shall issue a license as a mental health counselor to an applicant who the board certifies:

(a) Has submitted an ~~made~~ application ~~therefor~~ and paid the appropriate fee.

(b)1. Has a minimum of an earned master's degree from a mental health counseling program accredited by the Council for ~~the~~ Accreditation of Counseling and Related Educational Programs that consists of at least 60 semester hours or 80 quarter hours of clinical and didactic instruction, including a course in human sexuality and a course in substance abuse. If the master's degree is earned from a program related to the practice of mental health counseling that is not accredited by the Council for ~~the~~ Accreditation of Counseling and Related Educational Programs, then the coursework and practicum, internship, or fieldwork must consist of at least 60 semester hours or 80 quarter hours and meet the following requirements:

a. Thirty-three semester hours or 44 quarter hours of

graduate coursework, which must include a minimum of 3 semester hours or 4 quarter hours of graduate-level coursework in each of the following 11 content areas: counseling theories and practice; human growth and development; diagnosis and treatment of psychopathology; human sexuality; group theories and practice; individual evaluation and assessment; career and lifestyle assessment; research and program evaluation; social and cultural foundations; ~~counseling in community settings; and~~ substance abuse; and legal, ethical, and professional standards issues in the practice of mental health counseling. Courses in research, thesis or dissertation work, practicums, internships, or fieldwork may not be applied toward this requirement.

b. ~~A minimum of 3 semester hours or 4 quarter hours of graduate-level coursework in legal, ethical, and professional standards issues in the practice of mental health counseling, which includes goals, objectives, and practices of professional counseling organizations, codes of ethics, legal considerations, standards of preparation, certifications and licensing, and the role identity and professional obligations of mental health counselors. Courses in research, thesis or dissertation work, practicums, internships, or fieldwork may not be applied toward this requirement.~~

~~c.~~ The equivalent, as determined by the board, of at least 700 ~~1,000~~ hours of university-sponsored supervised clinical practicum, internship, or field experience that includes at least 280 hours of direct client services, as required in the accrediting standards of the Council for Accreditation of Counseling and Related Educational Programs for mental health

counseling programs. This experience may not be used to satisfy the post-master's clinical experience requirement.

2. If the course title which appears on the applicant's transcript does not clearly identify the content of the coursework, the applicant shall be required to provide additional documentation, including, but not limited to, a syllabus or catalog description published for the course.

Education and training in mental health counseling must have been received in an institution of higher education which at the time the applicant graduated was: fully accredited by a regional accrediting body recognized by the Council for Higher Education or its successor ~~Commission on Recognition of Postsecondary Accreditation~~; publicly recognized as a member in good standing with the Association of Universities and Colleges of Canada; or an institution of higher education located outside the United States and Canada, which at the time the applicant was enrolled and at the time the applicant graduated maintained a standard of training substantially equivalent to the standards of training of those institutions in the United States which are accredited by a regional accrediting body recognized by the Council for Higher Education or its successor ~~Commission on Recognition of Postsecondary Accreditation~~. Such foreign education and training must have been received in an institution or program of higher education officially recognized by the government of the country in which it is located as an institution or program to train students to practice as mental health counselors. The burden of establishing that the requirements of this provision have been

met shall be upon the applicant, and the board shall require documentation, such as, but not limited to, an evaluation by a foreign equivalency determination service, as evidence that the applicant's graduate degree program and education were equivalent to an accredited program in this country. Effective July 1, 2020, an applicant must have a master's degree accredited by the Council for Accreditation of Counseling and Related Educational Programs consisting of at least 60 semester hours or 80 quarter hours to apply for licensure under this subsection. The applicant's graduate program must have emphasized the common core curricular experience to include at least 3 semester hours or 4 quarter hours of coursework specifically addressing the diagnostic process, including differential diagnosis and the use of the current diagnostic tools, such as the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

(c) Has had at least ~~not less than~~ 2 years of clinical experience in mental health counseling, which must be at the post-master's level under the supervision of a licensed mental health counselor or the equivalent who is a qualified supervisor as determined by the board. An individual who intends to practice in Florida to satisfy the clinical experience requirements must register pursuant to s. 491.0045 before ~~prior to~~ commencing practice. If a graduate has a master's degree in ~~with a major related to the practice of~~ mental health counseling or a closely related field that did not include all the coursework required under sub-subparagraph (b)1.a. ~~sub-subparagraphs (b)1.a.-b.~~, credit for the post-master's level

clinical experience shall not commence until the applicant has completed a minimum of seven of the courses required under sub-subparagraph (b)1.a. ~~sub-subparagraphs (b)1.a.-b., as determined by the board, one of which must be a course in psychopathology or abnormal psychology~~. A doctoral internship may be applied toward the clinical experience requirement. A licensed mental health professional must be on the premises when clinical services are provided by a registered intern in a private practice setting. No registered intern may engage in his or her own independent practice ~~The clinical experience requirement may be met by work performed on or off the premises of the supervising mental health counselor or the equivalent, provided the off-premises work is not the independent private practice rendering of services that does not have a licensed mental health professional, as determined by the board, on the premises at the same time the intern is providing services~~.

(d) Has passed a theory and practice examination designated ~~provided~~ by the department ~~for this purpose~~.

(e) Has demonstrated~~, in a manner designated by rule of the board,~~ knowledge of the laws and rules governing the practice of clinical social work, marriage and family therapy, and mental health counseling as determined by the board.

~~(5) INTERNSHIP.—An individual who is registered as an intern and has satisfied all of the educational requirements for the profession for which the applicant seeks licensure shall be certified as having met the educational requirements for licensure under this section.~~

(5)~~(6)~~ RULES.—The board may adopt rules necessary to

implement any education or experience requirement of this section for licensure as a clinical social worker, marriage and family therapist, or mental health counselor.

Section 5. Section 491.0057, Florida Statutes, is amended to read:

491.0057 Dual licensure as a marriage and family therapist.—

(1) The department shall license as a marriage and family therapist a ~~any~~ person who demonstrates to the board that he or she:

(a) ~~(1)~~ Holds a valid, active license as a psychologist under chapter 490 or as a clinical social worker or mental health counselor under this chapter, or is certified under s. 464.012 as an advanced registered nurse practitioner who has been determined by the Board of Nursing as a specialist in psychiatric mental health.

(b) ~~(2)~~ Has held a valid, active license for at least 3 years.

(c) ~~(3)~~ Has passed the examination provided by the department for marriage and family therapy.

(2) This section is repealed July 1, 2020.

Section 6. Subsection (1) of section 491.006, Florida Statutes, is amended to read:

491.006 Licensure or certification by endorsement.—

(1) The department shall license or grant a certificate to a person in a profession regulated by this chapter who, upon applying to the department and remitting the appropriate fee, demonstrates to the board that he or she:

(a) Has demonstrated~~, in a manner designated by rule of the board,~~ knowledge of the laws and rules governing the practice of clinical social work, marriage and family therapy, and mental health counseling as defined by rule of the board.

(b)1. Holds an active valid license to practice in the profession for which the applicant seeks licensure ~~and has actively practiced the profession for which licensure is applied in another state for 3 of the last 5 years immediately preceding licensure~~.

2. Meets the education requirements of this chapter for the profession for which licensure is applied or has demonstrated proof of substantially equivalent education as defined by rule of the board.

3. Has passed the licensure examination designated by the board or has passed a substantially equivalent licensing examination in another state for the profession which the applicant seeks licensure ~~a substantially equivalent licensing examination in another state or has passed the licensure examination in this state in the profession for which the applicant seeks licensure~~.

4. Holds a license in good standing, is not under investigation for an act that would constitute a violation of this chapter, and has not been found to have committed any act that would constitute a violation of this chapter. ~~The fees paid by any applicant for certification as a master social worker under this section are nonrefundable.~~

Section 7. Subsections (2) and (3) of section 491.007, Florida Statutes, are amended to read:

491.007 Renewal of license, registration, or certificate.—

(2) Each applicant for renewal shall present satisfactory evidence that, in the period since the license or certificate was issued, the applicant has completed continuing education requirements set by rule of the board or department. The board may not require ~~Not~~ more than 25 classroom hours of continuing education per year ~~shall be required~~. ~~A certified master social worker is exempt from the continuing education requirements for the first renewal of the certificate.~~

~~(3) The board or department shall prescribe by rule a method for the biennial renewal of an intern registration at a fee set by rule, not to exceed $100.~~

Section 8. Paragraph (c) of subsection (1) and subsection (2) of section 491.009, Florida Statutes, are amended to read:

491.009 Discipline.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(c) Being convicted or found guilty of, or entering ~~regardless of adjudication, or having entered~~ a plea of nolo contendere to, a crime in any jurisdiction which directly relates to the practice of his or her profession or the ability to practice his or her profession, regardless of adjudication. ~~However, in the case of a plea of nolo contendere, the board shall allow the person who is the subject of the disciplinary proceeding to present evidence in mitigation relevant to the underlying charges and circumstances surrounding the plea.~~

(2) The board ~~department~~, or, in the case of certified master social workers ~~psychologists~~, the department ~~board~~, may

enter an order denying licensure or imposing any of the penalties in s. 456.072(2) against any applicant for licensure or licensee who is found guilty of violating any provision of subsection (1) of this section or who is found guilty of violating any provision of s. 456.072(1).

Section 9. Subsection (1) of section 491.0112, Florida Statutes, is amended to read:

491.0112 Sexual misconduct by a psychotherapist; penalties.—

(1) Any psychotherapist who commits sexual misconduct with a client~~,~~ or former client ~~when the professional relationship was terminated primarily for the purpose of engaging in sexual contact,~~ commits a felony of the third degree, punishable as provided in s. 775.082 or s. 775.083; however, a second or subsequent offense is a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 10. Paragraphs (c) and (n) of subsection (1) of section 491.012, Florida Statutes, are amended to read:

491.012 Violations; penalty; injunction.—

(1) It is unlawful and a violation of this chapter for any person to:

(c) Use the following titles or any combination thereof, unless she or he holds a valid, active license as a mental health counselor issued pursuant to this chapter:

1. "Licensed mental health counselor."

2. "Mental health counselor."

3. "Mental health therapist."

4. "Mental health consultant."

5. "Mental health counselor coach."

(n) ~~Effective October 1, 2000,~~ Practice juvenile sexual offender therapy in this state, as the practice is defined in s. 491.0144, for compensation, unless the person holds an active license issued under this chapter and meets the requirements to practice juvenile sexual offender therapy. An unlicensed person may be employed by a program operated by or under contract with the Department of Juvenile Justice or the Department of Children and Families ~~Family Services~~ if the program employs a professional who is licensed under chapter 458, chapter 459, s. 490.0145, or s. 491.0144 who manages or supervises the treatment services.

Section 11. Section 491.0145, Florida Statutes, is amended to read:

491.0145 Certified master social worker.—

(1) The department may certify an applicant for a designation as a certified master social worker upon the following conditions:

(a) ~~(1)~~ The applicant completes an application to be provided by the department and pays a nonrefundable fee not to exceed $250 to be established by rule of the department. The completed application must be received by the department at least 60 days before the date of the examination in order for the applicant to qualify to take the scheduled exam.

(b) ~~(2)~~ The applicant submits proof satisfactory to the department that the applicant has received a doctoral degree in social work, or a master's degree with a major emphasis or specialty in clinical practice or administration, including, but

not limited to, agency administration and supervision, program planning and evaluation, staff development, research, community organization, community services, social planning, and human service advocacy. Doctoral degrees must have been received from a graduate school of social work which at the time the applicant was enrolled and graduated was accredited by an accrediting agency approved by the United States Department of Education. Master's degrees must have been received from a graduate school of social work which at the time the applicant was enrolled and graduated was accredited by the Council on Social Work Education or the Canadian Association of Schools of Social Work or by one that meets comparable standards.

(c) ~~(3)~~ The applicant has had at least 3 years' experience, as defined by rule, including, but not limited to, clinical services or administrative activities as defined in paragraph (b) ~~subsection (2)~~, 2 years of which must be at the post-master's level under the supervision of a person who meets the education and experience requirements for certification as a certified master social worker, as defined by rule, or licensure as a clinical social worker under this chapter. A doctoral internship may be applied toward the supervision requirement.

(d) ~~(4)~~ Any person who holds a master's degree in social work from an institution ~~institutions~~ outside the United States may apply to the department for certification if the academic training in social work has been evaluated as equivalent to a degree from a school accredited by the Council on Social Work Education. Any such person shall submit a copy of the academic training from the Foreign Equivalency Determination Service of

the Council on Social Work Education.

(e)~~(5)~~ The applicant has passed an examination required by the department for this purpose. The nonrefundable fee for such examination may not exceed $250 as set by department rule.

(2) A certified master social worker is exempt from the continuing education requirements for the first renewal of the certificate.

(3)~~(6)~~ ~~Nothing in~~ This chapter does not ~~shall be construed to~~ authorize a certified master social worker to provide clinical social work services.

Section 12. Section 491.0149, Florida Statutes, is amended to read:

491.0149 Display of license; use of professional title ~~on promotional materials~~.—

(1)(a) A person licensed under this chapter as a clinical social worker, marriage and family therapist, or mental health counselor, or certified as a master social worker shall conspicuously display the valid license issued by the department or a true copy thereof at each location at which the licensee practices his or her profession.

(b)1. A licensed clinical social worker shall include the words "licensed clinical social worker" or the letters "LCSW" on all promotional materials, including cards, brochures, stationery, advertisements, ~~and~~ signs, and social media, naming the licensee.

2. A licensed marriage and family therapist shall include the words "licensed marriage and family therapist" or the letters "LMFT" on all promotional materials, including cards,

brochures, stationery, advertisements, ~~and~~ signs, and social media, naming the licensee.

3. A licensed mental health counselor shall include the words "licensed mental health counselor" or the letters "LMHC" on all promotional materials, including cards, brochures, stationery, advertisements, ~~and~~ signs, and social media, naming the licensee.

(2)(a) A person registered under this chapter as a clinical social worker intern, marriage and family therapist intern, or mental health counselor intern shall conspicuously display the valid registration issued by the department or a true copy thereof at each location at which the registered intern is completing the experience requirements.

(b) A registered clinical social worker intern shall include the words "registered clinical social worker intern," a registered marriage and family therapist intern shall include the words "registered marriage and family therapist intern," and a registered mental health counselor intern shall include the words "registered mental health counselor intern" on all records, reports, and promotional materials, including cards, brochures, stationery, advertisements, ~~and~~ signs, and social media, naming the registered intern.

(3)(a) A person provisionally licensed under this chapter as a provisional clinical social worker licensee, provisional marriage and family therapist licensee, or provisional mental health counselor licensee shall conspicuously display the valid provisional license issued by the department or a true copy thereof at each location at which the provisional licensee is

providing services.

(b) A provisional clinical social worker licensee shall include the words "provisional clinical social worker licensee," a provisional marriage and family therapist licensee shall include the words "provisional marriage and family therapist licensee," and a provisional mental health counselor licensee shall include the words "provisional mental health counselor licensee" on all promotional materials, including cards, brochures, stationery, advertisements, ~~and~~ signs, and social media, naming the provisional licensee.

Section 13. Section 491.017, Florida Statutes, is created to read:

491.017 Parenting plan recommendation; presumption of good faith; prerequisite to parent's filing suit; award of fees, costs, reimbursement.—

(1) A mental health professional licensed under this chapter who has been appointed by the court to develop a parenting plan recommendation in a dissolution of marriage, a case of domestic violence, or a paternity matter involving the relationship of a child and a parent, including time-sharing of children, is presumed to be acting in good faith if the mental health professional's recommendation has been reached under standards that a reasonable mental health professional would use to develop a parenting plan recommendation.

(2) An administrative complaint against a court-appointed mental health professional which relates to a parenting plan recommendation developed by the mental health professional may not be filed anonymously. The individual who files an

administrative complaint must include in the complaint his or her name, address, and telephone number.

(3) A parent who desires to file a legal action against a court-appointed mental health professional who has acted in good faith in developing a parenting plan recommendation must petition the judge who presided over the dissolution of marriage, case of domestic violence, or paternity matter involving the relationship of a child and a parent, including time-sharing of children, to appoint another mental health professional. Upon the parent's showing of good cause, the court shall appoint another mental health professional. The court shall determine who is responsible for all court costs and attorney fees associated with making such an appointment.

(4) If a legal action, whether it be a civil action, a criminal action, or an administrative proceeding, is filed against a court-appointed mental health professional in a dissolution of marriage, case of domestic violence, or paternity matter involving the relationship of a child and a parent, including time-sharing of children, the claimant is responsible for all reasonable costs and reasonable attorney fees associated with the action for both parties if the mental health professional is held not liable. If the mental health professional is held liable in civil court, the mental health professional must pay all reasonable costs and reasonable attorney fees for the claimant.

Section 14. This act shall take effect July 1, 2013.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 1161 (2013)

Amendment No. 1

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

Committee/Subcommittee hearing bill: Health Quality Subcommittee

Representative Baxley offered the following:

Amendment (with title amendment)

Remove line 132 and insert:

(6) Intern registration issued before July 1, 2016, shall expire 60 months after the date it was issued and

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

Remove line 9 and insert:

; prohibiting specified

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 1161 (2013)

Amendment No. 2

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

Committee/Subcommittee hearing bill: Health Quality Subcommittee

Representative Baxley offered the following:

Amendment (with title amendment)

Remove lines 306-318

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

Remove line 19 and insert:

specified licensure requirements; deleting duplicative marriage and therapist license requirements; amending s.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 1161 (2013)

Amendment No. 3

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

Committee/Subcommittee hearing bill: Health Quality Subcommittee

Representative Baxley offered the following:

Amendment

Remove line 542 and insert:

own independent private practice ~~The clinical experience requirement may~~

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HQS 13-01 Quality Cancer Care and Research
SPONSOR(S): Health Quality Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Quality Subcommittee		Holt	O'Callaghan

SUMMARY ANALYSIS

The bill creates the Cancer Center of Excellence Award to recognize hospitals, treatment centers, and other providers in Florida that demonstrate excellence in patient-centered, coordinated care for persons undergoing cancer treatment and therapy. This bill provides for the development of performance measures, a rating system, and a rating standard that must be achieved to be eligible for the three-year recognition. A team of independent evaluators is established by the bill to determine if such performance measures and standards are achieved or exceeded. The award and designation may be used in the provider's advertising and marketing for up to three years and it entitles the recipient to preferential consideration in competitive solicitations by a state agency or state university.

The bill also provides for endowments to cancer research institutions in the state to establish a funded research chair that will attract and retain a promising researcher in order to serve as a catalyst to attract other national grant-producing researchers to the state. The endowments are contingent upon funding in the General Appropriations Act.

This bill, if funds are appropriated, would have a fiscal impact on the state and no fiscal impact on local governments.

The bill has an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Cancer is the leading cause of death in Florida. Florida has the second-highest number of new cases of cancer in the U.S., even though it is the fourth-largest state in terms of population. However, there is only one National Cancer Institute-designated comprehensive cancer center in the state.[1] National Cancer Institute designation is nationally recognized as a marker of high-quality in cancer care and research and is linked to higher federal funding for cancer treatment. Florida has fewer designated cancer centers than peer states. For example, New York has four centers, Texas has three, and California has ten.[2]

The Biomedical Research Program

The Florida Biomedical Research Program within the Department of Health (DOH) includes two distinct programs: the James and Esther King Biomedical Research Program and the William G. "Bill" Bankhead, Jr., and David Coley Cancer Research Program.

James and Esther King Biomedical Research Program

In 1999, the Legislature created the Florida Biomedical Research Program in DOH to support research initiatives that address the health care problems of Floridians in the areas of cancer, cardiovascular disease, stroke, and pulmonary disease.[3] A component of the Biomedical Research Program was the Biomedical Research Advisory Council (BRAC).[4] The BRAC was created to advise the State Surgeon General on the direction and scope of the state's biomedical research program, to include:

- Providing advice on program priorities, emphases, and overall program budget;
- Participating in periodic program evaluation;
- Assisting in developing guidelines for fairness, neutrality, principles of merit, and quality in the conduct of the program;
- Assisting in developing linkages to nonacademic entities such as voluntary organizations, health care delivery institutions, industry, government agencies, and public officials;
- Developing guidelines, criteria and standards for the solicitation, review, and award of research grants and fellowships; and
- Developing and providing oversight regarding mechanisms for disseminating research results.

The BRAC is composed of 11 members:

- Two appointees by the Speaker of the House of Representatives from a professional medical organization or a comprehensive cardiovascular program with experience in biomedical research approved by the American College of Cardiology, and from a cancer program approved by the American College of Surgeons;
- Two appointees by the President of the Senate with expertise in behavioral or social research, and from a cancer program approved by the American College of Surgeons;
- Four appointees by the Governor with two members having expertise in biomedical research, one from a research university in Florida, and one representing the general public;
- A representative of the American Cancer Society;

[1] H. Lee Moffitt Cancer Center is the only designated cancer center.
[2] Department of Health Bill Analysis for SB 1660 dated March 8, 2013, on file with the House Health Quality Subcommittee staff.
[3] Chapter 99-167, L.O.F.
[4] Section 215.5602(3), F.S.

- A representative of the American Heart Association; and
- A representative of the American Lung Association.

At inception, the program was intended to be supported by funds from the Lawton Chiles Endowment Fund,[5] but a specific appropriation amount was not statutorily indicated.[6] Statute[7] further stipulated that appropriated funds were to be used by the Florida Biomedical Research Program to provide grants and fellowships for research relating to the diagnosis and treatment of diseases related to tobacco use, including cancer, cardiovascular disease, stroke, and pulmonary disease, and administrative expenditures. Today, appropriations made from the interest earnings in the Lawton Chiles Endowment Fund are placed in a special appropriation category called the James and Esther King Biomedical Research Program and deposited into the Biomedical Research Trust Fund in the DOH to support the program.

In 2001, the Legislature amended the legislative purpose of the program, stating that the intent for the program was to provide an annual and perpetual source of funding to support research initiatives that address the health care problems of Floridians in the areas of tobacco-related cancer, cardiovascular disease, stroke, and pulmonary disease.[8] In 2003, the Florida Biomedical Research Program was renamed the "James and Esther King Biomedical Research Program (King program)."[9]

The goals of the King Program are to:

- Improve the health of Floridians by researching better prevention, diagnoses, treatments, and cures for cancer, cardiovascular disease, stroke, and pulmonary disease.
- Expand the foundation of biomedical knowledge relating to the prevention, diagnosis, treatment, and cure of diseases related to tobacco use, including cancer, cardiovascular disease, stroke, and pulmonary disease.
- Improve the quality of the state's academic health centers by bringing the advances of biomedical research into the training of physicians and other health care providers.
- Increase the state's per capita funding for research by undertaking new initiatives in public health and biomedical research that will attract additional funding from outside the state.
- Stimulate economic activity in the state in areas related to biomedical research, such as the research and production of pharmaceuticals, biotechnology, and medical devices.

Bankhead-Coley Program

In 2006, the Legislature created the William G. "Bill" Bankhead, Jr., and David Coley Cancer Research Program (Bankhead-Coley program) within the DOH. The purpose of the program was to advance progress towards cures for cancer through grant awards. The funds are distributed as grants to researchers seeking cures for cancer, with emphasis given to the efforts that significantly expand cancer research capacity in the state.[10]

The goals of the Bankhead-Coley Program are to significantly expand cancer research capacity and cancer treatment in the state by:

- Identifying ways to attract new research talent and attendant national grant-producing researchers to cancer research facilities in this state;
- Implementing a peer-reviewed, competitive process to identify and fund the best proposals to expand cancer research institutes in this state;

[5]Section 215.5601(1)(d), F.S.
[6]Chapter 99-167, L.O.F.
[7]Section 215.5602(2), F.S.
[8]Chapter 2001-73, L.O.F.
[9]Chapter 2003-414, L.O.F.
[10]The efforts to improve cancer research are outlined in s. 381.921, F.S.

- Funding, through available resources, those proposals that demonstrate the greatest opportunity to attract federal research grants and private financial support;
- Encouraging the employment of bioinformatics in order to create a cancer informatics infrastructure that enhances information and resource exchange and integration through researchers working in diverse disciplines to facilitate the full spectrum of cancer investigations;
- Facilitating the technical coordination, business development, and support of intellectual property as it relates to the advancement of cancer research;
- Aiding in other multidisciplinary, research-support activities as they inure to the advancement of cancer research;
- Improving both research and treatment through greater participation in clinical trials networks; and
- Reducing the impact of cancer on disparate groups.

Biomedical Research Program Funding

The Florida Biomedical Research Program distributes grant awards for one-, two-, or three-year periods. Any university or research institute in Florida may apply for grant funding to support the goals of either the King program or Bankhead-Coley program. All qualified investigators in the state, regardless of the institution, have an equal opportunity to compete for funding. Applications are accepted annually and awards are announced every June/July. After the awards are announced, the program obtains a signed contract, final budget, and the required study approvals from the grant recipient. Funds are only released to recipients on an as-needed basis and the undispersed, but obligated funds, are held in an interest bearing account. The accrued interest is held in the Biomedical Research Trust Fund of DOH.

The extent of funding for these programs has varied significantly from year-to-year. In FY 2012-2013, funding for biomedical research occurred through several appropriations:

The King Program received $5 million from DOH which was funded from the tobacco surcharge. This funding was allocated through grants.[11]

- The total awarded under the King Program was approximately $3.9M.
- The largest research award under the King Program was $400,000.

The Bankhead-Coley Program received $5 million from DOH which was funded from the tobacco surcharge. These funds were allocated through grants.[12]

- The total awarded under the Bankhead/Coley Program was approximately $3.6M.
- The largest research award under the Bankhead/Coley Program was $374,000.

Direct appropriations to institutions:[13]

- Moffitt received $5 million from DOH which was funded from the tobacco surcharge and $10,576,930 in the General Appropriations Act (Section 2 – Education: Division of Universities).
- Shands Cancer Hospital received $5 million from DOH which was funded from tobacco surcharge and $2.5 million from General Revenue.
- Sylvester Comprehensive Cancer Center at the University of Miami received $5 million from which was funded from the tobacco surcharge and $2.5 million from General Revenue.
- Sanford-Burnham Medical Research Institute received $3 million from General Revenue.

[11] Email correspondence with DOH staff, on file with the Health Quality Subcommittee staff.
[12] *Id.*
[13] *Id.*

Other Cancer Related Bodies in Florida

Cancer Control and Research Advisory Council (CCRAB)

In 1979, the Florida Cancer Control and Research Act was created pursuant to, s. 1004.435, F.S., along with the Cancer Control Research Advisory Council (CCRAB). The CCRAB is housed within the H. Lee Moffitt Cancer Center and Research Institute, Inc. The CCRAB consists of 35 members, including appointees by: the Governor and Speaker of the House of Representatives, the President of the Senate and other persons representing the: [14]

> American Cancer Society, Florida Tumor Registrars Association, Sylvester Comprehensive Cancer Center of the University of Miami, DOH, University of Florida Shands Cancer Center, Agency for Health Care Administration, Florida Nurses Association, Florida Osteopathic Medical Association, American College of Surgeons, School of Medicine of the University of Miami, College of Medicine of the University of Florida, NOVA Southeastern College of Osteopathic Medicine, College of Medicine of the University of South Florida, College of Public Health of the University of South Florida, Florida Society of Clinical Oncology, Florida Obstetric and Gynecologic Society, Florida Ovarian Cancer Alliance Speaks, Florida Medical Association, Florida Pediatric Society, Florida Radiological Society, Florida Society of Pathologists, Moffitt, Florida Dental Association, Florida Hospital Association, Association of Community Cancer Centers, statutory teaching hospitals, Florida Association of Pediatric Tumor Programs, Inc., Cancer Information Services, Florida Agricultural and Mechanical University Institute of Public Health, Florida Society of Oncology Social Workers, and consumer advocates from the general public.

The CCRAB formulates and makes recommendations to the State Surgeon General, the Board of Governors, and the Florida Legislature. These recommendations include, but are not limited to, approval of the state cancer plan, cancer control initiatives, and the awarding of grants and contracts, as funds are available, to establish, or conduct programs in cancer control or prevention, cancer education and training, and cancer research. Technical Advisory Groups are formed by the Council to review such areas as the state cancer plan evaluation, tobacco use prevention, cancer disparities, cancer-related data, and legislative initiatives.

Regional Cancer Control Collaborative

According to the Florida Cancer Plan, due to Florida's geography and diversity, there was a need for more localized planning to create a true comprehensive cancer control plan.[15] Thus, in 2000, the U.S. Congress appropriated funds to develop comprehensive regional cancer control plans in Florida. Funding was awarded to the University of Miami, Sylvester Comprehensive Cancer Center through a cooperative agreement with the CDC as part of their Cancer Control Collaborative (CCC) Program. This resulted in the Florida Comprehensive Cancer Control Initiative, which established four regional cancer control collaboratives covering all 67 Florida counties (see map below).[16] From 2000 to 2003, cancer control stakeholders in each of the four regions were invited to participate in a strategic planning process. From this, four regional cancer control plans were developed. In addition to regional goals, objectives, and strategies, each plan included detailed county-level cancer and demographic data, as well as a directory of cancer resources. The regional plans are an integrated Florida Cancer Plan.[17]

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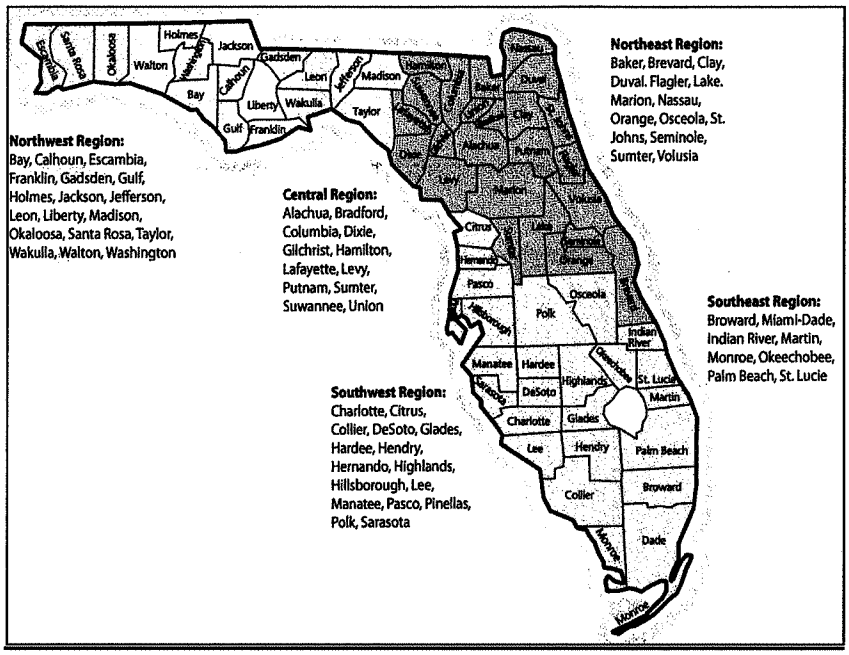
[14] Section 1004.435(4)(a), F.S.
[15] Florida Department of Health, Florida State Cancer Plan 2010, available at: http://www.doh.state.fl.us/Family/cancer/ccc/plan/index.html (last viewed March 27, 2011).
[16] *Id.*
[17] *Id.*



Statewide Cancer Registry

Section 385.202, F.S., requires each hospital or other licensed facility to report to the DOH information that indicates diagnosis, stage of disease, medical history, laboratory data, tissue diagnosis, and radiation, surgical, or other methods of diagnosis or treatment for each cancer diagnosed or treated by that facility to include Prostate Cancer.[18] The DOH, or a medical organization pursuant to a contract with the DOH, is required to maintain and make available for research such information in a statewide cancer registry.

Commission on Cancer for the American College of Surgeons

The Commission on Cancer (CoC) Accreditation Program encourages hospitals, treatment centers, and other facilities to improve their quality of patient care through various cancer-related programs. These programs focus on prevention, early diagnosis, pretreatment evaluation, staging, optimal treatment, rehabilitation, surveillance for recurrent disease, support services, and end-of-life care. [19]

Accredited cancer programs are assigned an accreditation category that describes the services available at the facility and the number of cases. Category assignments are made by CoC staff and are retained, unless there are changes to the services provided or the facility caseload over a three-year period. The cancer accreditation categories include the:[20]

- Academic Comprehensive Cancer Program;
- Community Cancer Program;
- Comprehensive Community Cancer Program;
- Free Standing Cancer Center Program;
- Hospital Associate Cancer Program;
- Integrated Network Cancer Program;
- NCI-Designated Comprehensive Cancer Center Program;
- Pediatric Cancer Program; and

[18] Chapter 78-171, L.O.F.
[19] American Colleges of Surgeons, Cancer Programs: Accreditation, *available* at: http://www.facs.org/cancer/coc/approval.html (last visited on March 12, 2013).
[20] American College of Surgeons Cancer Programs Categories of Accreditation for a description of the distinguishing characteristics of these categories, *available* at: http://www.facs.org/cancer/coc/categories3.html (last visited on March 12, 2013).

- Veterans Affairs Cancer Program.

Effects of Proposed Changes

Cancer Center of Excellence Award

The bill creates s. 381.925, F.S., the Cancer Center of Excellence Award. The three-year award recognizes hospitals, treatment centers, or other providers in Florida that demonstrate excellence in patient-centered, coordinated care for persons undergoing cancer treatment and therapy.

Winning the award affords the recipient preference in competitive solicitations for state funds. Moreover, the award may be used in advertising and marketing campaigns.

DOH must conduct biannual application cycles and to qualify for the award the applicant must at least:

- Maintain a license in this state which authorizes health care services be provided.
- Not have been disciplined or subject to any administrative enforcement action by the state or federal regulatory authority within the preceding 3 years.
- Be accredited by the Commission on Cancer of the American College of Surgeons.
- Actively participate in at least one regional cancer control collaborative that is operating pursuant to DOH's cooperative agreement with the CDC's National Comprehensive Cancer Control Program.
- Meet enhanced cancer care coordination standards set by the CCRAB and BRAC that focus on:

    - Coordination of care by cancer specialists, nursing and allied health professionals.
    - Psychosocial assessment and services.
    - Suitable and timely referrals and follow-up.
    - Providing accurate and complete information on treatment options, including clinical trials, which consider each person's needs, preferences, and resources, whether provided by the center or other providers.
    - Participation in a comprehensive network of cancer specialists of multiple disciplines allowing the patient to consult with variety of experts to evaluate other treatment options.
    - Family services and support.
    - Aftercare and survivor services.
    - Patient and family satisfaction survey results.

The State Surgeon General is required to appoint a 5-member team of independent evaluators to assess applicants to determine eligibility. Also, an application is to be evaluated independently of any other application. The team is comprised of the following in any combination:

- No more than 5 health care practitioners or health care facilities not licensed in Florida that provide cancer treatment or diagnosis;
- No more than 3 members from the Florida Cancer Control and Research Advisory Council;
- No more than 2 members from the Biomedical Research and Advisory Council; and
- No more than 1 layperson member who has experience as a cancer patient or family member who did not receive care from the facility being evaluated.

Evaluators are to be independent and free of any conflict of interest with respect to a health care provider or facility licensed in the state. Evaluators are required to sign a conflict of interest attestation before appointment. Two evaluators are permitted, as needed, to verify onsite documentation submitted with an application.

Each evaluator must report to the State Surgeon General the applicants that achieved or exceeded the required score based on a rating system developed jointly by the CCRAB and BRAC. The CCRAB and BRAC are also required to develop an application form, rigorous performance measures, and a rating standard that must be achieved to document and distinguish a cancer center that excels in providing quality, comprehensive, and patient-centered coordinated care program. The CCRAB and BRAC are directed to advise the State Surgeon General with respect to the Cancer Center for Excellence Award.

The bill requires the State Surgeon General to notify the Governor of the providers that are eligible for an award and submit an annual report to the Legislature beginning January 31, 2014. The report must include the status implementation; metrics on the number of applicants, number of award recipients by application cycle, list of awardees, and recommendations for legislation to strengthen the program.

The bill clarifies that the application submitted for a Cancer Center for Excellence Award is not an application for licensure, and therefore the provisions of s. 120.60, F.S., related to licensure do not apply. Additionally, the bill states that the notification by the State Surgeon General to the Governor of an eligible award entity is not considered final agency action, thus the provisions in ch.120, F.S., relating to challenges to agency action do not apply.

The bill grants DOH authority to adopt rules related to the application cycles and the submission of the application form.

Bankhead-Coley endowments for research chair

The bill creates s. 381.922(4), F.S., under the Bankhead-Coley program, to authorize the establishment of endowments for cancer research institutions within the state to fund an endowed research chair.

The endowment requires a specific appropriation, which will be used to establish endowment awards enabling a cancer research institution to provide stable funding for at least 7 years to recruit and retain experienced promising researchers. The endowed chairs are intended to specialize in a cancer-related field of research that will facilitate coordination among research institutions within the state and attract other promising researchers and national funding.

The research institution that receives an endowed chair must submit a report to the Governor, the President of the Senate and Speaker of the House of Representatives describing the research program and the responsibilities of the endowed chair. Upon final selection of the researcher, or if a replacement is needed for the original endowed chair, the research institution must notify the chairs of the appropriations committees of the Senate and House of Representatives of the name of the researcher and specific information about the endowment budget and research responsibilities. The research institution is required to report annually to the President of the Senate and the Speaker of the House of Representatives the following information pertaining to the endowment:

- Chair's name.
- Current salary.
- Research responsibilities.
- Percentage of time devoted to research if the chair also serves as a member of faculty.
- Reports on research progress and progress toward achieving the goals of the Bankhead-Coley program.
- Endowment expenditures and balance.
- Interest rate and interest earned on the endowment.

B. SECTION DIRECTORY:

Section 1. Creates s. 381.925, F.S., related to the Cancer Center of Excellence Award.
Section 2. Amends s. 215.5602, F.S., related to the James and Esther King Biomedical Research program.

Section 3. Amends s. 381.922, F.S., related to the William G. "Bill" Bankhead, Jr., and David Coley Cancer Research Program.

Section 4. Amends s. 1004.435, F.S., relating to the Florida Cancer Control and Research Advisory Council; creation; and composition.

Section 5. Provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   See FISCAL COMMENTS.

2. Expenditures:

   See FISCAL COMMENTS.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Although application for the Cancer Center of Excellence Award is voluntary, providers in the state who wish to be designated as such will incur indeterminable costs to align their programs with the standards contemplated by this bill. Providers receiving the award may be able to secure additional patient revenues as a result of the distinction of their care.

D. FISCAL COMMENTS:

The bill requires DOH to incur administrative costs to support the two programs established in the bill, but these costs are not expected to be significant. The amount of the endowments for the research chairs would need to be appropriated in the General Appropriations Act and would be significant.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill authorizes DOH sufficient authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Although the bill requires the Surgeon General to notify the Governor regarding the providers that are "eligible" to receive the Cancer Center of Excellence Award, it is not clear who actually grants the award and whether all those eligible to receive the award are granted an award.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to quality cancer care and research; creating s. 381.925, F.S.; providing legislative intent and goals; establishing a Cancer Center of Excellence Award for providers that excel in providing cancer care and treatment in this state; requiring the Florida Cancer Control and Research Advisory Council and the Biomedical Research Advisory Council to jointly develop performance measures, a rating system, and a rating standard in accordance with specified criteria for applicants to qualify for the award; providing minimum standards; authorizing a provider to apply to the Department of Health for the award; requiring the Florida Cancer Control and Research Advisory Council and the Biomedical Research Advisory Council to jointly develop an application form; requiring the department to conduct two application cycles each year; specifying that ch. 120, F.S., does not apply to the applications or notification of entities that are eligible for the award; requiring the State Surgeon General to assemble an evaluation team to assess applications; requiring each application to be evaluated independently of any other application; providing membership of and requirements for the evaluation team; providing duties of the members of the evaluation team; requiring the State Surgeon General to notify the Governor of the providers that are eligible to receive the award;

limiting the duration of the award; authorizing an award-winning cancer provider to use the designation in its advertising and marketing; providing that an award-winning cancer provider is granted preference in competitive solicitations for a specified period of time; requiring the State Surgeon General to report to the Legislature by a specified date, and annually thereafter, the status of implementing the award program; requiring the Department of Health to adopt rules related to the application cycles and submission of the application forms; amending s. 215.5602, F.S.; revising the responsibilities of the Biomedical Research Advisory Council with regard to the Cancer Center of Excellence Award program; amending s. 381.922, F.S.; authorizing endowments under the William G. "Bill" Bankhead, Jr., and David Coley Cancer Research Program for establishing funded research chairs at research institutions contingent upon an appropriation; requiring submission of proposals; requiring that research institutions report certain information regarding the selected research chair of the endowment and other information about the endowment; providing for qualifications of the chair; specifying the use of the funds in the endowment; amending s. 1004.435, F.S.; revising the responsibilities of the Florida Cancer Control and Research Advisory Council with regard to the Cancer Center of Excellence Award program; providing an

effective date.

Section 1. Section 381.925, Florida Statutes, is created to read:

381.925 Cancer Center of Excellence Award.—

(1) The Legislature intends to recognize hospitals, treatment centers, and other providers in this state which demonstrate excellence in patient-centered, coordinated care for persons undergoing cancer treatment and therapy in this state. The goal of this program is to encourage excellence in cancer care in this state, attract and retain the best cancer care providers to the state, and help Florida providers be recognized nationally as a preferred destination for quality cancer care. The Cancer Center of Excellence Award will recognize providers that exceed service standards and excel in providing a quality, comprehensive, and patient-centered, coordinated care program.

(2) The Florida Cancer Control and Research Advisory Council, established in s. 1004.435, and the Biomedical Research Advisory Council, established in s. 215.5602, shall jointly develop rigorous performance measures, a rating system, and a rating standard that must be achieved to document and distinguish a cancer center that excels in providing a quality, comprehensive, and patient-centered coordinated care program. At a minimum, the criteria must require that each hospital, treatment center, or other provider:

(a) Maintain a license in this state which authorizes health care services to be provided. A provider may not have been disciplined or subjected to any administrative enforcement

action by state or federal regulatory authorities within the preceding 3 years.

(b) Be accredited by the Commission on Cancer of the American College of Surgeons.

(c) Actively participate in at least one regional cancer control collaborative that is operating pursuant to the Florida Comprehensive Cancer Control Program's cooperative agreement with the Centers for Disease Control and Prevention's National Comprehensive Cancer Control Program.

(d) Meet enhanced cancer care coordination standards set by the councils which, at a minimum, focus on:

1. Coordination of care by cancer specialists and nursing and allied health professionals.

2. Psychosocial assessment and services.

3. Suitable and timely referrals and followup.

4. Providing accurate and complete information on treatment options, including clinical trials, which consider each person's needs, preferences, and resources, whether provided by that center or available through other health care providers.

5. Participation in a comprehensive network of cancer specialists of multiple disciplines, which enables the patient to consult with a variety of experts to examine treatment alternatives.

6. Family services and support.

7. Aftercare and survivor services.

8. Patient and family satisfaction survey results.

(3)(a) A provider may apply to the Department of Health

for a Cancer Center of Excellence Award. The Florida Cancer Control and Research Advisory Council and the Biomedical Research Advisory Council shall jointly develop an application form that requires, among other things, submission of documentation by the provider which demonstrates that the criteria in subsection (2) have been met.

(b) The Department of Health shall annually conduct two application cycles. The applications are not applications for licensure; the notification by the State Surgeon General to the Governor of the entities that are eligible for the award is not final agency action; and the Cancer Center of Excellence Award program is not subject to the provisions of chapter 120.

(4)(a) The State Surgeon General shall appoint a team of independent evaluators to assess applicants to determine eligibility for the award. An application is to be evaluated independently of any other application. The team shall consist of five evaluators to be selected, in any combination, from the following:

1. No more than five health care practitioners or health care facilities not licensed in this state which provide health care services involving cancer diagnoses or treatment;

2. No more than three members from the Florida Cancer Control and Research Advisory Council;

3. No more than two members from the Biomedical Research and Advisory Council; and

4. No more than one layperson who has experience as a cancer patient or as a family member of a cancer patient if that person or his or her family member did not receive care from the

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

V

applicant or providers being evaluated.

(b) Each evaluator must be independent and free of any conflict of interest with respect to a health care provider or facility licensed in this state. Each person selected to participate on the evaluation team must sign a conflict of interest attestation before being appointed to the evaluation team.

(5)(a) Two evaluation team members may, as necessary, verify onsite documentation submitted with an application for the award.

(b) Each member on the evaluation team shall report to the State Surgeon General those applicants that achieved or exceeded the required score based on the rating system developed in subsection (2) which demonstrates the cancer center excels in providing a quality, comprehensive, and patient-centered coordinated care program.

(6) The State Surgeon General shall notify the Governor regarding the providers that are eligible to receive the Cancer Center of Excellence Award.

(7) The award shall be recognized for a period of 3 years from the date of the award. A provider may reapply for subsequent awards.

(8) A provider that receives a Cancer Center of Excellence Award may use the designation in its advertising and marketing for up to 3 years from the date of the award. In addition, a provider that receives a Cancer Center of Excellence Award may be granted, for 3 years from the date of the award, a preference in competitive solicitations undertaken by a state agency or

state university.

(9) The State Surgeon General shall report to the President of the Senate and the Speaker of the House of Representatives by January 31, 2014, and annually thereafter, the status of implementing the Cancer Center of Excellence Award program, metrics on the number of applications received and the number of award recipients by application cycle, a list of award recipients, and recommendations for legislation to strengthen the program.

(10) The Department of Health shall adopt rules related to the application cycles and submission of the application form.

Section 2. Paragraph (j) is added to subsection (4) of section 215.5602, Florida Statutes, to read:

215.5602 James and Esther King Biomedical Research Program.—

(4) The council shall advise the State Surgeon General as to the direction and scope of the biomedical research program. The responsibilities of the council may include, but are not limited to:

(j) The council shall, with the Florida Cancer Control and Research Advisory Council, jointly develop performance measures, a rating system, a rating standard, and an application form for the Cancer Center of Excellence Award created in s. 381.925. The council shall also support the State Surgeon General in implementing the award program by ensuring that at least two members of the council, who must be independent of the applicants for the award, are available to serve on the evaluation team as requested by the State Surgeon General. The

council shall advise the State Surgeon General with respect to the Cancer Center for Excellence Award program.

Section 3. Subsection (4) of section 381.922, Florida Statutes, is renumbered as subsection (5), and a new subsection (4) is added to that section, to read:

381.922 William G. "Bill" Bankhead, Jr., and David Coley Cancer Research Program.—

(4) In order to attract and retain experienced research talent and attendant national grant-producing researchers to cancer research institutions in this state, the Department of Health shall award endowments to cancer research institutions for establishing a funded research chair, pursuant to the General Appropriations Act specifying an appropriation for this purpose. The purpose of the endowment is to provide a secure funding for at least 7 years to attract an experienced and promising researcher whose continued employment for this period is not contingent upon grant awards associated with time-limited research projects. In addition, the Legislature intends for a chair to specialize in a cancer-related research field that will facilitate coordination among research institutions within the state and attract other promising researchers and funding to the state.

(a) Any research institution funded pursuant to this subsection shall provide to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report that must, at a minimum, describe the research program and general responsibilities of the researcher who is to selected for the endowed chair. Upon final selection of the research

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chair, or if it becomes necessary to identify a replacement research chair, the research institution shall notify the chair of the Appropriations Committee of the Senate and the chair of the Appropriations Committee of the House of Representatives the research chair's name, the endowment budget, and the specific research responsibilities. The research institution shall annually report to the President of the Senate and the Speaker of the House of Representatives the research chair's name, current salary, research responsibilities, percentage of time devoted to research if the chair also serves as a member of the faculty, reports on research progress and progress toward achieving the goals of this program, endowment expenditures and balance, interest rate, and interest earned on the endowment.

Section 4. Paragraph (r) of subsection (4) of section 1004.435, Florida Statutes, is redesignated as paragraph (s), and a new paragraph (r) is added to that subsection, to read:

1004.435 Cancer control and research.—

(4) FLORIDA CANCER CONTROL AND RESEARCH ADVISORY COUNCIL; CREATION; COMPOSITION.—

(r) The council shall, with the Biomedical Research Advisory Council, jointly develop performance measures, a rating system, a rating standard, and an application form for the Cancer Center of Excellence Award created in s. 381.925. The council shall also support the State Surgeon General in implementing the Cancer Center of Excellence Award program by ensuring that at least three members of the council, who must be independent of the applicants for the award, are available to serve on the evaluation team as requested by the State Surgeon

General. The council shall advise the State Surgeon General with respect to the Cancer Center for Excellence Award program.

Section 5. This act shall take effect July 1, 2013.

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