Health & Human Services Committee

Wednesday, February 12, 2020
10:00 AM – 1:00 PM
Morris Hall (17 HOB)

Meeting Packet

Jose Oliva
Speaker

Ray Rodrigues
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health & Human Services Committee

Start Date and Time: Wednesday, February 12, 2020 10:00 am

End Date and Time: Wednesday, February 12, 2020 01:00 pm

Location: Morris Hall (17 HOB)

Duration: 3.00 hrs

Consideration of the following bill(s):

HB 163 Homelessness by Altman
HB 309 Prohibited Acts by Health Care Practitioners by Massullo
CS/HB 319 Florida Healthy Marriage Handbook by Civil Justice Subcommittee, Yarborough
HB 559 Institutional Formularies Established by Nursing Home Facilities by Byrd
CS/HB 573 Peer Support for First Responders by Civil Justice Subcommittee, Casello, McClain
CS/HB 577 Coordinated Specialty Care Programs by Children, Families & Seniors Subcommittee, Stevenson
CS/CS/HB 647 Recreational Vehicle Parks by Civil Justice Subcommittee, Health Quality Subcommittee, Drake
CS/CS/HB 649 Patient Brokering by Civil Justice Subcommittee, Children, Families & Seniors Subcommittee, Caruso
CS/HB 705 Emergency Sheltering of Persons with Pets by Oversight, Transparency & Public Management Subcommittee, Killebrew, Toledo
CS/HB 711 Hospital, Hospital System, or Provider Organization Transactions by Appropriations Committee, Burton
CS/CS/HB 713 Department of Health by Health Care Appropriations Subcommittee, Health Quality Subcommittee, Rodriguez, A. M.
CS/HB 767 Assisted Living Facilities by Health Market Reform Subcommittee, Grant, M.
CS/HB 825 Administration of Vaccines by Health Quality Subcommittee, Fernandez-Barquin
HB 833 Program of All-Inclusive Care for the Elderly by Rommel
HB 955 Physician Referrals by Shoaf
CS/HB 1083 Student Mental Health Procedures by PreK-12 Innovation Subcommittee, Webb
HB 1147 Patient Access to Records by Payne
CS/HB 1179 Nondiscrimination in Organ Transplants by Health Market Reform Subcommittee, Fischer
HB 1183 Home Medical Equipment Providers by Maggard
HB 1205 Price Transparency in Health Care Services by Rodriguez, A.
CS/HB 1255 Informed Consent for Midwifery Services by Health Quality Subcommittee, Mercado
CS/HB 1289 Informed Consent for Pelvic Examinations by Health Quality Subcommittee, Jenne
HB 6031 Florida Kidcare Program by Pigman
CS/HB 6059 Specialty Hospitals by Health Care Appropriations Subcommittee, Fitzenhagen
HB 7039 Repeal of Advisory Bodies and Programs by State Affairs Committee, Rodriguez, A.

Pursuant to rule 7.11, the deadline for amendments to bills on the agenda by non-appointed members shall be 6:00 p.m., Tuesday, February 11, 2020.

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, February 11, 2020.

NOTICE FINALIZED on 02/10/2020 4:06PM by Dewees.Cheryl

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 163 Homelessness
SPONSOR(S): Altman & others
TIED BILLS: **IDEN./SIM. BILLS:** SB 68

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	14 Y, 0 N	Guzzo	Brazzell
2) Health Care Appropriations Subcommittee	10 Y, 0 N	Fontaine	Clark
3) Health & Human Services Committee		Guzzo	Calamas

SUMMARY ANALYSIS

The Office of Homelessness (State Office) in the Department of Children and Families (DCF) provides coordination on issues relating to homelessness. DCF is required to establish local coalitions of providers, government entities, businesses and other parties which plan, network, coordinate, and monitor the delivery of services to the homeless, and awards state-funded grants to local agencies.

Local agencies address homelessness through services planned and carried out at the local level. Many agencies receive funding through the federal Department of Housing and Urban Development (HUD), based on a federal definition of "homeless" and compliance with various federal requirements relating to formation and operation of continuums of care, information technology systems, and priority populations for use of grant funds.

HB 163 revises the state's approach to homelessness by adopting the federal definition for "homeless" and aligning other state requirements with HUD requirements. The bill also changes the roles of the State Office and the requirements for its award of grants. For instance, the bill reduces the amount of matching funds or in-kind support required for a challenge grant recipient from 100% to 25%, increases the maximum percentage of grant funds that a Continuum of Care lead agency may spend on its administrative costs from 8% to 10%, and changes preference for funding to be to lead agencies for continuums of care that have a demonstrated ability to move households out of homelessness.

The 17-member Council on Homelessness develops recommendations on how to reduce homelessness statewide and advises the State Office. HB 163 adds a representative each from the Florida Housing Coalition and the Department of Elder Affairs to the council.

The bill amends sections of law outlining two approaches to housing services, Rapid ReHousing and Housing First. It requires that individuals and families being considered for Rapid ReHousing assistance be assessed and prioritized through the continuum of care's coordinated entry system. The bill also removes the program element indicating a benefit for an individual to have a background check and complete rehabilitation for any addiction to substances when participating in Housing First services.

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

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Federal Homelessness Grants

The Homeless Assistance Grants, administered by the federal Department of Housing and Urban Development (HUD), were first authorized by Congress in 1987 as part of the Stewart B. McKinney Homeless Assistance Act[1] to address the needs of the homeless, including food, shelter, health care, and education.[2] In 2000, the Act was renamed the McKinney-Vento Homeless Assistance Act.[3] At that time, the McKinney-Vento Act's definition of "homeless"[4] was sometimes described as requiring an individual to be literally homeless in order to receive assistance.[5] In 2009, Congress enacted the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act. The HEARTH Act broadened the definition of "homeless" to include programs or families which:

- Lack a fixed, regular, and adequate nighttime residence;
- Have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;
- Live in a supervised publicly or privately operated shelter designated to provide temporary living arrangements, including hotels and motels paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing; and
- Reside in a shelter or place not meant for human habitation and who is exiting an institution where he or she temporarily resided.[6]

In addition to addressing literal homelessness, the HEARTH Act also addresses housing instability as a form of homelessness. It includes situations where a person is at imminent risk of homelessness or where a family or unaccompanied youth is living unstably. Imminent risk includes situations where a person must leave their current housing within 14 days with no other place to go and no resources or support networks to obtain housing. Instability includes families with children and unaccompanied youth who:

- Are defined as homeless under other federal programs;
- Have experienced a long-term period without living independently in permanent housing;
- Have moved frequently; and
- Can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse, the presence of a child or youth with a disability, or multiple barriers to employment.[7]

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[1] The Stewart B. McKinney Homeless Assistance Act of 1987, Pub. L. 100-77, July 22, 1987, 101 Stat. 482, 42 U.S.C. § 11301.
[2] *Id*.
[3] The McKinney-Vento Homeless Assistance Act Pub. L. 106-400, October 30, 2000, 114 Stat. 1675, 42 U.S.C. § 11301.
[4] 42 U.S.C. § 11302 (1) an individual who lacks a fixed, regular, and adequate nighttime residence; and (2) an individual who has a primary nighttime residence that is—(A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); (B) an institution that provides a temporary residence for individuals intended to be institutionalized; or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.
[5] See, for example, the Department of Housing and Urban Development, *The Third Annual Homeless Assessment Report to Congress*, July 2008, p. 2, footnote 5, http://www.hudhre.info/documents/3rdHomelessAssessmentReport.pdf
[6] 42 U.S.C. § 11302(a).
[7] Id.

This allowed more individuals and families to qualify to receive homelessness services.

Emergency Solutions Grants Program

Funds from the ESG program are distributed by HUD to grantee states and local communities to assist those experiencing homelessness. ESG funds may be used for five program components:

- Street outreach;[8]
- Emergency shelter;[9]
- Homelessness prevention;[10]
- Rapid rehousing assistance;[11] and
- Homeless Management Information Systems and administrative activities.[12]

Recipients of ESG funds must make matching contributions in an amount equal to the recipient's fiscal year grant received.[13] Over the past three years, the State of Florida and local government grantees have received a total of $41,453,435 in ESG funds from HUD, including: $12,613,662 in 2019; $12,005,522 in 2018; and $16,834,251 in 2017.[14]

Continuum of Care (CoC) Program

The purpose of the HUD CoC program is to:

- Promote communitywide commitment to the goal of ending homelessness;
- Provide funding efforts by nonprofit providers, States, and local governments to quickly rehouse homeless individuals and families, while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness;
- Promote access to and effective utilization of mainstream programs by homeless individuals and families; and
- Optimize self-sufficiency among individuals and families experiencing homelessness.[15]

HUD considers a Continuum of Care or Continuum to mean a group organized to carry out certain responsibilities that is composed of representatives of organizations, including nonprofit homeless providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, organizations that serve homeless and

[8] 24 C.F.R. § 576.101(a) authorizes ESG funds to be used for costs of providing essential services necessary to reach out to unsheltered homeless people; connect them with emergency shelter, housing, or critical services; and provide urgent, nonfacility-based care to unsheltered homeless people who are unwilling or unable to access emergency shelter, housing, or an appropriate health facility.
[9] 24 C.F.R. § 576.102 authorizes ESG funds to be used for costs of providing essential services to homeless families and individuals in emergency shelters, renovating buildings to be used as emergency shelter for homeless families and individuals, and operating emergency shelters.
[10] 24 C.F.R. § 576.103 authorizes ESG funds to be used to provide housing relocation and stabilization services and short- and/or medium-term rental assistance necessary to prevent an individual or family from moving into an emergency shelter.
[11] 24 C.F.R. § 576.104 authorizes ESG funds to be used to provide housing relocation and stabilization services and short- and/or medium-term rental assistance as necessary to help a homeless individual or family move as quickly as possible into permanent housing and achieve stability in that housing.
[12] 24 C.F.R. § 576.107 authorizes ESG funds to be used to pay the costs of contributing data to the HMIS designated by the Continuum of Care for the area; and 24 C.F.R. § 576.108 authorizes recipients to use of to 7.5 percent of its ESG grant for the payment of administrative costs related to the planning and execution of ESG activities.
[13] 24 C.F.R. § 576.201.
[14] HUD Awards and Allocations, Find Award and Allocation Amounts for Grantees by Year, Program, and State, available at https://www.hudexchange.info/grantees/allocations-awards/ (last visited February 9, 2020).
[15] 24 C.F.R. § 578.1.

formerly homeless veterans, and homeless and formerly homeless persons to the extent these groups are represented within the geographic area and are available to participate.[16]

The responsibilities required by HUD of a Continuum of Care include developing a plan to coordinate the implementation of a housing and service system within its geographic area that meets the needs of the homeless individuals.[17] At a minimum the system must include: outreach, engagement, and assessment; shelter, housing, and supportive services; and prevention strategies. The Continuum of Care plan must also plan for and conduct, at least biennially, a point-in-time count of homeless persons within the geographic area. Further, Continuums of Care are required to designate a single Homeless Management Information System (HMIS) for the geographic area of each Continuum and an applicant to manage the Continuum's HMIS.[18]

The bulk of funding for the Homeless Assistance Grants is awarded as competitive grants through the CoC program.[19] The CoC program differs from the ESG program in that it focuses on the longer-term housing and service needs of homeless individuals and families. Prior to the enactment of the HEARTH Act, which created the CoC program by consolidating several programs, applicants were required to submit separate applications for each of these grant programs. The new consolidated CoC grant provides funds for all permanent housing, transitional housing, supportive services, rehousing activities and homeless management information services.[20]

There are two types of permanent housing permitted by HUD that grantees may provide under the CoC program, permanent supportive housing and rapid rehousing.[21] Grantees may provide permanent housing with supportive services to individuals with disabilities and families where an adult or child has a disability. Rapid rehousing is a process targeted to assist homeless individuals and families through supportive services and short-term[22] or medium-term[23] tenant-based rental assistance.

Transitional housing is housing available for up to 24 months to help homeless individuals and families transition from homelessness to permanent housing. Grant funds may be used for acquisition, rehabilitation, new construction, leasing, rental assistance, operating costs, and supportive services.[24]

CoC programs may fund an array of supportive services for homeless individuals and families.[25] The services include case management, child care, education services, employment assistance and job training, life skills training, legal services, mental health services, outpatient health services, substance abuse treatment, transportation, and payment of moving costs and utility deposits.[26]

CoC programs may provide funding for homeless management information services in the form of a database established at the local level through which homeless service providers collect, organize, and store information about homeless clients who receive services.

Continuums of Care must design, operate, and follow a collaborative process for the development of applications and approve the submission of applications in response to a notice of funding availability published by HUD.[27] The collaborative process must include establishing priorities for funding projects

[16] 24 C.F.R. § 578.3.
[17] 24 C.F.R. § 578.7(c).
[18] 24 C.F.R. § 578.7(b).
[19] Congressional Research Service, *The HUD Homeless Assistance Grants: Programs Authorized by the HEARTH Act,* August 2017, p. 10, available at https://fas.org/sgp/crs/misc/RL33764.pdf (last visited February 9, 2020).
[20] 24 C.F.R. § 578.37(a).
[21] 24 C.F.R. § 578.37(a)(1).
[22] For a period of up to three months.
[23] For a period of up to 24 months.
[24] 24 C.F.R. § 578.37(a)(2).
[25] 42 U.S.C. §11383(a)(6). In addition to being available to individuals and families who are experiencing homelessness, supportive services are available to formerly homeless individuals and families who are living in permanent supportive housing indefinitely and those who are living in permanent housing (but not *supportive* housing) for up to six months after finding housing.
[26] 42 U.S.C. §11360(27), 24 C.F.R. §578.53 at 77 *Federal Register* 45453.
[27] 24 C.F.R. § 578.9.

in the geographic area. The Continuum must then determine if one application for funding will be submitted for all projects within the geographic area or if more than one application will be submitted for the projects within the geographic area. If more than one application will be submitted, the Continuum must designate an eligible applicant to be the collaborative applicant[28] that will collect and combine the required application information from all applicants and for all projects within the geographic area that the Continuum has selected funding. In 2018, $85,425,367 in Federal funding was awarded under the CoC program to continuums of care in Florida.[29]

Homelessness in Florida

The definition of "homeless" in Florida Statutes addresses which individuals quality for services and thus affects whom providers serve and whether certain individuals receive services. Additionally, this definition affects client counts that factor into distribution of funding. Section 420.621, F.S., defines "homeless" as an individual who lacks a fixed, regular, and adequate nighttime residence and includes an individual who:

- Is sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason;
- Is living in a motel, hotel, travel trailer park, or camping ground due to a lack of alternative adequate accommodations;
- Is living in an emergency or transitional shelter;
- Has a primary nighttime residence that is a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings;
- Is living in a car, park, public space, abandoned building, bus or train station, or similar setting; or
- Is a migratory individual who qualifies as homeless because he or she is living in any of the circumstances described above.[30]

This definition of "homeless" does not align with the federal definition of "homeless", which presents operational challenges to local homeless providers which receive funding from both the state and federal government.

In 2019, 28,591 individuals who are homeless were identified in Florida.[31] This included 16,111 sheltered individuals and 12,480 unsheltered individuals.[32] Individuals in homeless households-including at least one adult and one child—comprised 7,287 of these individuals, or 25.5% of the total.[33] The 2019 point in time count represents a reduction of 1,126 individuals identified as homeless in the 2018 point in time count. Since 2015, the number of people experiencing homelessness in Florida has decreased by 20%.[34]

[28] A collaborative applicant is the eligible applicant that has been designated by the Continuum of Care to apply for CoC funds on behalf of the continuum.
[29] Department of Children and Families, Council on Homelessness Annual Report 2019, p. 3, available at https://myflfamilies.com/service-programs/homelessness/docs/2019CouncilReport.pdf (last visited February 9, 2020).
[30] The term does not include an individual imprisoned pursuant to state or federal law or individuals or families who are sharing housing due to cultural preferences, voluntary arrangements, or traditional networks of support. The terms include an individual who has been released from jail, prison, the juvenile justice system, the child welfare system, a mental health and developmental disability facility, a residential addiction treatment program, or a hospital, for whom no subsequent residence has been identified, and who lacks the resources and support network to obtain housing.
[31] Department of Children and Families, Council on Homelessness Annual Report 2019, p. 3, available at https://myflfamilies.com/service-programs/homelessness/docs/2019CouncilReport.pdf (last visited February 9, 2020).
[32] *Supra,* note 36 at 45.
[33] *Id.* at 49.
[34] *Id.* at 3.

State Office on Homelessness

In 2001, the Florida Legislature created the State Office on Homelessness (State Office) within the Department of Children and Families (DCF) to serve as a central point of contact within state government on issues relating to homelessness.[35] The State Office is responsible for coordinating resources and programs across all levels of government, and with private providers that serve the homeless. It also manages targeted state grants to support the implementation of local homeless service continuum of care plans.[36]

Council on Homelessness

The Legislature also created the inter-agency Council on Homelessness (Council) in 2001. The 17-member council develops recommendations on how to reduce homelessness statewide and advises the State Office. The Council includes:

- The Secretary of DCF, or his or her designee;
- The Executive Director of the Department of Economic Opportunity, or his or her designee, who shall advise the Council on issues related to rural development;
- The State Surgeon General, or his or her designee;
- The Executive Director of Veterans' Affairs, or his or her designee;
- The Secretary of Corrections, or his or her designee;
- The Secretary of the Agency for Health Care Administration, or his or her designee;
- The Commissioner of Education, or his or her designee;
- The Director of CareerSource Florida, Inc., or his or her designee;
- One representative of the Florida Association of Counties;
- One representative of the Florida League of Cities;
- One representative of the Florida Supportive Housing Coalition;
- The Executive Director of the Florida Housing Finance Corporation, or his or her designee;
- One representative of the Florida Coalition for the Homeless; and
- Four members appointed by the Governor.[37]

The Council is required to provide an annual report to the Governor, the Legislature, and the Secretary of DCF summarizing the extent of homelessness in the state and the Council's recommendations for reducing homelessness in Florida.[38]

Coalitions and Continuums of Care

Local Coalitions for the Homeless

DCF must establish local coalitions to plan, network, coordinate, and monitor the delivery of services to the homeless.[39] Groups and organizations provided the opportunity to participate in such coalitions include:

- Organizations and agencies providing mental health and substance abuse services;
- County health departments and community health centers;
- Organizations and agencies providing food, shelter, or other services targeted to the homeless;
- Local law enforcement agencies;
- Regional workforce boards;
- County and municipal governments;

[35] S. 420.622(1), F.S.
[36] S. 420.622(3), F.S.
[37] S. 420.622(2), F.S.
[38] S. 420.622(9), F.S.
[39] S. 420.623, F.S.

- Local public housing authorities;
- Local school districts
- Local organizations and agencies serving specific subgroups of the homeless population such as veterans, victims of domestic violence, persons with HIV/AIDS, runaway youth; and
- Local community-based care alliances.[40]

Continuums of Care

Section 420.621(1), F.S., defines "continuum of care" as the community components needed to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency; it includes action steps to end homelessness and prevent a return to homelessness.

A local homeless assistance continuum of care is a framework for a comprehensive and seamless array of emergency, transitional, and permanent housing, and services to address the various needs of the homeless and those at risk of homelessness.[41] The purpose of this framework is to help communities and regions envision, plan, and implement comprehensive and long-term solutions to homelessness in their own community or region.[42]

The local homeless assistance continuum of care planning effort is an ongoing process that addresses all subpopulations of the homeless. Section 420.624(7), F.S., lists elements that a continuum of care plan should include, such as outreach, intake and assessment procedures; emergency shelter; transitional housing; Rapid ReHousing; and permanent supportive housing.

Each local homeless assistance continuum of care plan must designate a lead agency that will serve as the point of contact and accountability to the State Office. The lead agency may be a local homeless coalition, municipal or county government, or other public agency or private, not-for-profit corporation.[43]

The State Office may only recognize one homeless assistance continuum of care plan and its designated lead agency for a local homeless assistance continuum of care.[44] Continuum of care catchment areas must be designated and revised as necessary by the State Office, with the input of local homeless coalitions and public or private organizations that have previously certified to HUD and that currently serve as lead agencies for a local homeless assistance continuum of care.[45] Designated catchment areas must not be overlapping, and the designations must be consistent with those made by HUD in conjunction with the awarding of federal Stewart B. McKinney Act homeless assistance funding.

Florida Homelessness Grants

Challenge Grants

In 2001, the Florida Legislature established the Challenge Grant and authorized the State Office to accept and administer moneys appropriated to it to provide Challenge Grants annually to designated lead agencies of homeless assistance continuums of care.

DCF must establish award levels for Challenge Grants specifying criteria to determine award levels and, after consultation with the Council on Homelessness, to specify the grant award levels in the

[40] *Id.*
[41] S. 420.624(1), F.S.
[42] S. 420.624(2), F.S.
[43] S. 420.624(4), F.S.
[44] S. 420.624(6), F.S.
[45] S. 420.624(5), F.S.

notice of solicitation of grant applications.[46] Any lead agency that receives a Challenge Grant must submit reports to DCF detailing its use of the grant funds.[47]

The State Office may award grants in an amount of up to $500,000 per lead agency.[48] In order to qualify for a grant, the lead agency must develop and implement a local homeless assistance continuum of care plan for its designated area. The continuum of care plan must implement a coordinated assessment or central intake system to screen, assess, and refer persons seeking assistance to the appropriate service provider. The lead agency must also document the commitment of local government or private matching funds or in-kind support in an amount equal to the grant requested.

Preference is given to lead agencies that have demonstrated the ability of their continuum of care to provide quality services to homeless persons and the ability to leverage federal homeless-assistance funding under the Stewart B. McKinney Act with local government funding or private funding for the provision of services to the homeless. Preference is also given to lead agencies in catchment areas with the greatest need for the provision of housing and services to the homeless, relative to the population of the catchment area.[49]

Challenge grants may be used to fund any of the housing, program, or service needs included in the local homeless assistance continuum of care plan. The lead agency may allocate the grant to programs, services, or housing providers that implement the local homeless assistance continuum of care plan. The lead agency may also provide sub-grants to a local agency to implement programs or services or provide housing identified for funding in the lead agency's application to DCF. Lead agencies are limited to spending a maximum of 8% of total funding on administrative costs.[50]

Section 420.622(6), F.S., requires the State Office, in conjunction with the Council, to establish performance measures and specific objectives by which it may evaluate the performance and outcomes of lead agencies that receive grant funds. Challenge grants made through the State Office must be distributed to lead agencies based on their overall performance and their achievement of specified objectives. In evaluating the performance of the lead agencies, the State Office must base its criteria on the program objectives, goals, and priorities that were set forth by the lead agencies in their proposals for funding. Such criteria may include the number of persons or households that are no longer homeless, the rate of recidivism to homelessness, and the number of individuals who obtain gainful employment.

Section 420.622(8), F.S., requires DCF, with input from the Council, to adopt rules relating to the challenge grants.

In 2019, the Legislature appropriated, and the State Office allocated $3,488,244.68 from the Local and State Government Housing Trust Fund to be awarded as challenge grants.[51]

Homeless Housing Assistance Grants

The State Office on Homelessness, with the concurrence of the Council on Homelessness, may administer money appropriated to it to provide homeless housing assistance grants annually to lead agencies for local homeless assistance continuum of care to acquire, construct, or rehabilitate transitional or permanent housing units for homeless persons. Such money shall consist of any sums

[46] S. 420.622(4), F.S.
[47] S. 420.622(4)(e), F.S.
[48] S. 420.622(4), F.S.
[49] S. 420.622(4)(a), F.S.
[50] S. 420.622(4)(d), F.S.
[51] *Supra,* note 38 at 45.

that the state may appropriate, as well as money received from donations, gifts, bequests, or otherwise from any public or private source.[52]

Grants applicants must be ranked competitively, and preference must be given to applicants who leverage additional private funds and public funds, particularly federal funds designated for the acquisition, construction, or rehabilitation of transitional or permanent housing for the homeless, and who:

- Acquire, build, or rehabilitate the greatest number of units; or
- Acquire, build, or rehabilitate in catchment areas having the greatest need for housing for the homeless relative to the population of the catchment area.[53]

Funding for any particular project may not exceed $750,000. Projects are required to reserve the number of units acquired, constructed, or rehabilitated through homeless housing assistance grant funding to serve persons who are homeless at the time they assume tenancy for a minimum of 10 years.[54] The maximum amount of funds allowed to be spent on administrative costs is 5% of total funds.[55]

Section 420.622(8), F.S., requires DCF, with input from the Council, to adopt rules relating to homeless housing assistance grants.

Grants in Aid

Section 420.625, F.S., outlines the grant-in-aid program. The purpose of this program is to assist persons in their communities who have become, or are about to become, homeless, and where possible, restore the homeless to suitable living conditions and self-sufficiency as quickly as possible.[56] DCF is to develop guidelines for the development of spending plans for the evaluation and approval of spending plans, based upon such factors as:

- Demonstrated level of need for the program,
- The demonstrated ability of the local agency or agencies seeking assistance to deliver the services and to assure that identified needs will be met,
- The ability of the local agency or agencies seeking assistance to deliver a wide range of services,
- The adequacy and reasonableness of proposed budgets and planned expenditures, and the demonstrated capacity of the local agency or agencies to administer the funds sought,
- A statement from the local coalition for the homeless as to the steps to be taken to assure coordination and integration of services in the district to avoid unnecessary duplication and costs,
- Assurances by the local coalition for the homeless that alternative funding strategies for meeting needs through the reallocation of existing resources, utilization of volunteers, and local government or private agency funding have been explored, and
- The existence of an evaluation component designed to measure program outcomes and determine the overall effectiveness of the local programs for the homeless for which funding is sought.

DCF is to allocate funds to its districts, which then distribute them to local agencies based upon recommendations of the local coalitions. These allocations are to be based upon sufficient documentation of:

[52] S. 420.622(5), F.S.
[53] S. 420.622(5)(a), F.S.
[54] S. 420.622(5)(c), F.S.
[55] S. 420.622(5)(f), F.S.
[56] S. 420.625(2), F.S.

- The magnitude of the problem of homelessness in the district, and the demonstrated level of unmet need for services in the district for those who are homeless or are about to become homeless.
- A strong local commitment to seriously address the problem of homelessness as evidenced by coordinated programs involving preventive, emergency, and transitional services and by the existence of active local organizations committed to serving those who have become, or are about to become, homeless.
- Agreement by local government and private agencies currently serving the homeless not to reduce current expenditures for services presently provided to those who are homeless or are about to become homeless if grant assistance is provided pursuant to this section.
- Geographic distribution of district programs to ensure that such programs serve both rural and urban areas, as needed.[57]

DCF no longer has districts, having moved to a regionally-based model.[58]

Effect of the Bill:

Many of the bill's provisions align Florida's approach to homeless services with federal law. Others increase the capacity of agencies to receive grant funds and administer them.

Homelessness

The bill redefines the term "homeless" to incorporate solely the conditions defined in federal regulations:

- An individual or family who lacks a fixed, regular, and adequate nighttime address, and
- An individual or family who will imminently lose their primary nighttime residence.

State Office on Homelessness

The bill revises many of the duties specified in statute for the State Office. These changes include:

- Changing references from "coalitions for the homeless" to "continuums of care";
- Focusing on ending homelessness instead of addressing the needs of the homeless;
- Specifying that the State Office must have input from continuums of care when conducting or promoting research on the effectiveness of current programs and proposing pilot projects, which must be aimed at ending homelessness rather than improving services, as is required by existing statute,
- Requiring the State Office to use summary data from databases and charts required by HUD instead of developing its own outcome and accountability measures; and
- Requiring the State Office's technical assistance to support and strengthen continuums of care rather than establish, maintain, and expand them.

Council on Homelessness

HB 163 adds two new members to the Council, bringing the total to 19 members. These two members would be the Secretary of the Department of Elder Affairs or his or her designee and one representative from the Florida Housing Coalition.

The Florida Housing Coalition is a statewide, nonprofit membership organization which consults on affordable housing and related issues and advocates for policies, programs and use of funding resources that maximize the availability and improve the quality of affordable housing in Florida.[59]

[57] S. 420.625(6), F.S.
[58] Department of Children and Families, *2020 Agency Legislative Bill Analysis,* September 16, 2019 (on file with the Health and Human Services Committee).

The bill also encourages representatives of the Council to have had experience in the provision of services to persons experiencing homelessness.

Coalitions and Continuums of Care

HB 163 repeals s. 420.623, F.S., regarding local coalitions for the homeless, and s. 420.624, F.S., regarding local homeless assistance continuums of care.

The bill redefines "continuum of care" to be solely a group organized to carry out the responsibilities imposed under ss. 420.621-420.628, F.S., to coordinate, plan, and pursue ending homelessness in a designated catchment area. It lists possible member organizations such as nonprofit homeless providers, victim service providers, faith-based organizations, governments, and businesses. The bill removes language including action steps as an element of a continuum of care.

HB 163 specifies that the purpose of a continuum of care is to coordinate community efforts to prevent and end homelessness in its catchment area and to fulfill the responsibilities set forth in ch. 420. The bill makes the "collaborative applicant" for HUD the lead agency for state purposes and requires the State Office to align its catchment areas for continuums of care with HUD's.

The bill requires each continuum of care to create a continuum of care plan which implements an effective and efficient housing crisis response system to prevent and end homelessness in the continuum of care catchment area. Further, the bill requires each continuum of care plan to include all of the following components:

- Outreach to unsheltered individuals and families to link them with appropriate housing interventions;
- A coordinated entry system, compliant with the requirements of the HEARTH Act, and designed to coordinate intake, utilize common assessment tools, prioritize households for housing interventions, and refer households to the appropriate housing intervention;
- Emergency shelter, designed to provide safe temporary shelter while the household is in the process of obtaining permanent housing;
- Supportive services, designed to maximize housing stability once the household is in permanent housing;
- Permanent supportive housing, designed to provide long-term affordable housing and support services to persons with disabilities who are moving out of homelessness;
- Rapid ReHousing;
- Permanent housing, including links to affordable housing, subsidized housing, long-term rental assistance, housing vouchers, and mainstream private sector housing; and
- An ongoing planning mechanism to end homelessness for all subpopulations of persons experiencing homelessness.

Each continuum of care must also promote participation by all interested individuals, acting in a nondiscriminatory manner, and must coordinate and integrate with other mainstream health, social services and employment programs for which homeless populations may be eligible.

Grants

Challenge Grants

The bill requires Challenge Grant recipients to use the funds for services implemented through the continuum of care's coordinated entry system. It specifies criteria that the State Office must use, at a minimum, when determining award of homeless housing assistance grants. These criteria consider

[59] Florida Housing Coalition, *"About Us",* http://www.flhousing.org/about/ (last visited February 9, 2020).

quality of services, ability to leverage other funding, need for services, and performance in maintaining housing. The bill also changes the preference for funding to be for lead agencies for continuums of care that have a demonstrated ability to move households out of homelessness; instead of giving such preference to lead agencies that provide quality services and effectively leverage federal and other sources of funding and to areas with the greatest need for housing and homeless services. Additionally, the bill removes the requirement for lead agencies to give the State Office a thorough evaluation of the grant-funded program's performance related to households that are no longer homeless, rate of recidivism, and number of persons who obtain gainful employment, and instead requires the State Office to use performance measures it establishes to evaluate the performance of lead agencies which receive state grant funds. The bill increases the grant amount award that continuum of care lead agencies can receive from $500,000 to $750,000, reduces the required matching funds or in-kind support provided by a continuum of care lead agency to receive a Challenge Grant 100% to 25% from; and increases the maximum percentage of grant funds that a continuum of care lead agency may spend on its administrative costs from 8% to 10%;

Grants in Aid

The bill repeals s. 420.625, F.S., regarding grants-in-aid and creates a new section, s. 420.6227, F.S., also addressing grants-in-aid. These changes update eligibility criteria by removing the preference for targeting the new and temporary homeless. It removes as the purpose helping homeless individuals find suitable living conditions and self-sufficiency and retains as the purpose to assist individuals who are or may become homeless, and to help homeless households move to permanent housing as quickly as possible.

HB 163 allows a continuum of care to use grants-in-aid funding for any component of their continuum of care plan, with funding to be awarded on a competitive basis and granted to agencies based on the recommendations of lead agencies in accordance with their plans. The bill removes the criteria in law for the evaluation and approval of spending plans and instead allows the State Office to develop the criteria. This creates more flexibility for DCF and grantees.

Rapid Re-Housing

The bill removes legislative findings on Rapid ReHousing. It requires that a homeless continuum of care assess and prioritize individuals and families being considered for Rapid ReHousing assistance through the continuum of care's coordinated entry system. HB 163 also changes the objective of Rapid ReHousing services from the recipients' not developing a dependency on the assistance to their attaining stability and integration into the community as quickly as possible.

Housing First

HB 163 removes legislative findings on Housing First and amends statute to emphasize the permanent, stable nature of the housing provided through the Housing First approach. It removes the element of Housing First service provision involving an individual having a background check and complete rehabilitation for any addiction to substances. It also removes reference to linkages between Housing First and emergency and transitional housing systems and instead states that the links are with community-based social service and health care organizations.

Discharge Policies

HB 163 amends s. 420.626, F.S., to require hospitals and inpatient medical facilities, crisis stabilization units, residential treatment facilities, assisted living facilities, and detoxification centers to communicate with programs to whom clients or patients might be discharged to determine their capability to serve these individuals and if they will be accepted into the programs.

B. SECTION DIRECTORY:

Section 1: Amends s. 420.621, F.S., relating to definitions.
Section 2: Amends s. 420.622, F.S., relating to State Office on Homelessness; Council on Homelessness.
Section 3: Creates s. 420.6225, F.S., relating to continuum of care.
Section 4: Creates s. 420.6227, F.S., relating to grant-in-aid program.
Section 5: Repeals s. 420.623, F.S., relating to local coalitions for the homeless.
Section 6: Repeals s. 420.624, F.S., relating to local homeless assistance continuum of care.
Section 7: Repeals s. 420.625, F.S., relating to grant-in-aid program.
Section 8: Amends s. 420.626, F.S., relating to homelessness; discharge guidelines.
Section 9: Amends s. 420.6265, F.S., relating to Rapid ReHousing.
Section 10: Amends s. 420.6275, F.S., relating to Housing First.
Section 11: Amends s. 420.507, F.S., relating to powers of the corporation.
Section 12: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:
See Fiscal Comments.

D. FISCAL COMMENTS:

The bill does not contain an appropriation, or otherwise affect state expenditures; however, it alters the criteria by which programs addressing homelessness are funded and how recipients may spend grant awards. To the extent that lead agencies increase their withholding of funds for administrative purposes (from 8 percent to 10 percent), the remaining funds available for direct services may decrease, since the appropriation is limited. Similarly, the bill increases the maximum award amount from $500,000 to $750,000, the source of which is a fixed appropriation.

The bill decreases the required local matching level from 100 percent to 25 percent, which may decrease the total funding available to an individual project when considering all funding sources. Also, modifications to the qualifying criteria and approval process may influence a prospective continuum of care agency's decision to apply.

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

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to homelessness; amending s. 420.621, F.S.; revising and providing definitions; amending s. 420.622, F.S.; increasing the number of members on the Council on Homelessness; revising the duties of the State Office on Homelessness; revising requirements for the state's system of homeless programs; requiring entities that receive state funding to provide summary aggregated data to the council; revising the qualifications for and amount of grant awards to continuum of care lead agencies; requiring continuum of care lead agencies to submit a report to the Department of Children and Families; increasing the minimum number of years for which projects must reserve certain units for the homeless; authorizing, rather than requiring, the Department of Children and Families to adopt certain rules; authorizing the office to administer certain money; creating s. 420.6225, F.S.; specifying the purpose of a continuum of care; requiring each continuum of care to designate a collaborative applicant; providing requirements for such applicants; authorizing such applicants to be referred to as continuum of care lead agencies; providing requirements for continuum of care catchment areas and lead agencies; requiring continuums of care

to create continuum of care plans; specifying requirements for such plans; requiring continuums of care to promote participation by all interested individuals and organizations; creating s. 420.6227, F.S.; providing legislative findings and program purpose; establishing a grant-in-aid program to help continuums of care prevent and end homelessness; providing requirements for such program; repealing s. 420.623, F.S., relating to local coalitions for the homeless; repealing s. 420.624, F.S., relating to local homeless assistance continuum of care; repealing s. 420.625, F.S., relating to a grant-in-aid program; amending s. 420.626, F.S.; revising procedures for certain facilities and institutions to implement when discharging specified persons to reduce homelessness; amending s. 420.6265, F.S.; revising the Rapid ReHousing methodology; amending s. 420.6275, F.S.; revising the Housing First methodology; amending s. 420.507, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Section 420.621, Florida Statutes, is amended to read:

420.621 Definitions.—As used in ss. 420.621-420.628, the term:

(1) "Continuum of care" means a group organized to carry out the responsibilities imposed under ss. 420.621-420.628 to coordinate, plan, and pursue ending homelessness in a designated catchment area. Such a group shall be composed of representatives from certain organizations, including, but not limited to, nonprofit homeless providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, organizations that serve homeless and formerly homeless veterans, and organizations that serve homeless and formerly homeless persons, to the extent that these organizations are represented within the designated catchment area and are available to participate ~~the community components needed to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency. It includes action steps to end homelessness and prevent a return to homelessness~~.

(2) "Continuum of care lead agency" or "continuum of care collaborative applicant" means the organization designated by a continuum of care under s. 420.6225.

(3) ~~(2)~~ "Council on Homelessness" means the council created

in s. 420.622.

(4)~~(3)~~ "Department" means the Department of Children and Families.

~~(4) "District" means a service district of the department, as set forth in s. 20.19.~~

(5) "Homeless~~,~~" means:

(a) An individual or family who lacks a fixed, regular, and adequate nighttime residence as defined under "homeless" in 24 C.F.R. 578.3; or

(b) An individual or family who will imminently lose their primary nighttime residence as defined under "homeless" in 24 C.F.R. 578.3.~~applied to an individual, or "individual experiencing homelessness" means an individual who lacks a fixed, regular, and adequate nighttime residence and includes an individual who:~~

~~(a) Is sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason;~~

~~(b) Is living in a motel, hotel, travel trailer park, or camping ground due to a lack of alternative adequate accommodations;~~

~~(c) Is living in an emergency or transitional shelter;~~

~~(d) Has a primary nighttime residence that is a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings;~~

~~(e) Is living in a car, park, public space, abandoned~~

~~building, bus or train station, or similar setting; or~~

~~(f) Is a migratory individual who qualifies as homeless because he or she is living in circumstances described in paragraphs (a)-(e).~~

~~The terms do not refer to an individual imprisoned pursuant to state or federal law or to individuals or families who are sharing housing due to cultural preferences, voluntary arrangements, or traditional networks of support. The terms include an individual who has been released from jail, prison, the juvenile justice system, the child welfare system, a mental health and developmental disability facility, a residential addiction treatment program, or a hospital, for whom no subsequent residence has been identified, and who lacks the resources and support network to obtain housing~~.

~~(6) "Local coalition for the homeless" means a coalition established pursuant to s. 420.623.~~

~~(7) "New and temporary homeless" means individuals or families who are homeless due to societal factors.~~

(6)~~(8)~~ "State Office on Homelessness" means the state office created in s. 420.622.

Section 2. Section 420.622, Florida Statutes, is amended to read:

420.622 State Office on Homelessness; Council on Homelessness.—

(1) The State Office on Homelessness is created within the Department of Children and Families to provide interagency, council, and other related coordination on issues relating to homelessness.

(2) The Council on Homelessness is created to consist of 19 ~~17~~ representatives of public and private agencies who shall develop policy and advise the State Office on Homelessness. The council members shall be: the Secretary of Children and Families, or his or her designee; the executive director of the Department of Economic Opportunity, or his or her designee, who shall advise the council on issues related to rural development; the State Surgeon General, or his or her designee; the Executive Director of Veterans' Affairs, or his or her designee; the Secretary of Corrections, or his or her designee; the Secretary of Health Care Administration, or his or her designee; the Commissioner of Education, or his or her designee; the Director of CareerSource Florida, Inc., or his or her designee; one representative of the Florida Association of Counties; one representative of the Florida League of Cities; one representative of the Florida Supportive Housing Coalition; one representative of the Florida Housing Coalition; the Executive Director of the Florida Housing Finance Corporation, or his or her designee; one representative of the Florida Coalition for the Homeless; the Secretary of the Department of Elder Affairs, or his or her designee; and four members appointed by the

Governor. The council members shall be nonpaid volunteers and shall be reimbursed only for travel expenses. The appointed members of the council shall be appointed to staggered 2-year terms~~,~~ and are encouraged to have experience in the administration or provision of resources, services, or housing that addresses the needs of persons experiencing homelessness. The council shall meet at least four times per year. The importance of minority, gender, and geographic representation shall be considered in appointing members to the council.

(3) The State Office on Homelessness, pursuant to the policies set by the council and subject to the availability of funding, shall:

(a) Coordinate among state, local, and private agencies and providers to produce a statewide consolidated inventory for the state's entire system of homeless programs which incorporates local continuum of care plans ~~regionally developed plans~~. Such programs include, but are not limited to:

1. Programs authorized under the McKinney-Vento Homeless Assistance ~~Stewart B. McKinney Homeless Assistance~~ Act of 1987, as amended by the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009, 42 U.S.C. ss. 11302 ~~ss. 11371~~ et seq., and carried out under funds awarded to this state; and

2. Programs, components thereof, or activities that assist persons who are homeless or at risk for homelessness.

(b) Collect, maintain, and make available information concerning persons who are homeless ~~or at risk for homelessness~~, including summary demographics information drawn from the local continuum of care Homeless Management Information System or the annual Point-in-Time Count, and the local continuum of care Housing Inventory Chart required by the United States Department of Housing and Urban Development ~~current services and resources available, the cost and availability of services and programs, and the met and unmet needs of this population~~. All entities that receive state funding must provide summary aggregated ~~access to all~~ data ~~they maintain in summary form~~, with no individual identifying information, to assist the council in providing this information. The State Office on Homelessness, in consultation with the designated lead agencies for a ~~local homeless~~ continuum of care and with the Council on Homelessness, shall develop a process by which summary data is collected ~~the system and process of data collection~~ from all continuum of care lead agencies for the purpose of analyzing trends and assessing impacts in the ~~statewide homeless delivery~~ system for delivering services to the homeless. ~~Any statewide homelessness survey and database system must comply with all state and federal statutory and regulatory confidentiality requirements.~~

(c) Annually evaluate state and continuum of care system programs ~~local services and resources~~ and develop a consolidated plan for addressing the needs of the homeless or those at risk

for homelessness.

(d) Explore, compile, and disseminate information regarding public and private funding sources for state and local programs serving the homeless and provide technical assistance in applying for such funding.

(e) Monitor and provide recommendations for coordinating the activities and programs of continuums of care ~~local coalitions for the homeless~~ and promote the effectiveness of programs to prevent and end homelessness in the state ~~addressing the needs of the homeless~~.

(f) Provide technical assistance to facilitate efforts to support and strengthen ~~establish, maintain, and expand local homeless assistance~~ continuums of care.

(g) Develop and assist in the coordination of policies and procedures relating to the discharge or transfer from the care or custody of state-supported or state-regulated entities persons who are homeless or at risk for homelessness.

(h) Spearhead outreach efforts for maximizing access by people who are homeless or at risk for homelessness to state and federal programs and resources.

(i) Promote a federal policy agenda that is responsive to the needs of those who are homeless or at risk of homelessness ~~the homeless population~~ in this state.

(j) Review reports on continuum of care system performance measures and ~~Develop outcome and accountability measures and~~

~~promote and~~ use such measures to evaluate program effectiveness and make recommendations for improving current practices to work toward ending homelessness in this state ~~in order to best meet the needs of the homeless~~.

(k) Formulate policies and legislative proposals aimed at preventing and ending homelessness in this state ~~to address more effectively the needs of the homeless~~ and coordinate the implementation of state and federal legislative policies.

(l) Convene meetings and workshops of state and local agencies, continuums of care ~~local coalitions and programs~~, and other stakeholders for the purpose of developing and reviewing policies, services, activities, coordination, and funding of efforts to end homelessness ~~meet the needs of the homeless~~.

(m) With the input of the continuums of care, conduct or promote research on the effectiveness of current programs and propose pilot projects aimed at ending homelessness ~~improving services~~.

(n) Serve as an advocate for issues relating to homelessness.

(o) Investigate ways to improve access to participation in state funding and other programs for the prevention and reduction ~~alleviation~~ of homelessness to faith-based organizations and collaborate and coordinate with faith-based organizations.

(4) The State Office on Homelessness~~, with the concurrence~~

~~of the Council on Homelessness,~~ shall accept and administer moneys appropriated to it to provide annual "challenge grants" to lead agencies of ~~homeless assistance~~ continuums of care designated by the State Office on Homelessness under ~~pursuant to~~ s. 420.6225 ~~s. 420.624~~. The department shall establish varying levels of grant awards up to $750,000 ~~$500,000~~ per continuum of care lead agency. The department, in consultation with the Council on Homelessness, shall specify a grant award level in the notice of the solicitation of grant applications.

(a) To qualify for the grant, a continuum of care lead agency must develop and implement a local ~~homeless assistance~~ continuum of care plan for its designated catchment area. The services and housing funded through the grant must be implemented through the continuum of care's ~~care plan must implement a~~ coordinated entry ~~assessment or central intake~~ system as provided in s. 420.6225(5)(b) and must be designed to ~~screen,~~ assess~~,~~ and refer persons seeking assistance to the appropriate housing intervention and service provider. The continuum of care lead agency shall also document the commitment of local government or private organizations to provide matching funds or in-kind support in an amount equal to 25 percent of the grant requested. Expenditures of leveraged funds or resources, including third-party cash or in-kind contributions, are authorized only for eligible activities carried out in connection with a ~~committed on one~~ project in which such funds

or resources have not been used as leverage or match for any other project or program. The expenditures ~~and~~ must be certified through a written commitment.

(b) Preference must be given to those continuum of care lead agencies that have demonstrated the ability of their continuum of care to help households move out of homelessness ~~provide quality services to homeless persons and the ability to leverage federal homeless-assistance funding under the Stewart B. McKinney Act with local government funding or private funding for the provision of services to homeless persons~~.

~~(c) Preference must be given to lead agencies in catchment areas with the greatest need for the provision of housing and services to the homeless, relative to the population of the catchment area.~~

(c)~~(d)~~ The grant may be used to fund any of the housing, program, or service needs included in the local ~~homeless assistance~~ continuum of care plan. The continuum of care lead agency may allocate the grant to programs, services, or housing providers that implement the local ~~homeless assistance~~ continuum of care plan. The continuum of care lead agency may provide subgrants to a local agency to implement programs or services or provide housing identified for funding in the continuum of care lead agency's application to the department. A continuum of care lead agency may spend a maximum of 10 ~~8~~ percent of its funding on administrative costs.

(d) ~~(c)~~ The continuum of care lead agency shall submit a final report to the department documenting the outcomes achieved by the grant-funded programs ~~grant~~ in enabling persons who are homeless to return to permanent housing, thereby ending such person's episode of homelessness.

(5) The State Office on Homelessness~~, with the concurrence of the Council on Homelessness,~~ may administer moneys given ~~appropriated~~ to it to provide homeless housing assistance grants annually to continuum of care lead agencies ~~for local homeless assistance continuum of care, as~~ recognized by the State Office on Homelessness~~,~~ to acquire, construct, or rehabilitate ~~transitional or~~ permanent housing units for homeless persons. These moneys shall consist of any sums that the state may appropriate, as well as money received from donations, gifts, bequests, or ~~otherwise from~~ any other public or private source, which are intended to acquire, construct, or rehabilitate ~~transitional or~~ permanent housing units for homeless persons.

(a) Grant applicants shall be ranked competitively based on criteria that include, but are not limited to, all of the following:

1. The ability of the continuum of care to provide quality services.

2. The ability of the continuum of care to leverage federal homeless assistance and private funding.

3. The extent of the need for providing housing and

services to individuals experiencing homelessness in a continuum of care's planning areas relative to the population of the counties served.

4. The effectiveness of the continuum of care in keeping families housed ~~Preference must be given to applicants who leverage additional private funds and public funds, particularly federal funds designated for the acquisition, construction, or rehabilitation of transitional or permanent housing for homeless persons; who acquire, build, or rehabilitate the greatest number of units; or who acquire, build, or rehabilitate in catchment areas having the greatest need for housing for the homeless relative to the population of the catchment area~~.

(b) Funding for any particular project may not exceed $750,000.

(c) Projects must reserve, for a minimum of 20 ~~10~~ years, the number of units acquired, constructed, or rehabilitated through homeless housing assistance grant funding to serve persons who are homeless at the time they assume tenancy.

(d) No more than two grants may be awarded annually in any given ~~local homeless assistance~~ continuum of care catchment area.

(e) A project may not be funded which is not included in the local ~~homeless assistance~~ continuum of care plan, as recognized by the State Office on Homelessness, for the catchment area in which the project is located.

(f) The maximum percentage of funds that the State Office on Homelessness and each applicant may spend on administrative costs is 10 ~~5~~ percent.

(6) The State Office on Homelessness, in conjunction with the Council on Homelessness, shall establish performance measures related to state funding provided through the State Office on Homelessness and use those grant-related measures to ~~and specific objectives by which it may~~ evaluate the performance and outcomes of continuum of care lead agencies that receive state grant funds. ~~Challenge Grants made through the State Office on Homelessness shall be distributed to lead agencies based on their overall performance and their achievement of specified objectives. Each lead agency for which grants are made under this section shall provide the State Office on Homelessness a thorough evaluation of the effectiveness of the program in achieving its stated purpose. In evaluating the performance of the lead agencies, the State Office on Homelessness shall base its criteria upon the program objectives, goals, and priorities that were set forth by the lead agencies in their proposals for funding. Such criteria may include, but are not limited to, the number of persons or households that are no longer homeless, the rate of recidivism to homelessness, and the number of persons who obtain gainful employment.~~

(7) The State Office on Homelessness must monitor the

challenge grants and homeless housing assistance grants to ensure proper expenditure of funds and compliance with the conditions of the applicant's contract.

(8) The Department of Children and Families, with input from the Council on Homelessness, may ~~must~~ adopt rules relating to the challenge grants and the homeless housing assistance grants and related issues consistent with the purposes of this section.

(9) The Council on Homelessness ~~council~~ shall, by June 30 of each year, provide to the Governor, the Legislature, and the Secretary of Children and Families a report summarizing the extent of homelessness in the state and the council's recommendations for ending ~~reducing~~ homelessness in this state.

(10) The State Office on Homelessness may administer moneys appropriated to it for distribution among the continuum of care lead agencies and entities funded in the 2018-2019 state fiscal year which are designated by the office as local coalitions for the homeless ~~28 local homeless continuums of care designated by the Department of Children and Families~~.

Section 3. Section 420.6225, Florida Statutes, is created to read:

420.6225 Continuum of care.—

(1) The purpose of a continuum of care, as defined in s. 420.621, is to coordinate community efforts to prevent and end homelessness in its catchment area designated as provided in

subsection (3) and to fulfill the responsibilities set forth in this chapter.

(2) Under the federal HEARTH Act of 2009, each continuum of care is required to designate a collaborative applicant that is responsible for submitting the continuum of care funding application for the designated catchment area to the United States Department of Housing and Urban Development. The designated continuum of care collaborative applicant shall serve as the point of contact for the State Office on Homelessness, is accountable for representations made in the application, and, in carrying out responsibilities under this chapter, may be referred to as the continuum of care lead agency.

(3) Continuum of care catchment areas must be designated and revised as necessary by the State Office on Homelessness and must be consistent with the continuum of care catchment areas recognized by the United States Department of Housing and Urban Development for the purposes of awarding federal homeless assistance funding for continuum of care programs.

(4) The State Office on Homelessness shall recognize only one continuum of care lead agency for each designated catchment area. Such continuum of care lead agency must be consistent with the designated continuum of care collaborative applicant recognized by the United States Department of Housing and Urban Development in the awarding of federal funds to continuums of care.

(5) Each continuum of care shall create a continuum of care plan, the purpose of which is to implement an effective and efficient housing crisis response system to prevent and end homelessness in the continuum of care catchment area. A continuum of care plan must include all of the following components:

(a) Outreach to unsheltered individuals and families to link them with appropriate housing interventions.

(b) A coordinated entry system, compliant with the requirements of the federal HEARTH Act of 2009, which is designed to coordinate intake, utilize common assessment tools, prioritize households for housing interventions, and refer households to the appropriate housing intervention.

(c) Emergency shelter, designed to provide safe temporary shelter while the household is in the process of obtaining permanent housing.

(d) Supportive services, designed to maximize housing stability once the household is in permanent housing.

(e) Permanent supportive housing, designed to provide long-term affordable housing and support services to persons with disabilities who are moving out of homelessness.

(f) Rapid ReHousing, as specified in s. 420.6265.

(g) Permanent housing, including links to affordable housing, subsidized housing, long-term rental assistance, housing vouchers, and mainstream private sector housing.

(h) An ongoing planning mechanism to end homelessness for all subpopulations of persons experiencing homelessness.

(6) Continuums of care must promote participation by all interested individuals and organizations and may not exclude individuals and organizations on the basis of race, color, national origin, sex, handicap, familial status, or religion. Faith-based organizations, local governments, and persons who have experienced homelessness are encouraged to participate. To the extent possible, these individuals and organizations must be coordinated and integrated with other mainstream health, social services, and employment programs for which homeless populations may be eligible, including, but not limited to, Medicaid, the state Children's Health Insurance Program, the Temporary Assistance for Needy Families Program, the Food Assistance Program, and services funded through the Mental Health and Substance Abuse Block Grant, the Workforce Innovation and Opportunity Act, and the welfare-to-work grant program.

Section 4. Section 420.6227, Florida Statutes, is created to read:

420.6227 Grant-in-aid program.—

(1) LEGISLATIVE FINDINGS.—The Legislature finds and declares that many services for households experiencing homelessness have been provided by local communities through voluntary private agencies and religious organizations and that those resources have not been sufficient to prevent and end

homelessness in the state. The Legislature recognizes that the level of need and types of problems associated with homelessness may vary from community to community, due to the diversity and geographic distribution of the homeless population and the resulting differing needs of particular communities.

(2) PURPOSE.—The principal purpose of the grant-in-aid program is to provide needed assistance to continuums of care to enable them to do all of the following:

(a) Assist persons in their communities who have become, or may likely become, homeless.

(b) Help homeless households move to permanent housing as quickly as possible.

(3) ESTABLISHMENT.—There is established a grant-in-aid program to help continuums of care prevent and end homelessness, which may include any aspect of the local continuum of care plan, as described in 420.6225.

(4) APPLICATION PROCEDURE.—Continuums of care that intend to apply for the grant-in-aid program must submit an application for grant-in-aid funds to the State Office on Homelessness for review.

(5) SPENDING PLANS.—The State Office on Homelessness shall develop guidelines for the development, evaluation, and approval of spending plans that are created by local continuum of care lead agencies.

(6) ALLOCATION OF GRANT FUNDS.—The State Office on

Homelessness shall administer grant-in-aid funds for continuums of care, which must be awarded on a competitive basis.

(7) DISTRIBUTION TO LOCAL AGENCIES.—The State Office on Homelessness shall distribute funds awarded under subsection (6) to local agencies to fund programs that are required by the local continuum of care plan, as described in s. 420.6225 and provided in subsection (3), based upon the recommendations of the local continuum of care lead agencies, in accordance with spending plans that are developed by the lead agencies and approved by the office. Not more than 10 percent of the total state funds awarded under a spending plan may be used by the continuum of care lead agency for staffing and administrative expenditures.

(8) LOCAL MATCHING FUNDS.—If an entity contracts with local agencies to provide services and receives financial assistance obtained under this section, the entity must provide at least 25 percent of the funding necessary for the support of project operations. In-kind contributions, including, but not limited to, materials, commodities, transportation, office space, other types of facilities, or personal services may be evaluated and counted as part or all of the required local funding, at the discretion of the State Office on Homelessness.

Section 5. Section 420.623, Florida Statutes, is repealed.

Section 6. Section 420.624, Florida Statutes, is repealed.

Section 7. Section 420.625, Florida Statutes, is repealed.

Section 8. Subsection (3) of section 420.626, Florida Statutes, is amended, and subsection (2) of that section is republished, to read:

420.626 Homelessness; discharge guidelines.—

(2) The following facilities and institutions are encouraged to develop and implement procedures designed to reduce the discharge of persons into homelessness when such persons are admitted or housed for more than 24 hours at such facilities or institutions: hospitals and inpatient medical facilities; crisis stabilization units; residential treatment facilities; assisted living facilities; and detoxification centers.

(3) The procedures should include all of the following:

(a) Development and implementation of a screening process or other mechanism for identifying persons to be discharged from the facility or institution who are at considerable risk for homelessness or face some imminent threat to health and safety upon discharge.~~;~~

(b) Development and implementation of a discharge plan addressing how identified persons will secure housing and other needed care and support upon discharge.~~;~~

(c) Communication with ~~Assessment of the capabilities of~~ the entities to whom identified persons may potentially be discharged to determine their capability to serve such persons and their acceptance of such persons into their programs, and

selection of the entity determined to be best equipped to provide or facilitate the provision of suitable care and support.~~;~~

(d) Coordination of effort and sharing of information with entities that are expected to bear the responsibility for providing care or support to identified persons upon discharge.~~;~~ ~~and~~

(e) Provision of sufficient medication, medical equipment and supplies, clothing, transportation, and other basic resources necessary to ensure ~~assure~~ that the health and well-being of identified persons are not jeopardized upon their discharge.

Section 9. Section 420.6265, Florida Statutes, is amended to read:

420.6265 Rapid ReHousing.—

~~(1) LEGISLATIVE FINDINGS AND INTENT.—~~

~~(a) The Legislature finds that Rapid ReHousing is a strategy of using temporary financial assistance and case management to quickly move an individual or family out of homelessness and into permanent housing.~~

~~(b) The Legislature also finds that public and private solutions to homelessness in the past have focused on providing individuals and families who are experiencing homelessness with emergency shelter, transitional housing, or a combination of both. While emergency shelter and transitional housing programs~~

~~may provide critical access to services for individuals and families in crisis, the programs often fail to address their long-term needs.~~

~~(c) The Legislature further finds that most households become homeless as a result of a financial crisis that prevents individuals and families from paying rent or a domestic conflict that results in one member being ejected or leaving without resources or a plan for housing.~~

~~(d) The Legislature further finds that Rapid ReHousing is an alternative approach to the current system of emergency shelter or transitional housing which tends to reduce the length of time a person is homeless and has proven to be cost effective.~~

~~(e) It is therefore the intent of the Legislature to encourage homeless continuums of care to adopt the Rapid ReHousing approach to preventing homelessness for individuals and families who do not require the intense level of supports provided in the permanent supportive housing model.~~

~~(2) RAPID REHOUSING METHODOLOGY.—~~

(1)~~(a)~~ The Rapid ReHousing response to homelessness differs from traditional approaches to addressing homelessness by focusing on each individual's or family's barriers to housing. By using this approach, communities can significantly reduce the amount of time that individuals and families are homeless and prevent further episodes of homelessness.

(2) ~~(b)~~ In Rapid ReHousing, when an individual or a family is identified as being homeless, the individual or family is assessed and prioritized for housing through the continuum of care's coordinated entry system, temporary assistance is provided to allow the individual or family to obtain permanent housing as quickly as possible, and necessary~~, if needed,~~ assistance is provided to allow the individual or family to retain housing.

(3) ~~(c)~~ The objective of Rapid ReHousing is to provide assistance for as short a term as possible so that the individual or family receiving assistance attains stability and integration into the community as quickly as possible ~~does not develop a dependency on the assistance~~.

Section 10. Section 420.6275, Florida Statutes, is amended to read:

420.6275 Housing First.—

~~(1) LEGISLATIVE FINDINGS AND INTENT.—~~

~~(a) The Legislature finds that many communities plan to manage homelessness rather than plan to end it.~~

~~(b) The Legislature also finds that for most of the past two decades, public and private solutions to homelessness have focused on providing individuals and families who are experiencing homelessness with emergency shelter, transitional housing, or a combination of both. While emergency shelter programs may provide critical access to services for individuals~~

~~and families in crisis, they often fail to address their long-term needs.~~

~~(c) The Legislature further finds that Housing First is an alternative approach to the current system of emergency shelter or transitional housing which tends to reduce the length of time of homelessness and has proven to be cost-effective.~~

~~(d) It is therefore the intent of the Legislature to encourage homeless continuums of care to adopt the Housing First approach to ending homelessness for individuals and families.~~

~~(2) HOUSING FIRST METHODOLOGY.—~~

(1)~~(a)~~ The Housing First approach to homelessness provides permanent ~~differs from traditional approaches by providing~~ housing assistance, followed by ~~case management, and~~ support services responsive to individual or family needs once ~~after~~ housing is obtained. By using this approach ~~when appropriate~~, communities can significantly reduce the amount of time that individuals and families are homeless and prevent further episodes of homelessness. Housing First emphasizes that social services provided to enhance individual and family well-being can be more effective when people are in their own home, and:

(a)~~1.~~ The housing is not time-limited.

(b)~~2.~~ The housing is not contingent on compliance with services. Instead, participants must comply with a standard lease agreement.

(c) Individuals and families ~~and~~ are provided with

individualized ~~the~~ services and support ~~that are~~ necessary to help them maintain stable housing ~~do so successfully~~.

~~3. A background check and any rehabilitation necessary to combat an addiction related to alcoholism or substance abuse has been completed by the individual for whom assistance or support services are provided.~~

(2)~~(b)~~ The Housing First approach addresses the societal causes of homelessness and advocates for the immediate return of individuals and families into housing and communities. Housing First links affordable housing with community-based social service and health care organizations ~~Housing First provides a critical link between the emergency and transitional housing system and community-based social service, educational, and health care organizations~~ and consists of four components:

(a)~~1.~~ Crisis intervention and short-term stabilization.

(b)~~2.~~ Screening, intake, and needs assessment.

(c)~~3.~~ Provision of housing resources.

(d)~~4.~~ Provision of case management.

Section 11. Paragraph (d) of subsection (22) of section 420.507, Florida Statutes, is amended to read:

420.507 Powers of the corporation.—The corporation shall have all the powers necessary or convenient to carry out and effectuate the purposes and provisions of this part, including the following powers which are in addition to all other powers granted by other provisions of this part:

(22) To develop and administer the State Apartment Incentive Loan Program. In developing and administering that program, the corporation may:

(d) In counties or rural areas of counties that do not have existing units set aside for homeless persons, forgive indebtedness for loans provided to create permanent rental housing units for persons who are homeless, as defined in s. 420.621 ~~s. 420.621(5)~~, or for persons residing in time-limited transitional housing or institutions as a result of a lack of permanent, affordable housing. Such developments must be supported by a ~~local homeless assistance~~ continuum of care developed under s. 420.6225 ~~s. 420.624~~, be developed by nonprofit applicants, be small properties as defined by corporation rule, and be a project in the local housing assistance continuum of care plan recognized by the State Office on Homelessness.

Section 12. This act shall take effect July 1, 2020.

HB 309

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 309 Prohibited Acts by Health Care Practitioners
SPONSOR(S): Massullo
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	12 Y, 2 N	Siples	McElroy
2) Health Care Appropriations Subcommittee	10 Y, 0 N	Mielke	Clark
3) Health & Human Services Committee		Siples	Calamas

SUMMARY ANALYSIS

The Division of Medical Quality Assurance (MQA), within the Department of Health (DOH), has general regulatory authority over health care practitioners. The MQA works in conjunction with 22 boards and four councils to license and regulate seven types of health care facilities and more than 40 health care professions, including allopathic physicians, osteopathic physicians, and podiatric physicians.

An unlicensed individual may be subject to administrative action or criminal penalties if the individual states or otherwise implies that he or she is a licensed medical professional. This may include the use of certain terms or titles that the public generally associates with a specific medical profession. DOH does not license a physician's specialty or sub-specialty based upon board certification, but does limit who can hold themselves out as board-certified specialists.

HB 309 prohibits a health care practitioner from knowingly using certain names or titles if the health care practitioner is not authorized under the law as an allopathic physician, osteopathic physician, or podiatric physician. The bill authorizes DOH to impose administrative penalties on a health care practitioner who violates this provision.

The bill has an indeterminate, but likely insignificant, negative fiscal impact on DOH, which current resources are adequate to absorb. The bill has no fiscal impact on local governments.

The bill takes effect upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Licensure and Regulation of Physicians

The Division of Medical Quality Assurance (MQA), within the Department of Health (DOH), has general regulatory authority over health care practitioners.[1] The MQA works in conjunction with 22 boards and four councils to license and regulate seven types of health care facilities and more than 40 health care professions, including Medical Doctors (allopathic physicians), Doctors of Osteopathic Medicine (osteopathic physicians), and Doctors of Podiatric Medicine (podiatric physicians).[2] Each profession is regulated by an individual practice act and by ch. 456, F.S., which provides general regulatory and licensure authority for the MQA.

Allopathic Physician Licensure

Chapter 458, F.S., governs licensure and regulation of the practice of medicine by the Florida Board of Medicine (allopathic board) in conjunction with DOH. The chapter imposes requirements for licensure examination and licensure by endorsement.

Allopathic Education and Training Requirements

An individual seeking to be licensed by examination as an allopathic physician must, among other things:

- Complete 2 years of post-secondary education which includes, at a minimum, courses in fields such as anatomy, biology, and chemistry prior to entering medical school;
- Meet one of the following medical education and postgraduate training requirements:
  - Graduate from an allopathic medical school recognized and approved by an accrediting agency recognized by the U.S. Office of Education or recognized by an appropriate governmental body of a U.S. territorial jurisdiction, and have completed at least one year of approved residency training;
  - Graduate from an allopathic foreign medical school registered with the World Health Organization and certified pursuant to statute as meeting the standards required to accredit U.S. medical schools, and have completed at least one year of approved residency training; or
  - Graduate from an allopathic foreign medical school that has not been certified pursuant to statute; have an active, valid certificate issued by the Educational Commission for Foreign Medical Graduates (ECFMG),[3] have passed that commission's examination; and have completed an approved residency or fellowship of at least 2 years in one specialty area; and

[1] Pursuant to s. 456.001(4), F.S., health care practitioners are defined to include acupuncturists, physicians, physician assistants, chiropractors, podiatrists, naturopaths, dentists, dental hygienists, optometrists, nurses, nursing assistants, pharmacists, midwives, speech language pathologists, nursing home administrators, occupational therapists, respiratory therapists, dieticians, athletic trainers, orthotists, prosthetists, electrologists, massage therapists, clinical laboratory personnel, medical physicists, dispensers of optical devices or hearing aids, physical therapists, psychologists, social workers, counselors, and psychotherapists, among others.
[2] Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long-Range Plan, Fiscal Year 2018-2019*, 6, *available at* http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/_documents/annual-report-1819.pdf (last visited October 29, 2019).
[3] A graduate of a foreign medical school does not need to present an ECFMG certification or pass its exam if the graduate received his or bachelor's degree from an accredited U.S. college or university, studied at a medical school recognized by the World Health Organization, and has completed all but the internship or social service requirements, has passed parts I and II of the National Board Medical Examiners licensing examination or the ECFMG equivalent examination. Section 458.311, F.S.

- Obtain a passing score on:
    - The United States Medical Licensing Examination (USMLE);
    - A combination of the USMLE, the examination of the Federation of State Medical Boards of the United States, Inc. (FLEX), or the examination of the National Board of Medical Examiners up to the year 2000; or
    - The Special Purpose Examination of the Federation of State Medical Boards of the United States (SPEX), if the applicant was licensed on the basis of a state board examination, is currently licensed in at least one other jurisdiction of the United States or Canada, and has practiced for a period of at least 10 years. [4]

An individual who holds an active license to practice medicine in another jurisdiction may seek licensure by endorsement to practice medicine in Florida.[5] The applicant must meet the same requirements for licensure by examination. To qualify for licensure by endorsement, the applicant must also submit evidence of the licensed active practice of medicine in another jurisdiction for at least 2 of the preceding 4 years, or evidence of successful completion of either a board-approved postgraduate training program within 2 years preceding filing of an application or a board-approved clinical competency examination within the year preceding the filing of an application for licensure.

Osteopathic Physician Licensure

Chapter 459, F.S., provides for the licensure and regulation of the practice of medicine by the Florida Board of Osteopathic Medicine (osteopathic board) in conjunction with DOH. The chapter imposes requirements for licensure by examination and licensure by endorsement.

Osteopathic Education and Training Requirements

An individual seeking to be licensed as an osteopathic physician must, among other things:[6]

- Graduate from a medical college recognized and approved by the American Osteopathic Association;
- Successfully complete a resident internship of at least 12 months in a hospital approved by the Board of Trustees of the American Osteopathic Association or any other internship approved by the osteopathic board; and
- Obtain a passing score, as established by rule of the osteopathic board, on the examination conducted by the National Board of Osteopathic Medical Examiners or other examination approved by the osteopathic board, no more than five years prior to applying for licensure.[7]

If an applicant for a license to practice osteopathic medicine is licensed in another state, the applicant must have actively practiced osteopathic medicine within the two years prior to applying for licensure in this state.

Podiatric Physicians

Chapter 460, F.S., provides for the licensure and regulation of the practice of podiatric medicine by the Florida Board of Podiatric Medicine (podiatric board) in conjunction with DOH. The chapter imposes requirements for licensure by examination and licensure by endorsement.

Podiatric Education and Training Requirements

An individual seeking to be licensed as a podiatric physician must, among other things:

[4] Section 458.311(1), F.S.
[5] Section 458.313, F.S.
[6] Section 459.0055(1), F.S.
[7] However, if an applicant has been actively licensed in another state, the initial licensure in the other state must have occurred no more than five years after the applicant obtained the passing score on the licensure examination.

- Graduate from a school or college of podiatric medicine or chiropody recognized and approved by the Council on Podiatry Education of the American Podiatric Medical Association;
- Successfully complete a one-year residency program approved by the podiatric board or have continuously practiced for 10 years in another state; and
- Obtain a passing score on the three parts of the national examination conducted by the National Board of Podiatric Medical Examiners.[8]

Unlicensed Practice of a Health Care Profession

Administrative Penalties

Florida law prohibits an individual from practicing a regulated health care profession without a license. An individual must meet minimum education and training requirements to become licensed and practice a health care profession.[9] An unlicensed individual providing healthcare services is subject to administrative and criminal penalties. DOH may issue a cease and desist letter to such a person and impose, by citation, an administrative penalty of up to $5,000 per offense.[10] DOH may also seek a civil penalty of up to $5,000 for each offense through the circuit court, in addition to or in lieu of the administrative penalty.[11] An individual practicing, attempting to practice or offering to practice, a health care profession without an active, valid Florida license is subject to criminal penalties, in addition to any administrative and civil penalties incurred by the unlicensed individual.[12]

Criminal Penalties

It is a third degree felony to practice medicine or attempt to practice medicine without a Florida license, and it is a first degree misdemeanor to lead the public to believe one is licensed to practice as a medical doctor or is engaged in the licensed practice of medicine, without holding a valid, active license.[13] It is a third degree felony to practice osteopathic medicine or attempt to practice osteopathic medicine without a Florida license.[14]

It is a third degree felony to practice podiatric medicine or attempt to practice medicine without a Florida license, and it is a first degree misdemeanor to use the title “podiatrist,” “doctor of podiatry,” “doctor of podiatric medicine,” “foot clinic,” “foot doctor,” “quiropedista,” or any other name, title, or phrase that would lead the public to believe that such person is practicing podiatric medicine, if the person does not hold a Florida license.[15]

Board Certification and Florida Licensure

DOH does not license physicians by specialty or subspecialty; however, current law limits which physicians may hold themselves out as board-certified specialists. An allopathic physician may not hold himself or herself out as a board-certified specialist unless he or she has received formal recognition as a specialist from a specialty board of the American Board of Medical Specialties (ABMS) or other recognizing agency[16] approved by the allopathic board.[17] Additionally, an allopathic physician may not

[8] Rule 64B18-11.002, F.A.C.
[9] s. 456.065(1), F.S.
[10] s. 456.065, F.S. Each day that the unlicensed practice continues after issuance of a notice to cease and desist constitutes a separate offense.
[11] s. 456.065(2)(c), F.S.
[12] s. 456.065(2)(d), F.S.
[13] Section 458.327, F.S. A third degree felony is punishable by a term of imprisonment not exceeding five years and a fine not to exceed $5,000. A first degree misdemeanor is punishable by a term of imprisonment not exceeding one year and a fine not to exceed $1,000. Penalties may be enhanced under certain circumstances. *See* ss. 775.082, 775.083, and 775.084.
[14] Section 459.013, F.S.
[15] Section 461.012, F.S.
[16] The allopathic board has approved the specialty boards of the ABMS as recognizing agencies. Rule 64B8-11.001(1)(f), F.A.C.
[17] Section 458.3312, F.S.

hold himself or herself out as a board-certified specialist in dermatology unless the recognizing agency, whether authorized in statute or by rule, is triennially reviewed and reauthorized by the allopathic board.[18] Similarly, an osteopathic physician may not hold himself or herself out as a board-certified specialist unless he or she has successfully completed the requirements for certification by the American Osteopathic Association (AOA) or the Accreditation Council on Graduate Medical Education (ACGME) and is certified as a specialist by a certifying agency[19] approved by the board.[20]

A podiatric physician may not hold himself or herself out as possessing a credential or certification from an organization unless the organization is approved by the podiatric board.[21] By rule, the American Podiatric Medical Association, the National Council of Competency Assurance, or any of their recognized component or affiliate organizations are approved.[22]

Effect of Proposed Legislation

HB 309 prohibits a health care practitioner from using certain titles unless the health care practitioner is licensed and authorized to use such title as an allopathic physician under chapter 458, F.S., an osteopathic physician under chapter 459, F.S., or a podiatric physician under chapter 461. DOH may impose penalties against any health care practitioner who knowingly uses one of the following titles but is not authorized to do so:

Physician	Gynecologist	Ophthalmologist
Surgeon	Hematologist	Orthopedic Surgeon
Medical Doctor	Hospitalist	Orthopedist
Doctor of Osteopathy	Internist	Osteopath
M.D.	Interventional Pain	Otologist
Anesthesiologist[23]	Medicine Physician	Otolaryngologist
Cardiologist	Laryngologist	Otorhinolaryngologist
Dermatologist	Nephrologist	Pathologist
Endocrinologist	Neurologist	Pediatrician
Gastroenterologist	Obstetrician	Podiatrist
General Practitioner	Oncologist	Primary Care Physician
Proctologist	Radiologist	Rhinologist
Psychiatrist	Rheumatologist	Urologist

In addition to these titles, the bill prohibits an unauthorized person from using any other words, letters, abbreviations, or insignia that indicates or implies that he or she is authorized to practice as such.

If a board or DOH, if there is no board, finds that a health care practitioner has violated this provision, the bill authorizes the board or DOH to:[24]

- Refuse to certify or to certify with restrictions, an application for a license;
- Suspend or permanently revoke a license;

[18] Id.
[19] The osteopathic board has approved the specialty boards of the ABMS and AOA as recognizing agencies. Rule 64B15-14.001(h), F.A.C.
[20] Section 459.0152, F.S.
[21] Rule 64B18-14.004(i), F.A.C.
[22] Id.
[23] The bill defines an anesthesiologist as an allopathic or osteopathic physician who holds an active, unrestricted license; who has successfully completed an anesthesiology training program by the Accreditation Council on Graduate Medical Education or its equivalent, or the American Osteopathic Association; and who is certified by the American Board of Certification or the American Osteopathic Board of Anesthesiology, or is eligible to take the certification exam of either board, or is certified by the Board of Certification in Anesthesiology affiliated with the American Association of Physician Specialties. *See* ss. 458.3475(1) and 459.023(1), F.S.
[24] Section 426.072(2), F.S.

- Restrict the license;
- Impose an administrative fine, not to exceed $10,000 for each count or separate offense;
- Issue a reprimand or letter of concern;
- Place the licensee on probation for a period of time and subject to the conditions of the board or DOH, if there is no board;
- Impose corrective action;
- Require the licensee to refund of fees billed and collected from the patient or a third party on behalf of the patient; or
- Require that the licensee undergo remedial education.

In determining which penalty to impose, the board or DOH, if there is no board, must consider what is necessary to protect the public or to compensate the patient.[25]

The bill takes effect upon becoming law.

B. SECTION DIRECTORY:

Section 1: Amends s. 456.072, F.S.; relating to grounds for discipline; penalties; enforcement.
Section 2: Provides an effective date of upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   DOH may experience an increase in revenue if health care practitioners are found to have violated the provisions of the bill and DOH imposes an administrative fine. It is not known how many health care practitioners may violate the provisions of the bill.

2. Expenditures:

   DOH may experience an indeterminate, but likely insignificant, negative fiscal impact due to an increase in investigation and enforcement actions. It is not known how many health care practitioners may violate the provisions of the bill but it is estimated current resources are adequate to absorb these costs.[26]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Health care practitioners who are found to have violated the provisions of the bill may be required to pay an administrative fine or otherwise be disciplined.

D. FISCAL COMMENTS:

None.

[25] Id.
[26] Department of Health, *Agency Legislative Analysis for HB 309*, on file with the Health Quality Subcommittee.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill limits the use of the term “physician” to health care practitioners licensed under chs. 458, 459, and 461, F.S., which appears to conflict with several statutory provisions that describe the term “physician”:

- Sections 456.039 and 456.031, F.S., include those licensed under ch. 460, F.S., (chiropractic medicine) in the term;
- Section 456.056, F.S., provides that the term includes those licensed under ch. 460, F.S., and ch. 463, F.S. (optometry);
- Section 456.073(12)(b), F.S., provides that the term includes those licensed under ch. 460, F.S., and ch. 466, F.S. (dentistry); and
- Section 456.44, F.S, includes those licensed under ch. 466, F.S., in its description of a physician.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to prohibited acts by health care practitioners; amending s. 456.072, F.S.; authorizing disciplinary action to be enforced by the Department of Health for the use of specified names or titles without a valid license or certification to practice as such; providing a definition; providing an effective date.

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

Section 1. Paragraph (pp) is added to subsection (1) of section 456.072, Florida Statutes, to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(pp)1. Knowingly using the name or title "physician," "surgeon," "medical doctor," "doctor of osteopathy," "M.D.," "anesthesiologist," "cardiologist," "dermatologist," "endocrinologist," "gastroenterologist," "general practitioner," "gynecologist," "hematologist," "hospitalist," "internist," "interventional pain medicine physician," "laryngologist," "nephrologist," "neurologist," "obstetrician," "oncologist," "ophthalmologist," "orthopedic surgeon," "orthopedist,"

"osteopath," "otologist," "otolaryngologist," "otorhinolaryngologist," "pathologist," "pediatrician," "podiatrist," "primary care physician," "proctologist," "psychiatrist," "radiologist," "rheumatologist," "rhinologist," or "urologist," or any other words, letters, abbreviations, or insignia indicating or implying that he or she is authorized by chapter 458, chapter 459, or chapter 461 to practice as such. If the department finds any person guilty of the grounds set forth in this paragraph, it may enter an order imposing one or more of the penalties provided in subsection (2).

2. For purposes of this paragraph, "anesthesiologist" has the same meaning as provided in s. 458.3475 or s. 459.023.

Section 2. This act shall take effect upon becoming a law.

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Massullo offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Section 456.0465, Florida Statutes, is created to read:

456.0465 Health care practitioners; prohibited actions.—

(1)(a) A health care practitioner licensed by the department may not use the name or title "family physician," emergency physician," "surgeon," "dentist," "medical doctor," "doctor of osteopathy," "doctor of dental medicine," "doctor of dental surgery," "M.D.," "D.M.D.," "D.D.S.," "anesthesiologist," "cardiologist," "dermatologist," "endocrinologist," "endodontist," "gastroenterologist," "general practitioner,"

"gynecologist," "hematologist," "hospitalist," "internist," "interventional pain medicine physician," "laryngologist," "nephrologist," "neurologist," "obstetrician," "oncologist," "ophthalmologist," "oral and maxillofacial surgeon," "orthodontist," "orthopedic surgeon," "orthopedist," "osteopath," "otologist," "otolaryngologist," "otorhinolaryngologist," "pathologist," "pediatrician," "physiatrist," "pedodontist," "periodontist," "podiatrist," "primary care physician," "proctologist," "prosthodontist," "psychiatrist," "radiologist," "rheumatologist," "rhinologist," or "urologist," or any other words, letters, abbreviations, or insignia indicating or implying that he or she is licensed or authorized by chapter 458, chapter 459, chapter 461, or chapter 466 to practice as such, unless he or she is licensed and authorized by one of those chapters, or is registered with the appropriate board as an allopathic, osteopathic, or podiatric physician or dentist pursuant to s. 456.47(4), to practice as such.

(b) If the department finds that any licensed health care practitioner has violated paragraph (a), the department shall issue a notice to the practitioner to cease and desist the use of such name, title, words, letters, abbreviations, or insignia. The department shall send the cease and desist notice to the practitioner by certified mail and email to the practitioner's physical address and email address of record with the department

and to any other mailing address or email address through which the department believes the person may be reached.

(c) If the practitioner does not cease and desist his or her actions in violation of paragraph (a) immediately upon receipt of the notice to cease and desist, the department shall enter an order imposing one or more of the following penalties until the practitioner complies with the notice to cease and desist:

1. A citation and a daily fine.

2. A reprimand or a letter of concern.

3. Suspension of license.

(d) Notwithstanding paragraphs (a)-(c):

1. A doctor of chiropractic medicine licensed under chapter 460, or a chiropractic physician registered with the board of chiropractic medicine pursuant to s. 456.47(4), to practice as such, may use the name or title "doctor of chiropractic medicine" or "chiropractic physician."

2. A licensed chiropractic physician who has achieved diplomate or fellow status from the American Board of Chiropractic Specialties, American Chiropractic Board of Sports Physicians, American College of Chiropractic Orthopedists, American Chiropractic Neurology Board, International Chiropractors Association, or International Chiropractic Pediatric Association, or in a specific specialty or subspecialty, may use, as appropriate for his or her diplomate

or fellow status, "chiropractic radiologist," "chiropractic internist," "chiropractic neurologist," "chiropractic orthopedist," or "chiropractic pediatrician," in addition to other names or titles associated with such diplomate or fellow status.

3. A licensed dentist who has achieved diplomate status or board certification from the American Board of Dental Public Health, the American Board of Endodontics, the American Board of Oral and Maxillofacial Pathology, the American Board of Oral and Maxillofacial Radiology, the American Board of Oral and Maxillofacial Surgery, the American Board of Orthodontics, the American Board of Pediatric Dentistry, the American Board of Periodontology, the American Board of Prosthodontics, the American Board of Oral Implantology/Implant Dentistry, the American Board of Oral Medicine, the American Board of Orofacial Pain, the American Dental Board of Anesthesiology, or the American Board of General Dentistry, in a specific specialty or subspecialty, may use, as appropriate for his or her diplomate status or board certification, the name or term "dental anesthesiologist," "doctor of oral medicine," "dental oral and maxillofacial radiologist," "dental orthodontic and dentofacial orthopedist," or "dental oral and maxillofacial pathologist," in addition to other names or titles associated with such diplomate status or board certification.

(2) The department may adopt rules to implement this section.

Section 2. This act shall take effect upon becoming a 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 prohibited acts by health care practitioners; creating s. 456.0465, F.S.; specifying names and titles that licensed health care practitioners are prohibited from using under certain circumstances; requiring the Department of Health to a notice to cease and desist for specified violations; providing exceptions; providing for service of the notice; providing penalties; authorizing the department to adopt rules; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 319 Florida Guide to a Healthy Marriage
SPONSOR(S): Civil Justice Subcommittee, Yarborough and others
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 682

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Civil Justice Subcommittee	13 Y, 0 N, As CS	Rochester	Luczynski
2) Health & Human Services Committee		Woodruff	Calamas
3) Judiciary Committee			

SUMMARY ANALYSIS

A marriage license is required to be married in Florida. Among other requirements for issuance, a couple seeking a marriage license must certify that they have read the family law handbook, which outlines the legal rights and responsibilities of marital partners to each other and to their children. Florida law also incentivizes, but not does require, completion of a premarital preparation course by reducing the marriage license fee and waiving a three-day waiting period for couples who complete the course.

CS/HB 319 creates the Florida Healthy Marriage Handbook and provides the handbook's required language. The handbook contains resources regarding conflict management, communication skills, financial responsibilities, and parenting responsibilities. As a prerequisite to obtaining a marriage license, applicants must verify that they have read or otherwise accessed either the guide or an alternative electronic presentation of information contained in the Family Law Handbook prepared by the Family Law Section of the Florida Bar and the Florida Healthy Marriage Handbook.

Each clerk of courts is required to make the guide available on its website and to make printed copies available to marriage license applicants if the committee has furnished them to the clerk.

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

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

A marriage license issued by a county court judge or the clerk of the circuit court is required in order to be married in Florida.[1] To be married, the parties must:

- Be at least 18 years old, subject to some exceptions;[2]
- Provide their social security number or other identification;[3]
- Obtain and read or otherwise access Florida's family law handbook;[4]
- Provide a written statement verifying that they have completed a premarital preparation course;[5]
- Pay the required fees;[6]
- Complete an application, required affidavits, and statements;[7] and
- Appear before the clerk or judge in person.[8]

Reading Florida's family law handbook is a prerequisite to receiving a marriage license.[9] The Family Law Section of The Florida Bar created the family law handbook, which covers the legal rights and responsibilities of marital partners to each other and to their children, both during a marriage and upon dissolution.[10] The Family Court Steering Committee and Florida Supreme Court reviews the handbook for accuracy prior to publication and distribution.[11] The clerk of court must make the handbook available upon application for a marriage license and may also make it available through electronic means or on videotape.[12] The book is 16 half-pages long and covers:

- Economic issues during marriage and upon the dissolution of marriage, including:
  - Assets;
  - Liabilities;
  - How the court divides assets and liabilities upon divorce;
  - Alimony;
  - Rights to assets upon the death of a spouse.
- Child-related issues, including:
  - Paying for children's expenses after divorce;
  - Making decisions for the children after divorce;
  - Where the children will live after divorce;
  - Contact with children;
  - Step-parenting.
- Domestic violence and child abuse;
- The process for ending a marriage; and
- Community resources.[13]

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[1] Ss. 741.01 and 741.08, F.S.
[2] S. 741.04(1) F.S.
[3] S. 741.04(2)(a), F.S.
[4] S. 741.0306, F.S.
[5] S. 741.04(2)(a), F.S.
[6] Ss. 741.01 & 741.02, F.S.
[7] Ss. 741.01(1) & 741.04, F.S.
[8] S. 741.04(2), F.S.
[9] Ss. 741.04(2)(b) & 741.0306, F.S.
[10] S. 741.0306(1); The Florida Bar, *Family Law Handbook*, https://www.marioncountyclerk.org/familylawhandbook (last viewed Feb. 5, 2020).
[11] S. 741.0306(1), F.S.
[12] S. 741.0306, F.S.
[13] The Florida Bar, *supra* note 10.

Although a couple is not required to complete a premarital preparation course, doing so reduces the marriage license fees and allows a couple to bypass a three-day waiting period.[14]

There were 156,168 marriages in Florida in calendar year 2018, and 77,054 dissolutions.[15] Both the marriage rate and the rate of dissolution have remained relatively constant in Florida over the past decade. Florida's rates of both marriage and dissolution have consistently been slightly above national averages.[16]

Year	Marriages			Dissolutions		
	Florida		U.S.	Florida		U.S.
	Number	Rate	Rate	Number	Rate	Rate
2007	155,998	8.4	7.5	84,386	4.6	3.6
2008	147,888	7.9	7.3	79,868	4.3	3.5
2009	139,127	7.4	7.1	78,752	4.2	3.5
2010	137,250	7.3	6.8	83,342	4.4	3.6
2011	140,900	7.4	6.8	84,785	4.5	3.6
2012	140,467	7.3	6.8	81,490	4.3	3.4
2013	137,127	7.1	6.8	80,619	4.2	3.3
2014	145,250	7.4	6.9	79,432	4.1	3.2
2015	166,921	8.4	6.9	80,204	4.0	3.1
2016	167,416	8.3	6.9	79,677	3.9	3.2
2017	163,746	8.0	6.9	75,781	3.7	2.9
2018	156,168	7.5	N/A	77,054	3.7	N/A

NOTE: The rates reflected above are rates per 1,000 population

Effect of Proposed Changes

CS/HB 319 creates the Florida Healthy Marriage Handbook and provides the handbook's required language. The handbook contains resources regarding conflict management, communication skills, financial responsibilities, and parenting responsibilities. As a prerequisite to obtaining a marriage license, applicants must verify that they have read or otherwise accessed either the guide or an alternative electronic presentation of information contained in the Family Law Handbook prepared by the Family Law Section of the Florida Bar, and the Florida Healthy Marriage Handbook.

Each of the state's clerks of court must make the guide available on its website and provide printed copies, if any are available, to marriage license applicants. The clerk of the circuit court is also encouraged to provide a list of course providers and sites where marriage and relationship skill-building classes are available.

The bill provides an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Creates s. 741.0307, F.S., relating to Marriage Education Committee; Florida Guide to a Healthy Marriage.
Section 2: Amends s. 741.04, F.S., relating to issuance of marriage license.
Section 3: Provides an effective date of July 1, 2020.

[14] Ss. 741.0305 & 741.04(4)(a), F.S.
[15] Florida Bureau of Vital Statistics, *Florida Vital Statistics Annual Report* (July 2019), http://www.flpublichealth.com/VSBOOK/pdf/2016/Marriage.pdf (last visited Feb. 5, 2020).
[16] *Id*. In this context, the term "dissolution" refers to both divorces and annulments.

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:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 4, 2020, the Civil Justice Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment:

- Removed provisions relating to the Marriage Education Committee.
- Clarified that the Florida Healthy Marriage Handbook supplements the Family Law Handbook created by the Family Law Section of the Florida Bar.
- Provided language contained in the Florida Healthy Marriage Handbook.

This analysis is drafted to the committee substitute as passed by the Civil Justice Subcommittee.

A bill to be entitled

An act relating to the Florida Healthy Marriage Handbook; creating s. 741.0307, F.S.; creating the Florida Healthy Marriage Handbook; providing requirements for the handbook; providing for distribution of printed copies of the handbook under certain circumstances; requiring clerks of court to post electronic copies of the handbook on its website and make the handbook available to certain applicants; encouraging clerks of court to provide a list of course providers and websites where certain classes are available; amending s. 741.04, F.S.; prohibiting the issuance of a marriage license until petitioners verify that both parties have obtained and read the Florida Healthy Marriage Handbook or some other presentation of similar information; providing an effective date.

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

Section 1. Section 741.0307, Florida Statutes, is created to read:

741.0307 Florida Healthy Marriage Handbook.—

(1) There shall be created a handbook which includes resources, information, and website links to assist in forming

and maintaining a long-term marital relationship. This handbook is supplemental to the Family Law Handbook created under s. 741.0306.

(2) The handbook shall read substantially as follows:

Introduction

Congratulations! You have made the decision to get married. This decision means that you and your partner agree to enter into a formal contract. This contract outlines the conditions of your new partnership. This partnership impacts the ownership of your money and possessions and the way you relate to each other. When you talk about your marriage expectations before getting married, you begin to understand the new roles and responsibilities. This mutual understanding helps to lay a foundation that can help you build a successful, enduring marriage.

The purpose of this handbook is to provide information to marriage license applicants that can help to create successful marriages. It includes topics such as learning to communicate effectively, building the team, solving problems collaboratively, and resolving conflicts. The handbook also provides general information on economic issues, raising a family, and the consequences that occur when marriages fail.

Building a Marriage

As you and your spouse begin your journey together, the first thing you will need to know is where you are going. Your shared destination is determined by your personal and shared values. The marriage journey will require lots of decisions from both of you. Through mutual respect, trust, honesty, and love, you will have a rewarding trip.

Understanding Your Values

Your values are the foundation for all of your thinking and decision-making. Every decision you make is an effort to align your actions to your values. When you marry, you will be sharing your life with another person. It is so important that you know your own values and the values of your intended spouse. Think about the values you consider sacred in your life and share this information with your partner.

Discuss these issues prior to making a marriage commitment. Build upon your mutual ideals. A harmonious, lasting marriage will be built upon a foundation of shared values and the effective communication of these values.

Building Your Team

Marriage is a team effort. One of the definitions of the word team is "a group of persons pulling together." Talking to each other and sharing in decisions that affect both team members is very important. Talking, listening, and valuing your partner's ideas and contributions will make your marriage team strong and healthy.

Learning Effective Communication

Learning to communicate effectively requires commitment from both you and your partner. It takes time and LOTS of energy, but it is worth the effort. To commune literally means "to put in common; to share." The goal of effective communication is to create a common understanding with your partner. This common understanding is the cement of a strong marriage. Honesty is an essential component of effective communication. However, honesty must be tempered with kindness. Good communication between both of you promotes mutual trust and respect.

Successful marriages depend on good communication between both partners. Learning to be a good communicator takes patience and practice.

Resolving Conflicts

Another step in building a lasting marriage is learning to examine and confront issues effectively. Couples in the healthiest marriages experience conflicts. Conflicts are normal because you and your partner have different beliefs and opinions. Conflict is simply a clash between these beliefs and opinions. The cause of conflict is that you and your partner see and approach situations and events differently. Conflict results when there are opposite points of view and each person believes that their viewpoint is right, and their partner's viewpoint is wrong. The result is two different interpretations.

People in conflict are seldom upset about what they think they are upset about. One event may trigger an emotional outburst. The outburst often is caused by a series of unresolved issues. A win/lose situation will not solve the problem. Resolving conflicts effectively strives to achieve a win/win solution for both of you. How can you find an answer that benefits you and your partner? The first step is for the two of you to step out of the battle and look beyond the event that created the conflict. The next step is to shift your focus to your common interests, mutual values, and positive qualities.

Refocusing your own thinking helps to calm emotions. You can

redirect your thinking — and your partner's — to what you both really want: an activity or mutual goal, something more satisfying than the conflict. Couples can change their conflict experiences by changing their thoughts about the situation.

Keeping the Marriage Vital

When you first get married, usually everything is new and exciting. But how do you keep your marriage new and exciting year after year? You have started a lifelong journey together. This journey will have many stops along the way. Each of your destinations will bring maturity to your relationship and to each of you. Your affection for each other increases through the lessons that you learn together and the laughter and the tears that you share. It is a good journey! Couples who can laugh together under challenging circumstances and gain the understanding of true friendship keep their marriage vital.

Addressing Economic Issues

As you prepare for your new journey as a couple, you have several financial issues to discuss. What financial resources and obligations do you bring into your marriage? Do you have business debts? Will you combine your finances and have joint checking and savings accounts or maintain separate accounts? Who

will pay the bills? Will you develop a budget together?

Talking to each other about how you plan to earn, spend, and save your money is easier when you agree on priorities. Your marriage benefits from forming and sticking to a spending plan that includes discussion and agreement.

Sharing Financial Responsibilities

It is wise to make major financial decisions together. You both will be responsible for those decisions. If you are uncomfortable at the thought of sharing financial responsibilities with your intended spouse, you might want to seek premarital counseling to determine underlying issues and to decide if marriage is the right decision for you at this time.

One of you may be better at balancing a checkbook, paying the bills, and developing a budget. As you take this marital journey with your partner, talk with each other about which one of you is best suited to do specific financial tasks. Then, after you are married, try out your new system! Adjust it if it doesn't work well.

Here are some specific financial planning tips. Decide together:

If you will maintain one joint checking account or separate individual checking accounts. Who will pay the bills and maintain the checking account(s)? How often and how much personal allowance each of you should receive. What is an appropriate savings and investment plan? How you will pay for large purchases such as automobiles and major appliances.

Building a Budget

Building a budget helps you to know how much income you will have, how much money you will spend, and how much money will be left over. It helps you to control your spending. A budget helps you to save money!

What are some steps to assist you?

1. Identify your financial goals: short range (e.g., buying groceries and gasoline) and long term (e.g., buying a house, setting up a college fund for your children).

2. Look at your current financial position. What is your monthly household income? What are your debts?

3. Write out a monthly budget for 12 months. Write out monthly expenses in the different categories (e.g., $300 car payment, $600 rent). Estimate how much you will spend in each category.

4. Compare your budget to your financial goals. Is there

money left over after meeting your monthly obligations? If so, how much of the leftover money can be used for your goals? If you follow the budget you set up, how long will it take you to reach your goals?

5. Compare your actual costs to the costs you budgeted. Was your budget realistic?

6. Review and revise your budget. Stay on track toward meeting your joint financial goals.

7. Decide who will work, who will provide childcare, and who will obtain further formal education.

8. How much insurance will be necessary?

It is important to make your budget realistic and flexible. Major categories of expenses are: rent or mortgage payment; utilities; food and household goods; clothing; healthcare; insurance premiums; tuition, charitable donations; transportation; household maintenance; credit card debt; hobbies and entertainment; vacation and holiday savings; and other expenses, such as cosmetics, hair care, veterinary fees (if you have pets), gifts, plants, and artwork.

Certain budget items are fundamental expenditures or "absolutes", such as housing, food, and transportation. Other budget items are less important. Hobbies, vacations, gifts, and artwork are a lower priority than shelter and food. These are

"discretionary" expenditures. Prioritize your budget items, starting with "absolutes."

Involve your spouse in major budget decisions. Talk together about the mutual benefit and impact of your budget decisions. For example, what should you do if one of you wants a new computer while the other wants new carpet, and there is money for only one of the two items?

Which of the purchases is most needed and beneficial to both of you? What is the impact on the quality of your life together if you buy the computer? The carpeting? Set your purchasing priorities together. Be a team working towards your shared financial goals.

Raising a Family

Deciding to start a family is a BIG decision! The change you experienced when your household became two, triples with the addition of a child! Children bring great joy, sleepless nights, and new roles and responsibilities for both of you.

Parenthood is a lifetime commitment. It requires emotional maturity from both partners. Raising children can be the most satisfying experience when both of you are ready to make this

unselfish commitment.

Taking Responsibility for Raising Children

The decision to have children needs to be mutual. Children bring an enormous change to your relationship with each other. Some of the spontaneity that you once had as a couple may change. Fatigue from early childcare demands and feelings of uncertainty in your new roles can cause temporary marital stress. Career and childcare decisions, economic implications and new financial demands, and new housing requirements will need to be discussed. But the joys of parenthood outweigh the tensions of change.

Raising a child is a team effort and requires both partners to be active participants. You are bringing into the world a new human being who will require your full support physically, emotionally, socially, instructionally, and economically. Both of you are responsible for your child's care. This mutual responsibility for the care of your child or children never ends. When you agreed to have a child, you signed on for life.

Coping with Family Challenges

Sometimes raising children can be very difficult. You may find that you need help. Some children have problems making friends,

getting along in school, and staying out of trouble with the law. Family counseling can strengthen families by providing a safe place to explore issues and resolve problems.

Walking Rocky Roads

If sad times start to outweigh happy times with your spouse, you are walking a lonely, rocky road in your marriage. Examine your own life, your spouse's life, and your relationship with each other. If you and your spouse can renew your love and commitment to each other, together you can remove the obstructions in your marriage. Professional counselors and/or members of the clergy may help you remove some of the boulders in your marriage path. Depending on the type of problems you encounter, you may find specific support groups and counseling classes to help you. Also refer to the phone book or online directories for listings of counselors, support groups, religious organizations, and other community resources.

Conclusion

This free handbook is one way that the State of Florida is showing its support of your decision to marry. The information has been intended to be a basic roadmap to guide you. The State of Florida hopes that you have a happy and healthy marriage!

Again, congratulations!

(3) The clerk of the circuit court shall post an electronic copy of the handbook on its website. Additionally, if printed copies of the handbook are made available to the office of the clerk of the circuit court, the clerk shall make the handbook available to marriage license applicants. The clerk of the circuit court is encouraged to provide a list of course providers and sites where marriage and relationship skill-building classes are available.

Section 2. Paragraph (b) of subsection (4) of section 741.04, Florida Statutes, is amended to read:

741.04 Issuance of marriage license.—

(4) A county court judge or clerk of the circuit court may not issue a license for the marriage of any person unless the county court judge or clerk of the circuit court is first presented with both of the following:

(b) A written statement that verifies that both parties have obtained and read or otherwise accessed the information contained in the handbooks ~~handbook~~ or other electronic media presentation of the rights and responsibilities of parties to a marriage specified in s. 741.0306 and 741.0307.

Section 3. This act shall take effect July 1, 2020.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 559 Institutional Formularies Established by Nursing Home Facilities
SPONSOR(S): Byrd
TIED BILLS: **IDEN./SIM. BILLS:** SB 1020

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	13 Y, 1 N	Siples	Calamas
2) Health Care Appropriations Subcommittee	11 Y, 0 N	Nobles	Clark
3) Health & Human Services Committee		Siples	Calamas

SUMMARY ANALYSIS

Nursing homes provide 24 hour a day care, case management, health monitoring, personal care, nutritional meals and special diets, physical, occupational, and speech therapy, social activities, and respite care for those who are ill or physically infirm. In providing such care, nursing homes acquire, dispense, or administer prescription medications to residents.

For most medicines, there exist several similar or alternative products which can be either generic or therapeutically equivalent brand name drugs. Therapeutic substitution is the practice of dispensing drugs that are chemically distinct from the prescribed drug, but therapeutically similar in terms of their efficacy, safety, and tolerability profiles. Therapeutic substitution is designed to achieve an improved or neutral outcome with a different drug, while reducing overall treatment costs. Currently, a pharmacist must dispense a prescription for a nursing home resident as written, unless substituting a generic or biosimilar drug. Otherwise, a pharmacist must contact the prescribing physician and request a new prescription.

HB 599 authorizes a nursing home facility to establish an institutional formulary by which a pharmacist may use therapeutic substitution without a new prescription to replace a resident's prescribed drug with a chemically different drug listed in the formulary that is expected to have the same clinical effect.

The bill requires each prescriber to opt into the institutional formulary for all the prescriber's patients entering the nursing home and allows a prescriber to opt out of the institutional formulary with regard to a specific patient, a particular drug, or a class of drugs. The bill authorizes a pharmacist to perform a therapeutic substitution in accordance with a nursing home's institutional pharmacy if the prescriber has agreed to its use.

The bill has an insignificant, negative fiscal impact on the Agency for Health Care Administration, which can be absorbed within existing resources. The bill has no fiscal impact on local governments.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Nursing Home Facilities

Nursing homes provide 24 hour a day care, case management, health monitoring, personal care, nutritional meals and special diets, physical, occupational, and speech therapy, social activities, and respite care for those who are ill or physically infirm.[1] Nursing homes are regulated by the Agency for Health Care Administration (AHCA) under the Health Care Licensing Procedures Act (Act) in part II of chapter 408, F.S., which provides licensure requirements for all provider types regulated by AHCA, and part II of chapter 400, F.S., which includes unique provisions for nursing home licensure beyond the uniform criteria in the Act.

Resident Rights

Florida law requires nursing homes to adopt the residents' bill of rights[2], which provides the rights and responsibilities of residents, and requires nursing homes to treat such residents in accordance with its provisions.[3] Nursing homes must provide a copy of the resident's bill of rights to each resident or the resident's legal representative at or before the resident's admission to the facility.[4] The residents' bill of rights include, among other things, the right to:[5]

- Civil and religious liberties, including knowledge of available choices and the right to independent personal decision, which will not be infringed upon, and the right to encouragement and assistance from staff to exercise these rights;
- Be adequately informed of his or her medical condition and proposed treatment, unless the resident is determined to be unable to provide informed consent under Florida law, or the right to be fully informed in advance of any nonemergency changes in care or treatment that may affect the resident's well-being; and except with respect to a resident adjudged incompetent, the right to participate in the planning of all medical treatment, including the right to refuse medication and treatment; and
- Receive adequate and appropriate health care and protective and support services.

The staff of the nursing home must receive training on resident rights and also be provided a copy of the resident's rights.[6] A nursing home may be subject to administrative fines, emergency moratorium on admissions, or denial, suspension, or revocation of license if it violates a resident's rights.[7]

Nursing Home Pharmacy Services

Nursing homes must adopt procedures to assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident.[8] Nursing homes must also employ the services of a state licensed consultant pharmacist to provide consultation on all

[1] Agency for Health Care Administration, *Nursing Homes*, available at https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Long_Term_Care/Nursing_Homes.shtml (last visited December 6, 2019).
[2] Rule 59A-4.106(1)(a)1., F.A.C.
[3] Section 400.022(1), F.S.
[4] Section 400.022(2), F.S.
[5] *Supra* note 3.
[6] Id.
[7] Section 400.022(3), F.S. The action imposed by AHCA will be dependent on the scope of the violation and the gravity of its probably effect on the residents. *See* part II of ch. 408, F.S.
[8] Rule 59A-4.112(1), F.A.C.

aspects of the provision of pharmacy services in the facility. Other duties of the consultant pharmacist include:[9]

- Establishing a system to accurately record the receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and
- Ensuring that all drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Prescription drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles.[10] Nursing homes must also maintain an emergency medication kit containing a limited supply of medications in the facility for use during emergency or after-hours situations. The contents of the kit is determined by the residents' needs, in consultation with the medical director, director of nursing, and pharmacist and must be in accordance with facility policies and procedures.[11]

Pharmacies

The Florida Pharmacy Act regulates the practice of pharmacy and contains the minimum requirements for safe practice.[12] The Board of Pharmacy (board) is tasked with adopting rules to implement the provisions of the chapter and setting standards of practice within the state.[13] Any person who operates a pharmacy in Florida must have a permit from the Department of Health (DOH).

DOH issues several types of pharmacy permits, including those for community pharmacies and institutional pharmacies. A community pharmacy is a location where medicinal drugs are compounded, dispensed, stored, or sold or where prescriptions are filled or dispensed on an outpatient basis;[14] generally, retail pharmacies such as CVS or Walgreens. An institutional pharmacy is a location in a hospital, clinic, nursing home, dispensary, sanitarium, extended care facility, or other facility where medicinal drugs are compounded, dispensed, stored, or sold.[15]

DOH issues four classes of permits for institutional pharmacies.[16] A Class I institutional pharmacy is a pharmacy in which all medicinal drugs are administered from individual prescription containers to the individual patient and in which medicinal drugs are not dispensed on the premises.[17] No medicinal drugs may be dispensed in a Class I Institutional pharmacy. A Special- Closed System Pharmacy Permit, Special Parenteral and Enteral Pharmacy Permit, or Community Pharmacy Permit fills and dispense individual patient prescriptions.

A Class II institutional pharmacy is a pharmacy which employs the services of a registered pharmacist who, in practicing institutional pharmacy, provides dispensing and consulting services on the premises to patients of that institution, for use on the premises of that institution.[18] A consultant pharmacist of record is responsible for establishing a written policy and procedure manual for the implementation of the drug delivery system and the requirement of Board rules.[19]

[9] Rule 59A-4.112(2)(3)(4), F.A.C.
[10] Rule 59A-4.112(5), F.A.C.
[11] Rule 59A-4.112(10), F.A.C.
[12] Chapter 465, F.S.
[13] Sections 465.005, 465.0155, and 465.022, F.S.
[14] Sections 465.003(11)(a)1. and 465.018, F.S.
[15] Sections 465.003(11)(a)2. and 465.019, F.S.
[16] Section 465.019, F.S.
[17] Section 465.019(2)(a), F.S.
[18] Section 465.019(2)(b), F.S.
[19] Rule 64B16-28.702, F.A.C.

A modified Class II institutional pharmacy is a pharmacy in a short-term, primary care treatment center that meet all the requirements for a Class II permit, except space and equipment requirements.[20] Modified Class II Institutional pharmacies are further classified according to the type of specialized pharmaceutical delivery system utilized.[21]

A Class III institutional pharmacy is a pharmacy, including central distribution facilities affiliated with a hospital that provides the same services as a Class II institutional pharmacy, but may also dispense, distribute, compound, and fill prescriptions for medicinal drugs and prepare prepackaged drug products.[22]

Formularies

A drug formulary is a continually updated list of medications supported by the clinical judgment of physicians, pharmacists, and other experts in the diagnosis, prophylaxis, or treatment of disease and promotion of health.[23] The purpose of a formulary is to encourage the use of safe, effective, and most affordable medication.[24] Formularies are primarily used by health care payers, such as employers and insurers, to reduce costs.

Institutional Formularies

An institutional formulary system is a method by which the medical staff evaluates, appraises, and selects those medicinal drugs or proprietary preparations, which, in the medical staff's clinical judgment, are the most useful in patient care, and which are available for dispensing by a practicing pharmacist in a Class II or Class III institutional pharmacy.[25] Under current law, a facility with a Class I or Class II institutional pharmacy that operates under a formulary system must establish policies and procedures for the development of the system in accordance with the joint standards of the American Hospital Association and American Society of Hospitals Pharmacists for the utilization of a hospital formulary system, which must be approved by medical staff.[26] Such standards include the following requirements.[27]

- An organized and representative pharmacy and therapeutics (P&T) committee or equivalent body, composed of actively participating physicians, other prescribers, pharmacists, nurses, administrators, quality improvement managers, and other health care professionals and staff who participate in the medication use process.
- Policies formulated by the P&T committee regarding evaluation, selection, diagnostic and therapeutic use, and monitoring of medications.
- Mechanisms to communicate to health care professionals, patients, and payers about all aspects of the formulary system, including changes to the formulary or policies and formulary decisions are made.

According to the joint standards of the American Hospital Association and American Society of Hospitals Pharmacists, a formulary system must also:[28]

- Evaluate the clinical use of medications (outcomes);

[20] Section 465.019(c)(c), F.S.
[21] *Supra* note 19.
[22] Section 465.019(2)(d), F.S.
[23] American Society of Health System Pharmacists, *ASHP Statement on the Pharmacy and Therapeutics Committee and the Formulary System,* AM J HEALTH SYST PHARM, 2008, 65:2384-6, available at https://www.ashp.org/-/media/assets/policy-guidelines/docs/statements/pharmacy-and-therapeutics-committee-and-formulary-system.ashx (last visited December 5, 2019).
[24] Academy of Managed Care Pharmacy, *Formulary Management*, (Nov. 2009), available at https://amcp.org/sites/default/files/2019-03/Formulary%20Management.pdf (last visited December 5, 2019).
[25] Section 465.003(7), F.S.
[26] Section 465.019(6), F.S.
[27] *Supra* note 23.
[28] Id.

- Establish and implement policies and quality assurance activities for medication use and administration;
- Evaluate and monitor adverse drug reactions and medication errors;
- Be endorsed by medical staff based on recommendations of the P&T committee; and
- Ensure that all personnel involved in patient care are informed about the existence of the formulary system, how to access the formulary system, the procedures governing operation, any changes in those procedures, and other necessary information.

Under these standard, an evidence-based institutional formulary, the P&T committee must:[29]

- Timely revise and maintain the formulary;
- Promote the rational, clinically appropriate, safe, and cost-effective use of medications via guidelines, protocols, and other mechanisms;
- Objectively appraise, evaluate, and select medications for addition to or deletion from the formulary, on an ongoing basis;
- Select formulary items based on their relative economic, clinical, and humanistic outcomes and not solely on economic factors;
- Identify potential safety concerns for each medication considered for inclusion and ensure those concerns are addressed if the medication is added to the formulary;
- Clearly define terminology related to the formulary; and
- Evaluate coordination issues with local health care plans and other organizations' formularies.

The formulary should be published and updated regularly.[30] It should also be readily available and accessible at all times to all personnel involved in patient care and the use of medications.[31] The P&T committee should also recommend or assist in the formulation of educational programs for professional staff, patients, families, and caregivers related to medications and medication use.

Similarly, the American Medical Association (AMA), recommends that institutional formularies meet the following standards:[32]

- Have the concurrence of the organized medical staff;
- Openly provide detailed methods and criteria for the selection and objective evaluation of all available pharmaceuticals;
- Have policies for the development, maintenance, approval, and dissemination of the drug formulary and for continuous and comprehensive review of formulary drugs;
- Provide for protocols for the procurement, storage, distribution, and safe use of formulary and non-formulary drugs;
- Have enough qualified medical staff, pharmacists, and other professionals to carry out required activities;
- Include policies that state practitioners will not be penalized for prescribing non-formulary drugs that are medically necessary; and
- Be in compliance with applicable state and federal rules and statutes.

Therapeutic Substitution of Prescription Drugs

For most medicines, there exist several similar or alternative products which can be either generic or therapeutically equivalent brand-name drugs.[33] Therapeutic substitution is the practice of switching or dispensing drugs that are chemically distinct but therapeutically similar in terms of their efficacy, safety,

[29] Id.
[30] Id.
[31] Id.
[32] Id.
[33] Rachel Chu, et al, *Patient Safety and Comfort - The Challenges of Switching Medicines* (2010), p. 8, available at http://www.patients-rights.org/uploadimages/Patient_Safety_and_Comfort_The_Challenges_of_Switching.pdf (last visited December 5, 2019).

and tolerability profiles.[34] Therapeutic substitution is designed to achieve an improved or neutral outcome by using the new drug, while reducing overall treatment costs.[35]

Substitution of brand name drugs may include substituting a brand-name drug for its generic equivalent. Generic drugs are copies of brand-name drugs with the same dosage form, safety, strength, route of administration, quality, and performance characteristics.[36] Therapeutic substitution may also involve brand name products that have been deemed to have therapeutic equivalence with an originally prescribed medicine or therapy.[37] These drugs will have a different chemical composition and use a different active ingredient than the originally prescribed drug.[38]

The AMA recommends therapeutic interchange, as long as it is authorized by the prescriber and occurs in accordance with previously established and approved written guidelines or protocols within a formulary system.[39] The AMA further states that facilities that perform therapeutic interchanges must inform the prescriber in a timely manner of any substitutions and allow the prescriber to override the system when necessary, without in appropriate burden. Such facilities must also provide active surveillance mechanisms to regularly monitor both compliance with standards and clinical outcomes where substitution has occurred, and intercede when indicated.

Three states authorize therapeutic substitution in community pharmacies: Arkansas, Idaho, and Kentucky.[40] In general, the prescriber must opt-in to allow the therapeutic substitution and the pharmacist must notify the prescriber of any interchanges made.[41] Arkansas and Idaho also require patient notification and allow patients to refuse the substitution.[42]

Some states authorize therapeutic substitution in institutional pharmacies. For example, Idaho, authorizes therapeutic substitution in a nursing home based on a formulary developed by the Board of Pharmacy.[43] Connecticut allows a medical director of a nursing home to substitute a prescribed drug for a resident of the facility, but requires approval from the prescriber before making the substitution.[44] Wisconsin authorizes a pharmacist to make therapeutic substitutions for a nursing home patient if approved by the patient's attending physician for the patient's period of stay within the nursing facility.[45]

Pharmacist Substitution in Florida

Florida law requires pharmacists to substitute a less expensive generic medication for a prescribed brand name medication.[46] The presenter of the prescription may specifically request the brand name medication to override this requirement.[47] The prescriber may also prevent substitution by indicating the brand name medication is "medically necessary" in writing, orally, or, in the case of an electronic

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[34] Flood, J., Mihalik, C., Fleming, R., Strober, B., Zucker, D., & Burgoyne, D., "The Use of Therapeutic Interchange for Biologic Therapies," Managed Care Magazine, January 2007, p. 51. http://www.managedcaremag.com/archives/0701/0701.peer_switch.html (last visited December 5, 2019).
[35] Id.
[36] U.S. Food and Drug Administration, *Generic Drug Facts*, (last rev. June 1, 2018), available at http://www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/understandinggenericdrugs/default.htm (last visited December 5, 2019).
[37] Id.
[38] *Supra* note 33.
[39] American Medical Association, "Drug Formularies and Therapeutic Interchange H-125.991," (last rev. 2010), available at https://policysearch.ama-assn.org/policyfinder/detail/Drug%20Formularies%20and%20Therapeutic%20Interchange%20H-125.991?uri=%2FAMADoc%2FHOD.xml-0-227.xml (last visited December 5, 2019),
[40] Vanderholm, T. Klepser, D., & Adams, A., "State Approaches to Therapeutic Interchange in Community Pharmacy Settings: Legislative and Regulatory Authority," J MANAG CARE SPEC PHARM, Dec. 2018, 24(12): 1260-1263, available at https://www.jmcp.org/doi/10.18553/jmcp.2018.24.12.1260 (last visited December 6, 2019).
[41] Id.
[42] Id.
[43] Rule 27.01.03, ID Admin. Code.
[44] *See* CT Public Act No. 12-30.
[45] Wis. Stat. s. 450.01.
[46] Section 465.025(2), F.S.
[47] Id.

transmission of the prescription, by making an overt act to indicate the brand name medication is "medically necessary."[48] The Board of Pharmacy and the Board of Medicine establish a formulary which lists brand name medications and generic medications they determine to be so clinically different as to be biologically and therapeutically inequivalent, which cannot be substituted.[49]

Florida law allows a pharmacist to substitute a biosimilar[50] for a prescribed biological product[51] if the biosimilar has been determined by the U.S. Food and Drug Administration to be interchangeable with the prescribed biological product and the prescriber does not express a preference against substitution in writing, orally, or electronically.[52] The ability of a pharmacist to substitute a biosimilar for a prescription biological product is permissive unlike the substitution of brand name drugs with generic drugs, which is mandatory.

For generic and biosimilar substitution, the pharmacist must notify the patient and advise the patient of the right to reject the substitution and request the prescribed brand name medication or biologic.[53]

Florida law does not specifically authorize a pharmacist to substitute a therapeutically equivalent, but chemically different, drug for a prescribed drug without the express authorization of the prescriber.

Effect of Proposed Changes

HB 599 authorizes a nursing home facility to establish an institutional formulary through which a pharmacist may use therapeutic substitution. This would allow a pharmacist to replace a resident's prescribed drug with a chemically different drug listed in the formulary that is expected to have the same clinical effect.

To implement an institutional formulary, a nursing home facility must:

- Establish a committee, which consists of the medical director, director of nursing, and a consultant pharmacist, to develop the institutional formulary, as well as written guidelines or procedures for the formulary;
- Establish methods and criteria for selecting and objectively evaluating available drugs that may be used as therapeutic substitutes;
- Establish and maintain policies and procedures for developing and maintaining an institutional formulary and for approving, disseminating, and notifying prescribers of the formulary and make such policies and procedures available to AHCA, upon request; and
- Quarterly monitor compliance with the established policies and procedures and the clinical outcomes of therapeutic substitutions.

Each prescriber must annually opt into the use of the institutional formulary, as well as any subsequent changes to the formulary. However, a prescriber who has authorized the use of the institutional formulary for his or her patients may opt out of the formulary with respect to an individual patient, drug, or class of drugs. If a prescriber does not want a therapeutic substitution for a particular prescription, the prescriber must indicate "NO THERAPEUTIC SUBSTITUTION" on the prescription. In cases in which the prescriber has opted out of the formulary, a pharmacist must dispense the drug or drugs as prescribed. The bill prohibits a nursing home facility from taking adverse action against a prescriber who refuses to agree to the use of its institutional formulary.

[48] Id.
[49] Section 465.025(6), F.S.; *see also* Rule 64B-16.27.500, F.A.C.
[50] 42 U.S.C. s. 262 (h) defines a "biosimilar" is a biological product that is highly similar to the licensed biological product or reference product, that notwithstanding minor differences in clinically inactive components, has no clinically meaningful differences in terms of safety, purity, and potency of the product.
[51] 42 U.S.C. s. 262 (h) defines "biological product" as a virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, protein, or analogous product, or arsphenamine or derivative of
[52] Section 465.0252(2), F.S. arsphenamine, applicable to the prevention, treatment, or cure of a disease or condition.
[53] Sections 465.025(3)(a) and 465.0252(2)(c), respectively.

The bill authorizes a pharmacist to perform a therapeutic substitution in accordance with a nursing home's institutional pharmacy if the prescriber has agreed to its use. The pharmacist may not therapeutically substitute a drug if the prescriber indicates verbally or electronically, "NO THERAPEUTIC SUBSTITUTION".

The bill does not require the nursing home facility to notify the prescriber when a substitution is made, as required in other states that authorize therapeutic substitutions. The bill also does not require that the facility notify the resident or resident's representative of a therapeutic substitution, or advise the resident or the resident's representative that the nursing home has implemented an institutional formulary. The resident's bill of rights in current law may require the nursing home facility to inform the resident of the use of an institutional formulary and substitutions planned for the resident, as the resident has the right to be informed of and participate in the planning of all medical treatment.

The bill provides an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Creates s. 400.143, F.S., relating to institutional formularies established by nursing home facilities.
Section 2: Amends s. 465.025, F.S., relating to substitution of drugs.
Section 3: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   AHCA may experience an insignificant, nonrecurring, negative fiscal impact to amend rules and survey materials to ensure nursing homes that adopt institutional formularies comply with the bill's requirements.

   The bill has no impact on the Medicaid program, which uses a preferred drug list and prior authorization protocol; the institutional formularies authorized by the bill would not apply to Medicaid patients.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Patients and nursing home facilities who receive a bundled payment for Medicare Part A patients may experience cost savings if a less expensive drug is therapeutically substituted for a prescribed drug, in instances where patients and nursing homes incur drug costs. It is unclear whether private insurers using their own formularies would experience an economic impact.

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:

AHCA has sufficient rulemaking authority in ss. 400.23 and 408.819, F.S., to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to institutional formularies established by nursing home facilities; creating s. 400.143, F.S.; providing definitions; authorizing a nursing home facility to establish and implement an institutional formulary; requiring a nursing home facility to establish a committee to develop an institutional formulary; providing for committee membership; providing requirements for the development and implementation of the institutional formulary; requiring a nursing home facility to maintain the written policies and procedures for the institutional formulary; requiring a nursing home facility to make available such policies and procedures to the Agency for Health Care Administration, upon request; requiring a prescriber to annually authorize the use of the institutional formulary for certain patients; requiring the prescriber to opt into any changes made to the institutional formulary; authorizing a prescriber to opt out of using the institutional formulary or to prevent a therapeutic substitution under certain circumstances; prohibiting a nursing home facility from taking adverse action against a prescriber for refusing to agree to the use of the institutional formulary; amending s. 465.025, F.S.;

authorizing a pharmacist to therapeutically substitute medicinal drugs under an institutional formulary established by a nursing home facility under certain circumstances; prohibiting a pharmacist from therapeutically substituting a medicinal drug under certain circumstances; providing an effective date.

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

Section 1. Section 400.143, Florida Statutes, is created to read:

400.143 Institutional formularies established by nursing home facilities.—

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

(a) "Institutional formulary" means a list of medicinal drugs established by a nursing home facility under this section for which a pharmacist may use a therapeutic substitution for a medicinal drug prescribed to a resident of the facility.

(b) "Medicinal drug" has the same meaning as provided in s. 465.003(8).

(c) "Prescriber" has the same meaning as provided in s. 465.025(1).

(d) "Therapeutic substitution" means the practice of replacing a nursing home facility resident's prescribed medicinal drug with another chemically different medicinal drug

that is expected to have the same clinical effect.

(2) A nursing home facility may establish and implement an institutional formulary in accordance with the requirements of this section.

(3) A nursing home facility that implements an institutional formulary under this section must:

(a) Establish a committee to develop the institutional formulary and written guidelines or procedures for such institutional formulary. The committee must consist of, at a minimum:

1. The facility's medical director.

2. The facility's director of nursing services.

3. A consultant pharmacist licensed by the Department of Health and certified under s. 465.0125.

(b) Establish methods and criteria for selecting and objectively evaluating all available pharmaceutical products that may be used as therapeutic substitutes.

(c) Establish policies and procedures for developing and maintaining the institutional formulary and for approving, disseminating, and notifying prescribers of the institutional formulary.

(d) Perform quarterly monitoring to ensure compliance with the policies and procedures established under paragraph (c) and monitor the clinical outcomes in circumstances in which a therapeutic substitution has occurred.

(4) The nursing home facility shall maintain all written policies and procedures for the institutional formulary established under this section. Each nursing home facility shall make available such policies and procedures to the agency, upon request.

(5)(a) A prescriber must annually authorize the institutional formulary for his or her patients. A prescriber must opt into any subsequent changes made to a nursing home facility's institutional formulary.

(b) A prescriber may opt out of the nursing home facility's institutional formulary with respect to a particular patient, medicinal drug, or class of medicinal drugs.

(c) A prescriber may prevent a therapeutic substitution for a specific medication order if such order is provided verbally or generated and transmitted electronically by indicating "NO THERAPEUTIC SUBSTITUTION" on the prescription.

(d) A nursing home facility may not take adverse action against a prescriber for refusing to agree to the use of the facility's institutional formulary.

Section 2. Subsection (9) is added to section 465.025, Florida Statutes, to read:

465.025 Substitution of drugs.—

(9) A pharmacist may therapeutically substitute medicinal drugs in accordance with an institutional formulary established under s. 400.143 for the resident of a nursing home facility if

the prescriber has agreed to the use of such institutional formulary. The pharmacist may not therapeutically substitute a medicinal drug pursuant to the facility's institutional formulary if the prescriber indicates verbally or electronically on the prescription "NO THERAPEUTIC SUBSTITUTION" as authorized under s. 400.143(5)(c).

Section 3. This act shall take effect July 1, 2020.

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Byrd offered the following:

Amendment (with title amendment)

Remove lines 81-94 and insert:

(5)(a) A prescriber using the institutional formulary must authorize its use for each patient. A nursing home facility must obtain the prescriber’s approval for any subsequent change to a nursing home facility's institutional formulary. A prescriber may opt out of the nursing home facility's institutional formulary with respect to a medicinal drug or class of medicinal drugs for any resident. A nursing home facility may not take adverse action against a prescriber for declining to use the facility's institutional formulary.

(b) A nursing home facility must notify the prescriber prior to each therapeutic substitution using a method of communication designated by the prescriber. A nursing home facility must document the therapeutic substitution in the resident's medical records.

(c) A prescriber may prevent a therapeutic substitution for a specific prescription by indicating "NO THERAPEUTIC SUBSTITUTION" on the prescription. If the prescription is provided orally, the prescriber must make an overt action to opt out of therapeutic substitution.

(6) The nursing home facility must obtain informed consent from a resident or a resident's legal representative or designee to the use of the institutional formulary for the resident. The nursing home facility must clearly inform the resident or the resident's legal representative or designee of the right to refuse to participate to the institutional formulary and may not take any adverse action against the resident refusing to agree to the use of the institutional formulary.

Section 2. Subsection (9) is added to section 465.025, Florida Statutes, to read:

465.025 Substitution of drugs.—

(9) A pharmacist may therapeutically substitute medicinal drugs in accordance with an institutional formulary established under s. 400.143 for the resident of a nursing home facility if the prescriber has agreed to the use of such institutional

formulary for the patient. The pharmacist may not therapeutically substitute a medicinal drug pursuant to the facility's institutional formulary if the prescriber indicates on the prescription "NO THERAPEUTIC SUBSTITUTION" or overtly indicates that therapeutic substitution is prohibited as authorized under s. 400.143(5)(c).

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

Remove lines 16-25 and insert:

requiring a prescriber to authorize the use of the institutional formulary for each specific patient; requiring the prescriber to opt into any changes made to the institutional formulary; authorizing a prescriber to opt out of using the institutional formulary or to prevent a therapeutic substitution under certain circumstances; requiring the nursing home facility to notify the prescriber of therapeutic substitutions by a certain method; prohibiting a nursing home facility from taking adverse action against a prescriber for refusing to agree to the use of the institutional formulary; requiring a nursing facility to obtain informed consent from a resident for the use of the institutional formula; requiring a resident be notified of the right to refuse the institutional formulary; prohibiting a nursing home facility from taking adverse action against a

resident for refusing to participate in the institutional formulary; amending s. 465.025, F.S.;

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 573 Peer Support for First Responders
SPONSOR(S): Civil Justice Subcommittee, Casello, McClain
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 160

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Civil Justice Subcommittee	15 Y, 0 N, As CS	Padgett	Luczynski
2) Health & Human Services Committee		Morris	Calamas
3) Judiciary Committee			

SUMMARY ANALYSIS

First responders, such as police officers, firefighters, and paramedics, are often exposed to traumatic events that can lead to post-traumatic stress disorder (PTSD), depression, and suicide. While some first responders report positive experiences with professional mental health help, others felt more distressed after such intervention. Peer support can reduce the stigma, scheduling difficulties, lack of access, lack of trust, and fear or repercussions that may prevent first responders from seeking mental health care.

Communications between a patient and a health care practitioner are confidential under doctor-patient or psychotherapist-patient privilege unless such confidentiality is waived. Florida law does not provide confidentiality for peer support communications between or involving non-practitioners.

CS/HB 573 provides confidentiality for peer support communications between a first responder and a first responder peer. The bill defines "first responder" to include a law enforcement officer, firefighter, emergency medical technician, paramedic, public safety communications officer, dispatcher, or 911 operator.

A "first responder peer" is defined as a person who:

- Is not a health care practitioner;
- Has experience working as or with a first responder regarding any physical or emotional conditions or issues associated with the first responder's employment; and
- Has been designated by the first responder's employing agency to provide peer support.

The bill provides four exceptions for such confidentiality, including:

- The first responder peer is a defendant in a proceeding arising from a complaint filed by the first responder;
- The first responder agrees, in writing, to allow the first responder peer to testify about or divulge information related to the peer support;
- The first responder peer suspects the first responder has committed, or intends to commit, a criminal act; or
- There are articulable facts or circumstances that would lead the first responder peer to fear for the safety of the first responder, another person, or society.

The bill defines a "peer support communication" as an oral communication between a first responder and a first responder peer, made with the mutual expectation of confidentiality, while the first responder peer is acting in his or her official capacity. Accordingly, the bill provides confidentiality for those peer support communications that may not otherwise be protected by doctor-patient privilege or psychotherapist-patient privilege.

The bill has no fiscal impact to state or local governments.

The bill has an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

First Responders

A first responder is a law enforcement officer,[1] firefighter,[2] or an emergency medical technician or paramedic[3] employed by state or local government.[4] Additionally, a volunteer law enforcement officer, firefighter, or emergency medical technician or paramedic engaged by the state or a local government is considered a first responder of the state or local government.[5]

First responders are often exposed to incidents of death and destruction that can result in post-traumatic stress disorder (PTSD), depression, and suicide.[6] A study by the Ruderman Family Foundation revealed that 35 percent of police officers have suffered from PTSD and 46.8 percent of firefighters have experienced suicidal thoughts.[7] Further, a 2015 survey of 4,000 first responders found that 6.6 percent had attempted suicide, which is more than 10 times the rate in the general population.[8] Firefighters are more likely to die by suicide than in the line of duty, according to the Firefighter Behavioral Health Alliance.[9]

Peer Support

Peer support consists of a person in stable recovery from mental health problems helping someone who needs assistance with establishing or maintaining his or her recovery.[10] Peer support services include social supports, such as mentoring, training, peer-led support groups, and assistance completing everyday tasks.[11] Peers are not health care practitioners, but their support extends the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustainable recovery process from mental health issues.[12]
A survey by the Journal of Emergency Medical Services revealed that first responders were less likely to contemplate suicide when they felt supported and encouraged at work.[13] One study showed that

[1] The term "law enforcement officer" means any person who is elected, appointed, or employed full time by any municipality or the state or any political subdivision thereof; who is vested with authority to bear arms and make arrests; and whose primary responsibility is the prevention and detection of crime or the enforcement of the penal, criminal, traffic, or highway laws of the state. The term includes all certified supervisory and command personnel whose duties include, in whole or in part, the supervision, training, guidance, and management responsibilities of full-time law enforcement officers, part-time law enforcement officers, or auxiliary law enforcement officers but does not include support personnel employed by the employing agency. S. 943.10, F.S.
[2] The term "firefighter" means an individual who holds a current and valid Firefighter Certificate of Compliance or Special Certificate of Compliance issued by the Division of State Fire Marshal within the Department of Financial Services. S. 633.102, F.S.
[3] The term "emergency medical technician" means a person who is certified by the Department of Health to perform basic life support. The term "paramedic" means a person who is certified by the Department of Health to perform basic and advanced life support. S. 401.23, F.S.
[4] S. 125.01045, F.S.
[5] *Id.*
[6] Miriam Heyman, Jeff Dill & Robert Douglas, *The Ruderman White Paper on Mental Health and Suicide of First Responders*, RUDERMAN FAMILY FOUNDATION 7, 9 (2018), https://issuu.com/rudermanfoundation/docs/first_responder_white_paper_final_ac270d530f8bfb (last visited Feb. 9, 2020).
[7] *Id.* at 12.
[8] Wes Venteicher, *Increasing suicide rates among first responders spark concerns*, FIRERESCUE NEWS, (Mar. 19, 2017), https://www.firerescue1.com/fire-ems/articles/222673018-Increasing-suicide-rates-among-first-responders-spark-concern/ (last visited Feb. 9, 2020).
[9] Heyman, Dill & Douglas, *supra* note 6, at 19.
[10] Substance Abuse and Mental Health Services Administration, *What Are Peer Recovery Support Services?,* (2009), https://store.samhsa.gov/system/files/sma09-4454.pdf (last visited Feb. 9, 2020).
[11] *Id.*
[12] Substance Abuse and Mental Health Services Administration, *Peers,* https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers (last visited Feb. 9, 2020)
[13] Journal of Emergency Medical Services, *Survey Reveals Alarming Rates of EMS Provider Stress and Thoughts of Suicide*, (Sept. 28, 2015), https://www.jems.com/2015/09/28/survey-reveals-alarming-rates-of-ems-provider-stress-and-thoughts-of-suicide/ (last visited Feb. 9, 2020).

while some firefighters reported positive experiences with professional mental health help, others felt more distressed after such intervention. Alternatively, these firefighters reported benefits from peer support, such as bonding with their fire crew after negative incidents, which can reduce the stigma, scheduling difficulties, lack of access, lack of trust, and fear or repercussions that may prevent first responders from seeking mental health care.[14]

Patient Confidentiality

Communications between a patient and a health care practitioner are confidential.[15] Information that a patient discloses to a health care practitioner may only be disclosed:

- To other health care practitioners involved in the care of the patient;
- If the patient agrees, in writing;
- If compelled by subpoena at a deposition, evidentiary hearing, or trial for which proper notice has been given.[16]

Additionally, confidentiality between a patient and a psychotherapist may be waived where:

- The psychotherapist is a defendant in a proceeding arising from a complaint filed by the patient and information divulged is limited to the scope of the proceeding;
- The patient agrees, in writing, to waiver of confidentiality;
- The psychotherapist believes there is imminent risk of physical harm to the patient or other members of society. The information may only be communicated to potential victims, appropriate family members, law enforcement, or other appropriate authority. There is no liability on the part of the person disclosing information in this circumstance, and no cause of action may arise under this provision.[17]

However, Florida law does not provide confidentiality for peer support communications between or involving non-practitioners.

Effect of Proposed Changes

CS/HB 573 provides confidentiality for peer support communications between a first responder and a first responder peer. First responders include:

- Law enforcement officers;
- Firefighters;
- Emergency medical technicians or paramedics;
- Public safety communications officers;
- Dispatchers; and
- 911 or other phone system operators whose job duties include providing support or services to first responders.

Under the bill, confidentiality applies only to communications with a first responder peer. The first responder peer cannot be a health care practitioner. He or she must have experience working as or with a first responder regarding any physical or emotional conditions or issues associated with the first responder's employment and must be designated by the first responder's employing agency to provide peer support.

The bill provides confidentiality only for peer support communication, which are one or more oral communications between a first responder and a first responder peer. These communications must be made with the mutual expectation of confidentiality, and the first responder must be acting in his or her official capacity, to trigger the confidentiality concerning physical or emotional issues relating to the first responder's employment.

[14] Substance Abuse and Mental Health Services Administration, *First Responders: Behavioral Health Concerns, Emergency Response, and Trauma*, DISASTER TECHNICAL ASSISTANCE CENTER SUPPLEMENTAL RESEARCH BULLETIN (May 2019), 10, 12, https://www.samhsa.gov/sites/default/files/dtac/supplementalresearchbulletin-firstresponders-may2018.pdf (last visited Feb. 9, 2020).
[15] Ss. 456.057, 456.059, 490.0147, 491.0147, and 90.503, F.S.
[16] S. 456.057, F.S.
[17] S. 491.0147, F.S.

The bill prevents a first responder peer from testifying about a peer support communication or otherwise divulging the information from these conversations, except when the person providing peer-to-peer support is a defendant in a proceeding arising from a complaint filed by the first responder and information divulged is limited to the scope of the proceeding. The bill also allows a first responder peer to divulge information if the first responder agrees, in writing, to allow the person to testify about or divulge information related to the peer-to-peer support.

Additionally, the first responder peer may reveal information from conversations with a first responder if he or she suspects the first responder has committed, or intends to commit, a criminal act, or if there are facts or circumstances that would lead a person to fear for the safety of the first responder, another person, or society. Such information may only be communicated to potential victims, appropriate family members, or law enforcement or other appropriate authorities. The bill provides immunity from liability under any cause of action for disclosing information in this circumstance.

The bill provides confidentiality for the peer support conversations that may not otherwise be protected by doctor-patient privilege or psychotherapist-patient privilege. The bill does not preclude first responders from engaging in confidential communications with a health care practitioner; rather, it expands the protection of confidentiality to those informal conversations with peers that relate to any physical or emotional conditions or issues associated with the first responder's employment.

The bill provides an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Creates s. 111.09, F.S., relating to peer-to-peer support for first responders.
Section 2: Provides an effective date of July 1, 2020.

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill does not define the term “peer support” though it allows a first responder who has been designated by his or her employing agency to provide peer support to a peer first responder. It is unclear what services are included as part of “peer support”.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 29, 2020, the Civil Justice Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment:

- Defined “first responder peer” and “peer support communication.”
- Required an employing agency to designate employees who are authorized to provide peer-to-peer support.
- Required the first responder peer to be acting in his or her official capacity for a peer support communication to maintain confidentiality.
- Added an exception to peer support communication confidentiality if the communication causes the first responder peer to suspect the first responder has committed, or intends to commit, a criminal act.

This analysis is drafted to the committee substitute as passed by the Criminal Justice Subcommittee.

A bill to be entitled

An act relating to peer support for first responders; creating s. 111.09, F.S.; providing definitions; prohibiting certain persons who participate in peer support communication with a first responder from testifying or divulging specified information under certain circumstances; providing exceptions; prohibiting liability and a cause of action under certain circumstances; providing construction; providing an effective date.

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

Section 1. Section 111.09, Florida Statutes, is created to read:

111.09 Peer support for first responders.—

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

(a) "First responder" has the same meaning as provided in s. 112.1815 and includes public safety communications officers, dispatchers, and 911 or other phone system operators whose job duties include providing support or services to first responders.

(b) "First responder peer" means a person who:

1. Is not a health care practitioner as defined in s. 456.001.

2. Has experience working as or with a first responder regarding any physical or emotional conditions or issues associated with the first responder's employment.

3. Has been designated by the first responder's employing agency to provide peer support as provided in this section.

(c) "Peer support communication" means one or more oral communications, made with a mutual expectation of confidentiality while a first responder peer is providing peer support in his or her official capacity, between a first responder and a first responder peer for the purpose of discussing physical or emotional conditions or issues associated with being a first responder.

(2) A first responder peer may not divulge information from or testify about a peer support communication in a civil, criminal, administrative, or disciplinary proceeding, unless:

(a) The first responder peer is a defendant in a civil, criminal, administrative, or disciplinary proceeding arising from a complaint filed by the first responder who was a party to the peer support communication, in which case such information may be divulged but is limited to the scope of the proceeding;

(b) The first responder who was a party to the peer support communication agrees, in writing, to allow the first responder peer to testify about or divulge information related to the peer support communications;

(c) Based on the peer support communications, the first

responder peer suspects that the first responder who was a party to the peer support communications has committed a criminal act or intends to commit a criminal act. There is no liability on the part of, and no cause of action of any nature may arise against, the first responder peer for disclosing information under this paragraph; or

(d) There are articulable facts or circumstances that would lead a reasonable, prudent person to fear for the safety of the first responder who was a party to the peer support communication, another person, or society, and the first responder peer communicates the information only to the potential victims, appropriate family members, or law enforcement or other appropriate authorities. There is no liability on the part of, and no cause of action of any nature may arise against, the first responder peer for disclosing information under this paragraph.

(3) This section does not limit the disclosure, discovery, or admissibility of information, testimony, or evidence that is obtained by a first responder peer from a source other than a first responder through a peer support communication.

Section 2. This act shall take effect July 1, 2020.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 577 First-episode Psychosis Programs
SPONSOR(S): Children, Families & Seniors Subcommittee, Stevenson
TIED BILLS: **IDEN./SIM. BILLS:** SB 920

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	14 Y, 0 N, As CS	Morris	Brazzell
2) Health Care Appropriations Subcommittee	9 Y, 0 N	Fontaine	Clark
3) Health & Human Services Committee		Morris	Calamas

SUMMARY ANALYSIS

"Psychosis" is used to describe conditions that affect the mind, involving some loss of contact with reality, such as hallucinations or delusions. Coordinated specialty care (CSC) programs use coordinated specialty care principles to provide early interventions for children and young adults exhibiting early symptoms of psychosis.

The bill establishes CSC programs as an essential element of a coordinated system of care in Florida, and requires DCF to assess the availability of and access to CSC programs in the state, including any gaps in availability or access that may exist.

The bill allows three-year implementation or expansion grants under the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program to support CSC programs.

The bill requires CSC programs to submit de-identified data to DCF regarding marijuana use by individuals served by these programs. DCF must include this assessment in the annual report to the Governor and Legislature on the assessment of behavioral health services in the state.

The bill has an indeterminate, insignificant, negative fiscal impact on DCF. The bill has no impact on local governments.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

First-Episode Psychosis

The term "psychosis" is used to describe a condition that affects the mind and generally involves some loss of contact with reality. Psychosis can include hallucinations (seeing, hearing, smelling, tasting, or feeling something that is not real), paranoia, delusions (believing something that is not real even when presented with facts), or disordered thoughts and speech.[1] Psychosis may be caused by medications or alcohol or drug abuse but can also be a symptom of mental illness or a physical condition.[2]

Psychosis affects people from all walks of life. Approximately three out of 100 people will experience psychosis at some time in their lives, often beginning when a person is in their late teens to mid-twenties.[3] Researchers are still learning about how and why psychosis develops, but it is generally thought to be a symptom of mental illness, such as schizophrenia or bipolar disorder, triggered by sleep deprivation, some general medical conditions, certain prescription medications, or the abuse of alcohol or other drugs.[4] As such, adolescents are at a greater risk of developing psychosis when facing life stressors such as physical illness, substance use, or psychological or physical trauma.[5]

Early psychosis, known as "first-episode psychosis," is the most important time to connect an individual with treatment.[6] Studies have shown that it is common for a person to experience psychotic symptoms for more than a year before ever receiving treatment.[7] Reducing the duration of untreated psychosis is critical to improving a person's chance of recovery.

Coordinated Specialty Care Programs

One treatment for early psychosis is coordinated specialty care, which uses a team-based approach with shared decision-making that focuses on working with individuals to reach their recovery goals.[8] Programs that provide coordinated specialty care are often called first-episode psychosis programs. Key components of coordinated specialty care (CSC) programs include:[9]

- **Case Management** – Working with the individual to develop problem-solving skills, manage medication and coordinate services.
- **Family Support and Education** – Giving families information and skills to support their loved one's treatment and recovery.
- **Psychotherapy** – Using cognitive behavioral therapy to learn to focus on resiliency, managing the condition, promoting wellness, and developing coping skills.
- **Medication Management** – Finding the best medication at the lowest possible dose.

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[1] National Institute of Mental Health, *Fact Sheet: First Episode Psychosis*, https://www.nimh.nih.gov/health/topics/schizophrenia/raise/fact-sheet-first-episode-psychosis.shtml (last visited Feb. 9, 2020).
[2] Id.
[3] Id.
[4] National Institute of Mental Health, *RAISE Questions and Answers,* https://www.nimh.nih.gov/health/topics/schizophrenia/raise/raise-questions-and-answers.shtml (last visited Feb. 9, 2020).
[5] Id.
[6] Id.
[7] *Supra* note 1.
[8] National Institute of Mental Health, *What is Coordinated Specialty Care (CSC)?,* https://www.nimh.nih.gov/health/topics/schizophrenia/raise/what-is-coordinated-specialty-care-csc.shtml (last visited Feb. 9, 2020)
[9] Id. *See also* National Institute of Mental Health, *Schizophrenia – Coordinated Specialty Care (CSC),* https://www.nimh.nih.gov/health/publications/schizophrenia/index.shtml (last visited Feb. 9, 2020)

- **Supported Education and Employment** – Providing support to continue or return to school or work.
- **Peer Support** – Connecting the person with others who have been through similar experiences.

In 2008, the National Institute of Mental Health (NIMH) started the Recovery After an Initial Schizophrenia Episode (RAISE) project.[10] RAISE is a large-scale research initiative that examines different aspects of coordinated specialty care treatments for people experiencing first-episode psychosis. The RAISE project determined clients who utilize coordinated specialty care programs stayed in treatment longer and experienced greater improvement in their symptoms, interpersonal relationships, and quality of life compared to clients at typical-care sites.[11] The RAISE project also developed tools and resources for implementation of coordinated specialty care programs for FEP in community health mental clinics.[12]

Several studies have linked marijuana use to increased risk for psychiatric disorders, including psychosis, depression, anxiety, and substance use disorders, but whether and to what extent it causes these conditions is not easy to determine.[13] Marijuana use has been shown to be a predictor of schizophrenia.[14] Current Florida law does not require CSC programs to submit data to The Department of Children and Families (DCF) relating to marijuana usage by individuals served by these programs.

Mental Health Treatment in Florida

DCF administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment, and recovery. It serves children and adults who are otherwise unable to obtain these services (such as individuals who are not covered under Medicaid or private insurance and do not have the financial ability to pay for the services themselves). SAMH programs include a range of prevention, acute interventions (such as crisis stabilization or detoxification), residential, transitional housing, outpatient treatment, and recovery support services. Services are provided based upon state and federally-established priority populations.[15]

Currently, there are seven Coordinated Specialty Care programs in Florida, located in Bay, Broward, Clay, Hillsborough, Miami Dade, Orange, and Palm Beach Counties.[16]

Coordinated System of Care

Managing Entities[17] are required to promote the development and implementation of a coordinated system of care.[18] A coordinated system of care means a full array of behavioral and related services in a region or community offered by all service providers, participating either under contract with a managing entity or by another method of community partnership or mutual agreement.[19] A community

[10] National Institute of Mental Health, *Recovery After an Initial Schizophrenia Episode (RAISE),* https://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml (last visited Feb. 9, 2020).
[11] *Supra,* note 4.
[12] Id.
[13] National Institutes on Drug Abuse, *Is there a link between marijuana use and psychiatric disorders?,* https://www.drugabuse.gov/publications/research-reports/marijuana/there-link-between-marijuana-use-psychiatric-disorders (last visited Feb. 9, 2020).
[14] Presentation to the Health and Human Services Committee by Bertha K. Madras, PhD, Professor of Psychobiology, Harvard Medical School, https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=2997&Session=2020&DocumentType=Meeting%20Packets&FileName=hhs%2010-15-19.pdf (Oct. 15, 2019).
[15] These priority populations include, among others, persons diagnosed with co-occurring substance abuse and mental health disorders, persons who are experiencing an acute mental or emotional crisis, children who have or are at risk of having an emotional disturbance, and children at risk for initiating drug use.
[16] Email from John Paul Fiore, Legislative Specialist, Florida Department of Children and Families, RE: Info. Request, (Dec. 27, 2019).
[17] S. 394.9082(2)(e), F.S., defines a "managing entity" as a corporation selected by and under contract with DCF to manage the daily operational delivery of behavioral health services through a coordinated system of care.
[18] S. 394.9082(5)(d), F.S.
[19] S. 394.4573(1)(c), F.S.

or region provides a coordinated system of care for those suffering from mental illness or substance abuse disorder through a no-wrong-door model, to the extent allowed by available resources. If funding is provided by the Legislature, DCF may award system improvement grants to managing entities.[20] Managing entities must submit detailed plans to enhance services based on the no-wrong-door model or to meet specific needs identified in DCF's assessment of behavioral health services in this state.[21] DCF must use performance-based contracts to award grants.[22]

There are several essential elements which make up a coordinated system of care, including:[23]

- Community interventions, such as prevention, primary care for behavioral health needs, therapeutic and supportive services, crisis response services, and diversion programs;
- A designated receiving system that consists of one or more facilities serving a defined geographic area and responsible for assessment and evaluation, both voluntary and involuntary, and treatment or triage of patients who have a mental health or substance use disorder, or co-occurring disorders;
- A transportation plan developed and implemented by each county in collaboration with the managing entity;
- Crisis services, including mobile response teams, crisis stabilization units, addiction receiving facilities, and detoxification facilities;
- Case management, defined as direct services to clients for assessing needs; planning; arranging services; coordinating service providers; linking the service system to a client; monitoring service delivery; and evaluating patient outcomes to ensure the client is receiving the appropriate services;
- Care coordination, defined as the implementation of deliberate and planned organizational relationships and service procedures that improve the effectiveness and efficiency of the behavioral health system by engaging in purposeful interactions with individuals who are not yet effectively connected with services to ensure service linkage;
- Outpatient services;
- Residential services;
- Hospital inpatient care;
- Aftercare and post-discharge services;
- Medication assisted treatment and medication management; and
- Recovery support, such as supportive housing, supported employment, family support and education, independent living skill development, wellness management, and self-care.

CSC programs are not currently included as an essential element of a coordinated system of care.

Criminal Justice, Mental Health, and Substance Abuse Statewide Grant Program

In 2007, the Legislature created the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program (Program). The purpose of the Program is to provide funding to counties to plan, implement, or expand initiatives that increase public safety, avert increased spending on criminal justice, and improve the accessibility and effectiveness of treatment services for adults and juveniles who have a mental illness, substance abuse disorder, or co-occurring mental health and substance abuse disorders and who are in, or at risk of entering, the criminal or juvenile justice systems.[24]

A county, non-profit community provider or managing entity designated by a county planning council or committee may apply for a one-year planning grant or a three-year implementation expansion grant

[20] S. 394.4573(3), F.S. As of Jan. 2, 2020, the Legislature has not funded system improvement grants.
[21] Id.
[22] Id.
[23] S. 394.4573(2), F.S.
[24] S. 394.656(1), F.S.

under the Program.[25] The purpose of the grants is to demonstrate that investment in treatment efforts related to mental illness, substance abuse disorders, or co-occurring mental health and substance abuse disorders results in a reduced demand on the resources of the judicial, corrections, juvenile detention, and health and social services systems.[26] Currently, there are 24 grant agreements for county programs.[27] Total funding for the 24 grant agreements over their lifetimes is $28,174,388.[28]

The Program does not currently support CSC programs.

Behavioral Health Services Annual Assessment

Managing entities are required to conduct a community behavioral health care needs assessment once every three years in the geographic area served by the managing entity, which identifies needs by sub region.[29] The assessments must be submitted to DCF for inclusion in the state and district substance abuse and mental health plan.[30]

DCF is required to submit an assessment of the behavioral health services in Florida to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1 of each year. The report must include a compilation of all plans submitted by managing entities and DCF's evaluation of each plan.[31] At a minimum, the assessment must consider the functionality of no-wrong-door models within designated receiving systems, the availability of treatment and recovery services that use recovery-oriented and peer-involved approaches, the availability of less-restrictive services, the use of evidence-informed practices, and the needs assessments conducted by managing entities.[32]

This assessment does not currently require CSC programs to submit data to DCF regarding current and historical marijuana use by individuals served by these programs.

Effect of the Bill

The bill establishes CSC programs as an essential element of a coordinated system of care. To be included in the system of care, a CSC must be an evidence-based program that uses intensive case management, individual or group therapy, supported employment, family education and supports, and appropriate psychotropic medication to treat individuals, regardless of age, who are experiencing early indications of serious mental illness, especially symptoms of a first psychotic episode. The bill requires DCF to assess the availability of and access to CSC programs in the state, including any gaps in availability or access that may exist. DCF must include this assessment in the annual report to the Governor and Legislature on the assessment of behavioral health services in the state.

The bill allows three-year implementation or expansion grants under the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program to support CSC programs.

The bill requires CSC programs to submit de-identified data to DCF regarding current and historical marijuana use by individuals served by these programs for inclusion in the behavioral health services assessment. Such data must also be included by DCF in the annual report to the Governor and Legislature on the assessment of behavioral health services in this state.

[25] S. 394.656(5), F.S.
[26] Id.
[27] *Florida Substance Abuse and Mental Health Plan – Triennial State and Regional Master Plan Fiscal Years 2019-2022,* Florida Department of Children and Families, p. 28, (May 2019), https://www.myflfamilies.com/service-programs/samh/publications/docs/SAMH%20Services%20Plan%202019-2022.pdf (last visited Feb. 9, 2020).
[28] Id. at 71-72.
[29] S. 394.9082(5)(b), F.S.
[30] S. 394.75(3), F.S.
[31] S. 394.4573, F.S.
[32] Id.

The bill makes technical and conforming changes.

The bill provides an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Amends s. 394.455, F.S., relating to definitions.
Section 2: Amends s. 394.67, F.S., relating to definitions.
Section 3: Amends s. 394.658, F.S., relating to Criminal Justice, Mental health, and Substance Abuse Reinvestment Grant Program requirements.
Section 4: Amends s. 394.4573, F.S., relating to coordinated system of care; annual assessment; essential elements; measures of performance; system improvement grants; reports.
Section 5: Amends s. 39.407, F.S., relating to medical, psychiatric, and psychological examination and treatment of a child; physical, mental, or substance abuse examination of person with or requesting child custody.
Section 6: Amends s. 394.495, F.S., relating to child and adolescent mental health system of care; programs and services.
Section 7: Amends s. 394.496, F.S., relating to service planning.
Section 8: Amends s. 394.674, F.S., relating to eligibility for publicly funded substance abuse and mental health services; fee collection requirements.
Section 9: Amends s. 394.74, F.S., relating to contracts for provision of local substance abuse and mental health programs.
Section 10: Amends s. 394.9085, F.S., relating to behavioral provider liability.
Section 11: Amends s. 409.972, F.S., relating to mandatory and voluntary enrollment.
Section 12: Amends s. 464.012, F.S., relating to licensure of advanced practice registered nurses; fees; controlled substance prescribing.
Section 13: Amends s. 744.2007, F.S., relating to powers and duties.
Section 14: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill requires DCF to conduct an assessment of and report on the availability and access of CSC programs in the state, including any gaps in availability or access that may exist. Additionally, the bill requires CSC programs to submit de-identified data to DCF regarding current and historical marijuana use by individuals served by these. The increased workload on DCF is indeterminate, but likely insignificant. Current resources are adequate to absorb this workload increase.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

Currently, the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program has 24 participants with awards totaling $28.2 million (cumulated over multiple fiscal years). This bill includes CSC programs as one of the services that may be funded with these awards. It is unknown how eligibility expansion may affect the awarding of these grants as a result of this bill, but is expected to be minimal given that CSC programs are one of many statutory qualifiers for this grant.

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:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 16, 2020, the Children, Families and Seniors Subcommittee adopted an amendment that:

- Changes references from “first episode psychosis” to “coordinated specialty care program” throughout the bill;
- Removes the age requirement to receive services through a coordinated specialty care program; and
- Requires coordinated specialty care programs to submit data to the Department of Children and Families on marijuana usage by individuals served by these programs.

The bill was reported favorably as a committee substitute.

The analysis is drafted to the committee substitute as passed by the Children, Families and Seniors Subcommittee.

A bill to be entitled

An act relating to coordinated specialty care programs; amending ss. 394.455 and 394.67, F.S.; defining the term "coordinated specialty care program"; amending s. 394.658, F.S.; revising the application criteria for the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program to include support for coordinated specialty care programs; amending s. 394.4573, F.S.; requiring the Department of Children and Families to include specified information regarding coordinated specialty care programs in its annual assessment of behavioral health services; providing that a coordinated system of care includes coordinated specialty care programs; requiring coordinated specialty care programs to submit certain data to the department; amending ss. 39.407, 394.495, 394.496, 394.674, 394.74, 394.9085, 409.972, 464.012, and 744.2007, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Subsections (10) through (48) of section 394.455, Florida Statutes, are renumbered as subsections (11) through (49), respectively, and a new subsection (10) is added

to that section to read:

394.455 Definitions.—As used in this part, the term:

(10) "Coordinated specialty care program" means an evidence-based program for individuals who are experiencing the early indications of serious mental illness, especially symptoms of a first psychotic episode, and which includes, but is not limited to, intensive case management, individual or group therapy, supported employment, family education and supports, and the provision of appropriate psychotropic medication as needed.

Section 2. Subsections (3) through (24) of section 394.67, Florida Statutes, are renumbered as subsections (4) through (25), respectively, present subsection (3) is amended, and a new subsection (3) is added to that section, to read:

394.67 Definitions.—As used in this part, the term:

(3) "Coordinated specialty care program" means an evidence-based program for individuals who are experiencing the early indications of serious mental illness, especially symptoms of a first psychotic episode, and which includes, but is not limited to, intensive case management, individual or group therapy, supported employment, family education and supports, and the provision of appropriate psychotropic medication as needed.

(4) ~~(3)~~ "Crisis services" means short-term evaluation, stabilization, and brief intervention services provided to a

person who is experiencing an acute mental or emotional crisis, as defined in subsection (18) ~~(17)~~, or an acute substance abuse crisis, as defined in subsection (19) ~~(18)~~, to prevent further deterioration of the person's mental health. Crisis services are provided in settings such as a crisis stabilization unit, an inpatient unit, a short-term residential treatment program, a detoxification facility, or an addictions receiving facility; at the site of the crisis by a mobile crisis response team; or at a hospital on an outpatient basis.

Section 3. Paragraph (b) of subsection (1) of section 394.658, Florida Statutes, is amended to read:

394.658 Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program requirements.—

(1) The Criminal Justice, Mental Health, and Substance Abuse Statewide Grant Review Committee, in collaboration with the Department of Children and Families, the Department of Corrections, the Department of Juvenile Justice, the Department of Elderly Affairs, and the Office of the State Courts Administrator, shall establish criteria to be used to review submitted applications and to select the county that will be awarded a 1-year planning grant or a 3-year implementation or expansion grant. A planning, implementation, or expansion grant may not be awarded unless the application of the county meets the established criteria.

(b) The application criteria for a 3-year implementation

or expansion grant shall require information from a county that demonstrates its completion of a well-established collaboration plan that includes public-private partnership models and the application of evidence-based practices. The implementation or expansion grants may support programs and diversion initiatives that include, but need not be limited to:

1. Mental health courts;

2. Diversion programs;

3. Alternative prosecution and sentencing programs;

4. Crisis intervention teams;

5. Treatment accountability services;

6. Specialized training for criminal justice, juvenile justice, and treatment services professionals;

7. Service delivery of collateral services such as housing, transitional housing, and supported employment; ~~and~~

8. Reentry services to create or expand mental health and substance abuse services and supports for affected persons; and

9. Coordinated specialty care programs.

Section 4. Section 394.4573, Florida Statutes, is amended to read:

394.4573 Coordinated system of care; annual assessment; essential elements; measures of performance; system improvement grants; reports.—On or before December 1 of each year, the department shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives an

assessment of the behavioral health services in this state. The assessment shall consider, at a minimum, the extent to which designated receiving systems function as no-wrong-door models, the availability of treatment and recovery services that use recovery-oriented and peer-involved approaches, the availability of less-restrictive services, and the use of evidence-informed practices. The assessment shall also consider the availability of and access to coordinated specialty care programs and identify any gaps in the availability of and access to such programs in the state, and shall include the data submitted to the department under paragraph (2)(n). The department's assessment shall consider, at a minimum, the needs assessments conducted by the managing entities pursuant to s. 394.9082(5). Beginning in 2017, the department shall compile and include in the report all plans submitted by managing entities pursuant to s. 394.9082(8) and the department's evaluation of each plan.

(1) As used in this section:

(a) "Care coordination" means the implementation of deliberate and planned organizational relationships and service procedures that improve the effectiveness and efficiency of the behavioral health system by engaging in purposeful interactions with individuals who are not yet effectively connected with services to ensure service linkage. Examples of care coordination activities include development of referral agreements, shared protocols, and information exchange

procedures. The purpose of care coordination is to enhance the delivery of treatment services and recovery supports and to improve outcomes among priority populations.

(b) "Case management" means those direct services provided to a client in order to assess his or her needs, plan or arrange services, coordinate service providers, link the service system to a client, monitor service delivery, and evaluate patient outcomes to ensure the client is receiving the appropriate services.

(c) "Coordinated system of care" means the full array of behavioral and related services in a region or community offered by all service providers, whether participating under contract with the managing entity or by another method of community partnership or mutual agreement.

(d) "No-wrong-door model" means a model for the delivery of acute care services to persons who have mental health or substance use disorders, or both, which optimizes access to care, regardless of the entry point to the behavioral health care system.

(2) The essential elements of a coordinated system of care include:

(a) Community interventions, such as prevention, primary care for behavioral health needs, therapeutic and supportive services, crisis response services, and diversion programs.

(b) A designated receiving system that consists of one or

more facilities serving a defined geographic area and responsible for assessment and evaluation, both voluntary and involuntary, and treatment or triage of patients who have a mental health or substance use disorder, or co-occurring disorders.

1. A county or several counties shall plan the designated receiving system using a process that includes the managing entity and is open to participation by individuals with behavioral health needs and their families, service providers, law enforcement agencies, and other parties. The county or counties, in collaboration with the managing entity, shall document the designated receiving system through written memoranda of agreement or other binding arrangements. The county or counties and the managing entity shall complete the plan and implement the designated receiving system by July 1, 2017, and the county or counties and the managing entity shall review and update, as necessary, the designated receiving system at least once every 3 years.

2. To the extent permitted by available resources, the designated receiving system shall function as a no-wrong-door model. The designated receiving system may be organized in any manner which functions as a no-wrong-door model that responds to individual needs and integrates services among various providers. Such models include, but are not limited to:

a. A central receiving system that consists of a

designated central receiving facility that serves as a single entry point for persons with mental health or substance use disorders, or co-occurring disorders. The central receiving facility shall be capable of assessment, evaluation, and triage or treatment or stabilization of persons with mental health or substance use disorders, or co-occurring disorders.

b. A coordinated receiving system that consists of multiple entry points that are linked by shared data systems, formal referral agreements, and cooperative arrangements for care coordination and case management. Each entry point shall be a designated receiving facility and shall, within existing resources, provide or arrange for necessary services following an initial assessment and evaluation.

c. A tiered receiving system that consists of multiple entry points, some of which offer only specialized or limited services. Each service provider shall be classified according to its capabilities as either a designated receiving facility or another type of service provider, such as a triage center, a licensed detoxification facility, or an access center. All participating service providers shall, within existing resources, be linked by methods to share data, formal referral agreements, and cooperative arrangements for care coordination and case management.

An accurate inventory of the participating service providers

which specifies the capabilities and limitations of each provider and its ability to accept patients under the designated receiving system agreements and the transportation plan developed pursuant to this section shall be maintained and made available at all times to all first responders in the service area.

(c) Transportation in accordance with a plan developed under s. 394.462.

(d) Crisis services, including mobile response teams, crisis stabilization units, addiction receiving facilities, and detoxification facilities.

(e) Case management. Each case manager or person directly supervising a case manager who provides Medicaid-funded targeted case management services shall hold a valid certification from a department-approved credentialing entity as defined in s. 397.311(10) by July 1, 2017, and, thereafter, within 6 months after hire.

(f) Care coordination that involves coordination with other local systems and entities, public and private, which are involved with the individual, such as primary care, child welfare, behavioral health care, and criminal and juvenile justice organizations.

(g) Outpatient services.

(h) Residential services.

(i) Hospital inpatient care.

(j) Aftercare and other postdischarge services.

(k) Medication-assisted treatment and medication management.

(l) Recovery support, including, but not limited to, support for competitive employment, educational attainment, independent living skills development, family support and education, wellness management and self-care, and assistance in obtaining housing that meets the individual's needs. Such housing may include mental health residential treatment facilities, limited mental health assisted living facilities, adult family care homes, and supportive housing. Housing provided using state funds must provide a safe and decent environment free from abuse and neglect.

(m) Care plans shall assign specific responsibility for initial and ongoing evaluation of the supervision and support needs of the individual and the identification of housing that meets such needs. For purposes of this paragraph, the term "supervision" means oversight of and assistance with compliance with the clinical aspects of an individual's care plan.

(n) Coordinated specialty care programs. Such programs must submit deidentified data regarding the historical and current use of marijuana by individuals who are served by such programs to the department for inclusion in the assessment of behavioral health services as required in this section.

(3) SYSTEM IMPROVEMENT GRANTS.—Subject to a specific

appropriation by the Legislature, the department may award system improvement grants to managing entities based on a detailed plan to enhance services in accordance with the no-wrong-door model as defined in subsection (1) and to address specific needs identified in the assessment prepared by the department pursuant to this section. Such a grant must be awarded through a performance-based contract that links payments to the documented and measurable achievement of system improvements.

Section 5. Paragraph (a) of subsection (3) of section 39.407, Florida Statutes, is amended to read:

39.407 Medical, psychiatric, and psychological examination and treatment of child; physical, mental, or substance abuse examination of person with or requesting child custody.—

(3)(a)1. Except as otherwise provided in subparagraph (b)1. or paragraph (e), before the department provides psychotropic medications to a child in its custody, the prescribing physician or a psychiatric nurse, as defined in s. 394.455, shall attempt to obtain express and informed consent, as defined in s. 394.455(16) ~~s. 394.455(15)~~ and as described in s. 394.459(3)(a), from the child's parent or legal guardian. The department must take steps necessary to facilitate the inclusion of the parent in the child's consultation with the physician or psychiatric nurse, as defined in s. 394.455. However, if the parental rights of the parent have been terminated, the parent's

location or identity is unknown or cannot reasonably be ascertained, or the parent declines to give express and informed consent, the department may, after consultation with the prescribing physician or psychiatric nurse, as defined in s. 394.455, seek court authorization to provide the psychotropic medications to the child. Unless parental rights have been terminated and if it is possible to do so, the department shall continue to involve the parent in the decisionmaking process regarding the provision of psychotropic medications. If, at any time, a parent whose parental rights have not been terminated provides express and informed consent to the provision of a psychotropic medication, the requirements of this section that the department seek court authorization do not apply to that medication until such time as the parent no longer consents.

2. Any time the department seeks a medical evaluation to determine the need to initiate or continue a psychotropic medication for a child, the department must provide to the evaluating physician or psychiatric nurse, as defined in s. 394.455, all pertinent medical information known to the department concerning that child.

Section 6. Subsection (3) of section 394.495, Florida Statutes, is amended to read:

394.495 Child and adolescent mental health system of care; programs and services.—

(3) Assessments must be performed by:

(a) A professional as defined in s. 394.455(5), (7), (33), ~~(32), (35), or~~ (36), or (37);

(b) A professional licensed under chapter 491; or

(c) A person who is under the direct supervision of a qualified professional as defined in s. 394.455(5), (7), (33), ~~(32), (35), or~~ (36), or (37) or a professional licensed under chapter 491.

Section 7. Subsection (5) of section 394.496, Florida Statutes, is amended to read:

394.496 Service planning.—

(5) A professional as defined in s. 394.455(5), (7), (33), ~~(32), (35), or~~ (36), or (37) or a professional licensed under chapter 491 must be included among those persons developing the services plan.

Section 8. Paragraph (a) of subsection (1) of section 394.674, Florida Statutes, is amended to read:

394.674 Eligibility for publicly funded substance abuse and mental health services; fee collection requirements.—

(1) To be eligible to receive substance abuse and mental health services funded by the department, an individual must be a member of at least one of the department's priority populations approved by the Legislature. The priority populations include:

(a) For adult mental health services:

1. Adults who have severe and persistent mental illness,

as designated by the department using criteria that include severity of diagnosis, duration of the mental illness, ability to independently perform activities of daily living, and receipt of disability income for a psychiatric condition. Included within this group are:

a. Older adults in crisis.

b. Older adults who are at risk of being placed in a more restrictive environment because of their mental illness.

c. Persons deemed incompetent to proceed or not guilty by reason of insanity under chapter 916.

d. Other persons involved in the criminal justice system.

e. Persons diagnosed as having co-occurring mental illness and substance abuse disorders.

2. Persons who are experiencing an acute mental or emotional crisis as defined in s. 394.67(18) ~~s. 394.67(17)~~.

Section 9. Paragraph (a) of subsection (3) of section 394.74, Florida Statutes, is amended to read:

394.74 Contracts for provision of local substance abuse and mental health programs.—

(3) Contracts shall include, but are not limited to:

(a) A provision that, within the limits of available resources, substance abuse and mental health crisis services, as defined in s. 394.67(4) ~~s. 394.67(3)~~, shall be available to any individual residing or employed within the service area, regardless of ability to pay for such services, current or past

health condition, or any other factor;

Section 10. Subsection (6) of section 394.9085, Florida Statutes, is amended to read:

394.9085 Behavioral provider liability.—

(6) For purposes of this section, the terms "detoxification services," "addictions receiving facility," and "receiving facility" have the same meanings as those provided in ss. 397.311(26)(a)4., 397.311(26)(a)1., and 394.455(40) ~~394.455(39)~~, respectively.

Section 11. Paragraph (b) of subsection (1) of section 409.972, Florida Statutes, is amended to read:

409.972 Mandatory and voluntary enrollment.—

(1) The following Medicaid-eligible persons are exempt from mandatory managed care enrollment required by s. 409.965, and may voluntarily choose to participate in the managed medical assistance program:

(b) Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or a treatment facility as defined in s. 394.455(48) ~~s. 394.455(47)~~.

Section 12. Paragraph (e) of subsection (4) of section 464.012, Florida Statutes, is amended to read:

464.012 Licensure of advanced practice registered nurses; fees; controlled substance prescribing.—

(4) In addition to the general functions specified in

subsection (3), an advanced practice registered nurse may perform the following acts within his or her specialty:

(e) A psychiatric nurse, who meets the requirements in s. 394.455(36) ~~s. 394.455(35)~~, within the framework of an established protocol with a psychiatrist, may prescribe psychotropic controlled substances for the treatment of mental disorders.

Section 13. Subsection (7) of section 744.2007, Florida Statutes, is amended to read:

744.2007 Powers and duties.—

(7) A public guardian may not commit a ward to a treatment facility, as defined in s. 394.455(48) ~~s. 394.455(47)~~, without an involuntary placement proceeding as provided by law.

Section 14. This act shall take effect July 1, 2020.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/HB 647 Recreational Vehicle Parks
SPONSOR(S): Civil Justice Subcommittee, Health Quality Subcommittee, Drake
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 772

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	14 Y, 0 N, As CS	Guzzo	McElroy
2) Civil Justice Subcommittee	11 Y, 1 N, As CS	Mawn	Luczynski
3) Health & Human Services Committee		Guzzo	Calamas

SUMMARY ANALYSIS

The Department of Health (DOH) is responsible for the permitting of recreational vehicle (RV) parks and is the exclusive regulatory and permitting authority for establishing sanitary standards for these entities. However, local governments may adopt ordinances that may affect the operation of an RV park within their jurisdictions, including ordinances establishing lot and density size and separation or setback distances for an RV park. Current law requires separation and setback distances within an RV park to remain those distances established at the time of the RV park's initial approval. However, when an RV park is damaged or destroyed by a natural disaster and rebuilt, the density standards of the rebuilt park must be those prescribed under the current applicable ordinance, which may be smaller than the standards originally imposed.

In addition to state and local regulation, an RV park is subject to laws protecting tenants in the state. Specifically, the Florida Residential Landlord Tenant Act (Act) applies to a guest occupying an RV in an RV park for more than six months, giving such tenant certain eviction and lost or abandoned property rights. However, the Act does not apply to a guest occupying an RV in the park for less than six months (transient guest). Thus, a transient guest may be ejected from the park without the need for an eviction, and property lost or abandoned by a transient guest becomes park property if certain conditions are met. However, Florida law does not specify a process for disposing of property left by a transient guest with an outstanding account who vacates an RV park without notice.

CS/CS/HB 647:

- Preempts all permitting authority to DOH for RV parks, mobile home parks, lodging parks, and recreational camps.
- Allows an RV park damaged or destroyed by a natural disaster to be rebuilt on the same site using the same density standards established at the time of the RV park's initial approval.
- Creates a rebuttable presumption that an RV park guest is a transient guest.
- Provides a method for the disposal of property left by a transient guest with an outstanding account who vacates an RV park without notice.
- Adds a posted park rules and regulations violation to the list of reasons a park operator may eject a transient guest or visitor from park premises and provides notice of ejection requirements.
- Provides that a park operator may refuse a transient guest or visitor access to the premises for specified conduct and request that such person leave the premises.
- Modifies the duties of a law enforcement officer called to assist with a person illegally on an RV park's premises to allow removal of such a person in lieu of arrest and limits the officer's liability.

The bill has no fiscal impact on state or local governments.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Regulation of Recreational Vehicle Parks

The Department of Health (DOH) is responsible for permitting recreational vehicle (RV) parks and is the exclusive regulatory and permitting authority for establishing sanitary standards for these entities.[1] This includes regulations relating to sanitation, control of communicable diseases, illnesses and hazards to health among humans and from animals to humans, and general health issues.

Before establishing a mobile home park, RV park, or recreational vehicle camp, a person must obtain a permit from DOH.[2] The permit must be renewed annually and a new permit is required when a park or camp is sold or its ownership is transferred.[3] A person maintaining or operating a park or camp without first obtaining a permit commits a second degree misdemeanor.[4]

When applying to DOH for a permit, the application must state the:

- Location of the existing or proposed park or camp;
- Type of park or camp to be established;
- Number of mobile homes, RVs, or tents to be accommodated;
- Type of water supply;
- Method of sewage disposal; and
- Any other information DOH requires.[5]

Parks and camps must also submit a valid set of plans to the county public health unit at the time of permit application.[6] The plans must include:

- A drawing[7] 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, RV, and tents spaces; and
- The location of all roadways.[8]

Additionally, for permanent buildings located within the park or camp, a floor plan must be submitted showing the number, types, and distribution of all plumbing fixtures.[9]

DOH will issue a permit if it determines that the park or camp complies with requirements in chapter 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]

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[1] S. 513.051, F.S.
[2] S. 513.02(1), F.S.
[3] S. 513.02(5), F.S.
[4] A second degree misdemeanor is punishable by up to 60 days in county jail and a $500 fine. Ss. 513.10(1), 775.082, and 775.083, F.S.
[5] S. 513.03(1), F.S.
[6] Rule 64E-15.010(2)(b), F.A.C.
[7] The drawing does not have to be drawn to scale or completed by an engineer if the space dimensions are shown. *Id.*
[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,* http://www.floridahealth.gov/environmental-health/mobile-home-parks/index.html (last visited Feb. 9, 2020).

Local Governments

Local governments have the authority to adopt ordinances that may affect the operation of an RV park within their jurisdiction. This includes regulation regarding lot and density size and separation or setback distances for an RV park. Current law requires separation and setback distances within an RV park to remain those distances established at the time of the RV park's initial approval by DOH and the local government of the jurisdiction in which the RV park is located.[12] However, when an RV park is destroyed by a natural disaster and the park operator chooses to rebuild, the density standards of the rebuilt park must be those prescribed under the current applicable ordinance.[13] Such standards may be smaller than the standards originally imposed, causing the park to lose lots and the business that goes with them.[14] This, in turn, reduces the number of RV park lots available for Florida's visitors.[15]

Rights of Transient and Non-Transient Guests

The Florida Residential Landlord Tenant Act (Act) governs most traditional rental arrangements, including those for apartments and single family housing units. The Act also applies to a guest occupying an RV in an RV park for more than six months (tenant). However, a guest registered in an RV park for six months or less (transient guest) is subject only to the protections offered under ch. 513, F.S.[16]

Ejectment & Eviction

A park operator can only recover possession of a lot without a tenant's consent through an eviction under the Act. A residential eviction begins when the park operator serves the tenant notice to vacate the premises either by mailing or delivering a copy to the tenant, or if the tenant is not on the premises, by leaving a copy at the RV.[17] Such notice must state the reason for the eviction, which may include failure to pay rent,[18] lease violations,[19] and destruction of property,[20] and the time by which the tenant must either cure the violation or vacate the premises. A landlord can bring an action for possession in the county court of the county where the park is located by filing a complaint describing the lot and stating the facts that authorize its recovery if a tenant does not vacate the premises after termination of the tenant's rental agreement.[21] Should the landlord prevail, the court will issue a writ of possession to the sheriff, authorizing the sheriff to put the landlord in possession of the lot after a 24-hour notice period.[22]

However, an RV park operator may eject from the park any transient guest who illegally possesses or deals in a controlled substance, disturbs the peace and comfort of others, physically harms the park, or fails to timely pay rent at the agreed rate.[23] An ejectment begins when a RV park operator notifies a transient guest in writing that the park "no longer desires to entertain the [transient] guest" and asks him or her to leave immediately.[24] If the transient guest paid advanced rent, the park must, at the time ejection notice is given, give the transient guest any unused portion of the advanced payment.[25] A

[12] S. 513.1115, F.S.
[13] Florida Department of Health, Agency Analysis of 2020 House Bill 647, p. 2 (Jan. 21, 2020).
[14] *Id.*
[15] *Id.*
[16] A transient guest means any guest registered as provided in s. 513.112, F.S., for six months or less. When a guest is permitted with the knowledge of the park operator to continuously occupy a RV in a RV park for more than six months, there is a rebuttable presumption that the occupancy is non-transient, and the eviction procedures of part II of ch. 83, F.S., apply. S. 513.01(12), F.S.
[17] S. 83.56(4), F.S.
[18] S. 83.56(3), F.S.
[19] S. 83.56(2)(b), F.S.
[20] S. 83.56(2)(a), F.S.
[21] S. 83.59, F.S.
[22] S. 83.62, F.S.
[23] S. 513.13(1), F.S.
[24] S. 513.13(2), F.S.
[25] *Id.*

transient guest who remains or attempts to remain in the park after receiving an ejection notice commits a second degree misdemeanor.[26]

If any person is on RV park premises illegally, the park operator may call upon any state law enforcement officer for help.[27] Such law enforcement officer has a duty, upon the park operator's request, to arrest the person illegally on RV park premises and take him or her into custody such a person, in the officer's presence:

- Illegally possess or deals in a controlled substance;
- Disturbs the peace and comfort of other persons;
- Causes harm to the physical park;
- Fails to pay rent at the agreed-upon rental rate by the agreed-upon time; or
- Remains in the park after being asked to leave.[28]

Unclaimed Property

A park operator must send written notice to a tenant or the property's owner when a tenant leaves personal property in an RV park after vacating the premises.[29] The notice must describe the property with enough detail that the property owner can identify it and, if not stored on park premises, state where the property is stored and that reasonable storage costs may be charged before the property is returned.[30] Additionally, the notice should specify where the property may be claimed and the date by which the claim must be made, which date must be at least ten days away if the notice is personally delivered and, if the notice is sent by mail, at least 15 days from the date the notice is placed in the mail.[31] The notice must be personally delivered or sent by first-class mail, postage prepaid, to the person to be notified at his or her last known address.[32] However, if a park operator has reason to believe that the notice will not be received by the intended person, the notice must also be delivered or sent to any other address known to the park operator where the person to be notified may reasonably be expected to receive it.[33]

A park operator must release the property if the property's owner pays the storage costs and acts to take possession of the property on or before the date specified in the notice.[34] However, a park operator may sell or dispose of the property if the property's owner does not respond in the timeframe specified in the notice.[35] Where the property's estimated value is less than $500.00, the park operator can dispose of it in any manner, but where the property's estimated value is $500.00 or more, the landlord must arrange for a public sale of the property at the nearest suitable place to where the property is held or stored.[36] A park operator must publish notice of the sale of the property once a week for two consecutive weeks in a newspaper of general circulation where the sale is to be held, and the advertisement must include the former tenant's name, the property's description, and the time and place of the sale.[37] If the property's owner pays the reasonable storage costs and claims the property prior to its sale, the park owner must withdraw the property from sale and release it to the owner.[38]

When property with an identifiable owner is left in an RV park by a transient guest, a park operator must send written notice to the transient guest or the property's owner and hold the property for 90

[26] *Id.*
[27] S. 513.13(4), F.S.
[28] *Id.*
[29] Ss. 715.101(1) and 715.104(1), F.S.
[30] Ss. 715.104(2) and 715.107, F.S.
[31] *Id.*
[32] S. 715.104(3), F.S.
[33] *Id.*
[34] S. 715.108, F.S.
[35] S. 715.109(1), F.S.
[36] *Id.*
[37] 715.109(2)-(3), F.S.
[38] S. 715.108(2), F.S.

days.[39] If the property remains unclaimed after the 90-day holding period, it becomes park property.[40] However, these procedures do not apply to property with an identifiable owner left by a transient guest who vacated the premises without notice to the park operator and with an outstanding account.[41]

Refusal of Accommodation & Services

An RV park operator may not cause the termination or interruption of any utility service furnished to a tenant, including water, electricity, and gas, whether or not the utility service is under the control of, or payment is made by, the park operator.[42] Further, a park operator may not prevent the tenant from obtaining reasonable access to his or her RV and lot by any means,[43] and can only regain possession of the lot through the eviction process.

An RV park operator may refuse to provide accommodations or service to any transient guest or visitor whose conduct on the park's premises displays intoxication, profanity, lewdness, or brawling; who indulges in such language or conduct in a manner that disturbs the peace or comfort of other guests; who engages in illegal or disorderly conduct; or whose conduct creates a nuisance.[44] However, ch. 513, F.S., does not expressly specify the process by which a park operator could require such a transient guest to immediately leave the premises, and law enforcement may be confused about whether such a transient guest can be trespassed without the park operator going through the eviction process.

Additionally, a park operator may not refuse to provide accommodations or service to any person, transient or otherwise, on the basis of a person's race, color, national origin, sex, physical disability, or creed. Such refusal violates Florida's Fair Housing Act, the federal Fair Housing Act, and the Fourteenth Amendment of the United States Constitution.[45]

Local Government Authority

The Florida Constitution grants counties[46] and municipalities[47] broad home rule authority. Non-charter county governments may exercise those powers of self-government provided by general or special law.[48] Counties operating under a county charter have all powers of self-government not inconsistent with general law or special law approved by vote of the electors.[49]

Municipalities have those governmental, corporate, and proprietary powers necessary to conduct municipal government, perform their functions and provide services, and exercise any power for municipal purposes,[50] except as otherwise provided by law.[51]

Preemption

Counties and municipalities have broad authority to legislate on any matter that is not inconsistent with federal or state law. A local government enactment may be inconsistent with state law if (1) the Legislature "has preempted a particular subject area" or (2) the local enactment conflicts with a state

[39] S. 513.115, F.S.
[40] *Id.*
[41] Id.; S. 513.115, F.S.
[42] S. 83.67(1), F.S.
[43] S. 83.67(2), F.S.
[44] S. 513.118, F.S.
[45] Ss. 513.118 and 760.23, F.S.; *see also* 42 U.S.C. §§ 3601-19.
[46] Counties are subdivisions of the state created by law. *See* art. VIII, s. 1(a), Fla. Const.
[47] Municipalities are created by general or special law or recognized pursuant to art. VIII, s. 2 or s. 6, Fla. Const. *See* s. 165.031(3), F.S. The term "municipality" may be used interchangeably with the terms "city," "town," or "village."
[48] Art. VIII, s. 1(f), Fla. Const.
[49] Art. VIII, s. 1(g), Fla. Const.
[50] A "municipal purpose" is any activity or power which may be exercised by the state or its political subdivisions. *See* s. 166.021(2), F.S.
[51] Art. VIII, s. 2(b), Fla. Const. *See also* s. 166.021(1), F.S.

statute. Where state preemption applies to a particular topic, it precludes a local government[52] from exercising authority in that particular area.[53]

Florida law recognizes two types of preemption: express and implied. Express preemption requires a specific legislative statement; it cannot be implied or inferred.[54] Express preemption of a field by the Legislature must be accomplished by clear language stating that intent.[55] In cases where the Legislature expressly or specifically preempts an area, the intent of the Legislature is readily ascertained.[56] In cases determining the validity of ordinances enacted in the face of state preemption, the effect has been to find such ordinances null and void.[57]

Implied preemption is a decision by the courts to recognize state preemption in the absence of an explicit legislative directive.[58] Preemption of a local government enactment is implied only where "the legislative scheme is so pervasive as to evidence an intent to preempt the particular area," and strong public policy reasons exist for finding preemption.[59] Implied preemption is found where the local legislation would present a danger of conflicting with the state's pervasive regulatory scheme.[60]

Effects of the Bill

Local Government Authority

CS/CS/HB 647 preempts all permitting authority to DOH for RV parks, mobile home parks, lodging parks, and recreational camps. The bill also allows an RV park damaged or destroyed by a natural disaster to be rebuilt on the same site using the same density standards established at the time of the RV park's initial approval. Further, the bill provides that DOH regulations relating to placement of RVs on lots in RV parks supersede any other county, municipality, or special district ordinance or regulation regarding the lot size, density, or separation or setback distance of an RV park which goes into effect after the initial permitting and construction of the park. These changes eliminate or significantly reduce local governments' authority to adopt ordinances affecting the operation of an RV park within their jurisdiction.

Rights of Transient and Non-Transient Guests

The bill creates a rebuttable presumption that a guest is a transient guest. Specifically, the bill provides if the guest registry shows that a length of stay under 6 months, the guest is presumed to be transient. Unless rebutted by the guest, this will allow an RV park operator to eject or evict a transient guest in accordance with the eviction requirements for RV parks in s. 513.13, F.S., instead of potentially having to go through the lengthy eviction process in accordance with landlord-tenant law if the transient guest claims to have occupied an RV in the RV park for more than six months.

[52] Including without limitation counties, municipalities, school districts, special districts, or any other subdivision of the state.
[53] Wolf, *The Effectiveness of Home Rule: A Preemption and Conflict Analysis*, 83 Fla. B.J. 92 (June 2009), available at https://www.floridabar.org/the-florida-bar-journal/the-effectiveness-of-home-rule-a-preemption-and-conflict-analysis/ (last visited Feb. 9, 2020).
[54] *See City of Hollywood v. Mulligan*, 934 So. 2d 1238, 1243 (Fla. 2006); *Phantom of Clearwater, Inc. v. Pinellas County*, 894 So. 2d 1011, 1018 (Fla. 2d DCA 2005), approved in *Phantom of Brevard, Inc. v. Brevard County*, 3 So. 3d 309 (Fla. 2008).
[55] *Mulligan*, *supra* at 934 So. 2d at 1243.
[56] *Sarasota Alliance for Fair Elections, Inc. v. Browning*, 28 So. 3d 880, 886 (Fla. 2010).
[57] *See, e.g., Nat'l Rifle Ass'n of Am., Inc. v. City of S. Miami,* 812 So.2d 504 (Fla. 3d DCA 2002).
[58] *Phantom of Clearwater, Inc.*, 894 So.2d at 1019.
[59] *Id*., quoting *Tallahassee Memorial Regional Medical Center, Inc. v. Tallahassee Medical Center, Inc.,* 681 So.2d 826, 831 (Fla. 1st DCA 1996), citing *Tribune Co. v. Cannella*, 458 So.2d 1075 (Fla. 1984).
[60] *Sarasota Alliance for Fair Elections, Inc.,* 28 So.3d at 886.

Unclaimed Property

The bill provides a method for handling property left in an RV park by a transient guest who has vacated the premises without notice to the operator and who has an outstanding account, specifying that such property is abandoned property and must be disposed of under the Disposition of Personal Property Landlord and Tenant Act. Thus, the bill makes the property disposal process the same for a transient guest and a tenant vacating the premises without notice and who have outstanding accounts.

Refusal of Accommodation & Services

The bill authorizes an RV park operator to refuse to provide accommodations, service, or access to the premises to any transient guest or visitor who:

- Displays intoxication, profanity, lewdness, or brawling;
- Indulges in language or conduct that disturbs the peace, quiet enjoyment, or comfort of other guests; or
- Engages in illegal or disorderly conduct or conduct constituting a nuisance or safety hazard.

Under the bill, a transient guest or visitor who refuses to leave after being asked to do so by the park operator commits trespass, and the operator may call a law enforcement officer to have the person and his or her property removed from the premises. The bill provides immunity from liability, except for tort liability,[61] for a law enforcement officer involved in the removal of a transient guest or visitor from an RV park under these circumstances, and provides that, if conditions do not allow for immediate removal of the person's property, he or she may arrange a time to pick up the property, in the company of a law enforcement officer, within 48 hours of his or her removal.

Ejectment and Eviction

The bill adds a posted park rules and regulations violation to the list of reasons for which a park operator may eject a transient guest from park premises. The bill also requires that, when a park operator sends a transient guest written notice of his her ejectment from the premises, such notice must state: "You are hereby notified that this recreational vehicle park no longer desires to entertain you as its guest, and you are requested to leave at once. To remain after receipt of this notice is a misdemeanor under the laws of this state".

Additionally, the bill gives a law enforcement officer called by a park owner to help with a person illegally on RV park premises the option to remove the person from the premises or arrest the person if the park operator requests such action and indicates that such a person:

- Illegally possessed or dealt in a controlled substance;
- Disturbed the peace and comfort of other persons;
- Caused harm to the physical park;
- Failed to pay rent at the agreed-upon rental rate by the agreed-upon time; or
- Remained in the park after being asked to leave.[62]

Thus, the officer no longer has to witness an offense before taking the person into custody, and may remove the offending person from the premises in lieu of making an arrest. Additionally, a person arrested or removed by a law enforcement officer under this section who cannot immediately remove his or her property may arrange a time to pick up the property in the company of a law enforcement officer within 48 hours of arrest or removal.

[61] The state waives sovereign immunity for tort liability for itself and its agencies and subdivisions. Thus, the bill provides that a law enforcement officer removing a person illegally on RV park premises does not have sovereign immunity where such an officer would not normally have sovereign immunity, i.e., for tort liability. S. 768.28, F.S.

[62] *Id.*

Finally, the bill changes references from “eviction” to “ejection” in the context of removing a transient guest, as such a guest is not protected by the Act and its eviction process.

The bill provides an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Amends s. 513.012, F.S., relating to public health laws; enforcement.
Section 2: Amends s. 513.02, F.S., relating to permit.
Section 3: Amends s. 513.051, F.S., relating to preemption.
Section 4: Amends s. 513.112, F.S., relating to maintenance of guest register and copy of laws.
Section 5: Amends s. 513.1115, F.S., relating to placement of recreational vehicles on lots in permitted parks.
Section 6: Amends s. 513.115, F.S., relating to unclaimed property.
Section 7: Amends s. 513.118, F.S., relating to conduct on premises; refusal of service.
Section 8: Amends s. 513.13, F.S., relating to recreational vehicle parks; eviction; grounds; proceedings.
Section 9: Provides an effective date of July 1, 2020.

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. The 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:

DOH has rulemaking authority under existing law.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 28, 2020, the Health Quality Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment changed the term “local government law” to “county, municipality, or special district ordinance”.

On February 4, 2020, the Civil Justice Subcommittee adopted two amendments and reported the bill favorably as a committee substitute. The amendments:

- Specified that the density standards at which an RV park damaged or destroyed by a natural disaster may rebuild are those standards that were both approved and permitted before the park was damaged or destroyed, rather than those standards that were either approved or permitted.
- Provided that a law enforcement officer removing a person illegally on recreational vehicle park premises is not immune from tort liability, as the state waives sovereign immunity for itself and its agencies and subdivisions for such liability.

The analysis is drafted to the committee substitute to the committee substitute as passed by the Civil Justice Subcommittee.

A bill to be entitled

An act relating to recreational vehicle parks; amending s. 513.012, F.S.; revising legislative intent; amending s. 513.02, F.S.; providing a timeframe for the application of a permit; amending s. 513.051, F.S.; preempting to the Department of Health the regulatory authority for permitting standards; amending s. 513.112, F.S.; providing that evidence of a certain length of stay in a guest register creates a rebuttable presumption that a guest is transient; amending s. 513.1115, F.S.; providing standards for a damaged or destroyed recreational vehicle park to be rebuilt under certain circumstances; superseding certain ordinances or regulations; amending s. 513.115, F.S.; specifying when certain property becomes abandoned; providing for disposition of such property; amending s. 513.118, F.S.; authorizing a park operator to refuse access to the premises and to eject transient guests or visitors based on specified conduct; providing that a person who refuses to leave the park premises commits the offense of trespass; providing immunity from liability for certain law enforcement officers; providing an exception; providing for removal of property; amending s. 513.13, F.S.; providing for ejection from a park and

specifying grounds and requirements therefor; providing for removal of property; providing an effective date.

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

Section 1. Section 513.012, Florida Statutes, is amended to read:

513.012 Public health laws; enforcement.—It is the intent of the Legislature that mobile home parks, lodging parks, recreational vehicle parks, and recreational camps be exclusively regulated under this chapter. As such, the department shall administer and enforce, with respect to such parks and camps, laws and rules relating to sanitation, control of communicable diseases, illnesses and hazards to health among humans and from animals to humans, and permitting and operational matters in order to protect the general health and well-being of the residents ~~people~~ of and visitors to the state. However, nothing in this chapter qualifies a mobile home park, a lodging park, a recreational vehicle park, or a recreational camp for a liquor license issued under s. 561.20(2)(a)1. Mobile home parks, lodging parks, recreational vehicle parks, and recreational camps regulated under this chapter are exempt from regulation under the provisions of chapter 509.

Section 2. Subsection (5) of section 513.02, Florida

Statutes, is amended to read:

513.02 Permit.—

(5) When a park or camp regulated under this chapter is sold or its ownership transferred, the transferee must apply for a permit to the department within 60 days after ~~before~~ the date of transfer. The applicant must provide the department with a copy of the recorded deed or lease agreement before the department may issue a permit to the applicant.

Section 3. Section 513.051, Florida Statutes, is amended to read:

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

Section 4. Subsection (3) is added to section 513.112, Florida Statutes, to read:

513.112 Maintenance of guest register and copy of laws.—

(3) When a guest occupies a recreational vehicle in a recreational vehicle park for less than 6 months, as evidenced by the length of stay shown in the guest register, there is a rebuttable presumption that the occupancy is transient.

Section 5. Subsection (3) of section 513.1115, Florida Statutes, is renumbered as subsection (4) and amended, and a new subsection (3) is added to that section, to read:

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

(3) If a recreational vehicle park is damaged or destroyed as a result of wind, water, or other natural disaster, the park may be rebuilt on the same site using the same density standards that were approved and permitted before the park was damaged or destroyed.

(4) ~~(3)~~ This section does not limit the regulation of the uniform firesafety standards established under s. 633.206. However, this section shall supersede any other county, municipality, or special district ordinance or regulation regarding the lot size, lot density, or separation or setback distance of a recreational vehicle park which goes into effect after the initial permitting and construction of the park.

Section 6. Section 513.115, Florida Statutes, is amended to read:

513.115 Unclaimed property.—Any property having an identifiable owner which ~~is left in a recreational vehicle park by a guest, other than property belonging to a guest who has vacated the premises without notice to the operator and with an outstanding account, which property~~ remains unclaimed after having been held by a ~~the~~ park for 90 days after written notice was provided to the guest or the owner of the property~~,~~ becomes the property of the park. Any property that is left by a guest who has vacated the premises without notice to the operator and

who has an outstanding account is considered abandoned property, and disposition thereof shall be governed by the Disposition of Personal Property Landlord and Tenant Act under s. 715.10.

Section 7. Section 513.118, Florida Statutes, is amended to read:

513.118 Conduct on premises; refusal of service.—

(1) The operator of a recreational vehicle park may refuse to provide accommodations, ~~or~~ service, or access to the premises to any transient guest or visitor ~~person~~ whose conduct on the premises of the park displays intoxication, profanity, lewdness, or brawling; who indulges in such language or conduct as to disturb the peace, quiet enjoyment, or comfort of other guests; who engages in illegal or disorderly conduct; or whose conduct constitutes a nuisance or safety hazard.

(2) The operator of a recreational vehicle park may request that a transient guest or visitor who violates subsection (1) leave the premises immediately. A person who refuses to leave the premises commits the offense of trespass as provided in s. 810.08 and the operator may call a law enforcement officer to have the person and his or her property removed under the supervision of the officer. A law enforcement officer is not liable for any claim involving the removal of the person or property from the recreational vehicle park under this section, except as provided in s. 768.28. If conditions do not allow for immediate removal of the person's property, he or she

may arrange a reasonable time, not to exceed 48 hours, with the operator to come remove the property, accompanied by a law enforcement officer.

(3) Such refusal of accommodations, ~~or~~ service, or access to the premises may ~~shall~~ not be based upon race, color, national origin, sex, physical disability, or creed.

Section 8. Section 513.13, Florida Statutes, is amended to read:

513.13 Recreational vehicle parks; ejection ~~eviction~~; grounds; proceedings.—

(1) The operator of any recreational vehicle park may remove or cause to be removed from such park, in the manner provided in this section, any transient guest of the park who, while on the premises of the park, illegally possesses or deals in a controlled substance as defined in chapter 893; who ~~or~~ disturbs the peace, quiet enjoyment, and comfort of other persons; who causes harm to the physical park; who violates the posted park rules and regulations; or who fails to make payment of rent at the rental rate agreed upon and by the time agreed upon. The admission of a person to, or the removal of a person from, any recreational vehicle park may ~~shall~~ not be based upon race, color, national origin, sex, physical disability, or creed.

(2) The operator of any recreational vehicle park shall notify such guest that the park no longer desires to entertain

the guest and shall request that such guest immediately depart from the park. Such notice shall be given in writing, as follows: "You are hereby notified that this recreational vehicle park no longer desires to entertain you as its guest, and you are requested to leave at once. To remain after receipt of this notice is a misdemeanor under the laws of this state." If such guest has paid in advance, the park shall, at the time such notice is given, tender to the guest the unused portion of the advance payment. Any guest who remains or attempts to remain in such park after being requested to leave commits ~~is guilty of~~ a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(3) If a guest has accumulated an outstanding account in excess of an amount equivalent to 3 ~~three~~ nights' rent at a recreational vehicle park, the operator may disconnect all utilities of the recreational vehicle and notify the guest that the action is for the purpose of requiring the guest to confront the operator or permittee and arrange for the payment of the guest's account. Such arrangement must be in writing, and a copy shall be furnished to the guest. Upon entering into such agreement, the operator shall reconnect the utilities of the recreational vehicle.

(4) If any person is illegally on the premises of any recreational vehicle park, the operator of such park may call upon any law enforcement officer of this state for assistance.

It is the duty of such law enforcement officer, upon the request of such operator, to remove from the premises or place under arrest ~~and take into custody for violation of this section~~ any guest who, according to the park operator, violated ~~violates~~ subsection (1) or subsection (2) ~~in the presence of the officer~~. If a warrant has been issued by the proper judicial officer for the arrest of any guest who violates ~~violator of~~ subsection (1) or subsection (2), the officer shall serve the warrant, arrest the guest ~~person~~, and take the guest ~~person~~ into custody. Upon removal or arrest, with or without warrant, the guest is deemed to have abandoned or given up any right to occupancy ~~or to have abandoned the guest's right to occupancy~~ of the premises of the recreational vehicle park; and the operator of the park shall employ all reasonable and proper means to care for any personal property left on the premises by such guest and shall refund any unused portion of moneys paid by such guest for the occupancy of such premises. If conditions do not allow for immediate removal of the guest's property, he or she may arrange a reasonable time, not to exceed 48 hours, with the operator to come remove the property, accompanied by a law enforcement officer.

(5) In addition to the grounds for ejection ~~eviction~~ established by law, grounds for ejection ~~eviction~~ may be established in a written lease agreement between a recreational vehicle park operator or permittee and a recreational vehicle park occupant.

Section 9. This act shall take effect July 1, 2020.

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Drake offered the following:

Amendment (with title amendment)

Between lines 31 and 32, insert:

Section 1. Present subsection (7) of section 514.0115, Florida Statutes, is redesignated as subsection (8), and a new subsection (7) is added to that section, to read:

514.0115 Exemptions from supervision or regulation; variances.-

(7) Until such time as the department adopts rules for the supervision and regulation of surf pools, a surf pool that is larger than 4 acres is exempt from supervision under this chapter, provided that it is permitted by a local government pursuant to a special use permit process in which the local

government asserts regulatory authority over the construction of the surf pool and, in consultation with the department, establishes through the local government's special use permitting process the conditions for the surf pool's operation, water quality, and necessary lifesaving equipment. This subsection does not affect the department's or a county health department's right of entry pursuant to s. 514.04 or its authority to seek an injunction pursuant to s. 514.06 to restrain the operation of a surf pool permitted and operated under this subsection if it presents significant risks to public health. For the purposes of this subsection, the term "surf pool" means a pool designed to generate waves dedicated to the activity of surfing on a surfboard or an analogous surfing device commonly used in the ocean and intended for sport, as opposed to general play intent for wave pools, other large-scale public swimming pools, or other public bathing places.

Section 2. Subsection (7) of section 553.77, Florida Statutes, is amended to read:

553.77 Specific powers of the commission.-

(7) Building officials shall recognize and enforce variance orders issued by the Department of Health pursuant to s. 514.0115(8) ~~s. 514.0115(7)~~, including any conditions attached to the granting of the variance.

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

Remove line 2 and insert:

An act relating to the Department of Health's regulation of recreational activities; amending s. 514.0115, F.S.; providing that certain surf pools are exempt from supervision for certain provisions under certain circumstances; providing construction; defining the term "surf pool"; amending s. 553.77, F.S.; conforming a cross-reference;

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 & Human Services Committee

Representative Drake offered the following:

Amendment

Remove line 103 and insert:

Personal Property Landlord and Tenant Act under s. 715.10 or under s. 705.185, as applicable.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/HB 649 Patient Brokering
SPONSOR(S): Civil Justice Subcommittee, Children, Families & Seniors Subcommittee, Caruso
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	15 Y, 0 N, As CS	Siples	Brazzell
2) Civil Justice Subcommittee	13 Y, 0 N, As CS	Frost	Luczynski
3) Health & Human Services Committee		Siples	Calamas

SUMMARY ANALYSIS

Florida's patient brokering statute makes it unlawful for a person to receive or provide a commission, benefit, bonus, rebate, kickback, or bribe, for the referral of a patient to or from a substance abuse provider or health care facility. The law provides a number of exceptions to the prohibition, including to any discount, waiver of payment or payment arrangement expressly authorized under the federal anti-kickback statute, which prohibits inducements for patient referrals for services payable by a federal health care program. Although the federal anti-kickback statute provides exceptions to its provisions, there may be payment arrangements that are not prohibited under the federal law but also not expressly authorized.

CS/CS/HB 649 expands the number of payment structures allowed under Florida's patient-brokering statute by exempting discounts, waivers of payment, or payments that are not prohibited by the federal anti-kickback statute, regardless of whether the discount, waiver, or payment involves items or services paid, in whole or in part, by a federal health care program.

The Criminal Justice Impact Conference considered the bill on January 27, 2020, and determined it will likely have a negative insignificant impact, meaning it will result in a decrease of 10 or fewer beds. The bill has no fiscal impact on local government.

The bill is effective upon becoming a law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Patient Brokering

In Florida, patient brokering is against the law.[1] Patient brokering is when a person pays to induce, or make a payment in return for, a referral of a patient to or from a health care provider or health care facility. Such payments can take many forms, including commissions, benefits, bonuses, rebates, kickbacks, bribes, split-fee arrangements, in cash or in kind, provided directly or indirectly.[2] The prohibition on patient brokering applies regardless of payment source.[3] There are significant penalties for patient brokering and penalties escalate as the number of patients involved increases. A person who violates the patient brokering statute commits a felony of the third degree.[4] If the violation involves 10 to 19 patients, the person commits a felony of the second degree.[5] If the violation involves 20 or more patients, the person commits a felony of the first degree.[6]

However, there are a number of exceptions to the prohibition on patient brokering, which means health care providers or other entities can engage in brokering practices without committing a crime. These exceptions include:[7]

- Any discount, payment, waiver of payment, or payment expressly authorized by the Federal Anti-Kickback Statute or regulations adopted thereunder;
- Any payment, compensation or financial arrangements within a group practice, provided such payment, compensation, or arrangement is not to or from persons who are not members of the group practice;
- Payments to a health care provider or health care facility for professional consultation services;
- Commissions, fees, or other remuneration lawfully paid to insurance agents;
- Payments by a health insurer who reimburses, provides, offers to provide, or administers health, mental health, or substance abuse goods or services under a health benefit plan;
- Payments to or by a health care provider or health care facility that has contracted with a health insurer, health care purchasing group, or the Medicare or Medicaid program to provide health, mental health, or substance abuse goods or services under a health benefit;
- Lawfully authorized insurance advertising gifts;
- Commissions or fees paid to a nurse registry for referring persons providing health care services to clients of the nurse registry;
- Certain payments by health care providers or health care facilities to a health, mental health, or substance abuse information service that provides information upon request and without charge to consumers about provider of health care good or services to enable consumers to select appropriate providers of facilities; and
- Certain payments authorized for assisted living facilities.

Federal Anti-Kickback Statute

[1] Section 817.505, F.S.
[2] Section 817.505(1), F.S.
[3] *See s.* 817.5050, F.S., which does not specify which payment sources are subject to its provisions; however, cases have been brought involving both private and public payers. *See, e.g., Prosper Diagnostic Centers, Inc. v. Allstate Insurance Company*, 964 So.2d 763 (Fla. 4d DCA 2007) and *State v. Rubio*, 967 So.2d 768 (Fla. 2007) .
[4] Punishable by a term of imprisonment not to exceed 5 years and a fine of $50,000.
[5] Punishable by a term of imprisonment not to exceed 15 years and a fine of $100,000.
[6] Punishable by a term of imprisonment not to exceed 30 years and a fine of $500,000.
[7] Section 817.505(3), F.S.

Federal law prohibits payment for the referral of an individual to a person for furnishing or arranging to furnish any item or service for which payment may be made under a federal health care program.[8] A federal health care program is any plan or program that provides health benefits, in whole or in part, by the United States government or any state health care program. State health care programs include Medicaid, maternal and child health services block grants, block grants and programs for social services and elder justice, and state children's health insurance programs.[9] Violation of the federal anti-kickback statute is a felony that is punishable by a fine of up to $25,000 or up to 5 years in prison, or both.[10] However, similar to Florida's patient brokering statute, there are several exceptions to the federal statute, such as:[11]

- Discounts properly disclosed and appropriately reflected in the costs claimed and charges made by the provider or entity;
- Payments between employers and employees for employment in the provision of covered items or services;
- Certain payments to a group purchasing organization;
- Waivers of co-insurance;
- Certain risk-sharing agreements; and
- The waiver of any cost-sharing provisions by a pharmacy.

Federal law allows other payment arrangements that are not specifically listed in law. Payment arrangements that do not squarely meet one of the exceptions are reviewed on a case-by-case basis to determine if the parties have the requisite criminal intent.[12] The Office of the Inspector General, within the U.S. Department of Health and Human Services, is proposing additional exceptions to the anti-kickback statute, including payment arrangements that are currently used by health care practitioners but are not specifically authorized under the statute.[13]

State Anti-Kickback Exception

As listed above, a current exception to the state patient brokering law is any discount, payment, waiver of payment, or payment practice that is expressly authorized by the federal anti-kickback statute. This language is a result of 2019 statute change.[14] This legislation changed this exception from payment schemes *not prohibited* under federal law to those *expressly authorized* under federal law.[15] This change created uncertainty for those using payment practices that were not prohibited under federal law but also not expressly authorized.[16] The federal anti-kickback statute applies only to those services for which payment is made by a federal health care program. Therefore, this exception does not apply to patient brokering involving any other payment sources, such as commercial health insurance policies and the prohibition against patient brokering would apply.

Effect of Proposed Changes

Currently, the patient brokering statute does not apply to any discount, payment, waiver of payment, or payment practice that is expressly authorized by the federal anti-kickback statute, which addresses this

[8] 42 U.S.C. s. 1320a-7b(b).
[9] Id.
[10] Id.
[11] Id.
[12] U.S. Department of Health and Human Services, *HHS Office of Inspector General Fact Sheet: Notice of Proposed Rulemaking OIG-0936-AA10-P*, (Oct. 2019), available at https://oig.hhs.gov/authorities/docs/2019/CoordinatedCare_FactSheet_October2019.pdf (last visited Feb. 5, 2020).
[13] Id.
[14] Chapter 2019-59, L.O.F.
[15] Id.
[16] *See* Florida Bar Health Law Section, *Health Law Section Adopts Legislative Position and Advocates for Revisions to Patient Brokering Act,* available at http://www.flabarhls.org/news/health-law-section-news/425-health-law-section-in-action (last visited Feb. 5, 2020); JDSupra, *Significant Changes to Florida's Patient Brokering Act: Uncertainty Lies Ahead – HealthCare Alert*, (Aug. 13, 2019), available at https://www.jdsupra.com/legalnews/significant-changes-to-florida-s-49130/ (last visited Feb. 5, 2020), and Jana Kolarik Anderson, Lawrence Vernaglia, and Jonathan Simler, *Florida: Changes to the State Patient Brokering Act*, NATIONAL LAW REVIEW, (Aug. 16, 2019), available at https://www.natlawreview.com/article/florida-changes-to-state-patient-brokering-act (last visited Feb. 5, 2020).

activity only in the context of federal health care programs.[17] CS/CS/HB 649 amends this provision so that the patient brokering statute does not apply to any such payment scheme not prohibited by the federal anti-kickback statute. This restores the law to the 2018 content before the 2019 revisions.

The bill significantly expands the application of this exemption to the prohibition on patient brokering by authorizing the exemption to apply regardless of whether the items or services are paid in whole or in part by a federal health care program that is designated in the federal anti-kickback law on March 1, 2020. This will allow more patient brokering than allowed by current law.

The bill is effective upon becoming a law.

B. SECTION DIRECTORY:

Section 1: Amends s. 817.505, F.S., relating to patient brokering prohibited; exceptions; penalties.
Section 2: Provides that the bill is effective upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The Criminal Justice Impact Conference considered the bill on January 27, 2020, and determined it will likely have a negative insignificant impact, meaning it will result in a decrease of 10 or fewer beds.[18]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill may alleviate confusion on which payment schemes are permissible under the state patient brokering law.

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.

[17] 42 U.S.C. §1320a-7b(f).
[18] Criminal Justice Impact Conference, *CS/HB 649*, available at http://edr.state.fl.us/Content/conferences/criminaljusticeimpact/CSHB649.pdf (last visited February 8, 2020).

B. RULE-MAKING AUTHORITY:

Rulemaking authority is not necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 22, 2020, the Children, Families & Seniors Subcommittee adopted a PCS and reported the bill favorably as a committee substitute. The PCS differed from the bill by:

- Removing the section relating to background checks of service provider personnel.
- Removing the section relating to voluntary certification of recovery residences.
- Removing the section relating to exemptions from disqualification for certain persons associated with applicant recovery residences.
- Amending the title from an act relating to substance abuse services to an act relating to patient brokering.

On February 4, 2020, the Civil Justice Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment:

- Defined "federal healthcare program" as provided under federal law on March 1, 2020.
- Changed the effective date of the bill to upon becoming a law.
- Made other minor technical changes.

This analysis is drafted to the committee substitute as passed by the Civil Justice Subcommittee.

A bill to be entitled

An act relating to patient brokering; amending s. 817.505, F.S.; revising provisions relating to payment practices exempt from prohibitions on patient brokering; providing an effective date.

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

Section 1. Paragraph (a) of subsection (3) of section 817.505, Florida Statutes, is amended to read:

817.505 Patient brokering prohibited; exceptions; penalties.—

(3) This section shall not apply to the following payment practices:

(a) Any discount, payment, waiver of payment, or payment practice not prohibited ~~expressly authorized~~ by 42 U.S.C. s. 1320a-7b(b) ~~42 U.S.C. s. 1320a-7b(b)(3)~~ or regulations promulgated ~~adopted~~ thereunder regardless of whether such discount, payment, waiver of payment, or payment practice involves items or services for which payment may be made in whole or in part under a federal healthcare program as defined in 42 U.S.C. s. 1320a-7b(f), as that definition exists on March 1, 2020.

Section 2. This act shall take effect upon becoming a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 705 Emergency Sheltering of Persons with Pets
SPONSOR(S): Oversight, Transparency & Public Management Subcommittee, Killebrew and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 752

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Oversight, Transparency & Public Management Subcommittee	14 Y, 0 N, As CS	Villa	Smith
2) Health & Human Services Committee		Guzzo	Calamas
3) State Affairs Committee			

SUMMARY ANALYSIS

The federal Pets Evacuation and Transportation Standards (PETS) Act of 2006 requires state and local emergency preparedness authorities to plan for how they will accommodate the needs of persons with pets and service animals prior to, during, and following a major disaster or emergency. The PETS Act also authorizes FEMA to provide rescue, care, shelter, and essential needs to persons with pets and service animals following a major disaster or emergency. Accordingly, FEMA authorizes state and local governments to seek reimbursement for pet rescue, shelter, and evacuation-support costs.

The Division of Emergency Management addresses the sheltering of service animals and persons with pets in the State Comprehensive Emergency Management Basic Plan and the Statewide Emergency Shelter Plan (Plans). Specifically, the Plans include information on the availability of shelters that accept pets, and states that a person who uses a service animal must be allowed to bring the service animal into a shelter and be accompanied by the service animal in all areas of public accommodation. Additionally, the Plans provide that the following be taken into consideration when developing strategies for the sheltering of persons with pets:

- Locating pet-friendly shelters within buildings with restrooms, running water, and proper lighting;
- Allowing pet owners to interact with their animals and care for them; and
- Ensuring animals are properly cared for during the emergency.

The bill requires counties that maintain designated shelters to designate a shelter that can accommodate persons with pets. The shelter must be in compliance with applicable FEMA Disaster Assistance Policies and Procedures and with safety procedures regarding the sheltering of pets established in the shelter component of both local and state comprehensive emergency management plans.

The bill requires the Department of Education to assist the Division of Emergency Management in determining strategies for the evacuation of persons with pets.

The bill may have an indeterminate fiscal impact on local governments. *See* Fiscal Comments. The bill has no fiscal impact on state government.

The bill provides an effective of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Pets Evacuation and Transportation Standards Act

On October 6, 2006, the federal Pets Evacuation and Transportation Standards (PETS) Act was signed into law amending the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act).[1] The PETS Act requires state and local emergency preparedness authorities to plan for how they will accommodate the needs of individuals with household pets and service animals prior to, during, and following a major disaster or emergency when presenting their plans to the Federal Emergency Management Agency (FEMA). The PETS Act also authorizes FEMA to provide rescue, care, shelter, and essential needs for individuals with household pets and service animals, and to the household pets and animals themselves, following a major disaster or emergency.

FEMA's Disaster Assistance Policy

FEMA's Disaster Assistance Policy (DAP) authorizes state and local governments that receive evacuees from areas declared a major disaster or emergency to seek reimbursement for pet rescue, sheltering, and evacuation-support costs. Contractors and nonprofit organizations may be indirectly reimbursed through a state or local government provided their operations and expenses are verified.[2]

FEMA's DAP identifies reimbursable expenses related to state and local governments' emergency pet evacuation and sheltering activities. For household pet rescue, reimbursable expenses include overtime for regular full-time employees, regular and overtime for contract labor, and the use of owned or leased equipment. For congregated household pet sheltering, reimbursable expenses include facilities, supplies and commodities, labor, equipment, emergency veterinary services, shelter safety and security, and cleaning and restoration services.[3]

Additionally, FEMA's DAP provides the following definitions:

> **Household pet** means a domesticated animal, such as a dog, cat, bird, rabbit, rodent, or turtle that is traditionally kept in the home for pleasure rather than for commercial purposes, can travel in commercial carriers, and be housed in temporary facilities. Household pets do not include reptiles (except turtles), amphibians, fish, insects and arachnids, farm animals (including horses), and animals kept for racing purposes.
>
> **Service animal** means any guide dog, signal dog, or other animal individually trained to provide assistance to an individual with a disability including, but not limited to, guiding individuals with impaired vision, alerting individuals with impaired hearing to intruders or sounds, providing minimal protection or rescue work, pulling a wheelchair, or fetching dropped items.[4]

[1] 42 U.S.C. 170b, 42 U.S.C. 5192; the Pets Evacuation and Transportation Standards Act (PETS Act) of 2006, P.L. No. 109-308, § 4, 120 Stat. 1725 (2006); and 44 CFR §§ 206.223(a), 206.225(a).
[2] Federal Emergency Management Agency, *FEMA Disaster Assistance Policy 9523.19*
, https://www.fema.gov/pdf/government/grant/pa/policy.pdf (last visited February 10, 2020).
[3] Id.
[4] Id.

Division of Emergency Management

The Division of Emergency Management (division) is responsible for all professional, technical, and administrative support functions necessary to carry out the State's Emergency Management Act.[5,6] The division, with the assistance of the Department of Agriculture and Consumer Services, is required to address strategies for the evacuation of persons with pets and must include similar strategies in its standards and requirements for local comprehensive emergency management plans.[7]

The State Comprehensive Emergency Management Basic Plan and the Statewide Emergency Shelter Plan (the Plans) address the sheltering of service animals and persons with pets.[8] Specifically, the Plans include information on the availability of shelters that accept pets, and states that a person who uses a service animal must be allowed to bring the service animal into a shelter and be accompanied by the service animal in all areas of public accommodation. Additionally, the Plans provide that the following be taken into consideration when developing strategies for the sheltering of persons with pets:

- Locating pet-friendly shelters within buildings with restrooms, running water, and proper lighting;
- Allowing pet owners to interact with their animals and care for them; and
- Ensuring animals are properly cared for during the emergency.

Emergency Sheltering Facilities

Counties may initiate their own protective measures, such as ordering evacuations and activating public shelters, including pet-friendly shelters.[9] Public facilities, including schools, postsecondary education facilities, and other facilities owned or leased by the state or local governments, which are suitable for use as public evacuation centers must be made available at the request of the local emergency management agencies.[10] Agencies must coordinate with these entities to ensure that designated facilities are ready to activate prior to an emergency or disaster.[11] Hospitals, hospice care facilities, assisted living facilities, and nursing homes may not be designated as emergency sheltering facilities.[12]

Effect of the Bill

The bill requires counties that maintain designated shelters to designate a shelter that can accommodate persons with pets. The shelter must be in compliance with applicable FEMA Disaster Assistance Policies and Procedures and with safety procedures regarding the sheltering of pets established in the shelter component of both local and state comprehensive emergency management plans.

The bill requires the Department of Education to assist the division in determining strategies for the evacuation of persons with pets.

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[5] Section 14.2016(1), F.S.
[6] Sections 252.31 – 252.63, F.S., are cited as the State Emergency Management Act. Section 252.31, F.S.
[7] Section 252.3568, F.S.
[8] Division of Emergency Management, *2018 Statewide Emergency Shelter Plan*, https://www.floridadisaster.org/globalassets/dem/response/sesp/2018/2018-sesp-a1-main-plan-text_final_1-30-18.pdf (last visited February 10, 2020); Division of Emergency Management, *2014 State of Florida Comprehensive Emergency Management Basic Plan*, https://www.floridadisaster.org/globalassets/importedpdfs/2014-state-cemp-basic-plan.pdf (last visited February 10, 2020).
[9] Division of Emergency Management, *2014 State of Florida Comprehensive Emergency Management Basic Plan*, *supra* FN 8.
[10] Section 252.385(4)(a), F.S.
[11] Id.
[12] Id.

B. SECTION DIRECTORY:

Section 1: Amends s. 252.3568, F.S., relating to emergency sheltering of persons with pets.
Section 2: Provides an effective date of July 1, 2020.

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:

See Fiscal Comments.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

The bill may have an indeterminate negative fiscal impact on counties to designate at least one shelter that can accommodate persons with pets. The bill provides that shelters must be in compliance with applicable FEMA Disaster Assistance Policies and Procedures and with safety procedures regarding the sheltering of pets established in the shelter component of both local and state comprehensive emergency management plans. The costs associated with designating appropriate facilities is indeterminate as each county would be responsible for determining their own standards.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

The county/municipality mandates provision of Art. VII, section 18, of the Florida Constitution may apply because this bill may require counties to expend funds in order to designate shelters that can accommodate persons with pets. However, an exemption may apply due to an insignificant fiscal cost.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Division of Emergency Management has sufficient rule-making authority to implement and enforce the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 4, 2020, the Oversight, Transparency & Public Management Subcommittee adopted a strike-all amendment and reported the bill favorably as a committee substitute. The strike-all amendment requires counties that maintain designated shelters to designate a shelter that can accommodate persons with pets. The shelters must be in compliance with applicable FEMA Disaster Assistance Policies and Procedures and with safety procedures regarding the sheltering of pets established in the shelter component of both local and state comprehensive emergency management plans.

The strike-all amendment requires the Department of Education to assist the division in determining strategies for the evacuation of persons with pets.

This analysis is drafted to the committee substitute as passed by the Oversight, Transparency & Public Management Subcommittee.

A bill to be entitled

An act relating to emergency sheltering of persons with pets; amending s. 252.3568, F.S.; requiring the Department of Education to assist the Division of Emergency Management in determining strategies regarding the evacuation of persons with pets; requiring counties that maintain designated shelters to designate a shelter that can accommodate persons with pets; specifying requirements for such shelters; providing an effective date.

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

Section 1. Section 252.3568, Florida Statutes, is amended to read:

252.3568 Emergency sheltering of persons with pets.—

(1) In accordance with s. 252.35, the division shall address strategies for the evacuation of persons with pets in the shelter component of the state comprehensive emergency management plan and shall include the requirement for similar strategies in its standards and requirements for local comprehensive emergency management plans. The Department of Agriculture and Consumer Services and the Department of Education shall assist the division in determining strategies regarding this activity.

(2) If a county maintains designated shelters it must also designate a shelter that can accommodate persons with pets. The shelter must be in compliance with applicable FEMA Disaster Assistance Policies and Procedures and with safety procedures regarding the sheltering of pets established in the shelter component of both local and state comprehensive emergency management plans.

Section 2. This act shall take effect July 1, 2020.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 711 Hospital, Hospital System, or Provider Organization Transactions
SPONSOR(S): Appropriations Committee, Burton & others
TIED BILLS: **IDEN./SIM. BILLS:** SB 758

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	15 Y, 0 N	Calamas	Calamas
2) Appropriations Committee	29 Y, 0 N, As CS	Jones	Pridgeon
3) Health & Human Services Committee		Calamas	Calamas

SUMMARY ANALYSIS

Healthy competition in economic markets keeps prices low and quality high for consumers. When one entity becomes too strong, it can stifle competition, leading to higher prices and harm to consumers. The goal of antitrust law is to protect and foster competition in economic markets, based on the idea that an unregulated market can lead to coercive monopolies.

When large hospitals systematically acquire smaller physician practices—a process known as vertical integration—such transactions can lead to less competition, price increases, and sometimes, coercive monopolies. To prevent such a transaction from occurring, a plaintiff, often the Attorney General, may bring an antitrust suit against the hospital. If a merger or acquisition violates antitrust law, a court may order the transaction undone. It is difficult for the Office of the Attorney General (OAG) to address antitrust activity once a transaction has occurred. However, Florida law does not require parties to such potentially monopolistic transactions to notify the OAG prior to execution.

CS/HB 711 amends the Florida Antitrust Act relating to the transactions by hospitals, hospital systems, and provider organizations. The bill imposes certain reporting requirements when a transaction between two entities in the health care market results in an affiliation or a material change to the health care market which could create a monopoly. An entity that fails to comply with these reporting requirements is subject to a civil penalty up to $500,000.

The notice requirements will provide a mechanism for the OAG to review transactions before they occur to determine whether a proposed transaction has antitrust implications and, if warranted, pursue action to prevent coercive monopolies from forming in the health care market.

The bill authorizes 12 full-time equivalent positions, associated salary rate of $629,382, and appropriates the sums of $1,221,249 in recurring funds and $47,472 in nonrecurring funds from the General Revenue Fund to the Department of Legal Affairs to implement changes made by the bill. The bill has no impact on local governments. The bill may negatively impact hospitals, hospital systems, and provider organizations engaging in anticompetitive behavior, but may positively impact independently operated hospitals or group practices, and consumers by providing greater competition. *See* Fiscal Analysis and Economic Impact Statement.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Federal Antitrust Law

Healthy competition in economic markets keeps prices low and quality high for consumers. When one entity becomes too strong, it can stifle competition, leading to higher prices and harm to consumers.

Antitrust law exists to protect competition, but not necessarily individual competitors, in economic markets. It is based on the idea that an unregulated market will lead to the creation of coercive monopolies.[1] Federal antitrust law includes the Sherman Antitrust Act, the Clayton Act, and the Federal Trade Commission Act. These laws are enforced in federal district court[2] by the U.S. Department of Justice, the Federal Trade Commission, state Attorneys General, and private plaintiffs. Antitrust case law is well-developed, and it is often difficult to distinguish aggressive, pro-competitive conduct—which is legal—from predatory, anti-competitive conduct.[3]

Clayton Act

The Clayton Act[4] prohibits specific business actions, including mergers and acquisitions, which may substantially lessen competition. To determine whether a merger violates the Clayton Act, a court must decide whether the merger is likely to create an appreciable danger of anticompetitive effects. The plaintiff must establish a prima facie case that a transaction is anticompetitive, such as by showing that an acquisition will significantly increase market concentration and lessen competition.[5] The burden then shifts to the defendant to rebut the prima facie case, such as by introducing evidence casting doubt on the plaintiff's prediction of anticompetitive effects.[6] If the defendant rebuts the prima facie case, the plaintiff has the final burden to demonstrate an antitrust violation.[7] If the plaintiff prevails, the customary remedy is for the court to order divestiture and unwind the merger.[8]

Sherman Antitrust Act

The Sherman Antitrust Act[9] prohibits any attempt to restrain trade or form a monopoly. A monopoly has two elements: (1) monopoly power and (2) willful acquisition or maintenance of that power, as opposed to power naturally resulting from a superior product, acumen, or historic accident. Stated differently, a plaintiff must prove the defendant acquired the monopoly power in a "predatory" manner. Penalties for violating the Sherman Act include up to ten years' imprisonment and a fine up to $100 million for a corporation or $1 million for any other person.[10]

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[1] John J. Miles, Antitrust Primer, 20140513 AHLA Seminar Papers 1 (2014) (stating the purpose of antitrust law is to "protect and promote competition as the primary method by which this country allocates scarce resources to maximize the welfare of consumers.").
[2] Steven Fox, Litigation Under Florida's Deceptive and Unfair Trade Practices Act, the Florida Antitrust Act, or Federal Antitrust Statutes, The Florida Bar, Business Litigation in Florida (2017) (federal district courts have exclusive jurisdiction over federal antitrust actions).
[3] Animesh Ballabh, Antitrust Law: An Overview, 88 J. Pat. & Trademark Off. Soc'y 877 (2006); John J. Miles, Antitrust Primer, 20140513 AHLA Seminar Papers 1 (2014).
[4] 15 U.S.C. s. 18.
[5] *Olin Corp. v. FTC*, 986 F.2d 1295, 1305 (9th Cir. 1993) (discussing how plaintiff's establishment of a prima facie case on statistical evidence is first step in analysis); *Chicago Bridge & Iron Co. v. FTC*, 534 F.3d 410, 423 (5th Cir. 2008).
[6] Id.
[7] *Chicago Bridge & Iron*, 534 F.3d at 423.
[8] *St. Alphonsus Med. Ctr. v. St. Luke's Health Sys.*, 778 F.3d 775, 792 (9th Cir. 2015).
[9] 15 U.S.C. ss. 1 et seq.
[10] 15 U.S.C. s. 1.

Florida Antitrust Law

Florida Antitrust Act of 1980

The Florida Antitrust Act of 1980[11] (the Act) is intended to complement federal antitrust law in order to foster effective competition. Implemented by the Office of the Attorney General (OAG), the Act essentially mirrors the federal Sherman Act, and prohibits:[12]

- Every contract, combination, or conspiracy in restraint of trade or commerce;[13] and
- Monopolization or attempted monopolization of any part of trade or commerce.[14]

A violation of Florida antitrust law can be penalized with up to three years' imprisonment and fines up to $1 million for a corporation and $100,000 for any other person.[15] There is also a private right of action for any person injured by certain violations.[16]

Florida Deceptive and Unfair Trade Practices Act (FDUTPA)

The FDUTPA broadly prohibits any unfair or deceptive act or practice committed in the conduct of any trade or commerce.[17] It provides a cause of action to make consumers whole for losses caused by fraudulent consumer practices. The FDUTPA applies to actions that do not yet constitute full-blown antitrust violations;[18] thus, an antitrust violation is also an unfair method of competition under the FDUTPA.[19] A willful violation of the FDUTPA is subject to a fine up to $10,000.[20]

Florida law does not provide a corollary to the federal Clayton Act, which specifically targets mergers and acquisitions that may lessen competition. However, the Attorney General considers the Florida Antitrust Act of 1980 and the FDUTPA broad enough to encompass those types of violations.[21]

Vertical Integration

When large hospitals or other medical facilities merge with one another or systematically acquire smaller physician practices, such transactions can lead to less competition, and sometimes, coercive monopolies.

Vertical integration broadly refers to transactions whereby a large medical entity, such as a hospital, acquires a smaller medical entity, such as a physician practice group, thereby expanding the hospital's market power. Vertical integration can occur in many ways, including by the following methods:

- **Complete buyout.** A hospital buys out a physician practice, including its physicians, staff, equipment, and patients. The physicians become hospital employees.
- **Asset purchase agreement.** A hospital acquires from a physician practice its channels of distribution, laboratories, equipment, or other assets.

[11] Ss. 542.15 – 542.36, F.S.
[12] S. 542.16, F.S.
[13] S. 542.18, F.S.
[14] S. 542.19, F.S.
[15] S. 542.21, F.S.
[16] Ss. 542.21, 542.22, F.S.
[17] Ss. 501.201 – 501.213, F.S.
[18] Steven Fox, *Litigation Under Florida's Deceptive and Unfair Trade Practices Act, the Florida Antitrust Act, or Federal Antitrust Statutes*, THE FLORIDA BAR, Business Litigation in Florida (2017).
[19] Id.; *see Omni Healthcare, Inc. v. Health First, Inc.*, *not reported in* F.Supp.3d (2016).
[20] S. 501.2075, F.S.
[21] *Supra* note 18; FLORIDA ATTORNEY GENERAL, *Antitrust*, http://myfloridalegal.com/antitrust (last visited Dec. 10, 2019).

- **Physician enterprise model.** A hospital and a physician practice enter into non-equity joint ventures together. The physicians preserve their autonomy and private practice model.[22]
- **Group practice subsidiary model.** A hospital purchases a physician practice group, but the physicians, who are not employed directly by the hospital, maintain control of the day-to-day operations of the practice group.[23]
- **Professional service agreement.** A hospital purchases a physician practice's technical component services and compensates the practice's physicians for professional services at the practice. The practice remains intact, while the hospital bills and collects professional fee-for-service revenue. The hospital compensates the practice for the services.[24]

Vertical integration has been on the rise in the last twenty years. Between 2002 and 2008 in the U.S., the share of physician practices owned by hospitals doubled,[25] and trends towards increased vertical integration continued from 2007 to 2013.[26] Whether the trend towards vertical integration benefits consumers is heavily debated.[27] Proponents of vertical integration argue that it can improve the quality and efficiency of care by strengthening ties between physicians and hospitals and improving communication.[28]

Critics of vertical integration argue that it increases a hospital's market share, potentially reducing or eliminating competition. Removing competition in the medical marketplace, in turn, may allow hospitals to raise their prices to a level that harms consumers.[29] Vertical integration may lead to:[30]

- Hospitals increasing their market power by amassing control over a larger bundle of services;
- Hospitals depriving their rivals of a source of destination for referrals; and
- Heightened incentives for physicians to supply unnecessary treatments to pay for kickbacks for inappropriate referrals.

One study analyzed the trends and effects of vertical integration in the U.S. and found that some loose forms of vertical integration might be socially beneficial. However, the study concluded that vertical integration increases healthcare costs:[31]

> Taken together, our results provide a mixed, although somewhat negative, picture of vertical integration from the perspective of the privately insured. Our most definitive finding is that hospital ownership of physician practices leads to higher prices and higher levels of hospital spending.

Similarly, another recent study found that hospital acquisitions of physician practices were responsible for an average price increase of 14.1% in fees for physician services, with larger increases where the

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[22] John W. McDaniel, *The Physician Enterprise Model: A Nonemployment Alternative*, ACMPE Executive View, Vol. 8, No. 1 (Spring 2012).
[23] PHYSICIANS PRACTICE, *Maintaining Independence as a Group Practice Subsidiary*, https://www.physicianspractice.com/maintaining-independence-group-practice-subsidiary (last visited Dec. 10, 2019).
[24] Marti Cox, *Physician-Hospital Alignment Models: An Evolving Lexicon*, MGMA, https://www.mgma.com/resources/resources/business-strategy/physician-hospital-alignment-models-an-evolving-l (last visited Dec. 10, 2019); CBIZ, *Professional Services Agreement: An Alternative Strategy to Hospital Employment*, https://www.cbiz.com/insights-resources/details/articleid/3197/ispreview/true/professional-services-agreement-an-alternative-strategy-to-hospital-employment-article (last visited Dec. 10, 2019).
[25] Laurence C. Baker, M. Kate Bundorf, and Daniel P. Kessler, *Vertical Integration: Hospital Ownership of Physician Practices is Associated with Higher Prices and Spending*, HEALTH AFFAIRS (May 2014), available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.1279 (last visited Dec. 10, 2019).
[26] Cory Capps, David Dranove, and Christopher Ody, *The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending*, JOURNAL OF HEALTH ECONOMICS (Apr. 22, 2018), https://www.sciencedirect.com/science/article/abs/pii/S016762961730485X (last visited Dec. 10, 2019).
[27] *Supra* note 25.
[28] Id.
[29] Id.
[30] Id.
[31] Id.

acquiring hospital was more dominant within its market. The price increases varied across specialties, ranging from a 15% price increase for primary care physicians up to a 33.5% price increase for cardiologists.[32]

The study estimated nearly half of the price increases were due to the exploitation of "facility fees," which hospitals are allowed to charge for procedures performed by hospital-owned physician groups.[33] When hospitals acquire physician practices, the simple change in ownership allows them to charge higher prices for the same procedure regardless of whether the procedure is performed in the hospital or in the physician's practice. The study found that the cardiologist specialty had the sharpest increase in vertical integration and prices, suggesting that more hospitals are acquiring cardiologists because of the higher reimbursement incentives for facility fees in that specialty. The study concluded:[34]

> Overall, we believe these results paint a relatively negative picture of hospital-physician VI [vertical integration]. However, given the evolving nature of healthcare reimbursement systems, future analyses will be important.

Antitrust Enforcement Mechanisms in Medical Markets

A plaintiff, such as the Attorney General, may bring an antitrust suit to prevent a merger or acquisition in the medical market.[35] If a merger or acquisition violates antitrust law, a court may order the transaction undone, or "unwound," or the court may order other remedies.[36]

For example, in *St. Alphonsus Medical Center v. St. Luke's Health System*, 778 F.3d 775 (9th Cir. 2015), an Idaho hospital purchased independent physician groups, resulting in the combined entity capturing 80% of the primary care physicians in the geographic market. Two medical centers and the FTC sued the acquiring hospital under state and federal antitrust law. The Court analyzed the transaction and found that while the intent of the acquisition may have been to improve patient outcomes, the acquisition would likely have anticompetitive effects and must be unwound under the Clayton Act.[37]

Under current law, a hospital's acquisition of a physician practice may be challenged by:

- The FTC[38] under the federal Clayton Act;[39]
- A private plaintiff under the FDUTPA; or
- The Attorney General under the Florida Antitrust Act.[40]

However, there is no reporting mechanism in current law that would alert the Attorney General to such acquisitions or transactions.

Effect of Proposed Changes

CS/HB 711 amends the Florida Antitrust Act relating to the acquisition of hospitals or other provider entities in the health care market. The bill imposes certain reporting requirements when a transaction between two entities in the health care market results in an affiliation or a material change to the health care market which could create a monopoly. An entity that fails to comply with these reporting

[32] *Supra* note 26.
[33] Id.
[34] Id.
[35] *See, e.g., St. Alphonsus Med. Ctr. v. St. Luke's Health Sys.*, 778 F.3d 775 (9th Cir. 2015) (where two hospitals merged, FTC and private plaintiffs brought antitrust suit, and court ordered divestiture of merger).
[36] *See id.*
[37] Id.
[38] *See, e.g., id.*; *F.T.C. v. Hosp. Bd. of Directors of Lee Cnty.*, 38 F.3d 1184 (11th Cir. 1994).
[39] *See also F.T.C. v. Univ. Health, Inc.*, 938 F.2d 1206 (11th Cir. 1991) (ruling against proposed acquisition of one hospital by another under the Clayton Act).
[40] S. 542.27(2), F.S., the Attorney General may institute any action authorized by federal law pertaining to antitrust or restraints of trade.

requirements is subject to a civil penalty up to $500,000.

It is difficult for the OAG to address antitrust activity once a transaction has occurred. These new notice requirements will provide a mechanism whereby the OAG will be able to review transactions before they are effective and will allow the OAG time to determine whether a proposed transaction has antitrust implications and if warranted, pursue action to prevent coercive monopolies from forming in the health care market.

Transactions Requiring Federal Reporting

Currently, when an entity operating in Florida reports a proposed merger or acquisition to the Federal Trade Commission or the U.S. Department of Justice under the federal Clayton Act, there is no requirement that Florida's Attorney General be notified. In these instances, the bill requires the entity to notify the OAG when it files any such report with the federal government.

Transactions Resulting in Material Change

In addition to the notices related to federal filings, the bill requires certain entities to notify the OAG of certain transactions not subject to the federal requirements.

A hospital, hospital system or provider organization must notify the OAG when it plans to enter into a transaction with another hospital, hospital system or provider organization, which is defined by the bill as a health care service entity which represents four or more health care providers in contracting with third-party payers for payments. Notice is only required for transactions that result in a material change, which is defined by the bill as a merger, acquisition or contract affiliation resulting in a combined revenue of $50 million or more. The bill requires these entities to submit such notices at least 90 days prior to the effective date of the transaction.

Notice Content

Under the bill, notices of transactions involving material changes and notices of transactions requiring federal reporting must include the following content.

- The name and business addresses of the parties to the transaction.
- A description of the proposed relationship among the parties.
- A description of services that will be provided at each location.
- The primary service area to be served by each location, which the bill defines as the area measured by the fewest number of zip codes from which the party draws at least 75 percent of its patients.
- A description of all acquisitions made by the parties in the last 5 years, which the bill defines as any activity by which a party to the noticed transaction obtains control of another hospital, hospital system, or provider organization..

When submitting this notice, the entity must identify any information that is a trade secret as defined in statute so that it can be protected from further disclosure. The bill expressly authorizes OAG to request additional information or issue a civil investigative demand for other documents or information relevant to antitrust investigations.[41] In addition, the bill expressly allows parties to a material change to voluntarily provide additional information to the OAG.

The bill requires the Attorney General to biennially report to the Legislature on its activities under this new section of law, beginning January 1, 2021.

[41] S. 542.28, F.S., currently authorizes the OAG to issue civil investigative demands, essentially a subpoena, for copies of any documents or information relevant to a civil antitrust investigation.

The bill is effective July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Creates s. 542.275, F.S., relating to hospital, hospital system, or provider organization mergers, acquisitions, and other transactions; notice; reporting; penalty.
Section 2: Creates an unnumbered section of law relating to reviews authorized under this act; expenses.
Section 3: Provides an appropriation.
Section 4: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The bill establishes a civil penalty which must be deposited in the Legal Affairs Revolving Trust Fund. To the extent that the OAG imposes such penalties, it will experience an increase in revenue.

2. Expenditures:

According to the OAG, the division will incur out-of-pocket expenses for staff and witnesses, expert fees and costs, court reporting costs, and the maintenance of a document review platform. The OAG projects it will receive at least 20 transaction reviews annually at an estimated cost of $16,000 per review for a total of $320,000 annually. Additionally, to implement the requirements of the bill, the OAG will need seven attorneys with antitrust or health care experience, three financial analysts or health economists, and two legal assistants.[42]

FTEs	Number	Rate	Total Salary & Benefits
Senior Legal Assistant	2	$36,478	$94,843
Economic Analyst	3	$43,498	$169,642
Assistant Attorney General	2	$51,636	$134,254
Senior Assistant Attorney General	5	$64,532	$419,458
Standard Expense Package (Professional)	10	$10,921	$109,210
Standard Expense Package (Support Staff)	2	$8,623	$17,246
Human Resources Package	12	$339	$4,068
Total FTE Costs	$948,721		
Special Category Antitrust Investigations	$320,000		
Total Nonrecurring	$47,472		
Total Recurring	$1,221,249		

The bill authorizes 12 additional FTEs and appropriates $1,221,249 in recurring funds and $47,472 in nonrecurring funds from the General Revenue Fund to cover these costs.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

[42] Correspondence from the Florida Department of Legal Affairs, Dec. 10, 2019(on file with Health Market Reform Subcommittee staff).

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

To the extent that the OAG discovers anticompetitive behavior under the new notice requirements of the bill, hospitals, hospital systems, and provider organizations engaging in such behavior will no longer be able to acquire and control monopolistic shares of the market. Entities that fail to comply with the notice requirements are subject to a civil penalty of up to $500,000. The bill also requires parties to the transaction to pay the reasonable expenses for the services of consultants, experts, accountants, economists, and other assistants used by the OAG to review transactions authorized by the act.

To the extent that the OAG is successful in reducing health care monopolies in the state, smaller or independent hospitals or group practices will be able to continue operating independently and may offer more competitive prices for health care services.

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:

The OAG does not require rulemaking authority to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 29, 2020, the Appropriations Committee adopted an amendment and reported the bill favorably as a committee substitute. The amendment reduced the appropriation provided in the bill to accurately reflect the OAG's most recent estimate of its projected costs to implement the bill.

This analysis is drafted to the committee substitute as passed by the Appropriations Committee.

A bill to be entitled

An act relating to hospital, hospital system, or provider organization transactions; creating s. 542.275, F.S.; providing definitions; requiring certain entities to submit written notice of a specified filing to the Office of the Attorney General relating to certain hospital, hospital system, or provider organization mergers, acquisitions, and other transactions within a specified timeframe; requiring that such entities submit written notice of a material change to the office within a specified period; providing requirements for such notice; authorizing the office to request additional information or issue a civil investigative demand; requiring the office to submit a biennial report to the Legislature by a specified date; providing a civil penalty; providing that such penalty be deposited into a specified trust fund; authorizing the office to engage the services of certain persons to fulfill its duties; authorizing positions and providing appropriations; providing an effective date.

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

Section 1. Section 542.275, Florida Statutes, is created

to read:

542.275 Hospital, hospital system, or provider organization mergers, acquisitions, and other transactions; notice; reporting; penalty.—

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

(a) "Acquisition" means an agreement, arrangement, or activity which results in a hospital, hospital system, or provider organization, directly or indirectly, obtaining control of another hospital, hospital system, or provider organization, including, but not limited to, the acquisition of voting securities and noncorporate interests, such as assets, capitol stock, membership interests, or equity interests.

(b) "Contracting affiliation" means a relationship between two or more entities wherein the entities have the ability to negotiate jointly with payors over rates for health care services, or one entity negotiates on behalf of the other entity with payors over rates for professional medical services in the primary service area in which the entities operate. The term does not include arrangements among entities under common ownership.

(c) "Health care provider" means a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461, or a person licensed under chapter 463 or a dentist licensed under chapter 466.

(d) "Hospital" has the same meaning as provided in s.

395.002.

(e) "Hospital system" means:

1. A corporation that owns one or more hospitals and any entity affiliated with such corporation through ownership or control; or

2. A hospital and any entity affiliated with such hospital through ownership.

(f) "Material change" means a merger, acquisition, or contracting affiliation that generates a combined revenue of $50 million or more between two or more entities of the following types:

1. Hospitals;

2. Hospital systems; or

3. Provider organizations.

(g) "Payor" means any entity or person that negotiates or assumes financial responsibility for a defined set of benefits from a health insurance plan or health insurance program. The term includes, but is not limited to, federal, state, and local governmental entities or agencies; affiliates; health insurance companies; health maintenance organizations; insurers; nonprofit religious organizations; persons; preferred provider organizations; prepaid limited health service organizations; and third-party administrators.

(h) "Primary service area" means the geographic area measured by the fewest number of zip codes from which the

hospital, hospital system, or provider organization draws at least 75 percent of its patients.

(i) "Provider organization" means a corporation, partnership, business trust, association, or organized group of persons, whether incorporated or not, which is in the business of health care services and represents four or more health care providers in contracting with payors for the payments of health care services. The term includes, but is not limited to, physician organizations, physician-hospital organizations, independent practice associations, provider networks, and accountable care organizations.

(2)(a) Any hospital, hospital system, or provider organization conducting business in this state which is required to file the Notification and Report Form for Certain Mergers and Acquisitions pursuant to the Hart-Scott-Rodino Antitrust Improvements Act, 15 U.S.C. s. 18a(a), shall provide written notice of such filing to the Office of the Attorney General at the same time that notice is filed with the Federal Government.

(b) Except when notice is required pursuant to paragraph (a), at least 90 days before the effective date of any transaction that would result in a material change, the parties to the transaction shall submit written notice to the Office of the Attorney General of such material change. Such written notice must identify all acquisitions that occurred during the 5 years preceding the date of the notice.

(c) The written notice required under paragraphs (a) and (b) shall include all of the following:

1. The names of the parties and their current business addresses.

2. A description of the proposed relationship among the parties to the proposed transaction.

3. A description of the health care services at each location at which services are currently provided and at any locations at which health care services will be provided.

4. The primary service area to be served by each location.

(d) Any written notice required under this subsection shall identify any information that the hospital, hospital system, or provider organization deems a trade secret, as defined in s. 688.002, or exempt from public records laws pursuant to any other statutory exemption.

(e) Upon receipt of any written notice submitted pursuant to this subsection, the Office of the Attorney General may request additional information or issue a civil investigative demand under s. 542.28.

(f) A hospital, hospital system, or provider organization who is a party to a material change may voluntarily provide additional information to the office.

(3) Beginning January 1, 2021, the Office of the Attorney General shall submit a biennial report to the President of the Senate and the Speaker of the House of Representatives regarding

its review of transactions under this section.

(4) A hospital, hospital system, or provider organization that fails to comply with this section is subject to a civil penalty of not more than $500,000, which shall be deposited into the Legal Affairs Revolving Trust Fund created under s. 16.53(1).

Section 2. In any review authorized under this act, the Office of the Attorney General may engage the services of consultants, experts, accountants, economists, analysts, and other assistants. When the review of a transaction is completed, the reasonable expenses related to such services shall be paid by the parties to the transaction.

Section 3. For the 2020-2021 fiscal year, 12 full-time equivalent positions with associated salary rate of 629,382 are authorized and the sums of $1,221,249 in recurring funds and $47,472 in nonrecurring funds from the General Revenue Fund are appropriated to the Department of Legal Affairs for the purpose of implementing s. 542.275, Florida Statutes.

Section 4. This act shall take effect July 1, 2020.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/HB 713 Department of Health
SPONSOR(S): Health Care Appropriations Subcommittee, Health Quality Subcommittee, Rodriguez, A. M.
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 230

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	11 Y, 0 N, As CS	Siples	McElroy
2) Health Care Appropriations Subcommittee	10 Y, 0 N, As CS	Mielke	Clark
3) Health & Human Services Committee		Siples	Calamas

SUMMARY ANALYSIS

CS/CS/HB 713 makes numerous changes to programs under the Department of Health (DOH) and health care professions regulated by Medical Quality Assurance within DOH. The bill:

- Authorizes DOH to establish patient care networks to plan for the care of individuals with the human immunodeficiency virus (HIV), rather than only those diagnosed with acquired immune deficiency syndrome (AIDS);
- Authorizes DOH to adopt rules to implement the Conrad 30 Waiver program;
- Revises DOH's rulemaking authority relating to the minimum standards for ground ambulances;
- Authorizes DOH to request a date of birth on a licensure application;
- Authorizes DOH to issue a temporary license that expires 60 days after issuance, rather than 30 days, to certain applicants who have not yet been issued a social security number;
- Repeals a requirement that DOH discipline a healthcare practitioner's license for failing to repay a student loan;
- Authorizes DOH to issue medical faculty certificates to certain full-time faculty members of Nova Southeastern University and Lake Erie College of Osteopathic Medicine;
- Repeals a requirement that the Board of Medicine triennially review board certification organizations for dermatology;
- Revises the requirements for osteopathic internships and residencies to include those accredited by the Accreditation Council for Graduate Medical Education ;
- Repeals a requirement that a Florida-licensed dentist grade the dental licensure examination and that a Florida-licensed dentist or dental hygienist grade the dental hygienist licensure examination;
- Requires dentists and dental hygienists to report adverse incidents to the Board of Dentistry;
- Requires DOH to biennially inspect dental laboratories;
- Repeals the voluntary registration of registered chiropractic assistants;
- Authorizes DOH to issue a single registration to a prosthetist-orthotist;
- Requires an athletic trainer to work within his or her scope of practice and revises licensure requirements;
- Limits massage therapy apprenticeships to those in colonic irrigations, and requires licensure applicants to pass a national licensure examination designated by the Board of Massage Therapy;
- Revises psychology licensure requirements;
- Authorizes the Board of Clinical Social Work, Marriage and Family Therapists, and Mental Health Counseling to approve a one-time exception to the 60-month limit on an internship registration;
- Revises the licensure requirements for Marriage and Family Therapists and Licensed Mental Health Counselors;
- Extends the sunset date for Florida Center for Nursing annual reports on nursing education to January 30, 2025;
- Revives and reenacts health access dental licenses and makes the reenactments retroactive to January 1, 2020; and
- Deletes obsolete language and makes technical and conforming changes.

The bill has an insignificant, positive fiscal impact and an insignificant, negative fiscal impact on the DOH, which current resources are adequate to absorb. The bill has no fiscal impact on local governments.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

HIV/AIDS

Human Immunodeficiency Virus (HIV) is an immune system debilitating virus that can lead to fatal acquired immunodeficiency syndrome (AIDS). HIV affects specific cells of the immune system and over time the virus can destroy enough of these cells that the body can no longer fight off infection and disease.[1] HIV is transmitted by sexual contact, sharing needles to inject drugs, and by a mother to her baby during pregnancy, birth, or breastfeeding.[2] There is no cure for HIV but it can be controlled with proper medical care, including antiretroviral therapy (ART). If taken properly, ART can dramatically prolong the lives of people infected with HIV, keep them healthy, and greatly lower the chance of infecting others.[3] However, untreated HIV is almost always fatal.[4]

There are three stages of HIV infection through which an infected person typically progresses:[5]

- Stage 1: Acute HIV infection. Within two to four weeks after infection with HIV, an individual may experience a flu-like illness.
- Stage 2: Clinical latency. HIV is still active but reproduces at a very low level. Those who are taking ART may remain at this stage for several decades.
- Stage 3: AIDS. This is the most severe phase of HIV infection. Opportunistic infections or cancers take advantage of a very weak immune system and signal that the person has AIDS. Without treatment, a person with AIDS typically survives about three years.

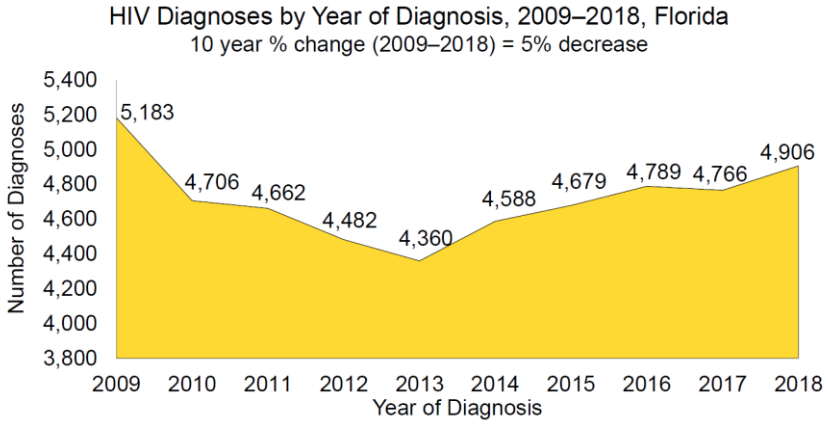
AIDS and HIV in Florida

The Department of Health (DOH) has identified the reduction in the transmission of HIV as one of its priority goals. It has adopted a comprehensive plan to prevent HIV transmission and strengthen patient care activities to reduce the risk of further transmission of HIV from those diagnosed and living with HIV. The plan includes:[6]

- Implementing routine HIV and sexually transmitted infections (STIs) screening in health care settings and priority testing in non-health care settings;
- Providing rapid access to treatment and ensuring retention in care;
- Improving and promoting access to antiretroviral pre-exposure prophylaxis and non-occupational post-exposure prophylaxis; and
- Increasing HIV awareness and community response through outreach, engagement, and messaging.

There has been an overall decrease in the number of newly diagnosed cases of HIV infection in the last 10 years. However, in the last five years, the number of newly diagnosed cases has increased.

[1] Centers for Disease Control and Prevention, *About HIV/AIDS*, (last rev. Aug. 14, 2019), available at: https://www.cdc.gov/hiv/basics/whatishiv.html (last visited November 22, 2019).
[2] Id.
[3] Id.
[4] Id.
[5] Id.
[6] Department of Health, *HIV/AIDS*, available at http://www.floridahealth.gov/diseases-and-conditions/aids/ (last visited December 6, 2019).



Approximately, 1,918 individuals in Florida have AIDS.[7] This number has steadily declined in the last 20 years, with 4,646 AIDS cases in the state in 1999.[8] With advances in the treatment of HIV with ART, the number of individuals living with HIV has increased. In 2018, there were 119,661 individuals living with HIV in this state.[9] In the U.S., approximately 15 percent of individuals who have HIV are unaware that they are infected.[10] DOH estimated in 2017, that more than 18,000 Floridians were unaware of their HIV infection.[11]

Patient Care Networks

Current law authorizes DOH to establish patient care networks for individuals with AIDS in those areas of the state where the number of cases of AIDS and other HIV infections justifies the establishment of such networks.[12] The patient care networks must plan for the care and treatment of individuals with AIDS and AIDS-related conditions in a cost-effective and dignified manner, which emphasizes outpatient and home care.[13] In establishing the networks, DOH must take into account the natural trade areas and centers of medical excellence in treating AIDS, as well as federal, state, and other funds. The patient care networks have been established in the following geographic areas:[14]

- South Florida, consisting of Dade and Monroe counties;
- Palm Beach County;
- East central Florida, consisting of Orange, Osceola, Seminole, and Brevard counties;
- West central Florida, consisting of Hillsborough, Polk, Pinellas, and Pasco counties; and
- Northeast Florida, consisting of Duval, St. Johns, Nassau, Baker, Clay, and Flagler counties.

Each network must annually make recommendations regarding patient care needs to DOH.[15]

Conrad 30 Waiver Program

Federal law requires a foreign physician pursuing graduate medical education or training in the United States to obtain a J-1 visa. A holder of a J-1 visa is ineligible to apply for an immigrant visa, permanent

[7] Department of Health, Florida Health Charts, *AIDS Cases*, available at http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=HIVAIDS.DataViewer&cid=0141 (last visited November 22, 2019).
[8] Id.
[9] Department of Health, Florida Health Charts, *Persons Living with HIV*, available at http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=HIVAIDS.DataViewer&cid=9866 (last visited November 22, 2019).
[10] HIV.gov, *Ending the HIV Epidemic: HIV in America*, (last rev. June 27, 2019), available at https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/hiv-in-america (last visited November 22, 2019).
[11] Department of Health, *2017 Florida HIV Surveillance Summary*, (Nov. 2018), available at http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/_documents/fact-sheet/HIV_Surveillance_Trifold.pdf (last visited November 22, 2019).
[12] Section 381.0042, F.S.
[13] Id.
[14] Rule 64D-2.001, F.A.C.
[15] *Supra* note 12.

residence, or certain nonimmigrant statuses unless he or she has resided and been physically present in his or her country of nationality for at least two years after completion of the J-1 visa program.[16] However, the Conrad 30 Waiver program allows such foreign physicians to apply for a waiver of the two-year residency requirement upon the completion of the J-1 visa program. To be eligible for a Conrad 30 Waiver, the foreign physician must:[17]

- Obtain a contract for full-time employment at a health care facility in an area dedicated as a Health Professional Shortage Area, Medically Underserved Area, or Medically Underserved Population;
- Obtain a "no objection" letter from his or her home country if the home government funded his or her exchange program; and
- Agree to begin employment at the health care facility within 90 days of receipt of the waiver, no later than the date his or her J-1 visa expires.

A state may only sponsor 30 physicians for waivers per year and each state may develop its own application rules and guidelines. DOH does not currently have statutory authority to develop rules and guidelines for its Conrad 30 program.

Florida has sponsored 30 physicians each year for each of the last 10 years under the program.[18] More than 70 percent, or nearly 450 physicians, have remained in practice in Florida since the inception of the Conrad 30 Waiver Program.[19] Currently, Florida approves these waivers on a first-come basis.

Emergency Medical Transportation Services

The Legislature recognized the need for the uniform and systematic provision of emergency medical services to save lives and reduce disability associated with illness and injury.[20] In 1973, the Florida Legislature passed and enacted what is known today as the Raymond H. Alexander, M.D., Emergency Medical Transportation Services Act (Act).[21] The Act establishes the licensing and operational requirements for emergency medical services.

The Act creates the Emergency Medical Services Advisory Council (Council)[22] to act as an advisory body to the emergency medical services within DOH.[23] The Council's duties include, among other things:[24]

- Identifying and making recommendations to the DOH regarding the appropriateness of suggested changes to statutes and administrative rules;
- Acting as a clearinghouse for information specific to changes in the provision of medical services and trauma care;
- Providing technical support to the DOH in the areas of emergency medical services and trauma systems design, required medical and rescue equipment, required drugs and dosages, medical

[16] Department of Homeland Security, U.S. Citizenship and Immigration Services, *Conrad 30 Waiver Program*, (last rev. May 5, 2014), available at https://www.uscis.gov/working-united-states/students-and-exchange-visitors/conrad-30-waiver-program#Background (last visited November 22, 2019).
[17] Id.
[18] Presentation by Jennifer Johnson, Division Director, Division of Public Health Statistics and Performance Management, Department of Health, before the Health Quality Subcommittee on January 23, 2019, available at https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3021&Session=2019&DocumentType=Meeting%20Packets&FileName=hqs%201-23-19.pdf (last visited November 22, 2019).
[19] Id.
[20] Section 401.211, F.S.
[21] Department of Health, *Emergency Medical Services System*, available at http://www.floridahealth.gov/licensing-and-regulation/ems-system/index.html (last visited December 11, 2019). The Act is codified at ss. 401.2101 – 401.465, F.S.
[22] Section 401.245(2), F.S. The Council consists of 15 members appointed by the State Surgeon General, except that state agency representatives are appointed by the respective agency heads. Members are typically appointed for four year terms, with the chair being designated by the State Surgeon General and Secretary of Health. Additional members include six ex officio representatives appointed by various other state agency heads.
[23] Section 401.245(1), F.S.
[24] *Id.*

treatment protocols and emergency medical services personnel education and training requirements;
- Providing a forum for discussing significant issues facing the emergency medical services and trauma care communities;
- Assisting the DOH in setting program priorities; and
- Providing feedback to the DOH on the administration and performance of the emergency medical services program.

Licensure

Current law requires providers of basic or advanced life support transportation services to be licensed by the DOH in their respective fields.[25] Basic life support (BLS) service refers to any emergency medical service that uses only basic life support techniques.[26] BLS includes basic non-invasive interventions to reduce morbidity and mortality associated with out-of-hospital medical and traumatic emergencies.[27] The services provided may include stabilization and maintenance of airway and breathing, pharmacological interventions, trauma care, and transportation to an appropriate medical facility.[28]

Advanced life support (ALS) service refers to any emergency medical or non-transport service that uses advanced life support techniques.[29] ALS includes the assessment or treatment of a person by a qualified individual, such as a paramedic, who is trained in the use of techniques such as the administration of drugs or intravenous fluid, endotracheal intubation, telemetry, cardiac monitoring, and cardiac defibrillation.[30]

To be licensed as a BLS or ALS service, an applicant must comply with the following requirements:

- The ambulances, equipment, vehicles, personnel, communications systems, staffing patterns, and services of the applicant meet the statutory requirement and administrative rules for either a BLS service or an ALS service, whichever is applicable;
- Have adequate insurance coverage or certificate of self-insurance for claims arising out of injury to or death of persons and damage to the property of others resulting from any cause for which the owner of such business or service would be liable; and
- A Certificate of Public Convenience and Necessity from each county in which the applicant will operate.[31]

DOH must establish rules for ground ambulance or vehicle design and construction that is at least equal to those recommended by the United States General Services Administration.[32] The federal guideline went into effect in 1974 and was for use by federal agencies and federal grant recipients purchasing ambulances.[33] This federal standard was to be discontinued in 2016, however, it was recently updated in July 2019.[34] Many states use the federal recommendations as there were no standards for ambulance design.[35] In recent years, however, at least two other organizations have created standards: the Commission on Accreditation of Ambulance Services and the National Fire Protection Association.[36]

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[25] Section 401.25(1), F.S.
[26] Section 401.23(8), F.S.
[27] Section 401.23(7), F.S., and U.S. Department of Transportation, National Highway Safety Administration, *National EMS Scope of Practice Model* 23-24, *available at* www.nhtsa.gov/people/injury/ems/pub/emtbnsc.pdf (last visited December 11, 2019).
[28] *Id*.
[29] Section 401.23(2), F.S.
[30] Section 401.23(1), F.S.
[31] Section 401.25(2), F.S.
[32] Section 401.35, F.S.
[33] Richard Huff, NREMT-B, *Competing Ambulance Safety Standards Await State Adoption*, 40 J EMER. MED. SERV. (Jan. 26, 2015), available at https://www.jems.com/2015/01/26/competing-ambulance-safety-standards-await-state-adoption/ (last visited December 11, 2019).
[34] Id., and SafeAmbulances.org, Ground Ambulance Standards and EMS Safety Resource, *General Services Administration*, available at https://www.safeambulances.org/organizations/gsa/ (last visited December 11, 2019).
[35] Id.
[36] *Supra* note 33.

In addition to the general licensure requirement, DOH provides a list of the equipment and supplies with which each BLS vehicle must be equipped and maintained and the equipment and medication with which each ALS vehicle must be equipped and maintained by rule.[37] Current law requires the list of equipment and supplies established by DOH in rule, be at least as comprehensive as those listed in the most current edition of the American College of Surgeons, Committee on Trauma, list of essential equipment for ambulances.[38] The American College of Surgeons developed this list more than 40 years ago, and in 2000, it jointly produced a list of standardized ambulance equipment with the American College of Emergency Physicians. Since that time, the joint document has been updated and has included participation by the National Association of EMS Physicians, Federal Emergency Medical Services for Children Stakeholder Group, National Association of State EMS Officials, Emergency Nurses Association, and endorsed by the American Academy of Pediatrics.[39]

Health Care Professional Licensure

The Division of Medical Quality Assurance (MQA), within the Department of Health (DOH), has general regulatory authority over health care practitioners.[40] MQA works in conjunction with 22 boards and 4 councils to license and regulate 7 types of health care facilities and more than 40 health care professions.[41] Each profession is regulated by an individual practice act and by ch. 456, F.S., which provides general regulatory and licensure authority for MQA.

General Licensure Requirements

There are general licensure provisions that apply to all licensure applications, regardless of profession. For example, all applicants for licensure must apply in writing on an application form approved by DOH or electronically on a web-based application form.[42] Additionally, an applicant must provide his or her social security number for identification purposes.[43] However, an applicant is not required to provide his or her date of birth as DOH is not currently authorized to collect this information.

If, at the time of application, an applicant has not been issued a social security number because he or she is not a U.S. citizen or resident, DOH may process the application using a unique personal identification number.[44] If the applicant is eligible for a license, the applicable board, or DOH when there is no board, may issue a temporary license to the applicant.[45] The temporary license is only valid for 30 days unless the applicant submits a social security number. On average, it takes about two weeks to receive a social security number once all required documentation is submitted to the U.S. Social Security Administration.[46] If the Social Security Administration is unable to immediately verify immigration documents with the U.S.

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[37] Rule 64J-1.002(4) F.A.C. (Basic Life Support Service License – Ground); Rule 64J-1.003(7), F.A.C. (Advanced Life Support Service License – Ground).
[38] Section 401.35, F.S.
[39] American Academy of Pediatrics, American College of Emergency Physicians, American College of Surgeons Committee on Trauma, Emergency Medical Services for Children, Emergency Nurses Association, National Association of EMS Physicians & National Association of State EMS Officials, *Equipment for Ground Ambulances*, PREHOSPITAL EMERGENCY CARE, 18:1, 92-97, (Oct. 2013), available at https://www.tandfonline.com/doi/pdf/10.3109/10903127.2013.851312 (last visited December 11, 2019).
[40] Pursuant to s. 456.001(4), F.S., health care practitioners are defined to include acupuncturists, physicians, physician assistants, chiropractors, podiatrists, naturopaths, dentists, dental hygienists, optometrists, nurses, nursing assistants, pharmacists, midwives, speech language pathologists, nursing home administrators, occupational therapists, respiratory therapists, dieticians, athletic trainers, orthotists, prosthetists, electrologists, massage therapists, clinical laboratory personnel, medical physicists, dispensers of optical devices or hearing aids, physical therapists, psychologists, social workers, counselors, and psychotherapists, among others.
[41] Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long-Range Plan, Fiscal Year 2018-2019*, available at http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/_documents/annual-report-1819.pdf (last visited November 22, 2019).
[42] Section 456.013, F.S.
[43] Id.
[44] Id.
[45] Id.
[46] U.S. Social Security Administration, *Apply for your Social Security Number While Applying for Your Work Permit*, available at https://www.ssa.gov/ssnvisa/ebe.html (last visited November 25, 2019).

Citizenship and Immigration Services, it may take an additional two weeks to issue the social security number.[47]

Health Care Licensure and Student Loans

Student loans are funds that are lent to students or parents to pay for higher education. Student loans may come from private sources, such as banks or other financial institutions, or from a state or the federal government.[48]

The Office of Student Financial Assistance (OSFA) within the Florida Department of Education (DOE) is responsible for administering state and federally funded programs and serves as the guarantor agency for certain federally-backed student loans.[49] The DOE is directed to exert every lawful and reasonable effort to collect all delinquent unpaid and uncanceled student loans.[50]

Increase in Defaults on Student Loans

An estimated 41.5 million Americans owe more than $1.2 trillion in outstanding federal loan debt. This is more than triple the $340 billion in student loan debt owed by Americans in 2001.[51] With this increase in student loan debt owed by Americans, there has been an increase in the number of people who are defaulting on or failing to pay their student loans. For most federal loans, default generally occurs when a payment has not been made for 270 days.[52] In 2018, 41,013 borrowers who attended Florida schools had defaulted on their federal student loans used to attend institutions ranging from universities to trade schools.[53]

Disciplining Professional Licenses for Defaulting on Student Loans

In the 1990s, as a result of a rising number of students defaulting on their federally-backed student loans, the federal government urged state legislators to send a message to students, post-secondary institutions, and lenders that high levels of default would not be tolerated. The federal government recommended that states take the following steps to curb student loan default:[54]

- Enact a state tax-refund offset program;
- Enact a wage garnishment program;
- Deny professional licenses to defaulters until they take steps towards repayment;
- Screen potential applicants for state jobs to prevent the hiring of loan defaulters who have not entered into repayment agreements; and
- Ensure that information available to state agencies such as the Department of Motor Vehicles, the tax department, and the unemployment commission is available to the state's guarantee agency.

As a result, many states, including Florida, began adopting various forms of disciplinary licensing laws for defaulting on government-backed student loans. By 2010, about half of the states had some form of

[47] Id.
[48] Consumer Financial Protection Bureau, *Student Loans: Choosing a loan that's right for you*, https://www.consumerfinance.gov/paying-for-college/choose-a-student-loan/#o1 (last visited Dec. 4, 2019).
[49] Office of Student Financial Assistance, *Mission Statement*, http://www.floridastudentfinancialaid.org/FFELP/mission_statement/mission_statement_052606.html (last visited on Nov. 26, 2019).
[50] S. 1009.95, F.S.
[51] Laura Feiveson, Alvaro Mezza, and Kamila Sommer, *Student Loan Debt and Aggregate Consumption Growth*, Board of Governors of the Federal Reserve System, (February 21, 2018), https://www.federalreserve.gov/econres/notes/feds-notes/student-loan-debt-and-aggregate-consumption-growth-20180221.htm (last visited on Nov. 26, 2019).
[52] United States Department of Education, Federal Student Aid, *Glossary, Default,* https://studentaid.ed.gov/sa/glossary#letter_d (last visited Nov. 26, 2019).
[53] Florida Business Daily, *41,013 borrowers in default on student loans after attending Florida schools,* May 17, 2018, https://flbusinessdaily.com/stories/511416784-41-013-borrowers-in-default-on-student-loans-after-attending-florida-schools (last visited Nov. 26, 2019).
[54] Mary Farrell, *Reducing Student Loan Defaults: A Plan for Action*, Department of Education at 63 (March 21, 1991) https://files.eric.ed.gov/fulltext/ED323879.pdf (last visited Nov. 26, 2019).

disciplinary licensing laws for defaulting on government-backed student loans. Since then, based on shifting concerns, there has been a trend to reduce or eliminate such laws. Currently, approximately 15 states, including Florida, still have some form of such laws.[55]

Federal Attempts to Prohibit State Disciplinary Licensing Laws

Recently, there have been attempts at the national level to prohibit state disciplinary licensing laws for defaulting on government-backed student loans. Bills were introduced in the United States Congress in 2018 and 2019 that would prohibit states from disciplining or denying state-issued licenses for defaulting on government-backed student loans.[56]

DOH Disciplinary Laws

Section 456.072(1)(k), F.S., authorizes DOH to discipline a health care practitioner for failing to perform any statutory or legal obligation placed upon a health care practitioner, which specifically includes failing to repay a government-backed student loan or comply with a service scholarship obligation. If DOH finds that a health care practitioner has defaulted on his or her student loans or failed to comply with a service scholarship, at a minimum, DOH must:

- Suspend the practitioner's license until he or she agrees to new loan repayment terms or resumes the scholarship obligation;
- Place the practitioner on probation for the duration of the student loan or scholarship obligation period; and
- Impose a fine equal to 10 percent of the defaulted loan amount.

Every month, DOH must obtain a list from USHHS of Florida-licensed health care practitioners who have defaulted on government-backed student loans.[57] Upon learning that a health care practitioner has defaulted on such a student loan, DOH must notify the practitioner that he or she has 45 days to provide DOH with proof of a new repayment plan, or such practitioner will be subject to an emergency order suspending the practitioner's license. Also, DOH may proceed with additional disciplinary action against the practitioner, regardless if he or she provides proof of entering a new repayment plan.[58]

During the 2017-2018 Fiscal Year, DOH handled 247 cases against health care practitioners for defaulting on student loans, and during the 2018-2019 Fiscal Year, DOH handled 722 cases.[59]

Case Status	2017-18 FY	2018-19 FY
Mediated	88	332
Dismissed	27	75
Discipline Imposed	23	36
No Probable Cause Found	9	41
Licensee is No Longer Licensed	54	55
Licensee is Deceased	3	2
Still Open	43	160
Complaint Withdrawn by DOE	0	21
Total	**247**	**722**

[55] Andrew Wagner, *Licensing Suspension for Student Loan Forgiveness*, NCSL (Oct. 1, 2018) http://www.ncsl.org/research/labor-and-employment/license-suspension-for-student-loan-defaulters.aspx (last visited Nov. 26, 2019).
[56] Protecting JOBs Act, S.3065, 115th Congress (2017-2018); Protecting JOBs Act, H.R.6156 115th Congress (2017-2018); Protecting JOBs Act, S.609, 116th Congress (2019-2020).
[57] Section 456.0721, F.S.
[58] Section 456.074(4), F.S.
[59] E-mail correspondence with Gary Landry, Office of Legislative Planning, Department of Health, dated Oct. 30, 2019, on file with the Health Quality Subcommittee.

Medical Faculty Certificates

The Board of Medicine may issue a medical faculty certificate to a qualified physician to practice in conjunction with a full-time faculty appointment at one of the following accredited medical school and its affiliated clinical facilities or teaching hospitals:[60]

- University of Florida;
- University of Miami;
- University of South Florida;
- Florida State University;
- Florida International University;
- University of Central Florida;
- Mayo Clinic College of Medicine and Science in Jacksonville, Florida;
- Florida Atlantic University; or
- Johns Hopkins All Children's Hospital in St. Petersburg, Florida

Although the applicant does not have to sit for and successfully pass a national examination, the applicant must meet specified statutory criteria for the medical faculty certificate.

There is no limit on the number of initial certificates a medical school or teaching institution may receive. However, the number of medical faculty certificates that may be renewed by each medical school or teaching institution is statutorily limited.[61] All medical schools, except the Mayo Clinic College of Medicine in Jacksonville, Florida, are limited to 30 renewed medical faculty certificates. The Mayo Clinic College of Medicine is limited to 10 renewed medical faculty certificates. The H. Lee Moffitt Cancer Center and Research Institute is also permitted to have up to 30 renewed faculty certificates.[62]

An annual review of each medical faculty certificate recipient is made by the dean of the certificate recipient's accredited 4-year medical school and reported to the BOM within the DOH on an annual basis.[63] Currently, there are 62 physicians holding a medical faculty certificate.[64]

Board Certification of Physicians

Medical licensure of physicians sets the minimum competency requirements to diagnose and treat patients; it is not specialty specific.[65] Medical specialty certification is a voluntary process that gives a physician a way to develop and demonstrate expertise in a particular specialty or subspecialty.[66]

Board Certification and Florida Licensure

DOH does not license a physician by specialty or subspecialty based upon board certification; however, ch. 458 and ch. 459, F.S., limit which physicians may hold themselves out as board-certified specialists. An allopathic physician licensed under ch. 458, F.S., may not hold himself or herself out as a board-certified specialist unless he or she has received formal recognition as a specialist from a specialty board of the American Board of Medical Specialties (ABMS) or other recognizing agency[67] approved by the allopathic board.[68]

[60] Section 458.3145, F.S.
[61] Section 458.3145(4), F.S.
[62] *Id.*
[63] Section 458.3145(5), F.S.
[64] *Supra* note 41.
[65] American Board of Physician Specialties, *Not All Physicians are Board Certified in the Specialties They Practice*, available at https://www.abpsus.org/physician-board-certified-specialties (last visited November 25, 2019).
[66] Id.
[67] The allopathic board has approved the specialty boards of the ABMS as recognizing agencies. Rule 64B8-11.001(1)(f), F.A.C.
[68] Section 458.3312, F.S.

Under Florida law, an allopathic physician may not hold himself or herself out as a board-certified specialist in dermatology unless the recognizing agency, whether authorized in statute or by rule, is triennially reviewed and reauthorized by the allopathic board.[69] Similarly, an osteopathic physician licensed under ch. 459, F.S., may not hold himself or herself out as a board-certified specialist unless he or she has successfully completed the requirements for certification by the American Osteopathic Association (AOA) or the Accreditation Council on Graduate Medical Education (ACGME) and is certified as a specialist by a certifying agency[70] approved by the board.[71] These limitations on advertising are set out in rule 64B8-11.001, F.A.C. for allopathic physicians and rule 64B15-14.001, F.A.C., for osteopathic physicians.

Osteopathic Residencies

Following graduation from an AOA-approved medical school, osteopathic physicians (DOs) must complete an approved 12-month internship.[72] Interns rotate through hospital departments, including internal medicine, family practice, and surgery. They may then choose to complete a residency program in a specialty area, which requires two to six years of additional training.[73]

Florida law requires DOs to complete an AOA-approved residency for licensure.[74] However, the Board of Osteopathic Medicine will accept a residency accredited by the ACGME[75] for licensure if the applicant demonstrates good cause, such as:[76]

- Personal limitation created by a documented physical or medical disability;
- Unique documented opportunity otherwise unavailable that meets a practice area of critical need;
- Documented legal restriction which requires the physical presence in a particular state or local area;
- Documented unusual or exceptional family circumstances which limit training opportunities;
- The previous program met all AOA requirements, but due to documented circumstances beyond the control of the applicant, was discontinued;
- Documented inability to relocate to another geographic area with undue hardship; or
- Documented inability to obtain an AOA internship.

Single Graduate Medical Education Accreditation System

In 2014, the ACGME, AOA, and American Association of Colleges of Osteopathic Medicine entered into a Memorandum of Understanding to transition to a single accreditation system for graduate medical education (GME).[77] Under this agreement, graduates of all allopathic and osteopathic medical schools complete residencies or fellowships in ACGME-accredited programs.[78] On July 1, 2015, the AOA and the ACGME began transitioning to a single GME accreditation system.[79]

[69] Id.
[70] The osteopathic board has approved the specialty boards of the ABMS and AOA as recognizing agencies. Rule 64B15-14.001(h), F.A.C.
[71] Section 459.0152, F.S.
[72] Florida Osteopathic Medical Association, *Osteopathic Education*, available at https://www.foma.org/osteopathic-education.html (last visited November 25, 2019).
[73] Id.
[74] Section 459.055(1)(l), F.S.
[75] The Accreditation Council for Graduate Medical Education sets the standards for U.S. graduate medical education (residency and fellowship) programs and accredits such programs based on compliance with these standards. In 2017-2018, there were 830 ACGME-accredited institutions sponsoring more than 11,000 residency and fellowship programs. *See* Accreditation Council for Graduate Medical Education*, What We Do*, available at https://www.acgme.org/What-We-Do/Overview (last visited November 25, 2019).
[76] Rule 64B15-16, F.A.C.
[77] American Association of Colleges of Osteopathic Medicine, *Single GME Accreditation System*, available at https://www.aacom.org/news-and-events/single-gme-accreditation-system (last visited November 25, 2019).
[78] Accreditation Council for Graduate Medical Education, *Single GME Accreditation System*, available at https://www.acgme.org/What-We-Do/Accreditation/Single-GME-Accreditation-System (last visited November 25, 2019).
[79] Id.

The parties to this agreement indicate that a single accreditation system will:[80]

- Establish and maintain consistent evaluation and accountability for the competency of resident physicians across all accredited GME programs;
- Eliminate duplication in GME accreditation;
- Achieve efficiencies and cost savings for institutions that sponsor both AOA-accredited and ACGME-accredited programs; and
- Ensure all residency and fellowship applicants are eligible to enter all accredited programs in the nation and can transfer from one accredited program to another without repeating training or causing a sponsoring institution to lose Medicare funding.

The AOA will cease accrediting GME programs on June 30, 2020.[81] The single accreditation system requires all training programs to be ACGME-accredited by that date. If a program is solely AOA-accredited, the program must apply for ACGME accreditation or stop accepting trainees by June 30, 2020.[82] However, the terms of the agreement allow the AOA to extend a program's accreditation if the program has made a good faith effort to obtain ACGME accreditation but has not transitioned to ACGME accreditation by June 30, 2020.[83]

Chiropractic Assistants

There are two types of chiropractic assistants: certified and registered.[84] A certified chiropractic assistant is an allied health professional who, under supervision, performs tasks or a combination of tasks traditionally performed by a chiropractic physician.[85] A registered chiropractic assistant is a professional, multi-skilled person dedicated to assisting in all aspects of chiropractic medical practice under the direct supervision of a chiropractic physician or certified chiropractic assistant.[86]

A registered chiropractic assistant voluntarily registers with the Board of Chiropractic Medicine.[87] There are no educational or eligibility standards set in statute or rule for such registration. However, a person who becomes a registered chiropractic assistant must adhere to ethical and legal standards of professional practice, recognize and respond to emergencies, and demonstrate professional characteristics.[88] A registered chiropractic assistant may:[89]

- Prepare patients for the chiropractic physician's care;
- Take vital signs;
- Observe and report patients' signs and symptoms;
- Administer basic first aid;
- Assist with patient examinations or treatments other than manipulations or adjustments;
- Operate office equipment;
- Collect routine laboratory specimens as directed by the chiropractic physician or certified chiropractic assistant;
- Administer nutritional supplements as directed by the chiropractic physician or certified chiropractic assistant; and

[80] Accreditation Council for Graduate Medical Education, *Frequently Asked Questions: Single Accreditation System*, available at https://www.acgme.org/Portals/0/PDFs/Nasca-Community/FAQs.pdf (last visited November 25, 2019).
[81] American Osteopathic Association, *Single GME Resident FAQs*, available at https://osteopathic.org/residents/resident-resources/residents-single-gme/single-gme-resident-faqs/ (last visited November 25, 2019).
[82] Id.
[83] Id.
[84] Sections 460.4165 and 460.4166, F.S.
[85] Rule 64B2-18(5), F.A.C.
[86] Section 460.4166(1), F.S.
[87] Section 460.4166(3), F.S.
[88] *Supra* note 86.
[89] Section 460.4166, F.S.

- Perform office procedures under the direct supervision of by the chiropractic physician or certified chiropractic assistant.

There are 3,991 registered chiropractic assistants.[90] DOH does not regulate the practice of registered chiropractic assistants.

Board of Nursing

Rulemaking Authority

The Board of Nursing has the authority to adopt rules to implement ch. 464, F.S., which regulates the practice of nursing in this state.[91] The Board of Nursing oversees the licensure and practice of certified nursing assistants, licensed practical nurses, registered nurses, and advanced registered nurse practitioners.

Certified Nursing Assistants

Certified Nursing Assistants (CNAs) provide care and assist individuals with tasks relating to the activities of daily living, such as those associated with personal care, nutrition and hydration, maintaining mobility, toileting, safety and cleaning, end-of-life care, cardiopulmonary resuscitation and emergency care.[92] An applicant for certification as a CNA must complete an approved training program, pass a competency examination, and pass a background screening.[93] A CNA who is certified in another state, is listed on that state's CNA registry[94] and has not been found to have committed abuse, neglect, or exploitation in that state, is eligible for certification by endorsement in Florida. However, a CNA from a territory of the United States or the District of Columbia is not eligible for certification by endorsement.

The Board of Nursing may discipline a CNA for two violations:[95]

- Obtaining or attempting to obtain certification or an exemption, or possessing or attempting to possess certification or letter of exemption, by bribery, misrepresentation, deceit, or through an error of the board; or
- Intentionally violating any provision of ch. 464, F.S., the practice act for nursing professions, ch. 456, F.S., the general licensing act, or the rules adopted by the Board of Nursing.

When seeking to discipline a CNA for violating the nurse practice act, the general licensing act, or a rule adopted thereunder, the Board of Nursing must prove that such violation is intentional. Therefore, if the Board of Nursing cannot prove intent or if a CNA acts negligently, the Board of Nursing is unable to discipline the CNA.

Florida Center for Nursing

The Florida Center for Nursing (center) was created in 2001[96] to address the issues of supply and demand for nursing, including issues of recruitment, retention, and utilization of nurse workforce issues. The center collects and analyzes nursing workforce data, develops and disseminates a strategic plan for

[90] *Supra* note 41.
[91] Section 464.006, F.S.
[92] Section 464.201(5), F.S.
[93] Section 464.203, F.S. *See also* Department of Health, Board of Nursing, *Certified Nursing Assistant (CNA) by Examination*, available at http://floridasnursing.gov/licensing/certified-nursing-assistant-examination/ (last visited November 25, 2019). An applicant who fails the competency examination 3 times, may not take the exam again until he or she completes an approved training program.
[94] A CNA Registry is a listing of CNAs who received certification and maintain an active certification. (Rule 64B9-15.004, F.A.C.)
[95] Section 464.204, F.S.
[96] Chapter 2001-277, L.O.F., codified at s. 466.0195, F.S.

nursing, develops and implements reward and recognition activities for nurses, and promotes nursing excellence programs, image building, and recruit into the profession.[97]

In 2009, the Legislature created a statutory framework for approving nursing education programs, which was revised in 2010 and 2014.[98] In 2014, the Legislature directed the center and the Office of Program Policy Analysis and Government Accountability (OPPAGA) to produce an annual report to the Governor and Legislature on nursing education programs until January 2020.[99] In 2017, the report became the sole responsibility of the center.[100]

The annual report includes data and measurements on:[101]

- The number of programs and slots available;
- The number of applications, qualified applicants, and accepted students;
- The number of program graduates;
- Program retention rates;
- Graduate passage rates on the National Council of State Boards of Nursing Licensure Examination;
- The number of graduates who become employed in the state; and
- The programs progress in meeting accreditation requirements.

The report also evaluates the Board of Nursing's implementation of the program approval process and accountability processes.[102]

Dentistry

Examination for Licensure

Any person wishing to practice dentistry in this state must apply to DOH and meet specified requirements. Section 466.006, F.S., requires dentistry licensure applicants to sit for and pass the following licensure examinations:

- The National Board of Dental Examiners dental examination (NBDE);
- A written examination on Florida laws and rules regulating the practice of dentistry; and
- A practical examination, which is the American Dental Licensing Examination developed by the American Board of Dental Examiners, Inc., and graded by a Florida-licensed dentist employed by DOH for such purpose.[103]

To qualify to take the Florida dental licensure examination, an applicant must be 18 years of age or older, be a graduate of a dental school accredited by the American Dental Association Commission on Dental Accreditation (CODA) or be a student in the final year of a program at an accredited institution, and have successfully completed the NBDE dental examination.[104] If the applicant is not a graduate of a CODA-accredited program, the applicant must demonstrate that he or she holds a degree from an accredited American dental school or has completed two years at a full-time supplemental general dentistry program

[97] Id. *See also*, Florida Center for Nursing, *Our History*, available at https://www.flcenterfornursing.org/AboutUs/OurHistory.aspx (last visited December 2, 2019).
[98] Chapters 2009-168, 2010-37, and 2014-92, L.O.F., respectively.
[99] Chapter 2014-92, L.O.F.
[100] Chapter 2017-134, L.O.F.
[101] Section 464.019(10), F.S.
[102] Id.
[103] A passing score is valid for 365 days after the date the official examination results are published. A passing score on an examination obtained in another jurisdiction must be completed on or after October 1, 2011.
[104] Section 466.006(2), F.S.

accredited by CODA.[105] DOH indicates that there is confusion on whether these programs may include specialty or advanced education programs.[106]

Any person wishing to be licensed as a dental hygienist must apply to DOH and meet the following qualifications:[107]

- Be 18 years of age or older;
- Be a graduate of an accredited dental hygiene college or school;[108] and
- Obtain a passing score on the:
    - Dental Hygiene National Board Examination;
    - Dental Hygiene Licensing Examination developed by the American Board of Dental Examiners, Inc., which is graded by a Florida-licensed dentist or dental hygienist employed by DOH for such purpose; and
    - A written examination on Florida laws and rules regulating the practice of dental hygiene.

According to DOH, limiting the grading to Florida-licensed dentists and dental hygienists has created a shortage of dentists and dental hygienists available to grade the examinations.[109]

Health Access Dental Licenses

The health access dental license was established in 2008 to attract out-of-state dentists to practice in underserved health access settings[110] in this state, without supervision.[111] In Fiscal Year 2018-2019, the Board of Dentistry issued 50 health access dental licenses.[112]

With this license, a dentist who holds a valid, active license in good state issued by another state, the District of Columbia, or a U.S. territory may practice in a health access setting if the dentist:[113]

- Applies to the Board of Dentistry and pays the appropriate fee;
- Has not been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;
- Submits proof of graduation from an accredited dental school;
- Submits documentation that the dentist has completed, or will obtain prior to licensure, continuing education equivalent to Florida's requirement for dentists for the last full reporting biennium;
- Submits proof of successful passage of parts I and II of the National Board of Dental Examiners and a state or regional clinical dental examination approved by the Board of Dentistry;
- Has never had a license revoked in another state, the District of Columbia, or a U.S. territory;
- Has never failed the Florida dental licensing examination, unless the dentist was reexamined and received a license to practice in Florida;
- Has not been reported to the National Practitioner Data Bank, unless the applicant successfully appealed to have his or her name removed from the databank; and
- Submits proof that he or she has been actively engaged in the clinical practice of dentistry providing direct patient care for the five years immediately preceding application, or proof of

[105] Section 466.006(3), F.S.
[106] Department of Health, *2020 Agency Legislative Analysis for SB 230*, on file with the Health Quality Subcommittee. SB 230 is substantively similar to HB 713.
[107] Section 466.007, F.S.
[108] If the school is not accredited, the applicant must have completed a minimum of 4 years of postsecondary dental education and received a dental school diploma, which must be reviewed and approved by the Board of Dentistry.
[109] *Supra* note 106, at p. 4.
[110] Section 466.003(14), F.S., defines "health access setting" as a program or institution operated by the Department of Children and Families, Department of Health, Department of Juvenile Justice, a nonprofit health care center, a Head Start center, a federally-qualified health center or a lookalike, a school-based prevention program, a clinic operated by an accredited college of dentistry, or certain accredited dental hygiene program.
[111] Chapter 2008-64, L.O.F., codified at s. 466.0067, F.S.
[112] *Supra* note 41.
[113] Section 466.0067, F.S.

continuous clinical practice providing direct patient care since graduation if the applicant graduated less than 5 years from his or her application.

Health access dental licenses must be renewed biennially[114]. A licensee must meet the same continuing education requirements as a Florida-licensed dentists.[115] Additionally, a licensee must continue to meet all the requirements met for initial license.[116]

The Board of Dentistry may revoke a health access dental license if the licensee is terminated from employment at the health access setting, practices outside of the health access setting, fails the Florida dental examination, or is found to have violated the Dental Practice Act, other than a minor violation or a citation offense.[117]

The program was repealed effective January 1, 2020, as the Legislature did not reenact DOH's authority to issue such licenses by the scheduled repeal date.[118]

Adverse Incident Reporting

Dentists and dental hygienists certified by DOH to administer anesthesia must report, in writing, any adverse incident that occurs to the Board of Dentistry within 48 hours by registered mail.[119] An adverse incident in an office setting is defined as any mortality that occurs during or as the result of a dental procedure, or an incident that results in a temporary or permanent physical or mental injury the requires hospitalization or emergency room treatment of a patient as a direct result of the use of general anesthesia,[120] deep sedation,[121] moderate sedation,[122] pediatric moderate sedation,[123] minimal sedation,[124] nitrous oxide,[125] or local anesthesia.[126] The dentist must file a complete written report with the Board of Dentistry within 30 days.[127]

Allopathic and osteopathic physicians are statutorily required to report adverse incidents in office practice settings.[128] Although required by rule, there is no statutory requirement that dentists or dental hygienists report adverse incidents that occur in the office practice settings.

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[114] Section 466.00671, F.S.
[115] Id.
[116] Id.
[117] Section 466.00672, F.S.
[118] Section 466.00673, F.S.
[119] Rule 64B5-14.006, F.A.C.
[120] General anesthesia is a controlled state of unconsciousness, produced by a pharmacologic agent, accompanied by a partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command. (Rule 64B5-14.001(2), F.A.C.)
[121] Deep sedation is a controlled state of depressed consciousness accompanied by partial loss of protective reflexes, including either or both the inability to continually maintain an airway independently or to respond appropriately to physical stimulation or verbal command, produced by pharmacologic or non-pharmacologic method or combination thereof. (Rule 64B5-14.001(3), F.A.C.)
[122] Moderate sedation is a depressed level of consciousness produced by the administration of pharmacologic substances, that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command. (Rule 64B5-14.001(4), F.A.C.)
[123] Pediatric moderate sedation is a depressed level of consciousness produced by the administration of pharmacologic substances, that retains a child patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command. (Rule 64B5-14.001(5), F.A.C.)
[124] Minimal sedation involves the perioperative use of medication to relieve anxiety before or during a dental procedure and does not produce a depressed level of consciousness and maintains the patient's ability to maintain an airway independently and to respond appropriately to physical and verbal stimulation. (Rule 64B5-14.001(10), F.A.C.)
[125] The use of nitrous oxide produces an altered level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command. (Rule 64B5-14.001(6), F.A.C.)
[126] Local anesthesia involves the loss of sensation of pain in a specific area of the body. (Rule 64B5-14.001(7), F.A.C.)
[127] *Supra* note 119.
[128] *See* ss. 458.351 and 459.026, F.S.

Dental Laboratories

A dental laboratory is a facility that supplies or manufactures artificial substitutes for natural teeth, or that furnishes, supplies, constructs, reproduces, or repairs a prosthetic denture, bridge, or appliance to be worn in the human mouth or that otherwise holds itself out as a dental laboratory.[129] Dental laboratories must biennially register with DOH, and the owner or at least one employee must complete 18 hours on continuing education each biennium.[130] A dental laboratory must:[131]

- Maintain and make available to DOH a copy of the laboratory's registration;
- Be clean and in good repair;
- Properly dispose of all waste materials at the end of each day in accordance with local restrictions;
- Maintain the original or a copy of a prescription from a dentist for each appliance or artificial restorative oral device authorizing its construction or repair for 4 years;
- Maintain a written policy and procedure manual on sanitation; and
- Have a designated receiving area.

A dental laboratory may not have dental chairs, x-ray machines, or anesthetics, sedatives, or medicinal drugs.[132] A dental laboratory may not solicit or advertise to the general public.[133]

DOH inspects dental laboratories at least once each year, and such inspections may occur with or without notice.[134]

Athletic Trainers

Athletic trainers provide service and care to individuals related to the prevention, recognition, evaluation, management, disposition, treatment, or rehabilitation of a physically active person who sustained an injury, illness, or other condition involving exercise, sport, recreation, or related physical activity.[135] To be licensed as an athletic trainer, an applicant must:[136]

- Hold a bachelor's degree or higher from an accredited athletic training degree program and pass the national examination to be certified by the Board of Certification;[137]
- If graduated before 2004, hold a current certification from the Board of Certification;
- Hold a current certification in both cardiopulmonary resuscitation and the use of an automated external defibrillator at the professional rescue level; and
- Pass a background screening.

Prior to 2004, athletic trainers could obtain training through a Board of Certification internship program to qualify for licensure.[138] Current law does not allow applicants who completed such an internship prior to 2004 to qualify for licensure.

An athletic trainer must renew his or her license biennially. During each biennial renewal period, an athletic trainer must complete at least 24 hours of continuing education, hold a current certification in both cardiopulmonary resuscitation and the use of an automated external defibrillator, and a current

[129] Section 466.031, F.S.
[130] Section 466.032, F.S. However, dental laboratories that are located in another state or country that provides services to a Florida-licensed dentist is not required to register with the state and may provide services to a dentist in this state.
[131] Rule 64B27-1.001, F.A.C.
[132] Id. Personal prescriptions are permissible.
[133] Section 466.035, F.S.
[134] Rule 64B27-1.001(1), F.S.
[135] Section 468.701(2), F.S.
[136] Section 468.707, F.S.
[137] The Board of Certification is a not-for-profit credentialing agency to provide a certification program for the entry level athletic training profession. *See* Board of Certification for the Athletic Trainer, *What is the BOC?*, available at http://www.bocatc.org/about-us#what-is-the-boc (last visited December 2, 2019).
[138] *Supra* note 106, at p. 4.

certification from the Board of Certification.[139] Although licensees must show current certification from the Board of Certification, there is no statutory requirement that a licensee maintain such certification without lapse and in good standing.

An athletic trainer must practice under the direction of an allopathic, osteopathic, or chiropractic physician,[140] and may provide care such as:[141]

- Injury prevention, recognition, and evaluation;
- First aid and emergency care;
- Injury management and treatment;
- Rehabilitation through the use of safe and appropriate physical rehabilitation practices;
- Conditioning;
- Performance of tests and measurements to prevent, evaluate, and monitor acute and chronic injuries;
- Therapeutic exercises;
- Massage;
- Cryotherapy and thermotherapy;
- Therapy using other agents such as water, electricity, light, or sound; and
- The application of topical prescription medications at the direction of a physician.

The physician must communicate his or her direction through oral or written prescriptions or protocols, and the athletic trainer must provide service or care in the manner dictated by the physician.[142] A licensed athletic trainer may not provide, offer to provide, or represent that he or she is qualified to provide any care or service that he or she lacks the education, training, or experience to provide, or that he or she is otherwise prohibited by law from providing.[143]

Orthotists and Prosthetists

The Board of Orthotists and Prosthetists oversees the licensure and regulation of orthotists[144] and prosthetists.[145] A person applying for licensure must first apply to DOH to take the appropriate licensure examination. The board may accept the exam results of a national orthotic or prosthetic, standards organization in lieu of administering the state exam.[146] The board must verify that an applicant for licensure examination meets the following requirements:[147]

- Has completed the application form and paid all applicable fees;
- Is of good moral character;
- Is 18 years of age or older;
- Has completed the appropriate educational preparation, including practical training requirements; and
- Has successfully completed an appropriate clinical internship in the professional area for which the license is sought.

[139] Section 468.711, F.S.
[140] Section 468.713, F.S.
[141] Rule 64B33-4.001, F.A.C.
[142] *Supra* note 140.
[143] Section 468.701(1), F.S.
[144] An orthotist is a health care professional who evaluates, formulates treatment, measures, designs, fabricates, assembles, fits, adjusts, services or provides necessary training to accomplish the fitting of an orthosis or pedorthics (s. 468.80(9)-(10), F.S.)
[145] An orthotist is a health care professional who evaluates, formulates treatment, measures, designs, fabricates, assembles, fits, adjusts, services or provides necessary training to accomplish the fitting of a prosthesis (s. 468.80(15)-(16), F.S.)
[146] Section 468.803(4), F.S. The Board has approved the American Board for Certification in Orthotics, Prosthetics, and Pedorthics (ABC) exam for orthotist and prosthetist applicants (r. 64B14-4.001, F.A.C.)
[147] Section 468.803(2), F.S.

In addition to the requirements listed above, an applicant must meet the following requirements for each license he or she is seeking:[148]

- A Bachelor of Science degree in Orthotics and Prosthetics from a regionally accredited college or university from an accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs, or a bachelor's degree with a certificate in orthotics or prosthetics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent;
- An internship of one year of qualified experience or a residency program recognized by the board;
- Completion of the mandatory classes;[149] and
- Passage of the state orthotic examination or board-approved orthotic examination if applying for an orthotist license, or the state prosthetic examination or board-approved examination if applying for a prosthetist license.

Currently, a person who qualifies to be registered as both an orthotist and a prosthetist must obtain two separate registrations.

Massage Therapy

Massage Therapists

To be licensed as a massage therapist, an applicant must:[150]

- Be at least 18 years of age or have received a high school diploma or graduate equivalency diploma;
- Complete a course of study at a board-approved massage school or apprentice program;
- Pass a board-approved examination;[151] and
- Pass a background screening.

In the 2017-2018 fiscal year, 3,380 individuals were granted licensure, 13 of which qualified for licensure by completing an approved Florida apprenticeship program.[152] Massage therapy education has become more formalized and massage therapists are trained in licensed massage schools. Florida is one of a very small number of states that continue to allow apprenticeship as an acceptable course of study for licensure as a massage therapist.[153]

Colonic Irrigation Apprenticeship Programs

A massage therapist, a massage apprentice, or a student in a board-approved massage therapy school may study colonic irrigation[154] under the direct supervision of a sponsor.[155] The sponsor must be licensed to practice massage, authorized to practice colonic irrigation, and have practiced colonic irrigation for at

[148] Section 468.803(5), F.S. Licenses must be renewed biennially.
[149] Pursuant to r. 64B14-5.005, F.A.C., mandatory courses include two hours on Florida laws and rules, two hours on the prevention of medical errors, one hour on infection disease control, and a CPR certification course.
[150] Section 480.041, F.S. DOH must deny an application if the applicant has been convicted or found guilty of, or entered a plea of nolo contedere to a crime related to prostitution or a felony offense related to certain other crimes.
[151] In r. 64B27-25.001(3), F.A.C., the Board of Massage Therapy has approved the following national licensure examinations: Massage and Bodywork Licensing Examination administered by the Federation of State Massage Therapy Boards, National Certification Board for Therapeutic Massage and Bodywork Examination, National Certification Examination for Therapeutic Massage, National Exam for State Licensure option administered by the National Certification Board for Therapeutic Massage and Bodywork, and for colonic irrigation, The National Board for Colon Hydrotherapy Examination.
[152] *Supra* note 106.
[153] Department of Health, *2019 Agency Legislative Analysis for HB 7031*, on file with the Health Quality Subcommittee.
[154] Colonic irrigation is a method of hydrotherapy used to cleanse the colon with the aid of a mechanical device and water (s. 480.033(6), F.S.).
[155] Rule 64B7-29.001, F.A.C.

least 3 years.[156] The apprenticeship must be completed within 12 months of commencement[157] and must consist of a minimum of 100 hours of training, including 45 hours of clinical practicum with a minimum of 20 treatments given.[158] Few schools in Florida offer a colonic irrigation program so apprenticeships are the primary method of training. There are 21 individuals certified to complete an apprenticeship in colonic irrigation.[159]

Psychologists

Licensure Requirements

The Board of Psychology oversees the licensure and regulation of psychologists.[160] To receive a license to practice psychology, an individual must:[161]

- Meet one of the following educational requirements:
  - Received a doctoral-level psychological education from an accredited school in the United States or Canada and a psychology program within that institution that is accredited from an agency recognized and approved by the U.S. Department of Education;[162]
  - Received the equivalent of a doctoral-level education from a program at a school or university located outside of the United States or Canada, which is officially recognized by the government of the country in which it is located as a program or institution to train students to practice professional psychology;
  - Received and submitted, prior to July 1, 1999, certification of an augmented doctoral-level psychological education from a doctoral-level psychology program accredited by an agency recognized and approved by the U.S. Department of Education; or
  - Received and submitted, prior to August 31, 2001, certification of a doctoral-level program that at the time the applicant was enrolled and graduated maintained a standard of education and training comparable to the standard of training of a doctoral-level psychology program accredited by an agency recognized and approved by the U.S. Department of Education;
- Complete 2 years or 4,000 hours of supervised experience;
- Pass the Examination for Professional Practice in Psychology;[163] and
- Pass an examination on Florida laws and rules.

The American Psychological Association (APA) is recognized by the U.S. Department of Education and the Council for Higher Education Accreditation as the national accrediting authority for professional education and training in psychology.[164] The APA no longer accredits programs in Canada.[165]

An applicant who holds an active, valid license in another state may also qualify for licensure in this state if at the time the license was issued, the requirements were substantially equivalent to or more stringent than those in Florida at that time.[166] Such individuals must have 20 years of experience as a licensed psychologist in any jurisdiction of the U.S. within the 25 years preceding the date of application. DOH indicates that under this standard, a law-to-law comparison is difficult and applicants who may otherwise qualify for licensure may be denied.[167]

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[156] Id.
[157] Rule 64B7-29.007, F.A.C.
[158] Rule 64B7-25.001, F.A.C.
[159] *Supra* note 106.
[160] Section 490.004, F.S.
[161] Section 490.005(1), F.S.
[162] Section 490.003(3), F.S., defines doctoral-level education as a Psy.D, an Ed.D., or a Ph.D in psychology.
[163] Rule 64B19-11.001, F.A.C.
[164] American Psychological Association, *Understanding APA Accreditation*, available at http://www.apa.org/ed/accreditation/about/index.aspx (last visited December 2, 2019).
[165] *Supra* note 106 at p. 5.
[166] Section 490.006, F.S.
[167] *Supra* note 106 at p. 5.

School Psychologists

To be licensed as a school psychologist, an applicant must:[168]

- Hold a doctorate, specialist, or equivalent degree from a program primarily psychological in nature and have completed 60 semester hours or 90 quarter hours of graduate study in an area related to school psychology from a college or university which at the time the applicant was enrolled and graduated was accredited by an accrediting agency recognized and approved by the Commission on Recognition of Postsecondary Accreditation or an institution recognized as a member in good standing with the Association of Universities and Colleges of Canada;
- Have a minimum of 3 years of experience in school psychology, 2 of which must be supervised by a licensed school psychologist or other qualified school psychologist supervisor; and
- Pass the PRAXIS II School Psychology examination.[169]

The Commission on Recognition of Postsecondary Accreditation was dissolved in 1997, and its successor organization is the Council on Higher Education Accreditation.[170] The Association of Universities and Colleges of Canada changed its name to Universities Canada.[171]

Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling

Intern Registration

To be licensed as a clinical social worker, marriage and family therapist, or mental health counselor, an applicant must meet educational requirements, complete at least 2 years of postgraduate or postmaster's clinical practice supervised by a licensed practitioner, and pass a theory and practice examination.[172] During the time in which an applicant is completing the required supervised clinical experience or internship, he or she must register with the DOH as an intern.[173] The supervised clinical experience may be met by providing at least 1,500 hours of face-to-face psychotherapy with clients, which may not be accrued in less than 100 weeks.[174]

An applicant seeking registration as an intern must:[175]

- Submit a completed application form and the nonrefundable fee to the DOH;
- Complete 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.

An intern registration expires 60 months after the date of issue and may only be renewed if the candidate has passed the theory and practice examination required for full licensure.[176] DOH has no authority to extend an intern registration beyond the 60 months if there are extenuating circumstances.

[168] Section 490.005(2), F.S.
[169] Department of Health, *School Psychology Licensing*, available at http://www.floridahealth.gov/licensing-and-regulation/school-psychology/licensing/index.html (last visited December 2, 2019).
[170] U.S. Department of Education, *Accreditation in the U.S.*, available at https://www2.ed.gov/admins/finaid/accred/accredus.html (last visited December 2, 2019).
[171] Universities Canada, *About Us*, available at https://www.univcan.ca/about-us/ (last visited December 2, 2019).
[172] Section 491.005, F.S. A procedure for licensure by endorsement is provided in s. 491.006, F.S.
[173] Section 491.0045, F.S.
[174] Rule 64B4-2.001, F.A.C.
[175] Section 491.0045(2), F.S.
[176] Section 491.0045(6), F.S.

Marriage and Family Therapists

Marriage and family therapy incorporates marriage and family therapy, psychotherapy, hypnotherapy, sex therapy, counseling, behavior modification, consultation, client-centered advocacy, crisis intervention, and the provision of needed information and education to clients.[177] An applicant seeking licensure as a mental health counselor must:[178]

- Possess a master's degree from an accredited program;
- Complete 36 semester hours of graduate coursework that includes a minimum of 3 semester hours of graduate-level coursework in:
    - The dynamics of marriage and family systems;
    - Marriage therapy and counseling theory;
    - Family therapy and counseling theory and techniques;
    - Individual human development theories throughout the life cycle;
    - Personality or general counseling theory and techniques;
    - Psychosocial theory; and
    - Substance abuse theory and counseling techniques.
- Complete at least one graduate-level course of 3 semester hours in legal, ethical, and professional standards;
- Complete as least one graduate-level course of 3 semester hours in diagnosis, appraisal, assessment, and testing for individual or interpersonal disorder or dysfunction;
- Complete at least one graduate-level course of 3 semester hours in behavioral research;
- Complete at least one supervised clinical practicum, internship, or field experience in a marriage and family counseling setting, during which the student provided 180 direct client contact hours of marriage and family therapy services;
- Complete two years of post-master's supervised experience under the supervision of a licensed marriage and family therapist with five years of experience 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.

DOH must verify that an applicant's education matches the specified courses and hours as outlined in statute. However, there are organizations that accredit marriage and family therapy education programs, including the Commission on Accreditation for Marriage and Family Therapy Education and the Council for the Accreditation of Counseling and Related Educational Programs that establish the minimum standards to meet the requirements to practice the profession.[179]

Mental Health Counselors

A mental health counselor is an individual who uses scientific and applied behavioral science theories, methods, and techniques to describe, prevent, and treat undesired behavior and enhance mental health and human development and is based on research and theory in personality, family, group, and organizational dynamics and development, career planning, cultural diversity, human growth and

[177] Id.
[178] Section 491.005(3), F.S. An individual may qualify for a dual license in marriage and family therapy if he or she passes an examination in marriage and family therapy and has held an active license for at least three years as 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 (s. 491.0057, F.S.)
[179] *See* Commission on Accreditation for Marriage and Family Therapy Education, *What Are the Benefits of COAMFTE Accreditation*, available at https://www.coamfte.org/COAMFTE/Accreditation/About_Accreditation.aspx (last visited December 2, 2019), and Council for the Accreditation of Counseling and Related Educational Programs, *About CACREP*, available at https://www.cacrep.org/about-cacrep/ (last visited December 2, 2019).

development, human sexuality, normal and abnormal behavior, psychopathology, psychotherapy, and rehabilitation.[180] To qualify for licensure as a mental health counselor, an individual must:[181]

- Have a master's degree from a mental health counseling program accredited by the Council of the Accreditation of Counseling and Related Educational Programs, or a program related to the practice of mental health counseling that includes coursework and a 1,000-hour practicum, internship, or fieldwork of at least 60 semester hours that meet certain requirements;
- Have at least two years of post-master's supervised clinical experience in mental health counseling;
- Pass an examination from the Professional Examination Service for the National Academy of Certified Clinical Mental Health Counselors; and
- Pass an eight-hour course on Florida laws and rules approved by the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling.[182]

Currently, an applicant for a mental health counselor license must, by rule, pass the National Clinical Mental Health Counseling Examination. Current law refers to an outdated mental health counseling examination.

Effect of Proposed Changes

CS/CS/HB 713 makes numerous changes to programs under DOH and professions regulated under the Division of Medical Quality Assurance within DOH.

HIV/AIDS

The bill expands DOH's authority to establish patient care centers for individuals who carry HIV rather than limiting patient care centers to those who have been diagnosed with AIDS. The inclusion of HIV providers into the network has a planning focus, not a service delivery focus. That planning, with this change, is more inclusive of persons living with HIV.[183]

Emergency Medical Transportation Services

The bill repeals a requirement that DOH rules on ground ambulance be at least as comprehensive as the standards published by the American College of Surgeons. DOH may use any standard it deems appropriate to develop the list of required equipment for licensed ground ambulances. The bill also repeals the requirement that DOH's rules on ambulance or vehicle design be at least equal to those recommended by the U.S. General Services Administration and requires that the rules be based on national standards recognized by DOH.

Conrad 30 Program

The bill authorizes DOH to adopt rules to implement the Conrad 30 Waiver program in this state. This allows DOH to set guidelines in addition to those required by federal law. The bill also directs DOH to develop strategies to maximize federal and state resources to recruit physicians to practice in medically underserved and rural areas in the state.

[180] Sections 491.003(6) and (9), F.S.
[181] Section 491.005(4), F.S.
[182] Section 491.005(4), F.S., and r. 64B4-3.0035, F.A.C.
[183] Email correspondence with Ty Gentle, Office of Budget and Revenue Management, Department of Health, dated Jan. 21, 2020, on file with the Health Care Appropriations Subcommittee.

General Licensure Requirements

The bill requires the application for licensure to include the applicant's date of birth, in addition to the currently required social security number. This will provide DOH an additional method to verify the identity of an individual applicant.

The bill also authorizes DOH to issue a temporary license to an eligible applicant, who has accepted a position with an accredited residency, internship, or fellowship program in Florida and who has submitted an application for registration for such position under s. 458.345, F.S., or s. 459.021, F.S., which expires 60 days, rather than 30 days, after issuance unless the applicant obtains and submits a social security number to DOH.

Student Loans

The bill expressly states that failing to repay a government-backed student loan does not constitute grounds for licensure discipline and repeals the requirement that DOH must issue an emergency order suspending a health care practitioner's license for a student loan default absent timely proof of a new repayment plan. DOH no longer has to obtain a monthly list from the USHHS of the Florida health care practitioners who have defaulted on their student loans. The bill also repeals DOH's authority to discipline a health care practitioner for failing to comply with a scholarship obligation and the associated mandatory disciplinary action.

Medical Faculty Certificates

The bill expands the current medical faculty certificate eligibility by allowing a medical faculty certificate to be issued without examination to an individual who has been offered and accepted a full-time faculty appointment to teach at Nova Southeastern University and Lake Erie College of Osteopathic Medicine. The Board of Medicine may issue up to 30 medical faculty certificates to each of the institutions.

Dermatology

Currently, dermatology is the only physician specialty that statutorily requires the allopathic board to review and authorize the recognizing agency. The bill repeals the prohibition against a physician holding himself or herself out as a board-certified dermatologist unless the recognizing agency is triennially reviewed and reauthorized by the Board of Medicine.

Osteopathic Physician Licensure

To qualify for licensure as an osteopathic physician, an applicant must currently complete a resident internship approved by the Board of Trustees of the American Osteopathic Association or an internship program approved by the osteopathic board. The bill requires that such internship or residency be approved by the American Osteopathic Association or the Accreditation Council for Graduate Medical Education, and repeals the authority of the osteopathic board to approve an internship program.

Registered Chiropractic Assistants

Currently, registered chiropractic assistants may voluntarily register with DOH. The bill repeals this voluntary registration, thereby eliminating registered chiropractic assistants.

Nursing

The bill authorizes the Board of Nursing to adopt rules related to disciplinary procedures and the standards of practice for CNAs. The bill authorizes CNA applicants who are licensed in other territories of the United States or the District of Columbia to qualify for licensure by endorsement. The bill also

authorizes the Board of Nursing to discipline CNAs for any violation of a law or rule regulating CNA practice, repealing the requirement that such violation be intentional.

The bill extends the date of the scheduled sunset of the annual report on nursing education programs produced by the Florida Center for Nursing from January 30, 2020, to January 30, 2025.

Dentistry

Dental Licensure

Current law requires that a dental licensure applicant who does not attend an accredited dental school must submit proof that he or she completed at least 2 academic years at a full-time supplemental general dentistry program approved by the American Dental Association.[184] The bill clarifies that a supplemental dentistry program does not include an advanced dental education program in a dental specialty.

The bill repeals a requirement that a Florida-licensed dentist grade the American Dental Licensing Examination, and that either a Florida-licensed dentist or dental hygienist grade Dental Hygienist Examination produced by the American Board of Dental Examiners, Inc., for applicants for licensure in this state. Therefore, dentists or dental hygienist licensed in other states may grade such licensure examinations.

Health Access Dental Licenses

The bill revives, reenacts, and repeals the scheduled January 1, 2020 sunset of health access dental licenses. The bill makes these changes apply retroactively to January 1, 2020.

Dental Adverse Incidents

Dentists and dental hygienists are currently required to submit adverse incidents related to the administration of anesthesia under rules adopted by the Board of Dentistry. The bill statutorily requires a dentist to report an adverse incident that occurs in his or her office to DOH in writing by certified mail and postmarked within 48 hours after the incident occurs. The bill defines an adverse incident as any death that occurs during or as a result of a dental procedure, or a temporary or permanent physical or mental injury that requires hospitalization or emergency room treatment as a result of the use of general anesthesia, deep sedation, conscious sedation, pediatric conscious sedation, oral sedation, minimal sedation, nitrous oxide, or local anesthesia.

The bill also requires a dentist to report any death or other adverse incident that occurs in the dentist's outpatient facility to the Board of Dentistry in writing by certified mail within 48 hours of such occurrence. Within 30 days, the dentist must file a complete report with the Board of Dentistry.

The bill requires a certified dental hygienist who holds a certificate to administer local anesthesia to notify the Board of Dentistry in writing by registered mail within 48 hours of an adverse incident that was related to or the result of the administration of local anesthesia. The dental hygienist must file a complete report with the Board of Dentistry within 30 days.

DOH must review each adverse incident report to determine whether the incident involved conduct by a health care practitioner that warrants disciplinary action by the applicable regulatory board. A dentist or dental hygienist who fails to timely and completely report adverse incidents as required is subject to disciplinary action by the Board of Dentistry.

[184] Section 466.006(3)(b), F.S.

Dental Laboratories

The bill authorizes an employee or independent contractor of a dental laboratory to engage in onsite consultations with a dentist during a dental procedure if such person is acting as an agent of the dental laboratory. The bill also requires DOH to biennially inspect dental laboratories, rather than annually as currently required by rule.

Athletic Trainers

The bill requires athletic trainers to work within her or his scope of practice as defined by the Board of Athletic Training in rule. The bill adds another route to licensure by authorizing individuals who hold a bachelor's degree, completed a Board of Certification internship, and hold a certification from the Board of Certification to be eligible for licensure.

The bill establishes that a licensed athletic trainer must maintain his or her certification from the Board of Certification in good standing to be eligible for licensure renewal. The bill authorizes the Board of Athletic Training to establish rules for the supervision of an athletic training student.

Orthotics and Prosthetics

The bill authorizes the Board of Orthotists and Prosthetists to issue a single registration for prosthetics and orthotics practice. Currently, an individual must hold two separate registrations: one as a prosthetist and one as an orthotist. For purposes of resident registration, DOH may recognize a dual certificate in prosthetics and orthotics for an applicant who holds a bachelor's degree from a regionally accredited college or university. The bill also authorizes the completion of a dual residency program to qualify for the licensure examination.

Massage Therapy

The bill limits apprenticeships to only those in colonic irrigations. A licensed massage therapist practicing colonic irrigation must supervise a colonic irrigation apprentice. The bill eliminates a massage therapy apprenticeship as a path to licensure. However, if an individual has been issued a license as a massage therapy apprentice before July 1, 2020, he or she may continue to perform massage therapy until the license expires. A massage therapist apprentice may apply for full licensure upon completion of the apprenticeship and before July 1, 2023.

The bill authorizes the Board of Massage Therapy to designate a national examination for licensure and repeals provisions requiring DOH to develop a licensure examination.

Psychologists

The bill requires psychology programs within educational institutions to be accredited by the American Psychological Association (APA), which is recognized as the national accrediting authority for professional education and training in psychology by the U.S. Department of Education and the Council for Higher Education Accreditation.[185] The bill replaces references to the Commission on Recognition of Postsecondary Accreditation to its successor organization, the Council for Higher Education Accreditation.[186] For applicants for licensure who obtained their education in Canada, the bill requires those applicants to demonstrate that they have completed a program comparable to APA-accredited programs.

[185] American Psychological Association, *Understanding APA Accreditation*, available at http://www.apa.org/ed/accreditation/about/index.aspx (last visited January 21, 2019).
[186] U.S. Department of Education, *Accreditation in the U.S.*, available at https://www2.ed.gov/admins/finaid/accred/accredus.html (last visited January 21, 2019).

The bill repeals a provision that allowed an applicant for licensure by endorsement to hold a license from another state that has licensure standards that are equivalent or more stringent than Florida to qualify for licensure. However, an individual may apply for licensure by endorsement if he or she has a doctoral degree in psychology and has practiced for at least 10 years of the last 25 years, rather than 20 years as required in current law.

The bill repeals obsolete provisions related to applicants for licensure prior to July 1, 1999.

Licensed Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling

Intern Registration

The bill authorizes the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling to make a one-time exception to the 60-month limit on an internship registration. Such exceptions may only be granted in an emergency or hardship case, as defined by rule. The bill deletes obsolete language related to biennial renewals of intern registrations.

Marriage and Family Therapists

The bill requires that an applicant for licensure hold a master's degree with an emphasis in marriage and family therapy from a program accredited by the Commission of Accreditation for Marriage and Family Therapy Education or a Florida university program accredited by the Council for Accreditation of Counseling and Related Educational Programs. An applicant may also qualify for licensure if he or she holds a master's degree in a closely related field and has completed graduated courses approved by the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling. The bill eliminates specified coursework and clinical experience required for licensure that is currently enumerated in statute.

To be licensed as a marriage and family therapist, s. 491.005(3), F.S., requires an applicant to complete two years of clinical experience. However, later in the same paragraph, it states the clinical experience required is three years. The bill corrects the scrivener's error in the paragraph to clarify that two years of clinical experience is required for licensure.

Licensed Mental Health Counselors

The bill updates the name of the organization that administers the licensure examination for mental health counseling licensure applicants to the National Board for Certified Counselors or its successor. This will conform the law to current practice.[187] The bill revises the content areas that must be included in educational programs used to qualify for licensure to include substance abuse; legal, ethical, and professional standards issues in the practice of mental health counseling; and diagnostic processes.

The bill reduces the number of hours required for the clinical practicum or internship from 1,000 hours to 700 hours to conform the number of hours to the accreditation standards established by the Council for Accreditation of Counseling and Related Educational Programs. The bill requires the clinical practicum or internship to include at least 280 hours of direct client services.

The bill requires that applicants who apply for licensure after July 1, 2025, to hold a master's degree from a program accredited by the Council for Accreditation of Counseling and Related Educational Programs.

Licensure by Endorsement

The bill repeals educational requirements for applicants for licensure by endorsement. Such applicant qualifies for licensure if he or she holds a valid, active license to practice in another state for 3 of the 5

[187] *Supra* note 106.

years preceding the date of application, passes an equivalent licensure examination, and is not under investigation for and has not been found to have committed any act that would constitute a licensure violation in Florida.

The bill clarifies that DOH may deny or impose penalties on the license of a certified master social worker who violates the practice act or ch. 456, F.S., the general regulatory statute by deleting an inaccurate reference to psychologists. This will alleviate confusion regarding the authority of DOH to impose such discipline or deny a license.

The bill deletes obsolete language and makes other technical and conforming changes.

The bill provides an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Amends s. 381.0042, F.S., relating to patient care for persons with HIV infection.
Section 2: Amends s. 381.4018, F.S., relating to physician workforce assessment and development.
Section 3: Amends s. 401.35, F.S., relating to rules.
Section 4: Amends s. 456.013, F.S., relating to department; general licensing provisions.
Section 5: Amends s, 456.072, F.S., relating to grounds for discipline; penalties; enforcement.
Section 6: Repeals s. 456.0721, F.S., relating to practitioners in default on student loans or scholarship obligations; investigation; report.
Section 7: Amends s. 456.074, F.S., relating to certain health care practitioners; immediate suspension of license.
Section 8: Amends s. 458.3145, F.S., relating to medical faculty certificate.
Section 9: Amends s. 458.3312, F.S., relating to specialties.
Section 10: Amends s. 459.0055, F.S., relating to general licensure requirements.
Section 11: Repeals s. 460.4166, F.S., relating to certified chiropractic physician's assistants.
Section 12: Amends s. 464.019, F.S., relating to approval of nursing education programs.
Section 13: Amends s. 464.202, F.S., relating to duties and powers of the board.
Section 14: Amends s. 464.203, F.S., relating to certified nursing assistants; certification requirement.
Section 15: Amends s. 464.204, F.S., relating to denial, suspension, or revocation of certification; disciplinary actions.
Section 16: Amends s. 466.006, F.S., relating to examination of dentists.
Section 17: Amends s. 466.0067, F.S., relating to application for health access dental license.
Section 18: Amends s. 466.00671, F.S., relating to renewal of the health access dental license.
Section 19: Amends s. 466.00672, F.S., relating to revocation of health access dental licenses.
Section 20: Makes the amendments and reenactments relating to health access dental licenses retroactive to January 1, 2020.
Section 21: Amends s. 466.007, F.S., relating to examination of dental hygienists.
Section 22: Amends s. 466.017, F.S., relating to prescription of drugs; anesthesia.
Section 23: Amends s. 466.031, F.S., relating to "dental laboratory" defined.
Section 24: Amends s. 466.036, F.S., relating to information; periodic inspections; equipment and supplies.
Section 25: Amends s. 468.701, F.S., relating to definitions.
Section 26: Amends s. 468.707, F.S., relating to licensure requirements.
Section 27: Amends s. 468.711, F.S., relating to renewal of license; continuing education.
Section 28: Amends s. 468.713, F.S., relating to responsibilities of athletic trainers.
Section 29: Amends s. 468.723, F.S., relating to exemptions.
Section 30: Amends s. 468.803, F.S., relating to license, registration, and examination requirements.
Section 31: Amends s. 480.033, F.S., relating to definitions.
Section 32: Amends s. 480.041, F.S., relating to massage therapists; qualifications; licensure; endorsement.
Section 33: Repeals s. 480.042, F.S., relating to examinations.
Section 34: Amends s. 490.003, F.S., relating to definitions.
Section 35: Amends s. 490.005, F.S., relating to licensure by examination.

Section 36: Amends s. 490.006, F.S., relating to licensure by endorsement.
Section 37: Amends s. 491.0045, F.S., relating to intern registration; requirements.
Section 38: Amends s. 491.005, F.S., relating to licensure by examination.
Section 39: Amends s. 491.006, F.S., relating to licensure or certification by endorsement.
Section 40: Amends s. 491.007, F.S., relating to renewal of license, registration, or certificate.
Section 41: Amends s. 491.009, F.S., relating to discipline.
Section 42: Amends s. 491.0046, F.S., relating to provisional license; requirements.
Section 43: Amends s. 945.42, related to definitions; ss. 945.40-945.49, F.S.
Section 44: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

DOH will experience a recurring decrease in revenue due to the loss of the 10% fine imposed on student loan default cases. In Fiscal Year 2018-2019 DOH received $461 in fine revenue.[188]

DOH will experience a loss of revenue from biennial registration fees due to the deregulation of registered chiropractic assistants. The estimated biennial loss of revenue is approximately $166,125.[189] However, the loss of revenue will be offset by eliminating the cost of registering chiropractic assistants.

DOH may experience a loss of revenue due to the authorization of a single prosthetist-orthotist registration. It is unknown how many single registrations may be issued but it is estimated the loss of revenue will be insignificant.

2. Expenditures:

The bill will have an insignificant, negative fiscal impact on DOH related to various rulemaking provisions. The bill authorizes DOH, or the appropriate regulatory board, to adopt or amend rules related to emergency medical transportation services, Conrad 30 Waiver program, general licensure requirements, medical faculty certificates, dermatology, osteopathic physician licensure, disciplinary guidelines and standards of practice for CNAs, dental licensure, athletic trainer licensure and supervision, massage therapy, psychology, licensed clinical social work, marriage and family therapy, and mental health counseling. Additionally, DOH will need to repeal adopted rules related to the deregulation of registered chiropractic assistants. Current resources are adequate to absorb these costs.

DOH may experience an increase in workload related to reviewing and investigating dental adverse incidents for disciplinary action. It is unknown how many adverse incidents may be reported, however, current resources are estimated to be adequate to absorb these costs.

DOH will experience a reduction in workload and costs due to the repeal of DOH's authority to discipline a health care practitioner for failing to repay government-backed student loans, changing the inspections of dental laboratories from annual to biennial, repealing the registration of chiropractic assistants, and reviewing and determining whether an applicant for osteopathic medicine licensure has demonstrated good cause completing an ACGME-accredited residency instead of an AOA-approved residency.

[188] Email correspondence with Daniel Leon, Office of Legislative Planning, Department of Health, dated Jan. 22, 2020, on file with the Health Care Appropriations Subcommittee
[189] *Supra* note 106.

DOH will also incur costs associated with making minor changes to its LEIDS licensure system to reflect changes made in the bill, which current resources are adequate to absorb.[190]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Individuals who voluntarily registered as chiropractic assistants will no longer have to pay fees associated with such registration due to the bill's repeal of the registration program.

Individuals who wish to obtain a single prosthetist-orthotist registration may save money because they will no longer have to obtain separate prosthetic and orthotic registrations.

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.

3. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rulemaking authority for DOH or the applicable regulatory boards to adopt rules.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On December 11, 2019, the Health Quality Subcommittee adopted two amendments and reported the bill favorably as a committee substitute. The amendments:

- Revised DOH rulemaking authority relating to the minimum standards for ground ambulance and vehicle equipment, supplies, design, and construction;
- Removed references to particular association standards and recommendations that DOH must consider when developing rules for ground ambulances and vehicles;

[190] Id.

- Required DOH to adopt rules based on national standards for ambulance and vehicle design and construction;
- Repealed a requirement that DOH discipline a licensee for failing to repay a student loan;
- Repealed a requirement that DOH obtain a monthly list from the U.S. Department of Health and Human Services of health care practitioners who have defaulted on their student loans; and
- Repealed a requirement that DOH issue an emergency order suspending the license of a health care practitioner who defaults on a student loan unless the licensee timely submits proof of a payment plan.

On January 28, 2020, the Health Care Appropriations Subcommittee adopted two amendments and reported the bill favorably as a committee substitute. The amendments:

- Removed the section of the bill related to radiation machine inspections and inspection fees.
- Made retroactive the sections of the bill related to the health access dental licenses to January 1, 2020.

The analysis is drafted to the committee substitute as passed by the Health Care Appropriations Subcommittee.

A bill to be entitled

An act relating to the Department of Health; amending s. 381.0042, F.S.; revising the purpose of patient care networks from serving patients with acquired immune deficiency syndrome to serving those with human immunodeficiency virus; conforming provisions to changes made by the act; deleting obsolete language; amending s. 381.4018, F.S.; requiring the Department of Health to develop strategies to maximize federal-state partnerships that provide incentives for physicians to practice in medically underserved or rural areas; authorizing the department to adopt certain rules; amending s. 401.35, F.S.; revising provisions relating to the applicability of rules to certain licensees; deleting a requirement that the department base rules governing medical supplies and equipment required in ambulances and emergency medical services vehicles on a certain association's standards; deleting a requirement that the department base rules governing ambulance or vehicle design and construction on a certain agency's standards and instead requiring the department to base such rules on national standards recognized by the department; amending s. 456.013, F.S.; revising health care practitioner licensure application requirements;

authorizing the board or department to issue a temporary license to certain applicants which expires after 60 days; amending s. 456.072, F.S.; conforming provisions to changes made by the act; repealing s. 456.0721, F.S., relating to health care practitioners in default on student loan or scholarship obligations; amending s. 456.074, F.S.; conforming provisions to changes made by the act; amending s. 458.3145, F.S.; revising the list of individuals who may be issued a medical faculty certificate without examination; amending s. 458.3312, F.S.; removing a prohibition against physicians representing themselves as board-certified specialists in dermatology unless the recognizing agency is reviewed and reauthorized on a specified basis by the Board of Medicine; amending s. 459.0055, F.S.; revising licensure requirements for a person seeking licensure or certification as an osteopathic physician; repealing s. 460.4166, F.S., relating to registered chiropractic assistants; amending s. 464.019, F.S.; extending through 2025 the Florida Center for Nursing's responsibility to study and issue an annual report on the implementation of nursing education programs; amending s. 464.202, F.S.; requiring the Board of Nursing to adopt rules that include disciplinary procedures and standards of

practice for certified nursing assistants; amending s. 464.203, F.S.; revising certification requirements for nursing assistants; amending s. 464.204, F.S.; revising grounds for board-imposed disciplinary sanctions; amending s. 466.006, F.S.; revising certain examination requirements for applicants seeking dental licensure; reviving, reenacting, and amending s. 466.0067, F.S., relating to the application for a health access dental license; reviving, reenacting, and amending s. 466.00671, F.S., relating to the renewal of such a license; reviving and reenacting s. 466.00672, F.S., relating to the revocation of such a license; providing for retroactive application; amending s. 466.007, F.S.; revising requirements for examinations of dental hygienists; amending s. 466.017, F.S.; requiring dentists and certified registered dental hygienists to report in writing certain adverse incidents to the department within a specified timeframe; providing for disciplinary action by the Board of Dentistry for violations; defining the term "adverse incident"; authorizing the board to adopt rules; amending s. 466.031, F.S.; making technical changes; authorizing an employee or an independent contractor of a dental laboratory, acting as an agent of that dental laboratory, to engage in

onsite consultation with a licensed dentist during a dental procedure; amending s. 466.036, F.S.; revising the frequency of dental laboratory inspections during a specified period; amending s. 468.701, F.S.; revising the definition of the term "athletic trainer"; deleting a requirement that is relocated to another section; amending s. 468.707, F.S.; revising athletic trainer licensure requirements; amending s. 468.711, F.S.; requiring certain licensees to maintain certification in good standing without lapse as a condition of renewal of their athletic trainer licenses; amending s. 468.713, F.S.; requiring that an athletic trainer work within a specified scope of practice; relocating an existing requirement that was stricken from another section; amending s. 468.723, F.S.; requiring the direct supervision of an athletic training student to be in accordance with rules adopted by the Board of Athletic Training; amending s. 468.803, F.S.; revising orthotic, prosthetic, and pedorthic licensure, registration, and examination requirements; amending s. 480.033, F.S.; revising the definition of the term "apprentice"; amending s. 480.041, F.S.; revising qualifications for licensure as a massage therapist; specifying that massage apprentices licensed before a specified date may

continue to perform massage therapy as authorized under their licenses; authorizing massage apprentices to apply for full licensure upon completion of their apprenticeships, under certain conditions; repealing s. 480.042, F.S., relating to examinations for licensure as a massage therapist; amending s. 490.003, F.S.; revising the definition of the terms "doctoral-level psychological education" and "doctoral degree in psychology"; amending s. 490.005, F.S.; revising requirements for licensure by examination of psychologists and school psychologists; amending s. 490.006, F.S.; revising requirements for licensure by endorsement of psychologists and school psychologists; amending s. 491.0045, F.S.; exempting clinical social worker interns, marriage and family therapist interns, and mental health counselor interns from registration requirements, under certain circumstances; amending s. 491.005, F.S.; revising requirements for the licensure by examination of marriage and family therapists; revising requirements for the licensure by examination of mental health counselors; amending s. 491.006, F.S.; revising requirements for licensure by endorsement or certification for specified professions; amending s. 491.007, F.S.; removing a biennial intern registration fee; amending s. 491.009,

F.S.; authorizing the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling or, under certain circumstances, the department to enter an order denying licensure or imposing penalties against an applicant for licensure under certain circumstances; amending ss. 491.0046 and 945.42, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Section 381.0042, Florida Statutes, is amended to read:

381.0042 Patient care for persons with HIV infection.—The department may establish human immunodeficiency virus ~~acquired immune deficiency syndrome~~ patient care networks in each region of the state where the number ~~numbers~~ of cases of ~~acquired immune deficiency syndrome and other~~ human immunodeficiency virus transmission ~~infections~~ justifies the establishment of cost-effective regional patient care networks. Such networks shall be delineated by rule of the department which shall take into account natural trade areas and centers of medical excellence that specialize in the treatment of human immunodeficiency virus ~~acquired immune deficiency syndrome~~, as well as available federal, state, and other funds. Each patient

care network shall include representation of persons with human immunodeficiency virus infection; health care providers; business interests; the department, including, but not limited to, county health departments; and local units of government. Each network shall plan for the care and treatment of persons with human immunodeficiency virus ~~acquired immune deficiency syndrome and acquired immune deficiency syndrome related complex~~ in a cost-effective, dignified manner that ~~which~~ emphasizes outpatient and home care. Once per ~~each~~ year, ~~beginning April 1989,~~ each network shall make its recommendations concerning the needs for patient care to the department.

Section 2. Subsection (3) of section 381.4018, Florida Statutes, is amended to read:

381.4018 Physician workforce assessment and development.—

(3) GENERAL FUNCTIONS.—The department shall maximize the use of existing programs under the jurisdiction of the department and other state agencies and coordinate governmental and nongovernmental stakeholders and resources in order to develop a state strategic plan and assess the implementation of such strategic plan. In developing the state strategic plan, the department shall:

(a) Monitor, evaluate, and report on the supply and distribution of physicians licensed under chapter 458 or chapter 459. The department shall maintain a database to serve as a statewide source of data concerning the physician workforce.

(b) Develop a model and quantify, on an ongoing basis, the adequacy of the state's current and future physician workforce as reliable data becomes available. Such model must take into account demographics, physician practice status, place of education and training, generational changes, population growth, economic indicators, and issues concerning the "pipeline" into medical education.

(c) Develop and recommend strategies to determine whether the number of qualified medical school applicants who might become competent, practicing physicians in this state will be sufficient to meet the capacity of the state's medical schools. If appropriate, the department shall, working with representatives of appropriate governmental and nongovernmental entities, develop strategies and recommendations and identify best practice programs that introduce health care as a profession and strengthen skills needed for medical school admission for elementary, middle, and high school students, and improve premedical education at the precollege and college level in order to increase this state's potential pool of medical students.

(d) Develop strategies to ensure that the number of graduates from the state's public and private allopathic and osteopathic medical schools is adequate to meet physician workforce needs, based on the analysis of the physician workforce data, so as to provide a high-quality medical

education to students in a manner that recognizes the uniqueness of each new and existing medical school in this state.

(e) Pursue strategies and policies to create, expand, and maintain graduate medical education positions in the state based on the analysis of the physician workforce data. Such strategies and policies must take into account the effect of federal funding limitations on the expansion and creation of positions in graduate medical education. The department shall develop options to address such federal funding limitations. The department shall consider options to provide direct state funding for graduate medical education positions in a manner that addresses requirements and needs relative to accreditation of graduate medical education programs. The department shall consider funding residency positions as a means of addressing needed physician specialty areas, rural areas having a shortage of physicians, and areas of ongoing critical need, and as a means of addressing the state's physician workforce needs based on an ongoing analysis of physician workforce data.

(f) Develop strategies to maximize federal and state programs that provide for the use of incentives to attract physicians to this state or retain physicians within the state. Such strategies should explore and maximize federal-state partnerships that provide incentives for physicians to practice in federally designated shortage areas, in otherwise medically underserved areas, or in rural areas. Strategies shall also

consider the use of state programs, such as the Medical Education Reimbursement and Loan Repayment Program pursuant to s. 1009.65, which provide for education loan repayment or loan forgiveness and provide monetary incentives for physicians to relocate to underserved areas of the state.

(g) Coordinate and enhance activities relative to physician workforce needs, undergraduate medical education, graduate medical education, and reentry of retired military and other physicians into the physician workforce provided by the Division of Medical Quality Assurance, area health education center networks established pursuant to s. 381.0402, and other offices and programs within the department as designated by the State Surgeon General.

(h) Work in conjunction with and act as a coordinating body for governmental and nongovernmental stakeholders to address matters relating to the state's physician workforce assessment and development for the purpose of ensuring an adequate supply of well-trained physicians to meet the state's future needs. Such governmental stakeholders shall include, but need not be limited to, the State Surgeon General or his or her designee, the Commissioner of Education or his or her designee, the Secretary of Health Care Administration or his or her designee, and the Chancellor of the State University System or his or her designee, and, at the discretion of the department, other representatives of state and local agencies that are

involved in assessing, educating, or training the state's current or future physicians. Other stakeholders shall include, but need not be limited to, organizations representing the state's public and private allopathic and osteopathic medical schools; organizations representing hospitals and other institutions providing health care, particularly those that currently provide or have an interest in providing accredited medical education and graduate medical education to medical students and medical residents; organizations representing allopathic and osteopathic practicing physicians; and, at the discretion of the department, representatives of other organizations or entities involved in assessing, educating, or training the state's current or future physicians.

(i) Serve as a liaison with other states and federal agencies and programs in order to enhance resources available to the state's physician workforce and medical education continuum.

(j) Act as a clearinghouse for collecting and disseminating information concerning the physician workforce and medical education continuum in this state.

The department may adopt rules to implement this subsection, including rules that establish guidelines to implement the federal Conrad 30 Waiver Program created under s. 214(l) of the Immigration and Nationality Act.

Section 3. Paragraphs (c) and (d) of subsection (1) of section 401.35, Florida Statutes, are amended to read:

401.35 Rules.—The department shall adopt rules, including definitions of terms, necessary to carry out the purposes of this part.

(1) The rules must provide at least minimum standards governing:

(c) Ground ambulance and vehicle equipment and supplies that a licensee with a valid vehicle permit under s. 401.26 is required to maintain to provide basic or advanced life support services ~~at least as comprehensive as those published in the most current edition of the American College of Surgeons, Committee on Trauma, list of essential equipment for ambulances, as interpreted by rules of the department~~.

(d) Ground ambulance or vehicle design and construction based on national standards recognized by the department and ~~at least equal to those most currently recommended by the United States General Services Administration as~~ interpreted by department rules ~~of the department~~.

Section 4. Paragraphs (a) and (b) of subsection (1) of section 456.013, Florida Statutes, are amended to read:

456.013 Department; general licensing provisions.—

(1)(a) Any person desiring to be licensed in a profession within the jurisdiction of the department must ~~shall~~ apply to the department in writing ~~to take the licensure examination~~. The

application must ~~shall~~ be made on a form prepared and furnished by the department. The application form must be available on the Internet, ~~World Wide Web~~ and the department may accept electronically submitted applications. The application shall require the social security number and date of birth of the applicant, except as provided in paragraphs (b) and (c). The form shall be supplemented as needed to reflect any material change in any circumstance or condition stated in the application which takes place between the initial filing of the application and the final grant or denial of the license and which might affect the decision of the department. If an application is submitted electronically, the department may require supplemental materials, including an original signature of the applicant and verification of credentials, to be submitted in a nonelectronic format. An incomplete application shall expire 1 year after initial filing. In order to further the economic development goals of the state, and notwithstanding any law to the contrary, the department may enter into an agreement with the county tax collector for the purpose of appointing the county tax collector as the department's agent to accept applications for licenses and applications for renewals of licenses. The agreement must specify the time within which the tax collector must forward any applications and accompanying application fees to the department.

(b) If an applicant has not been issued a social security

number by the Federal Government at the time of application because the applicant is not a citizen or resident of this country, the department may process the application using a unique personal identification number. If such an applicant is otherwise eligible for licensure, the board, or the department when there is no board, may issue a temporary license to the applicant~~,~~ which shall expire 30 days after issuance unless a social security number is obtained and submitted in writing to the department. A temporary license issued under this paragraph to an applicant who has accepted a position with an accredited residency, internship, or fellowship program in this state and is applying for registration under s. 458.345 or s. 459.021 shall expire 60 days after issuance unless the applicant obtains a social security number and submits it in writing to the department. Upon receipt of the applicant's social security number, the department shall issue a new license, which shall expire at the end of the current biennium.

Section 5. Paragraph (k) of subsection (1) of section 456.072, Florida Statutes, is amended to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(k) Failing to perform any statutory or legal obligation placed upon a licensee. For purposes of this section, failing to

repay a student loan issued or guaranteed by the state or the Federal Government in accordance with the terms of the loan is not ~~or failing to comply with service scholarship obligations shall be~~ considered a failure to perform a statutory or legal obligation~~, and the minimum disciplinary action imposed shall be a suspension of the license until new payment terms are agreed upon or the scholarship obligation is resumed, followed by probation for the duration of the student loan or remaining scholarship obligation period, and a fine equal to 10 percent of the defaulted loan amount~~. Fines collected shall be deposited into the Medical Quality Assurance Trust Fund.

Section 6. Section 456.0721, Florida Statutes, is repealed.

Section 7. Subsection (4) of section 456.074, Florida Statutes, is amended to read:

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

~~(4) Upon receipt of information that a Florida-licensed health care practitioner has defaulted on a student loan issued or guaranteed by the state or the Federal Government, the department shall notify the licensee by certified mail that he or she shall be subject to immediate suspension of license unless, within 45 days after the date of mailing, the licensee provides proof that new payment terms have been agreed upon by all parties to the loan. The department shall issue an emergency~~

~~order suspending the license of any licensee who, after 45 days following the date of mailing from the department, has failed to provide such proof. Production of such proof shall not prohibit the department from proceeding with disciplinary action against the licensee pursuant to s. 456.073.~~

Section 8. Subsection (1) of section 458.3145, Florida Statutes, is amended to read:

458.3145 Medical faculty certificate.—

(1) A medical faculty certificate may be issued without examination to an individual who:

(a) Is a graduate of an accredited medical school or its equivalent, or is a graduate of a foreign medical school listed with the World Health Organization;

(b) Holds a valid, current license to practice medicine in another jurisdiction;

(c) Has completed the application form and remitted a nonrefundable application fee not to exceed $500;

(d) Has completed an approved residency or fellowship of at least 1 year or has received training which has been determined by the board to be equivalent to the 1-year residency requirement;

(e) Is at least 21 years of age;

(f) Is of good moral character;

(g) Has not committed any act in this or any other jurisdiction which would constitute the basis for disciplining a

physician under s. 458.331;

(h) For any applicant who has graduated from medical school after October 1, 1992, has completed, before entering medical school, the equivalent of 2 academic years of preprofessional, postsecondary education, as determined by rule of the board, which must include, at a minimum, courses in such fields as anatomy, biology, and chemistry; and

(i) Has been offered and has accepted a full-time faculty appointment to teach in a program of medicine at:

1. The University of Florida;

2. The University of Miami;

3. The University of South Florida;

4. The Florida State University;

5. The Florida International University;

6. The University of Central Florida;

7. The Mayo Clinic College of Medicine and Science in Jacksonville, Florida;

8. The Florida Atlantic University; ~~or~~

9. The Johns Hopkins All Children's Hospital in St. Petersburg, Florida;

10. Nova Southeastern University; or

11. Lake Erie College of Osteopathic Medicine.

Section 9. Section 458.3312, Florida Statutes, is amended to read:

458.3312 Specialties.—A physician licensed under this

chapter may not hold himself or herself out as a board-certified specialist unless the physician has received formal recognition as a specialist from a specialty board of the American Board of Medical Specialties or other recognizing agency that has been approved by the board. However, a physician may indicate the services offered and may state that his or her practice is limited to one or more types of services when this accurately reflects the scope of practice of the physician. ~~A physician may not hold himself or herself out as a board-certified specialist in dermatology unless the recognizing agency, whether authorized in statute or by rule, is triennially reviewed and reauthorized by the Board of Medicine.~~

Section 10. Subsection (1) of section 459.0055, Florida Statutes, is amended to read:

459.0055 General licensure requirements.—

(1) Except as otherwise provided herein, any person desiring to be licensed or certified as an osteopathic physician pursuant to this chapter shall:

(a) Complete an application form and submit the appropriate fee to the department;

(b) Be at least 21 years of age;

(c) Be of good moral character;

(d) Have completed at least 3 years of preprofessional postsecondary education;

(e) Have not previously committed any act that would

constitute a violation of this chapter, unless the board determines that such act does not adversely affect the applicant's present ability and fitness to practice osteopathic medicine;

(f) Not be under investigation in any jurisdiction for an act that would constitute a violation of this chapter. If, upon completion of such investigation, it is determined that the applicant has committed an act that would constitute a violation of this chapter, the applicant is ineligible for licensure unless the board determines that such act does not adversely affect the applicant's present ability and fitness to practice osteopathic medicine;

(g) Have not had an application for a license to practice osteopathic medicine denied or a license to practice osteopathic medicine revoked, suspended, or otherwise acted against by the licensing authority of any jurisdiction unless the board determines that the grounds on which such action was taken do not adversely affect the applicant's present ability and fitness to practice osteopathic medicine. A licensing authority's acceptance of a physician's relinquishment of license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the osteopathic physician, shall be considered action against the osteopathic physician's license;

(h) Not have received less than a satisfactory evaluation

from an internship, residency, or fellowship training program, unless the board determines that such act does not adversely affect the applicant's present ability and fitness to practice osteopathic medicine. Such evaluation shall be provided by the director of medical education from the medical training facility;

(i) Have met the criteria set forth in s. 459.0075, s. 459.0077, or s. 459.021, whichever is applicable;

(j) Submit to the department a set of fingerprints on a form and under procedures specified by the department, along with a payment in an amount equal to the costs incurred by the Department of Health for the criminal background check of the applicant;

(k) Demonstrate that ~~he or~~ she or he is a graduate of a medical college recognized and approved by the American Osteopathic Association;

(l) Demonstrate that she or he has successfully completed an internship or residency ~~a resident internship~~ of not less than 12 months in a program accredited ~~hospital approved~~ for this purpose by ~~the Board of Trustees of~~ the American Osteopathic Association or the Accreditation Council for Graduate Medical Education ~~any other internship program approved by the board upon a showing of good cause by the applicant~~. This requirement may be waived for an applicant who matriculated in a college of osteopathic medicine during or before 1948; and

(m) Demonstrate that she or he has obtained a passing score, as established by rule of the board, on all parts of the examination conducted by the National Board of Osteopathic Medical Examiners or other examination approved by the board no more than 5 years before making application in this state or, if holding a valid active license in another state, that the initial licensure in the other state occurred no more than 5 years after the applicant obtained a passing score on the examination conducted by the National Board of Osteopathic Medical Examiners or other substantially similar examination approved by the board.

Section 11. Section 460.4166, Florida Statutes, is repealed.

Section 12. Subsection (10) of section 464.019, Florida Statutes, is amended to read:

464.019 Approval of nursing education programs.—

(10) IMPLEMENTATION STUDY.—The Florida Center for Nursing shall study the administration of this section and submit reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives annually by January 30, through January 30, 2025 ~~2020~~. The annual reports shall address the previous academic year; provide data on the measures specified in paragraphs (a) and (b), as such data becomes available; and include an evaluation of such data for purposes of determining whether this section is increasing the

availability of nursing education programs and the production of quality nurses. The department and each approved program or accredited program shall comply with requests for data from the Florida Center for Nursing.

(a) The Florida Center for Nursing shall evaluate program-specific data for each approved program and accredited program conducted in the state, including, but not limited to:

1. The number of programs and student slots available.

2. The number of student applications submitted, the number of qualified applicants, and the number of students accepted.

3. The number of program graduates.

4. Program retention rates of students tracked from program entry to graduation.

5. Graduate passage rates on the National Council of State Boards of Nursing Licensing Examination.

6. The number of graduates who become employed as practical or professional nurses in the state.

(b) The Florida Center for Nursing shall evaluate the board's implementation of the:

1. Program application approval process, including, but not limited to, the number of program applications submitted under subsection (1)~~,~~ the number of program applications approved and denied by the board under subsection (2)~~,~~ the number of denials of program applications reviewed under chapter

120,~~;~~ and a description of the outcomes of those reviews.

2. Accountability processes, including, but not limited to, the number of programs on probationary status, the number of approved programs for which the program director is required to appear before the board under subsection (5), the number of approved programs terminated by the board, the number of terminations reviewed under chapter 120, and a description of the outcomes of those reviews.

(c) The Florida Center for Nursing shall complete an annual assessment of compliance by programs with the accreditation requirements of subsection (11), include in the assessment a determination of the accreditation process status for each program, and submit the assessment as part of the reports required by this subsection.

Section 13. Section 464.202, Florida Statutes, is amended to read:

464.202 Duties and powers of the board.—The board shall maintain, or contract with or approve another entity to maintain, a state registry of certified nursing assistants. The registry must consist of the name of each certified nursing assistant in this state; other identifying information defined by board rule; certification status; the effective date of certification; other information required by state or federal law; information regarding any crime or any abuse, neglect, or exploitation as provided under chapter 435; and any disciplinary

action taken against the certified nursing assistant. The registry shall be accessible to the public, the certificateholder, employers, and other state agencies. The board shall adopt by rule testing procedures for use in certifying nursing assistants and shall adopt rules regulating the practice of certified nursing assistants, including disciplinary procedures and standards of practice, and specifying the scope of practice authorized and the level of supervision required for the practice of certified nursing assistants. The board may contract with or approve another entity or organization to provide the examination services, including the development and administration of examinations. The board shall require that the contract provider offer certified nursing assistant applications via the Internet, and may require the contract provider to accept certified nursing assistant applications for processing via the Internet. The board shall require the contract provider to provide the preliminary results of the certified nursing examination on the date the test is administered. The provider shall pay all reasonable costs and expenses incurred by the board in evaluating the provider's application and performance during the delivery of services, including examination services and procedures for maintaining the certified nursing assistant registry.

Section 14. Paragraph (c) of subsection (1) of section

464.203, Florida Statutes, is amended to read:

464.203 Certified nursing assistants; certification requirement.—

(1) The board shall issue a certificate to practice as a certified nursing assistant to any person who demonstrates a minimum competency to read and write and successfully passes the required background screening pursuant to s. 400.215. If the person has successfully passed the required background screening pursuant to s. 400.215 or s. 408.809 within 90 days before applying for a certificate to practice and the person's background screening results are not retained in the clearinghouse created under s. 435.12, the board shall waive the requirement that the applicant successfully pass an additional background screening pursuant to s. 400.215. The person must also meet one of the following requirements:

(c) Is currently certified in another state or territory of the United States or in the District of Columbia; is listed on that jurisdiction's ~~state's~~ certified nursing assistant registry; and has not been found to have committed abuse, neglect, or exploitation in that jurisdiction ~~state~~.

Section 15. Paragraph (b) of subsection (1) of section 464.204, Florida Statutes, is amended to read:

464.204 Denial, suspension, or revocation of certification; disciplinary actions.—

(1) The following acts constitute grounds for which the

board may impose disciplinary sanctions as specified in subsection (2):

(b) ~~Intentionally~~ Violating any provision of this chapter, chapter 456, or the rules adopted by the board.

Section 16. Subsections (3) and (4) of section 466.006, Florida Statutes, are amended to read:

466.006 Examination of dentists.—

(3) If an applicant is a graduate of a dental college or school not accredited in accordance with paragraph (2)(b) or of a dental college or school not approved by the board, the applicant is not entitled to take the examinations required in this section to practice dentistry until she or he satisfies one of the following:

(a) Completes a program of study, as defined by the board by rule, at an accredited American dental school and demonstrates receipt of a D.D.S. or D.M.D. from said school; or

(b) Submits proof of having successfully completed at least 2 consecutive academic years at a full-time supplemental general dentistry program accredited by the American Dental Association Commission on Dental Accreditation. This program must provide didactic and clinical education at the level of a D.D.S. or D.M.D. program accredited by the American Dental Association Commission on Dental Accreditation. For purposes of this paragraph, a supplemental general dentistry program does not include an advanced education program in a dental specialty.

(4) Notwithstanding any other provision of law in chapter 456 pertaining to the clinical dental licensure examination or national examinations, to be licensed as a dentist in this state, an applicant must successfully complete both of the following:

(a) A written examination on the laws and rules of the state regulating the practice of dentistry.~~;~~

(b)~~1.~~ A practical or clinical examination, which must ~~shall~~ be the American Dental Licensing Examination produced by the American Board of Dental Examiners, Inc., or its successor entity, if any, that is administered in this state ~~and graded by dentists licensed in this state and employed by the department for just such purpose~~, provided that the board has attained, and continues to maintain thereafter, representation on the board of directors of the American Board of Dental Examiners, the examination development committee of the American Board of Dental Examiners, and such other committees of the American Board of Dental Examiners as the board deems appropriate by rule to assure that the standards established herein are maintained organizationally. A passing score on the American Dental Licensing Examination administered in this state ~~and graded by dentists who are licensed in this state~~ is valid for 365 days after the date the official examination results are published.

1.~~2.a.~~ As an alternative to such practical or clinical examination ~~the requirements of subparagraph 1.~~, an applicant

may submit scores from an American Dental Licensing Examination previously administered in a jurisdiction other than this state after October 1, 2011, and such examination results shall be recognized as valid for the purpose of licensure in this state. A passing score on the American Dental Licensing Examination administered out of state ~~out-of-state~~ shall be the same as the passing score for the American Dental Licensing Examination administered in this state ~~and graded by dentists who are licensed in this state~~. The examination results are valid for 365 days after the date the official examination results are published. The applicant must have completed the examination after October 1, 2011.

~~b.~~ This subparagraph may not be given retroactive application.

2.~~3.~~ If the date of an applicant's passing American Dental Licensing Examination scores from an examination previously administered in a jurisdiction other than this state under subparagraph 1. ~~subparagraph 2.~~ is older than 365 days, ~~then~~ such scores are ~~shall~~ nevertheless ~~be recognized as~~ valid for the purpose of licensure in this state, but only if the applicant demonstrates that all of the following additional standards have been met:

a.~~(I)~~ The applicant completed the American Dental Licensing Examination after October 1, 2011.

~~(II)~~ This sub-subparagraph may not be given retroactive

application;

b. The applicant graduated from a dental school accredited by the American Dental Association Commission on Dental Accreditation or its successor entity, if any, or any other dental accrediting organization recognized by the United States Department of Education. Provided, however, if the applicant did not graduate from such a dental school, the applicant may submit proof of having successfully completed a full-time supplemental general dentistry program accredited by the American Dental Association Commission on Dental Accreditation of at least 2 consecutive academic years at such accredited sponsoring institution. Such program must provide didactic and clinical education at the level of a D.D.S. or D.M.D. program accredited by the American Dental Association Commission on Dental Accreditation. For purposes of this sub-subparagraph, a supplemental general dentistry program does not include an advanced education program in a dental specialty;

c. The applicant currently possesses a valid and active dental license in good standing, with no restriction, which has never been revoked, suspended, restricted, or otherwise disciplined, from another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico;

d. The applicant submits proof that he or she has never been reported to the National Practitioner Data Bank, the

Healthcare Integrity and Protection Data Bank, or the American Association of Dental Boards Clearinghouse. This sub-subparagraph does not apply if the applicant successfully appealed to have his or her name removed from the data banks of these agencies;

e.(I)(A) ~~In the 5 years immediately preceding the date of application for licensure in this state,~~ The applicant submits ~~must submit~~ proof of having been consecutively engaged in the full-time practice of dentistry in another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico in the 5 years immediately preceding the date of application for licensure in this state;~~,~~ or~~,~~

(B) If the applicant has been licensed in another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico for less than 5 years, the applicant submits ~~must submit~~ proof of having been engaged in the full-time practice of dentistry since the date of his or her initial licensure.

(II) As used in this section, "full-time practice" is defined as a minimum of 1,200 hours per year for each and every year in the consecutive 5-year period or, when ~~where~~ applicable, the period since initial licensure, and must include any combination of the following:

(A) Active clinical practice of dentistry providing direct patient care.

(B) Full-time practice as a faculty member employed by a dental or dental hygiene school approved by the board or accredited by the American Dental Association Commission on Dental Accreditation.

(C) Full-time practice as a student at a postgraduate dental education program approved by the board or accredited by the American Dental Association Commission on Dental Accreditation.

(III) The board shall develop rules to determine what type of proof of full-time practice is required and to recoup the cost to the board of verifying full-time practice under this section. Such proof must, at a minimum, be:

(A) Admissible as evidence in an administrative proceeding;

(B) Submitted in writing;

(C) Submitted by the applicant under oath with penalties of perjury attached;

(D) Further documented by an affidavit of someone unrelated to the applicant who is familiar with the applicant's practice and testifies with particularity that the applicant has been engaged in full-time practice; and

(E) Specifically found by the board to be both credible and admissible.

(IV) An affidavit of only the applicant is not acceptable proof of full-time practice unless it is further attested to by

someone unrelated to the applicant who has personal knowledge of the applicant's practice. If the board deems it necessary to assess credibility or accuracy, the board may require the applicant or the applicant's witnesses to appear before the board and give oral testimony under oath;

f. The applicant submits ~~must submit~~ documentation that he or she has completed, or will complete before he or she is licensed~~, prior to licensure~~ in this state, continuing education equivalent to this state's requirements for the last full reporting biennium;

g. The applicant proves ~~must prove~~ that he or she has never been convicted of, or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession in any jurisdiction;

h. The applicant has ~~must~~ successfully passed ~~pass~~ a written examination on the laws and rules of this state regulating the practice of dentistry and ~~must successfully pass~~ the computer-based diagnostic skills examination; and

i. The applicant submits ~~must submit~~ documentation that he or she has successfully completed the applicable examination administered by the Joint Commission on National Dental Examinations or its successor organization ~~National Board of Dental Examiners dental examination~~.

Section 17. Notwithstanding the January 1, 2020, repeal of section 466.0067, Florida Statutes, that section is revived,

reenacted, and amended, to read:

466.0067 Application for health access dental license.—The Legislature finds that there is an important state interest in attracting dentists to practice in underserved health access settings in this state and further, that allowing out-of-state dentists who meet certain criteria to practice in health access settings without the supervision of a dentist licensed in this state is substantially related to achieving this important state interest. Therefore, notwithstanding the requirements of s. 466.006, the board shall grant a health access dental license to practice dentistry in this state in health access settings as defined in s. 466.003 to an applicant who ~~that~~:

(1) Files an appropriate application approved by the board;

(2) Pays an application license fee for a health access dental license, laws-and-rule exam fee, and an initial licensure fee. The fees specified in this subsection may not differ from an applicant seeking licensure pursuant to s. 466.006;

(3) Has not been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;

(4) Submits proof of graduation from a dental school accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency;

(5) Submits documentation that she or he has completed, or

will obtain before ~~prior to~~ licensure, continuing education equivalent to this state's requirement for dentists licensed under s. 466.006 for the last full reporting biennium before applying for a health access dental license;

(6) Submits proof of her or his successful completion of parts I and II of the dental examination by the National Board of Dental Examiners and a state or regional clinical dental licensing examination that the board has determined effectively measures the applicant's ability to practice safely;

(7) Currently holds a valid, active~~,~~ dental license in good standing which has not been revoked, suspended, restricted, or otherwise disciplined from another of the United States, the District of Columbia, or a United States territory;

(8) Has never had a license revoked from another of the United States, the District of Columbia, or a United States territory;

(9) Has never failed the examination specified in s. 466.006, unless the applicant was reexamined pursuant to s. 466.006 and received a license to practice dentistry in this state;

(10) Has not been reported to the National Practitioner Data Bank, unless the applicant successfully appealed to have his or her name removed from the data bank;

(11) Submits proof that he or she has been engaged in the active, clinical practice of dentistry providing direct patient

care for 5 years immediately preceding the date of application, or in instances when the applicant has graduated from an accredited dental school within the preceding 5 years, submits proof of continuous clinical practice providing direct patient care since graduation; and

(12) Has passed an examination covering the laws and rules of the practice of dentistry in this state as described in s. 466.006(4)(a).

Section 18. Notwithstanding the January 1, 2020, repeal of section 466.00671, Florida Statutes, that section is revived, reenacted, and amended to read:

466.00671 Renewal of the health access dental license.—

(1) A health access dental licensee shall apply for renewal each biennium. At the time of renewal, the licensee shall sign a statement that she or he has complied with all continuing education requirements of an active dentist licensee. The board shall renew a health access dental license for an applicant who ~~that~~:

(a) Submits documentation, as approved by the board, from the employer in the health access setting that the licensee has at all times pertinent remained an employee;

(b) Has not been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;

(c) Has paid a renewal fee set by the board. The fee

specified herein may not differ from the renewal fee adopted by the board pursuant to s. 466.013. The department may provide payment for these fees through the dentist's salary, benefits, or other department funds;

(d) Has not failed the examination specified in s. 466.006 since initially receiving a health access dental license or since the last renewal; and

(e) Has not been reported to the National Practitioner Data Bank, unless the applicant successfully appealed to have his or her name removed from the data bank.

(2) The board may undertake measures to independently verify the health access dental licensee's ongoing employment status in the health access setting.

Section 19. Notwithstanding the January 1, 2020, repeal of section 466.00672, Florida Statutes, that section is revived and reenacted to read:

466.00672 Revocation of health access dental license.—

(1) The board shall revoke a health access dental license upon:

(a) The licensee's termination from employment from a qualifying health access setting;

(b) Final agency action determining that the licensee has violated any provision of s. 466.027 or s. 466.028, other than infractions constituting citation offenses or minor violations; or

(c) Failure of the Florida dental licensure examination.

(2) Failure of an individual licensed pursuant to s. 466.0067 to limit the practice of dentistry to health access settings as defined in s. 466.003 constitutes the unlicensed practice of dentistry.

Section 20. The amendments and reenactments made by this act to ss. 466.0067, 466.00671, and 466.00672, Florida Statutes, are remedial in nature and apply retroactively to January 1, 2020.

Section 21. Paragraph (b) of subsection (4) and paragraph (a) of subsection (6) of section 466.007, Florida Statutes, are amended to read:

466.007 Examination of dental hygienists.—

(4) Effective July 1, 2012, to be licensed as a dental hygienist in this state, an applicant must successfully complete the following:

(b) A practical or clinical examination approved by the board. The examination shall be the Dental Hygiene Examination produced by the American Board of Dental Examiners, Inc. (ADEX) or its successor entity, if any, if the board finds that the successor entity's clinical examination meets or exceeds the provisions of this section. The board shall approve the ADEX Dental Hygiene Examination if the board has attained and continues to maintain representation on the ADEX House of Representatives, the ADEX Dental Hygiene Examination Development

Committee, and such other ADEX Dental Hygiene committees as the board deems appropriate through rulemaking to ensure that the standards established in this section are maintained organizationally. The ADEX Dental Hygiene Examination or the examination produced by its successor entity is a comprehensive examination in which an applicant must demonstrate skills within the dental hygiene scope of practice on a live patient and any other components that the board deems necessary for the applicant to successfully demonstrate competency for the purpose of licensure. ~~The ADEX Dental Hygiene Examination or the examination by the successor entity administered in this state shall be graded by dentists and dental hygienists licensed in this state who are employed by the department for this purpose.~~

(6)(a) A passing score on the ADEX Dental Hygiene Examination administered out of state must ~~shall~~ be considered the same as a passing score for the ADEX Dental Hygiene Examination administered in this state ~~and graded by licensed dentists and dental hygienists~~.

Section 22. Subsections (9) through (15) are added to section 466.017, Florida Statutes, to read:

466.017 Prescription of drugs; anesthesia.—

(9) Any adverse incident that occurs in an office maintained by a dentist must be reported to the department. The required notification to the department must be submitted in writing by certified mail and postmarked within 48 hours after

the incident occurs.

(10) A dentist practicing in this state must notify the board in writing by certified mail within 48 hours after any adverse incident that occurs in the dentist's outpatient facility. A complete written report must be filed with the board within 30 days after the incident occurs.

(11) Any certified registered dental hygienist administering local anesthesia must notify the board in writing by registered mail within 48 hours after any adverse incident that was related to or the result of the administration of local anesthesia. A complete written report must be filed with the board within 30 days after the mortality or other adverse incident.

(12) A failure by the dentist or dental hygienist to timely and completely comply with all the reporting requirements in this section is the basis for disciplinary action by the board pursuant to s. 466.028(1).

(13) The department shall review each adverse incident and determine whether it involved conduct by a health care professional subject to disciplinary action, in which case s. 456.073 applies. Disciplinary action, if any, shall be taken by the board under which the health care professional is licensed.

(14) As used in subsections (9)-(13), the term "adverse incident" means any mortality that occurs during or as the result of a dental procedure, or an incident that results in a

temporary or permanent physical or mental injury that requires hospitalization or emergency room treatment of a dental patient which occurs during or as a direct result of the use of general anesthesia, deep sedation, moderate sedation, pediatric moderate sedation, oral sedation, minimal sedation (anxiolysis), nitrous oxide, or local anesthesia.

(15) The board may adopt rules to administer this section.

Section 23. Section 466.031, Florida Statutes, is amended to read:

466.031 ~~"~~Dental laboratories ~~laboratory" defined~~.—

(1) As used in this chapter, the term "dental laboratory" ~~as used in this chapter:~~

~~(1)~~ includes any person, firm, or corporation that ~~who~~ performs for a fee of any kind, gratuitously, or otherwise, directly or through an agent or an employee, by any means or method, or ~~who in any way~~ supplies or manufactures artificial substitutes for the natural teeth;~~, or who~~ furnishes, supplies, constructs, or reproduces or repairs any prosthetic denture, bridge, or appliance to be worn in the human mouth; or ~~who~~ in any way represents ~~holds~~ itself ~~out~~ as a dental laboratory.

~~(2)~~ The term does not include a ~~Excludes any~~ dental laboratory technician who constructs or repairs dental prosthetic appliances in the office of a licensed dentist exclusively for that ~~such~~ dentist ~~only and~~ under her or his supervision and work order.

(2) An employee or independent contractor of a dental laboratory, acting as an agent of that dental laboratory, may engage in onsite consultation with a licensed dentist during a dental procedure.

Section 24. Section 466.036, Florida Statutes, is amended to read:

466.036 Information; periodic inspections; equipment and supplies.—The department may require from the applicant for a registration certificate to operate a dental laboratory any information necessary to carry out the purpose of this chapter, including proof that the applicant has the equipment and supplies necessary to operate as determined by rule of the department, and shall require periodic inspection of all dental laboratories operating in this state at least once each biennial registration period. Such inspections must ~~shall~~ include, but need not be limited to, inspection of sanitary conditions, equipment, supplies, and facilities on the premises. The department shall specify dental equipment and supplies that are not allowed ~~permitted~~ in a registered dental laboratory.

Section 25. Subsection (1) of section 468.701, Florida Statutes, is amended to read:

468.701 Definitions.—As used in this part, the term:

(1) "Athletic trainer" means a person licensed under this part who has met the requirements of ~~under~~ this part, including the education requirements established ~~as set forth~~ by the

Commission on Accreditation of Athletic Training Education or its successor organization and necessary credentials from the Board of Certification. ~~An individual who is licensed as an athletic trainer may not provide, offer to provide, or represent that he or she is qualified to provide any care or services that he or she lacks the education, training, or experience to provide, or that he or she is otherwise prohibited by law from providing.~~

Section 26. Section 468.707, Florida Statutes, is amended to read:

468.707 Licensure requirements.—Any person desiring to be licensed as an athletic trainer shall apply to the department on a form approved by the department. An applicant shall also provide records or other evidence, as determined by the board, to prove he or she has met the requirements of this section. The department shall license each applicant who:

(1) Has completed the application form and remitted the required fees.

(2) ~~For a person who applies on or after July 1, 2016,~~ Has submitted to background screening pursuant to s. 456.0135. The board may require a background screening for an applicant whose license has expired or who is undergoing disciplinary action.

(3)(a) Has obtained, at a minimum, a bachelor's ~~baccalaureate or higher~~ degree from a college or university professional athletic training degree program accredited by the

Commission on Accreditation of Athletic Training Education or its successor organization recognized and approved by the United States Department of Education or the Commission on Recognition of Postsecondary Accreditation, approved by the board, or recognized by the Board of Certification, and has passed the national examination to be certified by the Board of Certification; or~~.~~

(b)~~(4)~~ Has obtained, at a minimum, a bachelor's degree, has completed the Board of Certification internship requirements, and holds ~~If graduated before 2004, has~~ a current certification from the Board of Certification.

(4)~~(5)~~ Has current certification in both cardiopulmonary resuscitation and the use of an automated external defibrillator set forth in the continuing education requirements as determined by the board pursuant to s. 468.711.

(5)~~(6)~~ Has completed any other requirements as determined by the department and approved by the board.

Section 27. Subsection (3) of section 468.711, Florida Statutes, is amended to read:

468.711 Renewal of license; continuing education.—

(3) If initially licensed after January 1, 1998, the licensee must be currently certified by the Board of Certification or its successor agency and maintain that certification in good standing without lapse.

Section 28. Section 468.713, Florida Statutes, is amended

to read:

468.713 Responsibilities of athletic trainers.—

(1) An athletic trainer shall practice under the direction of a physician licensed under chapter 458, chapter 459, chapter 460, or otherwise authorized by Florida law to practice medicine. The physician shall communicate his or her direction through oral or written prescriptions or protocols as deemed appropriate by the physician for the provision of services and care by the athletic trainer. An athletic trainer shall provide service or care in the manner dictated by the physician.

(2) An athletic trainer shall work within his or her allowable scope of practice as specified in board rule under s. 468.705. An athletic trainer may not provide, offer to provide, or represent that he or she is qualified to provide any care or services that he or she lacks the education, training, or experience to provide or that he or she is otherwise prohibited by law from providing.

Section 29. Subsection (2) of section 468.723, Florida Statutes, is amended to read:

468.723 Exemptions.—This part does not prohibit ~~prevent~~ or restrict:

(2) An athletic training student acting under the direct supervision of a licensed athletic trainer. For purposes of this subsection, "direct supervision" means the physical presence of an athletic trainer so that the athletic trainer is immediately

available to the athletic training student and able to intervene on behalf of the athletic training student. The supervision must comply with board rule ~~in accordance with the standards set forth by the Commission on Accreditation of Athletic Training Education or its successor~~.

Section 30. Subsections (1), (3), and (4) of section 468.803, Florida Statutes, are amended to read:

468.803 License, registration, and examination requirements.—

(1) The department shall issue a license to practice orthotics, prosthetics, or pedorthics, or a registration for a resident to practice orthotics or prosthetics, to qualified applicants. Licenses to practice ~~shall be granted independently in~~ orthotics, prosthetics, or pedorthics must be granted independently, but a person may be licensed in more than one such discipline, and a prosthetist-orthotist license may be granted to persons meeting the requirements for licensure both as a prosthetist and as an orthotist ~~license~~. Registrations to practice ~~shall be granted independently in~~ orthotics or prosthetics must be granted independently, and a person may be registered in both disciplines ~~fields~~ at the same time or jointly in orthotics and prosthetics as a dual registration.

(3) A person seeking to attain the ~~required~~ orthotics or prosthetics experience required for licensure in this state must be approved by the board and registered as a resident by the

department. Although a registration may be held in both disciplines ~~practice fields~~, for independent registrations the board may ~~shall~~ not approve a second registration until at least 1 year after the issuance of the first registration. Notwithstanding subsection (2), a person ~~an applicant~~ who has been approved by the board and registered by the department in one discipline ~~practice field~~ may apply for registration in the second discipline ~~practice field~~ without an additional state or national criminal history check during the period in which the first registration is valid. Each independent registration or dual registration is valid for 2 years after ~~from~~ the date of issuance unless otherwise revoked by the department upon recommendation of the board. The board shall set a registration fee not to exceed $500 to be paid by the applicant. A registration may be renewed once by the department upon recommendation of the board for a period no longer than 1 year, as such renewal is defined by the board by rule. The ~~registration~~ renewal fee may ~~shall~~ not exceed one-half the current registration fee. To be considered by the board for approval of registration as a resident, the applicant must have one of the following:

(a) A Bachelor of Science or higher-level postgraduate degree in orthotics and prosthetics from a regionally accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs. ~~or, at~~

(b) A minimum of~~,~~ a bachelor's degree from a regionally accredited college or university and a certificate in orthotics or prosthetics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board.~~; or~~

(c) A minimum of a bachelor's degree from a regionally accredited college or university and a dual certificate in both orthotics and prosthetics from programs recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board.

~~(b) A Bachelor of Science or higher-level postgraduate degree in Orthotics and Prosthetics from a regionally accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs or, at a minimum, a bachelor's degree from a regionally accredited college or university and a certificate in prosthetics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board.~~

(4) The department may develop and administer a state examination for an orthotist or a prosthetist license, or the board may approve the existing examination of a national standards organization. The examination must be predicated on a minimum of a baccalaureate-level education and formalized specialized training in the appropriate field. Each examination

must demonstrate a minimum level of competence in basic scientific knowledge, written problem solving, and practical clinical patient management. The board shall require an examination fee not to exceed the actual cost to the board in developing, administering, and approving the examination, which fee must be paid by the applicant. To be considered by the board for examination, the applicant must have:

(a) For an examination in orthotics:

1. A Bachelor of Science or higher-level postgraduate degree in orthotics and prosthetics from a regionally accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs or, at a minimum, a bachelor's degree from a regionally accredited college or university and a certificate in orthotics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board; and

2. An approved orthotics internship of 1 year of qualified experience, as determined by the board, or an orthotic residency or dual residency program recognized by the board.

(b) For an examination in prosthetics:

1. A Bachelor of Science or higher-level postgraduate degree in orthotics and prosthetics from a regionally accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs or, at a

minimum, a bachelor's degree from a regionally accredited college or university and a certificate in prosthetics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board; and

2. An approved prosthetics internship of 1 year of qualified experience, as determined by the board, or a prosthetic residency or dual residency program recognized by the board.

Section 31. Subsection (5) of section 480.033, Florida Statutes, is amended to read:

480.033 Definitions.—As used in this act:

(5) "Apprentice" means a person approved by the board to study colonic irrigation ~~massage~~ under the instruction of a licensed massage therapist practicing colonic irrigation.

Section 32. Subsections (1) and (2) of section 480.041, Florida Statutes, are amended, and subsection (8) is added to that section, to read:

480.041 Massage therapists; qualifications; licensure; endorsement.—

(1) Any person is qualified for licensure as a massage therapist under this act who:

(a) Is at least 18 years of age or has received a high school diploma or high school equivalency diploma;

(b) Has completed a course of study at a board-approved

massage school ~~or has completed an apprenticeship program~~ that meets standards adopted by the board; and

(c) Has received a passing grade on a national ~~an~~ examination designated ~~administered~~ by the board ~~department~~.

(2) Every person desiring to be examined for licensure as a massage therapist must ~~shall~~ apply to the department in writing upon forms prepared and furnished by the department. Such applicants are ~~shall be~~ subject to ~~the provisions of~~ s. 480.046(1). ~~Applicants may take an examination administered by the department only upon meeting the requirements of this section as determined by the board.~~

(8) A person issued a license as a massage apprentice before July 1, 2020, may continue that apprenticeship and perform massage therapy as authorized under that license until it expires. Upon completion of the apprenticeship, which must occur before July 1, 2023, a massage apprentice may apply to the board for full licensure and be granted a license if all other applicable licensure requirements are met.

Section 33. Section 480.042, Florida Statutes, is repealed.

Section 34. Subsection (3) of section 490.003, Florida Statutes, is amended to read:

490.003 Definitions.—As used in this chapter:

(3)~~(a) Prior to July 1, 1999, "doctoral-level psychological education" and "doctoral degree in psychology"~~

~~mean a Psy.D., an Ed.D. in psychology, or a Ph.D. in psychology from:~~

~~1. An educational institution which, at the time the applicant was enrolled and graduated, had institutional accreditation from an agency recognized and approved by the United States Department of Education or was recognized as a member in good standing with the Association of Universities and Colleges of Canada; and~~

~~2. A psychology program within that educational institution which, at the time the applicant was enrolled and graduated, had programmatic accreditation from an accrediting agency recognized and approved by the United States Department of Education or was comparable to such programs.~~

~~(b)~~ Effective July 1, 1999, "doctoral-level psychological education" and "doctoral degree in psychology" mean a Psy.D., an Ed.D. in psychology, or a Ph.D. in psychology from a psychology program at~~:~~

~~1.~~ an educational institution that ~~which~~, at the time the applicant was enrolled and graduated:

(a) ~~,~~ Had institutional accreditation from an agency recognized and approved by the United States Department of Education or was recognized as a member in good standing with the Association of Universities and Colleges of Canada; and

(b)~~2.~~ ~~A psychology program within that educational institution which, at the time the applicant was enrolled and~~

~~graduated,~~ Had programmatic accreditation from the American Psychological Association ~~an agency recognized and approved by the United States Department of Education~~.

Section 35. Paragraph (b) of subsection (1) and paragraph (b) of subsection (2) of section 490.005, Florida Statutes, are amended to read:

490.005 Licensure by examination.—

(1) Any person desiring to be licensed as a psychologist shall apply to the department to take the licensure examination. The department shall license each applicant who the board certifies has:

(b) Submitted proof satisfactory to the board that the applicant has received:

1. ~~Received~~ Doctoral-level psychological education~~, as defined in s. 490.003(3)~~; or

2. ~~Received~~ The equivalent of a doctoral-level psychological education, as defined in s. 490.003(3), from a program at a school or university located outside the United States of America ~~and Canada,~~ which was officially recognized by the government of the country in which it is located as an institution or program to train students to practice professional psychology. The applicant has the burden of establishing that this requirement has ~~the requirements of this provision have~~ been met ~~shall be upon the applicant;~~

~~3. Received and submitted to the board, prior to July 1,~~

~~1999, certification of an augmented doctoral-level psychological education from the program director of a doctoral-level psychology program accredited by a programmatic agency recognized and approved by the United States Department of Education; or~~

~~4. Received and submitted to the board, prior to August 31, 2001, certification of a doctoral-level program that at the time the applicant was enrolled and graduated maintained a standard of education and training comparable to the standard of training of programs accredited by a programmatic agency recognized and approved by the United States Department of Education. Such certification of comparability shall be provided by the program director of a doctoral-level psychology program accredited by a programmatic agency recognized and approved by the United States Department of Education~~.

(2) Any person desiring to be licensed as a school psychologist shall apply to the department to take the licensure examination. The department shall license each applicant who the department certifies has:

(b) Submitted satisfactory proof to the department that the applicant:

1. Has received a doctorate, specialist, or equivalent degree from a program primarily psychological in nature and has completed 60 semester hours or 90 quarter hours of graduate study, in areas related to school psychology as defined by rule

of the department, from a college or university which at the time the applicant was enrolled and graduated was accredited by an accrediting agency recognized and approved by the Council for Higher Education Accreditation or its successor organization ~~Commission on Recognition of Postsecondary Accreditation~~ or from an institution that ~~which~~ is ~~publicly recognized as~~ a member in good standing with the Association of Universities and Colleges of Canada.

2. Has had a minimum of 3 years of experience in school psychology, 2 years of which must be supervised by an individual who is a licensed school psychologist or who has otherwise qualified as a school psychologist supervisor, by education and experience, as set forth by rule of the department. A doctoral internship may be applied toward the supervision requirement.

3. Has passed an examination provided by the department.

Section 36. Subsection (1) of section 490.006, Florida Statutes, is amended to read:

490.006 Licensure by endorsement.—

(1) The department shall license a person as a psychologist or school psychologist who, upon applying to the department and remitting the appropriate fee, demonstrates to the department or, in the case of psychologists, to the board that the applicant:

~~(a) Holds a valid license or certificate in another state to practice psychology or school psychology, as applicable,~~

~~provided that, when the applicant secured such license or certificate, the requirements were substantially equivalent to or more stringent than those set forth in this chapter at that time; and, if no Florida law existed at that time, then the requirements in the other state must have been substantially equivalent to or more stringent than those set forth in this chapter at the present time;~~

(a) ~~(b)~~ Is a diplomate in good standing with the American Board of Professional Psychology, Inc.; or

(b) ~~(c)~~ Possesses a doctoral degree in psychology ~~as described in s. 490.003~~ and has at least 10 ~~20~~ years of experience as a licensed psychologist in any jurisdiction or territory of the United States within the 25 years preceding the date of application.

Section 37. Subsection (6) of section 491.0045, Florida Statutes, as created by chapter 2016-80 and chapter 2016-241, Laws of Florida, is amended to read:

491.0045 Intern registration; requirements.—

(6) A registration issued on or before March 31, 2017, expires March 31, 2022, and may not be renewed or reissued. Any registration issued after March 31, 2017, expires 60 months after the date it is issued. The board may make a one-time exception from the requirements of this subsection in emergency or hardship cases, as defined by board rule, if ~~A subsequent intern registration may not be issued unless~~ the candidate has

passed the theory and practice examination described in s. 491.005(1)(d), (3)(d), and (4)(d).

Section 38. Subsections (3) and (4) of section 491.005, Florida Statutes, are amended to read:

491.005 Licensure by examination.—

(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 of ~~to the department for~~ the purchase of the examination from the Association of Marital and Family Therapy Regulatory Board, or 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 application and paid the appropriate fee.

(b)1. Has a minimum of a master's degree with major emphasis in marriage and family therapy~~,~~ or a closely related field from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education or from a Florida university program accredited by the Council for Accreditation of Counseling and Related Educational Programs~~,~~ and graduate courses approved by the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling ~~has completed all of the following requirements:~~

~~a. Thirty-six semester hours or 48 quarter hours of graduate coursework, which must include a minimum of 3 semester~~

~~hours or 4 quarter hours of graduate-level 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. 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 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 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 that ~~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 that, ~~which~~ at the time the applicant graduated, was~~:~~ fully accredited by a regional accrediting body recognized by the Commission on Recognition of Postsecondary Accreditation or~~;~~ 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 applicant has 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 that ~~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 recognized by the United States Department of Education.

(c) Has had at least 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 commencing practice. If a graduate has a master's degree with a major emphasis in marriage and family therapy or a closely related field which ~~that~~ did not include all of the coursework required by subparagraph (b)1. ~~under sub-subparagraphs (b)1.a.-c.~~, credit for the post-master's level clinical experience may ~~shall~~ not commence until the applicant has completed a minimum of 10 of the courses required by subparagraph (b)1. ~~under 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 including those involving~~:~~ unmarried dyads, married couples, separating and divorcing couples, and family groups that include ~~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.

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

(e) Has demonstrated, in a manner designated by board 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.

~~(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 may ~~shall~~ not exceed those stated in this subsection.

(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 of ~~to the department for~~ purchase of the examination from the National Board for Certified Counselors or its successor ~~Professional Examination Service for the National Academy of Certified Clinical Mental Health Counselors or a similar national~~ organization, the department shall issue a license as a mental health counselor to an applicant who the board certifies:

(a) Has submitted an application 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 which ~~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 which ~~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 all of 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; substance abuse; and legal, ethical, and professional standards issues in the practice of mental health counseling ~~in community settings; and substance abuse~~. 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 addressing diagnostic processes, including differential diagnosis and the use of the current diagnostic tools, such as the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. The graduate program must have emphasized the common core curricular experience ~~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. Has provided additional documentation if a ~~the~~ course title that ~~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 must include, ~~including,~~ but is 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 that, ~~which~~ at the time the applicant graduated, was~~:~~ fully accredited by a regional accrediting body recognized by the Council for Higher Education Accreditation or its successor organization or ~~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 Accreditation or its successor organization ~~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 applicant has 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. Beginning July 1, 2025, an applicant must have a master's degree from a program that is accredited by the Council for Accreditation of Counseling and Related Educational Programs which consists of at least 60 semester hours or 80 quarter hours to apply for licensure under this paragraph.

(c) Has had at least 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 commencing practice. If a graduate has a master's degree with a major related to the practice of mental health counseling which ~~that~~ did not include all the coursework required under sub-subparagraphs (b)1.a. and b. ~~(b)1.a.-b.~~, credit for the post-master's level clinical experience may ~~shall~~ not commence until the applicant has completed a minimum of seven of the courses required under sub-subparagraphs (b)1.a. and b. ~~(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.

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

(e) Has demonstrated, in a manner designated by board 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.

Section 39. Paragraph (b) of 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:

(b)1. Holds an active valid license to practice and has actively practiced the licensed 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.~~

2.~~3.~~ Has passed 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; and~~.~~

3.~~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 40. Subsection (3) of section 491.007, Florida Statutes, is amended to read:

491.007 Renewal of license, registration, or 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 41. Subsection (2) of section 491.009, Florida Statutes, is amended to read:

491.009 Discipline.—

(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 authorized in s. 456.072(2) against any applicant for licensure or any licensee who violates ~~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 42. Subsection (2) of section 491.0046, Florida Statutes, is amended 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:

(a) Completed the application form and remitted a nonrefundable application fee not to exceed $100, as set by board rule; and

(b) Earned a graduate degree in social work, a graduate degree with a major emphasis in marriage and family therapy or a

closely related field, or a graduate degree in a major related to the practice of mental health counseling; and

(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. ~~s. 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.-c.

Section 43. Subsection (11) of section 945.42, Florida Statutes, is amended to read:

945.42 Definitions; ss. 945.40-945.49.—As used in ss. 945.40-945.49, the following terms shall have the meanings ascribed to them, unless the context shall clearly indicate otherwise:

(11) "Psychological professional" means a behavioral practitioner who has an approved doctoral degree in psychology as defined in s. 490.003(3) ~~s. 490.003(3)(b)~~ and is employed by the department or who is licensed as a psychologist pursuant to chapter 490.

Section 44. This act shall take effect July 1, 2020.

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Rodriguez, A. M. offered the following:

Amendment (with title amendment)

Between lines 136 and 137, insert:

Section 1. Paragraphs (a) and (b) of subsection (2) of section 39.303, Florida Statutes, are amended to read:

39.303 Child Protection Teams and sexual abuse treatment programs; services; eligible cases.—

(2)(a) The Statewide Medical Director for Child Protection must be a physician licensed under chapter 458 or chapter 459 who is a board-certified pediatrician with a subspecialty certification in child abuse from the American Board of Pediatrics. The Statewide Medical Director for Child Protection

shall report directly to the Deputy Secretary for Children's Medical Services.

(b) Each Child Protection Team medical director must be a physician licensed under chapter 458 or chapter 459 who is a board-certified physician in pediatrics or family medicine and, within 2 years after the date of employment as a Child Protection Team medical director, obtains a subspecialty certification in child abuse from the American Board of Pediatrics or within 2 years meet the minimum requirements established by a third-party credentialing entity recognizing a demonstrated specialized competence in child abuse pediatrics pursuant to paragraph (d). Each Child Protection Team medical director employed on July 1, 2015, must, by July 1, 2019, either obtain a subspecialty certification in child abuse from the American Board of Pediatrics or meet the minimum requirements established by a third-party credentialing entity recognizing a demonstrated specialized competence in child abuse pediatrics pursuant to paragraph (d). Child Protection Team medical directors shall be responsible for oversight of the teams in the circuits. The Statewide Child Protection Team Medical Director shall report directly to the Statewide Medical Director for Child Protection.

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

Between lines 2 and 3, insert:

s. 39.303, F.S.; specifying direct reporting requirements for certain positions within the Children's Medical Services program; amending

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Rodriguez, A. M. offered the following:

Amendment (with title amendment)

Between lines 274 and 275, insert:

Section 3. Paragraph (c) of subsection (4) of section 381.915, Florida Statutes, is amended to read:

381.915 Florida Consortium of National Cancer Institute Centers Program.—

(4) Tier designations and corresponding weights within the Florida Consortium of National Cancer Institute Centers Program are as follows:

(c) Tier 3: Florida-based cancer centers seeking designation as either a NCI-designated cancer center or NCI-

designated comprehensive cancer center, which shall be weighted at 1.0.

1. A cancer center shall meet the following minimum criteria to be considered eligible for Tier 3 designation in any given fiscal year:

a. Conducting cancer-related basic scientific research and cancer-related population scientific research;

b. Offering and providing the full range of diagnostic and treatment services on site, as determined by the Commission on Cancer of the American College of Surgeons;

c. Hosting or conducting cancer-related interventional clinical trials that are registered with the NCI's Clinical Trials Reporting Program;

d. Offering degree-granting programs or affiliating with universities through degree-granting programs accredited or approved by a nationally recognized agency and offered through the center or through the center in conjunction with another institution accredited by the Commission on Colleges of the Southern Association of Colleges and Schools;

e. Providing training to clinical trainees, medical trainees accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, and postdoctoral fellows recently awarded a doctorate degree; and

f. Having more than $5 million in annual direct costs associated with their total NCI peer-reviewed grant funding.

2. The General Appropriations Act or accompanying legislation may limit the number of cancer centers which shall receive Tier 3 designations or provide additional criteria for such designation.

3. A cancer center's participation in Tier 3 may not extend beyond June 30, 2024 ~~shall be limited to 6 years~~.

4. A cancer center that qualifies as a designated Tier 3 center under the criteria provided in subparagraph 1. by July 1, 2014, is authorized to pursue NCI designation as a cancer center or a comprehensive cancer center until June 30, 2024 ~~for 6 years after qualification~~.

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

Remove line 13 and insert:
certain rules; amending s. 381.915, F.S.; revising term limits for Tier 3 cancer center designations within the Florida Consortium of National Cancer Institute Centers Program; amending s. 401.35, F.S.; revising

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Rodriguez, A. M. offered the following:

Amendment (with title amendment)

Between lines 293 and 294, insert:

Section 4. Subsection (21) is added to section 404.031, Florida Statutes, to read:

404.031 Definitions.—As used in this chapter, unless the context clearly indicates otherwise, the term:

(21) "Useful beam" means that portion of the radiation emitted from a radiation machine through the aperture of the machine's beam-limiting device which is designed to focus the radiation on the intended target in order to accomplish the machine's purpose when the machine’s exposure controls are in a mode to cause the system to produce radiation.

Section 5. Subsection (7) is added to section 404.22, Florida Statutes, to read:

404.22 Radiation machines and components; inspection.—

(7) Radiation machines that are used to intentionally expose a human being to the useful beam:

(a) Must be maintained and operated according to manufacturer standards or nationally-recognized consensus standards accepted by the department;

(b) Must be operated at the lowest exposure that will achieve the intended purpose of the exposure; and

(c) May not be modified in a manner that causes the original parts to operate in a way that differs from the original manufacturer's design specification or the parameters approved for the machine and its components by the United States Federal Drug Administration.

(8) A human being may be exposed to the useful beam of a radiation machine only under the following conditions:

(a) For the purpose of medical or health care, if a licensed health care practitioner operating within the scope of his or her practice determines that the exposure provides a medical or health benefit greater than the health risks posed by the exposure and the health care practitioner uses the results of the exposure in the medical or health care of the exposed individual; or

(b) For the purpose of providing security for facilities or other venues, the exposure is determined to provide a life safety benefit to the individual exposed which is greater than the health risk posed by the exposure. Such determination must be made by an individual trained in evaluating and calculating comparative mortality and morbidity risks according to standards set by the department. To be valid, the calculation and method of making the determination must be submitted to and accepted by the department. Limits to annual total exposure for security purposes must be adopted by department rule based on nationally recognized limits or relevant consensus standards.

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

Between lines 23 and 24, insert:

amending s. 404.031, F.S.; defining the term "useful beam;" amending s. 404.202, F.S.; providing requirements for the maintenance, operation, and modification of certain radiation machines; providing conditions for the authorized exposure of human beings to the radiation admitted from a radiation machine;

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Rodriguez, A. M. offered the following:

Amendment (with title amendment)

Between lines 341 and 342, insert:

Section 1. Paragraph (e) of subsection (2) and paragraph (e) of subsection (3) of section 456.0635, Florida Statutes, are amended to read:

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

(2) Each board within the jurisdiction of the department, or the department if there is no board, shall refuse to admit a candidate to any examination and refuse to issue a license, certificate, or registration to any applicant if the candidate

or applicant or any principal, officer, agent, managing employee, or affiliated person of the candidate or applicant:

(e) Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities, except when such applicant is listed solely based on a default or delinquency on a student loan.

This subsection does not apply to an applicant for initial licensure, certification, or registration who was arrested or charged with a felony specified in paragraph (a) or paragraph (b) before July 1, 2009.

(3) The department shall refuse to renew a license, certificate, or registration of any applicant if the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant:

(e) Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities, except when such applicant is listed solely based on a default or delinquency on a student loan.

This subsection does not apply to an applicant for renewal of licensure, certification, or registration who was arrested or

charged with a felony specified in paragraph (a) or paragraph (b) before July 1, 2009.

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

Remove line 28 and insert:
after 60 days; amending 456.0635, F.S.; providing an exception to the requirement that certain entities prohibit a candidate from being examined for or issued, or having a renewed license, certificate, or registration to practice a health care profession if he or she is listed on a specified federal list of excluded individuals and entities; amending s. 456.072, F.S.; conforming

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 767 Assisted Living Facilities
SPONSOR(S): Health Market Reform Subcommittee, Grant, M.
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 402

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	13 Y, 0 N, As CS	Guzzo	Calamas
2) Health Care Appropriations Subcommittee	8 Y, 0 N	Nobles	Clark
3) Health & Human Services Committee		Guzzo	Calamas

SUMMARY ANALYSIS

An assisted living facility (ALF) is a residential establishment, or part of a residential establishment, that provides housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator. ALFs are licensed and regulated by the Agency for Health Care Administration (AHCA) under part I of ch. 429, F.S., and part II of ch. 408, F.S., and rule 59A-36. The bill amends various provisions in Ch. 429 regulating ALFs. Specifically, the bill:

- Requires AHCA to conduct a full inspection instead of an abbreviated biennial licensure inspection to review key quality-of-care standards for a facility that has a history of class I, class II, or uncorrected class III violations resulting from complaints referred by the State Long-Term Care Ombudsman Program.
- Codifies current rule requirements to law relating to training and education of facility staff.
- Allows ALFs to admit or retain residents that require the use of assistive devices, which are defined as any device designed or adapted to help a resident perform an action, task, an activity of daily living, a transfer, prevention of a fall, or recovery from a fall.
- Allows ALFs to admit residents that require 24-hour nursing care, or residents that are receiving hospice services, if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility.
- Allows ALFs to admit residents who are bedridden if they are bedridden for no more than 7 days, or for an ALF licensed as extended congregate care, no more than 14 days.
- Allows the use of certain physical restraints in ALFs, including, full-bed rails and geriatric chairs.
- Amends the Resident Bill of Rights to allow the State Long-Term Care Ombudsman Program to provide assistance to a resident who needs to be relocated due to the closure of the facility.
- Removes the requirement for ALF staff assisting with the self-administration of medication to read the label of the medication to the resident. Instead, the bill requires staff to, in the presence of the resident, confirm the medication is correct and advise the resident of the medication name and purpose.
- Authorizes rules to address technological advances in the provision of care, safety, and security, including the use of devices, equipment and other security measures for wander management, emergency response, staff risk management, and for the general safety and security of residents, staff, and the facility.

The bill has no fiscal impact on state or local governments.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

State Long-Term Care Ombudsman Program

The State Long-Term Care Ombudsman Program (LTCOP) is a statewide, volunteer-based system of local councils that act as advocates for residents of long-term care facilities.[1] Through 14 district and regional offices that together cover the entire state, volunteers identify, investigate, and resolve complaints made by, or on behalf of, residents of assisted living facilities (ALFs), nursing homes, adult family care homes, board and care facility, or any other similar residential adult care facility.[2]

In addition to investigating and resolving complaints, the LTCOP:

- Monitors, and comments on the development and implementation of federal, state, and local laws, regulations, and policies regarding health, safety, and welfare of residents in long-term care facilities;
- Provides information and referrals with regard to long-term care facilities; and
- Conducts annual assessments of long-term care facilities.[3]

A representative of the LTCOP has the right to enter an ALF unannounced to determine compliance with part I of ch. 429, F.S., part II of ch. 408, F.S., and applicable rules. Data collected by the LTCOP may be used by AHCA in investigations involving violations of regulatory standards.[4]

Assisted Living Facilities

Licensure

An assisted living facility (ALF) is a residential establishment, or part of a residential establishment, that provides housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.[5] A personal service is direct physical assistance with, or supervision of, the activities of daily living and the self-administration of medication.[6] Activities of daily living include ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks.[7]

ALFs are licensed and regulated by AHCA under part I of ch. 429, F.S., and part II of ch. 408, F.S., rule 59A-36, F.A.C. In addition to a standard license, an ALF may have one or more specialty licenses that allow the ALF to provide additional care. These specialty licenses include limited nursing services,[8] limited mental health services, and extended congregate care services.[9]

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[1] Part I of ch. 400, F.S.
[2] Florida Ombudsman Program, *FY 2019 Annual Report,* available at http://www.ombudsman.myflorida.com/publications/ar/LTCOP_2019_Annual_Report.pdf (last visited February 9, 2020).
[3] Id.
[4] S. 429.34(1), F.S.
[5] S. 429.02(5), F.S. An ALF does not include an adult family-care home or a non-transient public lodging establishment.
[6] S. 429.02(16), F.S.
[7] S. 429.02(1), F.S.
[8] S. 429.07(3)(c), F.S. Limited nursing services include acts that may be performed by a person licensed as a nurse but are not complex enough to require 24-hour nursing supervision and may include such services as the application and care of routine dressings, and care of casts, braces, and splints (s. 429.02(13), F.S.).
[9] S. 429.07(3)(b), F.S. Extended congregate care facilities provide services to an individual that would otherwise be ineligible for continued care in an ALF. The primary purpose is to allow a resident the option of remaining in a familiar setting from which they would otherwise be disqualified for continued residency as they become more impaired.

Current law requires rules governing ALFs promote a safe and sanitary environment that is residential and non-institutional in design or nature.[10] Current law also requires rules set requirements for and maintenance of facilities relating to plumbing, heating, cooling, lighting, ventilation, living space and other housing conditions that are not in conflict with ch. 553, F.S., governing building construction standards. Current law also requires AHCA to develop key quality-of-care standards for ALFs with input from the State Long-Term Care Ombudsman Council and representatives of provider groups for incorporation into its rules.[11] Rules must also address moratoriums, classification of deficiencies, the levying of penalties and the use of income from fees and fines.[12]

Some counties and municipalities require all businesses to obtain a business tax receipt, formerly known as an occupational license[13], prior to engaging in business.[14] A business tax receipt serves as evidence that a business is in compliance with all business tax regulations of the local governing authority.[15] Current law requires counties and municipalities to verify with AHCA that an ALF is licensed prior to issuing an occupational license. The term occupational license is no longer used in the Local Business Tax Act in ch. 205, F.S.[16]

Inspections, Surveys and Monitoring Visits

Current law requires AHCA to adopt rules on uniform standards and criteria to be used during standard biennial licensure inspections to determine compliance with facility standards and residents' rights. The rule requires AHCA to utilize certain core survey tasks during an inspection, including:

- Conducting a tour of the facility to observe and assess resident behavior and demeanor, adherence to facility abuse prohibition policy, adherence to facility infection control policy, and more;
- Conducting interviews with residents or their family members and staff; and
- Reviewing facility records.[17]

Current law also authorizes AHCA to use an abbreviated biennial licensure inspection that consists of key quality-of-care standards in lieu of a full inspection if the facility has a good record of past performance.[18] Current law requires a full inspection if a facility has a history of class I or class II violations, uncorrected class II violations, confirmed ombudsman complaints or confirmed licensure complaints.[19]

Section 408.813, F.S. categorizes violations into four classes according to the nature and gravity of its probable effect on residents. If an ALF is cited for a class I violation or three or more class II violations arising from separate surveys within a 60-day period or due to unrelated circumstances during the same survey, AHCA must conduct an additional licensure inspection within six months.[20]

During any calendar year in which no survey is performed, AHCA may conduct at least one monitoring visit of a facility, as necessary, to ensure compliance of a facility with a history of certain violations that

[10] S. 429.41(1), F.S.
[11] S. 429.41(5), F.S. AHCA reviews the key quality-of-care standards for compliance during an abbreviated biennial licensure inspection (s. 429.41(5), F.S.).
[12] S. 429.41(1)(f), F.S.
[13] Ch. 2006-152 Laws of Fla., amended ch. 205, F.S., to change the title from Local Occupational License Tax Act to Local Business Tax Act. The bill also changed all references of occupational license to business tax.
[14] S. 205.053, F.S.
[15] S. 205.022(2), F.S.
[16] Supra at 13.
[17] Rule 59A-36.001, F.A.C.
[18] S. 429.41(5), F.S.
[19] Id.
[20] S. 429.34(2), F.S.

threaten the health, safety, or security of residents. If warranted, AHCA will perform an inspection as a part of a complaint investigation of alleged noncompliance with the Resident Bill of Rights.[21]

Training and Education

Prior to 2019, the state had a bifurcated, two agency regulatory structure for ALFs. The Department of Elder Affairs (DOEA), was responsible for rulemaking while AHCA was responsible for enforcing the rules. In 2019, the legislature transferred rulemaking authority to AHCA to create operational efficiencies by virtue of allowing the state agency to adopt the rules that they are responsible for enforcing.[22] AHCA has since adopted rules relating to a variety of subjects, including, rules on training and education requirements for ALF administrators and staff.[23] Training and education requirements are also provided in statute. There are some differences in terminology used in the rule as compared to the statute. The training and education requirements in statute are also difficult to interpret as far as which requirements apply to administrators, and which requirements apply to other facility staff.

Current law requires all new ALF employees to complete a pre-service orientation prior to interacting with residents.[24]

Current law requires all administrators to complete a competency test to indicate successful completion of training and education requirements within 90 day of employment.[25]

Current ALF rule requires ALF staff who provide direct care to residents, other than administrators or managers, to participate in in-service training on certain topics, including, infection control, reporting adverse incidents, safe food handling practices, and emergency evacuation procedures.[26] Certificates or copies of certificates indicating completion of training requirements are required to be documented in the facility's personnel file, but the rule does not specify that the a single certificate of completion coving all required in-service training topics may be issued if the training is provided in a single training course.

Current ALF law authorizes AHCA to establish registration requirements for trainers to train ALF staff, and AHCA has already adopted such rules.[27] However, current law does not authorize AHCA to adopt rules on the revocation of a trainer's registration.

Current law authorizes AHCA to adopt rules to establish specific policies and procedures on resident elopement and resident elopement drill requirements.[28] ALF rule requires all facility staff to participate in in-service training on the facility's procedures for resident elopement within 30 days of employment.[29] ALF rule also requires the facility to document staff participation in resident elopement drills.[30]

Admission

An ALF must provide appropriate care and services to meet the needs of the residents admitted to the facility.[31] The owner or facility administrator determines whether an individual is appropriate for admission to the facility based on certain criteria.[32] Current law requires each resident to be examined by a physician or nurse practitioner within 60 days before admission to the ALF, if possible.[33] If an

[21] Id.
[22] Ch. 2019-11 Laws of Fla.
[23] Rule 59A-36.011, F.A.C.
[24] S. 429.52, F.S., and rule 59A-36.011(2), F.A.C.
[25] Id.
[26] Rule 59A-36.011(3), F.A.C.
[27] S. 429.52(12), F.S., F.S., and rule 59A-36.029, F.A.C.
[28] S. 429.41(1)(l), F.S.
[29] Rule 59A-36.011(3)(f), F.A.C.
[30] Id.
[31] For specific minimum standards, see Rule 59A-36.006, F.A.C.
[32] S. 429.26, F.S.
[33] S. 429.26(4), F.S.

examination has not been completed prior to admission, an examination must be made within 30 days after admission.[34] Current law requires the completed medical examination to be signed, but does not specify by whom. The owner or facility administrator must use the information contained in the medical examination report to determine the appropriateness of the resident's admission. If a resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, as determined by the facility administrator or a health care provider, the resident must be discharged in accordance with the Resident Bill of Rights.[35]

Current law allows an ALF to retain a terminally ill resident (including a resident who requires 24-hour nursing supervision, who no longer meets the criteria for continued residency), if the following conditions are met:

- The arrangement is mutually agreeable to the resident and the facility,
- Additional care is rendered through a licensed hospice, and
- The resident is under the care of a physician who agrees that the physical needs of the resident are being met.[36]

Rule 59A-36.006, F.A.C., authorizes an ALF with a standard license, a limited nursing services license, or a limited mental health license to retain a resident who is bedridden for up to 7 days. Further, the rule authorizes an ALF with an extended congregate care license to retain a resident who is bedridden for up to 14 days.

Resident Rights and Safety

A physical restraint is a device which physically limits, restricts, or deprives an individual of movement or mobility, including, but not limited to, a half-bed rail, a full-bed rail, a geriatric chair, and a posey restraint.[37] The term also includes any device which was not specifically manufactured as a restraint but which has been altered, arranged, or otherwise used for this purpose. Current law limits the use of physical restraints by an ALF to half-bed rails as prescribed by the resident's physician with consent of the resident or, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact.[38] Current ALF rule requires the prescribing physician to assess the need of the resident for physical restraints annually. Current law does not expressly authorize the use of geriatric chairs or full bed rails.

Current laws requires an ALF to provide notice of relocation to a resident, unless, the resident has been certified by a physician to require an emergency relocation to a facility that can provide a more skilled level of care, or, if the resident engages in a pattern of conduct that is harmful or offensive to other residents.[39] The notice of relocation must be in writing, and, must be provided at least 45 days prior to a change in residency.[40] Currently, the ALF is not required to provide notice of relocation to the resident's guardian, unless the resident has been adjudicated mentally incapacitated.

In the event an ALF decides to close its business operation, the facility must inform each resident or the next of kin, legal representative, or agency acting on each resident's behalf, of the expected time of discontinuance of the operation.[41] An ALF resident may have several agencies acting on their behalf, so it may be unclear to an ALF exactly which agency they are required to notify, and there is no statutory requirement for them to specifically notify AHCA. The notice of relocation or termination of

[34] S. 429.26(5), F.S.
[35] Rule 59A-36.006(5), F.A.C.
[36] S. 429.26(9) and (11), F.S.
[37] S. 429.02(18), F.S.
[38] S. 429.41(1)(k), F.S.
[39] S. 429.28(1)(k), F.S.
[40] Id.
[41] S. 429.31(1), F.S.

residency must be provided at least 45 days prior to a change in residency.[42] In the event a resident doesn't have anyone to represent them, the facility is responsible for referral to an appropriate social service agency for placement.[43] AHCA is required to monitor the transfer of residents to other facilities and ensure that resident's rights are being protected.[44] AHCA, in consultation with the Department of Children and Families, must specify procedures for ensuring that all residents who receive services are appropriately relocated.[45]

On October 31, 2019, the Miami Herald published an article about the closure of an ALF in Broward County describing issues faced by residents in receiving assistance with relocating to another facility.[46] According to the article, while the facility did timely notify its residents and AHCA, many residents did not receive the proper assistance with finding a new facility from the facility or state agencies.[47]

Assistance to Residents

Currently, the Resident Bill of Rights states that a resident has the right to assistance from the ALF in obtaining access to adequate and appropriate health care. Such assistance includes the management of medication, assistance in making appointments for health care services, providing transportation to health care appointments, and performing certain other health care services by appropriately licensed personnel or volunteers.

An unlicensed ALF staff member may provide assistance to a resident who is medically stable with self-administration of a routine, regularly scheduled medication that is intended to be self-administered if there is a documented request by and the written informed consent of the resident.[48] Assistance with medication includes, among other things, in the presence of the resident, reading the label, opening the container, removing the prescribed amount from the container, and closing the container.[49] Current law, does not provide that the resident may opt out of being read the label by facility staff.

Self-administered medication includes legend and over-the-counter oral dosage forms, topical dosage forms and topical ophthalmic, otic, and nasal dosage forms including solutions, suspensions, sprays, and inhalers. Currently, an unlicensed ALF staff member is not authorized to provide assistance to a resident with the self-administration of a transdermal patch.

Currently, unlicensed ALF staff are prohibited from assisting with the self-administration of medications, ordered by a physician, that have prescriptive authority to be given "as needed", unless, at the request of a competent resident, the order is written with specific parameters that remove independent judgement on the part of the unlicensed person.[50]

Current law requires ALFs to notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment.[51] If an underlying condition is determined to exist, ALF must arrange, with the appropriate health care provider, the necessary care and services to treat the condition.[52]

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[42] S. 429.28(1)(k), F.S.
[43] S. 429.31(1), F.S.
[44] S. 429.31(2), F.S.
[45] Id.
[46] Jack Brook, *Retirement Home Had Bad Bed Bugs. It's Closing, but Could Residents Wind Up Somewhere Worse,* Miami Herald, Oct. 31, 2019, available at https://www.miamiherald.com/news/local/article235871067.html (last visited February 9, 2020).
[47] Id. "AHCA spokesman said in a statement to the Miami Herald that AHCA had been properly notified by owners about the closure, but more than a week after the ALF handed out its notice to residents, word had not reached a key state monitor tasked with protecting residents' rights." "Broward's district ombudsman manager said she was not aware of the facility closing until contacted by a Miami Herald reporter."
[48] S. 429.256(2), F.S.
[49] S. 429.256(3)(b), F.S.
[50] S. 429.256(4)(g), F.S.
[51] S. 429.26(7), F.S.
[52] Id.

Adverse Incident Reporting Requirements

When an ALF has reason to believe that an adverse incident has occurred, current law requires them to submit a preliminary report to AHCA by electronic mail, facsimile, or United States mail, within one business day after the occurrence of an adverse incident.[53] The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. After submission of the preliminary report, if the event is still considered an adverse incident by the facility, the facility must submit a full report to AHCA by electronic mail, facsimile, or United States mail, within 15 days, which must include the results of the facility's investigation into the adverse incident.[54]

However, if, after submission of a preliminary report, the facility determines that the event was not an adverse incident, the facility is responsible for withdrawing the preliminary report. If a facility fails to withdraw a preliminary report, AHCA has no way of knowing that the event was determined not to be an adverse incident, so they still expect the facility to timely file a full report. A facility that fails to withdraw a preliminary report and later fails to timely file a full report will be subject to a citation from AHCA for failure to timely file a final report.

According to AHCA, based on ALF adverse incident reports submitted since June 27, 2017, AHCA has initiated 60 investigations on ALFs that forgot to withdraw preliminary reports prior to the deadline for final reports.[55]

Currently, AHCA is not required to remind the facility that an adverse incident report is due. However, AHCA does send an automated email one day prior to the deadline for the final report.[56]

Emergency Management Plan

Pursuant to s. 429.41, F.S., each ALF must prepare a written comprehensive emergency management plan that must address the following:

- Provision for all hazards;
- Provision for the care of residents remaining in the facility during an emergency, including, emergency power, supplies, and equipment;
- Provision for the care of additional residents who may be evacuated to the facility during an emergency;
- Identification of residents with Alzheimer's disease or related disorders, and residents with mobility limitations who may need specialized assistance;
- Identification of and coordination with the local emergency management agency;
- Arrangement for post-disaster activities, including, responding to family inquiries, transportation, and obtaining medical intervention for residents; and
- Identification of staff responsible for implementing each part of the plan.[57]

The comprehensive emergency management plan is subject to review and approval by the county emergency management agency. The county emergency management agency is required to ensure that volunteer organizations and other agencies are given the opportunity to review the plan, including DOH, AHCA, and the Division of Emergency Management.[58]

[53] S. 429.23(3), F.S.
[54] S. 429.23(4), F.S.
[55] Agency for Health Care Administration, 2020 Legislative Bill Analysis-HB 767, December 16, 2019 (on file with Health Market Reform Subcommittee staff).
[56] Id.
[57] Rule 59A-36.019, F.A.C.
[58] S. 429.41(1)(b), F.S.

New ALFs, and facilities whose ownership has been transferred, must submit an emergency management plan to the local emergency management agency within 30 days of obtaining a license.[59]

Uniform Fire Safety Standards

Section 633.206, F.S., authorizes the State Fire Marshal to establish uniform fire safety standards for ALFs, of which the State Fire Marshal is the final administrative interpreting authority. The State Fire Marshal is authorized to inspect an ALF at any reasonable hour if there is reasonable cause to believe that a violation of the fire safety code may exist.[60] Pursuant to rules adopted by the State Fire Marshal, the uniform fire safety standards applicable to ALFs in Florida are the standards of the National Fire Protection Association (NFPA) for life safety in the NFPA 101, Life Safety Code.[61]

The uniform fire safety standards for ALFs in Florida, adopted and enforced by the State Fire Marshal, allow the use of locking devices in ALFs.[62] Locking devices can be used in ALFs to separate certain residents by the level of care they are receiving.[63] For example, a locking device can be used to keep residents in a memory care unit separate from the general population of the facility. Locking devices may also be used for delayed egress on facility exit doors. For example, when someone pushes the horizontal crash bar of the locked door, a local buzzer will sound, and the door will automatically open within 15 seconds. Currently, AHCA does not have statutory authority to adopt rules on the use of locking devices in ALFs.

As of January 3, 2020, there were 3,080 licensed ALFs.[64]

Effect of the Bill

Licensure

The bill authorizes AHCA to adopt rules to cultivate technological advances in the provision of care, safety, and security, including the use of devices, equipment and other security measures for wander management, emergency response, staff risk management, and for the general safety and security of residents, staff, and the facility.

As a condition of licensure, ALFs must be inspected by the local county health department for food safety and environmental sanitation requirements, the local authority having jurisdiction over fire and life safety matters, as well as by AHCA. The bill moves portions of current law, which will result in no practical or measured effect. Specifically, the bill moves current law that:

- Authorizes AHCA to adopt rules relating to a safe and decent living environment and the sanitary condition of facilities that are not in conflict with the requirements in ch. 553, F.S., s. 381.006, F.S., s. 381.0072, F.S., or s. 633.206, F.S.[65]
- Requires the rules to clearly delineate the respective responsibilities of the agency's licensure and survey staff and the county health departments and ensure that inspections are not duplicative; and
- Authorizes AHCA to collect fees for food service inspections conducted by county health departments and transfer the fees to the Department of Health.

[59] Id.
[60] S. 633.216, F.S.
[61] Rule 69A-40.028, F.A.C.
[62] NFPA 101, *Life Safety Code,* 2018 Edition.
[63] Greene, L, *Following the Code-Code Changes are an Important Part of Access Control or Egress,* Security Today, April 1, 2016, available at https://securitytoday.com/Articles/2016/04/01/Following-the-Code.aspx (last visited February 9, 2020).
[64] AGENCY FOR HEALTH CARE ADMINISTRATION, *Facility/Provider Search Results – Assisted Living Facilities,* http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx (last visited February 9, 2020).
[65] Ch. 553, F.S., contains Building Construction Standards, s. 381.006, F.S., contains the Environmental Health Program administered by the Department of Health, s. 381.0072, F.S., contains food service protection requirements enforced by the Department of Health, and s. 633.206, F.S., contains the uniform fire safety standards.

The bill authorizes AHCA to adopt rules relating to furnishings for resident bedrooms or sleeping areas, linens, and other housing conditions relating to hazards, to promote the health, safety, and welfare of residents suitable to the size of the structure. AHCA has already adopted rules on all of these topics, so this will have no practical effect.

The bill removes the authority for rules that set standards for plumbing, heating, cooling, lighting, ventilation, living space and other housing conditions because references to the Florida Building Code were removed from ALF rules in 2010.[66] The bill removes the authority for rules that address the use of income from fees and fines because it is duplicative of a provision in s. 408.818, F.S. The bill removes the requirement that key quality-of-care standards be developed with input from the ombudsman and representatives of provider groups as the rulemaking process already allows for public participation.

The bill makes a conforming change to the prohibition on a county or municipality issuing an occupational license to a facility prior to determining whether the facility is licensed as an ALF by replacing the term "occupational license" with "business tax receipt". Counties and municipalities issue business tax receipts, not occupational licenses, to persons or entities that have complied with laws governing business taxes in ch. 205, F.S. Business taxes are fees charged by a county or municipality for the privilege of engaging in any business, profession, or occupation within its jurisdiction.[67]

Inspections, Surveys and Monitoring Visits

Current law requires AHCA to adopt rules on uniform standards and criteria to be used during inspections to determine compliance with facility standards and residents' rights. The bill removes this rulemaking authority. As a result, AHCA will be able to repeal the core survey inspection tasks contained in rule 59A-36.001, F.A.C. In effect, AHCA will not be confined to surveying for compliance with such a defined level of specificity. Instead, AHCA will be able to inspect facilities for a broad array of issues. The bill also requires inspections to be used to determine compliance with part I of ch. 429, F.S., in its entirety, instead of using them to determine only general compliance with facility standards and residents' rights.

The bill requires AHCA to conduct a full inspection instead of an abbreviated biennial licensure inspection to review key quality-of-care standards for a facility that has a class I, class II, or uncorrected class III violation resulting from a complaint referred by the State Long-Term Care Ombudsman Program.

Training and Education

Currently, there are some differences in terminology used in the training and education requirements in rule as compared to the statute. The training and education requirements in statute are also difficult to interpret as far as which requirements apply to administrators, and which requirements apply to other facility staff. The bill amends the training and education requirements for ALF administrators and staff to provide consistency between ALF statutes and rules, and to clearly illustrate which requirements apply to administrators and which requirements apply to other facility staff.

Current ALF law authorizes AHCA to establish registration requirements for trainers to train ALF staff, and AHCA has already adopted such rules. However, current law does not authorize AHCA to adopt rules on the revocation of a trainer's registration. The bill authorizes AHCA to adopt rules to establish a process for revocation of a trainer's registration.

The bill codifies to law an ALF rule to law that requires ALF staff who provide direct care to residents to participate in in-service training, which will have no practical effect because it is already required in rule.

[66] Agency for Health Care Administration, 2020 Legislative Bill Analysis-HB 767, December 16, 2019 (on file with Health Market Reform Subcommittee staff).
[67] S. 205.022, F.S.

However, the bill also provides that the topics covered during the pre-service orientation are not required to be repeated during in-service training. This provision is not currently in ALF rule, so ALF staff who provide direct care to residents will no longer have to repeat topics in in-service training that they have already learned in pre-service orientation. The bill allows a single certificate of completion that covers all required in-service training topics to be issued to a participating staff member if the training is provided in a single training session.

The bill authorizes AHCA to contract with another entity to administer the core competency test. AHCA has a contract with the MacDonald Research Institute to administer the test.[68]

The bill codifies in statute a current rule requirement that staff involved with the management of medications and assisting with the self-administration of medications must complete a minimum of 2 hours of continuing education on providing assistance with self-administration of medication and safe medication practices.

Current law authorizes AHCA to adopt rules to establish specific policies and procedures on resident elopement and resident elopement drill requirements.[69] The bill requires AHCA to adopt rules on resident elopement drill requirements. AHCA has already adopted such rules, so this requirement will have no effect. The bill codifies ALF rule requirement to law that requires administrators and direct care staff to review the facility's procedures on resident elopement, and requires the facility to document staff participation in resident elopement drills. This will have no effect because these requirements are already in rule.

Admission

The bill allows an ALF to admit or retain the following residents:

- Residents that receive a health care service or treatment designed to be provided within a private residential setting if all requirements for providing the service or treatment are met by the ALF or a third party; and
- Residents that require the use of assistive devices, which the bill defines as any device designed or adapted to help a resident perform an action, task, an activity of daily living, a transfer, prevention of a fall, or recovery from a fall.

The bill allows an ALF to admit a resident that requires 24-hour nursing care, or a resident that is receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. Current law only allows ALFs to retain such residents, rather than admit them.

The bill codifies a current ALF rule to law that allows an ALF to admit a bedridden resident if the resident is bedridden for no more than 7 days, or for an ALF licensed as extended congregate care, no more than 14 days. Currently, ALF statutes only allow ALFs to retain such residents, rather than admit them. This will have no practical effect because it is just codifying a current ALF rule to law.

Current law requires each resident to be examined by a physician or nurse practitioner within 60 days before admission to the ALF, if possible. If an examination has not been completed prior to admission, an examination must be made within 30 days after admission. The bill removes the "if possible" language from current law to explicitly require a resident to undergo a medical examination within 60 days before admission or within 30 days after admission. The bill provides that the medical examination form must be signed only by the practitioner, and may only be used to record the practitioner's direct

[68] Agency for Health Care Administration, 2020 Legislative Bill Analysis-HB 767, December 16, 2019 (on file with Health Market Reform Subcommittee staff).
[69] S. 429.41(1)(l), F.S.

observation of the patient at the time of examination and must include the patient's medical history. The form must only be used as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility.

Resident Rights and Safety

Current law limits the use of physical restraints by an ALF to half-bed rails as prescribed by the resident's physician with consent of the resident or, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact. The bill authorizes the use of full-bed rails, geriatric chairs, and any device the resident chooses to use and is able to remove or avoid independently, as prescribed by the resident's physician, and with consent of the resident or, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact. Current ALF rule requires the prescribing physician to assess the need of the resident for physical restraints annually, but does not specify requirements for care planning or staff monitoring. The bill authorizes AHCA to adopt rules to specify requirements for care planning and staff monitoring.

Current law requires an ALF to provide notification of a non-emergency relocation to a resident's legal guardian, but only for a resident who has been adjudicated mentally incapacitated. The bill requires an ALF to provide notice of a non-emergency relocation for any resident. The bill also requires the notice of relocation or termination to state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program.

The bill amends s. 429.31, F.S., to provide relocation assistance to a resident of an ALF whose residency is being terminated due to closure of the facility. Specifically, the bill requires the notice of relocation or termination to state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. The bill requires an ALF to notify AHCA of its plans to discontinue facility operation. Further, the bill requires AHCA, upon receiving notice of a facility's voluntary or involuntary termination, to immediately inform the State Long-Term Care Ombudsman Program so they can provide assistance with relocation to the resident.

Assistance to Residents

The bill removes the requirement that an ALF make arrangements with a health care provider for services to treat an underlying condition that contributes to a resident's dementia or cognitive impairment. Instead, the bill requires ALFs to assist in making appointments for the necessary care and services to treat the condition, and to notify the resident's representative or designee in of the need for health care services. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility must arrange with the appropriate health care provider for the necessary care and services to treat the condition.

The bill removes the requirement for ALF staff assisting with the self-administration of medication to read the label of the medication to the resident. Instead, the bill requires staff to, in the presence of the resident, confirm the medication is correct and advise the resident of the medication name and purpose. The bill also provides the resident with the ability to opt out of being orally advised of the medication name and dosage by signing a waiver. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change.

Currently, an unlicensed ALF staff member is not authorized to provide assistance to a resident with the self-administration of a transdermal patch. The bill adds transdermal patches to the list of medications to be considered self-administered medications.

Currently, unlicensed ALF staff are prohibited from assisting with the self-administration of medications, ordered by a physician, that have prescriptive authority to be given “as needed”, unless, at the request of a competent resident, the order is written with specific parameters that remove independent judgement on the part of the unlicensed person. The bill allows unlicensed staff to assist with the self-administration of medication, under the same circumstances, but requires the resident requesting assistance to be aware of their need for the medication and understand the purpose for taking it, instead of requiring them to be competent.

Adverse Incident Reporting Requirements

The bill amends s. 429.23, F.S., to require ALFs to submit the adverse incident preliminary report and final report through AHCA’s online portal, or by electronic mail if the portal is offline, instead of by facsimile or United States Mail. The bill also adds language to prevent an ALF from being fined for failing to submit a final report until three days after AHCA notifies the ALF that the final report is due if the incident is determined to, in fact, not be an adverse incident.

Emergency Management Plan

The bill codifies a current rule in law that requires new ALFs and facilities who have a change of ownership to submit a comprehensive emergency management plan to the county emergency management agency within 30 days of receiving a license. In addition, it removes current law that requires county emergency management agencies to give volunteer organizations an opportunity to review the plan.

Uniform Fire Safety Standards

The bill also authorizes AHCA to adopt rules on locking devices, which AHCA is currently not statutorily permitted to do. The uniform fire safety standards for ALFs in Florida, adopted and enforced by the State Fire Marshal, allow the use of locking devices in ALFs. Locking devices can be used in ALFs to separate certain residents by the level of care they are receiving. For example, a locking device can be used to keep residents in a memory care unit separate from the general population of the facility. Locking devices may also be used for delayed egress on facility exit doors. For example, when someone pushes the horizontal crash bar of the locked door, a local buzzer will sound, and the door will automatically open within 15 seconds. In effect, the bill allows AHCA to monitor the use of locking devices in ALFs in accordance with the rules they see appropriate to draft. However, such rules must not be in conflict with or duplicative of the uniform fire safety standards.

The bill also moves current law requirements for fire safety standards from the section governing rulemaking to a newly created section of law because the State Fire Marshal is responsible for adopting rules to enforce the Uniform Fire Safety Standards not AHCA. This will have no practical or measurable effect.

The bill provides an effective date of July 1, 2019.

B. SECTION DIRECTORY:

Section 1: Amends s. 429.02, F.S., relating to definitions.
Section 2: Amends s. 429.07, F.S., relating to license required; fee.
Section 3: Amends s. 429.11, F.S., relating to initial application for license; provisional license.
Section 4: Amends s. 429.176, F.S., relating to notice of change of administrator.
Section 5: Amends s. 429.23, F.S., relating to internal risk management and quality assurance program; adverse incidents and reporting requirements.
Section 6: Amends s. 429.255, F.S., relating to use of personnel; emergency care.
Section 7: Amends s. 429.256, F.S., relating to assistance with self-administration of medication.

Section 8: Amends s. 429.26, F.S., relating to appropriateness of placements; examinations of residents.
Section 9: Amends s. 429.28, F.S., relating to resident bill of rights.
Section 10: Amends s. 429.31, F.S., relating to closing of facility; notice; penalty.
Section 11: Amends s. 429.41, F.S., relating to rules establishing standards.
Section 12: Creates s. 429.435, F.S., relating to uniform firesafety standards.
Section 13: Amends s. 429.52, F.S., relating to staff training and educational programs; core educational requirement.
Section 14: Provides an effective date.

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rule-making authority to AHCA to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 15, 2020, the Health Market Reform Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment:

- Requires facility inspections and surveys to determine compliance with part I of ch. 429, F.S., which includes all ALF statutes, instead of determining compliance with only s. 429.28, F.S., and
- Deletes AHCA rule-making authority for uniform standards and criteria used to determine compliance with facility standards and residents' rights.

The analysis is drafted to the committee substitute as passed by the Health Market Reform Subcommittee.

A bill to be entitled

An act relating to assisted living facilities; amending s. 429.02, F.S.; providing and revising definitions; amending s. 429.07, F.S.; providing that an assisted living facility licensed to provide extended congregate care services or limited nursing services must maintain a written progress report on each person receiving services from the facility's staff; conforming a cross-reference; amending s. 429.11, F.S.; prohibiting a county or municipality from issuing a business tax receipt, rather than an occupational license, to a facility under certain circumstances; amending s. 429.176, F.S.; requiring an owner of a facility to provide certain documentation to the Agency for Health Care Administration regarding a new administrator; amending s. 429.23, F.S.; authorizing a facility to send certain reports regarding adverse incidents through the agency's online portal; requiring the agency to send reminders by electronic mail to certain facility contacts regarding submission deadlines for such reports within a specified timeframe; amending s. 429.255, F.S.; clarifying that the absence of an order not to resuscitate does not preclude a physician from withholding or withdrawing cardiopulmonary

resuscitation or use of an automated external defibrillator; amending s. 429.256, F.S.; revising the types of medications that may be self-administered; revising provisions relating to assistance with the self-administration of such medications; requiring a person assisting with a resident's self-administration of medication to confirm that the medication is intended for that resident and to orally advise the resident of the medication name and dosage; authorizing a resident to opt out of such advisement through a signed waiver; revising provisions relating to certain medications that are not self-administered with assistance; amending s. 429.26, F.S.; including medical examinations within criteria used for admission to an assisted living facility; providing specified criteria for determinations of appropriateness for admission to and continued residency in an assisted living facility; authorizing such facility to admit certain individuals under certain conditions; defining the term "bedridden"; requiring that a resident receive a medical examination within a specified timeframe after admission to a facility; requiring that such examination be recorded on a form; providing that such form may be used only to record a practitioner's

direct observations of the patient at the time of the examination; providing that such form is not a guarantee of a resident's admission to, continued residency in, or delivery of services at the facility; revising provisions relating to the placement of residents by the Department of Children and Families; requiring a facility to notify a resident's representative or designee of the need for health care services and to assist in making appointments for such care and services under certain circumstances; requiring the facility to arrange with an appropriate health care provider for the care and services needed to treat a resident under certain circumstances; removing provisions relating to the retention of certain residents in a facility; amending s. 429.28, F.S.; providing requirements for a notice of relocation or termination of residency from a facility; revising provisions requiring the agency to conduct a licensure survey to determine whether a facility has complied with certain standards and residents' rights; removing a requirement that the agency adopt certain rules; amending s. 429.31, F.S.; revising notice requirements for facilities that are terminating operations; requiring the agency to inform the State Long-Term Ombudsman Program immediately upon

notice of a facility's termination of operations; amending s. 429.41, F.S.; revising legislative intent; removing provisions to conform to changes made by the act; requiring county emergency management agencies, rather than local emergency management agencies, to review and approve or disapprove of a facility's comprehensive emergency management plan; requiring a facility to submit a comprehensive emergency management plan to the county emergency management agency within a specified timeframe after its licensure; revising the criteria under which a facility must be fully inspected; revising standards for the care of residents provided by a facility; prohibiting the use of Posey restraints in facilities; authorizing other physical restraints to be used under certain conditions and in accordance with certain rules; requiring the agency to establish resident elopement drill requirements; requiring that elopement drills include a review of a facility's procedures addressing elopement; requiring a facility to document participation in such drills; revising provisions requiring the agency to adopt by rule key quality-of-care standards; creating s. 429.435, F.S.; providing uniform firesafety standards for assisted living facilities; amending s. 429.52, F.S.; revising certain

provisions relating to facility staff training and educational requirements; requiring the agency, in conjunction with providers, to establish core training requirements for facility administrators; revising the training and continuing education requirements for facility staff who assist residents with the self-administration of medications; revising provisions relating to the training responsibilities of the agency; requiring the agency to contract with another entity to administer a certain competency test; requiring the agency to adopt a curriculum outline with learning objectives to be used by core trainers; conforming provisions to changes made by the act; providing an effective date.

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

Section 1. Subsections (7) through (27) of section 429.02, Florida Statutes, are renumbered as subsections (8) through (28), respectively, present subsections (11) and (18) are amended, and a new subsection (7) is added to that section, to read:

429.02 Definitions.—When used in this part, the term:

(7) "Assistive device" means any device designed or adapted to help a resident perform an action, a task, an

activity of daily living, or a transfer; prevent a fall; or recover from a fall. The term does not include a total body lift or a motorized sit-to-stand lift, with the exception of a chair lift or recliner lift that a resident is able to operate independently.

(12) ~~(11)~~ "Extended congregate care" means acts beyond those authorized in subsection (18) which ~~(17) that~~ may be performed pursuant to part I of chapter 464 by persons licensed thereunder while carrying out their professional duties, and other supportive services that ~~which~~ may be specified by rule. The purpose of such services is to enable residents to age in place in a residential environment despite mental or physical limitations that might otherwise disqualify them from residency in a facility licensed under this part.

(19) ~~(18)~~ "Physical restraint" means a device that ~~which~~ physically limits, restricts, or deprives an individual of movement or mobility, including~~, but not limited to, a half-bed rail, a full-bed rail, a geriatric chair, and a posey restraint. The term "physical restraint" shall also include~~ any device that is ~~which was~~ not specifically manufactured as a restraint but is ~~which has been~~ altered, arranged, or otherwise used for that ~~this~~ purpose. The term does ~~shall~~ not include any device that the resident chooses to use and is able to remove or avoid independently, or any bandage material used for the purpose of binding a wound or injury.

Section 2. Paragraphs (b) and (c) of subsection (3) of section 429.07, Florida Statutes, are amended to read:

429.07 License required; fee.—

(3) In addition to the requirements of s. 408.806, each license granted by the agency must state the type of care for which the license is granted. Licenses shall be issued for one or more of the following categories of care: standard, extended congregate care, limited nursing services, or limited mental health.

(b) An extended congregate care license shall be issued to each facility that has been licensed as an assisted living facility for 2 or more years and that provides services, directly or through contract, beyond those authorized in paragraph (a), including services performed by persons licensed under part I of chapter 464 and supportive services, as defined by rule, to persons who would otherwise be disqualified from continued residence in a facility licensed under this part. An extended congregate care license may be issued to a facility that has a provisional extended congregate care license and meets the requirements for licensure under subparagraph 2. The primary purpose of extended congregate care services is to allow residents the option of remaining in a familiar setting from which they would otherwise be disqualified for continued residency as they become more impaired. A facility licensed to provide extended congregate care services may also admit an

individual who exceeds the admission criteria for a facility with a standard license, if he or she is determined appropriate for admission to the extended congregate care facility.

1. In order for extended congregate care services to be provided, the agency must first determine that all requirements established in law and rule are met and must specifically designate, on the facility's license, that such services may be provided and whether the designation applies to all or part of the facility. This designation may be made at the time of initial licensure or relicensure, or upon request in writing by a licensee under this part and part II of chapter 408. The notification of approval or the denial of the request shall be made in accordance with part II of chapter 408. Each existing facility that qualifies to provide extended congregate care services must have maintained a standard license and may not have been subject to administrative sanctions during the previous 2 years, or since initial licensure if the facility has been licensed for less than 2 years, for any of the following reasons:

a. A class I or class II violation;

b. Three or more repeat or recurring class III violations of identical or similar resident care standards from which a pattern of noncompliance is found by the agency;

c. Three or more class III violations that were not corrected in accordance with the corrective action plan approved

by the agency;

d. Violation of resident care standards which results in requiring the facility to employ the services of a consultant pharmacist or consultant dietitian;

e. Denial, suspension, or revocation of a license for another facility licensed under this part in which the applicant for an extended congregate care license has at least 25 percent ownership interest; or

f. Imposition of a moratorium pursuant to this part or part II of chapter 408 or initiation of injunctive proceedings.

The agency may deny or revoke a facility's extended congregate care license for not meeting the criteria for an extended congregate care license as provided in this subparagraph.

2. If an assisted living facility has been licensed for less than 2 years, the initial extended congregate care license must be provisional and may not exceed 6 months. The licensee shall notify the agency, in writing, when it has admitted at least one extended congregate care resident, after which an unannounced inspection shall be made to determine compliance with the requirements of an extended congregate care license. A licensee with a provisional extended congregate care license which ~~that~~ demonstrates compliance with all the requirements of an extended congregate care license during the inspection shall be issued an extended congregate care license. In addition to

sanctions authorized under this part, if violations are found during the inspection and the licensee fails to demonstrate compliance with all assisted living facility requirements during a followup inspection, the licensee shall immediately suspend extended congregate care services, and the provisional extended congregate care license expires. The agency may extend the provisional license for not more than 1 month in order to complete a followup visit.

3. A facility that is licensed to provide extended congregate care services shall maintain a written progress report on each person who receives such nursing services from the facility's staff which describes the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. A registered nurse, or appropriate designee, representing the agency shall visit the facility at least twice a year to monitor residents who are receiving extended congregate care services and to determine if the facility is in compliance with this part, part II of chapter 408, and relevant rules. One of the visits may be in conjunction with the regular survey. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall serve as part of the team that inspects the facility. The agency may waive one of the required yearly monitoring visits for a facility that has:

a. Held an extended congregate care license for at least

24 months;

b. No class I or class II violations and no uncorrected class III violations; and

c. No ombudsman council complaints that resulted in a citation for licensure.

4. A facility that is licensed to provide extended congregate care services must:

a. Demonstrate the capability to meet unanticipated resident service needs.

b. Offer a physical environment that promotes a homelike setting, provides for resident privacy, promotes resident independence, and allows sufficient congregate space as defined by rule.

c. Have sufficient staff available, taking into account the physical plant and firesafety features of the building, to assist with the evacuation of residents in an emergency.

d. Adopt and follow policies and procedures that maximize resident independence, dignity, choice, and decisionmaking to permit residents to age in place, so that moves due to changes in functional status are minimized or avoided.

e. Allow residents or, if applicable, a resident's representative, designee, surrogate, guardian, or attorney in fact to make a variety of personal choices, participate in developing service plans, and share responsibility in decisionmaking.

f. Implement the concept of managed risk.

g. Provide, directly or through contract, the services of a person licensed under part I of chapter 464.

h. In addition to the training mandated in s. 429.52, provide specialized training as defined by rule for facility staff.

5. A facility that is licensed to provide extended congregate care services is exempt from the criteria for continued residency set forth in rules adopted under s. 429.41. A licensed facility must adopt its own requirements within guidelines for continued residency set forth by rule. However, the facility may not serve residents who require 24-hour nursing supervision. A licensed facility that provides extended congregate care services must also provide each resident with a written copy of facility policies governing admission and retention.

6. Before the admission of an individual to a facility licensed to provide extended congregate care services, the individual must undergo a medical examination as provided in s. 429.26(5) ~~s. 429.26(4)~~ and the facility must develop a preliminary service plan for the individual.

7. If a facility can no longer provide or arrange for services in accordance with the resident's service plan and needs and the facility's policy, the facility must make arrangements for relocating the person in accordance with s.

429.28(1)(k).

(c) A limited nursing services license shall be issued to a facility that provides services beyond those authorized in paragraph (a) and as specified in this paragraph.

1. In order for limited nursing services to be provided in a facility licensed under this part, the agency must first determine that all requirements established in law and rule are met and must specifically designate, on the facility's license, that such services may be provided. This designation may be made at the time of initial licensure or licensure renewal, or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with part II of chapter 408. An existing facility that qualifies to provide limited nursing services must have maintained a standard license and may not have been subject to administrative sanctions that affect the health, safety, and welfare of residents for the previous 2 years or since initial licensure if the facility has been licensed for less than 2 years.

2. A facility that is licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services <u>from the facility's staff</u>. The report must describe the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. A registered nurse representing the

agency shall visit the facility at least annually to monitor residents who are receiving limited nursing services and to determine if the facility is in compliance with applicable provisions of this part, part II of chapter 408, and related rules. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall also serve as part of the team that inspects such facility. Visits may be in conjunction with other agency inspections. The agency may waive the required yearly monitoring visit for a facility that has:

a. Had a limited nursing services license for at least 24 months;

b. No class I or class II violations and no uncorrected class III violations; and

c. No ombudsman council complaints that resulted in a citation for licensure.

3. A person who receives limited nursing services under this part must meet the admission criteria established by the agency for assisted living facilities. When a resident no longer meets the admission criteria for a facility licensed under this part, arrangements for relocating the person shall be made in accordance with s. 429.28(1)(k), unless the facility is licensed to provide extended congregate care services.

Section 3. Subsection (7) of section 429.11, Florida Statutes, is amended to read:

429.11 Initial application for license; provisional license.—

(7) A county or municipality may not issue a business tax receipt ~~an occupational license~~ that is being obtained for the purpose of operating a facility regulated under this part without first ascertaining that the applicant has been licensed to operate such facility at the specified location or locations by the agency. The agency shall furnish to local agencies responsible for issuing business tax receipts ~~occupational licenses~~ sufficient instruction for making such determinations.

Section 4. Section 429.176, Florida Statutes, is amended to read:

429.176 Notice of change of administrator.—If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements.

Section 5. Subsections (3), (4), and (5) of section 429.23, Florida Statutes, are amended to read:

429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.—

(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, ~~facsimile, or United States mail,~~ a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident.

(4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, ~~facsimile, or United States mail,~~ a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.

(5) Three business days before the deadline for the submission of the full report required under subsection (4), the agency shall send by electronic mail a reminder to the facility's administrator and other specified facility contacts. Within 3 business days after the agency sends the reminder, a facility is not subject to any administrative or other agency action for failing to withdraw the preliminary report if the facility determines the event was not an adverse incident or for failing to file a full report if the facility determines the event was an adverse incident ~~Each facility shall report monthly to the agency any liability claim filed against it. The report~~

~~must include the name of the resident, the dates of the incident leading to the claim, if applicable, and the type of injury or violation of rights alleged to have occurred. This report is not discoverable in any civil or administrative action, except in such actions brought by the agency to enforce the provisions of this part~~.

Section 6. Subsection (4) of section 429.255, Florida Statutes, is amended to read:

429.255 Use of personnel; emergency care.—

(4) Facility staff may withhold or withdraw cardiopulmonary resuscitation or the use of an automated external defibrillator if presented with an order not to resuscitate executed pursuant to s. 401.45. The agency shall adopt rules providing for the implementation of such orders. Facility staff and facilities may not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator pursuant to such an order and rules adopted by the agency. The absence of an order not to resuscitate executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator as otherwise permitted by law.

Section 7. Subsection (2), paragraph (b) of subsection

(3), and paragraphs (e), (f), and (g) of subsection (4) of section 429.256, Florida Statutes, are amended to read:

429.256 Assistance with self-administration of medication.—

(2) Residents who are capable of self-administering their own medications without assistance shall be encouraged and allowed to do so. However, an unlicensed person may, consistent with a dispensed prescription's label or the package directions of an over-the-counter medication, assist a resident whose condition is medically stable with the self-administration of routine, regularly scheduled medications that are intended to be self-administered. Assistance with self-medication by an unlicensed person may occur only upon a documented request by, and the written informed consent of, a resident or the resident's surrogate, guardian, or attorney in fact. For the purposes of this section, self-administered medications include both legend and over-the-counter oral dosage forms, topical dosage forms, transdermal patches, and topical ophthalmic, otic, and nasal dosage forms including solutions, suspensions, sprays, and inhalers.

(3) Assistance with self-administration of medication includes:

(b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage ~~reading the label~~,

opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change.

(4) Assistance with self-administration does not include:

(e) The use of irrigations or debriding agents used in the treatment of a skin condition.

(f) Assisting with rectal, urethral, or vaginal preparations.

(g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and ~~at~~ the ~~request of a competent~~ resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication.

Section 8. Section 429.26, Florida Statutes, is amended to read:

429.26 Appropriateness of placements; examinations of residents.—

(1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must ~~shall~~ be based upon an evaluation ~~assessment~~ of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility:

(a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party.

(b) A facility may admit or retain a resident who requires the use of assistive devices.

(c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the

facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident.

(d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to:

a. Move, turn, or reposition without total physical assistance;

b. Transfer to a chair or wheelchair without total physical assistance; or

c. Sit safely in a chair or wheelchair without personal assistance or a physical restraint.

2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days.

3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days.

(2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or

designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.

(3) ~~(2)~~ A physician, physician assistant, or advanced practice registered nurse ~~practitioner~~ who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests ~~interest~~ in the facility.

(4) ~~(3)~~ Persons licensed under part I of chapter 464 who are employed by or under contract with a facility shall, on a routine basis or at least monthly, perform a nursing assessment of the residents for whom they are providing nursing services ordered by a physician, except administration of medication, and shall document such assessment, including any substantial changes in a resident's status which may necessitate relocation to a nursing home, hospital, or specialized health care facility. Such records shall be maintained in the facility for inspection by the agency and shall be forwarded to the resident's case manager, if applicable.

(5) ~~(4)~~ ~~If possible,~~ Each resident must ~~shall~~ have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse ~~practitioner~~ within 60 days before admission to the facility or

within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The ~~signed and completed~~ medical examination form, signed only by the practitioner, must ~~report shall~~ be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or ~~and~~ continued residency ~~stay~~ in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes ~~report shall become~~ a permanent part of the facility's record of the resident ~~at the facility~~ and must ~~shall~~ be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and

s. 429.07(3)(b)6.

~~(5) Except as provided in s. 429.07, if a medical examination has not been completed within 60 days before the admission of the resident to the facility, a licensed physician, licensed physician assistant, or licensed nurse practitioner shall examine the resident and complete a medical examination form provided by the agency within 30 days following the admission to the facility to enable the facility owner or administrator to determine the appropriateness of the admission. The medical examination form shall become a permanent part of the record of the resident at the facility and shall be made available to the agency during inspection by the agency or upon request.~~

(6) Any resident accepted in a facility and placed by ~~the department or~~ the Department of Children and Families must ~~shall~~ have been examined by medical personnel within 30 days before placement in the facility. The examination must ~~shall~~ include an assessment of the appropriateness of placement in a facility. The findings of this examination must ~~shall~~ be recorded on the examination form provided by the agency. The completed form must ~~shall~~ accompany the resident and ~~shall~~ be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social

worker, or psychiatric nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that ~~providing~~ it was completed within 90 days prior to admission to the facility. The ~~applicable~~ Department of Children and Families shall provide to the facility administrator any information about the resident which ~~that~~ would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The ~~applicable~~ Department of Children and Families shall advise and assist the facility administrator when ~~where~~ the special needs of residents who are recipients of optional state supplementation require such assistance.

(7) The facility shall ~~must~~ notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. The notification

must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making appointments for ~~shall arrange, with the appropriate health care provider,~~ the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition.

(8) The Department of Children and Families may require an examination for supplemental security income and optional state supplementation recipients residing in facilities at any time and shall provide the examination whenever a resident's condition requires it. Any facility administrator; personnel of the agency, the department, or the Department of Children and Families; or a representative of the State Long-Term Care Ombudsman Program who believes a resident needs to be evaluated shall notify the resident's case manager, who shall take appropriate action. A report of the examination findings must ~~shall~~ be provided to the resident's case manager and the facility administrator to help the administrator meet his or her responsibilities under subsection (1).

~~(9) A terminally ill resident who no longer meets the~~

~~criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met.~~

(9) ~~(10)~~ Facilities licensed to provide extended congregate care services shall promote aging in place by determining appropriateness of continued residency based on a comprehensive review of the resident's physical and functional status; the ability of the facility, family members, friends, or any other pertinent individuals or agencies to provide the care and services required; and documentation that a written service plan consistent with facility policy has been developed and implemented to ensure that the resident's needs and preferences are addressed.

~~(11) No resident who requires 24-hour nursing supervision, except for a resident who is an enrolled hospice patient pursuant to part IV of chapter 400, shall be retained in a facility licensed under this part.~~

Section 9. Paragraph (k) of subsection (1) and subsection (3) of section 429.28, Florida Statutes, are amended to read:

429.28 Resident bill of rights.—

(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the

Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:

(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally incapacitated, the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must ~~shall~~ be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.

(3)(a) The agency shall conduct a survey to determine whether the facility is complying with this part ~~general compliance with facility standards and compliance with residents' rights~~ as a prerequisite to initial licensure or licensure renewal. ~~The agency shall adopt rules for uniform standards and criteria that will be used to determine compliance~~

~~with facility standards and compliance with residents' rights.~~

(b) In order to determine whether the facility is adequately protecting residents' rights, the licensure renewal ~~biennial~~ survey must ~~shall~~ include private informal conversations with a sample of residents and consultation with the ombudsman council in the district in which the facility is located to discuss residents' experiences within the facility.

Section 10. Subsections (1) and (2) of section 429.31, Florida Statutes, are amended to read:

429.31 Closing of facility; notice; penalty.—

(1) In addition to the requirements of part II of chapter 408, the facility shall inform, in writing, the agency and each resident or the next of kin, legal representative, or agency acting on each resident's behalf, of the fact and the proposed time of discontinuance of operation, following the notification requirements provided in s. 429.28(1)(k). In the event a resident has no person to represent him or her, the facility shall be responsible for referral to an appropriate social service agency for placement.

(2) Immediately upon the notice by the agency of the voluntary or involuntary termination of such operation, the agency shall inform the State Long-Term Care Ombudsman Program and monitor the transfer of residents to other facilities and ensure that residents' rights are being protected. The agency, in consultation with the Department of Children and Families,

shall specify procedures for ensuring that all residents who receive services are appropriately relocated.

Section 11. Subsections (1), (2), and (5) of section 429.41, Florida Statutes, are amended to read:

429.41 Rules establishing standards.—

(1) It is the intent of the Legislature that rules published and enforced pursuant to this section shall include criteria by which a reasonable and consistent quality of resident care and quality of life may be ensured and the results of such resident care may be demonstrated. Such rules shall also promote ~~ensure~~ a safe and sanitary environment that is residential and noninstitutional in design or nature and may allow for technological advances in the provision of care, safety, and security, including the use of devices, equipment, and other security measures related to wander management, emergency response, staff risk management, and the general safety and security of residents, staff, and the facility. It is further intended that reasonable efforts be made to accommodate the needs and preferences of residents to enhance the quality of life in a facility. ~~Uniform firesafety standards for assisted living facilities shall be established by the State Fire Marshal pursuant to s. 633.206. The agency may adopt rules to administer part II of chapter 408. In order to provide safe and sanitary facilities and the highest quality of resident care accommodating the needs and preferences of residents,~~ The

agency, in consultation with the Department of Children and Families and the Department of Health, shall adopt rules~~,~~ ~~policies, and procedures~~ to administer this part, which must include reasonable and fair minimum standards in relation to:

(a) The requirements for ~~and~~ maintenance and the sanitary condition of facilities, not in conflict with, or duplicative of, the requirements in chapter 553, s. 381.006, s. 381.0072, or s. 633.206, relating to a safe and decent living environment, including furnishings for resident bedrooms or sleeping areas, locking devices, linens ~~plumbing, heating, cooling, lighting, ventilation, living space~~, and other housing conditions relating to hazards, which will promote ~~ensure~~ the health, safety, and welfare ~~comfort~~ of residents suitable to the size of the structure. The rules must clearly delineate the respective responsibilities of the agency's licensure and survey staff and the county health departments and ensure that inspections are not duplicative. The agency may collect fees for food service inspections conducted by county health departments and may transfer such fees to the Department of Health.

~~1. Firesafety evacuation capability determination.—An evacuation capability evaluation for initial licensure shall be conducted within 6 months after the date of licensure.~~

~~2. Firesafety requirements.—~~

~~a. The National Fire Protection Association, Life Safety Code, NFPA 101 and 101A, current editions, shall be used in~~

~~determining the uniform firesafety code adopted by the State Fire Marshal for assisted living facilities, pursuant to s. 633.206.~~

~~b. A local government or a utility may charge fees only in an amount not to exceed the actual expenses incurred by the local government or the utility relating to the installation and maintenance of an automatic fire sprinkler system in a licensed assisted living facility structure.~~

~~c. All licensed facilities must have an annual fire inspection conducted by the local fire marshal or authority having jurisdiction.~~

~~d. An assisted living facility that is issued a building permit or certificate of occupancy before July 1, 2016, may at its option and after notifying the authority having jurisdiction, remain under the provisions of the 1994 and 1995 editions of the National Fire Protection Association, Life Safety Code, NFPA 101, and NFPA 101A. The facility opting to remain under such provisions may make repairs, modernizations, renovations, or additions to, or rehabilitate, the facility in compliance with NFPA 101, 1994 edition, and may utilize the alternative approaches to life safety in compliance with NFPA 101A, 1995 edition. However, a facility for which a building permit or certificate of occupancy is issued before July 1, 2016, that undergoes Level III building alteration or rehabilitation, as defined in the Florida Building Code, or~~

~~seeks to utilize features not authorized under the 1994 or 1995 editions of the Life Safety Code must thereafter comply with all aspects of the uniform firesafety standards established under s. 633.206, and the Florida Fire Prevention Code, in effect for assisted living facilities as adopted by the State Fire Marshal.~~

~~3. Resident elopement requirements.—Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills, which shall include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the drills are conducted in a manner consistent with the facility's resident elopement policies and procedures.~~

(b) The preparation and annual update of a comprehensive emergency management plan. Such standards must be included in the rules adopted by the agency after consultation with the Division of Emergency Management. At a minimum, the rules must provide for plan components that address emergency evacuation transportation; adequate sheltering arrangements; postdisaster activities, including provision of emergency power, food, and water; postdisaster transportation; supplies; staffing; emergency equipment; individual identification of residents and transfer of records; communication with families; and responses to family inquiries. The comprehensive emergency management plan is subject to review and approval by the county ~~local~~ emergency

management agency. During its review, the county ~~local~~ emergency management agency shall ensure that the following agencies, at a minimum, are given the opportunity to review the plan: the Department of Health, the Agency for Health Care Administration, and the Division of Emergency Management. ~~Also, appropriate volunteer organizations must be given the opportunity to review the plan.~~ The county ~~local~~ emergency management agency shall complete its review within 60 days and either approve the plan or advise the facility of necessary revisions. A facility must submit a comprehensive emergency management plan to the county emergency management agency within 30 days after issuance of a license.

(c) The number, training, and qualifications of all personnel having responsibility for the care of residents. The rules must require adequate staff to provide for the safety of all residents. Facilities licensed for 17 or more residents are required to maintain an alert staff for 24 hours per day.

~~(d) All sanitary conditions within the facility and its surroundings which will ensure the health and comfort of residents. The rules must clearly delineate the responsibilities of the agency's licensure and survey staff, the county health departments, and the local authority having jurisdiction over firesafety and ensure that inspections are not duplicative. The agency may collect fees for food service inspections conducted by the county health departments and transfer such fees to the~~

~~Department of Health.~~

(d) ~~(e)~~ License application and license renewal, transfer of ownership, proper management of resident funds and personal property, surety bonds, resident contracts, refund policies, financial ability to operate, and facility and staff records.

(e) ~~(f)~~ Inspections, complaint investigations, moratoriums, classification of deficiencies, levying and enforcement of penalties~~, and use of income from fees and fines~~.

(f) ~~(g)~~ The enforcement of the resident bill of rights specified in s. 429.28.

(g) ~~(h)~~ The care ~~and maintenance~~ of residents provided by the facility, which must include~~, but is not limited to~~:

1. The supervision of residents;

2. The provision of personal services;

3. The provision of, or arrangement for, social and leisure activities;

4. The assistance in making arrangements ~~arrangement~~ for appointments and transportation to appropriate medical, dental, nursing, or mental health services, as needed by residents;

5. The management of medication stored within the facility and as needed by residents;

6. The dietary ~~nutritional~~ needs of residents;

7. Resident records; ~~and~~

8. Internal risk management and quality assurance.

(h) ~~(i)~~ Facilities holding a limited nursing, extended

congregate care, or limited mental health license.

(i) ~~(j)~~ The establishment of specific criteria to define appropriateness of resident admission and continued residency in a facility holding a standard, limited nursing, extended congregate care, and limited mental health license.

(j) ~~(k)~~ The use of physical or chemical restraints. The use of Posey restraints is prohibited. Other physical restraints may be used in accordance with agency rules when ordered ~~is limited to half-bed rails as prescribed and documented~~ by the resident's physician and consented to by ~~with the consent of~~ the resident or, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact. Such rules must specify requirements for care planning, staff monitoring, and periodic review by a physician. The use of chemical restraints is limited to prescribed dosages of medications authorized by the resident's physician and must be consistent with the resident's diagnosis. Residents who are receiving medications that can serve as chemical restraints must be evaluated by their physician at least annually to assess:

1. The continued need for the medication.

2. The level of the medication in the resident's blood.

3. The need for adjustments in the prescription.

(k) ~~(l)~~ The establishment of specific resident elopement drill requirements and policies and procedures on resident elopement. Facilities shall conduct a minimum of two resident

elopement drills each year. All administrators and direct care staff shall participate in the drills, which must include a review of the facility's procedures to address resident elopement. Facilities shall document participation in the drills.

(2) In adopting any rules pursuant to this part, the agency shall make distinct standards for facilities based upon facility size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and the staffing characteristics of the facility. Rules developed pursuant to this section may not restrict the use of shared staffing and shared programming in facilities that are part of retirement communities that provide multiple levels of care and otherwise meet the requirements of law and rule. If a continuing care facility licensed under chapter 651 or a retirement community offering multiple levels of care licenses a building or part of a building designated for independent living for assisted living, staffing requirements established in rule apply only to residents who receive personal, limited nursing, or extended congregate care services under this part. Such facilities shall retain a log listing the names and unit number for residents receiving these services. The log must be available to surveyors upon request. ~~Except for uniform firesafety standards,~~ The agency shall adopt by rule separate and distinct standards for

facilities with 16 or fewer beds and for facilities with 17 or more beds. The standards for facilities with 16 or fewer beds must be appropriate for a noninstitutional residential environment; however, the structure may not be more than two stories in height and all persons who cannot exit the facility unassisted in an emergency must reside on the first floor. The agency may make other distinctions among types of facilities as necessary to enforce this part. Where appropriate, the agency shall offer alternate solutions for complying with established standards, based on distinctions made by the agency relative to the physical characteristics of facilities and the types of care offered.

(5) The agency may use an abbreviated biennial standard licensure inspection that consists of a review of key quality-of-care standards in lieu of a full inspection in a facility that has a good record of past performance. However, a full inspection must be conducted in a facility that has a history of class I or class II violations; ~~,~~ uncorrected class III violations; or a class I, class II, or uncorrected class III violation resulting from a complaint referred by the State Long-Term Care Ombudsman Program~~, confirmed ombudsman council complaints, or confirmed licensure complaints~~ within the previous licensure period immediately preceding the inspection or if a potentially serious problem is identified during the abbreviated inspection. The agency shall adopt by rule ~~develop~~

the key quality-of-care standards ~~with input from the State Long-Term Care Ombudsman Council and representatives of provider groups for incorporation into its rules~~.

Section 12. Section 429.435, Florida Statutes, is created to read:

429.435 Uniform firesafety standards.—Uniform firesafety standards for assisted living facilities, which are residential board and care occupancies, shall be established by the State Fire Marshal pursuant to s. 633.206.

(1) EVACUATION CAPABILITY.—A firesafety evacuation capability determination shall be conducted within 6 months after the date of initial licensure of an assisted living facility, if required.

(2) FIRESAFETY REQUIREMENTS.—

(a) The National Fire Protection Association, Life Safety Code, NFPA 101 and 101A, current editions, must be used in determining the uniform firesafety code adopted by the State Fire Marshal for assisted living facilities, pursuant to s. 633.206.

(b) A local government or a utility may charge fees that do not exceed the actual costs incurred by the local government or the utility for the installation and maintenance of an automatic fire sprinkler system in a licensed assisted living facility structure.

(c) All licensed facilities must have an annual fire

inspection conducted by the local fire marshal or authority having jurisdiction.

(d) An assisted living facility that was issued a building permit or certificate of occupancy before July 1, 2016, at its option and after notifying the authority having jurisdiction, may remain under the provisions of the 1994 and 1995 editions of the National Fire Protection Association, Life Safety Code, NFPA 101 and 101A. A facility opting to remain under such provisions may make repairs, modernizations, renovations, or additions to, or rehabilitate, the facility in compliance with NFPA 101, 1994 edition, and may utilize the alternative approaches to life safety in compliance with NFPA 101A, 1995 edition. However, a facility for which a building permit or certificate of occupancy was issued before July 1, 2016, which undergoes Level III building alteration or rehabilitation, as defined in the Florida Building Code, or which seeks to utilize features not authorized under the 1994 or 1995 editions of the Life Safety Code, shall thereafter comply with all aspects of the uniform firesafety standards established under s. 633.206 and the Florida Fire Prevention Code in effect for assisted living facilities as adopted by the State Fire Marshal.

Section 13. Section 429.52, Florida Statutes, is amended to read:

429.52 Staff training and educational requirements ~~programs; core educational requirement~~.—

(1) ~~Effective October 1, 2015,~~ Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record.

(2) Administrators and other assisted living facility staff must meet minimum training and education requirements established by the agency by rule. This training and education is intended to assist facilities to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements.

(3) The agency, in conjunction with providers, shall develop core training requirements for administrators consisting of core training learning objectives, a competency test, and a minimum required score to indicate successful passage ~~completion~~ of the core competency test ~~training and educational requirements~~. The required core competency test ~~training and education~~ must cover at least the following topics:

(a) State law and rules relating to assisted living

facilities.

(b) Resident rights and identifying and reporting abuse, neglect, and exploitation.

(c) Special needs of elderly persons, persons with mental illness, and persons with developmental disabilities and how to meet those needs.

(d) Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food.

(e) Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication.

(f) Firesafety requirements, including fire evacuation drill procedures and other emergency procedures.

(g) Care of persons with Alzheimer's disease and related disorders.

(4) A ~~new~~ facility administrator must complete the required core training ~~and education~~, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule.

(5) Administrators are required to participate in

continuing education for a minimum of 12 contact hours every 2 years.

(6) Staff ~~involved with the management of medications and~~ assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or~~,~~ a licensed pharmacist before providing assistance~~, or agency staff~~. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this ~~additional~~ training.

(7) ~~Other~~ Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule ~~of the agency~~. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course.

(8) If the agency determines that there are problems in a facility which could be reduced through specific staff training ~~or education~~ beyond that already required under this section, the agency may require~~,~~ and provide, or cause to be provided, the training ~~or education~~ of any personal care staff in the facility.

(9) The agency shall adopt rules related to these training

and education requirements, the competency test, necessary procedures, and competency test fees and shall adopt or contract with another entity to develop and administer the competency test. The agency shall adopt a curriculum outline with learning objectives to be used by core trainers~~, which shall be used~~ as the minimum core training content requirements. The agency shall consult with representatives of stakeholder associations and agencies in the development of the curriculum outline.

(10) The core training required by this section ~~other than the preservice orientation~~ must be conducted by persons registered with the agency as having the requisite experience and credentials to conduct the training. A person seeking to register as a core trainer must provide the agency with proof of completion of the ~~minimum~~ core training ~~education~~ requirements, successful passage of the competency test established under this section, and proof of compliance with the continuing education requirement in subsection (5).

(11) A person seeking to register as a core trainer also must ~~also~~:

(a) Provide proof of completion of a 4-year degree from an accredited college or university and must have worked in a management position in an assisted living facility for 3 years after being core certified;

(b) Have worked in a management position in an assisted living facility for 5 years after being core certified and have

1 year of teaching experience as an educator or staff trainer for persons who work in assisted living facilities or other long-term care settings;

(c) Have been previously employed as a core trainer for the agency or department; or

(d) Meet other qualification criteria as defined in rule, which the agency is authorized to adopt.

(12) The agency shall adopt rules to establish core trainer registration and removal requirements.

Section 14. This act shall take effect July 1, 2020.

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Grant, M. offered the following:

Amendment (with title amendment)

Remove lines 407-424 and insert:

Section 1. Paragraph (a) of subsection (1) and subsection (4) of section 429.255, Florida Statutes, are amended to read:

429.255 Use of personnel; emergency care.—

(1)(a) Persons under contract to the facility, facility staff, or volunteers, who are licensed according to part I of chapter 464, or those persons exempt under s. 464.022(1), and others as defined by rule, may administer medications to residents, take residents' vital signs, change bandages for minor cuts and abrasions, manage individual weekly pill organizers for residents who self-administer medication, give

prepackaged enemas ordered by a physician, observe residents, document observations on the appropriate resident's record, report observations to the resident's physician, and contract or allow residents or a resident's representative, designee, surrogate, guardian, or attorney in fact to contract with a third party, provided residents meet the criteria for appropriate placement as defined in s. 429.26. Nursing assistants certified pursuant to part II of chapter 464 may take residents' vital signs as directed by a licensed nurse or physician.

(4) Facility staff may withhold or withdraw cardiopulmonary resuscitation or the use of an automated external defibrillator if presented with an order not to resuscitate executed pursuant to s. 401.45. The agency shall adopt rules providing for the implementation of such orders. Facility staff and facilities may not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator pursuant to such an order and rules adopted by the agency. The absence of an order not to resuscitate executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator as otherwise permitted by law.

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

Between lines 22 and 23, insert:

authorizing facilities to make certain bandage changes;

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 & Human Services Committee

Representative Grant, M. offered the following:

Amendment

Remove line 503 and insert:

unscheduled needs of the resident, including, if applicable, staffing for nursing care.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 825 Administration of Vaccines
SPONSOR(S): Health Quality Subcommittee, Fernandez-Barquin
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	11 Y, 0 N, As CS	Siples	McElroy
2) Health & Human Services Committee		Siples	Calamas

SUMMARY ANALYSIS

Current law authorizes pharmacists and registered interns who meet certain educational requirements to administer vaccines to adults within an established protocol with a supervising physician. A pharmacist may administer:

- Immunizations or vaccines listed on the U.S. Centers for Disease Control and Prevention (CDC) Adult Immunization Schedule as of February 1, 2015;
- Vaccines recommended by the CDC for international travel as of July 1, 2015;
- Immunizations or vaccines approved by the Board of Pharmacy in rule; and
- Immunizations or vaccines approved by the Board of Pharmacy in response to a state of emergency declared by the Governor.

CS/HB 825 authorizes qualified Florida-licensed pharmacists or registered pharmacy interns to administer any CDC-recommended vaccine or vaccine licensed for use in the United States by the U.S. Food and Drug Administration to an adult. The bill also authorizes pharmacists to provide influenza vaccines to individuals age 7 and older.

The bill repeals the Board of Pharmacy's rulemaking authority to add vaccines to the list of vaccines that a pharmacist may administer. It also repeals the specific statutory limitation to the 2015 CDC-recommended vaccines.

The bill has an insignificant, negative fiscal impact on the Department of Health, which can be absorbed within existing resources. The bill has no fiscal impact on local governments.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Vaccinations

CDC Immunizations Recommendations

The Advisory Committee on Immunization Practices (ACIP) is comprised of medical and public health experts who develop recommendations on the use of vaccines in the United States.[1] The ACIP works with professional organizations, such as the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians to develop annual childhood and adult immunization schedules.[2] The Center for Disease Control and Prevention (CDC) reviews the ACIP's recommendations; and once approved, they are published as the CDC's official recommendations for immunizations of the U.S. population.[3] The current recommended immunization schedule for those ages 18 and under includes:[4]

- Hepatitis B
- Diphtheria, tetanus, & acellular pertussis
- Pneumococcal conjugate
- Influenza
- Varicella
- Meningococcal
- Meningococcal B
- Rotavirus
- Haemophilus influenza type b
- Inactivated poliovirus
- Measles, mumps, rubella (MMR)
- Hepatitis A
- Human papillomavirus
- Pneumococcal polysaccharide

The current recommended immunization schedule for adults includes:[5]

- Influenza (annually)
- Measles, mumps, rubella (if born in 1957 or later)
- Zoster
- Pneumococcal polysaccharide
- Haemophilus influenza type b
- Hepatitis B
- Meningococcal B
- Varicella (if born in 1980 or later)
- Tetanus, diphtheria, pertussis (booster every 10 years)
- Human papillomavirus
- Pneumococcal conjugate
- Hepatitis A
- Meningococcal A, C, W, Y

[1] Centers for Disease Control and Prevention, Advisory Committee on Immunization Practices (ACIP), *General Committee-Related Information*, available at https://www.cdc.gov/vaccines/acip/committee/index.html (last visited February 4, 2020).
[2] Centers for Disease Control and Prevention, Advisory Committee on Immunization Practices (ACIP), *ACIP Recommendations*, available at https://www.cdc.gov/vaccines/acip/recommendations.html (last visited February 4, 2020).
[3] Id.
[4] Centers for Disease Control and Prevention, *Recommended Child and Adolescent Immunization Schedule for Ages 18 Years and Younger, United States, 2020*, available at https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html (last visited February 4, 2020). The schedule provides the recommended age, as well as the administration intervals for vaccines that require multiple doses. Some vaccines are recommended only for populations with special situations that put these individuals at higher risk.
[5] Centers for Disease Control and Prevention, *Recommended Adult Immunization Schedule for Ages 19 Years or Older, United States, 2020*, available at https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html (last visited February 4, 2020). The schedule provides the recommended age, as well as the administration intervals for vaccines that require multiple doses. Some vaccines are recommended only for populations with special situations that put these individuals at higher risk.

New vaccines are considered for addition to the schedule after licensure by the United States Food and Drug Administration.[6] Not all newly licensed vaccines are added to the schedule. Some licensed vaccines are only recommended for people who are traveling to areas where other vaccine preventable diseases occur, such as yellow fever, cholera, dengue, Japanese encephalitis, plague, rabies, smallpox, and typhoid.[7]

CDC Health Information for International Travel

CDC's Health Information for International Travel, commonly called the Yellow Book (Book), is published biannually by the CDC as a reference for those who advise international travelers about health risks.[8] The Book includes the CDC's most current travel health guidelines, including pre-travel vaccine recommendations and destination-specific health advice. The Book is authored by subject-matter experts both within and outside the CDC and the guidelines in the Book are evidence-based and supported by best practices.[9]

Vaccinations are recommended by the CDC to protect international travelers from illness and prevent the importation of infectious diseases across international borders. The Book recommends that persons traveling internationally should be up to date on all CDC-recommended vaccines.[10] Additionally, the Book may recommend additional vaccinations based on traveler's destination and other factors. Examples of additional vaccines required for travelers based on the country of entry is yellow fever, meningococcal, and polio.[11] An example of a vaccine the CDC recommends travelers obtain to protect their health, even if they aren't required for entry into the country, is the typhoid vaccine.[12]

Practice of Pharmacy

Licensure

Pharmacy is the third largest health profession behind nursing and medicine.[13] The Board of Pharmacy (Board), in conjunction with the Department of Health (DOH), regulates the practice of pharmacists pursuant to ch. 465, F.S.[14] To be licensed as a pharmacist, a person must:[15]

- Complete an application and remit an examination fee;
- Be at least 18 years of age;
- Hold a degree from an accredited and approved school or college of pharmacy;[16]
- Have completed a Board-approved internship; and
- Successfully complete the Board-approved examination.

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[6] College of Physicians of Philadelphia, *The History of Vaccines: The Development of the Immunization Schedule,* available at http://www.historyofvaccines.org/content/articles/development-immunization-schedule (last visited February 4, 2020).
[7] Id. For a complete list of FDA-licensed vaccines, *see* U.S. Food & Drug Administration, *Vaccines Licensed for Use in the United States*, (last rev. Jan. 16, 2020), available at https://www.fda.gov/vaccines-blood-biologics/vaccines/vaccines-licensed-use-united-states (last visited February 4, 2020).
[8] Centers for Disease Control and Prevention. *CDC Yellow Book 2020: Health Information for International Travel*, available at https://wwwnc.cdc.gov/travel/page/yellowbook-home (last visited February 4, 2020).
[9] Id.
[10] Id.
[11] Centers for Disease Control and Prevention, *Travelers' Health Most Frequently Asked Questions,* available at https://wwwnc.cdc.gov/travel/page/faq (last visited February 4, 2020).
[12] Id.
[13] American Association of Colleges of Pharmacy, *About AACP*, available at https://www.aacp.org/about-aacp (last visited February 4, 2020).
[14] Sections 465.004 and 465.005, F.S.
[15] Section 465.007, F.S. DOH may also issue a license by endorsement to a pharmacist who is licensed in another state upon meeting the applicable requirements set forth in law and rule. *See* s. 465.0075, F.S.
[16] If the applicant has graduated from a 4-year undergraduate pharmacy program of a school or college of pharmacy located outside the United States, the applicant must demonstrate proficiency in English, pass the board-approved Foreign Pharmacy Graduate Equivalency Examination, and complete a minimum of 500 hours in a supervised work activity program within Florida under the supervision of a DOH-licensed pharmacist

A pharmacist must complete at least 30 hours of Board-approved continuing education during each biennial renewal period.[17] Pharmacists who are certified to administer vaccines or epinephrine autoinjections must complete a 3-hour continuing education course on the safe and effective administration of vaccines and epinephrine injections as a part of the biennial licensure renewal.[18] Pharmacists who administer long-acting antipsychotic medications must complete an approved 8-hour continuing education course as a part of the continuing education for biennial licensure renewal.[19]

Scope of Practice

In Florida, the practice of the profession of pharmacy includes:[20]

- Compounding, dispensing, and consulting concerning contents, therapeutic values, and uses of a medicinal drug;
- Consulting concerning therapeutic values and interactions of patent or proprietary preparations;
- Monitoring a patient's drug therapy and assisting the patient in the management of his or her drug therapy, including the review of the patient's drug therapy and communication with the patient's prescribing health care provider or other persons specifically authorized by the patient, regarding the drug therapy;
- Transmitting information from prescribers to their patients;
- Administering vaccines to adults;[21]
- Administering epinephrine injections;[22] and
- Administering antipsychotic medications by injection.[23]

Pharmacy Interns

To become a pharmacy intern, a person must be certified by the Board as enrolled in an intern program at an accredited school or college of pharmacy or as a graduate of an accredited school or college of pharmacy and not yet licensed as a pharmacist in Florida.[24] The Board's rules outline the registration process for pharmacy interns and the internship program requirements for U.S. pharmacy students or graduates and foreign pharmacy graduates.[25]

A pharmacist is responsible for any delegated act performed by a registered pharmacy intern employed or supervised by the pharmacist.[26]

Pharmacist Vaccine Administration

A pharmacist, or registered pharmacy intern under the supervision of a certified pharmacist, may administer immunizations and vaccines to adults within an established protocol under a licensed supervising physician.[27] The protocol between the pharmacist and the supervising physician dictates which types of patients to whom the pharmacist may administer allowable vaccines.[28] The terms, scope, and conditions set forth in the protocol must be appropriate to the pharmacist's training and certification. A supervising physician must review the administration of vaccines by the pharmacist.[29]

[17] Section 465.009, F.S.
[18] Section 465.009(6), F.S.
[19] Section 465.1893, F.S.
[20] Section 465.003(13), F.S.
[21] *See* s. 465.189, F.S.
[22] Id.
[23] Section 465.1893, F.S.
[24] Section 465.013, F.S.
[25] Rule 64B16-26.2032, F.A.C. (U.S. pharmacy students/graduates); Rule 64B16-26.2033, F.A.C. (foreign pharmacy graduates).
[26] Rule 64B16-27.430, F.A.C.
[27] Section 468.189(1), F.S.
[28] Section 465.189(7), F.S.
[29] Id.

To be certified to administer vaccines, a pharmacist or registered pharmacy intern must successfully complete a Board-approved vaccine administration certification program. The certification program requires a pharmacist or registered intern to complete 20 hours of Board-approved continuing education that addresses:[30]

- Mechanisms of action for vaccines, contraindications, drug interactions, and monitoring after vaccine administration;
- Immunization schedules;
- Immunization screening questions, provision of risk/benefit information, informed consent, recordkeeping, and electronic reporting into the statewide immunization registry maintained by DOH;
- Vaccine storage and handling;
- Bio-hazardous waste disposal and sterile technique;
- Entering, negotiating, and performing pursuant to physician oversight protocols;
- Community immunization resources and programs;
- Identifying, managing and responding to adverse incidents including but not limited to potential allergic reactions associated with vaccine administration;
- Procedures and policies for reporting adverse incidents to the Vaccine Adverse Event Reporting System;
- Reimbursement procedures and vaccine coverage by federal, state, and local governmental jurisdictions and private third party payers;
- Administration techniques;
- Administration of epinephrine using an autoinjector delivery system;
- The February 1, 2015, CDC Recommended Adult Immunization Schedule;
- The immunizations or vaccines recommended for international travel as of July 1, 2015, found in the CDC Health Information for International Travel (2014 Edition);
- State of emergency administration of immunizations or vaccines;
- Review of the current law permitting a pharmacist to administer vaccinations and epinephrine; and
- CPR training.

A pharmacist must also pass an examination and demonstrate vaccine administration technique.[31] Pharmacists who are certified to administer vaccines must maintain at least $200,000 of professional liability insurance.[32] A pharmacist is permitted to administer epinephrine to treat any allergic reaction resulting from a vaccine.

Current law restricts the vaccines a pharmacist may administer to adults to those vaccines listed in the February 1, 2015, CDC Recommended Adult Immunization Schedule, which is the same as the 2020 list of recommended vaccines (see pg. 3), except that the CDC has added the Meningococcal B vaccine to the list.[33]

The Board may authorize, by rule, additional vaccines a pharmacist may administer.[34] The Board may authorize pharmacists to administer vaccines in response to a declared state of emergency.[35] There

[30] Rule 64B16-26.1031, F.A.C.
[31] Id.
[32] Section 465.189(3), F.S.
[33] Centers for Disease Control and Prevention, *Recommended Adult Immunization Schedule, United States - 2015*, available at https://www.cdc.gov/vaccines/schedules/downloads/past/2015-adult.pdf (last visited February 4, 2020). The schedule provides the recommended age, as well as the administration intervals for vaccines that require multiple doses. Some vaccines are recommended only for populations with special situations that put these individuals at higher risk. *See also supra* note 5.
[34] Section 465.189, F.S..
[35] Section 465.189(1)(c), F.S.

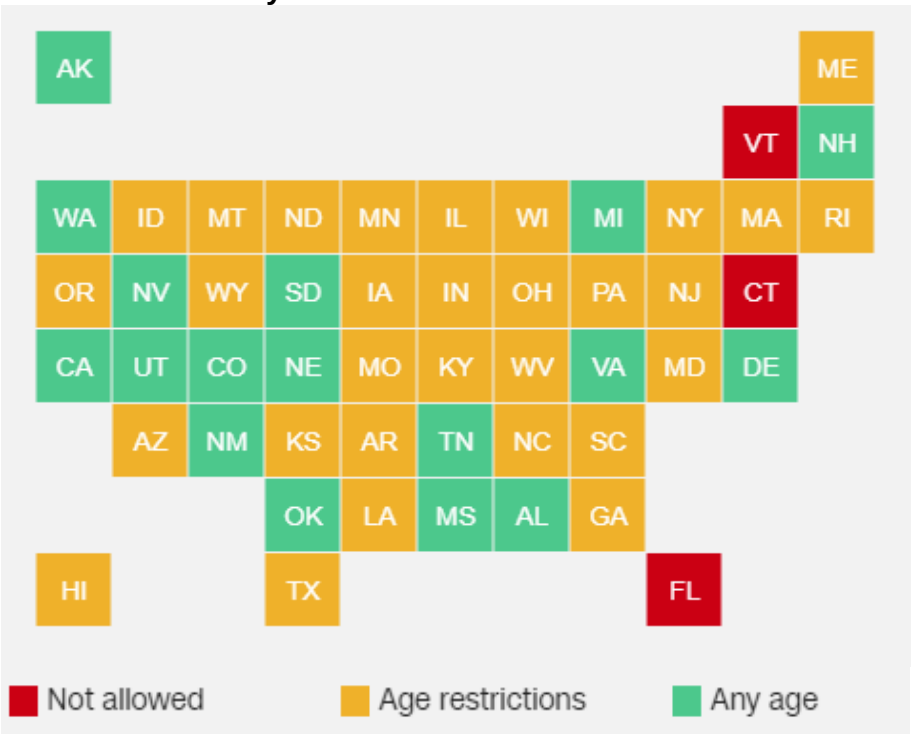
are 13,115 Florida-licensed pharmacists and 2,627 pharmacy interns who are certified to administer vaccines.[36]

Pharmacist Vaccination and Age Restrictions

Currently, all 50 states authorize pharmacists to administer vaccinations; however, that authority may vary by, among other things, the age of the patients that a pharmacist may vaccinate.[37] Seven states, including Florida, limit pharmacist vaccinations to adult patients.[38] Eight jurisdiction expressly indicate that there is no minimum age limit, and 12 states did not have any express language regarding the age of patients.[39] The remaining states have minimum age restrictions that range from 14 years to 3 years.[40]

Authority to administer influenza vaccines to minors differ by state. For example, some states, such as Arizona, allow pharmacists to administer influenza vaccines to children age 3 and over, while other states such as, Montana, only allow pharmacists to administer influenza vaccines to those age 12 and older.[41] Three states, including Florida, do not authorize pharmacists to administer influenza vaccines to minors, 30 states have age restrictions, and 17 others allow pharmacists to give influenza vaccines to children of any age:[42]

Pharmacist Authority to Administer the Influenza Vaccine to Minors



[36] E-mail correspondence with DOH, dated December 19, 2019, on file with the Health Quality Subcommittee.
[37] Yvette C. Terrie, BSPharm, RPH, *Vaccinations: The Expanding Role of Pharmacists*, PHARMACY TIMES, Jan. 15, 2010, available at https://www.pharmacytimes.com/publications/issue/2010/january2010/featurefocusvaccinations-0110 (last visited February 4, 2020).
[38] Cason D. Schmit, JD and Matthew S. Penn, JD, MLIS, *Expanding State Laws and Growing Roll for Pharmacists in Vaccination Services*, JOURNAL OF THE AMERICAN PHARMACISTS ASSOCIATION, Nov.-Dec. 2017, 57:(6), at pp. 661-669, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5704925/pdf/nihms921018.pdf (last visited February 4, 2020). The states that limit pharmacist vaccinations to adults are Connecticut, Delaware, Florida, Massachusetts, New York, Vermont, and West Virginia.
[39] Id. The eight states that expressly state that there is no minimum age restriction are Alaska, Georgia, Indiana, Missouri, New Hampshire, Nevada, Virginia, and the District of Columbia.
[40] Id. Minimum age limits: Hawaii and North Carolina is 14 years; Idaho, Montana, and South Carolina is 12 years; Illinois is 10 years; Kentucky, Maryland, Pennsylvania, and Rhode Island is 9 years; Arkansas, Louisiana, Maine, New Jersey, Ohio, Oregon and Wyoming is 7 years; Arizona, Iowa, Kansas, Minnesota, and Wisconsin is 6 years; North Dakota is 5 years; and California is 3 years.
[41] Elizabeth Cohen and John Bonifield, *Most States Make It Difficult for Children to Get a Flu Shot*, (Nov. 26, 2019), available at https://www.cnn.com/2019/11/26/health/flu-shots-children-pharmacy/index.html (last visited February 4, 2020).
[42] Id.

Effect of Proposed Changes

CS/HB 825 revises the list of immunizations that qualified pharmacists and registered pharmacy interns can provide to adults. Currently, pharmacists may only administer those vaccines listed in 2015 CDC-recommended immunization for adults and the 2015 CDC-recommended immunizations for international travels. The bill authorizes pharmacists to administer those vaccines or immunizations listed in the 2020 CDC Recommended Immunization Schedule for adults and the CDC's Health Information for International Travel. Therefore, pharmacists may administer the Meningococcal B vaccine, which is on the current recommended immunization schedule but was not on the 2015 recommended schedule.

The bill also authorizes a pharmacist to administer any vaccine that has been licensed for use in the United States by the U.S. Food and Drug Administration. This allows a pharmacist to administer vaccines for yellow fever, cholera, dengue, Japanese encephalitis, plague, rabies, smallpox, and typhoid, which are not in the CDC-recommended schedule but have been approved by the U.S. Food and Drug Administration. The bill expands the authority of qualified pharmacists and pharmacy interns to administer the influenza vaccines to allow them to administer the vaccine to individuals age 7 and older.

The bill repeals DOH's authority to adopt rules to authorize additional vaccines for administration by a pharmacist.

The bill provides an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Amends s. 465.189, F.S., relating to administration of vaccines and epinephrine autoinjection.
Section 2: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill may have an insignificant, negative fiscal impact on DOH, as the Board of Pharmacy will need to amend its rules.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Those between the ages of 7 and 18 may obtain influenza vaccinations from a qualified pharmacist, which may reduce costs associated with travel and physician office visits.

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:

Rule-making authority is not needed to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 3, 2020, the Health Quality Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment authorized a pharmacist to administer the influenza vaccine to individuals age 7 and older.

The analysis is drafted to the committee substitute as passed by the Health Quality Subcommittee.

A bill to be entitled

An act relating to administration of vaccines; amending s. 465.189, F.S.; revising the recommended immunizations or vaccines a pharmacist, or a registered intern under certain conditions, may administer; authorizing a certified pharmacist to administer the influenza vaccine to specified individuals; providing an effective date.

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

Section 1. Subsections (2) through (8) of section 465.189, Florida Statutes, are renumbered as sections (3) through (9), respectively, subsection (1) and present subsection (6) are amended, and a new subsection (2) is added to that section, to read:

465.189 Administration of vaccines and epinephrine autoinjection.—

(1) In accordance with guidelines of the Centers for Disease Control and Prevention for each recommended immunization or vaccine, a pharmacist, or a registered intern under the supervision of a pharmacist who is certified under subsection (7) ~~(6)~~, may administer the following vaccines to an adult within the framework of an established protocol under a supervising physician licensed under chapter 458 or chapter 459:

(a) Immunizations or vaccines listed in the ~~Adult Immunization Schedule as of February 1, 2015, by the~~ United States Centers for Disease Control and Prevention's Recommended ~~Prevention. The board may authorize, by rule, additional immunizations or vaccines as they are added to the Adult~~ Immunization Schedule, the United States Centers for Disease Control and Prevention's Health Information for International Travel, or the United States Food and Drug Administration's Vaccines Licensed for Use in the United States.

~~(b) Immunizations or vaccines recommended by the United States Centers for Disease Control and Prevention for international travel as of July 1, 2015. The board may authorize, by rule, additional immunizations or vaccines as they are recommended by the United States Centers for Disease Control and Prevention for international travel.~~

(b) ~~(c)~~ Immunizations or vaccines approved by the board in response to a state of emergency declared by the Governor pursuant to s. 252.36.

A registered intern who administers an immunization or vaccine under this subsection must be supervised by a certified pharmacist at a ratio of one pharmacist to one registered intern.

(2) A pharmacist who is certified under subsection (7) may administer influenza vaccines to individuals 7 years of age and

older within the framework of an established protocol under a supervising physician licensed under chapter 458 or chapter 459.

(7) ~~(6)~~ Any pharmacist or registered intern seeking to administer vaccines ~~to adults~~ under this section must be certified to administer such vaccines pursuant to a certification program approved by the Board of Pharmacy in consultation with the Board of Medicine and the Board of Osteopathic Medicine. The certification program shall, at a minimum, require that the pharmacist attend at least 20 hours of continuing education classes approved by the board and the registered intern complete at least 20 hours of coursework approved by the board. The program shall have a curriculum of instruction concerning the safe and effective administration of such vaccines, including, but not limited to, potential allergic reactions to such vaccines.

Section 2. This act shall take effect July 1, 2020.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 833 Program of All-Inclusive Care for the Elderly
SPONSOR(S): Rommel
TIED BILLS: **IDEN./SIM. BILLS:** SB 916

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	12 Y, 0 N	Grabowski	Calamas
2) Health Care Appropriations Subcommittee	11 Y, 0 N	Nobles	Clark
3) Health & Human Services Committee		Grabowski	Calamas

SUMMARY ANALYSIS

The Program of All-Inclusive Care for the Elderly (PACE) is a capitated health benefits program authorized by the federal Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system funded by a combination of federal Medicare and state Medicaid financing. PACE was created as a way to provide clients, family, caregivers and professional health care providers the flexibility to meet a person's health care needs while continuing to live safely in the community.

In Florida, the PACE is operated cooperatively by the Department of Elderly Affairs (DOEA) and the Agency for Health Care Administration (AHCA). AHCA and DOEA have operated the program using authority granted by the federal government.

HB 833 codifies the PACE in Florida law and sets specific parameters on program services and participating organizations. The bill directs AHCA, in consultation with DOEA, to review and consider program applications submitted by entities seeking to become PACE organizations.

The bill also requires PACE organizations to meet specific quality and performance standards, as outlined by the federal Centers for Medicare and Medicaid Services. AHCA is charged with monitoring the reporting requirements assigned to PACE organizations.

The bill has no fiscal impact on state or local government.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid serves approximately 3.8 million people in Florida, with over half of those being children and adolescents 19 years of age or younger. Medicaid is a partnership between the federal and state governments where the federal government establishes the structure for the program and pays a share of the cost. Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare and Medicaid Services or CMS. The plan outlines current Medicaid eligibility standards, policies, and reimbursement methodologies. To qualify for nursing home care under Medicaid, both an individual's income and assets must not exceed certain thresholds.

In Florida, the Medicaid program is administered by the AHCA. AHCA delegates certain functions to other state agencies, including the Department of Children, Families and Elder Affairs (DCF), the Agency for Persons with Disabilities (APD), and the DOEA. AHCA has overall responsibility for the program and qualifies providers, sets payment levels, and pays for services. DCF is responsible for determining financial eligibility for Medicaid recipients.

Program of All-Inclusive Care for the Elderly (PACE)

The PACE is a capitated health benefits program authorized by the federal Balanced Budget Act of 1997[1] that features a comprehensive service delivery system funded by a combination of federal Medicare and state Medicaid financing.[2] The PACE is an optional Medicaid benefit, but operates as a three-way agreement between the federal government, a state agency, and a PACE organization.[3] In Florida, the PACE is a Medicaid long-term care managed care plan option providing comprehensive long-term and acute care services which supports Medicaid and Medicare enrollees who would otherwise qualify for Medicaid nursing facility services.[4]

The PACE provides a range of integrated preventative, acute care, and long-term care services to manage the often complex medical, functional, and social needs of the frail elderly. PACE was created as a way to provide clients, family, caregivers and professional health care providers the flexibility to meet a person's health care needs while continuing to live safely in the community.[5] The purpose of a PACE program is to provide comprehensive health care services that are designed to:

- Enhance the quality of life and autonomy for frail, older adults;
- Maximize dignity of and respect for older adults;
- Enable frail, older adults to live in their homes and in the community as long as medically and socially feasible; and
- Preserve and support the older adult's family unit.[6]

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[1] Pub. L. 105-33.
[2] Services under the PACE program are authorized under Section 1905(a)(26) of the Social Security Act.
[3] Department of Health and Human Services, Centers for Medicare and Medicaid Services, CMS Manual System: Pub. 100-11 Programs of All-Inclusive Care for the Elderly (PACE) Manual (issued 6-9-2011), available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pace111c01.pdf (last accessed January 10, 2020).
[4] Department of Elder Affairs and Agency for Health Care Administration, *Program of All-Inclusive Care for the Elderly and Statewide Medicaid Managed Care Long-term Care Program Comparison Report* (Jan. 14, 2014), available at http://ahca.myflorida.com/docs/PACE_Evaluation_2014.pdf (last accessed January 10, 2020).
[5] Supra note 3.
[6] Supra note 4.

In Florida, the PACE is operated cooperatively by the Department of Elderly Affairs (DOEA) and the Agency for Healthcare Administration (AHCA). DOEA is the operating entity and oversees the participating PACE organizations, while AHCA is formally responsible for maintaining the PACE agreement with the federal government. DOEA, AHCA, and the federal Centers for Medicare and Medicaid Services (CMS) must approve any application for new PACE agreements, as well as any expansion of current PACE organizations.[7]

PACE Organizations

A PACE organization is a not-for-profit, for-profit private or public entity that is primarily engaged in providing PACE services. For-profit entities operating PACE organizations do so under demonstration authority. The following characteristics also apply to a PACE organization. It must:

- Have a governing body or a designated person functioning as a governing body that includes participant representation.
- Be able to provide the complete service package regardless of frequency or duration of services.
- Have a physical site and staff to provide primary care, social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals.
- Have a defined service area.
- Have safeguards against conflict of interest.
- Have demonstrated fiscal soundness.
- Have a formal participant bill of rights.
- Have a process to address grievances and appeals.[8]

Before being approved to operate and deliver services, PACE organizations are required to provide evidence of the necessary financial capital to deliver the benefits and services, which include a combined adult day care center and primary care clinic, transportation, and full range of clinical and support staff with the interdisciplinary team of professionals.[9]

Eligibility and Benefits

Under federal program rules, PACE participants must:

- Be age 55 or older.
- Reside in the PACE organization's service area.
- Be certified as eligible for nursing home care by their state and be able to live safely in a community setting at the time of enrollment.

Eligible beneficiaries who choose to enroll in PACE agree to forgo their usual sources of care and receive all their services through the PACE organization. PACE provides participants all the care and services covered by Medicare and Medicaid, as well as additional medically-necessary care and services not covered by Medicare and Medicaid. There are no limitations or condition as to amount, duration or scope of services and there are no deductibles, copayments, coinsurance, or other cost sharing that would otherwise apply under Medicare or Medicaid.

Under the PACE, an interdisciplinary team consisting of professional and paraprofessional staff assesses participants' needs, develops care plans, and delivers all services, including acute care and nursing facility services when necessary, which are integrated to provide a seamless delivery model. The benefit package for all PACE participants includes:

[7] Id.
[8] Id.
[9] Id.

- Primary Care;
- Hospital Care;
- Medical Specialty Services;
- Prescription Drugs (including Medicare Part D drugs);
- Nursing Home Services;
- Nursing Services;
- Personal Care Services;
- Emergency Services;
- Home Care;
- Physical Therapy;
- Occupational Therapy;
- Adult Day Health Care;
- Recreational Therapy;
- Meals;
- Dental Care;
- Nutritional Counseling;
- Social Services;
- Laboratory/X-Ray;
- Social Work Counseling;
- End of Life Care and Transportation.

In most cases, the comprehensive service package permits participants to continue living at home rather than be institutionalized.[10]

Quality of Care

Each PACE organization is responsible for identifying areas in which to improve service delivery and patient care as well as developing and implementing plans of action to improve or maintain quality of care. Such activities are documented in the PACE organization's Quality Assessment and Performance Improvement (QAPI) plan. The QAPI plan must demonstrate improved performance in regard to five areas:

- Utilization of services in the PACE organization, especially in key services.
- Participant and caregiver satisfaction with services.
- Data collected during patient assessments to determine if individual and organizational-level outcomes were achieved within a specified time period.
- Effectiveness and safety of direct and contracted services delivered to participants.
- Outcomes in the organization's non-clinical areas.[11]

Florida PACE Project

The Florida PACE project provides alternative, long-term care options for elders who qualify for Medicare and the state Medicaid program. Florida's first PACE organization was located in Miami-Dade County and began serving enrollees in February 2003 with a total of150 slots. Since then, the Legislature has approved additional slots either as part of the GAA or general law. Currently, PACE organizations with funded slots exist in these Florida counties: Baker, Broward, Charlotte, Clay, Collier, Desoto, Duval, Lee, Miami-Dade, Palm Beach, Pinellas, Manatee, Martin, Nassau, Sarasota, and St. John's.

In 2011, the Legislature moved administrative responsibility for the PACE program from the DOEA to the AHCA as part of the expansion of Medicaid managed care into the Statewide Medicaid Managed

[10] Id.
[11] Supra note 5.

Care program (SMMC).[12] Participation by PACE in SMMC is not subject to the procurement requirements or regional plan number limits normally applicable to SMMC managed care plans. Instead, PACE plans may continue to provide services to individuals at such levels and enrollment caps as authorized by the General Appropriations Act (GAA).[13]

The current PACE approval process requires any entity interested in becoming a PACE organization to submit a comprehensive PACE application to the AHCA, which sets forth details about the adult day care center, staffing, provider network, financial solvency and pro forma financial projections, and policies and procedures, among other elements. The application is similar in detail to the provider applications submitted by managed care plans seeking to provide medical care to Medicaid recipients. Providers operating in the same geographic region must establish that there is adequate demand for services so that each provider will be viable. The application requires that documentation be submitted demonstrating that neither provider is competing for the same potential enrollees.

The AHCA and the DOEA review the application and, when the entity has satisfied all requirements, conduct an on-site survey of the entity's readiness to serve PACE enrollees. Once all requirements are met, including full licensure of the center, staffing for key positions, and signed provider network contracts, the AHCA certifies to federal CMS that the PACE site is ready. At that time, CMS reviews the application and readiness certification and, if all requirements are satisfied, executes a three-way agreement with the PACE provider and the AHCA. The PACE provider may then begin enrolling members, subject to an appropriation to fund the slots.

Funding

Each year since the PACE's inception, the Legislature has appropriated funds for PACE organizations through the state's General Appropriations Act (GAA).[14] The 2019-2020 GAA provided just under $67 million in PACE program funding to PACE organizations around the state.[15] The following table includes allocation and enrollment information outlined in the 2019-2020 GAA.

Current PACE Programs[16]				
PACE Organization		**Enrollment**		
Service Area	**Organization**	**Authorized Slots**	**Funded Slots**	**Enrollment (Dec. 2019)**
Broward	Florida PACE	150	125	147
Charlotte	Hope Select PACE	150	150	99
Collier	Hope Select PACE	120	120	82
Duval	Northeast PACE Partners	100	100	0
Lee	Hope Select PACE	380	380	285
Martin	Morse PACE	75	75	0
Miami-Dade	Florida PACE	809	809	780
Orange	Cornerstone PACE	150	150	0
Palm Beach	Morse PACE	656	656	617
Pinellas	Suncoast Neighborly PACE	325	325	325
Statewide Totals		**2,915**	**2,890**	**2,335**

[12] Chapter 2011-135, s. 24, L.O.F., repeals s. 430.707, F.S., effective Oct. 1, 2013.
[13] Section 409.981(4), F.S.
[14] Chapter 2013-40, L.O.F.
[15] Chapter 2019-115, L.O.F.
[16] E-mail correspondence from Brian Clark, Budget Chief for the House Health Care Appropriations Subcommittee. January 10, 2020 (on file with staff of the Health Market Reform Subcommittee).

PACE organizations receive a capitated Medicaid payment for each enrolled Medicaid long-term care recipient and an enhanced Medicare payment for Medicare enrollees for acute care services from the federal government.

Effect of Proposed Changes

HB 833 creates s. 430.84, F.S., and codifies the Program of All-Inclusive Care for the Elderly (PACE). The program is not currently outlined in statute and has been operationalized through the annual appropriations process.

Program Parameters

The bill authorizes the AHCA, in consultation with the DOEA, to approve organizations who have submitted the required application and data to CMS as PACE organizations pursuant to 42 U.S.C. s. 1395eee (2019). Applications, as required by CMS, will be reviewed by the AHCA on an ongoing basis, in consultation with the DOEA for initial approval as PACE organizations. Notice of applications must also be published in the Florida Administrative Register.

A prospective PACE organization must submit an application to the AHCA before submitting a request for program funding. An applicant for a PACE program must do the following:

- Provide evidence that the applicant can meet all of the federal regulations and requirements established by CMS by the proposed implementation date.
- Provide market studies which include an estimate of the potential number of participants and which show the geographic area the applicant proposes to serve.
- Develop a business plan of operation, including pro forma financial statement and projections based on the planned implementation date.
- Show evidence of regulatory compliance and meet market studies requirements, if applicant is an existing PACE organization which seeks to expand to an additional service area.
- Implement program within 12 months after date of initial state approval if granted authorization as a prospective PACE organization or such approval is void.

Quality of Care

The bill requires that all PACE organizations meet specific quality and performance standards, as established by CMS. The bill designates AHCA as the state agency responsible for oversight of PACE organizations with regard to data reporting requirements.

Because the bill codifies current practices, it has no substantive effect on the PACE program.

The bill provides an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Creates s. 430.84, F.S.; relating to Program of All-Inclusive Care for the Elderly.
Section 2: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None. While AHCA may approve PACE organizations under the bill, approval does not create new PACE enrollment slots or expenditures. The Legislature will continue to make program scope and funding decisions through the appropriations process.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

Current law appears to provide AHCA with sufficient rule-making authority to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to the Program of All-Inclusive Care for the Elderly; creating s. 430.84, F.S.; providing definitions; authorizing the Agency for Health Care Administration, in consultation with the Department of Elderly Affairs, to approve entities applying to deliver PACE services in the state; requiring notice of applications in the Florida Administrative Register; providing specified application requirements for such prospective PACE organizations; requiring existing PACE organizations to meet specified requirements under certain circumstances; requiring prospective PACE organizations to submit a complete application to the agency and the Centers for Medicare and Medicaid Services within a specified period; requiring that PACE organizations meet certain federal quality and performance standards; requiring the agency to oversee and monitor the PACE program and organizations; providing that a PACE organization is exempt from certain requirements; providing an effective date.

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

Section 1. Section 430.84, Florida Statutes, is created to

read:

430.84 Program of All-Inclusive Care for the Elderly.—

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

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

(b) "Applicant" means an entity that has filed an application with the agency for consideration as a Program of All-Inclusive Care for the Elderly (PACE) organization.

(c) "CMS" means the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services.

(d) "Department" means the Department of Elderly Affairs.

(e) "PACE organization" means an entity under contract with the agency to deliver PACE services.

(f) "Participant" means an individual receiving services from a PACE organization who has been determined by the department to need the level of care required under the state Medicaid plan for coverage of nursing facility services.

(2) PROGRAM CREATION.—The agency, in consultation with the department, may approve entities that have submitted applications required by the CMS to the agency for review and consideration which contain the data and information required in subsection (3) to provide benefits pursuant to the PACE program as established in 42 U.S.C. s. 1395eee and in accordance with the requirements set forth in this section.

(3) PACE ORGANIZATION SELECTION.—The agency, in consultation with the department, shall, on a continuous basis, review and consider applications required by the CMS for PACE that have been submitted to the agency by entities seeking initial, state approval to become PACE organizations. Notice of such applications shall be published in the Florida Administrative Register.

(a) A prospective PACE organization shall submit application documents to the agency before requesting program funding. Application documents submitted to and reviewed by the agency, in consultation with the department, must include all of the following:

1. Evidence that the applicant has the ability to meet all of the applicable federal regulations and requirements, established by the CMS, for participation as a PACE organization by the proposed implementation date.

2. Market studies, including an estimate of the number of potential participants and the geographic service area in which the applicant proposes to serve.

3. A business plan of operation, including pro forma financial statements and projections, based on the proposed implementation date.

(b) Each applicant must propose to serve a unique and defined geographic service area without duplication of services or target populations. No more than one PACE organization may be

authorized to provide services within any unique and defined geographic service area.

(c) An existing PACE organization seeking authority to serve an additional geographic service area not previously authorized by the agency or Legislature, shall meet the requirements set forth in paragraphs (a) and (b).

(d) Any prospective PACE organization that is granted initial, state approval by the agency, in consultation with the department, shall submit its complete federal PACE application, in accordance with the application process and guidelines established by the CMS, to the agency and the CMS within 12 months after the date of initial, state approval, or such approval is void.

(4) ACCOUNTABILITY.—All PACE organizations must meet specific quality and performance standards established by the CMS for the PACE program. The agency shall oversee and monitor the PACE program and organizations based upon data and reports periodically submitted by PACE organizations to the agency and the CMS. A PACE organization is exempt from the requirements of chapter 641.

Section 2. This act shall take effect July 1, 2020.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 955 Physician Referrals
SPONSOR(S): Shoaf and others
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	11 Y, 2 N	McElroy	McElroy
2) Criminal Justice Subcommittee	13 Y, 1 N	Padgett	Hall
3) Health & Human Services Committee		McElroy	Calamas

SUMMARY ANALYSIS

Healthcare providers routinely refer patients to other healthcare providers if more specialized care is required. The Florida Patient Self-Referral Act of 1992 (Act) prohibits a Florida health care provider from referring a patient to an entity in which the health care provider holds an investment interest. There are limited exceptions to this prohibition, including an exception which allows health care providers to refer patients to hospitals in which the health care provider holds an investment interest.

Florida also prohibits a health care provider from offering, paying, soliciting or receiving a kickback, directly or indirectly, overtly or covertly, in cash or in kind for referring or soliciting a patient. Violations of the prohibition are considered patient brokering.

A Preferred Provider Organization (PPO) contracts with a network of health providers who participate for an alternative or reduced rate of payment. Generally, the member is responsible only for required cost-sharing if covered services are obtained from contracted (participating, preferred, or network) providers. A Health Maintenance Organization (HMO) provides health care services pursuant to contractual arrangements with preferred providers who have agreed to supply services to members at pre-negotiated rates. Traditionally, an HMO member must use the HMO's network of health care providers in order for the HMO to make payment of benefits. Currently, a health care provider is not required to notify a patient when the referred health care provider is an out-of-coverage provider.

HB 955 prohibits a health care provider from referring patients to any hospital in which the health care provider holds an investment interest. This eliminates the special exception in the law for hospitals and an individual or entity that participates in any such referral may now also be subject to the anti-kickback and felony patient brokering statutes.

The bill also requires health care providers to give a written notice to a patient any time the health care provider refers a patient to a provider not covered by the patient's insurance.

The bill has no fiscal impact on state or local governments.

The bill provides an effective date of January 1, 2021.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Florida Patient Self-Referral Act of 1992

The Patient Self-Referral Act of 1992 (Act) prohibits the referral of patients by a health care provider to an entity that the referring health care provider holds a financial interest, if the financial interest is a type that is regulated by the Act and an exemption does not apply.[1] The prohibition against patient self-referral stems from a concern that a health care practitioner with a personal financial involvement may overutilize health care services, thus driving up the cost of health care and possibly adversely affecting quality.[2]

The Act does not apply to certain financial interests, including an investment interest in an entity which owns or leases and operates a hospital.[3] For those financial interests subject to the Act, a health care provider is prohibited from referring a patient to an entity that the health care provider has an investment interest, unless:[4]

- For entities whose shares are publicly traded:
  - The provider's investment interest is in registered securities purchased on a national exchange or over-the-counter market and issued by a publicly held corporation; and
  - The entities total assets at the end of the corporation's most recent fiscal quarter exceeded $50 million; or
- For entities other than publicly held corporations:
  - No more than 50 percent of the value of the investment interests are held by investors who are in a position to make referrals to the entity;
  - The terms under which an investment interest is offered to an investor who is in a position to make referrals to the entity are no different from the terms offered to investors who are not in a position to make such referrals;
  - The terms under which an investment interest is offered to an investor who is in a position to make referrals to the entity are not related to the previous or expected volume of referrals from that investor to the entity; and
  - There is no requirement that an investor make referrals or be in a position to make referrals to the entity as a condition for becoming or remaining an investor.

The entity in which the health care provider holds an interest must also meet the following conditions for a referral to be exempt for the Act:[5]

- The entity or corporation does not loan funds to or guarantee a loan for an investor who is in a position to make referrals to the entity or corporation if the investor uses any part of such loan to obtain the investment interest; and
- The amount distributed to an investor representing a return on the investment interest is directly proportional to the amount of the capital investment, including the fair-market value of any preoperational services rendered, and invested in the entity or corporation by that investor.

[1] S. 456.053, F.S.
[2] S. 456.053(2), F.S.
[3] S. 456.053(3)(k), F.S.
[4] S. 456.053(5)(b), F.S.
[5] *Id.*

A health care provider found to have violated the Act is subject to one or more disciplinary actions or penalties, including:

- A penalty of up to $100,000 for each arrangement if a health care provider or other entity enters into an arrangement that has the principal purpose of assuring referrals between the provider and the entity;[6]
- Discipline by his or her regulatory board (hospitals are subject to penalties imposed by the Agency for Health Care Administration (AHCA));[7] and
- Being charged with a first degree misdemeanor[8] and subject to additional penalties and disciplinary action by his or her respective board if a health care provider fails to comply with the notice provisions of the Act and s. 456.052, F.S., which requires a physician to disclose to a patient if he or she has a financial interest in an entity to which the patient is being referred.[9]

A health care provider may not submit a claim for payment for a services provided pursuant to a referral prohibited by the Act; and if the provider receives payment for such services, he or she must be refund the payment.[10] Additionally, any person who knows or should know that such a claim is prohibited and who presents or causes to be presented such a claim, is subject to a fine of up to $15,000 per service to be imposed and collected by that person's regulatory board.[11]

Anti-Kickback and Patient Brokering Prohibitions

Anti-Kickback Statutes

Individual health care practitioners are prohibited from providing or receiving kickbacks for referring patients. Section 395.0185, F.S., prohibits any person from paying a commission, bonus, kickback,[12] or rebate or engaging in any form of split-fee arrangement with a physician, surgeon, organization, or person for patients referred to a licensed facility.[13] A health care provider is also specifically prohibited from offering, paying, soliciting or receiving a kickback, directly or indirectly, overtly or covertly, in cash or in kind for referring or soliciting a patient.[14]

Patient Brokering

Patient brokering is paying to induce, or make a payment in return for, a referral of a patient to or from a health care provider or health care facility. Such payments include commissions, bonuses, rebates, kickbacks, bribes, split-fee arrangements, in cash or in kind, provided directly or indirectly.[15] A violation of the patient brokering statute is punishable as either a first[16], second[17], or third degree felony,[18] based on the number of patients involved, and may also be remedied by an injunction. Private entities bringing

[6] S. 456.053(5)(f), F.S.
[7] S. 456.053(5)(g), F.S.
[8] A first degree misdemeanor is punishable by up to one year in jail and a $1,000 fine. Ss. 775.082 and 775.083, F.S.
[9] S. 456.053(5)(j), F.S.
[10] S. 456.053(5)(c)–(d), F.S.
[11] S. 456.053(5)(e), F.S.
[12] A kickback is a remuneration or payment, by or behalf of a health care provider to any person as an incentive or inducement to refer patients for past or future services. S. 456.054(1), F.S.
[13] The Agency for Health Care Administration (AHCA) enforces this provision and if the violator is not licensed by AHCA, the law authorizes AHCA to impose a fine of up to $1,000 nonetheless, and to recommend disciplinary action to the appropriate licensing board.
[14] S. 456.054, F.S. Violations of this provision are considered patient brokering.
[15] S. 817.505(1), F.S.
[16] A violation involving 20 or more patients is a first degree felony and a mandatory $500,000 fine. S. 817.505(4)(c), F.S. A first degree felony is punishable by up to 30 years imprisonment. S. 775.082, F.S.
[17] A violation involving between 10-19 patients is a second degree felony and a mandatory $100,000 fine. S. 817.505(4)(b), F.S. A second degree felony is punishable by up to 15 years imprisonment. S. 775.082, F.S.
[18] A violation involving fewer than 10 patients is a third degree felony and a mandatory $50,000 fine. S. 817.505(4)(a), F.S. A third degree felony is punishable by up to five years imprisonment. S. 775.082, F.S.

an action under the patient brokering statute may recover reasonable expenses, including attorney fees.[19]

Vertical Hospital Integration

When large hospitals or other medical facilities merge with one another or systematically acquire other, non-hospital, health care provider businesses, such transactions can lead to less market diversity, less competition and, sometimes, coercive monopolies.

Vertical integration broadly refers to transactions whereby a large medical entity, such as a hospital, acquires a smaller medical entity, such as a physician practice group, thereby expanding the hospital's market power. Vertical integration methods vary, including the following:

- **Complete buyout.** A hospital buys out a physician practice, including its physicians, staff, equipment, and patients. The physicians become hospital employees.
- **Asset purchase agreement.** A hospital acquires from a physician practice its channels of distribution, laboratories, equipment, or other assets.
- **Physician enterprise model.** A hospital and a physician practice enter into nonequity joint ventures together. The physicians preserve their autonomy and private practice model.[20]
- **Group practice subsidiary model.** A hospital purchases a physician practice group, but the physicians, who are not employed directly by the hospital, maintain control of the day-to-day operations of the practice group.[21]
- **Professional service agreement.** A hospital purchases a physician practice's technical component services and compensates the practice's physicians for professional services at the practice. The practice remains intact, while the hospital bills and collects professional fee-for-service revenue. The hospital compensates the practice for the services.[22]

Vertical integration has been on the rise in the last twenty years. Between 2002 and 2008 in the U.S., the share of physician practices owned by hospitals doubled,[23] and trends towards increased vertical integration continued from 2007 to 2013.[24]

Whether the trend towards vertical integration benefits consumers is heavily debated.[25] Proponents of vertical integration argue that it can improve the quality and efficiency of care by strengthening ties between physicians and hospitals and improving communication.[26]

[19] Ss. 817.505(4), (6), F.S.
[20] John W. McDaniel, The Physician Enterprise Model: A Nonemployment Alternative, ACMPE Executive View, Vol. 8, No. 1 (Spring 2012).
[21] Physicians Practice, Maintaining Independence as a Group Practice Subsidiary, https://www.physicianspractice.com/maintaining-independence-group-practice-subsidiary (last visited Feb. 4, 2020).
[22] MGMA, Physician-Hospital Alignment Models: An Evolving Lexicon, https://www.mgma.com/resources/resources/business-strategy/physician-hospital-alignment-models-an-evolving-l (last visited Feb. 4, 2020); CBIZ, Professional Services Agreement: An Alternative Strategy to Hospital Employment, https://www.cbiz.com/insights-resources/details/articleid/3197/ispreview/true/professional-services-agreement-an-alternative-strategy-to-hospital-employment-article (last visited Feb. 4, 2020).
[23] Laurence C. Baker, M. Kate Bundorf, and Daniel P. Kessler, *Vertical Integration: Hospital Ownership of Physician Practices is Associated with Higher Prices and Spending*, Health Affairs (May 2014), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.1279 (last visited Feb. 4, 2020).
[24] Cory Capps, David Dranove, and Christopher Ody, *The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending*, Journal of Health Economics (Apr. 22, 2018), https://www.sciencedirect.com/science/article/abs/pii/S016762961730485X (last visited Feb. 4, 2020).
[25] Laurence C. Baker, M. Kate Bundorf, and Daniel P. Kessler, *Vertical Integration: Hospital Ownership of Physician Practices is Associated with Higher Prices and Spending*, Health Affairs (May 2014), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.1279 (last visited Feb. 4, 2020).
[26] *Id.*

Critics of vertical integration argue that it increases a hospital's market share, potentially reducing or eliminating competition. Removing competition in the medical marketplace, in turn, may allow hospitals to raise prices to a level that harms consumers. Vertical integration may lead to:

- Hospitals increasing their market power by amassing control over a larger bundle of services;
- Hospitals depriving their rivals of a source of destination for referrals; and
- Heightened incentives for physicians to supply unnecessary treatments to pay for kickbacks for inappropriate referrals.[27]

One study of the trends and effects of vertical integration in the U.S. found that some loose forms of vertical integration might be socially beneficial. However, the study concluded that vertical integration causes increased healthcare costs:

> Taken together, our results provide a mixed, although somewhat negative, picture of vertical integration from the perspective of the privately insured. Our most definitive finding is that hospital ownership of physician practices leads to higher prices and higher levels of hospital spending.[28]

Similarly, another recent study found that hospital acquisitions of physician practices were responsible for an average price increase of 14.1% in fees for physician services, with larger increases where the acquiring hospital was more dominant within its market. The study estimated nearly half of the price increases were due to the exploitation of "facility fees," which hospitals are allowed to charge for procedures performed by hospital-owned physician groups.[29] The study concluded:

> Overall, we believe these results paint a relatively negative picture of hospital-physician VI [vertical integration]. However, given the evolving nature of healthcare reimbursement systems, future analyses will be important.[30]

Vertical integration also increases the likelihood that a health care provider will refer a patient to a hospital for services even though less expensive and higher quality alternatives are available. For example, one study found that orthopedic surgeons working in a hospital-owned practice were 27% more likely to refer patients to hospital-based MRI scans which were $277.19 more expensive.[31] Another study found that patients were more likely to choose a high-cost, low-quality hospital when the admitting physician's practice is owned by that hospital.[32]

Health Insurance Networks

Preferred Provider Organization[33]

A Preferred Provider Organization (PPO) is a health plan that contracts with providers, such as hospitals and doctors, to create a network of providers who participate for an alternative or reduced rate of payment. Generally, the member is only responsible for the policy co-payment, deductible, or co-insurance amounts if covered services are obtained from network providers. However, if a member

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[27] *Id.*
[28] *Id.*
[29] Cory Capps, David Dranove, and Christopher Ody, *The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending*, JOURNAL OF HEALTH ECONOMICS (Apr. 22, 2018), https://www.sciencedirect.com/science/article/abs/pii/S016762961730485X (last visited Feb. 4, 2020).
[30] *Id.*
[31] Michael Chernew, Zack Cooper, Eugene Larsen-Hallock and Fiona Scott Morton, *"Are Health Care Services Shoppable? Evidence from the Consumption of Lower-Limb MRI Scans"* Yale Institution for Social and Policy Studies (July 30, 2018), https://pdfs.semanticscholar.org/4d16/0450b82516df29fa3dded778919b77b49a88.pdf (last visited Feb. 4, 2020).
[32] Baker, Laurence C. & Bundorf, M. Kate & Kessler, Daniel P., 2016. *"The effect of hospital/physician integration on hospital choice,"* Journal of Health Economics, Elsevier, vol. 50(C), https://www.sciencedirect.com/journal/journal-of-health-economics/vol/50/suppl/C (last visited Feb. 4, 2020).
[33] *See generally* s. 627.6471, F.S.

chooses to obtain services from an out-of-network provider, those out-of-pocket costs likely will be higher. Currently, a health care provider is not required to notify a patient that the referred health care provider is an out-of-coverage provider.

Health Maintenance Organization[34]

A Health Maintenance Organization (HMO) is an organization that provides a wide range of health care services, including emergency care, inpatient hospital care, physician care, ambulatory diagnostic treatment and preventive health care pursuant to contractual arrangements with preferred providers in a designated service area. The network is made up of providers who have agreed to supply services to members at pre-negotiated rates. Traditionally, an HMO member must use the HMO's network of health care providers in order for the HMO to make payment of benefits. The use of a health care provider outside the HMO's network generally results in the HMO limiting or denying the payment of benefits for out-of-network services rendered to the member.[35] Currently, a health care provider is not required to notify a patient that the referred health care provider is an out-of-coverage provider.

Effect of Proposed Changes

HB 955 prohibits a health care provider from referring patients to any hospital in which the health care provider holds an investment interest. This eliminates the special exception in the law for hospitals. An individual or entity that refers patients in violation of the limitations in the bill is subject to penalties under the anti-kickback and felony patient brokering statutes, punishable as a first, second, or third degree felony and a mandatory fine.

The bill also requires health care providers to give a written notice to a patient any time the health care provider refers a patient to a provider not covered by the patient's insurance.

The bill provides an effective date of January 1, 2021.

B. SECTION DIRECTORY:

Section 1: Amends s. 456.053, F.S., relating to financial arrangements between referring health care providers and providers of health care services.
Section 2: Amends s. 456.0575, F.S., relating to duty to notify patients.
Section 3: Provides an effective date of January 1, 2021.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

[34] *See generally* part I of ch. 641, F.S.
[35] Section 641.31(38), F.S., creates an exception to this general rule. It authorizes an HMO to offer a point-of-service benefit. The benefit, offered pursuant to a rider, enables a subscriber to select, at the time of service and without referral, a nonparticipating provider for a covered service. The HMO may require the subscriber to pay a reasonable co-payment for each visit for services provided by a nonparticipating provider.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

DOH has sufficient rulemaking authority to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to physician referrals; amending s. 456.053, F.S.; revising the definition of the term "investment interest" to delete a provision exempting investment interests in an equity that owns or leases and operates licensed hospitals; authorizing a health care provider to refer a patient to a licensed hospital owned or leased and operated by an entity in which the provider has an investment interest; amending s. 456.0575, F.S.; requiring a health care practitioner to notify a patient in writing upon referring the patient to certain providers; providing requirements for such notice; providing an effective date.

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

Section 1. Paragraph (k) of subsection (3) and paragraph (b) of subsection (5) of section 456.053, Florida Statutes, are amended to read:

456.053 Financial arrangements between referring health care providers and providers of health care services.—

(3) DEFINITIONS.—For the purpose of this section, the word, phrase, or term:

(k) "Investment interest" means an equity or debt security

issued by an entity, including, without limitation, shares of stock in a corporation, units or other interests in a partnership, bonds, debentures, notes, or other equity interests or debt instruments. The following investment interests shall be excepted from this definition:

1. An investment interest in an entity that is the sole provider of designated health services in a rural area;

2. An investment interest in notes, bonds, debentures, or other debt instruments issued by an entity which provides designated health services, as an integral part of a plan by such entity to acquire such investor's equity investment interest in the entity, provided that the interest rate is consistent with fair market value, and that the maturity date of the notes, bonds, debentures, or other debt instruments issued by the entity to the investor is not later than October 1, 1996;~~.~~

3. An investment interest in real property resulting in a landlord-tenant relationship between the health care provider and the entity in which the equity interest is held, unless the rent is determined, in whole or in part, by the business volume or profitability of the tenant or exceeds fair market value; or

4. An investment interest in an entity which owns or leases and operates ~~a hospital licensed under chapter 395 or~~ a nursing home facility licensed under chapter 400.

(5) PROHIBITED REFERRALS AND CLAIMS FOR PAYMENT.—Except as

provided in this section:

(b) A health care provider may not refer a patient for the provision of any other health care item or service to an entity in which the health care provider is an investor unless:

1. The provider's investment interest is in registered securities purchased on a national exchange or over-the-counter market and issued by a publicly held corporation:

a. Whose shares are traded on a national exchange or on the over-the-counter market; and

b. Whose total assets at the end of the corporation's most recent fiscal quarter exceeded $50 million; ~~or~~

2. With respect to an entity other than a publicly held corporation described in subparagraph 1., and a referring provider's investment interest in such entity, each of the following requirements are met:

a. No more than 50 percent of the value of the investment interests are held by investors who are in a position to make referrals to the entity.

b. The terms under which an investment interest is offered to an investor who is in a position to make referrals to the entity are no different from the terms offered to investors who are not in a position to make such referrals.

c. The terms under which an investment interest is offered to an investor who is in a position to make referrals to the entity are not related to the previous or expected volume of

referrals from that investor to the entity.

d. There is no requirement that an investor make referrals or be in a position to make referrals to the entity as a condition for becoming or remaining an investor; or~~.~~

3. With respect to either such entity or publicly held corporation:

a. The entity or corporation does not loan funds to or guarantee a loan for an investor who is in a position to make referrals to the entity or corporation if the investor uses any part of such loan to obtain the investment interest.

b. The amount distributed to an investor representing a return on the investment interest is directly proportional to the amount of the capital investment, including the fair market value of any preoperational services rendered, invested in the entity or corporation by that investor.

This paragraph does not apply to a referral in which the health care provider has an investment interest in an entity that owns or leases and operates a hospital licensed under chapter 395. Additionally, ~~4.~~ each board and, in the case of hospitals, the Agency for Health Care Administration~~,~~ shall encourage the use by licensees of the declaratory statement procedure to determine the applicability of this section or any rule adopted pursuant to this section as it applies solely to the licensee. Boards shall submit to the Agency for Health Care Administration the

name of any entity in which a provider investment interest has been approved pursuant to this section.

Section 2. Subsection (2) of section 456.0575, Florida Statutes, is renumbered as subsection (3), and a new subsection (2) is added to that section to read:

456.0575 Duty to notify patients.—

(2) A health care practitioner shall notify a patient in writing upon referring the patient to a nonparticipating provider for nonemergency services, as those terms are defined in s. 627.64194(1), or to a provider, as defined in s. 641.47, that is not under contract with the patient's health maintenance organization. Such notice must state that the services will be provided on an out-of-network basis, which may result in additional cost-sharing responsibilities for the patient, and such notice must be documented in the patient's medical record. Failure to comply with this subsection, without good cause, shall result in disciplinary action against the health care practitioner.

Section 3. This act shall take effect January 1, 2021.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1083 Student Mental Health Procedures
SPONSOR(S): PreK-12 Innovation Subcommittee, Webb and others
TIED BILLS: None **IDEN./SIM. BILLS:** SB 1062

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) PreK-12 Innovation Subcommittee	17 Y, 0 N, As CS	McAlarney	Brink
2) Health & Human Services Committee		Morris	Calamas
3) Education Committee			

SUMMARY ANALYSIS

Traditional public and charter school principals have a duty to notify a parent when a student is removed from school grounds, school transportation, or a school-sponsored activity and taken to a receiving facility for involuntary examination. The bill adds to this duty by requiring a principal to also verify that de-escalation strategies have been used with the student and outreach to a mobile response team has been initiated prior to the student's removal.

The bill provides an exemption from this verification requirement when a principal reasonably believes that any delay in the student's removal will increase the likelihood of harm to the student or others.

The bill has no fiscal impact to state or local governments.

The bill has an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Parental Notification of Involuntary Examinations

Florida law requires K-12 public schools to give parents "accurate and timely information regarding their child's academic progress" and to inform parents "of ways they can help their child to succeed in school."[1] To inform parents and enable them to direct and control their child's education, current law specifies various parental notice requirements. For a traditional public or charter school student who is removed from school grounds, school transportation, or a school-sponsored activity and transported to an involuntary examination (Baker Act) receiving facility, a principal must immediately notify the student's parent.[2] However, the principal may delay notification for up to 24 hours if the principal believes it is in the student's best interest and a report has been made to the central abuse hotline pursuant to s. 39.201, F.S.[3]

Involuntary Examination "Baker Act"

A student with an acute mental health crisis may require emergency treatment to stabilize his or her condition. Florida law specifies criteria that a person must meet to be transported to a receiving facility for an involuntary examination; it also limits who may initiate the exam.[4] School personnel are not among those authorized to initiate an involuntary examination. Thus, in a school setting, often a law enforcement officer is called to evaluate the student and remove him or her from campus pursuant to s. 394.463(2)(a)2., F.S, if he or she appears to the law enforcement officer to meet criteria.

Students removed from school must be taken to either a public or a private facility that has been designated by the Department of Children and Families (DCF) as a Baker Act receiving facility. Under the Baker Act, a receiving facility must examine an involuntary patient within 72 hours of arrival.[5] During that 72 hours, an involuntary patient must be examined by a physician or a clinical psychologist, or by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist at a facility, to determine if criteria for involuntary services are met.[6] If the patient is a minor, the examination must be initiated within 12 hours.[7] Immediately after arrival, the facility is required to notify the minor's parent, guardian, caregiver, or guardian advocate.[8] The facility may delay notification for up to 24 hours if the facility believes it is in the minor's best interest and a report has been made to the central abuse hotline pursuant to s. 39.201, F.S.[9] The facility must continue notification attempts until notification is satisfied.[10]

In 2017, the Legislature created a task force within DCF[11] to address the issue of involuntary examination of minors age 17 years or younger.[12] The task force found that specific causes of

[1] Section 1002.20, F.S.
[2] Sections 1002.20(3), F.S., and 1002.33(9)(q), F.S.
[3] *Id*.
[4] Section 394.463, F.S.
[5] Section 394.463(2)(g), F.S.
[6] Section 394.463(2)(f), F.S.
[7] Section 394.463(2)(g), F.S.
[8] Section 394.4599(2)(c)1., F.S.
[9] *Id*.
[10] Section 394.4599(2)(c)2., F.S.
[11] Ch. 2017-151, L.O.F.
[12] Florida Department of Children and Families, *Task Force Report on Involuntary Examination of Minors*, (Nov. 2017), https://www.myflfamilies.com/service-programs/samh/publications/ (last visited Feb. 9, 2020).

increases in involuntary examinations of children are unknown. However, the task force provided a number of recommendations, including: increasing funding for mobile crisis teams; funding an adequate network of prevention and early intervention services so that mental health challenges are addressed prior to becoming a crisis; and requiring crisis intervention training for school resource officers and other law enforcement officers who initiate Baker Act examinations from schools.[13]

As a follow up to the 2017 task force report, in 2019, the Legislature instructed DCF to prepare a report on the initiation of involuntary examinations of minors age 17 years and younger and submit it by November 1 of each odd numbered year.[14] In the 2019 report, DCF recommended, among other things, ensuring that parents receive information about mobile crisis response teams and other community resources and supports upon child's discharge.[15]

Behavioral Health Crisis Management

To provide mental health and substance abuse services, DCF administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment, and recovery for children and adults who are otherwise unable to obtain these services. DCF contracts with seven managing entities (ME) across the state that in turn contract with local service providers[16] for the delivery of mental health and substance abuse services.[17] In FY 2018-2019, the network service providers under contract with the MEs served 339,093 individuals.[18]

MEs promote the development and implementation of a coordinated system of care[19] to enhance crisis services based on the no-wrong-door model or to meet specific needs identified in DCF's assessment of behavioral health services in this state.[20] There are several essential elements which make up a coordinated system of care, including crisis services mobile response teams, among others.[21]

Mobile response teams (MRT) provide readily available crisis care in a community-based setting and increase opportunities to stabilize individuals in the least restrictive setting to avoid the need for jail or hospital/emergency department utilization.[22] MRT providers are responsible for working with stakeholders to develop a community plan for immediate response and de-escalation, but also crisis and safety planning.[23] MRTs are available to individuals 25 years of age and under, regardless of their ability to pay, and must be ready to respond to any mental health emergency.[24] In 2018, there were 40 MRTs serving all 67 counties in Florida, targeting services to individuals under the age of 25.[25] Recent MRT monthly reports showed an 80% statewide average of diverting individuals from involuntary examination.[26]

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[13] *Id*.
[14] Ch. 2019-134, L.O.F.
[15] Florida Department of Children and Families, *Report on Involuntary Examination of Minors, 2019*, (Nov. 2019), https://www.myflfamilies.com/service-programs/samh/publications/ (last visited Feb. 9, 2020).
[16] Managing entities create and manage provider networks by contracting with service providers for the delivery of substance abuse and mental health services.
[17] Department of Children and Families, *Managing Entities*, https://www.myflfamilies.com/service-programs/samh/managing-entities/ (last visited Feb. 9, 2020).
[18] Department of Children and Families, *Substance Abuse and Mental Health Triennial Plan Update for Fiscal Year*, (Dec. 6, 2019) *available at* https://www.myflfamilies.com/service-programs/samh/publications/docs/SAMH%20Services%20Plan%202018%20Update.pdf.
[19] Section 394.9082(5)(d), F.S.
[20] Section 394.4573(3), F.S.
[21] Section 394.4573(2), F.S.
[22] Department of Children and Families, Mobile Response Teams Framework, (August 29, 2018), https://www.myflfamilies.com/service-programs/samh/publications/docs/Mobile%20Response%20Framework.pdf.
[23] *Id*.
[24] *Id*.
[25] *Id*.
[26] *Id*.

After the Marjory Stoneman Douglas High School shooting in 2018, school mental health services began focusing on training educators on how to de-escalate crisis.[27] De-escalation is "the reduction in the intensity of a conflict."[28] De-escalation training provides individuals with strategies to calmly deal with people who are experiencing mental crisis. De-escalation teaches individuals dealing with a person in crisis to use non-physical skills such as listening distracting the person, re-focusing the person on something positive, changing the subject, and empathizing with the person to defuse a potentially dangerous situation.[29]

Effects of Proposed Changes

Traditional public and charter school principals have a duty to notify a parent when a student is transported from school grounds, school transportation, or a school-sponsored activity and taken to a receiving facility for involuntary examination. The bill adds to this duty by requiring a principal to also verify that de-escalation strategies have been used with the student and outreach to a mobile response team has been initiated prior to the student's removal.

The bill provides an exemption from this verification when a principal reasonably believes that any delay in the student's removal will increase the likelihood of harm to the student or others.

The bill provides an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Amends s. 1002.20, F.S., relating to K-12 student and parent rights.
Section 2: Amends s. 1002.33, F.S., relating to charter schools.
Section 3: Provides an effective date of July 1, 2020.

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.

[27] EducationDive, *De-escalation strategies effective in working with traumatized students*, https://www.educationdive.com/news/de-escalation-strategies-effective-in-working-with-traumatized-students/519911/ (last visited Feb. 9, 2020).
[28] Florida Department of Children and Families, Center for Child Welfare, *Verbal De-escalation Training Video*, Part 2, at 8:11, August 8, 2014, *available at* http://centervideo.forest.usf.edu/verbaldeescalation/start.html.
[29] Northeast Washington Education Service District 101, Risk Management Services, *Using Verbal De-Escalation*, *available at* https://personnel.ky.gov/KEAP/Verbal%20De-escalation%20presentation.pdf.

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Current law contains sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 4, 2020, the PreK-12 Innovation Subcommittee adopted a proposed committee substitute (PCS) and reported the bill favorably. The PCS differs from HB 1083 in the following ways:

- Requires that a principal verify that de-escalation strategies have been used and outreach to a MRT has been initiated prior to a student's removal, and allows a delay in notification if it is in the student's best interest and a report has been submitted to the central abuse hotline.
- Deletes the requirement that a principal notify a parent before a student's removal.
- Deletes state and local data reporting requirements.
- Deletes the requirement that the least restrictive mode of restraint be used when a student is transported for involuntary examination.
- Deletes the provision requiring crisis intervention training for school safety officers.
- Removes the provision requiring a school district's mental health allocation plan include procedures for verbal de-escalation.
- Deletes the provision that a school district must have Memorandums of Understanding with MRTs and that district policy must mandate MRTs are contacted prior to initiating a Baker Act.

The bill analysis is drafted to the committee substitute adopted by the PreK-12 Innovation Subcommittee.

A bill to be entitled

An act relating to student mental health procedures; amending ss. 1002.20 and 1002.33, F.S.; requiring verification that certain strategies have been utilized and certain outreach has been initiated before a student is removed from school, school transportation, or a school-sponsored activity under specified circumstances; providing an exception; providing an effective date.

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

Section 1. Paragraph (l) of subsection (3) of section 1002.20, Florida Statutes, is amended to read:

1002.20 K-12 student and parent rights.—Parents of public school students must receive accurate and timely information regarding their child's academic progress and must be informed of ways they can help their child to succeed in school. K-12 students and their parents are afforded numerous statutory rights including, but not limited to, the following:

(3) HEALTH ISSUES.—

(l) Notification of involuntary examinations.—The public school principal or the principal's designee shall immediately notify the parent of a student who is removed from school, school transportation, or a school-sponsored activity and taken

to a receiving facility for an involuntary examination pursuant to s. 394.463. The principal or the principal's designee may delay notification for no more than 24 hours after the student is removed if the principal or the principal's designee deems the delay to be in the student's best interest and if a report has been submitted to the central abuse hotline, pursuant to s. 39.201, based upon knowledge or suspicion of abuse, abandonment, or neglect. Before a student is removed from school, school transportation, or a school-sponsored activity, the principal or the principal's designee must verify that de-escalation strategies have been utilized and outreach to a mobile response team has been initiated, unless the principal or the principal's designee reasonably believes that any delay in removing the student will increase the likelihood of harm to the student or others. Each district school board shall develop a policy and procedures for notification under this paragraph.

Section 2. Paragraph (q) of subsection (9) of section 1002.33, Florida Statutes, is amended to read:

1002.33 Charter schools.—

(9) CHARTER SCHOOL REQUIREMENTS.—

(q) The charter school principal or the principal's designee shall immediately notify the parent of a student who is removed from school, school transportation, or a school-sponsored activity and taken to a receiving facility for an involuntary examination pursuant to s. 394.463. The principal or

the principal's designee may delay notification for no more than 24 hours after the student is removed if the principal or the principal's designee deems the delay to be in the student's best interest and if a report has been submitted to the central abuse hotline, pursuant to s. 39.201, based upon knowledge or suspicion of abuse, abandonment, or neglect. Before a student is removed from school, school transportation, or a school-sponsored activity, the principal or the principal's designee must verify that de-escalation strategies have been utilized and outreach to a mobile response team has been initiated, unless the principal or the principal's designee reasonably believes that any delay in removing the student will increase the likelihood of harm to the student or others. Each charter school governing board shall develop a policy and procedures for notification under this paragraph.

Section 3. This act shall take effect July 1, 2020.

HB 1147

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1147 Patient Access to Records
SPONSOR(S): Payne
TIED BILLS: **IDEN./SIM. BILLS:** SB 1882

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	12 Y, 1 N	McElroy	McElroy
2) Health Care Appropriations Subcommittee	8 Y, 3 N	Nobles	Clark
3) Health & Human Services Committee		McElroy	Calamas

SUMMARY ANALYSIS

Patient engagement in their healthcare leads to better health outcomes, reduces administrative costs and increases patient satisfaction through better communication with providers. Patient access to treatment records is necessary for active engagement to occur. The use of electronic health records, patient portals and electronic personal health records by providers and patients facilitates access and, by default engagement.

Florida has enacted laws governing patient access to records; however these laws lack standardization. The right to inspect records, whether the records have to be produced in paper form or electronically, and the timeframe to produce copies are different depending on which kind of health care facility or health care practitioner is involved.

HB 1147 allows patients, residents and legal representatives to control how they receive requested records. Health care providers and facilities may produce the requested records in paper or electronic format, upon request. However, health care providers and facilities must produce the requested records in an electronic format, including access through a web-based patient portal or submission into a patient's electronic personal health record, if the health care provider or facility maintains an electronic health recordkeeping system.

The bill also standardizes access to treatment records for patients, residents and legal representatives, excluding nursing homes residents, predominantly utilizing elements of existing law or rule. It standardizes the timeframe that health care providers and facilities must produce records or allow inspection of records. All health care practitioners and facilities must provide records within 14 days of a request. The bill also requires health care facilities and providers to allow inspection of records within 10 days.

Federal law currently requires nursing homes to provide residents with access to their records within 24 hours (excluding holidays and weekends) and a copy of any requested records within two working days of request. The bill incorporates these timelines into Florida law.

The bill has no fiscal impact on state or local governments.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Access to Medical and Clinical Records – Federal Law

Health Insurance Portability and Accountability Act

The federal Health Insurance Portability and Accountability Act (HIPAA), enacted in 1996, protects personal health information (PHI).[1] In 2000, the U.S. Department of Health and Human Services promulgated privacy rules which established national standards to protect medical records and other PHI.[2] These rules address, among other things, the use and disclosure of an individual's PHI.

Only certain entities are subject to HIPAA's provisions. These "covered entities" include:

- Health plans;
- Health care providers;
- Health care clearinghouses; and
- Business associates of any of the above.[3]

HIPAA requires the disclosure of an individual's PHI to the individual who is the subject of the PHI information or his or her personal representative,[4] upon his or her request.[5] A covered entity must produce the PHI in the electronic form and format requested by the individual, if it is readily producible in such form and format.[6]

In general, HIPAA privacy rules preempt any state law that is contrary to its provisions.[7] However, if the state law is more stringent, the state law will apply.

Requirements for Long-Term Care Facilities

Access to medical and clinical records by residents of a nursing home receiving federal funding is controlled by 42 CFR s. 483.10 not HIPAA. Such nursing homes are required to provide residents with access to their records within 24 hours (excluding holidays and weekends) and a copy of any requested records within two working days of request.[8]

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[1] Pub. L. No. 104-191 (1996). Protected health information includes all individually identifiable health information held or transmitted by a covered entity or its business associate.
[2] U.S. Department of Health and Human Services, *Health Information Privacy*, available at https://www.hhs.gov/hipaa/for-professionals/privacy/index.html (last visited January 8, 2020). The rules were modified in 2002.
[3] U.S. Department of Health and Human Services, Office for Civil Rights, *Summary of the HIPAA Privacy Rule*, (last rev. May 2003), available at https://www.hhs.gov/sites/default/files/privacysummary.pdf. (last visited January 8, 2020).
[4] Supra, FN 2. A personal representative is generally a person with authority under state law to make health care decisions on behalf of an individual.
[5] Supra, FN 3. HIPAA limits the access to psychotherapy notes, certain lab results, and information compiled for legal proceedings. A covered entity may also deny access to personal health information in certain situations, such as when a health care practitioner believes access could cause harm to the individual or others.
[6] 45 CFR § 164.524(c)(2)(i).
[7] 45 C.F.R. s. 160.203.
[8] 42 CFR s. 483.10(2)(g)

Currently, all but two of the licensed nursing homes in this state receive federal funding and would be subject to these requirements.[9] The Agency for Health Care Administration cited six nursing homes for failing to meet these requirements in 2018 and five in 2019.[10]

Access to Medical and Clinical Records – Florida Law

Facilities

Chapter 408, F.S., is the core licensure act for health care facilities. Any requirement contained within this chapter applies to all health care facilities, which includes:[11]

- Laboratories authorized to perform testing under the Drug-Free Workplace Act;
- Birth centers;
- Abortion clinics;
- Crisis stabilization units;
- Short-term residential treatment facilities;
- Residential treatment facilities;
- Residential treatment centers for children and adolescents;
- Hospitals;
- Ambulatory surgical centers;
- Nursing homes;
- Assisted living facilities;
- Home health agencies;
- Nurse registries;
- Companion services or homemaker services providers;
- Adult day care centers;
- Hospices;
- Adult family-care homes;
- Homes for special services;
- Transitional living facilities;
- Prescribed pediatric extended care centers;
- Home medical equipment providers;
- Intermediate care facilities for persons with developmental disabilities;
- Health care services pools;
- Health care clinics; and,
- Multiphasic health testing centers.

Currently, Chapter 408 does not include a statute establishing standard requirements for health care facilities to produce, or allow inspection of, a patient's or resident's medical, clinical and interdisciplinary records. Rather, the requirements are in each facility licensure act and vary, sometimes greatly. Some health care facilities do not have statutory requirements related to a patient's access to records.

Hospitals, Ambulatory Surgical Centers, and Mobile Surgical Centers

After a patient has been discharged, a licensed hospital, ambulatory surgical center, and mobile surgical center (licensed facility) must, upon written request, timely provide patient records in its possession to the patient.[12] The records may also be released to the patient's guardian, curator, or personal representative, or in the absence of one of those persons, to the next of kin of a decedent or the parent of the minor, or to any other person designated in writing by such patient. A licensed facility

[9] Correspondence from the Agency for Health Care Administration to committee staff dated March 31, 2019, on file with the Health and Human Services Committee.
[10] Correspondence from the Agency for Health Care Administration to committee staff dated January 10, 2020, on file with the Health and Human Services Committee.
[11] Ss. 408.803(11) F.S., and 408.802, F.S.
[12] S. 395.3025, F.S. This does not apply to facilities that primarily provide psychiatric care or certain clinical records created at any licensed facility concerning certain mental health or substance abuse services.

must also allow a patient or their representative access to examine the records in its possession, but may establish reasonable terms to assure that the records will not be damaged, destroyed, or altered.[13] There is no statutorily established timeframe for when a licensed facility must provide this access.

Nursing Homes

Upon request, a nursing home must provide a competent resident with a copy of any paper and electronic records of the resident which it has in its possession.[14] Such records must include any medical records and records concerning the care and treatment of the resident performed by the nursing home, except for notes and report sections of a psychiatric nature.[15] A nursing home must provide these records within 14 days for a current resident and 30 days for a former resident.[16] A nursing home may refuse to furnish these records directly to a resident if it determines that disclosure would be detrimental to the resident's physical or mental health.[17] However, upon such a refusal, a resident may have his or her records furnished to a medical provider designated by the resident.[18]

A nursing home must also allow a resident's representative access to examine the records in its possession, but may establish reasonable terms to assure that the records will not be damaged, destroyed, or altered.[19] There is no statutorily established timeframe for when a nursing home must provide this access.

Mental Health Facilities

A clinical record is required for each patient receiving treatment for mental illness at a receiving facility[20] or treatment facility.[21] The treatment or receiving facility must release a patient's clinical records if requested by the patient, the patient's guardian or counsel or the Department of Corrections.[22] There is no statutorily timeframe for when a receiving or treatment facility must provide the requested clinical records.

Hospices

A hospice is required to release a patient's interdisciplinary record if requested by an individual authorized by the patient or by the court.[23] There is no statutorily established timeframe for when a hospice must release a patient's interdisciplinary record.

Practitioners

Unlike the law for health care facilities, health care practitioner law has standardized records access requirements that apply to all practitioners.[24] A practitioner must provide a copy of patient medical

[13] S. 395.3025(1), F.S.
[14] S. 400.145(1), F.S.
[15] Id.
[16] Id.
[17] S. 400.145(5), F.S.
[18] Id.
[19] Id.
[20] A "receiving facility" is a public or private facility or hospital designated by the Department of Children and Families to receive and hold or refer, as appropriate, involuntary patients under emergency conditions for mental health or substance abuse evaluation and to provide treatment or transportation to the appropriate service provider. S. 394.455(39), F.S.
[21] S. 394.4615(1), F.S.; A "treatment facility" is a state-owned, state-operated, or state-supported hospital, center, or clinic designated by the Department of Children and Families for extended treatment and hospitalization, beyond that provided for by a receiving facility, of persons who have a mental illness, including facilities of the United States Government, and any private facility designated by the Department of Children and Families when rendering such services. S. 394.455(47), F.S.
[22] S. 394.4615(2), F.S.
[23] S. 400.611(3), F.S.
[24] A health care practitioner is any person licensed under ch. 457, F.S., (acupuncture); ch. 458, F.S., (medical practice); ch. 459, F.S., (osteopathic medicine); ch. 460, F.S., (chiropractic medicine); ch. 461, F.S., (podiatric medicine); ch. 462, F.S., (naturopathy); ch. 463, F.S., (optometry); ch. 464, F.S., (nursing); ch. 465, F.S., (pharmacy); ch. 466, F.S., (dentistry, dental hygiene, and dental laboratories); ch. 467, F.S., (midwifery); part I, part II, part III, part V, part X, part XIII, or part XIV of ch. 468, F.S., (speech language pathology and audiology, nursing home administration, occupational therapy, respiratory therapy, dietetics and nutrition practice, athletic trainers, or orthotics, prosthetics, and pedorthics); ch. 478, F.S., (electrolysis); ch. 480, F.S., (massage practice); part III or part IV of ch. 483, F.S.,

records to the patient if requested by the patient or his or her legal representative.[25] The patient's medical records must be released without delay for legal review.

Medical Records Held by Substance Abuse Providers

A substance abuse service provider may only release records with the written consent of the individual whom they pertain.[26] However, under limited circumstances, such as a medical emergency, the service provider may release records without the consent of the individual whom they pertain.[27] There is no statutorily established timeframe for a service provider to release requested records.

Electronic Medical Records Patient Portals

Patient portals are health care provider-owned and -operated electronic applications which give patients secure access to protected health information and allow secure methods for communicating and sharing information with health care providers.[28] These portals are typically connected to the electronic health records of a particular health care provider, practice group or institution.[29]

Portals vary in sophistication ranging from those which only allow patients to view medical records to those which allow patients to access specific-patient educational materials, schedule appointments and request prescription refills.[30] Improved access to records and health care providers can promote better informed health care decision-making and patient engagement.[31]

One of the drawbacks to patient portals is the inability of patients to have a centralized repository of their health care records. Patient portals are owned by health care providers, rather than by patients, and may not be interoperable with the electronic health records of another provider. A patient who receives treatment or services from multiple health care providers or facilities could feasibly have his or her records dispersed between multiple patient portals.

Electronic Personal Health Record

An electronic personal health record (PHR) is a patient owned electronic application through which individuals can access, manage and share health information in a private, secure and confidential environment.[32] PHRs that are offered by health plans or health care providers are subject to the HIPAA privacy rule. [33] PHRs that are offered by vendors, employers and other non-covered entities are not subject to the HIPAA privacy rule. These entities have contractual privacy policies, which may vary, but are required under federal law to notify customers in the event of a security breach.[34]

(clinical laboratory personnel or medical physicists); ch. 484, F.S., (dispensers of optical devices and hearing aids); ch. 486, F.S., (physical therapy practice); ch. 490, F.S., (psychological services); or ch. 491, F.S., (clinical, counseling, and psychotherapy services).

[25] S. 456.057, F.S. In lieu of copies of certain medical records related to psychiatric or psychological treatment, a practitioner may release a report of examination and treatment.

[26] S. 397.501(7)(a), F.S.

[27] Id.

[28] Kooij, Groen, van Harten, *Barriers and Facilitators Affecting Patient Portal Implementation from an Organizational Perspective: Qualitative Study*, J Med Internet Res. 2018 May; 20(5): e183, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5970285/ (last viewed January 8, 2020).

[29] Id.

[30] Griffin, Skinner, Thornhill, Weinberger, *Patient Portals: Who uses them? What features do they use? And do they reduce hospital readmissions?*, Appl Clin Inform. 2016; 7(2): 489–501, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4941855/ (last visited on January 8, 2020).

[31] Id.

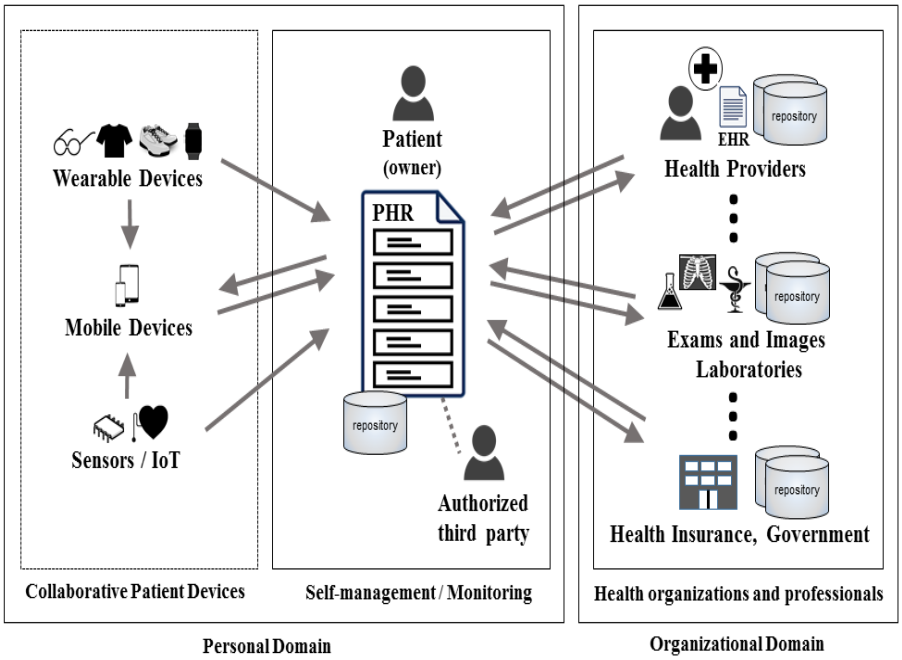
[32] Tang, Ash, Bates, Overhage, and Sands, *Personal Health Records: Definitions, Benefits, and Strategies for Overcoming Barriers to Adoption*, J Am Med Inform Assoc., 2006 Mar-Apr; 13(2): 121-126, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447551/pdf/121.pdf (last visited January 8, 2020).

[33] *Personal Health Records and the HIPAA Privacy Rule*, U.S. Department of Health and Human Services, Office for Civil Rights, available at https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/special/healthit/phrs.pdf (last visited January 8, 2020).

[34] 16 CFR § 318.3.

A PHR can be stand-alone or integrated. In a stand-alone PHR, the individual enters all information into the record.[35] This can be done manually by entering the medical data or by uploading medical records into the PHR. In an integrated PHR, information is submitted directly through electronic health care devices and through health care provider's electronic health records system.[36]

Integrated Personal Health Record[37]



Potential benefits of the use of a PHR, for patients, health care providers, and health care systems include:[38]

- **Empowerment of patients**. PHRs let patients verify the information in their medical record and monitor health data about themselves (very useful in chronic disease management). PHRs also provide scheduling reminders for health maintenance services.
- **Improved patient-provider relationships**. PHRs improve communication between patients and clinicians, allow documentation of interactions with patients and convey timely explanations of test results.
- **Increased patient safety**. PHRs provide drug alerts, help identify missed procedures and services, and get important test results to patients rapidly. PHRs also give patients timely access to updated care plans.
- **Improved quality of care**. PHRs enable continuous, comprehensive care with better coordination between patients, physicians and other providers.
- **More efficient delivery of care**. PHRs help avoid duplicative testing and unnecessary services. They provide more efficient communication between patients and physicians (e.g., avoiding congested office phones).
- **Better safeguards on health information privacy**. By giving patients control of access to their records, PHRs offer more selectivity in sharing of personal health information.
- **Bigger cost savings**. Improved documentation brought about by PHRs can decrease malpractice costs. PHRs' ability to reduce duplicative tests and services is a factor here, too.

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[35] Id.
[36] Id.
[37] Roehrs A, da Costa CA, da Rosa Righi R, de Oliveira KSF, *Personal Health Records: A Systematic Literature Review*, J Med Internet Res 2017;19(1):e13, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5251169/ (last visited on January 8, 2020)
[38] Endsley, Kibbe, Linares, MD, Colorafi, *An Introduction to Personal Health Records*, Fam Pract Manag. 2006 May;13(5):57-62, https://www.aafp.org/fpm/2006/0500/p57.html (last visited on January 8, 2020).

PHRs can also potentially be beneficial in ensuring continuity of care in mass evacuations situations, such as hurricanes and brushfires.[39]

There are numerous potential barriers to the adoption and use of PHRs. These include privacy and security concerns, costs, integrity, accountability, health literacy and legal and liability risk.[40]

Effect of Proposed Changes

HB 1147 allows patients, residents and legal representatives to control how they receive requested records. Health care providers and facilities may produce the requested records in paper or electronic format, upon request. However, health care providers and facilities must produce the requested records in an electronic format, including access through a web-based patient portal or submission into a patient's electronic personal health record, if the health care provider or facility maintains an electronic health recordkeeping system.

HB 1147 also standardizes access to treatment records for patients, residents and legal representatives, excluding nursing homes residents, predominantly utilizing elements of existing law or rule. It standardizes the timeframe that health care providers and facilities must produce records or allow inspection of records. All health care practitioners and facilities must provide records within 14 days of a request. The bill also requires health care facilities and providers to allow inspection of records within 10 days.

Federal law currently requires nursing homes to provide residents with access to their records within 24 hours (excluding holidays and weekends) and a copy of any requested records within two working days of request. The bill incorporates these timelines into Florida law.

The bill defines "legal representative" as a client's attorney who has been designated by the patient or resident to receive copies of the patient's or resident's medical, care and treatment, or interdisciplinary records; any legally recognized guardian of the patient or resident; any court appointed representative of the patient or resident; or any person designated by the patient or resident or by a court of competent jurisdiction to receive copies of the patient's or resident's medical, care and treatment, or interdisciplinary records. This is current definition of legal representative found in the Board of Medicine's rules.

The bill provides an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Amends s. 394.4615, F.S., relating to clinical records confidentiality.
Section 2: Amends s. 395.3025, F.S., relating to patient and personnel records.
Section 3: Amends s. 397.501, F.S., relating to rights of individuals.
Section 4: Amends s. 400.145, F.S., relating to copies of records of care and treatment of a resident.
Section 5: Creates s. 408.833, F.S., relating to client access to medical records.
Section 6: Amends s. 456.057, F.S., relating to ownership and control of patient records.
Section 7: Amends s. 316.1932, F.S., relating to tests for alcohol, chemical substances, or controlled substances.
Section 8: Amends s. 316.1933, F.S., relating to blood test for impairment or intoxication in cases of death or serious bodily injury; right to use reasonable force.
Section 9: Amends s. 395.4025, F.S., relating to trauma centers.
Section 10: Amends s. 440.185, F.S., relating to notice of injury or death.
Section 11: Provides an effective date of July 1, 2020.

[39] Tang, Ash, Bates, Overhage, and Sands, *Personal Health Records: Definitions, Benefits, and Strategies for Overcoming Barriers to Adoption*, J Am Med Inform Assoc., 2006 Mar-Apr; 13(2): 121-126, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447551/pdf/121.pdf (last visited January 8, 2020).
[40] Vance, Tomblin, Studney, Coustasse, *Benefits and Barriers for Adoption of Personal Health Records*, 2015, https://mds.marshall.edu/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=1135&context=mgmt_faculty (last visited January 8, 2020).

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

2. Other:
   None.

B. RULE-MAKING AUTHORITY:
   DOH and AHCA have sufficient rulemaking authority to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:
   None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to patient access to records; amending s. 394.4615, F.S.; requiring a service provider to furnish and provide access to records within a specified timeframe after receiving a request for such records; requiring that certain service providers furnish such records in the manner chosen by the requester; amending s. 395.3025, F.S.; removing provisions requiring a licensed facility to furnish patient records only after discharge to conform to changes made by the act; revising provisions relating to the appropriate disclosure of patient records without consent; amending s. 397.501, F.S.; requiring a service provider to furnish and provide access to records within a specified timeframe after receiving a request from an individual or the individual's legal representative; requiring that certain service providers furnish such records in the manner chosen by the requester; amending s. 400.145, F.S.; revising the timeframe within which a nursing home facility must provide access to and copies of resident records after receiving a request for such records; creating s. 408.833, F.S.; defining the term "legal representative"; requiring a provider to furnish and provide access to records within a specified timeframe

after receiving a request from a client or the client's legal representative; requiring that certain providers furnish such records in the manner chosen by the requester; authorizing a provider to impose reasonable terms necessary to preserve such records; providing exceptions; amending s. 456.057, F.S.; requiring certain licensed health care practitioners to furnish and provide access to copies of reports and records within a specified timeframe after receiving a request from a patient or the patient's legal representative; requiring that certain licensed health care practitioners furnish such reports and records in the manner chosen by the requester; providing a definition; authorizing such licensed health care practitioners to impose reasonable terms necessary to preserve such reports and records; amending ss. 316.1932, 316.1933, 395.4025, 429.294, and 440.185, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Subsections (3) through (11) of section 394.4615, Florida Statutes, are renumbered as subsections (4) through (12), respectively, and a new subsection (3) is added to

that section, to read:

394.4615 Clinical records; confidentiality.—

(3) Within 14 working days after receiving a request made in accordance with paragraphs (2)(a)-(c), a service provider must furnish clinical records in its possession. A service provider may furnish the requested records in paper form or, upon request, in an electronic format. A service provider who maintains an electronic health record system shall furnish the requested records in the manner chosen by the requester which must include electronic format, access through a web-based patient portal, or submission through a patient's electronic personal health record.

Section 2. Subsections (4) through (11) of section 395.3025, Florida Statutes, are renumbered as subsections (2) through (9), respectively, and subsections (1), (2), and (3), paragraph (e) of present subsection (4), paragraph (a) of present subsection (7), and present subsection (8) of that section, are amended to read:

395.3025 Patient and personnel records; copy costs ~~copies~~; examination.—

(1) ~~Any licensed facility shall, upon written request, and only after discharge of the patient, furnish, in a timely manner, without delays for legal review, to any person admitted therein for care and treatment or treated thereat, or to any such person's guardian, curator, or personal representative, or~~

~~in the absence of one of those persons, to the next of kin of a decedent or the parent of a minor, or to anyone designated by such person in writing, a true and correct copy of all patient records, including X rays, and insurance information concerning such person, which records are in the possession of the licensed facility, provided the person requesting such records agrees to pay a charge.~~ The exclusive charge for copies of patient records may include sales tax and actual postage, and, except for nonpaper records that are subject to a charge not to exceed $2, may not exceed $1 per page. A fee of up to $1 may be charged for each year of records requested. These charges shall apply to all records furnished, whether directly from the facility or from a copy service providing these services on behalf of the facility. However, a patient whose records are copied or searched for the purpose of continuing to receive medical care is not required to pay a charge for copying or for the search. ~~The licensed facility shall further allow any such person to examine the original records in its possession, or microforms or other suitable reproductions of the records, upon such reasonable terms as shall be imposed to assure that the records will not be damaged, destroyed, or altered.~~

~~(2) This section does not apply to records maintained at any licensed facility the primary function of which is to provide psychiatric care to its patients, or to records of treatment for any mental or emotional condition at any other~~

~~licensed facility which are governed by the provisions of s. 394.4615.~~

~~(3) This section does not apply to records of substance abuse impaired persons, which are governed by s. 397.501.~~

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

(e) The Department of Health ~~agency~~ upon subpoena issued pursuant to s. 456.071, but the records obtained thereby must be used solely for the purpose of the department ~~agency~~ and the appropriate professional board in its investigation, prosecution, and appeal of disciplinary proceedings. If the department ~~agency~~ requests copies of the records, the facility shall charge no more than its actual copying costs, including reasonable staff time. The records must be sealed and must not be available to the public pursuant to s. 119.07(1) or any other statute providing access to records, nor may they be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the department ~~agency~~ or the appropriate regulatory board. However, the department ~~agency~~ must make available, upon written request by a practitioner against whom probable cause has been found, any such records that form the basis of the determination of probable cause.

(5)~~(7)~~(a) If the content of any record of patient treatment is provided under this section, the recipient~~, if other than the patient or the patient's representative,~~ may use such information only for the purpose provided and may not further disclose any information to any other person or entity, unless expressly permitted by the written consent of the patient. A general authorization for the release of medical information is not sufficient for this purpose. The content of such patient treatment record is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(6)~~(8)~~ Patient records at hospitals and ambulatory surgical centers are exempt from disclosure under s. 119.07(1), except as provided by subsections (2) and (3) ~~(1)-(5)~~.

Section 3. Paragraphs (a) through (j) of subsection (7) of section 397.501, Florida Statutes, are redesignated as paragraphs (c) through (l), respectively, and new paragraphs (a) and (b) are added to that subsection, to read:

397.501 Rights of individuals.—Individuals receiving substance abuse services from any service provider are guaranteed protection of the rights specified in this section, unless otherwise expressly provided, and service providers must ensure the protection of such rights.

(7) RIGHT TO ACCESS AND CONFIDENTIALITY OF INDIVIDUAL RECORDS.—

(a) Within 14 working days after receiving a written request from an individual or an individual's legal representative, a service provider shall furnish a true and correct copy of all records in the possession of the service provider. A service provider may furnish the requested records in paper form or, upon request, in an electronic format. A service provider who maintains an electronic health record system shall furnish the requested records in the manner chosen by the requester which must include electronic format, access through a web-based patient portal, or submission through a patient's electronic personal health record. For the purpose of this section, the term "legal representative" has the same meaning as provided in s. 408.833.

(b) Within 10 working days after receiving such a request from an individual or an individual's legal representative, a service provider shall provide access to examine the original records in its possession, or microforms or other suitable reproductions of the records. A service provider may impose any reasonable terms necessary to ensure that the records will not be damaged, destroyed, or altered.

Section 4. Subsection (1) of section 400.145, Florida Statutes, is amended to read:

400.145 Copies of records of care and treatment of resident.—

(1) Upon receipt of a written request that complies with

the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and this section, a nursing home facility shall furnish to a competent resident, or to a representative of that resident who is authorized to make requests for the resident's records under HIPAA or subsection (2), copies of the resident's paper and electronic records that are in possession of the facility. Such records must include any medical records and records concerning the care and treatment of the resident performed by the facility, except for progress notes and consultation report sections of a psychiatric nature. The facility shall provide a resident with access to the requested records within 24 hours, excluding weekends and holidays, and provide copies of the requested records within 2 ~~14~~ working days after receipt of a request relating to a current resident or within 30 working days after receipt of a request relating to a former resident.

Section 5. Section 408.833, Florida Statutes, is created to read:

408.833 Client access to medical records.—

(1) For the purpose of this section, the term "legal representative" means an attorney who has been designated by a client to receive copies of the client's medical, care and treatment, or interdisciplinary records; a legally recognized guardian of the client; a court-appointed representative of the client; or a person designated by the client or by a court of

competent jurisdiction to receive copies of the client's medical, care and treatment, or interdisciplinary records.

(2) Within 14 working days after receiving a written request from a client or client's legal representative, a provider shall furnish a true and correct copy of all records, including medical, care and treatment, and interdisciplinary records, as applicable, in the possession of the provider. A provider may furnish the requested records in paper form or, upon request, in an electronic format. A provider who maintains an electronic health record system shall furnish the requested records in the manner chosen by the requester which must include electronic format, access through a web-based patient portal, or submission through a patient's electronic personal health record.

(3) Within 10 working days after receiving a request from a client or a client's legal representative, a provider shall provide access to examine the original records in its possession, or microforms or other suitable reproductions of the records. A provider may impose any reasonable terms necessary to ensure that the records will not be damaged, destroyed, or altered.

(4) This section does not apply to:

(a) Records maintained at a licensed facility, as defined in s. 395.002, the primary function of which is to provide psychiatric care to its patients, or to records of treatment for

any mental or emotional condition at any other licensed facility which are governed by s. 394.4615;

(b) Records of substance abuse impaired persons which are governed by s. 397.501; or

(c) Records of a resident of a nursing home facility.

Section 6. Subsection (6) of section 456.057, Florida Statutes, is amended to read:

456.057 Ownership and control of patient records; report or copies of records to be furnished; disclosure of information.—

(6)(a) Any health care practitioner licensed by the department or a board within the department who makes a physical or mental examination of, or administers treatment or dispenses legend drugs to, any patient ~~person~~ shall, upon request of such patient ~~person~~ or the patient's ~~person's~~ legal representative, furnish, within 14 working days after such request ~~in a timely manner, without delays for legal review~~, copies of all reports and records relating to such examination or treatment, including X-rays ~~X rays~~ and insurance information. A health care practitioner may furnish the requested reports and records in paper form or, upon request, in an electronic format. A health care practitioner who maintains an electronic health record system shall furnish the requested reports and records in the manner chosen by the requester which must include electronic format, access through a web-based patient portal, or submission

through a patient's electronic personal health record. For the purpose of this section, the term "legal representative" means a patient's attorney who has been designated by the patient to receive copies of the patient's medical records, a legally recognized guardian of the patient, a court-appointed representative of the patient, or any other person designated by the patient or by a court of competent jurisdiction to receive copies of the patient's medical records.

(b) Within 10 working days after receiving a written request by a patient or a patient's legal representative, a healthcare practitioner must provide access to examine the original reports and records, or microforms or other suitable reproductions of the reports and records in the healthcare practitioner's possession. The healthcare practitioner may impose any reasonable terms necessary to ensure that the reports and records will not be damaged, destroyed, or altered.

(c) ~~However,~~ When a patient's psychiatric, chapter 490 psychological, or chapter 491 psychotherapeutic records are requested by the patient or the patient's legal representative, the health care practitioner may provide a report of examination and treatment in lieu of copies of records. Upon a patient's written request, complete copies of the patient's psychiatric records shall be provided directly to a subsequent treating psychiatrist. The furnishing of such report or copies may ~~shall~~ not be conditioned upon payment of a fee for services rendered.

Section 7. Paragraph (f) of subsection (1) of section 316.1932, Florida Statutes, is amended to read:

316.1932 Tests for alcohol, chemical substances, or controlled substances; implied consent; refusal.—

(1)

(f)1. The tests determining the weight of alcohol in the defendant's blood or breath shall be administered at the request of a law enforcement officer substantially in accordance with rules of the Department of Law Enforcement. Such rules must specify precisely the test or tests that are approved by the Department of Law Enforcement for reliability of result and ease of administration, and must provide an approved method of administration which must be followed in all such tests given under this section. However, the failure of a law enforcement officer to request the withdrawal of blood does not affect the admissibility of a test of blood withdrawn for medical purposes.

2.a. Only a physician, certified paramedic, registered nurse, licensed practical nurse, other personnel authorized by a hospital to draw blood, or duly licensed clinical laboratory director, supervisor, technologist, or technician, acting at the request of a law enforcement officer, may withdraw blood for the purpose of determining its alcoholic content or the presence of chemical substances or controlled substances therein. However, the failure of a law enforcement officer to request the withdrawal of blood does not affect the admissibility of a test

of blood withdrawn for medical purposes.

b. Notwithstanding any provision of law pertaining to the confidentiality of hospital records or other medical records, if a health care provider, who is providing medical care in a health care facility to a person injured in a motor vehicle crash, becomes aware, as a result of any blood test performed in the course of that medical treatment, that the person's blood-alcohol level meets or exceeds the blood-alcohol level specified in s. 316.193(1)(b), the health care provider may notify any law enforcement officer or law enforcement agency. Any such notice must be given within a reasonable time after the health care provider receives the test result. Any such notice shall be used only for the purpose of providing the law enforcement officer with reasonable cause to request the withdrawal of a blood sample pursuant to this section.

c. The notice shall consist only of the name of the person being treated, the name of the person who drew the blood, the blood-alcohol level indicated by the test, and the date and time of the administration of the test.

d. Nothing contained in s. 395.3025(2) ~~s. 395.3025(4)~~, s. 456.057, or any applicable practice act affects the authority to provide notice under this section, and the health care provider is not considered to have breached any duty owed to the person under s. 395.3025(2) ~~s. 395.3025(4)~~, s. 456.057, or any applicable practice act by providing notice or failing to

provide notice. It shall not be a breach of any ethical, moral, or legal duty for a health care provider to provide notice or fail to provide notice.

e. A civil, criminal, or administrative action may not be brought against any person or health care provider participating in good faith in the provision of notice or failure to provide notice as provided in this section. Any person or health care provider participating in the provision of notice or failure to provide notice as provided in this section shall be immune from any civil or criminal liability and from any professional disciplinary action with respect to the provision of notice or failure to provide notice under this section. Any such participant has the same immunity with respect to participating in any judicial proceedings resulting from the notice or failure to provide notice.

3. The person tested may, at his or her own expense, have a physician, registered nurse, other personnel authorized by a hospital to draw blood, or duly licensed clinical laboratory director, supervisor, technologist, or technician, or other person of his or her own choosing administer an independent test in addition to the test administered at the direction of the law enforcement officer for the purpose of determining the amount of alcohol in the person's blood or breath or the presence of chemical substances or controlled substances at the time alleged, as shown by chemical analysis of his or her blood or

urine, or by chemical or physical test of his or her breath. The failure or inability to obtain an independent test by a person does not preclude the admissibility in evidence of the test taken at the direction of the law enforcement officer. The law enforcement officer shall not interfere with the person's opportunity to obtain the independent test and shall provide the person with timely telephone access to secure the test, but the burden is on the person to arrange and secure the test at the person's own expense.

4. Upon the request of the person tested, full information concerning the results of the test taken at the direction of the law enforcement officer shall be made available to the person or his or her attorney. Full information is limited to the following:

a. The type of test administered and the procedures followed.

b. The time of the collection of the blood or breath sample analyzed.

c. The numerical results of the test indicating the alcohol content of the blood and breath.

d. The type and status of any permit issued by the Department of Law Enforcement which was held by the person who performed the test.

e. If the test was administered by means of a breath testing instrument, the date of performance of the most recent

required inspection of such instrument.

Full information does not include manuals, schematics, or software of the instrument used to test the person or any other material that is not in the actual possession of the state. Additionally, full information does not include information in the possession of the manufacturer of the test instrument.

5. A hospital, clinical laboratory, medical clinic, or similar medical institution or physician, certified paramedic, registered nurse, licensed practical nurse, other personnel authorized by a hospital to draw blood, or duly licensed clinical laboratory director, supervisor, technologist, or technician, or other person assisting a law enforcement officer does not incur any civil or criminal liability as a result of the withdrawal or analysis of a blood or urine specimen, or the chemical or physical test of a person's breath pursuant to accepted medical standards when requested by a law enforcement officer, regardless of whether or not the subject resisted administration of the test.

Section 8. Paragraph (a) of subsection (2) of section 316.1933, Florida Statutes, is amended to read:

316.1933 Blood test for impairment or intoxication in cases of death or serious bodily injury; right to use reasonable force.—

(2)(a) Only a physician, certified paramedic, registered

nurse, licensed practical nurse, other personnel authorized by a hospital to draw blood, or duly licensed clinical laboratory director, supervisor, technologist, or technician, acting at the request of a law enforcement officer, may withdraw blood for the purpose of determining the alcoholic content thereof or the presence of chemical substances or controlled substances therein. However, the failure of a law enforcement officer to request the withdrawal of blood shall not affect the admissibility of a test of blood withdrawn for medical purposes.

1. Notwithstanding any provision of law pertaining to the confidentiality of hospital records or other medical records, if a health care provider, who is providing medical care in a health care facility to a person injured in a motor vehicle crash, becomes aware, as a result of any blood test performed in the course of that medical treatment, that the person's blood-alcohol level meets or exceeds the blood-alcohol level specified in s. 316.193(1)(b), the health care provider may notify any law enforcement officer or law enforcement agency. Any such notice must be given within a reasonable time after the health care provider receives the test result. Any such notice shall be used only for the purpose of providing the law enforcement officer with reasonable cause to request the withdrawal of a blood sample pursuant to this section.

2. The notice shall consist only of the name of the person being treated, the name of the person who drew the blood, the

blood-alcohol level indicated by the test, and the date and time of the administration of the test.

3. Nothing contained in s. 395.3025(2) ~~s. 395.3025(4)~~, s. 456.057, or any applicable practice act affects the authority to provide notice under this section, and the health care provider is not considered to have breached any duty owed to the person under s. 395.3025(2) ~~s. 395.3025(4)~~, s. 456.057, or any applicable practice act by providing notice or failing to provide notice. It shall not be a breach of any ethical, moral, or legal duty for a health care provider to provide notice or fail to provide notice.

4. A civil, criminal, or administrative action may not be brought against any person or health care provider participating in good faith in the provision of notice or failure to provide notice as provided in this section. Any person or health care provider participating in the provision of notice or failure to provide notice as provided in this section shall be immune from any civil or criminal liability and from any professional disciplinary action with respect to the provision of notice or failure to provide notice under this section. Any such participant has the same immunity with respect to participating in any judicial proceedings resulting from the notice or failure to provide notice.

Section 9. Subsection (13) of section 395.4025, Florida Statutes, is amended to read:

395.4025 Trauma centers; selection; quality assurance; records.—

(13) Patient care, transport, or treatment records or reports, or patient care quality assurance proceedings, records, or reports obtained or made pursuant to this section, s. 395.3025(2)(f) ~~s. 395.3025(4)(f)~~, s. 395.401, s. 395.4015, s. 395.402, s. 395.403, s. 395.404, s. 395.4045, s. 395.405, s. 395.50, or s. 395.51 must be held confidential by the department or its agent and are exempt from the provisions of s. 119.07(1). Patient care quality assurance proceedings, records, or reports obtained or made pursuant to these sections are not subject to discovery or introduction into evidence in any civil or administrative action.

Section 10. Subsection (1) of section 429.294, Florida Statutes, is amended to read:

429.294 Availability of facility records for investigation of resident's rights violations and defenses; penalty.—

(1) Failure to provide complete copies of a resident's records, including, but not limited to, all medical records and the resident's chart, within the control or possession of the facility in accordance with s. 408.833 ~~s. 400.145~~, shall constitute evidence of failure of that party to comply with good faith discovery requirements and shall waive the good faith certificate and presuit notice requirements under this part by the requesting party.

Section 11. Subsection (4) of section 440.185, Florida Statutes, is amended to read:

440.185 Notice of injury or death; reports; penalties for violations.—

(4) Additional reports with respect to such injury and of the condition of such employee, including copies of medical reports, funeral expenses, and wage statements, shall be filed by the employer or carrier to the department at such times and in such manner as the department may prescribe by rule. In carrying out its responsibilities under this chapter, the department or agency may by rule provide for the obtaining of any medical records relating to medical treatment provided pursuant to this chapter, notwithstanding the provisions of ss. 90.503 and 395.3025(2) ~~395.3025(4)~~.

Section 12. This act shall take effect July 1, 2020.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1179 Nondiscrimination in Organ Transplants
SPONSOR(S): Health Market Reform Subcommittee, Fischer
TIED BILLS: **IDEN./SIM. BILLS:** SB 1556

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	14 Y, 0 N, As CS	Morris	Calamas
2) Health & Human Services Committee		Morris	Calamas

SUMMARY ANALYSIS

Organ and tissue donation is the process of surgically removing an organ or tissue from one person (the donor) and transplanting it into another person (the recipient). Transplantation in such cases is necessary because the recipient's organ has failed or has been damaged by disease or injury.

The Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973 prohibit discrimination on the basis of disability. HB 1179 prohibits discrimination in access to anatomical gifts and organ transplants for individuals with disabilities. Health insurance policies and health maintenance organization contracts would also be prohibited from denying coverage for an organ transplant solely on the basis of an insured's or subscriber's disability.

The bill prohibits covered entities from taking specific actions against an individual with a developmental or intellectual disability who is eligible to receive an anatomical gift (human body parts donated after death for use in transplants, therapy, research, or education) based solely on the fact that they have a disability. Covered entities include health care practitioners, health care facilities, and any other entity responsible for potential recipients of anatomical gifts.

The bill requires covered entities to make reasonable accommodations in their policies, practices, or procedures, when necessary, to allow a patient with a disability access to services unless it is demonstrated that making the modification would fundamentally alter the nature of the services.

The bill provides injunctive relief for a qualified individual who is affected by violations of these provisions committed by a covered entity.

The bill has an indeterminate, insignificant, negative fiscal impact on AHCA and DOH.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Organ Donation

Organ and tissue donation is the process of surgically removing an organ or tissue from one person (the donor) and transplanting it into another person (the recipient). Transplantation in such cases is necessary because the recipient's organ has failed or has been damaged by disease or injury. Transplantable organs include the kidneys, liver, heart, lungs, pancreas and intestine.[1] Transplantable tissue include skin used as a temporary dressing for burns, serious abrasions and other exposed areas; heart valves used to replace defective valves; tendons used to repair torn ligaments on knees or other joints; veins used in cardiac by-pass surgery; corneas used to restore sight; and bone used in orthopedic surgery to facilitate healing of fractures or prevent amputation.[2]

A single person can save up to eight lives through organ donation, and dozens more lives may be improved through tissue donation.[3] While most organ and tissue donations occur after the donor has died, some organs, including a kidney or part of a liver or lung, and tissues can be donated while the donor is alive.[4] There are about as many living donors every year as there are deceased donors.[5]

Despite advances in medicine and technology, and increased awareness of organ donation and transplantation, more donors are needed to meet the demand for transplants.[6] As of January 2020, there are more than 112,000 children and adults[7], including over 5,000 Floridians.[8] Over 39,000 organ transplants were performed in 2019 with organs from more than 19,000 donors.[9]

Organ donation is not defined in Florida Statutes. Instead, statutes refer to anatomical gifts, which are human body parts donated after death for use in transplants, therapy, research, or education.[10]

Organ Donation and Transplant Process

Established by the National Organ Transplant Act of 1984, the Organ Procurement and Transplantation Network (OPTN) is a public-private partnership that links all professionals involved in the nation's donation and transplant system.[11] The United Network for Organ Sharing (UNOS), a private, non-profit organization based in Richmond, Virginia, serves as the OPTN under contract with the U.S. Department of Health and Human Resources.[12] UNOS coordinates how donor organs are matched and allocated to patients on the waiting list.[13] Non-profit, federally designated organ procurement organizations (OPOs) work closely with UNOS, hospitals, and transplant centers to facilitate the organ

[1] Donate Life Florida, *Frequently Asked Questions,* https://www.donatelifeflorida.org/categories/donation/ (last visited Feb. 9, 2020).
[2] Id.
[3] Id.
[4] U.S. Government Information on Organ Donation and Transplantation, U.S. Department of Health & Human Services, *How Organ Donation Works,* https://organdonor.gov/about/process.html (last visited Feb. 9, 2020).
[5] Id.
[6] Organ Procurement and Transplantation Network, U.S. Department of Health & Human Services, https://optn.transplant.hrsa.gov/ (last visited Feb. 9, 2020).
[7] Id.
[8] Supra, note 1.
[9] Id.
[10] S. 765.511(2), F.S.
[11] U.S. Department of Health and Human Services, *Organ Procurement and Transplantation Network – About the OPTN,* https://optn.transplant.hrsa.gov/governance/about-the-optn/ (last visited Feb. 9, 2020).
[12] Id.
[13] U.S. Government Information on Organ Donation and Transplantation, U.S. Department of Health & Human Services, *The Organ Transplant Process*, https://organdonor.gov/about/process/transplant-process.html (last visited Feb. 9, 2020).

donation and transplantation process,[14] including conducting a thorough medical and social history of the potential donor to help determine the suitability of his or her organs for transplantation.[15]

The donation process begins when a person, or their family if the person was not already a registered donor before brain death, decides to become an organ donor. After brain death is declared, the donor's body is kept functioning by artificial means, such as a ventilator support.[16] Specially-trained medical practitioners from the OPO evaluates the patient to determine if they are medically suitable to donate their organs.[17] If the patient is suitable, their organs are surgically removed and sent to the transplant hospitals where transplant candidates are waiting.[18] The deceased donor's blood type, height, weight, the hospital zip code, and other data are entered into UNOS' national computer system to begin the organ allocation process.[19]

Transplant candidates are patients on the transplant waiting list. A patient is usually referred to a transplant center by their physician for placement on the waiting list.[20] The transplant center's transplant teams, composed of transplant physicians, surgeons and other practitioners, perform a medical evaluation of the patient.[21] Each transplant center sets its own criteria to help determine if a patient is a good or bad candidate.[22] Typical criteria includes weight, age, and health history. If the patient is a bad candidate, the patient is not placed on the waiting list, but can try to get placed on the waiting list at another transplant center or be reconsidered by the same transplant center if their condition improves (for example, losing weight as directed).[23] If a patient is determined to be a good candidate for an organ transplant, they are placed on the waiting list by the transplant center and wait for an organ to become available. Candidates are able to be placed on the waiting list at more than one transplant center.[24]

When an organ becomes available, the OPO will query the OPTN database for a match based on a variety of factors, including relative location of the recipient to the organ, blood type, weight, and age.[25] If a match is found, the transplant surgeon will evaluate the potential recipient of the organ transplant and make a determination on whether the potential recipient is medically suitable.[26] The transplant team only has one hour to make this determination.[27] If suitable, the organ is transported to the transplant center where the recipient is waiting and the transplant surgery is performed, otherwise the potential recipient remains on the waiting list.

Medical urgency, blood type, size of the organ, whether the recipient is an adult or a child, relative distance between the donor and the recipient, and the degree of immune-system match between the

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[14] Donate Life Florida, *Organ Procurement Organizations and Transplant Centers*, https://www.donatelifeflorida.org/local-resources/transplant-centers/ (last visited Feb. 9, 2020).
[15] Organ Procurement and Transplantation Network, U.S. Department of Health & Human Services, *The Basic Path of Donation*, https://optn.transplant.hrsa.gov/learn/about-donation/the-basic-path-of-donation/ (last visited Feb. 9, 2020).
[16] Donate Life Florida, *Frequently Asked Questions - Donation,* https://www.donatelifeflorida.org/categories/donation/ (last visited Feb. 9, 2020).
[17] UNOS, *Deceased Donation,* https://unos.org/transplant/deceased-donation/ (last visited Feb. 9, 2020).
[18] Id.
[19] Id.
[20] Health Resources & Services Administration, *The Organ Transplant Process,* https://www.organdonor.gov/about/process/transplant-process.html#list (last visited Feb. 9, 2020).
[21] U.S. Department of Health and Human Services, *The Transplant Team,* https://optn.transplant.hrsa.gov/learn/about-transplantation/the-transplant-team/ (last visited Feb. 9, 2020).
[22] UNOS, *Frequently Asked Questions – What do I need to do to be considered for a transplant?,* https://unos.org/transplant/frequently-asked-questions/ (last visited Feb. 9, 2020).
[23] UNOS Transplant Living, *Frequently Asked Questions – Are there age limits or medical conditions that rule out organ transplantation?,* https://transplantliving.org/before-the-transplant/frequently-asked-questions/ (last visited Feb. 9, 2020).
[24] UNOS, *What Every Patient Needs to Know* (2019), https://unos.org/wp-content/uploads/unos/WEPNTK.pdf (last visited Feb. 9, 2020).
[25] Heath Resources & Services Administration, *Matching Donors and Recipients,* https://www.organdonor.gov/about/process/matching.html#criteria (last visited Feb. 9, 2020). *See also* Health Resources & Services Administration, *Find Your Local Organ Procurement Organization,* https://www.organdonor.gov/awareness/organizations/local-opo.html (last visited Feb. 9, 2020).
[26] UNOS Transplant Living, *Frequently Asked Questions – How does the matching process work?* https://transplantliving.org/before-the-transplant/frequently-asked-questions/ (last visited Feb. 9, 2020).
[27] Id.

donor and the recipient can impact who is prioritized for an organ for transplant.[28] Transplant centers may also include other factors in prioritization, such as the ability to take care of oneself after surgery, attend post operation doctor appointments, and stay current with medications.[29]

Disability

The term "disability" as enacted in the federal Americans with Disabilities Act (ADA)[30] means a physical or mental impairment that substantially limits one or more major life activities such as caring for oneself, performing manual tasks, seeing, walking, hearing, standing, learning, thinking, and communicating. The definition also includes individuals with a previous record of such an impairment and, under certain circumstances, who are generally regarded as having such an impairment. Types of disabilities include ambulatory, hearing, cognitive, vision, independent living, and self-care.[31] Disabilities can be related to conditions present at birth, associated with developmental conditions, related to an injury, or associated with a longstanding condition.[32] Individuals with disabilities are a diverse group of people with a wide range of needs.[33]

In addition to physical impairments, mental impairments can significantly interfere the everyday activities of life. Anxiety disorders, mood disorders, and schizophrenia disorders are all types of mental impairments. Mental disorders are among the most common causes of disability.[34] Additionally, individuals with intellectual disabilities, characterized by significant limitations in both intellectual functioning and adaptive behavior, suffer disproportionately from substance use problems.[35]

Approximately 12.7% [over 40 million people] of the U.S. population has a disability.[36] Florida's disability population is estimated at 13.6% (over 2.8 million people).

Organ Transplant Discrimination

The ADA and Section 504 of the federal Rehabilitation Act of 1973 prohibit discrimination on the basis of disability. The National Council on Disability (NCD) produced a report relating to discrimination against individuals with disabilities in the organ transplant process.[37] The NCD examined applicable federal and state laws, the disability-related policies of various transplant centers, and policies of the OPTN. The NCD found that:

- Discrimination continues to occur in the nine states[38] that have enacted laws expressly prohibiting such discrimination;
- Disabilities unrelated to a person's need for an organ transplant generally have little or no impact on the likelihood that the transplant will be successful; and
- Many organ transplant centers[39] have policies that bar or caution against placing people with HIV, psychiatric disabilities, or intellectual and developmental disabilities on the waiting list to receive an organ transplant because of concern the patient may not be able to take care of themselves after transplant surgery.

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[28] UNOS, *How we match organs,* https://unos.org/transplant/how-we-match-organs/ (last visited Feb. 9, 2020).
[29] Supra, note 24.
[30] 42 U.S.C. 12102
[31] United States Census Bureau, *Types of Disabilities,* https://www.census.gov/library/visualizations/2019/comm/types-of-disabilities.html (last visited Feb. 9, 2020).
[32] Centers for Disease Control and Prevention, *Disability Health Overview,* https://www.cdc.gov/ncbddd/disabilityandhealth/disability.html (last visited Feb. 9, 2020).
[33] Id.
[34] Office of Disease Prevention and Health Promotion, *Mental Health and Mental Disorders,* https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders (last visited Feb. 9, 2020).
[35] Shawna L. Carroll Chapman and Li-Tzy Wu, *Substance Abuse among Individuals with Intellectual Disabilities,* (July 2012) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3328139/ (last visited Feb. 9, 2020).
[36] United States Census Bureau 2018 American Community Survey, *Disability Characteristics,* https://data.census.gov/ (last visited Feb. 9, 2020).
[37] National Council on Disability, *Organ Transplant Discrimination Against People with Disabilities,* (Sept. 25, 2019) https://ncd.gov/sites/default/files/NCD_Organ_Transplant_508.pdf (last visited Feb. 9, 2020).
[38] California, Delaware, Kansas, Maryland, Massachusetts, New Jersey, Ohio, Oregon, and Pennsylvania.
[39] Id. at 55, including The University of Florida Health's transplant center and Tampa General Hospital.

Taking care of oneself post-transplant involves quite a bit of effort. Transplant recipients usually need to take an array of medications or prevent the body from rejecting the transplanted organ sometimes for life. Some medications may need to be taken several times a day and others only on certain days.[40] Dosages may be adjusted weekly or every few days in order to find the best combination for maximum benefits and minimum side effects. Managing medications can become complex and confusing.[41] Doctors monitor transplant patients for years after transplant surgery and laboratory tests become routine.[42] Living a healthy lifestyle that includes eating a balanced diet and exercise plays a key role in maintaining health after a transplant.[43]

Overall, long-term survival rates after transplants have increased since 1970.[44] In order for continued improvement in survival rates, long-term management and approaches post operation must continue to improve.[45]

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA)[46] imposed extensive requirements on health insurers and health insurance policies relating to required benefits, rating and underwriting standards, required review of rate increases, and other requirements.[47] Among its sweeping changes to the U.S. health care system are requirements for health insurers to make coverage available to all individuals and employers, without exclusions for preexisting conditions and without basing premiums on any health-related factors.[48]

Many of the changes in the PPACA apply to individual and small group markets, except those plans that have grandfathered status under the law.[49] For example, the PPACA requires coverage offered in the individual and small group markets to provide the certain categories of services, called essential health benefits.[50]

Also, the PPACA requires that premiums for individual and small group policies may vary only by:[51]

- Age, up to a maximum ratio of 3 to 1. This means that the rates for older adults cannot be more than three times greater than the rates for younger adults.
- Tobacco, up to a maximum ratio of 1.5 to 1.
- Geographic rating area.
- Whether coverage is for an individual or a family.

The PPACA prohibits an insurer from establishing rules for eligibility based on any of the following health status-related factors: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, disability, evidence of insurability (including conditions arising out

[40] Health Resources & Services Administration, *The Organ Transplant Process – After Your Transplant,* https://www.organdonor.gov/about/process/transplant-process.html#list (last visited Feb. 9, 2020).
[41] Id.
[42] Id.
[43] Id.
[44] Abbas Rana, MD and Elizabeth Louise Godfrey, BSBE, *Outcomes in Solid-Organ Transplantation: Success and Stagnation,* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6379008/ (last visited Feb. 9, 2020).
[45] Id.
[46] Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148.
[47] Most of the insurance regulatory provisions in PPACA amend Title XXVII of the Public Health Service Act (PHSA), 42 U.S.C. 300gg et seq.
[48] Under PPACA, the prohibition on preexisting condition exclusion refers to the fact that health insurance companies cannot refuse coverage or charge higher premiums to those who have a "pre-existing condition" — that is, a health problem that existed before the date that health coverage starts. Prior to passage of the PPACA, employers and insurers could exclude coverage for pre-existing conditions for a period of time if an individual had not maintained continuous insurance coverage, unless prohibited by state law.
[49] For an insured plan, grandfathered health plan coverage is group or individual coverage in which an individual was enrolled on March 23, 2010, subject to conditions for maintaining grandfathered status as specified by law and rule. *See* PPACA s. 1251; 42 U.S.C. s. 18011.
[50] PPACA s. 1302; 42 U.S.C. 300gg-6.
[51] PPACA s. 1201; 42 U.S.C. 300gg.

of domestic violence), or any other health-status related factor deemed appropriate by the U.S. Department of Health and Human Services.[52]

State Regulation of Health Insurance

The regulatory oversight of health insurance is generally reserved to the states, except when explicitly preempted by federal law. In Florida, the Office of Insurance Regulation (OIR) is responsible for all activities concerning insurers and other risk bearing entities, including licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the insurance code.[53]

All health insurance policies issued in the state of Florida, with the exception of certain self-insured policies[54], must meet certain requirements that are detailed throughout the Florida Insurance Code. Chapter 627, F.S., sets parameters and requirements for health insurance policies and ch. 641, F.S., provides requirements for insurance policies issued by health maintenance organizations (HMOs). At a minimum, insurance policies must specify premium rates, services covered, and effective dates. Insurers must document the time when a policy takes effect and the period during which the policy remains in effect.[55]

Effect of the Bill

HB 1179 prohibits discrimination in access to anatomical gifts and organ transplants for individuals with disabilities. Health insurance policies, health maintenance organizations, and group health policies would also be prohibited from denying coverage for a transplant based on a disability.

The bill prohibits covered entities from taking specific actions against an individual with a developmental or intellectual disability who is eligible to receive an anatomical gift based solely on the fact that they have a disability. The bill prohibits certain actions by licensed health care practitioners, health care facilities, and any other entity responsible for potential recipients of anatomical gifts. Such entities may not consider a qualified individual ineligible to receive an anatomical gift or organ transplant, deny medical or other services related to an organ transplant, refuse to refer the individual to an OPO or a specialist for a transplant evaluation, refuse to place the individual on the waiting list, or give the individual a lower priority position on the waiting list.

When making treatment or coverage recommendations for a patient, the bill allows a covered entity to take a disability into account if, after an evaluation, a physician finds the disability to be medically significant to the receipt of an anatomical gift. Additionally, a covered entity may not consider the patient's inability to comply with post-transplant medical requirements as medically significant if they have a support system to assist with such compliance.

The bill requires covered entities to make reasonable accommodations in their policies, practices, or procedures, when necessary, to allow a patient with a disability access to services unless it is demonstrated that making the modification would fundamentally alter the nature of the services. The accommodations include communicating with the people responsible for supporting the patient with their post-transplant care and the consideration of support networks available to the patient.

Under the bill, a covered entity must take the necessary steps to ensure that a person with a disability is not denied services due to the absence of auxiliary aids and services, including interpreters for those with hearing impairments, effective methods of delivering information to people with visual impairments, and supported decision making services. Such services may include the use of a support person to help make medical decisions and communicate information, disclosing health information to a person

[52] PPACA s. 1201; 42 U.S.C. s. 300gg-4.
[53] s. 20.121(3)(a)1., F.S. The OIR's commissioner is the agency head for purposes of final agency action, and its rulemaking body is the Financial Services Commission (the Governor and the Cabinet).
[54] 29 U.S.C. 18 § 1001 et seq. ERISA regulates certain self-insured plans, which represent approximately 50 percent of the insureds in Florida. These plans cannot be regulated by state law.
[55] S. 627.413(1)(d), F.S.

designated by the patient, using a court appointed guardian or other legal representative who is authorized to make health care decisions on behalf of the patient, and any other aid or service that can be used to understandably convey information to the patient.

The bill provides injunctive or other equitable relief for a qualified individual who is affected by a violation of such provisions committed by a covered entity.

The bill expressly states that it may not be interpreted as requiring a covered entity to make a referral or recommendation for, or to perform, a medically inappropriate transplant.

The bill prohibits discrimination by insurers against individuals who are recipients of organ transplants. This prohibition includes issuers of fully-insured individual and group health plans, as well as HMOs. The bill does not require coverage of organ transplant services, but prohibits plans that do cover organ transplants from denying coverage for an organ transplant solely on the basis of a covered individual having a disability.

The bill provides an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Creates s. 765.523, F.S., relating to discrimination in access to anatomical gifts and organ transplants prohibited.
Section 2: Creates s. 627.64197, F.S., relating to nondiscrimination of coverage for organ transplants.
Section 3: Creates s. 627.65736, F.S., relating to nondiscrimination of coverage for organ transplants.
Section 4: Creates s. 641.31075, F.S., relating to nondiscrimination of coverage for organ transplants.
Section 5: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill has an indeterminate, insignificant, negative fiscal impact on the Agency for Health Care Administration Division of Health Quality Assurance and the Department of Health Division of Medical Quality Assurance due to the investigation of complaints and enforcement relating to violations of any act proposed under this bill committed by a health care facility or a licensed health care practitioner. The impact can be absorbed within current resources.

   The bill has an indeterminate, insignificant, negative fiscal impact on the Office of Insurance Regulation and the Agency for Health Care Administration due to the investigation of complaints and enforcement relating to violations of any act proposed under this bill committed by insurance companies and HMOs.

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Current law contains sufficient rulemaking authority for AHCA to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 28, 2020, the Health Market Reform Subcommittee adopted an amendment that:

- Narrows the applicability of the bill to individuals with developmental or intellectual disabilities;
- Removes residential facilities for persons with developmental disabilities and institutional medical units in correctional facilities from the list of covered entities; and
- Makes technical and conforming changes.

The bill was reported favorably as a committee substitute.

The analysis is drafted to the committee substitute as passed by the Health Market Reform Subcommittee.

A bill to be entitled

An act relating to nondiscrimination in organ transplants; creating s. 765.523, F.S.; providing definitions; prohibiting certain entities from making certain determinations or engaging in certain actions related to organ transplants solely on the basis of an individual's disability; specifying an instance where certain entities may consider an individual's disability, with an exception; requiring certain entities to make reasonable modifications in their policies, practices, and procedures under certain circumstances, with an exception; providing criteria for such modifications; requiring certain entities to take certain necessary steps to ensure an individual with a disability is not denied services, with exceptions; providing a cause of action for injunctive and other relief; providing construction; creating ss. 627.64197, 627.65736, and 641.31075, F.S.; prohibiting insurers, nonprofit health care service plans, and health maintenance organizations that provide coverage for organ transplants from denying coverage solely on the basis of an individual's disability under certain circumstances; providing construction; defining the term "organ transplant"; providing an effective date.

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

Section 1. Section 765.523, Florida Statutes, is created to read:

765.523 Discrimination in access to anatomical gifts and organ transplants prohibited.—

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

(a) "Auxiliary aids and services" means:

1. Qualified interpreters or other effective methods of making aurally delivered materials available to individuals with hearing impairments.

2. Qualified readers, recorded texts, texts in an accessible electronic format, or other effective methods of making visually delivered materials available to individuals with visual impairments.

3. Supported decisionmaking services, including any of the following:

a. The use of a support person to assist an individual in making medical decisions, communicating information to the individual, or ascertaining his or her wishes.

b. The provision of information to a person designated by the individual, consistent with federal and state laws governing the disclosure of health information.

c. Measures used to ensure that the individual's guardian or legal representative, if any, is included in decisions

involving the individual's health care and that medical decisions are in accordance with the individual's own expressed interests.

d. Any other aid or service that is used to provide information in a format that is readily understandable and accessible to individuals with cognitive, neurological, developmental, or intellectual disabilities.

(b) "Covered entity" means any of the following:

1. A licensed health care practitioner as defined in s. 456.001.

2. A health care facility as defined in s. 408.07.

3. Any other entity responsible for potential recipients of anatomical gifts or organ transplants.

(c) "Disability" has the same meaning as "developmental disability" and "intellectual disability" as those terms are defined in s. 393.063.

(d) "Organ transplant" means the transplantation or transfusion of a part of a human body into the body of another individual for the purpose of treating or curing a medical condition.

(e) "Qualified individual" means an individual who has a disability and meets the clinical eligibility requirements for the receipt of an anatomical gift or an organ transplant, regardless of:

1. The support networks available to the individual;

2. The provision of auxiliary aids and services; or

3. Reasonable modifications to the policies, practices, or procedures of a covered entity pursuant to subsection (4).

(2) A covered entity may not do any of the following solely on the basis of an individual's disability:

(a) Consider a qualified individual ineligible to receive an anatomical gift or organ transplant.

(b) Deny medical or other services related to an organ transplant, including evaluation, surgery, counseling, and posttransplant treatment and services.

(c) Refuse to refer the individual to an organ procurement organization or a related specialist for the purpose of evaluation or receipt of an organ transplant.

(d) Refuse to place a qualified individual on an organ transplant waiting list.

(e) Place a qualified individual at a lower priority position on an organ transplant waiting list than the position at which the qualified individual would have been placed if not for the disability.

(3)(a) A covered entity may take an individual's disability into account if, following an individualized evaluation of him or her, a physician finds the individual's disability to be medically significant to the provision of the anatomical gift or organ transplant, but only to the extent that the covered entity is making treatment or coverage

recommendations or decisions for the individual.

(b) If an individual has the necessary support system to assist him or her in complying with posttransplant medical requirements, a covered entity may not consider the individual's inability to independently comply with the posttransplant medical requirements to be medically significant for the purposes of paragraph (a).

(4) A covered entity shall make reasonable modifications to policies, practices, or procedures when the modifications are necessary to allow an individual with a disability access to services, including transplant-related counseling, information, coverage, or treatment, unless the covered entity can demonstrate that making the modifications would fundamentally alter the nature of the services. Such modifications shall include, but need not be limited to, communication with the persons responsible for supporting the individual with his or her postsurgical and posttransplant care, including medication. Such modifications shall also consider the support networks available to the individual, including, but not limited to, family, friends, and home and community-based services coverage when determining whether the individual is able to comply with posttransplant medical requirements.

(5) A covered entity shall take such steps as may be necessary to ensure that an individual with a disability is not denied services, including transplant-related counseling,

information, coverage, or treatment, due to the absence of auxiliary aids and services, unless the covered entity can demonstrate that taking the steps would fundamentally alter the nature of the services being offered or would result in an undue burden on the covered entity.

(6) If a covered entity violates this section, the qualified individual who is affected by the violation may bring an action in the appropriate circuit court for injunctive or other equitable relief.

(7) This section may not be construed to require a covered entity to make a referral or recommendation for or perform a medically inappropriate organ transplant.

Section 2. Section 627.64197, Florida Statutes, is created to read:

627.64197 Coverage for organ transplants.—A health insurance policy issued, delivered, or renewed on or after July 1, 2020, in this state by an insurer which provides coverage for organ transplants on an expense-incurred basis may not deny coverage for an organ transplant solely on the basis of an insured's disability. This section may not be construed to require such insurer to provide coverage for an organ transplant that is not medically necessary. For purposes of this section, the term "organ transplant" has the same meaning as in s. 765.523.

Section 3. Section 627.65736, Florida Statutes, is created

to read:

627.65736 Coverage for organ transplants.—A group health insurance policy delivered, issued, or renewed on or after July 1, 2020, in this state by an insurer or nonprofit health care services plan which provides coverage for organ transplants on an expense-incurred basis may not deny coverage for an organ transplant solely on the basis of an insured's disability. This section may not be construed to require such insurer or nonprofit health care service plan to provide coverage for an organ transplant that is not medically necessary. For purposes of this section, the term "organ transplant" has the same meaning as in s. 765.523.

Section 4. Section 641.31075, Florida Statutes, is created to read:

641.31075 Coverage for organ transplants.—A health maintenance contract issued or renewed on or after July 1, 2020, in this state by a health maintenance organization which provides coverage for organ transplants may not deny coverage for an organ transplant solely on the basis of a subscriber's disability. This section may not be construed to require such health maintenance organization to provide coverage for an organ transplant that is not medically necessary. For purposes of this section, the term "organ transplant" has the same meaning as in s. 765.523.

Section 5. This act shall take effect July 1, 2020.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1183 Home Medical Equipment Providers
SPONSOR(S): Maggard
TIED BILLS: **IDEN./SIM. BILLS:** SB 1742

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	13 Y, 0 N	Guzzo	Calamas
2) Health Care Appropriations Subcommittee	11 Y, 0 N	Nobles	Clark
3) Health & Human Services Committee		Guzzo	Calamas

SUMMARY ANALYSIS

Home medical equipment providers are licensed and regulated by the Agency for Health Care Administration (AHCA) under part VII of ch. 400, F.S. The licensure requirements for home medical equipment providers apply to any person or entity that holds itself out to the public as providing home medical equipment and services or accepts physician orders for home medical equipment and services. Certain individuals and entities are exempt from the licensure requirements, including, for example, hospitals, nursing homes, hospices and pharmacies. Licensed health care practitioners who utilize home medical equipment in the course of their practice but do not sell or rent home medical equipment to their patients are also exempt from licensure.

Electrostimulation medical equipment can be used to treat a number of medical symptoms and conditions. Electrical stimulators can provide direct, alternating, and pulsed waveforms of energy to the human body through electrodes that may be implanted in the skin or used on the surface of the skin. Such devices may be used to exercise muscles, demonstrate a muscular response to stimulation of a nerve, relieve pain, relieve incontinence, and provide test measurements.

The bill amends s. 400.93, F.S., to exempt physicians licensed under chapters 458 and 459, F.S., and chiropractors licensed under ch. 460, F.S., who sell or rent electrostimulation medical equipment to their patients in the course of their practice from licensure as a home medical equipment provider.

The bill will have an insignificant negative fiscal impact on AHCA.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Home Medical Equipment Providers

Home medical equipment providers are licensed and regulated by the Agency for Health Care Administration (AHCA), under part VII of ch. 400, F.S., and Chapter 59A-25, F.A.C. A home medical equipment license is required for any person or entity that:

- Holds itself out to the public as providing home medical equipment[1] and services;[2]
- Accepts physician orders for home medical equipment and services; or
- Provides home medical equipment that typically requires home medical services.[3]

Section 400.931, F.S., requires any person or entity applying for a home medical equipment provider license to submit certain information to AHCA with the application, including:

- A report of the medical equipment and services that will be provided, and whether the equipment will be provided directly or by contract;
- A list of the persons and entities with whom the applicant contracts;
- Documentation of accreditation, or an application for accreditation, from an accrediting organization recognized by AHCA;
- Proof of liability insurance; and
- An application fee of $300 and an inspection fee of $400[4].

Section 400.934, F.S., requires home medical equipment providers to comply with minimum standards of operation relating to topics such as services, training and personnel, and emergency standards.

A home medical equipment provider must offer and provide home medical equipment and services, as necessary, to consumers who purchase or rent any equipment that requires such services, and must provide at least one category of equipment directly from their own inventory.[5] A home medical equipment provider is required to respond to orders for other equipment from either their own inventory or from the inventory of other contracted companies and must maintain and repair, either directly or through contract, items rented to consumers.[6]

Home medical equipment providers are required to maintain trained personnel to coordinate orders and scheduling of equipment and service deliveries and must ensure that their delivery personnel are appropriately trained.[7] Home medical equipment providers are required to ensure that all personnel have the necessary training and background screening.[8]

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[1] Defined in s. 400.925, F.S., as any product as defined by the federal Food and Drug Administration's Drugs, Devices and Cosmetics Act, any products reimbursed under the Medicare Part B Durable Medical Equipment benefits or any product reimbursed under the Florida Medicaid durable medical equipment program. Home medical equipment includes oxygen and related respiratory equipment; manual, motorized, or customized wheelchairs and related seating and positioning; motorized scooters; personal transfer systems; and specialty beds, for use by a person with a medical need. Home medical equipment does not include prosthetics or orthotics or any splints, braces, or aids custom fabricated by a licensed health care practitioner.

[2] Defined in s. 400.925, F.S., as equipment management and consumer instruction, including selection, delivery, set-up, and maintenance of equipment, and other related services for the use of home medical equipment in the customer's regular or temporary place of residence.

[3] S. 400.93(1) and (2), F.S.

[4] S. 400.933, F.S.; Provides that the home medical equipment provider is exempt from the inspection fee if a survey or inspection has been conducted by an accrediting organization.

[5] S. 400.934(1) and (2), F.S.

[6] S. 400.934(3) and (11), F.S.

[7] S. 400.934(4) and (5), F.S.

[8] S. 400.934(16), F.S.

A home medical equipment provider must comply with certain emergency standards, including:

- Ensuring that patients are aware of service hours and emergency service procedures;
- Maintaining a safe premises;[9]
- Preparing and maintaining a comprehensive emergency management plan that must be updated annually and provide for continuing home medical equipment services for life-supporting or life-sustaining equipment during an emergency;[10] and
- Maintaining a prioritized list of patients who need continued services during an emergency.[11]

Home medical equipment providers are also required to maintain a record for each patient that includes the equipment and services provided, which must contain:

- Any physician's order or certificate of medical necessity;
- Signed and dated delivery slips;
- Notes reflecting all services, maintenance performed, and equipment exchanges;
- The date on which rental equipment was retrieved; and
- Any other appropriate information.[12]

Licensed home medical equipment providers are subject to periodic inspections, including biennial licensure inspections, inspections directed by the federal Centers for Medicare and Medicaid Services, and licensure complaint investigations.[13] Currently there are 1,174 licensed home medical equipment providers in Florida.[14]

Certain individuals and entities are considered exempt from licensure, including:

- Providers operated by the Department of Health (DOH) or the federal government;
- Nursing homes;
- Assisted living facilities;
- Home health agencies;
- Hospices;
- Intermediate care facilities;
- Homes for special services;
- Transitional living facilities;
- Hospitals;
- Ambulatory surgical centers;
- Manufacturers and wholesale distributors that do not sell directly to the consumer; and
- Pharmacies.[15]

Licensed health care practitioners are also exempt from licensure, but only if they do not sell or rent home medical equipment to their patients.

Electrostimulation Medical Equipment

Neuromuscular electrical stimulation (NMES) devices can be used to stimulate the muscle of a patient with muscle atrophy. They can also be used to enhance functional activity in neurologically impaired

[9] S. 400.934(6), F.S.
[10] S. 400.934(20)(a), F.S.
[11] S. 400.934(21), F.S.
[12] S. 400.94, F.S.
[13] S. 400.932, F.S.
[14] AHCA , Florida Health Finder, *Facility/Provider Search, Home Medical Equipment Providers*, available at http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx (search conducted February 9, 2020).
[15] S. 400.93(5), F.S.

patients, which is commonly known as functional electrical stimulation (FES). There are two types of NMES: transcutaneous (surface) and percutaneous (partially implanted systems).[16]

Transcutaneous Electrical Nerve Stimulation (TENS) involves placing four electrodes on the skin, which passes a current through the skin to stimulate the appropriate muscles. TENS devices can be used for physical therapy in partially paralyzed patients. For example, a TENS device can be used to enhance flexibility of the foot of a partially paralyzed stroke patient to improve the patient's gate.[17] In addition to eliciting contraction of skeletal muscles TENS devices have been used in a variety of other applications, such as to contract the heart muscle (cardiac pacemakers), alleviate pain (TENS units), improve bladder control, control epileptic seizures, prevent progress of scoliosis, improve blood circulation, control respiration, and stimulate the auditory nerve and visual cortex.[18]

A percutaneous device is implanted into the body with leads and parts of the device remaining outside the body. Percutaneous leads require surgery and have been designed as either intramuscular electrodes that are embedded into the fibers of the muscle or epimysial electrodes that lay on the surface of the muscle.[19]

Effect of the Bill

The bill amends s. 400.93, F.S., to exempt physicians licensed under Chapters 458 and 459, F.S., and chiropractors licensed under ch. 460, F.S., who sell or rent electrostimulation medical equipment to their patients in the course of their practice from home medical equipment provider licensure requirements.[20] The bill permits physicians and chiropractors to sell or rent this type of home medical equipment directly to their patients without incurring a fee for licensure or licensure renewal. The bill maintains the limited exemption for other types of practitioners, who may not sell or rent such equipment without a home medical equipment provider license.

B. SECTION DIRECTORY:

Section 1: Amends s. 400.93, F.S., relating to licensure required; exemptions; unlawful acts; penalties.
Section 2: Provides an effective date of July 1, 2020.

[16] Jeffrey Shuren, MD, JD, Federal Centers for Medicare & Medicaid Services, *Decision Memo for Neuromuscular Electrical Stimulation for Spinal Cord Injury (CAG-00153R),* available at https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=55&TAId=5&NCDId=244&ncdver=1&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=STI&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAACAAQAAA& (last viewed February 9, 2020).
[17] 21 C.F.R., s. 882.5810.
[18] Sigmedics, Inc., Rehabilitation Technology for the Neurologically Impaired, *FAQ What is Functional Neuromuscular Stimulation*, available at https://www.sigmedics.com/faq (last viewed February 9, 2020).
[19] Supra FN 16.
[20] In 2015, the Florida Legislature passed HB 1305, which was identical to this bill, however, the bill was vetoed by Governor Scott before it became law. In a letter from former Governor Rick Scott to former Secretary of State Kenneth Detzner, Governor Scott explained his decision to repeal the bill as follows, "while I agree with the Legislature's attempt to deregulate and remove burdensome regulations, carve outs add additional levels of complexity to regulatory requirements while allowing outdated regulations to remain on the books. Carve outs also present an unfair advantage to certain entities competing within the same industry." Available at https://www.flgov.com/wp-content/uploads/2015/06/Transmittal-Letter-6.10.15-HB-1305.pdf (last viewed February 9, 2020).

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   AHCA may experience a decrease in revenues resulting from a reduction in the number of physicians and chiropractors paying licensure fees to sell or rent electrostimulation medical equipment directly to their patients. The exact amount is uncertain but is not expected to be significant.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Licensed physicians and chiropractors who sell or rent electrostimulation medical equipment to their patients will not have to pay licensure and licensure renewal fees.

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:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to home medical equipment providers; amending s. 400.93, F.S.; exempting allopathic, osteopathic, and chiropractic physicians who sell or rent electrostimulation medical equipment and supplies from licensure requirements under certain circumstances; providing an effective date.

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

Section 1. Paragraph (l) is added to subsection (5) of section 400.93, Florida Statutes, to read:

400.93 Licensure required; exemptions; unlawful acts; penalties.—

(5) The following are exempt from home medical equipment provider licensure, unless they have a separate company, corporation, or division that is in the business of providing home medical equipment and services for sale or rent to consumers at their regular or temporary place of residence pursuant to the provisions of this part:

(l) Physicians licensed under chapter 458, chapter 459, or chapter 460 for the sale or rental of electrostimulation medical equipment and electrostimulation medical equipment supplies to their patients in the course of their practice.

Section 2. This act shall take effect July 1, 2020.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1205 Price Transparency in Health Care Services
SPONSOR(S): Rodriguez, A.
TIED BILLS: **IDEN./SIM. BILLS:** SB 1626

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	14 Y, 0 N	Grabowski	Calamas
2) Insurance & Banking Subcommittee	13 Y, 0 N	Fortenberry	Cooper
3) Health & Human Services Committee		Grabowski	Calamas

SUMMARY ANALYSIS

The United States is experiencing significant changes in health care payment and delivery. Consumers bear a greater share of health care costs, and more participate in high deductible health plans. Clear, accurate information about the cost and quality of health care is necessary for consumers to select value-based health care.

HB 1205 prohibits a health insurer from limiting a health care provider's ability to disclose whether a patient's cost-sharing obligation under his or her health insurance exceeds the cash price for a covered service. In addition, insurers must not prevent providers from communicating the availability of more affordable services to insured patients.

The bill also prohibits an insurer from requiring an insured patient to make a payment for a health care service that exceeds the cash price of that service in the absence of health insurance.

The bill has no fiscal impact on state or local government.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Health Care Price Transparency

The United States is experiencing significant changes in health care payment and delivery. Consumers bear a greater share of health care costs, and more participate in high deductible health plans. Clear, factual information about the cost and quality of health care is necessary for consumers to select value-driven health care options and for consumers and providers to be involved in and accountable for decisions about health and health care services. To promote consumer involvement, health care pricing and other data needs to be free, timely, reliable, and reflect individual health care needs and insurance coverage.

Price transparency can refer to the availability of provider-specific information on the price for a specific health care service or set of services to consumers and other interested parties.[1] Price can be defined as an estimate of a consumer's complete cost on a health care service or services that reflects any negotiated discounts; is inclusive of all costs to the consumer associated with a service or services, including hospital, physician, and lab fees; and identifies a consumer's out-of-pocket cost.[2] Further, price transparency can be considered "readily available information on the price of health care services that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value."[3] Indeed, the definition or the price or cost of health care has different meanings depending on who is incurring the cost.[4]

As health care costs continue to rise, most health insurance buyers are asking their consumers to take on a greater share of their costs, increasing both premiums and out-of-pocket expenses. According to the Kaiser Family Foundation, more than one in five Americans with private insurance is enrolled in a high deductible health plan (HDHP). Most covered workers face additional out-of-pocket costs when they use health care services, such as co-payments or coinsurance for physician visits and hospitalizations. Eighty-one percent of covered workers have a general annual deductible for single coverage that must be met before most services are paid for by the plan.[5]

Among covered workers with a general annual deductible, the average deductible amount for single coverage is $1,573.[6] Deductibles differ by firm size; for workers in plans with a deductible, the average deductible for single coverage is $2,132 in small firms, compared to $1,355 for workers in large firms.[7] Sixty-eight percent of covered workers in small firms are in a plan with a deductible of at least $1,000 for single coverage compared to 54% in large firms; a similar pattern exists for those in plans with a deductible of at least $2,000 (42% for small firms vs. 20% for large firms). The chart below shows the percent of workers enrolled in employer-sponsored insurance with an annual deductible of $1,000 or more for single coverage by employer size for 2009 through 2018.[8]

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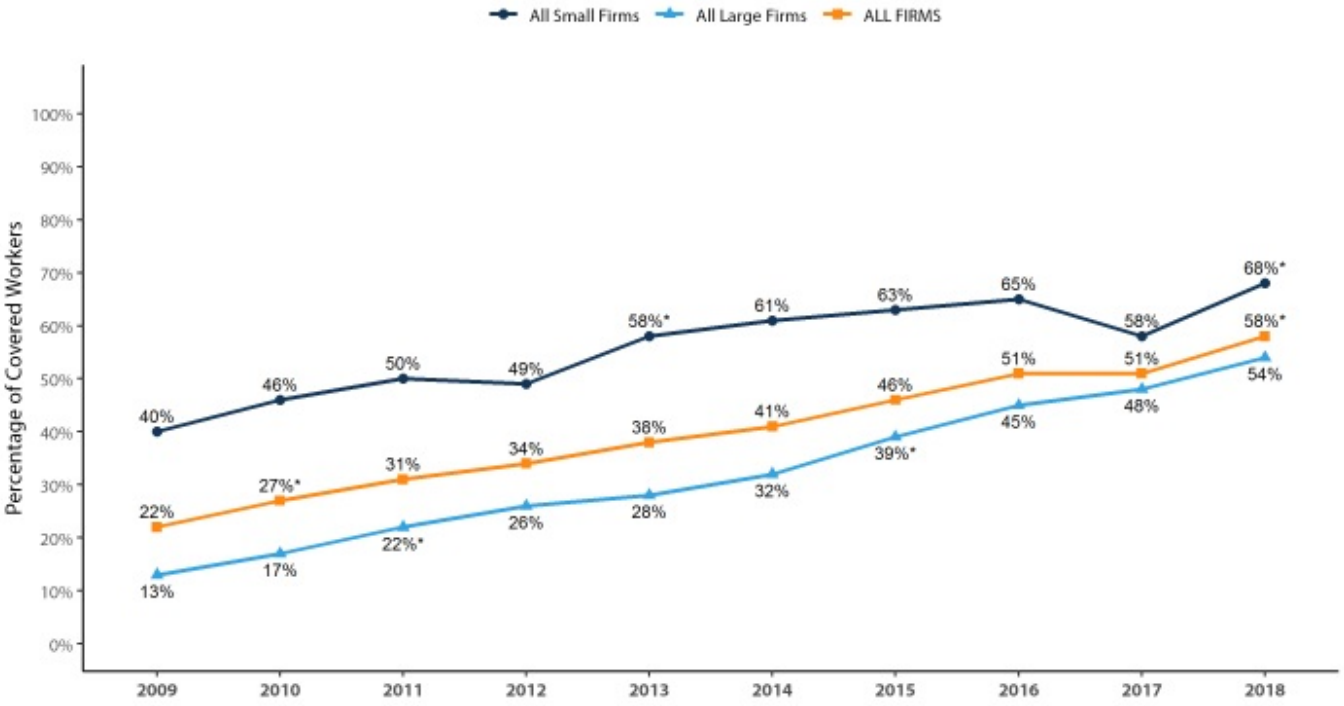
[1] Government Accounting Office, *Meaningful Price Information is Difficult for Consumers to Obtain Prior to Receiving Care*, September 2011, page 2, available at http://www.gao.gov/products/GAO-11-791 (last accessed December 16, 2019).
[2] Id.
[3] Healthcare Financial Management Association, *Price Transparency in Health Care: Report from the HFMA Price Transparency Task Force*, page 2, 2014, available at https://www.hfma.org/Content.aspx?id=22305 (last accessed December 16, 2019).
[4] Id.
[5] The Henry J. Kaiser Family Foundation, *2018 Employer Health Benefits Survey*, October 3, 2018, available at http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018 (last accessed December 16, 2019).
[6] Id.
[7] Id.
[8] Id, figure 7.13.

Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $1,000 or More for Single Coverage, by Firm Size, 2009-2018



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Looking at the increase in deductible amounts over time does not capture the full impact for workers because the share of covered workers in plans with a general annual deductible also has increased significantly, from 59% in 2008 to 78% in 2013 to 85% in 2018. If we look at the change in deductible amounts for all covered workers (assigning a zero value to workers in plans with no deductible), we can look at the impact of both trends together. Using this approach, the average deductible for all covered workers in 2018 is $1,350, up 53% from $883 in 2013 and 212% from $433 in 2008.

From 2013 to 2018, the average premium for covered workers with family coverage increased 20%, while wages have only increased 12%.[9] The dramatic increases in the costs of healthcare in recent years have focused significant attention on the need for greater communication and transparency to inform individual health care choices.

National Price Transparency Studies

To explore how expanding price transparency efforts could produce significant cost savings for the healthcare system, the Gary and Mary West Health Policy Center funded an analysis, "Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending." This report, conducted in collaboration with researchers from the Center for Studying Health System Change and RAND, found that implementation of three policy changes could save $100 billion over ten years.

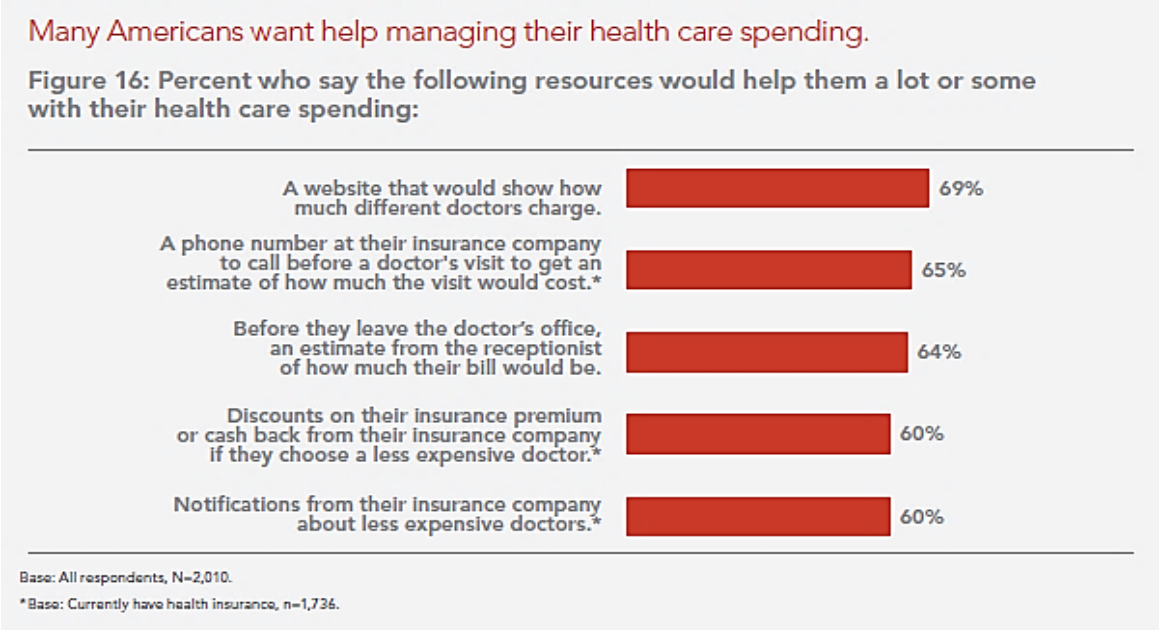
- Provide personalized out-of-pocket expense information to patients and families before receiving care.
- Provide prices to physicians through electronic health record systems when ordering treatments and tests.

[9] Id.

- Expand state-based all-payer health claims databases (APCDs), which could save up to $55 billion by collecting and providing data and analytics tools that supply quality, efficiency and cost information to policy makers, employers, providers, and patients.[10]

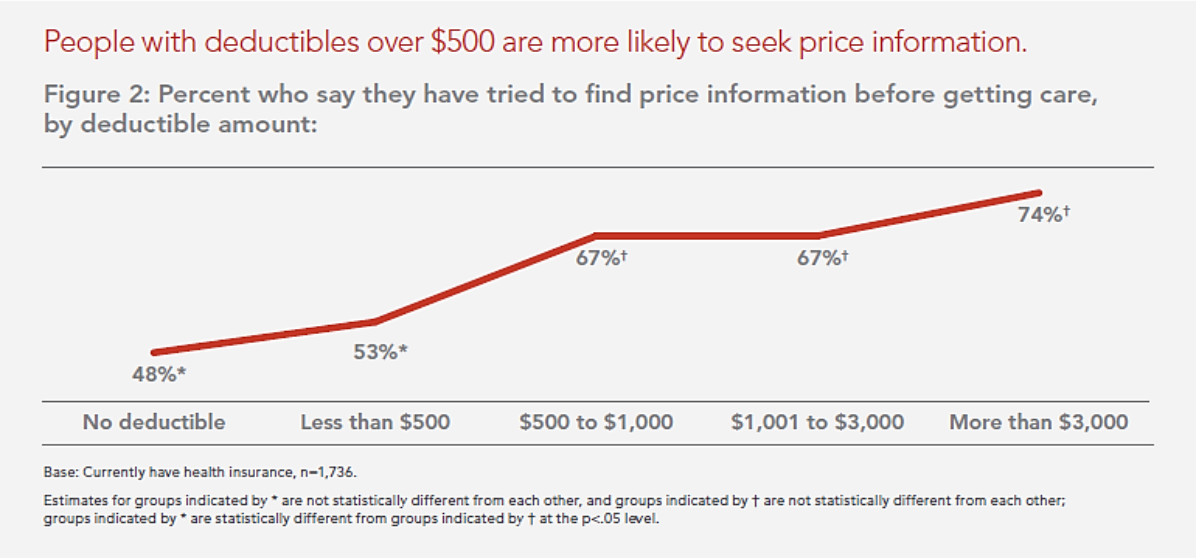
The report specifically found that requiring all private health insurance plans to provide personalized out-of-pocket price data to enrollees would reduce total health spending by an estimated $18 billion over the 10-year period from 2014 to 2023.[11]

As Americans take on more of their health care costs, research suggests that they are looking for more and better price information.[12]



[10] White, C., Ginsburg, P., et al., Gary and Mary West Health Policy Center, *Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending*, May 2014, available at http://www.westhealth.org/wp-content/uploads/2015/05/Price-Transparency-Policy-Analysis-FINAL-5-2-14.pdf (last accessed December 16, 2019).
[11] Id., pg. 1.
[12] Public Agenda and Robert Wood Johnson Foundation, *How Much Will It Cost? How Americans Use Prices in Health Care*, March 2015, pg. 34, available at https://www.publicagenda.org/files/HowMuchWillItCost_PublicAgenda_2015.pdf (last accessed December 16, 2019).

One study in 2014, which conducted a nationally representative survey of more than 2,000 adults, found that 56 percent of Americans actively searched for price information before obtaining health care, including 21 percent who compared the price of health care services across multiple providers.[13] The chart below illustrates the finding that, as a consumer's health plan deductible increases, the consumer is more likely to seek out price information.[14]



The individuals who compared prices stated that such research affected their health care choices and saved them money.[15] In addition, the study found that most Americans do not equate price with quality of care. Seventy one percent do not believe higher prices impart a higher level care quality and 63 percent do not believe that lower price is indicative of lower level care quality.[16] Consumers enrolled in high-deductible and consumer-directed health plans are more price-sensitive than consumers with plans that have much lower cost-sharing obligations. Accordingly, these consumers find an estimate of their individual out-of-pocket costs more useful than any other kind of health care price transparency tool.[17] Another study found that when they have access to well-designed reports on price and quality, 80 percent of health care consumers will select the highest value health care provider.[18]

Price Transparency in Florida Law

Patient's Bill of Rights and Responsibilities

In 1991, the Legislature enacted the Florida Patient's Bill of Rights and Responsibilities (Patient's Bill of Rights).[19] The statute established the right of patients to expect medical providers to observe standards of care in providing medical treatment and communicating with their patients.[20]

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[13] Id., pg. 3.
[14] Id., pg. 13.
[15] Id., pg. 4.
[16] Supra note 12.
[17] American Institute for Research, *Consumer Beliefs and Use of Information About Health Care Cost, Resource Use, and Value*, Robert Wood Johnson Foundation, October 2012, pg. 4, available at https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf402126 (last accessed December 16, 2019).
[18] Hibbard, JH, et al., An Experiment Shows That a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care, Health Affairs 2012; 31(3): 560-568.
[19] S. 1, ch. 91-127, Laws of Fla. (1991); s. 381.026, F.S.; The Florida Patient's Bill of Rights and Responsibilities is intended to promote better communication and eliminate misunderstandings between the patient and health care provider or health care facility. The rights of patients include standards related to individual dignity; information about the provider, facility, diagnosis, treatments, risks, etc.; financial information and disclosure; access to health care; experimental research; and patient's knowledge of rights and responsibilities. Patient responsibilities include giving the provider accurate and complete information regarding the patient's health, comprehending the course of treatment and following the treatment plan, keeping appointments, fulfilling financial obligations, and following the facility's rules and regulations affecting patient care and conduct.
[20] S. 381.026(3), F.S.

Under s. 381.026(4)(c), F.S., a patient has the right to request certain financial information from health care providers and facilities.[21] Specifically, upon request, a health care provider or health care facility must provide a person with a reasonable estimate of the cost of medical treatment prior to the provision of treatment.[22] Estimates must be written in language "comprehensible to an ordinary layperson".[23] The reasonable estimate does not preclude the health care provider or health care facility from exceeding the estimate or making additional charges as the patient's needs or medical condition warrant.[24] A patient has the right to receive a copy of an itemized bill upon request and to receive an explanation of charges upon request.[25]

The Patient's Bill of Rights also authorizes, but does not require, primary care providers[26] to publish a schedule of charges for the medical services offered to patients.[27] The schedule must include certain price information for at least the 50 services most frequently provided by the primary care provider.[28] The law also requires the posting of the schedule in a conspicuous place in the reception area of the provider's office and at least 15 square feet in size.[29] A primary care provider who publishes and maintains a schedule of charges is exempt from licensure fees for a single renewal of a professional license and from the continuing education requirements for a single 2-year period.[30] The law also requires urgent care centers to publish a schedule of charges for the medical services offered to patients.[31]

In addition, current licensure law requires all practitioners regulated by the Department of Health or its boards to provide an estimate for nonemergency services provided in a hospital or ambulatory surgical center, if the patient requests it. This provision is an enforceable licensure standard, and failure to provide the estimate is subject to a daily fine of $500 until the estimate is provided.[32]

Health Care Facilities

Under s. 395.301(1)(b)1., F.S., a health care facility[33] must provide, within 7 days of a request, a good faith estimate of reasonably anticipated charges for the facility to treat the patient's or prospective patient's condition. The facility is not required to adjust the estimate for any potential insurance coverage.[34] The facility must inform the patient or prospective patient of the option to contact his or her insurer or HMO to obtain additional information regarding cost-sharing.[35] Upon request, the facility must also notify the patient or prospective patient of any revision to the estimate.[36] Failure to timely provide the estimate as requested will result in a daily fine of $1,000 until the estimate is provided, with a total fine not to exceed $10,000.[37]

Pursuant to s. 395.301(1)(d)1., F.S., upon request and at discharges or release from a facility, the facility must provide a patient or the patient's survivor or legal guardian, an itemized bill or statement detailing the charges or expensed incurred by the patient.

Prescription Drug Transparency

[21] S. 381.026(4)(c), F.S.
[22] S. 381.026(4)(c)3., F.S.
[23] Id.
[24] Id.
[25] S. 381.026(4)(c)5., F.S.
[26] S. 381.026(2)(d), F.S., defines primary care providers to include allopathic physicians, osteopathic physicians, and nurses who provide medical services that are commonly provided without referral from another health care provider, including family and general practice, general pediatrics, and general internal medicine.
[27] S. 381.026(4)(c)3., F.S.
[28] Id.
[29] Id.
[30] S. 381.026(4)(c)4., F.S.
[31] S. 395.107(1), F.S.
[32] S. 456.0575(2), F.S.
[33] The term "health care facilities" refers to hospital, ambulatory surgical centers, and mobile surgical centers, all of which are licensed under ch. 395, part I, F.S.
[34] S. 395.301(1)(b)1., F.S.
[35] Id.
[36] Id.
[37] Id.

In 2018, the Legislature approved statutory changes to ensure that pharmacists can freely communicate pricing information to patients.[38] Those changes were aimed at pharmacy benefit managers (PBMs), which are entities that provide services related to the acquisition and distribution of prescription drugs. PBMs enter into contracts with both health plans and pharmacies. PBMs negotiate with drug manufacturers, on behalf of health plans, in an effort to purchase drugs at reduced prices or with the promise of additional rebates. This negotiation process often involves the development of drug formularies, which are tiered drug lists that incentivize the use of some drugs over others.[39] PBMs simultaneously negotiate with pharmacies to establish reimbursements for dispensing prescription drugs to patients.

Current Florida law requires contracts between pharmacy benefit managers (PBMs) and insurers or HMOs to include a prohibition on PBM practices that may limit the ability of a pharmacy or pharmacist to communicate with patients. Each contract must prohibit a PBM from restricting the ability of a pharmacy or pharmacist to disclose to a patient whether his or her cost sharing obligation under an insurance benefit exceeds the retail price of a drug, and whether a more affordable alternative drug may be available.[40]

Congress also passed two complementary laws in 2018 aimed at improving drug price transparency for insured patients.[41] The laws prohibit all private health insurers and all Medicare plans covering prescription drugs from limiting the ability of pharmacies and pharmacists to provide patients with relevant price information on the drugs they purchase. Under the laws, no PBM or insurer may prevent a pharmacist from informing a patient about any difference in the cost of a drug under that patient's insurance versus the cash price of the drug.

Both the federal laws and Florida law apply only to price information shared in the context of prescription drug coverage. Current law does not otherwise prohibit any limits on price transparency that may exist in contracts between health plans and service providers, such as physicians and clinics.

Effect of Proposed Changes

HB 1205 prohibits a health insurer from limiting a health care provider's ability to disclose whether a patient's cost-sharing obligation under his or her health insurance exceeds the cash price for a covered service.[42] The bill expands existing law protecting the communication rights of pharmacies and pharmacists to include all providers of health care services. In addition, an insurer may not prevent a provider from communicating the availability of more affordable services to an insured patient.

The bill also prohibits an insurer from requiring an insured patient to make a payment for a health care service that exceeds the cash price of that service in the absence of health insurance.

The bill provides an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Creates s. 627.4303, F.S.; relating to price transparency in contracts between health insurers and health care providers.
Section 2: Provides an effective date of July 1, 2020.

[38] Ch. 2018-91, Laws of Fla.
[39] Academy of Managed Care Pharmacy (AMCP). *Formulary Management*. Available at https://www.amcp.org/about/managed-care-pharmacy-101/concepts-managed-care-pharmacy/formulary-management (last accessed January 2, 2020). *See also* Pharmaceutical Care Management Association (PCMA). *Pharmacy Contracting & Reimbursement*. Available at https://www.pcmanet.org/policy-issues/pharmacy-contracting-reimbursement/ (last accessed January 2, 2020).
[40] Ss. 627. 64741, 627.6572, and 641.314, F.S.
[41] Public Laws 115-162 and 115-263.
[42] While cash price is not a defined term, in the healthcare context it generally refers to the price that a health care provider would charge a patient who does not have health insurance.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:
   None.

2. Expenditures:
   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:
   None.

2. Expenditures:
   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:
   None.

D. FISCAL COMMENTS:
   None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:
   Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:
   None.

B. RULE-MAKING AUTHORITY:
   The bill neither authorizes nor requires administrative rulemaking.

C. DRAFTING ISSUES OR OTHER COMMENTS:
   None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to price transparency in health care services; creating s. 627.4303, F.S.; defining the term "health insurer"; prohibiting limitations on price transparency with patients in contracts between health insurers and health care providers; prohibiting a health insurer from requiring an insured to make a payment in a certain amount for a covered service; providing an effective date.

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

Section 1. Section 627.4303, Florida Statutes, is created to read:

627.4303 Price transparency in health care services.—

(1) As used in this section, the term "health insurer" means a health insurer issuing major medical coverage through an individual or group policy or a health maintenance organization issuing major medical coverage through an individual or group contract.

(2) In its contract with a health care provider, a health insurer may not limit the health care provider's ability to disclose whether a patient's cost-sharing obligation exceeds the cash price for a covered service in the absence of health insurance coverage or the availability of a more affordable

service.

(3) A health insurer may not require an insured to make a payment for a covered service in an amount that exceeds the cash price of the service in the absence of health insurance coverage.

Section 2. This act shall take effect July 1, 2020.

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Rodriguez, A. offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Section 627.4303, Florida Statutes, is created to read:

627.4303 Price transparency in health care services.—

(1) As used in this section, the term "health insurer" means a health insurer issuing major medical coverage through an individual or group policy.

(2) In its contract with a health care provider, a health insurer may not limit the health care provider's ability to disclose whether a patient's cost-sharing obligation exceeds the cash price for a covered service in the absence of health

insurance coverage or the availability of a more affordable service.

(3) A health insurer may not require an insured to make a payment for a covered service in an amount that exceeds the cash price of the service in the absence of health insurance coverage.

Section 2. Paragraph (g) is added to subsection (5) of section 627.6699, Florida Statutes, to read:

627.6699 Employee Health Care Access Act.—

(5) AVAILABILITY OF COVERAGE.—

(g) A health benefit plan covering small employers must comply with s. 627.4303.

Section 3. Section 641.514, Florida Statutes, is created to read:

641.514 Price transparency in health care services.—

(1) This section applies to a health maintenance organization issuing major medical coverage through an individual or a group contract.

(2) In its contract with a health care provider, a health maintenance organization may not limit the health care provider's ability to disclose whether a patient's cost-sharing obligation exceeds the cash price for a covered service in the absence of coverage through the health maintenance organization or the availability of a more affordable service.

(3) A health maintenance organization may not require a subscriber to make a payment for a covered service in an amount that exceeds the cash price of the service in the absence of coverage through the health maintenance organization.

Section 4. This act shall take effect July 1, 2020.

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 price transparency in health care services; creating s. 627.4303, F.S.; defining the term "health insurer"; prohibiting limitations on price transparency with patients in contracts between health insurers and health care providers; prohibiting a health insurer from requiring an insured to make a payment for a covered service that exceeds a certain amount; amending s. 627.6699, F.S.; requiring health benefit plans covering small employers to comply with such restrictions; creating s. 641.514, F.S.; prohibiting limitations on price transparency with patients in contracts between health maintenance organizations and health care providers; prohibiting a health maintenance organization from requiring a subscriber to make a payment for a covered service that exceeds a certain amount; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1255 Childbirth
SPONSOR(S): Health Quality Subcommittee, Mercado
TIED BILLS: **IDEN./SIM. BILLS:** SB 1764

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	15 Y, 0 N, As CS	Siples	McElroy
2) Health & Human Services Committee		Siples	Calamas

SUMMARY ANALYSIS

Midwifery is the practice of supervising a normal labor and childbirth, with the informed consent of the parent, advising the parents as to the progress of childbirth, and rendering prenatal and postpartal care. The Department of Health (DOH) licenses and regulates the practice of midwifery in this state. The Council of Licensed Midwifery assists and advises DOH on midwifery, including the development of rules relating to regulatory requirements, including but not limited to training requirements, the licensure examination, responsibilities of midwives, emergency care plans, and reports and records to be filed by licensed midwives.

Informed consent generally requires a patient to confirm that they understand the risks and benefits of medical treatment and agree to undergo or participate in the medical treatment. Licensed midwives must obtain informed consent on a form developed by DOH. The form requires a licensed midwife to explain, among other things, the licensed midwife's services and qualifications and the nature of the risk of the procedures used by the licensed midwife. The informed consent form also expressly authorizes the midwife to provide midwifery services to the client.

CS/HB 1255 expands current statutory requirements for the DOH-developed informed consent form for midwifery services. The bill requires the DOH form to inform the patient of the option to obtain medical care from a licensed physician or certified nurse midwife and information detailing the licensed midwife's hospital admitting privileges and professional liability insurance status.

The bill will have an insignificant, negative fiscal impact on DOH, which can be absorbed within current resources. The bill has no fiscal impact on local governments.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Licensed Midwives

Midwifery is the practice of supervising a normal labor and childbirth, with the informed consent of the parent, advising the parents as to the progress of childbirth, and rendering prenatal and postpartal care.[1] The Department of Health (DOH) licenses and regulates the practice of midwifery in this state. The Council of Licensed Midwifery assists and advises DOH on midwifery, including the development of rules relating to regulatory requirements, including but not limited to training requirements, the licensure examination, responsibilities of midwives, emergency care plans, and reports and records to be filed by licensed midwives.[2]

An individual must graduate from an approved midwifery program and pass a licensure examination to be eligible for licensure as a midwife.[3] A licensed midwife must submit a general emergency care plan to DOH, which addresses consultation with other health care providers, emergency transfer protocols, and access to neonatal intensive care units and obstetrical units or other patient care areas with his or her application for licensure and licensure renewal.[4] A licensed midwife must also submit proof of professional liability coverage of at least $100,000, with an annual aggregate of at least $300,000.[5]

A licensed midwife must:[6]

- Accept only those patients who are expected to have a normal pregnancy, labor, and delivery;
- Provide collaborative prenatal and postnatal care, within a written protocol with a physician who maintains supervision for directing the specific course of treatment if a patient is not at low risk in her pregnancy;
- Ensure that each patient has signed the informed consent form developed by DOH;
- Administer medicinal drugs pursuant to a prescription issued by an allopathic or osteopathic physician;
- Prepare a written plan of action with the family to ensure continuity of medical care and to provide for immediate medical care if an emergency arises;
- Maintain appropriate equipment and supplies and instructing the patient and family regarding the preparation of the environment, if a home birth is planned;
- Instruct the patient in the hygiene of pregnancy and nutrition as it relates to prenatal care;
- Determine the progress of labor, and when birth is imminent, be immediately available until delivery is accomplished;
- Remain with the postpartal mother until the mother and neonate are stabilized;
- Instill a prophylactic into each eye of the newborn infant within one hour after birth for the prevention of neonatal ophthalmia;[7] and
- Ensure that the care of mothers and infants throughout the prenatal, intrapartal, and postpartal periods conforms to DOH rules and the state's public health laws.

[1] Section 467.003(8), F.S.
[2] Section 467.004, F.S.
[3] Section 467.011, F.S. Section 467.0125, F.S., provides for licensure by endorsement for applicants who hold a valid license to practice midwifery in another state.
[4] Section 467.017, F.S.
[5] Rule 64B24-7.013, F.A.C. An applicant does not have to submit proof of professional liability insurance if the applicant practices exclusively as an officer, employee, or agent of the federal government, practices only in conjunction with teaching duties at an approved midwifery school that provides such coverage on the applicant's behalf, or who does not practice midwifery in this state and provides proof of such.
[6] Section 467.015, F.S.
[7] Section 383.04, F.S.

Risk Assessment

A licensed midwife must assess the risk status of each potential patient to determine whether the licensed midwife can accept the patient or continue caring for the patient.[8] The licensed midwife must obtain a detailed medical history, perform a physical examination, and assess family circumstances along with social and psychological factors. DOH provides a scoring system, in rule, for these factors that assigns each factor a value of one to three.[9] For example, a heart disease assessed by a cardiologist which does not place the mother or fetus at any risk has a score of one and chronic hypertension has a score of three.

If the assessment results in a risk score of three or higher, the licensed midwife must consult with a physician who has obstetrical hospital privileges.[10] If there is a joint determination that the patient can be expected to have a normal pregnancy, labor, and delivery, the licensed midwife may provide services to the patient.[11]

Responsibilities during Pregnancy and Delivery

The Florida Administrative Code outlines the licensed midwife's responsibilities during the antepartum, intrapartum, and postpartum periods. During each of these periods, the licensed midwife must assess the patient for risk factors and either consult with or transfer the patient's care to a physician.

In the antepartum period, a licensed midwife must refer the patient for a consultation with a physician with hospital obstetrical privileges if one of the following occurs:

- Hematocrit of less than 33% at 37th week gestation or hemoglobin less than 11 gms/100 ml;
- Unexplained vaginal bleeding;
- Abnormal weight change defined as less than 12 or more than 50 pounds at term;
- Non-vertex presentation persisting past 37th week of gestation;
- Gestational age between 41 and 42 weeks;
- Genital herpes confirmed clinically or by culture at term;
- Documented asthma attack;
- Hyperemesis not responsive to supportive care; or
- Any other severe obstetrical, medical or surgical problem

A licensed midwife must transfer a patient if one of the following occurs:

- Genetic or congenital abnormalities or fetal chromosomal disorder;
- Multiple gestation;
- Pre-eclampsia;
- Intrauterine growth retardation;
- Thrombophlebitis;
- Pyelonephritis;
- Gestational diabetes confirmed by abnormal glucose tolerance test; or
- Laboratory evidence of Rh sensitization.

The licensed midwife may continue caring for the patient if the condition is resolved satisfactorily and the physician and licensed midwife determine that the patient is expected to have a normal pregnancy, labor, and deliver,.[12]

During the intrapartum period or labor, the licensed midwife must consult with a physician or refer or transfer a patient to a physician with hospital obstetrical privileges if one of the following occurs:[13]

[8] Rule 64B24-7.004, F.A.C.
[9] Rule 64B24-7.004(3), F.A.C.
[10] Rule 64B24-7.004(1), F.A.C.
[11] Id.
[12] Id.

- Premature labor, meaning labor occurring at less than 37 weeks of gestation;
- Premature rupture of membranes, meaning rupture occurring more than 12 hours before onset of regular active labor;
- Non-vertex presentation;
- Evidence of fetal distress;
- Abnormal heart tones;
- Moderate or severe meconium staining;
- Estimated fetal weight less than 2,500 grams or greater than 4,000 grams;
- Pregnancy induced hypertension;
- Failure to progress in active labor;
- Severe vulvar varicosities;
- Marked edema of cervix;
- Active bleeding;
- Prolapse of the cord;
- Active infectious process; or
- Other medical or surgical problems.

A licensed midwife may not perform any operative procedures other than clamping and cutting the umbilical cord, episiotomies, suturing to repair first and second degree lacerations, and artificial rupture of the membranes under certain conditions.[14] A licensed midwife may also not attempt to correct a fetal presentation and may not use artificial, forcible, or mechanical means to assist a birth.[15]

A licensed midwife must consult with physician or refer or transfer an infant under certain conditions, such as if the child has jaundice, respiratory problems, or major congenital anomalies.[16] The licensed midwife must consult with a physician or transfer a mother for emergency care if any postpartum complications arise, such as retained placenta or postpartum hemorrhage.[17] The licensed midwife must stay with the mother and infant for at least two hours after the birth or until the mother's and infant's conditions are stable, whichever is longer.[18]

Adverse Incident Reporting

A licensed midwife must submit an adverse incident report to DOH within 15 days of adverse incident occurring, providing a summary of the events that occurred. An adverse incident is an event over which the licensed midwife could exercise control and one of the following occurs:[19]

- A maternal death that occurs after delivery or within 42 days after delivery;
- A maternal patient is transferred to a hospital intensive care unit;
- A maternal patient experiences hemorrhagic shock or requires a transfusion of more than four units of blood or blood products;
- A fetal or newborn death, including a still birth, attributable to an obstetrical delivery;
- A newborn patient is transferred to a hospital neonatal intensive care unit (NICU) due to a traumatic birth injury; or
- A newborn patient is transferred to a hospital NICU within 72 hours after birth if the newborn remains in the NICU for more than 72 hours.

DOH must review the report and determine whether the incident involves conduct requiring disciplinary action against the midwife's license.[20]

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[13] Rule 64B24-7.008(4), F.A.C.
[14] Rule 64B24-7.008(5), F.A.C.
[15] Rules 64B24-7.008(6) and 64B24-7.008(8), F.A.C.
[16] Rule 64B24-7.009(2), F.A.C.
[17] Rule 64B24-7.009(5), F.A.C.
[18] Rule 64B24-7.009(4), F.A.C.
[19] Section 456.0495, F.S.
[20] Id.

Informed Consent

Informed consent is the process by which a patient learns about and understands the purpose, benefits, and potential risks of a medical intervention, and then agrees to receive the treatment.[21] Informed consent generally requires the patient, or the patient's representative if the patient is incapacitated, to sign a statement confirming that they understand the risks and benefits of the treatment or procedure.[22]

A licensed midwife must obtain informed consent from the patient on a form developed by DOH.[23] The form explains that licensed midwives care for women who have normal, uncomplicated pregnancies and expect a normal delivery of a healthy newborn.[24] In signing the informed consent form, the patient acknowledges that:[25]

- The licensed midwife has explained her training and experience;
- The patient is aware of the benefits of natural childbirth relating to avoidance of potential injury resulting from either invasive procedures, anesthesia, or surgical intervention;
- In order to obtain care by the midwife, the patient must:
    - Provide a complete medical, health, and maternity history;
    - Review risk factors and other requirements with the midwife;
    - Maintain a regular schedule for prenatal visits; and
    - Make a plan for emergency care, with the assistance of the midwife, for unforeseen complications that may arise during pregnancy and delivery, as well as any pediatric care necessary for the baby;
- The licensed midwife provided the status of the midwife's malpractice insurance, including the amount of insurance; and
- The patient had an opportunity to review and discuss information contained in the informed consent form, including the conditions which require the midwife to refer or transfer care.

The form also requires the patient to expressly authorize the licensed midwife to perform maternity services that are within the scope of the midwifery license and provides that a copy of the statute and rules are available upon request.[26]

Effect of Proposed Changes

CS/HB 1255 expands the requirements for informed consent for midwifery services and requires the form to include information on:

- The option to obtain medical care from a licensed physician or certified nurse midwife;
- The hospital admitting privileges of the licensed midwife; and
- The professional liability insurance status of the licensed midwife.

The bill also makes technical, non-substantive changes to improve readability.

The bill provides an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Amends s. 467.016, F.S., relating to informed consent.

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[21] William Schiel, Jr., MD, FACP, FACR, MedicineNet, *Medical Definition of Informed Consent*, (last rev. Dec. 2018), available at https://www.medicinenet.com/cosmetic_surgery_before_after_pictures_slideshow/article.htm (last visited January 22, 2020).
[22] Id.
[23] Section 467.016, F.S.
[24] Form DH-MQA 1047, Rev. 3/01, incorporated by reference in r. 64B24-7.005, F.A.C., available at http://www.floridahealth.gov/licensing-and-regulation/midwifery/resources/_documents/midwife-consent.pdf (last visited January 22, 2020).
[25] Id.
[26] Id.

Section 2: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   DOH will incur costs associated with undertaking rulemaking activities to revise the informed consent form, which can be absorbed within current resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Licensed midwives will have to print and make available revised informed consent forms.

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:

DOH has sufficient rulemaking authority to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to informed consent for midwifery services; amending s. 467.016, F.S.; requiring a licensed midwife to use a specified form to inform the client of options for obtaining medical care, the licensed midwife's admitting privileges at a hospital, and such midwife's professional liability insurance coverage; providing an effective date.

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

Section 1. Section 467.016, Florida Statutes, is amended to read:

467.016 Informed consent.—The department shall develop a uniform client informed-consent form to be used by the licensed midwife to obtain the client's consent for the provision of midwifery services and to inform the client of:

(1) The qualifications of a licensed midwife. ~~and~~

(2) The nature and risk of the procedures to be used by a licensed midwife.

(3) The option to obtain medical care from a physician licensed under chapter 458 or chapter 459 or a certified nurse midwife licensed under part I of chapter 464.

(4) The licensed midwife's admitting privileges at a hospital.

(5) The professional liability insurance coverage maintained by the licensed midwife ~~and to obtain the client's consent for the provision of midwifery services~~.

Section 2. This act shall take effect July 1, 2020.

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Mercado offered the following:

Amendment (with title amendment)

Between lines 23 and 24, insert:

(4) The licensure status of the midwife and any disciplinary action taken against the midwife's license within the preceding 5 years.

(5) The number of patients for which the midwife transferred care to a hospital or a physician within the preceding 5 years.

(6) The number of adverse incident reported to the department pursuant to s. 456.0459, within the preceding 5 years that resulted in disciplinary action against the midwife's license.

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

Remove line 5 and insert:
client of options for obtaining medical care, the availability of information on the midwife's license, the number of transfers of care and adverse incident reports by the midwife within a certain timeframe, the

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1289 Informed Consent for Pelvic Examinations
SPONSOR(S): Health Quality Subcommittee, Jenne
TIED BILLS: **IDEN./SIM. BILLS:** SB 1470

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	13 Y, 0 N, As CS	Siples	McElroy
2) Health & Human Services Committee		Siples	Calamas

SUMMARY ANALYSIS

Informed consent is a process in which a health care provider educates a patient about the risks, benefits, and alternatives of a given procedure or intervention. Such information will enable a patient to make a competent decision about whether to undergo a procedure or treatment.

Recently, news outlets have reported that medical students may be performing pelvic examinations on anesthetized or unconscious women, without obtaining informed consent from the woman prior to anesthesia or from any other person who can provide consent. This practice had been standard since the 1800s, but in recent years the practice has been met with disapproval by professional medical associations.

CS/HB 1289 prohibits a health care practitioner from performing a pelvic examination on a patient without express written consent unless an exception applies. A health care practitioner does not have to obtain written consent if the pelvic examination is required by a court order or is immediately necessary to avert a serious risk of imminent substantial and irreversible physical impairment of a major bodily function of the patient.

The bill has an insignificant, negative fiscal impact on the Department of Health, which current resources are sufficient to absorb. The bill has no fiscal impact on local governments.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Informed Consent

Informed consent for medical treatment is fundamental in both ethics and law.[1] Informed consent is a process in which a health care provider educates a patient about the risks, benefits, and alternatives of a given procedure or intervention.[2] A patient must be competent to make a voluntary decision about whether to undergo a procedure. Foregoing the process of consent within medicine can result in violations of both autonomy and basic rights, as well as trust.[3]

The idea of informed consent was established in 1914, in a case in which a patient was operated on without her consent.[4] In determining whether she had a cause of action against the hospital in which the operation was formed, Judge Cardozo opined that "every human being of adult years and sound mind has a right to determine what shall be done to his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable for damages."[5]

Florida Requirements for Informed Consent

Florida law does not contain a general statute on informed consent. However, Florida physicians and physicians practicing within a postgraduate training program approved by the Board of Medicine must explain the medical or surgical procedure to be performed to the patient and obtain the informed consent of the patient.[6] However, the physician does not have to obtain or witness the signature of the patient on a written form evidencing informed consent.

Pelvic Examinations

A pelvic examination involves the visual examination of the external genitalia and an internal visual examination of the vaginal walls and cervix using a speculum and palpation of the pelvic organs.[7] Health care practitioners often perform pelvic examinations as a part of the annual well woman visit.[8] A health care practitioner may also perform a pelvic examination to diagnose specific health conditions, such as cancer and bacterial vaginosis.[9]

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[1] American Medical Association, *Informed Consent: Code of Medical Ethics Opinion 2.1.1*, available at https://www.ama-assn.org/delivering-care/ethics/informed-consent (last visited January 31, 2020).
[2] William Gossman, Imani Thornton, John Hipskind, *Informed Consent*, (July 2019), available at https://www.ncbi.nlm.nih.gov/books/NBK430827/ (last visited January 31, 2020).
[3] Phoebe Friesen, *Educational Pelvic Exams on Anesthetized Women: Why Consent Matters (Abstract),* 32 BIOETHICS 298 (June 2018), available at https://onlinelibrary.wiley.com/doi/abs/10.1111/bioe.12441 (last visited January 31, 2020).
[4] *Schloendorff v. Society of N.Y. Hosp.*, 105 N>E. 92, 93 (N.Y. 1914).
[5] Id.
[6] Rule 64B8-9.007, F.A.C.
[7] Id. A pelvic examination usually involves an examination of woman's vulva, vagina, uterus, ovaries, and fallopian tubes. It may also include examination of the bladder and the rectum. Melissa Conrad Stoppler, MD, *Pelvic Exam*, MedicineNet, available at https://www.medicinenet.com/pelvic_exam/article.htm#why_is_a_pelvic_exam_performed (last visited January 31, 2020).
[8] Amir Qaseem, et al., *Screening Pelvic Examination in Adult Women: A Clinical Practice Guideline from the American College of Physicians*, 161 Ann Intern Med 67 (2014), available at https://annals.org/aim/fullarticle/1884537/screening-pelvic-examination-adult-women-clinical-practice-guideline-from-american?_ga=2.7498674.1663533724.1580510917-1215329083.1580510917 (last visited January 31, 2020).
[9] Id.

Benefits of routine pelvic examinations include early detection of treatable gynecologic conditions before symptoms occur and incidental findings such as dermatologic changes and foreign bodies.[10] These examinations also give the health care practitioner an opportunity to establish open communication with the patient to answer specific questions and reassure her of normalcy.[11]

New clinical guidelines have recommended against pelvic examinations on asymptomatic, non-pregnant, adult women.[12] Routine pelvic examination has not been shown to benefit such women in that it rarely detects important disease and does not reduce mortality.[13] Several harms have been identified for the performance of pelvic examinations including fear, anxiety, embarrassment, pain, and discomfort.[14] Other physical harms include urinary tract infections and symptoms such as dysuria and frequent urination.[15]

The American College of Obstetricians and Gynecologists finds that data is currently insufficient to make a recommendation for or against routine pelvic examinations.[16] Therefore, it recommends that pelvic examinations be performed when indicated by medical history or symptoms, such as abnormal bleeding, pelvic pain, or urinary issues.[17]

Pelvic Examinations on Unconscious or Anesthetized Patients

In recent years, articles have detailed reports of medical students performing pelvic examinations, without consent, on women who are anesthetized or unconscious.[18] This practice has been common since the late 1800s and in 2003, a study reported that 90 percent of medical students who completed obstetrics and gynecology rotations at four Philadelphia-area hospitals performed pelvic examinations on anesthetized patients for educational purposes.[19]

Several medical organizations have taken positions that pelvic examinations should not be performed on anesthetized or incapacitated patients. The American Medical Association Council on Ethical and Judicial Affairs recommends that in situations where the patient will be temporarily incapacitated (e.g., anesthetized) and where student involvement is anticipated, involvement should be discussed before the procedure is undertaken whenever possible.[20]
The Committee on Ethics of the American College of Obstetricians and Gynecologists resolved that "pelvic examinations on an anesthetized woman that offer her no personal benefit and are performed

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[10] American College of Obstetricians and Gynecologists, Committee on Gynecologic Practice, *ACOG Committee Opinion, Number 754*, 132(4) OBSTETRICS & GYNECOLOGY 174 (Oct. 2018), available at https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/The-Utility-of-and-Indications-for-Routine-Pelvic-Examination?IsMobileSet=false (last visited January 31, 2020).
[11] Id.
[12] *Supra* note 8. This recommendation does not apply to pap smears.
[13] American College of Physicians, *American College of Physicians Recommends Against Screening Pelvic Examinations in Adult, Asymptomatic, Average Risk, Non-Pregnant Women*, (July 1, 2014), available at https://www.acponline.org/acp-newsroom/american-college-of-physicians-recommends-against-screening-pelvic-examination-in-adult-asymptomatic (last visited on January 31, 2020).
[14] Id.
[15] Id.
[16] Id.
[17] Id.
[18] *For examples, see:* Paul Hsieh, *Pelvic Exams on Anesthetized Women Without Consent: A Troubling and Outdated Practice*, FORBES (May 14, 2018), available at https://www.forbes.com/sites/paulhsieh/2018/05/14/pelvic-exams-on-anesthetized-women-without-consent-a-troubling-and-outdated-practice/#74d152df7846 (last visited January 31, 2020); Dr. Jennifer Tsai, *Medical Students Regularly Practice Pelvic Exams on Unconscious Patients. Should They?*, ELLE (June 24, 2019), available at https://www.elle.com/life-love/a28125604/nonconsensual-pelvic-exams-teaching-hospitals/ (last visited January 31, 2020); Lorelei Laird, *Pelvic Exams Performed without Patients' Permission Spur New Legislation*, ABA JOURNAL (Sept. 2019), available at http://www.abajournal.com/magazine/article/examined-while-unconscious (last visited January 31, 2020); and Amanda Eisenberg, *New Bills Would Ban Pelvic Exams without Consent*, POLITICO (March 14, 2019), available at https://www.politico.com/states/new-york/albany/story/2019/03/13/new-bills-would-ban-pelvic-exams-without-consent-910976 (last visited January 31, 2020).
[19] John Duncan, Dan Luginbill, Matthew Richardson, Robin Fretwell Wilson, *Using Tort Law to Secure Patient Dignity: Often Used as Teaching Tools for Medical Students, Unauthorized Pelvic Exams Erode Patient Rights, Litigation Can Reinstate Them*, 40 TRIAL 42 (Oct. 2004).
[20] AMA Council on Ethical and Judicial Affairs, *Medical Student Involvement in Patient Care: Report of the Council on Ethical and Judicial Affairs*, AMA Journal of Ethics (Mar. 2001), available at https://journalofethics.ama-assn.org/article/medical-student-involvement-patient-care-report-council-ethical-and-judicial-affairs/2001-03 (last visited January 31, 2020).

solely for teaching purposes should be performed only with her specific informed consent obtained before her surgery".[21]

The Association of American Medical Colleges (AAMC), reversing its prior policy position, offered that "performing pelvic examinations on women under anesthesia, without their knowledge or approval … is unethical and unacceptable".[22] However, the chief health care officer for the AAMC notes that recent articles on unauthorized pelvic examinations rely on studies from more than 10 years ago and before more detailed informed consent forms were used. [23]The AAMC claims that students and residents typically practice pelvic examinations with special mannequins and standardized patients who are specifically trained for this purpose.[24]

California, Hawaii, Illinois, Iowa, Maryland, Oregon, Utah, and Virginia prohibit unauthorized pelvic examinations.[25]

Effect of Proposed Changes

CS/HB 1289 prohibits a health care practitioner[26] from performing a pelvic examination on a patient without express written consent unless an exception applies. A health care practitioner must obtain written consent from the patient or the patient's representative that expressly identifies that a pelvic examination will be performed. The bill does not require a health care practitioner does not have to obtain consent for a pelvic examination from a patient or patient's representative if:

- A court orders a pelvic examination be performed to collect evidence; or
- The pelvic examination is immediately necessary to avert a serious risk of imminent substantial and irreversible physical impairment of a major bodily function of the patient.

The bill defines pelvic examination as the direct palpation of the organs of the female internal reproductive system.

The bill provides an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Creates s. 456.51, F.S., relating to health care practitioners; consent for pelvic examinations.
Section 2: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

[21] American College of Obstetricians and Gynecologists, Committee on Ethics, *Professional Responsibilities in Obstetric-Gynecologic Medical Education and Training*, (Aug. 2011), available at https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/Professional-Responsibilities-in-Obstetric-Gynecologic-Medical-Education-and-Training?IsMobileSet=false (last visited January 31, 2020).
[22] Robin Fretwell Wilson, *Autonomy Suspended: Using Female Patients to Teach Intimate Exams Without Their Knowledge or Consent*, 8 J OF HEALTH CARE LAW AND POLICY 240, available at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=880120 (last visited January 31, 2020).
[23] Id.
[24] Id.
[25] Lorelei Laird, *Pelvic Exams Performed without Patients' Permission Spur New Legislation*, ABA JOURNAL (Sept 2019), available at http://www.abajournal.com/magazine/article/examined-while-unconscious (last visited January 31, 2020).
[26] Pursuant to s. 456.001(4), F.S., health care practitioners are defined to include acupuncturists, physicians, physician assistants, chiropractors, podiatrists, naturopaths, dentists, dental hygienists, optometrists, nurses, nursing assistants, pharmacists, midwives, speech language pathologists, nursing home administrators, occupational therapists, respiratory therapists, dieticians, athletic trainers, orthotists, prosthetists, electrologists, massage therapists, clinical laboratory personnel, medical physicists, dispensers of optical devices or hearing aids, physical therapists, psychologists, social workers, counselors, and psychotherapists, among others.

2. Expenditures:

   DOH may experience an increase in workload associated with additional complaints, investigations, and prosecutions, which current resources are adequate to absorb.[27]

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

Rule-making authority is not required to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 3, 2020, the Health Quality Subcommittee adopted a strike-all amendment and reported the bill favorably as a committee substitute. The strike-all amendment:

- Revised the definition of "pelvic examination" to mean the direct palpation of the internal reproductive organs of a female.
- Prohibited a health care practitioner from performing any pelvic examination without written consent of the patient or his or her representative, unless it is court-order or necessary to avert a serious health risk to the patient.

The analysis is drafted to the committee substitute as passed by the Health Quality Subcommittee.

[27] Department of Health, *2020 Agency Legislative Bill Analysis for HB 1289*, (Jan. 27, 2020), on file with the Health Quality Subcommittee.

A bill to be entitled

An act relating to informed consent for pelvic examinations; creating s. 456.51, F.S.; defining the term "pelvic examination"; prohibiting a health care practitioner from performing a pelvic examination on a patient without first obtaining the written consent of the patient or the patient's legal representative; providing exceptions; providing an effective date.

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

Section 1. Section 456.51, Florida Statutes, is created to read:

456.51 Health care practitioners; consent for pelvic examinations.—

(1) As used in this section, the term "pelvic examination" means the direct palpation of the organs of the female internal reproductive system.

(2) A health care practitioner may not perform a pelvic examination on a patient without the written consent of the patient or the patient's legal representative executed specific to, and expressly identifying, the pelvic examination, unless:

(a) A court orders performance of the pelvic examination for the collection of evidence; or

(b) The pelvic examination is immediately necessary to

avert a serious risk of imminent substantial and irreversible physical impairment of a major bodily function of the patient.

Section 2. This act shall take effect July 1, 2020.

HB 6031

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 6031 Florida Kidcare Program
SPONSOR(S): Pigman
TIED BILLS: **IDEN./SIM. BILLS:** SB 348

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	13 Y, 0 N	Grabowski	McElroy
2) Health Care Appropriations Subcommittee	11 Y, 0 N	Nobles	Clark
3) Health & Human Services Committee		Grabowski	Calamas

SUMMARY ANALYSIS

The Florida Kidcare Program (Kidcare) was created by the Florida Legislature in 1998 in response to the federal enactment of the State Children's Health Insurance Program in 1997 (CHIP). Kidcare provides subsidized health insurance coverage to uninsured children who do not qualify for Medicaid but who meet other eligibility requirements. The state statutory authority for Kidcare is found in part II of ch. 409, F.S. Kidcare coverage is funded by state and federal funds through Title XIX (Medicaid) and Title XXI (CHIP) of the federal Social Security Act.

Kidcare encompasses four programs: Medicaid for children, the Medikids program, the Children's Medical Services Network and the Florida Healthy Kids program. The Florida Healthy Kids program under the Florida Healthy Kids Corporation (FHKC) provides health coverage to children from age 5 through age 18 who live in households meeting certain eligibility thresholds.

Health care coverage provided under the Healthy Kids program is subject to a $1 million lifetime limit for each enrolled child. If an enrolled child incurs $1 million in health benefits expenditures, the child is disenrolled from the Healthy Kids program. In 2018, the federal Centers for Medicare and Medicaid Services (CMS) informed the Agency for Health Care Administration (AHCA) that Florida's use of the $1 million lifetime coverage limit for the Healthy Kids program was in violation of federal Title XXI regulations related to program eligibility and enrollment. As part of a required corrective action plan, the CMS directed AHCA to either eliminate the annual coverage limit or institute a coverage limit in compliance with federal CHIP regulations.

HB 6031 deletes the $1 million lifetime coverage limit that currently applies to each child enrolled in the Florida Healthy Kids program. With this change, no child would be removed from coverage eligibility by virtue of accumulating benefit claims that exceed a dollar amount threshold.

The bill has an insignificant, negative, recurring fiscal impact to the AHCA and no fiscal impact on local governments. The FHKC should be able to absorb the state and federal costs within existing appropriations and corporate reserve funds. If this bill becomes law, the Social Services Estimating Conference would incorporate the future minimal costs in the official expenditure estimates.

The bill takes effect upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Florida Kidcare Program

The Florida Kidcare Program (Kidcare) was created by the Florida Legislature in 1998 in response to the federal enactment of the State Children's Health Insurance Program in 1997, later known more simply as the Children's Health Insurance Program (CHIP). The federal authority for the CHIP is located in Title XXI of the Social Security Act. The CHIP provides subsidized health insurance coverage to uninsured children who do not qualify for Medicaid but who meet other eligibility requirements. The state statutory authority for the Program is found in part II of ch. 409, F.S.

Kidcare encompasses four programs:

- Medicaid for children;
- The Medikids program;
- The Children's Medical Services Network; and
- The Florida Healthy Kids program.

Kidcare coverage is funded by state and federal funds through Title XIX (Medicaid) and Title XXI (CHIP) of the federal Social Security Act. Families also contribute to the monthly premium cost of the coverage under the Title XXI-funded components of Kidcare based on their household size, income, and other eligibility factors. For families with incomes above the income limits for monthly premium assistance or who do not otherwise qualify for assistance, Kidcare also offers an option under the Healthy Kids component and the Medikids component for the family to obtain coverage for their children by paying the full premium.

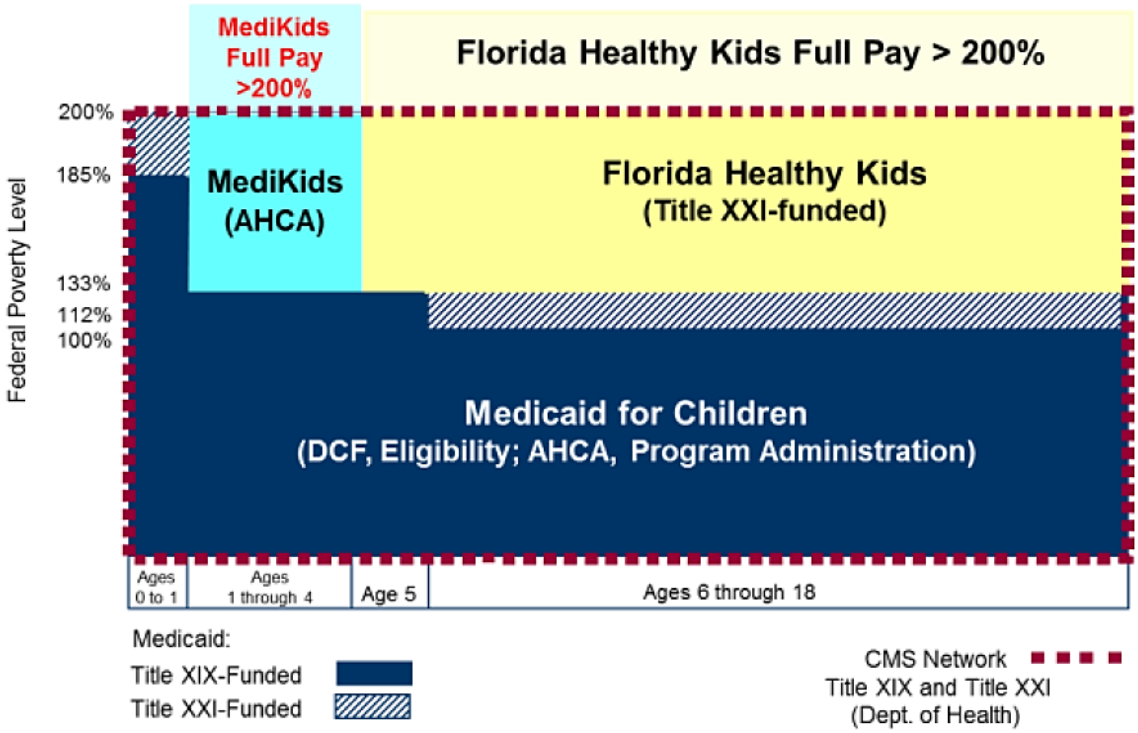
Eligibility for the Program components that are funded by Title XXI is determined in part by age and household income:

Program	Age Range	Family Income
Medicaid for Children	Birth until age 1	185-200% of federal poverty level (FPL)
Medikids	Age 1 until age 5	133-200% of FPL
Healthy Kids	Age 5 until age 6	133-200% of FPL
	Age 6 until age 19	100-200% FPL
Children's Medical Services Network	Birth until age 19 (children with special needs)	Up to 200% FPL

Kidcare is administered jointly by the Agency for Health Care Administration (AHCA), the Department of Children and Families (DCF), the Department of Health (DOH), and the Florida Healthy Kids Corporation (FHKC). Each entity has specific duties and responsibilities under Kidcare as detailed in part II of ch. 409, F.S. The DCF determines eligibility for Medicaid, and the FHKC processes all Kidcare applications and determines eligibility for the CHIP, which includes a Medicaid screening and referral process to the DCF, as appropriate. The Department of Health assesses whether children meet the Children's Medical Services Network clinical requirements.

At present, more than 2.4 million Florida children are enrolled in Kidcare.[1]
The following chart summarizes eligibility and funding for Kidcare.[2]

[1] Healthy Kids, *What is Florida KidCare?*, available at: https://www.healthykids.org/kidcare/what/ (last visited January 31, 2020).



Florida Healthy Kids Lifetime Maximum

Unlike the other components of Florida Kidcare, coverage provided under the Healthy Kids program is subject to a statutory $1 million lifetime limit for each enrolled child.[3] If an enrolled child incurs $1 million in health benefits expenditures, the FHKC removes that child from the Healthy Kids program. The FHKC reports that 12 children have been disenrolled from Health Kids in the past five years by virtue of exceeding the lifetime maximum coverage limit.[4] The FHKC notifies a family when a child has reached $700,000 in covered benefits, reminds the family of the $1 million coverage limit, and informs the family of alternative coverage options.[5]

On November 13, 2018, the federal Centers for Medicare and Medicaid Services (CMS) informed AHCA that Florida's use of the $1 million lifetime coverage limit for the Healthy Kids program was in violation of federal Title XXI regulations related to program eligibility and enrollment.[6] The CMS ordered the AHCA to complete a corrective action plan to address these violations and bring the Healthy Kids program into compliance with relevant federal regulations. The agency initially submitted a correction action plan to the CMS in February of 2019[7]; a revised version of this plan was approved by the CMS on July 26, 2019.[8]

As part of the approved corrective action plan, the AHCA agreed to submit a state plan amendment to the CMS to reflect revised program parameters. If the state wishes to establish a lifetime coverage limit

[2] Institute for Child Health Policy at University of Florida, *Florida KidCare Program Evaluation 2015*, available at http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/program_policy/FLKidCare/PDF/2015_Florida_Kidcare_Evaluation_Report.pdf (last viewed January 31, 2020).
[3] S. 409.815(2)(r), F.S.
[4] E-mail correspondence from Mr. Jeff Dykes, Interim Chief Executive Office for FHKC (September 27, 2019)(On file with the Health Quality Subcommittee).
[5] Agency for Health Care Administration, *Senate Bill 348 Analysis* (October 9, 2019) (On file with the Health Quality Subcommittee).
[6] Correspondence from the Centers for Medicare and Medicaid Services to the Agency for Health Care Administration (November 13, 2018)(On file with the Health Quality Subcommittee). The letter indicates violations of several federal regulations under 42 CFR 457.342.
[7] Correspondence from the Agency for Health Care Administration to the Centers for Medicare and Medicaid Services (February 11, 2019)(On file with the Health Quality Subcommittee).
[8] Correspondence from the Centers for Medicare and Medicaid Services to the Agency for Health Care Administration (July 26, 2019)(On file with the Health Quality Subcommittee).

for the Healthy Kids program, it must be in compliance with federal CHIP enrollment and eligibility regulations.[9] The CMS noted that the automatic disenrollment of children who reach a certain coverage threshold is inconsistent with continuous enrollment policies set at the federal level. Moreover, AHCA is required to reset the coverage balances for all children currently enrolled in the Healthy Kids program. Only services provided after January 1, 2020 may be counted towards any revised lifetime coverage limit.[10]

The AHCA has indicated that it will be submitting a state plan amendment to the CMS to reflect these directives, with an effective date of January 1, 2020.[11]

Effect of the Bill

HB 6031 repeals the $1 million lifetime coverage limit that currently applies to each child enrolled in the Florida Healthy Kids program. With this change, no child would be removed from coverage eligibility by virtue of accumulating benefit claims that exceed a dollar amount threshold.

Removing the lifetime coverage limit will result in the expenditure of additional state and federal revenues in support of the Healthy Kids program. See Fiscal Analysis & Economic Impact Statement.

The bill takes effect upon becoming law.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.815, F.S., relating to health benefits coverage; limitations.
Section 2: Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The FHKC has developed estimates of the additional federal Medicaid matching funds that would become available to the state following the elimination of the Healthy Kids lifetime limit[12], as follows:

FY 2019-20: $233,668
FY 2020-21: $893,373
FY 2021-22: $947,956

These estimates are based on the payment rate proposals submitted by the three carriers selected to contract with FHKC effective January 1, 2020.[13] The state would continue to collect recurring federal Medicaid funds in future years, relative to what would have been collected under current law.

2. Expenditures:

The FHKC also developed estimates of increased state general revenue spending that may occur following elimination of the Healthy Kids lifetime limit[14], as follows:

[9] Id.
[10] Id.
[11] Supra note 5.
[12] Letter from Mercer Consulting Services to Mr. Jeff Dykes, Chief Financial Officer for FHKC (January 17, 2020)(On file with the Health Care Appropriations Subcommittee).
[13] Supra note 12.
[14] Supra note 12.

FY 2019-20: $42,764
FY 2020-21: $281,163
FY 2021-22: $344,467

These estimates are based on the payment rate proposals submitted by the three carriers selected to contract with FHKC effective January 1, 2020.[15] The state would continue to spend recurring general revenue in future years, relative to what would have been spent under current law. The FHKC should be able to absorb the state and federal costs within existing appropriations and corporate reserve funds. If this bill becomes law, the Social Services Estimating Conference would incorporate the future minimal costs in the official expenditure estimates.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rulemaking authority to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[15] Supra note 12.

A bill to be entitled

An act relating to the Florida Kidcare program; amending s. 409.815, F.S.; removing the lifetime maximum cap on covered expenses for a child enrolled in the Florida Healthy Kids program; conforming a cross-reference; providing an effective date.

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

Section 1. Paragraph (r) and present paragraph (u) of subsection (2) of section 409.815, Florida Statutes, are amended to read:

409.815 Health benefits coverage; limitations.—

(2) BENCHMARK BENEFITS.—In order for health benefits coverage to qualify for premium assistance payments for an eligible child under ss. 409.810-409.821, the health benefits coverage, except for coverage under Medicaid and Medikids, must include the following minimum benefits, as medically necessary.

~~(r) *Lifetime maximum.*—Health benefits coverage obtained under ss. 409.810-409.820 shall pay an enrollee's covered expenses at a lifetime maximum of $1 million per covered child.~~

(t)~~(u)~~ *Enhancements to minimum requirements.*—

1. This section sets the minimum benefits that must be included in any health benefits coverage, other than Medicaid or Medikids coverage, offered under ss. 409.810-409.821. Health

benefits coverage may include additional benefits not included under this subsection, but may not include benefits excluded under paragraph (r) ~~(s)~~.

2. Health benefits coverage may extend any limitations beyond the minimum benefits described in this section.

Except for the Children's Medical Services Network, the agency may not increase the premium assistance payment for either additional benefits provided beyond the minimum benefits described in this section or the imposition of less restrictive service limitations.

Section 2. This act shall take effect upon becoming a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 6059 Specialty Hospitals
SPONSOR(S): Health Care Appropriations Subcommittee, Fitzenhagen
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	9 Y, 4 N	Guzzo	Calamas
2) Health Care Appropriations Subcommittee	7 Y, 4 N, As CS	Nobles	Clark
3) Health & Human Services Committee		Guzzo	Calamas

SUMMARY ANALYSIS

A specialty hospital, rather than treating all conditions for all populations as a general hospital does, instead offers:

- A range of medical services restricted to a defined age or gender group;
- A restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical or psychiatric illnesses or disorders; or
- Intensive residential treatment programs for children and adolescents.

Florida law bans certain types of specialty hospitals. It prohibits licensure of a hospital that restricts its medical and surgical services to primarily or exclusively cardiac, orthopedic, surgical, or oncology specialties; or for which more than 65 percent of discharges are for care of certain cardiac, orthopedic, or cancer-related diseases and disorders.

The bill repeals the prohibition on licensure of a specialty hospital that restricts its medical and surgical services to primarily or exclusively cardiac, orthopedic, surgical, or oncology specialties; or for which more than 65% of discharges are for care of certain cardiac, orthopedic, or cancer-related diseases and disorders.

Due to federal law, this repeal would have no impact on specialty hospitals that are partly or wholly owned by physicians.

CS/HB 6059 authorizes 2.0 full-time equivalent positions, with associated salary rate of 128,000, and appropriates the sums of $211,290 in recurring and $18,294 in nonrecurring funds from the Health Care Trust Fund to the Agency for Health Care Administration. The bill has no fiscal impact local on government.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Hospital Licensure

Hospitals are regulated by AHCA under chapter 395, F.S., and the general licensure provisions of part II, of chapter 408, F.S. Hospitals offer a range of health care services with beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care.[1] Hospitals must make regularly available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment.[2]

Hospitals must meet initial licensing requirements by submitting a completed application and required documentation, and the satisfactory completion of a facility survey. The license fee is $1,565.13 per hospital or $31.46 per bed, whichever is greater.[3] The inspection fee is $8.00 to $12.00 per bed, but at a minimum $400.00 per facility.[4]

Section 395.1055, F.S., authorizes AHCA to adopt rules for hospitals. Separate standards may be provided for general and specialty hospitals.[5] The rules for general and specialty hospitals must include minimum standards to ensure:

- A sufficient number of qualified types of personnel and occupational disciplines are on duty and available at all times to provide necessary and adequate patient care;
- Infection control, housekeeping, sanitary conditions, and medical record procedures are established and implemented to adequately protect patients;
- A comprehensive emergency management plan is prepared and updated annually;
- Licensed facilities are established, organized, and operated consistent with established standards and rules; and
- Licensed facility beds conform to minimum space, equipment, and furnishing standards.
- All hospitals submit such data as necessary to conduct certificate-of-need reviews required under part I of chapter 408, F.S.;
- Each hospital has a quality improvement program designed according to standards established by their current accrediting organization;
- Licensed facilities make available on their internet websites, and in a hard copy format upon request, a description of and a link to the patient charge and performance outcome data collected from licensed facilities;
- All hospitals providing organ transplantation, neonatal intensive care services, inpatient psychiatric services, inpatient substance abuse services, or comprehensive medical rehabilitation meet the minimum licensure requirements adopted by the agency.[6]

The minimum standards for hospital licensure are contained in Chapter 59A-3, F.A.C.

[1] S.395.002(12), F.S.
[2] Id.
[3] Rule 59A-3.066(3), F.A.C.
[4] S. 395.0161(3)(a), F.S.
[5] S. 395.1055(2), F.S.
[6] S. 395.1055(1), F.S.

Specialty Hospitals

A specialty hospital, rather than treating all conditions for all populations as a general hospital does, instead offers:

- A range of medical services restricted to a defined age or gender group;
- A restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical or psychiatric illnesses or disorders; or
- Intensive residential treatment programs for children and adolescents.[7]

Specialty hospitals may not provide any service or regularly serve any population group other than those services or groups specified in its license.[8]

Florida law bans certain types of specialty hospitals.[9] Florida law prohibits the licensure of a hospital that restricts its medical and surgical services to primarily or exclusively cardiac, orthopedic, surgical, or oncology specialties.[10] Florida law also prohibits the licensure of hospitals if 65 percent of more of the hospital's discharges are for the diagnostic care and treatment of patients who have:

- Cardiac-related diseases and disorders classified as diagnosis-related groups in major diagnostic category 5[11];
- Orthopedic-related diseases and disorders classified as diagnosis-related groups in major diagnostic category 8[12];
- Cancer-related diseases and disorders classified as discharges in which the principal diagnosis is neoplasm or carcinoma or is for an admission for radiotherapy or antineoplastic chemotherapy or immunotherapy; or
- Any combination of the above discharges.[13]

Florida law exempts from the ban hospitals classified as an exempt cancer center hospital pursuant to federal rule 42 C.F.R. s. 412.23(f)[14] as of December 31, 2005.[15] Two hospitals qualify for this exemption: H. Lee Mofitt Cancer and Research Institute Hospital, Inc., and the University of Miami Hospital and Clinics.[16]

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[7] S. 395.002(27), F.S.
[8] S. 395.003(6)(a), F.S.
[9] S. 395.003(8), F.S.
[10] S. 395.003(8)(b), F.S
[11] Major Diagnostic Category 5 is for diseases and disorders of the circulatory system.
[12] Major Diagnostic Category 8 is for diseases and disorders of the musculoskeletal system and connective tissue.
[13] S. 395.003(8)(a), F.S
[14] 42 C.F.R., s. 412.23(f)(1) *General Rule*- If a hospital meets the following criteria, it is classified as a cancer hospital and is excluded from the prospective payment systems: (i) It was recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983; (ii) It is classified on or before December 31, 1990, or, if on December 19, 1989, the hospital was located in a state operating a demonstration project, the classification is made on or before December 31, 1991; (iii) It demonstrates that the entire facility is organized primarily for treatment of and research on cancer (that is, the facility is not a subunit of an acute general hospital or university-based medical center; and (iv) It shows that at least 50% of its total discharges have a principal diagnosis that reflects a finding or neoplastic disease.
(2) *Alternative*- A hospital that applied for and was denied, on or before December 31, 1990, classification as a cancer hospital under the criteria in paragraph (f)(1) above is classified as a cancer hospital and is excluded from the prospective payment systems if it meets the criteria set forth in paragraph (f)(1)(i) above and the hospital is: (i) Licensed for fewer than 50 acute care beds as of August 5, 1997; (ii) Is located in a state that as of December 19, 1989, was not operating a demonstration project; and (iii) Demonstrates that, for the 4-year period ending on December 31, 1996, at least 50% of its total discharges have a principal diagnosis that reflects a finding of neoplastic disease.
[15] S. 395.003(8)(c), F.S
[16] Centers for Medicare & Medicaid Services, *PPS-Exempt Cancer Hospitals*, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/PPS_Exc_Cancer_Hospasp (last viewed February 9, 2020).

Florida law also exempts from the ban a hospital licensed as of June 1, 2004, if the hospital maintains the same ownership, facility street address, and range of services that were in existence on June 1, 2004.[17] H. Lee Mofitt Cancer and Research Institute Hospital, Inc., also qualifies for this exemption.

Physician Owned Hospitals

Under the federal Patient Protection and Affordable Care Act (PPACA), Medicare-certified hospitals that are partly or wholly owned by physicians as of December 31, 2010, are barred from increasing their aggregate percentage of physician ownership and expanding their number of operating and procedure rooms and beds unless they qualify for an exemption. Federal law also prohibits physicians from referring Medicaid or Medicare patients to any hospital in which they have an ownership share if the hospital was formed after December 31, 2010. A study of physician-owned hospitals found that the ban on Medicare and Medicaid reimbursement effectively banned the formation of new physician-owned hospitals.[18]

Effect of Proposed Changes

Specialty Hospitals

The bill repeals the prohibition on the licensure of a hospital that restricts its medical and surgical services to primarily or exclusively cardiac, orthopedic, surgical, or oncology specialties. The bill also repeals the prohibition on the licensure of specialty hospitals whose discharges are over 65 percent or more of the following:

- Cardiac-related diseases and disorders classified as diagnosis-related groups in major diagnostic category 5;
- Orthopedic-related diseases and disorders classified as diagnosis-related groups in major diagnostic category 8;
- Cancer-related diseases and disorders classified as discharges in which the principal diagnosis is neoplasm or carcinoma or is for an admission for radiotherapy or antineoplastic chemotherapy or immunotherapy; or
- Any combination of the above discharges.

As a result, non-physician-owned specialty hospitals would be permitted to dedicate up to 100 percent of their services to the diagnosis and treatment of cardiac, orthopedic, or cancer related diseases and disorders, and new specialty hospitals could be licensed.

Due to the PPACA ban on physician-owned hospitals, the bill would not result in additional physician-owned specialty hospitals.

The bill provides an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Amends s. 395.003, F.S., relating to licensure; denial, suspension, and revocation.
Section 2: Provides an effective date of July 1, 2020.

[17] S. 395.003(9), F.S.
[18] Elizabeth Plummer and William Wempe, *The Affordable Care Act's Effects on the Formation, Expansion, and Operation of Physician Owned Hospitals*, Health Affairs 2016; 35(8). Prior to the restrictions going into effect, there was a surge in the formation of physician owned hospitals in Texas that receded almost immediately afterwards. Between 2004 and 2009, 64 new physician owned hospitals were formed, representing just under 66% of all new for-profit hospitals in the state. In 2010, 20 new physician-owned hospitals were formed, amounting to more than 83% of new Texas hospitals. From 2011 through 2013, after the restrictions went into effect, only 9 new physician owned hospitals were formed, accounting for 41% of new for-profit hospitals. As of June 2016, all physician owned hospitals formed after 2011 were either sold or in bankruptcy proceedings.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

Applicants for licensure as a specialty hospital will be subject to the current Plans and Construction project review fee of $2,000[19] plus $100 per hour for building plan reviews[20], an application fee of at least $1,500[21], and a licensure inspection fee of $400[22].

Licensure and inspection fees would be collected every two years.

2. Expenditures:

The number of hospitals that might seek licensure as a specialty hospital is unknown. AHCA has indicated that as a result of the potential increased workload, additional FTEs will be needed for the bureau to continue to perform plans review timely.

For the 2020-2021 fiscal year, CS/HB 6059 as amended authorizes 2.0 full-time equivalent positions, with associated salary rate of 128,000, and appropriates the sums of $211,290 in recurring and $18,294 in nonrecurring funds from the Health Care Trust Fund to the Agency for Health Care Administration.

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

2. Other:

None.

[19] S. 395.0163(2), F.S.
[20] Id.
[21] Rule 59A-3.066(3), F.A.C.
[22] Rule 59A-3.253(4), F.A.C.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rulemaking authority to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 28, 2020, the Health Care Appropriations Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment authorizes 2.0 full-time equivalent positions, with associated salary rate of 128,000, and appropriates the sums of $211,290 in recurring and $18,294 in nonrecurring funds from the Health Care Trust Fund to the Agency for Health Care Administration for the purpose of implementing this act.

This analysis is drafted to the committee substitute as passed by the Health Care Appropriations Subcommittee.

A bill to be entitled

An act relating to specialty hospitals; amending s. 395.003, F.S.; removing provisions relating to the prohibition of licensure for certain hospitals that serve specific populations; authorizing positions and providing appropriations; providing an effective date.

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

Section 1. Subsections (8), (9), and (10) of section 395.003, Florida Statutes, are amended to read:

395.003 Licensure; denial, suspension, and revocation.—

~~(8) A hospital may not be licensed or relicensed if:~~

~~(a) The diagnosis-related groups for 65 percent or more of the discharges from the hospital, in the most recent year for which data is available to the Agency for Health Care Administration pursuant to s. 408.061, are for diagnosis, care, and treatment of patients who have:~~

~~1. Cardiac-related diseases and disorders classified as diagnosis-related groups in major diagnostic category 5;~~

~~2. Orthopedic-related diseases and disorders classified as diagnosis-related groups in major diagnostic category 8;~~

~~3. Cancer-related diseases and disorders classified as discharges in which the principal diagnosis is neoplasm or carcinoma or is for an admission for radiotherapy or~~

~~antineoplastic chemotherapy or immunotherapy; or~~

~~4. Any combination of the above discharges.~~

~~(b) The hospital restricts its medical and surgical services to primarily or exclusively cardiac, orthopedic, surgical, or oncology specialties.~~

~~(c) A hospital classified as an exempt cancer center hospital pursuant to 42 C.F.R. s. 412.23(f) as of December 31, 2005, is exempt from the licensure restrictions of this subsection.~~

~~(9) A hospital licensed as of June 1, 2004, shall be exempt from subsection (8) as long as the hospital maintains the same ownership, facility street address, and range of services that were in existence on June 1, 2004. Any transfer of beds, or other agreements that result in the establishment of a hospital or hospital services within the intent of this section, shall be subject to subsection (8). Unless the hospital is otherwise exempt under subsection (8), the agency shall deny or revoke the license of a hospital that violates any of the criteria set forth in that subsection.~~

~~(10) The agency may adopt rules implementing the licensure requirements set forth in subsection (8). Within 14 days after rendering its decision on a license application or revocation, the agency shall publish its proposed decision in the Florida Administrative Register. Within 21 days after publication of the agency's decision, any authorized person may file a request for~~

~~an administrative hearing. In administrative proceedings challenging the approval, denial, or revocation of a license pursuant to subsection (8), the hearing must be based on the facts and law existing at the time of the agency's proposed agency action. Existing hospitals may initiate or intervene in an administrative hearing to approve, deny, or revoke licensure under subsection (8) based upon a showing that an established program will be substantially affected by the issuance or renewal of a license to a hospital within the same district or service area.~~

Section 2. For the 2020-2021 fiscal year, two full-time equivalent positions with associated salary rate of 128,000 are authorized and the sums of $211,290 in recurring and $18,294 in nonrecurring funds from the Health Care Trust Fund are appropriated to the Agency for Health Care Administration for the purpose of implementing this act.

Section 3. This act shall take effect July 1, 2020.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7039 PCB SAC 20-01 Repeal of Advisory Bodies and Programs
SPONSOR(S): State Affairs Committee, Rodriguez, A.
TIED BILLS: None **IDEN./SIM. BILLS:** SB 1636

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: State Affairs Committee	23 Y, 0 N	Etheridge	Williamson
1) Education Committee	12 Y, 0 N	Fudge	Hassell
2) Health & Human Services Committee		Guzzo	Calamas

SUMMARY ANALYSIS

Under Florida law, a “committee” or “task force” is an advisory body created by the Legislature without specific statutory enactment, for a time not to exceed one year in duration, or created by specific statutory enactment, for a time not to exceed three years. Generally, a committee or task force is appointed to study a specific problem and recommend a solution or policy alternative addressing the problem, and upon completion of that mission, the committee terminates. The Legislature must terminate advisory bodies that are no longer necessary and beneficial to the furtherance of a public purpose.

The bill repeals advisory bodies and programs that have been deemed inactive or unnecessary and are therefore no longer necessary and beneficial to the furtherance of a public purpose.

The bill will likely have a positive fiscal impact on state government because abolishing these advisory bodies and councils will eliminate their administrative costs and expenses.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Advisory Bodies, Commissions, and Boards

Under Florida law, a "committee" or "task force" is an advisory body created by the Legislature without specific statutory enactment, for a time not to exceed one year in duration, or created by specific statutory enactment, for a time not to exceed three years.[1] Generally, a committee or task force is appointed to study a specific problem and recommend a solution or policy alternative addressing the problem, and upon completion of that mission, the committee terminates.

An advisory body, commission, board of trustees, or any other collegial body created by specific statutory authority as an adjunct to an executive agency must be established, evaluated, and maintained in accordance with the following provisions:[2]

- It must be created only when it is necessary and beneficial to the furtherance of a public purpose;
- It must be terminated when it is no longer necessary and beneficial to the furtherance of a public purpose;
- The Legislature and the public must be kept informed of the numbers, purposes, memberships, activities, and expenses of advisory bodies, commissions, boards of trustees, and other collegial bodies established as adjuncts to executive agencies; and
- It must meet a statutorily defined purpose and its power must conform to the definitions for governmental units.[3]

As such, the Legislature must terminate advisory bodies that are no longer necessary and beneficial to the furtherance of a public purpose.[4]

This bill repeals inactive or unnecessary advisory bodies and programs that are no longer necessary and beneficial to the furtherance of a public purpose.

Citrus/Hernando Waterways Restoration Council

Background

The Citrus/Hernando Waterways Restoration Council was established, in 2003, in response to regional concerns for the health of Citrus and Hernando county waterways.[5] It is the council's responsibility to review audits and all data specifically related to lake and river restoration techniques and sport fish population recovery strategies, evaluate whether additional studies are needed, explore all possible sources of funding to conduct restoration activities, and report to the Legislature on the progress made and any recommendations for the next fiscal year. The council last submitted an annual report in 2015.

In 2014, the Southwest Florida Water Management District formed its Springs Coast Steering Committee, which performs the same work as the council.

Effect of the Bill

The bill repeals the Citrus/Hernando Waterways Restoration Council.

[1] S. 20.03(8), F.S.
[2] S. 20.052, F.S.
[3] Section 20.03, F.S., provides definitions for governmental units.
[4] S. 20.052(2), F.S.
[5] Ch. 2003-28, Laws of Fla. In 2006, the Legislature expanded the council's responsibilities to include all of the waterways in Citrus and Hernando Counties. Ch. 2006-43, Laws of Fla.

My Safe Florida Home Program Advisory Council

Background

The My Safe Florida Home Program (program) is established within the Department of Financial Services (DFS) to develop and implement a comprehensive and coordinated approach for hurricane damage mitigation. The program provides trained and certified inspectors to perform inspections for owners of site-built, single-family, residential properties. It also provides grants to eligible applicants as funding allows.

In 2006, the My Safe Florida Home Program Advisory Council was established to advise DFS in its administration of the program.[6] The program, after fulfilling its purpose, ceased operations in 2008. As such, the council has not been utilized.

Effect of the Bill
The bill repeals the My Safe Florida Home Program Advisory Council.

The Great Floridian Program

Background

The Great Floridian Program is a program administered under the Division of Historical Resources within the Department of State to recognize and record the achievements of Floridians, living and deceased, who have made major contributions to the progress and welfare of this state.[7] Annually, the division must convene an ad hoc committee to nominate not fewer than two persons whose names must be submitted to the Secretary of State with the recommendation that they be honored with the designation "Great Floridian."[8]

The last time Great Floridian recognitions were made was in 2013. In addition, a 2008 sunset review report by the Office of Program Policy Analysis and Government Accountability recommended abolishing the committee.[9]

Effect of the Bill
The bill removes the requirement that the division annually convene an ad hoc committee to administer the Great Floridian Program.

Florida Film and Entertainment Advisory Council

Background

The Office of Film and Entertainment is created within the Department of Economic Opportunity (DEO) for the purpose of developing, marketing, promoting, and providing services to the state's entertainment industry.[10] The Florida Film and Entertainment Advisory Council was established to provide DEO and the Office of Film and Entertainment with industry insight and expertise related to developing, marketing, promoting, and providing service to the state's entertainment industry.[11] The Office of Film and Entertainment has not received funding for its program for several years. Without such funding, the office's operational capabilities and activities have been limited in recent years, which reduces or eliminates the need for an advisory council.

[6] S. 215.5586(4), F.S.
[7] S. 267.0731, F.S.
[8] *Id.*
[9] Office of Program Policy Analysis and Government Accountability, *Department of State Advisory Committees Assessment*, The Florida Legislature Sunset Review, December 2008, at 7. Available at http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/08-S12.pdf.
[10] S. 288.1251, F.S.
[11] S. 288.1252, F.S.

Effect of the Bill

The bill repeals the Florida Film and Entertainment Advisory Council.

Geneva Freshwater Lens Task Force

Background

The Geneva Freshwater Lens Task Force was created in 1993 to provide a means by which representatives from state agencies, local government, water management districts, environmental organizations, industry, and the public at large could evaluate the management needs of the Geneva Freshwater Lens for the proper protection of the public interest and to recommend actions for addressing any deficiencies discovered.[12] The task force was directed to present a report to the President of the Senate and the Speaker of the House of Representatives by December 1, 1993, which evaluated the adequacy of current planning, regulatory, and other programs and made recommendations for future management of the Geneva Freshwater Lens.[13]

The task force submitted its report and in 1995, the Legislature directed the appropriate state agencies to implement the recommendations of the Geneva Freshwater Lens Task Force.[14]

Effect of the Bill

The bill repeals provisions relating to the Geneva Freshwater Lens Task Force, because the task force has completed its responsibilities and the Legislature directed implementation of its recommendations.

Brownfield Areas Loan Guarantee Council

Background

The Brownfield Areas Loan Guarantee Council was established in 1998 to support the Brownfield Areas Loan Guarantee Program, which provides tax credits for rehabilitation of brownfield sites in designated brownfield areas. The term “brownfield sites” means real property, the expansion, redevelopment, or reuse of which may be complicated by actual or perceived environmental contamination.[15] The term “brownfield area” means a contiguous area of one or more brownfield sites, some of which may not be contaminated, and which has been designated by a local government by resolution. Brownfield areas may include all or portions of community redevelopment areas, enterprise zones, empowerment zones, other such designated economically deprived communities and areas, and Environmental Protection Agency-designated brownfield pilot projects.[16]

The Brownfield Areas Loan Guarantee Council reviews certain partnership agreements with local governments, financial institutions, and other entities associated with the redevelopment of brownfields for limited guarantees of loans or loss reserves.[17] By 2006, the loan guarantee provisions had been used only once. As such, the council does not appear to be active.

Effect of the Bill

The bill repeals the Brownfield Areas Loan Guarantee Council.

[12] Ch. 93-273, L.O.F.
[13] *Id.*
[14] Ch. 95-377, L.O.F.; codified at s. 373.4597(3), F.S.
[15] S. 376.79(4), F.S.
[16] S. 376.79(5), F.S.
[17] S. 376.86, F.S.

Nonmandatory Land Reclamation Committee

Background

The Nonmandatory Land Reclamation Committee was created within the Department of Environmental Protection (DEP) to advise the department on nonmandatory land reclamation and recommend approval, modification, or denial of reclamation grant applications submitted by landowners for lands disturbed by phosphate mining prior to July 1, 1975.[18] According to DEP's website, all projects for nonmandatory land reclamation have been identified and selected.[19] No new applicants are being accepted as the funding program will end when the last of the projects are funded and released. As such, the committee appears to be inactive.

Effect of the Bill

The bill repeals the Nonmandatory Land Reclamation Committee within DEP. The bill also modifies procedures governing reclamation program applications to conform to the repeal of the committee. Specifically, the bill requires DEP staff to present applicants to the Secretary of DEP and to make recommendations and prioritize applications for approval, rather than the committee. As such, if applicants are considered in the future, DEP will serve in place of the committee.

Sturgeon Production Working Group

Background

The Sturgeon Production Working Group was created within the Department of Agriculture and Consumer Services (DACS) to coordinate the implementation of a state sturgeon production management plan to promote the commercial production and stock enhancement of sturgeon in the state.[20] The group has not met since 2009.

Effect of the Bill

The bill repeals the Sturgeon Production Working Group within DACS.

Trap Certificate Technical Advisory and Appeals Board

Background

The Trap Certificate Technical Advisory and Appeals Board was established to consider and advise the Florida Fish and Wildlife Conservation Commission (FWC) on disputes and other problems arising from the implementation of the spiny lobster trap certificate program.[21] Current law provides that, beginning July 1, 1994, the board will no longer consider and advise FWC on disputes and other problems arising from implementation of the trap certificate program or allotment of certificates.[22] As such, the board no longer appears to be active or necessary.

Effect of the Bill

The bill repeals the Trap Certificate Technical Advisory and Appeals Board.

[18] S. 378.033, F.S. *See also* Nonmandatory Land Reclamation Program, DEP website https://floridadep.gov/water/mine-restoration-funding-program (last visited Jan. 14, 2020).
[19] Nonmandatory Land Reclamation Program, DEP website https://floridadep.gov/water/mine-restoration-funding-program (last visited Jan. 14, 2020).
[20] S. 379.2524, F.S.
[21] S. 379.3671, F.S.
[22] S. 379.3671(4)(i), F.S.

Clean Fuel Florida Advisory Board

Background

The Clean Fuel Florida Advisory Board was established within DEP to serve as a resource to the department and to provide the Governor, the Legislature, and the Secretary of DEP with private sector and other public agency perspectives on achieving the goal of increasing the use of alternative fuel vehicles in this state.[23] Current law provides for termination of the board five years after the effective date of s. 403.42, F.S.[24] The board appears to have terminated in 2006.

Effect of the Bill

The bill repeals the Clean Fuel Florida Advisory Board within DEP.

Technical Advisory Council, Water and Domestic Wastewater Operator Certification

Background

The Technical Advisory Council for Water and Domestic Wastewater Operator Certification was established in 1997 to advise DEP regarding the operator certification program and provide expertise on water and wastewater treatment.[25] The council does not appear to be active. In addition, DEP has a separate water and domestic wastewater operator certification program and likely does not need an advisory council.

Effect of the Bill

The bill repeals the Technical Advisory Council for Water and Domestic Wastewater Operator Certification.

Florida Health Choices Corporation

Background

The Florida Health Choices Corporation (corporation) was established in 2008 to create an online market for diverse health care coverage products, particularly for small businesses, as an Internal Revenue Code s. 125 cafeteria plan using pre-tax dollars.[26] The corporation is governed by a 15-member board of directors made up of members appointed by the Speaker, President, and Governor, as well as state agency ex-officio members.[27] The board of directors may establish technical advisory panels consisting of interested parties, including consumers, health care providers, individuals with expertise in insurance regulation, and insurers.[28] The last appropriation of funding for the corporation was vetoed in 2017. As such, the corporation does not appear to be active and the authority to establish advisory panels no longer appears to be necessary.

Effect of the Bill

The bill repeals the authorization for the Florida Health Choices Corporation Board of Directors to establish technical advisory panels, because such authority no longer appears necessary as the corporation is no longer active.

[23] S. 403.42(3), F.S.
[24] S. 403.42(3)(b)7., F.S.
[25] S. 403.87, F.S
[26] *See* s. 408.910, F.S.
[27] S. 408.910(11)(a), F.S.
[28] S. 408.910(11)(h), F.S.

Technical Advisory Panel, Child Welfare Results-Oriented Accountability Program

Background

The child welfare results-oriented accountability program monitors and measures the use of resources, the quality and amount of services provided, and child and family outcomes in Florida's child welfare system.[29] Current law requires the Department of Children and Families (DCF) to establish a technical advisory panel to advise DCF on the implementation of the results-oriented accountability program.[30] It appears DCF is no longer using this technical advisory panel for advice on implementing the program.

Effect of the Bill

The bill repeals the technical advisory panel for the child welfare results-oriented accountability program.

Learning Gateway Steering Committee

Background

In 2002, the Legislature authorized a three-year demonstration program called the Learning Gateway. The purpose of Learning Gateway is to provide parents access to information, referral, and services to lessen the effects of learning disabilities in children from birth to age 9.[31]

The Learning Gateway Steering Committee was established within the Department of Education to provide policy development, consultation, oversight, and support for the implementation of the Learning Gateway Programs and to advise the agencies, the Legislature, and the Governor on statewide implementation of system components and issues and on strategies for continuing improvement to the system.[32] No appointments have been made to the steering committee since the original three-year term appointments, and the steering committee was marked as inactive in 2014.

Effect of the Bill

The bill repeals the Learning Gateway program, which was only authorized for three years, and the steering committee, which is no longer active.

Department of Elderly Affairs Advisory Council

Background

The Department of Elderly Affairs Advisory Council was established within the Department of Elderly Affairs to serve in an advisory capacity to the Secretary of Elderly Affairs and to assist the secretary in carrying out the purpose, duties, and responsibilities of the department.[33] The advisory council is not required to submit any reports and only appears to serve as an advisor to the secretary, who may create an ad hoc group to advise him or her at any time. As such, the establishment of the advisory council in statute appears unnecessary.

Effect of the Bill

The bill repeals the Department of Elderly Affairs Advisory Council.

Florida Young Farmer and Rancher Advisory Council

[29] S. 409.997(2), F.S.
[30] S. 409.997(3), F.S.
[31] S. 411.226(1), F.S.
[32] S. 411.226(2), F.S.
[33] S. 430.05, F.S.

Background

The Florida Young Farmer and Rancher Advisory Council was created within DACS in 2018.[34] The council may, but is not required to, submit to the Commissioner of Agriculture findings and recommendations for mitigating challenges facing aspiring farmers and ranchers in the early stages of their careers.[35] The council may examine issues that include, but are not limited to, access to land, availability of credit and capital, and access to business skills training.[36] It does not appear that the council is active.

Effect of the Bill

The bill repeals the Florida Young Farmer and Rancher Advisory Council within DACS.

Florida Agricultural Promotional Campaign Advisory Council

Background

The Florida Agricultural Promotional Campaign Advisory Council is created within DACS[37] to review and make recommendations to the Commissioner of Agriculture regarding the Florida Agricultural Promotion Campaign.[38] The council does not appear to be active as the last noticed meeting was in 2013.

Effect of the Bill

The bill repeals the Florida Agricultural Promotional Campaign Advisory Council within DACS.

Healthy Schools for Healthy Lives Council

Background

The Healthy Schools for Healthy Lives Council is created within DACS to advise the department on matters relating to nutritional standards and the prevention of childhood obesity, nutrition education, anaphylaxis, and other needs to further the development of the various school nutrition programs.[39] The council does not appear to be active.

Effect of the Bill

The bill repeals the Healthy Schools for Healthy Lives Council within DACS.

Tropical Fruit Advisory Council

Background

Current law creates the Tropical Fruit Advisory Council within DACS to provide necessary assistance, review, and recommendations to the Commissioner of Agriculture for drafting a South Florida Tropical Fruit Plan.[40] However, the council does not appear to be active.

Effect of the Bill

The bill repeals the Tropical Fruit Advisory Council within DACS.

[34] Ch. 570.843, L.O.F.; codified as s. 570.843, F.S.
[35] S. 570.843(3), F.S.
[36] *Id*.
[37] S. 571.28(1), F.S.
[38] S. 571.28, F.S.
[39] S. 595.701(1), F.S.
[40] S. 603.203, F.S.

Advisory Board, Preeminent State Research University Institute for Online Learning

Background

Current law establishes a collaborative partnership between the Board of Governors (BOG) and the Legislature to elevate the academic and research preeminence of Florida's highest-performing state research universities. The partnership stems from the State University System Governance Agreement executed on March 24, 2010, wherein the Governor and leaders of the Legislature agreed to a framework for the collaborative exercise of their joint authority and shared responsibility for the State University System.[41]

The preeminent state research universities program requires each state research university that meets all 12 academic and research excellence standards, as verified by the BOG, to establish an institute for online learning.

In 2013, the BOG was required to convene an advisory body to support the development of high-quality, fully online baccalaureate degree programs; advise the BOG on the release of funding to the university; and monitor, evaluate, and report on the implementation of the plan to the BOG, the Governor, the President of the Senate, and the Speaker of the House of Representatives.[42] The advisory board for the preeminent state research university institute for online learning has completed its statutory duties.

Effect of the Bill

The bill repeals the advisory board for the preeminent state research university institute for online learning.

Florida Early Learning Advisory Council

Background

The Florida Early Learning Advisory Council was created within the Agency for Workforce Innovation in 2004[43] and was moved within the Office of Early Learning in 2011.[44] The Office of Early Learning provides staff and administrative support for the council.[45]

The Florida Early Learning Advisory Council is tasked with periodically analyzing and providing recommendations to the Office of Early Learning on the effective and efficient use of local, state, and federal funds; the content of professional development training programs; and best practices for the development and implementation of early learning coalition plans.[46] However, the advisory council does not appear to be active.

Effect of the Bill

The bill repeals the Florida Early Learning Advisory Council within the Office of Early Learning.

B. SECTION DIRECTORY:

Section 1: Repeals chapters 2003-287 and 2006-43, L.O.F., relating to the membership, powers, and duties of the Citrus/Hernando Waterways Restoration Council.

Section 2: Repeals s. 215.5586(4), F.S., relating to the advisory council for the My Safe Florida Home Program.

[41] S. 1001.7065(1), F.S.
[42] S. 1001.7065(4), F.S.
[43] S. 1, Ch. 2004-484, L.O.F.; codified at s. 1002.77, F.S.
[44] S. 457, Ch. 2011-142, L.O.F.
[45] S. 1002.77(5), F.S.
[46] S. 1002.77, F.S.

Section 3: Amends s. 267.0731, F.S., relating to the Great Floridians Program.
Section 4: Amends s. 288.1251, F.S., relating to promotion and development of entertainment industry; Office of Film and Entertainment; creation; purpose; powers and duties.
Section 5: Repeals s. 288.1252, F.S., relating to the Florida Film and Entertainment Advisory Council.
Section 6: Amends s. 288.1254, F.S., relating to entertainment industry financial incentive program.
Section 7: Amends s. 373.4597, F.S., relating to the Geneva Freshwater Lens Protection Act.
Section 8: Repeals s. 376.86, F.S., relating to the Brownfield Areas Loan Guarantee Program.
Section 9: Amends s. 378.032, F.S., relating to definitions.
Section 10: Repeals s. 378.033, F.S., relating to Nonmandatory Land Reclamation Committee; creation; composition.
Section 11: Amends s. 378.034, F.S., relating to submission of a reclamation program request; procedures.
Section 12: Repeals s. 379.2524, F.S., relating commercial production of sturgeon.
Section 13: Amends s. 379.361, F.S., relating to special activity licenses.
Section 14: Amends s. 379.367, F.S., relating to spiny lobster; regulation.
Section 15: Amends s. 379.3671, F.S., relating spiny lobster trap certificate program.
Section 16: Repeals s. 403.42, F.S., relating to the Florida Clean Fuel Act.
Section 17: Repeals s. 403.87, F.S., relating to the technical advisory council for water and domestic wastewater operator certification.
Section 18: Amends s. 408.910, F.S., the Florida Health Choices Program.
Section 19: Amends s. 409.997, F.S., relating to the child welfare results-oriented accountability program.
Section 20: Repeals s. 411.226, F.S., relating to the Learning Gateway.
Section 21: Repeals s. 430.05, F.S., relating to the Department of Elderly Affairs Advisory Council.
Section 22: Repeals s. 570.843, F.S., relating to the Florida Young Farmer and Rancher Advisory Council.
Section 23: Amends s. 517.24, F.S., relating to purpose; duties of the department.
Section 24: Repeals s. 571.28, F.S., relating to the Florida Agricultural Promotional Campaign Advisory Council.
Section 25: Repeals s. 595.701, F.S., relating to the Healthy Schools for Healthy Lives Council.
Section 26: Repeals s. 603.203, F.S., relating to the Tropical Fruit Advisory Council.
Section 27: Amends s. 603.204, F.S., relating to the South Florida Tropical Fruit Plan.
Section 28: Amends s. 1001.7065, F.S., relating to the preeminent state research universities program.
Section 29: Repeals s. 1002.77, F.S., relating to the Florida Early Learning Advisory Council.
Section 30: Amends s. 1002.83, F.S., relating to early learning coalitions.
Section 31: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   See Fiscal Comments.

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:

The bill will likely have a positive fiscal impact on state government because abolishing these advisory bodies will eliminate their administrative costs and expenses.

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:

The bill repeals inactive or unnecessary advisory bodies and programs but does not substantively affect any agency rulemaking.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to the repeal of advisory bodies and programs; repealing chapters 2003-287 and 2006-43, Laws of Florida, relating to the membership, powers, and duties of the Citrus/Hernando Waterways Restoration Council; amending s. 215.5586, F.S.; deleting the advisory council for the My Safe Florida Home Program; amending s. 267.0731, F.S.; removing the ad hoc committee that nominates persons for designation as Great Floridian; amending s. 288.1251, F.S.; conforming a provision to changes made by the act; repealing s. 288.1252, F.S., relating to the Florida Film and Entertainment Advisory Council; amending s. 288.1254, F.S.; conforming a provision to changes made by the act; amending s. 373.4597, F.S.; deleting references to the Geneva Freshwater Lens Task Force; repealing s. 376.86, F.S., relating to the Brownfield Areas Loan Guarantee Council and program; amending s. 378.032, F.S.; deleting a definition to conform to changes made by the act; repealing s. 378.033, F.S., relating to the Nonmandatory Land Reclamation Committee; amending s. 378.034, F.S.; conforming provisions to changes made by the act; repealing s. 379.2524, F.S., relating to the Sturgeon Production Working Group; amending s. 379.361, F.S.;

conforming cross-references to changes made by the act; amending s. 379.367, F.S.; conforming a cross-reference to changes made by the act; amending s. 379.3671, F.S.; deleting the Trap Certificate Technical Advisory and Appeals Board; repealing s. 403.42, F.S., relating to the Clean Fuel Florida Advisory Board; repealing s. 403.87, F.S., relating to the technical advisory council for water and domestic wastewater operator certification; amending s. 408.910, F.S.; deleting references to technical advisory panels that may be established by Florida Health Choices, Inc.; amending s. 409.997, F.S.; deleting the child welfare results-oriented accountability program technical advisory panel; repealing s. 411.226, F.S., relating to the Learning Gateway program and steering committee; repealing s. 430.05, F.S., relating to the Department of Elderly Affairs Advisory Council; repealing s. 570.843, F.S., relating to the Florida Young Farmer and Rancher Advisory Council; amending s. 571.24, F.S.; conforming a provision to changes made by the act; repealing s. 571.28, F.S., relating to the Florida Agricultural Promotional Campaign Advisory Council; repealing s. 595.701, F.S., relating to the Healthy Schools for Healthy Lives Council; repealing s. 603.203, F.S.,

relating to the Tropical Fruit Advisory Council; amending s. 603.204, F.S.; conforming a provision to changes made by the act; amending s. 1001.7065, F.S.; deleting the advisory board to support specific online degree programs at universities; repealing s. 1002.77, F.S., relating to the Florida Early Learning Advisory Council; amending s. 1002.83, F.S.; conforming a provision to changes made by the act; providing an effective date.

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

Section 1. Chapters 2003-287 and 2006-43, Laws of Florida, are repealed.

Section 2. Subsection (4) of section 215.5586, Florida Statutes, is amended to read:

215.5586 My Safe Florida Home Program.—There is established within the Department of Financial Services the My Safe Florida Home Program. The department shall provide fiscal accountability, contract management, and strategic leadership for the program, consistent with this section. This section does not create an entitlement for property owners or obligate the state in any way to fund the inspection or retrofitting of residential property in this state. Implementation of this program is subject to annual legislative appropriations. It is

the intent of the Legislature that the My Safe Florida Home Program provide trained and certified inspectors to perform inspections for owners of site-built, single-family, residential properties and grants to eligible applicants as funding allows. The program shall develop and implement a comprehensive and coordinated approach for hurricane damage mitigation that may include the following:

~~(4) ADVISORY COUNCIL.—There is created an advisory council to provide advice and assistance to the department regarding administration of the program. The advisory council shall consist of:~~

~~(a) A representative of lending institutions, selected by the Financial Services Commission from a list of at least three persons recommended by the Florida Bankers Association.~~

~~(b) A representative of residential property insurers, selected by the Financial Services Commission from a list of at least three persons recommended by the Florida Insurance Council.~~

~~(c) A representative of home builders, selected by the Financial Services Commission from a list of at least three persons recommended by the Florida Home Builders Association.~~

~~(d) A faculty member of a state university, selected by the Financial Services Commission, who is an expert in hurricane-resistant construction methodologies and materials.~~

~~(e) Two members of the House of Representatives, selected~~

~~by the Speaker of the House of Representatives.~~

~~(f) Two members of the Senate, selected by the President of the Senate.~~

~~(g) The Chief Executive Officer of the Federal Alliance for Safe Homes, Inc., or his or her designee.~~

~~(h) The senior officer of the Florida Hurricane Catastrophe Fund.~~

~~(i) The executive director of Citizens Property Insurance Corporation.~~

~~(j) The director of the Florida Division of Emergency Management.~~

~~Members appointed under paragraphs (a)–(d) shall serve at the pleasure of the Financial Services Commission. Members appointed under paragraphs (e) and (f) shall serve at the pleasure of the appointing officer. All other members shall serve as voting ex officio members. Members of the advisory council shall serve without compensation but may receive reimbursement as provided in s. 112.061 for per diem and travel expenses incurred in the performance of their official duties.~~

Section 3. Subsection (1) of section 267.0731, Florida Statutes, is amended to read:

267.0731 Great Floridians Program.—The division shall establish and administer a program, to be entitled the Great Floridians Program, which shall be designed to recognize and

record the achievements of Floridians, living and deceased, who have made major contributions to the progress and welfare of this state.

(1)(a) The division shall nominate present or former citizens of this state, living or deceased, who during their lives have made major contributions to the progress of the nation or this state and its citizens. Nominations shall be submitted to the Secretary of State who shall select from those nominated not less than two persons each year who shall be honored with the designation "Great Floridian," provided no person whose contributions have been through elected or appointed public service shall be selected while holding any such office.

(b)~~(a)~~ To enhance public participation and involvement in the identification of any person worthy of being nominated as a Great Floridian, the division shall seek advice and assistance from persons qualified through the demonstration of special interest, experience, or education in the dissemination of knowledge about the state's history.

~~(b) Annually, the division shall convene an ad hoc committee composed of representatives of the Governor, each member of the Florida Cabinet, the President of the Senate, the Speaker of the House of Representatives, and the Secretary of State. This committee shall meet at least twice. The committee shall nominate not fewer than two persons whose names shall be~~

~~submitted to the Secretary of State with the recommendation that they be honored with the designation "Great Floridian."~~

Section 4. Paragraph (a) of subsection (2) of section 288.1251, Florida Statutes, is amended to read:

288.1251 Promotion and development of entertainment industry; Office of Film and Entertainment; creation; purpose; powers and duties.—

(2) POWERS AND DUTIES.—

(a) The Office of Film and Entertainment, in performance of its duties, shall:

1. ~~In consultation with the Florida Film and Entertainment Advisory Council,~~ Update the strategic plan every 5 years to guide the activities of the Office of Film and Entertainment in the areas of entertainment industry development, marketing, promotion, liaison services, field office administration, and information. The plan shall:

a. Be annual in construction and ongoing in nature.

b. Include recommendations relating to the organizational structure of the office.

c. Include an annual budget projection for the office for each year of the plan.

d. Include an operational model for the office to use in implementing programs for rural and urban areas designed to:

(I) Develop and promote the state's entertainment industry.

(II) Have the office serve as a liaison between the entertainment industry and other state and local governmental agencies, local film commissions, and labor organizations.

(III) Gather statistical information related to the state's entertainment industry.

(IV) Provide information and service to businesses, communities, organizations, and individuals engaged in entertainment industry activities.

(V) Administer field offices outside the state and coordinate with regional offices maintained by counties and regions of the state, as described in sub-sub-subparagraph (II), as necessary.

e. Include performance standards and measurable outcomes for the programs to be implemented by the office.

f. Include an assessment of, and make recommendations on, the feasibility of creating an alternative public-private partnership for the purpose of contracting with such a partnership for the administration of the state's entertainment industry promotion, development, marketing, and service programs.

2. Develop, market, and facilitate a working relationship between state agencies and local governments in cooperation with local film commission offices for out-of-state and indigenous entertainment industry production entities.

3. Implement a structured methodology prescribed for

coordinating activities of local offices with each other and the commissioner's office.

4. Represent the state's indigenous entertainment industry to key decisionmakers within the national and international entertainment industry, and to state and local officials.

5. Prepare an inventory and analysis of the state's entertainment industry, including, but not limited to, information on crew, related businesses, support services, job creation, talent, and economic impact and coordinate with local offices to develop an information tool for common use.

6. Identify, solicit, and recruit entertainment production opportunities for the state.

7. Assist rural communities and other small communities in the state in developing the expertise and capacity necessary for such communities to develop, market, promote, and provide services to the state's entertainment industry.

Section 5. Section 288.1252, Florida Statutes, is repealed.

Section 6. Paragraph (b) of subsection (4) of section 288.1254, Florida Statutes, is amended to read:

288.1254 Entertainment industry financial incentive program.—

(4) TAX CREDIT ELIGIBILITY; TAX CREDIT AWARDS; QUEUES; ELECTION AND DISTRIBUTION; CARRYFORWARD; CONSOLIDATED RETURNS; PARTNERSHIP AND NONCORPORATE DISTRIBUTIONS; MERGERS AND

ACQUISITIONS.—

(b) Tax credit eligibility.—

1. General production queue.—Ninety-four percent of tax credits authorized pursuant to subsection (6) in any state fiscal year must be dedicated to the general production queue. The general production queue consists of all qualified productions other than those eligible for the commercial and music video queue or the independent and emerging media production queue. A qualified production that demonstrates a minimum of $625,000 in qualified expenditures is eligible for tax credits equal to 20 percent of its actual qualified expenditures, up to a maximum of $8 million. A qualified production that incurs qualified expenditures during multiple state fiscal years may combine those expenditures to satisfy the $625,000 minimum threshold.

a. An off-season certified production that is a feature film, independent film, or television series or pilot is eligible for an additional 5 percent tax credit on actual qualified expenditures. An off-season certified production that does not complete 75 percent of principal photography due to a disruption caused by a hurricane or tropical storm may not be disqualified from eligibility for the additional 5 percent credit as a result of the disruption.

b. If more than 45 percent of the sum of total tax credits initially certified and awarded after April 1, 2012, total tax

credits initially certified after April 1, 2012, but not yet awarded, and total tax credits available for certification after April 1, 2012, but not yet certified has been awarded for high-impact television series, then no high-impact television series is eligible for tax credits under this subparagraph. Tax credits initially certified for a high-impact television series after April 1, 2012, may not be awarded if the award will cause the percentage threshold in this sub-subparagraph to be exceeded. This sub-subparagraph does not prohibit the award of tax credits certified before April 1, 2012, for high-impact television series.

c. Subject to sub-subparagraph b., first priority in the queue for tax credit awards not yet certified shall be given to high-impact television series and high-impact digital media projects. For the purposes of determining priority between a high-impact television series and a high-impact digital media project, the first position must go to the first application received. Thereafter, priority shall be determined by alternating between a high-impact television series and a high-impact digital media project on a first-come, first-served basis. However, if the Office of Film and Entertainment receives an application for a high-impact television series or high-impact digital media project that would be certified but for the alternating priority, the office may certify the project as being in the priority position if an application that would

normally be the priority position is not received within 5 business days.

d. A qualified production for which at least 67 percent of its principal photography days occur within a region designated as an underutilized region at the time that the production is certified is eligible for an additional 5 percent tax credit.

e. A qualified production that employs students enrolled full-time in a film and entertainment-related or digital media-related course of study at an institution of higher education in this state is eligible for an additional 15 percent tax credit on qualified expenditures that are wages, salaries, or other compensation paid to such students. The additional 15 percent tax credit is also applicable to persons hired within 12 months after graduating from a film and entertainment-related or digital media-related course of study at an institution of higher education in this state. The additional 15 percent tax credit applies to qualified expenditures that are wages, salaries, or other compensation paid to such recent graduates for 1 year after the date of hiring.

f. A qualified production for which 50 percent or more of its principal photography occurs at a qualified production facility, or a qualified digital media project or the digital animation component of a qualified production for which 50 percent or more of the project's or component's qualified expenditures are related to a qualified digital media production

facility, is eligible for an additional 5 percent tax credit on actual qualified expenditures for production activity at that facility.

g. A qualified production is not eligible for tax credits provided under this paragraph totaling more than 30 percent of its actual qualified expenses.

2. Commercial and music video queue.—Three percent of tax credits authorized pursuant to subsection (6) in any state fiscal year must be dedicated to the commercial and music video queue. A qualified production company that produces national or regional commercials or music videos may be eligible for a tax credit award if it demonstrates a minimum of $100,000 in qualified expenditures per national or regional commercial or music video and exceeds a combined threshold of $500,000 after combining actual qualified expenditures from qualified commercials and music videos during a single state fiscal year. After a qualified production company that produces commercials, music videos, or both reaches the threshold of $500,000, it is eligible to apply for certification for a tax credit award. The maximum credit award shall be equal to 20 percent of its actual qualified expenditures up to a maximum of $500,000. If there is a surplus at the end of a fiscal year after the Office of Film and Entertainment certifies and determines the tax credits for all qualified commercial and video projects, such surplus tax credits shall be carried forward to the following fiscal year

and are available to any eligible qualified productions under the general production queue.

3. Independent and emerging media production queue.—Three percent of tax credits authorized pursuant to subsection (6) in any state fiscal year must be dedicated to the independent and emerging media production queue. This queue is intended to encourage independent film and emerging media production in this state. Any qualified production, excluding commercials, infomercials, or music videos, which demonstrates at least $100,000, but not more than $625,000, in total qualified expenditures is eligible for tax credits equal to 20 percent of its actual qualified expenditures. If a surplus exists at the end of a fiscal year after the Office of Film and Entertainment certifies and determines the tax credits for all qualified independent and emerging media production projects, such surplus tax credits shall be carried forward to the following fiscal year and are available to any eligible qualified productions under the general production queue.

4. Family-friendly productions.—A certified theatrical or direct-to-video motion picture production or video game determined by the Commissioner of Film and Entertainment~~, with the advice of the Florida Film and Entertainment Advisory Council,~~ to be family-friendly, based on review of the script and review of the final release version, is eligible for an additional tax credit equal to 5 percent of its actual qualified

expenditures. Family-friendly productions are those that have cross-generational appeal; would be considered suitable for viewing by children age 5 or older; are appropriate in theme, content, and language for a broad family audience; embody a responsible resolution of issues; and do not exhibit or imply any act of smoking, sex, nudity, or vulgar or profane language.

Section 7. Subsection (3) of section 373.4597, Florida Statutes, is amended to read:

373.4597 The Geneva Freshwater Lens Protection Act.—

~~(3) The Legislature hereby directs the appropriate state agencies to implement, by December 1, 1995, recommendations of the Geneva Freshwater Lens Task Force that do not require rule amendments. The Legislature directs such agencies to act, by July 1, 1996, upon recommendations of the task force that require rule amendments, unless otherwise noted in the report. The requirements of this bill related to actions to be taken by appropriate state agencies shall not require expenditures to be made by the government of Seminole County. The St. Johns River Water Management District shall continue to implement the recommendations contained in the Geneva Freshwater Lens Task Force report to the Legislature.~~

Section 8. Section 376.86, Florida Statutes, is repealed.

Section 9. Subsection (3) of section 378.032, Florida Statutes, is amended to read:

378.032 Definitions.—As used in ss. 378.032-378.038, the

term:

~~(3) "Committee" means the Nonmandatory Land Reclamation Committee.~~

Section 10. Section 378.033, Florida Statutes, is repealed.

Section 11. Subsections (5), (6), (7), (9), and (10) of section 378.034, Florida Statutes, are amended to read:

378.034 Submission of a reclamation program request; procedures.—

(5)(a) The department staff shall, by February 1 of each year, present to the secretary ~~committee~~ for his or her ~~its~~ consideration those reclamation program applications received by the preceding November 1.

(b) The department staff shall recommend an order of priority for the reclamation program applications that is consistent with subsection (6).

(c) The recommendation of the department staff shall include an estimate of the cost of each reclamation program or land acquisition.

(6) ~~The committee shall recommend approval, modification, or denial of the reclamation program applications, associated cost estimates, and the department staff's recommended prioritized list.~~ Recommendations on the order of priority shall be based, among other criteria, on the following criteria; however, department staff ~~the committee~~ may give greater weight

to one or more of the criteria depending on the overall needs of the nonmandatory land reclamation program:

(a) Whether health and safety hazards exist; and, if so, such hazards shall be given the greatest weight;

(b) Whether the economic or environmental utility or the aesthetic value of the land will return naturally within a reasonable period of time;

(c) Whether there is a reasonable geographic and applicant diversity in light of previously awarded reclamation contracts, reclamation program applications before the department staff ~~committee~~, and the remaining eligible lands;

(d) Whether reclamation is in the public interest;

(e) Whether the land has been naturally reclaimed or is eligible for acquisition by the state for hunting, fishing, or other outdoor recreation purposes or for wildlife preservation;

(f) Whether the land is to be reclaimed for agricultural use and the applicant has agreed to maintain the land in agricultural use for at least 5 years after the completion of the reclamation;

(g) Whether the program, alone or in conjunction with other reclamation programs, will provide a substantial regional benefit;

(h) Whether the program, alone or in conjunction with other reclamation programs, will benefit regional drainage patterns;

(i) Whether the land is publicly owned and will be reclaimed for public purposes;

(j) Whether the program includes a donation or agreement to sell a portion of the program application area to the state for outdoor recreational or wildlife habitat protection purposes;

(k) Whether the program is cost-effective in achieving the goals of the nonmandatory land reclamation program; and

(l) Whether the program will reclaim lands described in subsection (2).

(7) The prioritized list developed by department staff ~~approved by the committee~~ may contain more reclamation program applications than there are funds available during the year.

(9) ~~The committee recommendations shall be submitted to the secretary by April 1 of each year for final agency action~~ By June 1 of each ~~that~~ year, ~~.~~ the secretary shall approve, in whole or in part, the list of reclamation program applications in the order of priority in which the applications are presented by department staff.

(10) Any approved reclamation program application that was not funded shall, at the request of the applicant, be considered by department staff ~~the committee~~ at its next meeting called for that purpose, together with other reclamation program applications received by November 1 of the next year.

Section 12. Section 379.2524, Florida Statutes, is

repealed.

Section 13. Paragraph (b) of subsection (4) of section 379.361, Florida Statutes, is amended to read:

379.361 Licenses.—

(4) SPECIAL ACTIVITY LICENSES.—

(b) The Fish and Wildlife Conservation Commission is authorized to issue special activity licenses in accordance with this section ~~and s. 379.2524~~, to permit the importation and possession of wild anadromous sturgeon. The commission is also authorized to issue special activity licenses, in accordance with this section ~~and s. 379.2524~~, to permit the importation, possession, and aquaculture of native and nonnative anadromous sturgeon until best management practices are implemented for the cultivation of anadromous sturgeon pursuant to s. 597.004. The special activity license shall provide for specific management practices to protect native populations of saltwater species.

Section 14. Paragraph (b) of subsection (2) of section 379.367, Florida Statutes, is amended to read:

379.367 Spiny lobster; regulation.—

(2)

(b) Twenty-five dollars of the $125 fee for a spiny lobster endorsement required under subparagraph (a)1. must be used only for trap retrieval as provided in s. 379.2424. The remainder of the fees collected under paragraph (a) shall be deposited as follows:

1. Fifty percent of the fees collected shall be deposited in the Marine Resources Conservation Trust Fund for use in enforcing the provisions of paragraph (a) through aerial and other surveillance and trap retrieval.

2. Fifty percent of the fees collected shall be deposited as provided in s. 379.3671(4) ~~379.3671(5)~~.

Section 15. Subsection (4) of section 379.3671, Florida Statutes, is amended to read:

379.3671 Spiny lobster trap certificate program.—

~~(4) TRAP CERTIFICATE TECHNICAL ADVISORY AND APPEALS BOARD.—There is hereby established the Trap Certificate Technical Advisory and Appeals Board. Such board shall consider and advise the commission on disputes and other problems arising from the implementation of the spiny lobster trap certificate program. The board may also provide information to the commission on the operation of the trap certificate program.~~

~~(a) The board shall consist of the executive director of the commission or designee and nine other members appointed by the executive director, according to the following criteria:~~

~~1. All appointed members shall be certificateholders, but two shall be holders of fewer than 100 certificates, two shall be holders of at least 100 but no more than 750 certificates, three shall be holders of more than 750 but not more than 2,000 certificates, and two shall be holders of more than 2,000 certificates.~~

~~2. At least one member each shall come from Broward, Miami-Dade, and Palm Beach Counties; and five members shall come from the various regions of the Florida Keys.~~

~~3. At least one appointed member shall be a person of Hispanic origin capable of speaking English and Spanish.~~

~~(b) The term of each appointed member shall be for 4 years, and any vacancy shall be filled for the balance of the unexpired term with a person of the qualifications necessary to maintain the requirements of paragraph (a). There shall be no limitation on successive appointments to the board.~~

~~(c) The executive director of the commission or designee shall serve as a member and shall call the organizational meeting of the board. The board shall annually elect a chair and a vice chair. There shall be no limitation on successive terms that may be served by a chair or vice chair. The board shall meet at the call of its chair, at the request of a majority of its membership, at the request of the commission, or at such times as may be prescribed by its rules. A majority of the board shall constitute a quorum, and official action of the board shall require a majority vote of the total membership of the board present at the meeting.~~

~~(d) The procedural rules adopted by the board shall conform to the requirements of chapter 120.~~

~~(e) Members of the board shall be reimbursed for per diem and travel expenses as provided in s. 112.061.~~

~~(f) Upon reaching a decision on any dispute or problem brought before it, including any decision involving the allotment of certificates under paragraph (g), the board shall submit such decision to the executive director of the commission for final approval. The executive director of the commission may alter or disapprove any decision of the board, with notice thereof given in writing to the board and to each party in the dispute explaining the reasons for the disapproval. The action of the executive director of the commission constitutes final agency action.~~

~~(g) In addition to those certificates allotted pursuant to the provisions of subparagraph (2)(a)1., up to 125,000 certificates may be allotted by the board to settle disputes or other problems arising from implementation of the trap certificate program during the 1992-1993 and 1993-1994 license years. Any certificates not allotted by March 31, 1994, shall become permanently unavailable and shall be considered as part of the 1994-1995 reduction schedule. All appeals for additional certificates or other disputes must be filed with the board before October 1, 1993.~~

~~(h) Any trap certificates issued by the Department of Environmental Protection and, effective July 1, 1999, the commission as a result of the appeals process must be added to the existing number of trap certificates for the purposes of determining the total number of certificates from which the~~

~~subsequent season's trap reduction is calculated.~~

~~(i) On and after July 1, 1994, the board shall no longer consider and advise the Fish and Wildlife Conservation Commission on disputes and other problems arising from implementation of the trap certificate program nor allot any certificates with respect thereto.~~

Section 16. Section 403.42, Florida Statutes, is repealed.

Section 17. Section 403.87, Florida Statutes, is repealed.

Section 18. Paragraph (h) of subsection (11) of section 408.910, Florida Statutes, is amended to read:

408.910 Florida Health Choices Program.—

(11) CORPORATION.—There is created the Florida Health Choices, Inc., which shall be registered, incorporated, organized, and operated in compliance with part III of chapter 112 and chapters 119, 286, and 617. The purpose of the corporation is to administer the program created in this section and to conduct such other business as may further the administration of the program.

~~(h) The corporation may establish technical advisory panels consisting of interested parties, including consumers, health care providers, individuals with expertise in insurance regulation, and insurers.~~

Section 19. Subsection (3) of section 409.997, Florida Statutes, is amended to read:

409.997 Child welfare results-oriented accountability

program.—

~~(3) The department shall establish a technical advisory panel consisting of representatives from the Florida Institute for Child Welfare established pursuant to s. 1004.615, lead agencies, community-based care providers, other contract providers, community alliances, and family representatives. The President of the Senate and the Speaker of the House of Representatives shall each appoint a member to serve as a legislative liaison to the panel. The technical advisory panel shall advise the department on the implementation of the results-oriented accountability program.~~

Section 20. Section 411.226, Florida Statutes, is repealed.

Section 21. Section 430.05, Florida Statutes, is repealed.

Section 22. Section 570.843, Florida Statutes, is repealed.

Section 23. Subsection (7) of section 571.24, Florida Statutes, is amended to read:

571.24 Purpose; duties of the department.—The purpose of this part is to authorize the department to establish and coordinate the Florida Agricultural Promotional Campaign. The Legislature intends for the Florida Agricultural Promotional Campaign to serve as a marketing program to promote Florida agricultural commodities, value-added products, and agricultural-related businesses and not as a food safety or

traceability program. The duties of the department shall include, but are not limited to:

~~(7) Assisting the representative of the department who serves on the Florida Agricultural Promotional Campaign Advisory Council.~~

Section 24. Section 571.28, Florida Statutes, is repealed.

Section 25. Section 595.701, Florida Statutes, is repealed.

Section 26. Section 603.203, Florida Statutes, is repealed.

Section 27. Section 603.204, Florida Statutes, is amended to read:

603.204 South Florida Tropical Fruit Plan.—The Commissioner of Agriculture~~, in consultation with the Tropical Fruit Advisory Council,~~ shall develop and update a South Florida Tropical Fruit Plan, which shall identify problems and constraints of the tropical fruit industry, propose possible solutions to such problems, and develop planning mechanisms for orderly growth of the industry, including:

(1) Criteria for tropical fruit research, service, and management priorities.

(2) Proposed legislation that may be required.

(3) Plans relating to other tropical fruit programs and related disciplines in the State University System.

(4) Potential tropical fruit products in terms of market

and needs for development.

(5) Evaluation of production and fresh fruit policy alternatives, including, but not limited to, setting minimum grades and standards, promotion and advertising, development of production and marketing strategies, and setting minimum standards on types and quality of nursery plants.

(6) Evaluation of policy alternatives for processed tropical fruit products, including, but not limited to, setting minimum quality standards and development of production and marketing strategies.

(7) Research and service priorities for further development of the tropical fruit industry.

(8) Identification of state agencies and public and private institutions concerned with research, education, extension, services, planning, promotion, and marketing functions related to tropical fruit development, and delineation of contributions and responsibilities. The recommendations in the plan relating to education or research shall be submitted to the Institute of Food and Agricultural Sciences.

(9) Business planning, investment potential, financial risks, and economics of production and use.

Section 28. Paragraphs (a) through (f) of subsection (4) of section 1001.7065, Florida Statutes, are amended to read:

1001.7065 Preeminent state research universities program.—

(4) PREEMINENT STATE RESEARCH UNIVERSITY INSTITUTE FOR

ONLINE LEARNING.—A state research university that, as of July 1, 2013, meets all 12 of the academic and research excellence standards identified in subsection (2), as verified by the Board of Governors, shall establish an institute for online learning. The institute shall establish a robust offering of high-quality, fully online baccalaureate degree programs at an affordable cost in accordance with this subsection.

~~(a) By August 1, 2013, the Board of Governors shall convene an advisory board to support the development of high-quality, fully online baccalaureate degree programs at the university.~~

~~(b) The advisory board shall:~~

~~1. Offer expert advice, as requested by the university, in the development and implementation of a business plan to expand the offering of high-quality, fully online baccalaureate degree programs.~~

~~2. Advise the Board of Governors on the release of funding to the university upon approval by the Board of Governors of the plan developed by the university.~~

~~3. Monitor, evaluate, and report on the implementation of the plan to the Board of Governors, the Governor, the President of the Senate, and the Speaker of the House of Representatives.~~

~~(c) The advisory board shall be composed of the following five members:~~

~~1. The chair of the Board of Governors or the chair's~~

~~permanent designee.~~

~~2. A member with expertise in online learning, appointed by the Board of Governors.~~

~~3. A member with expertise in global marketing, appointed by the Governor.~~

~~4. A member with expertise in cloud virtualization, appointed by the President of the Senate.~~

~~5. A member with expertise in disruptive innovation, appointed by the Speaker of the House of Representatives.~~

~~(d) The president of the university shall be consulted on the advisory board member appointments.~~

~~(e) A majority of the advisory board shall constitute a quorum, elect the chair, and appoint an executive director.~~

~~(f) By September 1, 2013, the university shall submit to the advisory board a comprehensive plan to expand high-quality, fully online baccalaureate degree program offerings. The plan shall include:~~

~~1. Existing on-campus general education courses and baccalaureate degree programs that will be offered online.~~

~~2. New courses that will be developed and offered online.~~

~~3. Support services that will be offered to students enrolled in online baccalaureate degree programs.~~

~~4. A tuition and fee structure that meets the requirements in paragraph (k) for online courses, baccalaureate degree programs, and student support services.~~

~~5. A timeline for offering, marketing, and enrolling students in the online baccalaureate degree programs.~~

~~6. A budget for developing and marketing the online baccalaureate degree programs.~~

~~7. Detailed strategies for ensuring the success of students and the sustainability of the online baccalaureate degree programs.~~

~~Upon recommendation of the plan by the advisory board and approval by the Board of Governors, the Board of Governors shall award the university $10 million in nonrecurring funds and $5 million in recurring funds for fiscal year 2013-2014 and $5 million annually thereafter, subject to appropriation in the General Appropriations Act.~~

Section 29. Section 1002.77, Florida Statutes, is repealed.

Section 30. Subsection (11) of section 1002.83, Florida Statutes, is amended to read:

1002.83 Early learning coalitions.—

(11) Each early learning coalition shall establish terms for all appointed members of the coalition. The terms must be staggered and must be a uniform length that does not exceed 4 years per term. Coalition chairs shall be appointed for 4 years ~~in conjunction with their membership on the Early Learning Advisory Council~~ pursuant to s. 20.052. Appointed members may

serve a maximum of two consecutive terms. When a vacancy occurs in an appointed position, the coalition must advertise the vacancy.

Section 31. This act shall take effect July 1, 2020.

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Rodriguez, A. offered the following:

Amendment (with title amendment)

Between lines 556 and 557, insert:

Section 16. Subsections (10) and (11) and paragraphs (b) and (c) of subsection (14) of section 395.1055, Florida Statutes, are repealed.

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

Remove line 30 and insert:

Technical Advisory and Appeals Board; amending s. 395.1055, F.S., deleting the Pediatric Cardiac Technical Advisory Panel; repealing s.