Health & Human Services Committee

Tuesday, February 18, 2020
3:00 PM – 6:00 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: Tuesday, February 18, 2020 03:00 pm

End Date and Time: Tuesday, February 18, 2020 06:00 pm

Location: Morris Hall (17 HOB)

Duration: 3.00 hrs

Consideration of the following bill(s):

CS/HB 59 Automated Pharmacy Systems by Health Quality Subcommittee, Willhite
HB 89 Adoption Records by Stark
CS/HB 253 Elder Abuse Fatality Review Teams by Children, Families & Seniors Subcommittee, Driskell
HB 389 Testing for and Treatment of Influenza and Streptococcus by Sirois
HB 467 Physical Therapy Practice by Stevenson
CS/CS/HB 649 Patient Brokering by Civil Justice Subcommittee, Children, Families & Seniors Subcommittee, Caruso
CS/HB 763 Patient Safety Culture Surveys by Health Market Reform Subcommittee, Grant, M.
CS/HB 835 Alzheimer's Disease by Children, Families & Seniors Subcommittee, Willhite, Plakon
CS/HB 919 Property Tax Exemptions Used by Hospitals by Ways & Means Committee, Caruso
CS/HB 941 Treatment-based Drug Court Programs by Children, Families & Seniors Subcommittee, Buchanan
CS/HB 1071 Substance Abuse and Mental Health by Children, Families & Seniors Subcommittee, Grant, M.
CS/HB 1081 Substance Abuse and Mental Health by Children, Families & Seniors Subcommittee, Stevenson
CS/HB 1105 Child Welfare by Children, Families & Seniors Subcommittee, Tomkow
CS/HB 1187 Organ Donation by Health Market Reform Subcommittee, Latvala
HB 1217 Surrendered Newborn Infants by Beltran
HB 1273 Dentistry and Dental Hygiene by Buchanan
HB 1279 Health Insurance Benefits by Yarborough
CS/HB 1287 Reproductive Medicine by Health Quality Subcommittee, Jenne
CS/HB 1323 Economic Self-sufficiency by Oversight, Transparency & Public Management Subcommittee, Aloupis
HB 7025 Guardianship by Children, Families & Seniors Subcommittee, Fetterhoff
HB 7045 Prescription Drug Price Transparency by Health Market Reform Subcommittee, Andrade
CS/HB 7053 Direct Care Workers by Health Care Appropriations Subcommittee, Health Market Reform Subcommittee, Tomkow

Pursuant to rule 7.11, the deadline for amendments to bills on the agenda by non-appointed members shall be 6:00 p.m., Monday, February 17, 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., Monday, February 17, 2020.

NOTICE FINALIZED on 02/14/2020 4:06PM by Dewees.Cheryl

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 59 Automated Pharmacy Systems
SPONSOR(S): Health Quality Subcommittee, Willhite
TIED BILLS: **IDEN./SIM. BILLS:** SB 708

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	13 Y, 0 N, As CS	Siples	McElroy
2) Health Care Appropriations Subcommittee	11 Y, 0 N	Mielke	Clark
3) Health & Human Services Committee		Siples	Calamas

SUMMARY ANALYSIS

An automated pharmacy system is a mechanical system that dispenses prescription drugs received from a Florida-permitted pharmacy and maintains related transaction information. Such a system offers some mechanism, either videoconferencing or teleconferencing, by which a pharmacist may counsel a patient at the time of dispensing. Florida law currently authorizes the use of automated pharmacy systems in long-term care facilities, hospices, and state correctional institutions. The Board of Pharmacy has adopted rules regulating the use of such systems.

CS/HB 59 expands current law to authorize a community pharmacy to provide outpatient dispensing through the use of an automated pharmacy system. The bill establishes criteria for such systems and a community pharmacy's responsibilities when employing such a system.

The bill has an indeterminate, but likely insignificant, negative fiscal impact on the Department of Health, 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

The Florida Pharmacy Act (Act) regulates Florida pharmacies and contains the minimum requirements for safe practice.[1] The Board of Pharmacy within the Department of Health (DOH) is tasked with adopting rules to implement the provisions of the Act and setting standards of practice within the state.[2] A person must obtain a DOH-issued permit to operate a pharmacy:

- **Community pharmacy** - A permit is required for each location where medicinal drugs are compounded, dispensed, stored, or sold or where prescriptions are filled or dispensed on an outpatient basis.[3]
- **Institutional pharmacy** - A permit is required for every location in a hospital, clinic, nursing home, dispensary, sanitarium, extended care facility, or other facility where medicinal drugs are compounded, dispensed, stored, or sold.[4]
- **Nuclear pharmacy** - A permit is required for every location where radioactive drugs and chemicals within the classification of medicinal drugs are compounded, dispensed, stored, or sold. The term "nuclear pharmacy" does not include hospitals licensed under chapter 395 or the nuclear medicine facilities of such hospitals.[5]
- **Special pharmacy** - A permit is required for every location where medicinal drugs are compounded, dispensed, stored, or sold if the location does not otherwise meet an applicable pharmacy definition in s. 465.003, F.S.[6]
- **Internet pharmacy** - A permit is required for a location not otherwise licensed or issued a permit under chapter 465, F.S., within or outside this state, which uses the Internet to communicate with or obtain information from consumers in this state to fill or refill prescriptions or to dispense, distribute, or otherwise practice pharmacy in this state.[7]

All permitted pharmacies must pass an on-site inspection before DOH will issue an initial permit and an inspection is also required any time a pharmacy changes its ownership or address.[8]

Automated Pharmacy Systems

An automated pharmacy system is a mechanical system that delivers prescription drugs received from a Florida-permitted pharmacy and maintains related transaction information.[9] A Florida-licensed pharmacist must supervise the automated pharmacy system.[10] This supervision does not have to be at the same site of the automated pharmacy system and may be provided electronically.[11] The pharmacy operating the system must have policies and procedures in place to ensure sufficient security and protect patient confidentiality.[12]

[1] Chapter 465, F.S.
[2] Sections 465.005, 465.0155(1), and 465.022, F.S.
[3] Sections 465.003(11)(a)1. and 465.018, F.S.
[4] Sections 465.003(11)(a)2. and 465.019, F.S.
[5] Sections 465.003(11)(a)3. and 465.0193, F.S.
[6] Sections 465.003(11)(a)4. and 465.0196, F.S.
[7] Sections 465.003(11)(a)5. and 465.0197, F.S.
[8] Rule 64B16-28(1)(d), F.A.C.
[9] Section 465.003(17), F.S.
[10] Section 465.0235(3), F.S.
[11] Id.
[12] Rule 64B16-28.607, F.S.

Current law authorizes a pharmacy to use an automated pharmacy system to provide services to a long-term care facility, hospice, or a state correctional institution, and does not require such system to be located at the same location as the pharmacy.[13]

Current law does not explicitly authorize the use of automated pharmacy systems in community pharmacies. However, the Board of Pharmacy adopted rules allowing automated pharmacy systems to be used in community pharmacies. Under these rules, an automated pharmacy system must be located within or adjacent to the prescription department and must collect, control, and maintain all transaction information.[14] Such system may not compound or administer medicinal drugs.[15] All prescriptions dispensed from the system are considered to be certified by the pharmacist.[16] A pharmacy operating an automated pharmacy system must:[17]

- Have policies and procedures that address, among other things, security, a process for stocking the system, a method for identifying pharmacy personnel involved in the dispensing process, and a method for ensuring patient confidentiality;
- Ensure that each prescription is being dispensed in compliance with law;
- Maintain a readily retrievable electronic record to identify pharmacy personnel involved in the dispensing of a prescription;
- Be able to comply with product recalls;
- Only be stocked or restocked by a Florida-licensed pharmacist; and
- Use two separate verifications, such as a bar code verification, electronic verification, weight verification, or similar process to ensure that the proper medication is being dispensed.

It is unclear whether the Board of Pharmacy has sufficient statutory authority for these rules.

Effect of Proposed Changes

CS/HB 59 expands current law regulating automated pharmacy systems located in long-term care facilities, hospices, and state correctional institutions to include automated pharmacy systems employed by community pharmacies.

Under the bill, an automated pharmacy system employed by a community pharmacy does not need to be located at the same location as the community pharmacy if the system:

- Is under the supervision and control of Florida-permitted community pharmacy;
- Is under the supervision of a Florida-licensed pharmacist who is available and accessible for patient counseling prior to the dispensing of any medicinal drug;
- Does not store or dispense any controlled substances; and
- Ensures the confidentiality of personal health information.

The bill requires a community pharmacy to notify the Board of Pharmacy of the location of the system and any time the location of such system changes. The pharmacy must maintain a record of the medicinal drugs dispensed by the automated pharmacy system, including the identity of the pharmacist responsible for verifying the accuracy of the dosage and instructions for the prescription, as well as providing patient counseling. The bill provides that medicinal drugs stored in an automated pharmacy system for outpatient dispensing are part of the inventory of the community pharmacy operating the system and considered to have been dispensed by that pharmacy.

[13] Section 465.0235(1), F.S.
[14] Rule 64B16-28.141, F.S.
[15] Id.
[16] Id. A pharmacy must certify the accuracy of the final prescription. By doing so, the pharmacist assumes the responsibility for the prescription. (Rule 64B-27.1001, F.A.C.).
[17] Id.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 465.0235, F.S., relating to automated pharmacy systems used by long-term care facilities, hospices, and state correctional institutions.
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 experience a recurring increase in workload related to documenting the locations, inspecting, and regulating community pharmacy automated pharmacy systems.[18] It is unknown how many community pharmacies will employ an automated pharmacy system; however, it is estimated current resources are adequate to absorb these costs.[19]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Pharmacies that choose to employ automated pharmacy systems will incur costs associated with obtaining and maintaining those systems.

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.

[18] Department of Health, *2020 Agency Legislative Analysis for HB 59*, on file with the Health Quality Subcommittee.
[19] Id.

B. RULE-MAKING AUTHORITY:

The Board of Pharmacy has sufficient rulemaking authority to implement the bill under s. 465.0235, F.S.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to automated pharmacy systems; amending s. 465.0235, F.S.; authorizing a community pharmacy to use an automated pharmacy system under certain circumstances; providing that certain medicinal drugs stored in such system for outpatient dispensing are part of the inventory of the pharmacy providing services through such system; requiring the Board of Pharmacy to adopt rules; providing an effective date.

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

Section 1. Section 465.0235, Florida Statutes, is amended to read:

465.0235 Automated pharmacy systems used by long-term care facilities, hospices, or state correctional institutions, or for outpatient dispensing.—

(1) A pharmacy may provide pharmacy services to a long-term care facility or hospice licensed under chapter 400 or chapter 429 or a state correctional institution operated under chapter 944 through the use of an automated pharmacy system that need not be located at the same location as the pharmacy.

(2) A community pharmacy, as defined in s. 465.003 and licensed in this state, may provide pharmacy services for

outpatient dispensing through the use of an automated pharmacy system that need not be located at the same location as the community pharmacy if:

(a) The automated pharmacy system is under the supervision and control of the community pharmacy.

(b) The community pharmacy providing services through the automated pharmacy system notifies the board of the location of the automated pharmacy system and any changes in such location.

(c) The automated pharmacy system is under the supervision and control of a pharmacist, as defined in s. 465.003 and licensed in this state, who is available and accessible for patient counseling before the dispensing of any medicinal drug.

(d) The automated pharmacy system does not contain or dispense any controlled substance listed in s. 893.03 or 21 U.S.C. s. 812.

(e) The community pharmacy maintains a record of the medicinal drugs dispensed, including the identity of the pharmacist responsible for verifying the accuracy of the dosage and directions and providing patient counseling.

(f) The automated pharmacy system ensures the confidentiality of personal health information.

(3) ~~(2)~~ Medicinal drugs stored in bulk or unit of use in an automated pharmacy system servicing a long-term care facility, hospice, or correctional institution, or for outpatient dispensing, are part of the inventory of the pharmacy providing

pharmacy services to that facility, hospice, or institution, or for outpatient dispensing, and medicinal drugs delivered by the automated pharmacy system are considered to have been dispensed by that pharmacy.

(4) ~~(3)~~ The operation of an automated pharmacy system must be under the supervision of a ~~Florida-licensed~~ pharmacist licensed in this state. To qualify as a supervisor for an automated pharmacy system, the pharmacist need not be physically present at the site of the automated pharmacy system and may supervise the system electronically. The ~~Florida-licensed~~ pharmacist shall be required to develop and implement policies and procedures designed to verify that the medicinal drugs delivered by the automated pharmacy ~~dispensing~~ system are accurate and valid and that the machine is properly restocked.

(5) ~~(4)~~ The Legislature does not intend for this section to limit the current practice of pharmacy in this state. This section is intended to allow automated pharmacy systems to enhance the ability of a pharmacist to provide pharmacy services in locations that do not employ a full-time pharmacist. This section does not limit or replace the use of a consultant pharmacist.

(6) ~~(5)~~ The board shall adopt rules governing the use of ~~an~~ automated pharmacy systems ~~system by January 1, 2005~~, which must include ~~specify~~:

(a) Recordkeeping requirements.~~;~~

(b) Security requirements.~~; and~~

(c) Labeling requirements that permit the use of unit-dose medications if the facility, hospice, or institution maintains medication-administration records that include directions for use of the medication and the automated pharmacy system identifies:

1. The dispensing pharmacy.~~;~~

2. The prescription number.~~;~~

3. The name of the patient.~~; and~~

4. The name of the prescribing practitioner.

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 Willhite offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Section 465.0235, Florida Statutes, is amended to read:

465.0235 Automated pharmacy systems used by long-term care facilities, hospices, or state correctional institutions, or for outpatient dispensing.—

(1) A pharmacy may provide pharmacy services to a long-term care facility or hospice licensed under chapter 400 or chapter 429 or a state correctional institution operated under chapter 944 through the use of an automated pharmacy system that need not be located at the same location as the pharmacy.

(2) A community pharmacy, as defined in s. 465.003 and licensed in this state, may provide pharmacy services for outpatient dispensing through the use of an automated pharmacy system that need not be located at the same location as the community pharmacy if:

(a) The automated pharmacy system is under the supervision and control of the community pharmacy.

(b) The automated pharmacy system is housed in an indoor environment area and in a location to increase patients' access to their prescriptions, including but not limited to, medical facilities, places of business where essential goods and commodities are sold, rural areas of the state, large employer workplaces, and locations where access to a community pharmacy is limited.

(c) The community pharmacy providing services through the automated pharmacy system notifies the board of the location of the automated pharmacy system and any changes in such location.

(d) The automated pharmacy system has a mechanism that provides live, real-time patient counseling by a pharmacist, as defined in s. 465.003 and who is licensed in this state, before the dispensing of any medicinal drug.

(e) The automated pharmacy system does not contain or dispense any controlled substance listed in s. 893.03 or 21 U.S.C. s. 812.

(f) The community pharmacy maintains a record of the medicinal drugs dispensed, including the identity of the pharmacist responsible for verifying the accuracy of the dosage and directions and providing patient counseling.

(g) The automated pharmacy system ensures the confidentiality of personal health information.

(h) The community pharmacy maintains written policies and procedures to ensure the proper, safe, and secure functioning of the automated pharmacy system. The community pharmacy shall annually review the policies and procedures and maintain a record of such policies and procedures for a minimum of 4 years. The annual review must be documented in the community pharmacy's records and must be made available to the board upon request. The policies and procedures must, at a minimum, address all of the following:

1. Maintaining the automated pharmacy system and any accompanying electronic verification process in good working order.

2. Ensuring the integrity of the automated pharmacy system's drug identifier database and its ability to identify the person responsible for making database entries.

3. Ensuring the accurate filling, stocking, and verification of the automated pharmacy system.

4. Ensuring sanitary operation of the automated pharmacy system and prevention of cross-contamination of cells,

cartridges, containers, cassettes, or packages.

5. Testing the accuracy of the system and any accompanying electronic verification process. The automated pharmacy system and accompanying electronic verification process must, at a minimum, be tested before the first use of the system, upon restarting the system, and after a modification of the system or electronic verification process which alters the filling or electronic verification process.

6. Training persons authorized to access, stock, restock, or use the system.

7. Conducting routine and preventative maintenance of the automated pharmacy system, including calibration, if applicable.

8. Removing expired, adulterated, misbranded, or recalled drugs from the automated pharmacy system.

9. Preventing unauthorized persons from accessing the automated pharmacy system, including assigning, discontinuing, or modifying security access.

10. Identifying and recording persons responsible for stocking and filling the automated pharmacy system.

11. Ensuring compliance with state and federal law, including, but not limited to, all applicable labeling, storage, and security requirements.

12. Maintaining an ongoing quality assurance program that monitors performance of the automated pharmacy system and any accompanying electronic verification process to ensure proper

and accurate functioning, including tracking and documenting system errors. A community pharmacy must maintain such documentation for a minimum of 4 years and must produce it to the board upon request.

(3) ~~(2)~~ Medicinal drugs stored in bulk or unit of use in an automated pharmacy system servicing a long-term care facility, hospice, or correctional institution, or for outpatient dispensing, are part of the inventory of the pharmacy providing pharmacy services to that facility, hospice, or institution, or for outpatient dispensing, and medicinal drugs delivered by the automated pharmacy system are considered to have been dispensed by that pharmacy.

(4) ~~(3)~~ The operation of an automated pharmacy system must be under the supervision of a ~~Florida-licensed~~ pharmacist licensed in this state. To qualify as a supervisor for an automated pharmacy system, the pharmacist need not be physically present at the site of the automated pharmacy system and may supervise the system electronically. The ~~Florida-licensed~~ pharmacist shall be required to develop and implement policies and procedures designed to verify that the medicinal drugs delivered by the automated pharmacy ~~dispensing~~ system are accurate and valid and that the machine is properly restocked.

(5) ~~(4)~~ The Legislature does not intend for this section to limit the current practice of pharmacy in this state. This section is intended to allow automated pharmacy systems to

enhance the ability of a pharmacist to provide pharmacy services in locations that do not employ a full-time pharmacist. This section does not limit or replace the use of a consultant pharmacist.

(6)~~(5)~~ The board may ~~shall~~ adopt rules governing the use of ~~an~~ automated pharmacy systems. If adopted, such rules ~~system by January 1, 2005~~, which must include all of the following ~~specify~~:

(a) Recordkeeping requirements.~~;~~

(b) Security requirements.~~; and~~

(c) Labeling requirements that permit the use of unit-dose medications if the facility, hospice, or institution maintains medication-administration records that include directions for use of the medication and the automated pharmacy system identifies:

1. The dispensing pharmacy.~~;~~

2. The prescription number.~~;~~

3. The name of the patient.~~; and~~

4. The name of the prescribing practitioner.

Section 2. 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 automated pharmacy systems; amending s. 465.0235, F.S.; authorizing a community pharmacy to use an automated pharmacy system under certain circumstances; providing that certain medicinal drugs stored in an automated pharmacy system for outpatient dispensing are part of the inventory of the pharmacy providing services through such system; requiring community pharmacies to adopt certain policies and procedures; authorizing, rather than requiring, the Board of Pharmacy to adopt specified rules; deleting an obsolete date; providing an effective date.

HB 89

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 89 Adoption Records
SPONSOR(S): Stark and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 302

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	11 Y, 0 N	Siples	McElroy
2) Civil Justice Subcommittee	13 Y, 0 N	Frost	Luczynski
3) Health & Human Services Committee		Siples	Calamas

SUMMARY ANALYSIS

In Florida, all adoptions, whether private or from the child welfare system, are subject to the Florida Adoption Act (Act). The Act is intended to provide a stable and permanent home for adoptive children in a prompt manner, prevent the disruption of adoptive placement, and hold parents accountable for meeting the needs of children. All adoption records, including copies of an original birth certificate, are confidential and may not be released except by court order or authorization of all parties involved.

HB 89 authorizes each party to an adoption to authorize the release of his or her own records. Adoption records may still be released upon order of the court.

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:

Present Situation

Vital Statistics

The Florida Vital Statistics Act directs the Department of Health (DOH) to establish the Bureau of Vital Statistics (Bureau)[1] under the direction of a state registrar for the uniform and efficient registration, compilation, storage, and preservation of all vital records[2] in this state.[3] DOH must also establish registration districts throughout the state and appoint a local registrar of vital statistics for each registration district.

Birth Registration

Within five days of each live birth in this state, a certificate of live birth must be filed with the local registrar in the district where the birth took place.[4] The state registrar may receive the registration of the birth certificate electronically through facsimile or other electronic transfer.

A birth certificate may be amended under the following limited circumstances:

- Until a child's first birthday, a child's given name or surname may be amended if authorized by both parents named on the original birth certificate or by the registrant's guardian.[5]
- Upon receipt of a notarized voluntary acknowledgment of paternity by the mother and father acknowledging paternity of a registrant born out of wedlock.[6]
- Upon receipt of the report or certified copy of an adoption decree or an annulment-of-adoption decree.[7]
- Upon receipt of a name change order by a court of competent jurisdiction.[8]
- Upon receipt of a final judgment establishing paternity or disestablishing paternity.[9]

Certified copies of the original birth certificate or a new or amended birth certificate are confidential and exempt and may only be issued to the following specified persons:[10]

- The person named on the birth certificate (registrant), if the registrant has reached the age of majority, is a certified homeless youth, or is a minor who has had the disability of nonage legally removed;
- The parent, guardian, or other legal representative of the registrant;
- The spouse, child, grandchild, or sibling of the registrant, but only with a copy of the registrant's death certificate;
- Any person if the birth record is over 100 years old and not under seal pursuant to court order;
- Law enforcement agencies for official purposes;
- Any state or federal agency for official purposes approved by DOH; or

[1] Although the statute refers to an Office of Vital Statistics, it has been established as the Bureau of Vital Statistics within DOH.
[2] A vital record is defined as certificates or reports of birth, death, fetal death, marriage, dissolution of marriage, certain name changes, and data related thereto. Section 382.001(17), F.S.
[3] Section 382.003, F.S.
[4] Section 382.013, F.S.
[5] Section 382.016(1)(a), F.S.
[6] Section 382.016(1)(b), F.S.
[7] Section 382.015, F.S.
[8] Section 68.07, F.S.
[9] Section 742.18, F.S.
[10] Section 382.025(1), F.S.

- Any person authorized to receive the birth certificate by court order.

Adoption in Florida

The Florida Adoption Act (Act), ch. 63, F.S., applies to all adoptions, whether private or from the child welfare system, involving the following entities:[11]

- The Department of Children and Families (DCF);
- Child-placing agencies licensed by DCF under s. 63.202, F.S.;
- Child-caring agencies registered under s. 409.176, F.S.;
- An attorney licensed to practice in Florida; or
- A child-placing agency licensed in another state which is qualified by DCF to place children in Florida.

The Act is intended to provide stable and permanent homes for adoptive children in a prompt manner, to prevent the disruption of adoptive placements, and to hold parents accountable for meeting the needs of children.[12] In every adoption, the child's best interest should govern the court's determination in placement, and the court must specific findings as to those best interests.[13] The court must protect and promote the well-being of any person being adopted.[14] Certain statutory safeguards ensure that a minor is legally eligible for adoption, the required persons consent to the adoption, or a parent-child relationship is terminated by judgment of the court.[15]

The Act also provides the process and regulation of adoption in this state, such as, who may adopt, the rights and responsibilities of involved parties, proceedings for terminating parental rights, required notifications, licensure of adoption agencies, and confidentiality of adoption records.

Issuance of Birth Certificates in Adoption

Within 30 days of final disposition of an adoption case, the court clerk must forward a certified copy of the court order to the Bureau, with sufficient information to identify the original birth certificate and to create a new birth certificate.[16] Unless the court, adoptive parents, or adult adoptee object, the Bureau must prepare and file a new birth certificate. The new certificate must have the same file number as the original birth certificate.[17] The names and identifying information of the adoptive parents are entered on the new certificate without any reference to the parents being adoptive.[18] All other information remains the same, including the date of registration and filing.

Once a new birth certificate is prepared, DOH must substitute the new birth certificate for the original certificate on file.[19] Thereafter, DOH may only issue a certified copy of the new birth certificate, unless a court order requires a certified copy of the original birth certificate.[20] The original birth certificate and all related documents must be sealed and remain sealed, unless a court order or other law directs the unsealing.[21]

[11] Section 63.032(3), F.S.
[12] Section 63.022(1), F.S.
[13] Section 63.022(2), F.S.
[14] Section 63.022(3), F.S.
[15] Section 63.022(4), F.S.
[16] Section 382.015(1)(a), F.S.
[17] *Id*.
[18] *Id*.
[19] Section 382.015(4), F.S.
[20] *Id*.
[21] *Id*.

Confidentiality of Adoption Records

All documents and records related to an adoption, including the original birth certificate, are confidential.[22] Prior to an adoption becoming final, the adoptive parents must be provided with non-identifying information, including the family medical history and social history of the adoptee and the adoptee's parents, when available. Upon reaching the age of majority, an adoptee may also request such non-identifying information.[23] However, the name and identity of a birth parent, an adoptive parent, or an adoptee may not be disclosed unless:[24]

- The birth parent authorizes in writing the release of his or her name;
- An adoptee, age 18 or older, authorizes in writing the release of his or her name;
- An adoptive parent of an adoptee under age 18 provides written consent to disclose the adoptee's name;
- An adoptive parent authorizes in writing the release of his or her name; or
- Upon order of the court for good cause shown.

Effect of Proposed Changes

HB 89 authorizes the disclosure of adoption records without a court order, under the following circumstances:

- A birth parent may authorize, in writing, the disclosure of his or her name or identity;
- An adoptee, who is 18 or older, may authorize, in writing, the disclosure of his or her name or identity;[25] or
- An adoptive parent may authorize, in writing, the disclosure of his or her name or identity.

The bill clarifies that a party to an adoption does not need authorization from all other parties to an adoption in order to receive the name and identity of one party who has provided authorization. Meaning a party to an adoption may obtain records revealing:

- His or her own name and identity, with the name and identity of all other parties redacted; and
- The name or identity of any other party who authorizes disclosure, with the name and identity of any unauthorized person redacted.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 63.162, F.S., relating to hearings and records in adoption proceedings; confidential nature.
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.

[22] Section 63.162(2), F.S.
[23] Section 63.162(6), F.S.
[24] Section 63.162(4), F.S.
[25] The bill retains current law, which requires the adoptive parent's written authorization to release the name and identity of an adoptee who is under the age of 18.

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 has sufficient rulemaking authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

As drafted, the bill may allow a minor adoptee to obtain records, without parental consent from his or her adoptive parents, containing the name and identity of the adoptee's birth parents.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to adoption records; amending s. 63.162, F.S.; providing that the name and identity of a birth parent, an adoptive parent, and an adoptee may be disclosed from adoption records without a court order under certain circumstances; providing an effective date.

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

Section 1. Subsection (4) of section 63.162, Florida Statutes, is amended to read:

63.162 Hearings and records in adoption proceedings; confidential nature.—

(4)(a) A person may ~~not~~ disclose the following from the records without a court order ~~the name and identity of a birth parent, an adoptive parent, or an adoptee unless~~:

1.~~(a)~~ The name and identity of the birth parent, if the birth parent authorizes in writing the release of his or her name;

2.~~(b)~~ The name and identity of the adoptee, if the adoptee is 18 ~~or more~~ years of age or older and~~,~~ authorizes in writing the release of his or her name; or, if the adoptee is younger ~~less~~ than 18 years of age, written consent to disclose the adoptee's name is obtained from an adoptive parent; or

3.~~(c)~~ The name and identity of the adoptive parent, if the adoptive parent authorizes in writing the release of his or her name.~~; or~~

(b)~~(d)~~ A person may disclose from the records the name and identity of a birth parent, an adoptive parent, or an adoptee upon order of the court for good cause shown. In determining whether good cause exists, the court shall give primary consideration to the best interests of the adoptee, but must also give due consideration to the interests of the adoptive and birth parents. Factors to be considered in determining whether good cause exists include, but are not limited to:

1. The reason the information is sought;

2. The existence of means available to obtain the desired information without disclosing the identity of the birth parents, such as by having the court, a person appointed by the court, the department, or the licensed child-placing agency contact the birth parents and request specific information;

3. The desires, to the extent known, of the adoptee, the adoptive parents, and the birth parents;

4. The age, maturity, judgment, and expressed needs of the adoptee; and

5. The recommendation of the department, licensed child-placing agency, or professional that ~~which~~ prepared the preliminary study and home investigation, or the department if no such study was prepared, concerning the advisability of

disclosure.

Section 2. 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 Stark offered the following:

Amendment

Remove line 20 and insert:

name and the adoptee is 18 years of age or older; if the adoptee is younger than 18 years of age, the adoptive parent must also provide written consent to disclose the birth parent's name;

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 253 Elder Abuse Fatality Review Teams
SPONSOR(S): Children, Families & Seniors Subcommittee; Driskell and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 400

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	14 Y, 0 N, As CS	Morris	Brazzell
2) Oversight, Transparency & Public Management Subcommittee	13 Y, 0 N	Toliver	Smith
3) Health & Human Services Committee		Morris	Calamas

SUMMARY ANALYSIS

Florida has the highest percentage of senior residents in the nation, projected to increase from 20 to 25 percent (5.9 million seniors) by 2030. Mental and physical infirmities of aging and social isolation make elders vulnerable to abuse, which increases their rates of hospitalization and hastens death. One in 10 elders is abused, but incidents of elder abuse are reported in less than 5 percent of cases, primarily because the most common perpetrator is a relative, friend, neighbor, or caregiver whom the elder trusts or fears.

Florida has programs to systematically review deaths due to child abuse or domestic violence. Different than protective investigations, these fatality review teams are generally established to understand the causes and incidents of deaths, identify any gaps in support and service delivery, and improve preventive interventions.

The bill creates s. 415.1103, F.S., authorizing the creation of a multidisciplinary, multiagency elder abuse fatality review team (EA-FRT) in each judicial circuit to review closed cases where the death of an elderly person was caused by, or related to, abuse or neglect. EA-FRTs are housed in the Department of Elder Affairs (DOEA) for administrative purposes only. Participation in EA-FRT is voluntary and team members serve without compensation.

The bill includes procedures for organization and creation of an EA-FRT, appointment of EA-FRT members, and obtaining relevant records for an EA-FRT. In its review, an EA-FRT must consider the surrounding circumstances and events leading up to a fatal incident, identify any gaps in support and service delivery, and make recommendations for systemic improvements to prevent elder abuse and deaths. The bill grants EA-FRT members immunity from monetary liability and prohibits a cause of action relating to their participation in an EA-FRT in certain circumstances, with exceptions.

The bill requires each EA-FRT to submit an annual report on its findings to DOEA by September 1 and DOEA to submit a summary report to the Governor, the Legislature, and DCF by November 1 each year.

The bill has an indeterminate, insignificant, negative fiscal impact on DOEA.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

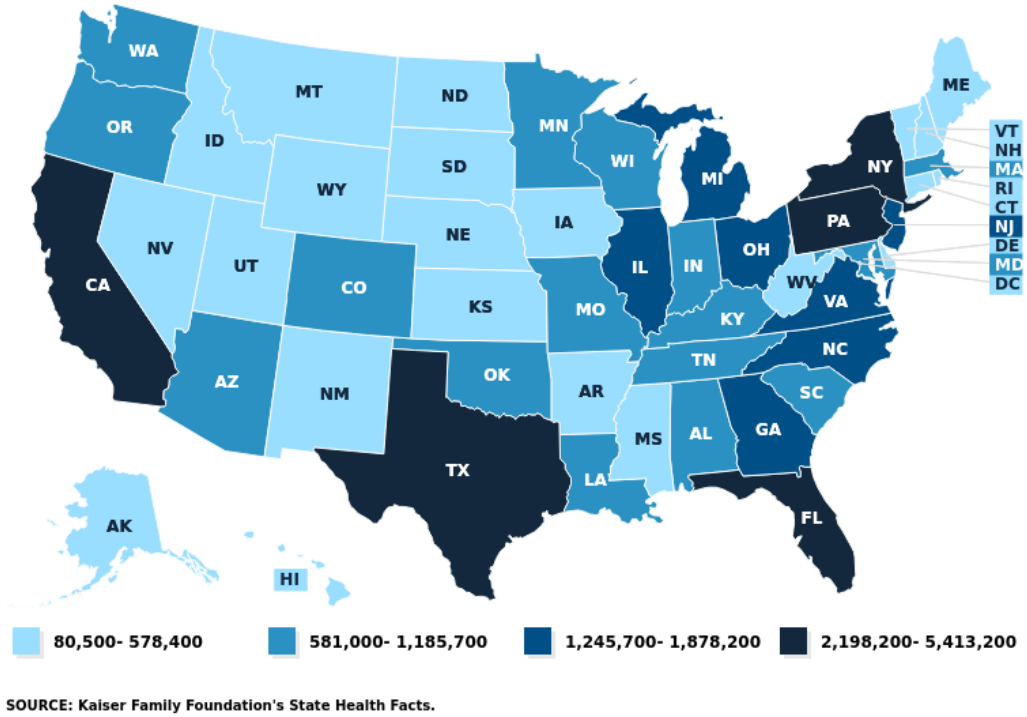
A. EFFECT OF PROPOSED CHANGES:

Background

Elder Population in Florida

As the country's "baby-boom" population reaches retirement age and life expectancy increases, the nation's elder population is projected to increase from 49.2 million in 2016[1] to 77 million by 2034.[2] Florida has long been a destination state for senior citizens and has the highest percentage of senior residents in the entire nation.[3] In 2018, Florida had an estimated 4.3 million people age 65 and older, approximately 20 percent of the state's population.[4] By 2030, this number is projected to increase to 5.9 million, meaning the elderly will make up approximately one quarter of the state's population and will account for most of the state's growth.[5]

National Distribution of Population Ages 65 and Older (2018)[6]



SOURCE: Kaiser Family Foundation's State Health Facts.

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[1] Press Release, U.S. Census Bureau, *The Nation's Older Population is Still Growing, Census Bureau Reports* (June 22, 2017), Release Number: CB17-100, *available at*: https://www.census.gov/newsroom/press-releases/2017/cb17-100.html (last visited Feb. 13, 2020).
[2] Press Release, U.S. Census Bureau, *Older People Projected to Outnumber Children for First Time in U.S. History* (revised Oct. 8, 2019), available at: https://www.census.gov/newsroom/press-releases/2018/cb18-41-population-projections.html (last visited Feb. 13, 2020).
[3] *Where Do the Oldest Americans Live?*, Pew Research Center, July 9, 2015, available at: https://www.pewresearch.org/fact-tank/2015/07/09/where-do-the-oldest-americans-live/ (last visited Feb. 13, 2020).
[4] U.S. Census Bureau, *Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States*, available at: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk (last visited Feb. 13, 2020).
[5] Florida Office of Economic & Demographic Research, *Population Data: 2016, 2020, 2025, 2030, 2035, 2040, & 2045, County by Age, Race, Sex, and Hispanic Origin*, pp. 89-90 and 269-70, available at: http://edr.state.fl.us/Content/population-demographics/data/Medium_Projections_ARSH.pdf (last visited Feb. 13, 2020); Florida Office of Economic & Demographic Research, *Econographic News: Economic and Demographic News for Decision Makers, 2019, Vol. 1*, available at: http://edr.state.fl.us/content/population-demographics/reports/econographicnews-2019v1.pdf (last visited Feb. 13, 2020).
[6] Kaiser Family Foundation, *State Health Facts, Population Distribution by Age,* https://www.kff.org/other/state-indicator/distribution-by-age/ (last visited Feb. 13, 2020).

Elder populations are vulnerable to abuse and exploitation due to risk factors associated with aging, such as physical and mental infirmities and social isolation.[7] In Florida, almost 1.3 million senior citizens live in medically underserved areas and 1.4 million suffer from one or more disabilities.[8] According to the Department of Justice, approximately 1 in 10 seniors is abused each year in the United States, and incidents of elder abuse are reported to local authorities in 1 out of every 23 cases.[9] Elder abuse can have significant physical and emotional effects on an older adult, and can lead to premature death.[10] Abused seniors are twice as likely to be hospitalized and three times more likely to die than non-abused seniors.[11]

Elder abuse occurs in community settings, such as private homes, as well as in institutional settings like nursing homes and other long-term care facilities. Prevalent forms of abuse are financial exploitation, neglect, emotional or psychological abuse, and physical abuse; however, an elder abuse victim will often experience multiple forms of abuse at the same time.[12] The most common perpetrators of elder abuse are relatives, such as adult children or a spouse, followed by friends and neighbors, and then home care aides.[13] Research shows that elder abuse is underreported, often because the victims fear retribution or care for or trust their perpetrators.[14] Elder abuse deaths are more likely to go undetected because an elder death is expected to occur, given age or infirmity, more so than other deaths due to abuse such as a child death or a death involving domestic violence.[15] Experts believe this may be one of the reasons elder abuse lags behind child abuse and domestic violence in research, awareness, and systemic change.[16]

Florida's Adult Protective Services System

Chapter 415, F.S., creates Florida's Adult Protective Services (APS) under the Department of Children and Families (DCF). DCF protects vulnerable adults,[17] including elders, from abuse, neglect, and exploitation through mandatory reporting and investigation of suspected abuse.[18] This includes deaths allegedly due to abuse, neglect, and exploitation.[19] In FY 2018-19, DCF received 37,145 reports of abuse, neglect, or exploitation of persons aged 60 years or older and investigated 252 deaths in which

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[7] National Center on Elder Abuse, *What are the Risk Factors?,* https://ncea.acl.gov/About-Us/What-We-Do/Research/Statistics-and-Data.aspx#risk (last visited Feb. 13, 2020); U.S. Department of Justice, *Elder Justice Initiative, Older Adults, Families, and Caregivers,* https://www.justice.gov/elderjustice/victims-families-caregivers (last visited Feb. 13, 2020). *See also*, Xing Qi Dong et al., *Elder Abuse as a Risk Factor for Hospitalization in Older Persons*, JAMA Intern Med. 173:10 at 911-917 (2013).

[8] Department of Elder Affairs, *2018 Profile of Older Floridians,* http://elderaffairs.state.fl.us/doea/pubs/stats/County_2018/Counties/Florida.pdf (last visited Feb. 13, 2020).

[9] U.S. Department of Justice, *Elder Justice Initiative*, https://www.justice.gov/elderjustice (last visited Feb. 13, 2020). *See also*, Ron Acierno et al., *Prevalence and Correlates of Emotional, Physical, Sexual, and Financial Abuse and Potential Neglect in the United States: The National Elder Mistreatment Study*, 100:2 Am. J. Pub. Health, at 292-297 (Feb. 2010), available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2804623/ (last visited Feb. 13, 2020).

[10] U.S. Department of Justice, *Elder Justice Initiative*, https://www.justice.gov/elderjustice (last visited Feb. 13, 2020). *See also*, Mark S. Lachs et al., *The Mortality of Elder Mistreatment*, 280:5 JAMA at 428-432 (1998), available at: https://jamanetwork.com/journals/jama/fullarticle/187817 (last visited Feb. 13, 2020).

[11] U.S. Department of Justice, *Elder Justice Initiative*, https://www.justice.gov/elderjustice (last visited Feb. 13, 2020). *See also*, Xing Qi Dong et al., *Elder Abuse as a Risk Factor for Hospitalization in Older Persons*, JAMA Intern Med. 173:10 at 911-917 (2013).

[12] National Center on Elder Abuse, *Challenges in Elder Abuse Research,* https://ncea.acl.gov/About-Us/What-We-Do/Research/Statistics-and-Data.aspx#challenges (last visited Feb. 13, 2020).

[13] National Center on Elder Abuse, *Who are the Perpetrators?*, https://ncea.acl.gov/About-Us/What-We-Do/Research/Statistics-and-Data.aspx#perpetrators (last visited Feb. 13, 2020).

[14] Center for Disease Control and Prevention, *Understanding Elder Abuse*, *Fact Sheet 2016*, https://www.cdc.gov/violenceprevention/pdf/em-factsheet-a.pdf (last visited Feb. 13, 2020).

[15] U.S. Department of Justice, National Institute of Justice, *Elder Justice Roundtable Report: Medical Forensic Issues Concerning Abuse and Neglect*, October 18, 2000, p. 8, available at: https://www.ncjrs.gov/pdffiles1/nij/242221.pdf (last visited Feb. 13, 2019).

[16] Id. at pp. 7-10.

[17] A vulnerable adult is a person 18 years of age or older whose ability to perform normal activities of daily living or to provide for his or her own care or protection is impaired due to mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging. S. 415.102(28), F.S.

[18] S. 415.101(2), F.S.

[19] Department of Children and Families, *CF Operating Procedure No. 140-2: Adult Protective Services* (Feb. 2019), pp. 4-9 - 4-10, http://www.dcf.state.fl.us/admin/publications/cfops/CFOP%20140-xx%20Adult%20Services/CFOP%20140-02,%20Adult%20Protective%20Services.pdf (last visited Feb. 13, 2020).

the death was allegedly due to abuse or neglect.[20] During that same fiscal year, DCF verified 6,277 allegations of abuse or neglect, 34 of which involved a fatality.[21] Eighty-one (81) percent of these reports were from in-home settings, which is consistent with the research findings that relatives, friends, or caregivers are the main perpetrators of elder abuse.

DCF Adult Investigations Involving Victims Age 60+
FYs 2012-2017[22]

FY	Reports Received [1]	Unique Reports [2]	# Verified	Deaths Reported/ Investigated [3]	# Verified	In-Home	Institutional
2018-2019	37,145	35,814	6,277	252	34	81.12%	18.88%
2017-2018	39,046	37,395	5,749	245	28	81.88%	18.12%
2016-2017	41,192	39,005	5,423	181	27	82.77%	17.23%
2015-2016	42,609	39,998	5,639	178	21	82.91%	17.09%
2014-2015	39,639	37,381	5,371	236	40	82.52%	17.48%
2013-2014	36,926	34,922	3,934	197	27	83.96%	16.04%
2012-2013	33,833	32,092	3,309	153	17	83.14%	16.86%

[1] Reports received ***counts Initial and Additional intakes accepted by the Hotline. There may be more than one call/reporter on the same incident.***

[2] Unique reports ***represents a unique count of intakes received. Multiple intakes on the same incident are not counted.***

[3] All reports accepted by the Hotline are investigated.

Central Abuse Hotline

DCF maintains a statewide 24/7 toll-free central abuse hotline where anyone can report known or suspected abuse, neglect, or exploitation.[23] This includes, but is not limited to, vulnerable adults. Any person that knows or has reasonable cause to suspect abuse, neglect, or exploitation of a vulnerable adult is required to immediately report this knowledge or suspicion to the central abuse hotline.[24] The hotline number must be provided to clients in nursing homes[25] and publicly displayed in every health facility licensed by the Agency for Health Care Administration (AHCA).[26] The number is also listed on the agency websites for DCF, AHCA, and the Department of Elder Affairs (DOEA).[27]

Additionally, any person who is required to investigate allegations of abuse, neglect, or exploitation, and who has reasonable cause to suspect that a vulnerable adult died as result of such harm must report that suspicion to DCF, the medical examiner, and appropriate criminal justice agency.[28] Medical examiners in turn are required to consider this information in their cause of death determinations and report their findings to DCF and the appropriate criminal justice agency and state attorney.[29]

Protective Investigations

Once DCF believes there is reasonable cause to suspect abuse or neglect of a vulnerable adult, they begin an investigation within 24 hours, to be conducted in cooperation with law enforcement and the state attorney.[30] DCF investigators determine, among other things, whether the vulnerable adult is in

[20] Email from Lindsey Zander, Deputy Director of Legislative Affairs, Department of Children and Families, RE: APS Statistics (Oct. 30, 2019) (On file with House Health and Human Services Committee staff).
[21] Id.
[22] Id.
[23] S. 415.103(1), F.S.
[24] S. 415.1034(1), F.S.
[25] S. 408.810(5)(a)2., F.S.
[26] S. 400.141(1)(m), F.S.; AHCA poster can be found here: https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Long_Term_Care/docs/Nursing_Homes/Posters/NURSING_HOME_POSTER_ENGLISH_LETTER.pdf (last visited Feb. 13, 2020).
[27] Department of Children and Families, *Report Abuse Neglect or Exploitation*, http://www.myflfamilies.com/service-programs/abuse-hotline/report-online (last visited Feb. 13, 2020); Agency for Health Care Administration, *Complaint Administration Unit*, http://ahca.myflorida.com/MCHQ/Field_Ops/CAU.shtml (last visited Feb. 13, 2020). Department of Elder Affairs, *Elder Abuse Prevention Program*, http://elderaffairs.state.fl.us/doea/abuse_prevention.php (last visited Feb. 13, 2020).
[28] S. 415.1034(2), F.S.
[29] S. 415.1034(2), F.S.
[30] S. 415.104(1), F.S. Note, DCF does not investigate reports of elder abuse when the adult victim is determined *not* to be vulnerable under s. 415.102(28), F.S. Those elder abuse cases are the sole jurisdiction of law enforcement agencies.

need of services, whether there is evidence of abuse, neglect or exploitation, the nature and extent of any harm, and what is necessary to ensure the victim's safety and well-being.[31] DCF investigators must complete their investigations and submit their recommendations within 60 days of the initial report.[32] If DCF determines that a victim is in need of protective services or supervision, it will provide or facilitate the provision of those services to the victim.[33] If a victim dies during an open investigation, DCF investigators must verify the cause of death before closing the case to determine if the death was related to abuse or neglect.[34]

If there is a report that a death occurred due to elder abuse, neglect, or exploitation, the DCF investigator notifies the department's registered nurse specialist (RNS)[35] staffing his or her region within 24 hours. If the alleged victim resided with other vulnerable adults, DCF conducts an on-site investigation to ensure the safety of these individuals as well.[36]

The DCF investigator and RNS work together to gather all relevant medical investigative information, including but not limited to medical records, the death certificate, the autopsy report, and specific questions to be included in the investigative process.[37] The DCF investigators also gather other relevant information such as copies of any related law enforcement investigations, criminal history and abuse reports relating to the alleged perpetrator, and prior adult protective services records relating to the victim or perpetrator, including the facilities where the death occurred.[38]

The DCF investigators review all of this information before making their determinations as to the cause of death and will summarize their findings in a report.[39] In these cases involving an elder abuse death, DCF designates a second party to review the DCF investigators' findings before closing the case.[40] The second party reviews the investigation process to ensure that it was thorough and that all issues were properly addressed; reviews the reports for completeness and accuracy; and documents its review for DCF's records.[41]

Adult Protection Teams

Current law authorizes DCF to create multidisciplinary Adult Protection Teams in each district[42] to support activities of the protective services program and provide services the team finds necessary for victims of elder abuse.[43] The teams can only provide these services with the consent of the vulnerable adult, the person's guardian, or court order, and should not duplicate services provided by other units or offices of DCF.[44]

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[31] S. 415.104(3), F.S.
[32] S. 415.104(4), F.S.
[33] S. 415.105(1), F.S.
[34] Department of Children and Families, *CF Operating Procedure No. 140-2: Adult Protective Services* (Feb. 2019), p. 15-2, available at: http://www.dcf.state.fl.us/admin/publications/cfops/CFOP%20140-xx%20Adult%20Services/CFOP%20140-02,%20Adult%20Protective%20Services.pdf (last visited Feb. 13, 2020).
[35] An RNS is a Florida-licensed registered nurse who assists the DCF in its APS investigations by providing medical expertise to help inform the DCF's findings, Department of Children and Families, *CF Operating Procedure No. 140-11: Adult Protective Services Registered Nurse Specialist* (Oct. 21, 2011), p. 1, available at: https://www.dcf.state.fl.us/admin/publications/cfops/CFOP%20140-xx%20Adult%20Services/CFOP%20140-11,%20Adult%20Protective%20Services%20Registered%20Nurse%20Specialist.pdf (last visited Feb. 13, 2020).
[36] *Supra* note 34, at 21-1.
[37] *Supra* note 34, at 21-2.
[38] Id.
[39] *Supra* note 34, at 21-2 - 21-3
[40] *Supra* note 34, at 21-3.
[41] Id.
[42] DCF has now adopted a regional structure rather than a district-based structure.
[43] Ss. 415.1102(1), 415.1102(4), F.S. DCF has established 15 Adult Protection Teams statewide, varying in how often and under what circumstances they convene, Email from Lindsey Perkins Zander, Deputy Director of Legislative Affairs, Department of Children and Families, RE: Adult Protective Services Statistics (Jan. 5, 2018) (On file with House Health and Human Services Committee staff).
[44] Ss. 415.1102(4), 415.1102(5), F.S.

The teams can consist of anyone trained in the prevention, identification, and treatment of abuse of elderly persons, such as:

- Psychiatrists, psychologists, other trained counseling personnel;
- Police officers or other law enforcement officers;
- Medical personnel who have sufficient training to provide health services;
- Social workers who have experience or training in preventing the abuse of elderly or dependent persons; or
- Public and professional guardians under part II of chapter 744, F.S.[45]
- The community-based care lead agency;
- State, county, or local law enforcement agencies;
- The school district;
- A mental health treatment provider;
- A certified domestic violence center;
- A substance abuse treatment provider; and
- Any other members that are determined by guidelines developed by the State Child Abuse Death Review Committee (CADR).[46]

Child Abuse Death Review Committee

Child Abuse Death Review (CADR) Committees are granted access to all information and records from any state agency or political subdivision so long as the information may assist in reviewing a child's death.[47] Local CADR committees review individual facts and circumstances of a child's death and provide the state CADR committee with demographic data, any gaps or deficiencies identified in the system, and recommendations for improvement.[48] The state CADR committee provides direction for the review system and analyzes the data and recommendations received from local CADR committees.[49] The state CADR committee then submits a comprehensive annual report to the Governor and Legislature by December 1 each year.[50]

In the last fiscal year, all 22 local CADR committees used collected data to develop prevention action plans, including 194 activities designed to prevent child abuse.[51] Because drowning and asphyxia were the top causes of death in the previous year's data review, action plans included media campaigns, education, and training for safe sleep and water safety.[52] Similarly, because there is significant overlap between child maltreatment and domestic violence, substance abuse, and mental health, some action plans also addressed improvements in and increased access to parenting education, domestic violence advocates, and mental health treatment.[53]

Florida's Domestic Violence Fatality Review Teams

The state's Domestic Violence Fatality Review Teams (DV-FRT) are multidisciplinary teams that review fatal and near-fatal incidents of domestic violence, related domestic violence matters, and suicides.[54] DV-FRTs can be established at the local, regional, or state level.[55] Currently, there are 25 local DV-

[45] Ss. 415.1102(1), 415.1102(2), F.S.
[46] S. 383.402(3)(a), F.S.
[47] S. 383.402(5), F.S.
[48] S. 383.402(3)(b), F.S.
[49] S. 383.402(2)(b), F.S.
[50] S. 383.402(4), F.S.
[51] Department of Health, *State Child Abuse Death Review Committee Annual Report December 2017*, p. 51, available at: http://www.flcadr.com/reports/_documents/Final_CADR_2017.pdf (last visited Feb. 13, 2020).
[52] Id.
[53] Id.
[54] S. 741.316(1), F.S.
[55] S. 741.316(2), F.S.

FRTs and one statewide team.[56] The DV-FRTs are assigned to the Florida Coalition against Domestic Violence for administrative purposes only, so the structure and activities of a team are determined at the local level.[57]

The DV-FRTs include, but are not limited to, representatives from the following agencies or organizations:

- Law enforcement agencies;
- The state attorney's office;
- The medical examiner's office;
- Certified domestic violence centers;
- Child protection service providers;
- The office of the court administration;
- The clerk of the court;
- Victim services programs;
- Child death review teams;
- Members of the business community;
- County probation or corrections agencies; and
- Any other persons who have knowledge regarding domestic violence fatalities, nonlethal incidents of domestic violence or suicide, including research, policy, law or other related matters.[58]

The DV-FRTs review events leading up to the domestic violence incident, available community resources, current laws and policies, actions taken by systems and individuals related to the incident and parties, and any information or action deemed relevant by the team.[59] The teams' purpose is to learn how to prevent domestic violence by intervening early and improving the response of an individual and the system to domestic violence.[60] Each team determines the number and type of incidents it will review and makes policy and other recommendations as to how incidents of domestic violence may be prevented.[61]

The Office of the Attorney General and the Florida Coalition against Domestic Violence co-chair the statewide DV-FRT, which meets quarterly to review data collected by the local teams, identify systemic gaps, and summarize its findings and recommendations for changes to the service delivery system in an annual report.[62]

Various initiatives were developed based on these reviews. For example, the reviews revealed that perpetrators had a prior history of domestic violence, substance abuse, or violent crimes in 50 percent of cases reviewed. In response, the statewide team developed a pilot project to train and increase coordination between local law enforcement agencies, prosecutors, judges, probation officers, and domestic violence advocates.[63] The purpose of this cooperation was to identify risk factors sooner, protect the victims, and prevent fatalities.[64] Similarly, the reviews showed that 70 percent of victims had surviving children--some of whom even witnessed the fatal incident. The statewide team identified the

[56] Report of the Attorney General's Statewide Domestic Violence Fatality Review Team, *Faces of Fatality Vol. IX,* (June, 2019) https://www.fcadv.org/sites/default/files/FACES%20OF%20FATALITY%20IXweb.pdf (last visited Feb. 13, 2020).
[57] Ss. 741.316(5), 741.316(2), F.S.
[58] S. 741.316(1), F.S.
[59] S. 741.316(2), F.S.
[60] S. 741.316(2), F.S.
[61] S. 741.316(2), F.S.
[62] *Supra* note 56.
[63] Report of the Attorney General's Statewide Domestic Violence Fatality Review Team, *Faces of Fatality, Vol. VII,* (June 2017), p. 21, http://fcadv.org/sites/default/files/face_fatality_vii.pdf (last visited Feb. 13, 2020).; Report of the Attorney General's Statewide Domestic Violence Fatality Review Team, *Faces of Fatality, Vol. VI,* (June 2016), pp. 6-8, http://fcadv.org/sites/default/files/FACES%20OF%20FATALITY%20VI.pdf (last visited Feb. 13, 2020).
[64] Id.

need for and promoted collaboration with community partners to protect and provide services to the surviving children.[65]

Elder Fatality Review Teams in other States

Currently, at least 15 jurisdictions have elder fatality review teams at the state or local level.[66] For example, California, another state with a disproportionate senior population, statutorily authorized local elder fatality review teams in 2003 and now has an elder fatality review team in over 30 of its 58 counties.[67]

One of the first multidisciplinary elder fatality review teams was created in 1999, in Sacramento County, California. After years of reviewing cases, the review team noted that a common pattern of abuse involved a relative caregiver's inability to cope with the responsibility of caring for an elder whose health and mobility were rapidly deteriorating. In response, the review team created a resource guide for elder caregivers and independent elders alike, including contact information for agencies that can help with financial issues, transportation, conservatorship, home repair, medical issues, mental health issues, and other important needs.[68] Pharmacies, senior centers, medical clinics, religious centers, and other senior organizations distributed the brochure.[69]

The team also facilitated cooperation between disciplines to provide comprehensive vital services to elders in one location.[70] Acting on the review team's recommendations, the local coroner's office and adult protective services launched a project to improve communication between both agencies, the local district attorney's office implemented training and education on elder issues, and the local sheriff's department launched a volunteer program in its elder abuse unit to better detect and investigate financial fraud cases. The review team also established an interdisciplinary team of adult protective services staff and medical staff to provide intensive case management services, which has resulted in a 49 to 69 percent reduction in emergency room visits for participating elders.[71]

Soon after its inception, an elder fatality review team in Ingham County, Michigan, including police, prosecutors, adult protective services, the medical examiner, and emergency personnel, identified elder abuse in a death that law enforcement had deemed ordinary: through this multidisciplinary approach, the team determined that the elder's state caregiver had administered a lethal dose of morphine. These findings facilitated the prosecution and conviction of the perpetrator.[72]

Florida law does not authorize the EA-FRTs.

American Bar Association Elder Abuse Fatality Review Team Manual

In 2001, the federal Department of Justice commissioned the American Bar Association Commission on Law and Aging (ABA-COLA) to identify promising practices in the development of elder abuse

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[65] *Supra* note 63.
[66] National Adult Protective Services Association, *The State of Elder Fatality Reviews in the U.S.* (Webinar), http://www.napsa-now.org/wp-content/uploads/2017/03/03142017-EFRT-Webinar.pdf (last visited on Feb. 13, 2020).
[67] The National Long-Term Care Ombudsman Resource Center, *Long-Term Care Ombudsman Activities Regarding Abuse, Neglect and Exploitation*, May 10, 2011, http://ltcombudsman.org/uploads/files/issues/Chart-Summary-SLTCO-FINAL-May-10.pdf (last visited Feb. 13, 2020).
[68] Sacramento County District Attorney's Office, *County of Sacramento Elder Death Review Team 2012 Report*, p. 5, http://www.sacda.org/files/7414/2671/1371/2012_EDRT_Annual_Report.pdf (last visited Feb. 13, 2020).
[69] Sacramento County District Attorney's Office, *County of Sacramento Elder Death Review Team 2008 Report*, p. 5, http://www.sacda.org/files/5514/2671/1055/2008_EDRT_Report_Final.pdf (last visited Feb. 13, 2020).
[70] Sacramento County District Attorney's Office, *County of Sacramento Elder Death Review Team 2015 Report*, p. 2-3, http://www.sacda.org/files/9914/2671/1266/EDRT_2015_Report_FINAL.pdf (last visited Feb. 13, 2020).
[71] *Supra* note 69.
[72] Chisun Lee, A.C. Thompson, and Carl Byker, *Gone Without a Case: Suspicious Elder Deaths Rarely Investigated*, Frontline PBS, https://www.pbs.org/wgbh/frontline/article/gone-without-a-case-suspicious-elder-deaths-rarely-investigated/ (last visited Feb. 13, 2020).

fatality review teams. The ABA-COLA studied pilot programs from 8 local and state jurisdictions.[73] The ABA-COLA then created a replication manual based on these 8 programs.[74]

The manual cites important factors for a successful review team: subject matter expertise and influence of membership, access to relevant records, confidentiality of review team meetings and records, and purpose and structure for the review process.

Recommendations for pilot programs were to:

- Improve the systems that caused, contributed to, or failed to prevent the death, and thereby ensure that services are provided to elder abuse victims to help to prevent similar deaths in the future; or
- Determine whether law enforcement investigation and prosecution of alleged perpetrators is appropriate, and supporting those efforts.

The manual recommends that review teams include representatives from agencies or organizations that can provide insight into the systems and issues affecting elders, elder abuse, and elder fatalities, such as Adult Protective Services, the Attorney General's Office, elder lawyers, forensic pathologists, medical examiners, geriatricians, health providers, or victim assistance programs.

On the premise that lack of awareness may lead investigators and other professionals to miss signs of abuse and neglect in cases where abuse truly is present, the manual recommends broadening the scope of eligible cases to include fatalities where a history of elder abuse existed or elder abuse was suspected to be a contributing factor, even if not verified to be the cause of death.

The pilot programs studied by the ABA generally required legislative authorization to access the otherwise confidential records that were necessary for effective review of their cases. Similarly, confidentiality of review meetings and records allowed for open communication and rapport between members.

On October 20, 2017, the Department of Justice announced more than $3.42 million in funding to respond to elder abuse and victims of financial crimes, which included funding to the ABA-COLA to enhance and evaluate elder abuse fatality review teams.[75]

Florida's Public Records and Open Meetings Requirements

The Florida Constitution provides that the public has the right to access government records and meetings.[76] The public may inspect or copy any public record made or received in connection with the official business of any public body, officer, or employee of the state, or of persons acting on their behalf.[77] The public also has a right to notice and access to meetings of any collegial public body of the executive branch of state government or of any local government.[78]

In addition to the Florida Constitution, the Florida Statutes specify conditions under which public access must be provided to government records and meetings. The Public Records Act guarantees every

[73] Houston, Texas; Maine; Orange County, California; Pima County, Arizona; Pulaski County, Arkansas; Sacramento, California' San Diego, California; and San Francisco, California. Lori A. Stiegel, J.D., *Elder Abuse Fatality Review Teams: A Replication Manual*, American Bar Association Commission on Law & Aging, https://www.americanbar.org/content/dam/aba/administrative/law_aging/fatalitymanual.authcheckdam.pdf (last visited Feb. 13, 2020).
[74] Id.
[75] Press Release, Department of Justice, *Justice Department Invests $3.42 Million in Fight Against Elder Abuse and Financial Exploitation* (Oct. 20, 2017), available at: https://www.justice.gov/opa/pr/justice-department-invests-342-million-fight-against-elder-abuse-and-financial-exploitation (last visited Feb. 13, 2020).
[76] Fla. Const., art. I, s. 24.
[77] Fla. Const., art. I, s. 24(a).
[78] Fla. Const., art. I, s. 24(b).

person's right to inspect and copy any state or local government public record.[79] The Sunshine Law requires all meetings of any board or commission of any state or local agency or authority at which official acts are to be taken be noticed and open to the public.[80]

The Legislature may create an exemption to public records or open meetings requirements if there is a specifically stated public necessity justifying the exemption and it is narrowly tailored to accomplish the stated purpose of the law.[81]

Confidentiality of Reports and Records Concerning Vulnerable Adults

Current law protects all records concerning reports of abuse, neglect, or exploitation of a vulnerable adult,[82] including reports made to the central abuse hotline,[83] and all records generated as a result of those reports are confidential and exempt[84] from public record requirements.[85] Access[86] to these records is granted only to the following entities in specified circumstances:

- DCF, AHCA, DOEA, and Agency for Persons with Disabilities employees or agents with certain relevant responsibilities, or the employees or agents of an agency of another state with jurisdiction similar to those agencies;
- A criminal justice agency investigating a report of known of suspect abuse, neglect, or exploitation of a vulnerable adult;
- The state attorney of the judicial circuit in which the vulnerable adult resides or in which the alleged abuse, neglect, or exploitation occurred;
- Any victim, the victim's guardian, caregiver, or legal counsel, and any person who DCF has determined might be abusing, neglecting, or exploiting the victim;
- A court;
- A grand jury, by subpoena upon its determination that access to such records is necessary;
- An official of the Florida advocacy council, State Long-Term Care Ombudsman program, or long-term care ombudsman council;
- Any person engaged in bona fide research or auditing, so long as the identifying information is not made available;
- The Public Employees Relations Commission for the sole purpose of obtaining evidence for appeals; and
- Any person in the event of the death of a vulnerable adult determined to be a result of abuse, neglect, or exploitation.[87]

Additionally, the identity of any person reporting abuse, neglect, or exploitation of a vulnerable adult may not be released, without that person's consent, to any person other than the employees of DCF

[79] Section 119.011(12), F.S., defines "public record" as all documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of the physical form, characteristics, or means of transmission, made or received pursuant to law or ordinance or in connection with the transaction of official business by any agency. Section 119.011(2), F.S. defines "agency" as any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law including, for the purposes of this chapter, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency. The Public Records Act does not apply to legislative or judicial records, *Locke v. Hawkes*, 595 So. 2d 32 (Fla. 1992). The Legislature's records are public under s. 11.0431, F.S.

[80] S. 286.011(1)-(2), F.S.

[81] Fla. Const., art. I, s. 24(c).

[82] *Supra* note 17.

[83] *Supra* note 23.

[84] There is a difference between records the Legislature designates exempt from public record requirements and those the Legislature deems confidential and exempt. A record classified as exempt from public disclosure may be disclosed under certain circumstances. *See WFTV, Inc. v. Sch. Bd. of Seminole*, 874 So.2d 48, 53 (Fla. 5th DCA 2004), *review denied* 892 So.2d 1015 (Fla. 2004); *City of Riviera Beach v. Barfield*, 642 So.2d 1135 (Fla. 4th DCA 1994); *Williams v. City of Minneola*, 575 So.2d 683, 687 (Fla. 5th DCA 1991). If the Legislature designates a record as confidential and exempt from public disclosure, such record may not be released, by the custodian of public records, to anyone other than the persons or entities specifically designated in statute. *See* Op. Att'y Gen. Fla. 85-62 (1985).

[85] S. 415.07, F.S.

[86] The term "access" is defined to mean a visual inspection or copy of the hard-copy record maintained in the district. S. 415.07(7), F.S.

[87] S. 415.07(3), F.S.

responsible for protective services, the central abuse hotline, or the appropriate state attorney or law enforcement agency.[88]

Effect of the Bill

Elder Abuse Fatality Review Teams in Florida

HB 253 creates s. 415.1103, F.S., authorizing the creation of a multidisciplinary, multiagency elder abuse fatality review team (EA-FRT) in each judicial circuit to review elderly persons' deaths alleged or found to have been caused by, or related to, abuse or neglect. The teams are housed in the Department of Elder Affairs (DOEA) for administrative purposes only.

Membership and Organization

An EA-FRT may include, but is not limited to, representatives from public and private entities that study, treat, investigate, or prevent elder abuse, including but not limited to law enforcement agencies, health and social services agencies, healthcare practitioners, and nonprofit organizations.[89] Participation in an EA-FRT is voluntary and members serve without compensation or reimbursement for per diem or travel expenses. Members or the entities they represent bear the administrative costs of operating the EA-FRT.

The state attorney or his or her designee may initiate establishment of an EA-FRT in his or her judicial circuit and may call the first organizational meeting of the team. At an initial EA-FRT meeting, members choose two members to serve as co-chairs and may reelect them by a majority vote for up to two consecutive terms. Members serve for two-year terms, to be staggered as determined by the chairs.

After its initial meeting, EA-FRTs determine their local operations, including the process for case selection and meeting schedule; however, EA-FRTs must limit their review to closed cases and meet at least once in each fiscal year.

The bill allows EA-FRTs already operating before July 1, 2020, to continue operating as long as they comply with the requirements established under the bill.

Review Process

An EA-FRT's review includes consideration of the events leading up to a fatal incident, available community resources, current law and policies, and the actions taken by public and private systems and individuals related to the fatal incident.

In its review, an EA-FRT must identify any gaps, deficiencies, or problems in the delivery of services that related to the fatal incident. Whenever possible, an EA-FRT should develop a communitywide approach to address these causes and contributing factors identified in its review. Lastly, an EA-FRT must recommend changes in law, rules, and policies to support the care of elderly persons and prevent elder abuse deaths.

[88] S. 415.07(6), F.S.

[89] Specifically: law enforcement agencies; the state attorney; the medical examiner; a county court judge; Adult Protective Services; the Aging and Disability Resource Center; the State Long-Term Care Ombudsman Program; the Agency for Health Care Administration; the Office of the Attorney General; the Office of the State Courts Administrator; the clerk of the court; a victim services program; an elder law attorney; emergency services personnel; a certified domestic violence center; an advocacy organization for victims of sexual violence; a funeral home director; a forensic pathologist; a geriatrician; a geriatric nurse; a geriatric psychiatrist or other individual licensed to offer behavioral health services; a hospital discharge planner; a public guardian; and/or other persons who have knowledge regarding fatal incidents of elder abuse, domestic violence, or sexual violence, including knowledge of research, policy, law, and other matters connected with such incidents or who are recommended for inclusion by the review team.

Records

An EA-FRT may access information that is publicly available from the state attorney's office or voluntarily provided by a victim's family or any other person. Any identifying information concerning the victim must be redacted before the records are received for review by an EA-FRT. The bill also requires an EA-FRT to inform any person who voluntarily provides information or records that such information or records are subject to public disclosure unless a public records exemption applies. The bill authorizes an EA-FRT to share information with other EA-FRTs.

Annual Reports

Each EA-FRT must prepare an annual report which includes, but is not limited to:

- Descriptive statistics of cases reviewed, including demographic information of the victims and the causes and nature of deaths;
- Current policies, procedures, rules, or statutes that the review team identified as contributing to the incidence of elder abuse and elder deaths, and recommendations for system improvements and needed resources, training, or information dissemination to address those identified issues; and
- Any other recommendations to prevent deaths from elder abuse or neglect based on an analysis of the data and information presented in the report.

Each EA-FRT must submit this report to DOEA by September 1 each year. DOEA will summarize all of these reports into one final report and submit it to the Governor, the President of the Senate, the Speaker of the House of Representatives, and DCF by November 1 each year.

Immunity

The bill provides EA-FRT members with immunity from monetary liability and prohibits a cause of action against them for matters that were in the performance of their duties as an EA-FRT member, such as any discussions by, or deliberations or recommendations of the team or the member. However, this immunity will not apply if the member acted in bad faith, with wanton and willful disregard of human rights, safety, or property.

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

B. SECTION DIRECTORY:

Section 1: Creates s. 415.1103, F.S., relating to elder abuse fatality review teams.
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 creates an indeterminate, but likely insignificant, negative fiscal impact on the Department of Elder Affairs (DOEA). To the extent that any EA-FRTs are established, DOEA is required to submit an annual report to the Governor, Legislature, and DCF summarizing the reports from all of the teams.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill creates an indeterminate negative fiscal impact on agencies and organizations that participate in an EA-FRT. However, such participation is voluntary.

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 does not require rulemaking to implement.

C. DRAFTING ISSUES OR OTHER COMMENTS:

It is unclear if EA-FRTs will be receiving only publicly available information or also confidential and exempt information. Further, any information voluntarily provided to an EA-FRT will be a public record unless an exemption applies. The bill does not identify who is responsible for redacting documents before an EA-FRT's receipt of such documents.

The source of cases for each EA-FRT's review is unclear. It is also unclear when a case is considered to be "closed", or what "cases" are.

The bill specifies that the administrative costs of operating each EA-FRT is borne by the team members or the entities they represent, so it is unclear why each team is required to be administratively housed within DOEA.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On November 7, 2019, the Children, Families and Seniors Subcommittee adopted an amendment that allows Elder Abuse Fatality Review Teams in existence on July 1, 2020, to continue to exist.

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 elder abuse fatality review teams; creating s. 415.1103, F.S.; authorizing the establishment of elder abuse fatality review teams in each judicial circuit, to be housed, for administrative purposes only, in the Department of Elderly Affairs; providing conditions for review team membership, establishment, and organization; specifying requirements for a review team's operations and meeting schedules; requiring that the administrative costs of operating a review team be paid by team members or the entities they represent; authorizing elder abuse fatality review teams in existence on a certain date to continue to exist; requiring such existing teams to comply with specified requirements; specifying review team duties; requiring each review team to annually submit to the department a summary report containing specified information by a certain date; requiring the department to annually prepare a summary report based on the review teams' information and submit such report to the Governor, the Legislature, and the Department of Children and Families; providing immunity from monetary liability for review team members under certain conditions; providing an effective date.

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

Section 1. Section 415.1103, Florida Statutes, is created to read:

415.1103 Elder abuse fatality review teams.—

(1)(a) An elder abuse fatality review team may be established in each judicial circuit to review deaths of elderly persons found to have been caused by, or related to, abuse or neglect. The review teams shall be housed, for administrative purposes only, in the Department of Elderly Affairs.

(b) An elder abuse fatality review team may include, but is not limited to, representatives from any of the following entities or persons located in the review team's judicial circuit:

1. Law enforcement agencies.

2. The state attorney.

3. The medical examiner.

4. A county court judge.

5. Adult protective services.

6. The area agency on aging.

7. The State Long-Term Care Ombudsman Program.

8. The Agency for Health Care Administration.

9. The Office of the Attorney General.

10. The Office of the State Courts Administrator.

11. The clerk of the court.

12. A victim services program.

13. An elder law attorney.

14. Emergency services personnel.

15. A certified domestic violence center.

16. An advocacy organization for victims of sexual violence.

17. A funeral home director.

18. A forensic pathologist.

19. A geriatrician.

20. A geriatric nurse.

21. A geriatric psychiatrist or other individual licensed to offer behavioral health services.

22. A hospital discharge planner.

23. A public guardian.

24. Any other persons who have knowledge regarding fatal incidents of elder abuse, domestic violence, or sexual violence, including knowledge of research, policy, law, and other matters connected with such incidents involving elders, or who are recommended for inclusion by the review team.

(c) A state attorney, or his or her designee, may initiate the establishment of a review team in his or her judicial circuit and may call the first organizational meeting of the team. At the initial meeting, members of a review team shall choose two members to serve as co-chairs and shall establish a

schedule for future meetings.

(d) Participation in a review team is voluntary. Members of a review team shall serve without compensation and may not be reimbursed for per diem or travel expenses.

(e) Members shall serve for terms of 2 years, to be staggered as determined by the co-chairs. Chairs may be reelected by a majority vote of a review team for not more than two consecutive terms.

(f) Each review team shall determine its local operations, including, but not limited to, the process for case selection. Reviews must be limited to closed cases in which an elderly person's death is found to have been caused by, or related to, abuse or neglect. All identifying information concerning the person must be redacted in documents received for review. Each review team shall meet at least once each fiscal year.

(g) Administrative costs of operating the review team must be borne by the team members or entities that they represent.

(2) An elder abuse fatality review team in existence on July 1, 2020, may continue to exist and must comply with the requirements of this section.

(3) An elder abuse fatality review team shall do all of the following:

(a) Review deaths of elderly persons in its judicial circuit which are found to have been caused by, or related to, abuse or neglect.

(b) Take into consideration the events leading up to a fatal incident, available community resources, current law and policies, and the actions taken by systems or individuals related to the fatal incident.

(c) Identify potential gaps, deficiencies, or problems in the delivery of services to elderly persons by public and private agencies which may be related to deaths reviewed by the team.

(d) Whenever possible, develop communitywide approaches to address the causes of, and contributing factors to, deaths reviewed by the team.

(e) Develop recommendations and potential changes in law, rules, and policies to support the care of elderly persons and to prevent elder abuse deaths.

(4)(a) A review team may share with other review teams in this state any relevant information that pertains to the review of the death of an elderly person.

(b) A review team member may not contact, interview, or obtain information by request directly from a member of the deceased elder's family as part of the review unless a team member is authorized to do so in the course of his or her employment duties. A member of the deceased elder's family may voluntarily provide information or any record to a review team but must be informed that such information or any record is subject to public disclosure unless a public records exemption

applies.

(5)(a) Annually by September 1, each elder abuse fatality review team shall submit a summary report to the Department of Elderly Affairs which includes, but is not limited to:

1. Descriptive statistics regarding cases reviewed by the team, including demographic information on victims and the causes and nature of their deaths;

2. Current policies, procedures, rules, or statutes the review team has identified as contributing to the incidence of elder abuse and elder deaths, and recommendations for system improvements and needed resources, training, or information dissemination to address such identified issues; and

3. Any other recommendations to prevent deaths from elder abuse or neglect, based on an analysis of the data and information presented in the report.

(b) Annually by November 1, the Department of Elderly Affairs shall prepare a summary report of the review team information submitted under paragraph (a). The department shall submit its summary report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Department of Children and Families.

(6) There is no monetary liability on the part of, and a cause of action for damages may not arise against, any member of an elder abuse fatality review team due to the performance of his or her duties as a review team member in regard to any

discussions by, or deliberations or recommendations of, the team or the member unless such member acted in bad faith, with wanton and willful disregard of human rights, safety, or property.

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 Driskell offered the following:

Amendment (with title amendment)

Remove lines 32-92 and insert:

(1)(a) A state attorney, or his or her designee, may initiate an elder abuse fatality review team in his or her judicial circuit to review deaths of elderly persons caused by, or related to, abuse or neglect.

(b) An elder abuse fatality review team may include, but is not limited to, representatives from any of the following entities or persons located in the review team's judicial circuit:

1. Law enforcement agencies.

2. The state attorney.

3. The medical examiner.
4. A county court judge.
5. Adult protective services.
6. The area agency on aging.
7. The State Long-Term Care Ombudsman Program.
8. The Agency for Health Care Administration.
9. The Office of the Attorney General.
10. The Office of the State Courts Administrator.
11. The clerk of the court.
12. A victim services program.
13. An elder law attorney.
14. Emergency services personnel.
15. A certified domestic violence center.
16. An advocacy organization for victims of sexual violence.
17. A funeral home director.
18. A forensic pathologist.
19. A geriatrician.
20. A geriatric nurse.
21. A geriatric psychiatrist or other individual licensed to offer behavioral health services.
22. A hospital discharge planner.
23. A public guardian.
24. Any other persons who have knowledge regarding fatal incidents of elder abuse, domestic violence, or sexual violence,

including knowledge of research, policy, law, and other matters connected with such incidents involving elders, or who are recommended for inclusion by the review team.

(c) Participation in a review team is voluntary. Members of a review team shall serve without compensation and may not be reimbursed for per diem or travel expenses. Members shall serve for terms of 2 years, to be staggered as determined by the co-chairs.

(d) The state attorney may call the first organizational meeting of the team. At the initial meeting, members of a review team shall choose two members to serve as co-chairs. Chairs may be reelected by a majority vote of a review team for not more than two consecutive terms. At the initial meeting, members of a review team shall establish a schedule for future meetings. Each review team shall meet at least once each fiscal year.

(e) Each review team shall determine its local operations, including but not limited to, the process for case selection. The state attorney shall refer cases to be reviewed by each team. Reviews must be limited to closed cases in which an elderly person's death was caused by, or related to, abuse or neglect. All identifying information concerning the elderly person must be redacted by the state attorney in documents received for review. As used in this section, the term “closed case” means a case involving no information considered active under s. 119.011(3).

(f) Administrative costs of operating the review team must be borne by the team members or entities they represent.

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

Remove lines 5-7 and insert:
each judicial circuit; providing conditions for review team

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 389 Testing for and Treatment of Influenza and Streptococcus
SPONSOR(S): Sirois
TIED BILLS: **IDEN./SIM. BILLS:** SB 714

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	11 Y, 3 N	Siples	McElroy
2) Health Care Appropriations Subcommittee	10 Y, 1 N	Mielke	Clark
3) Health & Human Services Committee		Siples	Calamas

SUMMARY ANALYSIS

Pharmacy is the third largest health profession behind nursing and medicine and, for many people, the most accessible. A pharmacist dispenses medications and counsels patients on the use of both prescription and over the counter medications. In Florida, the scope of practice for pharmacists has expanded to include administration of vaccines and immunizations, assistance with medication management, as well as injection of certain medications within an established protocol with a physician. Other states have expanded the scope of pharmacists to include prescribing medications, either independently or pursuant to a statewide or health care practitioner protocol.

The influenza virus (flu) and streptococcal bacteria (strep) are infectious and, if not diagnosed and treated timely, can lead to serious and even fatal health conditions. Rapid diagnostic tests are available for both the flu and strep, providing results within minutes.

HB 389 authorizes pharmacists to tests for and treat the flu and strep within the framework of an established written protocol with a physician licensed in this state. To provide such services, a pharmacist must meet certain criteria, including education, proof of liability insurance, and employer approval. The bill also establishes standards of practice for pharmacists providing these services.

The bill requires a supervising physician to review the actions taken by a pharmacist. The bill also prohibits any person from interfering with a physician's professional decision of whether to enter into a protocol to supervise a pharmacist to provide testing for and the treatment of the flu and strep.

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 takes effect upon becoming a law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Pharmacist Licensure

Pharmacy is the third largest health profession behind nursing and medicine.[1] The Board of Pharmacy (board), in conjunction with the Department of Health (DOH), regulates the practice of pharmacists pursuant to ch. 465, F.S.[2] To be licensed as a pharmacist in Florida, a person must:[3]

- 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;[4]
- Have completed a board-approved internship; and
- Successfully complete the board-approved examination.

A pharmacist must complete at least 30 hours of board-approved continuing education during each biennial renewal period.[5] 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.[6] 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.[7]

Pharmacist Scope of Practice

In Florida, the practice of the profession of pharmacy includes:[8]

- 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;
- Preparing prepackaged drug products in facilities holding Class III institutional facility permits;[9]
- Administering vaccines to adults;[10]
- Administering epinephrine injections;[11] and

[1] American Association of Colleges of Pharmacy, *About AACP*, available at https://www.aacp.org/about-aacp (last visited October 30, 2019).
[2] Sections 465.004 and 465.005, F.S.
[3] Section 465.007, F.S. The 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.
[4] 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
[5] Section 465.009, F.S.
[6] Section 465.009(6), F.S.
[7] Section 465.1893, F.S.
[8] Section 465.003(13), F.S.
[9] A Class III institutional pharmacy are those pharmacies affiliated with a hospital. *See* s. 465.019(2)(d), F.S.
[10] *See* s. 465.189, F.S.

- Administering antipsychotic medications by injection.[12]

A pharmacist may not alter a prescriber's directions, diagnose or treat any disease, initiate any drug therapy, or practice medicine or osteopathic medicine, unless permitted by law.[13]

Pharmacists may order and dispense drugs that are included in a formulary developed by a committee composed of members of the Boards of Medicine, Osteopathic Medicine, and Pharmacy.[14] The formulary may only include:[15]

- Medicinal drugs of single or multiple active ingredients in any strengths when such active ingredients have been approved individually or in combination for over-the-counter sale by the United States Food and Drug Administration;
- Medicinal drugs recommended by the United States Food and Drug Administration Advisory Panel for transfer to over-the-counter status pending approval by the United States Food and Drug Administration;
- Medicinal drugs containing an antihistamine or decongestant as a single active ingredient or in combination;
- Medicinal drugs containing fluoride in any strength;
- Medicinal drugs containing lindane in any strength;
- Over-the-counter proprietary drugs under federal law that have been approved for reimbursement by the Florida Medicaid Program; and
- Topical anti-infectives, excluding eye and ear topical anti-infectives.

A pharmacist may order, within his or her professional judgment and subject to the stated conditions:[16]

- Certain oral analgesics for mild to moderate pain. The pharmacist may order these drugs for minor pain and menstrual cramps for patients with no history of peptic ulcer disease. The prescription is limited to a six day supply for one treatment;
- Certain urinary analgesics;
- Certain otic analgesics;
- Anti-nausea preparations;
- Certain antihistamines and decongestants;
- Certain topical antifungal/antibacterials.
- Certain topical anti-inflammatory products;
- Certain otic antifungal/antibacterial preparations;
- Certain keratolytics;
- Vitamins with fluoride, excluding vitamins with folic acid in excess of 0.9 mg.
- Medicinal drug shampoos containing lindane for the treatment of head lice;
- Certain ophthalmic solutions;
- Certain histamine H2 antagonists;
- Certain acne products;
- Topical Antiviral for herpes simplex infections of the lips; and
- Penciclovir.

One category of pharmacist has a broader scope of practice. A consultant pharmacist, also known as a senior care pharmacist, provides expert advice on the use of medications to individuals or older adults,

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[11] *Id.*
[12] Section 465.1893, F.S.
[13] *Supra* note 8.
[14] Section 465.186, F.S.
[15] Id.
[16] Rule 64B16-27.220, F.A.C.

wherever they live.[17] In addition to the training and education received as a part of a degree program in pharmacy, a consultant pharmacist must complete a consultant pharmacy course and a period of assessment and evaluation under the supervision of a preceptor.[18]

A consultant pharmacist may order and evaluate laboratory testing in addition to the services provided by a pharmacist. For example, a consultant pharmacist can order and evaluate clinical and laboratory testing for a patient residing in a nursing home upon authorization by the medical director of the nursing home.[19] Additionally, a consultant pharmacist may order and evaluate clinical and laboratory testing for individuals under the care of a licensed home health agency, if authorized by a licensed physician, podiatrist, or dentist.[20]

Pharmacist Administration of Vaccines and Injections

A pharmacist may become certified to administer the immunizations or vaccines listed in the Centers for Disease Prevention and Control (CDC) Adult Immunization Schedule as of February 1, 2015, as well as those recommended for international travel as of July 1, 2015.[21] To be certified to administer vaccines, a pharmacist must:

- Enter into a written protocol under a supervising physician licensed under ch. 458, or ch. 459, F.S.;[22] which must:[23]
  - Specify the categories and conditions among patients to whom the pharmacist may administer such vaccines;
  - Be appropriate to the pharmacist's training and certification for administering such vaccine;
  - Outline the process and schedule for the review of the administration of vaccines by the pharmacists pursuant to the written protocol; and
  - Be submitted to the Board of Pharmacy;
- Successfully complete a board-approved vaccine administration certification program that consists of at least 20 hours of continuing education;[24]
- Pass an examination and demonstrate vaccine administration technique;[25]
- Must maintain and make available patient records using the same standards for confidentiality and maintenance of such records as required by s. 456.057, F.S., and maintain the records for at least five years;[26] and
- Maintain at least $200,000 of professional liability insurance.[27]

A pharmacist may also administer epinephrine using an autoinjector delivery system, within the framework of the established protocol with the supervising physician, to treat any allergic reaction

[17] American Society of Consultant Pharmacists, *What is a Consultant Pharmacist,* available at http://www.ascp.com/page/whatisacp (last visited October 30, 2019).
[18] Rule 64B16-26.300(3), F.A.C.
[19] Section 465.0125(1), F.S.
[20] Section 465.0125(2), F.S. To qualify to order and evaluate such testing, the consultant pharmacist or doctor of pharmacy must complete 3 hours of board-approved training, related to laboratory and clinical testing.
[21] Section 465.189, F.S. A registered intern may also administers immunizations or vaccinations under the supervision of a certified pharmacist.
[22] Section 465.189(1), F.S.
[23] Section 465.189(7), F.S.
[24] Section 465.189(6), F.S. Rule 64B16-26.1031, F.A.C., provides more detail regarding subject matter that must be included in the certification course.
[25] Id.
[26] Section 456.057, F.S., requires certain health care practitioners to develop and implement policies, standards, and procedures to protect the confidentiality and security of medical records, provides conditions under which a medical record may be disclosed without the express consent of the patient, provides procedures for disposing of records when a practice is closing or relocating, and provides for enforcement of its provisions.
[27] Section 465.189(3), F.S.

resulting from a vaccine.[28] A pharmacist administering vaccines must submit vaccination records to DOH for inclusion in the state's registry of immunization information.[29]

Pharmacist Administration of Antipsychotic Medication by Injection

In 2017, the Legislature authorized a licensed pharmacist to administer an injection of a long-acting antipsychotic medication[30] approved by the United States Food and Drug Administration.[31] To be eligible to administer such injections, a pharmacist must:[32]

- Be authorized by and acting within the framework of a protocol with the prescribing physician;
- Practice at a facility that accommodates privacy for nondeltoid injections and conforms with state rules and regulations for the appropriate and safe disposal of medication and medical waste;[33] and
- Complete an approved 8-hour continuing education course that includes instruction on the safe and effective administration of behavioral health and antipsychotic medications by injection, including potential allergic reactions.

A separate prescription from a physician is required for each injection a pharmacist administers.[34]

Diagnostic Tests for Influenza and Streptococcus

Influenza

Influenza (flu) is a viral, contagious respiratory illness that infects the nose, throat, and sometimes the lungs.[35] Although the flu virus may be detected at any time of the year, the flu virus is most common during the fall and winter.[36] Each year, on average 3 to 11 percent of the United States population gets sick from the flu, hundreds of thousands are hospitalized, and thousands die from flu-related illnesses.[37] Annually, the flu costs businesses and employers $10.4 billion in direct costs for hospitalizations and outpatient visits for adults.[38]

A person who has contracted the flu virus is most contagious in the first three to four days after the illness begins.[39] However, some individuals may be able to infect others beginning one day before symptoms develop and up to five to seven days after becoming sick.[40] According to the CDC, most people infected with the flu will have a mild illness and do not need medical care or antiviral medication.[41] The CDC recommends an annual vaccination as the best way to prevent flu.[42]

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[28] Section 465.189(2), F.S.
[29] Section 465.189(5), F.S.
[30] A long-acting injectable antipsychotic medication may be prescribed to treat symptoms of psychosis associated with schizophrenia or as a mood stabilizer in individuals with bipolar disorder. A long-acting injectable may last from two to 12 weeks. It may be prescribed for individuals who have difficulty remembering to take daily medications or who have a history of discontinuing medication. National Alliance on Mental Illness, *Long-Acting Injectables*, available at https://www.nami.org/Learn-More/Treatment/Mental-Health-Medications/Long-Acting-Injectables (last visited October 30, 2019).
[31] Chapter 2017-134, Laws of Fla., codified at s. 465.1893, F.S.
[32] Id.
[33] Section 381.0098, F.S., and r. 64E-16, F.A.C., regulate the disposal of biomedical waste.
[34] Section 465.1893(1)(b), F.S.
[35] Centers for Disease Control and Prevention, *Key Facts about Influenza (Flu)*, (last rev. Sept. 13, 2019), available at https://www.cdc.gov/flu/about/keyfacts.htm (last visited October 30, 2019).
[36] Centers for Disease Control and Prevention, *The Flu Season*, (last rev. July 12, 2018), available at https://www.cdc.gov/flu/about/season/flu-season.htm (last visited October 30, 2019).
[37] *Supra* note 35, and Centers for Disease Control and Prevention, *Key Facts about Seasonal Flu Vaccine*, (last rev. Oct. 21, 2019), available at https://www.cdc.gov/flu/prevent/keyfacts.htm (last visited October 30, 2019).
[38] Centers for Disease Control and Prevention, *Make It Your Business to Fight the Flu*, available at https://www.cdc.gov/flu/pdf/business/toolkit_seasonal_flu_for_businesses_and_employers.pdf (last visited October 30, 2019).
[39] *Supra* note 35.
[40] Id.
[41] Centers for Disease Control and Prevention, *People at High Risk for Flu Complications*, (last rev. Aug. 27, 2018), available at https://www.cdc.gov/flu/takingcare.htm (last visited February 21, 2019).

Individuals with weakened immune systems, the elderly, young children, pregnant women, people living in nursing homes or other long-term care facilities, or those with certain health conditions, may be at high risk of serious flu complications.[43] Complications of the flu may include bacterial pneumonia, ear infections, sinus infections, and worsening of chronic medical conditions, such as congestive heart failure, asthma, or diabetes.[44] Serious flu infections can result in hospitalizations or death.

In recent years, the Food and Drug Administration has approved several rapid influenza diagnostic tests (RIDTs) to identify the influenza virus in respiratory specimens.[45] These tests can provide results within approximately 15 minutes and may be used to help with diagnosis and treatment decisions for patients. Some RIDTs use an analyzer reader device to standardize the result interpretations. However, a variety of factors can influence the accuracy of an RIDT, including the type of specimen tested, time from illness onset to collection of the respiratory specimen for testing, and the prevalence of flu activity in the area. False positive results are more likely at the beginning or end of the flu season or during the summer. False negative results are more likely at the peak of the flu season.[46]

Rapid molecular assays are a new type of diagnostic test to detect viral flu and provide results in 15-30 minutes.[47] These tests are more accurate than RIDTs and the Infectious Diseases Society of America recommends the rapid molecular assays over RIDT for detecting the flu virus in outpatients. As with RIDTs, the accuracy of rapid molecular assays may be affected by the source of the specimen, specimen handling, and the timing of the collection of the specimen. False negative results may occur due to improper clinical specimen collection or handling or if the specimen is collected when the patient is no longer shedding detectable flu virus. Although a false positive is rare, it can occur through lab contamination or other factors.[48]

Testing is not needed for all patients with signs and symptoms of flu to make antiviral treatment conditions.[49] A health care practitioner may diagnose an individual with the flu based on symptoms and his or her clinical judgment, irrespective of the test results.

Some pharmacies may currently provide flu testing, as well as other health screenings.[50] However, these pharmacies vary by the types of patients seen, the array of services offered, the type of health care practitioner available, and the type of medications prescribed.

Streptococcus Testing

Streptococcus (strep) is a bacteria that causes a variety of infections. There are two types of strep that cause most of the strep infections in people: group A and group B. Group A strep infections include strep throat, scarlet fever, impetigo, toxic shock syndrome and cellulitis and necrotizing fasciitis (flesh-eating disease).[51] Group B strep may cause blood infections, pneumonia, and meningitis in newborns,

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[42] *Supra* note 35.
[43] *Supra* note 41.
[44] *Supra* note 35.
[45] Center for Disease Control and Prevention, *Rapid Influenza Diagnostic Tests*, (last rev. Oct. 25, 2016), available at https://www.cdc.gov/flu/professionals/diagnosis/clinician_guidance_ridt.htm (last visited October 30, 2019).
[46] Id.
[47] Centers for Disease Control and Prevention, *Information on Rapid Molecular Assays, RT-PCR, and other Molecular Assays for Diagnosis of Influenza Virus Infection*, (last rev. Oct. 21, 2019), available at https://www.cdc.gov/flu/professionals/diagnosis/molecular-assays.htm (last visited October 30, 2019).
[48] Id.
[49] Id., and *supra* note 45.
[50] For example, CVS Pharmacy offers services through its MinuteClinic®, which is staffed by nurse practitioners or physician assistants (*see* CVS, *MinuteClinic® Services*, available at https://www.cvs.com/minuteclinic/services?WT.ac=MC-Home-Badge1-services (last visited October 30, 2019)), and Walgreens offers services through its Healthcare Clinic, which offers services by licensed healthcare professionals to patients 18 months or older (*see* Walgreens, *Healthcare Clinic*, available at https://www.walgreens.com/topic/pharmacy/healthcare-clinic.jsp (last visited October 30, 2019)).
[51] U.S. National Library of Medicine, Medline Plus, *Streptococcal Infections*, (last rev. Sept. 27, 2019), available at https://medlineplus.gov/streptococcalinfections.html (last visited October 31, 2019).

as well as urinary tract infections, blood infections, skin infections, and pneumonia in adults.[52] Strep throat, along with minor skin infections, are the most common group A strep infection.[53]

Strep throat is a highly contagious group A strep infection. It is most common in children between ages 5 and 15; however, anyone may contract it.[54] Strep throat is passed through person-to-person contact. However, a person who has been treated with antibiotics for 24 hours or longer, can generally no longer transmit the bacteria.[55] If strep throat is not diagnosed and treated, it may lead to complications such as rheumatic fever, which can damage the heart, or glomerulonephritis, which affects the kidney.[56]

Rapid antigen diagnostic tests (RADTs) may be used to determine the presence of Group A strep in a patient's throat or other infected areas.[57] Results are generally available in 7 to 15 minutes.[58] RADTs, in general, have high diagnostic accuracy, with tests using newer techniques providing the greatest accuracy.[59]

Reporting of Diseases to DOH

Any licensed physician, chiropractic physician, nurse, midwife, or veterinarian licensed in this state must immediately report the diagnosis or suspected diagnosis of a disease of public health importance to DOH.[60] DOH, by rule, has designated the diseases and conditions that must be reported, as well as the timeframes for such reports.[61] A suspected or confirmed diagnosis of flu that is caused by a by novel or pandemic strain must be reported immediately.[62] However, strep throat is not among the diseases or conditions that must be reported. The practitioner must report the disease or condition on a form developed by DOH, which includes information such as the patient's name, demographic information, diagnosis, test procedure used, and treatment given.[63] The practitioner must make the patient's medical records for such diseases available for onsite inspection by DOH.[64]

Effect of Proposed Changes

HB 389 authorizes a pharmacist to test for and treat flu and strep, under certain conditions. To be eligible to provide such services, a pharmacist must:

- Complete a certification program approved by the Board of Pharmacy, in consultation with the Board of Medicine and the Board of Osteopathic Medicine, which consists of at least 8 hours of continuing education course approved by the board. The curriculum must be provided by an organization approved by the Accreditation Council for Pharmacy Education and must include

[52] Id.
[53] National Institute of Allergy and Infectious Diseases, *Group A Streptococcal Infections*, (last rev. Sept. 29, 2015), available at https://www.niaid.nih.gov/diseases-conditions/group-streptococcal-infections (last visited October 31, 2019).
[54] CDC, *Strep Throat: All You Need to Know*, (last rev. Nov. 1, 2018), available at https://www.cdc.gov/groupastrep/diseases-public/strep-throat.html (last visited October 31, 2019).
[55] CDC, *Pharyngitis (Strep Throat)*, (last rev. Jan. 22, 2019), available at https://www.cdc.gov/groupastrep/diseases-hcp/strep-throat.html (last visited October 31, 2019).
[56] *Supra* note 51.
[57] John Mersch, MD, FAAP, MedicineNet.Com, *Rapid Strep Test,* available at https://www.medicinenet.com/rapid_strep_test/article.htm (last visited February 21, 2019).
[58] American Academy of Family Physicians, *Rapid Strep Test*, available at https://familydoctor.org/rapid-strep-test/?adfree=true (last visited October 31, 2019).
[59] W. L. Lean et al., *Rapid Diagnostic Tests for Group A Streptococcal Pharyngitis: A Meta-analysis*, 134 Pediatrics 771–781 (2014), available at http://pediatrics.aappublications.org/content/pediatrics/early/2014/09/02/peds.2014-1094.full.pdf (last visited October 31, 2019).
[60] Section 381.0031, F.S. and r. 64D-3.030, FA.C. Medical examiners, hospitals, and laboratories are also required to report the diagnosis or suspected existence of such diseases to DOH.
[61] Rule 64D-3.029, F.A.C. *See also* http://www.floridahealth.gov/diseases-and-conditions/disease-reporting-and-management/_documents/reportable-diseases/_documents/reportable-diseases-list-practitioners.pdf (last visited October 31, 2019).
[62] Id.
[63] Rule 64D-3.030, F.A.C.
[64] Id.

instruction on point-of-care flu and strep testing and the safe and effective treatment of flu and strep infections;
- Maintain at least $200,000 of professional liability insurance;
- Act within the framework of a written protocol with a supervising physician that, at a minimum, includes:
    - The terms and conditions required in s. 489.189(7), F.S., which includes:
        - The specific categories and conditions among patients for whom the pharmacist is authorized to administer vaccines;
        - Limiting the terms, scope, and conditions to those that are appropriate for the pharmacist's training and certification for administering such vaccines;
        - Providing proof of current certification by the board to the supervising physician;
        - Requiring the supervising physician to review the administration of vaccines by the pharmacist as provided by the protocol; and
        - A process and schedule for the review;
    - The specific categories of patients the pharmacist is authorized to test for and treat flu and strep;
    - The supervising physician's instructions for treatment based on the patient's age, symptoms, and test results, including negative results;
    - A process and schedule for the supervising physician to review the pharmacist's actions under the protocol; and
    - A process and schedule for the pharmacist to notify the supervising physician of the patient's condition, tests administered, test results, and course of treatment; and
- Obtain the written approval of the owner of the pharmacy, if the pharmacist is acting as an employee of such pharmacy.

A pharmacist who is authorized to test for and treat flu and strep must use a test system that:

- Is waived from meeting the requirements of the Clinical Laboratory Improvement Amendments of 1988 (CLIA);[65]
- Provides automated readings to reduce user subjectivity in interpretation of results;
- Is capable of interfacing with electronic health record systems;
- Is capable of providing de-identified test results to the appropriate agencies; and
- Incorporates both internal and external controls and external calibration that show the reagent and assay procedure is performing properly.

The bill prohibits any person from interfering with a physician's professional decision of whether to enter into a protocol to supervise a pharmacist to provide testing for and the treatment of the flu and strep.

A pharmacist must also notify a patient's primary care provider within two business days after providing flu or strep testing or treatment. Each pharmacist who provides testing and treatment for flu and strep must maintain and make available patient records in the same manner as required under s. 457.057, F.S.[66] The clinical record created by the pharmacist under this bill must be maintained for at least 5 years.

Within 90 days of the bill becoming effective, the board must adopt rules establishing the requirements for the written protocol and approve the 8-hour certification course.

[65] CLIA regulates all facilities performing laboratory tests on human specimens for health assessment or the diagnosis, prevention, or treatment of a disease. Waived tests are those that have been cleared for home use and approved for waiver under CLIA criteria. CLIA requires waived test to be simple and have a low risk for erroneous results. *See* Centers for Disease Control and Prevention, *Clinical Laboratory Improvement Amendments (CLIA) – Waived Tests*, available at https://wwwn.cdc.gov/clia/resources/waivedtests/default.aspx (last visited February 21, 2019).

[66] Section 456.057, F.S., provides requirements on the maintenance and disclosure of medical records by a health care practitioner.

The bill revises the definition of “the practice of the profession of pharmacy” to include the testing for and treatment of influenza and streptococcus.

The bill takes effect upon becoming a law.

B. SECTION DIRECTORY:

Section 1: Amends s. 381.0031, F.S., relating to epidemiological research; report of diseases of public health significance to the department.
Section 2: Amends s. 465.003, F.S., relating to definitions.
Section 3: Creates s. 465.1895, F.S., relating to testing for and treatment of influenza and streptococcus.
Section 4: Provides an effective date of upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   DOH will incur insignificant, nonrecurring costs related to rulemaking, which current resources are adequate to absorb.

   DOH will incur insignificant, nonrecurring costs related to updating the LEIDS licensing system to include a new modifier to identify pharmacist certification, which current resources are adequate to absorb.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Pharmacists who provide flu and strep testing and treatment as authorized by the bill will incur costs associated with obtaining the required continuing education, maintaining liability insurance, and entering into a supervisory protocol.

Individuals with limited access to health care practitioner services may be able to more easily access testing for and treatment of the flu and strep.

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 Board of Pharmacy has broad rulemaking authority under its practice act; therefore, no additional rulemaking authority is needed.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill requires the written protocol to meet the terms and conditions specified in s. 465.189(7), F.S. The bill then states each of those requirements listed in s. 465.189(7), F.S., as requirements under the bill. It is unclear why this redundancy is necessary.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to the testing for and treatment of influenza and streptococcus; amending s. 381.0031, F.S.; requiring specified licensed pharmacists to report certain information to the Department of Health; amending s. 465.003, F.S.; revising the definition of the term "practice of the profession of pharmacy"; creating s. 465.1895, F.S.; authorizing pharmacists to test for and treat influenza and streptococcus and providing requirements relating thereto; requiring that the written protocol between a pharmacist and supervising physician contain certain information, terms, and conditions; requiring the Board of Pharmacy to adopt rules within a specified time period; requiring that a pharmacist notify a patient's primary care provider within a specified time period after providing any such testing or treatment; providing an effective date.

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

Section 1. Subsection (2) of section 381.0031, Florida Statutes, is amended to read:

381.0031 Epidemiological research; report of diseases of public health significance to department.—

(2) Any practitioner licensed in this state to practice medicine, osteopathic medicine, chiropractic medicine, naturopathy, or veterinary medicine; any licensed pharmacist authorized pursuant to a written protocol to order and evaluate laboratory and clinical tests; any hospital licensed under part I of chapter 395; or any laboratory appropriately certified by the Centers for Medicare and Medicaid Services under the federal Clinical Laboratory Improvement Amendments, and the federal rules adopted thereunder, which diagnoses or suspects the existence of a disease of public health significance shall immediately report the fact to the Department of Health.

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

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

(13) "Practice of the profession of pharmacy" includes compounding, dispensing, and consulting concerning contents, therapeutic values, and uses of any medicinal drug; consulting concerning therapeutic values and interactions of patent or proprietary preparations, whether pursuant to prescriptions or in the absence and entirely independent of such prescriptions or orders; and conducting other pharmaceutical services. For purposes of this subsection, "other pharmaceutical services" means the monitoring of the patient's drug therapy and assisting the patient in the management of his or her drug therapy, and includes review of the patient's drug therapy and communication

with the patient's prescribing health care provider as licensed under chapter 458, chapter 459, chapter 461, or chapter 466, or similar statutory provision in another jurisdiction, or such provider's agent or such other persons as specifically authorized by the patient, regarding the drug therapy. However, nothing in this subsection may be interpreted to permit an alteration of a prescriber's directions, the diagnosis or treatment of any disease, the initiation of any drug therapy, the practice of medicine, or the practice of osteopathic medicine, unless otherwise permitted by law. "Practice of the profession of pharmacy" also includes any other act, service, operation, research, or transaction incidental to, or forming a part of, any of the foregoing acts, requiring, involving, or employing the science or art of any branch of the pharmaceutical profession, study, or training, and shall expressly permit a pharmacist to transmit information from persons authorized to prescribe medicinal drugs to their patients. The practice of the profession of pharmacy also includes the administration of vaccines to adults pursuant to s. 465.189, the testing for and treatment of influenza and streptococcus pursuant to s. 465.1895, and the preparation of prepackaged drug products in facilities holding Class III institutional pharmacy permits.

Section 3. Section 465.1895, Florida Statutes, is created to read:

465.1895 Testing for and treatment of influenza and

streptococcus.—

(1) A pharmacist may test for and treat influenza and streptococcus if all of the following criteria are met:

(a) The pharmacist has entered into a written protocol with a supervising physician licensed under chapter 458 or chapter 459, and such protocol complies with the requirements in subsection (5) and board rules.

(b) The pharmacist uses an instrument and a waived test, as that term is defined in 42 C.F.R. s. 493.2.

(c) The pharmacist uses a testing system that:

1. Provides automated readings in order to reduce user subjectivity or interpretation of results.

2. Is capable of directly or indirectly interfacing with electronic medical records systems.

3. Is capable of electronically reporting daily deidentified test results to the appropriate agencies.

4. Uses an instrument that incorporates both internal and external controls and external calibration that show the reagent and assay procedure is performing properly. External controls must be used in accordance with local, state, and federal regulations and accreditation requirements.

(d) The pharmacist is certified to test for and treat influenza and streptococcus pursuant to a certification program approved by the board, in consultation with the Board of Medicine and the Board of Osteopathic Medicine, within 90 days

after the date upon which this section becomes effective. The certification program must require that the pharmacist attend, on a one-time basis, 8 hours of continuing education courses approved by the board. The continuing education curriculum must be provided by an organization of instruction approved by the Accreditation Council for Pharmacy Education and must include, at a minimum, point-of-care testing for influenza and streptococcus and the safe and effective treatment of influenza and streptococcus.

(2) A pharmacist may not enter into a written protocol under this section unless he or she maintains at least $200,000 of professional liability insurance and is certified as required in paragraph (1)(d).

(3) A pharmacist who tests for and treats influenza and streptococcus shall maintain and make available patient records using the same standards for confidentiality and maintenance of such records as those that are imposed on health care practitioners under s. 456.057. Such records shall be maintained for at least 5 years.

(4) The decision by a supervising physician licensed under chapter 458 or chapter 459 to enter into a written protocol under this section is a professional decision on the part of the physician and a person may not interfere with a physician's decision regarding entering into such a protocol. A pharmacist may not enter into a written protocol that is to be performed

while acting as an employee without the written approval of the owner of the pharmacy.

(5) The board shall adopt rules establishing requirements for the written protocol within 90 days after the date upon which this section becomes effective. At a minimum, the written protocol shall include:

(a) The terms and conditions required in s. 465.189(7).

(b) Specific categories of patients for whom the supervising physician authorizes the pharmacist to test for and treat influenza and streptococcus.

(c) The supervising physician's instructions for the treatment of influenza and streptococcus based on the patient's age, symptoms, and test results, including negative results.

(d) A process and schedule for the supervising physician to review the pharmacist's actions under the written protocol.

(e) A process and schedule for the pharmacist to notify the supervising physician of the patient's condition, tests administered, test results, and course of treatment.

(6) When the patient has a primary care provider, a pharmacist who provides testing for or treatment of influenza and streptococcus under this section shall notify the patient's primary care provider within 2 business days after providing any such testing or treatment.

Section 4. This act shall take effect upon becoming a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 467 Physical Therapy Practice
SPONSOR(S): Stevenson
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 792

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	13 Y, 0 N	Siples	McElroy
2) Health Care Appropriations Subcommittee	9 Y, 0 N	Mielke	Clark
3) Health & Human Services Committee		Siples	Calamas

SUMMARY ANALYSIS

Physical therapy practice is the performance of physical therapy assessments and treatment, or prevention of any disability, injury, disease, or other health conditions and rehabilitation using various modalities. In Florida, the Board of Physical Therapy Practice, within the Department of Health (DOH), regulates physical therapists (PTs).

Current law prohibits PTs from using acupuncture if it punctures the skin. In some states, PTs may use a technique called dry needling, which requires a PT to insert an acupuncture needle to penetrate the skin and stimulate underlying myofascial trigger points, and muscular and connective tissues to manage pain and movement impairments.

HB 467 eliminates the prohibition on performing acupuncture that pierces the skin and authorizes the Board of Physical Therapy Practice to adopt rules related to the standards of practice for PTs to perform dry needling.

The bill also revises the scope of practice for PTs and terminology to more closely align with the model practice act for physical therapy.

The bill may have an insignificant, negative fiscal impact on the DOH, 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

Physical therapists (PTs) are licensed in all 50 states. States utilize the National Physical Therapy Exam (NPTE), which was developed by the Federation of State Boards of Physical Therapy (FSBPT), to determine if a person has met competency standards for the safe provision of nationally accepted physical therapy procedural interventions.[1] Currently, all entry-level PT education programs in the U.S. only offer the Doctor of Physical Therapy (D.P.T.) degree.[2]

Model Practice Act

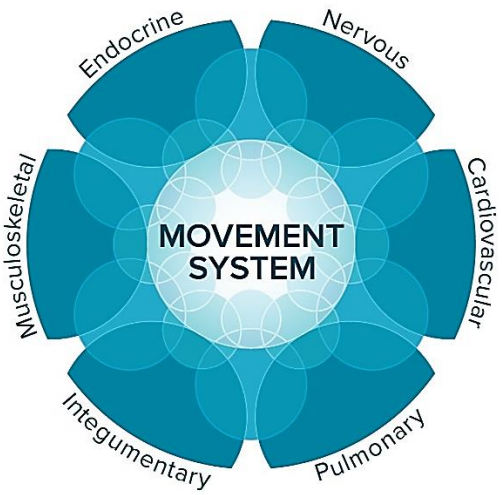
The FSBPT developed a model physical therapy practice act to revise and modernize state physical therapy laws.[3] The model practice act suggests statutory language that addresses the regulatory board's duties and powers, examination and licensure, and the regulation of physical therapy practice.[4] In the model practice act, the practice of physical therapy includes:[5]

- Examining, evaluating, and testing patients with mechanical, physiological, and developmental impairments, functional limitations, and disabilities or other health and movement-related conditions in order to determine a diagnosis, prognosis, and plan of treatment intervention, and to assess the ongoing effects of intervention.
- Alleviating impairments, functional limitations, and disabilities by designing, implementing, and modifying treatment interventions that may include, but are not limited to:
    - Therapeutic exercise;
    - Functional training in self-care and in-home, community or work integration or reintegration;
    - Manual therapy including soft tissue and joint mobilization/manipulation;
    - Therapeutic massage;
    - Prescription, application and, as appropriate, fabrication of assistive, adaptive, orthotic, prosthetic, protective and supportive devices and equipment;
    - Airway clearance techniques;
    - Integumentary protection and repair techniques;
    - Debridement and wound care;
    - Physical agents or modalities;
    - Mechanical and electrotherapeutic modalities, and
    - Patient-related instruction.
- Reducing the risk of injury, impairment, functional limitation, and disability, including the promotion and maintenance of fitness, health, and wellness.
- Engaging in administration, consultation, education, and research.

[1] American Physical Therapy Association, *About the National Physical Therapy Examination*, available at http://www.apta.org/Licensure/NPTE/ (last visited January 14, 2020).
[2] American Physical Therapy Association, *Physical Therapist (PT) Education Overview*, available at http://www.apta.org/For_Prospective_Students/PT_Education/Physical_Therapist_(PT)_Education_Overview.aspx (last visited March 4, 2016).
[3] Federation of State Boards of Physical Therapy, *Model Practice Act*, available at https://www.fsbpt.org/Free-Resources/Regulatory-Resources/Model-Practice-Act (last visited January 14, 2020).
[4] Federation of State Boards of Physical Therapy, *The Model Practice Act for Physical Therapy: A Tool for Public Protection and Legislative Change*, 6th Edition, (last rev. 2016), available at https://www.fsbpt.org/Portals/0/documents/free-resources/MPA_6thEdition2016.pdf?ver=2019-03-06-115216-323 (last visited January 14, 2020).
[5] Id.

Movement System

As a part of its guiding principles for the physical therapy profession, the American Physical Therapy Association (APTA), adopted a position that the movement system is at the core of physical therapy practice, education, and research.[6] The movement system is the integration of body systems that generate and maintain movement at all levels of bodily function.[7] The movement system incorporates several of the body's systems.[8]



APTA promotes that a PT must examine and evaluate the movement system, including diagnosis and prognosis, to provide a customized and integrated plan of care.[9] Uniform use of the term "movement system" will assist PTs in communicating effectively with communities internal and external to the profession.[10]

Physical Therapy Practice in Florida

PTs are regulated under ch. 486, F.S., the Physical Therapy Practice Act and the Board of Physical Therapy Practice (Board) within the Department of Health. In the 2018-2019 fiscal year, there were 19,324 licensed PTs in Florida.[11]

Licensure

To be licensed as a PT, an applicant must be at least 18 years old, be of good moral character, pass the Laws and Rules Examination offered by the FSBPT within 5 years before the date of application for licensure,[12] and meet one of the following requirements:[13]

[6] American Physical Therapy Association, *Vision Statement for the Physical Therapy Profession and Guiding Principles to Achieve the Vision*, (last rev. Sept. 25, 2019), available at https://www.apta.org/Vision/ (last visited January 16, 2020).
[7] American Physical Therapy Association, *Movement System*, available at https://www.apta.org/MovementSystem/ (last visited January 16, 2020).
[8] American Physical Therapy Association, *Movement System Diagram*, available at https://www.apta.org/uploadedFiles/APTAorg/Practice_and_Patient_Care/Movement_System/MovementSystemDiagram.pdf (last visited January 16, 2020).
[9] American Physical Therapy Association, *Physical Therapist Practice and the Movement System*, (Aug. 2015), available at https://www.apta.org/MovementSystem/WhitePaper/ (last visited January 16, 2020).
[10] Id.
[11] Department of Health, *2020 Agency Legislative Bill Analysis for HB 467*, on file with the Health Quality Subcommittee.
[12] Rule 64B17-3.002, F.A.C.
[13] Sections 486.031, F.S., and 486.051, F.S.

- Have graduated from an accredited PT training program and have passed the National Physical Therapy Examination (NPTE) for PTs offered by the FSBPT within 5 years before the date of application for licensure;[14]
- Have graduated from a PT training program in a foreign country, have had his or her credentials deemed by the Foreign Credentialing Commission on Physical Therapy or other board-approved credentialing agency to be equivalent to those of U.S.-educated PTs and have passed the NPTE for PTs within 5 years before the date of application for licensure;[15] or
- Have passed a board-approved examination and hold an active license to practice physical therapy in another state or jurisdiction if the board determines that the standards for licensure in that state or jurisdiction are equivalent to those of Florida.[16]

A PT must complete 24 hours of continuing physical therapy education for each biennial licensure renewal.[17] At least 1 hour of education must be on HIV/AIDS, and 2 hours must be on medical error prevention.[18]

Scope of Practice

In Florida, physical therapy practice is the performance of physical therapy assessments and treatment, or prevention of any disability, injury, disease, or other health conditions and rehabilitation using various modalities, such as:[19]

- Electricity;
- Exercise;
- Massage;
- Radiant energy, including ultraviolet, visible, and infrared rays;
- Ultrasound;
- Water; and
- Physical, chemical, and other properties of air.

A PT may also test neuromuscular functions or perform electromyography[20] to diagnose and treat conditions. A PT may only perform acupuncture when no penetration of the skin occurs and in compliance with criteria established by the Board of Medicine.[21]

Acupuncture

The Board of Acupuncture, within the Department of Health, regulates the practice of acupuncture.[22] Acupuncture is a form of primary health care based on traditional Chinese medical concepts and modern oriental medicine techniques that employ acupuncture diagnosis and treatment, as well as adjunctive therapies and diagnostic techniques.[23] The practice of acupuncture includes, among other things, the insertion of acupuncture needles to specific areas of the human body.[24]

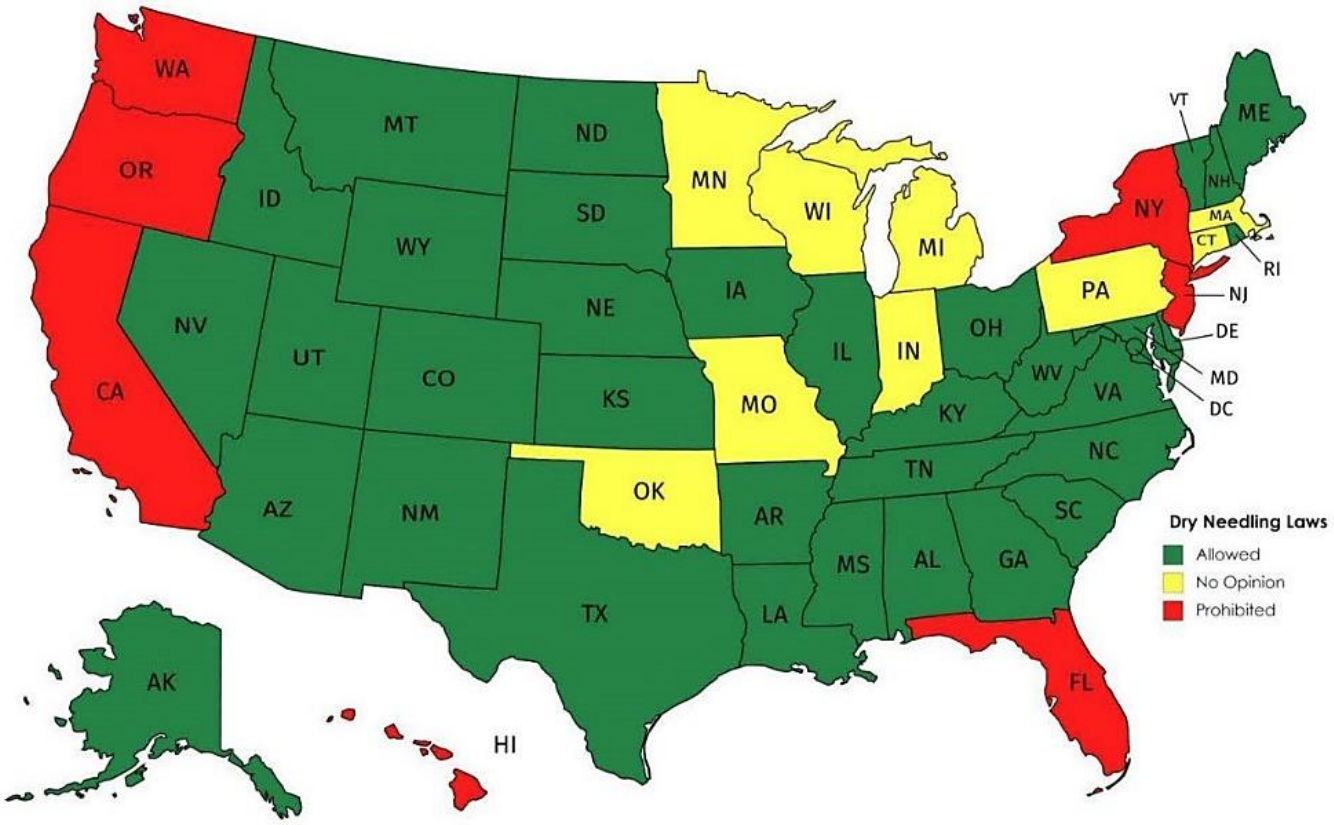
[14] *Id.*
[15] Rule 64B17-3.001, F.A.C.
[16] Rule 64B17-3.003, F.A.C.
[17] Rule 64B17-9.001, F.A.C.
[18] Id.
[19] Section 486.021(11), F.S.
[20] Rule 64B17-6.003, F.S., establishes the training, education, and supervised practice requirements a PT must meet to perform electromyography.
[21] *Supra* note 19.
[22] *See generally*, ch. 457, F.S.
[23] Section 457.102(1), F.S.
[24] Id.

Dry Needling

Dry needling[25] originated in the 1940s when practitioners discovered that pain could be relieved by simple hypodermic needling without injection of any substance.[26,] At that time, the needles used were mainly hollow; however, beginning in the late 1970s, acupuncture or solid filiform needles became the instrument of choice.[27]

The modern practice primarily involves a PT using a thin filiform needle to penetrate the skin and stimulate underlying myofascial trigger points, muscular, and connective tissues to manage neuromusculoskeletal pain and movement impairments.[28] The goal of dry needling is to release or inactivate trigger points and relieve pain.[29]

Thirty-four states authorize PTs to perform dry needling, nine states are silent on the issue, and seven states, including Florida, prohibit PTs from performing dry needling.[30]



[25] Dry needling may also be referred to as "trigger point manual therapy" or "intramuscular manual therapy. *See* American Physical Therapy Association, *Physical Therapists &The Performance of Dry Needling: An Educational Resource Paper*, (Jan. 2012), available at http://www.apta.org/StateIssues/DryNeedling/ResourcePaper/ (last visited January 16, 2020).
[26] Heming Zhu, PhD, CMD, MD, MAcu, LicAcu, and Heidi Most, MAcu, LicAcu, *Dry Needling Is One Type of Acupuncture*, MEDICAL ACUPUNCTURE 28:4 (2016), available at https://pdfs.semanticscholar.org/1340/eb3836f644a3c38813a52ea3eb75a27bfbca.pdf?_ga=2.106070723.1123509245.1579131193-624244151.1579131193 (last visited January 15, 2020).
[27] *Supra* note 26.
[28] American Physical Therapy Association, *Physical Therapists &The Performance of Dry Needling: An Educational Resource Paper*, (Jan. 2012), available at http://www.apta.org/StateIssues/DryNeedling/ResourcePaper/ (last visited January 16, 2020).
[29] Id.
[30] American Physical Therapy Association, *State Laws and Regulations Governing Dry Needling Performed by Physical Therapists in the U.S.*, (2019), available at https://www.apta.org/uploadedFiles/APTAorg/Advocacy/State/Issues/Dry_Needling/APTADryNeedlingLawsByState.pdf (last visited January 16, 2020).

Dry Needling in Florida

At least two practitioners have filed Petitions for Declaratory Statement[31] seeking guidance from the Board on whether dry needling was within the scope of practice for PTs licensed in Florida. In 2017, the Board found that a particular petitioner was uniquely qualified to perform dry needling and authorized the petitioner to do so without violating the practice act.[32] The Board denied a subsequent petition stating that dry needling was not prohibited and that the Board was moving forward with rulemaking to set the competencies required for a PT to practice dry needling.[33]

In 2018, the Board published a proposed rule that established the minimum standards of practice for dry needling in physical therapy practice.[34] The proposed rule defined "dry needling" as a skilled technique based on western medical concepts performed by a PT using filiform needles to penetrate the skin and/or underlying tissue to affect change in body structures and functions for the evaluation and management of neuromusculoskeletal conditions, pain, movement impairments, and disability.[35] The proposed rule also established minimum education requirements and prohibited a PT from delegating dry needling to a physical therapy assistant, unlicensed personnel, or any other person who is not a PT.[36]

The Florida State Oriental Medical Association (FSOMA) challenged the rule, arguing it was an invalid exercise of delegated legislative authority.[37] FSOMA argued that the proposed rule would allow PTs to perform acupuncture by inserting acupuncture needles into patients, in violation of the definition of the physical therapy scope of practice, which limits PTs' performance of acupuncture to noninvasive procedures. In January 2019, the Division of Administrative Hearings found that the proposed rule invalid, as alleged. Specifically, the Administrative Law Judge found that the proposed rule exceeded the grant of rulemaking authority because it:

- Expanded the scope of physical therapy practice;
- Enlarged, modified, or contravened the specific provisions of law implemented, s. 489.021(11), F.S., which stated that PTs may perform acupuncture only upon compliance with the criteria set by the Board of Medicine, when no penetration of the skin occurred; and
- Was arbitrary because dry needling was not within the statutory scope of practice for PTs in this state.

The Board withdrew the proposed rule in March 2019.[38]

Effect of Proposed Changes

HB 467 eliminates the prohibition on performing acupuncture that pierces the skin and authorizes the Board of Physical Therapy Practice to adopt rules related to the standards of practice for PTs to perform dry needling.

The bill also revises the scope of practice for PTs by amending the definition of "practice of physical therapy" to more closely reflect the definition in the model practice act. The bill revises the description

[31] Pursuant to s. 120.565, F.S., any substantially affected person may seek a declaratory statement regarding an agency's opinion as to the applicability of a statutory provision, or of any rule or order of the agency, as it applies to the petitioner's particular set of circumstances.
[32] *In re the Petition for Declaratory Statement of Robert Stanborough,* Final Order No. DOH-17-1605-DS-MQA (Aug. 30, 2017), available at http://www.floridahealth.gov/licensing-and-regulation/declaratory/_documents/CLF-5501-14672DOH17-1605DS.pdf (last visited January 16, 2020).
[33] 44 Fla. Admin. Reg. 165 (Aug. 23, 2018).
[34] Proposed rule 64B17-6.008, F.A.C., published in 44 Fla. Admin. Reg. 38 (Feb. 23, 2018).
[35] Id.
[36] Id.
[37] *Florida State Oriental Medical Ass'n v. Dep't of Health and Florida Physical Therapy Ass'n, Inc.*, No. 18-2508RP (Fla. DOAH Jan. 28, 2019).
[38] 45 Fla. Admin. Reg. 47 (Mar. 8, 2019).

of the modalities used by PT to alleviate impairments, functional limitations, and disabilities by designing, implementing, and modifying treatment interventions that may include, but are not limited to:

- Therapeutic exercise;
- Functional training in self-care and in-home, community or work integration or reintegration;
- Manual therapy;
- Therapeutic massage;
- Airway clearance techniques;
- Maintaining and restoring the integumentary system and wound care;
- Physical agent or modality;
- Mechanical and electrotherapeutic modality, and
- Patient-related instruction.

The bill retains the authority of a PT to test neuromuscular functions or perform electromyography to diagnose and treat conditions.

The bill also expands the systems that a PT evaluates for a physical therapy assessment to the movement system, which encompasses endocrine, nervous, cardiovascular, pulmonary, integumentary, and musculoskeletal sustems. PTs currently assess the musculoskeletal and neuromuscular systems only. The bill also authorizes a PT to evaluate motor control as a part of the physical therapy assessment.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 486.021, F.S., relating to definitions.
Section 2: Amends s. 486.025, F.S., relating to powers and duties of the Board of Physical Therapy Practice.
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:

   The bill may have an insignificant, negative fiscal impact on the DOH if the Board chooses to adopt rules related to dry needling.

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 rulemaking authority to implements its provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to physical therapy practice; amending s. 486.021, F.S.; revising the definitions of the terms "physical therapy assessment" and "practice of physical therapy"; amending s. 486.025, F.S.; revising the powers and duties of the Board of Physical Therapy Practice; providing an effective date.

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

Section 1. Subsections (10) and (11) of section 486.021, Florida Statutes, are amended to read:

486.021 Definitions.—In this chapter, unless the context otherwise requires, the term:

(10) "Physical therapy assessment" means observational, verbal, or manual determinations of the function of the movement ~~musculoskeletal or neuromuscular~~ system relative to physical therapy, including, but not limited to, range of motion of a joint, motor power, motor control, posture ~~postural attitudes~~, biomechanical function, locomotion, or functional abilities, for the purpose of physical therapy ~~making recommendations for~~ treatment.

(11) "Practice of physical therapy" means the performance of physical therapy assessments and the treatment of any disability, injury, disease, or other health condition of human

beings, or the prevention of such disability, injury, disease, or other health condition ~~of health~~, and the rehabilitation of such disability, injury, disease, or other health condition ~~as related thereto~~ by alleviating impairments, functional limitations, and disabilities by designing, implementing, and modifying treatment interventions through therapeutic exercise; functional training in self-care and in-home, community, or work integration or reintegration; manual therapy; therapeutic massage; airway clearance techniques; maintaining and restoring the integumentary system and wound care; physical agent or modality; mechanical or electrotherapeutic modality; patient-related instruction ~~the use of the physical, chemical, and other properties of air; electricity; exercise; massage; the performance of acupuncture only upon compliance with the criteria set forth by the Board of Medicine, when no penetration of the skin occurs; the use of radiant energy, including ultraviolet, visible, and infrared rays; ultrasound; water~~; the use of apparatus and equipment in the application of such rehabilitation ~~the foregoing or related thereto~~; the performance of tests of neuromuscular functions as an aid to the diagnosis or treatment of any human condition; or the performance of electromyography as an aid to the diagnosis of any human condition only upon compliance with the criteria set forth by the Board of Medicine.

(a) A physical therapist may implement a plan of treatment

developed by the physical therapist for a patient or provided for a patient by a practitioner of record or by an advanced practice registered nurse licensed under s. 464.012. The physical therapist shall refer the patient to or consult with a practitioner of record if the patient's condition is found to be outside the scope of physical therapy. If physical therapy treatment for a patient is required beyond 30 days for a condition not previously assessed by a practitioner of record, the physical therapist shall have a practitioner of record review and sign the plan. The requirement that a physical therapist have a practitioner of record review and sign a plan of treatment does not apply when a patient has been physically examined by a physician licensed in another state, the patient has been diagnosed by the physician as having a condition for which physical therapy is required, and the physical therapist is treating the condition. For purposes of this paragraph, a health care practitioner licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 and engaged in active practice is eligible to serve as a practitioner of record.

(b) The use of roentgen rays and radium for diagnostic and therapeutic purposes and the use of electricity for surgical purposes, including cauterization, are not "physical therapy" for purposes of this chapter.

(c) The practice of physical therapy does not authorize a

physical therapy practitioner to practice chiropractic medicine as defined in chapter 460, including specific spinal manipulation. For the performance of specific chiropractic spinal manipulation, a physical therapist shall refer the patient to a health care practitioner licensed under chapter 460.

(d) This subsection does not authorize a physical therapist to implement a plan of treatment for a patient currently being treated in a facility licensed pursuant to chapter 395.

Section 2. Section 486.025, Florida Statutes, is amended to read:

486.025 Powers and duties of the Board of Physical Therapy Practice.—The board may administer oaths, summon witnesses, take testimony in all matters relating to its duties under this chapter, establish or modify minimum standards of practice <u>of physical therapy as defined in s. 486.021, including, without limitation, standards of practice for the performance of dry needling by physical therapists</u>, and adopt rules pursuant to ss. 120.536(1) and 120.54 to implement ~~the provisions of~~ this chapter. The board may also review the standing and reputability of any school or college offering courses in physical therapy and whether the courses of such school or college in physical therapy meet the standards established by the appropriate accrediting agency referred to in s. 486.031(3)(a). In

determining the standing and reputability of any such school and whether the school and courses meet such standards, the board may investigate and personally inspect the school and courses ~~make personal inspection of the same~~.

Section 3. 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 Stevenson offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Subsections (10) and (11) of section 486.021, Florida Statutes, are amended, and subsections (12) and (13) are added to that section, to read:

486.021 Definitions.—In this chapter, unless the context otherwise requires, the term:

(10) "Physical therapy assessment" means observational, verbal, or manual determinations of the function of the movement ~~musculoskeletal or neuromuscular~~ system relative to physical therapy, including, but not limited to, range of motion of a joint, motor power, motor control, posture ~~postural attitudes~~,

biomechanical function, locomotion, or functional abilities, for the purpose of physical therapy ~~making recommendations for~~ treatment.

(11) "Practice of physical therapy" means the performance of physical therapy assessments and the treatment of any disability, injury, disease, or other health condition of human beings, or the prevention of such disability, injury, disease, or other health condition ~~of health~~, and the rehabilitation of such disability, injury, disease, or other health condition ~~as related thereto~~ by alleviating impairments, functional movement limitations, and disabilities by designing, implementing, and modifying treatment interventions through therapeutic exercise; functional movement training in self-management and in-home, community, or work integration or reintegration; manual therapy; massage; airway clearance techniques; maintaining and restoring the integumentary system and wound care; physical agent or modality; mechanical or electrotherapeutic modality; patient-related instruction ~~the use of the physical, chemical, and other properties of air; electricity; exercise; massage; the performance of acupuncture only upon compliance with the criteria set forth by the Board of Medicine, when no penetration of the skin occurs; the use of radiant energy, including ultraviolet, visible, and infrared rays; ultrasound; water~~; the use of apparatus and equipment in the application of such treatment, prevention, or rehabilitation ~~the foregoing or~~

~~related thereto~~; the performance of tests of neuromuscular functions as an aid to the diagnosis or treatment of any human condition; or the performance of electromyography as an aid to the diagnosis of any human condition only upon compliance with the criteria set forth by the Board of Medicine.

(a) A physical therapist may implement a plan of treatment developed by the physical therapist for a patient or provided for a patient by a practitioner of record or by an advanced practice registered nurse licensed under s. 464.012. The physical therapist shall refer the patient to or consult with a practitioner of record if the patient's condition is found to be outside the scope of physical therapy. If physical therapy treatment for a patient is required beyond 30 days for a condition not previously assessed by a practitioner of record, the physical therapist shall have a practitioner of record review and sign the plan. The requirement that a physical therapist have a practitioner of record review and sign a plan of treatment does not apply when a patient has been physically examined by a physician licensed in another state, the patient has been diagnosed by the physician as having a condition for which physical therapy is required, and the physical therapist is treating the condition. For purposes of this paragraph, a health care practitioner licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 and engaged in

active practice is eligible to serve as a practitioner of record.

(b) The use of roentgen rays and radium for diagnostic and therapeutic purposes and the use of electricity for surgical purposes, including cauterization, are not "physical therapy" for purposes of this chapter.

(c) The practice of physical therapy does not authorize a physical therapy practitioner to practice chiropractic medicine as defined in chapter 460, including specific spinal manipulation, or acupuncture as defined in chapter 457. For the performance of specific chiropractic spinal manipulation, a physical therapist shall refer the patient to a health care practitioner licensed under chapter 460.

(d) This subsection does not authorize a physical therapist to implement a plan of treatment for a patient currently being treated in a facility licensed pursuant to chapter 395.

(12) "Dry needling" means a skilled technique based on western medical concepts using apparatus or equipment of filiform needles to stimulate a myofascial trigger point for the evaluation and management of neuromusculoskeletal conditions, pain, movement impairments, and disabilities.

(13) "Myofascial trigger point" means an irritable section of the tissue often associated with palpable taut bands of muscle fibers.

Section 2. Section 486.025, Florida Statutes, is amended to read:

486.025 Powers and duties of the Board of Physical Therapy Practice.—

(1) The board may administer oaths, summon witnesses, take testimony in all matters relating to its duties under this chapter, establish or modify minimum standards of practice of physical therapy as defined in s. 486.021, including, but not limited to, standards of practice for the performance of dry needling by physical therapists, and adopt rules pursuant to ss. 120.536(1) and 120.54 to implement ~~the provisions of~~ this chapter. The board may also review the standing and reputability of any school or college offering courses in physical therapy and whether the courses of such school or college in physical therapy meet the standards established by the appropriate accrediting agency referred to in s. 486.031(3)(a). In determining the standing and reputability of any such school and whether the school and courses meet such standards, the board may investigate and personally inspect the school and courses ~~make personal inspection of the same~~.

Section 3. Section 486.117, Florida Statutes, is created to read:

486.117 Physical therapist; performance of dry needling.—

(1) The board shall establish minimum standards of practice for the performance of dry needling by physical therapists, to include, at a minimum, all of the following:

(a) Completion of 2 years of licensed practice as a physical therapist.

(b) Completion of 50 hours of face-to-face continuing education from an entity accredited in accordance with s. 486.109 on the topic of dry needling which must include a determination by the physical therapist instructor that the physical therapist demonstrates the requisite psychomotor skills to safely perform dry needling. The continuing education must include instruction on all of the following areas:

1. Theory of dry needling.

2. Selection and safe handling of needles and other apparatus and equipment used in dry needling, including instruction on the proper handling of biohazardous waste.

3. Indications and contraindications for dry needling.

4. Psychomotor skills needed to perform dry needling.

5. Postintervention care, including adverse responses, adverse event recordkeeping, and any reporting obligations.

(c)1. Completion of 25 patient sessions of dry needling performed under the indirect supervision of a physical therapist who holds an active license to practice physical therapy in any state or the District of Columbia and who has actively practiced dry needling for at least 1 year; or

2. Completion of 25 patient sessions of dry needling performed as a physical therapist licensed in another state or in the United States Armed Forces.

(d) A requirement that dry needling may not be performed without patient consent and must be a part of a patient's documented plan of care.

(e) A requirement that dry needling may not be delegated to any person other than a physical therapist who is authorized to engage in dry needling under this chapter.

(2) The performance of dry needling in the practice of physical therapy may not be construed to limit the scope of practice of other licensed health care practitioners not governed by this chapter.

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 line 7 and insert:

Practice; creating s. 486.117, F.S.; requiring the board to establish minimum standards of practice for the performance of dry needling by physical therapists; providing construction; providing an effective date.

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.

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 Caruso offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Paragraph (b) of subsection (4) of section 397.4073, Florida Statutes, is amended to read:

397.4073 Background checks of service provider personnel.—

(4) EXEMPTIONS FROM DISQUALIFICATION.—

(b) ~~Since rehabilitated substance abuse impaired persons are effective in the successful treatment and rehabilitation of individuals with substance use disorders,~~

1. For service providers which treat adolescents 13 years of age and older, service provider personnel whose background checks indicate crimes under s. 796.07(2)(e), s. 810.02(4), s.

812.014(2)(c), s. 817.563, s. 831.01, s. 831.02, s. 893.13, or s. 893.147, and any related criminal attempt, solicitation, or conspiracy under s. 777.04:~~—~~,

1. Shall ~~may~~ be exempted from disqualification from employment for these offenses pursuant to this paragraph if:

a. At least 5 years, or at least 3 years in the case of an individual seeking certification as a peer specialist under s. 397.417, have elapsed since the applicant for an exemption has completed or has been lawfully released from any confinement, supervision, or nonmonetary condition imposed by a court for the applicant's most recent disqualifying offense under this paragraph.

b. The applicant for an exemption has not been arrested for any offense during the 5 years, or 3 years in the case of a peer specialist, prior to the request for exemption.

2. May be exempted from disqualification from employment for such offenses without a waiting period under s. 435.07(2).

Section 2. Subsection (6) of section 397.487, Florida Statutes, is amended to read:

397.487 Voluntary certification of recovery residences.—

(6) All owners, directors, and chief financial officers of an applicant recovery residence are subject to level 2 background screening as provided under s. 408.809 and chapter 435. A recovery residence is ineligible for certification, and a credentialing entity shall deny a recovery residence's

application, if any owner, director, or chief financial officer has been found guilty of, or has entered a plea of guilty or nolo contendere to, regardless of adjudication, any offense listed in s. 408.809(4) or s. 435.04(2) unless the department has issued an exemption under s. 435.07 ~~s. 397.4073 or s. 397.4872~~. In accordance with s. 435.04, the department shall notify the credentialing agency of an owner's, director's, or chief financial officer's eligibility based on the results of his or her background screening.

Section 3. Subsection (5) of section 397.4871, Florida Statutes, is amended to read:

397.4871 Recovery residence administrator certification.—

(5) All applicants are subject to level 2 background screening as provided under chapter 435. An applicant is ineligible, and a credentialing entity shall deny the application, if the applicant has been found guilty of, or has entered a plea of guilty or nolo contendere to, regardless of adjudication, any offense listed in s. 408.809 or s. 435.04(2) unless the department has issued an exemption under ~~s. 397.4872~~ s. 435.07. In accordance with s. 435.04, the department shall notify the credentialing agency of the applicant's eligibility based on the results of his or her background screening.

Section 4. Subsections (2) and (3) of section 397.4872, Florida Statutes, are amended to read:

397.4872 Exemption from disqualification; publication.—

~~(2) The department may exempt a person from ss. 397.487(6) and 397.4871(5) if it has been at least 3 years since the person has completed or been lawfully released from confinement, supervision, or sanction for the disqualifying offense. An exemption from the disqualifying offenses may not be given under any circumstances for any person who is a:~~

~~(a) Sexual predator pursuant to s. 775.21;~~

~~(b) Career offender pursuant to s. 775.261; or~~

~~(c) Sexual offender pursuant to s. 943.0435, unless the requirement to register as a sexual offender has been removed pursuant to s. 943.04354.~~

(2) ~~(3) By April 1, 2016, each credentialing entity shall submit a list to the department of all recovery residences and recovery residence administrators certified by the credentialing entity that hold a valid certificate of compliance. Thereafter,~~ The credentialing entity must notify the department within 3 business days after a new recovery residence or recovery residence administrator is certified or a recovery residence or recovery residence administrator's certificate expires or is terminated. The department shall publish on its website a list of all recovery residences that hold a valid certificate of compliance. The department shall also publish on its website a list of all recovery residence administrators who hold a valid certificate of compliance. A recovery residence or recovery residence administrator shall be excluded from the list upon

written request to the department by the listed individual or entity.

Section 5. 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.

Section 6. 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 substance abuse services; amending s. 397.4073, F.S.; requiring, rather than authorizing, an exemption from disqualification from employment for certain substance abuse service provider personnel under certain circumstances; amending s. 397.487, F.S.; revising a cross-reference; amending s. 397.4871, F.S.; revising a cross-reference; amending s. 397.4872, F.S.; removing the authority of the Department of Children and Families to grant exemptions from disqualification

to certain individuals under certain circumstances under chapter 397; removing obsolete language; amending s. 817.505, F.S.; revising provisions relating to payment practices exempt from prohibitions on patient brokering; providing an effective date.

CS/HB 763

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 763 Patient Safety Culture Surveys
SPONSOR(S): Health Market Reform Subcommittee, Grant, M.
TIED BILLS: **IDEN./SIM. BILLS:** SB 1370

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	12 Y, 0 N, As CS	Guzzo	Calamas
2) Health Care Appropriations Subcommittee	10 Y, 0 N	Nobles	Clark
3) Health & Human Services Committee		Guzzo	Calamas

SUMMARY ANALYSIS

Patient safety culture is the extent to which the beliefs, values, and norms shared by the staff of a health care organization support and promote patient safety. Patient safety culture surveys are used to measure patient safety culture by determining what is rewarded, supported, expected, and accepted in a health care organization as it relates to patient safety. They provide health care organizations with an understanding of the safety related perceptions and attitudes of its managers and staff and are used as diagnostic tools to identify areas for improvement. These can also be used to measure organizational conditions that can lead to adverse incidents and patient harm.

The bill requires hospitals and ambulatory surgical centers (ASCs) to use the Hospital Survey on Patient Safety Culture (SOPS) to conduct patient safety culture surveys of facility staff. The facility must conduct the survey biennially, and submit the data to AHCA, in a format specified by rule. The bill requires the facility to conduct the survey anonymously to encourage staff employed by or working in the facility to complete the survey. The bill authorizes a hospital or ASC to contract to administer the survey, and to develop an internal action plan to identify survey measures to improve upon between surveys, which may be submitted to AHCA.

The bill requires AHCA to collect, compile, and publish patient safety culture survey data submitted by hospitals and ASCs. The bill requires AHCA to publish the survey results for each facility, in the aggregate, by composite measure, and by unit work areas. AHCA must designate the use of updated versions of the survey as they occur.

The bill requires AHCA to customize the survey to include questions that will generate certain data, including, data on the likelihood of a respondent to seek care for the respondent, and for the respondent's family, at the surveying facility, both in general and within the respondent's specific unit or department.

The bill also requires AHCA to customize the survey to allow a respondent to identify themselves as working in certain areas of a hospital or ASC that are not currently identifiable in the survey, including, a pediatric cardiology patient care unit and a pediatric cardiology surgical services unit.

The bill authorizes one full-time equivalent position, with associated salary rate of 45,560, and $74,173 in recurring funds and $87,474 in nonrecurring funds from the Health Care Trust Fund to the Agency for Health Care Administration. The bill has no fiscal impact on 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 Facility Regulation

Hospitals

Hospitals are regulated by the Agency for Health Care Administration (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]

Ambulatory Surgical Centers (ASCs)

An ASC is a facility, which is not a part of a hospital, the primary purpose of which is to provide elective surgical care, in which the patient is admitted and discharged within 24 hours.[3] ASCs are licensed and regulated by the AHCA under the same regulatory framework as hospitals.[4]

Health Care Quality

The United States is experiencing significant changes in health care payment and delivery. Record numbers of newly-insured persons are enrolled in both public and private health insurance. Americans 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 should be free, timely, reliable, and reflect individual health care needs and insurance coverage.

Most Americans believe that the health care they receive is the best available, but the evidence shows otherwise.[5] Although the U.S. spends more than $3 trillion a year on health care,[6] 18 percent of the gross national product,[7] research shows that the quality of health care in America is, at best, imperfect, and, at worst, deeply flawed.[8] Issues with health care quality fall into three categories:

- Underuse. Many patients do not receive medically necessary care.
- Misuse. Each year, more than 100,000 Americans get the wrong care and are injured as a result. More than 1.5 million medication errors are made each year.
- Overuse. Many patients receive care that is not needed or for which there is an equally effective alternative that costs less money or causes fewer side effects.

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[1] S. 395.002(12), F.S.
[2] Id.
[3] S. 395.002(3), F.S.
[4] SS. 395.001-1065, F.S., and Part II, Chapter 408, F.S.
[5] National Committee for Quality Assurance, *The Essential Guide to Health Quality*, page 6, available at http://www.kdheks.gov/hcf/news/download/04172007_NCQA_Health_Quality.pdf (last viewed January 1, 2020).
[6] The Henry J. Kaiser Foundation, Peterson-Kaiser Health System Tracker, *Health Spending Explorer-U.S. Health Expenditures 1960-2017*, available at https://www.healthsystemtracker.org/interactive/?display=U.S.%2520%2524%2520Billions&service=&rangeType=range&years=1960%252C2017 (last viewed January 1, 2020).
[7] The World Bank, *Data-United States*, available at http://data.worldbank.org/country/united-states (last viewed January 1, 2020).
[8] Supra, FN 5.

Research indicates that quality of care in the U.S. is uneven. For example, Americans receive appropriate, evidence-based care when they need it only 55 percent of the time.[9] Similarly, more than 250,000 people die each year as a result of preventable hospital errors in the U.S.[10], and more than 72,000 people died in 2015 from an infection obtained while in the hospital.[11]

Quality Measures

There are hundreds of health care quality measures developed, maintained, and evaluated for relevancy and accuracy by many different organizations, including the federal Agency for Healthcare Research and Quality, the National Quality Forum, and the National Committee for Quality Assurance. In general, health quality measures can be sorted into four categories:[12]

- **Structure measures**- assess the aspects of the health care setting, including facility, personnel, and policies related to the delivery of care.
    - Example- What is the nurse-to-patient ratio in a neonatal intensive care unit?
- **Process measures**- determine if the services provided to patients are consistent with routine clinical care.
    - Example- Does a doctor recommend prostate-specific antigen testing for his male patients at average risk for prostate cancer beginning at age 50?
- **Outcome measures**- evaluate patient health as a result of care received.
    - Example- What is the infection rate of patients undergoing cardiac surgery at a hospital?
- **Patient experience measures**- provide feedback on patients' experiences with the care received.
    - Example- Do patients recommend their doctor to others following a procedure?

Standardized healthcare performance measures are used by a range of healthcare stakeholders for a variety of purposes. Measures help clinicians, hospitals, and other providers understand whether the care they provide their patients is optimal and appropriate, and if not, where to focus their efforts to improve. Public and private payers also use measures for feedback and benchmarking purposes, public reporting, and incentive-based payment. Lastly, measures are an essential part of making the cost and quality of healthcare more transparent to all, particularly for those who receive care or help make care decisions for loved ones. The Institute of Medicine's six domains of quality—safe, effective, patient-centered, timely, efficient, and equitable—are one way to organize the information.[13] Studies have found patients find effectiveness, safety, and patient-centeredness to be most meaningful in their consideration of health care options.[14]

As more and more health care consumers shop for their health care, value becomes more important than price alone. Determining value means comparing the cost of care with information on the quality or benefit of the service. Presenting health care price information without accompanying quality

[9] McGlynn, E.A., Asch, S.M., et al., *The quality of health care delivered to adults in the United States*, New England Journal of Medicine, 348(26): 2635-45, June 2, 2003.
[10] John Hopkins Medicine, *Medical Error-The Third Leading Cause of Death in the U.S.,* available at https://www.bmj.com/content/353/bmj.i2139.full (last viewed January 1, 2020).
[11] Centers for Disease Control, *Healthcare-associated infections (HAI), Data and Statistics-HAI Prevalence Survey*, available at http://www.cdc.gov/HAI/surveillance/index.html (last viewed January 1, 2020).
[12] U.S. Government Accountability Office, *Health Care Transparency-Actions Needed to Improve Cost and Quality Information for Consumers*, October 2014, pgs. 6-7 (citing quality measure categories established by the U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality's National Quality Measures Clearinghouse, available at http://qualitymeasures.ahrq.gov/tutorial/varieties.aspx (last viewed January 1, 2020).
[13] Institute of Medicine, *Report: Crossing the Quality Chasm: A New Health System for the 21st Century*, March 1, 2001, available at http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf (last viewed January 1, 2020).
[14] Hibbard, JH, Greene, J, Daniel D., *What is Quality Anyway? Performance Reports That Clearly Communicate to Consumers the Meaning of Quality Care*, Med. Care Res. Rev., 67(3): 275-293 (2010).

information leads consumers to assume that high-priced care is high quality care.[15] In fact, there is no evidence of a correlation between cost and quality in health care.[16]

Showing cost and quality information together helps consumers clearly see variation among providers.[17] Further, it helps consumers understand that high costs do not necessarily mean high quality—high-quality care is available without paying the highest price.[18] One way to accomplish this would be to present comparative quality and cost information on one, consumer-friendly website, using several specific measures or scores so multiple metrics can be compared at the same time.[19]

Florida Center for Health Information and Transparency

The Florida Center for Health Information and Transparency (the Florida Center), within AHCA, provides a comprehensive health information system (information system) that includes the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of health-related data.

Current law requires every Florida licensed inpatient hospital, ambulatory surgery center (ASC), emergency department, and comprehensive rehabilitation hospital to report data to AHCA quarterly.[20] The Florida Center electronically collects this data validates it and maintains it in three major databases:

- The **hospital inpatient database** contains records for each patient stay at Florida acute care facilities, including long-term care hospitals and psychiatric hospitals. These records contain extensive patient information including discharge records, patient demographics, admission information, medical information, and charge data. This database also includes comprehensive inpatient rehabilitation data on patient-level discharge information from Florida's licensed freestanding comprehensive inpatient rehabilitation hospitals and acute care hospital distinct part rehabilitation units.
- The **ambulatory surgery database** contains "same-day surgery" data on reportable patient visits to Florida health care facilities, including freestanding ambulatory surgery centers, short-term acute care hospitals, lithotripsy centers, and cardiac catheterization laboratories. Ambulatory surgery data records include, but are not limited to, patient demographics, medical information, and charge data.
- The **emergency department database** collects reports of all patients who visited an emergency department, but were not admitted for inpatient care. Reports are electronically submitted to the AHCA and include the hour of arrival, the patient's chief complaint, principal diagnosis, race, ethnicity, and external causes of injury.

The Florida Center applies this data to standardized quality measures and price levels including total hospitalizations, high and low charges, infection rates, readmission rates and patient satisfaction among many other quality measures. The Florida Center maintains www.FloridaHealthFinder.gov, which was established to assist consumers in making informed health care decisions and lead to improvements in quality of care in Florida. The website provides a wide array of search and comparative tools to the public that allows access to information on hospitals, ambulatory surgery centers, emergency departments, hospice providers, physician volume, health plans, nursing homes, and prices for prescription drugs in Florida. The website also provides tools to researchers and

[15] Public Agenda and Robert Wood Johnson Foundation, *How Much Will It Cost? How Americans Use Prices in Health Care*, March 2015, page 5, available at http://www.publicagenda.org/files/HowMuchWillItCost_PublicAgenda_2015.pdf (last viewed January 1, 2020)
[16] Carman, KL, Maurer M., et al., *Evidence That Consumers Are Skeptical About Evidence-Based Health Care*, Health Affairs, 29(7): 1400-1406 (2010).
[17] American Institute of Research, The Robert Wood Johnson Foundation, *How to Report Cost Data to Promote High-Quality, Affordable Choices: Findings from Consumer Testing*, February 2014, available at https://www.rwjf.org/en/library/research/2014/02/how-to-report-cost-data-to-promote-high-quality--affordable-choi.html (last viewed January 1, 2020).
[18] Id.
[19] Id.
[20] S. 408.061, F.S.

professionals to allow specialized data queries, but requires users to have some knowledge of medical coding and terminology. Some of the features and data available on the website include a multimedia encyclopedia and symptoms navigator, hospital and ambulatory surgery centers performance data, data on mortality, complication, and infection rates for hospitals, and a facility/provider locator.

Patient Safety Culture Surveys[21]

Organizational culture refers to the beliefs, values, and norms shared by staff throughout the organization that influence their actions and behaviors. Patient safety culture is the extent to which these beliefs, values, and norms support and promote patient safety.[22] Patient safety culture can be measured by determining what is rewarded, supported, expected, and accepted in an organization as it relates to patient safety.[23] In a safe culture, employees are guided by an organization-wide commitment to safety in which each member upholds their own safety norms and those of their co-workers. Safety culture is increasingly recognized as an important strategy to improving deficits in patient safety.[24] The question for health care facilities is how to measure the patient safety climate in the facility.

Agency for Healthcare Research and Quality Hospital and ASC Patient Safety Culture Survey

In 2004, the federal Agency for Healthcare Research and Quality (AHRQ) released the Hospital Survey on Patient Safety Culture (SOPS 1.0), a staff survey designed to help hospitals assess the culture of safety in their institutions by measuring how their staff perceive various aspects of patient safety culture.[25] The survey occurs once every two years and has since been implemented in hundreds of hospitals across the United States, and in other countries.

In 2018, AHRQ began developing a new version of the survey, with the goal of shortening the survey.[26] A pilot test was conducted with 25 hospitals, the data of which was used to examine the survey's reliability. In 2019, AHRQ released a new version of the survey, the SOPS 2.0.[27]

Patient safety data collected from the survey results is not only provided in the aggregate, it can also be broken down to a more granular level. The first question on the survey allows the respondent to identify their position, title or area of expertise. The second question asks the respondent to identify the unit or department in which they work in the hospital. This allows survey data to be collected and categorized by staff position and by units or departments. As a result, a hospital can identify the specific positions and departments that may need improvement. The survey asks respondents to indicate to what degree they agree or disagree with a statement, how often something occurs, or provide a specific number or grade. Excerpts of the survey follow.

- Teamwork
    - In this unit, we work together as an effective team.
    - During busy times, staff in this unit help each other.

[21] Besides the two patient safety culture surveys highlighted is this section, other measures of safety climate include, but are not limited to, Zohar's (2000) assessment of unit safety climate; Zohar and Luria's (2005) measure of unit climate; Hofmann and Stetzer's (1996, 1998) measure of safety climate including safe practices, safety policies, and/or safety requirements; and Hofmann, Morgeson, and Gerras' (2003) measure of safety climate.
[22] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *2018 User Database Report-Hospital Survey on Patient Safety Culture*, at pg. 3, available at http://www.ahrq.gov/sites/default/files/wysiwyg/sops/quality-patient-safety/patientsafetyculture/2018hospitalopsreport_0.pdf (last viewed January 1, 2020).
[23] Id.
[24] Pronovost P, Sexton B. *Assessing safety culture: guidelines and recommendations*. Qual Saf Health Care 2005;14:231–3;
[25] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *Hospital Survey on Patient Safety Culture*, available at http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/index.html (last viewed January 1, 2020). Besides hospitals, AHRQ developed patient safety culture surveys for nursing homes, ambulatory outpatient medical offices, community pharmacies, and ambulatory surgery centers.
[26] U.S Department of Health and Human Services, Agency for Healthcare Research and Quality, *Pilot Test Results from the 2019 AHRQ Surveys on Patient Safety Culture (SOPS) Hospital Survey Version 2.0*, pg. 2, available at http://www.ahrq.gov/sites/default/files/wysiwyg/sops/surveys/hospital/hsops2-pilot-results-parti.pdf (last viewed January 1, 2020).
[27] The survey is available at http://www.ahrq.gov/sops/surveys/hospital/index.html (last viewed January 1, 2020).

    - There is a problem with disrespectful behavior by those working in this unit.
    - When one area in this unit gets really busy, others help out.
- Supervisor/Manager, or Clinical Leader Support for Patient Safety
    - My supervisor/manager, or clinical leader seriously considers staff suggestions for improving patient safety.
    - My supervisor/manager, or clinical leader wants us to work faster during busy times, even if it means taking shortcuts.
    - My supervisor/manager, or clinical leader takes action to address patient safety concerns that are brought to their attention.
- Hospital Management Support for Patient Safety
    - Hospital management provides adequate resources to improve patient safety.
    - The actions of hospital management show that patient safety is a top priority.
    - Hospital management seems interested in patient safety only after an adverse event happens.
- Communication Openness
    - In this unit, staff speak up if they see something that may negatively affect patient care.
    - When staff in this unit see someone with more authority doing something unsafe for patients, they speak up.
    - In this unit, staff are afraid to ask questions when something does not seem right.
- Handoffs and Information Exchange
    - When transferring patients from one unit to another, important information is often left out.
    - During shift changes, important patient care information is often left out.
    - During shift changes, there is adequate time to exchange all key patient care information.
- Patient Safety Grade- Poor, Fair, Good, Very Good, Excellent
    - How would you rate your unit/work area on patient safety?[28]

AHRQ developed a tool kit and a user guide to provide instruction to hospitals on administering the SOPS survey.[29] The user guide includes instructions for modification and customization of the survey. The staff positions and departments on the survey can be modified to better match the names and titles used within a hospital. The survey may also be customized by adding questions.

The rate at which hospital staff have participated in the survey has never been high and has declined slightly in recent years, going from 55 percent in 2016[30] to 54 percent in 2018[31]. This may be the result of the prior survey being perceived as long or tedious.

AHRQ developed a comparative database on the survey, comprised of data from U.S. hospitals that administered the survey and voluntarily submitted the data.[32] The database allows hospitals to compare their patient safety culture survey results to those of other hospitals in support of patient safety culture improvement.[33] AHRQ utilizes the database to publish a biennial report presenting non-identifiable statistics on the patient safety culture of all participating hospitals. In 2018, 630 hospitals

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[28] Id.
[29] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *Hospital Survey on Patient Safety Culture Version 2.0 User's Guide,* available at https://www.ahrq.gov/sites/default/files/wysiwyg/sops/surveys/hospital/hospitalsurvey2-users-guide.pdf (last viewed January 1, 2020).
[30] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *2016 User Database Report-Hospital Survey on Patient Safety Culture*, at pg. 8, available at http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/2016/2016_hospitalsops_report_pt1.pdf (last viewed January 1, 2020).
[31] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *2018 User Database Report-Hospital Survey on Patient Safety Culture*, at pg. 5, available at http://www.ahrq.gov/sites/default/files/wysiwyg/sops/quality-patient-safety/patientsafetyculture/2018hospitalopsreport_0.pdf (last viewed January 1, 2020).
[32] The database is available at http://www.ahrq.gov/sops/databases/hospital/index.html (last viewed January 1, 2020).
[33] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *2018 User Database Report-Hospital Survey on Patient Safety Culture*, at pg. 1, available at https://www.ahrq.gov/sites/default/files/wysiwyg/sops/quality-patient-safety/patientsafetyculture/2018hospitalsopsreport.pdf (last viewed January 1, 2020).

submitted survey results to the database. However, only 306 of those hospitals submitted surveys in 2016. As a result, to identify trends, comparisons can only be drawn from the data submitted by those 306 hospitals.[34]

The 2018 biennial report includes a chapter on trending that presents results showing change over time for the 306 hospitals that administered the survey and submitted data in 2016 and 2018.[35] The trends and findings include:

- The average scores across the 12 patient safety culture composites increased by 1 percentage point.
- For hospitals that increased on Patient Safety Grade, scores for "Excellent" or "Very Good" increased on average by 6 percent.
- For hospitals that increased on the number of respondents who reported at least one event in the past 12 months, the average increase was 5 percent.

This seems to suggest that these hospitals improved their patient safety cultures after publication of the 2016 survey results.

AHRQ also developed the Ambulatory Surgery Center Survey on Patient Safety Culture in response to interest from ambulatory surgery centers (ASCs) in assessing patient safety culture in their facilities. This survey is designed specifically for ASC staff and asks for their opinions about the culture of patient safety in their facility.[36] In 2014, AHRQ conducted a pilot study on the use of the Patient Safety Culture survey in 59 ASCs.[37] The pilot study was intended to help ASCs assess the extent to which their culture emphasizes the importance of patient safety by viewing the patient safety culture survey results of the ASCs participating in the study.[38] The study was also used to prove the reliability and structure of the questions and items contained the in the survey. Based on the testing and input from AHRQ and a technical expert panel, the survey was determined to be reliable and it was made available for industry use.

University of Texas Safety Attitudes Questionnaire

Another patient safety culture survey widely used by hospitals and other facilities to measure patient safety culture is the Safety Attitudes Questionnaire (SAQ) developed by researchers at the University of Texas. The SAQ was adapted from two other safety surveys from the aviation industry- the Flight Management Attitudes Questionnaire and its predecessor, the Cockpit Management Attitudes Questionnaire, developed over 30 years ago. The aviation questionnaires were created after researchers found that most airline accidents were due to breakdowns in interpersonal aspects of crew performance such as teamwork, speaking up, leadership, communication, and collaborative decision making. The FMAQ measures crew member attitudes about these topics, and was found to be reliable, sensitive to change, and predictive of flight crew performance. Researchers also found that many of the items contained in the aviation questionnaires were useful in measuring attitudes about the same topics in a medical setting, so the SAQ was developed.

The SAQ was specifically designed to measure safety culture at both the individual and group level. Both the healthcare version (SAQ) and aviation version (FMAQ) of this survey instrument were shown to identify variability within and between hospitals and airlines[39]. The SAQ went through full derivation

[34] Id. at pg. 29.
[35] Id.
[36] The survey is available at https://www.ahrq.gov/sops/surveys/asc/index.html.
[37] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *Results From the 2014 AHRQ Ambulatory Surgery Center Survey on Patient Safety Culture Pilot Study*, available at https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/asc/resources/asc_pilotstudy.pdf (last viewed January 1, 2020).
[38] Id. at pg. 1.
[39] Pronovost P, Sexton B. *Assessing safety culture: guidelines and recommendations*. Qual Saf Health Care 2005;14:231–3; see also Sexton JB, Thomas EJ. *Measurement: Assessing Safety Culture*. In: Leonard M, Frankel A, Simmonds T (eds). *Achieving Safe and*

and validation testing, and was determined to be both a valid and reliable measurement tool for determining patient safety culture.[40]

The SAQ is a one-page, 60 item survey instrument that assesses safety culture across six factors—perceptions of management, job satisfaction, working conditions, stress recognition, teamwork climate and safety climate.[41] The SAQ defines safety climate as perceptions of a strong and proactive organizational commitment to safety, as one aspect of overall safety culture. Each item is measured on a 5-point Likert scale, from disagree strongly to agree strongly, which is then converted to a 0–100 scale. The scaled scores correspond to the patient safety climate in a facility. The SAQ has been adapted for use in intensive care units, operating rooms, general inpatient settings, and ambulatory clinics.[42]

Research on Patient Safety Culture Surveys

Since 2000, a robust body of research has emerged to measure the effectiveness of patient safety culture surveys in identifying areas of improvement in hospitals, ASCs, and other health care settings. This research has found that facilities with a poor patient safety climate have poor or less desirable patient outcomes following treatment in those facilities. For example, in one study, the SAQ (operating version) was given to 60 hospitals in 16 states to administer to each hospital's operating room caregivers.[43] When the results of the surveys were compared with a chart showing surgical complication rates for each hospital participating in the study, the charts were nearly identical. The study showed that there was a correlation between patient safety culture in a hospital and patient outcomes.[44]

Another study examined the patient safety culture at 30 intensive care units (ICUs) across the country to determine if there was a correlation between safety culture and patient outcomes, specifically hospital mortality and length of stay.[45] Using the SAQ-ICU version, the study found that lower perceptions of management among ICU personnel were significantly associated with higher hospital mortality.[46] In fact, for every 10 percent decrease in an ICU's percentage of positive scores associated with perceptions of management, the odds of patient death in the ICU increased 1.24 times.[47] Also, the study found that lower safety climate, perceptions of management, and job satisfaction were significantly associated with increased lengths of stay in the hospital.[48] Other studies have also found a correlation between positive teamwork attitudes and patient outcomes in ICUs.[49]

Facilities whose frontline health care workers and managers score higher on patient safety climate surveys have been found to have lower rates of adverse patient safety indicators, such as postoperative sepsis, pressure ulcers, and inpatient falls resulting in a fractured hip.[50] Another study found a correlation between poor safety climate scores and high burnout rates among NICU nurses.[51]

Reliable Healthcare: Strategies and Solutions. Chicago, IL: Health Administration Press, 2004, pp. 115–27.

[40] Sexton JB, Helmreich RL, Neilands TB et al. *The Safety Attitudes Questionnaire: psychometric properties, benchmarking data, and emerging research*. BMC Health Serv Res 2006;6:44.

[41] Huang, D., Clermont, G. *Intensive care unit safety culture and outcomes: a U.S. multicenter study*. Intl. J. Quality in Health Care 2010;22:151-161.

[42] For each version of the SAQ, item content is the same, with minor modifications to reflect the clinical area.

[43] Makary M., Sexton B. *Patient safety in surgery*. Annals of Surgery 2006; 243:628-35.

[44] Makary, M. *Unaccountable: What Hospitals Won't Tell You and How Transparency Can Revolutionize Health Care* pgs. 90-92 (2012).

[45] Supra, FN 41.

[46] Id.

[47] Id.

[48] Id.

[49] Baggs J, Schmitt M, Mushlin A, Mitchell P, Eldredge D, Oakes D, Hutson AD: *Association between nurse-physician collaboration and patient outcomes in three intensive care units*. Crit Care Med 1999; 27:1991–8; Shortell S, Zimmerman J, Rousseau D, Gillies R, Wagner D, Draper E, Knaus W, Duffy J: *The performance of intensive care units: Does good management make a difference?* Med Care 1994; 32:508–25; Knaus W, Draper E, Zimmerman J: *An evaluation of outcome from intensive care in major medical centers.* Ann Intern Med 1986; 10:410–8.

[50] Singer S., Lin S. *Relationship of safety climate and safety performance in hospitals*. Health Serv Res 2009;44:399-421.

[51] Profit J., Sharek P. *Burnout in the NICU setting and its relation to safety culture*. BMJ Qual Saf 2014;23:806-813.

An additional study found that positive teamwork attitudes measured by patient safety culture survey tools are associated with better patient outcomes in pediatric surgery.[52]

Effect of Proposed Changes

The bill requires hospitals and ASCs to use the SOPS survey to conduct patient safety culture surveys of facility staff. The facilities must conduct the survey biennially, and submit the data to AHCA in a format specified by rule. The bill requires the facility to conduct the survey anonymously to encourage staff employed by or working in the facility to complete the survey. This will not only ensure a staff member's rights to privacy are protected, but it will lead to more reliable data by increasing the sample size of the survey. The bill authorizes a hospital or ASC to contract to administer the survey, and to develop an internal action plan to identify survey measures to improve upon between surveys, which may be submitted to AHCA.

The bill requires AHCA to collect, compile, and publish patient safety culture survey data submitted by hospitals and ASCs. The bill requires AHCA to publish the survey results for each facility, in the aggregate, by composite measure, and by unit work areas. AHCA must designate the use of updated versions of the survey as they occur.

The bill requires AHCA to customize the survey to include questions that will generate certain data, including, data on the likelihood of a respondent to seek care for the respondent, and for the respondent's family, at the surveying facility, both in general and within the respondent's specific unit or department.

The bill also requires AHCA to customize the survey to allow a respondent to identify themselves as working in certain areas of a hospital or ASC that are not currently identifiable in the survey, including, a pediatric cardiology patient care unit and a pediatric cardiology surgical services unit.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 395.1012, F.S., relating to patient safety.
Section 2: Amends s. 395.1055, F.S., relating to rules and enforcement.
Section 3: Amends s. 408.05, F.S., relating to Florida Center for Health Information and Transparency.
Section 4: Amends s. 408.061, F.S., relating to data collection; uniform systems of financial reporting; information relating to physician charges; confidential information; immunity.
Section 5: Provides for an appropriation.
Section 6: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

[52] de Leval M, Carthey J, Wright D, Farewell V, Reason J: *Human factors and cardiac surgery: A multicenter study.* J Thorac Cardiovasc Surg 2000;119:661–72.

2. Expenditures:

   The AHCA has projected a need for one full-time equivalent position to oversee the project and $85,000 in contracted services to build the survey system to include associated programming and web-design costs. The bill authorizes one full-time equivalent position, with associated salary rate of 45,560, and $74,173 in recurring funds and $87,474 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:

Health care consumers will have access to patient safety culture survey results from hospitals and ASCs. Consumers may use the information to make informed decisions about where they receive health care services. Hospitals and ASCs with poor survey results may realize a reduction in patient volume, while hospitals and ASCs with positive survey results may realize an increase in patient volume.

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

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

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

- Requires hospitals and ASCs to use the Hospital Survey on Patient Safety Culture developed by the federal Agency for Healthcare Research and Quality to conduct patient safety culture surveys of all facility staff;
- Requires hospitals and ASCs to conduct the survey biennially and anonymously;
- Requires hospitals and ASCs to submit the survey data and participation rate biennially to AHCA in a format specified by rule;
- Authorizes hospitals and ASCs to contract to administer the survey, and develop an internal action plan to identify survey measures to improve upon between surveys, which may be submitted to AHCA;
- Requires AHCA to collect, compile, and publish patient safety culture survey data submitted by hospitals and ASCs;
- Designate the use of updated versions of the survey as they occur;
- Customize the survey to include questions that will generate certain data;
- Customize the survey to allow a respondent to identify themselves as working in certain areas of a hospital that are not currently identifiable on the SOPS survey; and
- Publish the aggregate survey results for each facility by composite measure and unit work areas within the facility.

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 patient safety culture surveys; amending s. 395.1012, F.S.; requiring licensed facilities to biennially conduct an anonymous patient safety culture survey using a specified federal publication; authorizing facilities to contract for the administration of such survey; requiring facilities to biennially submit patient safety culture survey data to the Agency for Health Care Administration; authorizing facilities to develop an internal action plan for a specified purpose and submit such plan to the agency; amending s. 395.1055, F.S.; conforming a cross-reference; amending s. 408.05, F.S.; requiring the agency to collect, compile, and publish patient safety culture survey data submitted by facilities; amending s. 408.061, F.S.; revising requirements for the submission of health care data to the agency; providing appropriations; providing an effective date.

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

Section 1. Subsection (4) is added to section 395.1012, Florida Statutes, to read:

395.1012 Patient safety.—

(4) Each licensed facility must, at least biennially, conduct a patient safety culture survey using the Hospital Survey on Patient Safety Culture developed by the federal Agency for Healthcare Research and Quality. Each facility shall conduct the survey anonymously to encourage completion of the survey by staff working in or employed by the facility. Each facility may contract to administer the survey. Each facility shall biennially submit the survey data to the agency in a format specified by rule, which must include the survey participation rate. Each facility may develop an internal action plan between conducting surveys to identify measures to improve the survey and submit the plan to the agency.

Section 2. Paragraph (d) of subsection (14) of section 395.1055, Florida Statutes, is amended to read:

395.1055 Rules and enforcement.—

(14)

(d) Each onsite inspection must include all of the following:

1. An inspection of the program's physical facilities, clinics, and laboratories.

2. Interviews with support staff and hospital administrators.

3. A review of:

a. Randomly selected medical records and reports, including, but not limited to, advanced cardiac imaging,

computed tomography, magnetic resonance imaging, cardiac ultrasound, cardiac catheterization, and surgical operative notes.

b. The program's clinical outcome data submitted to the Society of Thoracic Surgeons and the American College of Cardiology pursuant to s. 408.05(3)(l) ~~s. 408.05(3)(k)~~.

c. Mortality reports from cardiac-related deaths that occurred in the previous year.

d. Program volume data from the preceding year for interventional and electrophysiology catheterizations and surgical procedures.

Section 3. Paragraphs (d) through (k) of subsection (3) of section 408.05, Florida Statutes, are redesignated as paragraphs (e) through (l), respectively, present paragraph (j) is amended, and a new paragraph (d) is added to that subsection, to read:

408.05 Florida Center for Health Information and Transparency.—

(3) HEALTH INFORMATION TRANSPARENCY.—In order to disseminate and facilitate the availability of comparable and uniform health information, the agency shall perform the following functions:

(d)1. Collect, compile, and publish patient safety culture survey data submitted by a facility pursuant to s. 395.1012.

2. Designate the use of updated versions of the survey as they occur, and customize the survey to:

a. Generate data regarding the likelihood of a respondent to seek care for the respondent and the respondent's family at the surveying facility, both in general and within the respondent's specific unit or work area; and

b. Revise the units or work areas identified in the survey to include a pediatric cardiology patient care unit and a pediatric cardiology surgical services unit.

3. Publish the survey results for each facility, in the aggregate, by composite measure as defined in the survey and the units or work areas within the facility.

(k) ~~(j)~~ Conduct and make available the results of special health surveys, including facility patient safety culture surveys, health care research, and health care evaluations conducted or supported under this section. Each year the center shall select and analyze one or more research topics that can be investigated using the data available pursuant to paragraph (c). The selected topics must focus on producing actionable information for improving quality of care and reducing costs. The first topic selected by the center must address preventable hospitalizations.

Section 4. Paragraph (a) of subsection (1) of section 408.061, Florida Statutes, is amended to read:

408.061 Data collection; uniform systems of financial reporting; information relating to physician charges; confidential information; immunity.—

(1) The agency shall require the submission by health care facilities, health care providers, and health insurers of data necessary to carry out the agency's duties and to facilitate transparency in health care pricing data and quality measures. Specifications for data to be collected under this section shall be developed by the agency and applicable contract vendors, with the assistance of technical advisory panels including representatives of affected entities, consumers, purchasers, and such other interested parties as may be determined by the agency.

(a) Data submitted by health care facilities, including the facilities as defined in chapter 395, shall include, but are not limited to: case-mix data, patient admission and discharge data, hospital emergency department data which shall include the number of patients treated in the emergency department of a licensed hospital reported by patient acuity level, data on hospital-acquired infections as specified by rule, data on complications as specified by rule, data on readmissions as specified by rule, with patient and provider-specific identifiers included, actual charge data by diagnostic groups or other bundled groupings as specified by rule, facility patient safety culture surveys, financial data, accounting data, operating expenses, expenses incurred for rendering services to patients who cannot or do not pay, interest charges, depreciation expenses based on the expected useful life of the

property and equipment involved, and demographic data. The agency shall adopt nationally recognized risk adjustment methodologies or software consistent with the standards of the Agency for Healthcare Research and Quality and as selected by the agency for all data submitted as required by this section. Data may be obtained from documents such as, but not limited to: leases, contracts, debt instruments, itemized patient statements or bills, medical record abstracts, and related diagnostic information. Reported data elements shall be reported electronically in accordance with rule 59E-7.012, Florida Administrative Code. Data submitted shall be certified by the chief executive officer or an appropriate and duly authorized representative or employee of the licensed facility that the information submitted is true and accurate.

Section 5. For the 2020-2021 fiscal year, one full-time equivalent position with associated salary rate of 46,560 is authorized, and the sums of $74,173 in recurring funds and $87,474 in nonrecurring funds from the Health Care Trust Fund are appropriated to the Agency for Health Care Administration, for the purpose of implementing the requirements of this act.

Section 6. 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 Grant, M. offered the following:

Amendment

Remove line 27 and insert:

conduct a patient safety culture survey using the applicable

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 lines 74-85 and insert:

2. Designate the use of updated versions of the applicable surveys as they occur, and customize the surveys to:

a. Generate data regarding the likelihood of a respondent to seek care for the respondent and the respondent's family at the surveying facility both in general and, for hospitals, within the respondent's specific unit or work area; and

b. Revise the units or work areas identified in the hospital survey to include a pediatric cardiology patient care unit and a pediatric cardiology surgical services unit.

3. Publish the survey results for each facility, in the aggregate, by composite measure as defined in the survey, and by the applicable units or work areas within the facility.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 835 Alzheimer's Disease and Dementia-Related Disorders
SPONSOR(S): Children, Families & Seniors Subcommittee, Willhite and others
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	Morris	Brazzell
2) Health & Human Services Committee		Morris	Calamas

SUMMARY ANALYSIS

In Florida, an estimated 560,000 individuals have Alzheimer's disease. The Alzheimer's Disease Advisory Committee (Committee) advises the Department of Elder Affairs (DOEA) on matters regarding individuals with Alzheimer's disease and their caretakers. The Committee is required to submit an annual report to the Governor, the Legislature, and the Secretary of DOEA including recommendations on Alzheimer's disease policy, state funded Alzheimer's disease efforts, and proposed updates to the Alzheimer's disease state plan initially created by the 2012 Purple Ribbon Task Force. DOEA is required to review and update the Alzheimer's disease state plan using the report submitted by the Committee and submit it to the Governor and Legislature every three years.

CS/HB 835 directs all state agencies to provide assistance to the Committee, upon request. It updates the name of Orlando's AdventHealth Memory Disorder Clinic (MDC) in statute, ensuring this MDC receives its designated state funding. The bill creates the position of Dementia Director within DOEA, to be appointed by the Secretary of DOEA. This position will collaborate with other state and local entities to facilitate programs supporting those living with Alzheimer's disease and other related forms of dementia and their caregivers.

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

Alzheimer's Disease

Alzheimer's disease is a form of dementia, a general term for memory loss. It is a progressive brain disorder that damages and eventually destroys brain cells, leading to memory loss and changes in the functions of the brain.[1] Alzheimer's disease accounts for 60 to 80 percent of dementia cases.[2] Alzheimer's disease is a progressive disease in which dementia symptoms worsen gradually over time. In the early stages of Alzheimer's disease, memory loss is mild, but in late-stage Alzheimer's, individuals lose the ability to carry on a conversation and respond to their environment.[3] Currently, there is no cure for Alzheimer's disease, but treatments that can temporarily slow the worsening of symptoms do exist.[4]

There are an estimated 5.8 million people in the United States with Alzheimer's disease, including 5.6 million people aged 65 and older and 200,000 individuals under age 65 who have younger-onset Alzheimer's disease.[5] By 2050, the number of people aged 65 and older with Alzheimer's disease in the U.S. is expected to nearly triple to a projected 13.8 million people.[6]

Florida has an increasing number of individuals with Alzheimer's disease. An estimated 560,000 Floridians have Alzheimer's disease.[7] The projected number of Floridians with Alzheimer's disease is estimated to increase by 28.6% to 720,000 individuals by 2025.[8]

Alzheimer's Disease Initiative

Section 430.503, F.S., creates the Alzheimer's Disease Initiative within the Department of Elder Affairs (DOEA).[9] The Alzheimer's Disease Initiative is a program operating statewide that provides services to individuals and families affected by Alzheimer's disease.[10] The initiative includes the following four programs administered by DOEA:[11]

- Respite care and other support services for caregivers,
- Memory Disorder Clinics,
- Specialized Alzheimer's Adult Day Care Centers, which provide specialized services for clients with Alzheimer's disease, and

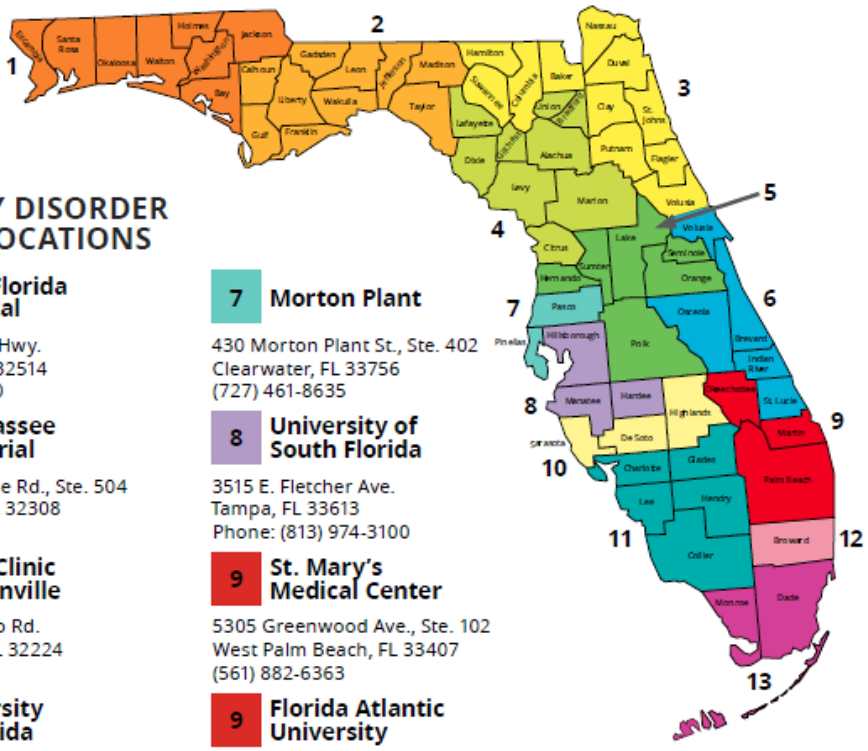
[1] Alzheimer's Association, *What is Alzheimer's?*, http://www.alz.org/alzheimers_disease_what_is_alzheimers.asp (last visited Feb. 13, 2020).
[2] Id.
[3] Id.
[4] Id.
[5] Alzheimer's Association, *2019 Alzheimer's Disease Facts and Figures*, https://www.alz.org/media/Documents/alzheimers-facts-and-figures-2019-r.pdf (last visited Feb. 13, 2020).
[6] Id.
[7] Alzheimer's Association, *Alzheimer's Statistics: Florida*, https://alz.org/getmedia/4d0840b6-0baa-4b97-8a0e-1775cfbf44a4/statesheet_florida (last visited Feb. 13, 2020).
[8] Id.
[9] S. 430.503(1), F.S.
[10] Florida Department of Elder Affairs, Agency Analysis of 2020 House Bill 835, p. 2 (Dec. 17, 2019).
[11] Florida Department of Elder Affairs, *Alzheimer's Disease Initiative,* http://elderaffairs.state.fl.us/english/alz.php (last visited Feb. 13, 2020).

- The Florida Alzheimer's Brain Bank, which is a service-and research-oriented network of statewide regional sites. The intent of the Brain Bank program is to collect and study the brains of deceased patients who had been clinically diagnosed with dementia.[12]

Memory Disorder Clinics

Section 430.502(1), F.S., designates 17 memory disorder clinics (MDCs)[13] that provide comprehensive assessments, diagnostic services, and treatment to individuals who exhibit symptoms of Alzheimer's disease and related memory disorders. The MDCs operate in 13 distinct service areas.[14]

MDC Service Areas and Locations[15]



MEMORY DISORDER CLINIC LOCATIONS

1 West Florida Hospital
8383 N. Davis Hwy.
Pensacola, FL 32514
(850) 494-6490

2 Tallahassee Memorial
1401 Centerville Rd., Ste. 504
Tallahassee, FL 32308
(850) 431-5001

3 Mayo Clinic Jacksonville
4500 San Pablo Rd.
Jacksonville, FL 32224
(904) 953-7103

4 University of Florida
1149 Newell Dr.
Gainesville, FL 32611
(352) 273-5550

5 Orlando Health Center for Aging
21 W. Columbia St.
Orlando, FL 32806
(321) 841-9700

5 Florida Hospital Orlando
601 E. Rollins St.
Orlando, FL 32803
(407) 303-3408

6 East Central Florida
3661 S. Babcock St.
Melbourne, FL 32901
(321) 434-7612

7 Morton Plant
430 Morton Plant St., Ste. 402
Clearwater, FL 33756
(727) 461-8635

8 University of South Florida
3515 E. Fletcher Ave.
Tampa, FL 33613
Phone: (813) 974-3100

9 St. Mary's Medical Center
5305 Greenwood Ave., Ste. 102
West Palm Beach, FL 33407
(561) 882-6363

9 Florida Atlantic University
777 Glades Rd., Bldg. AZ-79
Boca Raton, FL 33431
(561) 297-0502

10 Sarasota Memorial
1515 S. Osprey Ave., Ste. A-1
Sarasota, FL 34239
(941) 917-7197

11 Lee Memorial
12600 Creekside Ln., Ste. 7
Fort Myers, FL 33919
(239) 343-9220

12 Broward Health North
201 E. Sample Rd.
Deerfield Beach, FL 33064
(954) 786-7392

13 Mt. Sinai Medical Center
4300 Alton Rd.
Miami Beach, FL 33140
(305) 674-2543 ext. 54461

13 University of Miami
1695 N.W. 9th Ave., Ste. 3202
Miami, FL 33136
(305) 355-9065

[12] Florida Department of Elder Affairs, *The Florida Brain Bank*, http://elderaffairs.state.fl.us/doea/BrainBank/index.php (last visited Feb. 13, 2020).
[13] S. 430.502(1), F.S.
[14] Florida Department of Elder Affairs, *Summary of Programs and Services 2019*, *available at* http://elderaffairs.state.fl.us/doea/pubs/pubs/sops2019/2019_SOPS_A.pdf (last visited Feb. 13, 2020).
[15] Id.

MDCs also develop training programs and materials and conduct training for caregivers, respite service providers, and health care professionals in the care of persons with Alzheimer's disease and related memory disorders.[16] In addition, MDCs conduct service-related research projects through model day care programs and respite care programs.[17] MDCs are established at medical schools, teaching hospitals, and public and private not-for-profit hospitals throughout the state in accordance with s. 430.502, F.S. MDCs served 9,753 clients in 2017-2018.[18]

MDCs receive performance-based funding from the General Revenue Fund.[19] Generally, the Legislature appropriates funding for the Alzheimer's Disease Initiative program and DOEA determines the distribution amounts for the MDCs without legislative direction. For example, the 2019-2020 General Appropriations Act (GAA) provided $26,440,641 from the General Revenue Fund to the Alzheimer's Disease Initiative, but did not direct specific amounts to individual MDCs.[20] The 2018-2019 GAA also provided $26,916,231 from the General Revenue Fund to the Alzheimer's Disease Initiative without specific reference to the individual MDCs.[21]

At times, the Legislature has designated a specific appropriation for a new MDC, which amount is included (but not specifically identified) in the base total in the future years. For example, the 2018-2019 General Appropriations Act provided a specific line item for the new MDC at the Florida Hospital in Orange County.[22] Florida Hospital in Orange County recently changed its name to AdventHealth, causing the reference to the name of their MDC in statute to be out of date.[23]

To receive base level funding, MDCs must meet minimum performance measures established by DOEA. Fifteen of the MDCs receive $222,801 in annual base level funding.[24] One MDC, Mt. Sinai, receives $294,469 in annual base level funding.[25] Incentive funding, subject to legislative approval, is available for MDCs that meet additional performance measures established by DOEA.[26] DOEA establishes performance measures in its annual contracts with the MDCs.[27] In Fiscal Year 2018-2019, 14 MDCs received incentive funding from the $50,000 available.[28]

Purple Ribbon Task Force

Chapter 2012-172, Laws of Florida, created the Purple Ribbon Task Force. The task force was composed of 18 members with 6 members appointed by the Governor, 6 members appointed by the Speaker of the House of Representatives, and 6 members appointed by the President of the Senate.[29]

The law required the task force to conduct an interim study regarding Alzheimer's disease in the state.[30] This study required the task force to:[31]

- Assess the current and future impact of Alzheimer's disease on the state;
- Examine existing industries, services, and resources that address the needs of persons with Alzheimer's disease;

[16] *Supra,* note 11.
[17] Id.
[18] *Supra* note 14.
[19] S. 430.502(3) and (4), F.S.; Florida Department of Elder Affairs, Agency Analysis of 2020 House Bill 835 (Dec. 17, 2020).
[20] Conference Committee Report for enrolled Senate Bill 2500, 2019-2020 General Appropriations Act, Specific Appropriation 395.
[21] Conference Committee Report for enrolled House Bill 5001, 2018-2019 General Appropriations Act, Specific Appropriation 394.
[22] Conference Committee Report for enrolled House Bill 5001, 2018-2019 General Appropriations Act, Specific Appropriation 394.
[23] *Supra,* note 10 at 3.
[24] Email from Scott Read, Director of Legislative Affairs, Department of Elder Affairs, RE: Funding amounts for memory disorder clinics (Feb. 18, 2019).
[25] Id.
[26] Id.
[27] S. 430.502(3) and (4), F.S; Id.
[28] Email from Scott Read, Director of Legislative Affairs, Department of Elder Affairs, RE: HB 835 (Jan. 30, 2020).
[29] Ch. 2012-172, Laws of Fla.
[30] Id.
[31] Id.

- Develop a strategy to mobilize a state response to Alzheimer's disease; and
- Gather information on state trends and policy regarding Alzheimer's disease.

Additionally, the law required the task force to submit a report in the form of an Alzheimer's disease state plan.[32] The 2013 completed report by the task force is the *State Plan on Alzheimer's Disease and Related Forms of Dementia.*[33] The state report included the task force's findings and recommendations. Upon submission of this report, pursuant to law, the Purple Ribbon Task Force terminated.

Alzheimer's Disease Advisory Committee

Section 430.501, F.S., establishes the Alzheimer's Disease Advisory Committee (Committee) to advise DOEA on legislative, programmatic, and administrative matters regarding individuals with Alzheimer's disease and their caretakers. The committee is established within DOEA and composed of 11 members appointed by the Governor, 2 members appointed by the Senate President (one of which must be a sitting Senator), and 2 members appointed by the Speaker of the House of Representatives (one of which must be a sitting Representative).[34] The Governor's appointments must reflect the following representation:[35]

- At least four members must be persons licensed pursuant to ch.458 or 459, F.S., or hold a Ph.D. degree and be currently involved in research on Alzheimer's disease;
- At least four persons who have been caregivers of victims of Alzheimer's disease; and
- Whenever possible, a gerontologist, a geriatric psychiatrist, a geriatrician, a neurologist, a social worker, and a registered nurse.

Committee members are appointed to four-year staggered terms. The chair is elected by the Committee and serves a one-year term. The Committee may establish subcommittees as necessary to carry out the functions of the Committee. Currently, the Committee has four standing subcommittees regarding clinical services, home and community based care, education and research, and legislative advocacy.[36]

The Committee is required to submit an annual report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Secretary of Elder Affairs by September 1 of each year. The report must include recommendations on Alzheimer's disease policy, all state-funded Alzheimer's disease efforts, and proposed updates to the Alzheimer's disease state plan.

Duties of DOEA

In 2019, the Governor approved ch. 2019-147, Laws of Florida, requiring DOEA to review and update the Alzheimer's disease state plan, which must address the issues contained within the state plan initially created by the 2012 Purple Ribbon Task Force report. For example, the state plan must include an assessment on the current and future impact of Alzheimer's disease, an examination of existing resources available to persons living with Alzheimer's disease, and other information regarding Alzheimer's disease trends and policies in the state.

DOEA must use the report submitted by the Committee and collaborate with other organizations and professionals when updating the state plan. DOEA must submit the updated state plan every three years, beginning November 1, 2020, to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

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[32] Id.
[33] Florida Department of Elder Affairs, *Purple Ribbon Task Force State Plan on Alzheimer's Disease and Related Forms of Dementia*, *available at* https://www.alz.org/media/Documents/florida-state-plan-august-2013.pdf (last visited Feb. 13, 2020).
[34] S. 430.501, F.S.
[35] Id.
[36] Alzheimer's Disease Advisory Committee, *2009-2016 Summary of Accomplishments*, *available at* http://elderaffairs.state.fl.us/doea/alz/ADI_Accomplishments.pdf (last visited Feb. 13, 2020).

Effect of Proposed Changes

The bill directs all state agencies to provide assistance to the Alzheimer's Disease Advisory Committee, upon request in order to facilitate the Committee's duties.

The bill creates the position of Dementia Director (Director) within DOEA. The Director will be appointed by the Secretary of DOEA and have the following assigned duties and is required to facilitate coordination and support of policies and programs in the Legislature and the executive branch, including state agencies, relating to ADRD. Additionally, the Director must assist the Committee with updating and implementing the Alzheimer's disease state plan. He or she must support MDCs in meeting the performance goals for incentive funding developed by DOEA. The director is required to coordinate outreach programs and services between MDCs, Area Agencies on Aging (AAAs), and other interested groups to increase public awareness and education regarding ADRD. The Director must coordinate services and activities between groups interested in research relating ADRD, including AAAs, service providers, advocacy groups, legal services organizations, emergency personnel, law enforcement, the Florida College System, and state universities. The Director also must collect and monitor data related to the impact of Alzheimer's disease in Florida.

The Director is allowed to ask other state agencies for assistance in order to carry out his or her duties.

The bill updates the name of the MDC at Florida Hospital in Orange County to AdventHealth in Orange County to reflect the facility's recent name change and ensure this MDC continues to receive state funding associated with being a statutorily designated MDC.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 430.501, F.S., relating to Alzheimer's Disease Advisory Committee.
Section 2: Creates s. 430.5015, F.S., relating to Dementia Director.
Section 3: Amends s. 430.502, F.S., relating to Alzheimer's disease; memory disorder clinics and day care and respite care programs.
Section 4: 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. DOEA's current initiatives and statutorily-mandated responsibilities generally require the performance of the tasks assigned by the bill to a Dementia Director. The department may need to reassign tasks to place the responsibilities outlined by the bill under one individual.

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 provides sufficient rulemaking authority for DOEA to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to Alzheimer's disease; amending s. 430.501, F.S.; requiring state agencies to provide assistance to the Alzheimer's Disease Advisory Committee, upon request; creating s. 430.5015, F.S.; creating the position of Dementia Director within the Department of Elderly Affairs; requiring the Secretary of Elderly Affairs to appoint the director; authorizing the director to call upon certain agencies for assistance; providing duties and responsibilities of the director; amending s. 430.502, F.S.; revising the name of a memory disorder clinic in Orange County; providing an effective date.

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

Section 1. Paragraph (b) of subsection (3) of section 430.501, Florida Statutes, is amended to read:

430.501 Alzheimer's Disease Advisory Committee; research grants.—

(3)

(b)1. The Governor shall appoint members from a broad cross-section of public, private, and volunteer sectors. All nominations shall be forwarded to the Governor by the Secretary of Elderly Affairs in accordance with this subsection.

2. Members shall be appointed to 4-year staggered terms in accordance with s. 20.052, except for the sitting members of the Senate and House of Representatives, who shall be appointed to a term corresponding to their term of office.

3. The Secretary of Elderly Affairs shall serve as an ex officio member of the committee.

4. The committee shall elect one of its members to serve as chair for a term of 1 year.

5. The committee may establish subcommittees as necessary to carry out the functions of the committee.

6. The committee shall meet quarterly, or as frequently as needed.

7. The committee shall submit an annual report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Secretary of Elderly Affairs on or before September 1 of each year. The annual report shall include information and recommendations on Alzheimer's disease policy; all state-funded efforts in Alzheimer's disease research, clinical care, institutional, home-based and community-based programs and the outcomes of such efforts; and any proposed updates to the Alzheimer's disease state plan submitted under subparagraph 8.

8. Beginning in 2020, and every third year thereafter, on or before November 1, the Department of Elderly Affairs shall review the Alzheimer's disease state plan and submit an updated

state plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The Department of Elderly Affairs shall utilize the annual reports submitted by the committee and collaborate with state Alzheimer's disease organizations and professionals when considering such updates to the Alzheimer's disease state plan. The state plan shall:

a. Assess the current and future impact of Alzheimer's disease and related forms of dementia on the state.

b. Examine the existing industries, services, and resources addressing the needs of persons having Alzheimer's disease or a related form of dementia and their family caregivers.

c. Examine the needs of persons of all cultural backgrounds having Alzheimer's disease or a related form of dementia and how their lives are affected by the disease from younger-onset, through mid-stage, to late-stage.

d. Develop a strategy to mobilize a state response to this public health crisis.

e. Provide information regarding:

(I) State trends with respect to persons having Alzheimer's disease or a related form of dementia and their needs, including, but not limited to:

(A) The role of the state in providing community-based care, long-term care, and family caregiver support, including respite, education, and assistance to persons who are in the

early stages of Alzheimer's disease, who have younger-onset Alzheimer's disease, or who have a related form of dementia.

(B) The development of state policy with respect to persons having Alzheimer's disease or a related form of dementia.

(C) Surveillance of persons having Alzheimer's disease or a related form of dementia for the purpose of accurately estimating the number of such persons in the state at present and projected population levels.

(II) Existing services, resources, and capacity, including, but not limited to:

(A) The type, cost, and availability of dementia-specific services throughout the state.

(B) Policy requirements and effectiveness for dementia-specific training for professionals providing care.

(C) Quality care measures employed by providers of care, including providers of respite, adult day care, assisted living facility, skilled nursing facility, and hospice services.

(D) The capability of public safety workers and law enforcement officers to respond to persons having Alzheimer's disease or a related form of dementia, including, but not limited to, responding to their disappearance, search and rescue, abuse, elopement, exploitation, or suicide.

(E) The availability of home and community-based services and respite care for persons having Alzheimer's disease or a

related form of dementia and education and support services to assist their families and caregivers.

(F) An inventory of long-term care facilities and community-based services serving persons having Alzheimer's disease or a related form of dementia.

(G) The adequacy and appropriateness of geriatric-psychiatric units for persons having behavior disorders associated with Alzheimer's disease or a related form of dementia.

(H) Residential assisted living options for persons having Alzheimer's disease or a related form of dementia.

(I) The level of preparedness of service providers before, during, and after a catastrophic emergency involving a person having Alzheimer's disease or a related form of dementia and their caregivers and families.

(III) Needed state policies or responses, including, but not limited to, directions for the provision of clear and coordinated care, services, and support to persons having Alzheimer's disease or a related form of dementia and their caregivers and families and strategies to address any identified gaps in the provision of services.

9. All state agencies shall provide assistance to the committee, upon request.

10. The Department of Elderly Affairs shall provide staff support to assist the committee in the performance of its

duties.

11.~~10.~~ Members of the committee and subcommittees shall receive no salary, but are entitled to reimbursement for travel and per diem expenses, as provided in s. 112.061, while performing their duties under this section.

Section 2. Section 430.5015, Florida Statutes, is created to read:

430.5015 Dementia Director.—

(1) The position of Dementia Director is created within the Department of Elderly Affairs. The Secretary of Elderly Affairs shall appoint the director who shall serve at the pleasure of the secretary.

(2) The director may call upon appropriate agencies of state government for assistance as is needed pursuant to s. 430.04(13).

(3) The director shall:

(a) Facilitate coordination and support of policies and programs in the Legislature and the executive branch, including agencies of the executive branch, which relate to Alzheimer's disease and related forms of dementia.

(b) Facilitate coordination and support for the Alzheimer's Disease Advisory Committee and the implementation of and updates to the Alzheimer's disease state plan pursuant to s. 430.501(3)(b)8.

(c) Provide support to memory disorder clinics to help the

clinics meet or exceed the minimum performance standards under s. 430.502(3).

(d) Facilitate and support coordination of outreach programs and services between agencies, memory disorder clinics, area agencies on aging, and other interested groups for the purpose of fostering public awareness and education regarding Alzheimer's disease and related forms of dementia.

(e) Facilitate coordination of services and activities between groups interested in dementia research, programs, and services, including, but not limited to, area agencies on aging, service providers, advocacy groups, legal services, emergency personnel, law enforcement, and state colleges and universities.

(f) Collect and monitor data related to the impact of Alzheimer's disease in the state.

Section 3. Subsection (1) of section 430.502, Florida Statutes, is amended to read:

430.502 Alzheimer's disease; memory disorder clinics and day care and respite care programs.—

(1) There is established:

(a) A memory disorder clinic at each of the three medical schools in this state;

(b) A memory disorder clinic at a major private nonprofit research-oriented teaching hospital, and may fund a memory disorder clinic at any of the other affiliated teaching hospitals;

(c) A memory disorder clinic at the Mayo Clinic in Jacksonville;

(d) A memory disorder clinic at the West Florida Regional Medical Center;

(e) A memory disorder clinic operated by Health First in Brevard County;

(f) A memory disorder clinic at the Orlando Regional Healthcare System, Inc.;

(g) A memory disorder center located in a public hospital that is operated by an independent special hospital taxing district that governs multiple hospitals and is located in a county with a population greater than 800,000 persons;

(h) A memory disorder clinic at St. Mary's Medical Center in Palm Beach County;

(i) A memory disorder clinic at Tallahassee Memorial Healthcare;

(j) A memory disorder clinic at Lee Memorial Hospital created by chapter 63-1552, Laws of Florida, as amended;

(k) A memory disorder clinic at Sarasota Memorial Hospital in Sarasota County;

(l) A memory disorder clinic at Morton Plant Hospital, Clearwater, in Pinellas County;

(m) A memory disorder clinic at Florida Atlantic University, Boca Raton, in Palm Beach County;

(n) A memory disorder clinic at AdventHealth ~~Florida~~

~~Hospital~~ in Orange County; and

(o) A memory disorder clinic at Miami Jewish Health System in Miami-Dade County,

for the purpose of conducting research and training in a diagnostic and therapeutic setting for persons suffering from Alzheimer's disease and related memory disorders. However, memory disorder clinics shall not receive decreased funding due solely to subsequent additions of memory disorder clinics in this subsection.

Section 4. This act shall take effect July 1, 2020.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 919 Property Tax Exemptions Used by Hospitals
SPONSOR(S): Ways & Means Committee, Caruso
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	12 Y, 1 N	Calamas	Calamas
2) Ways & Means Committee	17 Y, 0 N, As CS	Curry	Langston
3) Health & Human Services Committee		Calamas	Calamas

SUMMARY ANALYSIS

Current law permits an ad valorem tax exemption for certain property used predominately for non-profit educational, literary, scientific, religious or charitable purposes, subject to criteria established by statute.

Generally, applicants for a religious, literary, scientific, or charitable exemption must be nonprofit entities. Hospitals, nursing homes, and homes for special services must also be a Florida non-profit corporation that is an exempt organization under the provisions of s. 501(c)(3) of the Internal Revenue Code.

The bill creates an additional requirement for hospitals to meet in order to qualify for a charitable tax exemption. The bill requires hospitals to document the value of charitable services they provide, and limits the charity tax exemption to the value of that charity care.

The bill has no fiscal impact on state government. The Revenue Estimating Conference has estimated that the bill would have a positive, indeterminate revenue impact on local governments.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Florida Charitable Property Tax Exemption

The Florida Constitution requires that all property be assessed at just value for ad valorem tax purposes,[1] and provides for specified assessment limitations, property classifications and exemptions.[2] After the local property appraiser considers any assessment limitation or use classification affecting the just value of a property, an assessed value is produced. The assessed value is then reduced by any exemptions to produce the taxable value.[3] Such exemptions include, but are not limited to, exemptions for such portions of property used predominately for educational, literary, scientific, religious or charitable purposes.[4]

The Legislature implemented these constitutional exemptions and set forth the criteria to determine whether property is entitled to an exemption for use as a charitable, religious, scientific, or literary purpose.[5] Specific provisions apply to property for hospitals, nursing homes, and homes for special services;[6] that for religious purposes,[7] educational institutions[8] and charter schools;[9] labor organization property;[10] nonprofit community centers;[11] biblical history displays;[12] and affordable housing.[13]

In determining whether the use of a property qualifies the property for an ad valorem tax exemption, the property appraiser must consider the nature and extent of the qualifying activity compared to other activities performed by the organization owning the property, and the availability of the property for use by other qualifying entities.[14] Only the portions of the property used predominantly for qualified purposes may be exempt from ad valorem taxation. If the property owned by an exempt organization is used exclusively for exempt purposes, it shall be totally exempt from ad valorem taxation.

Charitable Organizations

Under federal law, an organization may only be tax-exempt if it is organized and operated for exempt purposes, including charitable and religious purposes.[15] None of the organization's earnings may benefit any private shareholder or individual, and the organization may not attempt to influence legislation as a substantial part of its activities. Charitable purposes include relief of the poor, the distressed or the underprivileged, the advancement of religion, and lessening government burdens. Florida law defines a charitable purpose as a function or service which is of such a community service that its discontinuance could legally result in the allocation of public funds for the continuance of the function or the service.[16]

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[1] Fla. Const., art. VII, s. 4.
[2] Fla. Const., art. VII, ss. 3, 4, and 6.
[3] s. 196.031, F.S.
[4] Fla. Const., art. VII, s. 3.
[5] ss. 196.195 and 196.196, F.S.
[6] s. 196.197, F.S.
[7] ss. 196.1975(3) and 196.196(3), F.S.
[8] s. 196.198, F.S.
[9] s. 196.1983, F.S.
[10] s. 196.1985, F.S.
[11] s. 196.1986, F.S.
[12] s. 196.1987, F.S.
[13] s. 196.196(5), F.S.
[14] s. 196.196(1)(a)-(b), F.S.
[15] 26 U.S.C. § 501(c)(3).
[16] s. 196.012(7), F.S.

Determining Profit vs. Non-Profit Status of an Entity

Current law outlines the criteria a local property appraiser must consider in determining whether an applicant for a religious, literary, scientific, or charitable exemption is a nonprofit or profit-making venture for the purposes of receiving an exemption.[17] An applicant must provide the property appraiser with "such fiscal and other records showing in reasonable detail the financial condition, record of operations, and exempt and nonexempt uses of the property . . . for the immediately preceding fiscal year."[18]

The applicant must show that "no part of the subject property, or the proceeds of the sale, lease, or other disposition thereof, will inure to the benefit of its members, directors, or officers or any person or firm operating for profit or for a nonexempt purpose."[19]

Based on the information provided by the applicant, the property appraiser must determine whether the applicant is a nonprofit or profit-making venture or if the property is used for a profit-making purpose.[20] In doing so, the property appraiser must consider the reasonableness of various payments, loan guarantees, contractual arrangements, management functions, capital expenditures, procurements, charges for services rendered, and other financial dealings.

A religious, literary, scientific, or charitable exemption may not be granted until the property appraiser, or value adjustment board on appeal, determines the applicant to be nonprofit.[21]

Additional Criteria for Hospitals, Nursing Homes, and Homes for Special Services

In addition to the above criteria, hospitals[22], nursing homes[23] and homes for special services[24] must be Florida non-profit corporations that are exempt organizations under the provisions of s. 501(c)(3) of the Internal Revenue Code.[25]

In determining the extent of the exemption to be granted to hospitals, nursing homes, and homes for special services, portions of the property leased as parking lots or garages operated by private enterprise are not exempt from taxation.[26] Property or facilities which are leased to a nonprofit corporation which provides direct medical services to patients in a nonprofit or public hospital and qualify under s. 196.196, F.S., are exempt from taxation.[27]

In FY 2019-20, the exemption for non-profit hospitals resulted in an estimated $57 million in tax savings to the affected entities.[28]

Federal Charity Care Reporting Requirements

To qualify for federal tax exemption, hospitals must report their community benefit activities to the Internal Revenue Service by filing IRS Form 990 and a supplemental Schedule H form. Community

[17] s. 196.195, F.S.,
[18] s. 196.195(1), F.S.
[19] s. 196.195(3), F.S.
[20] s. 196.195(2)(a)-(e), F.S.
[21] s. 196.195(4), F.S.
[22] s. 196.012(8), F.S., "Hospital" means an institution which possesses a valid license granted under chapter 395 on January 1 of the year for which exemption from ad valorem taxation is requested
[23] s. 196.012(8), F.S., "Nursing home" or "home for special services" means an institution that possesses a valid license under chapter 400 or part I of chapter 429 on January 1 of the year for which exemption from ad valorem taxation is requested.
[24] Id; s. 400.801, F.S. "Home for special services" means a site licensed by AHCA prior to January 1, 2006, where specialized health care services are provided, including personal and custodial care, but not continuous nursing services.
[25] s. 196.197, F.S.
[26] Id.
[27] Id.
[28] Estimates provided Department of Revenue staff as background information for the Revenue Estimating Conference, February 7, 2020.

benefit activities include the net, unreimbursed costs of charity care (providing free or discounted services to patients who qualify under the hospital's financial assistance policy); participation in means-tested government programs, such as Medicaid; health professions education; health services research; subsidized health services; community health improvement activities; and cash or in-kind contributions to other community groups.[29] Net community benefit activities do not include revenue from uncompensated care pools or programs, such as Low Income Pool (LIP) or Disproportionate Share Hospital (DSH) funds.[30]

LIP and DSH Funding

The LIP program[31] provides government funding to safety net providers, including hospitals, for the costs of uncompensated charity care for low-income individuals who are uninsured. Uncompensated care (UC) includes charity care for the uninsured but does not include UC for insured individuals, bad debt, or Medicaid and the Children's Health Insurance Program (CHIP) shortfall. The low-income pool consists of a capped annual allotment of $1 billion total computable for each year of the 5 year demonstration period.[32] Local governments, such as counties, hospital taxing districts and other state agencies provide funding for the non-federal share of the $1 billion LIP distributions.[33] In Fiscal Year 2019-2020, non-profit Florida hospitals received $291,401,277 in LIP funding.

Hospitals that serve a significantly disproportionate number of low-income patients may receive DSH payments from the Centers for Medicare and Medicaid Services (CMS)[34] to cover the costs of providing care to uninsured patients.[35] Under federal law, state Medicaid programs are required to make DSH payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals.[36] Each year, the Florida Legislature delineates how the DSH funds will be distributed to each eligible facility through either statutory formulas or other direction in the implementing bill or proviso. For Fiscal Year 2019-2020, non-profit Florida hospitals received $72,891,031 in DSH funds.

Charitable Property Tax Exemptions for Hospitals in Other States

Utah

Utah requires a non-profit hospital to provide gifts to the community that exceed its' tax liability in order to receive a property tax exemption.[37] Community gifts may include indigent care, community education and service, unreimbursed care to patients covered by Medicaid, Medicare or other government programs, volunteer hours, and monetary donations, the operation of tertiary care services or other critical services or programs not otherwise available in the community, and the operation of hospitals where revenue is insufficient to cover the costs.[38]

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[29] James, Julia. Health Affairs, *Nonprofit Hospitals' Community Benefit Requirements* (2016), available at: https://www.healthaffairs.org/do/10.1377/hpb20160225.954803/full/ (last viewed January 13, 2020); Department of the Treasury, Internal Revenue Service, *Instructions for Schedule H (Form 990)* (2018), on file with Health Market Reform Subcommittee Staff.
[30] Department of the Treasury, Internal Revenue Service, *Instructions for Schedule H (Form 990)* (2018), on file with Health Market Reform Subcommittee Staff.
[31] *Managed Medical Assistance Section 1115 Demonstration Waiver Authorities*, (June 8, 2018), p. 29, *available at* https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/mma/Special_Terms_and_Conditions_CMS_Approved_June_8_2018.pdf (last viewed January 13, 2020).
[32] Florida Agency for Health Care Administration, *Low Income Pool Background*, available at: https://ahca.myflorida.com/Medicaid/Finance/finance/LIP-DSH/LIP/background.shtml (last viewed January 13, 2020)
[33] Id.
[34] CMS is a federal agency within the U.S. Department of Health and Human Services that administers healthcare coverage through the Medicare, Medicaid, CHIP, and the Health Insurance Marketplace.
[35] Health Resources and Services Administration, *Disproportionate Share Hospitals*, https://www.hrsa.gov/opa/eligibility-and-registration/hospitals/disproportionate-share-hospitals/index.html.
[36] MedicaidGov, *Medicaid Disproportionate Share Hospital (DSH) Payments*, https://www.medicaid.gov/medicaid/finance/dsh/index.html.
[37] Utah State Tax Commission, Property Tax Division, *Property Tax Exemptions, Standards of Practice 2, Nonprofit Hospital and Nursing Home Charitable Property Tax Exemption Standards, Appendix 2B* (May 2018) available at: https://propertytax.utah.gov/standards/standard02.pdf (last viewed January 13, 2020).
[38] Id.

Texas

Texas requires hospitals to provide a minimum level of charity care in order to qualify for a property tax exemption.[39] The minimum level of charity care may be calculated in one of the following ways[40]:

- Charity care and government-sponsored indigent health care must be provided at a level that is reasonable in relation to the community needs, as determined through the community needs assessment, the available resources of the hospital or hospital system, and the tax-exempt benefits received by the hospital or hospital system;
- Charity care and government-sponsored indigent health care must be provided in an amount equal to at least four percent of the hospital's or hospital system's net patient revenue;
- Charity care and government-sponsored indigent health care must be provided in an amount equal to at least 100 percent of the hospital's or hospital system's tax-exempt benefits, excluding federal income tax; or
- Charity care and community benefits must be provided in a combined amount equal to at least five percent of the hospital's or hospital system's net patient revenue, provided that charity care and government-sponsored indigent health care are provided in an amount equal to at least four percent of net patient revenue.

Illinois

Illinois requires hospitals to demonstrate that the value of charitable services it provides to address the health care needs of low-income or underserved individuals equals or exceeds the hospital's property tax liability in order to qualify for a property tax exemption.[41] The value of a hospital's charitable services is calculated by determining the value of the following services and activities provided by it[42]:

- Free or discounted services;
- Support for government health programs for low-income individuals;
- Government subsidies that pay for or subsidize activities or programs related to health care for low-income or underserved individuals;
- Unreimbursed costs for the treatment of low-income patients; and
- Relief of the burden of government related to health care of low-income individuals.

Effect of Proposed Changes

The bill requires local tax appraisers to compare the value of charity care provided by a hospital in each county to the tax value of the hospital's property exemption in each county. If the value of the charity care is less than the tax value of the all of the hospital's exempt property, then the hospital's exemption on each parcel in a county will be reduced to reflect the ratio of the hospital's charity care in the county to the tax value of all of the hospital's exempt property in the county. The language sets forth specific computations for the above.

The bill requires hospitals when applying for the exemption each year to provide their IRS form 990, schedule H, and a schedule displaying: the value of charitable services provided or performed in each Florida county in which a hospital's properties are located; and the portion of charitable services reported by the hospital on its most recently filed IRS Form 990, schedule H, attributable to the services and activities provided or performed by the hospital outside of Florida. The sum of the amounts provided in the schedule must equal the total net community benefit expense reported by the hospital on its most recently filed IRS Form 990, schedule H.

[39] See Tex. Health and Safety Code Ann. §11.1801.
[40] Id.
[41] See 35 ILCS 200/15-86(c).
[42] Id.

The bill also requires hospitals to provide a statement signed by the hospital's CEO and an independent certified public accountant that the information submitted is true and correct.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 196.197, F.S., relating to Additional provisions for exempting property used by hospitals, nursing homes, and homes for special services.
Section 2: 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:

The Revenue Estimating Conference has estimated that the bill would have a positive, indeterminate revenue impact on local governments.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Hospitals that currently qualify for a full property tax exemption may have a tax liability if the value of their community benefit value is less than the value of taxes that would apply if their property was not otherwise exempt. Such hospitals may increase benefits provided to the community to avoid tax liability.

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:

Rule-making is unnecessary to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 11, 2020, the Ways and Means Committee adopted a strike-all amendment and reported the bill favorably as a committee substitute. The amendment clarifies that the comparison of the value of charity care to tax value of the current exemption is to be done at the county-wide level instead of at the parcel level. The amendment added and defined additional terms used in the calculation of the hospital's tax exemption and explicitly included the property taxation of tangible personal property in the calculations.

The amendment also requires hospitals to provide additional documentation with their application for exemption. Specifically, the amendment requires hospitals to include a schedule displaying the value of charitable services attributable to the hospital properties in each Florida county where the properties for which the hospital is seeking a tax exemption are located and the portion of charitable services and activities provided or performed by the hospital outside of Florida. The sum of the amounts provided in the schedule must equal the total net community benefit expense reported by the hospital on its most recently filed IRS Form 990, schedule H.

This analysis is drawn to the committee substitute as passed by the Ways and Means Committee.

A bill to be entitled

An act relating to property tax exemptions used by hospitals; amending s. 196.197, F.S.; providing criteria to be used in determining the value of tax exemptions for charitable use of certain hospitals; providing definitions; providing application requirements for tax exemptions on certain properties; providing an effective date.

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

Section 1. Subsection (3) is added to section 196.197, Florida Statutes, to read:

196.197 Additional provisions for exempting property used by hospitals, nursing homes, and homes for special services.—In addition to criteria for granting exemptions for charitable use of property set forth in other sections of this chapter, hospitals, nursing homes, and homes for special services shall be exempt to the extent that they meet the following criteria:

(3)(a) The county property appraiser shall make the calculations described in this paragraph. In determining the extent of the exemption to be granted to institutions licensed as hospitals, the unadjusted exempt value of a parcel and the unadjusted exempt value of tangible personal property shall be multiplied by a fraction, not to exceed one, the numerator of

which is the county net community benefit expense, as determined under paragraph (b), and the denominator of which is the county tax assessment. For purposes of this subsection, the term:

1. "Adopted millage rate applicable to a parcel" means the sum of all ad valorem tax rates levied by all taxing jurisdictions within which a parcel is located.

2. "Adopted millage rate applicable to tangible personal property" means the sum of all ad valorem tax rates levied by all taxing jurisdictions within which tangible personal property is located.

3. "County tax assessment" means the sum of all parcel and tangible personal property tax assessments in a county for property owned by the applicant and for which an exemption is being sought.

4. "Parcel tax assessment" means the product of the unadjusted exempt value for a parcel for the immediately prior year and the most recent final adopted millage rate applicable to the parcel.

5. "Tangible personal property tax assessment" means the product of the unadjusted exempt value for tangible personal property for the immediately prior year and the most recent final adopted millage rate applicable to the tangible personal property.

6. "Unadjusted exempt value" means the value exempted in a tax year for the charitable use of property as provided in other

sections of this chapter and as limited by subsections (1) and (2).

(b) The county net community benefit expense, to be determined by the applicant, is that portion of the net community benefit expense reported by the applicant on its most recently filed Internal Revenue Service Form 990, schedule H, attributable to those services and activities provided or performed by the hospital in a county.

(c) The application by a hospital for an exemption under this section must include, but is not limited to:

1. A copy of the hospital owner's most recently filed Internal Revenue Service Form 990, schedule H.

2. A schedule displaying:

a. The county net community benefit expense for each Florida county in which properties are located.

b. The portion of net community benefit expense reported by the applicant on its most recently filed Internal Revenue Service Form 990, schedule H, attributable to those services and activities provided or performed by the hospital outside of the state.

c. The sum of amounts provided under sub-subparagraphs a. and b., which must equal the total net community benefit expense reported by the applicant on its most recently filed Internal Revenue Service Form 990, schedule H.

3. A statement signed by the hospital's chief executive

officer and independent certified public accountant that, upon his or her reasonable knowledge and belief, the statement of the county net community benefit expense is true and correct.

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 941 Treatment-based Drug Court Programs
SPONSOR(S): Children, Families & Seniors Subcommittee, Buchanan
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	Morris	Brazzell
2) Justice Appropriations Subcommittee	12 Y, 0 N	Smith	Gusky
3) Health & Human Services Committee		Morris	Calamas

SUMMARY ANALYSIS

Treatment-based drug courts are a type of problem-solving court aimed at providing an alternative to criminal imprisonment for offenders impaired by substance abuse. Generally, drug court programs identify individuals in either the criminal justice or dependency system who may benefit from substance abuse treatment. Those individuals may voluntarily enter into pretrial treatment programs or may be sentenced to post-adjudicatory treatment-based programs as a condition of probation or community control.

Electronic applications can be used to track attendance at work, school, and other functions. There are several available on the market, either for free or for a fee, for these purposes.

The bill allows a treatment-based drug court, if ordering a defendant to enter into a pretrial or postadjudicatory program, to offer the defendant the option of either electronic or written verification of participation in court-ordered ancillary services, including self-help and other support groups, if the defendant must document attendance at such services.

The bill has no fiscal impact on state government. The bill has an indeterminate, insignificant, negative 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:

Background

Substance Abuse

Substance abuse affects millions of people in the United States each year. Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.[1] Substance abuse disorders occur when the chronic use of alcohol or drugs causes significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.[2] Repeated drug use leads to changes in the brain's structure and function that can make a person more susceptible to developing a substance abuse disorder.[3] Brain imaging studies of persons with substance abuse disorders show physical changes in areas of the brain that are critical to judgment, decision making, learning and memory, and behavior control.[4]

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, a diagnosis of substance abuse disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.[5] The most common substance abuse disorders in the United States are from the use of alcohol, tobacco, cannabis, stimulants, hallucinogens, and opioids.[6]

Mental illness and substance abuse commonly co-occur. Approximately 9.2 million adults have co-occurring disorders.[7] In fact, more than half of all adults with severe mental illness are further impaired by substance use disorders (abuse or dependence related to alcohol or other drugs).[8] Drug abuse can cause individuals to experience one or more symptoms of another mental illness.[9] Additionally, individuals with mental illness may abuse drugs as a form of self-medication.[10] Examples of co-occurring disorders include the combinations of major depression with cocaine addiction, alcohol addiction with panic disorder, alcoholism and drug addiction with schizophrenia, and borderline personality disorder with episodic drug abuse.[11]

Substance Abuse Treatment in Florida

In the early 1970s, the federal government enacted laws creating formula grants for states to develop continuums of care for individuals and families affected by substance abuse. [12] The laws resulted in separate funding streams and requirements for alcoholism and drug abuse; in response to the laws, the Florida Legislature enacted Chapters 396, F.S., (alcohol) and 397, F.S. (drug abuse).[13] Each of these laws governed different aspects of addiction, and thus had different rules promulgated by the state to fully implement the respective pieces of legislation.[14] However, because persons with substance abuse

[1] World Health Organization, *Substance Abuse*, http://www.who.int/topics/substance_abuse/en/ (last visited Feb. 13, 2020).
[2] Substance Abuse and Mental Health Services Administration, *Substance Use Disorders,* http://www.samhsa.gov/disorders/substance-use (last visited Jan. 21, 2020).
[3] National Institute on Drug Abuse*, Drugs, Brains, and Behavior: The Science of Addiction*, https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction (last visited Feb. 13, 2020).
[4] Id.
[5] Supra, note 2.
[6] Id.
[7] National Alliance on Mental Illness, *Dual Diagnosis*, https://www.nami.org/learn-more/mental-health-conditions/related-conditions/dual-diagnosis (last visited Feb. 13, 2020).
[8] Psychology Today, *Co-Occurring Disorders*, https://www.psychologytoday.com/conditions/co-occurring-disorders (last visited Feb. 13, 2020).
[9] *Comorbidity: Addiction and Other Mental Illnesses*, National Institute on Drug Abuse, NIH Publication Number 10-5771, September 2010. https://www.drugabuse.gov/sites/default/files/rrcomorbidity.pdf (last visited Feb. 13, 2020).
[10] Id.
[11] Id.
[12] Florida Department of Children and Families, *Baker Act and Marchman Act Project Team Report for Fiscal Year 2016-2017*, p. 4-5.
[13] Id.
[14] Id.

issues often do not restrict their misuse to one substance or another, having two separate laws dealing with the prevention and treatment of addiction was cumbersome and did not adequately address Florida's substance abuse problem.[15] In 1993 legislation was adopted to combine Chapters 396 and 397, F.S., into a single law, the Hal S. Marchman Alcohol and Other Drug Services Act (Marchman Act).[16]

The Department of Children and Families licenses substance abuse treatment providers under ch. 397, F.S. Florida law references ancillary services, including self-help and other support groups and activities, as a service category for substance abuse services. However, such services are not a specified licensable service component encompassed in clinical treatment under ch. 397.[17] Licensable service treatment components specified in statute include:

- Addictions receiving facility;
- Day or night treatment;
- Day or night treatment with community housing;
- Detoxification;
- Intensive inpatient treatment;
- Intensive outpatient treatment;
- Medication-assisted treatment for opiate addiction;
- Outpatient treatment; and
- Residential treatment.

Ancillary services may be provided by providers of clinical treatment, or clinical treatment providers may refer individuals to ancillary services.[18]

Self-Help Groups

Self-help groups are informal groups of people who come together to address common problems.[19] While self-help might imply a focus on the individual, mutual support is an important characteristic of such groups. These groups can focus on a variety of topics, including substance abuse. Twelve-step groups, such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), use a method that focuses on fellowships of people recovering from various addictions, compulsive behaviors, and mental health problems. Attending self-help groups may be part of a coordinated strategy developed by a drug court team for a drug court participant.

Self-help groups are not considered clinical treatment but are included as an ancillary service in Florida law.[20] Clinical treatment typically includes working with a health care professional, such as a physician, psychiatrist, or licensed therapist. In contrast, self-help groups do not include treatment by a health care professional.

Self-help groups are typically anonymous, meaning that attendance verification can be difficult to obtain because members want to protect anonymity. As an example, AA has processes in place to verify attendance of court-ordered attendees while maintaining anonymity. When a court-ordered attendee requires written proof that he or she has attended AA meetings, the group's secretary or officer will only sign his or her first name or initials on an attendance document furnished by the court to verify the

[15] Id.
[16] Ch. 93-39, s. 2, Laws of Fla., codified in ch. 397, F.S.
[17] S. 397.311(26)(a), F.S.
[18] 65D-30.0044(2), F.A.C.
[19] National Center for Biotechnology Information, *Self-help groups,* https://www.ncbi.nlm.nih.gov/books/NBK310972/ (last visited Feb. 13, 2020).
[20] S. 397.64(24)(24)(e), F.S.

defendant's attendance.[21] However, some AA groups have elected not to sign documents to verify a defendant's attendance.[22] In some areas, courts furnish cooperating AA groups with sealed, stamped envelopes addressed to the court.[23] A defendant can write his or her name and return address on it and mail it to the court to verify attendance. Sign in sheets are also furnished by courts in some areas to anonymous groups where a defendant can sign his or her name after the meeting to confirm that defendant's attendance.[24] The group's secretary will then send the sheet back to the court. This way, the defendant's signature affirms he or she was at the meeting instead of the anonymous group itself.

It is difficult to determine if 12-step groups such as AA and NA are effective because they do not keep records.[25] A 2014 survey of AA members showed that 27% remained sober for less than one year and 24% remained sober for a period of 1-5 years.[26] The study also revealed that rates of abstinence are about twice as high among those who attended AA and more frequent attendance at meetings are related to higher rates of abstinence.[27]

Electronic Verification of Self-Help Group Attendance

Electronic applications and software can be used to track a person's attendance at work, school, and other functions.[28] There are several available on the market, either for free or for a fee, for these purposes.[29] These applications may use a photo, fingerprint, or GPS location of a person as a means of verification.[30] Such electronic applications can also be used to track court-mandated attendance at self-help group meetings in lieu of paper attendance verification.

Treatment-Based Drug Courts

Treatment-based drug courts are a type of problem-solving court aimed at providing an alternative to criminal imprisonment for offenders impaired by substance abuse.[31] Generally, drug court programs identify individuals in either the criminal justice or dependency system who may benefit from substance abuse treatment. Those individuals may voluntarily enter into pretrial treatment-based programs or may be sentenced to post-adjudicatory treatment-based programs as a condition of probation or community control. To assist these individuals with treatment, drug courts provide incentives, such as reduced penalties and increased support to the individual. Throughout the drug court evaluation and treatment process, records of a drug court participant's screenings,[32] diagnosis, and progress[33] are made part of the participant's court record.

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[21] Alcoholics Anonymous, *Alcoholics Anonymous as a Resource for Drug & Alcohol Court Professionals,* https://www.aa.org/pages/en_US/alcoholics-anonymous-as-a-resource-for-drug-and-alcohol-court-professionals (last visited Feb. 13, 2020).
[22] Id.
[23] Id.
[24] Id.
[25] Harvard Health Publishing – Harvard Medical School, *How Alcoholics Anonymous Works,* https://www.health.harvard.edu/newsletter_article/How_Alcoholics_Anonymous_works (last visited Feb. 13, 2020). *See also* Lee Ann Kaskutas, Dr.P.H., *Alcoholics Anonymous Effectiveness: Faith Meets Science,* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2746426/ (last visited Feb. 13, 2020).
[26] Lee Ann Kaskutas, Dr.P.H., *Alcoholics Anonymous Effectiveness: Faith Meets Science,* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2746426/ (last visited Feb. 13, 2020).
[27] Id. *See also* Brandon G. Bergman, Ph.D., M. Claire Greene, M.P.H., and John F. Kelly, Ph.D., *Psychiatric Comorbidity and 12-Step Participation: A Longitudinal Investigation of Treated Young Adults* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3946781/ (last visited Feb. 13, 2020).
[28] Megha Mandavia & Priyanka Sangani, *Digital identity verification firms are seeing higher demand as businesses rule out physical interaction with users* (Sept. 6, 2019), https://economictimes.indiatimes.com/tech/software/digital-identity-verification-firms-are-seeing-higher-demand-as-businesses-rule-out-physical-interaction-with-users/articleshow/71002346.cms (last visited Feb. 13, 2020).
[29] Id.
[30] Id.
[31] Section 397.305, F.S.
[32] Eligibility screening by mental health treatment professionals uses "evidence-based assessment tools and procedures" in order to determine the individual's level of risk and whether he or she can be treated safely and effectively. Section 397.334(2)-(3) and (5), F.S.
[33] A participant's treatment plan and progress is overseen by a multi-disciplinary drug court team, usually consisting of a judge or judicial officer, a case manager or treatment provider, the participant's legal representative, the participant, and representatives from any relevant state agencies. Section 397.334(5), F.S.

Entry into post-adjudicatory treatment-based programs must also be based upon the agreement of the individual to enter into the program. Ultimately, entry into a treatment-based drug court program is voluntary, and the written consent and agreement of the participant is necessary for the court to order him or her into a treatment program.

A drug court team develops a coordinated strategy for each participant in a drug court program.[34] A pretrial drug court program may use sanctions for noncompliance once a participant has agreed to the program, including placement in a treatment program or short periods of incarceration.[35] A court must dismiss the charges upon finding a person successfully completed the program.[36] If a person does not successfully complete the program, a court may order that person into further education and treatment or order that the charges revert to the normal channels for prosecution.[37]

The components of drug courts include:[38]

- Integration of alcohol and other drug treatment services into justice system case processing;
- Non-adversarial approach;
- Early identification of eligible participants;
- Continuum of services;
- Alcohol and drug testing for abstinence;
- Coordinated strategy for responses to participants' compliance;
- Ongoing judicial interaction;
- Monitoring and evaluation for program effectiveness;
- Interdisciplinary education; and
- Partnerships with stakeholders.

As of August 2019, Florida had 91 drug courts in operation, including 54 adult, 20 juvenile, 13 family dependency, and 4 DUI courts. In 2017, Florida drug courts admitted 6,195 participants, and 3,577 successfully completed their program.[39] In the same year, mental health courts admitted 929 participants, and 533 successfully completed their program.[40]

Florida law does not expressly address self-help groups as an element of drug court-ordered compliance. The extent to which drug courts order defendants into self-help groups, or track attendance at such meetings, of so ordered, is unknown.

Effect of Proposed Changes

The bill allows a treatment-based drug court, if ordering a defendant to enter into a pretrial or postadjudicatory program, to offer the defendant the option for either electronic or written verification of participation in court-ordered ancillary services, including self-help and other support groups, if the defendant is ordered to document attendance at such services. This means that some defendants participating in treatment-based drug courts will be able to choose which approach to use to verify attendance, if the court orders notification.

[34] Ss. 397.334(4) and 948.08(6)(b), F.S.
[35] S. 948.08(6)(b), F.S.
[36] S. 948.08(6)(c), F.S.
[37] Id.
[38] S. 397.334, F.S.
[39] Florida Courts, *Problem-Solving Courts Data*, https://www.flcourts.org/Resources-Services/Court-Improvement/Problem-Solving-Courts/Data (last visited Feb. 13, 2020).
[40] Id.

B. SECTION DIRECTORY:

Section 1: Amends s. 397.334, F.S., relating to treatment-based drug court programs.
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:

   The bill may increase local government expenditures, to the extent the court chooses to offers an electronic verification approach and if the court would require information technology upgrades for implementation.

   Florida law requires counties that choose to fund treatment-based drug courts to secure funding from sources other than the state for costs not otherwise assumed by the state. It also requires counties to fund court related communication services, including all telephone system infrastructure, computer systems, hardware, software, modems, printers, wiring, network connections, maintenance, support staff, and services.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill does not require the court to order a defendant to use an electronic method to verify his or her attendance, but if an electronic application for attendance verification is chosen, that application may charge a fee to the defendant for the service.

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:

Not applicable. The bill does not require rulemaking to implement.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to treatment-based drug court programs; amending s. 397.334, F.S.; authorizing a court to offer an option for verification of participation in self-help groups or activities to certain defendants; providing an effective date.

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

Section 1. Subsections (6) through (10) of section 397.334, Florida Statutes, are renumbered as subsections (7) through (11), respectively, and a new subsection (6) is added to that section, to read:

397.334 Treatment-based drug court programs.—

(6) If the court orders a defendant to enter into a pretrial treatment-based drug court program or a postadjudicatory treatment-based drug court program, and if the defendant is ordered to document participation in self-help or other support groups and activities as an element of ancillary services, as described in s. 394.67, the court may offer the defendant an option for either electronic or written verification of such participation.

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1071 Substance Abuse and Mental Health
SPONSOR(S): Children, Families & Seniors Subcommittee, Grant, M.
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	11 Y, 0 N, As CS	Morris	Brazzell
2) Health Care Appropriations Subcommittee	10 Y, 0 N	Fontaine	Clark
3) Health & Human Services Committee		Morris	Calamas

SUMMARY ANALYSIS

The Department of Children and Families (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). CS/HB 1071 makes a variety of changes to laws relating to substance abuse and mental health services.

The bill redefines “mental illness” related to the Baker Act to exclude dementia and traumatic brain injury.

The Community Action Treatment (CAT) teams model is an example of a comprehensive service approach that allows young people with mental illnesses who are at risk or out-of-home placements to receive services and remain in their communities with their caregivers. The bill adds two CAT teams to the statutory list of geographic locations to be served by these teams: one serving Charlotte County and the other serving Leon, Gadsden, and Wakulla counties.

The Statewide Grant Review Committee (Committee) is an advisory body charged with reviewing policy and funding issues and advising DCF in selecting priorities for grants and investing awarded grant moneys. The bill revises the membership and scope of the Committee by removing its ability to participate in the development of criteria used to review grants and in the selection of grant recipients, and assigning that duty to DCF, in collaboration with other state agencies.

The School Substance Abuse Prevention Partnership Grant Program (PPG) is a school-based, children’s substance abuse prevention grant program. DCF currently allocates PPG funds to managing entities (ME) to implement programs locally. The bill revises this process to give the MEs the ability to review PPG grant applications and award funding, instead of DCF, allowing local focus when deciding how to award funding.

Forensic mental health evaluation is performed by a mental health professional to provide relevant clinical and scientific data during civil or criminal proceedings. The bill requires continuing education every three years on specified topics for court-appointed forensic mental health evaluators.

Prevention coalitions are local partnerships between multiple sectors of the community that respond to community conditions by developing and implementing comprehensive plans that lead to reductions in drug use and related problems. The bill repeals the requirement for DCF to develop a certification process for community substance abuse prevention coalitions as Florida is the only state that requires such a certification.

The bill has a significant, negative, recurring fiscal impact on DCF, which is accommodated in the House proposed budget. The bill has no fiscal impact to local governments.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Mental Illness and Substance Abuse

Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community.[1] The primary indicators used to evaluate an individual's mental health are:[2]

- **Emotional well-being**- Perceived life satisfaction, happiness, cheerfulness, peacefulness;
- **Psychological well-being**- Self-acceptance, personal growth including openness to new experiences, optimism, hopefulness, purpose in life, control of one's environment, spirituality, self-direction, and positive relationships; and
- **Social well-being**- Social acceptance, beliefs in the potential of people and society as a whole, personal self-worth and usefulness to society, sense of community.

Mental illness is collectively all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress or impaired functioning.[3] Thus, mental health refers to an individual's mental state of well-being whereas mental illness signifies an alteration of that well-being.

Mental illness affects millions of people in the United States each year. Nearly one in five adults live with a mental illness.[4] An estimated 49.5% of adolescents aged 13-18 have a mental disorder.[5] Suicide is the tenth overall leading cause of death in the nation and the second leading cause of death among individuals between the ages of 10 and 24.[6]

Substance abuse also affects millions of people in the United States each year. Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.[7] Substance abuse disorders occur when the chronic use of alcohol or drugs causes significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.[8] Repeated drug use leads to changes in the brain's structure and function that can make a person more susceptible to developing a substance abuse disorder.[9] Brain imaging studies of persons with substance abuse disorders show physical changes in areas of the brain that are critical to judgment, decision making, learning and memory, and behavior control.[10]

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, a diagnosis of substance abuse disorder is based on evidence of impaired control, social impairment, risky use, and

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[1] World Health Organization, *Mental Health: Strengthening Our Response,* https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response (last visited Feb. 13, 2020).
[2] Centers for Disease Control and Prevention, *Learn About Mental Health*, http://www.cdc.gov/mentalhealth/basics.htm (last visited Feb. 13, 2020).
[3] Id.
[4] National Institute on Mental Health, *Mental Illness,* https://www.nimh.nih.gov/health/statistics/mental-illness.shtml, (last visited Feb. 13, 2020).
[5] National Institute on Mental Health, *Mental Illness – Prevalence of Any Mental Disorder Among Adolescents,* https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#part_155771 (last visited Feb. 13, 2020).
[6] National Institute on Mental Health, *Suicide,* https://www.nimh.nih.gov/health/statistics/suicide.shtml (last visited Feb. 13, 2020).
[7] *World Health Organization, Substance Abuse*, http://www.who.int/topics/substance_abuse/en/ (last visited Feb. 13, 2020).
[8] Substance Abuse and Mental Health Services Administration, *Substance Use Disorders,* http://www.samhsa.gov/disorders/substance-use (last visited Feb. 13, 2020).
[9] National Institute on Drug Abuse*, Drugs, Brains, and Behavior: The Science of Addiction*, https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction (last visited Feb. 13, 2020).
[10] Id.

pharmacological criteria.[11] The most common substance abuse disorders in the United States are from the use of alcohol, tobacco, cannabis, stimulants, hallucinogens, and opioids.[12]

Mental illness and substance abuse commonly co-occur. Approximately 9.2 million adults have co-occurring disorders.[13] In fact, more than half of all adults with severe mental illness are further impaired by substance use disorders (abuse or dependence related to alcohol or other drugs).[14] Drug abuse can cause individuals to experience one or more symptoms of another mental illness.[15] Additionally, individuals with mental illness may abuse drugs as a form of self-medication.[16] Examples of co-occurring disorders include the combinations of major depression with cocaine addiction, alcohol addiction with panic disorder, alcoholism and drug addiction with schizophrenia, and borderline personality disorder with episodic drug abuse.[17]

Mental Illness and Substance Abuse 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.[18]

DCF contracts for behavioral health services through regional systems of care called managing entities. The 7 managing entities, in turn, contract with and oversee local service providers for the delivery of mental health and substance abuse services throughout the state.[19] Treatment for substance abuse through this community-based provider system includes detoxification, treatment and recovery support for adolescents and adults affected by substance misuse, abuse or dependence.[20]

- **Detoxification Services:** Medical and clinical procedures to assist individuals and adults as they withdraw from the physiological and psychological effects of substance abuse.[21]
- **Treatment Services:** Assessment, counseling, case management, and support that are designed to help individuals who have lost their abilities to control their substance use on their own and require formal, structured intervention and support. Some of these services may also be offered to the family members of the individual in treatment. [22]
- **Recovery Support:** Transitional housing, life skills training, parenting skills, and peer-based individual and group counseling, offered during and following treatment to further assist

[11] *Supra*, note 8.
[12] Id.
[13] Substance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the U.S.: Results from the 2018 National Survey on Drug Use and Health,* (August 2019), https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf (last visited Feb. 13, 2020).
[14] Psychology Today, *Co-Occurring Disorders*, https://www.psychologytoday.com/conditions/co-occurring-disorders (last visited Feb. 13, 2020).
[15] *Comorbidity: Addiction and Other Mental Illnesses*, National Institute on Drug Abuse, NIH Publication Number 10-5771, September 2010. https://www.drugabuse.gov/sites/default/files/rrcomorbidity.pdf (last visited Feb. 13, 2020).
[16] Id.
[17] Id.
[18] 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.
[19] Department of Children and Families, *Managing Entities*, https://www.myflfamilies.com/service-programs/samh/managing-entities/ (last visited on Feb. 13, 2020).
[20] Department of Children and Families, *Treatment for Substance Abuse*, https://www.myflfamilies.com/service-programs/samh/substance-abuse.shtml, (last visited Feb. 13, 2020).
[21] Id.
[22] Id. Research indicates that persons who successfully complete substance abuse treatment have better post-treatment outcomes related to future abstinence, reduced use, less involvement in the criminal justice system, reduced involvement in the child-protective system, employment, increased earnings, and better health.

individuals in their development of the knowledge and skills necessary to maintain their recovery.[23]

The Florida Mental Health Act, otherwise known as the Baker Act, was enacted in 1971 to revise the state's mental health commitment laws. [24] The Act provides legal procedures for mental health examination and treatment, including voluntary and involuntary examinations. It additionally protects the rights of all individuals examined or treated for mental illness in Florida.[25]

Community Action Treatment Teams

According to the National Institute of Mental Health (NIMH), half of all lifetime cases of mental health disorders have begun by age 14 and three quarters have begun by age 24.[26] Successful transition between the children and adult systems is critical; many individuals with mental health disorders fall through the gaps between the children and adult mental health systems during a critical time in their lives.[27] In 2003, the New Freedom Commission on Mental Health released a report that identified further gaps in the mental health system and recommended transforming the mental health system through community-based services to help individuals with mental illnesses live successfully in their communities.[28] The Community Action Treatment (CAT) teams model is an example of a comprehensive service approach that allows young people with mental illnesses who are at risk or out-of-home placements to receive services and remain in their communities with their caregivers.[29]

CAT teams are intended to be a safe and effective alternative to out-of-home placement for children with a mental health condition and characteristics that impact their ability to function well in the community.[30] The goals of CAT teams are to:[31]

- Strengthen the family and support systems for youth and young adults to assist them to live successfully in the community;
- Improve school related outcomes such as attendance, grades and graduation rates;
- Decrease out-of-home placements;
- Improve family and youth functioning;
- Decrease substance use and abuse;
- Decrease psychiatric hospitalizations;
- Transition into age appropriate services; and
- Increase health and wellness.

To be eligible for services through a CAT team, the individual must be a child or young adult, up to 21 years old, with a mental health or co-occurring substance abuse diagnosis and specified accompanying characteristics, the requirements for which vary by age.[32] If the child is less than 11 years old he or she

[23] Id.
[24] Sections 394.451-394.47892, F.S.
[25] Section 394.459, F.S.
[26] Kessler, Berglund, Demler, Jin, Merikangas, and Walters, *Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication*, Archives of General Psychiatry. June 2005, https://www.ncbi.nlm.nih.gov/pubmed/15939837 (last visited Feb. 13, 2020).
[27] Maryann Davis and Bethany Hunt, *State efforts to expand transition supports for young adults receiving adult public mental health services*. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2005, https://pdfs.semanticscholar.org/40ae/063ae28b3273f498eb7c7b609677b1e5be92.pdf?_ga=2.44077420.995818869.1579903552-877004500.1579903552 (last visited Feb. 13, 2020).
[28] Letter from The President's New Freedom Commission on Mental Health to President George W. Bush, July 22, 2002, http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/FinalReport.pdf (last visited Feb. 13, 2020).
[29] Department of Children and Families, *Community Action Team Evaluation Report*, February 1, 2014, p. 6, https://www.myflfamilies.com/service-programs/samh/publications/docs/CAT_Team_Evaluation_January_31_2014.pdf (last visited Feb. 13, 2020).
[30] Department of Children and Families, *Fiscal Year 2017-18 Managing Entity Templates, Guidance 32 – Community Action Treatment (CAT) Team*, Effective January 1, 2018, p. 1 (Guidance Document on file with Health and Human Services Committee).
[31] Id. at 1-2.
[32] Id. at 2.

must meet two of the following accompanying characteristics; however, individuals aged 11-21 must only meet one of the following accompanying characteristics:[33]

- The individual is at-risk for out-of-home placement as demonstrated by repeated failures at less intensive levels of care;
- The individual has had two or more hospitalizations or repeated failures;
- The individual has had involvement with the Department of Juvenile Justice or multiple episodes involving law enforcement; or
- The individual has poor academic performance and/or suspensions.

The CAT model is an integrated service delivery approach that utilizes a team of individuals to comprehensively address the needs of the young person, and his or her family.[34] The CAT team includes a full-time team leader, mental health clinicians, a psychiatrist or advanced registered nurse practitioner (ARNP), a registered or licensed practical nurse, a case manager, therapeutic mentors, and support staff.[35] They work collaboratively to deliver the majority of behavioral health services, coordinate with other service providers when necessary, and assist the family in developing or strengthening its natural support system.[36]

CAT teams have greater flexibility than traditional mental health providers, which is intended to promote a "whatever it takes" approach to assisting young people with mental health or co-occurring substance use disorders and their families to achieve their goals.[37] One of the differences between CAT teams and traditional mental health services is that services are provided or coordinated by the multidisciplinary team; these services are individualized and often do not fit into the standard of medical necessity, and are typically not reimbursed by Medicaid or private insurance.[38] The number of sessions and the frequency at which they are provided is set through collaboration rather than service limits.[39] In addition, the family is treated as a unit, and the CAT team addresses all family members' needs.[40]

CAT teams provide services in the family's home or in other community locations that are convenient for the family being served. The mix of services and supports the CAT team provides to the individual and his or her family should be developmentally appropriate for the young person and serve to strengthen him or her and his or her family.[41] Examples of services provided by the CAT team are:[42]

- **Crisis Intervention and 24/7 On-call Coverage:** Assists the family with crisis intervention, referrals, or supportive counseling;
- **Family Education:** Families are educated on topics related to their treatment goals, including effective parenting skills and behavior management; and
- **Therapy:** Provides and coordinates individual, group, and family therapy services. The type, frequency and location of therapy provided are based on their individual needs.

In addition to the services the CAT team provides, it also encourages the young person and his or her family to develop connections to natural supports[43] within their own network of associates, such as friends and neighbors; through connections with the community; through service and religious organizations; and through participation in clubs and other civic activities.[44]

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[33] Id.
[34] Id.
[35] Id.
[36] Id.
[37] *Supra,* note 29, at 8.
[38] Id.
[39] Id.
[40] Id. at 9.
[41] *Supra,* note 30, at 7.
[42] *Supra,* note 29, at 9.
[43] Natural supports ease the transition from formal services and provide ongoing support after discharge.
[44] *Supra,* note 30, at 6.

Use of CAT Teams in Florida

In 2005, the Florida Legislature funded the first CAT team as a behavioral healthcare pilot project for children, adolescents, and young adults with significant mental health needs in Manatee County.[45] Manatee Glens, a non-profit behavioral health provider, implemented the first CAT team pilot project with the goal of diverting children and youth with significant behavioral health needs from residential mental health treatment, foster care, and juvenile detention facilities.[46]

In 2013, the Legislature funded ten pilot CAT teams through Specific Appropriation 352-A of the 2013–2014 GAA.[47] The Legislature directed DCF as part of the 352-A appropriation to develop a report that evaluates the effectiveness of CAT teams in meeting the goal of offering parents and caregivers of this target population a safe option for raising their child at home rather than utilizing more costly institutional placement, foster home care, or juvenile justice services.[48] Based on this directive, DCF published the Community Action Team Evaluation Report[49] on January 31, 2014. While the report was not able to provide an unequivocal conclusion as to the efficacy of the CAT team model, its assessment was positive and it found positive outcomes associated with the use of CAT teams, including diversion from out of home placement, functional improvement, improved school attendance, and an increased number of days spent in the community (i.e., not in a psychiatric hospital, juvenile detention center, residential treatment facility, or on runaway).[50]

Following the positive report on CAT teams, the Legislature allocated recurring funding and non-recurring funding to expand the number of CAT teams in Fiscal Years 2014-2015 to 2019-2020.[51]

As of July 1, 2019, recurring funding supports 23 CAT teams, and non-recurring funding supports 2 CAT teams (one team serving Charlotte County and one team serving Leon, Gadsden and Wakulla counties).[52] The 23 CAT teams receiving recurring funds are designated by statute, in s. 394.495(6), F.S. The two CAT teams receiving non-recurring funds are not in statute, but are funded annually in the GAA.

In DCF's SAMH Annual Plan for Fiscal Years 2017-2019, it identified the need to increase intensive, in-home team interventions that are available 24 hours per day, 7 days per week as part of its strategic initiative to increase access to quality, recovery-oriented system of care, and enhance the community-based service array to shift from an acute care model to a recovery based model of care.[53] DCF identified increasing the number of CAT and mobile crisis teams as a way to meet this objective.[54]

Defining Mental Health

The Baker Act defines mental illness as "an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with the person's ability to meet the ordinary demands of living."[55] The definition expressly excludes a developmental disability, intoxication, or conditions manifested only by antisocial behavior or substance abuse, but does not exclude dementia or traumatic brain injury

[45] *Supra,* note 30, at 1.
[46] Id.
[47] Fla. General Appropriation Act Fiscal Year 2013-2014, SB 1500 item 352-A, http://www.myfloridahouse.gov/filestores/Adhoc/Appropriations/GAA/2013-Senate/CR_SB_1500.pdf (last visited Feb. 13, 2018).
[48] Id.
[49] *Supra,* note 29.
[50] Id. at 22-26.
[51] Fla. General Appropriation Act Fiscal Years 2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020; HB 5001 item 349, SB 2500-A item 377G, HB 5001 item 382, SB 2500 item 361A, HB 5001 item 366, SB 2500 item 367, respectively.
[52] Fla. General Appropriation Act Fiscal Year 2019-2020, SB 2500 item 367.
[53] *Florida Substance Abuse and Mental Health Plan, Triennial State and Regional Master, Fiscal Years 2017-2019,* Department of Children and Families, Substance Abuse and Mental Health Program Office, January 31, 2016, pp. 8-9, https://www.myflfamilies.com/service-programs/samh/publications/docs/FL-SAMH-PlanFY17-19.pdf (last visited Feb. 13, 2020).
[54] Id. at 9.
[55] S. 394.455(28), F.S.

(TBI). This means that individuals with dementia or TBI (neither of which are a mental illness) who do not have a co-occurring mental illness can be subject to involuntary treatment under the Baker Act, disrupting them from their normal environment and possibly exacerbating their condition.

Criminal Justice, Mental Health, and Substance Abuse Statewide Reinvestment 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.[56]

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 under the Program.[57] 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.[58]

The Program is currently funded at $9 million annually.[59] DCF manages 8 planning grants, 18 implementation or expansion grants, and 1 contract providing counties with technical assistance through the University of South Florida.

The Statewide Grant Review Committee (Committee) is an advisory body charged with reviewing policy and funding issues and advising DCF in selecting priorities for grants and investing awarded grant moneys. The Committee is also responsible for reviewing grant applications and selecting the grant recipients, as well as notifying DCF in writing of the recipients' names before DCF can issue awards.

The Committee is composed of representatives from six state agencies, including DCF, and ten advocacy groups and professional and trade associations representing criminal justice professionals, behavioral health service providers, and local municipalities, each of which has varying degrees of involvement in county strategic planning and implementation of alternative service models addressing the Program's target populations.

According to DCF, this statutory responsibility of the Committee creates significant challenges implementing the grant review functions due to the affiliations of the Committee members representing the participating ten advocacy groups and professional and trade associations. Specifically, conflict of interest standards routinely interfere with participation in annual grant reviews by the non-state agency members. Four organizations represent the actual grant applicants identified in statute and are automatically excluded from participation in all grant award decisions. The remaining six organizations may or may not be excluded from some grant reviews, depending on whether their members include an applicant, an applicant's proposed sub-recipient, or proposed source of local matching funds.[60]

School Substance Abuse Prevention Partnership Grants

The School Substance Abuse Prevention Partnership Grant (PPG) is a school-based, children's substance abuse prevention grant program.[61] Every three years, DCF conducts a competitive grant

[56] S. 394.656(1), F.S.
[57] S. 394.656(5), F.S.
[58] Id.
[59] Department of Children and Families, Agency Bill Analysis for 2020 HB 1071 (Jan. 14, 2020) (On file with Children, Families, and Seniors Subcommittee Staff).
[60] Id.
[61] S. 397.399, F.S.

process for the PPG, in cooperation with the Department of Education (DOE) and the Department of Juvenile Justice (DJJ).[62] Prevention funds are competitively awarded for evidence-based programs, practices, or strategies.

Currently, DCF's Office of Substance Abuse and Mental Health conducts a statewide request for application with the assistance of evaluators designated by DCF's regional offices, managing entities, DOE, and DJJ.[63] Once awarded, DCF allocates PPG funds to the managing entities to implement the programs through subcontracts with network service providers.[64]

Historically, the PPG funds between 30 and 34 community programs.[65] In Fiscal Year 2018-2019, the PPG awards ranged from $338,547 to $450,000 for a total of 31 three-year grant awards.[66]

Community Substance Abuse Prevention Coalitions

Prevention coalitions are local partnerships between multiple sectors of the community that respond to community conditions by developing and implementing comprehensive plans that lead to measurable, population-level reductions in drug use and related problems. Generally, prevention coalitions have community wide involvement including parents, youth, teachers, police, faith-based leaders and business partners.[67]

Section 397.321, F.S., requires DCF to license and regulate all substance abuse providers in the state. For individual professionals, the Florida Certification Board, a non-profit professional credentialing entity, offers certifications for Certified Prevention Specialists and Certified Prevention Professionals, for those individuals who desire professional credentialing.

Some prevention coalitions choose to receive certification from nationally-recognized credentialing entities through an application process. Additionally, prevention coalitions do not provide licensable substance abuse clinical treatment services, and certification is not a requirement for eligibility to receive federal or state substance abuse prevention funding. To receive funding from DCF, a coalition must follow a comprehensive process that includes a detailed needs assessment and plan for capacity building, development, implementation, and sustainability to ensure that data-driven, evidence–based practices are employed for addressing substance misuse for state-funded coalitions.

However, current law also requires DCF to develop a certification process by rule for community substance abuse prevention coalitions. DCF has not adopted such a rule, so there is no process for state certification and no state certified providers.

Florida is the only state that requires prevention coalitions to be certified.[68]

Forensic Mental Health Evaluators

Forensic mental health evaluation is performed by a mental health professional to provide relevant clinical and scientific data during civil or criminal proceedings. Florida's circuit courts appoint mental health experts to conduct forensic evaluations of individuals with mental illnesses who are adjudicated incompetent to proceed of a felony offense or acquitted of a felony offense by reason of insanity.[69]

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[62] Department of Children and Families, *Prevention Partnership Grants (PPG),* https://www.myflfamilies.com/service-programs/samh/prevention/prevention-partnership-grants-ppg.shtml (last visited Feb. 13, 2020).
[63] *Supra,* note 59.
[64] Id.
[65] Id.
[66] Id.
[67] Department of Children and Families, Agency Bill Analysis for 2018 HB 0721 (Nov. 30, 2017) (On file with Children, Families, and Seniors Subcommittee Staff).
[68] Only one other state, Ohio, has established a certification program for prevention coalitions, and it is voluntary.
[69] *Supra,* note 59.

DCF is required to provide one time training for psychiatrists, psychologists, and other mental health professionals on how to conduct evaluations for criminal courts.[70] The training program is a three-day program offered through a course provided by the Louis de la Parte Florida Mental Health Institute at the University of South Florida which focuses on competence to stand trial and sanity evaluations.[71] Participants learn Florida laws and rules of criminal procedure relevant to forensic evaluation, general legal principles relevant to forensic evaluation, and assessment techniques and procedures used in competency to proceed and mental state at the time of the offense evaluations,[72] though no specific topics are required to be covered.

Because training for forensic evaluators is only a one-time requirement, mental health professionals who have completed the training can remain on the list of DCF approved evaluators for years without receiving continuing education, meaning that their initial training becomes outdated as statutes and practices change over time.[73]

Effect of Proposed Changes

Community Action Treatment Teams

The bill adds two CAT teams to the statutory list of geographic locations to be served by these teams: one serving Charlotte County and the other serving Leon, Gadsden, and Wakulla counties. This allows the CAT teams to receive recurring funding in the future, rather than non-recurring year-to-year appropriations.[74]

Defining Mental Health

The bill redefines "mental illness" related to the Baker act to exclude dementia and TBI. This will prohibit an individual who has dementia or TBI that lacks a co-occurring mental illness from being inappropriately admitted for involuntary examination at Baker Act receiving facilities. However, the proposed change will not prohibit an individual who has dementia or TBI with a co-occurring mental illness who is experiencing a mental health crisis from being admitted to a Baker Act receiving facility for involuntary examination.

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

The bill revises the duties of the Criminal Justice, Mental Health, and Substance Abuse Statewide Grant Review Committee and renames it the Criminal Justice, Mental Health, and Substance Abuse Statewide Grant Advisory Committee (committee). The bill revises the membership of the committee to remove the administrator of an assisted living facility that holds a limited mental health license, and add a representative of the Florida Behavioral Health Association, to reflect the merger of the Florida Alcohol and Drug Abuse Association with the Florida Council for Community Mental Health.

The bill removes the ability of the committee to participate in the development of criteria used to review grants and in the selection of grant recipients. Instead, DCF, in collaboration with the Department of Corrections, the Department of Juvenile Justice, the Department of Elder Affairs, the Office of the State Courts Administrator, and the Department of Veterans' Affairs, must establish criteria used to review applications and select the county that will be awarded implementation or expansion grants. This proposed change will eliminate conflicts of interest currently experienced by DCF during their annual grant review process since entities who may be applying for grants will also no longer be a part of the decision making process for awarding grants.

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[70] S. 916.111, F.S.
[71] Department of Children and Families, *Forensic Evaluator Training and the Importance of Appointing Approved Forensic Evaluators as Experts,* https://www.myflfamilies.com/service-programs/samh/adult-forensic-mental-health/forensic-evaluator-training-and-importance-appointing-approved-forensic-evaluators-experts.shtml (last visited Feb. 13, 2020).
[72] Id.
[73] *Supra,* note 59.
[74] *See,* Joint Rule 2.3, Joint Rules of the Florida Legislature (2018-2020).

The bill allows county consortiums to apply for implementation or expansion grants. It allows a county planning council or committee to designate the county sheriff or local law enforcement agency to apply for a grant on behalf of the county.

School Substance Abuse Prevention Partnership Grants

The bill allows managing entities, instead of DCF, to use a competitive solicitation process to review grant applications for the School Substance Abuse Prevention Partnership Grant Program. Each geographic area managing entities serve have unique needs, meaning this change will allow each managing entity to tailor solicitations to meet needs at the community level.

Community Substance Abuse Prevention Coalitions

The bill repeals the requirement that DCF develop a certification process by rule for community substance abuse prevention coalitions. Because DCF did not establish such a process, this has no impact on current practice.

Forensic Mental Health Evaluators

The bill requires court-appointed forensic evaluators to take continuing education on conducting forensic evaluations for the court every three years, allowing such individuals to remain up to date on changing laws, regulations, and trends in industry. At a minimum, the continuing education must provide current information on:

- Forensic statutory requirements;
- Recent changes to part II of ch. 916, F.S., relating to forensic services for persons who are mentally ill;
- Trends and concerns related to forensic commitments in the state;
- Alternatives to maximum security treatment facilities;
- Community forensic treatment providers;
- Evaluation requirements; and
- Forensic service array updates.

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. 394.495, F.S., relating to child and adolescent mental health system of care: programs and services.
Section 3: Amends s. 394.656, F.S., relating to criminal justice, mental health, and substance abuse reinvestment grant program.
Section 4: Amends s. 394.657, F.S., relating to county planning councils or committees.
Section 5: Amends s. 394.658, F.S., relating to criminal justice, mental health, and substance abuse reinvestment grant program requirements.
Section 6: Amends s. 397.321, F.S., relating to duties of the department.
Section 7: Amends s. 397.99, F.S., relating to school substance abuse prevention partnership grants.
Section 8: Amends s. 916.111, F.S., relating to training of mental health experts.
Section 9: Amends s. 916.115, F.S., relating to appointment of experts.
Section 10: 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 amends s. 394.495(6)(e)1, F.S., to include Charlotte, Leon, Gadsden, and Wakulla counties to the list of specified counties or regions required to be individually served by a CAT team. The Fiscal Year 2019-2020 General Appropriations Act provided $1,500,000 ($750,000 per team) in non-recurring General Revenue to fund two CAT teams in these counties.

The House proposed General Appropriations Act for Fiscal Year 2020-21 includes an additional, recurring $5,250,000 to expand the number of available CAT teams.

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 permits a county consortium to apply for a Criminal Justice, Mental Health, and Substance Abuse Statewide Reinvestment Grant, and allows such to designate the sheriff or local law enforcement agency to apply for a grant on the county's behalf. To the extent that a county is more likely to apply for a grant if the local sheriff or law enforcement agency is the applicant, there will be an increase of applicants to a grant program without an increase to the program's base appropriation.

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:

Current law provides sufficient rulemaking authority for DCF to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to substance abuse and mental health; amending s. 394.455, F.S.; revising the definition of "mental illness;" amending s. 394.495, F.S.; revising the counties that a community action treatment team must serve; amending s. 394.656, F.S.; revising membership and duties of the Criminal Justice, Mental Health, and Substance Abuse Statewide Grant Advisory Committee; authorizing additional entities that may apply for a grant on behalf of a county; providing for selection of grant recipients; amending s. 394.657, F.S.; conforming provisions to changes made by the act; amending s. 394.658, F.S.; revising requirements of the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program; amending s. 397.321, F.S.; removing the requirement that the department develop a certification process for community substance abuse prevention coalitions; amending s. 397.99, F.S.; requiring managing entities under contract with the department to use a specified process for school substance abuse prevention partnership grants; amending s. 916.111, F.S.; requiring the department to provide continuing education for specified mental health professionals; providing requirements for such education; amending s.

916.115, F.S.; revising requirements for the appointment of experts to evaluate certain defendants; providing an effective date.

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

Section 1. Subsection (28) of section 394.455, Florida Statutes, is amended to read:

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

(28) "Mental illness" means an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with the person's ability to meet the ordinary demands of living. For the purposes of this part, the term does not include a developmental disability as defined in chapter 393, intoxication, or conditions manifested only by antisocial behavior, dementia, traumatic brain injury, or substance abuse.

Section 2. Paragraph (e) of subsection (6) of section 394.495, Florida Statutes, is amended to read:

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

(6) The department shall contract for community action treatment teams throughout the state with the managing entities. A community action treatment team shall:

(e)1. Subject to appropriations and at a minimum, individually serve each of the following counties or regions:

a. Alachua.

b. Alachua, Columbia, Dixie, Hamilton, Lafayette, and Suwannee.

c. Bay.

d. Brevard.

e. Charlotte.

f.~~e.~~ Collier.

g.~~f.~~ DeSoto and Sarasota.

h.~~g.~~ Duval.

i.~~h.~~ Escambia.

j.~~i.~~ Hardee, Highlands, and Polk.

k.~~j.~~ Hillsborough.

l.~~k.~~ Indian River, Martin, Okeechobee, and St. Lucie.

m.~~l.~~ Lake and Sumter.

n.~~m.~~ Lee.

o. Gadsden, Leon, and Wakulla.

p.~~n.~~ Manatee.

q.~~o.~~ Marion.

r.~~p.~~ Miami-Dade.

s.~~q.~~ Okaloosa.

t.~~r.~~ Orange.

u.~~s.~~ Palm Beach.

v.~~t.~~ Pasco.

w.~~u.~~ Pinellas.

x.~~v.~~ Walton.

2. Subject to appropriations, the department shall contract for additional teams through the managing entities to ensure the availability of community action treatment team services in the remaining areas of the state.

Section 3. Section 394.656, Florida Statutes, is amended to read:

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

(1) There is created within the Department of Children and Families the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program. The purpose of the program is to provide funding to counties which they may use 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 use ~~abuse~~ disorder, or co-occurring mental health and substance use ~~abuse~~ disorders and who are in, or at risk of entering, the criminal or juvenile justice systems.

(2) The department shall establish a Criminal Justice, Mental Health, and Substance Abuse Statewide Grant Advisory ~~Review~~ Committee. The committee shall include:

(a) One representative of the Department of Children and

Families.~~;~~

(b) One representative of the Department of Corrections.~~;~~

(c) One representative of the Department of Juvenile Justice.~~;~~

(d) One representative of the Department of Elderly Affairs.~~;~~

(e) One representative of the Office of the State Courts Administrator.~~;~~

(f) One representative of the Department of Veterans' Affairs.~~;~~

(g) One representative of the Florida Sheriffs Association.~~;~~

(h) One representative of the Florida Police Chiefs Association.~~;~~

(i) One representative of the Florida Association of Counties.~~;~~

(j) One representative of the Florida Behavioral Health ~~Alcohol and Drug Abuse~~ Association.~~;~~

(k) One representative of the Florida Association of Managing Entities.~~;~~

~~(l) One representative of the Florida Council for Community Mental Health;~~

(l)~~(m)~~ One representative of the National Alliance of Mental Illness.~~;~~

(m)~~(n)~~ One representative of the Florida Prosecuting

Attorneys Association.~~;~~

(n)~~(o)~~ One representative of the Florida Public Defender Association~~; and~~

~~(p) One administrator of an assisted living facility that holds a limited mental health license~~.

(3) The committee shall serve as the advisory body to review policy and funding issues that help reduce the impact of persons with mental illness and substance use ~~abuse~~ disorders on communities, criminal justice agencies, and the court system. The committee shall advise the department in selecting priorities for grants ~~and investing awarded grant moneys~~.

(4) The committee must have experience in substance use and mental health disorders, community corrections, and law enforcement. ~~To the extent possible, the committee shall have expertise in grant review and grant application scoring.~~

(5)(a) A county, a consortium of counties, or an ~~a not-for-profit community provider or managing~~ entity designated by the county planning council or committee~~,~~ as described in s. 394.657, may apply for a 1-year planning grant or a 3-year implementation or expansion grant. The purpose of the grants is to demonstrate that investment in treatment efforts related to mental illness, substance use ~~abuse~~ disorders, or co-occurring mental health and substance use ~~abuse~~ disorders results in a reduced demand on the resources of the judicial, corrections, juvenile detention, and health and social services systems.

(b) To be eligible to receive a ~~1-year planning grant or a 3-year implementation or expansion~~ grant:

1. An ~~A county~~ applicant must have a planning council or committee that is in compliance with the membership requirements set forth in this section.

2. A county planning council or committee may designate a not-for-profit community provider, a ~~or~~ managing entity as defined in s. 394.9082, the county sheriff or his or her designee, or a local law enforcement agency to apply on behalf of the county. The county planning council or committee must provide ~~must be designated by the county planning council or committee and have written authorization to submit an application. A not-for-profit community provider or managing entity must have~~ written authorization for each designated entity and each submitted application.

(c) The department may award a 3-year implementation or expansion grant to an applicant who has not received a 1-year planning grant.

(d) The department may require an applicant to conduct sequential intercept mapping for a project. For purposes of this paragraph, the term "sequential intercept mapping" means a process for reviewing a local community's mental health, substance abuse, criminal justice, and related systems and identifying points of interceptions where interventions may be made to prevent an individual with a substance use ~~abuse~~

disorder or mental illness from deeper involvement in the criminal justice system.

(6) The department ~~grant review and selection committee~~ shall select the grant recipients in collaboration with the Department of Corrections, the Department of Juvenile Justice, the Department of Elderly Affairs, the Office of the State Courts Administrator, and the Department of Veterans' Affairs ~~and notify the department in writing of the recipients' names~~. Contingent upon the availability of funds ~~and upon notification by the grant review and selection committee of those applicants approved to receive planning, implementation, or expansion grants~~, the department may transfer funds appropriated for the grant program to a selected grant recipient.

Section 4. Subsection (1) of section 394.657, Florida Statutes, is amended to read:

394.657 County planning councils or committees.—

(1) Each board of county commissioners shall designate the county public safety coordinating council established under s. 951.26, or designate another criminal or juvenile justice mental health and substance abuse council or committee, as the planning council or committee. The public safety coordinating council or other designated criminal or juvenile justice mental health and substance abuse council or committee, in coordination with the county offices of planning and budget, shall make a formal recommendation to the board of county commissioners regarding

how the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program may best be implemented within a community. The board of county commissioners may assign any entity to prepare the application on behalf of the county administration for submission to the Criminal Justice, Mental Health, and Substance Abuse Statewide Grant Advisory ~~Review~~ Committee for review. A county may join with one or more counties to form a consortium and use a regional public safety coordinating council or another county-designated regional criminal or juvenile justice mental health and substance abuse planning council or committee for the geographic area represented by the member counties.

Section 5. 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~~, in collaboration with the Department of Corrections, the Department of Juvenile Justice, the Department of Elderly Affairs, the Department of Veterans' Affairs, and the Office of the State Courts Administrator, shall establish criteria to be used to review submitted applications and to select a ~~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.

(a) The application criteria for a 1-year planning grant must include a requirement that the applicant ~~county or counties~~ have a strategic plan to initiate systemic change to identify and treat individuals who have a mental illness, substance use ~~abuse~~ disorder, or co-occurring mental health and substance use ~~abuse~~ disorders who are in, or at risk of entering, the criminal or juvenile justice systems. The 1-year planning grant must be used to develop effective collaboration efforts among participants in affected governmental agencies, including the criminal, juvenile, and civil justice systems, mental health and substance abuse treatment service providers, transportation programs, and housing assistance programs. The collaboration efforts shall be the basis for developing a problem-solving model and strategic plan for treating individuals ~~adults and juveniles~~ who are in, or at risk of entering, the criminal or juvenile justice system and doing so at the earliest point of contact, taking into consideration public safety. The planning grant shall include strategies to divert individuals from judicial commitment to community-based service programs offered by the department ~~of Children and Families~~ in accordance with ss. 916.13 and 916.17.

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

or expansion grant must ~~shall~~ require the applicant to demonstrate ~~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.

(c) Each ~~county~~ application must include the following information:

1. An analysis of the current population of the jail and juvenile detention center in the county, which includes:

a. The screening and assessment process that the county uses to identify an adult or juvenile who has a mental illness, substance use ~~abuse~~ disorder, or co-occurring mental health and

substance use ~~abuse~~ disorders.~~;~~

b. The percentage of each category of individuals ~~persons~~ admitted to the jail and juvenile detention center that represents people who have a mental illness, substance use ~~abuse~~ disorder, or co-occurring mental health and substance use ~~abuse~~ disorders.~~; and~~

c. An analysis of observed contributing factors that affect population trends in the county jail and juvenile detention center.

2. A description of the strategies the applicant ~~county~~ intends to use to serve one or more clearly defined subsets of the population of the jail and juvenile detention center who have a mental illness or to serve those at risk of arrest and incarceration. The proposed strategies may include identifying the population designated to receive the new interventions, a description of the services and supervision methods to be applied to that population, and the goals and measurable objectives of the new interventions. An applicant ~~The interventions a county may use with the target population~~ may use ~~include~~, but is ~~are~~ not limited to, the following interventions:

a. Specialized responses by law enforcement agencies.~~;~~

b. Centralized receiving facilities for individuals evidencing behavioral difficulties.~~;~~

c. Postbooking alternatives to incarceration.~~;~~

d. New court programs, including pretrial services and specialized dockets.~~;~~

e. Specialized diversion programs.~~;~~

f. Intensified transition services that are directed to the designated populations while they are in jail or juvenile detention to facilitate their transition to the community.~~;~~

g. Specialized probation processes.~~;~~

h. Day-reporting centers.~~;~~

i. Linkages to community-based, evidence-based treatment programs for adults and juveniles who have mental illness or substance use ~~abuse~~ disorders.~~; and~~

j. Community services and programs designed to prevent high-risk populations from becoming involved in the criminal or juvenile justice system.

3. The projected effect the proposed initiatives will have on the population and the budget of the jail and juvenile detention center. The information must include:

a. An ~~The county's~~ estimate of how the initiative will reduce the expenditures associated with the incarceration of adults and the detention of juveniles who have a mental illness.~~;~~

b. The methodology that will be used ~~the county intends to use~~ to measure the defined outcomes and the corresponding savings or averted costs.~~;~~

c. An ~~The county's~~ estimate of how the cost savings or

averted costs will sustain or expand the mental health and substance abuse treatment services and supports needed in the community.~~; and~~

d. How the ~~county's~~ proposed initiative will reduce the number of individuals judicially committed to a state mental health treatment facility.

4. The proposed strategies ~~that the county intends to use~~ to preserve and enhance its community mental health and substance abuse system, which serves as the local behavioral health safety net for low-income and uninsured individuals.

5. The proposed strategies ~~that the county intends to use~~ to continue the implemented or expanded programs and initiatives that have resulted from the grant funding.

(2)(a) As used in this subsection, the term "available resources" includes in-kind contributions from participating counties.

(b) A 1-year planning grant may not be awarded unless the applicant ~~county~~ makes available resources in an amount equal to the total amount of the grant. A planning grant may not be used to supplant funding for existing programs. For fiscally constrained counties, the available resources may be at 50 percent of the total amount of the grant.

(c) A 3-year implementation or expansion grant may not be awarded unless the applicant ~~county or consortium of counties~~ makes available resources equal to the total amount of the

grant. For fiscally constrained counties, the available resources may be at 50 percent of the total amount of the grant. This match shall be used for expansion of services and may not supplant existing funds for services. An implementation or expansion grant must support the implementation of new services or the expansion of services and may not be used to supplant existing services.

(3) ~~Using the criteria adopted by rule, the county designated or established criminal justice, juvenile justice, mental health, and substance abuse planning council or committee shall prepare the county or counties' application for the 1-year planning or 3-year implementation or expansion grant.~~ The county shall submit the completed application to the department ~~statewide grant review committee~~.

Section 6. Subsections (16) of section 397.321, Florida Statutes, is amended to read:

397.321 Duties of the department.—The department shall:

~~(16) Develop a certification process by rule for community substance abuse prevention coalitions.~~

Section 7. Section 397.99, Florida Statutes, is amended to read:

397.99 School substance abuse prevention partnership grants.—

(1) GRANT PROGRAM.—

(a) In order to encourage the development of effective

substance abuse prevention and early intervention strategies for school-age populations, the school substance abuse prevention partnership grant program is established.

(b) The department shall administer the program in cooperation with the Department of Education, ~~and~~ the Department of Juvenile Justice, and the managing entities under contract with the department under s. 394.9082.

(2) APPLICATION PROCEDURES; FUNDING REQUIREMENTS.—

(a) Schools, or community-based organizations in partnership with schools, may submit a grant proposal for funding or continued funding to the managing entity in its geographic area ~~department~~ by March 1 of each year. Notwithstanding s. 394.9082(5)(i), the managing entity shall use a competitive solicitation process to review ~~The department shall establish~~ grant applications, ~~application procedures~~ which ensures ~~ensure~~ that grant recipients implement programs and practices that are effective. The managing entity ~~department~~ shall include the grant application document on its ~~an~~ Internet website.

(b) Grants may fund programs to conduct prevention activities serving students who are not involved in substance use, intervention activities serving students who are experimenting with substance use, or both prevention and intervention activities, if a comprehensive approach is indicated as a result of a needs assessment.

(c) Grants may target youth, parents, and teachers and other school staff, coaches, social workers, case managers, and other prevention stakeholders.

(d) Performance measures for grant program activities shall measure improvements in student attitudes or behaviors as determined by the managing entity ~~department~~.

(e) At least 50 percent of the grant funds available for local projects must be allocated to support the replication of prevention programs and practices that are based on research and have been evaluated and proven effective. The managing entity ~~department~~ shall develop related qualifying criteria.

(f) In order to be considered for funding, the grant application shall include the following assurances and information:

1. A letter from the administrators of the programs collaborating on the project, such as the school principal, community-based organization executive director, or recreation department director, confirming that the grant application has been reviewed and that each partner is committed to supporting implementation of the activities described in the grant proposal.

2. A rationale and description of the program and the services to be provided, including:

a. An analysis of prevention issues related to the substance abuse prevention profile of the target population.

b. A description of other primary substance use and related risk factors.

c. Goals and objectives based on the findings of the needs assessment.

d. The selection of programs or strategies that have been shown to be effective in addressing the findings of the needs assessment.

e. A method of identifying the target group for universal prevention strategies, and a method for identifying the individual student participants in selected and indicated prevention strategies.

f. A description of how students will be targeted.

g. Provisions for the participation of parents and guardians in the program.

h. An evaluation component to measure the effectiveness of the program in accordance with performance-based program budgeting effectiveness measures.

i. A program budget, which includes the amount and sources of local cash and in-kind resources committed to the budget and which establishes, to the satisfaction of the managing entity ~~department~~, that the grant applicant ~~entity~~ will make a cash or in-kind contribution to the program of a value that is at least 25 percent of the amount of the grant.

(g) The managing entity ~~department~~ shall consider the following in awarding such grants:

1. The number of youths that will be targeted.

2. The validity of the program design to achieve project goals and objectives that are clearly related to performance-based program budgeting effectiveness measures.

3. The desirability of funding at least one approved project in each of the department's substate entities.

(3) The managing entity must ~~department shall~~ coordinate the review of grant applications with local representatives of the Department of Education and the Department of Juvenile Justice and shall make award determinations no later than June 30 of each year. All applicants shall be notified by the managing entity ~~department~~ of its final action.

(4) Each entity that is awarded a grant as provided for in this section shall submit performance and output information as determined by the managing entity ~~department~~.

Section 8. Subsection (1) of section 916.111, Florida Statutes, is amended to read:

916.111 Training of mental health experts.—The evaluation of defendants for competency to proceed or for sanity at the time of the commission of the offense shall be conducted in such a way as to ensure uniform application of the criteria enumerated in Rules 3.210 and 3.216, Florida Rules of Criminal Procedure. The department shall develop, and may contract with accredited institutions:

(1) To provide:

(a) A plan for training mental health professionals to perform forensic evaluations and to standardize the criteria and procedures to be used in these evaluations.~~;~~

(b) Clinical protocols and procedures based upon the criteria of Rules 3.210 and 3.216, Florida Rules of Criminal Procedure.~~; and~~

(c) Training for mental health professionals in the application of these protocols and procedures in performing forensic evaluations and providing reports to the courts.~~; and~~

(d) Continuing education for mental health professionals who have completed the training required by paragraph (c) and s. 916.115(1). At a minimum, the continuing education must include current information on:

1. Forensic statutory requirements.

2. Recent changes to part II of this chapter.

3. Trends and concerns related to forensic commitments in the state.

4. Alternatives to maximum security treatment facilities.

5. Community forensic treatment providers.

6. Evaluation requirements.

7. Forensic service array updates.

Section 9. Subsection (1) of section 916.115, Florida Statutes, is amended to read:

916.115 Appointment of experts.—

(1) The court shall appoint no more than three experts to

determine the mental condition of a defendant in a criminal case, including competency to proceed, insanity, involuntary placement, and treatment. The experts may evaluate the defendant in jail or in another appropriate local facility or in a facility of the Department of Corrections.

(a) ~~To the extent possible,~~ The appointed experts must ~~shall~~ have completed forensic evaluator training approved by the department under s. 916.111(1)(c), and, to the extent possible, each shall be a psychiatrist, licensed psychologist, or physician. Appointed experts who have completed the training under s. 916.111(1)(c) must complete continuing education under s. 916.111(1)(d) every 3 years.

(b) The department shall maintain and annually provide the courts with a list of available mental health professionals who have completed the approved training under ss. 916.111(1)(c) and (d) ~~as experts~~.

Section 10. This act shall take effect July 1, 2020.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1081 Substance Abuse and Mental Health
SPONSOR(S): Children, Families & Seniors Subcommittee, Stevenson
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	11 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

The Department of Children and Families (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). CS/HB 1081 makes a variety of changes to laws relating to substance abuse and mental health services.

The bill redefines “mental illness” related to the Baker Act and post-adjudication commitment to exclude dementia and traumatic brain injury.

The bill allows licensed health care professionals and facilities to contract with DCF and managing entities to provide mental health services without a separate license from DCF.

Day or night treatment is a licensable, individual treatment service component of clinical treatment services under ch. 397, F.S. This service is provided in a nonresidential environment with a structured schedule of treatment and rehabilitative services. Some day or night treatment facilities have a community housing component, which is a program intended for individuals who can benefit from living independently in peer community housing while participating in treatment services at a day or night treatment facility. The bill removes day or night treatment with community housing as one of the licensable service components of clinical treatment services.

The bill requires county jails to administer the psychotropic medications prescribed by DCF when a forensic client is discharged and return to the county jail, unless the jail physician documents the need to change or discontinue such medication. The DCF treating physician must consult with the jail physician and consider prescribing medication included in the jail’s drug formulary. Additionally, the bill requires county jails to send all medical information for individuals in their custody who will be admitted to state mental health treatment facilities. DCF must request this information immediately upon receipt of a completed commitment packet. Upon receipt of such a request, the county jail must provide the requested information within three business days.

The bill does not have a fiscal impact on state government. The bill as an indeterminate, insignificant, negative impact local governments.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Mental Illness and Substance Abuse

Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community.[1] The primary indicators used to evaluate an individual's mental health are:[2]

- **Emotional well-being**- Perceived life satisfaction, happiness, cheerfulness, peacefulness;
- **Psychological well-being**- Self-acceptance, personal growth including openness to new experiences, optimism, hopefulness, purpose in life, control of one's environment, spirituality, self-direction, and positive relationships; and
- **Social well-being**- Social acceptance, beliefs in the potential of people and society as a whole, personal self-worth and usefulness to society, sense of community.

Mental illness is collectively all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress or impaired functioning.[3] Thus, mental health refers to an individual's mental state of well-being whereas mental illness signifies an alteration of that well-being.

Mental illness affects millions of people in the United States each year. Nearly one in five adults live with a mental illness.[4] An estimated 49.5% of adolescents aged 13-18 have a mental disorder.[5] Suicide is the tenth overall leading cause of death in the nation and the second leading cause of death among individuals between the ages of 10 and 24.[6]

Substance abuse also affects millions of people in the United States each year. Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.[7] Substance abuse disorders occur when the chronic use of alcohol or drugs causes significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.[8] Repeated drug use leads to changes in the brain's structure and function that can make a person more susceptible to developing a substance abuse disorder.[9] Brain imaging studies of persons with substance abuse disorders show physical changes in areas of the brain that are critical to judgment, decision making, learning and memory, and behavior control.[10]

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, a diagnosis of substance abuse disorder is based on evidence of impaired control, social impairment, risky use, and

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[1] World Health Organization, *Mental Health: Strengthening Our Response,* https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response (last visited Jan. 21, 2020).
[2] Centers for Disease Control and Prevention, *Learn About Mental Health*, http://www.cdc.gov/mentalhealth/basics.htm (last visited Jan. 21, 2020).
[3] Id.
[4] National Institute on Mental Health, *Mental Illness,* https://www.nimh.nih.gov/health/statistics/mental-illness.shtml, (last visited Feb. 13, 2020).
[5] National Institute on Mental Health, *Mental Illness – Prevalence of Any Mental Disorder Among Adolescents,* https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#part_155771 (last visited Feb. 13, 2020).
[6] National Institute on Mental Health, *Suicide,* https://www.nimh.nih.gov/health/statistics/suicide.shtml (last visited Feb. 13, 2020).
[7] *World Health Organization, Substance Abuse*, http://www.who.int/topics/substance_abuse/en/ (last visited Feb. 13, 2020).
[8] Substance Abuse and Mental Health Services Administration, *Substance Use Disorders,* http://www.samhsa.gov/disorders/substance-use (last visited Feb. 13, 2020).
[9] National Institute on Drug Abuse*, Drugs, Brains, and Behavior: The Science of Addiction*, https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction (last visited Feb. 13, 2020).
[10] Id.

pharmacological criteria.[11] The most common substance abuse disorders in the United States are from the use of alcohol, tobacco, cannabis, stimulants, hallucinogens, and opioids.[12]

Mental illness and substance abuse commonly co-occur. Approximately 9.2 million adults have co-occurring disorders.[13] In fact, more than half of all adults with severe mental illness are further impaired by substance use disorders (abuse or dependence related to alcohol or other drugs).[14] Drug abuse can cause individuals to experience one or more symptoms of another mental illness.[15] Additionally, individuals with mental illness may abuse drugs as a form of self-medication.[16] Examples of co-occurring disorders include the combinations of major depression with cocaine addiction, alcohol addiction with panic disorder, alcoholism and drug addiction with schizophrenia, and borderline personality disorder with episodic drug abuse.[17]

Mental Illness and Substance Abuse Treatment in Florida

The Florida Mental Health Act, otherwise known as the Baker Act, was enacted in 1971 to revise the state's mental health commitment laws. [18] The Act provides legal procedures for mental health examination and treatment, including voluntary and involuntary examinations. It additionally protects the rights of all individuals examined or treated for mental illness in Florida.[19]

The Department of Children and Families (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.[20]

DCF contracts for behavioral health services through regional systems of care called managing entities (MEs). The 7 managing entities, in turn, contract with and oversee local service providers for the delivery of mental health and substance abuse services throughout the state.[21] Treatment for substance abuse through this community-based provider system includes detoxification, treatment and recovery support for adolescents and adults affected by substance misuse, abuse or dependence.[22]

- **Detoxification Services:** Medical and clinical procedures to assist individuals and adults as they withdraw from the physiological and psychological effects of substance abuse.[23]
- **Treatment Services:** Assessment, counseling, case management, and support that are designed to help individuals who have lost their abilities to control their substance use on their

[11] *Supra,* note 8.
[12] Id.
[13] Substance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the U.S.: Results from the 2018 National Survey on Drug Use and Health,* (August 2019), https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf (last visited Feb. 13, 2020).
[14] Psychology Today, *Co-Occurring Disorders*, https://www.psychologytoday.com/conditions/co-occurring-disorders (last visited Jan. 21, 2020).
[15] *Comorbidity: Addiction and Other Mental Illnesses*, National Institute on Drug Abuse, NIH Publication Number 10-5771, September 2010. https://www.drugabuse.gov/sites/default/files/rrcomorbidity.pdf (last visited Jan. 21, 2020).
[16] Id.
[17] Id.
[18] Sections 394.451-394.47892, F.S.
[19] Section 394.459, F.S.
[20] 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.
[21] Department of Children and Families, *Managing Entities*, http://www.dcf.state.fl.us/service-programs/samh/managing-entities/index.shtml (last visited on Feb. 13, 2020).
[22] Department of Children and Families, *Treatment for Substance Abuse*, https://www.myflfamilies.com/service-programs/samh/substance-abuse.shtml, (last visited Feb. 13, 2020).
[23] Id.

own and require formal, structured intervention and support. Some of these services may also be offered to the family members of the individual in treatment. [24]

- **Recovery Support:** Transitional housing, life skills training, parenting skills, and peer-based individual and group counseling, offered during and following treatment to further assist individuals in their development of the knowledge and skills necessary to maintain their recovery.[25]

Licensure Requirements for Substance Abuse Service Providers

DCF regulates substance abuse treatment by licensing individual treatment components under statute and rule.[26] All private and publicly-funded entities providing substance abuse services must be licensed for each service component they provide.[27] However, current law exempts certain entities from licensure:[28]

- A hospital or hospital-based component;
- A nursing home facility;
- A substance abuse education program established under the public school system;
- A facility or institution operated by the Federal Government;
- An allopathic or osteopathic physician or physician assistant;
- A psychologist;
- A social worker;
- A marriage and family therapist;
- A mental health counselor;
- A church or nonprofit religious organization or denomination that provides services which are solely religious, spiritual, or ecclesiastical in nature;
- A facility licensed by the Agency for Persons with Disabilities;
- DUI education and screening services under the Florida Uniform Traffic Control Law; and
- A crisis stabilization unit.

This exemption from licensure does not apply if the entity provides state-funded services through the DCF managing entity system or provides services under a government-operated substance abuse program.[29]

Licensed service components include a continuum of substance abuse prevention,[30] intervention,[31] and clinical treatment services.[32] Clinical treatment is a professionally directed, deliberate, and planned regimen of services and interventions that are designed to reduce or eliminate the misuse of drugs and

[24] Id. Research indicates that persons who successfully complete substance abuse treatment have better post-treatment outcomes related to future abstinence, reduced use, less involvement in the criminal justice system, reduced involvement in the child-protective system, employment, increased earnings, and better health.
[25] Id.
[26] Ch. 397, F.S. and R. 65D-30, F.A.C.
[27] S. 397.403, F.S.
[28] S. 397.4012, F.S.
[29] S. 397.4012, F.S.
[30] S. 397.311(26)(c), F.S. Prevention is a process involving strategies that are aimed at the individual, family, community, or substance and that preclude, forestall, or impede the development of substance use problems and promote responsible lifestyles. *See also,* Department of Children and Families, *Substance Abuse: Prevention,* https://www.myflfamilies.com/service-programs/samh/prevention/ (last visited Jan. 21, 2020). Substance abuse prevention is best accomplished through the use of ongoing strategies such as increasing public awareness and education, community-based processes and evidence-based practices. These prevention programs are focused primarily on youth, and, recent years, have shifted to the local level, giving individual communities the opportunity to identify their own unique prevention needs and develop action plans in response. This community focus allows prevention strategies to have a greater impact on behavioral change by shifting social, cultural and community environments.
[31] S. 397.311(26)(b), F.S. Intervention is structured services directed toward individuals or groups at risk of substance abuse and focused on reducing or impeding those factors associated with the onset or the early stages of substance abuse and related problems.
[32] S. 397.311(25), F.S.

alcohol and promote a healthy, drug-free lifestyle.[33] "Clinical treatment services" include, but are not limited to, the following licensable service components: [34]

- Addictions receiving facility;
- Day or night treatment;
- Day or night treatment with community housing;
- Detoxification;
- Intensive inpatient treatment;
- Intensive outpatient treatment;
- Medication-assisted treatment for opiate addiction;
- Outpatient treatment; and
- Residential treatment.

Day-or-Night Treatment Facilities

Day or night treatment is one of the licensable individual treatment service components of clinical treatment services under ch. 397, F.S. This service is provided in a nonresidential environment with a structured schedule of treatment and rehabilitative services.[35] Some day or night treatment facilities have a community housing component, which is a program intended for individuals who can benefit from living independently in peer community housing while participating in treatment services at a day or night treatment facility for a minimum of 5 hours a day for a minimum of 25 hours per week.[36] There are 102 providers who hold a total of 108 licenses for day or night treatment with community housing (DNTCH), 85 of which are located in Broward, Palm Beach, and the Treasure Coast.[37]

These community housing components operate similarly to a recovery residence, as defined in statute, by providing a peer-supported, alcohol- and drug-free living environment. However, unlike recovery residences which operate independently and do not provide treatment to or otherwise have treatment requirements for their residents, community housing components operate directly under a licensed day or night treatment facility and are intended to house individuals while they are receiving treatment at the day or night treatment facility. As such, licensed day or night treatment facilities with group housing components are not required to obtain recovery residence certification to operate their group housing components.

DCF confirmed this in a declaratory statement, finding that a day or night treatment center with a community housing component is distinct from a recovery residence as defined in statute.[38] DCF declared that unlike a recovery residence, a day or night treatment facility with a community housing component is a licensable service component monitored by DCF and is a program which requires its residents to participate in minimum treatment hours each week at the day or night treatment facility.

Defining Mental Health

The Baker Act defines mental illness as "an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which

[33] Id.
[34] S. 397.311(25)(a), F.S.
[35] S. 397.311(26)(a)2., F.S.
[36] S. 397.311(26)(a)3., F.S.
[37] Department of Children and Families, Agency Bill Analysis for 2020 House Bill 1081, (Jan. 14, 2020) (On file with Children, Families, and Seniors Subcommittee Staff).
[38] *In the Matter of: Amethyst Recovery Center, LLC, Order on Petition for Declaratory Statement* (Case No. 18-064CF; Rendition No. DCF-18-196-DS, Aug. 21, 2018)(on file with the Children, Families, and Seniors Subcommittee staff). In June 2018, the facility filed a petition for declaratory judgment asking DCF to clarify whether a community housing component of a day or night treatment facility is required to obtain certification as a recovery residence in order for the day or night treatment facility to provide clinical services to its residents. DCF found that a licensed day or not treatment facility with a community housing component was not subject to the voluntary certification requirements for recovery residences.

impairment substantially interferes with the person's ability to meet the ordinary demands of living."[39] The definition expressly excludes a developmental disability, intoxication, or conditions manifested only by antisocial behavior or substance abuse, but does not exclude dementia or traumatic brain injury (TBI). This means that individuals with dementia or TBI (neither of which are a mental illness) who do not have a co-occurring mental illness can be subject to involuntary treatment under the Baker Act, disrupting them from their normal environment and possibly exacerbating their condition.

For the purpose of post-adjudication commitment, mental illness is "an impairment of the emotional process that exercises conscious control of one's actions, or of the ability to perceive or understand reality, which impairment substantially interferes with the defendant's ability to meet the ordinary demands of living." The definition expressly excludes an intellectual disability, autism, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment, but, just as with the Baker Act, does not exclude dementia or TBI.[40] This means that defendants with dementia or TBI who lack a co-occurring mental illness continue to be committed to forensic facilities, even though a state mental health treatment facility is not an appropriate setting for such a population.

State Forensic System – Mental Health Treatment for Criminal Defendants

The Due Process Clause of the 14th Amendment prohibits the states from trying and convicting defendants who are incompetent to stand trial.[41] The states must have procedures in place that adequately protect the defendant's right to a fair trial, which includes his or her participation in all material stages of the process.[42] Defendants must be able to appreciate the range and nature of the charges and penalties that may be imposed, understand the adversarial nature of the legal process, and disclose to counsel facts pertinent to the proceedings. Defendants also must manifest appropriate courtroom behavior and be able to testify relevantly.[43]

If a defendant is suspected of being incompetent, the court, counsel for the defendant, or the state may file a motion for examination to have the defendant's cognitive state assessed.[44] If the motion is well-founded the court will appoint experts to evaluate the defendant's cognitive state. The defendant's competency is then determined by the judge in a subsequent hearing.[45] If the defendant is found to be competent, the criminal proceeding resumes.[46] If the defendant is found to be incompetent to proceed, the proceeding may not resume unless competency is restored.[47]

Chapter 916, F.S., governs the state forensic system, which is a network of state facilities and community services for persons who have mental health issues, an intellectual disability, or autism and who are involved with the criminal justice system. Offenders who are charged with a felony and adjudicated incompetent to proceed[48] and offenders who are adjudicated not guilty by reason of

[39] S. 394.455(28), F.S.
[40] S. 916.106(14), F.S.
[41] *Pate v. Robinson*, 383 U.S. 375, 86 S.Ct. 836, 15 L.Ed. 815 (1966); *Bishop v. U.S.*, 350 U.S.961, 76 S.Ct. 440, 100 L.Ed. 835 (1956); *Jones v. State*, 740 So.2d 520 (Fla. 1999).
[42] Id. See also Rule 3.210(a)(1), Fla.R.Crim.P.
[43] Id. See also s. 916.12, 916.3012, and 985.19, F.S.
[44] Rule 3.210, Fla.R.Crim.P.
[45] Id.
[46] Rule 3.212, Fla.R.Crim.P.
[47] Id.
[48] "Incompetent to proceed" means "the defendant does not have sufficient present ability to consult with her or his lawyer with a reasonable degree of rational understanding" or "the defendant has no rational, as well as factual, understanding of the proceedings against her or him." s. 916.12(1), F.S.

insanity may be involuntarily committed to state civil[49] and forensic[50] treatment facilities by the circuit court,[51] or in lieu of such commitment, may be released on conditional release[52] by the circuit court if the person is not serving a prison sentence.[53] Conditional release is release into the community accompanied by outpatient care and treatment. The committing court retains jurisdiction over the defendant while the defendant is under involuntary commitment or conditional release.[54]

Sections 916.13 and 916.15, F.S., set forth the criteria under which a court may involuntarily commit a defendant charged with a felony who has been adjudicated incompetent to proceed, or who has been found not guilty by reason of insanity. If a person is committed pursuant to either statute, the administrator at the commitment facility must submit a report to the court:

- No later than 6 months after a defendant's admission date and at the end of any period of extended commitment; or
- At any time the administrator has determined that the defendant has regained competency or no longer meets the criteria for involuntary commitment.[55]

State Treatment Facilities

State treatment facilities are the most restrictive settings for forensic services. DCF oversees two state-operated forensic facilities, Florida State Hospital[56] and North Florida Evaluation and Treatment Center,[57] and two privately-operated, maximum security forensic treatment facilities.[58] The forensic facilities provide assessment, evaluation, and treatment to the individuals who have mental health issues and who are involved with the criminal justice system.[59] In addition to general psychiatric treatment approaches and environment, specialized services include:

- Psychosocial rehabilitation;
- Education;
- Treatment modules such as competency, anger management, mental health awareness, medication and relapse prevention;
- Sexually transmitted disease education and prevention;
- Substance abuse awareness and prevention;
- Vocational training;
- Occupational therapies; and

[49] A "civil facility" is: a mental health facility established within the Department of Children and Families (DCF) or by contract with DCF to serve individuals committed pursuant to chapter 394, F.S., and defendants pursuant to chapter 916, F.S., who do not require the security provided in a forensic facility; or an intermediate care facility for the developmentally disabled, a foster care facility, a group home facility, or a supported living setting designated by the Agency for Persons with Disabilities (APD) to serve defendants who do not require the security provided in a forensic facility. Section 916.106(4), F.S. DCF oversees two state-operated forensic facilities, Florida State Hospital and North Florida Evaluation and Treatment Center, and two privately-operated, maximum security forensic treatment facilities, South Florida Evaluation and Treatment Center and Treasure Coast Treatment Center.

[50] A "forensic facility" is a separate and secure facility established within DCF or APD to service forensic clients. A separate and secure facility means a security-grade building for the purpose of separately housing persons who have mental illness from persons who have intellectual disabilities or autism and separately housing persons who have been involuntarily committed pursuant to chapter 916, F.S., from non-forensic residents. Section 916.106(10), F.S.

[51] Sections 916.13, 916.15, and 916.302, F.S.

[52] Conditional release is release into the community accompanied by outpatient care and treatment. Section 916.17, F.S.

[53] Section 916.17(1), F.S.

[54] Section 916.16(1), F.S.

[55] Section 916.13(2), F.S.; section 916.15(3), F.S.

[56] Florida State Hospital has capacity for 959 individuals, of which 469 may receive forensic services. Up to an additional 245 individuals with forensic commitments (but do not require the security of a forensic setting) may occupy the hospital's civil beds. *See* Department of Children and Families, *Forensic Facilities*, https://www.myflfamilies.com/service-programs/samh/adult-forensic-mental-health/forensic-facilities.shtml (last visited Feb. 13, 2020).

[57] Id. The North Florida Evaluation and Treatment Center has 193 beds.

[58] Id. South Florida Evaluation and Treatment Center has a capacity to serve 238 individuals, and Treasure Coast Treatment Center has a contracted capacity of 208 beds.

[59] Florida Department of Children and Families, *About Adult Forensic Mental Health (AFMH)*, https://www.myflfamilies.com/service-programs/samh/adult-forensic-mental-health/forensic-facilities.shtml (last visited Feb. 13, 2020).

- Full range of medical and dental services.[60]

In Fiscal Year 2014-2015, there were 1,573 forensic commitments.[61] This number was 1,587 and 1,680 in Fiscal Years 2015-2016 and 2016-2017, respectively.[62] The increasing number of forensic commitments has made it difficult for DCF to admit individuals to state forensic facilities within the statutorily mandated 15 days.[63] Between July 1, 2016 and June 30, 2017, it took an average of 10 days to admit forensic individuals into state mental health treatment facilities.[64]

Medical Information Sharing Between County Jails and DCF

Forensic clients committed to DCF's state mental health treatment facilities are transferred to the facilities directly from the county jails, and some may have medical conditions that require on-going or immediate medical treatment.[65] Current law requires jail physicians to provide a current psychotropic medication[66] order at the time a forensic client is transferred to the state mental health treatment facility or upon request of the admitting physician after the client is evaluated.[67] However, there is no statutory timeframe within which a jail physician must respond to a request by DCF for such information, nor is there any requirement for jail physicians to provide other medical information about individuals being transferred to DCF. While DCF currently requests medical information from the county jails when a commitment packet is received from the courts, there is no statutory time requirement within which DCF must make the request. According to DCF, lack of continuity of care and lack of information on the individual's medical status can result in life-threatening situations.[68]

Continuation of Psychotropic Medications

When forensic clients are restored to competency and released from state mental health treatment facilities, most are returned to the county jail of the committing jurisdiction to await resolution of their court cases. Some individuals are maintained by county jails on the same psychiatric medication regimen prescribed and administered at the state mental health treatment facility, while others individuals are not.

Continuation of a forensic client's psychotropic medication treatment upon transfer from a state mental health treatment facility to a county jail may prevent negative health outcomes, including loss of competency.[69] If an individual loses competency, then the jail must return him or her to a secure forensic facility, as he or she once again becomes unable to stand trial or proceed with resolution of his or her court case.[70]

DCF defines a recidivist as an individual who is recommended as competent to the court, returned to the jail from the forensic facility, and then readmitted to the forensic facility as incompetent to proceed on the same charge for which he or she was originally found competent.[71] Over the last three years, an average of 12% of those deemed competent to proceed were readmitted to the forensic facility.[72] DCF

[60] Id.
[61] Department of Children and Families, *Exhibit D-3A, Expenditures by Issue and Appropriation Category, Budget Period 2019-2020*, p. 351.
[62] Id.
[63] Id. *See also* s. 916.107(1)(a), F.S.
[64] Id.
[65] *Supra*, note 37.
[66] Psychotropic medication is a broad term referring to medications that affect mental function, behavior, and experience; these medications include anxiolytic/hypnotic medications, such as benzodiazepines, antidepressant medications, such as selective serotonin reuptake inhibitors (SSRIs), and antipsychotic medications. Pamela L. Lindsey, *Psychotropic Medication Use among Older Adults: What All Nurses Need to Know*, J. Gerontol Nurs., (Sept. 2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3128509/ (last visited Jan. 21, 2020).
[67] S. 916.107(3)(a)2.a., F.S.
[68] *Supra,* note 65.
[69] Id.
[70] Id.
[71] Email from Lindsey Zander, Deputy Director of Legislative Affairs, Department of Children and Families, RE: Recidivist Data, (Dec. 17, 2017) (on file with Children, Families, and Seniors Subcommittee staff).
[72] Email from John Paul Fiore, Legislative Specialist, Department of Children and Families, RE: HB 1071 and 1081 Information, (Jan. 21, 2020) (on file with Children, Families, and Seniors Subcommittee staff).

does not collect information on the reason for the recidivism, so DCF cannot identify how often such recidivism is caused by the jail's failure to maintain the forensic client's psychotropic medication as determined by the state mental health treatment facility.

Effect of the Bill

Licensure Requirements for Substance Abuse Service Providers

The bill allows the following entities to contract with DCF and MEs without needing DCF licensure:

- A hospital or hospital-based component;
- A nursing home facility;
- An allopathic or osteopathic physician or physician assistant;
- A psychologist;
- A social worker;
- A marriage and family therapist;
- A mental health counselor; and
- A crisis stabilization unit.

This will expand the number of organizations with which DCF and MEs could contract to improve access to services for individuals with substance use disorders. Maintaining the exemption for these organizations will also remove the impediment to organizations of needing to be licensed by two different agencies.

The bill also exempts an inmate substance abuse program under the Department of Corrections from the accreditation requirements for licensure under the substance abuse chapter. While still subject to licensure, these programs are exempt from certain licensure requirements, such as background screening requirements for substance abuse provider personnel.[73]

Day-or-Night Treatment Facilities

The bill removes day or night treatment with community housing as one of the licensable service components of clinical treatment services under ch. 397, F.S. The treatment services of this component will continue to be regulated through the existing licensable component of day or night treatment. In addition, the housing component of this service meets the statutory definition for a recovery residence under s. 397.311(37), F.S. Current providers would have the following options:

- If they choose to continue to not provide any services in the housing portion, they may change their license to a day or night treatment license and treat the housing component as a recovery residence; or
- Change their license to a day or night treatment license and choose to turn the housing portion into residential treatment and obtain such a license.

Defining Mental Health

The bill redefines "mental illness" related to the Baker Act and post-adjudication commitment to exclude dementia and traumatic brain injury. This proposed change will prohibit individuals with dementia or TBI who lack a co-occurring mental illness form being inappropriately admitted for involuntary examination at Baker Act receiving facilities, or being involuntary admitted to a state mental health treatment facility. However, the proposed change will not prohibit an individual who has dementia or TBI with a co-occurring mental illness who is experiencing a mental health crisis from being admitted to a Baker Act receiving facility or a state mental health treatment facility for involuntary examination.

Medical Information Sharing Between County Jails and DCF

[73] Ss. 397.4073(a)1 and (e), F.S.

The bill also requires county jails to send all medical information for individuals in their custody who will be admitted to state mental health treatment facilities. The bill requires DCF to request this information immediately upon receipt of a completed commitment packet which is provided by the court. Upon receipt of such a request, the county jail must provide the requested information within 3 business days or at the time the defendant enters the physical custody of DCF, whichever is earlier. This proposed change will provide staff at the state mental health treatment facility the required information to provide continued or necessary medical care and treatment.

Continuation of Psychotropic Medication Treatment

The bill requires the treating physician to consult with the jail physician on the jail's drug formulary and consider prescribing the same psychotropic medications included in the jail's drug formulary. The bill requires county jails to administer the same psychotropic medications to a defendant as prescribed by the treating physician upon discharge by a mental health treatment facility, unless the jail physician determines there is a compelling medical reason to change or discontinue the medication for the health and safety of the defendant. If the jail physician changes or discontinues the medication and the defendant is later determined to be incompetent to stand trial and is recommitted to DCF, the bill requires the jail physician to refrain from changing or discontinuing the defendant's prescribed psychotropic medication upon the next discharge from a treatment facility. This proposed change is in an effort to stop the cycle of defendants decompensating and having to return to a forensic facility for treatment.

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. 394.9085, F.S., relating to behavioral provider liability.
Section 3: Amends s. 397.311, F.S., relating to definitions.
Section 4: Amends s. 397.4012, F.S., relating to exemptions from licensure.
Section 5: Amends s. 916.106, F.S., relating to definitions.
Section 6: Amends s. 916.13, F.S., relating to involuntary commitment of defendant adjudicated incompetent.
Section 7: Amends s. 916.15, F.S., relating to involuntary commitment of defendant adjudicated not guilty by reason of insanity.
Section 8: 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:

The bill may have an indeterminate, but likely insignificant, negative fiscal impact on county jails that are required to administer specific psychotropic medications that would not have otherwise been administered. The number of instances in which this occurs is unknown.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Providers of day or night treatment with community housing may experience both negative and positive economic impacts depending on the ability to transition operations to a different licensure category, or by establishing the community housing as a recovery residence. The number of providers who elect to make these changes is unknown.

There may be an increase of available behavioral health service providers, as the bill permits certain existing licensures to obtain DCF licensure. An increase of providers will expand the costs upon a fixed, available revenue for these services.

D. FISCAL COMMENTS:

None.

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 county jails to spend funds to continue psychotropic medications under limited conditions; however, an exemption applies because the bill amends criminal procedures and may have an insignificant fiscal impact.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Current law contains sufficient rulemaking authority to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to substance abuse and mental health; amending s. 394.455, F.S.; revising the definition of the term "mental illness" to exclude conditions manifested by dementia or traumatic brain injury; amending s. 394.9085, F.S.; conforming a cross-reference; amending s. 397.311, F.S.; revising definitions; amending s. 397.4012, F.S.; revising entities that are exempt from certain licensing requirements; amending s. 916.106, F.S.; revising the definition of the term "mental illness;" amending ss. 916.13 and 916.15, F.S.; authorizing jails to share medical information pertaining to specified defendants to the Department of Children and Families; requiring the maintenance of psychotropic medications to specified defendants under certain circumstances; providing an exception; providing an effective date.

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

Section 1. Subsection (28) of section 394.455, Florida Statutes, is amended to read:

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

(28) "Mental illness" means an impairment of the mental or emotional processes that exercise conscious control of one's

actions or of the ability to perceive or understand reality, which impairment substantially interferes with the person's ability to meet the ordinary demands of living. For the purposes of this part, the term does not include a developmental disability as defined in chapter 393, intoxication, or conditions manifested only by dementia, traumatic brain injury, antisocial behavior, or substance abuse.

Section 2. 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)3. ~~ss. 397.311(26)(a)4.~~, 397.311(26)(a)1., and 394.455(39), respectively.

Section 3. Paragraph (a) of subsection (26) of section 397.311, Florida Statutes, is amended to read:

397.311 Definitions.—As used in this chapter, except part VIII, the term:

(26) Licensed service components include a comprehensive continuum of accessible and quality substance abuse prevention, intervention, and clinical treatment services, including the following services:

(a) "Clinical treatment" means a professionally directed, deliberate, and planned regimen of services and interventions

that are designed to reduce or eliminate the misuse of drugs and alcohol and promote a healthy, drug-free lifestyle. As defined by rule, "clinical treatment services" include, but are not limited to, the following licensable service components:

1. "Addictions receiving facility" is a secure, acute care facility that provides, at a minimum, detoxification and stabilization services; is operated 24 hours per day, 7 days per week; and is designated by the department to serve individuals found to be substance use impaired as described in s. 397.675 who meet the placement criteria for this component.

2. "Day or night treatment" is a service provided in a nonresidential environment, with a structured schedule of treatment and rehabilitative services.

~~3. "Day or night treatment with community housing" means a program intended for individuals who can benefit from living independently in peer community housing while participating in treatment services for a minimum of 5 hours a day for a minimum of 25 hours per week.~~

3.~~4.~~ "Detoxification" is a service involving subacute care that is provided on an inpatient or an outpatient basis to assist individuals to withdraw from the physiological and psychological effects of substance abuse and who meet the placement criteria for this component.

4.~~5.~~ "Intensive inpatient treatment" includes a planned regimen of evaluation, observation, medical monitoring, and

clinical protocols delivered through an interdisciplinary team approach provided 24 hours per day, 7 days per week, in a highly structured, live-in environment.

5.~~6.~~ "Intensive outpatient treatment" is a service that provides individual or group counseling in a more structured environment, is of higher intensity and duration than outpatient treatment, and is provided to individuals who meet the placement criteria for this component.

6.~~7.~~ "Medication-assisted treatment for opioid use disorders ~~opiate addiction~~" is a service that uses methadone or other medication as authorized by state and federal law, in combination with medical, rehabilitative, supportive, and counseling services in the treatment of individuals who are dependent on opioid drugs.

7.~~8.~~ "Outpatient treatment" is a service that provides individual, group, or family counseling by appointment during scheduled operating hours for individuals who meet the placement criteria for this component.

8.~~9.~~ "Residential treatment" is a service provided in a structured live-in environment within a nonhospital setting on a 24-hours-per-day, 7-days-per-week basis, and is intended for individuals who meet the placement criteria for this component.

Section 4. Section 397.4012, Florida Statutes, is amended to read:

397.4012 Exemptions from licensure.—The following are

exempt from the licensing provisions of this chapter:

(1) A hospital or hospital-based component licensed under chapter 395.

(2) A nursing home facility as defined in s. 400.021.

(3) A substance abuse education program established pursuant to s. 1003.42.

(4) A facility or institution operated by the Federal Government.

(5) A physician or physician assistant licensed under chapter 458 or chapter 459.

(6) A psychologist licensed under chapter 490.

(7) A social worker, marriage and family therapist, or mental health counselor licensed under chapter 491.

(8) A legally cognizable church or nonprofit religious organization or denomination providing substance abuse services, including prevention services, which are solely religious, spiritual, or ecclesiastical in nature. A church or nonprofit religious organization or denomination providing any of the licensed service components itemized under s. 397.311(26) is not exempt from substance abuse licensure but retains its exemption with respect to all services which are solely religious, spiritual, or ecclesiastical in nature.

(9) Facilities licensed under chapter 393 which, in addition to providing services to persons with developmental disabilities, also provide services to persons developmentally

at risk as a consequence of exposure to alcohol or other legal or illegal drugs while in utero.

(10) DUI education and screening services provided pursuant to ss. 316.192, 316.193, 322.095, 322.271, and 322.291. Persons or entities providing treatment services must be licensed under this chapter unless exempted from licensing as provided in this section.

(11) A facility licensed under s. 394.875 as a crisis stabilization unit.

The exemptions from licensure in subsections (3), (4), (8), (9), and (10) ~~this section~~ do not apply to any service provider that receives an appropriation, grant, or contract from the state to operate as a service provider as defined in this chapter or to any substance abuse program regulated under ~~pursuant to~~ s. 397.4014. Furthermore, this chapter may not be construed to limit the practice of a physician or physician assistant licensed under chapter 458 or chapter 459, a psychologist licensed under chapter 490, a psychotherapist licensed under chapter 491, or an advanced practice registered nurse licensed under part I of chapter 464, who provides substance abuse treatment, so long as the physician, physician assistant, psychologist, psychotherapist, or advanced practice registered nurse does not represent to the public that he or she is a licensed service provider and does not provide services to

individuals under ~~pursuant to~~ part V of this chapter. Failure to comply with any requirement necessary to maintain an exempt status under this section is a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

Section 5. Subsection (14) of section 916.106, Florida Statutes, is amended to read:

916.106 Definitions.—For the purposes of this chapter, the term:

(14) "Mental illness" means an impairment of the emotional processes that exercise conscious control of one's actions, or of the ability to perceive or understand reality, which impairment substantially interferes with the defendant's ability to meet the ordinary demands of living. For the purposes of this chapter, the term does not apply to defendants who have only an intellectual disability or autism or a defendant with traumatic brain injury or dementia who lacks a co-occurring mental illness, and does not include intoxication or conditions manifested only by antisocial behavior or substance abuse impairment.

Section 6. Subsection (2) of section 916.13, Florida Statutes, is amended to read:

916.13 Involuntary commitment of defendant adjudicated incompetent.—

(2) A defendant who has been charged with a felony and who has been adjudicated incompetent to proceed due to mental

illness, and who meets the criteria for involuntary commitment under this chapter, may be committed to the department, and the department shall retain and treat the defendant.

(a) Immediately after receipt of a completed copy of the court commitment order containing all documentation required by the applicable Florida Rules of Criminal Procedure, the department shall request all medical information relating to the defendant from the jail. The jail shall provide the department with all medical information relating to the defendant within 3 business days after receipt of the department's request or at the time the defendant enters the physical custody of the department, whichever is earlier.

(b)1. To ensure continuity of care when a defendant returns to jail, the facility physician shall consult with the jail physician regarding the jail's drug formulary and consider prescribing medication included in the jail's drug formulary when the facility physician prescribes psychotropic medications to the defendant.

2. Each defendant returning to a jail shall continue to receive the same psychotropic medications as prescribed by the facility physician at the time of discharge from a forensic or civil facility, unless the jail physician determines there is a compelling medical reason to change or discontinue the medication. If the jail physician changes or discontinues the medication and the defendant is later determined at the

competency hearing to be incompetent to stand trial and is recommitted to the department, the jail physician may not change or discontinue the defendant's prescribed psychotropic medication upon the defendant's next discharge from the forensic or civil facility.

(c) ~~(a)~~ Within 6 months after the date of admission and at the end of any period of extended commitment, or at any time the administrator or designee determines that the defendant has regained competency to proceed or no longer meets the criteria for continued commitment, the administrator or designee shall file a report with the court pursuant to the applicable Florida Rules of Criminal Procedure.

(d) ~~(b)~~ A competency hearing shall be held within 30 days after the court receives notification that the defendant is competent to proceed or no longer meets the criteria for continued commitment. The defendant must be transported to the committing court's jurisdiction for the hearing.

Section 7. Subsection (3) of section 916.15, Florida Statutes, is amended to read:

916.15 Involuntary commitment of defendant adjudicated not guilty by reason of insanity.—

(3) (a) Every defendant acquitted of criminal charges by reason of insanity and found to meet the criteria for involuntary commitment may be committed and treated in accordance with the provisions of this section and the

applicable Florida Rules of Criminal Procedure.

(b) Immediately after receipt of a completed copy of the court commitment order containing all documentation required by the applicable Florida Rules of Criminal Procedure, the department shall request all medical information relating to the defendant from the jail. The jail shall provide the department with all medical information relating to the defendant within 3 business days after receipt of the department's request or at the time the defendant enters the physical custody of the department, whichever is earlier.

(c)1. The department shall admit a defendant so adjudicated to an appropriate facility or program for treatment and shall retain and treat such defendant. To ensure continuity of care when a defendant returns to jail, the facility physician shall consult with the jail physician regarding the jail's drug formulary and consider prescribing medication included in the jail's drug formulary when the facility physician prescribes psychotropic medications to the defendant.

2. Each defendant returning to a jail shall continue to receive the same psychotropic medications as prescribed by the facility physician at the time of discharge from a forensic or civil facility, unless the jail physician determines there is a compelling medical reason to change or discontinue the medication. If the jail physician changes or discontinues the medication and the defendant is later determined at the

competency hearing to be incompetent to stand trial and is recommitted to the department, the jail physician may not change or discontinue the defendant's prescribed psychotropic medication upon the defendant's next discharge from the forensic or civil facility.

(d) No later than 6 months after the date of admission, before ~~prior to~~ the end of any period of extended commitment, or at any time the administrator or designee determines ~~shall have determined~~ that the defendant no longer meets the criteria for continued commitment placement, the administrator or designee shall file a report with the court pursuant to the applicable Florida Rules of Criminal Procedure.

Section 8. 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 Stevenson offered the following:

Amendment

Remove lines 64-97 and insert:

3. "Day or night treatment with community housing" means a program intended for individuals who can benefit from living independently in peer community housing while participating in treatment services for a minimum of 5 hours a day for a minimum of 25 hours per week.

4. "Detoxification" is a service involving subacute care that is provided on an inpatient or an outpatient basis to assist individuals to withdraw from the physiological and psychological effects of substance abuse and who meet the placement criteria for this component.

5. "Intensive inpatient treatment" includes a planned regimen of evaluation, observation, medical monitoring, and clinical protocols delivered through an interdisciplinary team approach provided 24 hours per day, 7 days per week, in a highly structured, live-in environment.

6. "Intensive outpatient treatment" is a service that provides individual or group counseling in a more structured environment, is of higher intensity and duration than outpatient treatment, and is provided to individuals who meet the placement criteria for this component.

7. "Medication-assisted treatment for opioid use disorders ~~opiate addiction~~" is a service that uses methadone or other medication as authorized by state and federal law, in combination with medical, rehabilitative, supportive, and counseling services in the treatment of individuals who are dependent on opioid drugs.

8. "Outpatient treatment" is a service that provides individual, group, or family counseling by appointment during scheduled operating hours for individuals who meet the placement criteria for this component.

9. "Residential treatment" is a service provided in a structured live-in environment within a nonhospital setting on a 24-hours-per-day, 7-days-per-week basis, and is intended for individuals who meet the placement criteria for this component.

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 Stevenson offered the following:

Amendment (with title amendment)

Between lines 262 and 263, insert:

Section 8. Paragraphs (a) and (d) of subsection (2) of section 14.2019, Florida Statutes, are amended, and paragraphs (e) and (f) are added to that subsection, to read:

14.2019 Statewide Office for Suicide Prevention.—

(2) The statewide office shall, within available resources:

(a) Develop a network of community-based programs to improve suicide prevention initiatives. The network shall identify and work to eliminate barriers to providing suicide prevention services to individuals who are at risk of suicide.

The network shall consist of stakeholders advocating suicide prevention, including, but not limited to, not-for-profit suicide prevention organizations, faith-based suicide prevention organizations, law enforcement agencies, first responders to emergency calls, veterans, servicemembers, suicide prevention community coalitions, schools and universities, mental health agencies, substance abuse treatment agencies, health care providers, and school personnel.

(d) Coordinate education and training curricula in suicide prevention efforts for law enforcement personnel, first responders to emergency calls, veterans, servicemembers, health care providers, school employees, and other persons who may have contact with persons at risk of suicide.

(e) Act as a clearinghouse for information and resources related to suicide prevention by:

1. Disseminating and sharing evidence-based best practices relating to suicide prevention;

2. Collecting and analyzing data on trends in suicide and suicide attempts annually by county, age, gender, profession, and other demographics as designated by the statewide office.

(f) Advise the Department of Transportation on the implementation of evidence-based suicide deterrents in the design elements and features of infrastructure projects throughout the state.

Section 9. Paragraph (c) of subsection (1) and subsection (2) of section 14.20195, Florida Statutes, are amended, and paragraph (d) is added to subsection (1) of that section, to read:

14.20195 Suicide Prevention Coordinating Council; creation; membership; duties.—There is created within the Statewide Office for Suicide Prevention a Suicide Prevention Coordinating Council. The council shall develop strategies for preventing suicide.

(1) SCOPE OF ACTIVITY.—The Suicide Prevention Coordinating Council is a coordinating council as defined in s. 20.03 and shall:

(c) Make findings and recommendations regarding suicide prevention programs and activities, including, but not limited to, the implementation of evidence-based mental health awareness and assistance training programs and suicide risk identification training in municipalities throughout the state. The council shall prepare an annual report and present it to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, each year. The annual report must describe the status of existing and planned initiatives identified in the statewide plan for suicide prevention and any recommendations arising therefrom.

(d) In conjunction with the Department of Children and Families, advise members of the public on the locations and availability of local behavioral health providers.

(2) MEMBERSHIP.—The Suicide Prevention Coordinating Council shall consist of 31 ~~27~~ voting members and one nonvoting member.

(a) Seventeen ~~Thirteen~~ members shall be appointed by the director of the Statewide Office for Suicide Prevention and shall represent the following organizations:

1. The Florida Association of School Psychologists.

2. The Florida Sheriffs Association.

~~3. The Suicide Prevention Action Network USA.~~

3.~~4.~~ The Florida Initiative of Suicide Prevention.

4.~~5.~~ The Florida Suicide Prevention Coalition.

5.~~6.~~ The American Foundation of Suicide Prevention.

6.~~7.~~ The Florida School Board Association.

7.~~8.~~ The National Council for Suicide Prevention.

8.~~9.~~ The state chapter of AARP.

9.~~10.~~ The Florida Behavioral Health Association ~~The Florida Alcohol and Drug Abuse Association.~~

10.~~11.~~ ~~The Florida Council for Community Mental Health.~~

~~12.~~ The Florida Counseling Association.

11.~~13.~~ NAMI Florida.

12. The Florida Medical Association.

13. The Florida Osteopathic Medical Association.

14. The Florida Psychiatric Society.
15. The Florida Psychological Association.
16. Veterans Florida.
17. The Florida Association of Managing Entities.

(b) The following state officials or their designees shall serve on the coordinating council:

1. The Secretary of Elderly Affairs.
2. The State Surgeon General.
3. The Commissioner of Education.
4. The Secretary of Health Care Administration.
5. The Secretary of Juvenile Justice.
6. The Secretary of Corrections.
7. The executive director of the Department of Law Enforcement.
8. The executive director of the Department of Veterans' Affairs.
9. The Secretary of Children and Families.
10. The executive director of the Department of Economic Opportunity.

(c) The Governor shall appoint four additional members to the coordinating council. The appointees must have expertise that is critical to the prevention of suicide or represent an organization that is not already represented on the coordinating council.

(d) For the members appointed by the director of the Statewide Office for Suicide Prevention, seven members shall be appointed to initial terms of 3 years, and seven members shall be appointed to initial terms of 4 years. For the members appointed by the Governor, two members shall be appointed to initial terms of 4 years, and two members shall be appointed to initial terms of 3 years. Thereafter, such members shall be appointed to terms of 4 years. Any vacancy on the coordinating council shall be filled in the same manner as the original appointment, and any member who is appointed to fill a vacancy occurring because of death, resignation, or ineligibility for membership shall serve only for the unexpired term of the member's predecessor. A member is eligible for reappointment.

(e) The director of the Statewide Office for Suicide Prevention shall be a nonvoting member of the coordinating council and shall act as chair.

(f) Members of the coordinating council shall serve without compensation. Any member of the coordinating council who is a public employee is entitled to reimbursement for per diem and travel expenses as provided in s. 112.061.

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

Remove line 17 and insert:

providing an exception; amending s. 14.2019, F.S.; providing additional duties for the Statewide Office for Suicide Prevention; amending s. 14.20195, F.S.; providing additional duties for the Suicide Prevention Coordinating Council; revising the composition of the council; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1105 Child Welfare
SPONSOR(S): Children, Families & Seniors Subcommittee, Tomkow
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	Woodruff	Brazzell
2) Appropriations Committee	26 Y, 0 N	Fontaine	Pridgeon
3) Health & Human Services Committee		Woodruff	Calamas

SUMMARY ANALYSIS

Chapter 39, F.S., creates the dependency system charged with protecting child welfare. The Department of Children and Families (DCF) administers the state's child welfare system and works in partnership with local communities and the courts to ensure the safety, timely permanency and well-being of children involved in the dependency process.

HB 1105 amends various sections in Ch. 39, F.S., to balance placement stability with child safety and permanency. Specifically, the bill:

- Requires certain training for dependency court judges on the benefits of stable placements and related issues.
- Requires judges to consider certain factors related to placement stability when determining whether to change a child's placement.
- Requires DCF to notify judges of all central abuse hotline reports that are accepted for an investigation involving a child over whom the court has jurisdiction.
- Allows DCF to file a petition to initiate court oversight when a family is receiving services from a community-based care lead agency (CBC) without court involvement, if the parent has been receiving voluntary services for a period of time.
- Prohibits the court from ending jurisdiction if a CBC has to continue to provide an in-home safety plan for a child to live at home.

The bill amends current law to require the court and case managers to monitor relationships between foster parents and biological parents at various stages in the dependency process to encourage a productive working relationship that includes meaningful communication and mutual support.

The bill relocates language relating to quality parenting from s. 409.145, F.S., to a new section and expands it to apply to caregivers caring for children in out-of-home care. The new section directs DCF and CBCs to develop and support relationships between foster families and biological parents of children in out-of-home care, when it is safe and in the child's best interest.

Further, the bill allows a CBC to demonstrate a justification of need to provide more than 35 percent of direct care services to children and families in its geographic service area.

HB 1105 has an indeterminate, insignificant, negative impact on the court system, and no impact on local government.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Florida's Child Welfare System

Chapter 39, F.S., creates the dependency system charged with protecting child welfare. Florida's child welfare system identifies children and families in need of services through reports to the central abuse hotline (hotline) and child protective investigations. The Department of Children and Families (DCF) administers the state's child welfare system and works in partnership with local communities and the courts to ensure the safety, timely permanency and well-being of children involved in the dependency process.[1] If the problems cannot be addressed, the child welfare system finds safe out-of-home placements for these children.

DCF's child welfare practice model focuses on preserving and strengthening the child's family ties whenever possible, and removing the child from the home when the child's welfare cannot be adequately safeguarded otherwise.[2]

Community-Based Care Organizations and Services

DCF contracts for case management, out-of-home care, and related services with community-based care lead agencies (CBCs). Using CBCs to provide child welfare services is designed to increase local community ownership of service delivery and design.[3] DCF, through CBCs, administers a system of care for children with the goals of:

- Prevention of separation of children from their families;
- Intervention to allow children to remain safely in their own homes;
- Reunification of families who have had children removed from their care;
- Safety for children who are separated from their families;
- Well-being of children through emphasis on educational stability and timely health care;
- Achievement of permanency; and
- Effective transition to independence and self-sufficiency.

CBCs provide foster care and related services, including, but not limited to, counseling, domestic violence services, substance abuse services, family preservation, emergency shelter, and adoption.[4] CBCs contract with a number of subcontractors for case management and direct care services to children and their families.[5] There are 17 CBCs statewide, which together serve the state's 20 judicial circuits.[6]

However, CBCs contract with various organizations to provide direct care services to children and families, and may also provide such services themselves. CBCs are statutorily prohibited from directly providing more than 35 percent of all child welfare services in the circuit it services.[7]

[1] S. 39.001, F.S.
[2] S. 39.001(4), F.S.
[3] Florida Department of Children and Families, *Community-Based Care*, https://www.myflfamilies.com/service-programs/community-based-care/ (last visited Jan. 14, 2020).
[4] S. 409.145(1), F.S.
[5] *Id*.
[6] Florida Department of Children and Families, *Community-Based Care Lead Agency Map*, http://www.myflfamilies.com/service-programs/community-based-care/cbc-map (last visited Jan. 14, 2020).
[7] S. 409.988(1)(j), F.S.

Dependency Court

Dependency court judge must act in the child's best interest when presiding over a dependency case governed by Ch. 39, F.S. In doing this, the judge considers a number of factors, known as the child's best interest factors, throughout various stages of the dependency court process. Chapter 63, F.S., relating to adoptions, and s. 409.145, F.S., relating to reasonable prudent parenting, outlines specific factors for the judge to consider when determining what is in the child's best interest. However, Ch. 39, F.S., does not provide factors or guidance on what a dependency court judge should consider when determining what is in the child's best interest.

The Dependency Court Process

Dependency Proceeding	Description of Process	Controlling Statute
Removal	A child protective investigation determines the child's home is unsafe, and the child is removed.	s. 39.401, F.S.
Shelter Hearing	A shelter hearing occurs within 24 hours after removal. The judge determines whether to keep the child out-of-home.	s. 39.401, F.S.
Petition for Dependency	A petition for dependency occurs within 21 days of the shelter hearing. This petition seeks to find the child dependent.	s. 39.501, F.S.
Arraignment Hearing and Shelter Review	An arraignment and shelter review occurs within 28 days of the shelter hearing. This allows the parent to admit, deny, or consent to the allegations within the petition for dependency and allows the court to review any shelter placement.	s. 39.506, F.S.
Adjudicatory Trial	An adjudicatory trial is held within 30 days of arraignment. The judge determines whether a child is dependent during trial.	s. 39.507, F.S.
Disposition Hearing	If the child is found dependent, disposition occurs within 15 days of arraignment or 30 days of adjudication. The judge reviews the case plan and placement of the child. The judge orders the case plan for the family and the appropriate placement of the child.	s. 39.506, F.S. s. 39.521, F.S.
Postdisposition hearing	The court may change temporary placement at a postdisposition hearing any time after disposition but before the child is residing in the permanent placement approved at a permanency hearing.	s. 39.522, F.S.
Judicial Review Hearings	The court must review the case plan and placement every 6 months, or upon motion of a party.	s. 39.701, F.S.
Petition for Termination of Parental Rights	Once the child has been out-of-home for 12 months, if DCF determines that reunification is no longer a viable goal, termination of parental rights is in the best interest of the child, and other requirements are met, a petition for termination of parental rights is filed.	s. 39.802, F.S. s. 39.8055, F.S. s. 39.806, F.S. s. 39.810, F.S.
Advisory Hearing	This hearing is set as soon as possible after all parties have been served with the petition for termination of parental rights. The hearing allows the parent to admit, deny, or consent to the allegations within the petition for termination of parental rights.	s. 39.808, F.S.
Adjudicatory Hearing	An adjudicatory trial shall be set within 45 days after the advisory hearing. The judge determines whether to terminate parental rights to the child at this trial.	s. 39.809, F.S.

Training for Dependency Court Judges

There are currently 114 judges and 31 magistrates throughout the state who hear dependency court cases.[8] Judges receive some training on the dependency court process and what to do when considering what is in the child's best interest. All judges new to the bench are required to complete the Florida Judicial College program during their first year of judicial service following selection to the

[8] Email from J. Blair Williams, Senior Court Analyst II, Office of State Courts Administrator, RE: Information Requested on Call Today 1/3/19 (Jan. 13, 2020) on file with Children, Families, and Seniors Subcommittee staff.

bench.[9] The Florida Court Education Council[10] sponsors the 10-day program, which provides general court information as well as information on substantive and procedural matters.[11] However, this program is only for judges new to the bench, and is not required for existing judges rotating to the dependency bench. Judges are also required to earn a minimum of 30 approved credit hours of continuing judicial education every three years.[12] Although there is training available on dependency topics, the only statutorily mandated training is for judges who have responsibility for domestic violence cases.[13]

Dependency System Process

When a child is in danger of, or has suffered from, abuse, abandonment or neglect, the dependency system is set up to protect the child's welfare. The dependency process includes, among other things:

- A report to the central abuse hotline (hotline);
- A child protective investigation to determine the safety of the child;
- The court finding the child dependent;
- Case planning to address the problems resulting in the child's dependency; and
- Reunification with the child's parent or another option to establish permanency, such as adoption.

Central Abuse Hotline

DCF operates the Florida central abuse hotline (hotline), which accepts reports 24 hours a day, seven days a week, of known or suspected child abuse, abandonment or neglect.[14] Statute mandates any person who knows or suspects that a child is abused, abandoned, or neglected to report such knowledge or suspicion to the hotline.[15] A child protective investigation begins if the hotline determines the allegations meet the statutory definition of abuse, abandonment or neglect.[16] A child protective investigator either verifies,[17] does not substantiate,[18] or finds no indicators of abuse or neglect after a child protective investigation.[19]

When the hotline receives a call regarding possible abuse, abandonment or neglect, the hotline counselor researches the child welfare information system to determine if the child or family is currently involved with the child welfare system.[20] If so, the child protective investigator notifies the child's case manager and DCF's attorney of the report.[21]

[9] S. 25.385, F.S. *See* Florida Courts, *Information for New Judges*, https://www.flcourts.org/Resources-Services/Judiciary-Education/Information-for-New-Judges (last visited Jan. 14, 2020).
[10] Established in 1978, the Florida Court Education Council is charged with coordinating and overseeing the creation and maintenance of a comprehensive education program and making budgetary, programmatic, and policy recommendations to the court regarding continuing education.
[11] Florida Office of State Courts Administrator, *Short History of Florida State Court System, Processes, Programs, and Initiatives*, (2016), https://www.flcourts.org/content/download/216626/1965702/Short-History_2016.pdf (last visited Jan. 14, 2020).
[12] *Id*.
[13] S. 25.385, F.S.
[14] S. 39.201(5), F.S.
[15] S. 39.201(1)(a), F.S.
[16] S. 39.201(2)(a), F.S.
[17] "Verified" findings are when a preponderance the evidence results in a determination the specific harm or threat of harm was the result of abuse, abandonment or neglect. These findings require the investigator to take action to protect the child. *See* Florida Department of Children and Families, CF Operating Procedure No. 170-5.
[18] "Not substantiated" findings result from an investigation when there is credible evidence which does not meet the standard or being a preponderance to support that the specific harm was the result of abuse, abandonment, or neglect. *See* Florida Department of Children and Families, CF Operating Procedure No. 170-5.
[19] "No indicators" findings result when there is no credible evidence to support the allegations of abuse, abandonment, or neglect. *See* Florida Department of Children and Families, CF Operating Procedure No. 170-5.
[20] Florida Department of Children and Families, Agency Analysis of HB 1105, on file with Children, Families, and Seniors Subcommittee.
[21] *Id.*

Currently, case managers and DCF attorneys are only required to notify dependency court judges of verified findings during six-month judicial review hearings. If a child protective investigation does not have verified findings of abuse, abandonment or neglect, current law does not require case managers and DCF attorneys to notify the court of the report, even if the court has protective oversight.

Child Protective Investigations

A child protective investigation must be commenced immediately or within 24 hours after a hotline report is received, depending on the nature of the allegation.[22] The child protective investigator (CPI) assesses the safety and perceived needs of the child and family, and if services are needed, whether the child should receive in-home or out-of-home services.

A CPI is required to offer services for voluntary acceptance, even if the CPI determines the child is unsafe, unless there are high-risk factors that may impact the ability of the parents or legal custodians to exercise judgment, or there is a high likelihood of lack of compliance with voluntary services.[23] When the parent accepts voluntary services offered by DCF, the dependency court does not have court oversight of the family. When the child is unsafe and remains in the home without court oversight, DCF must implement a safety plan for the child and the CBC makes sure the family receives needed services.

Safety Methodology

In 2013, DCF began using a new child welfare practice model (model) that standardized the approach to making safety decisions and risk assessments for children.[24] The model seeks the goals of safety, permanency, and child and family well-being.[25] The model emphasizes parent engagement and empowerment as well as training and support of child welfare professionals to assess child safety.[26]

To further implement this model, in 2014 the Legislature required CPIs to implement in-home safety plans to ensure the child's safety while the child remains in the home or is returned home after an out-of-home placement.[27] A safety plan controls and manages danger threats to a child when a parent is unavailable, unable, or unwilling to protect his or her child.[28] In-home safety plans must be specific, sufficient, feasible and sustainable to ensure child safety while the child remains in the home.[29] It may include tasks or responsibilities for a parent, caregiver, or legal custodian.

A safety plan may be used in several situations, such as when:

- the child remains in the home while the child protective investigation is underway;
- the child remains in the home after abuse or neglect is verified, but the parent accepts services voluntarily;
- the child has been placed in the home by the court instead of being sheltered out of home after the parent is found to have neglected or abused the child; and
- the child is reunified with the parent by the court after being in out-of-home care before the parent has completed his or her case plan or demonstrated that he or she has developed the protective capacities necessary to keep the child safe without a safety plan.

When the safety plan is for a child during a child protective investigation, the CPI works with the CBC to develop the safety plan and identify services necessary for the successful implementation of the plan.

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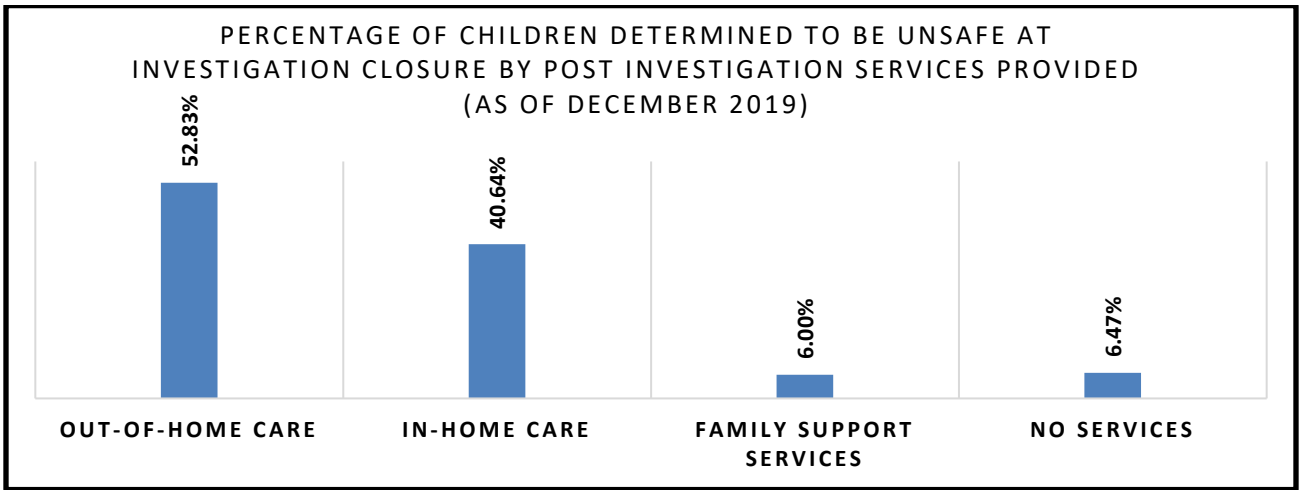
[22] S. 39.301(1), F.S.
[23] S. 39.301(14), F.S.
[24] Florida Department of Children and Families, *2013 Year in Review*, http://www.dcf.state.fl.us/admin/publications/year-in-review/2013/page19.shtml (last visited Jan. 14, 2020).
[25] Florida Department of Children and Families, *Florida's Child Welfare Practice Model*, https://www.myflfamilies.com/service-programs/child-welfare/child-welfare-practice-model.shtmll (last visited Jan. 14, 2020).
[26] *Id.*
[27] S. 39.301(9)(a)6.a., F.S.
[28] Florida Department of Children and Families, CF Operating Procedure No. 170-7.
[29] S. 39.301(9)(a)6.a., F.S.

The CPI monitors the plan to ensure the child's safety until the CPI transfers the case to the CBC to monitor the plan's implementation.[30]

In cases involving an in-home safety plan where there is no court involvement, the CBC case manager over the child's case must request a staffing with a DCF attorney to determine legal actions necessary when the in-home safety plan is no longer protecting the child or the parent is not demonstrating efforts to achieve outcomes that address the child's need for safety.[31] DCF is authorized to file a shelter or dependency petition on a family when the safety plan is no longer sufficient to keep the child safe, but there are currently no statutory timeframes for filing either petition.[32]

When there is court involvement and a safety plan has been implemented, the court retains jurisdiction to review the status of the child for at least six months after the child is reunified with a parent.[33] Currently, it is in the court's discretion when to terminate judicial oversight of the child after retaining jurisdiction for at least six months after reunification. The court can terminate oversight even if a safety plan is in place to protect the child, even though the child welfare safety model contemplates the court retaining jurisdiction as long as a safety plan is in place to protect the child.

The graph below shows the percentage of children, as of December 2019, determined to be unsafe and provided services out of the home compared with those either receiving services in the home or through family support services, which are offered to families on a voluntary basis.[34] Additionally, the graph shows the percentage of children who did not receive services after an investigation.[35] This indicates about half of children determined unsafe are remaining in the parent's home at case closure.



Case Plans

Pursuant to s. 39.6011, F.S., DCF must prepare a case plan for each child receiving services. It must be developed in a face-to-face conference with the child's parent, any court-appointed Guardian ad Litem, and, if appropriate, the child and the temporary custodian of the child.

Each case plan must contain:

- The problem being addressed, including the parent's behavior or acts resulting in risk to the child and the reason for the intervention by DCF.
- The permanency goal.

[30] S. 39.301(9)(a)6.c., F.S.
[31] *Supra* note 28.
[32] *Id*.
[33] S. 39.701, F.S.
[34] Department of Children and Families, *Child Welfare Key Indicators Monthly Report*, (Dec. 2019), *available at* http://www.centerforchildwelfare.org/qa/cwkeyindicator/KI_Monthly_Report_December_2019.pdf (last visited Jan. 13, 2020).
[35] *Id*.

- If concurrent planning is being used, a goal of reunification in addition to one of the remaining permanency goals provided in statute.
- The date the case plan compliance expires. The case plan must be limited to as short a period as possible for accomplishing its provisions. The plan's compliance period expires no later than 12 months after the date the child was removed from the home, the child was adjudicated dependent, or the date the case plan was accepted by the court, whichever occurs first.
- A written notice to the parent that failure to substantially comply with the case plan may result in the termination of parental rights, and that a material breach of the case plan may result in the filing of a petition for termination of parental rights sooner than the compliance period set forth in the case plan.[36]

Additionally, the case plan must describe:
- The role of foster parents or legal custodians when developing the services for the child, foster parents, or legal custodians;
- The responsibility of the case manager to forward a relative's request to receive notification of all proceedings and hearings;
- The minimum number of face-to-face meetings to be held each month between the parents and DCF to review the progress of the case plan, to eliminate barriers to progress, and to resolve conflicts or disagreements; and
- The parent's responsibility for financial support of the child.[37]

All parties must sign the case plan, including the child, unless the child is not of an age or capacity to participate in the case-planning process. Signing the case plan acknowledges that individuals have participated in developing the terms and conditions.[38]

Reunification

Federal law requires states to show, except in certain circumstances such as where the parent committed an especially egregious act, that they have made "reasonable efforts" to provide services to prevent a child's removal or to reunify a child with his or her family prior to termination of parental rights.[39] This federal requirement makes reunification a key goal for children placed in out-of-home care. Additionally, reunification is the primary permanency goal under Florida law.[40] Throughout the dependency process, if a child is in out-of-home care, the court reviews the parent's case to determine when reunification is safe for the child.

The court decides whether a child should receive services in-home or out-of-home at a disposition hearing.[41] If the court places a child out-of-home at disposition, the court can reunify the child with the parent postdisposition if it determines the circumstances that caused the out-of-home placement have been remedied to the extent that returning the child home with an in-home safety plan will not be detrimental to the child.[42] However, if the court does not place a child in out-of-home care at disposition, there is currently no easy mechanism or guidelines in statute for the court to place a child in out-of-home care at postdisposition if the court finds the child is not safe. If the court needs to place a child in out-of-home care after allowing the child to remain home at disposition, it would have to schedule a shelter hearing.

[36] S. 39.6011(2), F.S.
[37] S. 39.6011(4), F.S.
[38] S. 39.6011(3), F.S.
[39] Adoption Assistance and Child Welfare Act of 1980, Public L. No. 96-272, H.R. 3434, 96th Cong. (1980).
[40] S. 39.621(3)(a), F.S.
[41] S. 39.01(25), F.S.
[42] S. 39.522(2), F.S.

Foster Parents

Children who are receiving care out of the home can be placed with foster parents licensed by CBCs or its subcontractors. As of November 2018, there were 5,358 foster parents licensed in Florida, and as of November 2019, 7,738 children were in licensed foster care.[43]

Foster parents care for the children placed in their home and serve as role models for the biological parents working to reunify with their children. To qualify as a potential foster parent, applicants must go through a rigorous interview process, complete a training program, and participate in a home inspection and background check.[44] Foster parents are expected to:[45]

- Provide parenting that consists of a loving commitment to the child and the child's safety and wellbeing;
- Provide opportunities to develop the child's interests and skills;
- Care for the child in light of the child's culture, religion, ethnicity, special physical or psychological needs and unique situations;
- Assist the biological parents in improving their ability to care for and protect their children and to provide continuity for the child;
- Assist the child in visitation and other forms of communication with his or her biological family;
- Obtain and maintain records that are important to the child's wellbeing, such as medical records and records of achievements;
- Advocate for children in their care with the child welfare system, the court, and community agencies, such as schools, child care, and health providers;
- Participate fully in the child's medical, psychological, and dental care as they would for their biological child; and
- Support the child's school success by participating in school activities and meetings.

Quality Parenting Initiative

The Quality Parenting Initiative (QPI), a strategy of the Youth Law Center in California, is an approach to strengthening foster care, focused on improving foster parenting for all children in the child welfare system. It was launched in 2008 in Florida, and as of 2018, over 75 jurisdictions in 10 states have adopted the QPI approach.[46]

When parents cannot care for their children, a foster parent or other caregiver must be able to provide loving, committed, and skilled care that the child needs, in partnership with the system, to ensure that children thrive. QPI was developed to ensure that every child removed from their home because of abuse, abandonment, or neglect is cared for by a foster family that provides skilled, nurturing parenting while helping the child maintain connections with his or her family.

In 2013, the Legislature enacted some of the basic principles of quality parenting in s. 409.145(2), F.S., including roles and responsibilities for caregivers, DCF, CBCs, and other agency staff to work together for children in out-of-home care.[47]

When DCF places a child in out-of-home care, foster parents receive a "Partnership Plan for Children in Out-of-Home Care" (Plan) during the initial foster parent licensing process to inform them of their roles

[43] Florida Department of Children and Families, *Children & Young Adults in Out-of-Home Care – Statewide*, https://www.myflfamilies.com/programs/childwelfare/dashboard/c-in-ooh.shtml (last visited Jan. 20, 2020).
[44] Florida Department of Children and Families, *How Do I Become a Foster Parent?*, http://www.dcf.state.fl.us/service-programs/foster-care/how-do-I.shtml (last visited Jan. 14, 2020).
[45] Florida Department of Children and Families, *Partnership Plan for Children in Out-of-Home Care*¸ *available at* http://centerforchildwelfare.fmhi.usf.edu/kb/OOHPublications/PartnershipPlan.pdf (last visited Jan. 14, 2020).
[46] QPI Florida, Quality Parenting Initiative, *Just in Time Training*, http:www.qpiflorida.org/about.html (last visited Jan. 20, 2020).
[47] S. 409.145, F.S.

and responsibilities for quality parenting.[48] The Plan outlines the values, principles and relationships between DCF, CBCs, and caregivers, like foster parents, in fulfilling their responsibility to care for children in out-of-home care.

Effect of Proposed Changes

HB 1105 amends various sections in Ch. 39, F.S., to address the interaction of placement stability with child safety and permanency.

Changes in Placement

Current law does not provide guidance to courts when it is determining whether a change of placement for a child would be in his or her best interest. HB 1105 amends s. 39.522, F.S., relating to postdisposition change of custody, to provide this guidance.

The bill amends s. 39.522(1)(a), F.S., to add factors the court must consider when determining whether a change of legal custody or placement is in the child's best interest. This will ensure judges are considering all relevant factors on a consistent basis when determining what is in the child's best interest during a dependency court proceeding. These factors include:

- The child's age.
- The physical, mental, and emotional health benefits to the child by remaining in his or her current placement or moving to the proposed placement.
- The stability and longevity of the child's current placement.
- The established bonded relationship between the child and the current or proposed caregiver.
- The reasonable preference of the child, if the court has found that the child is of sufficient intelligence, understanding, and experience to express a preference.
- The recommendation of the child's current caregiver.
- The recommendation of the child's guardian ad litem, if one has been appointed.
- The child's previous and current relationship with a sibling, if the change of legal custody or placement will separate or reunite siblings.
- The likelihood of the child attaining permanency in the current or proposed placement.

Additionally, the bill creates s. 39.522(4), F.S., to provide guidance to the court when it is determining at postdisposition whether to place a child in out-of-home care when the child is living at home with his or her parents with an in-home safety plan. Under this section, the bill outlines factors the court must consider, at a minimum, in making its determination to include:

- The circumstances that caused the child's dependency and other subsequently identified issues.
- The length of time the child has been placed in the home with an in-home safety plan.
- The parent's or caregiver's current level of protective capacities.
- The level of increase, if any, in the parent's or caregiver's protective capacities since the child's placement in the home based on the length of time the child has been placed there.

This creates a mechanism for the court to remove a child from an unsafe home without requiring another shelter hearing when the child is already under the jurisdiction of the court. It will also ensure judges are considering relevant factors on a consistent basis when determining whether to remove a child from the home at postdisposition.

Further, the bill requires the court to evaluate in each change of placement or removal the child's permanency goal and change the goal as needed if doing so is in the best interest of the child. This will ensure that when a court changes a child's placement, or removes the child from his or home, the

[48] R. 65C-13.025(4)(k).

permanency goal in their case plan reflects what is in the child's best interest to reach long-term permanency.

Hotline Reports

The bill amends s. 39.301(1)(b), F.S., to require DCF to promptly notify the court of any report to the hotline that is accepted for an investigation and involves a child over whom the court has jurisdiction. This would require DCF to notify the court of reports that are accepted for an investigation because the allegations meet the statutory definition of abuse, abandonment, or neglect rather than only reports that produce a verified finding after an investigation. This will give a dependency court judge more information on a family whom it has protective oversight so he or she can make more informed decisions to protect the child's health and well-being.

Foster Parents

The bill amends various statutes to promote a good working relationship between foster parents and biological parents that includes meaningful communication and mutual support and requires the court to review the relationship at judicial review hearings.

Case Plans

The bill amends s. 39.6011(5)(b), F.S., to require the case plan to specify the responsibilities of the parents and caregivers to work together to successfully implement the case plan and to include language specifying how the case manager will assist the parents and caregivers in developing a productive relationship, including meaningful communication and mutual support. The case plan must also describe the parent's or caregiver's ability to notify the court or the case manager if ineffective communication takes place that negatively impacts the child.

The bill amends s. 39.701(2)(a)6, F.S., to require the report for judicial review hearings to contain a statement from a foster parent or legal custodian regarding the well-being of the child, the impact of any services provided to the child, and the working relationship between the caregiver and the parents.

The bill also amends s. 39.701(2)(c), F.S., to require the court to determine at judicial review hearings if the parents and caregivers have developed a productive relationship that includes meaningful communication and mutual support.

The bill also amends s. 39.6011(5)(d), F.S., to specify that case managers are to resolve conflicts or disagreements between parents and caregivers, service providers, or any professionals assisting the parents in completion of the case plan.

Quality Parenting and Parenting Partnerships

The bill relocates current statutory language in s. 409.145(2), F.S., related to quality parenting into a new section and expands it to apply to all caregivers caring for a child in out-of-home care. The new section also incorporates the Partnership Plan for Children in Out-of-Home Care into law. Section 409.1415, F.S., directs DCF and CBCs to support relationships between foster families and biological parents of children in out-of-home care by:

- Facilitating telephone communication between the foster parent and the birth or legal parent as soon as possible after the child is placed in the home.
- Facilitating and attending an in-person meeting between the foster parent and the birth or legal parent within two weeks after placement.
- Developing and supporting a plan for the birth or legal parents to participate in medical appointments, educational and extra-curricular activities, and other events involving the child.
- Facilitating participation by the foster parent in visitation between the birth parent and child.
- Involving the foster parent in planning meetings with the birth parent.

- Developing and implementing effective transition plans for the child's return home or placement in any other living environment.
- Supporting continued contact between the foster family and the child after the child returns home or moves to another permanent living arrangement.
- Supporting continued connection with the birth parent after adoption.

This language provides more guidance how biological parents and caregivers, like foster parents, must work together and how CBCs must support them.

Further, the bill amends s. 39.701(2)(a)7, F.S., to require the judicial review report to contain the caregiver's recommendations for an expansion or restriction on future visitations with the birth or legal parent. This will allow caregivers to have additional input regarding the child's safety at judicial review hearings.

Judicial Training

The bill amends s. 25.385, F.S., to require the Florida Court Education Council (FCEC) to establish standards for instruction of circuit court judges who have responsibility for dependency cases regarding the benefits of a secure attachment with a primary caregiver, the importance of a stable placement, and the impact of trauma on child development. The FCEC shall provide such instruction on a periodic and timely basis.

Although new judges currently receive training on the dependency process, this would ensure statewide consistent understanding of the importance of stable and permanent placements for children in the child welfare system.

Court Jurisdiction

The bill amends s. 39.301(9)(a)6., F.S., to allow DCF to file a shelter or dependency petition to initiate court jurisdiction when the family is receiving services from a CBC without judicial oversight. DCF may file a petition if the child has an in-home safety plan and the parent or caregiver has not sufficiently increased his or her protective capacities within 90 days after the CPI transfers the child's case to the CBC. This will provide an incentive for family engagement in voluntary services so children can be safe at home without the use of an in-home safety plan.

The bill amends s. 39.701(1)(b), F.S., to prohibit the court from terminating jurisdiction over a child if the child is placed in a home with a parent or caregiver with an in-home safety plan and the safety plan remains necessary for the child to reside safely in the home. This is consistent with DCF practice and Florida's Safety Methodology. However, judges are not bound by the same standards unless it is in statute and expressed in other court rules.

Community-Based Care Services

The bill amends s. 409.988(1)(j), F.S., to allow a CBC to exceed the 35 percent threshold of providing direct care services to children and families in its circuit if approved by the court to do so. The lead agency must provide a justification of need to stakeholders to exceed the threshold. Stakeholders will review the justification of need and recommend to DCF whether it should approve or deny the request.

The bill amends various statutes to conform cross references to changes in the bill.

The bill will take effect July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Amending s. 25.385, F.S., relating to standards for instruction of circuit and county court judges.
Section 2: Amending s. 39.301, F.S., relating to initiation of protective investigations.
Section 3: Amending s. 39.522, F.S., relating to postdisposition change of custody.
Section 4: Amending s. 39.6011, F.S., relating to case plan development.
Section 5: Amending s. 39.701, F.S., relating to judicial review.
Section 6: Creating s. 409.1415, F.S., relating to parenting partnerships for children in out-of-home care.
Section 7: Amending s. 409.145, F.S., relating to care of children; quality parenting; "reasonable and prudent parent" standard.
Section 8: Amending s. 409.988, F.S., relating to lead agency duties; general provisions.
Section 9: Amending s. 39.302, F.S., relating to protective investigations of institutional child abuse, abandonment, or neglect.
Section 10: Amending s. 39.6225, F.S., relating to guardian assistance program.
Section 11: Amending s. 393.065, F.S., relating to application and eligibility determination.
Section 12: Amending s. 409.1451, F.S., relating to the road-to-independence program.
Section 13: Providing 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 does not have a fiscal impact upon DCF.

   The State Court System indicates the bill's numerous changes to ss. 39.301 and 39.522, F.S, may have an indeterminate fiscal impact. The bill requires DCF to notify the court of reports to the hotline that involve a child whose care is under jurisdiction of the court. This may increase judicial workload as additional hearings are conducted when a court is notified of such reports. Additionally, the bill amends the factors a court is required to consider when evaluating a change in a child's custody or placement, which would also negatively impact judicial workload. It is unknown how many additional hearings and evaluations may result from this bill.

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 provides DCF sufficient rulemaking authority to implement the bill's provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 22, 2020, the Children, Families, and Seniors Subcommittee adopted a strike-all amendment and reported the bill favorably as a committee substitute. The strike-all amendment:

- Requires the Florida Court Educational Council to provide certain training to circuit and county court judges handling dependency cases.
- Relocates current statutory language in s. 409.145, F.S., relating to quality parenting, to a new section, s. 409.1415, F.S.; expands it to caregivers caring for children in out-of-home care; and directs DCF and CBCs to develop and support relationship between foster families and biological parents of children in out-of-home care, when it is safe and in the child's best interest, by:
  - Facilitating communication between foster parents and biological parents.
  - Developing a plan for biological parents to be involved in events involving their children.
  - Facilitating visitation between the biological parents and the child.
  - Developing a transition plan if the child needs to move placements.
  - Continuing relationships between biological parents and the child after adoption.

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 child welfare; amending s. 25.385, F.S.; requiring the Florida Court Educational Council to establish certain standards for instruction of circuit and county court judges for dependency cases; requiring the council to provide such instruction on a periodic and timely basis; amending s. 39.301, F.S.; requiring the Department of Children and Families to notify the court of certain reports; authorizing the department to file specified petitions under certain circumstances; amending s. 39.522, F.S.; requiring the court to consider specified factors when making certain determinations; requiring a child's case plan to be amended if the court changes the permanency goal; amending s. 39.6011, F.S.; revising and providing requirements for case plan descriptions; amending s. 39.701, F.S.; requiring the court to retain jurisdiction over a child under certain circumstances; requiring specified parties to disclose certain information to the court; providing for certain caregiver recommendations to the court; requiring the court and citizen review panel to determine whether certain parties have developed a productive relationship; creating s. 409.1415, F.S.; providing legislative findings and intent; requiring

the department and community-based care lead agencies to develop and support relationships between certain foster families and legal parents of children; providing responsibilities for foster parents, birth parents, the department, community-based care lead agency staff, and other agency staff; defining the term "excellent parenting"; requiring caregivers employed by residential group homes to meet specified requirements; requiring the department to adopt rules; amending s. 409.145, F.S.; removing certain responsibilities of caregivers, the department, community-based care lead agency staff, and other agency staff; removing requirements relating to transitions, information sharing, and certain caregivers; amending s. 409.988, F.S.; authorizing a lead agency to provide more than 35 percent of all child welfare services under certain conditions; requiring a specified local community alliance, or specified representatives in certain circumstances, to review and recommend approval or denial of the lead agency's request for a specified exemption; amending ss. 39.302, 39.6225, 393.065, and 409.1451, F.S.; conforming cross-references to changes made by the act; providing an effective date.

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

Section 1. Section 25.385, Florida Statutes, is amended to read:

25.385 Standards for instruction of circuit and county court judges ~~in handling domestic violence cases~~.—

(1) The Florida Court Educational Council shall establish standards for instruction of circuit and county court judges who have responsibility for domestic violence cases, and the council shall provide such instruction on a periodic and timely basis.

~~(2)~~ As used in this subsection, ~~section:~~

~~(a)~~ the term "domestic violence" has the meaning set forth in s. 741.28.

~~(b) "Family or household member" has the meaning set forth in s. 741.28.~~

(2) The Florida Court Educational Council shall establish standards for instruction of circuit and county court judges who have responsibility for dependency cases regarding the benefits of a secure attachment with a primary caregiver, the importance of a stable placement, and the impact of trauma on child development. The council shall provide such instruction to the circuit and county court judges handling dependency cases on a periodic and timely basis.

Section 2. Subsection (1) and paragraph (a) of subsection (9) of section 39.301, Florida Statutes, are amended to read:

39.301 Initiation of protective investigations.—

(1)(a) Upon receiving a report of known or suspected child abuse, abandonment, or neglect, or that a child is in need of supervision and care and has no parent, legal custodian, or responsible adult relative immediately known and available to provide supervision and care, the central abuse hotline shall determine if the report requires an immediate onsite protective investigation. For reports requiring an immediate onsite protective investigation, the central abuse hotline shall immediately notify the department's designated district staff responsible for protective investigations to ensure that an onsite investigation is promptly initiated. For reports not requiring an immediate onsite protective investigation, the central abuse hotline shall notify the department's designated district staff responsible for protective investigations in sufficient time to allow for an investigation. At the time of notification, the central abuse hotline shall also provide information to district staff on any previous report concerning a subject of the present report or any pertinent information relative to the present report or any noted earlier reports.

(b) The department shall promptly notify the court of any report to the central abuse hotline that is accepted for a protective investigation and involves a child over whom the court has jurisdiction.

(9)(a) For each report received from the central abuse

hotline and accepted for investigation, the department or the sheriff providing child protective investigative services under s. 39.3065, shall perform the following child protective investigation activities to determine child safety:

1. Conduct a review of all relevant, available information specific to the child and family and alleged maltreatment; family child welfare history; local, state, and federal criminal records checks; and requests for law enforcement assistance provided by the abuse hotline. Based on a review of available information, including the allegations in the current report, a determination shall be made as to whether immediate consultation should occur with law enforcement, the Child Protection Team, a domestic violence shelter or advocate, or a substance abuse or mental health professional. Such consultations should include discussion as to whether a joint response is necessary and feasible. A determination shall be made as to whether the person making the report should be contacted before the face-to-face interviews with the child and family members.

2. Conduct face-to-face interviews with the child; other siblings, if any; and the parents, legal custodians, or caregivers.

3. Assess the child's residence, including a determination of the composition of the family and household, including the name, address, date of birth, social security number, sex, and race of each child named in the report; any siblings or other

children in the same household or in the care of the same adults; the parents, legal custodians, or caregivers; and any other adults in the same household.

4. Determine whether there is any indication that any child in the family or household has been abused, abandoned, or neglected; the nature and extent of present or prior injuries, abuse, or neglect, and any evidence thereof; and a determination as to the person or persons apparently responsible for the abuse, abandonment, or neglect, including the name, address, date of birth, social security number, sex, and race of each such person.

5. Complete assessment of immediate child safety for each child based on available records, interviews, and observations with all persons named in subparagraph 2. and appropriate collateral contacts, which may include other professionals. The department's child protection investigators are hereby designated a criminal justice agency for the purpose of accessing criminal justice information to be used for enforcing this state's laws concerning the crimes of child abuse, abandonment, and neglect. This information shall be used solely for purposes supporting the detection, apprehension, prosecution, pretrial release, posttrial release, or rehabilitation of criminal offenders or persons accused of the crimes of child abuse, abandonment, or neglect and may not be further disseminated or used for any other purpose.

6. Document the present and impending dangers to each child based on the identification of inadequate protective capacity through utilization of a standardized safety assessment instrument. If present or impending danger is identified, the child protective investigator must implement a safety plan or take the child into custody. If present danger is identified and the child is not removed, the child protective investigator shall create and implement a safety plan before leaving the home or the location where there is present danger. If impending danger is identified, the child protective investigator shall create and implement a safety plan as soon as necessary to protect the safety of the child. The child protective investigator may modify the safety plan if he or she identifies additional impending danger.

a. If the child protective investigator implements a safety plan, the plan must be specific, sufficient, feasible, and sustainable in response to the realities of the present or impending danger. A safety plan may be an in-home plan or an out-of-home plan, or a combination of both. A safety plan may include tasks or responsibilities for a parent, caregiver, or legal custodian. However, a safety plan may not rely on promissory commitments by the parent, caregiver, or legal custodian who is currently not able to protect the child or on services that are not available or will not result in the safety of the child. A safety plan may not be implemented if for any

reason the parents, guardian, or legal custodian lacks the capacity or ability to comply with the plan. If the department is not able to develop a plan that is specific, sufficient, feasible, and sustainable, the department shall file a shelter petition. A child protective investigator shall implement separate safety plans for the perpetrator of domestic violence, if the investigator, using reasonable efforts, can locate the perpetrator to implement a safety plan, and for the parent who is a victim of domestic violence as defined in s. 741.28. Reasonable efforts to locate a perpetrator include, but are not limited to, a diligent search pursuant to the same requirements as in s. 39.503. If the perpetrator of domestic violence is not the parent, guardian, or legal custodian of any child in the home and if the department does not intend to file a shelter petition or dependency petition that will assert allegations against the perpetrator as a parent of a child in the home, the child protective investigator shall seek issuance of an injunction authorized by s. 39.504 to implement a safety plan for the perpetrator and impose any other conditions to protect the child. The safety plan for the parent who is a victim of domestic violence may not be shared with the perpetrator. If any party to a safety plan fails to comply with the safety plan resulting in the child being unsafe, the department shall file a shelter petition.

b. The child protective investigator shall collaborate

with the community-based care lead agency in the development of the safety plan as necessary to ensure that the safety plan is specific, sufficient, feasible, and sustainable. The child protective investigator shall identify services necessary for the successful implementation of the safety plan. The child protective investigator and the community-based care lead agency shall mobilize service resources to assist all parties in complying with the safety plan. The community-based care lead agency shall prioritize safety plan services to families who have multiple risk factors, including, but not limited to, two or more of the following:

(I) The parent or legal custodian is of young age;

(II) The parent or legal custodian, or an adult currently living in or frequently visiting the home, has a history of substance abuse, mental illness, or domestic violence;

(III) The parent or legal custodian, or an adult currently living in or frequently visiting the home, has been previously found to have physically or sexually abused a child;

(IV) The parent or legal custodian or an adult currently living in or frequently visiting the home has been the subject of multiple allegations by reputable reports of abuse or neglect;

(V) The child is physically or developmentally disabled; or

(VI) The child is 3 years of age or younger.

c. The child protective investigator shall monitor the implementation of the plan to ensure the child's safety until the case is transferred to the lead agency at which time the lead agency shall monitor the implementation.

d. The department may file a petition for shelter or dependency without a new child protective investigation or the concurrence of the child protective investigator if the child is unsafe but for the use of a safety plan and the parent or caregiver has not sufficiently increased protective capacities within 90 days after the transfer of the safety plan to the lead agency.

Section 3. Subsection (1) of section 39.522, Florida Statutes, is amended, and subsection (4) is added to that section, to read:

39.522 Postdisposition change of custody.—The court may change the temporary legal custody or the conditions of protective supervision at a postdisposition hearing, without the necessity of another adjudicatory hearing.

(1)(a) At any time before a child is residing in the permanent placement approved at the permanency hearing, a child who has been placed in the child's own home under the protective supervision of an authorized agent of the department, in the home of a relative, in the home of a legal custodian, or in some other place may be brought before the court by the department or by any other interested person, upon the filing of a motion

alleging a need for a change in the conditions of protective supervision or the placement. If the parents or other legal custodians deny the need for a change, the court shall hear all parties in person or by counsel, or both. Upon the admission of a need for a change or after such hearing, the court shall enter an order changing the placement, modifying the conditions of protective supervision, or continuing the conditions of protective supervision as ordered. The standard for changing custody of the child shall be the best interests ~~interest~~ of the child. When determining whether a change of legal custody or placement is in ~~applying this standard, the court shall consider the continuity of the child's placement in the same out-of-home residence as a factor when determining~~ the best interests of the child, the court shall consider:

1. The child's age.

2. The physical, mental, and emotional health benefits to the child by remaining in his or her current placement or moving to the proposed placement.

3. The stability and longevity of the child's current placement.

4. The established bonded relationship between the child and the current or proposed caregiver.

5. The reasonable preference of the child, if the court has found that the child is of sufficient intelligence, understanding, and experience to express a preference.

6. The recommendation of the child's current caregiver.

7. The recommendation of the child's guardian ad litem, if one has been appointed.

8. The child's previous and current relationship with a sibling, if the change of legal custody or placement will separate or reunite siblings.

9. The likelihood of the child attaining permanency in the current or proposed placement.

10. Any other relevant factors.

(b) If the child is not placed in foster care, ~~then~~ the new placement for the child must meet the home study criteria and court approval under ~~pursuant to~~ this chapter.

(4) In cases in which the issue before the court is whether to place a child in out-of-home care after the child was placed in the child's own home with an in-home safety plan or the child was reunified with a parent or caregiver with an in-home safety plan, the court must consider the factors in paragraph (1)(a) and, at a minimum, the following additional factors in making its determination whether to place the child in out-of-home care:

(a) The circumstances that caused the child's dependency and other subsequently identified issues.

(b) The length of time the child has been placed in the home with an in-home safety plan.

(c) The parent's or caregiver's current level of

protective capacities.

(d) The level of increase, if any, in the parent's or caregiver's protective capacities since the child's placement in the home based on the length of time the child has been placed in the home.

The court shall additionally evaluate the child's permanency goal and change the permanency goal as needed if doing so would be in the best interests of the child. If the court changes the permanency goal, the case plan must be amended pursuant to s. 39.6013(5).

Section 4. Subsection (5) of section 39.6011, Florida Statutes, is amended to read:

39.6011 Case plan development.—

(5) The case plan must describe all of the following:

(a) The role of the foster parents or caregivers ~~legal custodians~~ when developing the services that are to be provided to the child, foster parents, or caregivers. ~~legal custodians;~~

(b) The responsibility of the parents and caregivers to work together to successfully implement the case plan, how the case manager will assist the parents and caregivers in developing a productive relationship that includes meaningful communication and mutual support, and the ability of the parents or caregivers to notify the court or the case manager if ineffective communication takes place that negatively impacts

the child.

(c) ~~(b)~~ The responsibility of the case manager to forward a relative's request to receive notification of all proceedings and hearings submitted under ~~pursuant to~~ s. 39.301(14)(b) to the attorney for the department.~~;~~

(d) ~~(c)~~ The minimum number of face-to-face meetings to be held each month between the parents and the department's family services counselors to review the progress of the plan, to eliminate barriers to progress, and to resolve conflicts or disagreements between parents and caregivers, service providers, or any other professional assisting the parents in the completion of the case plan.~~; and~~

(e) ~~(d)~~ The parent's responsibility for financial support of the child, including, but not limited to, health insurance and child support. The case plan must list the costs associated with any services or treatment that the parent and child are expected to receive which are the financial responsibility of the parent. The determination of child support and other financial support shall be made independently of any determination of indigency under s. 39.013.

Section 5. Paragraph (b) of subsection (1) and paragraphs (a) and (c) of subsection (2) of section 39.701, Florida Statutes, are amended to read:

39.701 Judicial review.—

(1) GENERAL PROVISIONS.—

(b)1. The court shall retain jurisdiction over a child returned to his or her parents for a minimum period of 6 months following the reunification, but, at that time, based on a report of the social service agency and the guardian ad litem, if one has been appointed, and any other relevant factors, the court shall make a determination as to whether supervision by the department and the court's jurisdiction shall continue or be terminated.

2. Notwithstanding subparagraph 1., the court must retain jurisdiction over a child if the child is placed in the home with a parent or caregiver with an in-home safety plan and such safety plan remains necessary for the child to reside safely in the home.

(2) REVIEW HEARINGS FOR CHILDREN YOUNGER THAN 18 YEARS OF AGE.—

(a) Social study report for judicial review.—Before every judicial review hearing or citizen review panel hearing, the social service agency shall make an investigation and social study concerning all pertinent details relating to the child and shall furnish to the court or citizen review panel a written report that includes, but is not limited to:

1. A description of the type of placement the child is in at the time of the hearing, including the safety of the child and the continuing necessity for and appropriateness of the placement.

2. Documentation of the diligent efforts made by all parties to the case plan to comply with each applicable provision of the plan.

3. The amount of fees assessed and collected during the period of time being reported.

4. The services provided to the foster family or caregiver ~~legal custodian~~ in an effort to address the needs of the child as indicated in the case plan.

5. A statement that either:

a. The parent, though able to do so, did not comply substantially with the case plan, and the agency recommendations;

b. The parent did substantially comply with the case plan; or

c. The parent has partially complied with the case plan, with a summary of additional progress needed and the agency recommendations.

6. A statement from the foster parent or caregiver ~~legal custodian~~ providing any material evidence concerning the well-being of the child, the impact of any services provided to the child, the working relationship between the parents and caregivers, and the return of the child to the ~~parent or~~ parents.

7. A statement concerning the frequency, duration, and results of the parent-child visitation, if any, and the agency

and caregiver recommendations for an expansion or restriction of future visitation.

8. The number of times a child has been removed from his or her home and placed elsewhere, the number and types of placements that have occurred, and the reason for the changes in placement.

9. The number of times a child's educational placement has been changed, the number and types of educational placements which have occurred, and the reason for any change in placement.

10. If the child has reached 13 years of age but is not yet 18 years of age, a statement from the caregiver on the progress the child has made in acquiring independent living skills.

11. Copies of all medical, psychological, and educational records that support the terms of the case plan and that have been produced concerning the parents or any caregiver since the last judicial review hearing.

12. Copies of the child's current health, mental health, and education records as identified in s. 39.6012.

(c) Review determinations.—The court and any citizen review panel shall take into consideration the information contained in the social services study and investigation and all medical, psychological, and educational records that support the terms of the case plan; testimony by the social services agency, the parent, the foster parent or caregiver ~~legal custodian~~, the

guardian ad litem or surrogate parent for educational decisionmaking if one has been appointed for the child, and any other person deemed appropriate; and any relevant and material evidence submitted to the court, including written and oral reports to the extent of their probative value. These reports and evidence may be received by the court in its effort to determine the action to be taken with regard to the child and may be relied upon to the extent of their probative value, even though not competent in an adjudicatory hearing. In its deliberations, the court and any citizen review panel shall seek to determine:

1. If the parent was advised of the right to receive assistance from any person or social service agency in the preparation of the case plan.

2. If the parent has been advised of the right to have counsel present at the judicial review or citizen review hearings. If not so advised, the court or citizen review panel shall advise the parent of such right.

3. If a guardian ad litem needs to be appointed for the child in a case in which a guardian ad litem has not previously been appointed or if there is a need to continue a guardian ad litem in a case in which a guardian ad litem has been appointed.

4. Who holds the rights to make educational decisions for the child. If appropriate, the court may refer the child to the district school superintendent for appointment of a surrogate

parent or may itself appoint a surrogate parent under the Individuals with Disabilities Education Act and s. 39.0016.

5. The compliance or lack of compliance of all parties with applicable items of the case plan, including the parents' compliance with child support orders.

6. The compliance or lack of compliance with a visitation contract between the parent and the social service agency for contact with the child, including the frequency, duration, and results of the parent-child visitation and the reason for any noncompliance.

7. The frequency, kind, and duration of contacts among siblings who have been separated during placement, as well as any efforts undertaken to reunite separated siblings if doing so is in the best interests ~~interest~~ of the child.

8. The compliance or lack of compliance of the parent in meeting specified financial obligations pertaining to the care of the child, including the reason for failure to comply, if applicable.

9. Whether the child is receiving safe and proper care according to s. 39.6012, including, but not limited to, the appropriateness of the child's current placement, including whether the child is in a setting that is as family-like and as close to the parent's home as possible, consistent with the child's best interests and special needs, and including maintaining stability in the child's educational placement, as

documented by assurances from the community-based care lead agency ~~provider~~ that:

a. The placement of the child takes into account the appropriateness of the current educational setting and the proximity to the school in which the child is enrolled at the time of placement.

b. The community-based care lead agency has coordinated with appropriate local educational agencies to ensure that the child remains in the school in which the child is enrolled at the time of placement.

10. A projected date likely for the child's return home or other permanent placement.

11. When appropriate, the basis for the unwillingness or inability of the parent to become a party to a case plan. The court and the citizen review panel shall determine if the efforts of the social service agency to secure party participation in a case plan were sufficient.

12. For a child who has reached 13 years of age but is not yet 18 years of age, the adequacy of the child's preparation for adulthood and independent living. For a child who is 15 years of age or older, the court shall determine if appropriate steps are being taken for the child to obtain a driver license or learner's driver license.

13. If amendments to the case plan are required. Amendments to the case plan must be made under s. 39.6013.

14. If the parents and caregivers have developed a productive relationship that includes meaningful communication and mutual support.

Section 6. Section 409.1415, Florida Statutes, is created to read:

409.1415 Parenting partnerships for children in out-of-home care.—

(1) LEGISLATIVE FINDINGS AND INTENT.—

(a) The Legislature finds that reunification is the most common outcome for children in out-of-home care and that foster parents are one of the most important resources to help children reunify with their families.

(b) The Legislature further finds that the most successful foster parents understand that their role goes beyond supporting the children in their care to supporting the children's families, as a whole, and that children and their families benefit when foster and birth parents are supported by an agency culture that encourages a meaningful partnership between them and provides quality support.

(c) Therefore, in keeping with national trends, it is the intent of the Legislature to bring birth parents and foster parents together in order to build strong relationships that lead to more successful reunifications and more stability for children being fostered in out-of-home care.

(2) PARENTING PARTNERSHIPS.—

(a) General provisions.—In order to ensure that children in out-of-home care achieve legal permanency as soon as possible, to reduce the likelihood that they will reenter care or that other children in the family are abused or neglected or enter out-of-home care, and to ensure that families are fully prepared to resume custody of their children, the department and community-based care lead agencies shall develop and support relationships between foster families and the legal parents of children in out-of-home care, to the extent that it is safe and in the child's best interest, by:

1. Facilitating telephone communication between the foster parent and the birth or legal parent as soon as possible after the child is placed in the home.

2. Facilitating and attending an in-person meeting between the foster parent and the birth or legal parent within 2 weeks after placement.

3. Developing and supporting a plan for birth or legal parents to participate in medical appointments, educational and extracurricular activities, and other events involving the child.

4. Facilitating participation by the foster parent in visitation between the birth parent and child.

5. Involving the foster parent in planning meetings with the birth parent.

6. Developing and implementing effective transition plans for the child's return home or placement in any other living environment.

7. Supporting continued contact between the foster family and the child after the child returns home or moves to another permanent living arrangement.

8. Supporting continued connection with the birth parent after adoption.

(b) Responsibilities.—To ensure that a child in out-of-home care receives support for healthy development which gives him or her the best possible opportunity for success, foster parents, birth parents, the department, community-based care lead agency staff, and other agency staff, as applicable, shall work cooperatively in a respectful partnership by adhering to the following requirements:

1. All members of the partnership must interact and communicate professionally with one another, must share all relevant information promptly, and must respect the confidentiality of all information related to a child and his or her family.

2. Caregivers, the family, the department, community-based care lead agency staff, and other agency staff must participate in developing a case plan for the child and family, and all members of the team must work together to implement the plan. Caregivers must participate in all team meetings or court

hearings related to the child's care and future plans. The department, community-based care lead agency staff, and other agency staff must support and facilitate caregiver participation through timely notification of such meetings and hearings and an inclusive process, and by providing alternative methods for participation for caregivers who cannot be physically present at a meeting or hearing.

3. Excellent parenting is a reasonable expectation of caregivers. Caregivers must provide, and the department, community-based care lead agency staff, and other agency staff must support, excellent parenting. "Excellent parenting" means a loving commitment to the child and the child's safety and well-being; appropriate supervision and positive methods of discipline; encouragement of the child's strengths; respect for the child's individuality and likes and dislikes; providing opportunities to develop the child's interests and skills; being aware of the impact of trauma on behavior; facilitating equal participation of the child in family life; involving the child within his or her community; and a commitment to enable the child to lead a normal life.

4. Children in out-of-home care may be placed only with a caregiver who has the ability to care for the child, is willing to accept responsibility for providing care, and is willing and able to learn about and be respectful of the child's culture, religion, and ethnicity; special physical or psychological

needs; any circumstances unique to the child; and family relationships. The department, the community-based care lead agency, and other agencies must provide a caregiver with all available information necessary to assist the caregiver in determining whether he or she is able to appropriately care for a particular child.

5. A caregiver must have access to and take advantage of all training that he or she needs to improve his or her skills in parenting a child who has experienced trauma due to neglect, abuse, or separation from home; to meet the child's special needs; and to work effectively with child welfare agencies, the courts, the schools, and other community and governmental agencies.

6. The department, community-based care lead agency staff, and other agency staff must provide caregivers with the services and support they need to enable them to provide quality care for the child.

7. Once a family accepts the responsibility of caring for a child, the child may be removed from that family only if the family is clearly unable to care for him or her safely or legally, when the child and his or her biological family are reunified, when the child is being placed in a legally permanent home in accordance with a case plan or court order, or when the removal is demonstrably in the best interests of the child.

8. If a child must leave the caregiver's home for one of the reasons stated in subparagraph 7., and in the absence of an unforeseeable emergency, the transition must be accomplished according to a plan that involves cooperation and sharing of information among all persons involved, respects the child's developmental stage and psychological needs, ensures the child has all of his or her belongings, allows for a gradual transition from the caregiver's home, and, if possible, allows for continued contact with the caregiver after the child leaves.

9. When the plan for a child includes reunification, caregivers and agency staff must work together to assist the biological parents in improving their ability to care for and protect their children and to provide continuity for the child.

10. A caregiver must respect and support the child's ties to his or her biological family including parents, siblings, and extended family members and must assist the child in visitation and other forms of communication. The department, community-based care lead agency staff, and other agency staff must provide caregivers with the information, guidance, training, and support necessary for fulfilling this responsibility.

11. A caregiver must work in partnership with the department, community-based care lead agency staff, and other agency staff to obtain and maintain records that are important to the child's well-being including, but not limited to, child

resource records, medical records, school records, photographs, and records of special events and achievements.

12. A caregiver must effectively advocate for a child in his or her care with the child welfare system, the court, and community agencies, including schools, child care providers, health and mental health providers, and employers. The department, community-based care lead agency staff, and other agency staff must support a caregiver in effectively advocating for a child and may not retaliate against the caregiver as a result of this advocacy.

13. A caregiver must be as fully involved in the child's medical, psychological, and dental care as he or she would be for his or her biological child. Agency staff must support and facilitate such participation. Caregivers, the department, community-based care lead agency staff, and other agency staff must share information with each other about the child's health and well-being.

14. A caregiver must support a child's school success, including, when possible, maintaining school stability by participating in school activities and meetings, including individual education plan meetings; assisting with school assignments; supporting tutoring programs; meeting with teachers and working with an educational surrogate, if one has been appointed; and encouraging the child's participation in extracurricular activities. Agency staff must facilitate this

participation and must be kept informed of the child's progress and needs.

15. Caseworkers and caseworker supervisors must mediate disagreements that occur between foster parents and birth parents.

(c) Residential group homes.—All caregivers employed by residential group homes must meet the same education, training, and background and other screening requirements as foster parents and must adhere to the requirements in paragraph (b).

(3) RULEMAKING.—The department shall adopt by rule procedures to administer this section.

Section 7. Section 409.145, Florida Statutes, is amended to read:

409.145 Care of children; ~~quality parenting;~~ "reasonable and prudent parent" standard.—The child welfare system of the department shall operate as a coordinated community-based system of care which empowers all caregivers for children in foster care to provide quality parenting, including approving or disapproving a child's participation in activities based on the caregiver's assessment using the "reasonable and prudent parent" standard.

(1) SYSTEM OF CARE.—The department shall develop, implement, and administer a coordinated community-based system of care for children who are found to be dependent and their families. This system of care must be directed toward the

following goals:

(a) Prevention of separation of children from their families.

(b) Intervention to allow children to remain safely in their own homes.

(c) Reunification of families who have had children removed from their care.

(d) Safety for children who are separated from their families by providing alternative emergency or longer-term parenting arrangements.

(e) Focus on the well-being of children through emphasis on maintaining educational stability and providing timely health care.

(f) Permanency for children for whom reunification with their families is not possible or is not in the best interest of the child.

(g) The transition to independence and self-sufficiency for older children who remain in foster care through adolescence.

~~(2) QUALITY PARENTING.—A child in foster care shall be placed only with a caregiver who has the ability to care for the child, is willing to accept responsibility for providing care, and is willing and able to learn about and be respectful of the child's culture, religion and ethnicity, special physical or psychological needs, any circumstances unique to the child, and~~

~~family relationships. The department, the community-based care lead agency, and other agencies shall provide such caregiver with all available information necessary to assist the caregiver in determining whether he or she is able to appropriately care for a particular child.~~

~~(a) Roles and responsibilities of caregivers.—A caregiver shall:~~

~~1. Participate in developing the case plan for the child and his or her family and work with others involved in his or her care to implement this plan. This participation includes the caregiver's involvement in all team meetings or court hearings related to the child's care.~~

~~2. Complete all training needed to improve skills in parenting a child who has experienced trauma due to neglect, abuse, or separation from home, to meet the child's special needs, and to work effectively with child welfare agencies, the court, the schools, and other community and governmental agencies.~~

~~3. Respect and support the child's ties to members of his or her biological family and assist the child in maintaining allowable visitation and other forms of communication.~~

~~4. Effectively advocate for the child in the caregiver's care with the child welfare system, the court, and community agencies, including the school, child care, health and mental health providers, and employers.~~

~~5. Participate fully in the child's medical, psychological, and dental care as the caregiver would for his or her biological child.~~

~~6. Support the child's educational success by participating in activities and meetings associated with the child's school or other educational setting, including Individual Education Plan meetings and meetings with an educational surrogate if one has been appointed, assisting with assignments, supporting tutoring programs, and encouraging the child's participation in extracurricular activities.~~

~~a. Maintaining educational stability for a child while in out-of-home care by allowing the child to remain in the school or educational setting that he or she attended before entry into out-of-home care is the first priority, unless not in the best interest of the child.~~

~~b. If it is not in the best interest of the child to remain in his or her school or educational setting upon entry into out-of-home care, the caregiver must work with the case manager, guardian ad litem, teachers and guidance counselors, and educational surrogate if one has been appointed to determine the best educational setting for the child. Such setting may include a public school that is not the school of origin, a private school pursuant to s. 1002.42, a virtual instruction program pursuant to s. 1002.45, or a home education program pursuant to s. 1002.41.~~

~~7. Work in partnership with other stakeholders to obtain and maintain records that are important to the child's well-being, including child resource records, medical records, school records, photographs, and records of special events and achievements.~~

~~8. Ensure that the child in the caregiver's care who is between 13 and 17 years of age learns and masters independent living skills.~~

~~9. Ensure that the child in the caregiver's care is aware of the requirements and benefits of the Road-to-Independence Program.~~

~~10. Work to enable the child in the caregiver's care to establish and maintain naturally occurring mentoring relationships.~~

~~(b) Roles and responsibilities of the department, the community-based care lead agency, and other agency staff.—The department, the community-based care lead agency, and other agency staff shall:~~

~~1. Include a caregiver in the development and implementation of the case plan for the child and his or her family. The caregiver shall be authorized to participate in all team meetings or court hearings related to the child's care and future plans. The caregiver's participation shall be facilitated through timely notification, an inclusive process, and alternative methods for participation for a caregiver who cannot~~

~~be physically present.~~

~~2. Develop and make available to the caregiver the information, services, training, and support that the caregiver needs to improve his or her skills in parenting children who have experienced trauma due to neglect, abuse, or separation from home, to meet these children's special needs, and to advocate effectively with child welfare agencies, the courts, schools, and other community and governmental agencies.~~

~~3. Provide the caregiver with all information related to services and other benefits that are available to the child.~~

~~4. Show no prejudice against a caregiver who desires to educate at home a child placed in his or her home through the child welfare system.~~

~~(c) Transitions.—~~

~~1. Once a caregiver accepts the responsibility of caring for a child, the child will be removed from the home of that caregiver only if:~~

~~a. The caregiver is clearly unable to safely or legally care for the child;~~

~~b. The child and his or her biological family are reunified;~~

~~c. The child is being placed in a legally permanent home pursuant to the case plan or a court order; or~~

~~d. The removal is demonstrably in the child's best interest.~~

~~2. In the absence of an emergency, if a child leaves the caregiver's home for a reason provided under subparagraph 1., the transition must be accomplished according to a plan that involves cooperation and sharing of information among all persons involved, respects the child's developmental stage and psychological needs, ensures the child has all of his or her belongings, allows for a gradual transition from the caregiver's home and, if possible, for continued contact with the caregiver after the child leaves.~~

~~(d) Information sharing.—Whenever a foster home or residential group home assumes responsibility for the care of a child, the department and any additional providers shall make available to the caregiver as soon as is practicable all relevant information concerning the child. Records and information that are required to be shared with caregivers include, but are not limited to:~~

~~1. Medical, dental, psychological, psychiatric, and behavioral history, as well as ongoing evaluation or treatment needs;~~

~~2. School records;~~

~~3. Copies of his or her birth certificate and, if appropriate, immigration status documents;~~

~~4. Consents signed by parents;~~

~~5. Comprehensive behavioral assessments and other social assessments;~~

~~6. Court orders;~~

~~7. Visitation and case plans;~~

~~8. Guardian ad litem reports;~~

~~9. Staffing forms; and~~

~~10. Judicial or citizen review panel reports and attachments filed with the court, except confidential medical, psychiatric, and psychological information regarding any party or participant other than the child.~~

~~(c) Caregivers employed by residential group homes.—All caregivers in residential group homes shall meet the same education, training, and background and other screening requirements as foster parents.~~

(2)~~(3)~~ REASONABLE AND PRUDENT PARENT STANDARD.—

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

1. "Age-appropriate" means an activity or item that is generally accepted as suitable for a child of the same chronological age or level of maturity. Age appropriateness is based on the development of cognitive, emotional, physical, and behavioral capacity which is typical for an age or age group.

2. "Caregiver" means a person with whom the child is placed in out-of-home care, or a designated official for a group care facility licensed by the department under s. 409.175.

3. "Reasonable and prudent parent" standard means the standard of care used by a caregiver in determining whether to allow a child in his or her care to participate in

extracurricular, enrichment, and social activities. This standard is characterized by careful and thoughtful parental decisionmaking that is intended to maintain a child's health, safety, and best interest while encouraging the child's emotional and developmental growth.

(b) Application of standard of care.—

1. Every child who comes into out-of-home care pursuant to this chapter is entitled to participate in age-appropriate extracurricular, enrichment, and social activities.

2. Each caregiver shall use the reasonable and prudent parent standard in determining whether to give permission for a child living in out-of-home care to participate in extracurricular, enrichment, or social activities. When using the reasonable and prudent parent standard, the caregiver must consider:

a. The child's age, maturity, and developmental level to maintain the overall health and safety of the child.

b. The potential risk factors and the appropriateness of the extracurricular, enrichment, or social activity.

c. The best interest of the child, based on information known by the caregiver.

d. The importance of encouraging the child's emotional and developmental growth.

e. The importance of providing the child with the most family-like living experience possible.

f. The behavioral history of the child and the child's ability to safely participate in the proposed activity.

(c) Verification of services delivered.—The department and each community-based care lead agency shall verify that private agencies providing out-of-home care services to dependent children have policies in place which are consistent with this section and that these agencies promote and protect the ability of dependent children to participate in age-appropriate extracurricular, enrichment, and social activities.

(d) Limitation of liability.—A caregiver is not liable for harm caused to a child who participates in an activity approved by the caregiver, provided that the caregiver has acted in accordance with the reasonable and prudent parent standard. This paragraph may not be interpreted as removing or limiting any existing liability protection afforded by law.

(3) ~~(4)~~ FOSTER CARE ROOM AND BOARD RATES.—

(a) Effective July 1, 2018, room and board rates shall be paid to foster parents as follows:

Monthly Foster Care Rate

0-5 Years Age	6-12 Years Age	13-21 Years Age
$457.95	$469.68	$549.74

(b) Each January, foster parents shall receive an annual cost of living increase. The department shall calculate the new room and board rate increase equal to the percentage change in the Consumer Price Index for All Urban Consumers, U.S. City Average, All Items, not seasonally adjusted, or successor reports, for the preceding December compared to the prior December as initially reported by the United States Department of Labor, Bureau of Labor Statistics. The department shall make available the adjusted room and board rates annually.

(c) Effective July 1, 2019, foster parents of level I family foster homes, as defined in s. 409.175(5)(a) shall receive a room and board rate of $333.

(d) Effective July 1, 2019, the foster care room and board rate for level II family foster homes as defined in s. 409.175(5)(a) shall be the same as the new rate established for family foster homes as of January 1, 2019.

(e) Effective January 1, 2020, paragraph (b) shall only apply to level II through level V family foster homes, as defined in s. 409.175(5)(a).

(f) The amount of the monthly foster care room and board rate may be increased upon agreement among the department, the community-based care lead agency, and the foster parent.

(g) From July 1, 2018, through June 30, 2019, community-based care lead agencies providing care under contract with the

department shall pay a supplemental room and board payment to foster care parents of all family foster homes, on a per-child basis, for providing independent life skills and normalcy supports to children who are 13 through 17 years of age placed in their care. The supplemental payment shall be paid monthly to the foster care parents in addition to the current monthly room and board rate payment. The supplemental monthly payment shall be based on 10 percent of the monthly room and board rate for children 13 through 21 years of age as provided under this section and adjusted annually. Effective July 1, 2019, such supplemental payments shall only be paid to foster parents of level II through level V family foster homes.

(4) ~~(5)~~ RULEMAKING.—The department shall adopt by rule procedures to administer this section.

Section 8. Paragraph (j) of subsection (1) of section 409.988, Florida Statutes, is amended to read:

409.988 Lead agency duties; general provisions.—

(1) DUTIES.—A lead agency:

(j) May subcontract for the provision of services required by the contract with the lead agency and the department; however, the subcontracts must specify how the provider will contribute to the lead agency meeting the performance standards established pursuant to the child welfare results-oriented accountability system required by s. 409.997. The lead agency shall directly provide no more than 35 percent of all child

welfare services provided unless it can demonstrate a need, within the lead agency's geographic service area, to exceed this threshold. The local community alliance in the geographic service area in which the lead agency is seeking to exceed the threshold shall review the lead agency's justification for need and recommend to the department whether the department should approve or deny the lead agency's request for an exemption from the services threshold. If there is not a community alliance operating in the geographic service area in which the lead agency is seeking to exceed the threshold, such review and recommendation shall be made by representatives of local stakeholders, including at least one representative from each of the following:

1. The department.

2. The county government.

3. The school district.

4. The county United Way.

5. The county sheriff's office.

6. The circuit court corresponding to the county.

7. The county children's board, if one exists.

Section 9. Paragraph (b) of subsection (7) of section 39.302, Florida Statutes, is amended to read:

39.302 Protective investigations of institutional child abuse, abandonment, or neglect.—

(7) When an investigation of institutional abuse, neglect,

or abandonment is closed and a person is not identified as a caregiver responsible for the abuse, neglect, or abandonment alleged in the report, the fact that the person is named in some capacity in the report may not be used in any way to adversely affect the interests of that person. This prohibition applies to any use of the information in employment screening, licensing, child placement, adoption, or any other decisions by a private adoption agency or a state agency or its contracted providers.

(b) Likewise, if a person is employed as a caregiver in a residential group home licensed under ~~pursuant to~~ s. 409.175 and is named in any capacity in three or more reports within a 5-year period, the department may review all reports for the purposes of the employment screening required under s. 409.1415(2)(c) ~~pursuant to s. 409.145(2)(c)~~.

Section 10. Paragraph (d) of subsection (5) of section 39.6225, Florida Statutes, is amended to read:

39.6225 Guardianship Assistance Program.—

(5) A guardian with an application approved pursuant to subsection (2) who is caring for a child placed with the guardian by the court pursuant to this part may receive guardianship assistance payments based on the following criteria:

(d) The department shall provide guardianship assistance payments in the amount of $4,000 annually, paid on a monthly basis, or in an amount other than $4,000 annually as determined

by the guardian and the department and memorialized in a written agreement between the guardian and the department. The agreement shall take into consideration the circumstances of the guardian and the needs of the child. Changes may not be made without the concurrence of the guardian. However, ~~in no case shall~~ the amount of the monthly payment may not exceed the foster care maintenance payment that would have been paid during the same period if the child had been in licensed care at his or her designated level of care at the rate established in s. 409.145(3) ~~s. 409.145(4)~~.

Section 11. Paragraph (b) of subsection (5) of section 393.065, Florida Statutes, is amended to read:

393.065 Application and eligibility determination.—

(5) The agency shall assign and provide priority to clients waiting for waiver services in the following order:

(b) Category 2, which includes individuals on the waiting list who are:

1. From the child welfare system with an open case in the Department of Children and Families' statewide automated child welfare information system and who are either:

a. Transitioning out of the child welfare system at the finalization of an adoption, a reunification with family members, a permanent placement with a relative, or a guardianship with a nonrelative; or

b. At least 18 years but not yet 22 years of age and who

need both waiver services and extended foster care services; or

2. At least 18 years but not yet 22 years of age and who withdrew consent pursuant to s. 39.6251(5)(c) to remain in the extended foster care system.

For individuals who are at least 18 years but not yet 22 years of age and who are eligible under sub-subparagraph 1.b., the agency shall provide waiver services, including residential habilitation, and the community-based care lead agency shall fund room and board at the rate established in s. 409.145(3) ~~s. 409.145(4)~~ and provide case management and related services as defined in s. 409.986(3)(e). Individuals may receive both waiver services and services under s. 39.6251. Services may not duplicate services available through the Medicaid state plan.

Within categories 3, 4, 5, 6, and 7, the agency shall maintain a waiting list of clients placed in the order of the date that the client is determined eligible for waiver services.

Section 12. Paragraph (b) of subsection (2) of section 409.1451, Florida Statutes, is amended to read:

409.1451 The Road-to-Independence Program.—

(2) POSTSECONDARY EDUCATION SERVICES AND SUPPORT.—

(b) The amount of the financial assistance shall be as follows:

1. For a young adult who does not remain in foster care

and is attending a postsecondary school as provided in s. 1009.533, the amount is $1,256 monthly.

2. For a young adult who remains in foster care, is attending a postsecondary school, as provided in s. 1009.533, and continues to reside in a licensed foster home, the amount is the established room and board rate for foster parents. This takes the place of the payment provided for in s. 409.145(3) ~~s. 409.145(4)~~.

3. For a young adult who remains in foster care, but temporarily resides away from a licensed foster home for purposes of attending a postsecondary school as provided in s. 1009.533, the amount is $1,256 monthly. This takes the place of the payment provided for in s. 409.145(3) ~~s. 409.145(4)~~.

4. For a young adult who remains in foster care, is attending a postsecondary school as provided in s. 1009.533, and continues to reside in a licensed group home, the amount is negotiated between the community-based care lead agency and the licensed group home provider.

5. For a young adult who remains in foster care, but temporarily resides away from a licensed group home for purposes of attending a postsecondary school as provided in s. 1009.533, the amount is $1,256 monthly. This takes the place of a negotiated room and board rate.

6. A young adult is eligible to receive financial assistance during the months when he or she is enrolled in a

postsecondary educational institution.

Section 13. 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 Tomkow offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Section 25.385, Florida Statutes, is amended to read:

25.385 Standards for instruction of circuit and county court judges ~~in handling domestic violence cases~~.—

(1) The Florida Court Educational Council shall establish standards for instruction of circuit and county court judges who have responsibility for domestic violence cases, and the council shall provide such instruction on a periodic and timely basis.

~~(2)~~ As used in this subsection, ~~section:~~

~~(a)~~ the term "domestic violence" has the meaning set forth in s. 741.28.

~~(b) "Family or household member" has the meaning set forth in s. 741.28.~~

(2) The Florida Court Educational Council shall establish standards for instruction of circuit and county court judges who have responsibility for dependency cases regarding the benefits of a secure attachment with a primary caregiver, the importance of a stable placement, and the impact of trauma on child development. The council shall provide such instruction to the circuit and county court judges handling dependency cases on a periodic and timely basis.

Section 2. Section 39.01304, Florida Statutes, is created to read:

39.01304 Early childhood court programs.—

(1) A circuit court may create an early childhood court program to serve the needs of infants and toddlers in dependency court. If a circuit court creates an early childhood court, it may consider all of the following components:

(a) The court supporting the therapeutic needs of the parent and child in a nonadversarial manner.

(b) A multidisciplinary team made up of key community stakeholders to work with the court to restructure the way the community responds to the needs of maltreated children.

(c) A community coordinator to facilitate services and resources for families, serve as a liaison between a

multidisciplinary team and the judiciary, and manage data collection for program evaluation and accountability. The Office of the State Courts Administrator may coordinate with each participating circuit court to fill a community coordinator position for the circuit's early childhood court program.

(d) A continuum of mental health services which includes those that support the parent-child relationship and are appropriate for children and family served.

(2) The Office of State Courts Administrator shall contract with one or more university-based centers that have expertise in infant mental health to ensure the quality, accountability, and fidelity of the program's evidence-based treatment. The Office of State Courts Administrator may provide, or contract for the provision of, training and technical assistance related to program services, consultation and guidance for difficult cases, and ongoing training for court teams.

Section 3. Subsection (1) of section 39.0138, Florida Statutes, is amended to read:

39.0138 Criminal history and other records checks; limit on placement of a child.—

(1) The department shall conduct a records check through the State Automated Child Welfare Information System (SACWIS) and a local and statewide criminal history records check on all persons, including parents, being considered by the department for placement of a child under this chapter, including all

nonrelative placement decisions, and all members of the household, 12 years of age and older, of the person being considered. For purposes of this section, a criminal history records check may include, but is not limited to, submission of fingerprints to the Department of Law Enforcement for processing and forwarding to the Federal Bureau of Investigation for state and national criminal history information, and local criminal records checks through local law enforcement agencies of all household members 18 years of age and older and other visitors to the home. The department must complete this record check within 14 business days after receiving the criminal history results, unless additional information is required to complete processing. An out-of-state criminal history records check must be initiated for any person 18 years of age or older who resided in another state if that state allows the release of such records. The department shall establish by rule standards for evaluating any information contained in the automated system relating to a person who must be screened for purposes of making a placement decision.

Section 4. Subsection (1) and paragraph (a) of subsection (9) of section 39.301, Florida Statutes, are amended to read:

39.301 Initiation of protective investigations.—

(1)(a) Upon receiving a report of known or suspected child abuse, abandonment, or neglect, or that a child is in need of supervision and care and has no parent, legal custodian, or

responsible adult relative immediately known and available to provide supervision and care, the central abuse hotline shall determine if the report requires an immediate onsite protective investigation. For reports requiring an immediate onsite protective investigation, the central abuse hotline shall immediately notify the department's designated district staff responsible for protective investigations to ensure that an onsite investigation is promptly initiated. For reports not requiring an immediate onsite protective investigation, the central abuse hotline shall notify the department's designated district staff responsible for protective investigations in sufficient time to allow for an investigation. At the time of notification, the central abuse hotline shall also provide information to district staff on any previous report concerning a subject of the present report or any pertinent information relative to the present report or any noted earlier reports.

(b) The department shall promptly notify the court of any report to the central abuse hotline that is accepted for a protective investigation and involves a child over whom the court has jurisdiction.

(9)(a) For each report received from the central abuse hotline and accepted for investigation, the department or the sheriff providing child protective investigative services under s. 39.3065, shall perform the following child protective investigation activities to determine child safety:

1. Conduct a review of all relevant, available information specific to the child and family and alleged maltreatment; family child welfare history; local, state, and federal criminal records checks; and requests for law enforcement assistance provided by the abuse hotline. Based on a review of available information, including the allegations in the current report, a determination shall be made as to whether immediate consultation should occur with law enforcement, the Child Protection Team, a domestic violence shelter or advocate, or a substance abuse or mental health professional. Such consultations should include discussion as to whether a joint response is necessary and feasible. A determination shall be made as to whether the person making the report should be contacted before the face-to-face interviews with the child and family members.

2. Conduct face-to-face interviews with the child; other siblings, if any; and the parents, legal custodians, or caregivers.

3. Assess the child's residence, including a determination of the composition of the family and household, including the name, address, date of birth, social security number, sex, and race of each child named in the report; any siblings or other children in the same household or in the care of the same adults; the parents, legal custodians, or caregivers; and any other adults in the same household.

4. Determine whether there is any indication that any child in the family or household has been abused, abandoned, or neglected; the nature and extent of present or prior injuries, abuse, or neglect, and any evidence thereof; and a determination as to the person or persons apparently responsible for the abuse, abandonment, or neglect, including the name, address, date of birth, social security number, sex, and race of each such person.

5. Complete assessment of immediate child safety for each child based on available records, interviews, and observations with all persons named in subparagraph 2. and appropriate collateral contacts, which may include other professionals. The department's child protection investigators are hereby designated a criminal justice agency for the purpose of accessing criminal justice information to be used for enforcing this state's laws concerning the crimes of child abuse, abandonment, and neglect. This information shall be used solely for purposes supporting the detection, apprehension, prosecution, pretrial release, posttrial release, or rehabilitation of criminal offenders or persons accused of the crimes of child abuse, abandonment, or neglect and may not be further disseminated or used for any other purpose.

6. Document the present and impending dangers to each child based on the identification of inadequate protective capacity through utilization of a standardized safety assessment

instrument. If present or impending danger is identified, the child protective investigator must implement a safety plan or take the child into custody. If present danger is identified and the child is not removed, the child protective investigator shall create and implement a safety plan before leaving the home or the location where there is present danger. If impending danger is identified, the child protective investigator shall create and implement a safety plan as soon as necessary to protect the safety of the child. The child protective investigator may modify the safety plan if he or she identifies additional impending danger.

a. If the child protective investigator implements a safety plan, the plan must be specific, sufficient, feasible, and sustainable in response to the realities of the present or impending danger. A safety plan may be an in-home plan or an out-of-home plan, or a combination of both. A safety plan may include tasks or responsibilities for a parent, caregiver, or legal custodian. However, a safety plan may not rely on promissory commitments by the parent, caregiver, or legal custodian who is currently not able to protect the child or on services that are not available or will not result in the safety of the child. A safety plan may not be implemented if for any reason the parents, guardian, or legal custodian lacks the capacity or ability to comply with the plan. If the department is not able to develop a plan that is specific, sufficient,

feasible, and sustainable, the department shall file a shelter petition. A child protective investigator shall implement separate safety plans for the perpetrator of domestic violence, if the investigator, using reasonable efforts, can locate the perpetrator to implement a safety plan, and for the parent who is a victim of domestic violence as defined in s. 741.28. Reasonable efforts to locate a perpetrator include, but are not limited to, a diligent search pursuant to the same requirements as in s. 39.503. If the perpetrator of domestic violence is not the parent, guardian, or legal custodian of any child in the home and if the department does not intend to file a shelter petition or dependency petition that will assert allegations against the perpetrator as a parent of a child in the home, the child protective investigator shall seek issuance of an injunction authorized by s. 39.504 to implement a safety plan for the perpetrator and impose any other conditions to protect the child. The safety plan for the parent who is a victim of domestic violence may not be shared with the perpetrator. If any party to a safety plan fails to comply with the safety plan resulting in the child being unsafe, the department shall file a shelter petition.

b. The child protective investigator shall collaborate with the community-based care lead agency in the development of the safety plan as necessary to ensure that the safety plan is specific, sufficient, feasible, and sustainable. The child

protective investigator shall identify services necessary for the successful implementation of the safety plan. The child protective investigator and the community-based care lead agency shall mobilize service resources to assist all parties in complying with the safety plan. The community-based care lead agency shall prioritize safety plan services to families who have multiple risk factors, including, but not limited to, two or more of the following:

(I) The parent or legal custodian is of young age;

(II) The parent or legal custodian, or an adult currently living in or frequently visiting the home, has a history of substance abuse, mental illness, or domestic violence;

(III) The parent or legal custodian, or an adult currently living in or frequently visiting the home, has been previously found to have physically or sexually abused a child;

(IV) The parent or legal custodian or an adult currently living in or frequently visiting the home has been the subject of multiple allegations by reputable reports of abuse or neglect;

(V) The child is physically or developmentally disabled; or

(VI) The child is 3 years of age or younger.

c. The child protective investigator shall monitor the implementation of the plan to ensure the child's safety until

the case is transferred to the lead agency at which time the lead agency shall monitor the implementation.

d. The department may file a petition for shelter or dependency without a new child protective investigation or the concurrence of the child protective investigator if the child is unsafe but for the use of a safety plan and the parent or caregiver has not sufficiently increased protective capacities within 90 days after the transfer of the safety plan to the lead agency.

Section 5. Subsection (1) of section 39.522, Florida Statutes, is amended, and subsection (4) is added to that section, to read:

39.522 Postdisposition change of custody.—The court may change the temporary legal custody or the conditions of protective supervision at a postdisposition hearing, without the necessity of another adjudicatory hearing.

(1)(a) At any time before a child is residing in the permanent placement approved at the permanency hearing, a child who has been placed in the child's own home under the protective supervision of an authorized agent of the department, in the home of a relative, in the home of a legal custodian, or in some other place may be brought before the court by the department or by any other interested person, upon the filing of a motion alleging a need for a change in the conditions of protective supervision or the placement. If the parents or other legal

custodians deny the need for a change, the court shall hear all parties in person or by counsel, or both. Upon the admission of a need for a change or after such hearing, the court shall enter an order changing the placement, modifying the conditions of protective supervision, or continuing the conditions of protective supervision as ordered. The standard for changing custody of the child shall be the best interests ~~interest~~ of the child. When determining whether a change of legal custody or placement is in ~~applying this standard, the court shall consider the continuity of the child's placement in the same out-of-home residence as a factor when determining~~ the best interests of the child, the court shall consider:

1. The child's age.

2. The physical, mental, and emotional health benefits to the child by remaining in his or her current placement or moving to the proposed placement.

3. The stability and longevity of the child's current placement.

4. The established bonded relationship between the child and the current or proposed caregiver.

5. The reasonable preference of the child, if the court has found that the child is of sufficient intelligence, understanding, and experience to express a preference.

6. The recommendation of the child's current caregiver.

7. The recommendation of the child's guardian ad litem, if one has been appointed.

8. The child's previous and current relationship with a sibling, if the change of legal custody or placement will separate or reunite siblings.

9. The likelihood of the child attaining permanency in the current or proposed placement.

10. Any other relevant factors.

(b) If the child is not placed in foster care, ~~then~~ the new placement for the child must meet the home study criteria and court approval under ~~pursuant to~~ this chapter.

(4) In cases in which the issue before the court is whether to place a child in out-of-home care after the child was placed in the child's own home with an in-home safety plan or the child was reunified with a parent or caregiver with an in-home safety plan, the court must consider, at a minimum, the following factors in making its determination whether to place the child in out-of-home care:

(a) The circumstances that caused the child's dependency and other subsequently identified issues.

(b) The length of time the child has been placed in the home with an in-home safety plan.

(c) The parent's or caregiver's current level of protective capacities.

(d) The level of increase, if any, in the parent's or caregiver's protective capacities since the child's placement in the home based on the length of time the child has been placed in the home.

The court shall additionally evaluate the child's permanency goal and change the permanency goal as needed if doing so would be in the best interests of the child. If the court changes the permanency goal, the case plan must be amended pursuant to s. 39.6013(5).

Section 6. Subsection (5) of section 39.6011, Florida Statutes, is amended to read:

39.6011 Case plan development.—

(5) The case plan must describe all of the following:

(a) The role of the foster parents or caregivers ~~legal custodians~~ when developing the services that are to be provided to the child, foster parents, or caregivers. ~~legal custodians;~~

(b) The responsibility of the parents and caregivers to work together when safe to do so, including:

1. How parents and caregivers will work together to successfully implement the case plan.

2. How the case manager will assist the parents and caregivers in developing a productive relationship that includes meaningful communication and mutual support.

3. How the parents and caregivers may notify the court or the case manager if ineffective communication takes place that negatively impacts the child.

(c) ~~(b)~~ The responsibility of the case manager to forward a relative's request to receive notification of all proceedings and hearings submitted under ~~pursuant to~~ s. 39.301(14)(b) to the attorney for the department.~~;~~

(d) ~~(c)~~ The minimum number of face-to-face meetings to be held each month between the parents and the case managers ~~department's family services counselors~~ to review the progress of the plan and services to the child, to eliminate barriers to progress, and to resolve conflicts or disagreements between parents and caregivers, service providers, or any other professional assisting the parents in the completion of the case plan.~~; and~~

(e) ~~(d)~~ The parent's responsibility for financial support of the child, including, but not limited to, health insurance and child support. The case plan must list the costs associated with any services or treatment that the parent and child are expected to receive which are the financial responsibility of the parent. The determination of child support and other financial support shall be made independently of any determination of indigency under s. 39.013.

Section 7. Paragraph (b) of subsection (1) and paragraphs (a) and (c) of subsection (2) of section 39.701, Florida Statutes, are amended to read:

39.701 Judicial review.—

(1) GENERAL PROVISIONS.—

(b)1. The court shall retain jurisdiction over a child returned to his or her parents for a minimum period of 6 months following the reunification, but, at that time, based on a report of the social service agency and the guardian ad litem, if one has been appointed, and any other relevant factors, the court shall make a determination as to whether supervision by the department and the court's jurisdiction shall continue or be terminated.

2. Notwithstanding subparagraph 1., the court must retain jurisdiction over a child if the child is placed in the home with a parent or caregiver with an in-home safety plan and such safety plan remains necessary for the child to reside safely in the home.

(2) REVIEW HEARINGS FOR CHILDREN YOUNGER THAN 18 YEARS OF AGE.—

(a) Social study report for judicial review.—Before every judicial review hearing or citizen review panel hearing, the social service agency shall make an investigation and social study concerning all pertinent details relating to the child and

shall furnish to the court or citizen review panel a written report that includes, but is not limited to:

1. A description of the type of placement the child is in at the time of the hearing, including the safety of the child and the continuing necessity for and appropriateness of the placement.

2. Documentation of the diligent efforts made by all parties to the case plan to comply with each applicable provision of the plan.

3. The amount of fees assessed and collected during the period of time being reported.

4. The services provided to the foster family or caregiver ~~legal custodian~~ in an effort to address the needs of the child as indicated in the case plan.

5. A statement that either:

a. The parent, though able to do so, did not comply substantially with the case plan, and the agency recommendations;

b. The parent did substantially comply with the case plan; or

c. The parent has partially complied with the case plan, with a summary of additional progress needed and the agency recommendations.

6. A statement from the foster parent or caregiver ~~legal custodian~~ providing any material evidence concerning the well-

being of the child, the impact of any services provided to the child, the working relationship between the parents and caregivers, and the return of the child to the ~~parent or~~ parents.

7. A statement concerning the frequency, duration, and results of the parent-child visitation, if any, and the agency and caregiver recommendations for an expansion or restriction of future visitation.

8. The number of times a child has been removed from his or her home and placed elsewhere, the number and types of placements that have occurred, and the reason for the changes in placement.

9. The number of times a child's educational placement has been changed, the number and types of educational placements which have occurred, and the reason for any change in placement.

10. If the child has reached 13 years of age but is not yet 18 years of age, a statement from the caregiver on the progress the child has made in acquiring independent living skills.

11. Copies of all medical, psychological, and educational records that support the terms of the case plan and that have been produced concerning the parents or any caregiver since the last judicial review hearing.

12. Copies of the child's current health, mental health, and education records as identified in s. 39.6012.

(c) Review determinations.—The court and any citizen review panel shall take into consideration the information contained in the social services study and investigation and all medical, psychological, and educational records that support the terms of the case plan; testimony by the social services agency, the parent, the foster parent or caregiver ~~legal custodian~~, the guardian ad litem or surrogate parent for educational decisionmaking if one has been appointed for the child, and any other person deemed appropriate; and any relevant and material evidence submitted to the court, including written and oral reports to the extent of their probative value. These reports and evidence may be received by the court in its effort to determine the action to be taken with regard to the child and may be relied upon to the extent of their probative value, even though not competent in an adjudicatory hearing. In its deliberations, the court and any citizen review panel shall seek to determine:

1. If the parent was advised of the right to receive assistance from any person or social service agency in the preparation of the case plan.

2. If the parent has been advised of the right to have counsel present at the judicial review or citizen review hearings. If not so advised, the court or citizen review panel shall advise the parent of such right.

3. If a guardian ad litem needs to be appointed for the child in a case in which a guardian ad litem has not previously been appointed or if there is a need to continue a guardian ad litem in a case in which a guardian ad litem has been appointed.

4. Who holds the rights to make educational decisions for the child. If appropriate, the court may refer the child to the district school superintendent for appointment of a surrogate parent or may itself appoint a surrogate parent under the Individuals with Disabilities Education Act and s. 39.0016.

5. The compliance or lack of compliance of all parties with applicable items of the case plan, including the parents' compliance with child support orders.

6. The compliance or lack of compliance with a visitation contract between the parent and the social service agency for contact with the child, including the frequency, duration, and results of the parent-child visitation and the reason for any noncompliance.

7. The frequency, kind, and duration of contacts among siblings who have been separated during placement, as well as any efforts undertaken to reunite separated siblings if doing so is in the best <u>interests</u> ~~interest~~ of the child.

8. The compliance or lack of compliance of the parent in meeting specified financial obligations pertaining to the care of the child, including the reason for failure to comply, if applicable.

9. Whether the child is receiving safe and proper care according to s. 39.6012, including, but not limited to, the appropriateness of the child's current placement, including whether the child is in a setting that is as family-like and as close to the parent's home as possible, consistent with the child's best interests and special needs, and including maintaining stability in the child's educational placement, as documented by assurances from the community-based care lead agency ~~provider~~ that:

a. The placement of the child takes into account the appropriateness of the current educational setting and the proximity to the school in which the child is enrolled at the time of placement.

b. The community-based care lead agency has coordinated with appropriate local educational agencies to ensure that the child remains in the school in which the child is enrolled at the time of placement.

10. A projected date likely for the child's return home or other permanent placement.

11. When appropriate, the basis for the unwillingness or inability of the parent to become a party to a case plan. The court and the citizen review panel shall determine if the efforts of the social service agency to secure party participation in a case plan were sufficient.

12. For a child who has reached 13 years of age but is not yet 18 years of age, the adequacy of the child's preparation for adulthood and independent living. For a child who is 15 years of age or older, the court shall determine if appropriate steps are being taken for the child to obtain a driver license or learner's driver license.

13. If amendments to the case plan are required. Amendments to the case plan must be made under s. 39.6013.

14. If the parents and caregivers have developed a productive relationship that includes meaningful communication and mutual support.

Section 8. Subsection (3) of section 63.092, Florida Statutes, is amended to read:

63.092 Report to the court of intended placement by an adoption entity; at-risk placement; preliminary study.—

(3) PRELIMINARY HOME STUDY.—Before placing the minor in the intended adoptive home, a preliminary home study must be performed by a licensed child-placing agency, a child-caring agency registered under s. 409.176, a licensed professional, or an agency described in s. 61.20(2), unless the adoptee is an adult or the petitioner is a stepparent or a relative. If the adoptee is an adult or the petitioner is a stepparent or a relative, a preliminary home study may be required by the court for good cause shown. The department is required to perform the preliminary home study only if there is no licensed child-

placing agency, child-caring agency registered under s. 409.176, licensed professional, or agency described in s. 61.20(2), in the county where the prospective adoptive parents reside. The preliminary home study must be made to determine the suitability of the intended adoptive parents and may be completed prior to identification of a prospective adoptive minor. Preliminary home studies for identified prospective adoptive minors who are in the custody of the department must be completed within 30 days of initiation. A favorable preliminary home study is valid for 1 year after the date of its completion. Upon its completion, a signed copy of the home study must be provided to the intended adoptive parents who were the subject of the home study. A minor may not be placed in an intended adoptive home before a favorable preliminary home study is completed unless the adoptive home is also a licensed foster home under s. 409.175. The preliminary home study must include, at a minimum:

(a) An interview with the intended adoptive parents;

(b) Records checks of the department's central abuse registry, which the department shall provide to the entity conducting the preliminary home study, and criminal records correspondence checks under s. 39.0138 through the Department of Law Enforcement on the intended adoptive parents;

(c) An assessment of the physical environment of the home;

(d) A determination of the financial security of the intended adoptive parents;

(e) Documentation of counseling and education of the intended adoptive parents on adoptive parenting, as determined by the entity conducting the preliminary home study. The training specified in s. 409.175(14) shall only be required for persons who adopt children from the department;

(f) Documentation that information on adoption and the adoption process has been provided to the intended adoptive parents;

(g) Documentation that information on support services available in the community has been provided to the intended adoptive parents; and

(h) A copy of each signed acknowledgment of receipt of disclosure required by s. 63.085.

If the preliminary home study is favorable, a minor may be placed in the home pending entry of the judgment of adoption. A minor may not be placed in the home if the preliminary home study is unfavorable. If the preliminary home study is unfavorable, the adoption entity may, within 20 days after receipt of a copy of the written recommendation, petition the court to determine the suitability of the intended adoptive home. A determination as to suitability under this subsection does not act as a presumption of suitability at the final hearing. In determining the suitability of the intended adoptive home, the court must consider the totality of the circumstances

in the home. A minor may not be placed in a home in which there resides any person determined by the court to be a sexual predator as defined in s. 775.21 or to have been convicted of an offense listed in s. 63.089(4)(b)2.

Section 9. Section 63.093, Florida Statutes, is created to read:

63.093 Adoption of a child from the child welfare system.—

(1) The department, community-based care lead agency, as defined in s. 409.986(2), or its subcontracted agency must respond to an initial inquiry from a prospective adoptive parent within 7 business days after receipt. The response shall inform the prospective adoptive parent of the process and requirements for adopting a child from the child welfare system.

(2) The department, community-based care lead agency, or its subcontracted agency must refer a prospective adoptive parent interested in adopting children in the custody of the department to a department-approved adoptive parent training program. All prospective adoptive parents must successfully complete the training except licensed foster parents and relative and nonrelative caregivers who:

(a) Previously attended the training within the last 5 years; or

(b) Have had the child available for adoption currently placed in their home for 6 months or longer, and have been determined to understand the challenges and parenting skills needed to successfully parent the child available for adoption.

(3) A prospective adoptive parent must complete an adoption application created by the department.

(4) Prior to the adoptive placement of a child, the community-based care lead agency or its subcontracted agency must complete an adoptive home study of a prospective adoptive parent that includes observation, screening, and evaluation of the child and the prospective adoptive parent. An adoptive home study shall be valid for 12 months from the approval date. In addition, the community-based care lead agency or its subcontracted agency shall complete a preparation process, as established by rule, with the prospective adoptive parent.

(6) At the conclusion of the home study and preparation process, a decision shall be made about the family's appropriateness to adopt. This decision shall be reflected in the final recommendation included in the home study. If the recommendation is for approval, the adoptive parent application file must be submitted to the community-based care lead agency or subcontracted agency for approval. The community-based care lead agency or its subcontracted agency must approve the home study within 14 business days after receipt of the recommendation.

With the exception of (1) and (2), the provisions of this section do not apply to children adopted through the process provided for in s. 63.082(6), F.S.

Section 10. Section 409.1415, Florida Statutes, is created to read:

409.1415 Parenting partnerships for children in out-of-home care.—

(1) LEGISLATIVE FINDINGS AND INTENT.—

(a) The Legislature finds that reunification is the most common outcome for children in out-of-home care and that caregivers are one of the most important resources to help children reunify with their families.

(b) The Legislature further finds that the most successful caregivers understand that their role goes beyond supporting the children in their care to supporting the children's families, as a whole, and that children and their families benefit when caregivers and birth or legal parents are supported by an agency culture that encourages a meaningful partnership between them and provides quality support.

(c) Therefore, in keeping with national trends, it is the intent of the Legislature to bring birth parents and caregivers together in order to build strong relationships that lead to more successful reunifications and more stability for children being fostered in out-of-home care.

(2) PARENTING PARTNERSHIPS.—

(a) General provisions.—In order to ensure that children in out-of-home care achieve legal permanency as soon as possible, and to reduce the likelihood that they will reenter care or that other children in the family are abused or neglected or enter out-of-home care, and to ensure that families

are fully prepared to resume custody of their children, the department and community-based care lead agencies shall develop and support relationships between caregivers and birth or legal parents of children in out-of-home care, to the extent that it is safe and in the child's best interest, by:

1. Facilitating telephone communication between the caregiver and the birth or legal parent as soon as possible after the child is placed in the home of the caregiver.

2. Facilitating and attending an in-person meeting between the caregiver and the birth or legal parent as soon as possible after the child’s placement with the caregiver.

3. Developing and supporting a plan for the birth or legal parent to participate in medical appointments, educational and extracurricular activities, and other events involving the child.

4. Facilitating participation by the caregiver in visitation between the birth or legal parent and the child.

5. Involving the caregiver in planning meetings with the birth or legal parent.

6. Developing and implementing effective transition plans for the child's return home or placement in any other living environment.

7. Supporting continued contact between the caregiver and the child after the child returns home or moves to another permanent living arrangement.

(b) Responsibilities.—To ensure that a child in out-of-home care receives support for healthy development which gives the child the best possible opportunity for success, caregivers, birth or legal parents, the department, and community-based care lead agency, as applicable, shall work cooperatively in a respectful partnership by adhering to the following requirements:

1. All members of the partnership must interact and communicate professionally with one another, must share all relevant information promptly, and must respect the confidentiality of all information related to a child and his or her family.

2. Caregivers, the birth or legal parent, the child, if appropriate, the department, and community-based care lead agency must participate in developing a case plan for the child and the birth or legal parent. All members of the team must work together to implement the case plan. Caregivers must have the opportunity to participate in all team meetings or court hearings related to the child's care and future plans. The department and community-based care lead agency must support and facilitate caregiver participation through timely notification of such meetings and hearings and provide alternative methods for participation for caregivers who cannot be physically present at a meeting or hearing.

3. Caregivers must strive to provide, and the department and community-based care lead agency must support, excellent parenting, which includes:

a. A loving commitment to the child and the child's safety and well-being.

b. Appropriate supervision and positive methods of discipline.

c. Encouragement of the child's strengths

d. Respect for the child's individuality and likes and dislikes.

e. Providing opportunities to develop the child's interests and skills.

f. Being aware of the impact of trauma on behavior.

g. Facilitating equal participation of the child in family life.

h. Involving the child within his or her community.

i. A commitment to enable the child to lead a normal life.

4. Children in out-of-home care must be placed with a caregiver who has the ability to care for the child, is willing to accept responsibility for providing care, and is willing and able to learn about and be respectful of the child's culture, religion, and ethnicity; special physical or psychological needs; circumstances unique to the child; and family relationships. The department, the community-based care lead agency, and other agencies must provide a caregiver with all

available information necessary to assist the caregiver in determining whether he or she is able to appropriately care for a particular child.

5. A caregiver must have access to and take advantage of all training that he or she needs to improve his or her skills in parenting a child who has experienced trauma due to neglect, abuse, or separation from home; to meet the child's special needs; and to work effectively with child welfare agencies, the courts, the schools, and other community and governmental agencies.

6. The department and community-based care lead agency must provide caregivers with the services and support they need to enable them to provide quality care for the child.

7. Once a caregiver accepts the responsibility of caring for a child, the child may be removed from the home of the caregiver only if:

a. the caregiver is clearly unable to safely or legally care for the child;

b. The child and the birth or legal parentare reunified;

c. The child is being placed in a legally permanent home in accordance with a case plan or court order; or

d. The removal is demonstrably in the best interests of the child.

8. If a child must leave the caregiver's home for one of the reasons stated in subparagraph 7., and in the absence of an

unforeseeable emergency, the transition must be accomplished according to a plan that involves cooperation and sharing of information among all persons involved, respects the child's developmental stage and psychological needs, ensures the child has all of his or her belongings, allows for a gradual transition from the caregiver's home, and, if possible, allows for continued contact with the caregiver after the child leaves.

9. When the case plan for a child includes reunification, caregivers, the department and community-based care lead agency must work together to assist the birth or legal parent in improving his or her ability to care for and protect the child and to provide continuity for the child.

10. A caregiver must respect and support the child's ties to his or her birth or legal family including parents, siblings, and extended family members, and must assist the child in maintaining allowable visitation and other forms of communication. The department and community-based care lead agency must provide caregivers with the information, guidance, training, and support necessary for fulfilling this responsibility.

11. A caregiver must work in partnership with the department and community-based care lead agency to obtain and maintain records that are important to the child's well-being including, but not limited to, child resource records, medical

records, school records, photographs, and records of special events and achievements.

12. A caregiver must advocate for a child in his or her care with the child welfare system, the court, and community agency, including schools, child care providers, health and mental health providers, and employers. The department and community-based care lead agency must support a caregiver in advocating for a child and may not retaliate against the caregiver as a result of this advocacy.

13. A caregiver must be as fully involved in the child's medical, psychological, and dental care as he or she would be for his or her biological child. The department and community-based care lead agency must support and facilitate such participation. Caregivers, the department, and community-based care lead agency must share information with each other about the child's health and well-being.

14. A caregiver must support a child's school success, including, when possible, maintaining school stability by participating in school activities and meetings.. The department and community-based care lead agency must facilitate this participation and be informed of the child's progress and needs.

15. A caregiver must ensure that a child in his or her care who is between 13 and 17 years of age learns and masters independent living skills.

16. Case managers and case manager supervisors must mediate disagreements that occur between caregivers and birth or legal parents.

(c) Residential group homes.—All employees of a residential group home must meet the background screening requirements under s. 39.0138 and the level 2 standards for screening under chapter 435. Employees in residential group homes working directly with children as caregivers must meet, at a minimum, the same education, training, background, and other screening requirements as level 2 licensed foster parents.

(3) RULEMAKING.—The department shall adopt rules necessary to administer this section.

Section 11. Section 409.145, Florida Statutes, is amended to read:

409.145 Care of children; ~~quality parenting;~~ "reasonable and prudent parent" standard.—The child welfare system of the department shall operate as a coordinated community-based system of care which empowers all caregivers for children in foster care to provide quality parenting, including approving or disapproving a child's participation in activities based on the caregiver's assessment using the "reasonable and prudent parent" standard.

(1) SYSTEM OF CARE.—The department shall develop, implement, and administer a coordinated community-based system of care for children who are found to be dependent and their

families. This system of care must be directed toward the following goals:

(a) Prevention of separation of children from their families.

(b) Intervention to allow children to remain safely in their own homes.

(c) Reunification of families who have had children removed from their care.

(d) Safety for children who are separated from their families by providing alternative emergency or longer-term parenting arrangements.

(e) Focus on the well-being of children through emphasis on maintaining educational stability and providing timely health care.

(f) Permanency for children for whom reunification with their families is not possible or is not in the best interest of the child.

(g) The transition to independence and self-sufficiency for older children who remain in foster care through adolescence.

~~(2) QUALITY PARENTING.—A child in foster care shall be placed only with a caregiver who has the ability to care for the child, is willing to accept responsibility for providing care, and is willing and able to learn about and be respectful of the child's culture, religion and ethnicity, special physical or~~

~~psychological needs, any circumstances unique to the child, and family relationships. The department, the community-based care lead agency, and other agencies shall provide such caregiver with all available information necessary to assist the caregiver in determining whether he or she is able to appropriately care for a particular child.~~

~~(a) Roles and responsibilities of caregivers.—A caregiver shall:~~

~~1. Participate in developing the case plan for the child and his or her family and work with others involved in his or her care to implement this plan. This participation includes the caregiver's involvement in all team meetings or court hearings related to the child's care.~~

~~2. Complete all training needed to improve skills in parenting a child who has experienced trauma due to neglect, abuse, or separation from home, to meet the child's special needs, and to work effectively with child welfare agencies, the court, the schools, and other community and governmental agencies.~~

~~3. Respect and support the child's ties to members of his or her biological family and assist the child in maintaining allowable visitation and other forms of communication.~~

~~4. Effectively advocate for the child in the caregiver's care with the child welfare system, the court, and community~~

~~agencies, including the school, child care, health and mental health providers, and employers.~~

~~5. Participate fully in the child's medical, psychological, and dental care as the caregiver would for his or her biological child.~~

~~6. Support the child's educational success by participating in activities and meetings associated with the child's school or other educational setting, including Individual Education Plan meetings and meetings with an educational surrogate if one has been appointed, assisting with assignments, supporting tutoring programs, and encouraging the child's participation in extracurricular activities.~~

~~a. Maintaining educational stability for a child while in out-of-home care by allowing the child to remain in the school or educational setting that he or she attended before entry into out-of-home care is the first priority, unless not in the best interest of the child.~~

~~b. If it is not in the best interest of the child to remain in his or her school or educational setting upon entry into out-of-home care, the caregiver must work with the case manager, guardian ad litem, teachers and guidance counselors, and educational surrogate if one has been appointed to determine the best educational setting for the child. Such setting may include a public school that is not the school of origin, a private school pursuant to s. 1002.42, a virtual instruction~~

~~program pursuant to s. 1002.45, or a home education program pursuant to s. 1002.41.~~

~~7. Work in partnership with other stakeholders to obtain and maintain records that are important to the child's well-being, including child resource records, medical records, school records, photographs, and records of special events and achievements.~~

~~8. Ensure that the child in the caregiver's care who is between 13 and 17 years of age learns and masters independent living skills.~~

~~9. Ensure that the child in the caregiver's care is aware of the requirements and benefits of the Road-to-Independence Program.~~

~~10. Work to enable the child in the caregiver's care to establish and maintain naturally occurring mentoring relationships.~~

~~(b) Roles and responsibilities of the department, the community-based care lead agency, and other agency staff.—The department, the community-based care lead agency, and other agency staff shall:~~

~~1. Include a caregiver in the development and implementation of the case plan for the child and his or her family. The caregiver shall be authorized to participate in all team meetings or court hearings related to the child's care and future plans. The caregiver's participation shall be facilitated~~

~~through timely notification, an inclusive process, and alternative methods for participation for a caregiver who cannot be physically present.~~

~~2. Develop and make available to the caregiver the information, services, training, and support that the caregiver needs to improve his or her skills in parenting children who have experienced trauma due to neglect, abuse, or separation from home, to meet these children's special needs, and to advocate effectively with child welfare agencies, the courts, schools, and other community and governmental agencies.~~

~~3. Provide the caregiver with all information related to services and other benefits that are available to the child.~~

~~4. Show no prejudice against a caregiver who desires to educate at home a child placed in his or her home through the child welfare system.~~

~~(c) Transitions.—~~

~~1. Once a caregiver accepts the responsibility of caring for a child, the child will be removed from the home of that caregiver only if:~~

~~a. The caregiver is clearly unable to safely or legally care for the child;~~

~~b. The child and his or her biological family are reunified;~~

~~c. The child is being placed in a legally permanent home pursuant to the case plan or a court order; or~~

~~d. The removal is demonstrably in the child's best interest.~~

~~2. In the absence of an emergency, if a child leaves the caregiver's home for a reason provided under subparagraph 1., the transition must be accomplished according to a plan that involves cooperation and sharing of information among all persons involved, respects the child's developmental stage and psychological needs, ensures the child has all of his or her belongings, allows for a gradual transition from the caregiver's home and, if possible, for continued contact with the caregiver after the child leaves.~~

~~(d) Information sharing.—Whenever a foster home or residential group home assumes responsibility for the care of a child, the department and any additional providers shall make available to the caregiver as soon as is practicable all relevant information concerning the child. Records and information that are required to be shared with caregivers include, but are not limited to:~~

~~1. Medical, dental, psychological, psychiatric, and behavioral history, as well as ongoing evaluation or treatment needs;~~

~~2. School records;~~

~~3. Copies of his or her birth certificate and, if appropriate, immigration status documents;~~

~~4. Consents signed by parents;~~

~~5. Comprehensive behavioral assessments and other social assessments;~~

~~6. Court orders;~~

~~7. Visitation and case plans;~~

~~8. Guardian ad litem reports;~~

~~9. Staffing forms; and~~

~~10. Judicial or citizen review panel reports and attachments filed with the court, except confidential medical, psychiatric, and psychological information regarding any party or participant other than the child.~~

~~(c) Caregivers employed by residential group homes.—All caregivers in residential group homes shall meet the same education, training, and background and other screening requirements as foster parents.~~

(2)~~(3)~~ REASONABLE AND PRUDENT PARENT STANDARD.—

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

1. "Age-appropriate" means an activity or item that is generally accepted as suitable for a child of the same chronological age or level of maturity. Age appropriateness is based on the development of cognitive, emotional, physical, and behavioral capacity which is typical for an age or age group.

2. "Caregiver" means a person with whom the child is placed in out-of-home care, or a designated official for a group care facility licensed by the department under s. 409.175.

3. "Reasonable and prudent parent" standard means the standard of care used by a caregiver in determining whether to allow a child in his or her care to participate in extracurricular, enrichment, and social activities. This standard is characterized by careful and thoughtful parental decisionmaking that is intended to maintain a child's health, safety, and best interest while encouraging the child's emotional and developmental growth.

(b) Application of standard of care.—

1. Every child who comes into out-of-home care pursuant to this chapter is entitled to participate in age-appropriate extracurricular, enrichment, and social activities.

2. Each caregiver shall use the reasonable and prudent parent standard in determining whether to give permission for a child living in out-of-home care to participate in extracurricular, enrichment, or social activities. When using the reasonable and prudent parent standard, the caregiver must consider:

a. The child's age, maturity, and developmental level to maintain the overall health and safety of the child.

b. The potential risk factors and the appropriateness of the extracurricular, enrichment, or social activity.

c. The best interest of the child, based on information known by the caregiver.

d. The importance of encouraging the child's emotional and developmental growth.

e. The importance of providing the child with the most family-like living experience possible.

f. The behavioral history of the child and the child's ability to safely participate in the proposed activity.

(c) Verification of services delivered.—The department and each community-based care lead agency shall verify that private agencies providing out-of-home care services to dependent children have policies in place which are consistent with this section and that these agencies promote and protect the ability of dependent children to participate in age-appropriate extracurricular, enrichment, and social activities.

(d) Limitation of liability.—A caregiver is not liable for harm caused to a child who participates in an activity approved by the caregiver, provided that the caregiver has acted in accordance with the reasonable and prudent parent standard. This paragraph may not be interpreted as removing or limiting any existing liability protection afforded by law.

(3) ~~(4)~~ FOSTER CARE ROOM AND BOARD RATES.—

(a) Effective July 1, 2018, room and board rates shall be paid to foster parents as follows:

Monthly Foster Care Rate

0-5 Years Age	6-12 Years Age	13-21 Years Age
$457.95	$469.68	$549.74

(b) Each January, foster parents shall receive an annual cost of living increase. The department shall calculate the new room and board rate increase equal to the percentage change in the Consumer Price Index for All Urban Consumers, U.S. City Average, All Items, not seasonally adjusted, or successor reports, for the preceding December compared to the prior December as initially reported by the United States Department of Labor, Bureau of Labor Statistics. The department shall make available the adjusted room and board rates annually.

(c) Effective July 1, 2019, foster parents of level I family foster homes, as defined in s. 409.175(5)(a) shall receive a room and board rate of $333.

(d) Effective July 1, 2019, the foster care room and board rate for level II family foster homes as defined in s. 409.175(5)(a) shall be the same as the new rate established for family foster homes as of January 1, 2019.

(e) Effective January 1, 2020, paragraph (b) shall only apply to level II through level V family foster homes, as defined in s. 409.175(5)(a).

(f) The amount of the monthly foster care room and board rate may be increased upon agreement among the department, the community-based care lead agency, and the foster parent.

(g) From July 1, 2018, through June 30, 2019, community-based care lead agencies providing care under contract with the department shall pay a supplemental room and board payment to foster care parents of all family foster homes, on a per-child basis, for providing independent life skills and normalcy supports to children who are 13 through 17 years of age placed in their care. The supplemental payment shall be paid monthly to the foster care parents in addition to the current monthly room and board rate payment. The supplemental monthly payment shall be based on 10 percent of the monthly room and board rate for children 13 through 21 years of age as provided under this section and adjusted annually. Effective July 1, 2019, such supplemental payments shall only be paid to foster parents of level II through level V family foster homes.

(4) ~~(5)~~ RULEMAKING.—The department shall adopt by rule procedures to administer this section.

Section 12. Paragraphs (d) through (k) of subsection (6) of section 409.175, Florida Statutes, are renumbered (e) through (l), respectively, and paragraph (b) and present paragraph (d) of that section are amended to read:

409.175 Licensure of family foster homes, residential child-caring agencies, and child-placing agencies; public records exemption.—

(6)

(b) The department shall prescribe in rule the various roles of entities involved in the application process. Upon application for licensure, the department shall conduct a licensing study based on its licensing rules; shall inspect the home or the agency and the records, including financial records, of the applicant or agency; and shall interview the applicant. The department may authorize a licensed child-placing agency to conduct the licensing study of a family foster home to be used exclusively by that agency and to verify to the department that the home meets the licensing requirements established by the department. The department or authorized licensed child-placing agency must complete the licensing study of a family foster home within 30 days of initiation. The department shall post on its website a list of the agencies authorized to conduct such studies. Upon certification by a licensed child-placing agency that a family foster home meets the licensing requirements and upon receipt of a letter from a community-based care lead agency in the service area where the home will be licensed which indicates that the family foster home meets the criteria established by the lead agency, the department shall issue the license. A letter from the lead agency is not required if the

lead agency where the proposed home is located is directly supervising foster homes in the same service area.

(d) The department shall approve or deny a license within 10 business days after receipt of a complete family foster home application and other required documentation as prescribed in rule. The department shall approve or deny a complete application no later than 100 calendar days after the orientation required by s. 409.175(14). The department may exceed 100 calendar days to approve or deny a license if additional certifications are required by s. 409.175(5)(a).

Section 13. Paragraph (j) of subsection (1) of section 409.988, Florida Statutes, is amended to read:

409.988 Lead agency duties; general provisions.—

(1) DUTIES.—A lead agency:

(j) May subcontract for the provision of services required by the contract with the lead agency and the department; however, the subcontracts must specify how the provider will contribute to the lead agency meeting the performance standards established pursuant to the child welfare results-oriented accountability system required by s. 409.997. The lead agency shall directly provide no more than 35 percent of all child welfare services provided unless it can demonstrate a need, within the lead agency's geographic service area, to exceed this threshold. The local community alliance in the geographic service area in which the lead agency is seeking to exceed the

threshold shall review the lead agency's justification for need and recommend to the department whether the department should approve or deny the lead agency's request for an exemption from the services threshold. If there is not a community alliance operating in the geographic service area in which the lead agency is seeking to exceed the threshold, such review and recommendation shall be made by representatives of local stakeholders, including at least one representative from each of the following:

1. The department.

2. The county government.

3. The school district.

4. The county United Way.

5. The county sheriff's office.

6. The circuit court corresponding to the county.

7. The county children's board, if one exists.

Section 14. Paragraph (b) of subsection (7) of section 39.302, Florida Statutes, is amended to read:

39.302 Protective investigations of institutional child abuse, abandonment, or neglect.—

(7) When an investigation of institutional abuse, neglect, or abandonment is closed and a person is not identified as a caregiver responsible for the abuse, neglect, or abandonment alleged in the report, the fact that the person is named in some capacity in the report may not be used in any way to adversely

affect the interests of that person. This prohibition applies to any use of the information in employment screening, licensing, child placement, adoption, or any other decisions by a private adoption agency or a state agency or its contracted providers.

(b) Likewise, if a person is employed as a caregiver in a residential group home licensed under ~~pursuant to~~ s. 409.175 and is named in any capacity in three or more reports within a 5-year period, the department may review all reports for the purposes of the employment screening required under s. 409.1415(2)(c) ~~pursuant to s. 409.145(2)(e)~~.

Section 15. Paragraph (d) of subsection (5) of section 39.6225, Florida Statutes, is amended to read:

39.6225 Guardianship Assistance Program.—

(5) A guardian with an application approved pursuant to subsection (2) who is caring for a child placed with the guardian by the court pursuant to this part may receive guardianship assistance payments based on the following criteria:

(d) The department shall provide guardianship assistance payments in the amount of $4,000 annually, paid on a monthly basis, or in an amount other than $4,000 annually as determined by the guardian and the department and memorialized in a written agreement between the guardian and the department. The agreement shall take into consideration the circumstances of the guardian and the needs of the child. Changes may not be made without the

concurrence of the guardian. However, ~~in no case shall~~ the amount of the monthly payment may not exceed the foster care maintenance payment that would have been paid during the same period if the child had been in licensed care at his or her designated level of care at the rate established in s. 409.145(3) ~~s. 409.145(4)~~.

Section 16. Paragraph (b) of subsection (5) of section 393.065, Florida Statutes, is amended to read:

393.065 Application and eligibility determination.—

(5) The agency shall assign and provide priority to clients waiting for waiver services in the following order:

(b) Category 2, which includes individuals on the waiting list who are:

1. From the child welfare system with an open case in the Department of Children and Families' statewide automated child welfare information system and who are either:

a. Transitioning out of the child welfare system at the finalization of an adoption, a reunification with family members, a permanent placement with a relative, or a guardianship with a nonrelative; or

b. At least 18 years but not yet 22 years of age and who need both waiver services and extended foster care services; or

2. At least 18 years but not yet 22 years of age and who withdrew consent pursuant to s. 39.6251(5)(c) to remain in the extended foster care system.

For individuals who are at least 18 years but not yet 22 years of age and who are eligible under sub-subparagraph 1.b., the agency shall provide waiver services, including residential habilitation, and the community-based care lead agency shall fund room and board at the rate established in s. 409.145(3) ~~s. 409.145(4)~~ and provide case management and related services as defined in s. 409.986(3)(e). Individuals may receive both waiver services and services under s. 39.6251. Services may not duplicate services available through the Medicaid state plan.

Within categories 3, 4, 5, 6, and 7, the agency shall maintain a waiting list of clients placed in the order of the date that the client is determined eligible for waiver services.

Section 17. Paragraph (b) of subsection (2) of section 409.1451, Florida Statutes, is amended to read:

409.1451 The Road-to-Independence Program.—

(2) POSTSECONDARY EDUCATION SERVICES AND SUPPORT.—

(b) The amount of the financial assistance shall be as follows:

1. For a young adult who does not remain in foster care and is attending a postsecondary school as provided in s. 1009.533, the amount is $1,256 monthly.

2. For a young adult who remains in foster care, is attending a postsecondary school, as provided in s. 1009.533,

and continues to reside in a licensed foster home, the amount is the established room and board rate for foster parents. This takes the place of the payment provided for in s. 409.145(3) ~~s. 409.145(4)~~.

3. For a young adult who remains in foster care, but temporarily resides away from a licensed foster home for purposes of attending a postsecondary school as provided in s. 1009.533, the amount is $1,256 monthly. This takes the place of the payment provided for in s. 409.145(3) ~~s. 409.145(4)~~.

4. For a young adult who remains in foster care, is attending a postsecondary school as provided in s. 1009.533, and continues to reside in a licensed group home, the amount is negotiated between the community-based care lead agency and the licensed group home provider.

5. For a young adult who remains in foster care, but temporarily resides away from a licensed group home for purposes of attending a postsecondary school as provided in s. 1009.533, the amount is $1,256 monthly. This takes the place of a negotiated room and board rate.

6. A young adult is eligible to receive financial assistance during the months when he or she is enrolled in a postsecondary educational institution.

Section 18. 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 child welfare; amending s. 25.385, F.S.; requiring the Florida Court Educational Council to establish certain standards for instruction of circuit and county court judges for dependency cases; requiring the council to provide such instruction on a periodic and timely basis; creating s. 39.01304, F.S.; authorizing circuit courts to create early childhood court programs; requiring the Office of State Courts Administrator to contract with certain university-based centers to evaluate the early childhood court program; amending s. 39.0138, F.S.; requiring the department to complete background screenings within a specified timeframe; amending s. 39.301, F.S.; requiring the department to notify the court of certain reports; authorizing the department to file specified petitions under certain circumstances; amending s. 39.522, F.S.; requiring the court to consider specified factors when making certain determinations; requiring a child's case plan to be amended if the court changes the permanency goal; amending s. 39.6011, F.S.; revising and providing requirements for case plan descriptions; amending s. 39.701, F.S.; requiring the court to retain jurisdiction over a child under certain circumstances; requiring specified parties to disclose certain information to the court; providing for certain caregiver recommendations to the court; requiring the court and citizen review panel to determine whether certain parties have developed a productive

relationship; amending s. 63.092, F.S.; providing a deadline for completion of a preliminary home study; creating s. 63.093, F.S.; providing requirements and processes for the adoption of children from the child welfare system; creating s. 409.1415, F.S.; providing legislative findings and intent; requiring the department and community-based care lead agencies to develop and support relationships between caregivers and parents of children; providing responsibilities for caregivers, birth or legal parents, the department, and community-based care lead agency; requiring caregivers employed by residential group homes to meet specified requirements; requiring the department to adopt rules; amending s. 409.145, F.S.; removing certain responsibilities of caregivers, the department, community-based care lead agency staff, and other agency staff; removing requirements relating to transitions, information sharing, and certain caregivers; amending s. 409.175, F.S.; revising requirements for the licensure of family foster homes; requiring the department to issue determinations for family foster home licenses within a specified time frame; providing an exception; amending s. 409.988, F.S.; authorizing a lead agency to provide more than 35 percent of all child welfare services under certain conditions; requiring a specified local community alliance, or specified representatives in certain circumstances, to review and recommend approval or denial of the lead agency's request for a specified exemption; amending ss. 39.302, 39.6225,

393.065, and 409.1451, F.S.; conforming cross-references to changes made by the act; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1187 Organ Donation
SPONSOR(S): Health Market Reform Subcommittee, Latvala
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	13 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 and injury. CS/HB 1187 amends multiple sections of law related to organ donation.

The bill requires AHCA to include minimum volume standards for organ transplants and neonatal intensive care services in their rules for health care facilities. It also requires the Organ and Tissue Procurement and Transplantation Advisory Board to submit recommendations relating to the regulation of organ transplants to AHCA.

The bill prohibits a transplant facility from charging the donor, or his or her family, any fees for services related to the procurement or donation of his or her organs.

The bill adds a requirement to educate the public on state and federal law relating to the organ donation transplant process to the current public education program administered by AHCA.

The bill requires individuals who make requests to patients, living donors, or family members for a decedent's organs to explain the protocols of the hospital and federal and state regulations regarding organ donation.

The bill has no 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

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 and Transplant Process

Established by the National Organ Transplant Act (NOTA) 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.[10] 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 Services.[11] UNOS coordinates how donor organs are matched and allocated to patients on the waiting list.[12] Non-profit, federally designated organ procurement organizations (OPOs) work closely with UNOS, hospitals, and transplant centers to facilitate the organ donation and transplantation process,[13] including conducting a thorough medical

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[1] Donate Life Florida, *Frequently Asked Questions,* https://www.donatelifeflorida.org/categories/donation/ (last visited Feb. 13, 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. 13, 2020).
[5] Id.
[6] Organ Procurement and Transplantation Network, U.S. Department of Health & Human Services, https://optn.transplant.hrsa.gov/ (last visited Feb. 13, 2020).
[7] Id.
[8] Supra, note 1.
[9] Id.
[10] 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. 13, 2020).
[11] Id.
[12] 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. 13, 2020).
[13] Donate Life Florida, *Organ Procurement Organizations and Transplant Centers*, https://www.donatelifeflorida.org/local-resources/transplant-centers/ (last visited Feb. 13, 2020).

and social history of the potential donor to help determine the suitability of his or her organs for transplantation.[14]

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.[15] Specially-trained medical practitioners from the OPO evaluates the patient to determine if they are medically suitable to donate their organs.[16] If the patient is suitable, their organs are surgically removed and sent to the transplant hospitals where transplant candidates are waiting.[17] 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.[18]

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.[19] The transplant center's transplant teams, composed of transplant physicians, surgeons and other practitioners, perform a medical evaluation of the patient.[20] Each transplant center sets its own criteria to help determine if a patient is a good or bad candidate.[21] 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).[22] 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.[23]

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.[24] 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.[25] The transplant team only has one hour to make this determination.[26] 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.

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[14] 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. 13, 2020).
[15] Donate Life Florida, *Frequently Asked Questions - Donation,* https://www.donatelifeflorida.org/categories/donation/ (last visited Feb. 13, 2020).
[16] UNOS, *Deceased Donation,* https://unos.org/transplant/deceased-donation/ (last visited Feb. 13, 2020).
[17] Id.
[18] Id.
[19] Health Resources & Services Administration, *The Organ Transplant Process,* https://www.organdonor.gov/about/process/transplant-process.html#list (last visited Feb. 13, 2020).
[20] 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. 13, 2020).
[21] 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. 13, 2020).
[22] 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. 13, 2020).
[23] UNOS, *What Every Patient Needs to Know* (2019), https://unos.org/wp-content/uploads/unos/WEPNTK.pdf (last visited Feb. 13, 2020).
[24] Heath Resources & Services Administration, *Matching Donors and Recipients,* https://www.organdonor.gov/about/process/matching.html#criteria (last visited Feb. 13, 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. 13, 2020).
[25] UNOS Transplant Living, *Frequently Asked Questions – How does the matching process work?* https://transplantliving.org/before-the-transplant/frequently-asked-questions/ (last visited Feb. 13, 2020).
[26] Id.

Regulation of Organ Donation and Transplantation in Florida

The Agency for Health Care Administration (AHCA) oversees the various organizations and facilities involved in the organ procurement and transplant process in this state. AHCA licenses transplant facilities, contracts with an organization to educate the public on organ donation, sets requirements for training individuals who engage with families whose deceased relatives may be a good candidate for organ donation, and oversees the Organ Transplant Advisory Council and the Organ and Tissue Procurement and Transplantation Advisory Board.

Donor Education

AHCA, in collaboration with the Department of Highway Safety and Motor Vehicles, contracts with Donate Life Florida (DFL) to operate a statewide donor registry, increase registry enrollment, and educate Floridians about organ donation.[27] Established in 1997, DFL is a non-profit organization dedicated to motivating Floridians to designate themselves as organ, tissue, and eye donors.[28] Florida law requires DFL to operate a continuing program to educate the public about state laws relating organ transplants and the need for organ donations.[29]

When a patient dies in a hospital and is not a registered organ donor, but is determined to be a good candidate by the hospital's medical staff and the OPO, a representative of the OPO or a member of the hospital's staff may approach the patient's family about organ donation.[30] AHCA has developed rules for training and guidelines for the person making the request for organ donation.[31] The requestor is trained in explaining the process of organ donation to the patient's family, including their right to allow or refuse donation and for what purpose the organs would be donated (transplantation, research, or education).[32] The requestor is also specifically trained in the different types of approaches to deal with a family's grief and offering them the opportunity for organ donation.[33] The current rules require the requestor to explain the requirements needed to be met under Florida law in order for a donation to be allowed, but not federal regulations stating such requirements.

Organ Donation Fees

Generally, an organ donor and their family are not charged by a transplant facility for the medical care required to donate an organ.[34] Families pay for medical care and funeral costs, but costs related to living or deceased donation are paid by the recipient, usually through insurance, Medicare, or Medicaid.[35] Typically, any cost that falls outside of the transplant center's donor evaluation or actual surgery, such as travel, lodging, lost wages, and other non-medical expenses, is borne by the living donor or recipient.[36]

[27] Agency for Health Care Administration, Agency Bill Analysis for 2020 HB 1187 (Jan. 31, 2020) (On file with Health Market Reform Subcommittee Staff). *See also* Donate Life Florida https://www.donatelifeflorida.org (last visited Feb. 13, 2020).
[28] Donate Life Florida, *About the Joshua Abbott Organ Donation and Tissue Donor Registry,* https://www.donatelifeflorida.org/about/ (last visited Feb. 13, 2020).
[29] S. 765.5155, F.S.
[30] Health Resources and Services Administration, *The Deceased Donation Process,* https://www.organdonor.gov/about/process/deceased-donation.html#authorize (last visited Feb. 13, 2020). *See also* s. 765.522, F.S.
[31] Ch. 59A-3.274, F.A.C.
[32] Id.
[33] Id.
[34] Health Resources Services Administration, *Organ Donation Frequently Asked Questions,* https://www.organdonor.gov/about/facts-terms/donation-faqs.html (last visited Feb.13, 2020).
[35] Id. *See also* UNOS, *Living Donation Costs,* https://transplantliving.org/financing-a-transplant/living-donation-costs/ (last visited Feb. 13, 2020).
[36] UNOS, *Living Donation Costs,* https://transplantliving.org/financing-a-transplant/living-donation-costs/ (last visited Feb. 13, 2020).

Organ and Tissue Procurement and Transplantation Advisory Board

Created by the Legislature in 1991, the Organ and Tissue Procurement and Transplantation Advisory Board (board) is housed at AHCA. Current law requires the board to assist AHCA in the development of professional qualifications of people involved in the organ donation and transplant process. The board is also tasked with helping AHCA monitor expenses associated with organ and tissue procurement, processing, and distribution for transplantation. Current law requires the board to provide assistance to the Florida Medical Examiners Commission in the development of appropriate procedures and protocols to ensure the continued improvement in the approval and release of potential donors by the district medical examiners and associate medical examiners.[37]

Additionally, the board works with AHCA on necessary recommendations for procedures and protocols to assure that all Floridians have reasonable access to available organ and tissue transplants according to the severity of his or her medical condition and need. In collaboration with AHCA, the board also develops recommendations for any changes to state laws or administrative rules to ensure that the statewide organ and tissue procurement and transplantation system is able to function smoothly, effectively, and efficiently, in accordance with federal laws.[38]

The board consists of 14 members who are appointed by the Secretary of AHCA, including:[39]

- Two with expertise in vascular organ transplant surgery;
- Two with expertise in vascular organ procurement, preservation, and distribution;
- Two with expertise in musculoskeletal tissue transplant surgery;
- Two with expertise in musculoskeletal tissue procurement, processing, and distribution;
- One with expertise in eye and cornea transplant surgery;
- One with expertise in eye and cornea procurement, processing, and distribution;
- One with expertise in bone marrow procurement, processing, and transplantation;
- A representative from the Florida Pediatric Society;
- A representative from the Florida Society of Pathologists; and
- A representative from the Florida Medical Examiners Commission.

The board has not met since 2013.[40]

Organ Transplantation Regulation

Federal law requires transplant hospitals to be a member of the OPTN and abide by OPTN bylaws in order to provide transplant services.[41] The federal certification requirements include minimum volume standards for initial certification.[42] To obtain initial certification, an organ-specific transplant program must generally perform 10 transplants over a 12-month period.[43]

Current AHCA rule contains provisions relating to licensure of organ transplantation programs in the state, but does not include minimum volume standards for organ transplant services.[44] AHCA recently

[37] S. 765.543, F.S.
[38] Id.
[39] S. 765.543, F.S. *See also* Agency for Health Care Administration, *Organ and Tissue Procurement and Transplantation Advisory Board,* https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Lab_HomeServ/OrganTissueBoard.shtml (last visited Feb. 13, 2020).
[40] *Supra,* note 27.
[41] 42 C.F.R. §482.72.
[42] 42 C.F.R. §482.80.
[43] Id.
[44] R. 59C-1.044, F.A.C.

proposed a rule to require organ transplant licensees and applicants to seek and maintain federal certification from the federal Centers for Medicare and Medicaid Services.[45]

A proposed AHCA rule requires a hospital providing adult heart, kidney, liver, or lung transplants to meet such requirement within one year from initial licensure of each transplant program and to maintain such requirement in order to keep their license.[46] OPTN bylaws require transplant programs to meet the following volume requirements to remain functionally active:[47]

For This Transplant Program Type	Functional Inactivity Definition
Kidney, Liver, or Heart	Failure to perform at least 1 transplant in 3 consecutive months
Lung	Failure to perform at least 1 transplant in 6 consecutive months
Stand-alone pediatric	Failure to perform at least 1 transplant in 12 consecutive months
Pancreas	*Both* of the following: 1. Failure to perform at least 2 transplants in 12 consecutive months; and 2. *Either* of the following in 12 consecutive months: • A median waiting time of the program's kidney-pancreas and pancreas candidates that is above the 67th percentile of the national waiting time; or • The program had no kidney-pancreas or pancreas candidates registered at the program.
Islet, intestinal, and vascularized composite allograft	No functional inactivity definitions have been established.

Neonatal Intensive Care Units

A Neonatal Intensive Care Unit (NICU) is a specialized area in a hospital for newborn babies who need extra care with breathing, medicines, and life-saving procedures.[48] Current AHCA rule requires a hospital applying for a level II Neonatal Intensive Care Services license to meet minimum volume requirements, including a minimum service volume of 1,000 live births for the most recent 12-month period.[49] Current AHCA rule also requires a hospital applying for a level III Neonatal Intensive Care Service license to have a minimum volume of 1,500 live births for the most recent 12-month period.[50] AHCA recently developed a proposed rule that provides requirements for initial and continued licensure as a level II or III Neonatal Intensive Care Unit (NICU).[51] The proposed rule also creates a level IV NICU and provides requirements for initial and continued licensure of such facilities.

The proposed rule does not include minimum volume standards for any NICU level.

[45] Proposed rule 59A-3.246, F.A.C. A public hearing is scheduled on February 27, 2020. A copy of the draft rule is available at https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Hospital_Outpatient/Hospitals/docs/Text_DRAFT_59A-3.246_Licensed_Programs_H.pdf (last visited February 13, 2020).
[46] *Supra,* note 45.
[47] OPTN, *Bylaws,* (Jan. 13, 2020) https://optn.transplant.hrsa.gov/media/1201/optn_bylaws.pdf (last visited Feb. 13, 2020).
[48] UF Health, *Neonatal Unit (NICU) Guide,* https://neonatology.pediatrics.med.ufl.edu/resources/neonatal-unit-nicu-guide/ (last visited Feb. 13, 2020).
[49] R. 59C-1.042(6), F.A.C.
[50] Id.
[51] Proposed rule 59A-3.249, F.A.C. A public hearing is scheduled on February 27, 2020. A copy of the draft rule is available at https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Hospital_Outpatient/Hospitals/docs/Text_DRAFT_59A-3.249_Neonatal_Intensive_Care_H.pdf (last visited February 13, 2020).

Effect of Proposed Changes

Regulation of Organ Donation and Transplantation in Florida

The bill substantially revises the duties of AHCA relating to organ donation, including the duties of the Organ and Tissue Procurement and Transplantation Advisory Board, rulemaking, and mandated reports.

Donor Education

The bill requires Donate Life to modify their education program to include federal laws relating to anatomical gifts and the organ donation and transplantation process. AHCA may need to amend their current contract with Donate Life to address the new requirements.

The bill amends AHCA's requirement to develop rules and guidelines associated with organ donor education to require that individuals designated by the hospital administrator or organ procurement organization who make a request for donor consent clearly explain hospital protocols and state and federal regulations pertaining to organ donation.

Organ Donation Fees

The bill prohibits an organ transplantation facility from charging a donor or his or her family member any fee for services related to the donation or procurement of his or her organs. The impact of this is unclear, since, generally, the recipient or his or her insurance carrier pay for the services.

The bill also requires the uniform donor registration card to include language declaring that neither the donor nor the donor's family is responsible for the payment of fees associated with procurement of the donor's organs. A uniform donor card is used to express the donor's wishes for the donation of his or her organs. This new requirement may not be appropriate for inclusion in the uniform donor card.

Organ and Tissue Procurement and Transplantation Advisory Board

The bill revises the duties of the Organ and Tissue Procurement and Transplantation Advisory Board by requiring the board to submit recommendations to AHCA by September 1, 2021, relating to the following:

- Frequency of communication between patients and transplant coordinators;
- Monitoring of transplant facilities and annual reporting of aggregate organ recipient data, including relevant information regarding the number of patients on the waiting list statewide and the number of patients who receive transplants;
- Establishment of a communication system between living donors and transplant facilities;
- Incentives necessary to increase organ donation;
- Creation of a more efficient organ donation process;
- Opportunities and incentives for organ transplantation research;
- Best practices for transplant hospitals and OPOs to promote the most effective and efficient patient outcomes; and
- Monitoring of OPOs.

Organ Transplantation Regulation

The bill requires AHCA to include minimum volume standards for organ transplants in their rule regulating minimum standards for health care facilities.

Current rules do not require minimum volume standards for the provision of organ transplant services. AHCA is currently in the rulemaking process to establish initial and continued licensure requirements

for organ transplant programs. The current proposed rule draft includes minimum volume standards for the provision of organ transplant services. If AHCA finalizes the rules prior to the bill becoming law, AHCA will not have to change the rules to include minimum volume standards.

Neonatal Intensive Care Units

The bill requires AHCA to include minimum volume standards for neonatal intensive care services in their rule regulating minimum standards for health care facilities.
Current rules require minimum volume standards for the provision of neonatal intensive care services. AHCA is currently in the rulemaking process to establish initial and continued licensure requirements for NICU programs. The current proposed rule drafts do not include minimum volume standards for the provision of neonatal intensive care services. If AHCA finalizes the rules prior to the bill becoming law, AHCA may have to change the rules to include minimum volume standards.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 395.1055, F.S., relating to rules and enforcement.
Section 2: Amends s. 765.5155, F.S., relating to donor registry, education program.
Section 3: Amends s. 765.517, F.S., relating to rights and duties at death.
Section 4: Amends s. 765.522, F.S., relating to duty of hospital administrators; liability of hospital administrators and procurement organizations.
Section 5: Amends s. 765.543, F.S., relating to Organ and Tissue Procurement and Transplantation Advisory Board; duties.
Section 6: 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:

The bill prohibits transplant facilities from charging a donor or the donor's family for fees related to the donation or procurement of the donor's organs. Since such facilities generally do not charge such fees, this provision has no fiscal impact to transplant facilities.

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 and the bill provide sufficient rule-making authority for AHCA to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

AHCA recommends repealing s. 765.53, F.S., relating to the Organ Transplant Advisory Council.[52]

The duties of the council are also performed by the federal Centers for Medicare and Medicaid Services, the OPTN, Health Resources and Services Administration, UNOS, OPOs, and the Joint Commission.[53] According to AHCA, there has been no substantive reason for the council to meet in recent years.[54]

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 4, 2020, the Health Market Reform Committee adopted an amendment and was reported favorably as a committee substitute. The amendment:

- Requires AHCA to include minimum volume standards for organ transplants and neonatal intensive care services in their rule regulating minimum standards for health care facilities;
- Adds a requirement to educate the public on state and federal law relating to the organ donation transplant process to the current AHCA public education program;
- Prohibits a transplant facility from charging the donor, or his or her family, any fees for services related to the procurement or donation of his or her organs;
- Requires individuals who make organ requests to living donors, or to patients, or family members for a decedent's organs, to explain the protocols of the hospital and federal and state regulations regarding organ donation; and
- Requires the Organ and Tissue Procurement and Transplantation Advisory Board to submit recommendations relating to organ transplants to AHCA.

The analysis is drafted to the committee substitute as passed by the Health Market Reform Subcommittee.

[52] *Supra,* note 40.
[53] Id.
[54] Id.

A bill to be entitled

An act relating to organ donation; amending s. 395.1055, F.S.; revising a provision relating to certain rules adopted by the Agency for Health Care Administration; amending s. 765.5155, F.S.; revising the responsibilities of a contractor procured by the agency for the purpose of educating and informing the public about anatomical gifts; amending s. 765.517, F.S.; prohibiting an organ transplantation facility from charging a donor or his or her family member any fee for services relating to the procurement or donation of organs; amending s. 765.522, F.S.; revising a requirement that the agency establish rules and guidelines relating to the education of certain individuals designated to perform certain organ donation procedures; amending s. 765.543, F.S.; revising the duties of the Organ and Tissue Procurement and Transplantation Advisory Board; requiring the board to submit certain recommendations to the agency by a specified date; providing an effective date.

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

Section 1. Paragraph (i) of subsection (1) of section

395.1055, Florida Statutes, is amended to read:

395.1055 Rules and enforcement.—

(1) The agency shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part, which shall include reasonable and fair minimum standards for ensuring that:

(i) 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. Such licensure requirements must include quality of care, nurse staffing, physician staffing, physical plant, equipment, emergency transportation, and data reporting standards. Agency rules shall include minimum volume standards for organ transplantation and neonatal intensive care services.

Section 2. Paragraph (b) of subsection (3) of section 765.5155, Florida Statutes, is amended to read:

765.5155 Donor registry; education program.—

(3) The contractor shall be responsible for:

(b) A continuing program to educate and inform medical professionals, law enforcement agencies and officers, other state and local government employees, high school students, minorities, and the public about federal and state ~~the~~ laws ~~of this state~~ relating to anatomical gifts and the need for

anatomical gifts, including the organ donation and transplantation process.

1. Existing community resources, when available, must be used to support the program and volunteers may assist the program to the maximum extent possible.

2. The contractor shall coordinate with the head of a state agency or other political subdivision of the state, or his or her designee, to establish convenient times, dates, and locations for educating that entity's employees.

Section 3. Subsection (4) of section 765.517, Florida Statutes, is amended to read:

765.517 Rights and duties at death.—

(4) All reasonable additional expenses incurred in the procedures to preserve the donor's organs or tissues shall be reimbursed by the procurement organization. An organ transplantation facility may not charge a donor or his or her family member any fee for services relating to the procurement or donation of his or her organs.

Section 4. Subsection (3) of section 765.522, Florida Statutes, is amended to read:

765.522 Duty of hospital administrators; liability of hospital administrators and procurement organizations.—

(3) The agency shall establish rules and guidelines concerning the education of individuals who may be designated to perform the request and the procedures to be used in making the

request, including a requirement that such individuals clearly explain to patients and living organ donors the protocols of the hospital and the federal and state regulations regarding organ donation. The agency is authorized to adopt rules concerning the documentation of the request, where such request is made.

Section 5. Subsection (3) of section 765.543, Florida Statutes, is amended to read:

765.543 Organ and Tissue Procurement and Transplantation Advisory Board; creation; duties.—

(3) The board shall:

(a) Assist the agency, in collaboration with other relevant public or private entities, in the development of necessary professional qualifications, including, but not limited to, the continuing education, training, and performance of persons engaged in the various facets of organ and tissue procurement, processing, preservation, and distribution for transplantation;

(b) Assist the agency in monitoring the appropriate and legitimate expenses associated with organ and tissue procurement, processing, and distribution for transplantation and developing methodologies to assure the uniform statewide reporting of data to facilitate the accurate and timely evaluation of the organ and tissue procurement and transplantation system;

(c) Provide assistance to the Florida Medical Examiners Commission in the development of appropriate procedures and protocols to ensure the continued improvement in the approval and release of potential donors by the district medical examiners and associate medical examiners;

(d) Develop with and recommend to the agency the necessary procedures and protocols required to assure that all residents of this state have reasonable access to available organ and tissue transplantation therapy and that residents of this state can be reasonably assured that the statewide procurement transplantation system is able to fulfill their organ and tissue requirements within the limits of the available supply and according to the severity of their medical condition and need; and

(e) Develop with and recommend to the agency any changes to the laws of this state or administrative rules or procedures to ensure that the statewide organ and tissue procurement and transplantation system is able to function smoothly, effectively, and efficiently, in accordance with the Federal Anatomical Gift Act and in a manner that assures the residents of this state that no person or entity profits from the altruistic voluntary donation of organs or tissues. In addition to the duties described in this subsection, the board must submit to the agency, by September 1, 2021, recommendations that address the following:

1. Frequency of communication between patients and organ transplant coordinators.

2. Monitoring of each organ transplantation facility and the annual reporting and publication of relevant information regarding the statewide number of patients placed on waiting lists and the number of patients who receive transplants, aggregated by the facility.

3. Establishment of a coordinated communication system between organ transplantation facilities and living organ donors for the purpose of minimizing the cost and time required for duplicative lab tests, including the sharing of lab results between facilities.

4. Potential incentives for organ transplantation facilities to increase organ donation in the state.

5. Creation of a more efficient regional or statewide living organ donor process.

6. Potential opportunities and incentives for organ transplantation research.

7. Best practices for organ transplantation facilities and organ procurement organizations that promote the most efficient and effective outcomes for patients.

8. Monitoring of organ procurement organizations.

Section 6. This act shall take effect July 1, 2020.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1217 Surrendered Newborn Infants
SPONSOR(S): Beltran and others
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 864

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	12 Y, 0 N	Cunningham	Calamas
2) Health Care Appropriations Subcommittee	8 Y, 1 N	Mielke	Clark
3) Health & Human Services Committee		Cunningham	Calamas

SUMMARY ANALYSIS

Florida law allows parents who are unwilling or unable to care for their infants to safely relinquish them at hospitals, fire stations, and emergency medical services stations. This 'safe haven law' allows parents to anonymously surrender infants up to seven days old and grants the parents immunity from criminal prosecution unless there is actual or suspected child abuse or neglect.

A newborn safety device, or baby box, provides a place for a mother in crisis to safely, securely, and anonymously surrender her unwanted newborn. The concept of a baby box has existed for centuries throughout Europe, and over 20 countries still utilize some form of a baby box today.

HB 1217 increases the age that an infant may be surrendered from seven days old to 30 days old. The bill authorizes hospitals, emergency medical service stations, and fire stations that are staffed 24 hours a day to opt to utilize newborn safety devices, and specifies the requirements for such devices.

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

Safe Haven Laws

Safe haven laws allow parents or agents of the parents to safely relinquish babies at designated locations while remaining anonymous, and confer immunity from criminal liability and prosecution for child endangerment, abandonment, or neglect.[1] The purpose of safe haven laws is to ensure that abandoned infants are left with those who can provide immediate care necessary for the children's safety and wellbeing.[2]

In 1999, Texas was the first State to enact safe haven legislation.[3] Now each of the 50 states, the District of Columbia, and Puerto Rico all have variations of safe haven laws.[4] In 11 states and Puerto Rico, only infants who are up to 72 hours old may be relinquished to a designated site, and in 19 states infants are accepted up to one month old.[5] Additionally, 16 states and Puerto Rico require parents to surrender their infants only to a hospital, emergency medical services provider, or healthcare facility.[6] In 27 states, fire stations are also designated as safe haven providers.[7] Personnel at police stations or other law enforcement agencies may accept infants in 25 states.[8]

Since the initial enactment of safe haven legislation in 1999, there have been an estimated 4,015 surrenders at safe havens and 1,465 illegal abandonments across the United States.[9]

Florida Safe Haven Law

Florida enacted safe haven legislation in 2000 in response to tragedies of newborn abandonment at unsafe locations, such as public restrooms or trash receptacles.[10] The law authorizes parents to surrender a newborn infant up to seven days old at a hospital, fire station or emergency medical service station. It creates a presumption that the parents consent to the termination of their parental rights[11], and for the transport and medical treatment for the child[12]. The law expressly grants the parents a right to anonymity and to not be pursued, and requires hospital registrars to complete the infant's birth certificate without naming the mother, if she requests it and expresses an intent to leave without the infant and not return. The law also grants the parents immunity from criminal prosecution unless there is actual or suspected abuse or neglect of the infant.[13]

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[1] *Infant Safe Haven Laws*, CHILD WELFARE INFORMATION GATEWAY (Dec. 2016), https://www.childwelfare.gov/pubPDFs/safehaven.pdf
[2] *Id.*
[3] NY LEGISLATIVE COUNSEL BUREAU, *A Study of Infant Abandonment Legislation*, https://www.leg.state.nv.us/Division/Research/Publications/Bkground/BP01-03.pdf (last visited Jan. 22, 2020).
[4] *Id.*
[5] *Id.*
[6] *Supra* note 1.
[7] *Id.*
[8] *Id.*
[9] A SAFE HAVEN FOR NEWBORNS, *Safe Haven Statistics*, https://asafehavenfornewborns.com/what-we-do/safe-haven-statistics/ (last visited Jan. 29, 2020).
[10] S. 383.50, F.S.; *see* ch. 2000-188, Laws of Fla.
[11] S. 63.0423, F.S.
[12] S. 383.50, F.S.
[13] *Id.*

The Florida safe haven law requires hospitals, fire stations, and emergency medical services stations that are staffed with full-time firefighters or emergency medical technicians to accept any newborn infant left with a firefighter or emergency medical technician. The law grants emergency medical technicians, paramedics and fire department staff immunity from criminal and civil liability when acting in good faith for a surrendered infant.[14]

Since 2000, approximately 310 newborns have been surrendered at a safe haven in Florida. In that time, 64 infants are known to have been unsafely abandoned, of which 34 died.[15]

Newborn Safety Devices

For centuries, mothers throughout Europe have surrendered their babies in hatches or crib structures, commonly referred to as "foundling wheels" or "baby boxes," at the entrance of a place of worship, a charity organization, or hospital.[16] The modern-day newborn safety device was created in South Africa in 1999, in which mothers placed their child in a hatch in a church wall and the door automatically locked, sending a signal to care workers inside.[17]

Over 20 countries currently have some form of baby boxes, including Austria, Germany, Italy, Poland, Portugal, and Slovakia.[18] Approximately 200 baby boxes have been installed across Europe in the past decade.[19] There are about 30 baby boxes located throughout the United States.[20]

Indiana's Baby Boxes

Indiana's safe haven law authorizes the use of newborn safety devices, called Safe Haven Boxes.[21] Indiana has utilized the Safe Haven Baby Box since 2016, and there are currently 19 baby boxes in use throughout the state.[22]

The box is installed on the exterior wall of a designated safe haven, with an interior access door attached.[23] Once a parent has placed the baby in the padded box, the door will automatically lock and an alarm is triggered alerting personnel that a baby needs to be picked up.[24] The boxes are similar to incubators, with heating and cooling functions to keep the baby safe until help arrives.[25] The boxes cost between $10,000 and $15,000.[26]

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[14] *Id.*
[15] *Supra* note 9.
[16] Atsushi Asai, *Should We Maintain Baby Hatches in Our Society?*, BMC MED. ETHICS (Feb. 22, 2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3586365/#B1
[17] *Baby Boxes Allow Mothers to Drop-off Unwanted Children*, APOLITICAL (Aug. 22, 2019), https://apolitical.co/solution_article/baby-boxes-allow-mothers-to-drop-off-unwanted-children
[18] EUROPEAN COMMISSION, *Child Abandonment and Its Prevention,* http://ec.europa.eu/justice/grants/results/daphne-toolkit/content/child-abandonment-and-its-prevention_en (last visited Jan. 22, 2020).
[19] Amber Hildebrandt,*The Revival of 'Baby Boxes' for Unwanted Infants*, CBC NEWS (May 07, 2013), https://www.cbc.ca/news/canada/the-revival-of-baby-boxes-for-unwanted-infants-1.1357615
[20] A SAFE HAVEN FOR NEWBORNS, *Baby Box Locations,* https://shbb.org/locations (last visited Jan. 22, 2020).
[21] Associated Press, *Northwest Indiana to Get More Baby Boxes for Abandoned Newborns,* WGN9 (Nov. 9, 2019), https://wgntv.com/2019/11/09/northwest-indiana-to-get-more-baby-boxes-for-abandoned-newborns/
[22] *Indiana Nears 20 Baby Boxes for Surrendering Newborns,* WBIW (Jan. 2, 2020), http://www.wbiw.com/2020/01/02/indiana-nears-20-baby-boxes-for-surrendering-newborns/
[23] A SAFE HAVEN FOR NEWBORNS, *What is a Safe Haven Baby Box?,* https://shbb.org/ (last visited Jan. 22, 2020).
[24] *Id.*; *See also* https://www.usatoday.com/story/life/parenting/2019/09/13/safe-haven-laws-things-you-didnt-know-surrendering-newborn/2031516001/
[25] Jennie Runevitch, *Safe Haven Baby Boxes: Here's How They Work*, WTHR-TV CHANNEL 13 (Oct. 18, 2019), https://www.wthr.com/article/safe-haven-baby-boxes-heres-how-they-work
[26] *Supra* note 14.

Effect of Proposed Changes

HB 1217 amends Florida's safe haven law to increase the infant age limit from seven days old to 30 days old. This gives parents more time to make this decision, possibly preventing the unsafe abandonment of infants older than seven days.

The bill also authorizes the use of newborn safety devices, or baby boxes, at the designated safe haven sites, if they are staffed 24 hours a day.

The boxes must be physically part of the hospital, fire station or emergency medical services station, and installed in an exterior wall. The boxes must have an exterior point of access that locks. The box must have an interior point of access in an area that is conspicuous and visible to facility employees. Placing an infant inside the box must automatically trigger an alarm inside the building has to alert individuals inside the building to safely retrieve the newborn infant.

The bill requires facilities that use a newborn safety device to check the device at least twice a day and test the device at least once a week to ensure that the alarm system is in working order.

The bill makes all the provisions in the current safe haven law applicable to surrendering an infant using a baby box, including parental consent for the child's transport and medical treatment, consent to termination of parental rights, the right to anonymity and non-pursuit, and the immunities for both the parents and the receiving facility's staff.

B. SECTION DIRECTORY:

Section 1: Amends s. 383.50, F.S., relating to the treatment of a surrendered newborn infant.
Section 2: Amends s. 63.0423, F.S., to incorporate a conforming cross-reference revision.
Section 3: 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:

Private sector facilities that opt to use a newborn safety device as a means for the relinquishment of a newborn will incur the cost of acquisition and installation of the new device.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

Rulemaking is not authorized by the bill and is not necessary to implement it.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to surrendered newborn infants; amending s. 383.50, F.S.; revising the definition of the term "newborn infant"; defining the term "newborn safety device"; authorizing hospitals, emergency medical services stations, and fire stations to use newborn safety devices to accept surrendered newborn infants under certain circumstances; requiring such hospital, emergency medical services station, or fire station to visually check and test the device within specified timeframes; conforming provisions to changes made by the act; providing additional locations under which the prohibition on the initiation of criminal investigations based solely on the surrendering of a newborn infant applies; amending s. 63.0423, F.S.; conforming a cross-reference; providing an effective date.

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

Section 1. Present subsections (2) through (10) of section 383.50, Florida Statutes, are redesignated as subsections (3) through (11), respectively, a new subsection (2) is added to that section, and present subsections (1), (3), (5), and (10) of that section are amended, to read:

383.50 Treatment of surrendered newborn infant.—

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

(a) "Newborn infant" means a child who a licensed physician reasonably believes is approximately 30 ~~7~~ days old or younger at the time the child is left at a hospital, an emergency medical services station, or a fire station.

(b) "Newborn safety device" means a fixture installed in an exterior wall of a building which has an exterior point of access that locks and automatically triggers an alarm inside the building upon placement of a newborn infant inside and which has an interior point of access that allows individuals inside the building to safely retrieve the newborn infant.

(2)(a) A hospital, an emergency medical services station, or a fire station that is staffed 24 hours per day may use a newborn safety device to accept surrendered newborn infants under this section if the device is:

1. Physically part of the hospital, emergency medical services station, or fire station;

2. Located in such a way that the interior point of access is in an area that is conspicuous and visible to the employees of the hospital, emergency medical services station, or fire station; and

3. Equipped with a dual alarm system connected to the physical location of the device.

(b) A hospital, an emergency medical services station, or

a fire station that uses a newborn safety device to accept surrendered newborn infants must visually check the device at least twice a day and must test the device at least once a week to ensure the alarm system is in working order.

(4) ~~(3)~~ Each emergency medical services station or fire station staffed with ~~full-time~~ firefighters, emergency medical technicians, or paramedics 24 hours per day shall accept any newborn infant left with a firefighter, an emergency medical technician, or a paramedic, or in a newborn safety device that is physically part of the emergency medical services station or fire station. The firefighter, emergency medical technician, or paramedic shall consider these actions as implied consent to and shall:

(a) Provide emergency medical services to the newborn infant to the extent he or she is trained to provide those services, and

(b) Arrange for the immediate transportation of the newborn infant to the nearest hospital having emergency services.

A licensee as defined in s. 401.23, a fire department, or an employee or agent of a licensee or fire department may treat and transport a newborn infant pursuant to this section. If a newborn infant is placed in the physical custody of an employee or agent of a licensee or fire department, or in a newborn

safety device that is physically part of an emergency medical services station or a fire station, such placement shall be considered implied consent for treatment and transport. A licensee, a fire department, or an employee or agent of a licensee or fire department is immune from criminal or civil liability for acting in good faith pursuant to this section. Nothing in this subsection limits liability for negligence.

(6) ~~(5)~~ Except when there is actual or suspected child abuse or neglect, any parent who leaves a newborn infant in a newborn safety device or with a firefighter, an emergency medical technician, or a paramedic at a fire station or emergency medical services station, leaves a newborn infant in a newborn safety device at a hospital, or brings a newborn infant to an emergency room of a hospital and expresses an intent to leave the newborn infant and not return, has the absolute right to remain anonymous and to leave at any time and may not be pursued or followed unless the parent seeks to reclaim the newborn infant. When an infant is born in a hospital and the mother expresses intent to leave the infant and not return, upon the mother's request, the hospital or registrar shall complete the infant's birth certificate without naming the mother thereon.

(11) ~~(10)~~ A criminal investigation shall not be initiated solely because a newborn infant is left at a hospital, an emergency medical services station, or a fire station under this

section unless there is actual or suspected child abuse or neglect.

Section 2. Subsection (4) of section 63.0423, Florida Statutes, is amended to read:

63.0423 Procedures with respect to surrendered infants.—

(4) The parent who surrenders the infant in accordance with s. 383.50 is presumed to have consented to termination of parental rights, and express consent is not required. Except when there is actual or suspected child abuse or neglect, the licensed child-placing agency shall not attempt to pursue, search for, or notify that parent as provided in s. 63.088 and chapter 49. For purposes of s. 383.50 and this section, an infant who tests positive for illegal drugs, narcotic prescription drugs, alcohol, or other substances, but shows no other signs of child abuse or neglect, shall be placed in the custody of a licensed child-placing agency. Such a placement does not eliminate the reporting requirement under s. 383.50(8) ~~s. 383.50(7)~~. When the department is contacted regarding an infant properly surrendered under this section and s. 383.50, the department shall provide instruction to contact a licensed child-placing agency and may not take custody of the infant unless reasonable efforts to contact a licensed child-placing agency to accept the infant have not been successful.

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1273 Dentistry and Dental Hygiene
SPONSOR(S): Buchanan
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	15 Y, 0 N	Siples	McElroy
2) Health Care Appropriations Subcommittee	12 Y, 0 N	Mielke	Clark
3) Health & Human Services Committee		Siples	Calamas

SUMMARY ANALYSIS

The Board of Dentistry, within the Department of Health (DOH), regulates dental practice in Florida, including dentists, dental hygienists, and dental assistants under the Dental Practice Act. A dentist is licensed to examine, diagnose, treat, and care for conditions within the human oral cavity and its adjacent tissues and structures. A dental hygienist provides education and preventive and delegated therapeutic dental services.

Currently, all applicants for licensure as a dentist or dental hygienist must pass a practical examination developed by the American Board of Dental Examiners, Inc. (ADEX), in addition to meeting other qualifications. The ADEX examination must be graded by Florida-licensed practitioners.

HB 1273 authorizes the Board of Dentistry to accept passing scores on the examinations produced by the Western Regional Examining Board (WREB) for licensure as a dentist or dental hygienist, in addition to the ADEX examinations it currently accepts. The bill requires the WREB examination to be graded by Florida-licensed practitioners.

The bill has an insignificant, negative fiscal impact on 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

Dentistry

The Board of Dentistry, within the Department of Health (DOH), regulates dental practice in Florida, including dentists, dental hygienists, and dental assistants under the Dental Practice Act.[1] A dentist is licensed to examine, diagnose, treat, and care for conditions within the human oral cavity and its adjacent tissues and structures.[2] A dental hygienist provides education, preventive and delegated therapeutic dental services.[3]

Dental 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 examiner (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.[4]

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 or be a student in the final year of a program at an accredited institution, and have successfully completed the NBDE dental examination.

Dental Hygiene Licensure

Any person wishing to be licensed as a dental hygienist must apply to DOH and meet the following qualifications:[5]

- Be 18 years of age or older;
- Be a graduate of an accredited dental hygiene college or school;[6] 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.

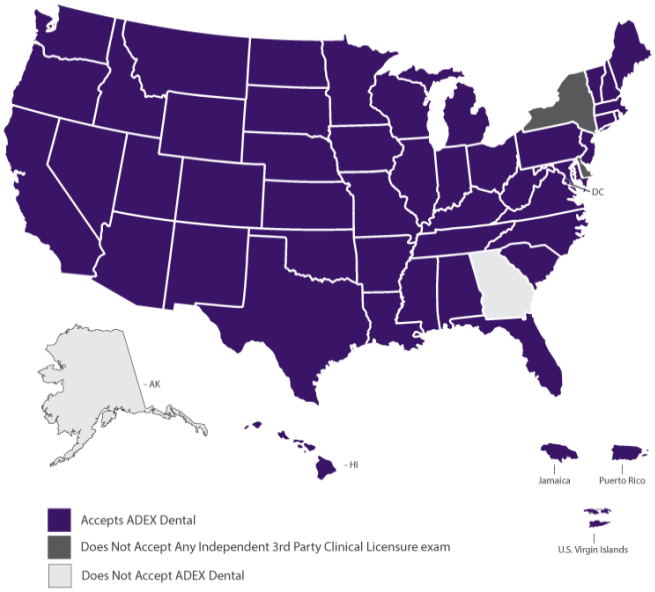
[1] Section 466.004, F.S.
[2] Section 466.003(3), F.S.
[3] Section 466.003(4)-(5), F.S.
[4] A passing score is valid for 365 days after the date the official examination results are published. A passing score on an examination obtained in another jurisdiction must be completed on or after October 1, 2011.
[5] Section 466.007, F.S.
[6] 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.

A dental hygienist may also apply to be certified to administer local anesthesia under the direct supervision of a non-sedated, adult patient if the dental hygienist completes an accredited course of 30 hours of didactic training and 30 hours of clinical training and is certified in basic or advanced cardiac life support.[7]

American Board of Dental Examiners

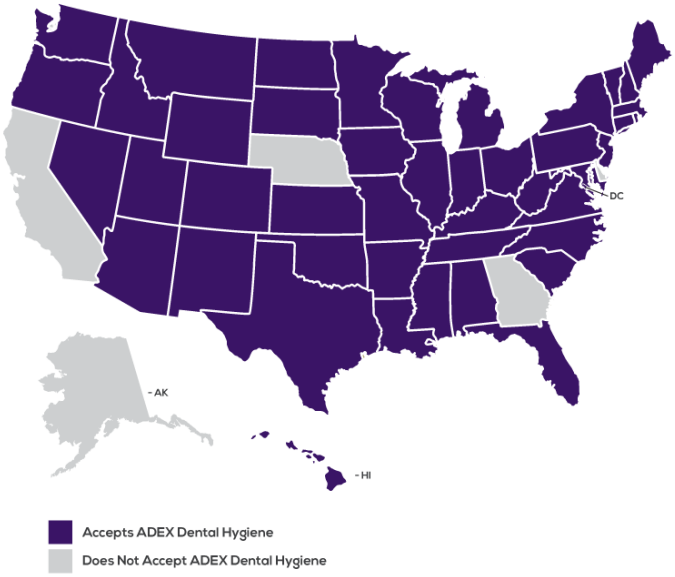
The American Board of Dental Examiners (ADEX) is a consortium of state and regional dental boards that provides for the ongoing development of uniform national dental and dental hygiene licensure examinations.[8] ADEX was created in 2003, with representatives from four regional testing agencies and 12 states. At the time ADEX was created, there were 16 different dental and dental hygiene examinations.[9]

The Commission on Dental Competency Assessment (CDCA), formerly known as the Northeast Regional Board, and the Council of Interstate Testing Agencies (CITA) administers the ADEX dental licensure examination to graduates of accredited dental schools and students about to enter their senior year at an accredited dental school.[10] The ADEX dental examination consists of three portions: a computer-based examination, simulated clinical examinations, and clinical examinations on live patients.[11] Florida law requires a Florida-licensed dentist to grade the examination.[12] The ADEX examination is widely accepted for dental licensure.[13]



[7] Section 466.017(5), F.S.
[8] American Board of Dental Examiners, Inc., *About ADEX*, available at https://adexexams.org/about-adex/ (last visited January 23, 2020).
[9] Id.
[10] Commission on Dental Competency Assessments, *Registration and DSE OSCE Manual: 2020 ADEX Dental Examination Series*, available at https://www.cdcaexams.org/documents/manuals/Dental_DSE_OSCE2020.pdf (last visited January 23, 2020).The cost of the ADEX dental examinations is $2,295; however, additional fees may be assessed, such as a facility or score report fee. The fee is reduced for partial exams and retakes. *See* Commission on Dental Competency Assessments, *Dental (ADEX) Exam*, available at https://www.cdcaexams.org/dental-exams/ (last visited January 23, 2020).
[11] Id at p. 4. The simulated clinical examinations assesses skills related to endodontics and fixed prosthodontics. The clinical examinations on live patients assesses skills related to restorative and periodontal procedures.
[12] Section 466.006(4), F.S.
[13] Commission on Dental Competency Assessments, *ADEX Acceptance Map*, available at https://www.cdcaexams.org/adex-acceptance-map/ (last visited January 23, 2020).

As with the dental examination, CDCA and CITA administer the ADEX dental hygiene examination.[14] The ADEX dental hygiene examination consists of two portions: a computer-simulated examination and a clinical examination on live patients.[15] Florida law requires a Florida-licensed dentist or dental hygienist to grade the examination.[16] The ADEX examination is widely accepted for dental hygiene licensure.[17]



Florida only accepts the ADEX examinations and the Legislature found, when specifying the ADEX examination for use in dental licensure, that the ADEX examinations, in both structure and functions, consistently meet generally accepted testing standards and that it adequately and reliably measures an applicant's ability to practice dentistry.[18] DOH contracts with the CDCA to administer the ADEX examinations, as well as the jurisprudence examinations.[19] In Fiscal Year 2018-2019, 840 dentists and 812 dental hygienists applied to the take the ADEX examinations.[20]

Western Regional Examining Board

The Western Regional Examining Board (WREB) was created in 1976 when Utah and Oregon made an arrangement to have a simultaneous dental licensure examination.[21] WREB offered its first dental hygiene examination in 1979.[22]

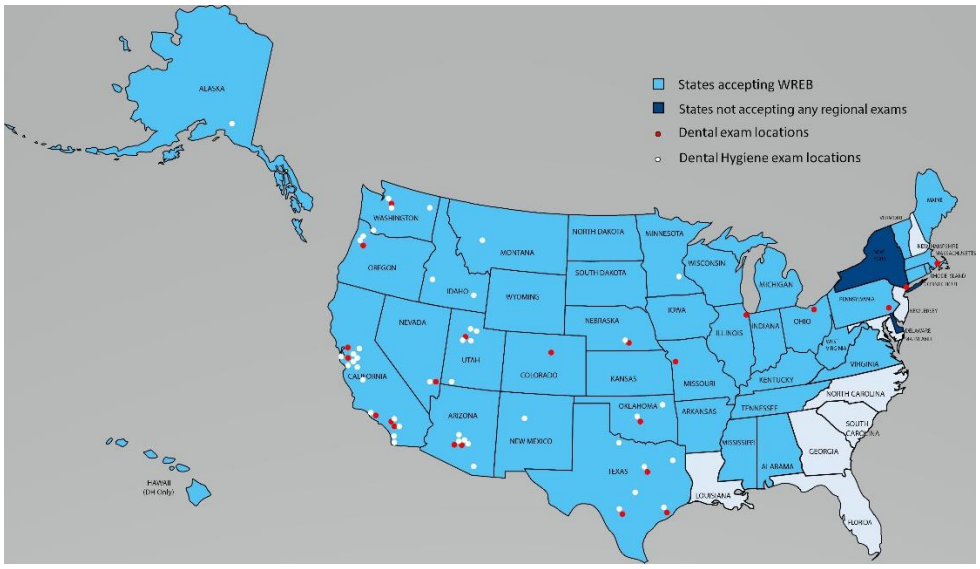
The WREB dental examination consists of three sections: operative, endodontics, and comprehensive treatment planning.[23] The operative section is performed on a live patient and the candidate must

[14] Commission on Dental Competency Assessments, *Candidate Registration and CSCE OSCE Manual: 2020 ADEX Dental Hygiene Examination*, available at https://www.cdcaexams.org/documents/manuals/Dental_Hygiene_Candidate_Registration2020.pdf (last visited January 23, 2020). The cost of the ADEX dental hygiene examinations is $995; however, additional fees may be assessed, such as a facility or score report fee.
[15] Id.
[16] Section 466.007(4), F.S.
[17] *Supra* note 13.
[18] Section 466.006(1)(a), F.S.
[19] Department of Health, *2020 Agency Legislative Bill Analysis for HB 1273,* (Jan. 21, 2020), on file with the Health Quality Subcommittee.
[20] Id.
[21] Western Regional Examining Board, *About Us*, available at https://wreb.org/about-us/ (last visited January 23, 2020). The members of the Western Regional Examining Board include Utah, Oregon, Arizona, Idaho, Alaska, New Mexico, Texas, Oklahoma, Washington, Wyoming, California, Missouri, Kansas, North Dakota, Illinois, Nevada, and Kentucky. West Virginia is an affiliate.
[22] Id.
[23] Western Regional Examining Board, *2020 WREB Exam Procedures*, available at https://wreb.org/Candidates/Dental/dentalPDFs/1_2020_WREB_Exam_Procedures.pdf (last visited January 23, 2020). The WREB

complete up to two restorative procedures. The endodontics section is simulated and the comprehensive treatment planning section is a computer-based written examination. A periodontal examination, which is performed on a live patient, and a prosthodontics examination, which is a simulated examination, are available for candidates in those states that require the examinations.[24]

The WREB dental hygiene examination assesses the candidates on patient qualification, extraoral and intraoral evaluation, calculus detection and removal, tissue management, periodontal assessment, and professional judgment.[25]

The Western Regional Examining Board's licensure examinations are widely accepted for licensure.[26]



The WREB does not administer a state-specific jurisprudence examination. Florida does not accept the WREB dentist or dental hygiene examinations for licensure.

Effect of Proposed Changes

HB 1273 authorizes the Board of Dentistry to accept passing scores on the examinations produced by the Western Regional Examining Board for licensure as a dentist or dental hygienist, in addition to the ADEX examinations it currently accepts. The bill requires the WREB examination to be graded by Florida-licensed practitioners.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 466.006, F.S., relating to examination of dentists.
Section 2: Amends s. 466.007, F.S., relating to examination of dental hygienists.
Section 3: Provides an effective date of July 1, 2020.

dental examination costs $2,560 plus an additional school use fee that varies by site. *See* Western Regional Examining Board, *2020 Dental Exam Fees*, available at https://wreb.org/dental-candidates/2019-dental-exam-fees/ (last visited January 23, 2020).
[24] Id. Florida requires a prosthodontics examination for licensure.
[25] Western Regional Examining Board, *2020 Dental Hygiene Examination Candidate Guide*, available at https://wreb.org/Candidates/Hygiene/hygienePDFs/2020_DH_Forms/2020_WREB_Candidate_Guide_HYG_v11012019.pdf (last visited January 23, 2020). The WREB dental hygiene examination costs $1,175 plus a school use fee, which varies by site. *See* Western Regional Examining Board, *Dental Hygiene, Local Anesthesia, and Restorative Exam Fees*, available at https://wreb.org/hygiene-candidates/2018-hygiene-exam-fees/ (last visited January 23, 2020).
[26] *Supra* note 21.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   DOH will experience an insignificant increase in workload associated with providing input into the test development and administration process for the WREB examinations, which current resources can absorb.[27] DOH will incur insignificant costs related to modifying applications, rulemaking, updating Board websites, facilitating electronic submission of WREB examination scores, and updating the LEIDS licensure system, which current resources can absorb.[28]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Dentists and dental hygienists who have received acceptable scores on the WREB examinations graded by Florida-licensed practitioners will not incur additional expense to take the ADEX examinations when applying for Florida licensure.

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 Board of Dentistry has sufficient rulemaking authority to implement the bill.

[27] *Supra* note 19.
[28] None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to dentistry and dental hygiene; amending ss. 466.006 and 466.007, F.S.; authorizing the use of certain examinations produced by the Western Regional Examining Board to measure an applicant's ability to practice the profession of dentistry or dental hygiene; providing an effective date.

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

Section 1. Subsection (1), paragraph (b) of subsection (4), paragraph (a) of subsection (5), and paragraph (a) of subsection (6) of section 466.006, Florida Statutes, are amended to read:

466.006 Examination of dentists.—

(1)(a) It is the intent of the Legislature to reduce the costs associated with an independent state-developed practical or clinical examination to measure an applicant's ability to practice the profession of dentistry and to use the American Dental Licensing Examination developed by the American Board of Dental Examiners, Inc., or the Western Regional Examining Board (WREB) Dental Examination in lieu of an independent state-developed practical or clinical examination. The Legislature finds that the American Dental Licensing Examination and the

WREB Dental Examination, in both their ~~its~~ structure and function, consistently meet ~~meets~~ generally accepted testing standards and have ~~has~~ been found, as they are ~~it is~~ currently organized and operating, to adequately and reliably measure an applicant's ability to practice the profession of dentistry.

(b) Any person desiring to be licensed as a dentist shall apply to the department to take the licensure examinations and shall verify the information required on the application by oath. The application shall include two recent photographs. There shall be an application fee set by the board not to exceed $100 which shall be nonrefundable. There shall also be an examination fee set by the board, which shall not exceed $425 plus the actual per-applicant ~~per applicant~~ cost to the department for purchase of some or all of the examination from the American Board of Dental Examiners, the WREB, or a ~~its~~ successor entity, if any, provided the board finds the successor entity's clinical examination complies with ~~the provisions of~~ this section. The examination fee may be refundable if the applicant is found ineligible to take the examinations.

(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 the following:

(b)1. A practical or clinical examination, which shall be the American Dental Licensing Examination produced by the

American Board of Dental Examiners, Inc., the WREB Dental Examination, or an examination produced by a ~~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 or the Western Regional Examining Board as the board deems appropriate by rule to ensure ~~assure~~ that the standards established herein are maintained organizationally. A passing score on the American Dental Licensing Examination or the WREB Dental 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.

2.a. As an alternative to the requirements of subparagraph 1., an applicant may submit scores from an American Dental Licensing Examination or a WREB Dental 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 or the WREB Dental Examination administered out-of-state shall be

the same as the passing score for the American Dental Licensing Examination or the WREB Dental 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.

3. If the date of an applicant's passing American Dental Licensing Examination or passing WREB Dental Examination scores from an examination previously administered in a jurisdiction other than this state under subparagraph 2. is older than 365 days, then such scores 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 or the WREB Dental 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;

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) In the 5 years immediately preceding the date of application for licensure in this state, the applicant 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, or, 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 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, 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 must submit documentation that he or she has completed, or will complete, before ~~prior to~~ licensure in this state, continuing education equivalent to this state's requirements for the last full reporting biennium;

g. The applicant 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 must successfully 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 must submit documentation that he or she has successfully completed the National Board of Dental Examiners dental examination.

(5)(a) The practical examination required under subsection (4) shall be the American Dental Licensing Examination developed by the American Board of Dental Examiners, Inc., the WREB Dental Examination, or an examination developed by a ~~its~~ successor entity, if any, provided the board finds that the successor entity's clinical examination complies with ~~the provisions of~~ this section, and shall include, at a minimum:

1. A comprehensive diagnostic skills examination covering the full scope of dentistry and an examination on applied clinical diagnosis and treatment planning in dentistry for dental candidates;

2. Two restorations on a live patient or patients. The board by rule shall determine the class of such restorations;

3. A demonstration of periodontal skills on a live

patient;

4. A demonstration of prosthetics and restorative skills in complete and partial dentures and crowns and bridges and the utilization of practical methods of evaluation, specifically including the evaluation by the candidate of completed laboratory products such as, but not limited to, crowns and inlays filled to prepared model teeth;

5. A demonstration of restorative skills on a mannequin which requires the candidate to complete procedures performed in preparation for a cast restoration;

6. A demonstration of endodontic skills; and

7. A diagnostic skills examination demonstrating ability to diagnose conditions within the human oral cavity and its adjacent tissues and structures from photographs, slides, radiographs, or models pursuant to rules of the board. If an applicant fails to pass the diagnostic skills examination in three attempts, the applicant shall not be eligible for reexamination unless she or he completes additional educational requirements established by the board.

The department shall require a mandatory standardization exercise for all examiners before ~~prior to~~ each practical or clinical examination and shall retain for employment only those dentists who have substantially adhered to the standard of grading established at such exercise.

(6)(a) It is the finding of the Legislature that absent a threat to the health, safety, and welfare of the public, the relocation of applicants to practice dentistry within the geographic boundaries of this state, who are lawfully and currently practicing dentistry in another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico, based on their scores from the American Dental Licensing Examination or the WREB Dental Examination administered in a state other than this state, is substantially related to achieving the important state interest of improving access to dental care for underserved citizens of this state and furthering the economic development goals of the state. Therefore, in order to maintain valid active licensure in this state, all applicants for licensure who are relocating to this state based on scores from the American Dental Licensing Examination or the WREB Dental Examination administered in a state other than this state must actually engage in the full-time practice of dentistry inside the geographic boundaries of this state within 1 year after ~~of~~ receiving such licensure in this state. The Legislature finds that, if such applicants do not actually engage in the full-time practice of dentistry within the geographic boundaries of this state within 1 year of receiving such a license in this state, access to dental care for the public will not significantly increase, patients' continuity of care will not be attained, and the economic

development goals of the state will not be significantly met.

Section 2. Paragraph (b) of subsection (4) and subsections (5) and (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 (ADEX), Inc., the Western Regional Examining Board (WREB) Dental Hygiene Examination, ~~(ADEX)~~ or an examination produced by a ~~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 or the WREB 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 or WREB 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, the WREB Dental Hygiene Examination, or an ~~the~~ examination produced by a ~~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, the WREB Dental Hygiene Examination, or an ~~the~~ examination produced by a ~~the~~ successor entity and administered in this state shall be graded by licensed dentists and dental hygienists ~~licensed in this state~~ who are employed by the department for this purpose.

(5) Effective July 1, 2012, an applicant who has completed the ADEX Dental Hygiene Examination or the WREB Dental Hygiene Examination in a jurisdiction other than this state and who has obtained a passing score may practice dental hygiene in this state if the applicant:

(a) Has successfully completed the National Board Dental Hygiene Examination at any time before the date of application;

(b) Has been certified by the American Dental Association Joint Commission on National Dental Examinations at any time before the date of application, as specified by state law;

(c) Has successfully completed a written examination on the laws and rules of this state regulating the practice of dental hygiene;

(d) Has not been disciplined by a board, except for citation offenses or minor violations; and

(e) 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.

(6)(a) A passing score on the ADEX Dental Hygiene Examination or the WREB Dental Hygiene Examination administered out of state shall be considered the same as a passing score for the ADEX Dental Hygiene Examination or the WREB Dental Hygiene Examination administered in this state and graded by licensed dentists and dental hygienists.

(b) If an applicant fails to pass the ADEX Dental Hygiene Examination or the WREB Dental Hygiene Examination in three attempts, the applicant is not eligible to retake the examination unless the applicant completes additional education requirements as specified by the board.

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

HB 1279

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1279 Health Insurance Benefits
SPONSOR(S): Yarborough
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	13 Y, 0 N	Grabowski	Calamas
2) Appropriations Committee	25 Y, 0 N	Nobles	Pridgeon
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.

The Florida Center for Health Information and Transparency (Florida Center) is responsible for collecting, compiling, analyzing and disseminating health related data for the purpose of developing public policy and promoting the transparency of consumer health care information through www.FloridaHealthFinder.gov. The Center is overseen by the Agency for Health Care Administration (AHCA) and provides health care price transparency to both patients and researchers.

In 2019, the Legislature enacted the Patient Savings Act, which allows health insurers and health maintenance organizations (HMOs) to create a shared savings incentive program (Program) to encourage insured individuals to shop for high quality, lower cost health care services and share any savings realized as a result of the insured's choice. The Act provided a range of methods by which a Program may financially reward patients who use shoppable health care services. Patients may receive financial incentives in the form of premium reductions, or deposits into a flexible spending account, health savings account, or health reimbursement account.

HB 1279 amends the Patient Savings Act by increasing the range of services defined as "shoppable" for purposes of earning shared savings incentives under a Program. In addition to the specific services outlined in the Act, the bill extends the "shoppable" service designation to those services identified by the Florida Center as having the most significant price variation at statewide and regional levels. The bill also allows a Program to provide cash or a cash-equivalent reward to a program participant who earns a shared savings incentive.

The bill also requires the Florida Center to publish an annual report identifying health care services with the most significant price variation at statewide and regional levels.

The bill has a negative, but likely insignificant, fiscal impact on AHCA which can be absorbed within existing resources and no fiscal impact on local government.

The bill provides an effective date of January 1, 2021.

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]

The average deductible amount for single coverage is $1,573, among covered workers with a general annual deductible.[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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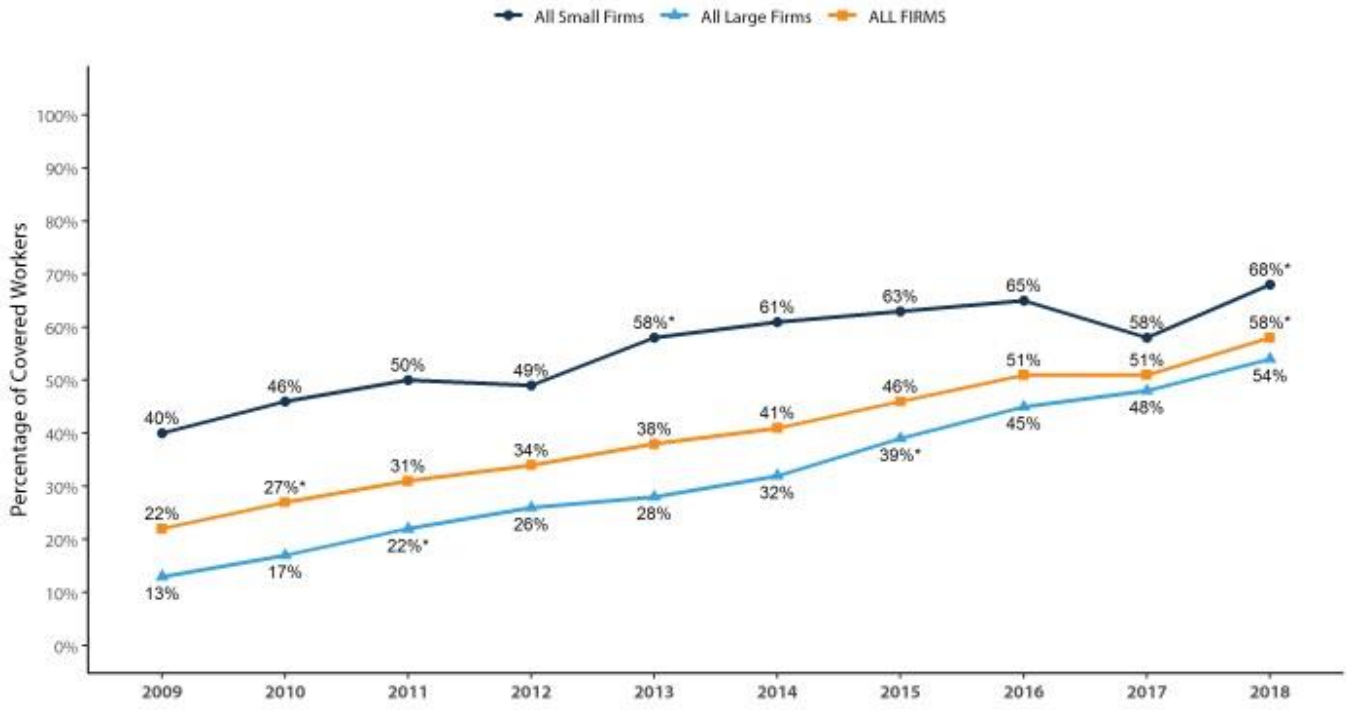
[1] Government Accounting Office, *Meaningful Price Information is Difficult for Consumers to Obtain Prior to Receiving Care*, September 2011, page 2, available at http://www.gao.gov/products/GAO-11-791 (last accessed January 23, 2020).
[2] Id.
[3] Healthcare Financial Management Association, *Price 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 January 23, 2020).
[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 January 23, 2020).
[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.[9]

From 2013 to 2018, the average premium for covered workers with family coverage increased 20%, while wages only increased 12%.[10] 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:

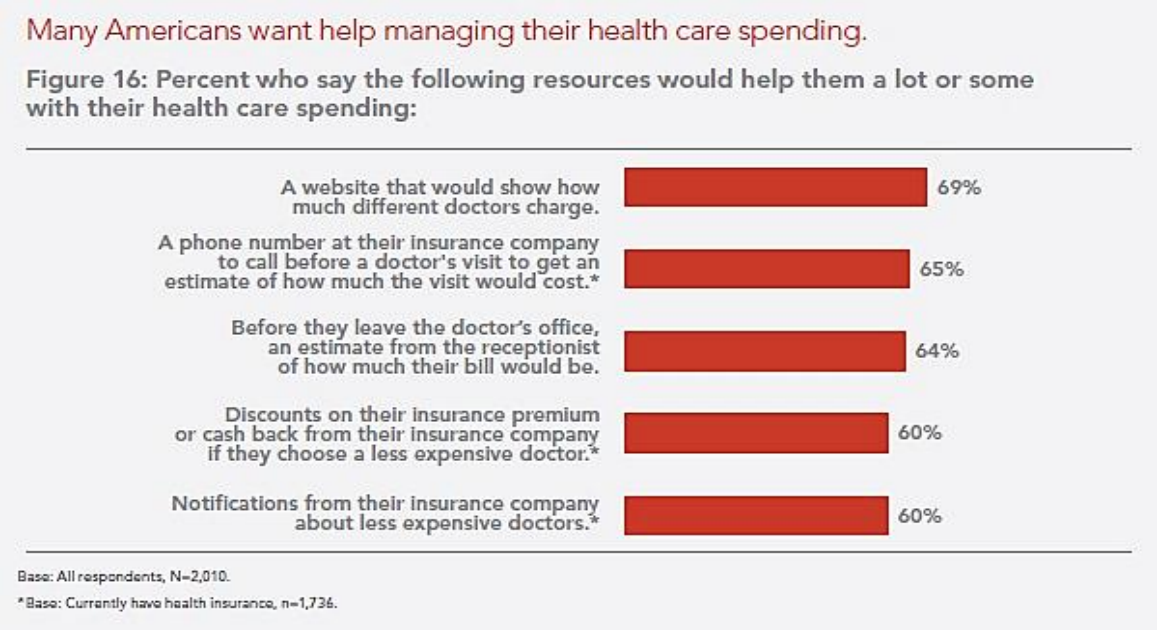
- Provide personalized out-of-pocket expense information to patients and families before receiving care.

[9] Id.
[10] Id.

- Provide prices to physicians through electronic health record systems when ordering treatments and tests.
- 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.[11]

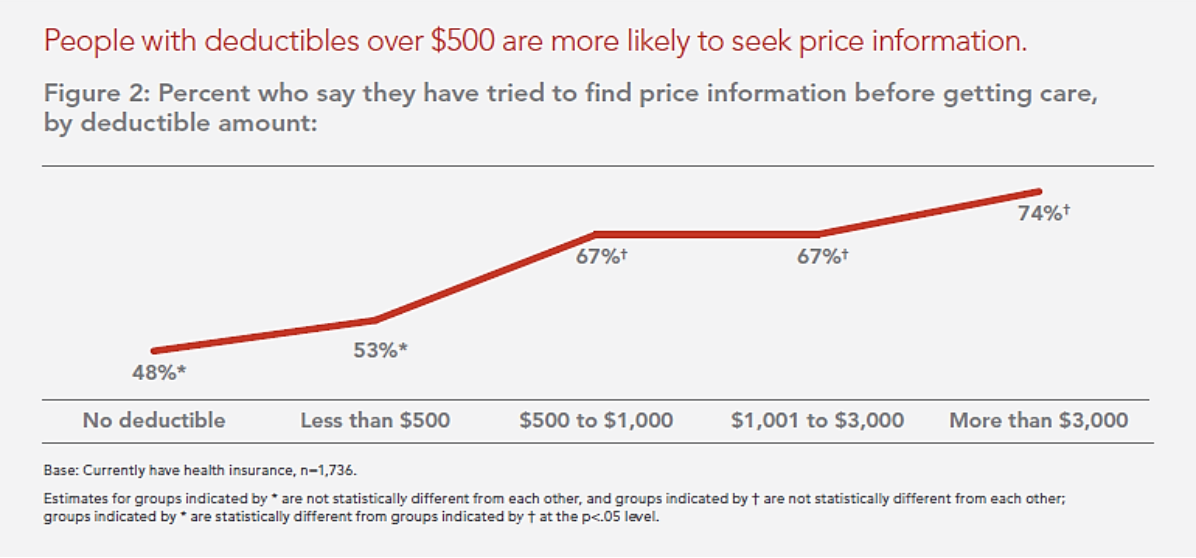
The report specifically found that requiring all private health insurance plans to provide personalized out-of-pocket price data to enrollees would reduce total health spending by an estimated $18 billion over the 10-year period from 2014 to 2023.[12]

As Americans take on more of their health care costs, research suggests that they are looking for more and better price information.[13]



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.[14] 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.[15]

[11] 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 January 23, 2020).
[12] Id., pg. 1.
[13] Public Agenda and Robert Wood Johnson Foundation, *How Much Will It Cost? How Americans Use Prices in Health Care*, March 2015, page 34, available at https://www.publicagenda.org/files/HowMuchWillItCost_PublicAgenda_2015.pdf (last accessed January 23, 2020).
[14] Id., pg. 3.
[15] Id., pg. 13.



The individuals who compared prices stated that such research affected their health care choices and saved them money.[16] 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.[17] 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.[18] Another study found that 80 percent of health care consumers will select the highest value health care provider when they have access to well-designed reports on price and quality.[19]

Shoppable Health Care Services

As Americans are given greater access to health care cost information, they will be faced with decisions on how to use the cost information. Shopping for health care services can be very difficult due to the structure of our current health care system. A patient's need for health care services can be unpredictable and patients can be in a vulnerable position and unable to negotiate.

There are many factors that impact the "shoppability" of services – how complex the service is, how urgent it is, if the patient knows what they need versus if they need a recommendation from a doctor. Physicians have a growing role in the price conversation, but evidence suggests they are not engaging in the discussion of price as much as they could be. Furthermore, doctors may have a wider influence on costs, extending beyond the prices they charge their patients. Patients who visit doctors with lower-cost office visits have lower spending, on average, than those who visit high-cost doctors.[20]

[16] Id., pg. 4.
[17] Supra note 13.
[18] American Institute for Research, *Consumer Beliefs and Use of Information About Health Care Cost, Resource Use, and Value*, Robert Wood Johnson Foundation, October 2012, page 4, available at https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf402126 (last accessed January 23, 2020).
[19] 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.
[20] "From The Archives: Prices And Consumer Shopping, " Health Affairs Blog, July 19, 2017, available at https://www.healthaffairs.org/do/10.1377/hblog20170719.061105/full/ (last accessed January 23, 2020).

Price Transparency in Florida

Florida Center for Health Information and Transparency

The Florida Center for Health Information and Transparency (the Florida Center), housed within the Agency for Health Care Administration (AHCA), provides a comprehensive health information system (information system) that includes the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of health-related data.[21]

The Florida Center identifies existing health-related data and collects data for use in the information system, including information on health care costs and financing, trends in health care prices and costs, the sources of payment for health care services, and federal, state, and local expenditures for health care.[22]

Florida Consumer Price Portal

The Florida Center maintains www.FloridaHealthFinder.gov, which was established by law in 2016[23], to assist consumers in making informed health care decisions and lead to improvements in quality of care in Florida. The website provides a wide array of search and comparative tools to the public which allow easy access to information on hospitals, ambulatory surgery centers, emergency departments, hospice providers, physician volume, health plans, nursing homes, and prices for prescription drugs in Florida.

The cost information on the website is searchable, and based on descriptive bundles of commonly performed procedures and services. Consumers can view typical payments[24] for common medical procedures and diagnostic tests, with information presented at both statewide and local levels. In other words, a patient in Tampa can see recent prices paid for a chest x-ray at local facilities and a statewide average price. The consumer search tool is accessible at https://pricing.floridahealthfinder.gov/#!.

The website also provides tools to researchers and professionals allowing for specialized data queries, but requires users to have some knowledge of medical coding and terminology.[25] Some of the features and data available on the website include a multimedia encyclopedia and symptoms navigator, hospital and ambulatory surgery centers performance data, data on mortality, complication, and infection rates for hospitals, and a facility/provider locator.[26]

Patient Savings Act

In 2019, the Legislature enacted the Patient Savings Act[27], which allows health insurers and health maintenance organizations (HMOs) to create a shared savings incentive program (Program) to encourage insured individuals to shop for high quality, lower cost health care services and share any savings realized as a result of the insured's choice. The Act authorizes implementation of these incentive programs for plan years beginning January 1, 2020.

Health insurers and HMOs that choose to offer a Program must develop a website outlining the range of shoppable health care services available to insureds. This website must provide patients with an

[21] S. 408.05(1), F.S.
[22] S. 408.05(2), F.S.
[23] Ch. 2016-234, L.O.F. See also S. 408.05(3), F.S.
[24] The website provides information on *payments* for services, and not facility *charges*. Very few patients or insurers actually pay the full charge for a service, so reporting of payments provides a more accurate estimate of costs that patients and/or their health plans can expect to incur.
[25] Agency for Health Care Administration, Florida Center for Health Information and Policy Analysis, *2017 Annual Report*, pgs. 4-8, available at https://fhfstore.blob.core.windows.net/documents/researchers/documents/2017%20FL%20Center%20Annual%20Report%20FINAL.PDF (last accessed January 24, 2020).
[26] Id., pgs. 6-8.
[27] Ss. 627.6387, 627.6648, and 641.31076, F.S.

inventory of participating health care providers and an accounting of the shared savings incentives available for each shoppable service. The Act provides a list of nonemergency services that qualify as "shoppable health care services". These include, but are not limited to:

- Clinical laboratory services.
- Infusion therapy.
- Inpatient and outpatient surgical procedures.
- Obstetrical and gynecological services.
- Outpatient nonsurgical diagnostic tests and procedures.
- Physical and occupational therapy services.
- Radiology and imaging services.
- Prescription drugs.
- Services provided through telehealth.

The Act defines a "shared savings incentive" as an optional financial incentive that may be paid to an insured for choosing certain shoppable health care services under a Program. When a patient obtains a shoppable health care service for less than the average price for the service, the bill requires the savings to be shared by the health insurer and the patient. A patient is entitled to a financial incentive that is no less than 25 percent of the savings that accrue to the insurer as a result of the patient's participation.

The bill provides a range of methods by which a Program may financially reward patients who save money by shopping for health care services. Patients may receive financial incentives in the form of premium reductions, or deposits into a flexible spending account, health savings account, or health reimbursement account.[28]

Effect of Proposed Changes

HB 1279 requires the Florida Center to publish an annual report identifying health care services with the most significant price variation at statewide and regional levels. This report will be due on July 1 of each year.

The bill also amends the Patient Savings Act by increasing the range of services defined as "shoppable" for purposes of earning a shared savings incentive under a Program. In addition to the examples of specific services outlined in the Act, the bill extends the "shoppable" service designation to those services identified by the Florida Center's annual report as having the most significant price variation at statewide and regional levels.

Under current law, insurers and HMOs operating a Program may reward participants through deposits to health-related accounts or through premium reductions. The bill expands the range of rewards to include cash or cash-equivalent incentives.[29]

The bill provides an effective date of January 1, 2021.

B. SECTION DIRECTORY:

Section 1: Amends s. 408.05.012, F.S., relating to Florida Center for Health Information and Transparency.
Section 2: Amends s. 627.6387, F.S., relating to shared savings incentive program.
Section 3: Amends s. 627.6648, F.S., relating to shared savings incentive program.

[28] Id.
[29] To the extent that a cash incentive paid to an insured increases that insureds total income, he or she will be responsible for income-related taxes that may be due on this additional income.

Section 4: Amends s. 641.31076, F.S., relating to shared savings incentive program.
Section 5: 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:

   AHCA may incur some additional costs associated with completion of the annual reporting requirement for the Florida Center. These costs can be absorbed using existing resources.

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 health insurance benefits; amending s. 408.05, F.S.; requiring the Agency for Health Care Administration to publish an annual report identifying certain health care services by a specified date; amending s. 627.6387, 627.6648, and 641.31076, F.S.; revising the definition of the term "shoppable health care service"; revising duties of certain health insurers and health maintenance organizations; providing an effective date.

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

Section 1. Paragraph (l) is added to subsection (3) of section 408.05, Florida Statutes, to read:

408.05 Florida Center for Health Information and Transparency.—

(3) HEALTH INFORMATION TRANSPARENCY.—In order to disseminate and facilitate the availability of comparable and uniform health information, the agency shall perform the following functions:

(l) By July 1 of each year, publish a report identifying the health care services with the most significant price variation both statewide and regionally.

Section 2. Paragraph (e) of subsection (2) and paragraph

(e) of subsection (3) of section 627.6387, Florida Statutes, are amended to read:

627.6387 Shared savings incentive program.—

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

(e) "Shoppable health care service" means a lower-cost, high-quality nonemergency health care service for which a shared savings incentive is available for insureds under a health insurer's shared savings incentive program. Shoppable health care services may be provided within or outside this state and include, but are not limited to:

1. Clinical laboratory services.

2. Infusion therapy.

3. Inpatient and outpatient surgical procedures.

4. Obstetrical and gynecological services.

5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.

6. Physical and occupational therapy services.

7. Radiology and imaging services.

8. Prescription drugs.

9. Services provided through telehealth.

10. Any additional services published by the Agency for Health Care Administration that have the most significant price variation pursuant to s. 408.05(3)(l).

(3) A health insurer may offer a shared savings incentive program to provide incentives to an insured when the insured

obtains a shoppable health care service from the health insurer's shared savings list. An insured may not be required to participate in a shared savings incentive program. A health insurer that offers a shared savings incentive program must:

(e) At least quarterly, credit or deposit the shared savings incentive amount to the insured's account as a return or reduction in premium, or credit the shared savings incentive amount to the insured's flexible spending account, health savings account, or health reimbursement account, or reward the insured directly with cash or a cash equivalent ~~such that the amount does not constitute income to the insured~~.

Section 3. Paragraph (e) of subsection (2) and paragraph (e) of subsection (3) of section 627.6648, Florida Statutes, are amended to read:

627.6648 Shared savings incentive program.—

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

(e) "Shoppable health care service" means a lower-cost, high-quality nonemergency health care service for which a shared savings incentive is available for insureds under a health insurer's shared savings incentive program. Shoppable health care services may be provided within or outside this state and include, but are not limited to:

1. Clinical laboratory services.

2. Infusion therapy.

3. Inpatient and outpatient surgical procedures.

4. Obstetrical and gynecological services.

5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.

6. Physical and occupational therapy services.

7. Radiology and imaging services.

8. Prescription drugs.

9. Services provided through telehealth.

10. Any additional services published by the Agency for Health Care Administration that have the most significant price variation pursuant to s. 408.05(3)(l).

(3) A health insurer may offer a shared savings incentive program to provide incentives to an insured when the insured obtains a shoppable health care service from the health insurer's shared savings list. An insured may not be required to participate in a shared savings incentive program. A health insurer that offers a shared savings incentive program must:

(e) At least quarterly, credit or deposit the shared savings incentive amount to the insured's account as a return or reduction in premium, or credit the shared savings incentive amount to the insured's flexible spending account, health savings account, or health reimbursement account, or reward the insured directly with cash or a cash equivalent ~~such that the amount does not constitute income to the insured~~.

Section 4. Paragraph (e) of subsection (2) and paragraph (e) of subsection (3) of section 641.31076, Florida Statutes,

are amended to read:

641.31076 Shared savings incentive program.—

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

(e) "Shoppable health care service" means a lower-cost, high-quality nonemergency health care service for which a shared savings incentive is available for subscribers under a health maintenance organization's shared savings incentive program. Shoppable health care services may be provided within or outside this state and include, but are not limited to:

1. Clinical laboratory services.

2. Infusion therapy.

3. Inpatient and outpatient surgical procedures.

4. Obstetrical and gynecological services.

5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.

6. Physical and occupational therapy services.

7. Radiology and imaging services.

8. Prescription drugs.

9. Services provided through telehealth.

10. Any additional services published by the Agency for Health Care Administration that have the most significant price variation pursuant to s. 408.05(3)(l).

(3) A health maintenance organization may offer a shared savings incentive program to provide incentives to a subscriber when the subscriber obtains a shoppable health care service from

the health maintenance organization's shared savings list. A subscriber may not be required to participate in a shared savings incentive program. A health maintenance organization that offers a shared savings incentive program must:

(e) At least quarterly, credit or deposit the shared savings incentive amount to the subscriber's account as a return or reduction in premium, or credit the shared savings incentive amount to the subscriber's flexible spending account, health savings account, or health reimbursement account, or reward the subscriber directly with cash or a cash equivalent ~~such that the amount does not constitute income to the subscriber~~.

Section 5. This act shall take effect January 1, 2021.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1287 Reproductive Medicine
SPONSOR(S): Health Quality Subcommittee, Jenne
TIED BILLS: **IDEN./SIM. BILLS:** SB 698

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	12 Y, 0 N, As CS	Siples	McElroy
2) Health & Human Services Committee		Siples	Calamas

SUMMARY ANALYSIS

Infertility is the inability to conceive a child, and generally, a person is considered to be infertile after one year of unsuccessful conception. A physician may treat infertility by using intrauterine insemination or assistive reproductive technology. In intrauterine insemination, the physician uses reproductive material from the woman's partner or a donor. In assistive reproductive technology, an egg is fertilized in a laboratory using reproductive material from the woman's partner or a donor.

With the rising popularity of at-home genetic testing, former patients and adult children are learning that fertility doctors used their own reproductive material without the consent of their former patients. This practice is now known as fraudulent insemination or fertility fraud. Currently, Florida law does not specifically prohibit this practice.

CS/HB 1287 bans a physician from inseminating or implanting a patient or causing a patient to be inseminated or implanted with his or her own reproductive material. The bill establishes such action as a ground for disciplinary action against the physician's license. The bill also prohibits any health care practitioner from intentionally implanting, inseminating, or causing to be implanted or inseminated reproductive material into a patient from a donor unless the patient has consented to the use of that donor's reproductive material.

Effective October 1, 2020, the bill creates the crime of reproductive battery, which prohibits a healthcare practitioner from intentionally penetrating the vagina of a patient with the reproductive material of a donor or any object containing the reproductive material of a donor knowing the patient has not consented to the use of reproductive material from that donor. The bill tolls the statute of limitations for criminal prosecution of a reproductive battery until the date a violation is discovered and reported to law enforcement or another governmental agency.

The Criminal Justice Impact Conference considered the bill on February 10, 2020, and determined that it will likely have a positive insignificant impact, meaning it will result in an increase of 10 or fewer beds. The bill has an insignificant, negative fiscal impact on the Department of Health, 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

Florida licenses two types of physicians: allopathic and osteopathic. Allopathic physicians diagnose, treat, operate, or prescribe for any human disease, pain, injury, deformity, or other physical or mental condition.[1] The scope of practice for osteopathic physicians is the same as that of allopathic physicians; however, osteopathic medicine emphasizes the importance of the musculoskeletal structure and manipulative therapy in the maintenance and restoration of health.[2]

Physician Licensure in Florida

Allopathic Physicians

Chapter 458, F.S., governs licensure and regulation of the practice of medicine by the Florida Board of Medicine (allopathic board) in conjunction the Department of Health (DOH). The chapter provides, among other things, licensure requirements by examination for medical school graduates and licensure by endorsement requirements.

Allopathic Licensure by Examination

An individual seeking to be licensed by examination as an allopathic physician, must meet the following requirements:[3]

- Be at least 21 years of age;
- Be of good moral character;
- Has not committed an act or offense that would constitute the basis for disciplining a physician, pursuant to s. 458.331, F.S.;
- 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;
- Meets one of the following medical education and postgraduate training requirements:
    - Is a graduate of 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 has completed at least one year of approved residency training;
    - Is a graduate of 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 has completed at least one year of approved residency training; or
    - Is a graduate of an allopathic foreign medical school that has not been certified pursuant to statute; has an active, valid certificate issued by the Educational Commission for Foreign Medical Graduates (ECFMG),[4] has passed that commission's examination; and has completed an approved residency or fellowship of at least 2 years in one specialty area;

[1] Section 458.305, F.S.
[2] Section 459.003, F.S.
[3] Section 458.311(1), F.S.; s. 458.313, F.S. offers a path to licensure by endorsement for physicians who hold an active license to practice medicine in another jurisdiction.
[4] 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.)

- Has submitted to a background screening by the DOH; and
- Has obtained 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.

Osteopathic Physicians

Chapter 459, F.S., governs licensure and regulation of the practice of medicine by the Florida Board of Osteopathic Medicine (osteopathic board), in conjunction the DOH. The chapter provides, among other things, general licensure requirements, including by examination for medical school graduates and licensure by endorsement requirements.

Osteopathic General Licensure

An individual seeking to be licensed as an osteopathic physician must meet the following requirements:[5]

- Complete at least three years of pre-professional post-secondary education;
- Has not committed, or be under investigation in any jurisdiction for, an act or offense that would constitute the basis for disciplining an osteopathic physician, unless the osteopathic board determines such act does not adversely affect the applicant's present ability and fitness to practice osteopathic medicine;
- Has 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 in any jurisdiction;
- Has not received less than a satisfactory evaluation from an internship, residency, or fellowship training program;
- Has submitted to a background screening by the DOH;
- Has graduated from a medical college recognized and approved by the American Osteopathic Association;
- Successfully completes 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
- Obtains 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.[6]

Infertility

Infertility is the inability to conceive a child, and generally, a person is considered to be infertile after one year of unsuccessful conception.[7] The Centers for Disease Control (CDC) estimates about 12 percent of women aged 15 to 44 years in the United States have difficulty getting pregnant or carry a

[5] Section 459.0055(1), F.S.
[6] 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.
[7] Centers for Disease Control and Prevention, *Infertility FAQs*, available at https://www.cdc.gov/reproductivehealth/infertility/index.htm (last visited January 25, 2020).

pregnancy to term.[8] Infertility affects both men and women equally. In approximately forty percent of infertile couples, the male partner is either the sole cause or a contributing cause of infertility.[9]

Treatment of Infertility

Health care practitioners may treat infertility using a number of methods: medicine, surgery, intrauterine insemination, or assisted reproductive technology.[10] Health care practitioners often use more than one of these methods concurrently. The treatment used by the health care practitioner depends on the:[11]

- Factors contributing to the infertility.
- Duration of the infertility.
- Age of the female.
- Couple's treatment preference after counseling about success rates, risks, and benefits of each treatment option.

Eighty-five to ninety percent of infertility cases are treated with medication or surgery.[12] A health care practitioner may use intrauterine insemination (IUI), also known as artificial insemination, if medication or surgery is not indicated or is unsuccessful in resolving the infertility. With IUI, specially prepared sperm are inserted into a woman's uterus.[13] The sperm may be the sperm of her partner or from a donor.

Assistive reproductive technology (ART) includes all fertility treatments in which both the eggs and the embryos are handled outside of the body. Examples of ART includes in vitro fertilization (IVF), gamete intrafallopian transfer, pronuclear stage tubal transfer, tubal embryo transfer, and zygote intrafallopian transfer.[14]

IVF involves surgically removing eggs from a woman's ovaries and combining them with her partner's sperm or donor sperm in a laboratory.[15] After 40 hours the eggs are examined to see if they have become fertilized by sperm and are dividing into cells. The fertilized eggs or embryos are then placed in the woman's uterus.[16] The transfer may occur at the time they are fertilized or the embryos may be cryopreserved for future use.

Fraudulent Insemination

With the rising popularity of at-home genetic testing, adult children are learning that they are not biologically related to their fathers and that they may have multiple half-siblings. Beginning in 2016, cases began to emerge where male physicians had used their own sperm in the 1970s through 1990s to inseminate patients without their knowledge.[17]

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[8] Id.
[9] American Society for Reproductive Medicine, *Quick Facts about Infertility*, available at https://www.reproductivefacts.org/faqs/quick-facts-about-infertility/ (last visited February 1, 2020).
[10] *Supra* note 7.
[11] Id.
[12] *Supra* note 9.
[13] *Supra* note 7.
[14] American Society for Reproductive Medicine, *Assisted Reproductive Technologies*, available at https://www.reproductivefacts.org/topics/topics-index/assisted-reproductive-technologies/ (last visited February 1, 2020).
[15] American Society for Reproductive Medicine, *What is In Vitro Fertilization?*, available at https://www.reproductivefacts.org/faqs/frequently-asked-questions-about-infertility/q05-what-is-in-vitro-fertilization/ (last visited February 1, 2020).
[16] Id.
[17] Dr. Jody Lynee Madeira, *Uncommon Misconceptions: Holding Physicians Accountable for Fertility Fraud*, 37 LAW & INEQUALITY 45 (Winter 2019), available at https://scholarship.law.umn.edu/cgi/viewcontent.cgi?article=1605&context=lawineq (last visited February 1, 2020).

When infertility treatment was relatively new, physicians would mix a spouse's sample with that of a donor, and physicians typically provided little information about the donor to the patient.[18] A survey conducted by the federal Office of Technology Assessment in 1987, revealed that approximately two percent of fertility doctors who responded had use their own sperm to inseminate patients.[19] Physicians have justified this practice by indicating that the donors were advised that the sperm donors were anonymous and would not provide any other information to protect that anonymity.[20] Unlike the practice in 1970s and 1980s, many donations today are provided to sperm banks, rather than directly to practitioners, that typically catalog donations, along with profiles of the donors.[21]

Former patients impacted by fraudulent insemination feel physically violated and assaulted, and may feel guilty or remorseful for seeking accountability due to their affection for their children.[22] Children who resulted from fraudulent insemination may experience disruption in personal identity and may become estranged from their families if they pursue relationships with their newly found half-siblings.[23]

Criminal Liability

Current law presents several obstacles to imposing criminal sanctions for fraudulent insemination. As of 2019, no health care practitioner has been held criminally liable for conduct relating to the unauthorized use of human reproductive material.[24] Prosecuting authorities have charged health care practitioners with mail fraud, wire fraud, perjury, and obstruction of justice when state laws have failed to specifically provide criminal penalties for such conduct.[25]

Florida

Florida law does not specifically prohibit a health care practitioner from implanting or inseminating a patient with human reproductive material from an unspecified donor without the patient's consent. The elements of some existing crimes come close to capturing the conduct, but present challenges when applied in a health care setting. For example, it is unlikely that the crime of battery[26] captures fraudulent insemination. A person commits battery when he or she:[27]

- Actually and intentionally touches or strikes another person against the will of the other; or
- Intentionally causes another person bodily harm.

A fertility patient consents to an insemination procedure prior to sperm being injected. Even if a fertility patient would not have consented to the sperm's source, because she consents to the actual "touching" required for a battery, it may be difficult to prove a violation. Moreover, other states have resisted applying battery statutes to fraudulent insemination out of concern that a jury may determine that a patient consented to conduct in cases where anonymous donor sperm is used for insemination.[28]

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[18] Dov Fox, JD, DPhil, I. Glenn Cohen, JD, and Eli Y. Adashi, MD, MS, *Fertility Fraud, Legal Firsts, and Medical Ethics (Abstract)*, 134 Obstetrics & Gynecology 918 (Nov. 2019), available at https://journals.lww.com/greenjournal/Citation/2019/11000/Fertility_Fraud,_Legal_Firsts,_and_Medical_Ethics.4.aspx (last visited February 1, 2020).
[19] *Supra* note 17.
[20] Michael Cook, *Another Case of Fertility Fraud, This Time in Colorado*, BIOEDGE, (Feb. 1, 2020), available at https://www.bioedge.org/bioethics/another-case-of-fertility-fraud-this-time-in-colorado/13311 (last visited February 1, 2020).
[21] *Supra* note 18.
[22] *Supra* note 17.
[23] Id.
[24] *Supra* note 17.
[25] Jody Lynee Madeira, *Understanding Illicit Insemination and Fertility Fraud, From Patient Experience to Legal Reform*, (Jan. 29, 2020) https://journals.library.columbia.edu/index.php/cjgl/article/view/4559 (last visited Feb. 1, 2020).
[26] Section 784.03, F.S.
[27] Battery is a first degree misdemeanor, punishable by up to one year in county jail and a fine up to $1,000. Sections 775.082 and 775.083, F.S.
[28] *Supra* note 17.

Similarly, the elements of fraudulent insemination are likely not captured by the existing crime of sexual battery. Sexual battery is the oral, anal, or vaginal penetration by, or union with, the sexual organ of another or the anal or vaginal penetration of another by any other object.[29] Sexual battery does not include an act done for a bona fide medical purpose.[30] Although sexual battery does not require proof that the act was performed for the purpose of sexual gratification, the fact that the act is performed in a clinical setting in which the patient has consented to the procedure may present obstacles to proving a violation.[31]

Other States

Texas prohibits a person from using genetic material without disclosing the source of such material as a form of sexual assault. Under the law, it is a felony to implant human reproductive material without a patient's consent, and a violation is punishable by six months to two years imprisonment and a fine up to $10,000.[32] Indiana prohibits making a misrepresentation involving human reproductive material or a medical procedure, device, or drug. A violation of the prohibition is punishable by one to six years imprisonment and a fine up to $10,000.[33] Currently, Texas and Indiana are the only states that have criminalized conduct related to fraudulent insemination.[34]

California law makes it a crime for a person to knowingly use reproductive material in ART, for any purpose other than that authorized by the provider of the reproductive material.[35] It also prohibits anyone from knowingly implanting reproductive material, through ART, into a recipient who is not the provider of the reproductive material without the written consent of both the provider and recipient.[36]

Statute of Limitations

The statute of limitations (SOL) determines the timeframe in which a criminal prosecution must be initiated.[37] The SOL in effect at the time a crime is committed controls.[38] In general, time is calculated from the day after a person commits an offense, and the filing of a charging document such as an indictment or information initiates the prosecution for the purpose of satisfying the time limitations.[39] Regardless of whether a charging document is filed, the time limitation does not run during any time an offender is continuously absent from the state or otherwise undiscoverable because he or she lacks a reasonably ascertainable home address or place of employment; however, an extension under this scenario may not exceed the normal time limitation by more than three years.[40]

Capital felonies,[41] life felonies,[42] and felonies resulting in a death are not subject to time constraints, and the state may bring charges at any time.[43] The standard time limitations for other crimes are:[44]

- Four years for a first degree felony.

[29] The act must be committed without the victim's consent. S. 794.011(1)(h), F.S.
[30] A person 18 years of age or older who commits sexual battery upon a person 18 years of age or older, without that person's consent, and in the process does not use physical force or violence likely to cause serious personal injury commits a second degree felony, punishable by 15 years imprisonment and a $10,000 fine. Ss. 775.082 and 775.083, F.S.
[31] Jody Lynee Madeira, *Understanding Illicit Insemination*, *supra* note 2.
[32] Tex. Penal Code Ann. § 22.011 (2019).
[33] Ind. Code § 35-43-5-3 (2019).
[34] Jody Lynee Madeira, *Fertility Fraud: An Update*, Society for Reproductive Technology (Oct. 21, 2019), https://www.sart.org/news-and-publications/news-and-research/legally-speaking/fertility-fraud-an-update/ (last visited Feb. 2, 2020).
[35] Cal. Penal Code § 367g (2019).
[36] Id.
[37] Section 775.15, F.S.
[38] *Beyer v. State*, 76 So. 3d 1132, 1135 (Fla. 4th DCA 2012).
[39] Sections. 775.15(3)–(4), F.S.
[40] Section 775.15(5), F.S.
[41] Section 775.082, F.S.
[42] Id.
[43] Section 775.15(1), F.S.
[44] Section 775.15(2), F.S.

- Three years for a second or third degree felony.
- Two years for a first degree misdemeanor.
- One year for a second degree misdemeanor.

Exceptions to the standard SOL apply to certain crimes and circumstances. In particular, Florida extends or removes time limitations or changes the date on which calculation of the SOL begins for sex crimes, including sexual battery, lewd or lascivious offenses, and human trafficking.[45]

The potential lapse of time between a fraudulent insemination and the discovery of such conduct may present a barrier to prosecution. Patients often do not discover fertility fraud until several years after the insemination has occurred.[46] For example, Donald Cline, an obstetrician from Indianapolis, Indiana, fraudulently inseminated multiple patients and fathered several children between 1974 and 1987.[47] His conduct was not discovered until 2014.[48]

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.[49] 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.[50] Each profession is regulated by an individual practice act and by ch. 456, F.S., which provides general regulatory and licensure authority for MQA.

Section 456.072, F.S., authorizes a regulatory board or DOH, if there is no board, to discipline a health care practitioner's licensure for a number of offenses, including but not limited to:

- Making misleading, deceptive, or fraudulent representations in or related to the practice of the licensee's profession;
- Making deceptive, untrue, or fraudulent representations in or related to the practice of a profession or employing a trick or scheme in or related to the practice of a profession; or
- Engaging or attempting to engage in sexual misconduct as defined in s. 456.063, F.S.

Although a board or DOH, if there is no board, may find that a health care practitioner who commits fraudulent insemination is subject to discipline under one of the fraud provisions. Sexual misconduct involves a health care practitioner engaging, or attempting to engage, in verbal or physical sexual activity outside the scope of the professional practice of his or her health care profession with a patient or client, or an immediate family member, guardian, or representative of a patient or client.[51] It is not known if health care practitioner who fraudulent inseminates a patient would be subject to licensure discipline since the behavior may be deemed not to constitute sexual activity as contemplated by statute.

[45] An extension of a particular crime's SOL does not violate the ex post facto clause of the State Constitution if the extension takes effect before prosecution of an offense is barred by the old SOL and the new SOL clearly indicates it applies to cases pending upon its effective date. Art. I, s. 10, Fla. Const.; *Andrews v. State*, 392 So. 2d 270, 271 (Fla. 2d DCA 1980).
[46] *Supra* note 17.
[47] Id.
[48] Id.
[49] 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.
[50] 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 February 2, 2020).
[51] Section 456.063, F.S. A person who commits such sexual misconduct is disqualified from licensure in this state.

If the appropriate regulatory board or DOH, if there is no board, finds that a licensee committed a violation, the board or DOH may:[52]

- Refuse to certify, or to certify with restrictions, an application for a license;
- Suspend or permanently revoke a license;
- Place a restriction on the licensee's practice or license;
- Impose an administrative fine not to exceed $10,000 for each count or separate offense; if the violation is for fraud or making a false representation, a fine of $10,000 must be imposed for each count or separate offense;
- Issue a reprimand or letter of concern;
- Place the licensee on probation;
- Require a corrective action plan;
- Refund fees billed and collected from the patient or third party on behalf of the patient; or
- Require the licensee to undergo remedial education.

The board or DOH, if there is no board, must consider what is necessary to protect the public or to compensate the patient when it decides the penalty to impose.[53]

Effect of Proposed Changes

CS/HB 1287 bans a physician from inseminating or implanting a patient or causing a patient to be inseminated or implanted with the reproductive material[54] of the physician. The bill establishes such action as a ground for disciplinary action against the physician's license.

The bill also prohibits any health care practitioner from intentionally implanting, inseminating, or causing to be implanted or inseminated reproductive material into a patient from a donor whom the patient has not consented to the use of reproductive material. A health care practitioner who intentionally performs this act is subject to licensure discipline.

Effective October 1, 2020, the bill creates the crime of reproductive battery, which prohibits a healthcare practitioner from intentionally penetrating the vagina of a patient with the reproductive material[55] of a donor or any object containing the reproductive material of a donor knowing the patient has not consented to the use of reproductive material from that donor. A health care practitioner who violates the prohibition commits a third degree felony, punishable by up to five years imprisonment and a $5,000 fine.[56]

The bill tolls the statute of limitations for criminal prosecution of a reproductive battery until the date a violation is discovered and reported to law enforcement or another governmental agency. As such, the standard three-year statute of limitations for a third degree felony does not apply to a reproductive battery. This exception to the general statute of limitations will prevent a prosecution from being barred by a patient's failure to discover the healthcare practitioner's conduct until several years after the offense occurred.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 456.072, F.S., relating to grounds for discipline; penalties; enforcement.

[52] Section 456.072(2), F.S.
[53] Id.
[54] The bill defines reproductive material as any human egg, preembryo, or sperm.
[55] Reproductive material means any human egg, preembryo, or sperm, as those terms are defined in s. 742.13, F.S.
[56] Ss. 775.082, 775.083, or 775.084, F.S.

Section 2: Amends s. 458.331, F.S., relating to grounds for discipline; action by the board and department.
Section 3: Amends s. 459.015, F.S., relating to grounds for discipline; action by the board and department.
Section 4: Creates s. 784.006, F.S., relating to reproductive battery effective October 1, 2020.
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 Criminal Justice Impact Conference considered the bill on February 10, 2020, and determined that it will likely have a positive insignificant impact, meaning it will result in an increase of 10 or fewer beds.[57]

   DOH may incur an insignificant, negative fiscal impact to investigate and the new grounds for discipline; however, existing resources should be adequate to absorb.

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 has no effect on municipal or county governments.

2. Other:

   None.

[57] Criminal Justice Impact Conference, *CS/HB 1287*, available at http://edr.state.fl.us/Content/conferences/criminaljusticeimpact/CSHB1287.pdf (last visited February 14, 2020).

B. RULE-MAKING AUTHORITY:

DOH has sufficient rule-making authority to implement the provisions of the bill relating to health care practitioner licensure discipline.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to reproductive medicine; amending s. 456.072, F.S.; providing that certain health care profession licensees who intentionally perform specified acts with human reproductive material without a recipient's consent are subject to certain disciplinary action; amending ss. 458.331 and 459.015, F.S.; providing that a physician who performs specified acts with human reproductive material is subject to certain disciplinary action; creating s. 784.086, F.S.; providing definitions; prohibiting a health care practitioner from intentionally performing specified acts with the human reproductive material of a donor without a recipient's consent; providing penalties; tolling applicable time limitations for criminal prosecution; providing effective dates.

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) Intentionally implanting or inseminating a patient or causing a patient to be implanted or inseminated with the human reproductive material, as defined in s. 784.086, of a donor without the recipient's consent to the use of the reproductive material from that donor.

Section 2. Paragraph (ww) is added to subsection (1) of section 458.331, Florida Statutes, to read:

458.331 Grounds for disciplinary action; action by the board and department.—

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

(ww) Implanting or inseminating a patient or causing a patient to be implanted or inseminated with the human reproductive material, as defined in s. 784.086, of the licensee.

Section 3. Paragraph (yy) is added to subsection (1) of section 459.015, Florida Statutes, to read:

459.015 Grounds for disciplinary action; action by the board and department.—

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

(yy) Implanting or inseminating a patient or causing a patient to be implanted or inseminated with the human reproductive material, as defined in s. 784.086, of the licensee.

Section 4. Effective October 1, 2020, section 784.086, Florida Statutes, is created to read:

784.086 Reproductive battery.—

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

(a) "Donor" means a person who donates reproductive material, regardless of whether for personal use or compensation.

(b) "Health care practitioner" has the same meaning as provided in s. 456.001.

(c) "Recipient" means a person who receives reproductive material from a donor.

(d) "Reproductive material" means any human "egg," "preembryo," or "sperm," as those terms are defined in s. 742.13.

(2) A health care practitioner may not intentionally penetrate the vagina of a recipient with the human reproductive material of a donor or any object containing the reproductive material of a donor, knowing the recipient has not consented to the use of the reproductive material from that donor.

(3) A health care practitioner who violates this section commits reproductive battery, a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(4) Notwithstanding any other provision of law, the period of limitation for a violation under this section does not begin to run until the date on which the violation is discovered and

reported to law enforcement or any other governmental agency.

Section 5. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2020.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1323 Economic Self-sufficiency
SPONSOR(S): Oversight, Transparency & Public Management Subcommittee; Aloupis
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 1624

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Oversight, Transparency & Public Management Subcommittee	15 Y, 0 N, As CS	Toliver	Smith
2) Health Care Appropriations Subcommittee	9 Y, 0 N	Fontaine	Clark
3) Health & Human Services Committee		Grabowski	Calamas

SUMMARY ANALYSIS

The bill requires the Department of Children and Families (DCF) to contract for an evaluation on the effectiveness of the following programs:

- Medicaid;
- Temporary cash assistance program;
- School Readiness program;
- Supplemental Nutrition Assistance Program; and
- Housing Choice Voucher Program

The evaluations must include a review of the following aspects of those programs:

- History and description of the programs;
- Analysis of the impacts and effectiveness of the programs;
- Eligibility, including:
  - Criteria for eligibility;
  - Frequency of eligibility determinations;
  - Clarity in written, electronic, and verbal communication in which eligibility requirements are conveyed to current and potential program subscribers; and
  - The process used to establish and document eligibility;
- The changes in levels of economic self-sufficiency among Floridians over the life of the program;
- The degree to which the program is responsible for any positive changes in economic self-sufficiency;
- The strengths and weaknesses in the methods of assistance used by the program;
- Opportunities for improving service efficiency and efficacy; and
- Potential innovations in, alternatives to, or improvements in the program to increase achievement of economic self-sufficiency.

The bill requires DCF to establish a working group to develop criteria for selecting an entity to conduct the program evaluations, evaluate the bid responses, and select the entity to conduct the evaluations. The working group will consist of two representatives from each of the following agencies: DCF, the Agency for Health Care Administration, the Department of Economic Opportunity, the Department of Education, and the Florida Housing Finance Corporation.

The program evaluations must be compiled into a final report by February 1, 2021, which must then be sent to various persons, including the Governor, the President of the Senate, and the Speaker of the House of Representatives.

The bill has a significant negative fiscal impact on DCF, which can likely be absorbed with existing resources. See Fiscal Analysis & Economic Impact Statement.

The bill takes effect upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Florida Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families (DCF), which makes eligibility determinations.

The structure of each state's Medicaid program varies, but what states must pay for is largely determined by the federal government, as a condition of receiving federal funds.[1] Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states. The federal government sets the minimum mandatory populations to be included in every state Medicaid program. The federal government also sets the minimum mandatory benefits to be covered in every state Medicaid program. These benefits include physician services, hospital services, home health services, and family planning.[2] States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, ambulatory surgical center services, and dialysis.[3]

The Florida Medicaid program covers approximately 3.8 million low-income individuals.[4]
Medicaid is the second largest single program in the state, behind public education, representing approximately one-third of the total FY 2019-2020 state budget.[5]

Temporary Aid for Needy Families

Under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996,[6] the Temporary Aid for Needy Families (TANF) program replaced the welfare programs known as Aid to Families with Dependent Children, the Job Opportunities and Basic Skills Training program, and the Emergency Assistance program. The law ended federal entitlement to assistance and instead created TANF as a block grant that provides federal funds to states, territories, and tribes each year. These funds cover benefits, administrative expenses, and services targeted to needy families. TANF became effective July 1, 1997, and was reauthorized by the Deficit Reduction Act of 2005. States receive block grants to operate their individual programs and to accomplish the goals of the TANF program.

Florida's Temporary Cash Assistance Program

Florida's temporary cash assistance (TCA) program is one of several programs funded with TANF block grant funds. The purpose of the TCA program is to help families with children become self-

[1] 42 U.S.C. §§ 1396-1396w-5; 42 C.F.R. Part 430-456 (§§ 430.0-456.725) (2016).
[2] Section 409.905, F.S.
[3] Section 409.906, F.S.
[4] Agency for Health Care Administration, *Florida Statewide Medicaid Monthly Enrollment Report*, September 2019, https://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited Jan. 31, 2020).
[5] Chapter 2019-115, L.O.F.; *see also Fiscal Analysis in Brief: 2019 Legislative Session*, http://flsenate.gov/UserContent/Committees/Publications/FiscalAnalysisInBrief/2019_Fiscal_Analysis_In_Brief.pdf (last visited Jan. 31, 2020).
[6] P.L. 104-193.

supporting while allowing children to remain in their own homes. It provides cash assistance to families that meet the technical, income, and asset requirements.[7]

Various state agencies and entities work together through a series of contracts or memoranda of understanding to administer the TCA program. DCF receives the federal TANF block grant and administers the TCA program, monitoring eligibility and dispersing benefits. The Department of Economic Opportunity (DEO) is responsible for financial and performance reporting to ensure compliance with federal and state measures, and for providing training and technical assistance to Local Workforce Development Boards (LWDBs). LWDBs provide information about available jobs, on-the-job training, and education and training services within their respective areas and contract with one-stop career centers.[8] CareerSource Florida has planning and oversight responsibilities for all workforce-related programs.

School Readiness Program

Established in 1999,[9] the School Readiness Program provides subsidies for child care services and early childhood education for children of low-income families; children in protective services who are at risk of abuse, neglect, abandonment, or homelessness; foster children; and children with disabilities.[10] The School Readiness Program offers financial assistance for child care to these families while supporting children in the development of skills for success in school. Additionally, the program provides developmental screening and referrals to health and education specialists where needed. These services are provided in conjunction with other programs for young children such as Head Start, Early Head Start, Migrant Head Start, Child Care Resource and Referral and the Voluntary Prekindergarten Education Program.[11]

The School Readiness Program is a state-federal partnership between Florida's Office of Early Learning (OEL)[12] and the Office of Child Care of the United States Department of Health and Human Services.[13] It is administered by early learning coalitions (ELC) at the county or regional level.[14] Florida's OEL administers the program at the state level, including statewide coordination of ELCs.[15]

The Florida DCF's Office of Child Care Regulation, as the agency responsible for the state's child care provider licensing program, inspects all child care providers that provide the School Readiness Program for specified health and safety standards.[16] The law authorizes a county to designate a local licensing agency to license providers if its licensing standards meet or exceed DCF's standards. Five counties have done this – Broward, Hillsborough, Palm Beach, Pinellas, and Sarasota. Thus, in these five counties the local licensing agency, not DCF, inspects child care providers that provide the School Readiness Program[17] for health and safety standards.

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7 Children must be under the age of 18, or under age 19 if they are full time secondary school students. Parents, children and minor siblings who live together must apply together. Additionally, pregnant women may also receive TCA, either in the third trimester of pregnancy if unable to work, or in the 9th month of pregnancy.

8 CareerSource Florida, Inc., *Workforce Investment Act – Workforce Innovation and Opportunity Act Annual Report for 2015-2016 Program Year*, https://careersourceflorida.com/wp-content/uploads/2016/10/161003_AnnualReport.pdf (last visited Jan. 31, 2020).

9 Section 1, ch. 99-357, L.O.F.

10 Sections 1002.81 and 1002.87, F.S.

11 Florida Office of Early Learning, *School Readiness Program,* http://www.floridaearlylearning.com/family-resources/financial-assistance (last visited Feb. 2, 2020).

12 In 2013, the Legislature established the Office of Early Learning in the Office of Independent Education and Parental Choice within the Department of Education. The office is administered by an executive director and is fully accountable to the Commissioner of Education but shall independently exercise all powers, duties, and functions prescribed by law, as well as adopt rules for the establishment and operation of the School Readiness Program and the VPK Program. Section 1, ch. 2013-252, L.O.F., *codified at* s. 1001.213, F.S.

13 *See* U.S. Department of Health and Human Services, *Office of Child Care Fact Sheet*, http://www.acf.hhs.gov/programs/occ/fact-sheet-occ(last visited Feb. 2, 2020).

14 Section 1002.83, F.S.

15 Section 1001.213(3), F.S.

16 *See* ss. 402.301-402.319 and 1002.88, F.S.

17 Section 402.306(1), F.S.

Supplemental Nutrition Assistance Program (SNAP)

The Food and Nutrition Service (FNS), under the U.S. Department of Agriculture (USDA), administers the Supplemental Nutrition Assistance Program (SNAP).[18] SNAP offers nutrition assistance to millions of eligible, low-income individuals and families, in the form of funds to purchase "eligible food,"[19] and provides economic benefits to communities by reducing poverty and food insecurity.[20]

The federal government funds 100% of the benefit amount. However, FNS and states share the administrative costs of the program. Federal laws, regulations, and waivers provide states with various policy options to better target benefits to those most in need, streamline program administration and field operations, and coordinate SNAP activities with those of other programs.[21]

The amount of benefits, or allotment, for which a households qualifies depends on the number of individuals in the household and the household's net income. To calculate a household's allotment, 30% of its net income is subtracted from the maximum allotment for that household size.[22] This is because SNAP households are expected to spend about 30% of their own resources on food.[23]

Housing Choice Voucher Program

The Housing Choice Voucher Program (HCVP) "is the federal government's major program for assisting very low-income families, the elderly, and the disabled to afford decent, safe, and sanitary housing in the private market."[24] There are two different types of assistance under the HCVP: tenant-based and project-based.[25] Tenant-based assistance is an arrangement where the unit is selected by the family, wherever they wish to live, and the PHA pays the landlord a subsidy and the family pays the difference between the rent price and subsidy. In project-based assistance, "rental assistance is paid for families living in specific housing developments or units."[26]

The U.S. Department of Housing and Urban Development (HUD) oversees the HCVP,[27] but the program "is generally administered by State or local governmental entities called public housing agencies (PHAs)."[28] HUD provides funding to the PHAs, who then contract with a landlord to subsidized rent on behalf of the program participant.[29] Housing units receiving HCVP funding must meet and maintain certain housing quality standards.[30] To be eligible for HCVP the applicant must be a low income family[31] with "the family's income not exceeding 50% of the median income for the county or metropolitan area."[32]

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[18] U.S. Department of Agriculture, Food and Nutrition, *A Short History of SNAP*, https://www.fns.usda.gov/snap/short-history-snap (last visited December 7, 2017).
[19] The Food and Nutrition Act of 2008 defines eligible food as any food or food product intended for human consumption except alcoholic beverages, tobacco, hot foods and hot food products prepared for immediate consumption, with some exceptions. 7 USC § 2012(k).
[20] For a detailed overview of SNAP, *see* Randy Alison Aussenberg, *Supplemental Nutrition Assistance Program (SNAP): A Primer on Eligibility and Benefits*, CONGRESSIONAL RESEARCH SERVICE, Dec. 29, 2014, *available at* https://www.fas.org/sgp/crs/misc/R42505.pdf (last visited Feb. 2, 2020).
[21] U.S. Department of Agriculture, Food and Nutrition, *State Options Report: Supplemental Nutrition Assistance Program* , (11th ed.), Sept. 2013, *available at* http://www.fns.usda.gov/sites/default/files/snap/11-State_Options.pdf (last visited Feb. 2, 2020).
[22] U.S. Department of Agriculture Food and Nutrition Service, *SNAP Eligibility*, https://www.fns.usda.gov/snap/recipient/eligibility (last visited Feb. 2, 2020).
[23] *Id.*
[24] *Housing Choice Vouchers Fact Sheet*, U.S. Department of Housing and Urban Development, https://www.hud.gov/program_offices/public_indian_housing/programs/hcv/about/fact_sheet (last visited Jan. 31, 2020).
[25] 24 C.F.R. § 982.201.
[26] *Id.*
[27] *See* 42 U.S.C. s. 1437.
[28] 24 C.F.R. § 982.1.
[29] *Id.*
[30] *See* 24 C.F.R. § 982.401.
[31] 24 C.F.R. § 982.201.
[32] U.S. Department of Housing and Urban Development, *Housing Choice Vouchers Fact Sheet,* https://www.hud.gov/program_offices/public_indian_housing/programs/hcv/about/fact_sheet (last visited Jan. 31, 2020).

Effect of the Bill

The bill requires the Department of Children and Families (DCF) to contract for an evaluation on the effectiveness of the following programs:

- Medicaid;
- The Temporary cash assistance program;
- The School Readiness program;
- The Supplemental Nutrition Assistance Program; and
- The Housing Choice Voucher Program

The evaluations must include a review of the following aspects of those programs:

- History and description of the programs;
- Analysis of the impacts and effectiveness of the programs;
- Eligibility, including:
  - Criteria for eligibility;
  - Frequency of eligibility determinations;
  - Clarity in written, electronic, and verbal communication in which eligibility requirements are conveyed to current and potential program subscribers; and
  - The process used to establish and document eligibility.
- The changes in levels of economic self-sufficiency among Floridians over the life of the program;
- The degree to which the program is responsible for any positive changes in economic self-sufficiency;
- The strengths and weaknesses in the methods of assistance used by the program;
- Opportunities for improving service efficiency and efficacy; and
- Potential innovations in, alternatives to, or improvements in the program to increase achievement of economic self-sufficiency.

The bill requires DCF to establish a working group to develop criteria for selecting an entity to conduct the program evaluations, evaluate the bid responses, and select the entity to conduct the evaluations. The working group will consist of two representatives from each of the following agencies: DCF, the Agency for Health Care Administration, the Department of Economic Opportunity, the Department of Education, and the Florida Housing Finance Corporation. One of the two representatives from DCF will serve as chair. The criteria used to select the entity must identify datasets necessary to evaluate the effectiveness of the programs and determine the qualifications necessary in order to bid on the contract.

The program evaluations must be compiled into a final report by February 1, 2021. DCF must submit the report to the following public officers:

- The Governor,
- The President of the Senate,
- The Speaker of the House of Representatives;
- The Secretary of the Agency for Health Care Administration;
- The Director of the Department of Economic Opportunity;
- The Commissioner of Education; and
- The Board of Directors of the Florida Housing Finance Corporation.

B. SECTION DIRECTORY:

Section 1 creates an unnumbered section of a law related to the evaluation of certain programs.

Section 2 provides an effective date of upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

According to DCF, the costs associated with a contracted evaluation of the five state programs are expected to total approximately $2.5 million[33], as follows:

Program	Estimated cost
Medicaid	$500,000
Temporary Cash Assistance	$500,000
School Readiness	$500,000
Supplemental Nutrition Assistance	$500,000
Housing Choice Voucher	$500,000
Total	**$2,500,000**

Based upon a review of historical budget reversions from contracted services appropriations, it is expected that DCF can absorb these nonrecurring costs within existing resources.

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 does not confer rulemaking authority nor require the promulgation of rules.

[33] Department of Children and Families, *Agency Bill Analysis for CS/HB 1323*, February 6, 2020.

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:

- Removed the requirement that the auditor general audit each of the programs at least triennially;
- Removed the provision of the bill deleting certain definition from s. 1002.81, F.S.;
- Removed a provision of the bill requiring parents who have an intensive services account or an individual training account be given priority for participation in the School Readiness program equal to parents receiving TCA benefits
- Requires DCF to contract with a third party for an evaluation on the effectiveness of the programs;
- Provides requirements for aspects of the program to be reviewed in the evaluations;
- Requires the establishment of a working group to aid in the procurement of the third party;
- Requires DCF to provide a final report on the program evaluations by February 1, 2021.

The analysis is drafted to the committee substitute as approved by the Oversight, Transparency & Public Management Subcommittee.

A bill to be entitled

An act relating to economic self-sufficiency; requiring the Department of Children and Families to contract for an evaluation of the effectiveness of certain programs; creating an interagency working group for specified purposes; providing membership and duties of the working group; providing requirements for specified evaluations; requiring a report be submitted to specified entities by a certain date; providing for future expiration; providing an effective date.

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

Section 1. (1) The Department of Children and Families shall contract for an evaluation of and a report on the effectiveness of the following programs in this state:

(a) The Supplemental Nutrition Assistance Program established under 7 U.S.C. ss. 2011 et seq.

(b) The temporary cash assistance program under s. 414.095, Florida Statutes.

(c) The Medicaid program under s. 409.963, Florida Statutes.

(d) The school readiness program under Part VI of chapter 1002, Florida Statutes.

(e) The housing choice voucher program established under 42 U.S.C. s. 1437.

(2) The Department of Children and Families, in coordination with the Agency for Health Care Administration, the Department of Economic Opportunity, the Department of Education, and the Florida Housing Finance Corporation, shall establish a working group comprised of two representatives from each agency with a representative from the Department of Children and Families serving as chair. The working group shall:

(a) Develop criteria for selecting an entity to conduct an evaluation of the effectiveness of the programs described in subsection (1). The criteria must, at a minimum, identify datasets necessary to evaluate the effectiveness of the programs and determine the qualifications necessary in order to bid on the contract.

(b) Evaluate the bid responses and select an entity to conduct the program evaluations.

(3) The program evaluations must include a history of the program; a description of the program, including its objectives, methods of assistance, and ongoing accountability activities; an analysis of the impacts and effectiveness of the program; a review of the eligibility criteria for the program; the process used to establish and document eligibility; the frequency of eligibility determinations; the clarity in written, verbal, and electronic communication in which eligibility requirements are

conveyed to current and potential program subscribers; and the opportunities for improving service efficiency and efficacy. In addition, to the degree possible for each program, the program evaluation must quantify the changes in levels of economic self-sufficiency among Floridians over the life of the program; assess the degree to which the program is responsible for any positive changes in economic self-sufficiency and identify any contributing factors; identify the strengths and weaknesses in the methods of assistance used by the program; and identify potential innovations in, alternatives to, or improvements in the program that may increase achievement of economic self-sufficiency.

(4) Program evaluations must be compiled into a final report. The Department of Children and Families must submit the final report by February 1, 2021, to the Governor, the President of the Senate, and the Speaker of the House of Representatives. In addition, the department must provide copies of the report to the Secretary of the Agency for Health Care Administration, the Director of the Department of Economic Opportunity, the Commissioner of Education, and the Board of Directors of the Florida Housing Finance Corporation.

(5) This section expires July 1, 2021.

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7025 PCB CFS 20-01 Guardianship
SPONSOR(S): Children, Families & Seniors Subcommittee, Fetterhoff
TIED BILLS: **IDEN./SIM. BILLS:** SB 1762

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Children, Families & Seniors Subcommittee	15 Y, 0 N	Morris	Brazzell
1) Health Care Appropriations Subcommittee	9 Y, 0 N	Nobles	Clark
2) Health & Human Services Committee		Morris	Calamas

SUMMARY ANALYSIS

Guardianship is a concept whereby a “guardian” acts on behalf of a “ward” whom the law regards as incapable of managing his or her own person or property, or both, due to age or incapacity. A court may appoint a public or private guardian if there is no family member or friend, other person, bank, or corporation willing and qualified to serve as guardian of that ward. Before a guardian may be appointed to act for the ward, a court must determine that the ward is incapable of handling his or her affairs. HB 7025 amends sections of law relating to guardianship.

The bill removes the requirement that the executive director of the Office of Public and Professional Guardians (OPPG) within the Department of Elder Affairs (DOEA) be a member of the Florida Bar. It revises the duties of the executive director of the OPPG to include offering and making certain information about guardianship available for dissemination by the Area Agencies on Aging and Aging Resource Centers in this state.

It requires professional guardians to submit and maintain information with the OPPG relating to their employees and counties in which they are appointed to a ward.

The bill increases the continuing education requirements of professional guardians and specifies which topics are required to be studied.

The bill revises the process by which the OPPG investigates complaints by providing a timeline of events and notification requirements to guardians and complainants of the investigation process.

The bill requires the Clerks of the Circuit Court (Clerks) to report sanctions imposed by the court on a professional guardian to the OPPG.

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

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Guardianship

When an individual is unable to make legal decisions regarding his or her person or property, a guardian may be appointed to act on his or her behalf. A guardian is someone who is appointed by the court to act on behalf of a ward (an individual who has been adjudicated incapacitated) regarding his or her person or property or both.[1] Adjudicating a person totally incapacitated and in need of a guardian deprives a person of his or her civil and legal rights.[2] The Legislature has recognized that the least restrictive form of guardianship should be used to ensure the most appropriate level of care and the protection of that person's rights.[3]

The process to determine an individual's incapacity and the subsequent appointment of a guardian begins with a verified petition detailing the factual information supporting the reasons the petitioner believes the individual to be incapacitated, including the rights the alleged incapacitated person is incapable of exercising.[4] Once a person has been adjudicated incapacitated (termed a "ward"), the court appoints a guardian, and the letters of guardianship are issued.[5] The order appointing a guardian must be consistent with the ward's welfare and safety, must be the least restrictive appropriate alternative, and must reserve to the ward the right to make decisions in all matters commensurate with his or her ability to do so.[6]

Appointment of a Guardian

The following may be appointed guardian of a ward:

- Any resident of Florida who is 18 years of age or older and has full legal rights and capacity;
- A nonresident if he or she is related to the ward by blood, marriage, or adoption;
- A trust company, a state banking corporation, or state savings association authorized and qualified to exercise fiduciary powers in this state, or a national banking association or federal savings and loan association authorized and qualified to exercise fiduciary powers in Florida;
- A nonprofit corporation organized for religious or charitable purposes and existing under the laws of Florida;
- A judge who is related to the ward by blood, marriage, or adoption, or has a close relationship with the ward or the ward's family, and serves without compensation;
- A provider of health care services to the ward, whether direct or indirect, when the court specifically finds that there is no conflict of interest with the ward's best interests; or
- A for-profit corporation that meets certain qualifications, including being wholly owned by the person who is the circuit's public guardian in the circuit where the corporate guardian is appointed.[7]

Guardians[8] who are not professional guardians are required to complete 8 hours of instruction and training through a course approved by the chief judge of the circuit court and taught by a court-

[1] S. 744.102(9), F.S.
[2] S. 744.101(1), F.S.
[3] S. 744.101(2), F.S
[4] S. 744.3201, F.S.
[5] ss. 744.3371-744.345, F.S.
[6] S. 744.2005, F.S.
[7] s. 744.309, F.S.
[8] Other than a parent who is the guardian of the property of a minor child.

approved organization within 4 months after being appointed to a ward.[9] The instruction and training must cover:[10]

- The legal duties and responsibilities of the guardian;
- The rights of the ward;
- The availability of local resources to aid the ward; and
- The preparation of habilitation plans and annual guardianship reports, including financial accounting for the ward's property.

Office of Public and Professional Guardians

In 1999 the Legislature created the "Public Guardianship Act" and established the Statewide Public Guardianship Office (SPGO) within the Department of Elder Affairs (DOEA).[11] By December 2013, the SPGO had expanded public guardianship services to cover all 67 counties.[12] In 2016, the Legislature renamed the Statewide Public Guardianship Office within the DOEA as the Office of Public and Professional Guardians (OPPG), required OPPG to regulate professional guardians and investigate complaints, and added 6 full-time equivalent positions to the OPPG, including an attorney and investigators.[13] The OPPG appoints local public guardian offices to provide guardianship services to people who have neither adequate income nor assets to afford a private guardian, nor any willing family or friend to serve.[14]

There are 17 public guardian offices that serve all 67 counties.[15] In fiscal year 2017-2018, the public guardian offices served 3,846 wards.[16] Currently, there are 515 professional guardians registered with the Office of Public and Professional Guardians within the Department of Elder Affairs.[17] The total number of wards served by registered professional guardians in this state is unknown by DOEA.[18]

Executive Director

The executive director of the OPPG is responsible for the oversight of all public and professional guardians.[19] The Secretary of the DOEA appoints the executive director as the head of the OPPG. The executive director must:[20]

- Be a member of the Florida Bar;
- Be knowledgeable of guardianship law and of the social services available to meet the needs of incapacitated persons;
- Serve on a full-time basis; and
- Personally, or through a representative of the OPPG, carry out the purposes and functions of the OPPG in accordance with state and federal law.

The executive director's oversight responsibilities for professional guardians include standards of practice for public and professional guardians and reviewing and approving the standards and criteria

[9] S. 744.3145, F.S.
[10] Id.
[11] S. 744.701, F.S. (1999).
[12] Florida Department of Elder Affairs, Summary of Programs and Services, February, 2014, *available at* http://elderaffairs.state.fl.us/doea/pubs/pubs/sops2014/2014%20SOPS_complete.pdf (last visited Jan. 13, 2020).
[13] Ch. 2016-40, Laws of Florida.
[14] Department of Elder Affairs, *Office of Public and Professional Guardians*, available at http://elderaffairs.state.fl.us/doea/spgo.php (last visited Jan. 13, 2020).
[15] Office of Public and Professional Guardians, *2018 Annual Report,* available at http://elderaffairs.state.fl.us/doea/SPGO/pubs/OPPG_AR_2018.pdf (last visited Jan. 13, 2020).
[16] Id.
[17] Email from Derek Miller, Legislative Analyst, Department of Elder Affairs, RE: HB 709 Analysis, (Dec. 9, 2019).
[18] Id.
[19] S. 744.2001(2)(a), F.S.
[20] S. 744.2001, F.S.

for the education, registration, and certification of public and professional guardians. The executive director is also responsible for developing a guardianship training program curriculum that may be offered to all guardians. He or she is also responsible for developing and implementing a monitoring tool to use for periodic monitoring activities of professional guardians; however, this monitoring tool may not include a financial audit as required to be performed by the clerk of the circuit court (clerk) in order to avoid a duplication of efforts. The executive director must develop procedures for the review of an allegation that a professional guardian has violated an applicable statute, fiduciary duty, standard of practice, rule, regulation, or other requirement governing the conduct of professional guardians and establish disciplinary proceedings, conducting hearings, and taking administrative action under ch. 120, F.S.

Complaint Investigations

Any person may submit a complaint against a professional guardian to the OPPG. Once the OPPG receives a complaint, it is required to:

- Review and, if determined legally sufficient,[21] investigate complaints against professional guardians;
- Initiate an investigation no later than 10 business days after OPPG receives a complaint;
- Complete and provide initial investigative findings and recommendations, if any, to the professional guardian and person filing the complaint within 60 days;
- Obtain supporting information, including interviewing the ward, family member, or interested party, or documentation to determine the legal sufficiency of a complaint;
- Dismiss any complaint that is not legally sufficient; and
- Coordinate with the clerks of the court to avoid duplication of duties.

In a presentation to the Children, Families, and Seniors Subcommittee on November 7, 2019, the Secretary of DOEA noted a backlog of complaints that had gone uninvestigated.[22] Almost 300 complaints have been received by the OPPG since 2017. As of October 12, 2019, 193 backlogged investigations were completed, leading to 13 registration revocation letters, 1 administrative complaint, 6 reprimand letters, and 42 letters of concern.[23]

The OPPG has undergone operational improvements, including:[24]

- Revising its investigation referral process;
- Implementing new processes to improve transparency and responsiveness to complainants and affected guardians following the completion of investigations; and
- Continuing efforts with the Clerks to improve complaint intake and referral procedures.

<u>Professional Guardians</u>

A professional guardian is a guardian who has at any time rendered services to three or more wards as their guardian; however, a person serving as a guardian for two or more relatives is not considered a professional guardian.[25] A public guardian is considered a professional guardian for purposes of regulation, education, and registration.[26]

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[21] S. 744.2004(1), F.S., states that a complaint is legally sufficient if it contains ultimate facts that show a violation of a standard of practice by a professional guardian has occurred.
[22] Presentation to the Children, Families, and Seniors Subcommittee by the Florida Department of Elder Affairs, https://myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3019&Session=2020&DocumentType=Meeting%20Packets&FileName=cfs%2011-7-19.pdf (Nov. 7, 2019).
[23] Id.
[24] Id.
[25] S. 744.102(17), F.S
[26] Id.

Registration

A professional guardian must register with the OPPG annually.[27] As part of the registration, the professional guardian must:[28]

- Provide sufficient information to identify the professional guardian;
- Complete a minimum of 40 hours of instruction and training through a course approved or offered by the OPPG (may not be paid with the assets of the ward);
- Successfully pass an examination approved by DOEA[29] to demonstrate competency to act as a professional guardian;
- Undergo a criminal background check by the Federal Bureau of Investigation and the Florida Department of Law Enforcement;
- Submit to a credit history check; and
- Maintain a current blanket bond.

Guardians registered with the OPPG must complete a minimum of 16 hours of continuing education every 2 calendar years after the year in which the initial 40-hour educational requirement is met. The ward's assets may not be used to pay for such education.[30]

Guardians seeking appointment by the court and all employees of a professional guardian who have a fiduciary responsibility to the ward must submit to a credit history check and undergo a level 2 background screening.[31] The DOEA must ensure the clerks of the court and the chief judge of each judicial circuit receive information about each registered professional guardian.[32]

The executive director of the OPPG may deny registration to a professional guardian if the executive director determines that the guardian's proposed registration, including the guardian's credit or criminal investigations, indicates that registering the professional guardian would violate any provision of ch. 744, F.S.[33] The OPPG is required to report any suspension or revocation of a professional guardian's registration to the court of component jurisdiction for any guardianship case to which the professional guardian is currently appointed.[34] However, the court is the only entity that can remove a guardian from a case to which he or she has been appointed. Also, the court or the clerk is not required to report removal of guardians to the OPPG.

Responsibilities of the Clerk of the Circuit Court

In addition to the duty to serve as the custodian of the guardianship files, the clerk must review each initial and annual guardianship report to ensure that it contains required information about the ward.[35] Guardians are required to file initial reports and annual reports consisting of accounting and/or guardianship plans after they are appointed to a ward.[36] The initial guardianship report, for a guardian of a ward's property, must consist of a verified inventory of such property.[37] For a guardian of a person, the initial guardianship report must consist of an initial guardianship plan, including details such as where the ward will live and any medical or social services the ward may need.[38] Annual plans must

[27] S. 744.2002, F.S.
[28] S. 744.2002(3), F.S.; S. 744.2003, F.S.; S. 744.3135, F.S.
[29] The examination is currently administered by the University of South Florida's College of Education. University of South Florida, *Florida Professional Guardian Examination*, http://guardianship.usf.edu/index.html (last visited Jan. 13, 2020).
[30] S. 744.2003(3), F.S.
[31] S. 744.3135(1), F.S.
[32] S. 744.2002(9), F.S.
[33] S. 744.2002, F.S.
[34] S. 744.2004(4), F.S.
[35] S. 744.368, F.S.
[36] S. 744.361, F.S.
[37] S. 744.362, F.S.,
[38] Ss. 744.362–744.363, F.S.

consist of an annual accounting of the ward's property and the process by which the ward is being served by the guardian.[39]

The clerk is required to complete his or her review of the initial or annual report within 30 days after the filing of such reports.[40] The clerk is also required to audit the verified inventory and accountings report within 90 days of its filing, and report his or her findings to the court.[41] The clerk must notify the court when a required report is not timely filed by a guardian.[42]

If the clerk has reason to believe further review is appropriate, the clerk may request and review records and documents that reasonably impact guardianship assets, including, but not limited to, the beginning inventory balance and any fees charged to the guardianship.[43]

If a guardian fails to produce records and documents to the clerk upon request, the clerk may request the court to enter an order requiring a guardian to file the report.[44] The judge may also impose sanctions on the guardian, which may include contempt, removal of the guardian, and fines.[45]

Guardian Investigations

In July 2019, Steven Stryker, a ward appointed to professional guardian Rebecca Fierle,[46] died in a Tampa hospital after choking on food.[47] Hospital staff could not perform lifesaving procedures on him due to a do-not-resuscitate order (DNRO) executed by Fierle.[48]

It was also reported that Fierle had billed AdventHealth, an Orlando area hospital, approximately $4 million for services rendered to wards[49] and developed conflicts of interest with members of appointed examining committees used to determine incapacity of a person.[50]

The Clerk of the Circuit Court and Comptroller of Okaloosa County (Clerk)[51] investigated complaints filed against Fierle with the OPPG. The Clerk found Fierle had executed a DNRO against Stryker's wishes, violating the standards of practice established by the OPPG.[52] The Clerk reported that Fierle kept a DNRO in place after a psychiatrist examined Stryker while he was admitted to St. Joseph's Hospital and determined Stryker had the ability to decide that he wanted to live and stated that Stryker wanted to be resuscitated.

The Orange County Comptroller also investigated Fierle's guardianships.[53] The Comptroller found Fierle had submitted over 6,000 invoices and charges of at least $3.9M to AdventHealth for payments

[39] S. 744.367, F.S.
[40] *Supra,* note 35.
[41] Id.
[42] Id.
[43] Id.
[44] Ss. 744.368–744.3685, F.S.
[45] S. 744.3685(3) and S. 744.367(5), F.S.
[46] The Orlando Sentinel, *Florida's Troubled Guardian Program,* https://www.orlandosentinel.com/news/florida/guardians/ (last visited Dec. 6, 2019).
[47] Adrianna Iwasinski, *Orange commissioners approve new position to help monitor guardianship cases,* Click Orlando (Oct. 22, 2019), https://www.clickorlando.com/news/2019/10/23/orange-commissioners-approve-new-position-to-help-monitor-guardianship-cases/ (last visited Jan. 13, 2020).
[48] Id.
[49] *Supra* note 46.
[50] Monivette Cordeiro, *Florida's troubled guardianship system riddled with conflicts of interest, critics claim | Special Report,* Orlando Sentinel (Aug. 14, 2019), https://www.orlandosentinel.com/news/florida/guardians/os-ne-guardianship-examining-committee-conflicts-20190814-osbekpwlnfezneolyxttvzmrhy-story.html (last visited Jan. 13, 2020).
[51] J.D. Peacock II, Clerk of the Circuit Court and Comptroller Okaloosa County, Florida, *OPPG Investigation Case Number 19-064* (July 9, 2019), https://www.scribd.com/document/417992870/Fierle-State-Report (last visited Jan. 13, 2020).
[52] Id.
[53] Orange County Comptroller, *Report No. 479 – Investigation of Payments Made to Professional Guardian – Rebecca Fierle by AdventHealth,* https://www.occompt.com/download/Audit%20Reports/rpt479.pdf (last visited Jan. 13, 2020).

between January 2009 and June 2019.[54] The payments were made on behalf of 682 patients. The Comptroller also found that in some cases Fierle had billed both AdventHealth and the wards for identical fees and services. Additionally, the Comptroller identified conflicts of interest, including several situations in which Fierle had previous relationships with wards to whom she was appointed guardian and did not disclose these relationships in the petitions for appointment of a guardian.

An Orange County judge removed Fierle from nearly 100 cases to which she had been appointed.[55] Fierle has appealed the judge's decision.[56] In a letter to the OPPG, Fierle resigned from all appointed guardianship cases (approximately 450 in 13 counties) in July, 2019.[57] As of November 2019, Fierle is under criminal investigation by the Florida Department of Law Enforcement.[58]

In January 2017, the Clerk and Comptroller for Lake County conducted an investigation into a complaint filed against Fierle.[59] The complaint made several allegations against Fierle, including that Fierle was "not following statutes." The investigation report noted information they came across in their investigation into Fierle, including noting that Fierle employed staff whose responsibilities included "visiting wards, reviewing the charts of wards and participating in their care plans, inspecting the physical health of the wards, and ensuring their needs were being met and they are getting the proper care." The investigation report stated that there is no clear requirement to disclose the names and information of a guardian's employees to the OPPG or to the courts and that employees with direct, unsupervised access to wards are not held to the same requirements of a credit history check and level 2 background check which is required for employees who have a fiduciary responsibility to the ward. The investigation report concludes that the OPPG should consider "the need for appropriate legislation and/or rules to better protect wards in these circumstances."

Effect of Proposed Changes

Office of Public and Professional Guardians

The bill revises the requirements and responsibilities of the executive director of the OPPG. Specifically, the bill removes the requirement that the executive director of the OPPG be a member of the Florida Bar. It requires the executive director, within available resources, to offer an online education course for guardians who are not professional guardians. The bill also requires the OPPG to provide information relating to guardianship to Area Agencies on Aging and Aging Resource Centers for dissemination to the populations they serve, allowing the public to become more aware of guardianships and what options may be available to them.

Professional Guardians

The bill revises the continuing education requirements of professional guardians by increasing the hours of continuing education required to be taken by a professional guardian from 16 hours to 20 hours every two years and be completed through a course approved or offered by the OPPG. The bill specifically requires that continuing education include at least:

- 2 hours on fiduciary responsibilities;
- 2 hours on professional ethics;

[54] Id.
[55] *Supra* note 46.
[56] Id.
[57] Greg Angel, *Embattled Guardian Resigns From Cases Statewide; Criminal Investigation Continues,* Spectrum News 13 (July 29, 2019), https://www.mynews13.com/fl/orlando/crime/2019/07/29/embattled-guardian-resigns-from-cases-statewide (last visited Jan. 13, 2020).
[58] Greg Angel, *Watchdog: Judge Dismisses Embattled Guardian's Appeal to Reverse Court Order,* Spectrum News 13 (Nov. 19, 2019) https://www.mynews13.com/fl/orlando/news/2019/11/19/watchdog-fierle-appeal-to-reverse-court-order-dismissed (last visited Jan. 13, 2020).
[59] Neil Kelly, Clerk of Circuit Court, Lake County Florida, *Investigation Report Case Number 2016-002,* (Jan. 9, 2017) (on file with Children, Families, and Seniors Subcommittee staff).

- 1 hour on advance directives;
- 3 hours on abuse, neglect, and exploitation; and
- 4 hours on guardianship law.

The bill requires professional guardians to submit and maintain the names and titles of their employees and the counties in which they are appointed to a ward with the OPPG.

Complaint Investigations by the OPPG

The bill revises the process by which the OPPG is required to investigate complaints made against a professional guardian and details timelines for providing information to the complainant and the professional guardian who is subject to the complaint. The OPPG must notify the complainant no later than 10 business days after the OPPG determines a complaint is not legally sufficient. Additionally, within 45 business days after receipt of a complaint by the OPPG, it must complete and provide initial investigative findings and recommendations, if any, to the professional guardian and the complainant. Within 10 business days after completing an investigation, the OPPG must provide the complainant and the professional guardian with a written statement specifying any finding of a violation of a standard of practice by a professional guardian and any actions taken, or specifying that no such violation was found.

Guardian Education Requirements

The bill allows a guardian who is not a professional guardian to complete his or her required eight hours of education through a course offered by the OPPG, in addition to a course approved by the chief judge of the circuit court and taught by a court-approved organization. Additionally, the bill removes the ability of the court to waive some or all of the education requirements of a guardian.

Responsibilities of the Clerk of the Circuit Court

The bill adds the reporting of any sanctions imposed by the court on a professional guardian, including, but not limited to, contempt of court or removal of the professional guardian, to the responsibilities of the clerk of the circuit court. The clerk must submit such information to the OPPG within 10 business days after the court imposes any sanctions, which will close the communication loop between the court and the OPPG.

The bill makes technical and conforming changes.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 744.2201, F.S., relating to Office of Public and Professional Guardians.
Section 2: Amends s. 744.2003, F.S., relating to regulation of professional guardians; application; bond required; educational requirements.
Section 3: Amends s. 744.2004, F.S., relating to complaints, disciplinary proceedings, penalties, enforcement.
Section 4: Amends s. 744.3145, relating to guardian education requirements.
Section 5: Amends s. 744.368, F.S., relating to responsibilities of the clerk of the circuit court.
Section 6: 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 the OPPG to offer and place online an education course for use by guardians who are not professional guardians, and to provide information on guardianship for the Area Agencies on Aging and the Aging and Disability Resource Centers to disseminate. OPPG must also implement new procedural changes. Per DOEA, these changes have no fiscal impact on DOEA.

   OPPG must also collect additional information from guardians. Per DOEA, these changes have no fiscal impact on DOEA.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The expenses incurred by a guardian who is not a professional guardian to satisfy his or her required training may be paid from the ward's estate, unless the court directs that such expenses be paid by the guardian individually.

The increase in the required continuing education hours for professional guardians may result in a negative fiscal impact on the professional guardians as a ward's assets may not be used to fund this continuing education.

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 provides sufficient rulemaking authority to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to guardianship; amending s. 744.2001, F.S.; deleting the requirement that the executive director of the Office of Public and Professional Guardians be a member of The Florida Bar; requiring the executive director to offer and make certain education courses available online; requiring the executive director to produce and make available information about alternatives to and types of guardianship for dissemination by certain entities; deleting obsolete language; amending s. 744.2003, F.S.; revising continuing education requirements for guardians; requiring professional guardians to submit to and maintain with the office specified information; amending s. 744.2004, F.S.; deleting obsolete language; revising the office's disciplinary procedures; requiring the office to notify parties to the complaint of certain information within specified timeframes; amending s. 744.3145, F.S.; authorizing guardians to satisfy certain education requirements through courses offered by the office; removing the court's ability to waive education requirements for guardians; amending s. 744.368, F.S.; requiring the clerks of court to notify the office of any sanctions imposed on professional guardians, within a specified

timeframe; providing an effective date.

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

Section 1. Subsections (1), (2), and (3) of section 744.2001, Florida Statutes, are amended to read:

744.2001 Office of Public and Professional Guardians.—There is created the Office of Public and Professional Guardians within the Department of Elderly Affairs.

(1) The Secretary of Elderly Affairs shall appoint the executive director, who shall be the head of the Office of Public and Professional Guardians. The executive director must be ~~a member of The Florida Bar,~~ knowledgeable of guardianship law and of the social services available to meet the needs of incapacitated persons, shall serve on a full-time basis, and shall personally, or through a representative of the office, carry out the purposes and functions of the Office of Public and Professional Guardians in accordance with state and federal law. The executive director shall serve at the pleasure of and report to the secretary.

(2) The executive director shall, within available resources:

(a) Have oversight responsibilities for all public and professional guardians.

(b) Establish standards of practice for public and

professional guardians by rule, in consultation with professional guardianship associations and other interested stakeholders~~, no later than October 1, 2016. The executive director shall provide a draft of the standards to the Governor, the Legislature, and the secretary for review by August 1, 2016~~.

(c) Review and approve the standards and criteria for the education, registration, and certification of public and professional guardians in Florida.

(d) Offer and make available online an education course to satisfy the requirements of s. 744.3145(2).

(e) Produce and make available information about alternatives to and types of guardianship for dissemination by area agencies on aging as defined in s. 430.203 and aging resource centers as described in s. 430.2053.

(3) The executive director's oversight responsibilities of professional guardians ~~must be finalized by October 1, 2016, and~~ shall include, but are not limited to:

(a) Developing and implementing a monitoring tool to ensure compliance of professional guardians with the standards of practice established by the Office of Public and Professional Guardians. This monitoring tool may not include a financial audit as required by the clerk of the circuit court under s. 744.368.

(b) Developing procedures, in consultation with professional guardianship associations and other interested

stakeholders, for the review of an allegation that a professional guardian has violated the standards of practice established by the Office of Public and Professional Guardians governing the conduct of professional guardians.

(c) Establishing disciplinary proceedings, conducting hearings, and taking administrative action pursuant to chapter 120.

Section 2. Subsection (10) of section 744.2003, Florida Statutes, is renumbered as subsection (11), subsection (3) is amended, and a new subsection (10) is added to that section, to read:

744.2003 Regulation of professional guardians; application; bond required; educational requirements.—

(3)(a) Each professional guardian as defined in s. 744.102(17) and public guardian must receive a minimum of 40 hours of instruction and training. Each professional guardian must receive a minimum of 20 ~~16~~ hours of continuing education every 2 calendar years after the year in which the initial 40-hour educational requirement is met, which must include at least 2 hours each on fiduciary responsibilities and professional ethics, respectively; 1 hour on advance directives; 3 hours on abuse, neglect, and exploitation; and 4 hours on guardianship law.

(b) The instruction, training, and education required under paragraph (a) must be completed through a course approved

or offered by the Office of Public and Professional Guardians. The expenses incurred to satisfy the educational requirements prescribed in this section may not be paid with the assets of any ward.

(c) This subsection does not apply to any attorney who is licensed to practice law in this state or an institution acting as guardian under s. 744.2002(7).

(10) Each professional guardian shall submit to and maintain with the Office of Public and Professional Guardians all of the following information:

(a) The names and position titles of all employees of the professional guardian.

(b) The counties in which the professional guardian is appointed to any ward.

Section 3. Subsections (1) and (6) of section 744.2004, Florida Statutes, are amended to read:

744.2004 Complaints; disciplinary proceedings; penalties; enforcement.—

(1) ~~By October 1, 2016,~~ The Office of Public and Professional Guardians shall establish procedures to:

(a) Review and, if determined legally sufficient, initiate an investigation of ~~investigate~~ any complaint that a professional guardian has violated the standards of practice established by the Office of Public and Professional Guardians governing the conduct of professional guardians within 10

business days after receipt of the complaint. A complaint is legally sufficient if it contains ultimate facts that show a violation of a standard of practice by a professional guardian has occurred.

(b) Notify the complainant no later than 10 business days after the Office of Public and Professional Guardians determines that a complaint is not legally sufficient ~~Initiate an investigation no later than 10 business days after the Office of Public and Professional Guardians receives a complaint~~.

(c) Complete and provide initial investigative findings and recommendations, if any, to the professional guardian and the person who filed the complaint within 45 business ~~60~~ days after receipt of a complaint.

(d) Obtain supporting information or documentation to determine the legal sufficiency of a complaint.

(e) Interview a ward, family member, or interested party to determine the legal sufficiency of a complaint.

(f) Dismiss any complaint if, at any time after legal sufficiency is determined, it is found there is insufficient evidence to support the allegations contained in the complaint.

(g) Within 10 business days after completing an investigation, provide to the complainant and the professional guardian a written statement specifying any finding of a violation of a standard of practice by a professional guardian and any actions taken or specifying that no such violation was

found.

(h) ~~(g)~~ Coordinate, to the greatest extent possible, with the clerks of court to avoid duplication of duties with regard to the financial audits prepared by the clerks pursuant to s. 744.368.

(6) ~~By October 1, 2016,~~ The Department of Elderly Affairs shall adopt rules to implement ~~the provisions of~~ this section.

Section 4. Subsection (7) of section 744.3145, Florida Statutes, is renumbered as subsection (6), and subsection (4) and present subsection (6) of that section are amended, to read:

744.3145 Guardian education requirements.—

(4) Each person appointed by the court to be a guardian must complete the required number of hours of instruction and education within 4 months after his or her appointment as guardian. The instruction and education must be completed through a course approved by the chief judge of the circuit court and taught by a court-approved organization or through a course offered by the Office of Public and Professional Guardians under s. 744.2001. Court-approved organizations may include, but are not limited to, community or junior colleges, guardianship organizations, and the local bar association or The Florida Bar.

~~(6) The court may, in its discretion, waive some or all of the requirements of this section or impose additional requirements. The court shall make its decision on a case-by-~~

~~case basis and, in making its decision, shall consider the experience and education of the guardian, the duties assigned to the guardian, and the needs of the ward.~~

Section 5. Subsection (8) is added to section 744.368, Florida Statutes, to read:

744.368 Responsibilities of the clerk of the circuit court.—

(8) Within 10 business days after the court imposes any sanctions on a professional guardian, including, but not limited to, contempt of the court or removal of the professional guardian, the clerk shall report such actions to the Office of Public and Professional Guardians.

Section 6. This act shall take effect July 1, 2020.

HB 7045

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7045 PCB HMR 20-02 Prescription Drug Price Transparency
SPONSOR(S): Health Market Reform Subcommittee, Andrade
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Market Reform Subcommittee	14 Y, 1 N	Grabowski	Calamas
1) Appropriations Committee	27 Y, 0 N	Helpling	Pridgeon
2) Health & Human Services Committee		Grabowski	Calamas

SUMMARY ANALYSIS

Pharmacy benefit managers (PBMs) represent health insurers, self-insured employers, union health plans, and government purchasers in the selection, purchase, and distribution of pharmaceuticals. Until recently, PBMs operated largely in the absence of federal or state regulation. PBMs earn profits through a combination of revenues, which may include administrative fees charged to health plans, retention of drug rebates paid by pharmaceutical manufacturers, fees charged to network pharmacies, among others.

HB 7045 imposes additional reporting requirements that must be included in contracts between PBMs and health insurers and HMOs. A PBM must disclose information on aggregate pharmaceutical rebates, administrative fees, and spread pricing revenues to each health plan for which it provides services, as well as the Office of Insurance Regulation (OIR).

PBMs routinely audit pharmacies on behalf of health insurers and HMOs. While the parameters of pharmacy audits are generally set in contracts between pharmacies and PBMs or payors, the Florida Pharmacy Act establishes a set of rights for licensed pharmacies that are subject to these audits. However, the Board of Pharmacy has no authority to enforce these rights. The bill reproduces several audit-related provisions of the Florida Pharmacy Act in the context of the Florida Insurance Code, including those that set timelines for onsite audits and require the timely submission of audit reports to pharmacies. The bill authorizes OIR to enforce the pharmacy audit provisions.

Pharmaceutical manufacturers are regulated by federal and state law. In Florida, the Department of Business and Professional Regulation's (DBPR) Division of Drugs, Devices, and Cosmetics issues permits to manufacturers who produce or sell prescription drugs in the state. The bill requires prescription drug manufacturers to provide notice of upcoming product price increases as a condition of receiving a permit from DBPR. A manufacturer will be required to notify all health plans at least 60 days in advance of a drug price increase, along with the amount of the forthcoming price increase. Manufacturers would also be required to submit an annual report to DBPR and OIR on each drug price increase, along with a justification for the price increase.

The bill has a negative, but likely insignificant, fiscal impact on DBPR and OIR, which can be absorbed using existing resources. The bill has no fiscal impacts on local governments.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

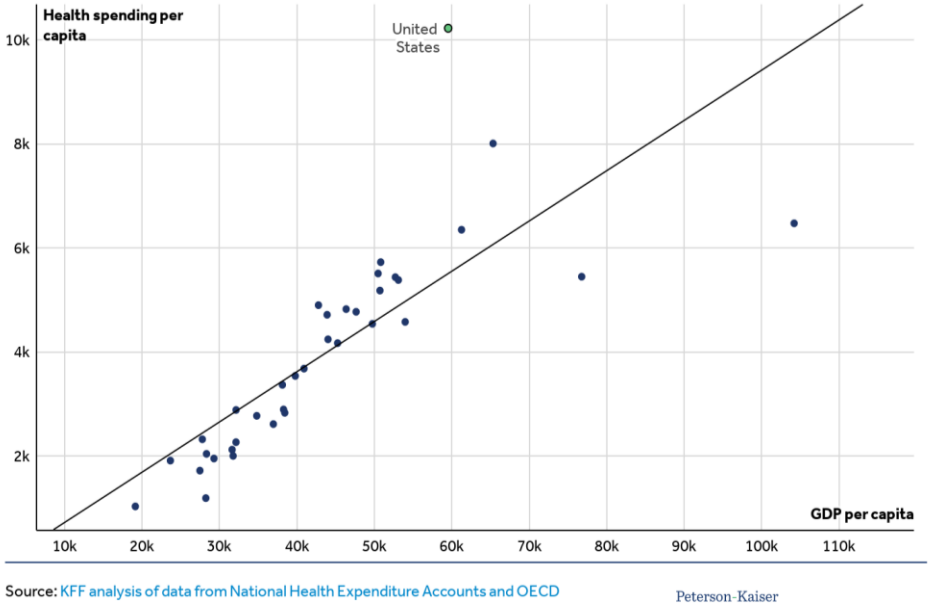
A. EFFECT OF PROPOSED CHANGES:

Background

Prescription Drugs

The United States spends $3.5 trillion on health care, or $10,739 per person, each year. One-tenth of that, approximately $333.4 billion, is spent on retail prescription drugs,[1] with 14 percent ($46.7 billion) paid out-of-pocket by consumers.[2] The United States spends significantly more on healthcare than any country in the world and is an outlier even when compared to other developed and wealthy nations, even after adjusting for drug industry rebates.[3] The United States overall spends 30 to 190 percent more on prescription drugs than other developed countries and pays up to 174 percent more for the same prescription drug.[4]

GDP per Capita and Health Spending per Capita, 2017 (U.S. Dollars, PPP Adjusted)[5]



[1] U.S. Centers for Medicare & Medicaid Services, *National Health Expenditures 2017 Highlights,* Dec. 6, 2018, *available at* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf (last accessed January 3, 2020).
[2] U.S. Centers for Medicare & Medicaid Services, *National Health Expenditures by Type of Service and Source of Funds, CY 1960-2017*, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html (last accessed January 3, 2020).
[3] Peterson-Kaiser Health System Tracker, *How Does Health Spending in the U.S. Compare to Other Countries?*, https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#item-start (last accessed January 3, 2020); Robert Langreth, *The U.S. Pays a Lot More for Top Drugs Than Other Countries,* BLOOMBERG, (Dec. 18, 2015), https://www.bloomberg.com/graphics/2015-drug-prices/ (last accessed January 3, 2020).
[4] Peterson-Kaiser Health System Tracker, *What Are the Recent and Forecasted Trends in Prescription Drug Spending?, https://www.healthsystemtracker.org/chart-collection/recent-forecasted-trends-prescription-drug-spending/#item-start* (last accessed January 3, 2020); *See also,* David O. Sarnak, et. al, *Paying for Prescription Drugs Around the World: Why is the U.S. an Outlier?*, The Commonwealth Fund, Issue Brief: Oct. 2017, available at: https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_oct_sarnak_paying_for_rx_ib_v2.pdf (last accessed January 3, 2020).
[5] Id. Adjusted for purchasing power parity.

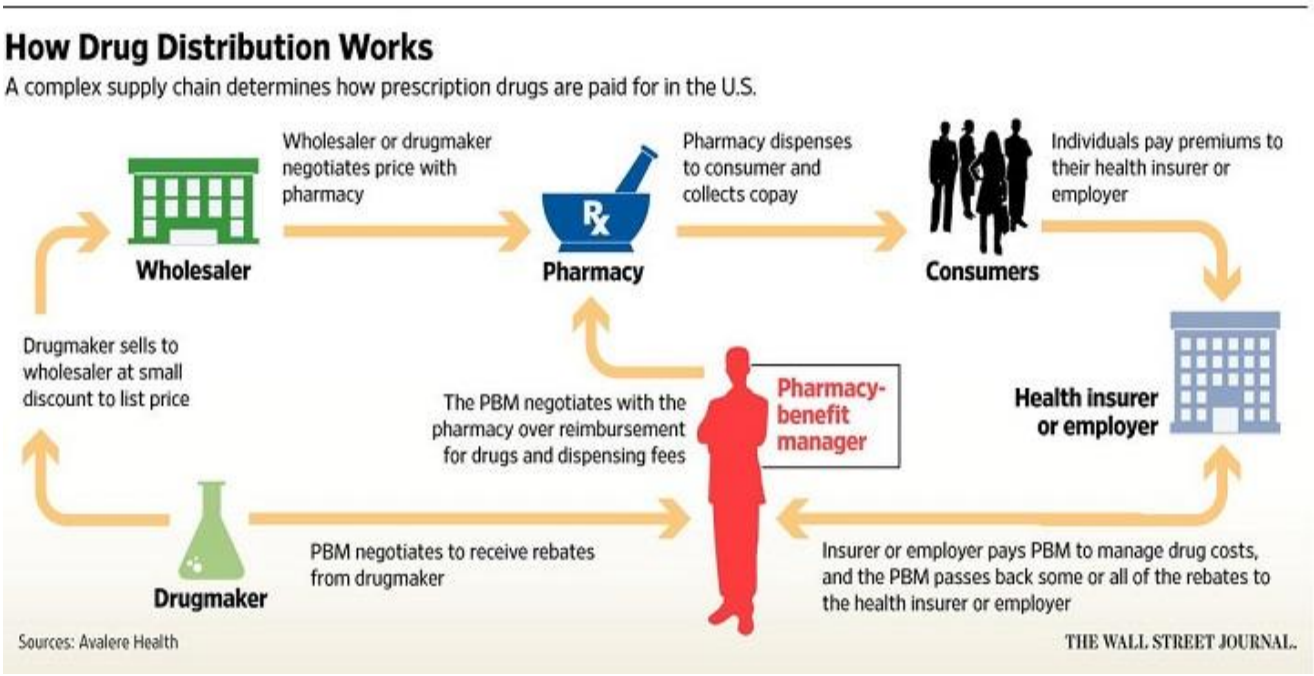
Although many patients are shielded from the high list prices of prescription medications by their insurance coverage, the number of patients with high-deductible health plans is increasing. The rising prices of drugs mean more costs are being passed on to consumers in the form of deductibles, premiums, or coinsurance.[6] Insurers and other health plan sponsors increasingly rely on pharmacy benefit managers to restrain spending on prescription drugs.

Pharmacy Benefit Managers

Pharmacy benefit managers (PBMs) represent health insurers and plan sponsors, which include self-insured employers, union health plans, and government purchasers, in the selection, purchase, and distribution of pharmaceuticals.[7]

PBMs negotiate with drug manufacturers, on behalf of plan sponsors, in an effort to purchase drugs at reduced prices or with the promise of additional rebates. This often involves the development of drug formularies, which are tiered drug lists that incentivize the use of some drugs over others.[8] PBMs simultaneously negotiate with pharmacies to establish reimbursements for dispensing prescription drugs to patients.

The U.S. pharmaceutical supply system is complex, and involves multiple organizations that play differing, but sometimes overlapping, roles in drug distribution and contracting. PBMs generally do not take physical possession of prescription drugs when performing their core pharmaceutical management functions, but they play an integral role in determining how much a plan sponsor and a patient will pay for a given drug.[9] The following graphic offers a simplified glimpse of the prescription drug supply chain.



[6] Daniel H, Bornstein SS, for the Health and Public Policy Committee of the American College of Physicians, *Policy Recommendations for Pharmacy Benefit Managers to Stem the Escalating Costs of Prescription Drugs: A Position Paper From the American College of Physicians*, Ann Intern Med. 2019;171:823–824. Available at https://annals.org/aim/fullarticle/2755578/policy-recommendations-pharmacy-benefit-managers-stem-escalating-costs-prescription-drugs (last accessed January 9, 2020).
[7] "Health Policy Brief: Pharmacy Benefit Managers," *Health Affairs*, September 14, 2017. https://www.healthaffairs.org/do/10.1377/hpb20171409.000178/full/healthpolicybrief_178.pdf (last accessed January 3, 2020).
[8] 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).
[9] Henry J. Kaiser Family Foundation, *Follow the Pill: Understanding the U.S. Commercial Pharmaceutical Supply Chain*, March 2005, available at https://www.kff.org/other/report/follow-the-pill-understanding-the-u-s/ (last accessed January 9, 2020).

PBMs have become major participants in the pharmaceutical supply chain. These entities first emerged as claims processors in the late-1960s and early 1970s, but began to assume much more complex responsibilities in the 1990s in concert with advancements in information technology.[10] Currently, PBMs are responsible for managing the pharmacy benefits of about 270 million Americans.[11] Around 60 PBMs are currently operational in the United States, and the three largest – Express Scripts, CVS Caremark, and OptumRx – have a combined market share of more than 75%.[12]

PBM Revenue Streams

PBMs generate revenue from:

- Administrative fees from their clients (insurers, self-insured employers, union health plans, and government) for the administration of claims and drug dispensing;
- Rebates negotiated from drug companies – in some cases, the rebates are shared between the PBM and the health insurer or plan sponsor; and,
- Fees charged to pharmacies, which may including per prescription fees from network pharmacies and/or fees associated with participating in a PBM's network.[13]

Each PBM generates revenues from all or some combination of these sources. In theory, the negotiating power of PBMs should translate into savings for patients, employers and insurers in the form of reduced drug costs. In addition, health plan sponsors benefit from sharing in the increased manufacturer rebates that PBMs are often able to realize,[14] which may also reduce costs for consumers and employers.

It is clear that some plan sponsors negotiate favorable terms when contracting with a PBM. A recent survey of PBMs indicated that roughly 91% of rebates received from pharmaceutical manufacturers were passed on to health plan sponsors in 2016.[15] However, it is also apparent that some small employers and less engaged plan sponsors may not receive such a large share of rebates negotiated by their contracted PBM.[16]

Some PBMs also generate revenue using spread pricing arrangements. A pricing spread occurs when a PBM is reimbursed by a plan sponsor at one price for a given drug, but pays a dispensing pharmacy a lower price for that drug. In other words, the PBM retains some portion of the plan sponsor reimbursement as earned income.[17] PBM critics contend that this practices increases costs for health plan sponsors, or alternatively, results in lower reimbursements to pharmacies.[18]

Health plan sponsors with sufficient resources can negotiate with PBMs to limit the PBMs ability to collect certain revenues. Florida's Division of State Group Insurance (DSGI)[19], which provides health benefits to state employees and their dependents, has negotiated contract language that prevents its

[10] "The ABCs of PBMs: Issue Brief." National Health Policy Forum. October 27, 1999, available at https://www.nhpf.org/library/issue-briefs/IB749_ABCsofPBMs_10-27-99.pdf (last accessed January 3, 2020).
[11] Pharmaceutical Care Management Association (PCMA). *The Value of PBMs*, available at https://www.pcmanet.org/the-value-of-pbms (last accessed January 3, 2020).
[12] Advisory Board Company, *Pharmacy benefit managers, explained*, November 13, 2019, available at https://www.advisory.com/daily-briefing/2019/11/13/pbms (last accessed January 6, 2020).
[13] Supra note 7.
[14] Id.
[15] Pew Charitable Trusts, *The Prescription Drug Landscape, Explained,* March 2019, available at https://www.pewtrusts.org/en/research-and-analysis/reports/2019/03/08/the-prescription-drug-landscape-explored (last accessed January 7, 2020).
[16] Supra note 7.
[17] Prime Therapeutics, *Can You Follow the Money?*, March 17, 2017, available at https://www.primetherapeutics.com/en/services-solutions/connect/contributors/follow_the_money.html (last accessed January 10, 2020).
[18] "Policy Options To Help Self-Insured Employers Improve PBM Contracting Efficiency," *Health Affairs* Blog, May 29, 2019, available at https://www.healthaffairs.org/do/10.1377/hblog20190529.43197/full/ (last accessed January 11, 2020).
[19] The state group insurance program is governed by Ss. 110.123 through 110.125, F.S.

chosen PBM – CVS Caremark – from using spread pricing at retail pharmacies. In addition, the contract stipulates that the PBM will pass through 100% of the rebates received from pharmaceutical manufacturers to DSGI.[20] Private health plan sponsors may also use these types of contract clauses to define which types of revenue may be earned by contracted PBMs.

In a similar vein, the Agency for Health Care Administration (AHCA) recently contracted with a consulting firm to undertake an analysis of PBM practices in the Florida Medicaid program.[21] Managed care plans providing coverage to Medicaid recipients have some flexibility to contract with PBMs, but it is unclear how PBMs may be generating revenues by virtue of serving the Medicaid population.

PBMs assert that their services result in significant savings for both insurers and patients.[22] Alternatively, PBMs have been characterized merely as "middlemen", who are hired by health plans to design formularies, negotiate rebates, set up pharmacy networks, and process claims.[23] Some critics contend that a large share of rebates are retained by PBMs rather than being passed through to payers and policy holders in the form of lower drug prices. Pharmacies and pharmacists have alleged that PBMs use contract clauses to block the flow of pricing information to patients. In a statement prepared for the U.S. House Committee on Oversight and Government Reform, the National Community Pharmacists Association asserted that pharmacies have been subject to "take it or leave it" contracts with PBMs that include "clauses that restrict their (pharmacists) ability to communicate with patients".[24] In addition, PBM contracts with health plan sponsors have been criticized for being confidential and complex in nature.[25]

PBM Regulation

Until recently, PBMs operated largely in the absence of federal or state regulation. In the past five years, a plurality of state legislatures have passed laws to prohibit specific practices by PBMs.[26] Both the Legislature[27] and Congress[28] have prohibited the use of so-called "gag clauses" by PBMs. A gag clause refers to a contractual requirement that prevents a pharmacy or pharmacist from telling a patient when it would cost less to pay cash for a prescription than to pay the copayment under that patient's health insurance.

In 2018, the Legislature created a registration program for PBMs.[29] Since January 1, 2019, PBMs operating in the state are required to register with the Office of Insurance Regulation (OIR) by submitting a completed application form and fee for registration. The registration requires that a PBM provide basic identifying information to the state, but does not authorize state oversight of

[20] See *Pharmacy Benefit Management Services*, Contract between CaremarkPCS Health, L.L.C. and Florida Department of Management Services, available at https://www.dms.myflorida.com/content/download/107930/607791/2015_PBM_Contract_REDACTED_FINAL.pdf (last accessed January 22, 2020).
[21] E-mail correspondence from James Kotas, Deputy Chief of Staff for the Agency for Health Care Services, January 22, 2020 (on file with staff of the Health Market Reform Subcommittee). AHCA has awarded the project to Milliman, Inc. The Agency has an existing contract with Milliman for actuarial services that will facilitate the project.
[22] Visante. *The Return on Investment (ROI) on PBM Services*, November 2016, available at https://www.pcmanet.org/wp-content/uploads/2016/11/ROI-on-PBM-Services-FINAL.pdf (last accessed January 3, 2020).
[23] "Rebates, Coupons, PBMs, And The Cost Of The Prescription Drug Benefit," *Health Affairs Blog*, April 26, 2018, available at https://www.healthaffairs.org/do/10.1377/hblog20180424.17957/full/ (last accessed January 7, 2020).
[24] National Community Pharmacists Association. *Statement for the Record: National Community Pharmacists Association*. U.S. House Committee on Oversight and Government Reform. February 4, 2016. Available at http://www.ncpa.co/pdf/ncpa-ogr-statement.pdf (last accessed December 21, 2017).
[25] Supra note 18.
[26] See National Conference of State Legislatures, *PBM State Legislation*, May 16, 2019, available at https://www.ncsl.org/research/health/pbm-state-legislation.aspx (last accessed January 10, 2020).
[27] Ch. 2018-91, L.O.F. Ss. 627.64741, 627.6572, and 641.314, F.S.
[28] Public Law No.115-263.
[29] Ch. 2018-91, L.O.F.

PBM practices.[30] According to OIR, 42 PBMs were registered to operate in Florida during calendar year 2019.[31]

Current law also requires contracts between PBMs and insurers or HMOs to include specific limits on the cost sharing that will be incurred by patients. Each contract must specify that a patient's cost share shall equal the lower of the following prices:

- The applicable cost sharing obligation under a patient's insurance; or,
- The retail (or "cash") price of the drug prescribed.[32]

This requirement prohibits PBMs from applying any mechanisms that would prevent a patient from paying the lowest applicable price for a particular drug.

Pharmacy Audits

PBMs and health plan sponsors use audits to review payments to pharmacies. The audits are designed to ensure that procedures and reimbursement mechanisms are consistent with contractual and regulatory requirements. Several different types of audits have been developed to address changes in benefit and billing processes:

- Concurrent daily review audit – intended to make immediate changes to a claim before payment is made and is triggered when a PBM or health plan sponsor's computer systems identify an unusual prescription, which can be identified according to the volume dispensed or number of days supplied.
- Retrospective audit – may be conducted as a desktop audit or an in-pharmacy audit. PBM or health plan sponsor staff conduct a desk audit remotely by contacting pharmacies to obtain supporting documentation, such as the written prescription, for a claim the staff are reviewing.
- In-pharmacy audit – most extensive type of audit and can last for days or weeks. During an in-pharmacy audit, audit staff require pharmacies to provide documentation for prescriptions dispensed during a specified time period. When the auditors identify errors or lack of documentation to support the claim, they notify the pharmacy and request repayment of all or a portion of the prescription cost.
- Investigative audit – occurs where there is a suspicion of fraud or abuse.[33]

While the parameters of pharmacy audits are generally set in contracts between pharmacies and PBMs or payors, the Florida Pharmacy Act establishes a set of rights[34] for licensed pharmacies that are subject to audits by these entities. The Act attempts to address many of the complaints expressed by pharmacies in relation to perceived inequity, unfairness, or burdensome practices involved in PBM audits. In particular, the Act provides the following rights to a pharmacy regarding an audit:

- To be given 7 days of notice prior to the initial onsite audit of each audit cycle.
- To have an onsite audit scheduled after the first 3 calendar days of the month, unless the pharmacist consents to an earlier audit date.
- To limit the audit period to 24 months from the date a claim was submitted to or adjudicated by the entity conducting the audit.
- To have an audit which requires clinical or professional judgment conducted by or in consultation with a pharmacist.

[30] S. 624.490, F.S.
[31] E-mail correspondence from Grant Phillips, Florida Office of Insurance Regulation, September 9, 2019 (on file with staff of the Health Market Reform Subcommittee).
[32] Ss. 627.64741, 627.6572, and 641.314, F.S.
[33] American Pharmacy Cooperative, Inc., *Audit Information – Types of Audits*, available at https://www.apcinet.com/Services/CAPS/AuditInformation/tabid/667/Default.aspx (last accessed January 11, 2020).
[34] S. 465.1885, F.S.

- To use the written and verifiable records of a hospital or authorized practitioner to validate a pharmacy record in accordance with state and federal law.
- To be reimbursed for a claim that was retroactively denied for a clerical, scrivener's, typographical, or computer error if the patient received the correct medication, dose, and instructions for administration, unless a pattern of errors exists or fraud is alleged, or the error results in actual financial loss to the entity.
- To receive a preliminary audit report within 120 days after conclusion of the audit.
- To produce documentation to challenge a discrepancy or finding within 10 days after the preliminary audit report is delivered to the pharmacy.
- To receive the final audit report within 6 months of receiving the preliminary audit report.
- To have penalties and recoupments based on actual overpayments and not according to accounting principles of extrapolation.

However, the Pharmacy Act does not provide a mechanism for the enforcement of these rights. The Board of Pharmacy is tasked with adopting rules to implement the provisions of the Act and setting standards of practice within the state, but the Board has no authority to regulate the actions of PBMs and insurers.[35]

Prescription Drug Manufacturers

Federal Regulation of Drug Manufacturers

The United States Food and Drug Administration (FDA) is responsible for ensuring that foods, drugs, biological products, and medical devices are effective and safe for public consumption.[36] The FDA regulates these areas under the authority of the Federal Food, Drug, and Cosmetic Act (FDCA).[37] The FDCA prohibits any drug from being introduced or delivered for introduction into interstate commerce unless approved by the FDA. The FDCA further prohibits adulterated or misbranded drugs and devices from being introduced, delivered for introduction, or received in interstate commerce.

State Regulation of Drug Manufacturers

The Department of Business and Professional Regulation's (DBPR) Division of Drugs, Devices, and Cosmetics and the Department of Health's (DOH) Board of Pharmacy regulate prescription drugs in the state from manufacture to distribution and dispensing. All entities engaged in any process along this continuum must be either licensed or permitted to engage in such activity, subject to relevant laws and rules and enforcement authority of DBPR or DOH. Due to the overlap in these two industries, the law requires entities permitted or licensed under either DBPR or the Board to comply with the laws and rules of both.[38]

The DBPR's Division of Drugs, Devices, and Cosmetics protects the health, safety, and welfare of Floridians from adulterated, contaminated, and misbranded drugs, drug ingredients, and cosmetics by enforcing Part I of ch. 499, F.S., the Florida Drug and Cosmetic Act.[39] The Florida Drug and Cosmetic Act conforms to FDA drug laws and regulations and authorizes DBPR to issue permits to Florida drug manufacturers and wholesale distributors and register drugs manufactured, packaged, repackaged, labeled, or relabeled in Florida.[40]

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[35] Ss. 465.005, 465.0155, and 465.022, F.S. The authority of the Board of Pharmacy is limited to regulation of pharmacies and pharmacists.
[36] U.S. Food & Drug Administration, *What We Do*, available at https://www.fda.gov/AboutFDA/WhatWeDo/default.htm (last accessed January 7, 2020).
[37] 21 U.S.C. § 355(a).
[38] Ss. 499.067 and 465.023, F.S.
[39] Florida Department of Business and Professional Regulation, *Division of Drugs, Devices, and Cosmetics,* available at http://www.myfloridalicense.com/DBPR/drugs-devices-and-cosmetics/ (last visited January 7, 2020).
[40] S. 499.01, F.S.

Florida has 18 distinct permits based on the type of entity and intended activity, and includes permits for entities within the state, out of state, or even outside of the United States.[41] DBPR has broad authority to inspect and discipline permittees for violations of state or federal laws and regulations, which can include seizure and condemnation of adulterated or misbranded drugs or suspension or revocation of a permit.[42]

Prescription Drug Manufacturer Permit

Drug manufacturing includes the preparation, deriving, compounding, propagation, processing, producing, or fabrication of any drug.[43] A prescription drug manufacturer permit is required for any person that is a manufacturer of a prescription drug and that manufactures or distributes such prescription drugs in this state.[44] Such manufacturer must comply with all state and federal good manufacturing practices. A permitted prescription drug manufacturer may engage in distribution of its own manufactured drug without requiring a separate permit.[45] The distribution of drugs includes the selling, purchasing, trading, delivering, handling, storing, and receiving of drugs, but does not include the administration or dispensing of drugs.[46]

Nonresident Prescription Drug Manufacturer Permit

A nonresident prescription drug manufacturer permit is required for any person that is a manufacturer of prescription drugs located outside of this state or outside the United States that engages in the distribution in this state of such prescription drugs.[47] Such manufacturer must comply with all of the same requirements as prescription drug manufacturers operating in the state. The permittee must also comply with the licensing or permitting requirements of the state or jurisdiction in which it is located and must comply with federal and Florida laws and regulations when distributing any prescription drugs in the state. If the manufacturer intends to distribute prescription drugs for which it is not the original manufacturer, an out-of-state prescription drug wholesale distributor permit is required.[48]

Effect of Proposed Changes

Pharmacy Benefit Managers – Reporting Requirements

The bill imposes additional reporting requirements that must be included in contracts between PBMs and health insurers and HMOs. A PBM must annually report the following to health plans with which it contracts:

- The aggregate amount of all rebates received from drug manufacturers in association with claims administered on behalf of the health plan, and the aggregate amount of those rebates that was not passed on to the health plan.
- The aggregate amount of administrative fees paid to the PBM by the health plan for administration of the health plan's drug benefit.
- The types and aggregate amount of any fees paid by pharmacies to the PBM.

[41] A permit is required for a prescription drug manufacturer; a prescription drug repackager; a nonresident prescription drug manufacturer; a prescription drug wholesale distributor; an out-of-state prescription drug wholesale distributor; a retail pharmacy drug wholesale distributor; a restricted prescription drug distributor; a complimentary drug distributor; a freight forwarder; a veterinary prescription drug retail establishment; a veterinary prescription drug wholesale distributor; a limited prescription drug veterinary wholesale distributor; an over-the-counter drug manufacturer; a device manufacturer; a cosmetic manufacturer; a third party logistics provider; or a health care clinic establishment. S. 499.01(1), F.S.
[42] Ss. 499.051, 499.062, 499.065. 499.066, 499.0661, and 499.067, F.S.
[43] S. 499.003(28), F.S.
[44] S. 499.01(2), F.S.
[45] S. 499.01(2), F.S.
[46] S. 499.003(16), F.S.
[47] S. 499.01(2), F.S.
[48] S. 499.01(2), F.S.

- The aggregate amount of revenue generated by the PBM using spread pricing in administration of the health plan's drug benefit.

Beginning June 30, 2021, each health plan will be required to provide this information to OIR as part of an annual report. The OIR is then required to publish the reports on its website, along with an analysis of the reported information.

The reporting of aggregate rebates, administrative fees, and spread pricing may provide additional insight on the nature of PBM revenues in the state. To date, this information has been largely unknown outside the industry.

Pharmacy Audits

The bill reproduces several audit-related provisions of the Florida Pharmacy Act in the context of the Florida Insurance Code. Namely, the bill requires that an entity conducting an audit of a pharmacy licensed under ch. 465, F.S.:

- Must notify the pharmacy at least 7 calendar days before the initial onsite audit for each audit cycle.
- May only conduct an audit after the first 3 calendar days of a month unless the pharmacist consents otherwise.
- Must limit the audit period to 24 months after the submission or adjudication of a claim.
- Must provide a preliminary audit report to the pharmacy within 120 days of the conclusion of the audit.
- Must provide a final audit report to the pharmacy within 6 months of providing the preliminary report.

The OIR now has authority to enforce these provisions and respond to potential violations as necessary. This enforcement could provide pharmacies with additional predictability in their business relationships with PBMs and health plans.

Prescription Drug Manufacturers

The bill requires prescription drug manufacturers to provide notice of upcoming product price increases as a condition of receiving a permit from DBPR. A manufacturer must to notify all health plans at least 60 days in advance of a drug price increase, along with the amount of the forthcoming price increase.

The bill also establishes a new reporting requirement for prescription drug manufacturers. Each drug manufacturer must annually submit a report to both DBPR and the OIR on each drug price increase made during the preceding calendar year. This report must include a list of all the affected drug products and both the dollar amount and the percentage increase of each drug price increase. Manufacturers must also describe the factors contributing to each drug price increase.

The responsibilities placed on drug manufacturers may increase transparency in the pricing of prescription drugs, which could assist health plans in assessing actuarial risk. At present, manufacturers are under no obligation to justify price increases or notify health plans of anticipated price changes.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 499.012, F.S., relating to permit application requirements.
Section 2: Creates s. 499.026, F.S., relating to prescription drug price increases.
Section 3: Creates s. 624.491, F.S., relating to pharmacy audits.

Section 4: Amends s. 627.64741, F.S., relating to pharmacy benefit manager contracts.
Section 5: Amends s. 627.6572, F.S., relating to pharmacy benefit manager contracts.
Section 6: Amends s. 641.314, F.S., relating to pharmacy benefit manager contracts.
Section 7: 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:

   DBPR and OIR will need to collect, report, and analyze data from PBMs. Any additional workload or information technology programming modifications necessary to implement the bill can be accomplished within existing resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill may have a negative fiscal impact on PBMs and pharmaceutical manufacturers due to compliance with the bill's reporting requirements.

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:

DBPR and the OIR have sufficient rulemaking authority 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 prescription drug price transparency; amending s. 499.012, F.S.; providing that permits for prescription drug manufacturers and nonresident prescription drug manufacturers are subject to specified requirements; creating s. 499.026, F.S.; providing definitions; requiring prescription drug manufacturers to provide notice of drug price increases to insurers; requiring prescription drug manufacturers to provide an annual report on drug price increases to the Department of Business and Professional Regulation and the Office of Insurance Regulation; providing report requirements; creating s. 624.491, F.S.; providing timelines and documentation requirements for pharmacy audits conducted by certain health insurers, health maintenance organizations, or their agents; amending s. 627.64741, F.S.; providing definitions; requiring reporting requirements in contracts between health insurers and pharmacy benefit managers; requiring health insurers to submit an annual report to the office; requiring the office to publish such reports and analyses of specified information; revising applicability; amending s. 627.6572, F.S.; providing definitions; requiring reporting requirements in

contracts between health insurers and pharmacy benefit managers; requiring health insurers to submit an annual report to the office; requiring the office to publish such reports and analyses of specified information; revising applicability; amending s. 641.314, F.S.; providing definitions; requiring reporting requirements in contracts between health maintenance organizations and pharmacy benefit managers; requiring health maintenance organizations to submit an annual report to the office; requiring the office to publish such reports and analyses of specified information; revising applicability; providing an effective date.

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

Section 1. Subsection (16) is added to section 499.012, Florida Statutes, to read:

499.012 Permit application requirements.—

(16) A permit for a prescription drug manufacturer or a nonresident prescription drug manufacturer is subject to the requirements of s. 499.026.

Section 2. Section 499.026, Florida Statutes, is created to read:

499.026 Prescription drug price increases.—

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

(a) "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, regulated under chapter 627 or chapter 641.

(b) "Manufacturer" means any person holding a prescription drug manufacturer permit or a nonresident prescription drug manufacturer permit under s. 499.01.

(2) At least 60 days before the effective date of any manufacturer drug price increase, a manufacturer must provide notification of the upcoming drug price increase and the amount of the drug price increase to every health insurer that covers the drug.

(3) By April 1 of each year, a manufacturer must submit a report to the department and the Office of Insurance Regulation on each manufacturer drug price increase made during the previous calendar year. At a minimum, the report shall include:

(a) A list of all drugs affected by the drug price increase and both the dollar amount of each drug price increase and the percentage increase of each drug price increase, relative to the previous price of the drug.

(b) A complete description of the factors contributing to the drug price increase.

Section 3. Section 624.491, Florida Statutes, is created

to read:

624.491 Pharmacy audits.—A health insurer or health maintenance organization providing pharmacy benefits through a major medical individual or group health policy or health maintenance contract, respectively, shall comply with the requirements of this section when the insurer or health maintenance organization or any entity acting on behalf of the insurer or health maintenance organization, including, but not limited to, a pharmacy benefit manager, audits the records of a pharmacy licensed under chapter 465. The entity conducting such an audit shall:

(1) Notify the pharmacy at least 7 calendar days before the initial onsite audit for each audit cycle.

(2) Ensure the audit is not initiated during the first 3 calendar days of a month unless the pharmacist consents otherwise.

(3) Limit the audit period to 24 months after the date a claim is submitted to or adjudicated by the entity.

(4) Provide a preliminary audit report to the pharmacy within 120 days after the conclusion of the audit.

(5) Provide a final audit report to the pharmacy within 6 months after having providing the preliminary audit report.

Section 4. Section 627.64741, Florida Statutes, is amended to read:

627.64741 Pharmacy benefit manager contracts.—

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

(a) "Administrative fee" means a fee or payment under a contract between a health insurer and a pharmacy benefit manager associated with the pharmacy benefit manager's administration of the insurer's prescription drug benefit programs that is paid by the insurer to the pharmacy benefit manager.

(b) ~~(a)~~ "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a prescription drug, excluding dispensing fees, prior to the application of copayments, coinsurance, and other cost-sharing charges, if any.

(c) ~~(b)~~ "Pharmacy benefit manager" means a person or entity doing business in this state which contracts to administer or manage prescription drug benefits on behalf of a health insurer to residents of this state.

(d) "Rebate" means all discounts and other negotiated price concessions based on utilization of a prescription drug and paid by the pharmaceutical manufacturer or other entity, other than an insured, to the pharmacy benefit manager after the claim has been adjudicated at the pharmacy.

(e) "Spread pricing" means any amount a pharmacy benefit manager charges or receives from a health insurer for payment of a prescription drug or pharmacy service that is greater than the amount the pharmacy benefit manager paid to the pharmacist or pharmacy that filled the prescription or provided the pharmacy

service.

(2) A contract between a health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager:

(a) Update maximum allowable cost pricing information at least every 7 calendar days.

(b) Maintain a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(3) A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from limiting a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, pursuant to s. 465.0244.

(4) A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring an insured to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

(a) The applicable cost-sharing amount; or

(b) The retail price of the drug in the absence of prescription drug coverage.

(5) A contract between a health insurer and a pharmacy benefit manager must require the pharmacy benefit manager to

report annually the following to the insurer:

(a) The aggregate amount of rebates the pharmacy benefit manager received in association with claims administered on behalf of the insurer and the aggregate amount of such rebates the pharmacy benefit manager received that were not passed through to the insurer.

(b) The aggregate amount of administrative fees paid to the pharmacy benefit manager by the insurer for the administration of the insurer's prescription drug benefit programs.

(c) The types and aggregate amounts of any fees or remittances paid to the pharmacy benefit manager by pharmacies.

(d) The aggregate amount of revenue generated by the pharmacy benefit manager through the use of spread pricing in association with the administration of the insurer's pharmacy benefit programs.

(6) Not later than June 30, 2021, and annually thereafter, a health insurer shall submit a report to the office that includes the information provided by its contracted pharmacy benefit managers under subsection (5). The office shall publish the reports and an analysis of the reported information on its website.

(7) ~~(5)~~ This section applies to contracts entered into or renewed on or after July 1, 2020 ~~2018~~.

Section 5. Section 627.6572, Florida Statutes, is amended

to read:

627.6572 Pharmacy benefit manager contracts.—

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

(a) "Administrative fee" means a fee or payment under a contract between a health insurer and a pharmacy benefit manager associated with the pharmacy benefit manager's administration of the insurer's prescription drug benefit programs that is paid by the insurer to the pharmacy benefit manager.

(b) ~~(a)~~ "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a prescription drug, excluding dispensing fees, prior to the application of copayments, coinsurance, and other cost-sharing charges, if any.

(c) ~~(b)~~ "Pharmacy benefit manager" means a person or entity doing business in this state which contracts to administer or manage prescription drug benefits on behalf of a health insurer to residents of this state.

(d) "Rebate" means all discounts and other negotiated price concessions based on utilization of a prescription drug and paid by the pharmaceutical manufacturer or other entity, other than an insured, to the pharmacy benefit manager after the claim has been adjudicated at the pharmacy.

(e) "Spread pricing" means any amount a pharmacy benefit manager charges or receives from a health insurer for payment of a prescription drug or pharmacy service that is greater than the

amount the pharmacy benefit manager paid to the pharmacist or pharmacy that filled the prescription or provided the pharmacy service.

(2) A contract between a health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager:

(a) Update maximum allowable cost pricing information at least every 7 calendar days.

(b) Maintain a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(3) A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from limiting a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, pursuant to s. 465.0244.

(4) A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring an insured to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

(a) The applicable cost-sharing amount; or

(b) The retail price of the drug in the absence of prescription drug coverage.

(5) A contract between a health insurer and a pharmacy benefit manager must require the pharmacy benefit manager to report annually the following to the insurer:

(a) The aggregate amount of rebates the pharmacy benefit manager received in association with claims administered on behalf of the insurer and the aggregate amount of such rebates the pharmacy benefit manager received that were not passed through to the insurer.

(b) The aggregate amount of administrative fees paid to the pharmacy benefit manager by the insurer for the administration of the insurer's prescription drug benefit programs.

(c) The types and aggregate amounts of any fees or remittances paid to the pharmacy benefit manager by pharmacies.

(d) The aggregate amount of revenue generated by the pharmacy benefit manager through the use of spread pricing in association with the administration of the insurer's pharmacy benefit programs.

(6) Not later than June 30, 2021, and annually thereafter, a health insurer shall submit a report to the office that includes the information provided by its contracted pharmacy benefit managers under subsection (5). The office shall publish the reports and an analysis of the reported information on its website.

(7) ~~(5)~~ This section applies to contracts entered into or

renewed on or after July 1, 2020 ~~2018~~.

Section 6. Section 641.314, Florida Statutes, is amended to read:

641.314 Pharmacy benefit manager contracts.—

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

(a) "Administrative fee" means a fee or payment under a contract between a health maintenance organization and a pharmacy benefit manager associated with the pharmacy benefit manager's administration of the health maintenance organization's prescription drug benefit programs that is paid by the health maintenance organization to the pharmacy benefit manager.

(b) ~~(a)~~ "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a prescription drug, excluding dispensing fees, prior to the application of copayments, coinsurance, and other cost-sharing charges, if any.

(c) ~~(b)~~ "Pharmacy benefit manager" means a person or entity doing business in this state which contracts to administer or manage prescription drug benefits on behalf of a health maintenance organization to residents of this state.

(d) "Rebate" means all discounts and other negotiated price concessions based on utilization of a prescription drug and paid by the pharmaceutical manufacturer or other entity, other than a subscriber, to the pharmacy benefit manager after

the claim has been adjudicated at the pharmacy.

(e) "Spread pricing" means any amount a pharmacy benefit manager charges or receives from a health maintenance organization for payment of a prescription drug or pharmacy service that is greater than the amount the pharmacy benefit manager paid to the pharmacist or pharmacy that filled the prescription or provided the pharmacy service.

(2) A contract between a health maintenance organization and a pharmacy benefit manager must require that the pharmacy benefit manager:

(a) Update maximum allowable cost pricing information at least every 7 calendar days.

(b) Maintain a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(3) A contract between a health maintenance organization and a pharmacy benefit manager must prohibit the pharmacy benefit manager from limiting a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, pursuant to s. 465.0244.

(4) A contract between a health maintenance organization and a pharmacy benefit manager must prohibit the pharmacy

benefit manager from requiring a subscriber to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

(a) The applicable cost-sharing amount; or

(b) The retail price of the drug in the absence of prescription drug coverage.

(5) A contract between a health maintenance organization and a pharmacy benefit manager must require the pharmacy benefit manager to report annually the following to the health maintenance organization:

(a) The aggregate amount of rebates the pharmacy benefit manager received in association with claims administered on behalf of the health maintenance organization and the aggregate amount of such rebates the pharmacy benefit manager received that were not passed through to the health maintenance organization.

(b) The aggregate amount of administrative fees paid to the pharmacy benefit manager by the health maintenance organization for the administration of the health maintenance organization's prescription drug benefit programs.

(c) The types and aggregate amounts of any fees or remittances paid to the pharmacy benefit manager by pharmacies.

(d) The aggregate amount of revenue generated by the pharmacy benefit manager through the use of spread pricing in association with the administration of the health maintenance

organization's pharmacy benefit programs.

(6) Not later than June 30, 2021, and annually thereafter, a health maintenance organization shall submit a report to the office that includes the information provided by its contracted pharmacy benefit managers under subsection (5). The office shall publish the reports and an analysis of the reported information on its website.

(7)~~(5)~~ This section applies to contracts entered into or renewed on or after July 1, 2020 ~~2018~~.

Section 7. 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 Andrade offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Subsection (16) is added to section 499.012, Florida Statutes, to read:

499.012 Permit application requirements.—

(16) A permit for a prescription drug manufacturer or a nonresident prescription drug manufacturer is subject to the requirements of s. 499.026.

Section 2. Section 499.026, Florida Statutes, is created to read:

499.026 Prescription drug price increases.—

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

(a) “Drug Price Increase” means a manufacturer price increase equal to or greater than 15 percent of the price of a drug for a brand-name prescription drug with a wholesale acquisition cost of $50 or more, or a manufacturer price increase equal to or greater than 25 percent of the price of a drug for a generic prescription drug or a biosimilar drug with a wholesale acquisition cost of $25 or more, for a 30-day supply.

(b) "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, regulated under chapter 627 or chapter 641.

(c) "Manufacturer" means any person holding a prescription drug manufacturer permit or a nonresident prescription drug manufacturer permit under s. 499.01.

(d) “Wholesale acquisition cost” means that term as defined in 42 U.S.C. § 1395w-3a.

(2) At least 60 days before the effective date of any drug price increase, a manufacturer must provide notification of the upcoming drug price increase and the amount of the drug price increase to every health insurer that covers the drug. A manufacturer must make the notification using the contact list published by the Office of Insurance Regulation pursuant to ss. 627.42394 and 641.3131. Notification shall be presumed to occur on the date that a manufacturer attempts to communicate with the

applicable point of contact published by the Office of Insurance Regulation.

(3) By April 1 of each year, a manufacturer must submit a report to the department and the Office of Insurance Regulation on each drug price increase made during the previous calendar year. At a minimum, the report shall include:

(a) A list of all drugs affected by the drug price increase and both the dollar amount of each drug price increase and the percentage increase of each drug price increase, relative to the previous price of the drug.

(b) A complete description of the factors contributing to the drug price increase.

Section 3. Section 624.491, Florida Statutes, is created to read:

624.491 Pharmacy audits.—

(1) A health insurer or health maintenance organization providing pharmacy benefits through a major medical individual or group health policy or health maintenance contract, respectively, shall comply with the requirements of this section when the insurer or health maintenance organization or any entity acting on behalf of the insurer or health maintenance organization, including, but not limited to, a pharmacy benefit manager, audits the records of a pharmacy licensed under chapter 465. This section does not apply to audits in which suspected fraudulent activity or other intentional or willful

misrepresentation is evidenced by a physical review, review of claims data or statements, or other investigative methods; audits of claims paid for by federally funded programs; or concurrent reviews or desk audits that occur within 3 business days of transmission of a claim and where no chargeback or recoupment is demanded. An entity that audits a pharmacy located within a Health Care Fraud Prevention and Enforcement Action Team (HEAT) Task Force area designated by the United States Department of Health and Human Services and the United States Department of Justice may dispense with the notice requirements if such pharmacy has been a member of a credentialed provider network for less than 12 months.

(2) An entity conducting a pharmacy audit shall:

(a) Notify the pharmacy at least 7 calendar days before the initial onsite audit for each audit cycle.

(b) Ensure the audit is not initiated during the first 3 calendar days of a month unless the pharmacist consents otherwise.

(c) Limit the audit period to 24 months after the date a claim is submitted to or adjudicated by the entity.

(d) Provide a preliminary audit report to the pharmacy within 120 days after the conclusion of the audit.

(e) Provide a final audit report to the pharmacy within 6 months after having providing the preliminary audit report.

Section 4. Section 627.42394, Florida Statutes, is created to read:

627.42394 Formulary changes resulting from drug price increases.—

(1) A health insurer issuing a major medical individual or group policy shall submit, and update as necessary, contact information for a single point-of-contact for use by prescription drug manufacturers to comply with s. 499.026. The Office shall maintain and publish a list of such points of contact.

(2) A health insurer issuing a major medical individual or group policy must provide written notice to affected insureds at least 30 days in advance of making a drug formulary change resulting from a drug price increase reported pursuant to s. 499.026.

(3) This section applies to policies entered into or renewed on or after January 1, 2021.

Section 5. Section 627.64741, Florida Statutes, is amended to read:

627.64741 Pharmacy benefit manager contracts.—

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

(a) "Administrative fee" means a fee or payment under a contract between a health insurer and a pharmacy benefit manager associated with the pharmacy benefit manager's administration of

the insurer's prescription drug benefit programs that is paid by the insurer to the pharmacy benefit manager.

(b) ~~(a)~~ "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a prescription drug, excluding dispensing fees, prior to the application of copayments, coinsurance, and other cost-sharing charges, if any.

(c) ~~(b)~~ "Pharmacy benefit manager" means a person or entity doing business in this state which contracts to administer or manage prescription drug benefits on behalf of a health insurer to residents of this state.

(d) "Rebate" means all discounts and other negotiated price concessions based on utilization of a prescription drug and paid by the pharmaceutical manufacturer or other entity, other than an insured, to the pharmacy benefit manager after the claim has been adjudicated at the pharmacy.

(e) "Spread pricing" means any amount a pharmacy benefit manager charges or receives from a health insurer for payment of a prescription drug or pharmacy service that is greater than the amount the pharmacy benefit manager paid to the pharmacist or pharmacy that filled the prescription or provided the pharmacy service.

(2) A contract between a health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager:

(a) Update maximum allowable cost pricing information at least every 7 calendar days.

(b) Maintain a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(3) A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from limiting a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, pursuant to s. 465.0244.

(4) A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring an insured to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

(a) The applicable cost-sharing amount; or

(b) The retail price of the drug in the absence of prescription drug coverage.

(5) A contract between a health insurer and a pharmacy benefit manager must require the pharmacy benefit manager to report annually the following to the insurer:

(a) The aggregate amount of rebates the pharmacy benefit manager received in association with claims administered on

behalf of the insurer and the aggregate amount of such rebates the pharmacy benefit manager received that were not passed through to the insurer.

(b) The aggregate amount of administrative fees paid to the pharmacy benefit manager by the insurer for the administration of the insurer's prescription drug benefit programs.

(c) The types and aggregate amounts of any fees or remittances paid to the pharmacy benefit manager by pharmacies. The pharmacy benefit manager shall distinguish between fees paid by covered entities, as defined in 42 U.S.C. § 256b, and fees paid by pharmacies which are not covered entities.

(d) The aggregate amount of revenue generated by the pharmacy benefit manager through the use of spread pricing in association with the administration of the insurer's pharmacy benefit programs.

(6) Not later than June 30, 2021, and annually thereafter, a health insurer shall submit a report to the office that includes the information provided by its contracted pharmacy benefit managers under subsection (5). The office shall publish on its website an analysis of the reported information required to be provided to the insurer under subsection (5) in an aggregated amount for each pharmacy benefit manager.

(7)~~(5)~~ This section applies to contracts entered into or renewed on or after July 1, 2020~~2018~~.

Section 6. Section 627.6572, Florida Statutes, is amended to read:

627.6572 Pharmacy benefit manager contracts.—

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

(a) "Administrative fee" means a fee or payment under a contract between a health insurer and a pharmacy benefit manager associated with the pharmacy benefit manager's administration of the insurer's prescription drug benefit programs that is paid by the insurer to the pharmacy benefit manager.

(b) ~~(a)~~ "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a prescription drug, excluding dispensing fees, prior to the application of copayments, coinsurance, and other cost-sharing charges, if any.

(c) ~~(b)~~ "Pharmacy benefit manager" means a person or entity doing business in this state which contracts to administer or manage prescription drug benefits on behalf of a health insurer to residents of this state.

(d) "Rebate" means all discounts and other negotiated price concessions based on utilization of a prescription drug and paid by the pharmaceutical manufacturer or other entity, other than an insured, to the pharmacy benefit manager after the claim has been adjudicated at the pharmacy.

(e) "Spread pricing" means any amount a pharmacy benefit manager charges or receives from a health insurer for payment of

a prescription drug or pharmacy service that is greater than the amount the pharmacy benefit manager paid to the pharmacist or pharmacy that filled the prescription or provided the pharmacy service.

(2) A contract between a health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager:

(a) Update maximum allowable cost pricing information at least every 7 calendar days.

(b) Maintain a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(3) A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from limiting a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, pursuant to s. 465.0244.

(4) A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring an insured to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

(a) The applicable cost-sharing amount; or

(b) The retail price of the drug in the absence of prescription drug coverage.

(5) A contract between a health insurer and a pharmacy benefit manager must require the pharmacy benefit manager to report annually the following to the insurer:

(a) The aggregate amount of rebates the pharmacy benefit manager received in association with claims administered on behalf of the insurer and the aggregate amount of such rebates the pharmacy benefit manager received that were not passed through to the insurer.

(b) The aggregate amount of administrative fees paid to the pharmacy benefit manager by the insurer for the administration of the insurer's prescription drug benefit programs.

(c) The types and aggregate amounts of any fees or remittances paid to the pharmacy benefit manager by pharmacies. The pharmacy benefit manager shall distinguish between fees paid by covered entities, as defined in 42 U.S.C. § 256b, and fees paid by pharmacies which are not covered entities.

(d) The aggregate amount of revenue generated by the pharmacy benefit manager through the use of spread pricing in association with the administration of the insurer's pharmacy benefit programs.

(6) Not later than June 30, 2021, and annually thereafter, a health insurer shall submit a report to the office that

includes the information provided by its contracted pharmacy benefit managers under subsection (5). The office shall publish on its website an analysis of the reported information required to be provided under subsection (5) in an aggregated amount for each pharmacy benefit manager.

(7)~~(5)~~ This section applies to contracts entered into or renewed on or after July 1, 2020~~2018~~.

Section 7. Section 641.3131, Florida Statutes, is created to read:

641.3131 Formulary changes resulting from drug price increases.—

(1) A health maintenance organization issuing a major medical or other comprehensive coverage contract shall submit, and update as necessary, contact information for a single point-of-contact for use by prescription drug manufacturers to comply with s. 499.026. The Office shall maintain and publish a list of such points of contact.

(2) A health maintenance organization issuing a major medical or other comprehensive coverage contract must provide written notice to affected subscribers at least 30 days in advance of making a drug formulary change resulting from a drug price increase reported pursuant to s. 499.026.

(3) This section applies to contracts entered into or renewed on or after January 1, 2021.

Section 8. Section 641.314, Florida Statutes, is amended to read:

641.314 Pharmacy benefit manager contracts.—

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

(a) "Administrative fee" means a fee or payment under a contract between a health maintenance organization and a pharmacy benefit manager associated with the pharmacy benefit manager's administration of the health maintenance organization's prescription drug benefit programs that is paid by the health maintenance organization to the pharmacy benefit manager.

(b) ~~(a)~~ "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a prescription drug, excluding dispensing fees, prior to the application of copayments, coinsurance, and other cost-sharing charges, if any.

(c) ~~(b)~~ "Pharmacy benefit manager" means a person or entity doing business in this state which contracts to administer or manage prescription drug benefits on behalf of a health maintenance organization to residents of this state.

(d) "Rebate" means all discounts and other negotiated price concessions based on utilization of a prescription drug and paid by the pharmaceutical manufacturer or other entity, other than a subscriber, to the pharmacy benefit manager after the claim has been adjudicated at the pharmacy.

(e) "Spread pricing" means any amount a pharmacy benefit manager charges or receives from a health maintenance organization for payment of a prescription drug or pharmacy service that is greater than the amount the pharmacy benefit manager paid to the pharmacist or pharmacy that filled the prescription or provided the pharmacy service.

(2) A contract between a health maintenance organization and a pharmacy benefit manager must require that the pharmacy benefit manager:

(a) Update maximum allowable cost pricing information at least every 7 calendar days.

(b) Maintain a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(3) A contract between a health maintenance organization and a pharmacy benefit manager must prohibit the pharmacy benefit manager from limiting a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, pursuant to s. 465.0244.

(4) A contract between a health maintenance organization and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring a subscriber to make a payment

for a prescription drug at the point of sale in an amount that exceeds the lesser of:

(a) The applicable cost-sharing amount; or

(b) The retail price of the drug in the absence of prescription drug coverage.

(5) A contract between a health maintenance organization and a pharmacy benefit manager must require the pharmacy benefit manager to report annually the following to the health maintenance organization:

(a) The aggregate amount of rebates the pharmacy benefit manager received in association with claims administered on behalf of the health maintenance organization and the aggregate amount of such rebates the pharmacy benefit manager received that were not passed through to the health maintenance organization.

(b) The aggregate amount of administrative fees paid to the pharmacy benefit manager by the health maintenance organization for the administration of the health maintenance organization's prescription drug benefit programs.

(c) The types and aggregate amounts of any fees or remittances paid to the pharmacy benefit manager by pharmacies. The pharmacy benefit manager shall distinguish between fees paid by covered entities, as defined in 42 U.S.C. § 256b, and fees paid by pharmacies which are not covered entities.

(d) The aggregate amount of revenue generated by the pharmacy benefit manager through the use of spread pricing in association with the administration of the health maintenance organization's pharmacy benefit programs.

(6) Not later than June 30, 2021, and annually thereafter, a health maintenance organization shall submit a report to the office that includes the information provided by its contracted pharmacy benefit managers under subsection (5). The office shall publish on its website an analysis of the reported information required to be provided to the health maintenance organization under subsection (5) in an aggregated amount for each pharmacy benefit manager.

(7)~~(5)~~ This section applies to contracts entered into or renewed on or after July 1, 2020~~2018~~.

Section 9. (1) The Agency for Health Care Administration shall contract for an independent analysis of pharmacy benefit management practices under the Statewide Medicaid Managed Care program. The analysis shall outline the types of pharmacy benefit pricing contracts in place between managed care plans and contracted pharmacy benefit managers and between managed care plans or pharmacy benefit managers and pharmacies. At a minimum, the analysis shall include:

(a) An examination of the fees paid to each contracted pharmacy benefit manager by each managed care plan.

(b) An examination of the fees charged to pharmacies by each managed care plan or contracted pharmacy benefit manager.

(c) A determination of spread pricing revenues retained by each managed care plan or contracted pharmacy benefit manager.

(2) For purposes of this section, the term "pharmacy benefit manager" means a person or entity doing business in this state which contracts to administer or manage prescription drug benefits on behalf of a managed care plan.

(3) For purposes of this section, the term "spread pricing" refers to any amount a managed care plan or pharmacy benefit manager received from the Medicaid program for payment of a prescription drug that is greater than that paid to the pharmacist or pharmacy that filled a prescription for that prescription drug.

(4) The agency shall submit the completed analysis to the Governor, the President of the Senate, and the Speaker of the House of Representatives by June 30, 2020.

Section 10. The Agency for Health Care Administration shall conduct an analysis of managed care plan pharmacy networks under the Statewide Medicaid Managed Care program to ensure that enrollees have sufficient choice of pharmacies within established geographic parameters. The agency must also analyze the composition of each managed care plan pharmacy network to determine the market share of large chain pharmacies, small

chain pharmacies, and independent pharmacies, respectively. The analysis shall include:

(a) An examination of the pharmacy contracting patterns by each managed care plan or contracted pharmacy benefit manager.

(b) An examination of any financial relationship between a managed care provider or contracted pharmacy benefit manager and its contracted pharmacies. The analysis shall examine whether a managed care plan or pharmacy benefit manager establishes a network which favors pharmacies in which the managed care plan or pharmacy benefit manager owns a controlling or substantial financial interest.

(2) For purposes of this section, the term "pharmacy benefit manager" means a person or entity doing business in this state which contracts to administer or manage prescription drug benefits on behalf of a managed care plan.

(3) The agency shall submit the completed analysis to the Governor, the President of the Senate, and the Speaker of the House of Representatives by June 30, 2020.

Section 11. This act shall take effect upon becoming 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 prescription drug price transparency; amending s. 499.012, F.S.; providing that permits for prescription drug manufacturers and nonresident prescription drug manufacturers are subject to specified requirements; creating s. 499.026, F.S.; providing definitions; requiring prescription drug manufacturers to provide notice of drug price increases to insurers; requiring prescription drug manufacturers to provide an annual report on drug price increases to the Department of Business and Professional Regulation and the Office of Insurance Regulation; providing reporting requirements; creating s. 624.491, F.S.; providing timelines and documentation requirements for pharmacy audits conducted by certain health insurers, health maintenance organizations, or their agents; providing that such requirements do not apply to audits in which certain conditions are met; creating s. 627.42394. F.S.; requiring insurers to establish a single point of contact for manufacturer reporting of drug price increases; requiring the Office of Insurance Regulation to publish and maintain a list of such contacts; requiring insurers to provide written notice to insureds in advance of formulary changes resulting from manufacturer drug price increases; providing applicability; amending s. 627.64741, F.S.; providing definitions; requiring reporting requirements in contracts between health insurers and pharmacy benefit managers; requiring health insurers to submit an annual report to the office;

requiring the office to publish such reports and analyses of specified information; revising applicability; amending s. 627.6572, F.S.; providing definitions; requiring reporting requirements in contracts between health insurers and pharmacy benefit managers; requiring health insurers to submit an annual report to the office; requiring the office to publish such reports and analyses of specified information; revising applicability; creating s. 641.3131, F.S.; requiring health maintenance organizations to establish a single point of contact for manufacturer reporting of drug price increases; requiring the Office of Insurance Regulation to publish and maintain a list of such contacts; requiring health maintenance organizations to provide written notice to subscribers in advance of formulary changes resulting from manufacturer drug price increases; providing applicability; amending s. 641.314, F.S.; providing definitions; requiring reporting requirements in contracts between health maintenance organizations and pharmacy benefit managers; requiring health maintenance organizations to submit an annual report to the office; requiring the office to publish such reports and analyses of specified information; revising applicability; requiring the Agency for Health Care Administration to contract for an independent analysis of pharmacy benefit practices under the Statewide Medicaid Managed Care program; defining terms; requiring the Agency for Health Care Administration to conduct an analysis of pharmacy networks

under the Statewide Medicaid Managed Care program; defining terms; providing an effective date.

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 Toledo offered the following:

Amendment to Amendment (917373) by Representative Andrade (with title amendment)

Between lines 6 and 7 of the amendment, insert:

Section 1. Subsection (11) is added to Section 110.12315, Florida Statutes, to read:

110.12315 Prescription drug program.—

(11) The department shall contract for an annual audit of any pharmacy benefit vendor contracted under the program. At a minimum, the audit shall determine whether state funds are expended in accordance with the terms of the vendor contract and shall include an assessment of compliance with contract terms. The audit shall identify any noncompliance and make

recommendations for corrective action by a pharmacy benefit vendor. Specifically, the audit shall examine whether a pharmacy benefit vendor is compliant with contract provisions related to pass-through of pharmaceutical rebates and spread pricing, as set forth in a contract between the department and such a vendor.

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

Between lines 433 and 434 of the amendment, insert:
amending s. 110.12315, F.S.; requiring the Department of Management Services to contract for an annual audit of any pharmacy benefit vendor contracted under the state employees' prescription drug program;

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 Market Reform Subcommittee

Representative Toledo offered the following:

Amendment to Amendment (917373) by Representative Andrade

Between lines 179 and 180 of the amendment, insert:

(e) The type and aggregate amount of any other fees collected by the pharmacy benefit manager in association with claims administered on behalf of the insurer.

Between lines 260 and 261 of the amendment, insert:

(e) The type and aggregate amount of any other fees collected by the pharmacy benefit manager in association with claims administered on behalf of the insurer.

Between lines 364 and 365 of the amendment, insert:

(e) The type and aggregate amount of any other fees collected by the pharmacy benefit manager in association with

claims administered on behalf of the health maintenance organization.

HB 7053

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 7053 PCB HMR 20-03 Direct Care Workers
SPONSOR(S): Health Market Reform Subcommittee, Health Care Appropriations Subcommittee, Tomkow
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 1676

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Market Reform Subcommittee	10 Y, 5 N	Siples	Calamas
1) Health Care Appropriations Subcommittee	10 Y, 0 N, As CS	Nobles	Clark
2) Health & Human Services Committee		Siples	Calamas

SUMMARY ANALYSIS

Direct care workers, such as certified nursing assistants (CNAs), home health aides (HHAs), and personal care assistants (PCAs), provide hands-on assistance to older adults and disabled individuals. They assist with bathing, eating, dressing, and housekeeping. Florida, with its large aging population, is facing a shortage of direct care workers. However, employers find it difficult to retain individuals in these positions due to a lack of full-time employment and upward mobility.

CS/HB 7053 increases opportunity for advancement for direct care workers by expanding the authority of registered nurses to delegate certain tasks to a certified nursing assistant or a home health aide. A registered nurse may delegate any task to a CNA or HHA that the nurse determines that the CNA or HHA can safely perform. The bill also authorizes CNAs and HHAs to administer certain medications if the CNA or HHA has completed training as required by the bill, and a physician or registered nurse has validated the CNA's or HHA's competency to perform medication administration.

The bill also expands the scope of practice for CNAs and HHAs in home health agencies by authorizing CNAs and HHAs to assist with preventative skin care and basic wound care when assisting with the application of topical medications and to assist with intermittent positive pressure breathing treatments and nebulizer treatments. The bill also authorizes a nursing home facility to use dining room assistants to meet minimum staffing requirements.

The bill requires the Agency for Health Care Administration (AHCA) to create and maintain a direct care worker registry. Direct care workers, as well as licensed entities providing such services, may list themselves in the registry, along with their contact information, qualifications, background screening information, and photograph.

Currently, there is no reliable state-based data on the Florida direct care workforce. The bill requires all licensed nursing home facilities, home health agencies, hospices, nurse registries, and homemaker and companion services providers to complete a workforce survey at each biennial licensure renewal.

The bill creates an Excellence in Home Health Program that awards a designation to home health agencies that meet certain criteria. The home health agency may use the designation in marketing materials until such time that the home health agency no longer holds the designation or no longer qualifies for the designation.

The bill authorizes 4.0 full-time equivalent positions, with associated salary rate of 166,992, and appropriates the sums of $643,659 in recurring and $555,200 in nonrecurring funds from the Health Care Trust Fund to AHCA for the purpose of implementing this act.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

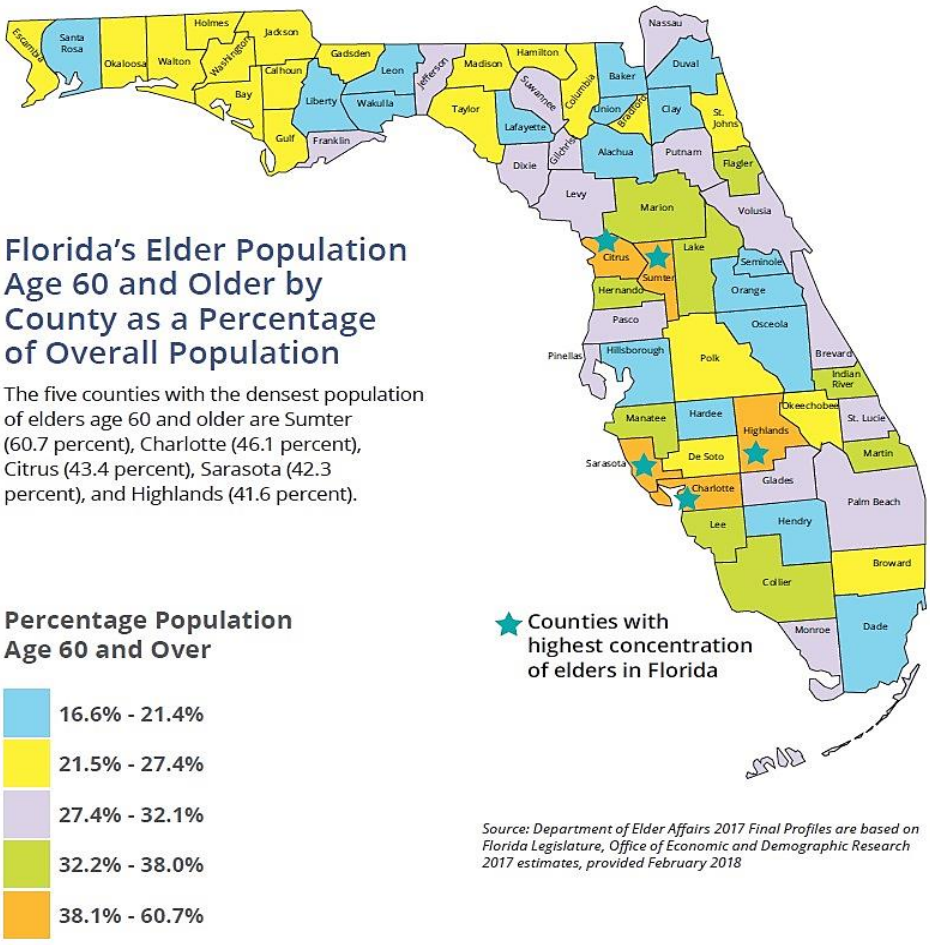
A. EFFECT OF PROPOSED CHANGES:

Present Situation

Florida's Aging Population

In the U.S. in 2015, nearly 19 million people under the age of 65 and nearly 14 million people over the age of 65 reported that they had difficulty taking care of themselves or living independently.[1]

Florida ranks first in the nation in the percentage of residents who are age 65 or older.[2] It is estimated that 20.5 percent of the state's population is over the age of 65.[3] Florida ranks fourth in the nation in the percentage of residents who are 60 and older,[4] and there are 21 counties in which residents aged 60 and older comprise at least 25 percent of the population.[5]



[1] Paul Osterman, WHO WILL CARE FOR US: LONG-TERM CARE AND THE LONG-TERM CARE WORKFORCE 3 (2017).
[2] Department of Elder Affairs, *2019 Summary of Programs and Services*, (Jan. 2019), available at http://elderaffairs.state.fl.us/doea/pubs/pubs/sops2019/2019_SOPS_A.pdf (last visited January 10, 2020).
[3] U.S. Census Bureau, *Quick Facts: Florida*, (July 1, 2019), available at https://www.census.gov/quickfacts/FL (last visited January 10, 2020). Florida's population is estimated to be 21,477,737.
[4] *Supra* note 1 at p. 8.
[5] Id.

Someone turning 65 today has almost a 70 percent chance of needing some type of long term care services and supports in their remaining years.[6] As Florida grays, individuals with disabilities who need assistance with activities of daily living, such as eating, grooming, and making meals, may also lose their caretakers. Direct care workers may provide such care and enable these individuals to remain in the community.

Direct Care Workers

Direct care workers assist older individuals and those with disabilities with daily tasks, such as dressing, bathing, and eating.[7] They work in many different settings, such as private homes, group homes, residential care facilities, assisted living facilities, skilled nursing facilities, and hospitals.[8] Direct care workers account for 70 to 80 percent of all paid hands-on long-term care and personal assistance for the elderly or disabled.[9]

Florida Direct Care Workers

Nursing Assistants or Nursing Aides

Nursing assistants or nursing aides generally work in nursing homes, although some work in assisted living facilities, other community-based settings, or hospitals.[10] The Florida Board of Nursing, within the Department of Health, certifies nursing assistants (CNAs) who must, among other things, hold a high school diploma or equivalent, complete a 120-hour board-approved training program, and pass a nursing assistant competency exam, which includes written and practical portions.[11] A CNA must biennially complete 24 hours of inservice training to maintain certification.[12]

The Board of Nursing establishes the general scope of practice for CNAs. A CNA performs services under the general supervision[13] of a registered nurse or licensed practical nurse.[14] A CNA may perform the following services:[15]

- Personal care services, such as bathing, dressing grooming, and light housekeeping;
- Tasks associated with maintaining mobility, such as ambulating, transferring, positioning, lifting, and performing range of motion exercises;
- Nutrition and hydration tasks, such a feeding or assisting with eating and drinking;
- Tasks associated with elimination, such as toileting, providing catheter care, and emptying or changing ostomy bags;
- Tasks associated with using assistive devices;
- Maintaining the environment and resident safety;
- Taking measurements and gathering data, i.e. pulse, blood, pressure, height, and weight;

[6] U.S. Department of Health and Human Services, *How Much Care Will You Need?*, (last rev. Oct. 2017), available at https://longtermcare.acl.gov/the-basics/how-much-care-will-you-need.html (last visited January 20, 2020).
[7] Paraprofessional Healthcare Institute, *Understanding the Direct Care Workforce*, available at https://phinational.org/policy-research/key-facts-faq/ (last visited November 8, 2019).
[8] Paraprofessional Healthcare Institute, *Direct Care Workforce 2018 Year in Review*, https://phinational.org/resource/the-direct-care-workforce-year-in-review-2018/ (last visited November 12, 2019) and Paraprofessional Healthcare Institute, *Who Are Direct-Care Workers?* https://phinational.org/wp-content/uploads/legacy/clearinghouse/NCDCW%20Fact%20Sheet-1.pdf (last visited January 14, 2020).
[9] Id.
[10] Paraprofessional Healthcare Institute, *Who Are Direct-Care Workers?*, (Feb. 2011), available at https://phinational.org/wp-content/uploads/legacy/clearinghouse/NCDCW%20Fact%20Sheet-1.pdf (last visited January 14, 2020).
[11] Section 464.203, F.S., and r. 64B9-15.006, F.A.C. Eighty hours must be classroom instruction and 40 hours must be clinical instruction, 20 of which must be in long term care clinical instruction in a licensed nursing home. 42 C.F.R. § 483.95 requires 75 hours of training; Florida training requirements exceed the federal minimum training requirements.
[12] Section 464.203(7), F.S.
[13] Under general supervision, the registered nurse or licensed practical nurse does not need to be present but must be available for consultation and advice, either in person or by a communication device. Rule 64B9-15.001(5), F.A.C
[14] Rule 64B9-15.002, F.A.C.
[15] *Supra* note 14.

- Reporting abnormal resident findings, signs, and symptoms;
- Post mortem care;
- Tasks associated with end of life care;
- Tasks associated with resident socialization, leisure activities, reality orientation, and validation techniques;
- Performing basic first aid, CPR, and emergency care; and
- Documentation of CNA services provided to the resident.

A CNA may not work independently and may not may not perform any tasks that requires specialized nursing knowledge, judgement, or skills.[16]

Home Health Aides

Home health aides (HHA) provide essentially the same care and services as nursing assistants, but they assist people in their homes or in community settings under the supervision of a nurse or a physical, speech, occupational, or respiratory therapist.[17] In Florida, HHAs are not licensed or certified. However, the Agency for Health Care Administration (AHCA) licenses home health agencies and establishes training requirements for HHAs employed by home health agencies. A HHA must complete at least 75 hours of training and/or successfully pass a competency evaluation by the home health agency.[18] HHAs who work for a home health agency that is not certified by Medicare or Medicaid or who work for a nurse registry must complete 40 hours of training or pass an AHCA-developed competency examination.[19]

AHCA establishes the scope of practice for HHAs performing services under a licensed home health agency. A HHA performs services delegated by and under the supervision of a registered nurse, which include:[20]

- Assisting the patient or client with personal hygiene, ambulation, eating, dressing, shaving, physical transfer, and other personal care activities;
- Maintaining a clean, safe, and healthy environment, including light housekeeping;
- Activities taught by a licensed health professional for a specific patient or client and restricted to:
    - Toileting;
    - Assisting with tasks related to elimination;
    - Assisting with the use of devices for aid to daily living, such as a wheelchair;
    - Assisting with prescribed range of motion exercises;
    - Assisting with prescribed ice cap or collar;
    - Doing simple urine tests for sugar, acetone, or albumin;
    - Measuring and preparing special diets; and
- Assisting with self-administration of medication.

A HHA may not change sterile dressings, irrigate body cavities, irrigate a colostomy or wound, perform gastric irrigation or enteral feeding, catheterize a patient, administer medication, apply heat by any method, care for a tracheotomy tube, or any other services that has not been included in the patient's plan of care.[21]

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[16] *Supra* note 14.
[17] *Supra* note 10. If the only service the home health agency provides, is physical, speech, or occupational therapy, in additional to the home health aide or CNA services, the licensed therapist may provide supervision.
[18] Agency for Health Care Administration, *Home Health Aides,* available at https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Lab_HomeServ/HHA/Home_health_aides.shtml (last visited January 20, 2020).
[19] Rules 59A-8.0095(5)
[20] Id., and 64B9-15.002, F.A.C.
[21] Rule 59A-8.0095(5)(p), F.A.C.

Personal Care Assistants

Personal care assistants (PCAs) work in either private or group homes.[22] They have many titles, including personal care attendant, home care worker, homemaker/companion, and direct support professional.[23] (The latter work with people with intellectual and developmental disabilities). In addition to providing assistance with activities of daily living, they also help individuals go to work and remain engaged in their communities.[24] A growing number of these workers are employed and supervised directly by consumers.

There are no minimum training requirements for PCAs, and there is no agency that directly regulates them. PCAs may be employed by or provide services through a home health agency or homemaker/companion agency, although some PCAs work independently and are directly supervised by the employing family or individual.

A PCA does not have a clearly defined scope of practice because it is not a regulated profession. However, the Florida Medicaid program defines personal care services as medically necessary assistance with activities of daily living to enable an individual to accomplish tasks they would normally be able to do for themselves if they did not have a medical condition or disability.[25] Florida Medicaid authorizes the following personal care services:[26]

- Bathing or assistance with bathing;
- Assistance with dressing, including application of prosthetic devices or therapeutic stockings;
- Grooming and skin care;
- Positioning;
- Transfers;
- Toileting and maintaining continence;
- Assistance with eating; and
- Non-skilled medical task delegated by a registered nurse, and may include assisting with pre-measured medications, monitoring vital signs, and measuring intake and output.

Medication Administration and Assistance with Self-Administration

Medication Administration

Medication administration means to obtain and provide a single dose of a medication to a patient for his or her consumption.[27] Currently, neither CNAs nor HHAs may administer medication to a patient. However, Florida law authorizes unlicensed direct care personnel who complete a 6-hour training course to administer medication under the developmental disabilities program.[28] Many other states authorize HHAs or CNAs who complete additional training to administer medication.[29] For example, Texas authorizes home health medication aides.[30] Arizona, Georgia, Illinois, Minnesota, and North Arizona authorize CNAs to administer medication upon completion of specialized training.[31] Connecticut has a stand-alone medication administration technician profession.[32]

[22] *Supra* note 10.
[23] Id.
[24] Id.
[25] Agency for Health Care Administration, Florida Medicaid, *Personal Care Services Coverage Policy*, (Nov. 2016), adopted in r. 59G-4.215, F.A.C.
[26] Id.
[27] Section 465.003, F.S.
[28] Section 393.506, F.S.
[29] Some states specifically certify or license medication aides.
[30] *See* TEX. HEALTH & SAFETY CODE 242 and 26 TEX. ADMIN. CODE 557.128.
[31] *See* ARIZ. REV. STAT. §32-1650, GA. CODE. ANN. 31-7-12.2, 225 ILL. COMP. STAT. 65 (pilot program), MINN. R. 4658.1360, N.C. GEN. STAT. § 131E-114.2, respectively.
[32] *See* CONN. GEN. STAT. §17a-210-1, et. seq.

Assistance with Self-Administration

Some patients are capable of administering their own medication, but need assistance to ensure that they are taking the correct medication, at the proper dosage, and at the correct time. Under current law, HHAs may assist with self-administration after completion of prescribed training.

HHAs must complete two hours of training to assist with self-administration of medication.[33] The training must include state law and rule requirements for assistance with self-administration of medication in the home, procedures for assisting the patient with self-administration, common medications, recognition of side effects and adverse reactions, and procedures to follow if patients appear to be experiencing side effects or adverse reactions.[34] This 2-hour training may be included in the primary 75-hour or 40-hour HHA training.

Assistance with self-administration of medication includes:[35]

- Taking the medication, in its properly labeled container, from where it is stored to the patient;
- In the presence of the patient, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container;
- Placing an oral dose in the patient's hand or placing the dosage in another container and helping the patient by lifting the container to his or her mouth;
- Applying topical medications;
- Returning the medication container to proper storage; and
- Keeping a record of when a patient receives assistance.

A HHA with the authority to assist with self-administration of medication may not:[36]

- Mix, compound, convert, or calculate medication doses;
- Prepare syringes for injection or the administration of medications by any injectable route;
- Administer medications through intermittent positive pressure breathing machines or a nebulizer;
- Administer medications by way of a tube inserted in a cavity of the body;
- Administer parenteral preparations;
- Irrigate or use debriding agents to treat a skin condition;
- Prepare rectal, urethral, or vaginal medications.
- Administer 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 HHA, and at the request of a competent patient;
- Administer medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.

CNAs who are not working for a home health agency may not assist with medication administration.

<u>Challenges of the Direct Care Workforce</u>

The federal Bureau of Labor Statistics estimate that home health aides and personal care assistants are in the top five occupations with the fastest job growth in the U.S. economy.[37] The demand for home

[33] *Supra* note 19.
[34] Id.
[35] Section 400.488(3), F.S.
[36] Section 400.488(4), F.S.
[37] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, National Center for Health Workforce Analysis, *Long-Term Services and Supports: Direct Care Worker Demand Projections 2015-2030*,

health aides and nursing assistants is expected to increase by 34 percent by 2025.[38] However, the turnover rate in long term care is estimated to be between 45 to 66 percent.[39]

Many factors contribute to the high turnover rate, including compensation, lack of full-employment, and low job satisfaction.[40] Direct care workers also often have substantial family caregiving obligations, which adds to the stress of the job and contribute to the days missed from work.[41]

High turnover rates have a negative impact on both employers and patients. Turnover may have a negative impact on patient care and employers must incur costs for continuous recruitment and training of new employees.[42] Indirect costs to employers include lost productivity, lost revenue, and reduced service quality.[43] Employers must pay costs related to filling vacancies and training new employees. It is estimated that turnover costs direct care employers approximately $4.1 billion per year.[44] Turnover can cause a break in continuity of care and a reduction in the quality of care, which may ultimately affect the patient's quality of life.[45]

Approximately two-thirds of HHAs and PCAs work part time.[46] This may be due to personal needs; however, many home care workers receive several assignments to work in a day the total of which does not amount to a full work day. For example, a HHA may be scheduled to see two separate clients for three hours each, but due to the time to travel between patients, the HHA is unable to achieve a full 8-hour work day. Many direct workers also face other obstacles to remaining in their jobs, including challenges with transportation, family commitments, or health care.[47] Some states or regions have launched matching service registries to make it easier for workers to find clients and build schedules to suit individual needs and commitments.[48]

Low job satisfaction, which in turn leads to higher turnover, results from inadequate training and lack of opportunities for advancement.[49] Many direct care workers chose the career because they wanted to help people, and this motivation also plays a role in retaining workers in direct care.[50] However, many direct care workers leave the career field for other entry-level jobs in the food and hospitality industry that pay similarly, are less mentally and physically strenuous, and provide opportunities for advancement.[51] In fact, one in four CNAs and one in five HHAs report that they are actively seeking another job.[52]

(March 2018), available at https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/hrsa-ltts-direct-care-worker-report.pdf (last visited January 14, 2020).
[38] Id.
[39] Kezia Scales, PhD, *Staffing in Long-Term Care is a National Crisis*, (June 8, 2018), available at https://phinational.org/recruitment-retention-long-term-care-national-perspective/ (last visited January 14, 2020).
[40] *Supra* note 1, at pp. 27-37.
[41] U.S. Department of Health and Human Services, *Understanding Direct Care Workers: A Snapshot of Two of America's Most Important Jobs – Certified Nursing Assistants and Home Health Aides*, (March 2011), available at https://www.ahcancal.org/quality_improvement/Documents/UnderstandingDirectCareWorkers.pdf (last visited January 20, 2020).
[42] Institute of Medicine, Committee on the Future Health Care Workforce for Older Americans, Board on Health Care Services, *Retooling for an Aging America: Building the Health Care Workforce*, (2008), available at https://www.ncbi.nlm.nih.gov/books/NBK215401/pdf/Bookshelf_NBK215401.pdf (last visited January 14, 2020).
[43] Dorie Seavey, Better Jobs Better Care, *The Cost of Frontline Turnover in Long-Term Care*, (Oct. 2004), available at https://phinational.org/wp-content/uploads/legacy/clearinghouse/TOCostReport.pdf (last visited January 25, 2020).
[44] *Supra* note 42.
[45] Id.
[46] Paraprofessional Healthcare Institute, *U.S. Home Care Workers: Key Facts*, available at https://phinational.org/wp-content/uploads/2017/09/phi_homecare_factsheet_2017_0.pdf (last visited January 14, 2020).
[47] Paraprofessional Healthcare Institute, *Growing a Strong Direct Care Workforce: A Recruitment and Retention Guide for Employers*, available at https://phinational.org/wp-content/uploads/2018/05/RRGuide-PHI-2018.pdf (last visited January 20, 2020).
[48] Allison Cook, Paraprofessional Healthcare Institute, *Issue Brief: Localized Strategies For Addressing the Workforce Crisis in Home Care*, (Oct. 2019), available at https://phinational.org/wp-content/uploads/2019/11/Localized-Strategies-2019-PHI.pdf (last visited January 20, 2020).
[49] *Supra* note 41.
[50] *Supra* note 41, at p. 48.
[51] *Supra* note 42.
[52] Id.

Direct care workers are also at an increased risk of work-related injuries.[53] Direct care workers have an injury rate of 144 injuries per 10,000 workers among PCAs, 116 among HHAs, and 337 among CNAs.[54] By contrast, the injury rate across all occupations is 100 per 10,000 workers.[55]

In order to meet the future demand for direct care worker, employers will need to consider options such as offering better compensation, full-time hours, better training and advancement opportunities, and improved working conditions.[56]

Direct Care Workforce Data

In 2009, the federal Centers for Medicare and Medicaid Services (CMS) issued a report acknowledging that there was a lack of ongoing, reliable state-based information about the direct care workforce.[57] This lack of information has hampered the ability to develop policy to ensure that a stable and quality direct care workforce is available to meet the increasing demand for long term care services.[58]

CMS proposed that states collect a minimum data set of information on direct care workers, including the:

- Number umber of direct care workers (full time and part time);
- Stability of the direct care workforce (turnover and vacancies); and
- Average compensation of workers (wages and benefits).

Collecting this minimum data on the direct care workforce enables states to, among other things:[59]

- Create a baseline against which the progress of workforce initiatives can be measured;
- Inform policy formulation regarding workforce initiatives;
- Help identify and set long-term priorities for long-term care reform and system changes; and
- Promote integrated planning and coordinated approaches for long-term care and comparability of data across programs to assist in the assessment and evaluation of adopted policy initiatives.

This information will also enable states to determine the most useful deployment of state resources, anticipate increased demand for services, and assess trends in workforce turnover and related costs.[60]

In addition to direct care workers who are employed by entities, like home health agencies and nursing home facilities, there is a growing “gray market” comprised of independent providers. These independent providers are directly employed by the individuals to whom they provide care[61] and some may be employed by individuals through government-funded programs, such as Medicaid.[62] However, since these individuals are directly employed by patients, it is difficult to quantify the size of this market.

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[53] *Supra* note 41.
[54] Stephen Campbell, Paraprofessional Healthcare Institute, *Issue Brief: Workplace Injuries and the Direct Care Workforce*, (April 2018), available at https://phinational.org/wp-content/uploads/2018/04/Workplace-Injuries-and-DCW-PHI-2018.pdf (last visited January 20, 2020).
[55] Id.
[56] *Supra* note 46, at p. 8.
[57] Centers for Medicare and Medicaid Services, National Direct Service Workforce Resource Center, *The Need for Monitoring Long-Term Direct Service Workforce and Recommendations for Data Collection*, (Feb. 2009), available at https://www.medicaid.gov/sites/default/files/2019-12/monitoring-dsw.pdf (last visited January 8, 2020).
[58] Id.
[59] Id at p. 8.
[60] Id.
[61] *Supra* note 1 at 18.
[62] For example, see *supra* note 25.

Regulation of Long Term Care Providers

The Division of Health Quality Assurance (HQA) within AHCA licenses, certifies, and regulates 40 different types of health care providers. Regulated providers include, among others, these providers of long-term care services:

- Nursing home facilities under part II of ch. 400, F.S.
- Assisted living facilities under part I of ch. 429, F.S.
- Home health agencies under part III of ch. 400, F.S.
- Companion or homemaker services providers under part III of ch. 400, F.S.
- Nurse registries under part III of ch. 400, F.S.
- Hospices under part IV of ch. 400, F.S.

In addition to provider-specific requirements listed in the authorizing statutes for each provider type listed above, the Health Care Licensing Procedures Act (Act), in part II of ch. 408, F.S., establishes uniform licensing procedures and statutes for 29 provider types regulated by HQA. The Act authorizes HQA to inspect facilities, verify compliance with licensure requirements, identify deficiencies or violations, and impose fines and penalties for noncompliance.

Nursing Home Staffing

Section 400.23(3), F.S., establishes minimum staffing requirements for nursing home facilities:

- A minimum weekly[63] average of 3.6 hours of direct care per resident per day provided by a combination of certified nursing assistants and licensed nursing staff.
- A minimum of 2.5 hours of direct care per resident per day provided by certified nursing assistant staff. A facility may not staff at a ratio of less than one certified nursing assistant per 20 residents.
- A minimum of 1.0 hour of direct care per resident per day provided by licensed nursing staff. A facility may not staff at a ratio of less than one licensed nurse per 40 residents.

When computing the staffing ratio for certified nursing assistants, nursing home facilities are allowed to use uncertified nursing assistants under certain conditions to satisfy the staffing ratio requirements so long as their job duties only include nursing assistant-related duties.[64] If approved by AHCA, licensed nurses may also be used to meet staffing requirements for CNAs if the licensed nurses are performing the duties of a CNA and the facility otherwise meets minimum staffing requirements for licensed nurses.[65] Additionally, non-nursing staff providing eating assistance to residents do not count toward compliance with minimum staffing requirements.[66]

Background Screening

Certain licensees, including CNAs, and certain individuals who provide services to vulnerable populations[67] must pass a background screening to be approved for certification or employment. Chapter 435, F.S., outlines the screening requirements.

[63] A week is defined as Sunday through Saturday.
[64] Sections 400.23(3)(a)2. and 400.211(2), F.S. Nursing facilities may employ uncertified nursing assistants for up to 4 months if they are enrolled in, or have completed, a state-approving nursing assistant program, have been positively verified as actively certified and on the registry in another state with no findings of abuse, neglect, or exploitation in that state, or have preliminarily passed the state's certification exam.
[65] Section 400.23(3)(a)4., F.S., and r. 59A-4.108(7), F.A.C. The hours of a licensed nurse with dual job responsibilities may not be counted twice.
[66] Sections 400.23(3)(b), F.S.
[67] "Vulnerable person" means a minor or a person over the age of 18 whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, sensory, long-term physical, developmental disability or dysfunction, or brain damage, or the infirmities of aging.

Every person required by law to be screened pursuant to ch. 435, F.S., must submit a complete set of information necessary to conduct a screening to his or her employer.[68] A level 1 screening includes, at a minimum, employment history checks and statewide criminal correspondence checks through the Florida Department of Law Enforcement (FDLE) and a check of the Dru Sjodin National Sex Offender Public Website,[69] and may include criminal records checks through local law enforcement agencies. A level 2 background screening includes, but, is not limited to, fingerprinting for statewide criminal history records checks through FDLE and national criminal history checks through the Federal Bureau of Investigation (FBI), and may include local criminal records checks through local law enforcement agencies.[70]

For both level 1 and 2 screenings, the employer must submit the information necessary for screening to FDLE within five working days after receiving it.[71] The FDLE notifies the employer or agency whether a screening has revealed any disqualifying information.[72]

The Care Provider Background Screening Clearinghouse (Clearinghouse), housed within AHCA, warehouses criminal history checks of individuals who have direct contact with vulnerable persons and are required to be screened by AHCA, Department of Health, Department of Children and Families, Agency for Persons with Disabilities, Division of Vocational Rehabilitation, Department of Elder Affairs, Department of Juvenile Justice, and local child care licensing agencies.[73] The Clearinghouse allows the background screening results to be shared among these agencies, so that the employee or licensee does not have to undergo multiple background screenings when changing employers.[74] Employers register with the Clearinghouse and maintain the employment status of its employees listed in the Clearinghouse by timely reporting changes in employment.[75]

Effect of Proposed Bill

Nurse Delegation

HB 7053 authorizes a registered nurse to delegate any task, including medication administration, to a CNA or HHA, as long as the registered nurse determines that the CNA or HHA is competent to perform the tasks, the task is delegable under federal law, and the task:

- Is within the nurse's scope of practice;
- Frequently recurs in the routine care of a patient or group of patients;
- Is performed according to an established sequence of steps;
- Involved little or no modification from one patient to another;
- May be performed with a predictable outcome;
- Does not inherently involve ongoing assessment, interpretation, or clinical judgement; and
- Does not endanger a patient's life or well-being.

Medication Administration

Currently, HHAs can only assist a patient with medication but not actually provide it to the patient; CNAs can neither provide medication nor assist a patient with medication. The bill authorizes a registered nurse to delegate administration of oral, transdermal, ophthalmic, otic, rectal, inhaled,

[68] Section 435.05(1)(a), F.S.
[69] The Dru Sjodin National Sex Offender Public Website is a U.S. government website that links public state, territorial, and tribal sex offender registries in one national search site. The website is available at https://www.nsopw.gov/ (last visited January 20, 2020).
[70] Section 435.04, F.S.
[71] Section 435.05(1)(b)-(c), F.S.
[72] Section 435.05(1)(c), F.S.
[73] Section 435.12, F.S.
[74] Section 435.12(1), F.S.
[75] Section 435.12(20, F.S.

enteral, or topical prescription medications to a CNA or HHA. Once delegated the authority, the CNA or HHA can provide a dose of a prescribed or over-the-counter medication to a patient in the manner indicated by the prescribing health care practitioner. A nurse may delegate medication administration to the CNA or HHA if the CNA or HHA:

- Has completed a 6-hour training course approved by the Board of Nursing or AHCA, respectively; and
- Has been found competent to administer medication to a patient in a safe and sanitary manner.

A registered nurse or physician must conduct the training and determine whether the CNA or HHA can competently administer medication, and annually validate such competency. A CNA or HHA who has qualified to administer medications must annually complete 2 hours of inservice training in medication administration and medication error prevention. This inservice training is in addition to the training that CNAs and HHAs must currently complete. The bill places an affirmative duty on a nursing facility or home health agency to ensure that CNAs or HHAs performing medication administration meet these requirements.

The bill requires the Board of Nursing and AHCA to adopt rules, in consultation with each other, on the standards and procedures that a CNA or HHA must follow for medication administration. Such rules must address qualifications for trainers, medication label requirements, documentation and recordkeeping, storage and disposal of medication, instructions for safe medication administration, informed consent, training curriculum, and validation procedures.

The bill specifically prohibits a registered nurse from delegating the administration of medications listed as Schedule II, Schedule III, or Schedule IV controlled substances. However, a CNA or HHA may administer Schedule V controlled substances.

The bill authorizes the Board of Nursing to adopt rules, in consultation with AHCA, on delegation of duties. The bill also creates a grounds for discipline against a registered nurse's license if the nurse delegates responsibilities to an individual that the nurse knows or has reason to know that such individual is not qualified to perform.

This authority will align Florida with other states that allow CNAs or HHAs to administer medication.

Direct Care Worker Survey

Beginning January 1, 2021, the bill requires each licensed nursing home facility, assisted living facility, home health agency, nurse registry, or companion or homemaker services provider to complete a survey on the direct care workforce at each license renewal. AHCA must adopt a survey form by rule, which requests the following information of each licensee:

- Number of direct care workers employed by the licensee;
- Turnover and vacancy rates of direct care workers and contributing factors;
- Average employee wage for each category of direct care worker;
- Employment benefits for direct care workers and average cost to the employer and employee; and
- Type and availability of training for direct care workers.

AHCA may not issue a license renewal until the licensee submits a completed survey. The administrator or designee must complete the survey and attest to the accuracy of the information provided, to the best of his or her knowledge.

AHCA must review and analyze the data received at least monthly and publish the results of the analysis on its website. The analysis should address:

- The number of direct care workers in the state, both full-time and part-time;
- Turnover rate and causes of turnover;
- Vacancy rate;
- Average hourly wage;
- Benefits offered; and
- Availability of post-employment training.

Direct Care Worker Registry

The bill directs AHCA to create and maintain a voluntary registry of home care workers,[76] accessible by the general public. A link to the registry must be available on the home page of its website. The registry must include:

- The full name, date of birth, social security number,[77] and a full face, passport-type color photograph of the home care worker;
- Contact information for the home care worker, including his or her city, county and phone number, or contact information for the employing home health agency;
- Name of the state-approved training program the home care worker completed and the date on which the training was completed;
- The number of years the home care worker has provided home health care services for compensation;
- Any disciplinary action taken or pending against a certification by the Department of Health, if the home care worker is a CNA; and
- Whether the home care worker provides services to special populations.

The bill authorizes AHCA to automatically populate work history information based on information in its records. The bill also authorizes AHCA to enter into an agreement with the Department of Health to obtain disciplinary history. A home care worker must meet the same background screening requirements to be included in the registry if the home care worker is not a CNA or currently employed by a home health agency.

The bill requires AHCA to post a disclaimer on each page of the home care worker registry website in bold, 14-point font stating that AHCA does not guarantee the accuracy of the information entered by a third party and does not endorse any individual listed in the registry.

Excellence in Home Health Award Program

The bill creates a gold seal program to designate home health agencies that meet certain criteria. The home health agency must have been actively licensed and operating for at least 24 months and have had no licensure denials revocations, or serious deficiencies during the preceding 24 months to be considered for the award

AHCA must adopt rules establishing standards for the award, including those relating to:

- Patient satisfaction;
- Patients requiring emergency care for wound infections;

[76] The bill defines "home care worker" as a certified nursing assistant certified under Part II of ch. 464, F.S., or a home health aide as defined in s. 400.462, F.S., which is a person who is trained or qualified, as provided by rule, and who provides hands-on personal care, performs simple procedures as an extension of therapy or nursing services, assists in ambulation exercises, or assists in administering medication as permitted in rule and for which the person has received training established by AHCA.
[77] The bill expressly prohibits AHCA from displaying the social security number on its website.

- Patients admitted or re-admitted to an acute care hospital;
- Patient improvement in the activities of daily living;
- Employee satisfaction;
- Quality of employee training; and
- Employee retention rates.

The bill authorizes an award recipient to use the designation in advertising and marketing. However, a home health agency may not use the designation if the agency:

- Has not been awarded the designation;
- Fails to review the award upon expiration of an award designation;
- Has undergone a change in ownership;
- Has been notified that it no longer meets the criteria for the award upon re-application after expiration of the award designation.

The award designation is not transferrable. The award designation is not subject to chapter 120, F.S.

Self-Administration of Medication

The bill authorizes a CNA or HHA to provide assistance with preventative skin care and basic wound care by assisting with the application of topical medications. The bill also authorizes a CNA or HHA to assist with intermittent positive pressure breathing treatments and nebulizer treatments to include:

- Assisting with devices set up and cleaning in the presence of the patient;
- Confirming that the medication is intended for the patient;
- Orally advising the patient of the medication name and purpose;
- Removing the prescribed amount for a single treatment from a properly labeled container; and
- Assisting the patient with placing the dose into the medicine receptacle or mouthpiece.

The bill requires a CNA or HHA assisting with self-administration to confirm that the medication is intended for the patient taking the medication. The CNA or HHA must also verbally advise the resident of the name and the purpose of the medication.

The bill authorizes a nursing home facility to count non-nursing staff who assist residents with eating to meet minimum staffing requirements.

The bill takes effect upon becoming a law.

B. SECTION DIRECTORY:

Section 1: Amends s. 400.141, F.S., relating to administration and management of nursing home facilities.
Section 2: Creates s. 400.212, F.S., relating to nurse delegated tasks.
Section 3: Amends s. 400.23, F.S., relating to rules; evaluation and deficiencies; licensure status.
Section 4: Amends s. 400.462, F.S., relating to definitions.
Section 5: Amends s. 400.464, F.S., relating to home health agencies to be licensed; expiration of license; unlawful acts; penalties.
Section 6: Amends s. 400.488, F.S., relating to assistance with self-administration of medication.
Section 7: Creates s. 400.489, F.S., relating to administration of medication; staff training; requirements.
Section 8: Creates s. 400.490, F.S., relating to nurse delegated tasks.
Section 9: Creates s. 400.52, F.S., relating to Excellence in Home Health program.
Section10: Creates s. 408.064, F.S., relating to registry of home care workers.
Section 11: Creates s. 408.822, F.S., relating to direct care workforce survey.
Section 12: Creates s. 464.0156, F.S., relating to delegation of duties.

Section 13: Amends s. 464.018, F.S., relating to disciplinary actions.
Section 14: Creates s. 464.2035, F.S., relating to administration of medication.
Section 15: Provides an appropriation.
Section 16: Provides an effective date of upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   HB 7053 authorizes 4.0 full-time equivalent positions, with associated salary rate of 166,992, and appropriates the sums of $643,659 in recurring and $555,200 in nonrecurring funds from the Health Care Trust Fund to the Agency for Health Care Administration for the purpose of implementing this act.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Home health agencies and nursing facilities may incur costs associated with providing medication administration training to CNAs and HHAs.

Consumers will have access to a centralized database of home care workers and may reduce costs associated with researching and hiring such individuals. Home care workers may acquire work, or more consistent work, using the registry.

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 rulemaking authority to the Agency for Health Care Administration and the Board of Nursing to implement its provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 11, 2020, the Health Care Appropriations Subcommittee adopted an amendment that authorizes 4.0 full-time equivalent positions, with associated salary rate of 166,992, and appropriates the sums of $643,659 in recurring and $555,200 in nonrecurring funds from the Health Care Trust Fund to the Agency for Health Care Administration for the purpose of implementing this act. The bill was reported favorably as amended.

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 direct care workers; amending s. 400.141, F.S.; requiring a nursing home facility that authorizes a registered nurse to delegate tasks to a certified nursing assistant to ensure that certain requirements are met; creating s. 400.212, F.S.; authorizing a certified nursing assistant to perform tasks delegated by a registered nurse; amending s. 400.23, F.S.; authorizing certain nonnursing staff to count toward compliance with staffing standards; amending s. 400.462, F.S.; revising the definition of "home health aide"; amending s. 400.464, F.S.; requiring a licensed home health agency that authorizes a registered nurse to delegate tasks to a certified nursing assistant to ensure that certain requirements are met; amending s. 400.488, F.S.; authorizing an unlicensed person to assist with self-administration of certain treatments; revising the requirements for such assistance; creating s. 400.489, F.S.; authorizing a home health aide to administer certain prescription medications under certain conditions; requiring the home health aide to meet certain training and competency requirements; requiring that the training, determination of competency, and annual validations be performed by a

registered nurse or a physician; requiring a home health aide to complete annual inservice training in medication administration and medication error prevention in addition to existing annual inservice training requirements; requiring the Agency for Health Care Administration, in consultation with the Board of Nursing, to adopt rules for medication administration; creating s. 400.490, F.S.; authorizing a certified nursing assistant or home health aide to perform tasks delegated by a registered nurse; creating s. 400.52, F.S.; creating the Excellence in Home Health Program within the agency; requiring the agency to adopt rules establishing program criteria; requiring the agency to annually evaluate certain home health agencies that apply for a program award; providing eligibility requirements; requiring an agency to reapply biennially for the award designation; authorizing an award recipient to use the designation in advertising and marketing; prohibiting a home health agency from using the award designation in any advertising or marketing under certain circumstances; providing that an application for an award designation under the program is not an application for licensure and such designation does not constitute final agency action subject to certain administrative procedures; creating

s. 408.064, F.S.; providing definitions; requiring the agency to develop and maintain a voluntary registry of home care workers; providing requirements for the registry; requiring a home care worker to apply to be included in the registry; requiring the agency to develop a process by which a home health services provider may include its employees on the registry; requiring certain home care workers to undergo background screening and training; requiring each page of the registry website to contain a specified notice; requiring the agency to adopt rules; creating s. 408.822, F.S.; defining the term "direct care worker"; requiring certain licensees to provide specified information about employees in a survey beginning on a specified date; requiring that the survey be completed on a form with a specified attestation adopted by the agency in rule; requiring a licensee to submit such survey before the agency renews its license; requiring the agency to analyze the results of such survey and publish its results on the agency's website; requiring the agency to update such information monthly; requiring the agency's analysis to include specified information; creating s. 464.0156, F.S.; authorizing a registered nurse to delegate tasks to a certified nursing assistant or home health aide under certain

conditions; providing the criteria that a registered nurse must consider in determining if a task may be delegated; authorizing a registered nurse to delegate medication administration to a certified nursing assistant or home health aide if certain requirements are met; requiring the Board of Nursing, in consultation with the agency, to adopt rules; amending s. 464.018, F.S.; providing that a registered nurse who delegates certain tasks to a person the registered nurse knows or has reason to know is unqualified is grounds for licensure denial or disciplinary action; creating s. 464.2035, F.S.; authorizing a certified nursing assistant to administer certain prescription medications under certain conditions; requiring the certified nursing assistant to meet certain training and competency requirements; requiring the training, determination of competency, and annual validations to be performed by a registered nurse or a physician; requiring a certified nursing assistant to complete annual inservice training in medication administration and medication error prevention in addition to existing annual inservice training requirements; requiring the board, in consultation with the agency, to adopt rules; authorizing positions and providing appropriations; providing an effective date.

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

Section 1. Paragraph (v) is added to subsection (1) of section 400.141, Florida Statutes, to read:

400.141 Administration and management of nursing home facilities.—

(1) Every licensed facility shall comply with all applicable standards and rules of the agency and shall:

(v) Ensure that a certified nursing assistant meets the requirements of chapter 464 and the rules adopted thereunder, if the facility authorizes a registered nurse to delegate tasks, including medication administration, to the certified nursing assistant.

Section 2. Section 400.212, Florida Statutes, is created to read:

400.212 Nurse delegated tasks.—A certified nursing assistant may perform any task delegated to him or her by a registered nurse as provided in chapter 464, including, but not limited to, medication administration.

Section 3. Paragraph (b) of subsection (3) of section 400.23, Florida Statutes, is amended to read:

400.23 Rules; evaluation and deficiencies; licensure status.—

(3)

(b) Nonnursing staff providing eating assistance to residents may ~~shall not~~ count toward compliance with minimum staffing standards.

Section 4. Subsection (15) of section 400.462, Florida Statutes, is amended to read:

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

(15) "Home health aide" means a person who is trained or qualified, as provided by rule, and who provides hands-on personal care, performs simple procedures as an extension of therapy or nursing services, assists in ambulation or exercises, or assists in administering medications as permitted in rule and for which the person has received training established by the agency under this part or performs tasks delegated to him or her pursuant to chapter 464 ~~s. 400.497(1)~~.

Section 5. Subsections (5) and (6) of section 400.464, Florida Statutes, are renumbered as subsections (6) and (7), respectively, present subsection (6) is amended, and a new subsection (5) is added to that section, to read:

400.464 Home health agencies to be licensed; expiration of license; exemptions; unlawful acts; penalties.—

(5) If a licensed home health agency authorizes a registered nurse to delegate tasks, including medication administration, to a certified nursing assistant pursuant to chapter 464 or a home health aide pursuant to s. 400.490, the licensed home health agency must ensure that such delegation

meets the requirements of this chapter, chapter 464, and the rules adopted thereunder.

(7) ~~(6)~~ Any person, entity, or organization providing home health services which is exempt from licensure under subsection (6) ~~(5)~~ may voluntarily apply for a certificate of exemption from licensure under its exempt status with the agency on a form that specifies its name or names and addresses, a statement of the reasons why it is exempt from licensure as a home health agency, and other information deemed necessary by the agency. A certificate of exemption is valid for a period of not more than 2 years and is not transferable. The agency may charge an applicant $100 for a certificate of exemption or charge the actual cost of processing the certificate.

Section 6. Subsections (2) and (3) of section 400.488, Florida Statutes, are amended to read:

400.488 Assistance with self-administration of medication.—

(2) Patients 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 patient 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 patient or the patient's surrogate, guardian, or attorney in fact. For purposes of this section, self-administered medications include both 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, intermittent positive pressure breathing treatments, and nebulizer treatments.

(3) Assistance with self-administration of medication includes:

(a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored and bringing it to the patient.

(b) In the presence of the patient, confirming that the medication is intended for that patient, orally advising the patient of the medication name and purpose ~~reading the label~~, opening the container, removing a prescribed amount of medication from the container, and closing the container.

(c) Placing an oral dosage in the patient's hand or placing the dosage in another container and helping the patient by lifting the container to his or her mouth.

(d) Applying topical medications, including routine preventative skin care and basic wound care.

(e) Returning the medication container to proper storage.

(f) For intermittent positive pressure breathing treatments or nebulizer treatments, assisting with setting up and cleaning the device in the presence of the patient, confirming that the medication is intended for that patient, orally advising the patient of the medication name and purpose, opening the container, removing the prescribed amount for a single treatment dose from a properly labeled container, and assisting the patient with placing the dose into the medicine receptacle or mouthpiece.

(g) ~~(f)~~ Keeping a record of when a patient receives assistance with self-administration under this section.

Section 7. Section 400.489, Florida Statutes, is created to read:

400.489 Administration of medication by a home health aide; staff training requirements.—

(1) A home health aide may administer oral, transdermal, ophthalmic, otic, rectal, inhaled, enteral, or topical prescription medications if the home health aide has been delegated such task by a registered nurse licensed under chapter 464; has satisfactorily completed an initial 6-hour training course approved by the agency; and has been found competent to administer medication to a patient in a safe and sanitary manner. The training, determination of competency, and initial and annual validations required in this section shall be conducted by a registered nurse licensed under chapter 464 or a

physician licensed under chapter 458 or chapter 459.

(2) A home health aide must annually and satisfactorily complete a 2-hour inservice training course in medication administration and medication error prevention approved by the agency. The inservice training course shall be in addition to the annual inservice training hours required by agency rules.

(3) The agency, in consultation with the Board of Nursing, shall establish by rule standards and procedures that a home health aide must follow when administering medication to a patient. Such rules must, at a minimum, address qualification requirements for trainers, requirements for labeling medication, documentation and recordkeeping, the storage and disposal of medication, instructions concerning the safe administration of medication, informed-consent requirements and records, and the training curriculum and validation procedures.

Section 8. Section 400.490, Florida Statutes, is created to read:

400.490 Nurse delegated tasks.—A certified nursing assistant or home health aide may perform any task delegated by a registered nurse as provided in chapter 464, including, but not limited to, medication administration.

Section 9. Section 400.52, Florida Statutes, is created to read:

400.52 Excellence in Home Health Program.—

(1) There is created within the agency the Excellence in

Home Health Program for the purpose of awarding home health agencies that meet the criteria specified in this section.

(2)(a) The agency shall adopt rules establishing criteria for the program which must include, at a minimum, meeting standards relating to:

1. Patient satisfaction.

2. Patients requiring emergency care for wound infections.

3. Patients admitted or readmitted to an acute care hospital.

4. Patient improvement in the activities of daily living.

5. Employee satisfaction.

6. Quality of employee training.

7. Employee retention rates.

(b) The agency must annually evaluate home health agencies seeking the award to apply on a form and in the manner designated by rule.

(3) The home health agency must:

(a) Be actively licensed and operating for at least 24 months to be eligible to apply for a program award. An award under the program is not transferrable to another license, except when the existing home health agency is being relicensed in the name of an entity related to the current licenseholder by common control or ownership, and there will be no change in the management, operation, or programs of the home health agency as a result of the relicensure.

(b) Have had no licensure denials, revocations, or any Class I, Class II, or uncorrected Class III deficiencies within the 24 months preceding the application for the program award.

(4) The award designation shall expire on the same date as the home health agency's license. A home health agency must reapply and be approved for the award designation to continue using the award designation in the manner authorized under subsection (5).

(5) A home health agency that is awarded under the program may use the designation in advertising and marketing. A home health agency may not use the award designation in any advertising or marketing if the home health agency:

(a) Has not been awarded the designation;

(b) Fails to renew the award upon expiration of the award designation;

(c) Has undergone a change in ownership that does not qualify for an exception under paragraph (3)(a); or

(d) Has been notified that it no longer meets the criteria for the award upon reapplication after expiration of the award designation.

(6) An application for an award designation under the program is not an application for licensure. A designation awarded by the agency under this section does not constitute final agency action subject to chapter 120.

Section 10. Section 408.064, Florida Statutes, is created

to read:

408.064 Home Care Services Registry.—

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

(a) "Home care services provider" means a home health agency licensed under part III of chapter 400 or a nurse registry licensed under part III of chapter 400.

(b) "Home care worker" means a home health aide as defined in s. 400.462 or a certified nursing assistant certified under part II of chapter 464.

(2) The agency shall develop and maintain a voluntary registry of home care workers. The agency shall display a link to the registry on its website homepage.

(3) The registry shall include, at a minimum:

(a) Each home care worker's full name, date of birth, social security number, and a full face, passport-type, color photograph of the home care worker. The home care worker's date of birth and social security number may not be publicly displayed on the website.

(b) Each home care worker's contact information, including but not limited to, his or her city, county, and phone number. If employed by a home care services provider, the home care worker may use the provider's contact information.

(c) Any other identifying information of the home care worker, as determined by the agency.

(d) The name of the state-approved training program

successfully completed by the home care worker and the date on which such training was completed.

(e) The number of years the home care worker has provided home health care services for compensation. The agency may automatically populate employment history as provided by current and previous employers of the home care worker. The agency must provide a method for a home care worker to correct inaccuracies and supplement the automatically populated employment history.

(f) For a certified nursing assistant, any disciplinary action taken or pending against the nursing assistant's certification by the Department of Health. The agency may enter into an agreement with the Department of Health to obtain disciplinary history.

(g) Whether the home care worker provides services to special populations and the identities of such populations.

(4) A health care worker must submit an application on a form adopted by the agency to be included in the registry. The agency shall develop a process by which a home health services provider may include its employees in the registry by providing the information listed in subsection (3).

(5) A home care worker who is not employed by a home care services provider must meet the background screening requirements under s. 408.809 and chapter 435 and the training requirements of part III of chapter 400 or part II of chapter 464, as applicable, which must be included in the registry.

(6) Each page of the registry website shall contain the following notice in at least 14-point boldfaced type:

NOTICE

The Home Care Services Registry provides limited information about home care workers. Information contained in the registry is provided by third parties. The Agency for Health Care Administration does not guarantee the accuracy of such third-party information and does not endorse any individual listed in the registry. In particular, the information in the registry may be outdated or the individuals listed in the registry may have lapsed certifications or may have been denied employment approval due to the results of a background screening. It is the responsibility of those accessing this registry to verify the credentials, suitability, and competency of any individual listed in the registry.

(7) The agency shall develop rules necessary to implement the requirements of this section.

Section 11. Section 408.822, Florida Statutes, is created to read:

408.822 Direct care workforce survey.—

(1) For purposes of this section, the term "direct care worker" means a certified nursing assistant, home health aide, personal care assistant, companion services or homemaker services provider, or other individuals who provide personal care as defined in s. 400.462 to individuals who are elderly, developmentally disabled, or chronically ill.

(2) Beginning January 1, 2021, each licensee that applies for licensure renewal as a nursing home facility licensed under part II of chapter 400; an assisted living facility licensed under part I of chapter 429; or a home health agency, nurse registry, or a companion services or homemaker services provider licensed under part III of chapter 400 must furnish the following information to the agency in a survey on the direct care workforce:

(a) The number of direct care workers employed by the licensee.

(b) The turnover and vacancy rates of direct care workers and contributing factors to the rates.

(c) Average employee wage for each category of direct care workers.

(d) Employment benefits for direct care workers and average cost to the employer and employee.

(e) Type and availability of training for direct care workers.

(3) An administrator or designee shall include the

information required in subsection (2) on a survey form developed by the agency in rule which must contain an attestation that the information provided is true and accurate to the best of his or her knowledge.

(4) The licensee must submit the completed survey prior to the agency issuing the license renewal.

(5) The agency shall continually analyze the results of the survey and publish the results on its website. The agency must update the information published on its website monthly. The analysis must include the:

(a) Number of direct workers in the state, including the number of full-time workers and the number of part-time workers.

(b) Turnover rate and causes of turnover.

(c) Vacancy rate.

(d) Average hourly wage.

(e) Benefits offered.

(f) Availability of post-employment training.

Section 12. Section 464.0156, Florida Statutes, is created to read:

464.0156 Delegation of duties.—

(1) A registered nurse may delegate a task to a certified nursing assistant certified under part II of this chapter or a home health aide as defined in s. 400.462, if the registered nurse determines that the certified nursing assistant or home health aide is competent to perform the task, the task is

delegable under federal law, and the task:

(a) Is within the nurse's scope of practice.

(b) Frequently recurs in the routine care of a patient or group of patients.

(c) Is performed according to an established sequence of steps.

(d) Involves little or no modification from one patient to another.

(e) May be performed with a predictable outcome.

(f) Does not inherently involve ongoing assessment, interpretation, or clinical judgement.

(g) Does not endanger a patient's life or well-being.

(2) A registered nurse may delegate to a certified nursing assistant or a home health aide the administration of medication of oral, transdermal, ophthalmic, otic, rectal, inhaled, enteral, or topical prescription medications if the certified nursing assistant or home health aide meets the requirements of s. 464.2035 or s. 400.489, respectively. A registered nurse may not delegate the administration of any controlled substance listed in Schedule II, Schedule III, or Schedule IV of s. 893.03 or 21 U.S.C. s. 812.

(3) The board, in consultation with the Agency for Health Care Administration, may adopt rules to implement this section.

Section 13. Paragraph (r) is added to subsection (1) of section 464.018, Florida Statutes, to read:

464.018 Disciplinary actions.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in ss. 456.072(2) and 464.0095:

(r) Delegating professional responsibilities to a person when the nurse delegating such responsibilities knows or has reason to know that such person is not qualified by training, experience, certification, or licensure to perform them.

Section 14. Section 464.2035, Florida Statutes, is created to read:

464.2035 Administration of medication.—

(1) A certified nursing assistant may administer oral, transdermal, ophthalmic, otic, rectal, inhaled, enteral, or topical prescription medication to a resident of a nursing home or a patient of a home health agency if the certified nursing assistant has been delegated such task by a registered nurse licensed under part I of this chapter, has satisfactorily completed an initial 6-hour training course approved by the board, and has been found competent to administer medication to a resident or patient in a safe and sanitary manner. The training, determination of competency, and initial and annual validations required in this section shall be conducted by a registered nurse licensed under this chapter or a physician licensed under chapter 458 or chapter 459.

(2) A certified nursing assistant must annually and

satisfactorily complete 2 hours of inservice training in medication administration and medication error prevention approved by the board, in consultation with the Agency for Health Care Administration. The inservice training is in addition to the annual inservice training hours required under this part.

(3) The board, in consultation with the Agency for Health Care Administration, shall establish by rule standards and procedures that a certified nursing assistant must follow when administering medication to a resident or patient. Such rules must, at a minimum, address qualification requirements for trainers, requirements for labeling medication, documentation and recordkeeping, the storage and disposal of medication, instructions concerning the safe administration of medication, informed-consent requirements and records, and the training curriculum and validation procedures.

Section 15. For the 2020-2021 fiscal year, four full-time equivalent positions with associated salary rate of 166,992 are authorized and the sums of $643,659 in recurring and $555,200 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 16. 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 Tomkow offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Paragraph (v) is added to subsection (1) of section 400.141, Florida Statutes, to read:

400.141 Administration and management of nursing home facilities.—

(1) Every licensed facility shall comply with all applicable standards and rules of the agency and shall:

(v) Be allowed to use paid feeding assistants in accordance with federal nursing home regulations, if the paid feeding assistant has successfully completed a feeding assistant training program meeting federal nursing home requirements and

approved by the agency. The feeding assistant training program must consist of a minimum of 12 hours of education.

Section 2. Paragraph (b) of subsection (3) of section 400.23, Florida Statutes, is amended to read:

400.23 Rules; evaluation and deficiencies; licensure status.—

(3)

(b) Paid feeding assistants and nonnursing staff providing eating assistance to residents shall not count toward compliance with minimum staffing standards.

Section 3. Subsection (15) of section 400.462, Florida Statutes, is amended to read:

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

(15) "Home health aide" means a person who is trained or qualified, as provided by rule, and who provides hands-on personal care, performs simple procedures as an extension of therapy or nursing services, assists in ambulation or exercises, or assists in administering medications as permitted in rule and for which the person has received training established by the agency under this part or performs tasks delegated to him or her pursuant to chapter 464 ~~s. 400.497(1)~~.

Section 4. Subsections (5) and (6) of section 400.464, Florida Statutes, are renumbered as subsections (6) and (7), respectively, present subsection (6) is amended, and a new subsection (5) is added to that section, to read:

400.464 Home health agencies to be licensed; expiration of license; exemptions; unlawful acts; penalties.—

(5) If a licensed home health agency authorizes a registered nurse to delegate tasks, including medication administration, to a certified nursing assistant pursuant to chapter 464 or a home health aide pursuant to s. 400.490, the licensed home health agency must ensure that such delegation meets the requirements of this chapter, chapter 464, and the rules adopted thereunder.

(7) ~~(6)~~ Any person, entity, or organization providing home health services which is exempt from licensure under subsection (6) ~~(5)~~ may voluntarily apply for a certificate of exemption from licensure under its exempt status with the agency on a form that specifies its name or names and addresses, a statement of the reasons why it is exempt from licensure as a home health agency, and other information deemed necessary by the agency. A certificate of exemption is valid for a period of not more than 2 years and is not transferable. The agency may charge an applicant $100 for a certificate of exemption or charge the actual cost of processing the certificate.

Section 5. Subsections (2) and (3) of section 400.488, Florida Statutes, are amended to read:

400.488 Assistance with self-administration of medication.—

(2) Patients 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 patient 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 patient or the patient's surrogate, guardian, or attorney in fact. For purposes of this section, self-administered medications include both 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, intermittent positive pressure breathing treatments, and nebulizer treatments.

(3) Assistance with self-administration of medication includes:

(a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored and bringing it to the patient.

(b) In the presence of the patient, confirming that the medication is intended for that patient, orally advising the patient of the medication name and purpose ~~reading the label~~,

opening the container, removing a prescribed amount of medication from the container, and closing the container.

(c) Placing an oral dosage in the patient's hand or placing the dosage in another container and helping the patient by lifting the container to his or her mouth.

(d) Applying topical medications, including routine preventive skin care and applying and replacing bandages for minor cuts and abrasions as provided by the agency in rule.

(e) Returning the medication container to proper storage.

(f) For intermittent positive pressure breathing treatments or nebulizer treatments, assisting with setting up and cleaning the device in the presence of the patient, confirming that the medication is intended for that patient, orally advising the patient of the medication name and purpose, opening the container, removing the prescribed amount for a single treatment dose from a properly labeled container, and assisting the patient with placing the dose into the medicine receptacle or mouthpiece.

(g) ~~(f)~~ Keeping a record of when a patient receives assistance with self-administration under this section.

Section 6. Section 400.489, Florida Statutes, is created to read:

400.489 Administration of medication by a home health aide; staff training requirements.—

(1) A home health aide may administer oral, transdermal, ophthalmic, otic, rectal, inhaled, enteral, or topical prescription medications if the home health aide has been delegated such task by a registered nurse licensed under chapter 464; has satisfactorily completed an initial 6-hour training course approved by the agency; and has been found competent to administer medication to a patient in a safe and sanitary manner. The training, determination of competency, and initial and annual validations required in this section shall be conducted by a registered nurse licensed under chapter 464 or a physician licensed under chapter 458 or chapter 459.

(2) A home health aide must annually and satisfactorily complete a 2-hour inservice training course in medication administration and medication error prevention approved by the agency. The inservice training course shall be in addition to the annual inservice training hours required by agency rules.

(3) The agency, in consultation with the Board of Nursing, shall establish by rule standards and procedures that a home health aide must follow when administering medication to a patient. Such rules must, at a minimum, address qualification requirements for trainers, requirements for labeling medication, documentation and recordkeeping, the storage and disposal of medication, instructions concerning the safe administration of medication, informed-consent requirements and records, and the training curriculum and validation procedures

Section 7. Section 400.490, Florida Statutes, is created to read:

400.490 Nurse delegated tasks.—A certified nursing assistant or home health aide may perform any task delegated by a registered nurse as provided in chapter 464, including, but not limited to, medication administration.

Section 8. Section 400.52, Florida Statutes, is created to read:

400.52 Excellence in Home Health Program.—

(1) There is created within the agency the Excellence in Home Health Program for the purpose of awarding home health agencies that meet the criteria specified in this section.

(2)(a) The agency shall adopt rules establishing criteria for the program which must include, at a minimum, meeting standards relating to:

1. Patient satisfaction.

2. Patients requiring emergency care for wound infections.

3. Patients admitted or readmitted to an acute care hospital.

4. Patient improvement in the activities of daily living.

5. Employee satisfaction.

6. Quality of employee training.

7. Employee retention rates.

8. High performance under federal Medicaid electronic visit verification requirements.

(b) The agency must annually evaluate home health agencies seeking the award which apply on a form and in the manner designated by rule.

(3) The home health agency must:

(a) Be actively licensed and operating for at least 24 months to be eligible to apply for a program award. An award under the program is not transferrable to another license, except when the existing home health agency is being relicensed in the name of an entity related to the current licenseholder by common control or ownership, and there will be no change in the management, operation, or programs of the home health agency as a result of the relicensure.

(b) Have had no licensure denials, revocations, or any Class I, Class II, or uncorrected Class III deficiencies within the 24 months preceding the application for the program award.

(4) The award designation shall expire on the same date as the home health agency's license. A home health agency must reapply and be approved for the award designation to continue using the award designation in the manner authorized under subsection (5).

(5) A home health agency that is awarded under the program may use the designation in advertising and marketing. A home health agency may not use the award designation in any advertising or marketing if the home health agency:

(a) Has not been awarded the designation;

(b) Fails to renew the award upon expiration of the award designation;

(c) Has undergone a change in ownership that does not qualify for an exception under paragraph (3)(a); or

(d) Has been notified that it no longer meets the criteria for the award upon reapplication after expiration of the award designation.

(6) An application for an award designation under the program is not an application for licensure. A designation award or denial by the agency under this section does not constitute final agency action subject to chapter 120.

Section 9. Section 408.064, Florida Statutes, is created to read:

408.064 Home Care Services Registry.—

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

(a) "Home care services provider" means a home health agency licensed under part III of chapter 400 or a nurse registry licensed under part III of chapter 400.

(b) "Home care worker" means a home health aide as defined in s. 400.462 or a certified nursing assistant certified under part II of chapter 464.

(2) The agency shall develop and maintain a voluntary registry of home care workers. The agency shall display a link to the registry on its website homepage.

(3) The registry shall include, at a minimum:

(a) Each home care worker's full name, date of birth, social security number, and a full face, passport-type, color photograph of the home care worker. The home care worker's date of birth and social security number may not be publicly displayed on the website.

(b) Each home care worker's preferred contact information. If employed by a home care services provider, the home care worker may use the provider's contact information.

(c) Any other identifying information of the home care worker, as determined by the agency.

(d) The name of the state-approved training program successfully completed by the home care worker and the date on which such training was completed.

(e) The number of years the home care worker has provided home health care services for compensation. The agency may automatically populate employment history as provided by current and previous employers of the home care worker. The agency must provide a method for a home care worker to correct inaccuracies and supplement the automatically populated employment history.

(f) For a certified nursing assistant, any disciplinary action taken or pending against the nursing assistant's certification by the Department of Health. The agency may enter into an agreement with the Department of Health to obtain disciplinary history.

(g) Whether the home care worker provides services to special populations and the identities of such populations.

(4) A home care worker must submit an application on a form adopted by the agency to be included in the registry. The agency shall develop a process by which a home care services provider may include its employees in the registry by providing the information listed in subsection (3).

(5) A home care worker who is not employed by a home care services provider must meet the background screening requirements under s. 408.809 and chapter 435 and the training requirements of part III of chapter 400 or part II of chapter 464, as applicable, which must be included in the registry.

(6) Each page of the registry website shall contain the following notice in at least 14-point boldfaced type:

NOTICE

The Home Care Services Registry provides limited information about home care workers. Information contained in the registry is provided by third parties. The Agency for Health Care Administration does not guarantee the accuracy of such third-party information and does not endorse any individual listed in the registry. In particular, the information in the registry may be outdated or the individuals listed in

the registry may have lapsed certifications or may have been denied employment approval due to the results of a background screening. It is the responsibility of those accessing this registry to verify the credentials, suitability, and competency of any individual listed in the registry.

(7) The agency shall develop rules necessary to implement the requirements of this section.

Section 10. Section 408.822, Florida Statutes, is created to read:

408.822 Direct care workforce survey.—

(1) For purposes of this section, the term "direct care worker" means a certified nursing assistant, home health aide, personal care assistant, companion services or homemaker services provider, paid feeding assistant, or other individuals who provide personal care as defined in s. 400.462 to individuals who are elderly, developmentally disabled, or chronically ill.

(2) Beginning January 1, 2021, each licensee that applies for licensure renewal as a nursing home facility licensed under part II of chapter 400; an assisted living facility licensed under part I of chapter 429; or a home health agency, nurse registry, or a companion services or homemaker services provider licensed under part III of chapter 400 must furnish the

following information to the agency in a survey on the direct care workforce:

(a) The number of registered nurses, licensed practical nurses, and direct care workers employed the licensee.

(b) The turnover and vacancy rates of registered nurses, licensed practical nurses, and direct care workers and contributing factors to the rates.

(c) Average wage for registered nurses, licensed practical nurses, and each category of direct care workers.

(d) Employment benefits for direct care workers or contractors and average cost to the employer and employee.

(e) Type and availability of training for registered nurses, licensed practical nurses, and direct care workers.

(3) An administrator or designee shall include the information required in subsection (2) on a survey form developed by the agency in rule which must contain an attestation that the information provided is true and accurate to the best of his or her knowledge.

(4) The licensee must submit the completed survey at such time designated by the agency in rule. The agency may not issue a license renewal until the licensee submits a completed survey.

(5) The agency shall continually analyze the results of the survey and publish the results on its website. The agency must update the information published on its website monthly. The analysis must include the:

(a) Number of direct workers in the state, including the number of full-time workers and the number of part-time workers.

(b) Turnover rate and causes of turnover.

(c) Vacancy rate.

(d) Average hourly wage.

(e) Benefits offered.

(f) Availability of post-employment training.

Section 11. Section 464.0156, Florida Statutes, is created to read:

464.0156 Delegation of duties.—

(1) A registered nurse may delegate a task to a certified nursing assistant certified under part II of this chapter or a home health aide as defined in s. 400.462, if the registered nurse determines that the certified nursing assistant or home health aide is competent to perform the task, the task is delegable under federal law, and the task:

(a) Is within the nurse's scope of practice.

(b) Frequently recurs in the routine care of a patient or group of patients.

(c) Is performed according to an established sequence of steps.

(d) Involves little or no modification from one patient to another.

(e) May be performed with a predictable outcome.

(f) Does not inherently involve ongoing assessment, interpretation, or clinical judgement.

(g) Does not endanger a patient's life or well-being.

(2) A registered nurse may delegate to a certified nursing assistant or a home health aide the administration of medication of oral, transdermal, ophthalmic, otic, rectal, inhaled, enteral, or topical prescription medications to a patient of a home health agency if the certified nursing assistant or home health aide meets the requirements of s. 464.2035 or s. 400.489, respectively. A registered nurse may not delegate the administration of any controlled substance listed in Schedule II, Schedule III, or Schedule IV of s. 893.03 or 21 U.S.C. s. 812.

(3) The board, in consultation with the Agency for Health Care Administration, shall adopt rules to implement this section.

Section 12. Paragraph (r) is added to subsection (1) of section 464.018, Florida Statutes, to read:

464.018 Disciplinary actions.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in ss. 456.072(2) and 464.0095:

(r) Delegating professional responsibilities to a person when the nurse delegating such responsibilities knows or has

reason to know that such person is not qualified by training, experience, certification, or licensure to perform them.

Section 13. Section 464.2035, Florida Statutes, is created to read:

464.2035 Administration of medication.—

(1) A certified nursing assistant may administer oral, transdermal, ophthalmic, otic, rectal, inhaled, enteral, or topical prescription medication to a patient of a home health agency if the certified nursing assistant has been delegated such task by a registered nurse licensed under part I of this chapter, has satisfactorily completed an initial 6-hour training course approved by the board, and has been found competent to administer medication to a patient in a safe and sanitary manner. The training, determination of competency, and initial and annual validations required in this section shall be conducted by a registered nurse licensed under this chapter or a physician licensed under chapter 458 or chapter 459.

(2) A certified nursing assistant must annually and satisfactorily complete 2 hours of inservice training in medication administration and medication error prevention approved by the board, in consultation with the Agency for Health Care Administration. The inservice training is in addition to the annual inservice training hours required under this part.

(3) The board, in consultation with the Agency for Health Care Administration, shall establish by rule standards and procedures that a certified nursing assistant must follow when administering medication to a patient of a home health agency. Such rules must, at a minimum, address qualification requirements for trainers, requirements for labeling medication, documentation and recordkeeping, the storage and disposal of medication, instructions concerning the safe administration of medication, informed-consent requirements and records, and the training curriculum and validation procedures.

Section 14. For the 2020-2021 fiscal year, four full-time equivalent positions with associated salary rate of 166,992 are authorized and the sums of $643,659 in recurring and $555,200 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 15. This act shall take effect upon becoming a law.

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

Remove lines 3-10 and insert:
400.141, F.S.; authorizing a nursing home facility to use paid feeding assistants in accordance with federal law under certain circumstances; amending s. 400.23, F.S.; prohibiting paid

feeding assistants from counting toward compliance with minimum staffing standards;